THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 27 / APRIL 2024

midwives

SAFE SPACE
HOW HYWEL DDA BECAME THE DREAM TEAM

COMPLEX CASES
THE WONDERS OF BESPOKE CARE

PART OF THE SOLUTION
SMALL GREEN CHANGES MAKE A BIG DIFFERENCE

The RCM belongs to you

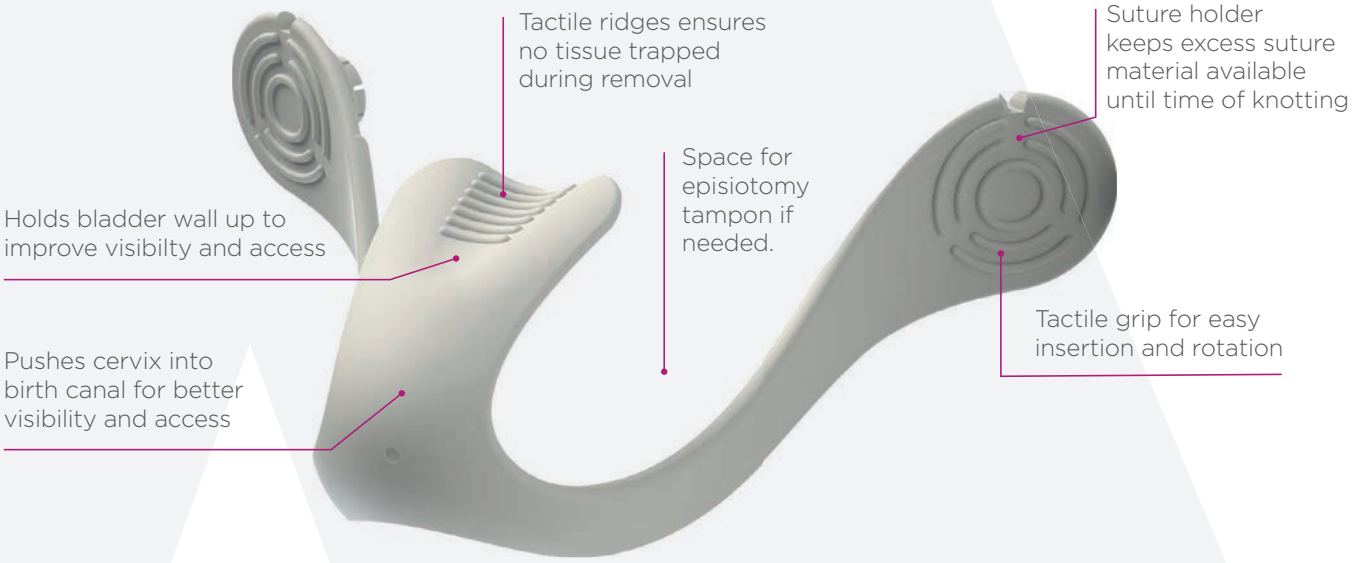
TOGETHER WE CAN SHAPE THE FUTURE OF MATERNITY

APRIL 2024

The Hegenberger Retractor

An **extra hand**, when you need it!

An innovative vaginal retractor that dramatically improves **visibility** and **access** for **postpartum tears** and **episiotomies**



100%
of clinicians found the device allowed clear visibility of trauma during trials.[1]

94%
of clinicians believe that the Retractor will minimise the risk of needlestick injury.[2]

94%
of clinicians feel the Retractor allowed them to suture in a more timely manner.[2]

1. Kozlyk D. MIDIRS Midwifery Digest, vol 32, no3, September 2022,p 380-385. Original article. @MIDRS 2022. 2. Data on file - post market surveillance

KIMAL | Hegenberger Medical

For further information, support or samples contact **Hegenberger@Kimal.co.uk**

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midwives

The official magazine of
The Royal College of Midwives
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Magazine subscription rates
(For non-members only, per annum)
UK £130
European Union £175
Rest of the world £185

Magazine subscription queries
Curwood CMS Ltd
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Printed by Precision
Colour Printing.
Mailed by MAFMK.

All members and associates of
the RCM receive the magazine free.

Full article references are
available on request from
magazine@midwives.co.uk

Midwives ISSN 1479-2915

RCM CEO Gill Walton says ending the midwife shortage is a realistic goal

Welcome

We've challenged the next Government in Westminster to fix the maternity staffing crisis. We don't want the incoming Government to put maternity services into the 'too difficult' basket, so we've set out the solutions in a *How to fix the midwifery staffing crisis* guide for politicians not only in England, but right across the UK.

Low-cost answers to improving working conditions for midwives, suggestions for improving retention among students and professionals and practical examples of how flexible working can work are among its key recommendations. We're acutely aware that the lack of flexible working in a primarily female dominated profession like midwifery is something that has been overlooked for far too long. Members, especially those with caring responsibilities, tell us the lack of flexible working opportunities is why they have left or are considering leaving.

Asking staff when they are available to work and building rotas around their availability works – we have seen it in practice. In this issue, we're looking at flexible working solutions and compassionate workplace policies such as flexible childcare and support to breastfeed after returning to work. We are encouraging services that have tackled issues to share solutions with the ones that are struggling, but we cannot do that alone. NHS employers need to act. We also expect MPs to champion maternity services in their constituencies and work with us on improving them – not only for you, but for the women and families you care for.

We expect MPs to champion maternity services

There's just no excuse not to make fixing the staffing crisis in maternity a priority, not least because it is taking an unacceptable toll on us all and the care that we want to provide.

We're doing this because I hear too often that you feel undervalued and uncared for, whether that's on pay, policy, workload or wellbeing. I want you to know that we are here for you fighting your corner, because if one suffers we all suffer.

That's why we're launching an initiative to get to know you better, and find out what you want and need so we can do it. See our cover story on page 14. We also hope to see you in Liverpool for the RCM conference 2024. I can't wait to get together again to feel that energy of our maternity community sharing ideas and support.

midwives

VOLUME 27 / APRIL 2024

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Investment, finally

Both the RCM and the RCOG welcomed the Government's budget announcement in March of £35m to improve maternity safety in England, with an emphasis on training for midwives and other maternity staff.

RCM's chief executive Gill Walton said: "Multiprofessional working plays a vital role in the provision of high-quality care for mothers and their babies. The RCOG and RCM both recognise this to be a key component in the delivery of safe maternity care and emphasise the importance of respectful team working to build a supportive workplace culture. We look forward to discussing what the budget announcement means in practice with the secretary of state in the coming weeks."

Dr Ranee Thakar, president of the RCOG, said: "The inescapable reality is maternity services are under incredible strain, so we welcome this much needed investment for maternity staffing and training, which will help to retain our skilled maternity workforce and deliver improvements in care."

The RCM is also encouraged to hear plans for a new rostering app for staff. The lack of these is often a barrier to midwives remaining within the NHS, especially for those with caring responsibilities **(see page 20 for more)**.

WATCH
The annual Florence Nightingale Commemoration Service in Westminster Abbey on 15 May

one to watch

CALCULATE
Other measures in the budget that may impact midwives and maternity support workers (MSWs) include:

- An increase in the number of paid childcare hours, which will provide a lifeline for midwives and MSWs struggling with the cost of living
- An increase in the High Income Child Benefit Charge threshold to £60,000 (currently £50,000) from April 2024
- National insurance will be cut from 10% to 8%.

JOIN
The specialist Communications Midwives network – see page 8.

General election

U K hon?

Figures out in March showed that public satisfaction with the NHS has dropped. In the British Social Attitudes survey, just 24% said they were satisfied with the NHS in 2023 (in 2010, the figure was 70%). The major reasons were long waiting times, staffing shortages and lack of funding.

It echoes a recent YouGov poll commissioned by the Joseph Rowntree Foundation and a survey from the Office for National Statistics, both of which showed respondents ranking the NHS as the number one election issue.

To help politicians tackle the issues in maternity care, the RCM has released a series of *How to fix...* guides. *How to fix the maternity staffing crisis* can be downloaded at **bit.ly/RCM-HowTo-staffing**

Understaffing

To the point

At the All-Party Parliamentary Group (APPG) on Maternity, Gill Walton told MPs and policy-makers the realities of understaffing in maternity. "We hear far too often from our members that they feel undervalued and uncared for, unable to take breaks to drink water or even go to the toilet. Are these the conditions you would work in yourself?"

She noted that small changes such as building rotas that cover breaks and ensuring those on night shifts have access to hot food make a huge difference to the wellbeing of staff.

The most recent NHS staff survey highlighted that only around 30% of staff were satisfied with flexible working options

FIT TO PRACTISE?

The NMC is taking decisive action in a situation where it believes a proxy had been taking a key test in Nigeria on behalf of nurses so they could join the register and work in the UK. The times recorded in the computer-based test raised suspicions because of their speed.

There are 48 nurses working in the NHS who will face individual NMC hearings. Meanwhile, 665 Nigerian nurses and four midwives have not been approved to join the NMC register while it continues to investigate.

Andrea Sutcliffe, the NMC's chief executive and registrar, said it had taken necessary action after being alerted last year to what she called "widespread fraudulent activity".

She said: "We'll hold hearings where an independent panel will decide whether those [48] individuals gained fraudulent entry to our register. If so, they're likely to be removed. We're reviewing each [of the 669] carefully in line with our guidance on health and character. We've refused entry to the register for the vast majority we've considered so far."

Read more at bit.ly/Guardian-nurses

Drugs

Epilepsy and pregnancy

The Hughes report, by England's patient safety commissioner Dr Henrietta Hughes, has recommended a compensation scheme for families of children harmed by sodium valproate taken in pregnancy to manage epilepsy and bipolar disorder.

It is estimated that 20,000 children in Britain are affected. Henrietta has suggested initial payments of £100,000, and described the damage caused by the drug as "a bigger scandal than thalidomide".

