THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 25 / OCTOBER 2023

midwives

ONE IN FIVE
A ROADMAP FOR PERINATAL MENTAL HEALTH CARE

LEADING THE CHARGE
FINDING THE RESEARCH PRIORITIES OF THE FUTURE

MORE THAN NUMBERS
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OCTOBER 2023

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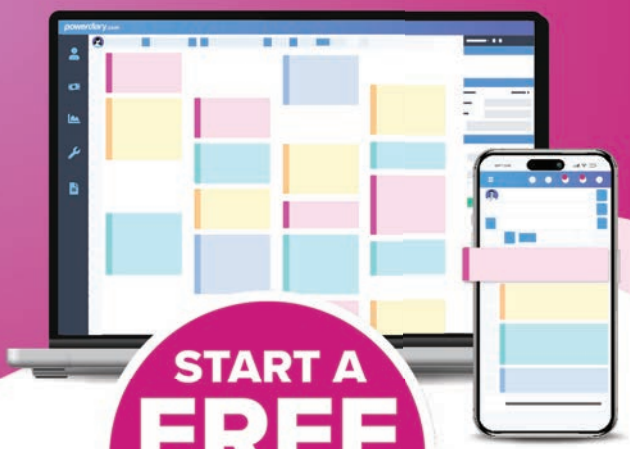

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RCM CEO Gill Walton says now is the time to use our influence for political action

Welcome

When we are busy, as midwives and maternity support workers (MSWs) so often are, we often miss what's going on around us. Except, working in maternity services or midwifery education, what's going on around us has such an incredible impact on our working lives.

Even the most cursory look at the news is enough to tell us that there's a general election in the offing. It may be 12 months away or it may be this year, but it's definitely coming. The positioning and policy announcements from politicians of every stripe that are starting to come thick and fast are a clear indication of that. And, while the RCM is not affiliated with any political party, we constantly have our ear to the ground to find out what may be in store for our members.

Every day we seek to influence those policies

We don't just sit and wait, though. Every day, on your behalf, we seek to influence those policies and shape them so they make sense for midwifery. It can be a slow and frustrating process – especially when you find yourself having the same discussion over and over, with no sign of any shift. But midwives and MSWs are nothing if not patient. And sometimes – often, in fact – that patience pays off.

Take the NHS Long Term Workforce Plan for England, for example. We worked hard for years talking about the need to focus on retention, not just recruitment, for more flexible working and for better career progression. All of that now appears in the Workforce Plan – and now we have to hold them to it!

Publications such as our *State of Maternity Services* reports, which we've produced for each of the home nations this year, our *State of Midwifery Education* report and, of course, our perinatal mental health roadmap set out in the clearest of terms what we want and need from politicians. And we know that midwifery leaders are also using them to persuade their Boards and Trusts to invest more into services.

Anyone who has heard me speak will know that I am always solutions-focused. Yes, we all like a grumble, but what we really want is change. We have to decide what change we want to see and we have to be prepared to fight for it. That's not about shouting the odds – it's about demonstrating that we have the best ideas and that we are partners in making it happen.

midwives

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Caring for you

Research

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The longer read

Communication corner

External submission

Employment advice

Refresher

Talking point

Voice of a father

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Women's health strategy

Women in England are being asked to respond to a reproductive health survey covering periods, contraception, fertility, pregnancy and menopause. This is in order to help shape the UK Government's women's reproductive health strategy.

Last year, nearly 100,000 women took part in a consultation that led to the Government's 10-year Women's Health Strategy. Many highlighted doctors' ignorance of women's health issues and having to advocate for themselves just to get a diagnosis.

The minister for women's health Maria Caulfield noted her shock: "There are deep-seated, systemic issues we must address to ensure women receive the same standards of care as men, universally and by default." Alongside women's health ambassador Professor Dame Lesley Regan, she's encouraging every woman aged 16-55 to take part in this new survey to build a picture of the reproductive health services they need.

The women's reproductive health survey opened on 7 September and will stay open for six weeks. Take part at **bit.ly/DHSC-survey**

READ
The Infertile Midwife by Sophie Martin, published by Hardie Grant
Read more on p14.

one to watch

SHARE
The COVID-19 inquiry is asking for as many people as possible to share their experiences of the pandemic. Share yours at **bit.ly/COVID19-stories**

IMAGES: ISTOCK / SHUTTERSTOCK / QUADRILLE

Report results

MBRRACE-UK report

The latest MBRRACE-UK Report has shown a concerning rise in stillbirths, particularly among global majority babies. Black babies are more than twice as likely as white babies to be stillborn.

The report showed there were 2,473 stillbirths in 2021, compared with 2,292 stillbirths in 2020. MBRRACE-UK's perinatal lead Professor Elizabeth Draper believes that the rise is a direct result of the stress of the COVID-19 pandemic – the changes to services, fear of going into hospitals and the virus itself have all taken a toll. Though the pandemic has clearly had an effect, she notes that the widening ethnic disparity demands further investigation.

Birte Harlev-Lam, RCM's executive director midwife, said: "We should not forget that behind these statistics there are women and families who have experienced loss and the huge impact that has. What is clear from this report is that we need to address health inequalities and improve care for Black women and those living in the most deprived areas and their babies."

For more on pregnancy and baby loss, see page 14.

Race and health

Outdated tests

Sheffield Hallam University, commissioned by the Race and Health Observatory, has found that neonatal tests involving assessments of the baby's skin tone, heart rate, reflexes, muscle tone and breathing within a few minutes of birth give misleading results for global majority babies.

The review found that some guidance on a healthy newborn's skin tone still referred to terms such as pink, blue and pale, with no reference to equivalent descriptions for global majority skin types. The report concluded that standard neonatal assessments such as these were putting babies' lives at risk.

Read more on page 37.

RIGHT TO STRIKE

The annual meeting of the Trades Union Congress (TUC) in September passed a resolution of a 'strategy of non-compliance' with the Government's so-called 'anti-strike' legislation.

The legislation allows public sector employers to issue a 'work notice' in advance of industrial action to establish 'minimum service levels' on strike days. Employees named in the work notice have to work, even if they are supporting the strike, and can be fired if they fail to do so.

The resolution states: "We have no choice but to build mass opposition to the minimum service levels laws, up to and including a strategy of non-compliance and non-cooperation to make them unworkable, including industrial action." The motion calls for a "special congress" to be held "to explore options for non-compliance and resistance".

Government response

Kirkup response

The Government's full response to Dr Bill Kirkup's inquiry into maternity services at East Kent Hospitals University NHS Foundation Trust was finally published this summer. It has committed to a new oversight group – chaired by the minister for women's health – overseeing maternity services nationwide, and it has appointed Dr Kirkup to lead work with healthcare partners. He will be leading on two of the key recommendations to improve teamwork in maternity and neonatal services.

Gill Walton, RCM chief executive, said: "This response has been a long time coming. What is important now, though, is that all of us with a stake in maternity services – policy-makers, clinical staff and the women and families in our care – work together to make sure quality and safety are paramount.

"Women and their families deserve and should expect to be cared for in services that are safe, adequately staffed and properly resourced. The RCM is fully committed to making maternity services better, not just for those accessing them but those working within them too."

In this respect, the RCM is collaborating closely with the Royal College of Obstetricians and Gynaecologists and many other organisations to support midwives, maternity support workers (MSWs) and other maternity staff to deliver the safest possible care, such as the Avoiding Brain Injury in Childbirth programme, Tommy's National Centre for Maternity Improvement and Each Baby Counts projects.

DHSC response

Pregnancy loss review response

The Department of Health and Social Care (DHSC) responded to the Independent Pregnancy Loss Review, led by Zoe Clark-Coates and Samantha Collinge, with a commitment to implement each of the recommendations. The RCM welcomed the report and the Government's response, particularly the recommendation for better counselling and perinatal mental health provision for those who have experienced loss.

Birte Harlev-Lam, RCM executive director midwife, said: "There are some excellent examples of bereavement support across the country, but perinatal mental health is too often the poor relation in maternity services. Better support, including following pregnancy loss, could have a hugely positive impact on women and families, but sadly it is often sacrificed because of a lack of funding and staff shortages."

See P14 for more

MIDIRS Digest

1 Research and midwifery – reflecting on how they are joined, Donna Jones

2 Review of the effectiveness of pay and reward and its impact on midwifery staff retention – a single centre qualitative study, Stella Nwogu

3 The impact of the Pregnancy Sickness Support training session on the knowledge and attitudes of student midwives towards hyperemesis gravidarum: an evaluative research project, Gillian Knight, Caitlin Dean

4 The importance of pain histories for latent phase labour, Carol J Clark, Vanessa Bartholomew, Dominique Mylod, Vanora A Hundley

The above papers are published in MIDIRS Digest. Access them at **midirs.org**

Some *Evidence Based Midwifery* papers are reprinted in MIDIRS Digest. Visit **bit.ly/RCM-EBMjournal**

midirs

Waiting times

Perinatal mental health

An analysis by *The Guardian* has shown that waiting times for perinatal mental health care have increased. From August 2022 to March 2023, the number of women waiting rose by 40%, and more than 30,000 women who are pregnant or have newly given birth are on waiting lists for mental health support, according to NHS England data.

The article notes that a freedom of information request made by Labour to NHS England seeking the longest waiting times in the last five years shockingly showed one woman had waited 319 days from referral to first contact.

Karen Middleton, head of policy at the Maternal Mental Health Alliance, was "sadly unsurprised" at the rise in demand, saying there were too many areas across the entire UK unable to meet basic standards.

The RCM has long been calling for a strategy and funding to be established to support mental health needs in maternity. One in five women will experience mental health issues during pregnancy and up to a year after birth, ranging from anxiety and depression to more significant illness. Furthermore, suicide remains one of the leading causes of death in new mothers up to the first year after giving birth.

Birte Harlev-Lam OBE, RCM's executive director midwife, said: "Mental ill health ranks with physical factors as one of the leading causes of maternal deaths in the UK, and yet this is not reflected in the resources allocated to it, whether in terms of staffing or other support.

"Midwives need time to care and there needs to be more midwives to share the workload. We estimate that fewer than 350 additional specialist perinatal mental health midwives could bring about the results that we all want to see – and that women deserve."
Read the RCM *Strengthening perinatal mental health* roadmap at **bit.ly/RCM-perinatalMH**

What's on?

OCTOBER
Black History Month

9-15 OCT
Baby Loss Awareness Week

10 OCT
World Mental Health Day

18 OCT
World Menopause Day

2 NOV
National Stress Awareness Day

16 NOV
Joint RCM/INMO All Ireland Annual Midwifery Conference & Exhibition **bit.ly/RCM-INMO-conference**

24 NOV
MSW Celebration Day

25 NOV
White Ribbon Day #ChangeTheStory on violence for women and girls **bit.ly/WhiteRibbonDay-2023**

25 NOV TO 10 DEC
16 Days of Activism against Gender-Based Violence

Working for you

Here's some of what the RCM has been doing on behalf of its members this month

State of Maternity Services, Wales

RCM's *State of Maternity Services in Wales* report shows that, although the number of midwives in Wales remains virtually the same now as it was in 2016, the number of experienced midwives (those aged 46-55) working in maternity services has declined.

Julie Richards, RCM director for Wales, said: "Despite more people using midwifery services and the steady increase in more complicated pregnancies, the actual number of midwives hasn't risen over the past five years. This is bound to impact on the quality of care. Let's be clear – services are currently coping only because of the superhuman efforts of their staff. In Wales, we have seen a worrying decline in the number of experienced midwives. When these midwives leave, they take their knowledge and experience, needed to help train the next generation of midwives, with them."

The report also outlines growing numbers of women with additional health needs. Nearly 30% of women report having a mental health condition during their pregnancy. Nearly 30% of women were recorded as obese at their initial assessment, and a similar number are overweight. Such conditions require more focus and care from maternity staff, which, in turn, places additional burdens on workforce planning.

Julie added: "There needs to be a comprehensive plan by the Welsh Government to recruit and train more midwives and retain the current ones already in the workforce."

STATE OF MATERNITY SERVICES, ENGLAND

The RCM's "stark and sobering" assessment of the state of England's maternity services came hot on the heels of the NHS Long Term Workforce Plan. Staffing shortages and more complex needs (including rising levels of obesity in pregnancy and increases in the number of older women having babies) are increasing demands on maternity services, says the report. Midwifery staffing levels have not kept pace with demands, and this is hitting the quality and safety of care.

If the number of NHS midwives in England had risen at the same pace as the overall health service workforce since the last general election, there would be no midwife shortage. Indeed, there would be 3,100 more midwives in the NHS, rather than having a shortfall of 2,500 full-time midwives. Since the last election, the midwifery workforce rose by an average of fewer than 100 per year – not enough to put a dent in the ongoing shortage. Retention is a key element of the NHS' plan. This can be supported through initiatives such as more flexible working and tackling poor workplace cultures, says the RCM.

Birte Harlev-Lam, executive director midwife at the RCM, said: "This report lays out the challenges facing midwives and their colleagues and what needs to be done to turn this situation around. The NHS workforce plan is a start. Women and maternity staff deserve nothing less than total commitment from the Government."

IMAGES: ISTOCK / SHUTTERSTOCK

Annual accounts
The RCM Annual Report and Accounts have been published and are available to view at **rcm.org.uk**

RCM Board elections
The RCM welcomes seven new midwives and maternity support workers (MSWs) to the Board following the elections in June:

- Shani Woodbridge
- Yana Richens
- Melissa Davis
- Barbara Kuypers
- Declan Symington
- Cherylene Dougan
- Angharad Oyler.

Three existing Board members – Sarah Jones, Dee Davies and Keelie Barrett – have been re-elected. They join existing members Benedicta Agbagwara-Osuji and Nerys Kirtley.

The RCM Board is responsible for the overall direction and control of the RCM. This includes ensuring that the RCM is efficient, effective, properly managed, supervised and accountable. The Board provides long-term vision, sets strategic goals and objectives and protects the reputation and values of the RCM. The Board also ensures legal and regulatory requirements are met. **Visit bit.ly/RCM-board**

STAY UP TO DATE
Contact the RCM on 0300 303 0444, email *enquiries@rcm.org.uk* or update your details via the My RCM portal

RCM in brief

Get involved

Want to help shape your RCM?

The RCM is running a series of listening groups in October and November to hear what members want to see and hear from their professional association and trade union. Taking place across the country, the sessions are targeted at those members we rarely hear from – the silent majority.

Jo Tanner, the RCM's director of communication and engagement, said: "Everything we do is driven by our members, which is why we want to hear directly from you about what we do well and what we can do better. Our activists and networks give us great insight, but I know there are plenty of members who aren't part of these groups. You're who we want to hear from."

The sessions will be face-to-face in city centre locations and take two to three hours. Travel expenses will be covered and there will be refreshments. If you've been randomly selected, you'll receive an email from us. Simply reply to indicate your interest.

Care and support

Investing in mental health

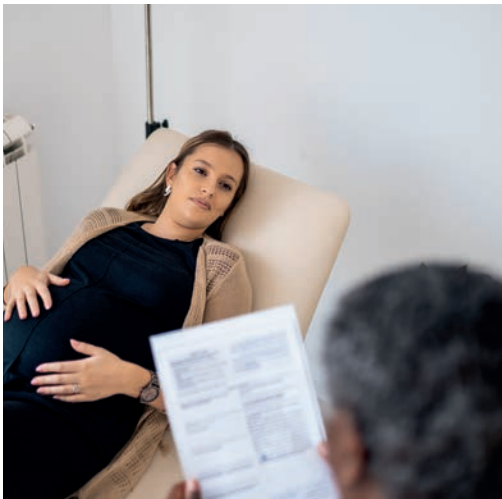
The RCM has published a new 'roadmap' to improve perinatal mental health care in the UK (see page 54). It highlights how very few of the women who died as a result of poor perinatal mental health actually received a formal mental health diagnosis, despite reported symptoms.

