



Royal College
of Midwives



James
Lind
Alliance
Priority Setting Partnerships

Report of the Research
Prioritisation Project into

midwifery

Practice and Maternity Care

March 2026



influence the future of research



Royal College
of Midwives

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Forewords

Service-user representatives in the Steering Group

We were honoured to be involved in this valuable project and thank the Royal College of Midwives (RCM) team for taking our contributions seriously. We felt listened to at every stage, and that women and birthing people were centred throughout.

This began with agreeing the scope, alongside a team of professionals, to ensure a clear focus on relevant aspects of maternity care. We contributed to the design of the surveys and helped with their dissemination. A major aspect was ensuring that the wording of the potential research questions reflected the range of respondents' voices from the first survey. This was done in small multidisciplinary teams - ensuring all voices were heard. Our final role was agreeing a list of questions to go to the prioritisation workshop, to reflect the findings of the second survey.

We saw this exercise as an important use of our time. We are aware from our own lived and living experiences, and that of the service users we support, that there is a lack of good research-based information to inform decision making in maternity. Maternity is an area that is currently under-researched and under-funded, especially when considering the number of service users and families it potentially affects. Also, the research that is undertaken does not always reflect the priorities of service users. This illustrates how crucial this project is in encouraging future research that meets the needs of all stakeholders.

Our hopes are:

- That the Top 10 list will inspire researchers to prioritise projects that meet the needs of service users, their families and healthcare professionals.
- That researchers will look more deeply into maternity services research as a whole, including those shortlisted questions that nearly made the Top 10.
- That funders will be guided by this priority list in their decisions about which projects to support and the impact projects could have on improving outcomes. That all future maternity-related research maintains the same level of participation from service users and front-line staff.

Written by Steering Group members Amber Marshall - Big Births, Abi Gay, Nadia Higson - AIMS, Laura-Rose Thorogood - LGBT Mummies

On behalf of the Steering Group



Gill Walton

CEO, Royal College of Midwives

I am proud that the Royal College of Midwives has led this nationally important project. For the first time a UK-wide James Lind Alliance (JLA) priority setting project about midwifery practice and maternity care has been undertaken and we now have a Top 10 research priority list to guide our practice. The priority areas focus on a range of vital clinical, education, and workforce issues. As the CEO of the Royal College of Midwives, I am encouraged that this project can help members of our profession to lead important research based on the topic areas that women and midwives see as most important to them.

The success of this project was only achieved through collaboration, and I am grateful to the members of the project Steering Group and all of the Project Partner organisations who raised its profile across the UK. The RCM will now champion the priorities to maintain this momentum. Doing so is already a central plank in the *RCM Research and Development Strategy 2025-27*.¹ We need to make sure that research within these Top 10 priority areas is funded, so that the voices heard within the project have the impact that they deserve.

Gill Walton

Executive Summary

The Royal College of Midwives (RCM) launched the James Lind Alliance (JLA) 'Midwifery Practice and Maternity Care' Priority Setting Partnership (PSP)² in July 2023. The aim of this project was to identify the Top 10 research priority areas for midwifery practice in the United Kingdom (UK). The JLA is a non-profit making initiative, funded by the National Institute for Health Research (NIHR), to bring patients, carers and clinicians together in JLA Priority Setting Partnerships. This project had a broad scope, considering midwifery practice as defined by the NMC in its *Standards of Proficiency for Midwives*,³ the work undertaken by midwives and maternity support workers/maternity care assistants (MSW/MCAs) working as part of the multi-professional team, midwifery education and development, and workforce and staff wellbeing.

As the project co-leads, we worked under the direction of a project Steering Group comprising 16 members representing midwives, midwifery students, MSW/MCAs, service users and representatives of maternity service user supporting organisations. Additional academic support was provided by a Review Group of three UK midwifery professors. 87 Project Partner organisations from across the UK supported the project by promoting it amongst their networks.

The project was conducted according to the JLA approach, comprising two online surveys and a final workshop. The first survey received 937 responses and enabled the development of 67 summary questions that were shared in the second survey. The second survey received responses from 931 respondents, 556 of whom completed the survey. The Steering Group selected 26 summary questions that were taken to the in-person workshop. The workshop was attended by 23 participants, with representation from midwives, MSW/MCAs, midwifery students, service users and representatives of maternity service user supporting organisations. The Top 10 research priorities were identified using three rounds of consensus building activities.

The Top 10 research priority areas for midwifery practice and maternity care were announced at the RCM conference in May 2025. They reflect the full scope of the project, and illustrate the range of issues that matter to the people accessing and providing midwifery care in the UK in 2025.

The Top 10 priorities for midwifery practice and maternity care are:

1. What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum and ongoing learning in clinical settings play in improving cultural competence and safety?
2. What are the appropriate reasons for induction of labour? What are the short- and long-term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?
3. What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?
4. How does the culture within the maternity services, including racism, incivility and other negative behaviours amongst staff impact on midwives, maternity support workers and maternity care assistants and what can be done to address this?
5. What factors mean that birth is becoming increasingly medicalised, and what are the long- and short-term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?

6. How can the causes and consequences of pre-existing psychological trauma during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it?
7. How can postnatal care be prioritised and improved so that mothers and birthing parents and their babies receive high-quality care that meets their individual needs?
8. How can the maternity services improve bereavement care? How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death?
9. How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care?
10. What are the specific needs of neurodiverse individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care?

Each of the priority areas are broad, reflecting the large number and breadth of responses that were received to the first project survey. They are not intended to be used in their entirety as research questions but are instead to be viewed as priority areas containing many potential focused research questions that need to be answered. Further details concerning question creation, including examples of anonymised raw data, can be viewed on the JLA website ([Midwifery Practice and Maternity Care | NIHR JLA](#)).²

While the RCM initiated and led this project, the Top 10 priority areas have been identified by midwives, women and birthing people and their supporters from across the UK. The RCM will now champion the Top 10 priorities in the aim of creating a lasting and sustainable impact within the UK maternity research and policy agendas. We urge readers of this report to do the same.



Jenny Cunningham (left) and **Dr. Jude Field** (right)

RCM Research Advisors and project co-leads

How to reference this report: Royal College of Midwives. *Report of the Research Prioritisation Project into Midwifery Practice and Maternity Care*. 2026.

Glossary

CDT - Core Data Team

EDI - Equality, Diversity and Inclusion

EOI - Expression of Interest

HRA - Health Research Authority

JLA - James Lind Alliance

MSW/MCA - Maternity Support Worker/Maternity Care Assistant

NIHR - National Institute for Health Research

PP - Project Partner

PSP - Priority Setting Partnerships

RCM - Royal College of Midwives

RG - Review Group

SG - Steering Group

Introduction

The Royal College of Midwives (RCM) included the plan for a prioritisation project in its first *Research and development strategy 2021-2024*.⁴ The need to undertake such a project was clear. Midwifery focused and midwifery-led research was much needed to improve the care of women, birthing people and their babies. Midwives are an underrepresented profession in healthcare research and as such are eligible to apply for the NIHR's funding stream for underrepresented disciplines and specialisms. The project also responded to the strategy plan for research by the Chief Midwifery Officer for England⁵ which included, as its first aim, the timely identification of research priorities and evidence gaps to improve care and experiences for women, babies and their families.

Additionally, a report in 2020⁶ identified that maternity care was less well funded than other areas of healthcare; that for every £1 spent on pregnancy care in the UK only around 1p is spent on research. This compares unfavourably with other 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 chose to work with the James Lind Alliance (JLA) on the research prioritisation project. The JLA is a non-profit making organisation, funded by the National Institute for Health and Care Research (NIHR), based within a small team at the School of Healthcare Enterprise and Innovation, University of Southampton. The JLA method allows flexibility within its approach whilst maintaining several key principles to ensure consistency, transparency and inclusion.⁷

This was the first time that a UK-wide priority-setting partnership (PSP) about midwifery practice and maternity care had been undertaken and was jointly led by the RCM's Research Advisors, Jenny Cunningham and Dr Jude Field, with oversight from Dr Sara Webb, RCM Head of Research.

Review Group

The co-leads invited three professors of midwifery to form a Review Group before the launch of the project. This was an additional layer to the JLA project structure and was felt to be helpful to bring expertise, experience and academic rigour to the process. The Review Group consisted of Vanora Hundley, Professor of Midwifery at Bournemouth University, Helen Cheyne, Professor of Midwifery at the University of Stirling and Julia Sanders, Professor of Clinical Midwifery at Cardiff University. This ensured that the project had representation from England, Scotland and Wales. During the life of the project, there was no position of professor of midwifery in Northern Ireland.

The Review Group provided guidance and support throughout the duration of the project and met six times online and provided comments and feedback via email outside the meetings.

Steering Group

All key project decisions were guided by a project Steering Group (SG) made up of eight midwives, one midwifery student, two MSW/MCAs, five service users and representatives of maternity service user supporting organisations. Membership of the project Steering Group was decided following the submission of an Expression of Interest (EOI) via an online form which was open from 17 July to 6 August 2023. In total, 66 EOIs were received and any out-of-scope applications were disregarded (e.g. living outside the UK). All service user applications in scope were invited to join the SG. A decision-making matrix was used to support decisions about the midwife applicants. Consideration was given to ensuring four UK country representation and the inclusion of a range of midwifery roles and experiences (clinical practice, research, education and leadership). In addition, the three winners of the RCM Small Research Awards 2023 were invited to be part of the SG, with one acceptance.

The JLA Guidebook⁷ advises that individuals from the research community who are not also clinicians, patients, or carers should not participate in the priority-setting process. However, following consultation with the JLA Advisor and the JLA team, it was agreed that research midwives and midwifery PhD students could be included in the SG. These roles were considered distinct from the 'research roles' that the JLA aims to exclude, as they are closely aligned with clinical practice. In contrast, midwifery professors - whose positions represent more senior and influential research roles - were not invited to join the SG.

The co-leads discussed with the JLA Advisor the gaps in SG membership in terms of job roles, ethnicity and sexuality. They made active attempts to seek out potential new members and were successful in expanding the diversity of membership. Final membership was decided in consultation with the JLA Advisor on 14 August 2023 (Appendix 1). Ongoing work continued to invite members of the global majority to the SG until the release of survey 1.

The SG, chaired by JLA Advisor Dr Nahid Ahmad, met for the first time on 11 September 2023. All meetings were conducted online due to the geographic spread of the SG members and the convenience this offered attendance. The SG met monthly (apart from a summer break in 2024) during the life of the project, in total 13 times. Each meeting lasted between 1.5 and 2 hours. See Appendix 2 for the Terms of Reference.

The project aims and objectives

The project aim was to identify the future research priorities for midwifery practice and maternity care and disseminate widely, with the objectives to:

- Establish a 'Top10' list of research priorities for midwifery practice and maternity care decided by midwives, student midwives, maternity support workers, women and birthing people and other service users.
- Publicise the results of the prioritisation exercise with RCM members, maternity professional organisations, women's stakeholder groups, policymakers and funding bodies.

The project scope

The scope of the Midwifery Practice and Maternity Care PSP project was to identify unanswered questions about all areas or aspects of midwifery practice and agree the most important areas for research to address. This also included the work of MSWs and MCAs who work under the supervision of midwives. Whilst the project was focused on midwifery practice and care, the service user representatives of the SG requested that 'maternity' was included in the scope as only with this added, would the project feel relevant to women and birthing people.

The scope included perspectives from all four countries of the UK.

From:

- Midwives (regardless of current professional focus), student midwives and MSW/MCAs
- Service users – which include women and birthing people, their partners, families and friends
- Service user organisations
- Supporters – including doulas, antenatal teachers, and infant feeding specialists

About:

- Midwifery practice as defined by the NMC in its *Standards of proficiency for midwives*³
- The work undertaken by midwives and MSW/MCAs working as part of the multi-professional team where they contribute and influence maternity care
- Education and development
- Workforce and staff wellbeing.