In 2012, Emma Murphy and Janet Williams set up the Independent Fetal Anti Convulsant Trust (In-FACT) after their own experiences. They hoped to find and support families like theirs, as well as raise awareness of the issues they faced. Their determination got fetal valproate spectrum disorder (FVSD) included in the World Health Organization's International Classification of Diseases. From then, its effects on babies have been researched and better understood.

The Hughes report also said: "The Government must ensure the launch of a redress scheme is accompanied by an awareness-raising campaign to ensure that all potentially eligible patients are made aware of the scheme's existence.

"The Government must also make specific efforts to ensure patients from disadvantaged and marginalised groups are reached."

Read more at bit.ly/ERIUK-valproate

Specialist midwives

Communications network

Midwives Didi Craze and Clare Clifford Turner are specialist communications midwives focusing on messaging, social media management and information flow within their Trust's maternity services – for example, bridging communication gaps between managers and staff, providing channels for staff to voice concerns and enhancing accessibility of senior team members. They hope this will lead to nationwide improvements in maternity care within the NHS.

Partnering with the RCM, they aim to establish a network to address the challenges. The Communications Midwives network will facilitate connections, experience sharing and learning among midwives with similar roles, and foster collaboration and professional development. Supported by the RCM, the network will host meetings, workshops and online forums, creating an environment for learning and tackling communication challenges.

To find out more, contact c.clifford-turner@nhs.net and didi.craze1@nhs.net

MIDIRS Digest

1 Supporting autistic midwifery students: fostering inclusion and empowerment, Emilie Edwards

2 Under-representation of Black women in UK research, Sarah Esegbona-Adeigbe

3 Conducting research with a marginalised, trauma-experienced maternity population: deconstructing an ethic of care, Tamsin Bicknell

4 A qualitative study exploring the factors impacting student midwives' experience of developing their breastfeeding support skills, Michelle Tant, Tania Staras

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

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

midirs

IMAGES: ISTOCK/SHUTTERSTOCK

Working for you

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

Salary

Pay to stay

The message from the RCM to the NHS Pay Review Body (PRB) as it submits evidence for the 2024/25 pay round is: "Paying staff fairly and valuing the skilled work they do is an important part of the solution to the maternity staffing crisis."

Below-inflation pay awards and decades of pay restraint are just two of the reasons the NHS is losing so many experienced midwives. Alongside this, a lack of flexible working opportunities and having to work hours unpaid are cited by midwives who are considering leaving. The impact pay has on staff retention and workforce shortages has been laid bare in the RCM's evidence – which also shows the challenges for maternity services often only functioning safely because of staff working long and additional hours, often unpaid.

RCM CEO Gill Walton said: "Midwives and maternity support workers (MSWs) have had to face the cost-of-living crisis with a below-inflation pay award – how is that fair? It has made staff feel less valued and chipped away at morale. Moreover, it has meant that some of our members are really struggling financially and turning to foodbanks for support. Some staff rooms even have food boxes to help those struggling, which is something I never thought I'd see.

"The Government must do all it can to retain the midwives we have. Urgent action on staff retention is crucial. While pay is not the whole solution, it is absolutely a key factor to staff wanting to stay working in the NHS. We've also asked the NHS PRB to consider our solutions and recommend that the Government delivers a credible plan to restore the pay lost by NHS staff."

PAY IN NORTHERN IRELAND

After the campaigning, strike action and a reformed Executive, the Northern Ireland Department of Health has finally updated its pay offering.

The offer includes the restoration of pay parity with England with an uplift of 5% and a one-off payment of £1,505. The pay uplift will be backdated to April 2023.

This will be a relief to many midwives and MSWs who have had to face the cost-of-living crisis without any pay award in 2023.

In the RCM's consultation with members in March, 86.3% voted to accept the pay award.

Karen Murray, director of RCM Northern Ireland, said: "First and foremost, I want to pay tribute to our members. Their resilience over the past few years has been stretched to the limit, so having a resolution will be a huge relief. Rebuilding trust will be vital and I look forward to working with the minister to make that happen."

RCM CEO Gill Walton said the pay offer had been a long time coming: "While this deal is not everything our members deserve, it's an important start and allows us to move forward."

IMAGES: ISTOCK/SHUTTERSTOCK

Survey

RCM Research Prioritisation Project

The RCM has extended the project's survey deadline until 9 May for respondents who identify as being from the global majority. This is because the survey responses are not currently representative of the UK population.

If you identify as being from the global majority, please consider completing the survey. All responses are anonymous.

You can access the survey with this QR code.

In September there will be another opportunity for everyone to have their say when the second survey opens. The research team is keen to continue linking in with new project partner organisations from across the UK to reach even more midwives, MSWs and midwifery students, as well as women, birthing people and their families.

Is your Trust, Health Board or university a Project Partner? If not, ask your local RCM representative for posters to display.

If you would like the research team to speak at an event or to write a piece for a branch or unit newsletter, contact **researchpriorities@rcm.org.uk**

FORGIVE STUDENT DEBT

The RCM motion to the TUC Women's Conference called on the Government to forgive student midwife debt and expand financial support for all healthcare students.

Most student midwives are women, half of those are over the age of 30 and many have caring responsibilities and financial commitments such as childcare costs and mortgages. For many, graduating with significant debt to work in the NHS is no longer an option.

The RCM staunchly opposed the abolition of the student midwife bursary and the reintroduction of tuition fees in 2017, warning at the time of the detrimental impact it would have on the profession.

IMAGES: ISTOCK/SHUTTERSTOCK

Solutions to shortages
The RCM has launched a pre-election guide for politicians. Low-cost solutions to improve working conditions for midwives, practical examples of how flexible working can work and suggestions to improve education and student attrition rates are among its key advice. The RCM's *How to fix the midwifery staffing crisis* guide has been developed for current and future members of Parliament for the issues faced right across the UK.

Speaking at the All-Party Parliamentary Group on Maternity session, Gill said: "We don't want the next Government coming in and putting maternity services in the 'too difficult' basket. That's why we are taking this opportunity to set out the solutions."

Ahead of the general election, the RCM will publish further instalments of its *How to fix* guides, which will support MPs and others to see that, amid the many challenges for UK maternity services, there are also answers.

New in i-learn
Detecting anorectal malformations – **bit.ly/RCM-ilearn-ARMs**
Down syndrome: The importance of language – visit **bit.ly/RCM-ilearn-Downlang**
Down syndrome: breastfeeding – visit **ilearn.rcm.org.uk**

i-learn

RCM in brief

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

RCM conference 2024

Energising excellence. Bringing research, education, practice and leadership to life

In May, more than 1,500 midwives, student midwives and MSWs will head to the Liverpool Docks to hear inspiring speeches and imparted knowledge from professionals, peers, policy-makers, educators and partners at the RCM Conference 2024.

The theme is 'Energising excellence. Bringing research, education, practice and leadership to life'. The conference will have a dynamic series of sessions across three rooms that will have something for everyone.

Over the two days, Room 1 sessions will cover: excellence in care, narrowing health inequalities, futureproofing the profession by supporting midwives to work across research, education, practice and leadership, integrating trauma-informed care into practice, supporting perinatal mental health, individualised care and surrogacy, retention and support, and leadership. The Zepherina Veitch Memorial Lecture will feature Wendy Warrington talking about her experiences of being a midwife in a warzone.

Room 2 sessions will include: supporting MSW career development, neurodivergence in education, midwifery degree apprenticeships, bereavement care, and genomics and newborn screening – plus abstracts and presentations.

Room 3 will host sessions that cover: innovations in communication, sustainability in the NHS, investing in leadership, improving perinatal pelvic health, caring for families with additional needs, and multidisciplinary learning. There will also be a wealth of abstracts and sponsored sessions.

Expect to be engaged, informed and inspired by hearing from a diverse range of voices sharing ideas and best practice at an event that connects you to peers. The RCM conference 2024 builds community, mutual support and common purpose.

EVENT:
RCM conference 2024
DATE: 8-9 May 2024, 9am until 4pm
LOCATION:
ACC Liverpool, King's Dock, Port of Liverpool, Kings Dock St, Liverpool L3 4FP

St David's Day Conference

In one of the happiest days of 2024 so far, RCM in Wales celebrated maternity professionals at the St David's Day conference on 1 March 2024 at the Angel Hotel in Cardiff. Following feedback from members in Wales, this year the focus was on inclusivity in midwifery so we can better support each other and the women, birthing people and families we care for.

The day began with a trio of titans: CEO and general secretary for the RCM Gill Walton, director RCM Wales Julie Richards and chief nursing officer for Wales Sue Tranka. Gill set the tone of the conference and said: "As midwives, we support all women and birthing people in our care without fear or favour. Everyone deserves the same quality of care, the same compassion. As members of the RCM, I want to reassure you that you're not alone – that we see you, we hear you and most of all we value you. You may belong to the RCM, but in truth the RCM belongs to each and every one of you."

Julie welcomed the delegates in Welsh and English – "Bore Dda a croseo cynnes cymreag", meaning "Good morning and a warm Welsh welcome" – before introducing the inspirational first speaker Sue. She spoke about improving EDI awareness in the working environment, and her own journey and experiences. She inspired delegates to bring about change, to treat people with dignity and respect and to always be fair to people.

"I'm so proud to be a Welsh midwife. Feelings of belonging, togetherness, acceptance and love were high today"

Jamie Morris, EDI lead midwife for the Welsh Government, explored cultural awareness in maternity and was joined by Christianah Ugbaja and Bec Woolley from the Birth Partner Project. In this session delegates heard personal stories of care that no one would claim were caring. They also heard successes where maternity staff have made a difference, with a resounding cheer as one of the individuals mentioned turned out to be present as a delegate… #BeLikeWendy #WeAllNeedaWendy

The next session introduced LGBTQ+ competency in perinatal services. AJ Silver from the Queer Birth Club presented how we can best support individualised care for birthing people and how we each have a role in ensuring that everyone deserves and receives the same quality of care and the same compassion.