The RCM also demonstrates the irrefutable economic and social case for more mental health resources. When mental ill-health remains undiagnosed and untreated, there is a financial burden to the state – roughly £8.1bn each year. Investing in perinatal mental health and training would be a fraction of that cost. The key changes the RCM is calling for include:

* All professionals working with women in the perinatal period to have the necessary knowledge and understanding of perinatal mental health
* Every maternity service to have a minimum whole-time equivalent Band 7 perinatal specialist midwife
* All maternity professionals to be equally concerned with mental as well as physical health in pregnancy, childbirth and postnatal period.

Birte Harlev-Lam OBE, RCM's executive director midwife, said: "Quite simply, midwives need time to care and there needs to be more midwives to share the workload. We are not asking for the moon; we estimate that fewer than 350 additional specialist perinatal mental health midwives could bring about the results that we all want to see – and that women deserve."

New in ilearn: Perinatal mental health (study time 1 hr)



Vaccination

RSV immunisation

The UK Health Security Agency (UKHSA) is commencing a vaccination and immunisation programme for respiratory syncytial virus (RSV) and is asking for RCM members to help by taking a short survey to hear their views on providing the vaccine/immunisation to women and babies.

RSV is a leading cause of infant mortality in the UK and accounts for approximately 33,500 NHS hospitalisations annually in children under five. Major developments in infant monoclonal antibody preparations means it is suitable for all infants and in maternal vaccines from around 28 weeks gestation.

The Joint Committee on Vaccination and Immunisation (JCVI) has been considering the evidence on efficacy, safety and duration of protection for neonatal RSV immunisation and maternal vaccination because a program is likely. Read more at **bit.ly/DHSC-JCVIadvice**

Take the survey by scanning this **QR code**.

Fundraising

10K your way

October is Cavell's 10k, the biggest fundraising event of the year for nurses and midwives currently facing personal or financial hardship. Cavell asks you to run, swim or cycle 10k, or get creative. You could walk 10,000 steps, or read or sing for 10,000 seconds – whatever you fancy, it's 10k your way.

For more information on how to take part visit **bit.ly/Cavell-10k**

For more on the work of Cavell supporting those in financial difficulty, visit **bit.ly/RCM-Cavell**

Government support

NHS England workforce plan

NHS England's long-awaited Long Term Workforce Plan focuses on many of the areas the RCM has long been lobbying for, including the expansion of apprenticeships for midwifery and greater investment in the retention of existing midwives.

Gill Walton, RCM chief executive, said: "We are pleased to see the challenges in maternity services being addressed, particularly the need for sustainable growth in the midwifery workforce. However – and sadly there has to be this caveat – unless those routes into midwifery are properly funded and those MSW roles are backfilled to allow apprentices to work and study, the scheme is doomed to fail."

RCM WALES INCLUSIVE MATERNITY NETWORK

RCM Wales launched an inclusive network to engage with global majority RCM members and prospective members working as midwives or MSWs in Wales. It plans to meet three times a year to provide a safe space for individuals to share experiences of their working lives and gain support, information and advice from group members and speakers. The next meetings will be on 6 October 2023 and 4 January 2024. Register your interest by emailing **pri.patel@rcm.org.uk**

Don't miss RCM St David's Day conference on 1 March 2024 – check the website for details.

WHAT'S ON

1 OCT STUC Black Workers' Conference

5 OCT Wales Inclusive Network

10 OCT 10k your Way, with Cavell

30 OCT STUC Women's Conference

2 NOV Scottish Health Awards

16 NOV RCM/INMO Conference

21 NOV RCM Student Conference

24 NOV MSW Day

Pay and conditions

Action in Northern Ireland

Midwives and MSWs across Northern Ireland took to the picket lines in September in frustration at the ongoing political stalemate.

Karen Murray, RCM director of Northern Ireland, said: "Six months ago we paused strike action in good faith because we were invited by the secretary of state to meet to discuss HSC pay. In those six months, all that's happened is that midwives and MSWs have become the lowest paid in the UK and their frustration with politicians has reached an all-time high. Women and families deserve better than to have their care treated like a political football. None of us wanted to be on picket lines, but what choice did we have?"

Despite pay settlements being reached in England, Wales and Scotland, there is no such agreement in Northern Ireland. The RCM hopes the demonstration of the deep sense of anger among midwives and MSWs will bring politicians back around the negotiating table. The RCM worked with the five Trusts in Northern Ireland to ensure that care continued throughout the industrial action.

"You saw a lot of frustration on the picket lines and a lot of sorrow and genuine despair at where we find ourselves. We are fighting for safety and fairness. The safety of our maternity services is reliant on midwives and MSWs, but if we don't pay them fairly, they will leave. It's as simple and as stark as that – and we're already seeing it happen. Politicians can stem that tide, and they need to do it now."

Conference

Student midwives conference 2023

DATE: 21 November 2023
LOCATION: Doncaster Racecourse, Bawtry Road, Doncaster, DN2 6BB

Students attending the RCM's first conference for student midwives will hear from a range of speakers, including updates from the chief midwifery officers for England, Scotland and Wales and the NMC's Dr Jacqui Williams. Dr Monica Doyle will discuss civility in practice, Alicia Walker will discuss managing feelings of trauma in practice, Caitlin Wilson will present on preceptorship, RCM student-award winner Rachel Brackpool will discuss how to thrive as a student, Professor Hora Soltani will talk on the care of refugees and asylum seekers and Emilie Edwards will explore neurodivergence in education.

In addition, there will be presentations on research and writing for publication and best practice, as well as opportunities to get involved with the student midwife forum (SMF) and boost professional networks.

For the full programme and to book a place, visit bit.ly/RCM-studentcon

ILLUSTRATION: LOU KISS

hope conquers all

Pregnancy loss, infertility, miscarriage, bereavement... do you really know what the person sitting in front of you at the antenatal appointment has been through to get there?

For Sophie Martin it's only been a few weeks since the publication of her book *The Infertile Midwife: In Search of Motherhood - a Memoir*. It is a deeply personal account of her struggle to have a baby. The journey has taken her through difficult times and profound trauma; in 2019, she and her husband James endured the loss of their twin sons Cecil and Wilfred, born at 21 weeks. There has also been great joy with the birth of their son Percy just over two years ago. Throughout it all, as she grappled with infertility, bereavement and round after gruelling round of IVF, Sophie continued to work as a midwife in a busy London hospital.

"For midwives, when a woman in front of you is 36 weeks pregnant, for example, you can almost forget about the emotional journey they've had to get there. But, for a lot of women – and I would count myself among them – going through a pregnancy after infertility and loss was the hardest thing I have ever done in my life. The mental and emotional output required was monumental, and I had no understanding of that before it happened to me." She says she made "all the mistakes myself in the past, because everybody does until you know better". Although they are lessons she might rather never have learned, they have given her great insight into the sensitive care those with IVF and baby loss experiences might need.

"As a midwife, you don't doubt that a baby will be born living – as a profession we tend to be positive, always hoping and expecting a good outcome. But the woman might feel no certainty whatsoever. It is so important to acknowledge their very real fear that their baby won't go home

with them. When I was pregnant with Percy, my babies dying was 100% of my experience at that time," she says.

The emotional complexity doesn't end with birthing a healthy baby either, adds Sophie. "I felt a huge tidal wave of grief after Percy was born because it made me understand even more clearly everything I would never have with the twins; the first time I bathed him was really emotional because I knew I would never bathe Cecil and Wilfred.

"In the postnatal period, while there is elation and relief that the baby is okay, it doesn't wipe the slate clean. It actually took a really long time for me to stop thinking that Percy would die. I panicked about sudden infant death syndrome (SIDS) and worried that someone would take him away from me – irrational things – but, given my experience, they didn't feel irrational to me."

There is also the issue of a partner's experience of infertility and loss not being seen or acknowledged, which compounds the pressure and grief the couple are experiencing. "There is a huge chasm in care for men and partners in our maternity system," says Sophie. "I remember when we had the twins, James was handed a Sands pamphlet about support for partners – and that was it. And when I was pregnant again after that loss, not only did he have his own anxiety and stress, but he also had to look after me because I was struggling. Even now I'm not sure how, as a service aimed at women, we can manage that better."

Understanding IVF

The journey to pregnancy through infertility and IVF is often arduous and fraught. Sophie points out that many need extra support, "especially, and I count myself among them, long-term 'IVF-ers' who have had multiple rounds to get there".

The process can be gruelling, explains Sophie. "Especially during the stimulation phase, which is when you're trying to get the follicles to mature. There are daily injections, screens and bloods, or every other day in some clinics, until the follicles are big enough to produce eggs. Then collection is most likely done under sedation when a small catheter is used to suck out the egg.

"Then there are more injections, more tablets and pessaries, and always a lot of waiting – waiting to see if anything is maturing, if anything is ready for transfer, if anything has embedded. And of course there is everything you've done to get to that point – multiple tests, maybe a laparoscopy and so many vaginal scans.

"There are the mood swings from the hormones, you can be really sore from repeated injections, you can get very bloated. I had a colleague congratulate me once thinking I was pregnant when it was really bloating from the IVF. You can get headaches, nausea – it's endless, really.

"A lot of the time you will stay on the medications until 12 weeks of pregnancy. Weaning off them can be really hard emotionally and psychologically because, while there is no need for them medically, you feel like that's what's keeping you pregnant."

Even just entering IVF, you're grieving for the loss of a normal, natural way to have a baby

As midwives always do a mental health assessment at booking, Sophie suggests infertility and IVF should be considered as a risk factor and a reason to keep a closer eye on them. Unfortunately, she believes that midwifery training currently leaves most midwives poorly equipped to have these conversations: "First and foremost, IVF should be included in training for student midwives. It should be part of the curriculum and they should spend time in a fertility clinic, even for a week – they could learn so much in that time. How on earth are midwives supposed to understand the process if they've never seen it?"

Five years of trying

Ruth and her partner Ed had been trying naturally for two years without success before starting three rounds of IVF with the NHS. "I was sent for tests: scans, dye in fallopian tubes to check for blockages, internal ultrasounds. I had one where they blew a balloon up in my uterus and it was so painful I screamed. They are done one at a time and you often have to wait ages for the results, all the time thinking the worst. As each test comes back normal, you realise that you've been pinning everything on each one being the reason why it's not working. Even just entering IVF, you're grieving for the loss of a normal, natural way to have a baby," she says.

Ruth had friends who had been going through IVF without success, so knew it wasn't an easy fix. "I knew the stats, why they give you three rounds – because statistically you won't be successful on the first one. And I knew each round was a huge ordeal."

IVF involves different injections in different places with different techniques; some are ready-mixed, while

some involve drawing liquid from a vial to mix with powder in accordance with an individual's protocol. The cycle involves a 'shutdown' of the body's natural hormone cycle, then weeks of 'stimulation' with synthetic hormone injections. Then there is a 'trigger' injection to release eggs, to be delivered accurately to the minute, so they can be collected. They are looking for as many eggs as possible because after fertilisation "it is like *The Hunger Games* for embryos – each day they call you to say some didn't make it". On day five you hope to have a healthy embryo to implant.

"I was told early on that my womb lining was a little thin – it was a throwaway comment, but I obsessed about it being the cause of the problem. When they told me mine had cleared the minimum they look for, I was so overjoyed I cried in the nurse's room and she was a little taken aback that I was so emotional," says Ruth.

After the transfer, there's a two-week wait before you can do a pregnancy test. "Each time, BFN – big fat negative," says Ruth. "You build yourself up and when it doesn't work there's incredible grief.

"For me, having a baby wasn't a 'nice to have' – it's the only thing I knew I wanted in my life, to be a mum. During the process, I found it hard to hear people complain about the lack of sleep as parents – I wasn't sleeping because I was anxious that I would never be a mother, but that's not acknowledged. I know we were both depressed at points – Ed's normally so carefree, so it was hard to see him like that."

The mountain ahead

Ruth and Ed went for private IVF, underwent more tests, including sperm DNA fragmentation and PGT-A embryo testing, and took even more medication than before. "At one point I had 30 alarms going off on my phone in 24 hours for different injections, pills, pessaries, patches and supplements," she says.

"Suddenly, there was a BFP – big fat positive. We told friends and family and were really excited. I was pregnant for a few weeks and then miscarried on Mother's Day. We were devastated – it was my first positive pregnancy test in four years of trying. I felt we'd at least got a step further."

The only thing they'd not tried yet was immunology. Ruth has vitiligo, an autoimmune condition that causes patches of skin to lose pigment or colour. "I'd heard it can affect fertility and I remember asking a consultant early on if it could be a factor. He looked at me like I was crazy. But I did my research and followed TTC – trying to conceive – communities on Instagram and reproductive immunology communities on Facebook. I read *Is Your Body Baby Friendly?* by Alan Beer. Using immune therapy for unexplained infertility is not well known and it's not well regulated or evidenced, but the success stories are persuasive. It's practised more in the US – in the UK, there are only a handful of clinics that offer it to varying degrees."

Testing showed Ruth had a very aggressive immune system. She spent six months in the lead-up to her next embryo transfer on "crazy immunology treatments". These included injections of white blood cells extracted from Ed's blood. This is thought to increase tolerance to the partner's cells, helping the immune system to accept a pregnancy. Equally controversially, she continued the treatments throughout pregnancy "because I'd seen so many horror stories of late pregnancy loss from when it was stopped.

"The embryo was transferred on Bonfire Night, the stars aligned and the pregnancy test was BFP!" says Ruth. From that point, Ruth's pregnancy was back in the care of the NHS. "When I went for my first

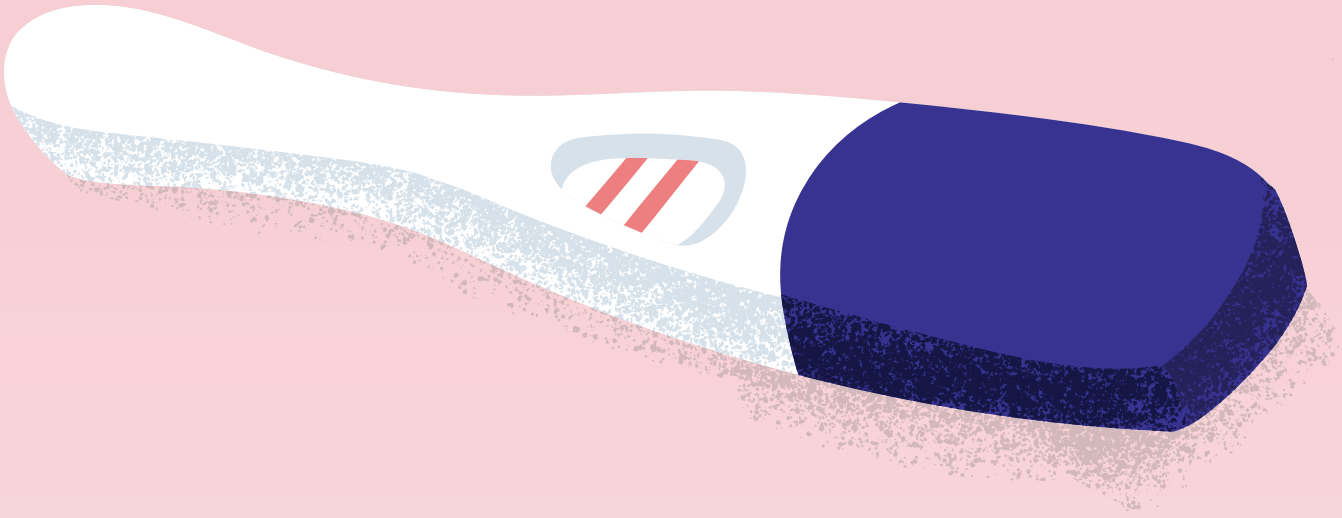


IMAGE: SHUTTERSTOCK

midwife appointment they asked if I was on any medications. I said, 'Oh yes' and showed them a list of all the different medications and dosages. They were flabbergasted – they'd never even come across some of them."

Despite her history of IVF and her age of 39, she was deemed not high risk, something that "miffed" her as she was relying on the extra scans for reassurance. "It didn't sink in and become real until 20 weeks" she says. She is now a proud and grateful mum to Stella.

Pregnancy loss

Every year in the UK, an estimated 250,000 pregnancies end through miscarriage, making it the most common complication of pregnancy, experienced by an estimated one in five women. There are also around 11,000 hospital admissions each year for losses due to ectopic pregnancies, 19,000 admissions for molar pregnancies and, in 2021, around 3,300 women made the difficult decision to terminate a much-wanted pregnancy for medical reasons.