Dissemination before and during project

Launch

The project was officially launched at an online Teams meeting on 17 July 2023. The event was publicised by the RCM through social media accounts and member newsletters. Additionally, emails to relevant individuals and organisations had also been sent by the co-leads inviting them to register to attend. In total, 227 people registered to attend, and 130 attended. There was representation from service users, service user supporting organisations, NHS Trusts and Boards, midwifery organisations and universities. The project co-leads provided an overview of the aims of the project, and the predicted timescale for the work. The meeting also included a pre-recorded presentation by Gill Walton, CEO of the RCM, and presentations by Professor Jane Sandall, CBE who at the time was Head of Midwifery Research at NHS England, and Rachael Leonard, Research and Service Development Officer at the NCT. A post-launch email was sent to all the registered attendees, with a link to a recording of the meeting, and an Expression of Interest (EOI) form. Attendees were informed that they were welcome to share information about the project across their networks.

Expressions of Interest initiative

A project EOI form was a flexible document that was in use throughout the life of the project to invite interest and offer opportunities to get involved. The opportunities to register for the different project roles were as follows:

- Steering Group member: applications open 17 July – 6 August 2023
- Project Partners (See Appendix 3 for the invitation letter): applications open 17 July – close of project
- Interested Parties (these were individuals who signed to receive project information, including surveys and the final report): applications open 17 July – close of project
- Workshop attendee: applications open 26 November 2024 – 25 February 2025.

Access to the EOI form was facilitated in several different ways throughout the project. Initial access was provided at the launch event and post-launch event email, the link was included in all four of the project newsletters (sent to Interested Parties and Project Partner organisations, to be shared across their networks), in all of the presentations undertaken by the co-leads throughout the project, and as a final page at the end of both of the project surveys.

RCM branches and posters

As a membership organisation, the RCM has 174 branches within NHS Trusts and Boards across the UK. Each branch Learning Rep or Chair (the latter in the absence of a Learning Rep) was contacted via email, offering to send posters about the project that could be displayed in clinical areas and staff rooms. The posters had a QR code direct to the surveys to enable easy participation. Five of the Welsh branches responded to a request for posters to be provided at an upcoming St David's Day in-person event. 72 posters were provided in this way. A further 38 branches responded to ask for posters to be posted directly to them, and 492 posters were sent out across the UK.

Meetings and events

The co-leads attended many meetings, both in-person and online to promote the project and the first survey. This approach was chosen to both disseminate information about how to take part in the project, but also to be clear about the responses to the surveys from the different categories of respondent (e.g. midwife, service user). The co-leads also were transparent in their presentations about the involvement of the global ethnic majority in the project and the need to improve the number of respondents to better reflect the UK population.

Project Partners

A core value of the JLA is that a prioritisation project is a collaborative process, involving (in most PSPs), 'patients, their carers and professionals'. For this project, 'patients' were replaced with 'women and birthing people' whilst 'carers' were replaced by 'their partners, families and supporters'. Professionals were midwives, midwifery students and MSWs/MCAs. The co-leads and SG decided that a key success of the project was to engage a diverse range of individuals and organisations in the project so that the final priorities reflected women and midwives from all backgrounds across the UK.

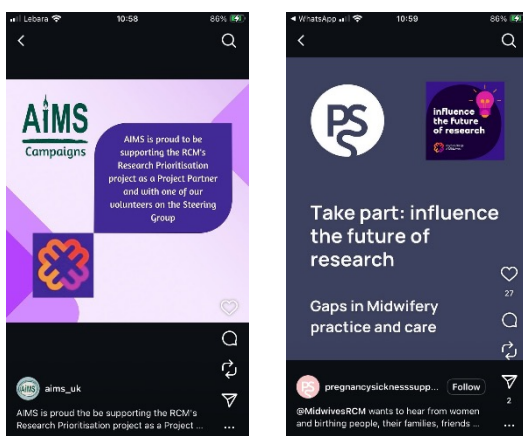


Figure 1: Examples of social media posts

The RCM project team reached out to service user organisations, via introductions from colleagues, 'cold calling' via a generic email inbox, using social media and recommendations from SG members. This resulted in a wide range of local and national organisations who became Project Partners (PPs). PPs acted in a dissemination capacity for the two surveys and other project information. The project was supported by 87 professional and service user organisations, hospital Trusts and Boards and universities (Appendix 5). The project team provided resources for the PPs to support them to promote the surveys in their networks and on social media, with examples in figure 1, and content for newsletters/blogs for individual organisations. Newsletters were written by the co-leads to update the PPs on the progress of the project and provide examples where certain PPs had found successful ways to disseminate the surveys (Appendix 6).

Methodology

The JLA framework was followed, details of which were provided in the JLA guidebook.⁷ This provided a step-by-step guide to the established methods of the JLA to ensure the project followed a trusted and credible process. Any queries about the process were directed to the JLA Advisor who was able to provide feedback, sometimes in consultation with her JLA colleagues. The key elements of a JLA project are two surveys and a workshop. Following use of the Health Research Authority (HRA) decision tool, ethical approval was not required.



Figure 2: Timeline of the project

1. Survey 1

The first project survey was designed collaboratively with the SG, between October 2023 and January 2024. Guidance was also sought from the project RG and the RCM EDI Lead. The co-leads decided to use the Microsoft Forms platform. The SG felt it important to be able to see who had responded and to understand how representative the responses were to the population of the UK (e.g. from which UK country and ethnicity) but acknowledged that not all respondents may wish to provide this information. Therefore, non-compulsory demographic questions were included at the end of the survey.

Consideration was given to the potential for the survey to be viewed by respondents as a way of reaching help at a time of distress, either as users of the maternity service or as a maternity service professional. The survey therefore provided a clear statement that the provision of support via the survey was not possible, and a document signposting to key organisations, such as The Samaritans and The Birth Trauma Association (Appendix 7), and information about professional sources of support for midwives, midwifery students and MSWs/MCAs was provided.

The survey was piloted by members of the SG, as well as the RG and three PP organisations. One person who identified as non-binary also reviewed the survey, focusing solely on language and imagery in relation to gender. Feedback was implemented and the Steering Group approved the final version on 3 January 2025.

The survey was launched on 8 January 2025 (see Appendix 8 for some screenshots of the survey) with the initial end date scheduled for 7 April 2025. The survey asked respondents to check a box stating in which category they identified (e.g. midwife, mother or birthing person, midwifery student). Respondents were free to check as many of the boxes that fitted them. The survey started with directions about how to translate the survey into a different language and then moved to five free-text boxes asking the respondent what was important to them and where they thought the gaps in evidence were. There was no word limit, and respondents were free to write as much as they liked about their thoughts and experiences.

A non-compulsory one-hour online meeting for PPs was held on 8 January 2025 to assist them in survey promotion and 63 individuals attended. The co-leads led the meeting and shared some suggested social media content and printable posters (Appendix 9). Attendees were also invited to share their ideas for promoting the survey amongst their networks. These were collated into a 'Top Tips' document (Appendix 10) and this was shared via an online PP resource folder. This was updated throughout the life of the survey, including a video provided by Autistic Parents UK giving practical guidance on survey completion.

A Steering Group meeting was held in February 2024, which was the survey mid-point, to assess its reach across the UK population. At this time point, 88% of respondents identified as White, which was a higher proportion than the UK population of 81.7%.⁸ The project co-leads shared their engagement strategy, including linking in with organisations working in diverse areas of the UK, updating PPs and further discussion with the RCM EDI Lead. On 4 March 2024, with the support of the SG, the co-leads discussed with the JLA Advisor and confirmed that the survey would be extended until 5 May 2024 for members of the global majority. Due to the various measures taken, the final proportion of respondents of White ethnicity lowered to 83.2% which is more in line with the UK population.

a. Respondents to survey 1

Individual responses:

Online

The majority (98.7%) of responses to the survey were received electronically via Microsoft Forms and numbered 937.

Paper

One PP, Black Mothers Matter, asked for paper copies of the survey for their members and returned eight completed surveys.

Focus group responses:

Two PPs undertook focus groups, which were counted as one response each:

- AIMS (Association for Improvements in the Maternity Services): held one focus group with 12 AIMS volunteers
- BANMA (British Arab Nurse and Midwife Association): held four focus groups from their membership, 3 x men and 14 x women in total.

Impact of the extension for members of the global ethnic majority

10 eligible online submissions received.

The co-chairs of the Race and Health Observatory Maternity and Neonatal Health Working Group submitted a letter via email, detailing its priorities, which were also included in the responses.

b. Data analysis

A Core Data Team (CDT) comprised the project co-leads, RCM Head of Research, Dr Sara Webb, and Library and Information Services Lead at the Midwifery Information and Resource Service (MIDIRS), Louise Deighton-O'Hara who acted as the Information Specialist. The CDT conducted the majority of the data analysis with Dr Yana Richens, Director of Midwifery Services at Liverpool Women's hospital included as a member until 1 September 2024.

The Information Specialist broke down the responses into individual questions or statements and created a master spreadsheet using Microsoft Excel with 3,272 lines of data from all the responses detailed in the data collection section. The master spreadsheet was for her use only. A copy of the spreadsheet with data was created for use by the CDT to begin analysis.

The CDT worked collaboratively, online, at the beginning of May 2024 to identify broad themes within the data, and to identify Out of Scope (OSS) submissions. Examples of OSS submissions included IVF treatment, questions about training doctors and the influence of TikTok. The broad themes were created quickly by the team as a means to manage the large quantity of data. Examples of the themes were 'postnatal', 'infant feeding', 'workforce' (see figure 3 below).

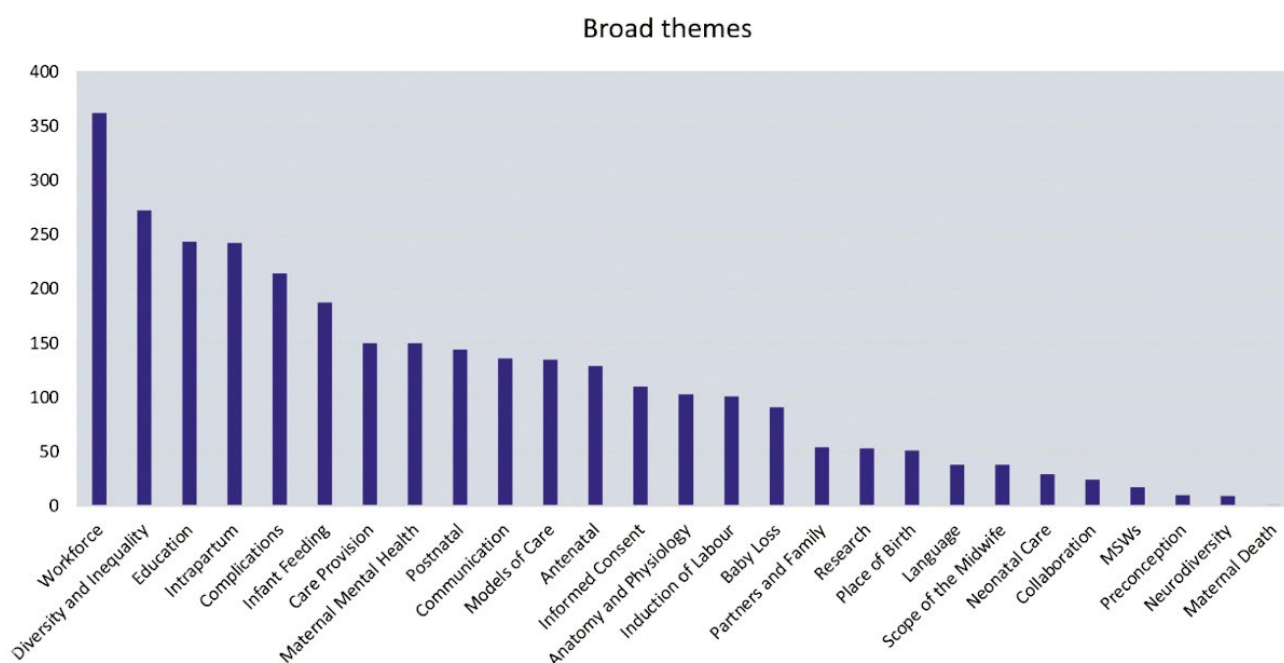


Figure 3: Initial broad themes created showing amount of data in each theme

The next step in the analysis was to create sub-themes from the broad themes. The CDT chose the broad theme of 'Maternal Mental Health' to pilot the process. Sub-themes were created and then statements or topics based on these sub-themes were identified as an interim step towards creating the final summary questions. The team continued this process for each broad theme, moving the data lines accordingly within the Excel spreadsheet. A checklist was used so each person's work was reviewed and confirmed by another member of the team. Any differences in approach were solved by a discussion and agreement. If necessary, a third member of the CDT would also be invited to review the differences, although this was rarely necessary. The SG was also invited to consider areas where there was uncertainty about how to categorise pieces of data.