After recess to peruse the stalls, network and battle for the best Welsh cake, Ruby Handley-Stone facilitated the neurodiversity in maternity services panel session, before the penultimate session exploring surrogacy, issues within maternity from service users and how maternity staff can support surrogates and intended parents.

Finally, the use of Welsh language in maternity services was explored with an

interactive session with Catrin Roberts and Siwan Humphreys, midwifery lecturers from Bangor University. Everyone was up and out of their seats practising a bit of Cymraeg.

The day ended spectacularly with a stirring rendition of Calon Lan from Oasis One World Choir, a local choir with volunteers that come from both the local Cardiff community and the refugee and asylum-seeking community. The resulting chemistry of the wonderful people from around the globe making music together was the crescendo to our conference.

We wanted the event to encourage open dialogue, improve people's knowledge and reduce the fear members sometimes feel about asking questions. We believe that this was proudly achieved.

Members' feedback has shown that, despite shining a light on areas that are difficult to look at, we did so in a safe and encouraging environment. Diolch o gallon – a heartfelt thank you.

THANK YOU

The RCM is grateful for the financial funding from Health Education Inspectorate Wales, Wales Union Learning Fund and other sponsors for helping keep the costs to delegates low and making this conference possible.

"This was one of the best conferences I've attended! Great atmosphere, great speakers and great food! Thank you to you and all your team at RCM Wales"

belonging

The RCM is its members – it is each and every one of you – so isn't it about time we got to know each other better?

At the St David's Day conference in March, RCM CEO Gill Walton told delegates: "You may belong to the RCM, but in truth the RCM belongs to you."

And she's right. The RCM's purpose is to support its members; to work on your behalf to influence policy and advance the profession; and to speak up for the resources and training you need to provide the standard of care you want. It is the only professional organisation and trade union dedicated to serving midwifery that is led by midwives and maternity support workers (MSWs). In short, it is the voice of midwifery and embodies the professional pride that we all feel.

Perhaps it's professional pride that really connects us. As *Midwives* editorial board member and midwife Jessica James-Hill notes: "For me, being an RCM member has many different meanings. It is a way to connect with colleagues outside of my 'team' and celebrate midwifery and maternity services with different events – for example, through International Day of the Midwife. It gives me opportunities to be involved with open days and newly qualified midwife [NQM] days. There are also opportunities through additional training – through i-learn and those available to me as a committee member – the RCM conference and the magazine."

All of this culminates in a sense of belonging to a professional community that shares knowledge and faces issues together. This is *Midwives* editorial board member and midwife Kashmira Parekh's experience: "For me, the RCM has been beneficial around the Black, Asian and Ethnic Minority focus group with Turning the Tide and being able to speak to a mentor to help me with my career progression."

Being part of the RCM brings confidence and provides professional opportunities – however, as editorial board member Ruth Sanders notes, it's more than that. "Obviously it feels reassuring to have the support of a union and that has always been

a large part of my membership, but that has felt different since moving into academia.

"I have a strong sense of professional identity, but as an academic midwife I value the networking opportunities RCM provides. It presents a chance for me to give back. For example, I am involved in the research buddy scheme and I support other midwives interested in a research or educationally focused career. Being a member provides a platform and network for this. It is also helpful to understand what the outward view of our profession is as a holistic body."

What do you want from the RCM?

The RCM may well present a united stance to the wider world, but that stance is informed by each one of its 50,000 members.

It's important to note that one of our strategic objectives is to listen and learn from our members so that we can lead and influence effectively, and also proactively engage and listen to members at local, regional, national and global events and through the membership survey.

So, we thought it would be a good time to find out more about you, our members. In the coming months, the RCM will be sending out a census asking who you are, what career stage you are at, what career path interests you, what you hope for in your professional life, what your day-to-day working life looks like, what challenges and joys you experience and how the RCM can support you in all of these things.

Gill Walton will be going out to as many units as she is able. She says: "Everyone who knows me knows how much I enjoy meeting members – whether that's at regional events, the RCM awards or the RCM conference.

"I spend a lot of time talking to politicians and policy-makers about maternity services, but one of my greatest

pleasures is hearing directly from members. Passing on those experiences, those real-life examples, really helps the people in power to understand the pressures you're under – and how to fix them. We're always fighting your corner on pay and working conditions and championing the amazing work you do.

"I am so proud to be a midwife and even prouder to be the chief executive of the RCM, representing you all and my profession. I can't wait to visit units across the UK and see many of you at the conference in May. The laughter and chatter reminds us that no matter how hard it is in practice, there is incredible joy in maternity care."

The personal touch

Another of the RCM's strategic objectives is to deliver products and services that offer value for money and meet the needs of our members. That's why we're relaunching our website with better search functions and up-to-the-minute information to support you in your practice. Not only has it been redesigned to better reflect what our members want and need, it will also be customisable so you can find what interests you quickly and easily. Keep your eyes peeled for the launch just before conference and let us know what you think.

The RCM is focused on influencing those in power on matters relating to funding and training, recruitment and retention, staffing, safety and professional standards. We can only do that by making sure we're representing the experiences of the members themselves, and we can only find that out by talking to you. So please take time to fill in the census, speak to us when we visit your unit or come and speak to us at the conference. You are the RCM, and we want to hear your voice loud and clear.

YOUR RCM

The RCM Board is an elected Board of qualified midwives and MSWs who are also RCM members. The Board sets the broad strategic direction of the organisation, ensuring it is properly managed.

The chief executive is responsible for the day-to-day running and management of the RCM. They work with the executive management team to carry out the tactical operations of the organisation. Gill Walton is the current chief executive.

The RCM president is the RCM's ceremonial figurehead and one of the RCM's two principal ambassadors (the other being the CEO) representing the RCM at national and international events. Rebeccah Davies is the current RCM president.

The RCM staff are a team of 100 who are based in headquarters in London, offices in Belfast, Cardiff and Edinburgh, and at home across the UK. The offices in each of the four countries provide professional advice and employment relations services to RCM members.

The RCM Trust is a charity that works together with the RCM to maintain and improve standards of professional midwifery. The Trust conducts and commissions research, publishes information, provides education and training, and organises conferences, campaigns and other events. It's managed by a chief executive and governed by a Board of trustees, who are responsible for directing its affairs.

ILLUSTRATION: GIACOMO BAGNARA / SYNERGY ART

enter now

RCM Awards 2024

Free to enter for RCM members

Entry deadline: 3 May 2024

Categories include:

- Excellence in Midwifery for Leadership
- Outstanding Contribution to Midwifery Services: Perinatal Mental Health
- Outstanding Contribution to Midwifery Services: Pregnancy Loss & Bereavement Care
- Race Matters Unsung Hero:
  - Midwife or Higher Education Institution Staff
  - Maternity Support Worker or Student
- Student Midwife of the Year
- Maternity Support Worker of the Year

@MidwivesRCM | #rcmawards | rcmawards.com

book now

RCM conference

8-9 May 2024 – ACC, Liverpool

Explore some of the sessions

Day 1

11:50 - 12:40: Being green: sustainability in the NHS

Alifia Chakera | Jo Frame | Manraj Phull



15:00 - 16:00: Integrating trauma informed care into practice

Jo Cull | Lorraine Farrow | Sophie Olson



Royal College of Midwives

Day 1

16:45 - 17:45: Zepherina Veitch lecture - Midwife in a warzone

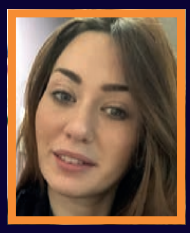
Wendy Warrington

When Wendy Warrington, a semi-retired midwife, saw the impact of Russia's invasion of Ukraine on pregnant women, she knew she had to do what she can to help. Fundraising turned to transporting supplies to the Poland-Ukraine border, and, once there, she couldn't help but provide support and care to women displaced by war. In this year's Zepherina Veitch lecture, she talks about her experiences as a midwife under fire.

Day 2

09:30 - 10:30: Listening to words unsaid: Supporting perinatal mental health

Melissa Addy | Kerry Adekoya | Yasmeen Akhtar | Nafizar Anwar | Carmel Doyle


11:50 - 12:40: Delivering good bereavement care

Sue McKellar | Lesley Rowe


Free to book for RCM members

@MidwivesRCM | #rcmconf24

rcm.org.uk/conference2024

Headline sponsor:

Pfizer

Let's talk about flex

Employment policies should make things fairer and improve the working environment for all. Flexible working promises just that

Last year, more than 30,000 staff left their NHS role due to work/life balance, and there are currently more than 120,000 vacancies in the NHS in the UK. Maternity is no stranger to this acute staffing shortage: it has led to a vicious cycle of vacancies and increasing workloads. These, in turn, are compounding the burnout and low morale reported by many. Isn't it time to do things differently?

Through the NHS Staff Council in England, Wales and Northern Ireland, health unions negotiated certain contractual rights for all NHS employees on flexible working (the Once for Scotland flexible working policy differs – see bit.ly/NHSS-flexible). Employees have the right to request flexible working from the first day of employment; there's no limit to the number of requests that can be made and employees have the right to have these requests considered fairly, whatever the reason for making them.

In addition, the Employee Relations (Flexible Working) Act 2023 means that, from April 2024, all UK employees will have enhanced rights to flexible working. These include:

- Employees can now make two formal flexible working requests within a 12-month period (previously, people could only submit one request within a 12-month period)
- Employees no longer have to set out how they think their flexible working request will impact the employer or how they think it could be accommodated
- Managers will need to respond to a flexible working request (with a decision) within two months rather than three. This timescale can be extended by mutual agreement – for example, if a request has gone to an 'escalation stage' so that wider options can be looked at
- Managers will need to consult with the individual directly to explain why they are declining a flexible working request.

Despite changes introduced to enhance rights for flexible working, and recognition in NHS England's Long Term Workforce Plan of its critical role, there are gaps in people's awareness, areas of poor practice and lingering barriers and misconceptions. It's important to note as well that managers who are on board with flexible working in principle can find it's easier said than done in practice. Maternity is a 24/7 service and shifts need to be covered – that's why a range of options is needed.