Pre-24-week pregnancy loss can be extremely isolating and significantly impact the emotional and psychological wellbeing of women and their families. This is something that bereavement lead midwife Samantha Collinge and Zoe Clark-Coates, founder of The Mariposa Trust (sayinggoodbye.org), know all too well. In 2018, they were appointed by the secretary of state for health to lead the Independent Pregnancy Loss Review, the first Government review into the care and support provided to all people who lose babies prior to 24 weeks gestation.

Leading the review involved listening to women's often harrowing experiences and trying to put them into a workable UK-wide strategy for best practice. It must have been hard not to feel overwhelmed hearing accounts of women being made to wait in public spaces bleeding through their clothing, or women who had miscarried at home being

ILLUSTRATION: LOU KISS

advised to retrieve their baby's remains from the toilet and store them in a plastic tub in the fridge, sometimes for days, until their local early pregnancy loss unit was open.

"It was challenging," says Zoe, "but as a grief specialist, I've heard countless similar stories of people let down by healthcare and support services. This review allowed me to voice the experiences of thousands of bereaved families. It was wonderful to know their bravery in sharing would change things for so many others.

"We started by asking, 'What does great care look like? How can we change this experience for everyone?'"

"Healthcare professionals too," says Samantha, "are working with loss on a daily basis and vulnerable to 'burn out'. During the review process, we met many who have taken this on, even though it's not in their remit, because there aren't the services in place. Some admitted they've had little or no bereavement training, and aren't given the hours, resources or space to do it. One bereavement midwife was doing incredible work but her office was a cupboard."

It was wonderful to know that bereaved families' bravery in sharing would change things for so many others

BECCA'S STORY

Becca and her partner's son Max was born with Dyskeratosis Congenita, a rare genetic condition for which Becca was a carrier. "I had no idea. No one else in my family is a carrier – it came out of nowhere," she says.

After Max's death, Becca got pregnant again naturally but as the baby was shown to have the condition, the couple sadly had to terminate the pregnancy. "It was an awful choice, but we couldn't bring another baby into the world knowing what they would suffer. We chose to go through IVF because it was the only way to test embryos beforehand."

They underwent IVF through the NHS, which included pre-implantation genetic testing (PGD). "Your cycles are monitored – there are loads of injections, morning and evening, and you're shown how to inject yourself. I reacted to the treatment, everything from skin rashes to swelling. I kept a journal of it all. It was awful but like most people going through IVF, you'd do the injections a 100 times over if you know you're going to get the result you want."

At the egg collection, Becca remembers "the woman next to me was told they'd got 18 eggs and she was really disappointed. So in my head it needed to be more. You can imagine how I felt when they said they'd got eight. Of these, only three fertilised and then only one made it. I was told, 'It's a girl and it's a carrier.'"

It's such a rare disease that no one really knows much about it. "As a carrier I've not experienced any significant health problems, but I couldn't be certain that would be her experience. I spoke to Max's consultant, who said there was only one known case of a carrier not making it into adulthood, so we took the decision to implant the healthy embryo.

"The pregnancy was straightforward, though I had to have extra scans and Rhesus injections. I rarely saw the same midwife at each appointment so I had to go through everything over and over again. Often, I'd be asked why I had IVF and I'd have to explain. It was hard to have to go through the loss and grief again, especially when so few people know what Dyskeratosis Congenita is. I also felt under a lot of pressure – I didn't want to feel like I was failing everyone. Thankfully my daughter Summer has made it all worthwhile. She's on the database now so that others can learn more about Dyskeratosis Congenita."

Pregnancy Loss Review

The scale of issues saw a submitted report with 73 recommendations. Of the 73, many are so straightforward that it is shocking they aren't already in place – such as a meeting with a consultant as standard practice to discuss why the pregnancy loss occurred, what the implications are for future pregnancies and specialist care for any future pregnancies. Zoe points to women's health inequity as the reason. "It's not a priority, and services and research are not linked up. Miscarriage is seen as a medical complication rather than a bereavement, so there's no wraparound care.

"You have this horrible hamster wheel of women miscarrying in areas where the Early Pregnancy Assessment Unit (EPAU) isn't open 24 hours. A call to 111 will send them to A&E as a clinical incident. Here they'll have to wait to be seen in an environment that isn't sensitive to the emotional trauma they're experiencing. Since it's not seen as a bereavement, very few women we spoke to had had any offer of emotional support or mental health screening, and this was even less in the case of their partners."

The recommendations fit broadly into three areas: providing better information to families, not least who to call in an emergency; the pooling of the services that are available to join up care, especially in an emergency; and better training of medical staff. The Government has accepted all the recommendations – prioritising 20 based on what infrastructure is in place that can support their immediate implementation – but with a promise to implement all as part of a long-term strategy. Both Samantha and Zoe are delighted.

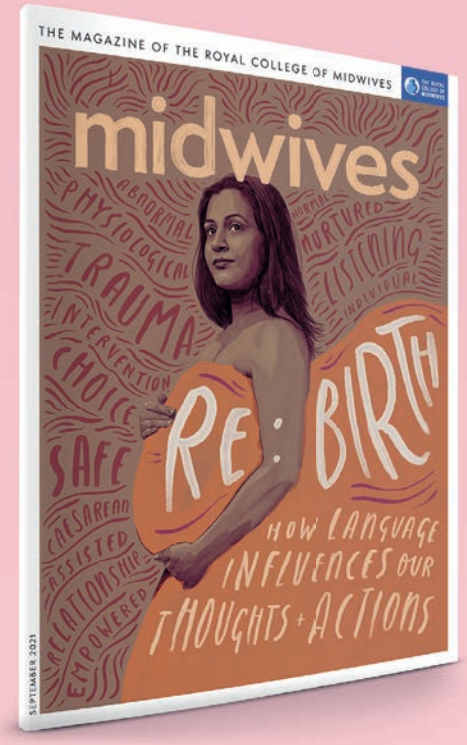
Some immediate changes include the production of a CCC kit (compassionate clinical care kit), which includes a container to collect and store baby remains, plus a baby-loss lanyard so health professionals are aware of the current or previous loss. Another is a certificate of baby loss, available to anyone who requests it after experiencing a loss pre-24 weeks gestation. It is backdate-able with no cut-off point so people with a historic loss may also access this official recognition (Baroness Floella Benjamin has been championing the Certificate of Loss Bill through the House of Lords). Zoe, who has herself experienced the loss of five babies in pregnancy, says: "You're often told that it's just one of those things, and the only evidence is a positive pregnancy test. It's not enough – it's not recognition of that life or the hopes you had for it.

"This certificate shows your baby existed, to the medical profession as much as families. It validates the experience of loss and bereavement. It also means being able to talk about it, so grief doesn't have to be hidden. There's a 'rule' in maternity to not tell friends and family until the 12-week mark because it's accepted that [the baby] could die – why is that acceptable? It also means that grief takes place in private too. Many women with historic miscarriages have never spoken about the baby they lost – they've been left feeling as though it didn't exist. The certificate gives dignity to the loss of a life." If the 12-week rule reinforces the idea that if the death happens before 12 weeks it somehow doesn't count, then how does that make someone feel who's been through hell just to get to that point?

Language and improved care

Despite the rigours of IVF and the trauma of bereavement, Sophie never stopped wanting to work with women and babies. She explains: "IVF impacts every single aspect of your life and I felt like I couldn't have another thing ruined for me. I love being a midwife and I just wanted to be able to go to work and do a really good job. Focusing on what I was doing and caring for the person in front of me felt like a relief."

That said, Sophie is concerned that there is no structural support or formal training in place. "I'm a Band 7 team leader, and I've never been offered training around how to support someone going through



The Re:Birth project featured in the September 2021 issue of *Midwives*

IVF or baby loss, especially in the context of being a midwife and still having to go to work in a difficult and triggering environment. When you are sitting on both sides of it – the professional and the personal - that is such a rich source of knowledge. There is a great opportunity there for us to learn and improve our practice."

Another aspect of her care that Sophie has reflected on over the years is language, especially the language used around women's bodies. "We talk about failure to progress, failed inductions, incompetent cervix, failed IVF, a failed cycle and being a 'poor responder' to fertility medications.

"We would never describe a man as having an 'incompetent penis' if he had erectile dysfunction – why are we describing women's cervixes as 'incompetent'? With a man, a body part is seen as not functioning – but for a woman, her entire existence is a failure.

"One term that really gets me is 'late miscarriage,' which is the medical term for what I had, but I don't at all associate it with my experience. It's like saying I'm so rubbish that I couldn't even have my dead babies on time – I find that really offensive. For me a 'second trimester loss' feels more appropriate."

In 2021, the RCM did a significant body of work around the language that's used in maternity, how it can inadvertently convey negativity to service users and how it affects attitudes and behaviours of maternity professionals. The Re:Birth project is about making sure that the language is inclusive and supportive, and makes everyone feel safe. In 2022, it was revisited to include advice such as acknowledging if the woman has had a previous birth or a previous bereavement.

Sophie agrees that healthcare professionals risk causing pain by using language thoughtlessly, and not recognising the layers of cultural meaning and personal associations with certain words. "It can be the simplest thing,' she says, "for example, I found it really challenging when people referred to my son Percy as my first child or called me a 'primip' as I'd been through labour and given birth to two babies, Cecil and Wilfred. To be described as a first-time mum was incredibly hard.

"I also had an experience with a health visitor who kept calling me 'Mum' when I was pregnant with Percy – firstly, I thought she should have used my name, but also I was so very anxious at that point that he wasn't going to live and that I was never going to bring a living child home. Even though I felt like a mum to Cecil and Wilfred, I wasn't a mum in a practical sense and the word really triggered me."

Getting it right isn't easy, she acknowledges. Not least because if you're meeting a new person every time, you can't expect them to confide all their fears and experiences to you.

Perhaps the strongest piece of advice is not to make any assumptions about the person in front of you at the antenatal appointment. Understand that pregnancy is an intensely personal journey and you have no idea what they've been through to get there. Perhaps you could just start by asking them.

MORE INFO

Find out more about the **RCM Re:Birth project** at **bit.ly/RCM-ReBirth22**

Find out more about the work of The Mariposa Trust, which supports parents bereaved in early pregnancy, at **mariposatrust.org**

Read the Independent Pregnancy Loss Review at **bit.ly/GOV-pregnancyloss**

IMAGE: SHUTTERSTOCK

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*Aimed at supporting midwifery leaders and midwives to implement recommendations laid out in the Ockenden Review to improve the quality of care they are delivering for women and their babies

COMMUNICATION CORNER

How do I... process trauma?

Things don't always go as expected, so how do you process tragedy and continue to work, giving the best care to those in your charge?

Salford University's Sarah Davies and Dr Liz Coldridge's paper *"Am I too emotional for this job?" An exploration of student midwives' experiences of coping with traumatic events in the labour ward* explored how student midwives felt and acted in response to trauma at work. It offers some insight into how all professionals can better process trauma.

It's good to talk

Students in the study reported the need to talk about distressing events, especially with peers, but felt they couldn't find anywhere they felt was a 'safe space' to do so. One student in the study noted that the only place they saw peers was during breaktime in the staffroom but noted that as midwives and maternity support workers (MSWs) were present too, they felt under pressure to not speak honestly about how they were feeling.

"The culture in midwifery of soldiering on in silence was reinforced by a fear that speaking out about distress would render the student vulnerable to being labelled as inadequate or difficult," says the report. Another student talked about the need for a safe space in hospitals to sit and talk with other students, a space to reflect on and process their anxieties and painful experiences.

Obviously, the study focused on students who are being assessed so may well have felt under undue scrutiny, but the telling thing here is the idea that the culture in midwifery is of 'soldiering on in silence', which compounds the problem.

The truth is that talking is the best way to process trauma. If not the staffroom, then a place that is private, where you can speak to a colleague in confidence, let your guard down and say out loud what is going through your mind. It isn't something that can wait either, it needs to be done at the time so that the trauma isn't taken home or, in fact, taken to the next person in your care.

Don't suppress empathy

"Silence may have also represented a profession uneasy with thinking the unthinkable, that midwives may 'fail' and that not all births are [straightforward]," says the report. "Students described some midwives as mechanical, cold or emotionally shut down and struggled to understand how they could carry on in their role. Some saw this demeanour as a response to trauma, as an attempt to erect buffers against the pain and distress generated by intimacy with women. 'Keep it inside, move on to the next person because you can't have what happened impact on somebody else but … if you do that and you keep everything inside and hold it all for yourself and try and deal with it all yourself, it's not a healthy way of being'," says one student.

IMAGE: GETTY

It's an important point – the very word 'midwife' means 'with woman' – and it is the empathetic connection with a woman going through a life-changing event that makes midwifery so special. If, due to trauma, you are detaching from those in your care then you won't feel as fulfilled in your role and you won't be able to give the kind of care that you want to give.

It's important to understand that a traumatic event doesn't mean you have 'failed' and that the only thing that will make it less traumatic for both you and the woman in your care is to show empathy. By supporting her as best you can, you are being 'with woman' and it will help you to process the events later knowing you did everything you could. Empathy is your strength.

Reflective practice

It is a fine line though, between too much and too little. The study notes: "Students often articulated an ideal vision of midwifery that emphasised a commitment to be a companion in a caring contract as part of a transformative journey... They often elected to be with women in labour after their shifts were over. Being physically present and psychologically receptive for long periods promoted attachment and empathic availability to women but also may have created unconscious identifications with them that were hard to manage. In this sense, a capacity to separate psychologically from the mothers in their care was often lessened."

As a student, experiencing midwifery for the first time, understanding the parameters of the role is part of the learning journey. However, as an experienced midwife or MSW, the same principle applies. If you don't take breaks or interludes where you can withdraw from events to gather yourself or reflect, you'll be unable to put things in perspective. It's vital you take time to reflect on both the good and bad events of the shift: how it made you feel, how you reacted to the situation and the woman in

your care, to help you to see it as part of the whole remit of maternity.

Normalising emotional responses

The study makes it clear that in your role you must juggle conflicting emotions while you train and hope for a good outcome. You also have to be "able to contemplate the horror of things going wrong for a mother and baby". It's important to normalise this and the inevitable anxieties that you face in practice, where this is always a possibility.

In fact, the report states: "Awareness of the fact that not all labours end with an optimal outcome and that the emotional expectations associated with normal birth are not always fulfilled. Midwives need to retain an openness to and honour the possibility of loss in order that they are able to emotionally contain mothers in these situations." It describes this as being able to "appreciate the psychological unknowability of the moment".

For many, this may sound out of your comfort zone, but ultimately it means that accepting and even being comfortable with these ever-present anxieties doesn't mean not caring. Quite the opposite – and it means you'll be more resilient and better able to process trauma.

Coldridge and Davies' study showed that when students experienced care and understanding from colleagues, they were more able to continue to face unexpected events in practice. "They were deeply appreciative of those individuals who held them unjudgmentally or who tutored them into an understanding of the difficulties they encountered in labour. It highlighted the important role of colleagues' capacities to validate and normalise their emotional responses."

The study suggests that to deal with trauma, it's vital that you:

- Talk to a colleague or peer in private, where you feel safe to say what you feel
- Not shut off emotionally: empathy and kindness will give you strength
- Use reflective practice
- Consider the events of your shift, both good and bad, to help put them in perspective
- Understand that the possibility of a poor outcome is ever present and that the trauma and stress following a poor outcome are normal emotional responses and nothing to feel ashamed of.

IMAGE: SHUTTERSTOCK

"Midwives need to retain an openness to and honour the possibility of loss"

MORE INFO

Read *"Am I too emotional for this job?" An exploration of student midwives' experiences of coping with traumatic events in the labour ward* at **bit.ly/Midwifery-emotional**

Back to basics

Slimming World's registered nutritionist, **Alex Clark**, advises how you can prepare quick and nutritious work-friendly meals that don't need heating and can be eaten while you're out and about

No two days are ever the same as a midwife and it can be difficult to plan your meals ahead of an unpredictable shift. Even more so if you are a community midwife or working in a geographically challenging area – you may spend a lot of time in your car with no access to a microwave or kettle.