The CDT worked mostly online but also met in-person at the RCM London HQ on 8 October 2024, with additional support from Mary Alvarez, NIHR Senior Research Lead Midwife and Heather Johnson, midwifery student. At this data analysis meeting, the topics were reviewed together with the data, providing sense-checking. For the first time, questions were created from the topics. The day was a collaborative as well as an individual activity. Opinions were sought when needed and the approach was taken of discussion and agreement. Conscious of JLA guidance to limit the number of summary questions (SQs) to 75 or fewer, the CDT created large SQs by merging statements and topics and used AI selectively to help with the wording of some of the SQs.

In line with the JLA approach, from November 2024 onwards the SQs were all considered and signed off by the SG. Some SQs required further revisions after initial consideration by the SG, and so were reconsidered for a second or third time. The SG met twice as a whole group [21 November 2024 and 10 January 2025], with two extra meetings [11 December 2024 and 19 December 2024] convened to enable a flexible approach for SQ sign-off, as long as at least one service user and one service provider SG member was in attendance. An initial idea to create 'Triads' containing two service provider members and one service user member had not proved workable because of SG members' differing commitments at this time of year. Towards the end of this process some CDT decisions were approved over email. Care was made to ensure that a sufficient length of time was provided for SG members to express their dissent or to provide any feedback.

On 17 January 2025, the final list of 68 SQs was signed off. Details of the individual questions associated with each summary question are available on the [JLA website](#).

2. Evidence checking



Figure 4: Hands on data analysis: From left to right; Jude Field, Heather Johnson, Sara Webb, Louise Deighton-O'Hara, Mary Alvarez and Jenny Cunningham

In January 2025 the core data team began the evidence-checking process. Following advice in the JLA guidebook, the team used documents from the National Institute for Health and Care Excellence, the Scottish Intercollegiate Guidelines Network, the Royal College of Obstetricians and Gynaecologists, and Cochrane systematic reviews, but found that much of the evidence contained in these publications was published prior to the recommended three years. The team therefore took advice from the JLA Advisor who supported the co-leads to move to evidence checking against any systematic reviews published within the past three years [from January 2022]. Following the evidence check, a number of SQs were amended to reflect the evidence base, for instance, changing to implementation-focused questions. One priority topic was found to be answered, which was 'How can perineal trauma be minimised, what are its impacts on physical and mental health, and what constitutes optimal aftercare?'

Uncertainty (PICD formatted indicative uncertainty where possible. Advised minimum requirements are 'Population' and 'intervention'. Not all submissions may be suitable for PICD structure, but they should be in a format that will ultimately be of value to the research community)	Original uncertainty	Evidence (reference, and weblink where available, to the most recent relevant systematic review identified by the PSP, plus a maximum of 2 other systematic reviews, including protocols for future systematic reviews, that the PSP considers relevant.)	Source of Uncertainty (if there are multiple sources, a PSP may wish to show them e.g. 1 x patient, 15 x clinician, 4 x research recommendations)
How can perineal trauma be minimised, what are its impacts on physical and mental health, and what constitutes optimal aftercare?	<p>"Perineal bundles that we offer, we don't have any evidence on whether they increase the risk of 1st or 2nd degree tears. And from my reading they actually increase the risk of tearing for multiples having a physiological birth"</p> <p>"perineal guarding review of the physiology of DASI management"</p>	<p>There are Systematic Reviews which answer the uncertainty:</p> <p>Morganelli G, Fieni S, dell'Ono S, Capozzi VA, Di Serio M, Dall'Asta A, Chi T. Efficacy of intrapartum bundles and interventions in reducing vaginal delivery-related perineal trauma: a systematic review. <i>Eur J Obstet Gynecol Reprod Biol.</i> 2024 Dec; 12:305-107-119. doi: 10.1016/j.ejogrb.2024.12.008. Epub ahead of print. PMID: 39675167.</p> <p>Roman MP, Aggarwal S, Doumouchakis SK, CHORUS, an International Collaboration for Harmonising Outcomes, Research and Standards in Urogynaecology and Women's Health [in-chorus.org]. A systematic review and meta-synthesis of qualitative studies on childbirth perineal trauma for the development of a Core Outcome Set. <i>Eur J Obstet Gynecol Reprod Biol.</i> 2023 Nov;230:51-59. doi: 10.1016/j.ejogrb.2023.09.010. Epub 2023 Sep 11. PMID: 37734138</p>	<p>2 responses:</p> <p>8x service user; 10x professional; 3x service user+professional</p>
What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?	<p>"In particular, what training and support do they need in order to support and give respectful personalized care to women and birthing people who decline aspects of routine care or the interventions that they are offered, especially in the case of those who have been labelled 'high risk'?"</p> <p>"How it feels to be a woman in pain and losing agency as clinicians tell you what you can and cannot do"</p> <p>"Care seems a bit one size fits all unless you have the support, knowledge or confidence to advocate for yourself"</p>	<p>One Systematic Review and one umbrella review are relevant to the uncertainty:</p> <p>Alnuwaihi TA, Crawford K, Jahanzar S, Hampton K, Footad E. Pregnant persons and birth partners' experiences of shared decision-making during pregnancy and childbirth: An umbrella review. <i>Patient Educ Couns.</i> 2023 Sep;114:107832. doi: 10.1016/j.pec.2023.107832. Epub 2023 Jun 2. PMID: 37295043.</p> <p>Whitrow R, Webster LM, Seed PT, Sandall J, Chappell LC. The effectiveness of decision aids for pregnancy related decision-making in women with pre-pregnancy mobility: systematic review and meta-analysis. <i>BMC Pregnancy Childbirth.</i> 2022 Jan 23;22(1):81. doi: 10.1186/s12884-022-04402-w. PMID: 35033017; PMCID: PMC8801107.</p>	<p>18 responses:</p> <p>78x service user; 30x professional; 3x other supporter (Doula, AN teacher etc); 6x service user+professional; 1x service user+other supporter</p>

Figure 5: Image of evidence check from JLA spreadsheet

The remaining 67 priorities went forward to the second survey, which can be viewed on the JLA [website](#).²

3. Survey 2

The Survey Monkey platform was used for the second survey due to its ability to have a two-stage process to allow respondents to first choose as many of the 67 priorities (Appendix 11) as they wished. Following this choice in the survey, respondents were then invited to select up to 10 priorities for submission. Non-compulsory demographic questions were included once again. The survey was designed so the questions were randomised to a different order for each respondent. The survey was piloted with two individuals with an LGBTQ+ lens and four Project Partners who provided feedback, which was implemented.

The survey was released on 31 January 2025 and sent to over 200 Interested Parties and 100 contacts within our Project Partner organisations. Other relevant organisations with a global majority focus, but not at that stage involved formally in the project, were also emailed the survey. Whilst the survey closed on 2 March 2025, the Steering Group made the decision to extend the survey for global majority respondents until 16 March 2025. The survey closed to all respondents on 16 March 2025 with 931 respondents, 556 of whom completed, making a response rate of 59%.

a. Data analysis

The co-leads used the Survey Monkey software to analyse the data in nine ways, to provide the SG members with sufficient information to decide which SQs should be taken to the workshop. SQ members were informed which of the SQs were the ten most prioritised in survey 2, which of the remaining SQs were in the Top 20 across all of the nine groups, and which of the SQs had been more prioritised by women and birthing people [N = 6], and those which had been more prioritised by respondents who identified as being from the

global majority, the LGBTQ+ community, and as having a disability [N=10]. This approach enabled the overall preferences of all the respondents to be acknowledged, whilst also permitting consideration of the different respondent groups, and an EDI lens was applied to this important step in the project.

Table 1: Example of how different questions were ranked

Summary Questions	RANK - Overall	RANK - Professionals [Midwives, Midwifery students, MSWs]	RANK - Service users [Women, birthing people, partners, friends and family supporters]	RANK - Supporters [Doulas, AN educators, Lactation Consultants]	RANK - Midwives	RANK - Women and birthing people	RANK - Global majority	RANK - Respondents who identify as belonging to the LGBTQ+ community	RANK - Respondents who identify as having a disability
What are the appropriate reasons for induction of labour? What are the short- and long-term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?	1	1	1	1	1	2	5	1	2
How can midwives use the available evidence to facilitate and support the body's natural processes during labour and birth (physiological birth)? Would more knowledge about the anatomy and physiology of labour and birth, including biomechanics, be beneficial?	5	6	5	3	7	5	9	11	9
How can the known evidence be built on to improve support for infant feeding for all babies and all mothers and birthing parents by ensuring consistent, accurate information and services throughout the antenatal, intrapartum, and postnatal periods?	27	>20	8	6	32	10	>12	19	16
What support and care provision should be available for families following a maternal death?	33	>20	19	10	30	18	8	16	21

Guidance from our JLA Adviser was to limit the number of SQs being taken to the workshop to 26 so four of the SQs that had been prioritised by some of the smaller respondent groups were combined into two SQs to enable them to be taken forward:

Table 2: Combining of summary questions

	Original SQ	Original SQ	Combined final SQ
1	What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority?	To what extent are current actions to tackle racism and decolonise the midwifery curriculum, and ongoing learning in clinical settings, effective in improving cultural competence and safety?	What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum, and ongoing learning in clinical settings, play in improving cultural competence and safety?
2	What support and care provision should be available for families following a maternal death?	How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer loss in their current or previous pregnancies?	How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death?

Additionally, further discussion about the SQ related to infant feeding prompted a change to ensure that inclusive language was being used. The SG members discussed options and approved the addition of '(both breast/chest and formula)' to the existing SQ:

How can the known evidence be built on to improve support for infant feeding (*both breast/chest and formula*) for all babies and all mothers and birthing parents by ensuring consistent, accurate information and services throughout the antenatal, intrapartum, and postnatal periods?

4. In-person prioritisation workshop

The second survey and third project newsletter included a link to an EOI form for those who wanted to be considered for the workshop. This was open from 25 November 2024 and closed 25 February 2025. All service users who expressed an interest were invited and professionals were invited according to a decision matrix, which included location (UK country), current midwifery role and previous experience. EDI considerations were also used. Further attempts were made across professional and personal networks throughout March 2025 to invite additional service users to the workshop.

The workshop took place on Thursday 17 April 2025 at the Edgbaston Campus of the University of Birmingham, with 23 participants. In addition, there were a number of observers, including the four members of the data team, CEO of the RCM Gill Walton and Professor Julia Sanders, Review Group member. The workshop was chaired by the JLA Adviser and two of her JLA Advisor colleagues. All three acted as facilitators in the two breakout groups during the day.

The day followed a precise JLA format (see JLA Guidebook)⁷ and participation in the breakout groups enabled delegates to discuss which priority topics were important to them and explain why. The priorities had been printed on A4 sheets of paper, with the overall ranking and ranking by respondents identifying as belonging to the global majority, the LGBTQ+ community or having a disability on the reverse side. The participants were asked to collaborate to decide the priority order for the 26 priorities. This involved sensitive and supportive discussions on topics such as baby loss and experience of racism. A plenary session came next with feedback about how the 26 priorities had been ranked by each group and what a combined ranking showed. The subsequent breakout rooms had different participants and used the combined ranking order for the 26 priorities. Each group then had to discuss how to work forward together to decide a Top 10. The final plenary session followed analysis by the JLA Advisors, who were then able to announce the Top 10, followed by the ranking of 11-26, to the workshop participants and observers.



Figure 6: Workshop participants

Top 10 priorities for midwifery practice and maternity care

1. Top 10 priorities

The most important priority areas

1. What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum and ongoing learning in clinical settings play in improving cultural competence and safety?
2. What are the appropriate reasons for induction of labour? What are the short- and long- term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?
3. What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?
4. How does the culture within the maternity services, including racism, incivility and other negative behaviours among staff impact on midwives, maternity support workers and maternity care assistants and what can be done to address this?
5. What factors mean that birth is becoming increasingly medicalised, and what are the long- and short-term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?
6. How can the causes and consequences of pre-existing psychological trauma during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it?
7. How can postnatal care be prioritised and improved so that mothers and birthing parents and their babies receive high-quality care that meets their individual needs?
8. How can the maternity services improve bereavement care? How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death?
9. How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care?
10. What are the specific needs of neurodiverse individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care?