In March, NHS unions launched a joint campaign to increase awareness about flexible working rights and benefits and to support more NHS employers to take positive action. From self-rostering to a nine-day fortnight, or compressed hours (working your contracted hours over a shorter number of days), term-time working or even day/night-only working, there are options. 'Let's Talk About Flex' has plenty of resources, scenarios and case studies of areas that have made flexible working work.

Staffing app

The Birthrate Plus Team – Marie Washbrook, Richard Griffin, Annette Barton and Tash McAvoy-Jones – note the launch of an updated tool that can potentially accommodate flexible, part-time-working, staggered, compressed or term-time hours for staff based on the projected needs of the women and babies in their care.

Having appropriate levels of staffing across the whole maternity pathway, including

for 'in-patient' services, underpins safe and effective care. In 2015, Birthrate Plus launched the Ward Acuity App (WAA) to help services assess staffing need in their maternity 'inpatient' ward areas. Alongside it, a complementary real-time deployment tool was also designed for intrapartum care.

The WAA assesses the needs of women and babies using clinical indicators over a prospective six-hour period. Once indicators have been determined, the details of staffing are added.

Nearly a decade after the WAA's launch, Birthrate Plus has been reviewing how the WAA might be improved, including taking account of recent guidelines around neonatal care – for example, in regard of jaundice management and IV management.

This review has also provided insights into how ward-based care has changed. For example, this includes the increased use of non-midwifery staff, in particular an enhanced role for maternity support workers (MSWs) reflecting the national MSW competency framework and apprenticeships developed in 2018. There has also been a noticeable increase in systems-wide collaboration (the WAA allows local maternity and neonatal services to review and respond to needs across a system).

The WAA reflects the dynamic nature of care on wards. It accommodates the fact that the needs of mothers and babies (now recorded separately) can change. It records when midwives and other staff do not work a full shift due to escalation or when they may be working a twilight shift. Furthermore, the fraction of hours function can be used when redeploying staff from other areas to support the ward, or when specialist or management teams are supporting the ward area during periods of staffing pressures or escalation.

Wards are dynamic environments; it is essential to ensure sufficient staffing

Locally, the WAA allows services to see the status of each ward, including across multiple sites, allowing for direct redeployment of staff within a unit to provide safe and effective care to women and their babies as required. The WAA provides a record of the resulting impact on the acuity, whether this be due to staffing, workload or if a significant event occurs. Staff can record any clinical or managerial actions, factors or red flags taken to maintain safety at that time, plus specific information for reporting purposes.

The review of the WAA has shown that, compared to a decade ago, there are now

FLEXIBLE CHILDCARE

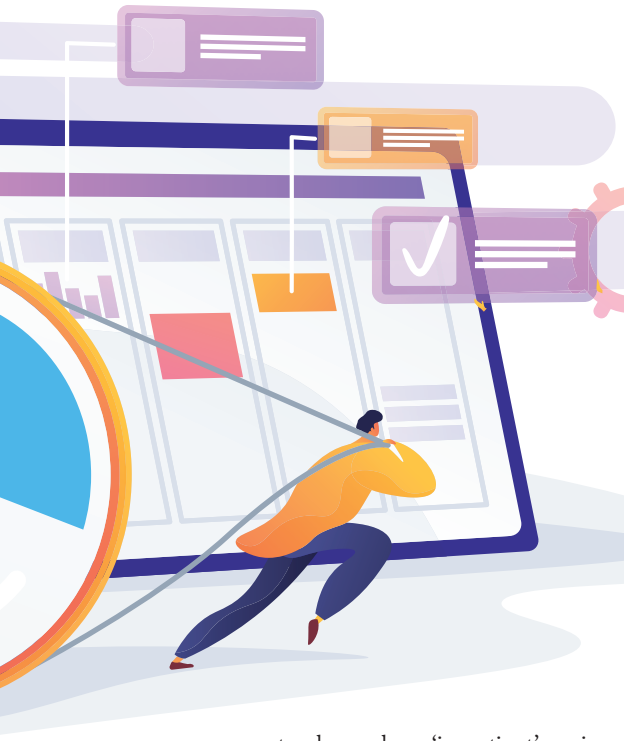
RCM director for Scotland Jaki Lambert notes: "Flexible working policies are important in terms of retaining midwives; however, flexible childcare gets to the root of the challenge for many of the midwives we talk to.

"Maternity services are a 24/7 365-day essential element of healthcare that require the majority of the workforce to be flexible, available for shifts at night and during the day and for some to provide regular periods of on-call and respond to emergencies and unplanned care.

"According to data from NHS Education Scotland, in the December statistics around 60% (1,868) of midwives in Scotland work part-time, and 99.7% of the workforce are women. The median age of staff has reduced to 42, in the past five years and continues to fall.

"The turnover of midwives continues to rise year on year at unprecedented levels while recruitment has become a recurring risk across Scotland. These risks have adversely impacted the ability of maternity services to ensure safe and appropriate staffing. One of the reasons midwives have given for leaving their posts and profession or reducing their hours by requesting part-time working (if other options are not available) is to reduce costs and improve the ability to access childcare. Many rely on extended family and friends; however, the demographics of society have shifted further over the past few decades, meaning this is far less likely to be a viable option for many.

"Childcare providers are not always available within manageable distances and their operating hours are in the main restricted to weekday and day hours. Additionally, the costs often consume a significant



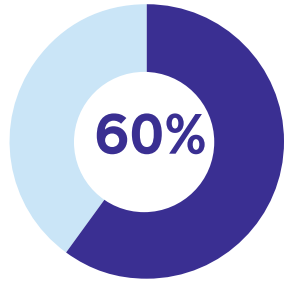
greater demands on 'in-patient' services, not least due to the increasing care needs of babies. There has also been a greater and more optimal use of MSWs, including where there is high acuity relating to babies. For staff generally, there is now a need for more flexible deployment, and the WAA's use of retrospective data allows for better workforce planning to cope with peaks in demand across the intrapartum and ward areas. There has also been a growth in systems working. What has not changed is that wards are dynamic environments where needs can change during a shift; it is essential to ensure there is sufficient staffing to support women and babies.

Why is flex needed?

Flexible working takes on particular significance when you consider that one in three NHS workers have caring responsibilities. With only 0.4% of the maternity workforce being male, and women more likely to take on this role, it isn't hard to see why flexible working options are needed.

Rising costs of childcare and other care costs are adding to that pressure. Flexible working becomes one of a raft of 'compassionate' workplace policies that make it easier to recruit and retain staff. For example, those approaching or returning from maternity leave need support in the workplace to manage their shift around fatigue and reasonable childcare hours. If the workplace isn't able to accommodate shift patterns and offer facilities that support the staff member, then they may delay returning to work or leave altogether. This is also true for those with responsibilities for older adults or grandchildren.

Flexible working improves work/life balance and wellbeing, and offering it could help to retain and attract staff. Moreover, for many it is a necessity for working life; it's about time it was made to work for everyone who requests it.



Around 60% (1,868) of midwives in Scotland work part-time
NHS Education Scotland

FURTHER READING

NHS Joint Trade Unions campaign 'Let's Talk About Flex' launched in March to promote flexible working to NHS staff: **bit.ly/lets-talk-about-flex** and **bit.ly/NHSEmployers-flexible-working** and **bit.ly/NHSEmployers-flex-myths**

Maternity Action has advice for those needing child-friendly working hours: **bit.ly/Maternity-Action-flexible-working**

Read more about the RCM campaign to improve support for breastfeeding staff. If the NHS isn't providing these facilities, it makes it vastly harder for much-needed maternity staff to return to work: **bit.ly/RCM-breastfeeding-workers**

percentage of wages, with midwives sometimes having to pay for regular sessions that they cannot use rather than those that meet their shift requirements.

"The Scottish Women's Budget Group (which looks at the impact of spending and tax decisions on women and whether the Government is allocating resources to meet its policy objectives) produced a report based on its 2023 childcare survey that demonstrates that women in Scotland reduce or compress hours to manage caring commitments.

"The Scottish Government commissions midwifery student numbers and the Health Boards to employ midwives. It is therefore a false economy not to provide accessible flexible childcare.

"It is welcome then that Kaukab Stewart MSP has called for a cross-party motion to address the childcare needs of Scotland to see a fundamental shift in provision. The RCM is calling on the Scottish TUC conference to campaign for increased access and reduced or supported costs for safe and flexible childcare. This will enable families to contribute to the maternity and wider healthcare workforce without being forced to live in borderline poverty or give up their profession."

IMAGES: SHUTTERSTOCK/ISTOCK

Midwives and maternal vaccination: leading the way

Maternal immunisation is an effective method to help a pregnant woman pass on disease-specific antibodies to her fetus in the third trimester, so that the baby can be protected during their most vulnerable first months of life.[1-3]

Find out about how maternal immunisation protects babies

1. Vaccination of pregnant woman[2]

2. Pregnant woman generates antibodies against vaccine antigen(s)[2]

3. Antibodies travel through the bloodstream to the placenta[2]

4. Antibodies are pumped into the placenta by FcRn proteins[1]

5. Fetus receives antibodies, which circulate in the fetal bloodstream[1]

6. Antibodies can offer protection for up to 6 months in a newborn baby[3]

Scan the QR code or use the link below to visit our website and learn more about maternal immunisation

https://www.pfizerpro.co.uk/therapy-areas/vaccines/vaccine-technologies/maternal-immunisation

FcRn = neonatal crystallisable fragment receptor

1. Etti M, Calvert A, Galiza E et al. Maternal vaccination: a review of current evidence and recommendations. Am J Obstet Gynecol 2022;226(4):459-474. **2.** Faucette AN, Unger BL, Gonik B et al. Maternal vaccination: moving the science forward. Hum Reprod Update 2015;21(1):119-135. **3.** Niewiesk S. Maternal antibodies: clinical significance, mechanism of interference with immune responses, and possible vaccination strategies. Front Immunol 2014;5:446.