Alex says: "Grabbing a bite to eat in the form of a high-fat, salt or sugar snack may feel like just what you need in the moment, but it's unlikely to have the nutritional value to keep you feeling on top form for the remainder of your shift. What's better are nutritious meals full of flavour that you can prepare in advance and that will keep you going until you clock off.

"There's nothing wrong with snacking between your meals to get through your busy shift and it's handy to identify which snacks leave you feeling more sluggish than refreshed. By choosing well-balanced, filling meals with healthy, energy-boosting snacks, you're on track to getting to the end of the day feeling motivated and vitalised.

"Slimming World's Food Optimising healthy eating plan is packed full of filling foods that you can eat freely to satisfy your appetite. There are plenty of delicious, nutritious meals quick and easy to prepare that can be eaten when you're not at home. And if you are looking to find a snack that fits in with the needs of your busy day, our Free Foods list has more than 350 foods you can have without counting, weighing or measuring, including healthy snacks you can enjoy while managing your weight."

Why not give these recipes a try?

MINTED AUBERGINE, COURGETTE AND COUSCOUS SALAD

Serves 4
Ready in 25 minutes

- Low-calorie cooking spray
- 1 thin aubergine, sliced into 1cm rounds
- 1 courgette, sliced into 1cm rounds
- 150g dried couscous
- 300ml hot vegetable stock
- 200g cherry tomatoes, halved
- 25g bottled roasted red peppers in brine, roughly chopped
- A large handful of fresh mint leaves, roughly chopped
- Juice of 1 lemon
- Juice of 1 orange

Spray a griddle with low-calorie cooking spray, season the aubergine and courgette slices and fry over a high heat for 5 minutes on each side or until browned and softened. Alternatively, season the aubergine and courgette, spray with low-calorie cooking spray and cook on a baking sheet under a hot grill for 12-15 minutes, turning and spraying with more low-calorie cooking spray halfway through.

Meanwhile, put the couscous in a large bowl. Pour in the hot stock, cover and leave to stand for 10 minutes.

Fluff up the couscous with a fork. Stir in the aubergine, courgette, cherry tomatoes, peppers and mint. Drizzle over the lemon and orange juice and season to taste.

Cool, cover and chill until you're ready to eat.

CRUSTLESS RED ONION AND COURGETTE QUICHE

Serves 4
Ready in 1 hour, plus standing

- 2 courgettes
- Low-calorie cooking spray
- 2 red onions, halved and finely sliced
- 1 red chilli, deseeded and finely chopped
- 100g low-fat natural cottage cheese
- 6 large eggs
- 1 tsp dried mixed herbs
- A small handful of finely chopped fresh mint

Preheat the oven to 180˚C/fan 160˚C/gas 4.

Coarsely grate the courgettes and place in a large sieve. Press down to remove as much liquid as possible and set aside.

Lightly spray a 20cm round, shallow baking dish with low-calorie cooking spray and set aside.

Spray a large frying pan with low-calorie cooking spray and place over a medium heat. Add the onions, courgettes and chilli and stir-fry for 10 minutes. Season to taste and transfer to the prepared baking dish, spreading evenly across the base. Spread the cottage cheese over the vegetable mixture.

Beat the eggs in a large bowl, season and add the dried mixed herbs and mint. Pour the egg mixture over the cottage cheese.

Place in the oven and cook for 30 minutes or until set and golden. Remove from the oven and allow to rest for about 15 minutes before cutting into wedges. Serve with salad.

BEEF AND CREAMY BEETROOT COLESLAW SANDWICH

Makes 1
Ready in 10 minutes

- ½ small, cooked beetroot, peeled and coarsely grated
- 4 tbsp fat-free natural Greek yogurt
- 1 tbsp finely chopped red onion
- ½ apple, peeled, cored, and coarsely grated
- A handful of rocket leaves
- 2 slices of wholemeal bread (from a 400g loaf)
- 2 thick slices of lean roast beef, all visible fat removed
- Mixed salad, to serve

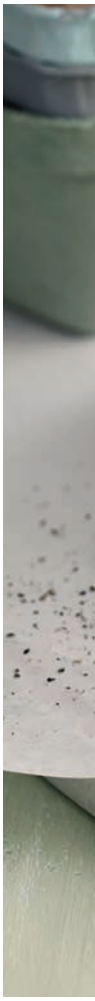
Make a coleslaw by mixing together the beetroot, yogurt, onion and apple.

Season to taste and mix well.

Place the rocket leaves on one slice of the bread and top with the beef.

Spread the beetroot coleslaw over the beef and sandwich with another slice of the bread.

Serve with the salad.



NAKED CHICKEN BURRITO JAR

Serves 2
Ready in 35 minutes

- 140g dried rice
- 1 small red onion, halved and thinly sliced
- 2 medium skinless and boneless chicken breasts, cut into short, thin strips
- 1 red pepper, deseeded and thinly sliced
- ½ tsp hot smoked paprika
- ½ tsp ground cumin
- Low-calorie cooking spray
- 150g can borlotti beans, drained and rinsed
- A few lettuce leaves, shredded
- 100g can sweetcorn kernels, drained
- 1 tomato, diced
- 2 spring onions, sliced
- 40g pickled jalapeño chillies, drained and roughly chopped
- 4 tsp lime juice, plus slices to serve
- 2 tbsp chopped fresh coriander, plus a few sprigs
- 4 heaped tbsp fat-free natural Greek yogurt

Cook the rice according to the pack instructions, then drain and spread it out on a plate to cool quickly. While the rice is cooling, toss the onion, chicken, red pepper, paprika, cumin and a little seasoning in a bowl and stir well.

Spray a frying pan with low-calorie cooking spray and place over a high heat. Sizzle the chicken mixture for 4-5 minutes or until the chicken is cooked through. Set aside to cool.

Divide the rice between 2 x 500ml clip-top jars, then add layers of the beans, lettuce and the chicken mixture. Press it all down lightly, then add the sweetcorn, tomato, spring onions and pickled chillies and drizzle with the lime juice. Add coriander sprigs and lime slices and seal the jar.

Mix the yogurt with the chopped coriander and a pinch of salt and divide between two sealable pots. Cover and chill until you're ready to eat.

Tip: This is just as delicious with brown rice, which will give you an extra fibre boost for filling power.

All recipes are taken from Slimming World's collection. Recipes are based on Slimming World's Food Optimising plan and the liberating concept of Free Food – food that is naturally lower in energy density (calories per gram) and most satiating, so you stay fuller for longer. To find out more about Slimming World and how to join, visit slimmingworld.co.uk or slimmingworld.ie, or call 0344 897 8000 or 01 656 9696.

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Leading the charge

The RCM is embarking on a project to establish the research priorities for midwifery and maternity services. Research advisors Dr Judith Field and Jenny Cunningham explain how members can help to shape research for the future by getting involved

When you think about all the elements of being a midwife, you may not think of research, but the RCM wants to change that. It intends to influence the future of research by establishing the top 10 research priorities for midwifery and maternity care – and needs your help to do this.

Identifying the priorities for midwifery research means that the RCM can highlight the important areas for research that would mean better care for women, babies and families. This project has not been done before and the RCM is thrilled to be leading it.

It is not only clinical midwifery care that the priorities hope to address – the project also plans to identify what the priorities for research might be for midwifery education and workforce wellbeing. In fact, any topic that is part of the midwifery sphere of practice will form part of the project.

For that reason, the RCM is calling on everyone in maternity to get involved, including maternity support workers (MSWs) who are key members of maternity staff and make a vital contribution to

IMAGE: SHUTTERSTOCK

the safe care of women and babies. Their perspective on about how care could be improved will be incredibly valuable.

Funding gaps

To illustrate the lack of funding for maternity research, a report in 2020 found that for every £1 spent on pregnancy care in the UK, only around a penny is spent on research. This compares unfavourably with other, better funded, areas of health, such as stroke (3p for every £1), dementia (6p for every £1), heart disease (7p for every £1) and cancer (12p for every £1). The RCM plans to influence organisations that fund research, such as the National Institute for Health and Social Care Research (NIHR), to secure vital funding for maternity research.

Midwives have also been recognised as an under-represented profession in healthcare research and the RCM is working with others to change this. The project will demonstrate the important role that midwives and MSWs can play in improving care for women and their families, as well as influence policy-makers so they understand where the gaps are and if their policies have a strong enough evidence base.

What does the project involve?

The RCM is working with the James Lind Alliance (JLA) to find the top 10 priorities for midwifery and maternity research. The JLA's work is to identify and prioritise unanswered questions or evidence uncertainties with healthcare professionals and those they care for. For the RCM project, this means midwives, student midwives, MSWs and women. We will work together to build a consensus of what the priorities will be and follow the JLA method to do this.

Inclusion and diversity are the basic principle of this project and we want it to reach as wide a spread of people as possible. The RCM is working with its equality, diversity and inclusion lead and using its networks across the UK to reach as many people as possible from different backgrounds. Members are

key to this and the RCM has built a team for the project see above:

As research advisors, we are the co-leads of the project and are being supported in this work by Dr Sara Webb, RCM head of research and information, and Dr Yana Richens, senior research leader, appointed by the NIHR.

The project has a review group of three eminent professors of midwifery to guide and ensure academic rigour: Professor Helen Cheyne from the University of Stirling, Professor Vanora Hundley from Bournemouth University and Professor Julia Sanders from Cardiff University.

There is a steering group from all four UK countries to bring different experiences of midwifery, research, leadership, education and the user experience of maternity care. The RCM team is thrilled to have such a strong group of individuals who will work together throughout the length of the project.

Finally, project partners are organisations that can share the project with their members and staff. If you are involved with an organisation, midwifery body or service user organisation and are interested in becoming a project partner, please contact us.

This is not a quick fix, and the project will take a full year to gather the priorities, followed by focused time for the report writing. We anticipate the final report will be published in May 2025.

How can you get involved?

To find out where the gaps in evidence are, the RCM will be circulating two surveys. The first will be short, inviting you to give your thoughts about evidence uncertainties. The second will be a list of priorities that will have been gathered from responses of the first survey. You will be asked to prioritise the list in the second survey, to be reviewed again. The last stage is an in-person workshop where the final top 10 list will be confirmed. The project will be inviting people to take part in the workshop nearer the time.

The RCM will be gathering responses from as many midwives, student midwives and MSWs as possible, as well as the views of women and pregnant people on what is important to them and where they think the gaps in evidence are. We want you to influence the future of research by taking part.

You can get involved by responding to the short survey that will be released in January 2024. This is for all midwives, student midwives and MSWs, in every sphere of practice. You do not need to have had experience of research to complete the survey. It will simply ask where you think there is an evidence gap – or what you see are the areas of importance. Your answer can be as specific (how do student midwives prefer to be taught anatomy and physiology?) or as general (how can we retain clinical midwives?) as you like.

Please share the details of the project with work colleagues, friends and family. The RCM will be producing posters for maternity units, GP surgeries, community noticeboards, supermarkets and child nurseries to reach midwives, student midwives, MSWs and women and their families. The RCM will include information on the project in member and activist newsletters and use social media to spread the word.

The end result

The RCM will produce a report at the end of the project and use this to champion the priorities. Members will be asked to raise awareness of the priority list that they helped determine. The RCM will be evaluating the success of the project in different ways – for instance, how many NIHR-funded research studies are aligned to the priorities and how many midwives are using the top 10 when they apply for personal awards.

Above all, the RCM wants to influence those who invest money in research and ensure that midwifery and maternity has its fair share. Locally, nationally and internationally, the RCM wants to see more midwives and MSWs leading research.

TO TAKE PART...

Please collaborate in this exciting project. If you have any questions or comments, contact **researchpriorities@rcm.org.uk**

IMAGE: SHUTTERSTOCK

Raising awareness

Candace Imison, deputy director of dissemination and knowledge mobilisation at the National Institute for Health and Care Research (NIHR), explains how research can support improvements to maternity services

At NIHR Evidence, we summarise complex research papers and put them in context for professionals with little time on their hands in order to help improve clinical practice. Recently, we drew together evidence that could drive improvements in maternity care. We looked at areas including teamwork and compassion when a baby dies and cultural sensitivity.

Teamwork is vital

In the NHS Staff Survey, only half those responding said that teams within their organisation worked well together. Similarly, only half felt that team disagreements were dealt with constructively. Two-fifths said their team did not meet to discuss their effectiveness. These challenges to teamwork threaten the quality of maternity care.

Teamwork, in which members value each other's skills and competences, is fundamental to high-performing maternity organisations. Disruptive or bullying behaviours need to be managed effectively; while open discussion and reference to shared goals can help to settle disagreements. A review of teamwork in maternity services concluded that effective interventions:

- Enable all team members to have a voice in improvement
- Encourage honest feedback
- Allow comparison within and between teams (benchmarking)
- Include different types of teams, such as those which manage safety/risk or work cross-boundaries
- Build in managerial support.

Kind and compassionate

Kind and compassionate care is core to maternity services. A named midwife will build trusting relationships that contribute to improving clinical outcomes and women's experiences.

Parents whose child has died have an intense need for kindness and compassion in maternity services and can benefit from high-quality bereavement care. NIHR research found that almost one in three women who

IMAGE: GETTY IMAGES

experience early pregnancy loss develop post-traumatic stress disorder.

The National Bereavement Care Pathway helps professionals support families to cope with different types of loss. Mothers particularly valued a recommendation in the pathway to make memories with their critically ill child, for example, washing or clothing them. This finding was echoed in an NIHR study which examined the experiences of mothers whose newborn babies were dying. Women expressed their intense need for physical contact with their baby, which was sometimes difficult due to delicate skin or feeding tubes.

Effective communication in bereavement care was highlighted in a study of parents who had lost a baby. When people were told they were 'losing a baby' rather than 'having a miscarriage', they were more prepared for what was to come. Careful choice of words helped validate their loss.

One case in the study noted how the midwife's care that was sensitive to bereavement was really appreciated, especially the offer to take pictures. "They said 'You will appreciate these pictures. Not now, not tomorrow, but in the future.' And they're right.'"

Support for fathers is often overlooked in bereavement care; most research has focused on the experiences of women. In an investigation into the experiences of parents who had lost a child, one mother said: "A father's loss isn't understood… it's rather like a primer applied to a wall, which eventually is painted over."

Culturally sensitive care

A national review of ethnic disparities in maternal deaths found that some clinicians thought Black British women had a lower pain threshold than white women. Women who did not speak English had their agitation attributed to mental health problems, rather than distress. Improved understanding of different cultures would allow clinicians to appreciate women's needs, and to provide personalised care.

The RCM has done a lot of work in this area and released the Decolonising Midiwifery toolkit to help maternity professionals to be aware of and challenge these deep-rooted 'colonial' attitudes in healthcare.

A report from the charity Birthrights (2022) recommended cultural awareness training to increase clinicians' awareness of their own biases and how they impact care.

The importance of research

Evidence from NIHR-funded studies and other sources can help maternity services address key areas of good maternity care. In addition to the evidence, there is much to be learnt from service users' complaints and safety incidents. The hospital Board or Trust also has a role in supporting a culture of continuous improvement. Together, management and staff can provide a firm foundation for high-quality maternity care based on research findings.

FURTHER READING

National Bereavement Care Pathway: **nbcpathway.org.uk**

Review of ethnic disparities in maternal deaths: **bit.ly/ethnic-disparities-review**

RCM Decolonising Midwifery toolkit: **bit.ly/RCM-decolonising-midwifery**

NIHR evidence report: **bit.ly/NIHR-evidence-report**

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Think again

The NHS Race and Health Observatory report has yet again highlighted the problem of racial bias and inequality in maternal and neonatal healthcare; it calls on maternity to reconsider its assessment methods

Compared with white women, Black women in the UK are almost four times more likely to die in pregnancy, childbirth and up to a year postnatally, while South Asian women are 1.8 times and mixed race women 1.3 times more likely to die. This is partly due to working practices and assessments that discriminate against global majority women and their new babies, researchers say. The Apgar score, for example, which is widely used around the world to assess newborns' heart rate, muscle tone and other signs to see if extra medical care is needed, was developed in 1952 by mostly observing white babies.