2. Priorities 11-26

The following questions were also discussed and put in order of priority at the workshop:

11. How can midwives use the available evidence to facilitate and support the body's natural processes during labour and birth (physiological birth)? Would more knowledge about the anatomy and physiology of labour and birth, including biomechanics, be beneficial?
12. What are the most effective strategies for implementing continuity of midwifery care for all, which are sustainable for midwives and respond to the needs of mothers and birthing parents?
13. What do women and birthing parents with learning disabilities, and those who support them, want and need during their maternity care and how can this be provided?
14. How can women and birthing parents, and their partners and families be protected from developing poor mental health during the perinatal period? When people have a mental health problem, how can this be recognised, treatment and support given, and the potential impact reduced?
15. What should midwifery education include for students to become confident and competent midwives, with critical thinking skills and the ability to give compassionate safe care in today's maternity service? Once qualified, how should continuing professional education for midwives be provided?
16. What support and care do women and birthing parents need during the latent phase of labour, and what are the best indicators for timely recognition of active labour?
17. Is the way that BMI is being used during pregnancy helpful? Should other factors such as ethnicity, muscle mass, heart health and other lifestyle factors be taken into account too?
18. How can parent education be designed and provided to meet the needs of all parents, including those with specific pregnancy, postnatal and birth and newborn care requirements, taking into account the wider influences that shape parental expectations and knowledge?
19. How can good multidisciplinary team working be promoted to ensure clear, compassionate, and effective communication between clinicians and with women, birthing parents and families?
20. How do different types of fetal monitoring affect women's and birthing parents' experiences of labour and birth, the wellbeing of their babies, and how can midwives use this knowledge in their practice?
21. How can access to midwifery-led units and home birth be ensured for all women and birthing parents, including those considered 'high risk', or from marginalised or underserved communities. What evidence is needed to support this?
22. How can the known evidence be built on to improve support for infant feeding (both breast/chest and formula) for all babies and all mothers and birthing parents by ensuring consistent, accurate information and services throughout the antenatal, intrapartum, and postnatal periods?
23. How is Artificial Intelligence (AI) currently being used in maternity care? How might AI be used in the future? What are the potential impacts on women's, birthing parents' and babies' outcomes and experiences?
24. How can the best care for newborns of all skin tones be provided at birth and in the early postnatal period for those with existing diagnoses and to promptly identify complications?
25. How can access to pools for labour and birth be offered across all birth settings, including for women and birthing parents classified as high risk under clinical guidelines?
26. How can the physical birth environment—such as noise and light levels, furnishings, and equipment—be designed and implemented to optimise physiological birth and promote women's and birthing parents' wellbeing?

Discussion

This project encompassed the broad remit of midwives and their influence in maternity care. The Top 10 priorities for Midwifery Practice and Maternity Care reflect the current concerns of women, birthing people and midwives and their shared commitment to improvement. It was the first time such a wide-ranging JLA PSP had been undertaken in relation to midwifery practice and maternity care, and its ambition could be seen in the number and variety of responses received. The Top 10 priorities are a wide-ranging list, covering women's experiences as well as workforce issues and education. This section of the report examines how these priorities might contribute towards current public policy discussions around midwifery and maternity service.

The first priority area reflects the national concern about the disparity in outcomes for global majority women and birthing people in the UK. Reports have consistently showed that racially minoritised women and their babies have a poorer experience than women of white ethnicity.^{9,10,11,12,13} The priority aims to address this inequality and calls for improved outcomes through implementing culturally safe maternity care. The priority includes topics such as the need for interpretation services, an improved understanding of different cultural needs through better spread of cultural competence training, better support for global majority staff and decolonisation of the education of midwifery students.¹⁴ In 2025, the NIHR launched its first 'Challenge' funding call of £50 million to tackle inequalities in maternity care. Nine UK universities have been selected for the new NIHR Challenge Maternity Disparities consortium which will focus on inequalities before, during and after pregnancy. This includes a specific theme 'Intersectionality and tackling systemic racism / discrimination' – an encouraging step towards gathering evidence in this priority area.¹⁵

A number of priorities responded to what some have termed the 'UK Maternity Crisis',¹⁶ a key factor being the increasing medicalisation of birth.¹⁷ This is the fifth priority area and participants called for research to determine which factors are making birth more medicalised and the resultant short- and long-term impacts. Closely linked is priority area two, which focuses on the rising use of induction of labour, its frequency and its impact on both woman and baby. Other priorities, outside the Top 10, were also aligned with concerns about increasing medicalisation and the role of the midwife, which include supporting birth physiology (priorities 11 and 26), implementing strategies for continuity of midwifery care (priority 12) and enhancing access to birthplace choices which the existing evidence base suggests facilitates birth physiology (priorities 21 and 25).

Other significant impacts on maternity care arise from staff shortages, poor work cultures and staff burnout. Our participants requested further research to address racism, incivility and other negative behaviours amongst staff, which became priority area 4. In 2021 the RCM and Royal College of Obstetricians and Gynaecologists (RCOG) wrote a joint statement on undermining and bullying behaviour, but this continues to be a key area for maternity staff.¹⁸ Another key and related topic was how midwifery can continue to be an attractive career, and qualified staff be supported to stay in the profession, which became priority area 9. Midwives are working 100,000 hours' unpaid overtime each week.¹⁹ There are concerns that plans to recruit and educate new midwives will be jeopardised without substantial and sustained investment in midwifery education, including reintroduction of the bursary in England and increased financial support across the UK.²⁰

The importance of the relational nature of the work of midwives was made clear by our respondents with priority area 3 concerning personalised care. This broad topic included responses about respectful care, informed choice and decision making, all of high importance, ensuring a good experience for women and birthing people.^{21,22} The importance of the provision of appropriate care when care is declined, requested outside of guidance, or involves unregulated people is highlighted by the NMC.²² Implementing Continuity of Care as priority area 12 also reflects the interpersonal role of a midwife and its significance to women's

perinatal care. The midwifery continuity of care model finds women more likely to experience positive experiences during pregnancy, labour and postnatally and less likely to have a caesarean birth or instrumental vaginal birth.²⁴ However, it remains elusive due to complex systemic factors. The importance of personalised care and relational connections were also seen in the request for more evidence to support neurodivergent individuals during maternity care. This priority is tenth in the list and many of the submissions from both women and midwives directed their focus on the need for improved communication skills for midwives and other maternity care professionals.

Priority area 6 encompasses both the causes and consequences of pre-existing psychological trauma during the perinatal period and included responses about trauma informed care. Many of the responses referred to birth trauma and the long-term negative impact this can have, and this has been highlighted in the recent APPG report.²⁵ Additionally, another JLA PSP identified the need to prevent re-traumatisation when accessing health services, including those providing intimate care such as the maternity services.²⁶

Priority area 14 addresses the related area of poor mental health. Perinatal mental health is the most common health complication during or after pregnancy, but gaps remain in access to treatment.²⁷ The most recent MMBRACE report tells us that suicide remains the leading cause of late maternal death²⁸ and the RCM Perinatal Mental Health Roadmap²⁹ provides a clear set of recommendations calling on policy makers and service providers to commit to sustainable investment in services, workforce and education.

Postnatal care is priority 7 with research required to find how it can be prioritised and improved within maternity services. Postnatal care has for many years been termed the 'Cinderella service'³⁰ and our respondents suggest it is not improving. Related to postnatal care is support for all forms of infant feeding, priority 22. Our respondents expressed the negative impacts that insufficient support and care had on their early days with their newborns, and for many their abilities to feed them in the way that they wished. Recent research by Wheeler et al³¹ found that amongst mothers who had experienced birth trauma, positive breastfeeding experiences helped them to bond with their baby and protected their mental health, whilst those who had a difficult breastfeeding experience reported how this further negatively impacted their wellbeing.

Bereavement care is the eighth priority area, with the majority of submissions focused on the needs of parents whose baby has died during pregnancy or soon after (miscarriage, stillbirth, neonatal death). Whilst there is a national pathway for bereaved parents, the responses suggest that this is not embedded in practice throughout the UK. This priority also includes the bereavement suffered by a family following a maternal (woman's/birthing person's) death. Whilst this is a rare occurrence in the UK it has devastating consequences and research should be undertaken to establish the holistic needs of a bereaved family in these situations.

Finally, this project has highlighted the inter-professional nature of maternity care. The Royal College of Obstetricians and Gynaecologists has in its Top 10 research priorities across the life course for women's health, two focused on maternity care.³² In recent years reviews of maternity safety in individual hospital Trusts (Morecambe Bay, Cwm Taf, Ockenden, East Kent) have outlined poor and disrespectful experiences of maternity care, resulting in baby loss and long-lasting trauma for parents.^{33,34,35,36} Other investigations have taken a different approach and identified system failings which need to be addressed before maternity care can improve.^{37,38} The current National Maternity and Neonatal Investigation, chaired by Baroness Amos, aims to develop recommendations to improve high quality and safe maternity and neonatal care and reduce inequalities experienced in these services. This project with its Top 10 priorities (and priorities 11-26) has demonstrated the commonality and shared concerns of service users and midwives and many of the priorities can only be taken forward with a whole team approach, with midwives central to the research.

Strengths and Limitations

There were a number of strengths and limitations which have been identified for this project. In terms of strengths, the JLA methodology was used, a well-designed and systematic approach and this was the first of its kind for UK maternity care. The project was led and managed by a small and close team which included expertise in qualitative data analysis as well as data safety. The RCM is a well networked organisation with a far reach through its membership and professional work. The team was able to capitalise on these relationships but went beyond them to involve new people and groups. EDI considerations were at the heart of the project and used to reflect the diversity of the UK population in the surveys and the priorities which went to the workshop. There was a strong and engaged Steering Group membership with effective online meetings. The Review Group was a valuable addition for guidance and continued support for dissemination. The workshop was held in person and only one person was unable to attend, which meant there was good representation from midwifery and service user groups.

In terms of limitations, there was a lack of diversity (ethnicity, sexuality, gender and disability) in the Core Project Team. Insufficient outreach due to the constraints of resources and time meant that the project lacked connections to non-English speaking and ethnically diverse populations. Survey 2 completion rate was lower at about 60% (although this was anticipated), fewer service users took part and responses from the global majority were less than the UK population. The nature of the project, linking with Project Partner organisations to reach their networks naturally meant that those with more established communication networks and greater membership meant that smaller organisations may have had a smaller 'voice' in our data.

Conclusion

The Top 10 priorities reflect the current maternity care experience for women and midwives. This first-time project into the priorities of midwifery practice and maternity care has demonstrated the breadth of interest in and concern for evidence which supports positive experiences for women and staff. It used a robust and transparent methodology and employed an experienced JLA Advisor to steer throughout its lifespan.

Research questions can be formulated from the Top 10 priorities, using different methodological approaches, dependent upon researcher interest. There is application of these priorities within an educational setting so that midwifery students can use them to decide the focus of an assignment. The rationale for this project was to improve the care of women, birthing people and their babies and to establish the priority areas for research. We therefore invite midwifery researchers and others who undertake maternity research to use these priorities when deciding on the focus of studies and applying for funding.

Generating impact

The completion of the project and publication of this report is just the beginning. The RCM has started, and will continue, to embed the priorities within its work and outputs. The important work of dissemination and influence has begun, and the RCM has begun to widely disseminate the priorities.

Approaches to dissemination include publication and distribution of this report, publishing an article in a peer reviewed journal, conference presentations, webinars and discussions with funders of healthcare research, such as the NIHR (funding is now available in Wales and Scotland, as well as England) and the Wellcome Trust. The RCM will also engage with charities which support maternity research, including the Wellbeing of Women and the Iolanthe Midwifery Trust.

The RCM will encourage the promotion of the priorities within research funding schemes and promote opportunities for funding in specific funding calls, such as for the NIHR Research for Patient Benefit and the Health Technology Assessment programmes. It will champion the midwifery practice and maternity care priorities within the rolling programme for JLA funded research. In doing so, the RCM will raise awareness of the priorities amongst the different funding committees. To evaluate the success of the priorities, the RCM will map the funding of studies against the Top 10. This will be undertaken on a continuous basis.