PP-A1G-GBR-0075 | March 2024

Breast practice

As RCM's Julie Richards and Lesley Wood note, when you work in maternity services, people would expect your workplace to be the one of the most supportive around pregnancy and breastfeeding. Yet an RCM survey found this to be far from the truth. To encourage NHS employers, here are some examples of workplace breastfeeding best practice

Donna Robertson
INFANT-FEEDING ADVISOR, VICTORIA HOSPITAL, KIRKCALDY, NHS FIFE

Our maternity services have been Unicef Baby Friendly Initiative (BFI) accredited since 2005 and we have had gold accreditation since 2019, so infant-feeding relationships are high on our radar and something we're always talking about.

We start from the point of view that all women should be supported to feed their babies for as long as they wish. As employers, we need to think about what the barriers and stressors are for our staff, and what we can do to ease them. We know more women are returning to work from maternity leave potentially sooner than they might want to due to cost-of-living and

financial pressures, so we're thinking about how we can nurture them and how they nurture their families.

Our policy at the hospital is to have open and frank conversations around feeding intentions and plans, both during pregnancy and at least four weeks before returning to work, when workers will discuss with their line manager what they need as they return to work.

To assist staff, we look at flexible working patterns; we've had staff coming back on temporarily reduced hours, or not doing any night shifts for a period of time. It's about looking at what each person needs and seeing how we can accommodate that.

We also offer extra breaks to express or feed, and we've facilitated staff members' babies being brought in so that they can breastfeed on the unit while they're on shift. For midwives in the community, we facilitated additional travel time so that they could come back to base to feed their child while on shift.

In the general hospital we have a feeding room, although we often find staff are happy to find somewhere quiet on the unit to feed or express. They have access to our pumps if they wish, and they can store breastmilk in a designated fridge.

We're also aware that being separated from their babies can be quite challenging for some, so we know maternity staff also benefit from taking time out in the wellbeing hubs which have been created for staff across the hospital, including relaxation pods and gardens.

The result is that coming back to work feels more manageable. Crucially, they know that their colleagues are supportive of them because supporting breastfeeding is so embedded in our culture, both within the service and across NHS Fife; this is all part of business as usual.

Gemma McBride

INTERIM INFANT-FEEDING LEAD AT DUNLUCE HEALTH CENTRE, BELFAST HEALTH AND SOCIAL CARE TRUST

Unfortunately, legislation around breastfeeding in employment isn't as robust in Northern Ireland as it is across the water, which makes raising awareness even more important.

We have a specific Trust policy for employees returning to work while breastfeeding, which was updated in September, setting out what managers should do to support those mums, and line managers' responsibilities.

We suggest breastfeeding mums should be given one or two additional breaks of about 20 minutes, to express or breastfeed their babies, on top of their normal breaks. That must be decided with their line manager depending on the needs of the service, but we hope people will be fairly creative in order to allow mums to continue to breastfeed. Directly breastfeeding your baby while at work could be facilitated on a case-by-case basis, depending on the workplace environment. It could work particularly well in a community setting for example.

The policy calls for a clean, private place to feed or pump, with access to an electric outlet and ideally a sink as well, and somewhere to store milk. All breastfeeding mums who have a Belfast Trust health visitor as well as Trust employees can avail themselves of a back-to-work pack: a coolbag, ice pack, a milk storage bottle and a water bottle, as well as a leaflet about expressing and milk storage. These are incredibly useful for healthcare practitioners – a community midwife, for example, who might need to store milk safely until she can get to a fridge.

A lot has been done around awareness and education: the policy has been shared with human resources and disseminated among line managers. It also outlines employees' responsibilities around good management and storage of breastmilk and communicating their needs with their supervisors.

Ideally, a line manager will have a discussion with a breastfeeding employee ahead of time about their needs and how they will facilitate them. It can feel quite overwhelming to try to balance breastfeeding and being a working mum, so it's important to get plans in place early.

Every service in the NHS is under acute pressure and it can initially appear difficult to support employees in a practical way, but as healthcare practitioners we are so much more aware of the benefits of breastfeeding for both mums and babies. Thus we are ideally placed to lead by good example to other employers, in the way we support parents working in our services who want to breastfeed to continue to do that for as long as possible.

Natalie Boxall
SPECIALIST MIDWIFE, INFANT FEEDING, AT KING'S MILL HOSPITAL, SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

In November 2022, we became the first UK hospital to provide a specialist pod for visitors and staff to breastfeed their babies and young children.

It all started when a member of staff from another department made a complaint about their experience on returning to work – that was sent to the chief executive and then, because I have feeding in my title, it came to me.

Over 18 months we brought the plans and the finance together to install a pod, giving staff and visitors a private and comfortable place to feed their babies and express milk. We also make it clear on screens around the hospital that parents are welcome to breastfeed their babies anywhere in the hospital, as this is their legal right.

Human rights are also the focus of the Trust-wide policy for returning to work while breastfeeding. The policy states the Trust must provide flexible breaks so that women and birthing parents can express milk or feed their child, provide a private, lockable space, access to a clean fridge and flexible working hours.

Having a clear, written policy not only helps staff advocate for themselves but helps managers to support their staff. Crucially, it helps them understand the individualised conversations they need to have before people return to work.

Staff coming back from maternity leave can feel vulnerable, and managers need to be aware of physiological changes. For example, without breaks, some members of staff could end up with mastitis or even an abscess.

Communication also helps to reduce your anxiety; you want to know you're supported and that your baby is going to be okay. You are returning to work as a parent, not just as an employee.

We took a 360-degree, holistic approach to this: venue, policy and information. Even in midwifery there is a perception that breastmilk 'turns off' or has no value after six months, so I collated evidence about how and why you can continue breastfeeding up to age two and beyond, into a staff leaflet, which is available in the pod.

The feedback we've had has been universally positive. We also know that we have quite a lot of people who come back to work still breastfeeding. This isn't just about putting in a pod – it's really about a culture of listening to people, finding out what is important to them and facilitating it.

It's a culture of listening to people, finding out what is important to them

Julie Richards
RCM DIRECTOR FOR WALES

We have met with strategic midwifery leaders for Wales and we're hoping to have all seven Health Boards signed up to the RCM Caring for You charter by the end of March. We will be encouraging them to review their breastfeeding at work policies and make a clear commitment to support continuation of breastfeeding on return to work.

We are working with TUC Wales and an all-Wales group of directors for workforce for all employers to raise the standards of support and facilities for breastfeeding staff. No matter where they work, it's important to take a collective stance, showing solidarity and seeking to influence at a national level and at a policy level.

The RCM guidance makes explicit what that looks like: good facilities, good milk storage and a real opportunity for good flexible working as well. That means employers and managers asking, 'What can we do to support you in your feeding intention?' rather than the staff member having to ask for what they need.

We need to be starting conversations during pregnancy and 'keep in touch' contacts during maternity leave around how those feeding intentions can be enabled and supported on return to work.

As midwives, we know the evidence is clear about the benefits of continuing to breastfeed both for mums and babies, but we don't always put ourselves first. If you work in maternity, it is so important that you feel welcomed, valued and supported during this period – which is only a short time in a midwife's working life.

This is also a really important part of how we retain midwives, especially in Wales, where we know from the recent *State of Maternity Services* report that we have a much younger profile of midwives, and with that comes a higher number on maternity leave.

It is so important that you feel welcomed, valued and supported in this period

Examples of good practice include Betsi Cadwaladr University Health Board, where there are well-signposted rooms set up for feeding and storage of milk. Most importantly, their policy is really clear.

We want to ensure that our young midwifery workforce knows what good support should look like. But if that level of good support isn't normal custom and practice in a service, midwives who want to continue to breastfeed after returning from maternity leave can feel they are asking for something extraordinary. It should be routine.

MORE INFO

See the RCM's survey on breastfeeding workers: **bit.ly/RCM-breastfeeding-workers**

Join the conversation on RCM resources to support breastfeeding in the workplace: **bit.ly/RCM-breastfeeding-at-work**

i-learn: Understanding pregnancy and maternity rights at work

IMAGES: SHUTTERSTOCK

Kelly Leonard
COMMUNITY INFANT FEEDING COORDINATOR AT HOLYWOOD HEALTH AND CARE CENTRE, SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST, BELFAST

One of the priorities when I came into post in September 2022 was developing a policy supporting breastfeeding staff on their return to work. It was adopted last summer, coinciding with World Breastfeeding Awareness Week, which had the theme 'Let's Make Breastfeeding and Work, Work!', so the timing of that really helped push it forward.

From then, the breastfeeding and return-to-work policy, along with the links to the Trust's infant feeding page, has been included in the information pack available to staff online (or on request via HR) when applying for maternity leave. That was such an important step as it encourages women to think, at an early stage, about how they might continue breastfeeding or expressing on returning to work.

Having a written policy helps to ensure staff are supported and managers are aware of their roles and responsibilities and are thinking about how to meet those. That might mean scoping out safe, quiet, comfortable and clean places for someone to express in an unfamiliar building where staff training is taking place for example, which is something I have done for a returning member of staff.

Our Unicef Baby Friendly Initiative gold-accredited health-visiting service, in collaboration with the Trust's health development team, also provides return-to-work breastfeeding packs (a coolbag, icepack, milk storage bottle and water bottle). This initiative was in place prior to my coming to post, but we managed to secure more funding to keep it going.

Many women give up breastfeeding earlier than they want because they're coming back to work and don't feel they will be supported, or don't have the confidence to approach their employer – not in the NHS specifically, but across different sectors.

The return-to-work breastfeeding packs can help spark conversations, which is why we share information about them on social media pages as well as to health-visiting contacts and groups; it might just give someone that bit of encouragement to approach their employer and ask for the support they need.

Many women give up breastfeeding early because they don't feel they will be supported

As a Trust, having all the relevant information about returning to work while breastfeeding included in the maternity packs is so important in building awareness. Staff can make plans earlier and feel more confident that they'll be supported to continue on their feeding journey.