"The Apgar score is still a valid tool, but it does not give guidance if the baby is Black, brown or of mixed ethnicities," says Professor Jacqueline Dunkley-Bent, chief midwife at the International Confederation of Midwives and co-chair of the NHS Race and Health Observatory's maternity advisory group.

Historically, there has not been much evidence examining whether current guidance for assessing a baby's condition after birth is suitable for global majority babies.

"We have not made much progress for the health outcomes of Black and brown women and babies and other ethnic minority groups over the past few decades. We recognised that how we assess the wellbeing of babies with non-white skin needed some attention," she says. "We wanted to do work that makes a fundamental difference, not

IMAGE: GETTY


The longer read

through the looking glass

Countless reports highlight disparities in maternity outcomes for Black and brown women, yet little has been done to address the root causes. How can we bring about change for all women?

midwives

Midwives July-Sept 2023 issue looked at how historic knowledge and attitudes effect outcomes for global majority women and babies

just a piece of paper gathering dust on a shelf."

The lack of existing evidence prompted the NHS Race and Health Observatory to fund a research project that, earlier this year, shone a light on the ethnic inequalities within neonatal health outcomes. The findings led researchers to call for transformative change across clinical guidance and policy.

Research in action

"There is a growing recognition about the disparities within maternity heath services with regard to ethnicity, which can be partially attributed to the Black Lives Matter movement," says Hora Soltani, co-author of the report and professor of maternal and infant health at Sheffield Hallam University.

"We have been trying to understand why we have got these disparities among women and mothers from ethnic minority backgrounds in their experience of maternity services."

The evidence review, which analysed around 200 studies and 80 policies and interviewed healthcare professionals and parents, found that tests that assess a baby's skin tone, heart rate, reflexes, muscle tone and breathing within a few minutes of birth, including the Apgar score, give misleading scores for global majority babies.

Their review focused on assessments for hypoxia, cyanosis and jaundice, which all partly rely on the assessment of skin tone and calls for improved access to and use of bilirubinometers to assess jaundice.

"This is a device that community midwives can carry in their bags to use if there are concerns about assessing jaundice, particularly in babies who are non-white," says Jacqueline.

However, bilirubinometers, which have been found to be a more accurate method of detecting jaundice than visual assessment alone, can also give inconsistent results on different skin tones. Hora says their accuracy should be improved to better detect jaundice for babies with different skin colours.

"Jaundice is a very common condition and usually clears up by two weeks. This is not always the case, however, maybe because of other disorders, or if the baby is premature. If it is not recognised when it gets to a certain point where it becomes problematic, it could lead to a long-term brain injury in severe cases. Therefore, timely identification is very important to prevent this," says Hora.

The researchers also found that detection of cyanosis – which indicates possible decreased oxygen in the bloodstream and a problem with the lungs or heart – from skin colour alone has led to many false positives and false negatives. The researchers recommend that midwives use pulse oximetry screening where there is any concern over oxygenation.

"With cyanosis, the neonatal report finding that some midwives will look at lip colour instead of skin colour for babies with darker skin tone is unwarranted and can lead to delays in treatment," notes Jacqueline. "There must be guidance around using pulse oximetry screening if there are any concerns over oxygenation. This, along with using bilirubinometers, are two things that can be done to influence the curve of history in relation to inequality in the assessment of newborns."

IMAGE: GETTY

Inequality in education

The researchers also called for improvements to education and training for professionals and students around undertaking clinical assessments on newborns from global majority backgrounds. They found that training material was focused on white babies, which limits learning opportunities, says Hora.

Jacqueline agrees, saying all learners across healthcare should have mannequins with varying skin tones. Though anatomically no different, using only white-skinned mannequins impresses on students a familiarity with white Europeans and creates an 'otherness' in brown- or Black-skinned people. This unconsciously permeates practice and means that women are treated differently because of their race.

Students – and families – should also have access to a national data bank of open-access images of global majority babies, the researchers say, to aid diagnosis in practice and for families to use to know signs to look out for.

The researchers' literature review and interviews also found that women from Black and Asian backgrounds feel that healthcare professionals made assumptions about their education and lifestyle and felt they were labelled as 'aggressive' or 'difficult'.

"I'm saddened by this because if you're not being cared for and listened to how would you respond? We need to do better in modern society in England," says Jacqueline. "Listening is key, and understanding what has been heard and then acting in a mutually agreeable way will help."

While the way assessments are currently carried out do not necessarily directly create inequality in healthcare for global majority babies, she adds, if you cannot assess their health appropriately at the start of their lives, the consequences may be associated with ill health in non-white babies that lead to morbidity and mortality.

Since its publication in July, the report has been well received, Jacqueline adds. "But many reports are well received with no action. There needs to be some pace around this because this is about people who deserve a health system that can provide all with the same care as those who receive the best.

"Action is required; they need timely and appropriate care. If these babies start life with a health disadvantage and have challenges with inequality and racism that remain in society, how will they ever catch up? What midwives and neonatal nurses do will ripple through generations. It is time to act now," says Jacqueline. "If we're serious about ensuring equality, we must listen to women, then understand, then act in an agreeable way."

Listening is key, and understanding what has been heard and then acting in a mutually agreeable way will help

MORE INFO
Read the report at
bit.ly/RHO-review

RCM DECOLONISING MATERNITY TOOLKIT

The RCM has long been advocating for awareness of latent attitudes and unconscious racial bias in education and clinical practice. Following a significant body of work, the RCM released a toolkit to enable those in education and in practice to question accepted norms and challenge behaviours. Scan the QR code to download the toolkit.

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Welcome to the world

Midwife Jenny Smith and anaesthetist Felicity Plaat hope to raise the profile of 'natural caesareans' as a 'gentle' method

Although much effort has gone into improving vaginal birth experiences, with birth centres offering calm, relaxing environments, double beds and more home-from-home experiences, little has changed with regards to improving the caesarean birth experience other than spinal anaesthesia and partner presence.

The first paper we were involved in on the natural caesarean, *The natural caesarean: a woman-centred technique*, was published in 2008. This was at a time when the majority of caesarean births in the UK were undertaken purely for medical reasons. The natural caesarean aimed to encompass as many aspects of vaginal birth that had been shown to be beneficial as possible.

The technique was developed by a multidisciplinary team, including a professor of obstetrics, a midwife and an obstetric anaesthetist at Queen Charlotte's and Chelsea Hospital, London. The concept was simple – the woman-baby-partner triad was to be the central focus of care. The philosophy behind the initiative was a holistic approach with the focus on the birth rather than the surgery, while the individualised care and kindness of the vaginal birth experience could be brought into the operating theatre. The key elements of the natural caesarean include parental participation, walking the baby out, auto-resuscitation, delayed cord clamping and immediate skin-to-skin contact.

Parental participation

This begins with an individualised plan being developed antenatally. Women were invited to plan their birth experience, including music, clothing and photographing their birth in the theatre.

In theatre, the anaesthetist ensures that monitoring of the mother will not interfere with skin-to-skin contact. ECG stickers are placed on the shoulders and side of the body and the oxygen saturation probe is placed on the toe. One of the woman's arms is freed from the theatre gown in readiness for skin-to-skin contact. The anaesthetist ensures that the ambient temperature in theatre is appropriate.

Once birth is imminent, the surgical drape is lowered so the parents may observe their baby's birth. The obstetrician delivers the head and shoulders and then supports the neonate as they wriggle free, often taking their first breaths and crying before birth is complete. The aim for the obstetrician is to adopt a hands-off technique, allowing the baby to be born through a process of uterine contraction and wriggling. The slow delivery of the

IMAGE: SHUTTERSTOCK

baby's body is eminently suited to delayed cord clamping. By adopting a slower process of birth, the baby breathes while some of their body is still inside, allowing for a longer period of chest compression and encouraging expulsion of lung fluid to aid breathing. Anecdotally, placenta delivery seems easier and blood loss is less.

The baby is lain straight onto the woman's bare chest either by the obstetrician or the midwife. The midwife will dry the baby and ensure they are covered in dry warm towels. The midwife will then stay at the 'head end' with the new family and the anaesthetist. Labelling and vitamin K can all be administered while skin-to-skin contact is maintained.

Support and criticism of the concept

Interest in the natural caesarean approach developed rapidly, fuelled by increasing demands from parents, articles in the lay press and TV coverage.

The natural caesarean, however, was not without its critics. In her 2009 paper *How natural can major surgery really be? A critique of 'the natural caesarean' technique*, Lareen Newman was concerned that there was "great danger to legitimising C-section ... the term natural CS is as misleading as 'friendly fire'". She challenged the ethics of making surgical birth nicer.

Jennifer Fenwick went further in *Caesarean section: the ultimate by-product of the one two punch theory* (2009), stating that the natural caesarean birth meant "we have rendered a highly natural process dysfunctional, fixed the problem with technology and reframed the technology as a natural solution".

The biggest challenge to implementing this new way of managing surgical birth has not been the criticism published in peer-reviewed journals, however, but of implementing change itself. The behavior of the clinical team in theatre is determined by rituals that have been followed without question for many years.

The birthing technique has been renamed the 'gentle caesarean' or 'family-centered caesarean'

For example, the neonate is whisked straight to the resusscitaire to be checked over, to avoid getting cold and to be labelled. The obstetrician must under no circumstances go anywhere near the unsterile part of the mother for fear of contamination. The midwife's role is to prioritise completing all documentation over promoting mother-baby bonding through skin-to-skin contact. Anaesthetists in theatre are not used to the neonate entering their zone of activity and worry they will be required to divert their attention from mother to baby.

The evidence to date, however, suggests that these rituals can be modified or even discarded. Two randomised controlled trials demonstrated that the new approach is safe for woman and baby. This was corroborated by two further studies that indicated there was no increased risk of peri-operative haemorrhage or wound infections. A retrospective study also found that prolonging skin-to-skin time during surgery may give babies more time to adjust to ex-utero life and reduce infection.

Although the natural caesarean technique originally was for planned caesarean with singleton cephalic babies, it has been safely used for more complex cases.

Practical changes

Renewed interest in delayed cord clamping may encourage other changes in theatre practice. It has been suggested that early and uninterrupted skin-to-skin contact could be included in the WHO safety checklist modified for maternity. The next focus might be to increase parents' participation in enhanced recovery.

It is often still common practice for planned caesarean patients to fast overnight before surgery; however, some practice guidelines recommend six to eight hours of fasting, with a high-calorie carbohydrate drink two hours before as this has been shown to reduce pre-operative thirst. Unrestricted water intake before caesarean birth has long been advocated in the anaesthetic literature.

Urinary catheters are commonly left in for 24 hours, but it has been suggested that removal at seven hours would enhance mobilisation - this would require careful attention to subsequent bladder care. Some authorities have suggested that staff on postnatal wards should be trained to scan bladders to streamline this process. Effective post-operative pain relief that obviates or minimises the need for opioids is key. This can be achieved by use of the combined spinal epidural and topping up the epidural component in recovery and early regular oral non-opioid analgesia.

Women could be informed of remedies they could bring to relieve trapped air post-operatively, such as peppermint water, chewing gum and heat patches. A light diet within the first couple of hours is already part of the enhanced recovery pathway. At home, following suture removal, women could be taught to apply steri-strips, massage the scar or apply anti-keloid creams or silicone scar sheets.

It is partly in response to initial criticism of the term and partly to emphasise a crucial aspect that the technique has been renamed the 'gentle caesarean' or 'family-centered caesarean'. I believe this method has many benefits, not least making the prospect of a surgical birth less worrisome and more inclusive for women and their partners.

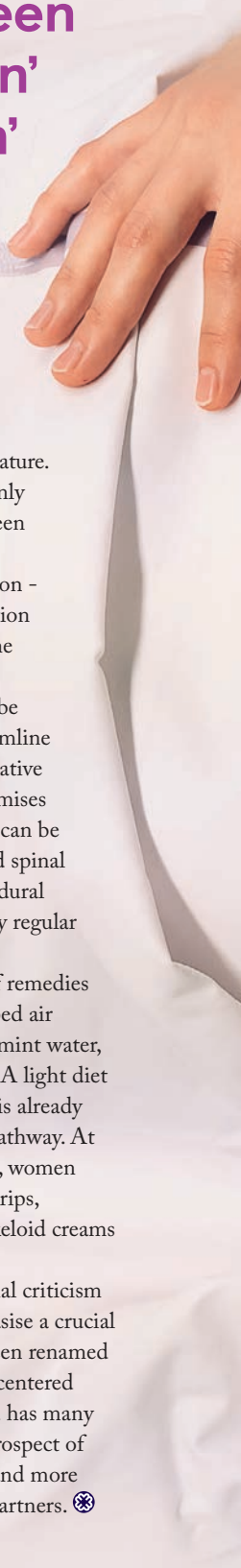


IMAGE: SHUTTERSTOCK

FURTHER READING

The natural caesarean: a woman-centred technique **bit.ly/BJOG-natural**

The Charité caesarean birth: a family orientated approach of caesarean section **bit.ly/JMFNM-Charite**

Family-centered cesarean delivery: a randomized controlled trial **pubmed.ncbi.nlm.nih.gov/34454161**

All references available on request.

More than numbers

With Governments in varying states of readiness to tackle the midwifery staffing crisis, it's being addressed by innovative scheduling, ways to personalise working patterns and new thinking on recruitment

Since addressing the exodus of midwives from the workforce in the April issue of *Midwives*, reports published in all four countries in the UK have reasserted, in black and white, the extent of the problem. The RCM's *State of Maternity Services* reports for Northern Ireland, Wales, England and Scotland released in May, June, July and September respectively shed further light on the realities and made the case to Government for strategy and investment.

The reports for Northern Ireland and Wales outline the need for the implementation of a new maternity strategy alongside the need for more midwives. "This is not simply about numbers," the RCM warns in its report for Wales. "Retaining experienced staff supports those joining the workforce and ensures that the new staff we train are actively adding to the workforce and not simply replacing those who leave." How is that achieved, the Northern Ireland report asks? "We pay them better and treat them better."

In England, where the RCM calculates a shortage of 2,500 midwives, the report states that many staff "feel burnt out and leave before they reach retirement age. Much more needs to be done to retain existing staff, as well as train and recruit new midwives." And the RCM's Scotland report reinforces a similar message.

The long-awaited Long Term Workforce Plan from NHS England, backed by the Government, "focuses on retaining existing talent and making the best of new technology alongside the biggest recruitment drive in health service history". It advocates for greater investment in the retention of midwives and the expansion of apprenticeships in the profession. But there

ILLUSTRATION: ISTOCK

are fears the recruitment plan, which would see an increase of nursing and midwifery training intakes by around 32,000 by 2031-32, "risks being derailed" by difficulties in finding enough applicants and a shortfall of staff to teach them.

Invention from necessity

In the meantime, it would seem that it falls upon individual Trusts and Boards to employ the resourceful thinking to keep, or entice back, skilled and talented staff. One such example is the 'any hours' scheme devised by Sue Chatterley, head of midwifery (HoM) at Lewisham and Greenwich NHS Trust.

Since flexibility – whether for childcare, healthcare or any other need – is vital, this simple roster system, whereby staff can cover the hours that are convenient for them and pick up extra, is an easy win. "I have a midwife with a really young family whose childcare arrangements had fallen through," says Sue. "They couldn't afford to pay for professional childcare, so she was forced to look at leaving the profession because her partner also worked odd hours and she couldn't see a way out of it. By me saying, you can have whatever suits you – if he has a day off and you want to come in, you can come – it's kept her on the register.

"As her children grow, they will become less needing of her attention and in years to come she will probably pick up more hours. So we're playing the long game."

And the strategy has worked to retain older, more experienced staff needing a change in pace. Sue mentions a midwife on the postnatal ward: "She likes that work, but it's back-breaking. If you're in your 60s, you don't need it. She now comes mid- to late morning and she leaves late afternoon – and we've kept her a bit longer."

Sue has been auditing the 'any hours' scheme and is keen for the system to be adopted more widely so that other Trusts and Boards can benefit. "People struggle to believe it's really that easy," she says. "Do the thinking behind it and play to people's strengths.