The RCM has an ongoing role to encourage maternity researchers to use the priorities in their work and to advocate for midwives to lead research teams. It will hold an annual research symposium to encourage dissemination of studies which align with the priorities. Whilst we will champion midwife-led research, the symposia will be for all maternity researchers from different professions and disciplines. In addition, the RCM will deliver training and education to support midwives and others to create fundable research questions from the broad priorities.

Another initiative will be to develop educational resources to encourage student engagement with the priorities. The RCM will work with its Education Team and educationalists from around the UK to produce and disseminate a lecturer/student pack to use for assignments and dissertation writing. It will also support students with their research ideas and in formal research proposals and reports.

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Appendices

1. Membership of the Steering Group

Member	Role
Laura Abbott	Midwife, England
Claire Bertorelli	Midwife, Wales
Mel Cooper	Maternity Stream, City of Sanctuary
Racheal Crane	MSW, England
Sarah Esegbona-Adeigbe	Midwife, England
Christine Furbey	Midwife, England
Abi Gay	Service user
Melanie Harrington	Midwifery student, Northern Ireland
Stephanie Heys	Midwife, England
Nadia Higson	AIMS
Emma Lesley	MSW, England
Katherine Letley	Maternity Stream, City of Sanctuary (until 10 December 2024)
Amber Marshall	Big Births
Tom McEwan	Midwife, Scotland
Jennie McNeill	Midwife, Northern Ireland
Sian Rogers	Midwife, England
Laura-Rose Thorogood	LGBT Mummies

2. TOR for Steering Group



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Midwifery and Maternity Priority Setting Partnership Steering Group – Terms of Reference 11 September 2023

This document sets out the Terms of Reference for the Steering Group of the James Lind Alliance (JLA) midwifery practice and maternity care Priority Setting Partnership (PSP).

In line with JLA principles, this Steering Group will include representatives of patients, carers and clinicians. These may be people with lived experience, members of a charity or professional organisation or individual health professionals within the area of the PSP.

Members will bring with them knowledge of midwifery and maternity, an understanding of the patient, carer and clinician populations and access to networks of patients, carers and clinicians. Members will need to be fully engaged in the process and have the time to carry out the work involved.

The background and wider aims and responsibilities of the midwifery practice and maternity care PSP are set out in its Protocol.

Introduction to the James Lind Alliance and priority setting

The JLA is a non-profit making initiative which enables patients, carers and clinicians to work together to identify and agree priorities for research.

Each PSP consists of patients, carers and their representatives, and clinicians, and is led by a Steering Group. The Steering Group oversees the activities of the PSP and has responsibility for the activity and the outcomes of the PSP. Collaboration between patients, carers and clinicians to set the research agenda is vital in drawing issues to the attention of research funders that might not otherwise be suggested or prioritised.

The role of the PSP is to identify questions that have not been answered by research to date, and then to agree which of these are the most important. The first stage is to ask patients, carers and clinicians, often via an online survey, for unanswered questions about midwifery and maternity. These questions are then assessed to check they are in scope for the PSP and are checked to make sure they have not already been answered by research. An interim prioritisation exercise then takes place, where people with an interest in midwifery and maternity choose which questions are most important to them. Finally,



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there is a priority setting workshop where participants discuss the most important questions and agree a list of the Top 10.

The aim of the PSP is to highlight the important areas of research to the research and funding community and to work with them to develop the priorities into researchable questions.

In addition to the PSP's own reporting activity, the JLA will publish all priorities on the JLA website. Further details about the JLA and PSPs are at <http://www.jla.nhr.ac.uk/>. A flowchart of the PSP process can be seen in the Templates and useful documents section of the JLA website at <http://www.jla.nhr.ac.uk/about-the-james-lind-alliance/templates-and-useful-documents.htm>

The Midwifery Practice and Maternity Care Priority Setting Partnership

Membership of the Steering Group

The Steering Group membership must include women, birthing people and professionals. It is agreed that for the midwifery practice and maternity care PSP, two service user or service user representative and two maternity care professionals will need to be present for Steering Group meetings to be quorate.

Role of Steering Group members

Steering Group members are asked to contribute, as a minimum, their expertise and their time, and to be prepared to approach their established contacts and networks.

All Steering Group members are asked to commit to working according to the JLA principles:

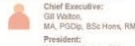
- **Inclusivity:** working with other members supportively, respectfully and constructively and aiming to ensure the full range of patient, carer and clinical stakeholders are involved in the PSP process
- **Equality:** patients, carers and clinicians, and the knowledge and experience they bring, are of equal value to the PSP. Their opinions are treated equally and differences in opinions are respected
- **Fairness and transparency:** declaring any personal interests, and ensuring decisions and activities are documented openly
- **Evidence based:** ensuring the work of the PSP recognises the existing knowledge base for midwifery and maternity care and other spheres of midwifery practice and contributes to this through the PSP's evidence checking and open



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publication of information from the PSP

Members of the Steering Group will need to agree the resources (including time and expertise) that they will contribute to ensure that each stage of the process is completed. Members of the Steering Group will:

- Publicise the PSP to potential partners. This includes advising on contacts for the PSP (to ensure a wide and representative group of women, service user organisations and clinicians) and emailing contacts to invite them to participate
- Publicise and participate in an initial awareness meeting if this takes place
- Take part in monthly online Steering Group meetings. It is usual for a Steering Group to meet on an approximately monthly basis to keep momentum around the PSP and to maintain their relationship as a team
- If unable to attend, submit comments ahead of the meeting. Where a Steering Group member is unable to attend a meeting, decisions made at the meeting will be respected
- Respond promptly with feedback on project materials by responding to emails
- Have oversight of the collection of evidence uncertainties from women and midwives, student midwives and MSWs and existing literature
- Oversee and lend expertise to the data management process, including agreeing the scope and process for data-checking
- Have oversight of the interim priority setting stage
- Sign off the final shortlist of questions to be taken to the priority setting workshop
- Oversee the planning for the priority setting workshop and help to publicise it. This is the one-day workshop that brings women and maternity care professionals together to debate, rank and agree a final Top 10. Participants are women, service user representatives, midwives, student midwives and MSWs. Typically, not all members of the Steering Group take part, allowing space for new participants
- Ensure that the PSP's working spreadsheet of uncertainties and the final prioritised list of questions are supplied to the JLA, for publication on the JLA website
- Help publicise the final top 10 uncertainties to the research community
- Be involved in the development of research questions from the agreed priorities, and work with research funders where necessary to provide any extra information they need.



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Specific Roles

Chair: The PSP will be chaired by Nahid Ahmad, a JLA Adviser. The JLA Adviser also Chairs and runs the priority setting workshop. The JLA Adviser's role is to support and guide the PSP, as a neutral facilitator, ensuring that the process is followed in a fair, transparent way, with equal input from patients, carers and clinicians and their representatives.

Lead: Jenny Cunningham and Dr Jude Field are the leads for the PSP. The Lead works closely with the JLA Adviser and the PSP coordinator to champion the PSP and ensure it is successfully promoted, completed and disseminated to funders. The co-leads are supported by Dr Yana Richens, as Senior Research Leader appointed by the NIHR, and Dr Sara Webb, RCM lead for research and information.

Coordinator: Dr Jude Field and Jenny Cunningham are responsible for the coordination and administration of the PSP. This includes arranging all meetings and workshops, and ensuring that:

- requests for agenda items are discussed with the group
- papers are available at least a week before meetings
- meeting notes are reviewed by the Chair, circulated within two weeks, and reviewed and agreed at the next meeting

Information Specialist: Anastasia Spiliopoulou (to be confirmed) is the Information Specialist for the PSP. Their role is to advise the Steering Group on data management and analysis strategies and agree these with the group. They also review and analyse the data collected, review existing evidence, and help develop the long list of questions, under the guidance and assurance of the Steering Group. It is helpful if the Information Specialist has content knowledge in the subject area of the PSP. However, if the Information Specialist is well supported by the Steering Group this is not essential. The outputs delivered by the Information Specialist will be approved by the Steering Group.

Code of Conduct

It is important that members of the Steering Group work to high personal and professional standards. Steering Group members are expected to:

- behave in a manner which does not bring the PSP or the JLA into disrepute or damage the relationship with Steering Group members, partners and any other stakeholders in the PSP
- maintain confidentiality when sensitive information is shared
- actively support diversity and inclusion and not discriminate against any person.

Everyone involved in the PSP should feel safe, respected and able to contribute fully.



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Anyone found to be in breach of this code may be removed from the Steering Group at the discretion of the PSP leader. Any concerns related to conduct should be raised with the PSP leader and/or the JLA Adviser.

Declaring interests

Steering Group members are asked to declare any interests relevant to the midwifery and maternity PSP. The JLA provides an example Interests and Privacy form, and the interests of each member will be shared among the group. This is to encourage a culture of openness and transparency. Relevant interests may be professional, personal or related to an interest in or involvement in clinical research. The same form asks Steering Group members to consider their agreement to being named in publicity about the PSP. Researchers may sit on the Steering Group if the group feels this is appropriate and useful – the JLA Adviser will ensure that they do not have an undue influence on the outcome. Researchers who are currently clinically active may participate in the priority setting if they declare their interests.

Timescales

The midwifery and maternity PSP first Steering Group meeting will be on 11 September 2023. We propose that the priority setting workshop takes place in January 2025.

Please refer to the Midwifery and Maternity PSP protocol for details of the steering group members and their roles.



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3. Role of Project Partner – blank letter



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of Midwives

February 2024

Dear colleague

This letter provides you with a brief background to the RCM James Lind Alliance Research Prioritisation project, and outlines the role that Project Partners play within the project.

Project background

The aim of the project is to identify the unanswered questions about midwifery practice and maternity care and other spheres of midwifery practice from service user and clinical perspectives, and then prioritise those that women, birthing people and maternity health professionals agree are the most important for research to address.

In case you are not already familiar with the work of the James Lind Alliance, you can access further information about their work [here](#).

The project forms the last major project of the current RCM [Research and Development strategy](#), and aims to:

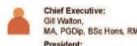
- Influence funding bodies, such as the NIHR, to fund more midwifery and maternity research
- Influence policy makers about gaps in evidence and the importance of midwifery and maternity research
- Provide a list of RCM priorities when requested by outside bodies
- Encourage midwives to take part in a consensus building exercise with a research focus
- Build networks within maternity healthcare
- Support midwifery researchers to identify topics, including those applying to the RCM Wellbeing of Women awards and the Iolanthe Trust Jean Davies award



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- Raise the RCM's profile in terms of its involvement and commitment to midwifery and maternity research

The data collection process consists of two online surveys. The 1st survey opened on the 8 January and will close on the 7 April 2024, and the 2nd will commence in September 2024. We will also be holding a final project workshop in January 2025. The final project report will be published in May 2025.

The final Top Ten priorities will ultimately be developed from our first survey – so we need to get everyone's thoughts and ideas included here, so that their voice is heard within the final Top Ten. If you are able to become a Project Partner before April, this will mean that your networks will have increased opportunity to have their views included in the first survey findings.

All James Lind Alliance projects work with relevant Project Partners who commit to supporting the project, promoting the process and encouraging their represented groups or members to participate. In this project our Project Partners represent the following groups:

- people who have been or are pregnant
- families of people who have been or are pregnant
- midwives, midwifery students and maternity support workers
- those who provide support roles for maternity service users

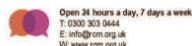
There are several aspects to the role that we will ask our Project Partners to undertake, and these are outlined below in relation to compulsory, and non-compulsory aspects. We anticipate that the role will take Partners approximately 2-3hrs across the life of the project.

Compulsory:

- Provide an organisation logo to be included on the [RCM project website](#) and in resulting publications



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- Dissemination of the two online surveys to your membership, and also wider networks
- Disseminate the expression of interest to attend the final PSP workshop to your membership

Non-compulsory:

- Attendance at occasional online meetings
- Piloting the two online surveys amongst your staff and/or membership
- To share the project poster electronically on your relevant social media or in hard copy in your organisation locations

If you are interested in your organisation registering as a Project Partner please confirm this by emailing the Project Co-leads Jude Field and Jenny Cunningham at researchpriorities@rcm.org.uk, providing your organisation logo. Additionally if you would like any further information please contact us, and we can aim to answer any questions that you have over email or a Teams call. Equally, if you feel that this opportunity is not appropriate for your organisation please just let us know.