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Breastfeeding support

RCM health and safety advisor Lesley Wood says returning to work and breastfeeding your baby shouldn't be an either/or choice

Q: I have just had a baby and I'm keen to try to breastfeed for the first year, but I'm worried about how I will do this if I go back to work after six months. I'm considering taking the full year of maternity leave in order to be able to do it, but I'm worried about my income.

A: We are all aware of the barriers breastfeeding workers face, but being provided with somewhere to express in privacy shouldn't be difficult. However, many report being told to use a toilet cubicle, and having little time to express and nowhere to store milk safely. Members have reported giving up breastfeeding and experiencing associated feelings of stress, anxiety and guilt. I understand why you would consider taking the full year as we have anecdotal evidence that some mothers delay or decide not to return to work.

It is for this reason that the RCM has developed a resource to support breastfeeding members returning to the workplace to understand their rights. It should also enable members to have a good understanding of the employment rights of women in their care. Some of these women may feel that returning to work would be a barrier to breastfeeding or that they need to give up in advance of the end of maternity leave.

Breastfeeding rights

In 2013, Parliament failed to adopt proposed legislation making

breastfeeding/expressing breaks in the workplace a statutory requirement. An advisory panel of breastfeeding organisations including La Leche League GB and Maternity Action provided evidence-based information about how milk supply works, along with the practicalities of what women need for breastfeeding breaks. In 2014, ACAS published guidance setting out what is required of employers by law in providing support to employees returning to work following maternity leave.

In the 10 years since, the guidance hasn't been updated, even though workplace practices have changed – for example, with flexible working. In 2021, the RCM presented a motion to the TUC Congress stating that ACAS guidance was being ignored by many organisations and this was affecting breastfeeding rates in the UK, which are among the world's lowest. The RCM called for the ACAS guidance to have a statutory footing so that employers have a legal duty to implement, and last year the RCM included it in its Caring for You charter.

Your rights

There is no legal right to time off to breastfeed or to provide facilities for expressing and storing milk. However, if an employer refuses to meet these needs, then contact your workplace representative because this could be considered sexual discrimination under the Equality Act 2010.

In addition, the Management of Health and Safety at Work Regulations 1999 require the employer to manage the risks to women of a childbearing age, pregnant workers and new mothers (regulation 16); to adhere to advice from a doctor or midwife if night work will affect the health of pregnant workers and new mothers (regulation 17); and to set out duties once notified a worker is pregnant, has given birth in the past six months or is breastfeeding (regulation 18).

Section 67 of the Employment Rights Act 1996 states that suitable alternative work should be offered, if available, on the same terms and conditions, while regulation 25 of the Workplace (Health, Safety and Welfare) Regulations 1992 states that employers must provide a suitable place for pregnant and breastfeeding workers to rest.

It is also unlawful to dismiss, discriminate against or harass a worker because they are pregnant or a new mother.

In addition, guidance from the Health and Safety Executive to employers states that pregnant workers and breastfeeding mothers are entitled to more frequent rest breaks and a suitable area where they can rest should be provided. This should be hygienic and private so they can express milk if they choose to – toilets are not a suitable place for this – and somewhere suitable to store the milk should also be provided.

Your workplace rep can represent your interests and negotiate with management on your behalf

If you have concerns

Speak to your line manager before you return to work to understand the facilities and support available. Meet your RCM branch rep who will look at the policies in your workplace and, if necessary, discuss provisions with managers and HR. An employer should also undertake an individual risk assessment for all breastfeeding employees. Your workplace rep can support you, represent your interests and negotiate with management on your behalf. If you don't know who your workplace representative is, contact RCM Connect on 0300 303 0444.

There's no reason why you should feel that taking full maternity leave is the only option available to you because you want to breastfeed your baby.

MORE INFO

RCM guide to understanding your rights: **bit.ly/RCM-breastfeeding-at-work**
RCM i-learn: **Understanding pregnancy and maternity rights at work**
NHS UK: **bit.ly/NHS-breastfeeding-at-work**
HSE: **hse.gov.uk/mothers**
ACAS: **bit.ly/Acas-breastfeeding-at-work**
Unicef Baby Friendly: **unicef.org.uk/babyfriendly**

IMAGES: SHUTTERSTOCK

Aseptic technique

Carrying out a procedure in a way that minimises the risk of contamination is known as an aseptic technique

1

First steps

Hands are decontaminated, with liquid soap and warm running water and dried with paper towels, or an alcohol handrub is used and allowed to dry. The professional should be bare below the elbows.

2

Ensuring sterility

The surface to be used for the sterile field is decontaminated with a detergent wipe, or detergent and warm water, and dried with paper towels.

3

Opening the package

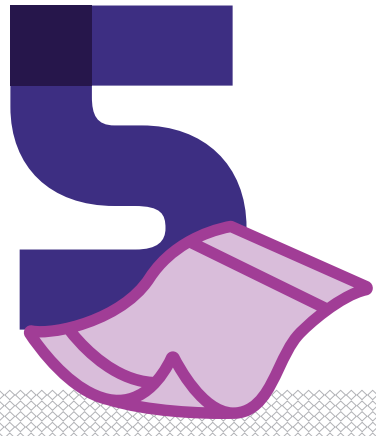
All sterile items are checked to ensure they are intact and within the expiry date. The pack is peeled open and the sterile gloves opened on top. Sterile gloves should be donned and all the sterile contents should be arranged with the gloves on.

4

Pre-gloves procedure

Hands are decontaminated again, using the correct technique, with liquid soap and warm water and dried with paper towels, or an alcohol handrub is used and allowed to dry. Sterile gloves are put on without contaminating the outer surface of the gloves.

5



At the wound site

The sterile sheet is arranged at the site and the procedure is carried out, including cleaning of the skin where applicable, maintaining a sterile field throughout the procedure.

6

Waste disposal

PPE should be removed – gloves then apron – and disposed of safely. Hands are decontaminated again following the proceedure.

Safe space

When a maternity team in Wales decided to overhaul their approach to risk and governance, they hoped to see improvements in care – what they hadn't anticipated was a culture change

Working in an environment where, minute-by-minute, every decision you make is vital demands a strong sense of psychological safety – that is, the belief that if you speak up with ideas, questions or concerns, you won't be humiliated or penalised. When an RCM survey in autumn 2022 revealed that some members felt their workplace lacked psychological safety, the maternity services team at Hywel Dda University Health Board in Wales took notice.

"The survey talked about escalation and people being fearful of submitting incidents for review," says Cerian Llewellyn, lead midwife for risk and governance. "This was something that, anecdotally, we were aware some of our own staff had concerns around." But while this feeling may have been rumbling in the background, the survey not only brought it under the spotlight, but demonstrated that this was not singular to any one hospital.

Neither was it particular to midwifery, says Tipswalo Day, obstetrician and gynaecologist at Hywel Dda. "I was in ST7 [speciality trainee year 7] in 2021 – part of which was gathering feedback – and what came up were concerns around bullying, undermining, people not feeling listened to and a sense of hierarchical working." These feelings were mirrored by surveys carried out by the General Medical Council and Health Education Improvement Wales around the same time. "It was really important to see that this problem didn't belong to one particular professional group," says Cerian, and alongside Tipswalo – with whom she shares a working relationship and an office – she had a determination that something had to change. This feeling was shared by their head of midwifery and women's services Kathryn Greaves.

The "tangible" belief from staff that there was a blame culture at play, says Kathryn, was a driving force for change, as was the knowledge that "our clinicians had the answers, if only we'd involve them. But we [maternity and neonates] were working as absolute separate entities, under separate management teams."

There have been several national reviews into maternity services with high levels of infant and maternal mortalities, which found that these were in part caused by a lack of interdepartmental working and an absence of learning from events as a system, says Kathryn. "The rich learning evident from those seminal reports was that we had to change, and we had to collaborate and create a perinatal workforce and a perinatal pathway."

The rich learning evident from those seminal reports was that we had to change and collaborate

Strength in numbers

This was the inception of Hywel Dda's maternity and neonatal risk and governance framework: a clear process, which was co-produced, understood and engaged with by all professions within the maternity unit. Cerian says: "It was really important that we had a relationship built on equality, which recognised that individually we were experts in our fields, but collectively we represented something much stronger."

Fortunately, the framework had instant buy-in from everyone involved: Kathryn

IMAGES: SHUTTERSTOCK/ISTOCK

Are you contacting this staff member for advice? Do you want them to come and do something? Or are you just informing them?

and Tipswalo, as well as lead consultants from the paediatric and neonatal units. What was more of a challenge, however, was convincing those higher up the scale. "We were all quite new into our senior leadership posts so there was a bit of an issue getting that validity and respect," says Cerian. "Historically the NHS is quite ageist and it's about how long you've been in the profession, rather than your experience and what you've done with it."

But the support of stakeholders was necessary if the framework was to have any chance of success, Cerian adds, so an internal survey, which specifically looked at risk and governance, was used to demonstrate to seniors that staff felt fearful, anxious and stressed. "There was very little within the responses that offered you any reassurances that people felt safe, which was quite difficult for people to digest." But it was accepted that change was needed, the first step of which was to demystify risk and governance.

"We came to realise that people were fearful of the whole process, not necessarily because they'd experienced it, but because they imagined it to be something that it wasn't," she continues. "We said, 'This door is open for everybody, please come and be a part of this [incident review] meeting because I want you to see that it's not about the individuals involved – it's about the systems in which we work.'"

Staff were educated, for instance, on the incident reporting pathway in order to see that once something was reported via Datex, all details regarding staff and service users involved were anonymised. The aim is to "identify whether there are any care issues, and whether there are things that could have been improved," says Cerian, not to see who was to blame. It took a while for people to trust that incidence reporting was a safe space "but once you start building trust within a process and people come and witness it first-hand, they feed back to their colleagues and realise it's authentic".