"If you have a labour ward midwife coming in for four hours, she might do medication rounds, discharges, baby checks. Don't put her on the postnatal ward because she's not going to like it. It's a team-building exercise; don't be afraid of power sharing."

It falls upon Trusts and Boards to employ the resourceful thinking to keep talented staff

NHS ENGLAND'S RETURN TO MIDWIFERY

- 153 midwives have been welcomed back to practice since 2017 through the NHS England Return to Midwifery programme.
- Resources for return to practice employers: **bit.ly/HEE-return-to-practice**
- FAQs for midwives considering a return: **bit.ly/return-to-work-FAQs**
- Advice on where to start: **bit.ly/NHS-where-to-start**

Flexible working

In the case of Trudy Berlet, a lack of flexible working nearly cost the profession. She was supported by NHS England's Return to Midwifery initiative. Trudy, team lead and specialist midwife at Herefordshire and Worcestershire Health and Care NHS Trust (although from October she will be maternity matron of community and continuity at Worcestershire Acute Hospitals NHS Trust), took a nine-year hiatus from midwifery after she wasn't granted the flexible working she needed for her family.

"I moved to a new area and needed flexible working around childcare. I was a community midwife and the Trust that I moved to wouldn't offer it, so the only option was to come out of practice.

"I really missed midwifery. But in the time that I was out of practice, I volunteered with Relate and trained as a therapist with them. Then I got to the point where the children were a bit older and I was doing quite a lot of work with couples that had experienced perinatal loss. Bereavement had always been an area

that I was interested in and when we could juggle childcare a bit more easily, I thought I could take some of those skills back into midwifery.

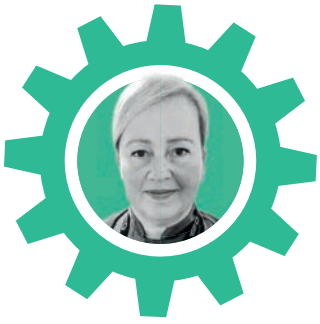
"I did a 'return to practice' course with Coventry University because it was the nearest one and they were offering a bursary. During my course, I had a buddy and the inpatient matron oversaw my progress. When I got my pin back, I did a six-month preceptorship programme and again I was allocated a buddy. We went through all the additional competencies together. I was incredibly well supported.

"Then I went back to the same Trust and they were really supportive. Nine years had gone by, so practices were different. I could work whatever hours fitted with me, as long as I had a mentor. Thanks to the skills I had developed when I was out of practice and the support of colleagues, I was able to establish a supportive bereavement service and provide a level of support to the staff as well, thereby encouraging that culture of taking care of each other."

Bringing expertise back

Heather Irving, returning midwife at the Mid Yorkshire Hospitals NHS Trust,

WORKPLACE CHAMPION



Alison Jones is clinical and operational lead midwife at Hywel Dda UHB, Wales. She was nominated as a workplace champion at the RCM Awards for the measures she has implemented around staff wellbeing in the Health Board.

Retention is vital as staff are our greatest asset. Supporting them makes them feel valued and better equipped to provide high levels of care to the women/birthing people and their families.

As a service, much work has been completed on psychological safety and supporting staff to feel confident to speak up, especially where they may not have had confidence to previously. We have an open-door policy and all of the senior management team are based within the unit. This allows the team to be both visible and present for staff.

Ours is a team culture – ensuring that every member of staff feels their value within the team, regardless of position or banding. We also undertake quality improvement on a regular basis and staff are invited and encouraged to participate – to share their ideas – and lead on change with the support from the senior team.

We also support flexible working, with different shift patterns, part-time working and flexibility for some home-based working. We have supported staff who are unable to undertake clinical duties for a period of time to work in a temporary non-clinical role. This has been planned on an individual basis with the member of staff and it's obviously had a positive impact on psychological wellbeing.

Transparency

The maternity wellbeing committee was set up in 2022. It is chaired jointly by the health and safety rep and senior midwife manager. Members include midwives, maternity support workers (MSWs), healthcare support workers and obstetricians, but it is open to all staff within the service.

Having joint chairs ensures an open and transparent dedication to improvement and supports a sustainable, happy and healthy workplace. The committee ensures the service is committed to the health, safety and wellbeing of all staff and students. Staff presence is encouraged at bi-monthly meetings: the committee recognises the importance of engagement and how that can facilitate improvements in the workplace. It is dedicated to listening to find out what is working and what can be improved.

Given the increased demand on maternity services staff, it's essential to understand the impact of experiences that make the sense of belonging and ownership central in developing support initiatives for staff. Having an active, engaging committee, with representation from all staff groups, has been crucial in understanding the pressures of each individual and the staff as a whole.

brought her experience and skillset back to the profession after retirement, supported by NHS England's Return to Midwifery initiative.

"Because I had entered the workforce in 1984, I was eligible for retirement at 55. I retired in 2020 and started to do bank agency work in community, within GP surgeries, COVID-19 vaccinations and in community midwifery clinics.

I felt that I wanted to be challenged further. I didn't want to stop being a midwife and I had developed a breadth of experience and confidence to offer the service I didn't want to leave behind.

"I didn't have the skills to work on a labour ward, which is how I wanted to end my career – where I started. I wanted to work flexibly, but I couldn't offer myself to agency without those skills. I saw an advert for an upskill course that laid out everything I wanted with an individualised approach. I already knew I had plenty of experience and knowledge, I just needed to hone my skills. Now I am back and working towards being fully upskilled.

"The Trust has been hugely supportive of my wider health concerns. I had some health problems that resulted in me starting menopause. My immediate response was to hand in my notice to try and sort myself out as I felt I couldn't work. But the Trust offered different roles across non-clinical, education, audit – whatever I wanted – to support my changed circumstances. It has helped me start to feel more like myself again, and I have been working in triage.

"Addressing how staff can be supported through [menopause] is vital for Trusts to develop policies for."

Both Trudy and Heather benefited from NHS England's Return to Midwifery support (see page 45). The programme was set up to try to prevent talent being lost to the profession due to circumstance.

Future-proofing retention

Another way of looking at improving retention is to recruit staff who are more likely to stay. Richard Griffin, professor of healthcare management at King's College London, who recently undertook an evaluation of registered midwifery degree apprenticeships (RMDAs), says: "The overall clear message is that RMDAs are really effective ways of boosting the supply of future midwives. And the reason for that is the attrition on the programmes is really low, almost 0% – I think one person left – while it's around 13% on average for the fee-paying, traditional students."

The RCM's director of midwifery policy and practice Sally Ashton-May, who co-chaired the trailblazer group to develop the RMDA programme, believes it could surpass the expectation set out by the Long Term Workforce Plan that 5% of students are trained via apprenticeships by 2028 – as long as the Government provides it with equitable funding to the nursing and nursing associate degrees. "We know that lots of directors and heads of midwifery are really keen to support it, but can't afford it," she says. "So, while the ambition is in the plan, nobody's yet said what funding will support delivery. The RCM has written to [women's and health minister] Maria Caulfield to express its support for the plan and state the need for the Government to ringfence funding for midwifery apprenticeships."

In the meantime, the five UK universities running the RMDA programme are producing valuable members of the midwifery workforce, who are likely to go the distance. "This is a route that can deliver learners with high resilience," says Richard. "And we have apprentices with first-class honours coming out of it, so there's no issue around the academic study. I'm not saying it should replace anything else, but I think alongside the other approaches – such as international recruitment and return to practice – this really does offer the chance for a sustainable way of building the workforce. And it's potentially going to be more diverse because it's coming from largely local communities."

The committee also has a plan to support and promote wellbeing, which includes Wellbeing Wednesdays. Activities include a rounders team, mindfulness walks, events to celebrate MSW Day and St David's Day and a Christmas craft fayre. Wellbeing Wednesday gives us an opportunity to say thank you to everyone. I think it's no coincidence we have seen a significant fall in the number of leavers over the past year.

My advice to other midwifery teams looking to improve retention is to take time to listen to staff, acknowledge their basic needs, say 'thank you' and work with other departments and services.

Feeling the heat

Lesley Wood, RCM health and safety advisor, discusses rights in the workplace for those experiencing perimenopause and menopause

Q: The Government this year rejected making menopause a protected characteristic in the 2010 Equalities Act, but is it still something that employers need to have an HR policy for?

A: Yes, employers should have policy on this. Most NHS Trusts and Health Boards locally and regionally have developed menopause policies. The Advisory, Conciliation and Arbitration Service (ACAS) states there should be "steps, procedures and support in place to help staff affected by menopause" and that employers should make sure they know how menopause relates to the law, including the:

- Equality Act 2010, which protects workers against discrimination
- Health and Safety at Work etc Act 1974, which says an employer must, where reasonably practical, ensure everyone's health, safety and welfare at work.

The menopause is not a specific protected characteristic under the Equality Act 2010. But if an employee or worker is put at a disadvantage and treated less favourably because of their menopause symptoms, this could be discrimination if related to a protected characteristic – for example, age, disability, gender reassignment or sex.

So, if someone experiences less favourable treatment because they are going through menopause, that may be considered discrimination on the grounds of age – also true for someone experiencing medical or early menopause. The NHS has a significant female workforce, including most midwives and maternity support workers (MSWs), who need support going through menopause. If this isn't available, it could be considered discrimination on the grounds of sex.

ACAS also notes that menopause could be considered a disability under equity law. This means the employer must make reasonable adjustments to reduce or remove any disadvantages they might experience because of it. For example, this might include agreeing to record absence because of menopause separately from other sickness absence. We will come to this in a second.

For all these reasons – and because it's the right thing to do – employers should have policies in place and be prepared to work sensitively with employees going through menopause.

IMAGE: SHUTTERSTOCK

Menopause in the workplace

Work in maternity units is physically, mentally and emotional demanding, and menopause takes its toll in all these areas. The loss of sleep can reduce the ability to concentrate and stay focused, which is vital in an unpredictable environment; hot flushes are overwhelming and can happen at inconvenient times; while mood swings and irritability could affect relationships with colleagues and those in their care – especially in moments of high emotion. Moreover, physical conditions such as restrictive uniforms,

MENOPAUSE SYMPTOMS

Menopause is different for every woman, but these are the most common.

Physical symptoms:

- Hot flushes
- Night sweats
- Sleep disturbances and insomnia
- Fatigue
- Poor concentration and memory
- Headaches
- Heavy, irregular or painful periods
- Vaginal itching, dryness and discomfort
- Loss of libido.

Mental symptoms:

- Depression
- Anxiety
- Panic attacks
- Mood swings
- Irritability
- Problems with memory
- Loss of confidence.

Women experiencing symptoms from HRT treatment may also require support and adjustments in the workplace.

higher temperatures on wards and not being able to take toilet breaks may exacerbate symptoms.

Managing these symptoms can also make someone want to reduce their hours or be absent from work more frequently. Very severe symptoms could mean they cannot work at all. In many workplaces it does not receive the attention it requires and many do not realise that they are legally entitled to support with their menopause symptoms.

Employer obligations

The employer should have a flexible working policy. Sickness policies should cater for menopause-related sickness absence – including being recorded as an ongoing, long-term health condition rather than individual absences.

The workplace itself should be assessed for temperature, ventilation, toilet facilities and access to cold water so as not to worsen symptoms.

Line managers should be trained to be aware of the symptoms of menopause, understand how they can affect working women and know what adjustments may be necessary to support them. Support for mental health and wellbeing should also be available, with other members of staff who aren't the line manager.

If a worker is put at a disadvantage and treated less favourably because of their menopause symptoms, this could be discrimination

With 23% of maternity staff aged between 45 and 54, almost a quarter of maternity staff could be experiencing menopause at any one time. It is vital that anyone who is struggling with menopausal symptoms is given support, advice and suitable adjustments to their work and workplace.

Employers could consider an occupational health awareness campaign that highlights the issues among all staff, and guidance on how to deal with menopause should be freely available in the workplace. Moreover, all staff should be clear about the effects of menopause and understand that it is not a joke.

RCM workplace reps play an important role in challenging attitudes to menopause, making sure employers have procedures in place and offering support to members who are experiencing problems.

Contact RCM Connect on 0300 303 0444 for advice or to be put in touch with your workplace representative.

MORE INFO

Find out more at **bit.ly/RCM-working-with-menopause**

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- ✓ Cleansing the birth canal with chlorhexidine reduced early neonatal and maternal postpartum infectious problems.[2]

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Presentation: Hibitane™ Obstetric Cream is a cream containing Chlorhexidine Gluconate 1% w/w. **Indication:** An antimicrobial preparation for use as an antiseptic and lubricant in obstetric and gynaecological practice. **Dosage and Administration:** Apply liberally to the skin around the vulva and perineum of the patient, and to the gloved hands of the midwife or doctor. **Contraindications:** Contraindicated for patients who have previously shown a hypersensitivity reaction to chlorhexidine. However, such reactions are extremely rare. **Warnings and Precautions:** For topical application only. Keep out of the eyes and ears and avoid contact with the brain and meninges. Local stinging and/or chemical burns have been reported following off-label use of gauze packs soaked in Hibitane™ Obstetric Cream and left intra-vaginally for prolonged periods. **Undesirable Effects:** Irritative skin reactions can occasionally occur. Generalised allergic reactions to chlorhexidine including anaphylaxis have been reported but are extremely rare. **Package Quantities:** 50ml, 10 x 50ml and 250ml bottle. **Pharmaceutical Precautions:** Store below 30ºC. **Basic NHS Price:** £4.80 (1 x 50ml), £48 (10 x 50ml) and £20.88 (1 x 250ml). **Legal Category:** GSL. **Marketing Authorisation Number:** PL 19876/0009. **Marketing Authorisation Holder:** Derma UK Ltd, Toffee Factory, Ouseburn, Newcastle upon Tyne, NE1 2DF, UK. "Hibitane" and "Derma UK" are registered Trade Marks. **Date of Revision of Text:** June 2022.

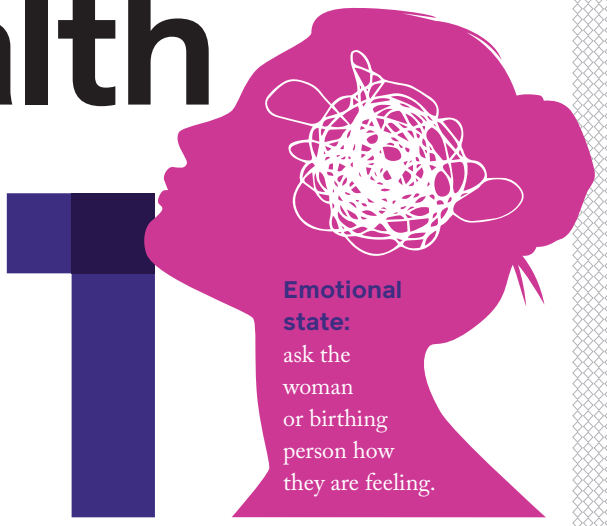
Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Derma UK on +44 (0) 191 375 9020.

1. Derma UK Ltd., 'Summary of HibitaneTM Obstetric Cream Product Characteristics (SmPC).' 2021
2. A, Fayez Bakr et al, Effect of Cleansing the Birth Canal with Antiseptic Solution on Maternal and Neonatal Mortality in Alexandria, American Journal of Paediatrics. July 2002, p. 379-383

HIB/104/0923
Date of preparation: September 2023

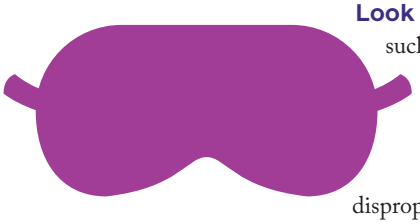
Perinatal mental health

Poor mental health during the perinatal period (from pregnancy to a year post-birth) is common and, if left undiagnosed and unsupported, can have devastating effects. It is important at every antenatal and postnatal interaction to talk openly about mental health and the feelings the mother may be experiencing – and to offer reassurance that it is common and nothing to be ashamed about.



1 **Emotional state:** ask the woman or birthing person how they are feeling.

2 **Listen intently without making judgements.** Concentrate on their needs at that moment.