Your sincerely

J. Field & *J. Cunningham*

Dr. Jude Field and Jenny Cunningham

RCM Research Advisors & Project Co-leads

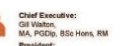
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4. List of Project Partners

AIMS

Amma Birth Companions

Action on Pre-eclampsia (APEC)

Antenatal Results and Choices (ARC)

ASAM Midwives

Autistic Parents UK

Betsi Cadwaladr University Health Board

Best Beginnings

Birmingham Women's and Children's NHS Foundation Trust

Birth Partner Project

Big Birthas

Birth Companions

Birth Trauma Association

Black Mothers Matter

British Arab Nursing and Midwifery Association (BANMA)

British Association of Perinatal Medicine

Bournemouth University

Cambridge University

Cardiff University

Cleft Lip and Palate Association (CLAPA)

Consultant Midwives Cymru

Cwm Taf Morgannwg University Health Board

Dads Rock

Diverse Cymru

Doncaster and Bassetlaw RCM Branch

Ectopic Pregnancy

Edinburgh Napier University

Elizabeth Bryant Multiple Birth Centre

Frimley Health NHS Foundation Trust

Friends, Families and Travellers

GBS Support
Great Western Hospitals NHS Foundation Trust
Hertfordshire University
James Paget University Hospitals
Kingston University
LGBT+ Mummies
London South Bank University
Liverpool John Moores University
Liverpool Women's Hospital
Lost Mothers
Make Birth better
Manchester University
Manchester University Foundation Trust
Maternal Mental Health Alliance
Maternity Autism Research Group (MARG)
Maternity City of Sanctuary
Miscarriage Association
MISS Support
Mothers for Mothers
NCT
NHS Grampian
National Institute for Health and Care Research (NIHR)
NIHR Research Champions
Nursing and Midwifery Council
North Bristol NHS Trust
Northumbria University
North West Ambulance Service
National Maternity and Perinatal Audit
National Perinatal Epidemiology Unit
Nurture the Borders
PANDAS

Parent Infant Foundation
Pregnancy Sickness Support
Powys LHB
Queens University, Belfast
Queer Birth Club
Royal Cornwall Hospital NHS Trust
RCN Foundation
Royal Devon University Healthcare
Salford University
Sands
Sandwell and West Birmingham
Swansea Bay
Swansea University
The Birth House
The Circle
The Down's Syndrome Association
The Fathers Network Scotland
The Lost Mothers Project
The MASIC Foundation
Twins Trust
UK network of Professors in midwifery and maternal and newborn health
University of Brighton
University of Plymouth Hospital Trust
Walsall Manor Hospital
Wellbeing of Women
Wirral University Teaching Hospital

5. Project newsletters

No. 1 – December 2023



Welcome to our first Royal College of Midwives James Lind Alliance Research Prioritisation Project newsletter!



As project leads, we are pleased to share an update on how our research prioritisation progress is progressing. Since our project launch on 17 July 2023, we have been busy working with our James Lind Advisor Dr Nahid Ahmed, our Steering Group and, more recently, our Project Partners to reach the point where we are almost ready to launch our first online survey.

This project is important as maternity research receives less funding than many other areas of healthcare. The RCM is bringing together a range of stakeholders to discover the gaps in evidence across all areas of midwifery practice and maternity care and to agree which are the most important for future research to address.

The final top 10 research priorities will be championed by the RCM and other organisations in order to influence funders and policy makers.

Working with the James Lind Alliance (JLA):

We are thrilled to be working with the JLA. It is a non-profit making organisation, and in relation to our project, involves bringing together women and birthing people, their families and friends; midwifery students and maternity support workers (MSWs) as co-leads of the project we are ^{sup}Priority Setting Partnerships^{CM} Head of Research and Information and Dr Yana Richens, Senior Research Leader, appointed by the NIHR. We also have a dedicated Information Specialist, Louise Deighton-O'Hara from MIDIRS.



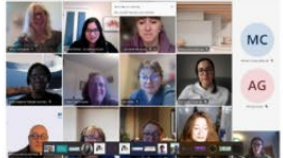

In addition to the JLA proposed structure, we have a Review Group, three eminent Professors of Midwifery to guide us and ensure academic rigour. Prof Helen Cheyne from the University of Stirling, Prof Vanora Hundley from Bournemouth University and Prof Julia Sanders from Cardiff University.

The project will shortly be included on to the James Lind Alliance [website](#).

Royal College of Midwives Research Prioritisation Project: Newsletter 1, December 2023

Introducing our Steering Group:


We were thrilled to receive over 60 applications for Steering Group membership and it was a difficult process to decide who to invite to join us. Membership includes midwives, a midwifery student, MSWs and service user representation from across the UK. Members bring a wide range of perspectives and experiences to the group.



You will soon be able to see names of our Steering Group members on our RCM project webpage and the JLA website.

Our Project Partners:

The project is supported by a fantastic range of Project Partners and we are adding new organisations every week – these Partners are committing to raise awareness of the project across their networks. We are holding our first Project Partner meeting on 8 January 2024. Please get in touch on researchpriorities@rcm.org.uk if you have not received your invitation.

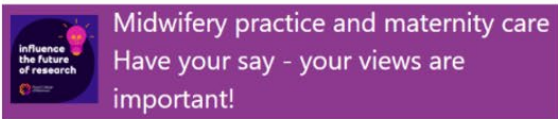


Royal College of Midwives Research Prioritisation Project: Newsletter 1, December 2023


New Project Partners can register and play an important part in the project until it concludes in May 2025. There is a simple Microsoft Forms that you can complete [here](#).

Project next steps

The first project survey opens in early to mid-January. We will be inviting midwives, midwifery students, MSWs, women and birthing people, their supporters and service user organisations to respond to this survey. We'd love to hear your ideas and suggestions about what information is needed to improve midwifery practice and maternity care. If you would like to have the survey sent to your email address you can complete a simple Microsoft Forms [here](#).



The survey title



The project timeline

The second survey in September 2024 will ask people to rank the list of priorities which we will have gathered from responses of the first survey.

The final stage will be in-person workshop in January 2025 where the final top 10 list is confirmed. We will be inviting people to take part in the workshop nearer the time.

Survey Dissemination

We will be providing Project Partners with resources to help members take part in the survey. This will include content for social media posts and newsletters. In addition, if you have a house publication you would like us to write for, please contact us. When we launch the survey, we will have a poster with the survey link available which can be printed out and used in any setting. We will be working with our Project Partners to reach people in different communities around the UK.

Royal College of Midwives Research Prioritisation Project: Newsletter 1, December 2023

What happens at the end of the project?

We will produce a report in May 2025 and use this to champion the top 10 priorities. We hope that all those involved in midwifery and maternity care will also raise awareness of our priority list and be able to encourage others to do the same.


Please share this newsletter with anyone you think may also be interested.

If you would like any more information, we have a project specific email address where you can contact us directly: researchpriorities@rcm.org.uk

With best wishes,

Jenny & Jude

RCM Research Advisors and Co-Leads for the project



No. 2 – March 2024

Royal College of Midwives Research Prioritisation Project: Newsletter 2, March 2024



Welcome to our second Royal College of Midwives James Lind Alliance Research Prioritisation Project newsletter



As project leads, we are pleased to share an update on how our research prioritisation progress is progressing and to encourage everyone to keep promoting the 1st project survey.

So much has happened since the last newsletter.

Just as a reminder, this is such an important piece of work which we hope will influence those who fund research in the UK maternity services.

Jude Field and Jenny Cunningham, Project Leads

Thank you to everyone who has helped to get the message out, and taken the time to share their thoughts and ideas.

We need to keep up the momentum:

We're really pleased to have reached so many people already, and we still have the chance to reach more.

So far we've heard from **869** people!




Our demographic data shows that 88% of the people who have completed the survey so far identify as white ethnicity. This does not accurately reflect the ethnic diversity of the UK population. We know that people from the global ethnic majority* are often under-represented in research, and that women and birthing people from these communities are more likely to report poor care and experience poorer outcomes.

For these reasons the Steering Group has decided we should be proactive and extend the deadline survey for those from the global ethnic majority until the **9 May 2024**. For everyone else the survey ends as planned on **7 April 2024**.

*This refers to Black, Asian, mixed and other ethnic communities who are often called "ethnic minorities". This does not include white British and other white groups, including white ethnic minorities

Ethnicity breakdown of responses as at 16 March


1

Royal College of Midwives Research Prioritisation Project: Newsletter 2, March 2024

Our Project Partners:

We're continuing to welcome Project Partners, and now have around 80 organisations across the UK who are supporting the project. If you know of an organisation who might like to become a Project Partner please share the invitation, and ask them to complete the simple Microsoft Form via this [link](#).

Project Partners have access to a SharePoint folder containing useful resources to support them in their role.



Our Project Partners to date

Examples of Project Partner support:

All of our Project Partners are doing great work. Here are some examples that we've been given permission to share:

University Hospitals of Leicester NHS Trust, under the leadership of Dalvir Kandola, Consultant Midwife for Inclusion, are inviting all the women and birthing people who meet the research team to complete the survey. They have multi-lingual staff who can help with this process

Mary Alvarez, Senior Research Midwife & West of England research champion from the North Bristol NHS Trust, has put up posters and spoken to all clinical areas within maternity, and has ensured that the project information is emailed to all staff who work for the Trust


Nadia Higson, who is an AIMS volunteer and a project Steering Group member, held a session with volunteers to discuss priorities and added the list they developed to a webpage. AIMS has also been active on social media about the project.

Ruth Jenks from Autistic Parents UK has made a screen recording of her completing the online survey to give clarification to people who have found this a difficult process. We have added Ruth's recording to the SharePoint folder.

We'd love to share your dissemination ideas – please email us at researchpriorities@rcm.org.uk

And what have we been doing?...

Over the last few months we've spoken to hundreds of people, across a range of meetings and conferences; written for several Project Partners' newsletters; and been active on social media. Let us know if you'd like us to speak or write for you



2

Royal College of Midwives Research Prioritisation Project: Newsletter 2, March 2024

Project next steps

Once the survey closes we will be starting the important work of data analysis. We will be working with our Information Specialist Louise Deighton-O'Hara, along with Dr. Sara Webb and Dr. Yana Richens to review all of the ideas and suggestions that we've received. Our Steering Group colleagues will also be involved in this process. We're anticipating that there will be about 3000 suggestions for us to consider. The second survey, in September 2024, will list research questions developed from the first survey. Watch this space!

The final stage will be in-person workshop in January 2025 where the final top 10 list is confirmed. We will be inviting people to take part in the workshop nearer the time.

Please share this newsletter with anyone you think may also be interested.

If you would like to have the survey sent to your email address you can complete a simple Microsoft Forms [here](#).

You can access the survey directly [here](#) and via the QR on the right.

If you would like any more information, we have a project specific email address where you can contact us directly: researchpriorities@rcm.org.uk

With best wishes,

Jenny & Jude

RCM Research Advisors and Co-Leads for the project




Please share this newsletter amongst your networks so that as many people as possible can hear about this project. Thank you

3

No. 3 – December 2024

Royal College of Midwives Research Prioritisation Project: Newsletter 3, December 2024

Welcome to our Royal College of Midwives James Lind Alliance Research Prioritisation Project - newsletter number 3




As December approaches it feels like a good time to write to all of our project supporters with an update on the Royal College of Midwives James Lind Alliance Research Prioritisation Project.

This newsletter will give you information about the outcomes from the first project survey, and our plans for the second survey and in-person project workshop.

We hope that you can continue to support the final few months of this important project, and then afterwards to help the findings become embedded across the UK!

The first survey:

Thank you to everyone who has helped to get the message out about our project and survey. In our last newsletter, we explained that we had decided to extend the deadline for our survey for individuals who were from the global ethnic majority. This was so our project would better reflect the diversity of the UK population. We would like to thank two organisations in particular who gave additional support in sharing the survey to their members. [Black Mothers Matter](#) distributed paper copies of the survey and [the British Arab Nursing & Midwifery Association](#) held focus groups with their members. Dalvir Kandola, Consultant Midwife - Lead for Inclusivity at University Hospitals Leicester NHS Trust was also really supportive. The proportion of responses from people who did not identify as from a White ethnicity increased to over 17% (from 12% at the mid-way stage).