Improved service

This transparency was extended to every stage of the process, including engagement with families where incidences had occurred. "We now try and see any duty of candour and bereavement cases as a multidisciplinary team (MDT)," says Tipswalo. "Previously, families would receive one answer from obstetrics, one from midwifery and one from the paediatric team, but we're coming together to give a shared response. We've had comments about how nice it is to have that level of honesty and for them to see that we are taking their feedback forward."

Recognising what the families they serve needed was as important as understanding staff concerns, says Kathryn, who is keen to emphasise that the team didn't invent anything "ground-breaking" for the framework: no extra resource was available, she says, so "we had to work together and think smartly to bring about improvements". This included examining what national tools were already out there – "systems that are designed and standardised across the NHS" – and deciding how best they could serve Hywel Dda: a rural Health Board that covers a third of the landmass in Wales.

The RCM/RCOG escalation toolkit is one such tool and has become a fundamental part of the framework. While previously doctors and midwives often had to decipher what the other was trying to communicate during the escalation process – and why – the toolkit provides clarity.

"It's about being really clear on what your expectations are," says Tipswalo.

"Are you contacting this staff member for advice? Do you want them to come and do something? Or are you just informing them?" This strategy helps ensure that "when there's a woman you're concerned about, you can have a clear conversation with a colleague," she says.

"Even if there are disagreements, you can come to a shared understanding of what that plan of care is going to be." This is vital in providing optimum care for families, but also helps senior leaders model how an MDT "can all get along. And even if we don't agree on everything, we can have courageous conversations and conflict with one another and still have a respectful relationship."

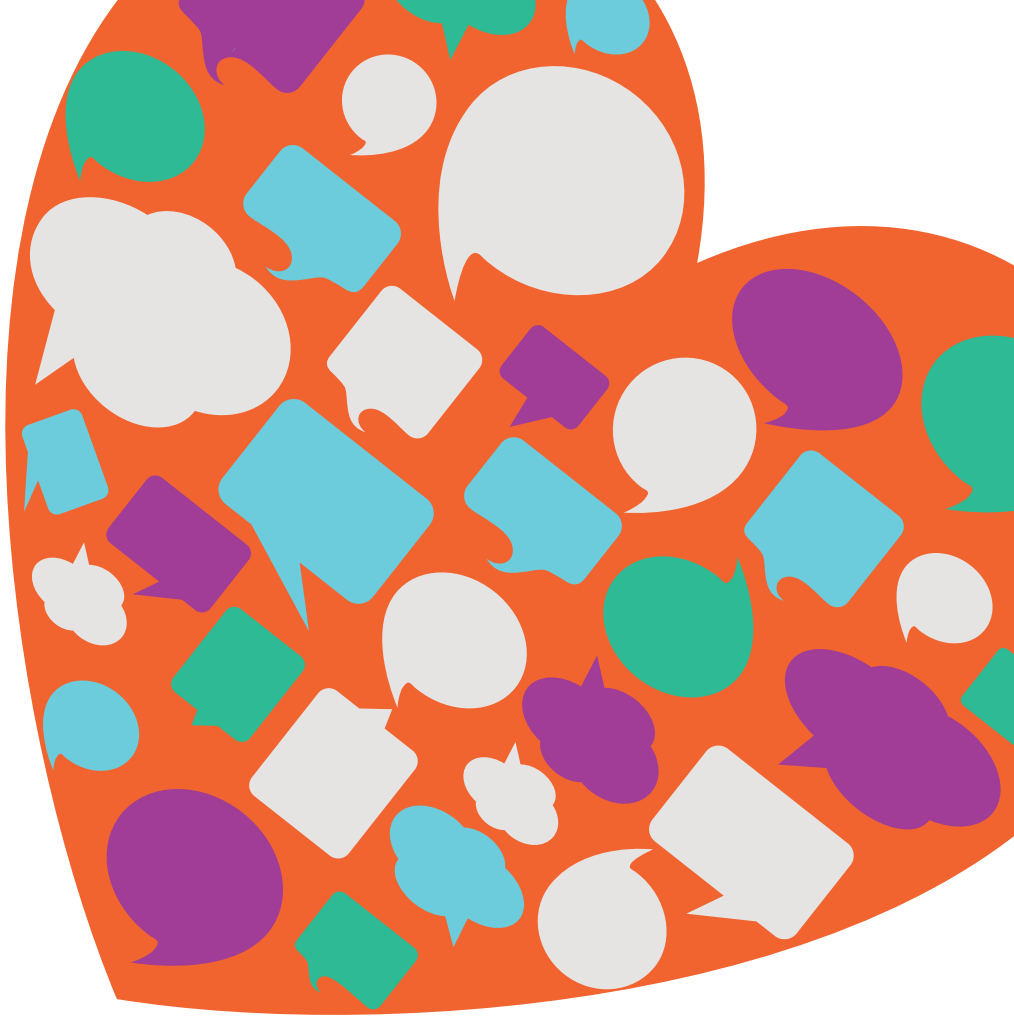
While a commitment to working collaboratively is laudable, it must be combined with a genuine understanding of, and respect for, each other's roles if it is to work. "There were things I didn't understand about the complexities of being a midwife in a room with a woman for a very long period of time," says Tipswalo. "It makes you that woman's advocate." This can come through when an obstetric, or any other professional, is recommending a certain line of treatment. In order to help the rest of the MDT understand her role and the decisions she has to make, Tipswalo has used a range of resources "because we know everybody's learning style is different". Videos, for instance, invite the viewer to go on a journey with a woman in their care and make decisions based on the CTG. "You then see what the outcomes would be, and from there we talk about key points we've identified from our incidence reviews, so things like different types of hypoxia and managing sepsis."

Results we could only dream of

Like Kathryn, Cerian insists that it is less the individual aspects of the framework that have led to its success, but rather the combined impact of "streamlining all the processes, making them open, working in co-production and being committed to the idea that risk and governance belongs to everybody".

While the literature says it can take eight years to achieve culture change, in just 14 months they have seen a marked difference. The most recent internal survey, for instance, not only had more respondents, but used words such as "supportive", "open" and "transparent" rather than "unfair" and "punitive". "It was just really positive about the process of learning," says Cerian.

This has made a tangible difference too, with staff turnover decreasing ("we're probably one of the only units that can say we're staffed fully to birth rate," says Cerian) and incident reporting increasing. During the period 2020-23, the number of reports grew by 46%. While that figure made the directorate level "think things were suddenly



going awry," she laughs, "a high level of reporting is actually really good evidence that people are not frightened of being open and honest. And that is what psychological safety is all about."

Not only did people feel safer to report, says Kathryn, but "because we're now flooding the system with information we didn't have before, we've been able to address the learning and therefore drive the system to bring about improvements."

Most importantly, this has filtered down to the people who need it the most. "We've always worked on the basis that in maternity services, babies don't die because people lack the clinical skills," says Cerian. "Babies die because of the systems that people work in, so it's been really reassuring to see that we've had a downward trend in stillbirth rates and a decrease in the number of babies born with Apgar scores of less than seven."

Recognition of achievements

Unsurprisingly, this incredible success has been noticed on a wider scale, with the Hywel Dda University Health Board's maternity services team winning the Health Service Journal's Patient Safety Award for developing a positive safety culture in September of last year, followed by an NHS Wales Award for improving patient safety.

"We're really, really proud of those awards, because it was a lot of hard work," says Kathryn, whose joy is palpable. "To be honest, we weren't sure we'd win because we're just a very little Health Board in Wales … but it shows that it's not about the size of the service, it's about the quality of what we're doing, and how the experiences our families had driven that will to do better."

Indeed, on multiple levels, there is a sense that this is a recognition of the 'little things' that are in fact of huge significance. "There are very few examples where maternity services get to be shortlisted to that level of award in Wales," says Julie Richards, RCM director for Wales. "The fact that they were successful is a huge credit to their achievements."

Within the discipline itself, governance – as Kathryn puts it – "isn't a subject that ignites passion, because it's complex." But by taking it seriously, investing time and commitment to the framework and bringing the process out of the shadows, the Hywel Dda team have seen improvements of a kind that "two years ago, we could have only dreamed of," says Cerian.

Kathryn attributes much of the success to "my team of incredible people, who are very, very talented." The part she herself played was pivotal, as Cerian notes: "All this work had been evolving in the background, but when Kathryn came [in 2022] that's when things started changing because she gave us the freedom to lead in a way we wanted to." Julie agrees: "Kathryn really wanted to listen to what members were feeling … the fact that they took [the RCM survey] so seriously has made a whole system change."

This wholly deserved national recognition is far from the end of the journey. Julie explains that they would like to see the framework included as part of the Mat-Neo Safety Support Programme in Wales, and the team is chomping at the bit to use their momentum to do more. "We're getting out there and talking to as many other people as we can to build up those professional relationships and collaborations," says Tipswalo.

She adds they are trying to emphasise that "we didn't have any additional funding, just had a group of really passionate people." For now, they're focusing on "trying to collaborate across Wales," she says, "because that's slightly more achievable at the moment."

They may be a small Health Board that births a (relatively) small number of babies, but their achievements so far have been great. Whatever they do next, everyone would do well to pay attention.

MORE INFO

NHS Wales Awards: Changing Workplace Culture and Multidisciplinary Engagement in Maternity and Neonatal Clinical Risk and Governance:
bit.ly/NHS-Wales-award
RCM Raising concerns:
bit.ly/RCM-Raising-concerns
RCM/RCOG escalation toolkit:
bit.ly/RCOG-escalation-toolkit

standing up for high standards

Your guide for raising concerns:

Step 1:

Talk to your local RCM workplace rep or your Regional/National Officer about your concerns to determine the best course of action.

Step 2:

Check your employer's policy on raising concerns so that you know the right route to take.

Step 3:

Be clear about the requirements of your professional code. Raise immediately with your Supervisor of Midwives/Professional Midwifery Advocate/Clinical Supervisor for Midwives or RCM representative if you are being asked to contravene your code.