3 **Look for symptoms,** such as feeling sad or down, confused thinking or reduced ability to concentrate, disproportionate fears or worries, extreme feelings of guilt, extreme mood changes between highs and lows, withdrawal from friends and activities or significant tiredness.

4 **Let them know it is okay** to feel all these things and ask them what they feel would help them.

5 **Practice kindness and compassion** – reassure them that help is available and that mental health problems can be treated.

6 **A good support network is key** for mother and baby, so it's worth checking on the partner's mental health too. They may need to step in to support the mother and baby or any other children in the family. This NHS guide offers advice on supporting the mother's wider network: bit.ly/NHS-good-practice

One in five

Midwives working on the front lines of perinatal mental health care talk about the work they do, the level of need they're seeing, the challenges they face and what it would take to improve care

One in five women will experience mental health issues during pregnancy and up to a year after birth, and suicide remains one of the leading causes of death in new mothers.

Earlier this year, the RCM asked midwives and maternity support workers (MSWs) to help develop a new perinatal mental health (PNMH) strategy. Using a survey and targeted focus groups to build a picture of the current provision, they identified what's working, as well as the challenges and gaps.

The resulting *Strengthening perinatal mental health* roadmap, launched in August, sets out what is needed to improve care – and the pressing need to do so.

It calls for a fundamental shift in how mental ill health is seen, calling out the lack of parity in the allocation of resources so at odds with the fact that mental ill health ranks with physical factors as one of the leading causes of maternal deaths in the UK.

Recommendations include ensuring there are enough specialist midwives in post with adequate time and support to do the job and specifying that every service should have a Band 7 specialist PNMH midwife. It also sets out the need for a review of midwifery training so that midwives – and all healthcare professionals working with women at this time – are equipped with adequate knowledge and understanding of PNMH.

Read the RCM's *Strengthening perinatal mental health* roadmap

Amanda Mansfield
RCM MIDWIFERY ADVISOR

Amanda is midwifery advisor on the RCM's professional midwifery team and led the RCM's work developing the *Strengthening perinatal mental health* roadmap.

We found that midwives are really committed to the mental health needs of women, but the caveat is that the reality is they are not always given the time, training or resources they need to deliver that care.

We heard from specialist midwives that they are not being given the right conditions to be successful. Some don't have a desk to work at, or they find there is no space for them to see women in clinics. They're also being called to cover staffing shortages elsewhere rather than focus on their specialist role, which is being diluted as a result.

RCM members also described a wide variation in the hours they were employed and ambiguities in the role title. Some specialist midwives are only employed one half-day a week, while in other areas there is a whole team. There are 'midwives with a specialist interest', which is quite different to a midwife with a specialist role, and I think we need to ask ourselves what message that sends out.

One of the key items on the roadmap was the need for commissioners of PNMH services to look closely at their own populations to identify the level of need locally. If we don't understand the demand and the capacity, we're never even going to get to the start line.

We also saw that there still isn't parity of esteem between physical and mental health. Creating the right environment starts with training student midwives and allowing them to have those conversations in a culturally sensitive, trauma-informed way, because we know that many women who experience PNMH issues have a background of trauma or a previous complex history.

Perinatal mental ill health is now the most common complication of childbirth, so enhancing the conversations midwives are having around mental health is crucial – especially as we know 70% of women will either hide or underplay the severity of their mental health problems.

A woman will have at least seven antenatal appointments with her midwife before having her baby – every check affords an important opportunity to revisit the discussion.

We found that midwives are really committed to the mental health needs of women, but the caveat is that the reality is they are not always given the time, training or resources they need to deliver that care

Nana Onyinah
LEAD MENTAL HEALTH MIDWIFE

Nana is lead mental health midwife at University College Hospital London (UCLH).

My role has changed so much over time. At the hospital where I first became a PNMH midwife, it was a new service – there wasn't even a PNMH service in the area at that time. Where I am now, we have a team of psychologists and a specialist perinatal service, so I can refer mums to both ends of the spectrum. It is so important we have mental health services with a perinatal focus.

The MBRRACE-UK reports have shone a light on how critical this stage is and the devastating effects when interventions are not put in place as soon as possible. In most Trusts and Boards, services have evolved from a small group of professionals to a much more diverse group looking out for the mental health needs of mums. The latest addition to services at UCLH is the trauma service, which is excellent, and I'm excited to say this is being extended to include women from Camden and Islington from October 2023.

I have a caseload of women who are under the specialist PNMH service with moderate to severe mental health conditions. My role is to ensure the pregnancy runs smoothly, supporting them emotionally. I liaise across all the specialist teams and services caring for them – I am like the mortar between them.

I see some women face-to-face, while in other cases it will be a telephone conversation. Most women still see their community midwife and come to my clinics in addition. However, for some, I am their only midwife – especially those women who are hard to reach or tend to miss appointments, as I have more flexibility to be able to see them.

I am also there to support other midwives, providing expert knowledge, advising them and helping them care for a woman with mental health needs. I do a lot of training – not only mandatory annual training, but if I see that midwives are struggling with something, I will make that a 'hot topic' and produce posters covering it.

I have a helicopter view, not just over the mums, but also over the services. A PNMH midwife is someone who can audit and evaluate care, assess outcomes, spot the gaps, ensure that services are effective and evidence-based, and develop implementation plans to deliver improvements – all those things that can't fall on every midwife's shoulders. And at the same time, you are still on the ground with women. That is why it is a unique and vital role.

Fiona Laird
CONSULTANT MIDWIFE

Fiona is consultant midwife clinical lead for PNMH and public health.

I set up Magnolia Midwives in 2019 after a scoping exercise identified that 17% of our women told us they experienced mental health problems, and of those 13% had moderate or severe mental health issues identified at booking.

That, combined with suicide being the leading cause of maternal death and Better Births bringing a focus on continuity of carer (CoC) models, made me determined to ensure that these women were in the first cohort to receive this type of care.

A CoC team of eight PNMH Magnolia Midwives were trained, established, integrated into and supported by the wider North Central London PNMH team, offering enhanced antenatal and postnatal care to women with moderate to severe mental health issues.

Many of our women have never had someone in their lives they could trust, so often it's very hard for them to tell their stories when they are sitting down with a different midwife every time. Giving them a dedicated midwife is vital so they can build that trust. Yes, there is clinical expertise, but most importantly there is commitment, compassion and empathy.

We can give our women the time they need to help keep them and their babies safe, enhancing care antenatally, with holistic therapies playing an important role alongside traditional care. After we discharge on day 28, women can come along to our weekly postnatal drop-in group for up to a year – some are still coming back after three.

Our midwives sit alongside our women at case conferences and safeguarding meetings. We ensure women are on the right pathways with the right people; we see ourselves as 'case holding' because as midwives we hold these women – we're with them.

It can be emotionally challenging at times, which is why clinical supervision is so important to prevent burnout. We work closely with clinical psychologists, clinical psychiatrists and a named obstetrician, and once a week we meet as a multidisciplinary team to talk through all new and current cases. Joint working means joint risk-holding and improves communication across the multidisciplinary team – it helps prevent our vulnerable women from slipping through the clinical net.

Our clinical outcomes for mothers and babies are better than or equal to national benchmarks, but the real evidence that this works is the feedback from women – most reported their mental health improved or stabilised through their pregnancy, and almost all described the service as excellent or very good. We make a difference because our women know we are with them, no matter what.

Many of our women have never had someone in their lives they could trust

When student midwives come to work with me, they're shocked – it's like I've opened a page they didn't know existed before

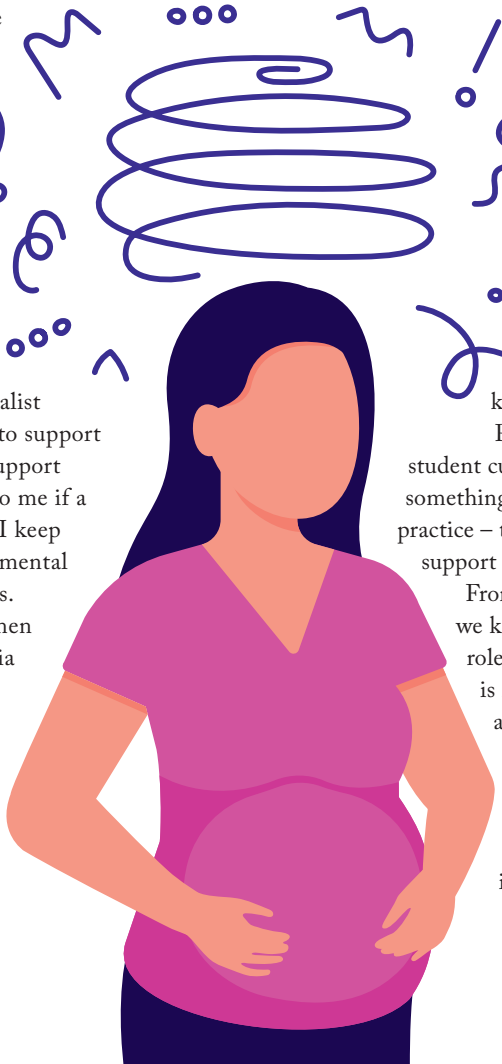
Olla Adebayo
PNMH MIDWIFE

Olla is the PNMH midwife working in the Lavender Team, which provides specialised care for women with mental health, social, or safeguarding needs.

In my role, I am supported by two consultant obstetricians with a special interest in mental health. The service receives approximately 30 referrals per week, which are triaged in a weekly multidisciplinary team meeting and rated red, amber or green, based on the severity and history of mental health. My role as the PNMH midwife is to caseload the women categorised as red.

Women rated as green or amber are referred to the Lavender Team, where the midwives have some specialist mental health knowledge to be able to support these women. I provide them with support and advice, and they can refer back to me if a woman's mental health deteriorates. I keep a helicopter view of all women with mental health issues using maternity services.

I am currently caseloading 39 women with conditions such as schizophrenia and bipolar disorder. Some of these women have comorbidities such as post-traumatic stress disorder, childhood sexual abuse or neglect. Some have been through children's services themselves or had children removed to social services care previously.



I provide one-to-one midwifery care throughout the antenatal period and up to 28 days postnatally. I am the only PNMH midwife at the Trust and I am passionate about what I do.

As specialist mental health midwives, we see a lot of anxiety among midwives about dealing with mental health issues. There is an excellent opportunity there, especially for community midwives, to ask, 'How are you feeling?' or, 'How is your mental health?' – however, they can shy away from it because they don't feel confident about what to do.

When student midwives come to work with me, they're shocked – it's like I've opened a page they didn't know existed before.

PNMH needs at least a module in the student curriculum and more awareness. It's something they will come across every day in practice – they need to be confident to identify, support and signpost women.

From speaking to colleagues on the forum, we know there is no consistency around the role of specialist PNMH midwife; banding is inconsistent with the work we do, and we don't have deputies or access to supervision and psychological support. A lot are even being pulled away to cover elsewhere. In my opinion, there still isn't enough value placed on the important work we do.

Laura Bridle

SENIOR MIDWIFE, MATERNAL MENTAL HEALTH SERVICES

Laura, a senior midwife in maternal mental health services, worked as a PNMH midwife for six years and, until April, was chair of the UK PNMH Midwives Forum.

We have seen an increase in need, especially since COVID-19. Social connections and peer support groups disappeared and services changed overnight – you had people birthing without partners, and this anxiety and birth trauma has come with them in subsequent pregnancies. In the PNMH Midwives Forum, we noticed an increase in maternal anxiety and eating disorders, and in the number of women requesting caesarean births. We also know that Black and South Asian women are disproportionately affected – and there is a lack of culturally sensitive services to meet their needs.

Services are developing. I started the forum with just six PNMH midwives based in London and now it's UK-wide, with more than 170 members sharing resources and taking examples of great practice back to their Trusts and Boards. These dedicated midwives are flagging issues, figuring out guidelines and pathways and developing services – working with lived experience to do so. This is so important and so powerful.

Unfortunately, in some Trusts and Boards, having a perinatal specialist midwife is still just a tick-box exercise – they employ someone two days a week and expect them to do everything alone. Similarly, at some universities, student midwives are getting dedicated mental health training each semester, looking at trauma-informed care, maternal OCD and postpartum psychosis, while others get just a quick look at the 'baby blues'. I want to see PNMH embedded in midwifery, which is why I was so pleased to see the RCM's roadmap on this.

Clinical supervision is another issue; when I started out as a maternal health midwife I was working in isolation, hearing traumatic stories and dealing with really hard things alone. Supervision and support for midwives are vital, so they can support women.

Serious mental illness is not at all common, and those women tend to be well held in the care of a PNMH team. It's those with mild to moderate needs that can fall through the gaps. In a 15- or 20-minute appointment, their midwife has so many other things to focus on – they might be scared to ask, 'How are you?' in case their clinic overruns.

That's why you need a mental health midwife. If I'm honest, you need a whole team that can offer online drop-in sessions or special classes on birthing anxiety and grounding techniques. There are specialist midwives doing amazing things like these, but they aren't happening across the country, and there is only so much they can do without more dedicated time. For that, maternal mental health needs to be valued as much as physical health.

Unfortunately, in some Trusts and Boards, having a perinatal specialist midwife is still just a tick-box exercise

Louise Nunn
CONSULTANT MIDWIFE

Louise is a consultant midwife and as a specialist PNMH midwife she is now co-chair of a PNMH Clinical Network.

Over the years, as perinatal services have been commissioned across the UK, the funding has rightly been focused on the 5% to 10% of women with severe mental illness – but this has also meant that funding has not been directed to maternity services to help support all women who experience mental health difficulties. The vital role midwives have is in danger of getting lost, despite their unique position of caring for all women, regardless of complexity.

We have worked to raise the profile of the specialist PNMH midwife through local and regional clinical networks and the development of an active PNMH midwives forum. What has been missing is proper funding and leadership at a commissioning level – which is why I'm so pleased to see the RCM's new roadmap.

All services must have a specialist midwife with protected time, funding and support. But there are so few Trusts or Boards with a consultant midwife who has a PNMH remit and we need that kind of leadership. We need midwives with big voices who can sit at the right tables to push through change and guide strategy in every Trust and Board, ensuring mental health is given parity of esteem with physical health for all women in our care.

There is clear evidence that women with mental health problems have worse obstetric outcomes, and we know from year-on-year MBRRACE-UK reports that mental illness is still among the biggest causes of maternal deaths – antenatal suicide rates have actually increased since the pandemic. We can't ignore this – there is a danger that this is pushed to one side with the focus on maintaining safety and physical health. We should improve all aspects of care, but one thing can't exist without the other.

Educating midwives must be the way forward; we play such an important role as every woman sees a midwife during their maternity care, while very few see a doctor. But PNMH education is still woefully lacking in pre-registration training and there is often little provided for qualified midwives. Yet we are expected to feel confident in identifying and caring for women with a wide range of mental health disorders.

We need good, personalised universal care, with every midwife able to ask those crucial questions and identify women who need more support. I have seen how mental illness can be treated effectively with specialist support and treatment, with life-changing results – but we need to be getting it right the first time.

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Kate Knightly-Jones

CONSULTANT MIDWIFE

Kate is a specialist PNMH midwife and qualified advanced clinical practice midwife. She has an honorary contract with the University of Greenwich providing PNMH training for third-year student midwives.