We received **946** responses to our survey, which added up to over **3,000** questions and suggestions about a whole range of issues and topics which affect women, families, midwives and maternity support workers. The responses include questions about midwifery care during pregnancy, birth and the postnatal period, as well as issues about education and those which affect staff wellbeing.



1

Royal College of Midwives Research Prioritisation Project: Newsletter 3, December 2024

Survey data analysis:

Since the closure of the first survey, we have been analysing the responses – or data. The graph below shows the big themes we created to get a sense of the whole of the data.




While much of the analysis has been conducted online over Teams, a small team of us met at the RCM HQ in Union Street, London, on 8 October 2024 to start the process of creating the questions for the second survey.

This was a fantastic day, spent using post it notes, print outs of all 3,347 suggestions, and a constant 'checking-in' process. We managed to write 80 draft questions.

In the following weeks, they have been reviewed and re-written and shared for discussion and agreement with the Steering Group. We anticipate that all of the questions will be created by mid-December.

Project next steps:

Once we have created our 75 (or so) questions, the Steering Group members review each question again so ensure that each of the data fits with the question, and that the language used is clear.

Each approved question is then checked against the existing evidence base, such as the Cochrane Library and NICE guidance to make sure that it has not already been answered by previous research. Any questions that have already been answered will be excluded from the second survey.



2

Royal College of Midwives Research Prioritisation Project: Newsletter 3, December 2024

The second project survey:

The second – and final - survey will be released in January 2025. We have had to delay the original planned publication date of this survey due to the high number of responses which contained such important topics and suggestions.

This survey will take a different format to the first. You can complete this survey even if you did not complete the first survey. It will contain a list of around 75 research questions and you will be invited to decide your top 10 from the list (or fewer if preferred). The responses from this survey will then be reviewed to prepare for an in-person workshop.

As with the first survey, if you can help us to members of the diverse communities across the UK we will be grateful for your support.

If you would like to have the survey sent direct to your email address you can complete a simple Microsoft Forms [here](#).

The in-person workshop:

The final stage of the project will be in-person workshop on 17 April 2025 at Birmingham University. This where the top 25-30 questions will be discussed. The final top 10 list will be decided at this event through a consensus building approach.

We are inviting expressions of interest for the in-person workshop. Please complete [this form](#) if you would like to be considered as an attendee.

Announcing the final Top 10 priorities:

We will announce the top 10 research priorities at the RCM Conference 30 April – 1 May 2025 in Birmingham. This event is free for RCM members [to attend](#).


A final report will follow. Please complete [this form](#) if you would like to be sent a copy of the final report.

Please share this newsletter with anyone you think may also be interested. There are no limitations on who this newsletter can be shared with.

If you would like any more information, we have a project specific email address where you can contact us directly: researchpriorities@rcm.org.uk

With best wishes,

Jenny & Jude
RCM Research Advisors and Co-Leads for the project



3

Royal College of Midwives Research Prioritisation Project: Newsletter 4, May 2025

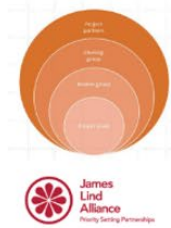
Welcome to our Royal College of Midwives James Lind Alliance Research Prioritisation Project - newsletter number 4



We have reached the end of this nationally important project and now have the top 10 research priorities for midwifery practice and maternity care. See page 2 of this newsletter.

We launched the project in July 2023 so it has taken nearly 2 years to complete. We have been supported by our Project Partners as well as a committed and engaged Steering Group. We were also supported by a Review Group of three UK midwifery Professors. Thank you to everyone.

We have worked closely with the James Lind Alliance to ensure our project is a high quality one and the priorities will have the support of funders.



The workshop attendees holding up their favourite question at the end of the workshop

The in-person workshop

The final stage of the project was the in-person workshop on 17 April 2025 at Birmingham University. The final top 10 list were decided by the 24 workshop attendees.

The people who took part were women and birthing people who had either already received maternity care or planned to use maternity services, Project Partner representatives, midwives, midwifery students and a maternity care assistant. We had a fantastic group of individuals who worked well together to reach a consensus.

Royal College of Midwives Research Prioritisation Project: Newsletter 4, May 2025

The top 10 research priorities for midwifery practice and maternity care

1. What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum and ongoing learning in clinical settings play in improving cultural competence and safety?
2. What are the appropriate reasons for induction of labour? What are the short and long term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?
3. What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?
4. How does the culture within the maternity services, including racism, incivility and other negative behaviours among staff impact on midwives, maternity support workers and maternity care assistants and what can be done to address this?
5. What factors mean that birth is becoming increasingly medicalised, and what are the long and short-term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?
6. How can the causes and consequences of pre-existing psychological trauma during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it?
7. How can postnatal care be prioritised and improved so that mothers and birthing parents and their babies receive high quality care that meets their individual needs?
8. How can the maternity services improve bereavement care? How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death?
9. How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care?
10. What are the specific needs of neurodivergent individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care.

Royal College of Midwives Research Prioritisation Project: Newsletter 4, May 2025

Announcing the final Top 10 priorities:



On 1 May 2025 at the national RCM conference, we announced the top 10 priorities for the midwifery practice and maternity care prioritisation project. The conference, held at the ICC in Birmingham and was attended by over 1,000 midwives, midwifery students, maternity support workers and maternity care assistants.

What next?

We will

- Disseminate the top 10 to maternity professionals and service users
- Speak to funders to discuss how the top 10 will be supported
- Recommend the top 10 to be used by researchers in their projects
- Establish the impact of the top 10 priorities on maternity research

You can support us in this work and spread the word to your members, colleagues and networks. Please let us know if we can be part of your discussions.

Please share this newsletter with anyone you think may also be interested. There are no limitations on who this newsletter can be shared with.

If you would like any more information, we have a project specific email address where you can contact us directly: researchpriorities@rcm.org.uk

You can also subscribe to the RCM WhatsApp channel and receive posts, including a research bulletin each Tuesday. Follow this [link](#) or use the QR code



With best wishes, **Jenny & Jude**

RCM Research Advisors and Co-Leads for the project



A final report will follow this summer. If you have not done so already, please complete [this form](#) if you would like to be sent a copy.

6. Support for maternity service users document

Supporting Organisations

If you need urgent help you can call the emergency services on 999

You can also call The Samaritans <https://www.samaritans.org> on 116 123 This number is free to call from both landlines and mobiles, including pay-as-you-go mobiles. You do not need to have any credit or call allowance on your plan. We offer a safe place for you to talk any time you like, in your own way – about whatever's getting to you. We won't judge you or tell you what to do, we'll listen to you.

We've drawn on our Project Partners to provide a list of supporting organisations for women, birthing people and families who are experiencing emotional difficulties after maternity care. You can also look at the full list of Project Partner logos on our [website](#), to find other organisations that may be able to provide you with specialist support.

Birth Trauma Association <https://www.birthtraumaassociation.org/>

Founded and run by women who have experienced birth trauma, we are the only charity in the UK solely dedicated to supporting women and families who have experienced traumatic birth. Our peer supporters offer support over email and phone. Let us know in your initial contact if you'd like to speak to someone with similar experiences to your own.

Call us: 0203 621 6338

Email us: support@birthtraumaassociation.org.uk

The Miscarriage Association <https://www.miscarriageassociation.org.uk/>

If you've been affected by miscarriage, molar pregnancy or ectopic pregnancy, we hope this website will provide the information and support that you're looking for. We're here to help you through.

Pregnancy loss phone helpline. You can call us: 01924 200799.

PANDAS <https://pandasfoundation.org.uk/>

We are here, whatever the weather, to offer hope, empathy and support for every parent or network affected by perinatal mental illness.

Our FREE PANDAS Helpline is available from 10am-5pm Monday – Friday (excluding bank holidays). Call us on 0808 1961 776.

Sands <https://www.sands.org.uk/>

Sands exists to reduce the number of babies dying and to support anyone affected by the death of a baby, before, during or shortly after birth, whenever this happened and for as long as they need support.

The Sands National Helpline provides a safe, confidential place for anyone who has been affected by the death of a baby. Whether your baby died long ago or recently, we are here for you. Call Sands Helpline - 0808 164 3332 helpline@sands.org.uk



7. Survey 1



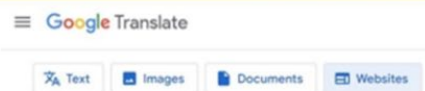
Midwifery practice and maternity care - what matters to you?

What are the gaps in our knowledge about midwifery practice and how to give the best maternity care? You can help us to decide the Top 10 research priorities.

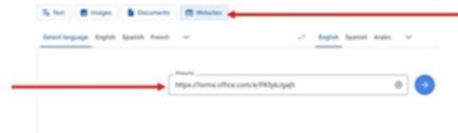
If you need to, you can translate this survey

Using a mobile phone  or a laptop 

1. Open Google Translate



2. Click on 'Websites' and paste the survey link



3. Choose the language you would like to use



Next

Page 1 of 9

Help us find the Top 10 research priorities for UK midwifery practice and maternity care



The survey is now only open for members of the global ethnic majority*, and closes at midnight on Thursday 9 May 2024.

Fewer people from the global ethnic majority have completed the survey than we had hoped. To be proactive the survey is now extended to enable responses from people who identify as belonging to the global ethnic majority. This is to try to get a more balanced representation from the UK population.

*We use 'global ethnic majority' to refer to all ethnic groups from Black, Asian, mixed, and other ethnic communities who are often called "ethnic minorities". This does not include white British and other white groups, including white ethnic minorities.

We are inviting you to take part if you are a:

- Woman or birthing person (pregnant now, have been pregnant or hope to be pregnant in the future)
- A partner, family member or friend
- Midwife, midwifery student or maternity support worker
- A representative of an organisation or charity which supports women
- A person who supports pregnant women, such as a doula or antenatal teacher

We want to find out the most important gaps in knowledge and hear what matters to you in the following areas:

- Pregnancy, birth and postnatal care
- The work of midwives, midwifery students and maternity support workers - clinical, educational, workforce or any other aspect of midwifery practice
- The role of family members, friends and birth supporters

You can write your ideas and suggestions in any way, but we ask that you do not include personal information (eg. your name, where you live, work or received care).

This survey is the first in a larger project that aims to find the Top 10 future research priorities for midwifery practice and maternity care in the UK. We will turn the ideas and suggestions that you share into research questions, and these will then be included in a second survey. We expect this survey to open in September 2024.

The second survey will ask you to say which of the suggested research questions you think are the most important. The final Top 10 priorities will be decided in a workshop in January 2025. We hope that the Top 10 priorities will be used by individuals and organisations to decide which research projects should receive funding.

The project is being led by the Royal College of Midwives, with support from the James Lind Alliance, and a Steering Group made up of midwives, maternity support workers and women and birthing people.

Please tell us your ideas and suggestions here



3

What are the gaps in our knowledge about how to provide the best midwifery and maternity care? *

Tell us by writing your thoughts in any way. You can draw on your personal experiences, but please do not share any personal information.

There are 5 boxes below. Please use the first box to write your suggestion and idea for future research. For example, about pregnancy and labour care, baby feeding, looking after midwives and MSWs at work, or midwifery education. Completion of the first box is compulsory.

You can then use the next 4 boxes to write more suggestions or ideas. Completion of these next boxes is not compulsory.

Enter your answer

4

What are the gaps in our knowledge about how to provide the best midwifery and maternity care? [optional]

Enter your answer

5

What are the gaps in our knowledge about how to provide the best midwifery and maternity care? [optional]

Enter your answer

6

What are the gaps in our knowledge about how to provide the best midwifery and maternity care? [optional]

Enter your answer

7

What are the gaps in our knowledge about how to provide the best midwifery and maternity care? [optional]

Enter your answer

Information about you

These questions are optional, but we would appreciate knowing a little about you to help us make sure we hear from a wide range of people. These answers are confidential. No individual will be identified when we publish the results.



8. Project Poster

what matters to you?

We want to know what you think

Influence the future of research, and help us find the top 10 priorities for midwifery practice and maternity care.

You can take part if you are a:

- Woman or birthing person, a partner, family member or friend
- Midwife, student midwife or maternity support worker
- An organisation or charity which supports pregnant women
- Supporting pregnant women, such as a doula or antenatal teacher



Access the survey here



You can find out more information about the project here



Royal College of Midwives

9. Project Partner 'Top tips' document

Hints and tips for survey dissemination

The following comments were made by Project Partners at the meeting 08/01/2024 – thank you!

- We will put it in our newsletter (circulation 9000) and across our social networks.
- It's great you have provided paragraphs for social media which we'll use and we'll add to our monthly newsletter.
- We will add ours to a newsletter and socials.
- We will share this across Directors of Midwifery Advisory Group Wales and locally.
- We will likely share it across all our socials, and will chat to our Digital team about potentially embedding the survey link into our app too as that's where most of our users engage with our content.
- Social media, through MNVP, staff learning platforms, across national Consultant midwife group.
- We have a council of clinicians we will forward to plus an active social media presence we will circulate amongst too will also ask all of our clinical trustees to circulate.
- We run online events with parents and also have an antenatal group so we will share there too.
- I will add the survey to our newsletter too and our staff group chats etc.
- We've got an online conference at the end of January so will include it into the slides.
- We can share with our subscribers and add to our newsletter, and our social media. Also, we have networks with parenting groups and other charities we can share with.
- We have a wide reach across Scotland so will use a mixture of approaches to get the survey out to a diverse audience.
- I can circulate the link internally (to staff) and speak to our comms team about possibly sharing on social media channels.
- Retweet and share RCM social media posts [Twitter, Instagram & Facebook]

An email template for those who would like one:

Dear

Have you had experience of midwifery care and maternity services as a woman, birthing person or family member, friend or supporter? Are you a midwife, midwifery student or maternity support worker? We are working with the Royal College of Midwives to find the top 10 research priorities for midwifery practice and maternity care. Please [click here](#) and follow the link to the survey as your voice matters. You can find more information about the project on the RCM's website by clicking [here](#).

Don't forget #RCMresearchpriorities

Some additional thoughts:

Midwifery practice and maternity care affects everyone – please share widely within and beyond your professional networks. Some examples are given below:

- Try to reach widely – for example, in a university, please do not only share with midwifery students and midwifery staff, and in a Health Board or NHS Trust not just to maternity service users and midwifery /MSW staff
- Do you know people who work for large non-maternity related organisations who can share?
- Do you visit sports centres, supermarkets, faith centres and can put up a poster?
- Could you circulate to family and friends [e.g. on Facebook or WhatsApp], and encourage them to do the same?

No permission is needed to share.

Don't forget #RCMresearchpriorities

10. Survey 2 – list of 67 priorities

How can postnatal care* be prioritised and improved so that mothers and birthing parents and their babies receive high quality care that meets their individual needs? *This is the time after the baby has been born and includes the first weeks.

What can be done to promote midwives working as autonomous and independent professionals?

What do women and birthing parents with physical disabilities want and need during their maternity care and how can this be provided?

What are the best ways of supporting decision making and providing pregnancy and labour care for women and birthing parents who have had previous caesarean birth[s]

How to evaluate and improve maternity care for women, birthing people and their babies, including learning from positive and negative feedback?

How can maternity services use the available evidence to provide the best care for women and birthing parents whose babies are breech including the options of a safe supported vaginal breech birth or external cephalic version (ECV)?

What support and care provision should be available for families following a maternal death?

What role can midwives and maternity services play in improving outcomes for women with one or more social complexities?

How to provide the best perinatal care for women, birthing parents and families who are LGBTQIA+? This is a term that is often used to refer to the many different types of sexual identities that exist outside of heterosexuality, e.g. families that have two mothers or families where a parent does not see themselves as a woman or a man).

How can maternity services foster a research positive culture that includes service user voices, where midwives and MSWs conduct and engage in research, and are able to use the best quality evidence in their practice?

What are the best ways to include and support partners and families in maternity care?

What are the appropriate reasons for Induction of Labour? What are the short and long term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?

What is the best way of recording and sharing women's maternity information to enable satisfaction and quality care?

How can the causes and consequences of pre-existing psychological trauma* during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it? * such as sexual abuse and sexual violence, and birth trauma

What are the specific needs of neurodivergent individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care?

How do we remove male-dominated practices, languages and resulting inequalities from midwifery practice and maternity care?

How can we build on the known evidence and improve support for infant feeding (both breast and formula) for all babies* and all mothers and birthing parents by ensuring consistent, accurate information and services throughout the antenatal, intrapartum, and postnatal periods? *This includes babies with complications and disabilities

What are the most effective strategies for implementing continuity of midwifery care for all, which are sustainable for midwives and respond to the needs of mothers and birthing parents?

How can we support UK based internationally educated midwives to join the UK workforce and develop their midwifery careers?

How can parent education be designed and provided to meet the needs of all parents, including those with specific pregnancy, postnatal and birth and newborn care requirements, taking into account the wider influences that shape parental expectations and knowledge?

How can informed decision making and evidence-based practices for managing the third stage of labour—the birth of the placenta, membranes and control of blood loss, either naturally or with medical involvement (eg injection) —be provided across all birth settings and what are the outcomes to the different approaches?

Is the way that BMI is being used during pregnancy helpful? Should other factors such as ethnicity, muscle mass, heart health and other lifestyle factors be taken into account too?

What design and delivery best support midwifery education in university and clinical practice settings? How can we ensure balance and a fair assessment processes?

What are the best ways, in relation to baby outcomes and women's and birthing parents' experiences, to assess the wellbeing and growth of the unborn baby*, including the prevention of baby loss? *This includes routine and additional or specialised care

What is the impact of nitrous oxide (Entonox) on the maternity workforce and what measures should be taken to reduce its negative effects?

How acceptable are the different ways of providing maternity triage (for example walk-in / telephone) and how effective are the different options?

What impact does the presence of a paid or volunteer birth supporter, such as a doula, have on the physical and emotional outcomes of birth for both mother and baby?

How can we promote good multidisciplinary team working to ensure clear, compassionate, and effective communication between clinicians and with women, birthing parents and families?

What are the experiences of, and outcomes following, freebirth for mother, birthing parent and baby, and how do they compare to giving birth with a midwife present?

How do we ensure best practice in the antenatal screening and diagnosis of Down's Syndrome so that the information given is balanced, comprehensive and evidence based? What support should be offered to women and birthing parents in pregnancy and post pregnancy?

What verbal and non-verbal communication approaches should midwives, maternity support workers and maternity care assistants use to ensure women and birthing parents feel listened to and respected?

In order to provide the best care, when and where should women and birthing parents be seen by a midwife during the antenatal period? What is the most appropriate mode (eg in-person or via telephone) and length of the different appointments?

How can maternity services use the available evidence to meet the needs of surrogates, intended parents and babies?

How can we ensure inclusion and equity of opportunities for midwives of all ethnicities and backgrounds to develop their careers* locally and nationally? What is needed to ensure they have the skills and opportunities to undertake these roles effectively and how can their impact be measured? * Clinical, research, education, leadership

How should women and birthing parents who have conceived through fertility treatment be cared for during pregnancy, labour and birth?

What should midwifery education include for students to become confident and competent midwives, with critical thinking skills and the ability to give compassionate safe care in today's maternity service? Once qualified, how should continuing professional education for midwives be provided?

How can the physical birth environment—such as noise and light levels, furnishings, and equipment—be designed and implemented to optimise physiological birth and promote women's well-being?

What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?

How do different types of fetal monitoring affect women's and birthing parents experiences of labour and birth, the wellbeing of their babies, and how can midwives use this knowledge in their practice?

What is the importance of community midwifery care to a local community? How can midwives, including newly qualified midwives, be supported to work in community settings?

How can midwifery care in rural and remote areas of the UK be provided in a way that is sustainable for the maternity service, and also provides quality care for women, birthing people and their families?

How can access to midwifery-led units and home birth be ensured for all women and birthing people, including those considered 'high risk', or from marginalised or underserved communities. What evidence is needed to support this?

How can staff be supported to routinely use interpreters and other appropriate translation approaches to communicate with and care for women and birthing parents with limited English proficiency? What is the impact on and experiences of those using and providing the language services.

How can we adapt midwifery and maternity services to be more proactive towards climate change and its adverse affects on women and birthing parents and their children?

What role can midwives and maternity services play to promote public health and prevent health inequalities?

How does the use of gender diverse language (eg "birthing parent") impact those who access maternity care?

How should maternity support workers and maternity care assistants be educated, trained and and their role developed to support the provision of quality maternity care for women, birthing parents and their babies?

What factors mean that birth is becoming increasingly medicalised, and what are the long and short term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?

How can the role of midwives improve the pregnancy experience for women and birthing parents who suffer with hyperemesis (severe sickness and nausea during pregnancy)?

How can the voluntary sector be involved in maternity services to enhance experiences and care outcomes for women and babies?

How to promote and support the role of the midwife educator and other educators working within midwifery education

How do negative experiences related to informed consent affect women and birthing parents? What structural changes and training should be put in place to address this?

How can midwives use the available evidence to facilitate and support the body's natural processes during labour and birth (physiological birth)? Would more knowledge about the anatomy and physiology of labour and birth, including biomechanics, be beneficial?

What do women and birthing parents with learning disabilities, and those who support them, want and need during their maternity care and how can this be provided?

How can access to pools for labour and birth be offered across all birth settings, including for women and birthing parents classified as high risk under clinical guidelines?

To what extent are current actions to tackle racism and decolonise the midwifery curriculum, and the ongoing learning for qualified midwives and MSWs, effective in improving cultural competence and safety?

How can we prevent women and birthing parents, and their partners and families developing poor mental health during the perinatal period? When people have a mental health problem, how can this be recognised, treatment and support given, and the potential impact reduced?

How does the culture within the maternity services, including racism, incivility and other negative behaviours amongst staff, impact on midwives and MSWs, and what can be done to address this?

What advice and options for pain management* should be offered to women and birthing parents during the different stages of labour and how should these be discussed? How effective are the different methods and what are their impacts? *this also includes complementary methods such as massage, water and hypnobirthing.

What support and care do women need during the latent phase of labour, and what are the best indicators for timely recognition of the active stage?

How is Artificial Intelligence (AI) currently being used in maternity care? How might AI be used in the future? What are the potential impacts on women and babies' outcomes and experiences?

How can midwives be educated and supported to provide the best care to newborns of all skin tones during routine care at birth and in the early postnatal period for those with complications? (for example jaundice, cleft palate, Erb's palsy, Group B Strep, sepsis)

How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies?

How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care?

What pre-pregnancy care could midwives give to women and birthing people and how should this be organised?

What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies from the global ethnic majority?

How can the recognition, referral and additional care be improved for women, birthing parents and babies with complications during pregnancy, labour and birth and the postnatal period?

11. Acknowledgements

We would like to thank the Royal College of Midwives for supporting this national project. Our thanks go to Dr Sara Webb, RCM head of research, and Louise Deighton-O'Hara, Library Information Services Lead at the Midwifery Information and Resource Service (MIDIRS).

We would also like to extend our thanks to others who helped with the data analysis - Dr Yana Richens, Director of Midwifery Services at Liverpool Women's hospital, Mary Alvarez, NIHR Senior Research Lead midwife and Senior Research Midwife at North Bristol Trust and Heather Johnson, midwifery student.

Our project would not have been possible without the calm and strong steer of Dr Nahid Ahmad, the project's JLA Advisor. Dr Ahmad was a continual source of support and information to the co-leads and the Steering Group.

We are very grateful for the commitment and involvement of the Steering Group members, who met throughout the life of the project and shared their knowledge and gave their opinions respectfully and clearly. Thanks also go to the Review Group members who generously gave their time and expertise to the project.

We were well supported by the many Project Partners who helped to disseminate the surveys, and we thank them for their interest and help.

We would like to thank the workshop attendees who spent the day with us in Birmingham who remained focused, committed and respectful throughout. Special thanks to Kevin Shepherd, University of Birmingham administrator for his time and support in organising the final workshop.

Finally, we would like to thank the respondents to the surveys. Many of the responses to survey 1 were detailed and heartfelt. The ranking that was required in survey 2 took time and thought and we are grateful to those who completed this. We will work hard to share the Top 10 priorities and influence those who fund research.

Jenny Cunningham and Dr Jude Field, Research Advisors and Project co-leads.



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**Report of the Research Prioritisation Project
into Midwifery Practice and Maternity Care**

Published: March 2026

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