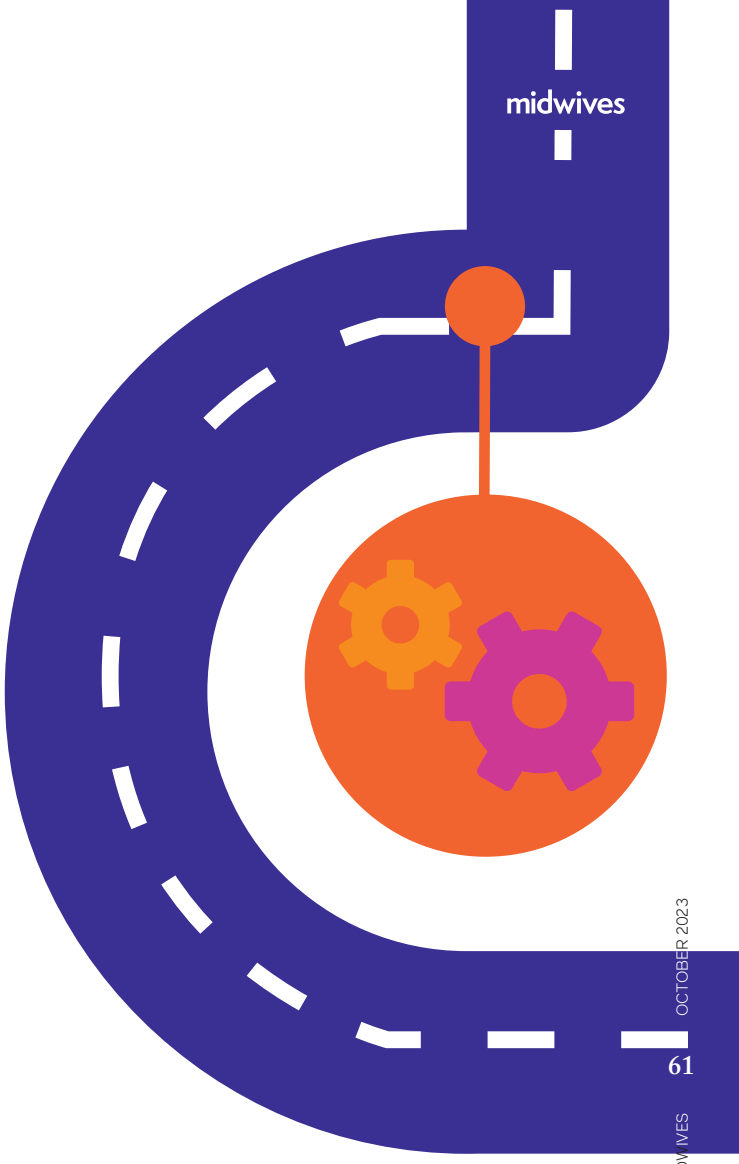
I offer two hours of theory and a day-long practical session with different simulations using actors to play the women. We began doing the sessions in 2019 – we were the first university in the country to do so – after I connected with Yemi Onilude [senior lecturer in midwifery at Greenwich], who was interviewing PNMH midwives as part of her PhD exploring undergraduates' preparedness for practice.

Speaking to Yemi, we decided our student midwives needed to practise different mental health scenarios, where they could stop, ask questions, say the wrong thing, discuss and start again. Students should be prepared to deal with mental health emergencies in the same way they are for postpartum haemorrhage or any other emergency.

The simulations cover everything from postnatal depression and anxiety to personality disorder and postpartum psychosis. The students go in blind and deal with it in real-time, and afterwards we talk about what worked, what didn't, what felt uncomfortable and how we could do better. The midwives who have graduated since are so much more prepared for practice; it gives them the confidence to risk assess and refer.

We have roughly 5,000 births a year and in the past year 1,256 women booked with a previous mental health problem – that's without anyone else who develops a mental health problem during the perinatal period. COVID-19 had a massive impact, as has the cost-of-living crisis, the change in the benefits system and the change in the housing system. We work with vulnerable women and families, so it's no surprise that when all these things compound, more people are becoming unwell and needing mental health support.

Since I became a PNMH midwife in 2018, we have built the service around our demographic. We needed to be able to fit the women's needs and assess mental health, prescribe medication and provide more social support such as foodbank vouchers and nicotine replacement therapies. We also collect second-hand cots, prams and baby items and redistribute them to families in need. It's become a one-stop shop for vulnerable women and families.



We know that women trust their midwives and hopefully have the continuity to feel safe to disclose. The perinatal period is also a catalyst for change – women want to do better and feel better for their babies. That's why responding to mental health needs to be in the basic skillset of all midwives, but that won't be the case until all universities are spending the same amount of time on it as Greenwich.

Liz Hopkinson

LEAD PNMH MIDWIFE

Liz is a lead PNMH midwife and co-chair of the UK PNMH Midwives Forum.

I work across three counties, three PNMH services, five community mental health services and eight Improving Access to Psychological Therapies (IAPT) services (NHS Talking Therapies).

I'm not able to caseload due to the numbers; last year I had input with 630 families' care. The year before it was 750. I rely on our community and hospital midwives who maintain their scheduled contacts and care – mine are in addition.

We have women with mild to moderate mental health difficulties, right through to those with moderate to severe illness, who are more directly in the care of the PNMH service and mental health service. I am happy to be the linchpin, liaising and making sure everybody is communicating.

When I first started in 2016, this role didn't really exist; I built the service alongside the consultant obstetrician. We started off identifying women with moderate to severe mental health difficulties at booking and brought them into the clinic – some 150 families in the first year. I started with one clinic a week, and I've expanded to two, one of which is for urgent cases.

I do a lot of training: I teach in the PNMH module at university; I've trained obstetricians and GPs; and, since starting in the role, I've delivered the Trust's yearly mandatory PNMH training for midwives.

With that in place, helping educate and empower midwives and clinicians to know what to look out for, what services are available and how to make referrals, we have been seeing many more families with mental health needs who wouldn't have previously disclosed.

Midwives are starting to feel more comfortable asking those questions, provided they are backed up by good Trust and Board guidance, as we have here. Ensuring they know what to do in different scenarios is vital; each year we change our training to cover topics flagged by our midwives. For example, this year we covered what to ask if someone discloses self-harming.

The role of the specialist mental health midwife is so valuable to families; that relationship-building means that sometimes a woman will tell me something that she won't disclose to another professional. Unfortunately, as our survey of PNMH midwives showed, they are still being pulled away to cover staff shortages elsewhere – how can they deliver a service when that's the case?

I would like to see a greater onus on maternity services to provide gold standard PNMH care, with money ringfenced to do so, and greater consistency in what services are offered so there isn't a postcode lottery across the country.

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How are you doing, Dad?

Mark Williams experienced a breakdown following the traumatic birth of his son and coping with his wife's severe postnatal depression. He says society should do more to understand and support new dads struggling with their mental health

In 2004, my wife Michelle was taken to the theatre for an emergency caesarean for the birth of our son. It was a traumatic experience and I was obviously scared. I thought she was going to die. Both Michelle and our baby Ethan were okay, thankfully, but what became apparent soon after was that my wife was suffering from anxiety and depression.

I remember at the time having dreams about both of them dying in the theatre and vividly thinking about the knives on the table next to me. I would wake up thinking it was all real, but little did I know just how real things would get when Michelle developed severe postnatal depression.

I was 30 years old and had never known anyone with the illness. I was so uneducated about mental health that I would think, "How can people be depressed?" But within weeks, I had to give up my job to care for Michelle and Ethan.

I had loved the social side of my work and now I was totally isolated; I didn't even get out the front door for days. My personality quickly changed and I was drinking more to cope. I became angry, to the point that when I did manage to

get out with friends, I wanted to fight the doorman, to get hurt and stop these feelings I was getting. I even broke my hand after punching the sofa – totally out of character – when Ethan was about six months old. I was experiencing suicidal thoughts and couldn't control them.

I knew I had to be strong and look after both of them. But the truth is, I wasn't well either. I didn't know at the time and I struggled on without telling anyone. I was afraid of people knowing, fearing it might affect my work and be recorded in medical records if I were to change careers.

I didn't know anyone who had suffered so I kept up my appearance and kept smiling, as I didn't want it to affect Michelle's mental health.

Society's attitudes

The problem was that, at the time, I didn't feel like I could talk to anyone. I was brought up in a working-class community where my father and his father were coal miners. I felt under pressure to 'man up'. As much as we are a close family, there weren't many emotions shown when things were tough. In keeping it all suppressed, I felt like a gas bottle ready to explode.

Michelle's postnatal depression lasted around 18 months – not knowing how long she would be unwell was the most difficult part. Of course, it also impacted our relationship, which may well have ended, as happens to so many families with no early prevention.

I started lying to Michelle. I would tell her I was going to work but I was isolating myself from people. I was my own boss, so I could get away with it; I didn't see the point of it all at times and felt totally alone.

I suffered mood changes for years after until, sadly, my grandfather passed away. Then, within a few weeks, my beloved mother was diagnosed with cancer. Thankfully she recovered, but for a while I thought I was going to lose her as well. This, I believe, triggered more of those thoughts and nightmares. In 2010, while

ENGAGING DADS

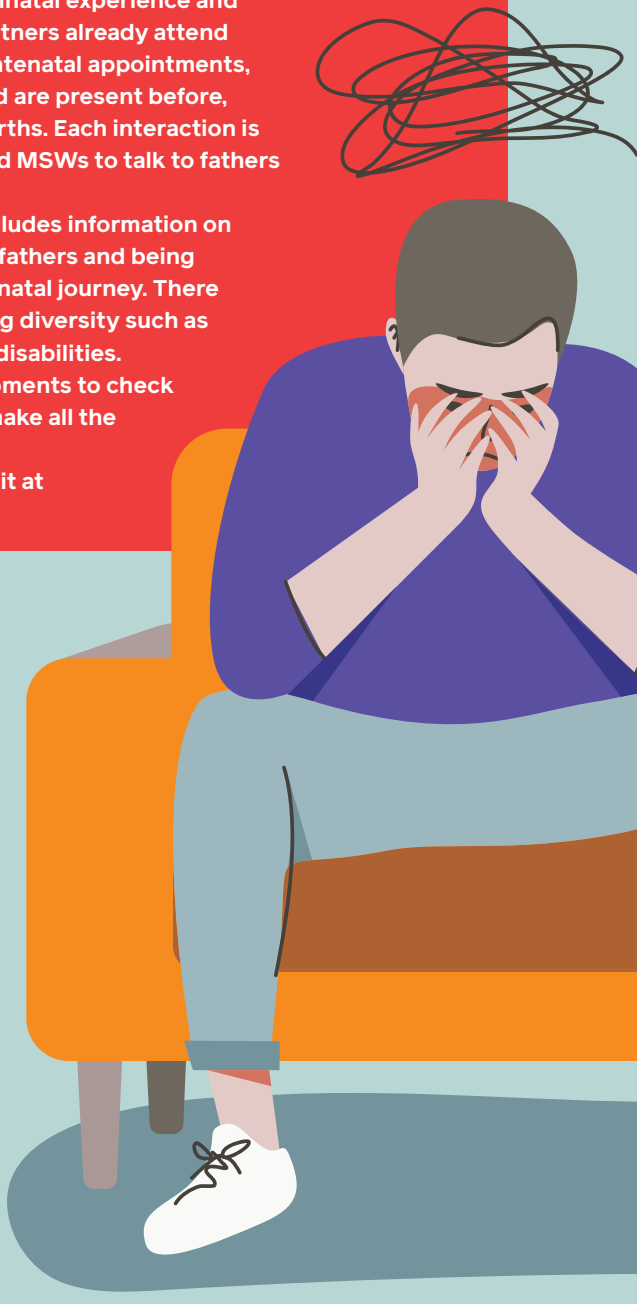
As Mark Williams says, taking the time to ask dads and partners how they are feeling can make a big difference. Midwives and maternity support workers (MSWs) have a unique role in engaging with families during the perinatal period. That's why the RCM, alongside the Fatherhood Institute, has created an Engaging Dads toolkit and series of resources to help midwives and maternity staff communicate effectively with fathers and partners.

It is recognised that well-supported partners can have a positive impact on women's perinatal experience and outcomes. Most fathers and partners already attend maternity services, including antenatal appointments, scans and antenatal classes, and are present before, during and after their babies' births. Each interaction is an opportunity for midwives and MSWs to talk to fathers and partners and offer support.

The Engaging Dads toolkit includes information on improving communication with fathers and being father-inclusive during the perinatal journey. There is also information on supporting diversity such as young fathers and fathers with disabilities.

As Mark says, taking a few moments to check how the partner is feeling can make all the difference for a new family.

View the Engaging Dads toolkit at bit.ly/Engaging-Dads



I love my son more than life itself, but I very much struggled during that first year of fatherhood

IMAGE: SHUTTERSTOCK

sitting in my car before heading into work, I had what I now recognise as a breakdown.

Getting help

Eventually, I was put on medication, underwent a course of cognitive behavioural therapy and mindfulness and was lucky to be able to turn things around. I was diagnosed with attention deficit hyperactivity disorder (ADHD) at the age of 40. Had I been screened, I know I would have been diagnosed with postnatal depression and post-traumatic stress disorder (PTSD) from witnessing both the traumatic birth of my son and the experience of my wife trying to take her life.

I didn't want any more children afterwards. I think that's how I could ensure that I would never have to go through that experience again. I love my son more than life itself – he is now 18 years old – but I very much struggled during that first year of fatherhood. There were many reasons why I was depressed during the postnatal period. The lack of sleep, isolation, undiagnosed ADHD, witnessing a traumatic birth, caring for my wife and baby, and having to give up work all brought strain on my health. Only now are people understanding that there are biological risk factors to fathers from changes in hormones, including testosterone, oestrogen, cortisol, vasopressin and prolactin.

Fathers need help too

We have to be aware that fathers can suffer too. PTSD is an anxiety disorder caused by either witnessing or experiencing a life-threatening event. I have seen so much trauma in my life, but still there's nothing worse than that postnatal situation.

The biggest killer in men in the UK under 45 is suicide. The research suggests that fathers are up to 47 times more at risk of suicide. This shows that we need to start engaging with fathers better, with an excellent pathway of care.

My wife and I are now fine – and we both work in mental health. I have become a keynote speaker on the subject and deliver training on perinatal mental health after writing a book with Dr Jane Hanley. I have successfully campaigned for better services and even started the campaign to reopen a dedicated mother and baby unit in Wales after seven years.

It's a simple message: when you support all new parents for their mental health, it has far better outcomes for the whole family and the developing baby. So why not just take time to ask new dads, "How are you?" It could make all the difference.

SUPPORT AND RESOURCES

Dads Rock: peer support for dads in Edinburgh
dadsrock.org.uk

NHS Inform Scotland: Ready Steady Baby!
nhsinform.scot/ready-steady-baby

Dads Project: supporting separated dads in Northern Ireland
parentingni.org/parents/dads-project

Families Need Fathers: parenting charity in Northern Ireland
fnf.org.uk/northern-ireland

Brecon & District Mind Dads Group: Facebook group for dads and dads-to-be in Wales
facebook.com/groups/dadsbreconmind

Dope Black Dads: digital safe space for fathers in England who wish to discuss their experiences of being Black, a parent and masculinity in the modern world
dopeblack.org/dopeblackdads

Anxiety UK
anxietyuk.org.uk
Helpline: **03444 775 774**
Text support service: **07537 416905**

CALM
thecalmzone.net
Helpline **0800 58 58 58**

Mental Health Forum
mentalhealthforum.net
Helpline **028 3025 2423**

Mind
mind.org.uk
Helpline **0208 215 2243**

No Panic
nopanic.org.uk
Helpline **0300 772 9844**

Rethink Mental Illness
rethink.org (includes information on financial support while undergoing treatment)
Breathing Space
0808 801 0745

Samaritans
samaritans.org
Helpline **116 123**

SANE
sane.org.uk
Helpline **0300 304 7000**

In an emergency, call an ambulance on 999.

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The salary scales:
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Informal enquiries to:
Ms Siobhan Canny, Group Director of Midwifery.
Email: siobhan.canny@hse.ie
Application:
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- Letterkenny University Hospital Co Donegal
- Mayo University Hospital, Co Mayo
- Portiuncula University Hospital, Co. Galway
- Sligo University Hospital, Co. Sligo

Contract type:
Permanent
Specialised Areas:
Inpatient and Community Midwifery, Ambulatory Gynaecology, and Neonatal Intensive Care (level 1 & 2)
Banding:
Staff and Senior Grades for Midwives and Nurses (equivalent to Bands 5 – 7 depending on length of qualification)
The salary scales:
For staff midwives and nurses are €33,193 to €52,512 with additional benefits from qualification and unsocial allowances. Employees are also eligible to join the HSE pension.
Start date: ASAP following successful interview
Informal enquiries to: Ms Siobhan Canny, Group Director of Midwifery: email: siobhan.canny@hse.ie
Applications: Please submit CV and cover letter detailing your experience, speciality area of interest, hospital preference to resources.human@hse.ie.

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