Step 4:

Be clear about what you are concerned about and why.

Step 5:

Place your concerns on record - your RCM representative can help you with this.

Step 6:

Be prepared to have meetings to explain your concerns and determine the way forward.

Step 7:

If, having completed steps one to six you remain concerned, contact your local Freedom to Speak Up Guardian/Raising concerns champion.

Step 8:

If you are considering using the whistleblowing policy, seek support and advice from either your local RCM representative or Regional/National Officer.

Find out more here

Royal College of Midwives

Part of the solution

International Day of the Midwife on 5 May this year highlights the escalating climate crisis, but what is its impact on maternity care?

"Climate change is the greatest health challenge of our time. Our warming planet has more heatwaves, more floods and more natural disasters that significantly impact the health of women and babies. Putting resources and efforts into addressing the climate crisis is a matter of extreme urgency ... For this reason, the theme for this year's International Day of the Midwife is 'Midwives: a vital climate solution'."

The extreme urgency mentioned by the International Confederation of Midwives (ICM) here is not an alarmist term: a risk assessment carried out by the European Environment Agency suggests the continent is not sufficiently prepared for the rapidly growing climate dangers it faces – from wildfires burning down homes to violent weather straining public finances.

The threat to our planet and people is real – but in what ways is the climate crisis affecting maternity? Lia Brigante, RCM international professional policy advisor and board member for Europe at the ICM, says: "As the temperature rises every year, there are more extreme weather events and clusters of heatwaves. There's a lot of data now that shows women exposed to compound heatwaves are more likely to

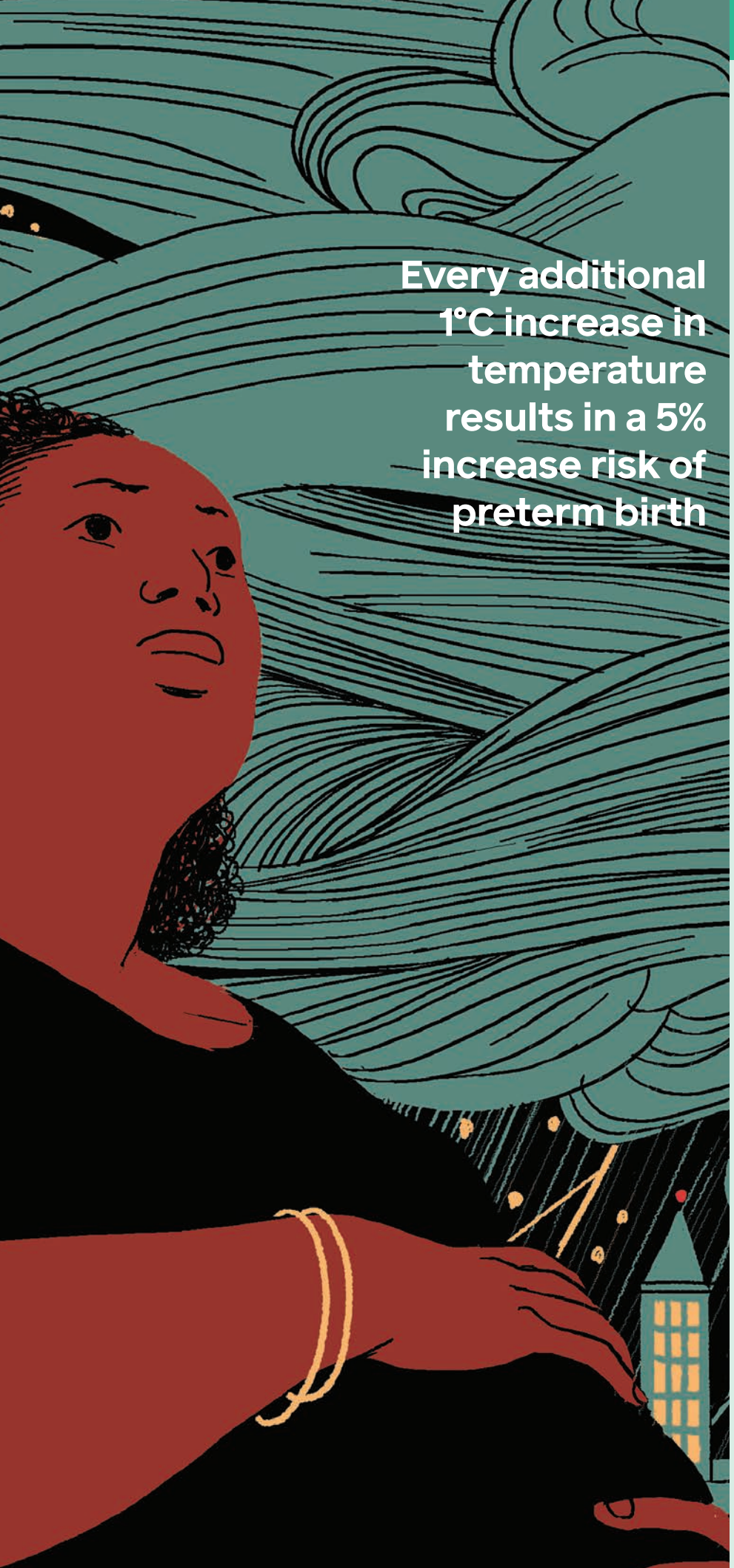


ILLUSTRATION: ELEANOR DAVIS

experience a preterm birth – and early term birth. Lower to middle income countries are experiencing some of the highest rates of poor birth outcomes.

"There is also evidence from high-income countries showing a disproportionate impact on women from lower socio-economic groups, who might not have access to air conditioning [during a heatwave] and are more likely to experience heatstroke, respiratory conditions, preterm birth and low birth weight. Small and preterm babies require enhanced care and increased rates have significant public health implications.

"These are the main health affects of climate change in terms of the effects on pregnant women and babies. In urban areas like London, the detrimental effects of air pollution, such as increased asthma in children and disproportionate effects on pregnant Black women, have also been flagged by campaigners."

Mervi Jokinen, RCM professional advisor for Europe, agrees complications are rising as the climate crisis deepens. "Last summer, southern Europe was hit really hard by climate change. It was of concern to have more women coming to hospitals for care, because they had more requirements than they would have otherwise. I think it's very important that midwives are much more aware of how they can help reduce climate change and provide optimum care for women."

Jo Frame, practice development midwife and chief sustainability officer's clinical fellow (FMLM 2022/23), agrees. "The climate crisis can affect all aspects of health; the *Lancet Countdown* report (2022) tracked the links between health and climate change. Its findings reaffirm that, globally, climate change is exacerbating food insecurity, health impacts from extreme heat, the risk of infectious disease outbreaks and life-threatening extreme weather events. All of these compound the inequalities that women, girls and children already experience.

"Then there's an ever-growing body of evidence highlighting the impact

the climate crisis has upon childbearing – for example, the Chersich et al study (2020) found that every additional 1°C increase in temperature results in a 5% increase risk of preterm birth. So it is vital that our profession understands the impact that the climate crisis has upon our service users and that we do all we can to adopt and support sustainable maternity care to help the NHS tackle its own impact on the environment."

What's being done?

The health service contributes around 4% to 5% of total UK carbon emissions, and the NHS in England alone is responsible for almost half (40%) of the public sector's emissions. "Much is already being done to reduce this," says Jo. "Maternity services span all care settings – primary care, outpatient, day assessments, theatres and in the home. This means we're in a unique position to adopt environmentally sustainable changes such as reusable products, wipeable tourniquets and theatre caps; encouraging CTG belts to be single patient rather than single use; and supporting the transition from IV medications to oral as soon as appropriate to do so."

In 2020, NHS England set out a roadmap towards making the NHS the first net-zero health service in the world by 2045 in its *Delivering a net zero health service* report. Since then, other UK nations have announced targets: net zero by 2045 for Scotland and a 34% reduction by 2030 in Wales as part of the wider goal of a net-zero public sector by 2030.

And although Northern Ireland's health service has not yet set a target, the country's midwifery services are leading the way in transitioning to a paperless, digital record-keeping system that is the same system across the country so records are transferable, no matter which unit the service user walks into.

Small measures and tweaks to processes and practice are going to prove invaluable to the collective efforts, says Sarah Jones, the lead midwife for practice development and education at Manchester University NHS Foundation Trust (MFT) and RCM board member. She is set to chair an RCM webinar in the autumn in which she will discuss her team's project. "We did things like removed paper, went electronic, turned computers and lights off – and we've done recycling. We're looking at efficiency.

"And then the other side of it was wellbeing, so getting our team to go outside, using the green space and healthy eating in the office. Sustainability is about the bigger picture, but actually it starts with us. We can do small things."

Liz Murphy, senior midwife and senior sustainability officer at MFT, who will also feature in the RCM webinar, says the women she cares for are eco-conscious in their plans for birth. "Some women say, 'I want to have a lower-risk, lower-care birth at home because of the environment,' and the same with breastfeeding to use less plastic," she says. "I think it will become more of a consideration in the future."

Liz adds that hospitals ensuring they're segregating waste correctly is another seemingly small yet vital measure. "We have three different waste streams: domestic waste, offensive waste and infectious waste. When hospitals just use the infectious waste stream, it costs more in carbon and financial terms than the offensive waste stream because it has to be incinerated at high temperature. So midwives have got a responsibility in waste segregation and how they get rid of the resources they use."

Jo agrees, saying: "Every person within the NHS has the opportunity

to make more sustainable choices in daily practice. Case studies from Greener NHS show the carbon and cost savings, and improvements to service user experience can be made by initiatives such as reducing non-sterile single-use gloves and avoiding unnecessary cannulation in place of oral medications. Maternity leaders also have the opportunity to incorporate sustainability into quality improvement initiatives – the national roll-out of the perinatal pelvic health service is a fantastic example.

"Service users are empowered through assessment and education during the antenatal period via apps and video calls, thus reducing travel emissions. By preventing significant incontinence issues, it reduces future pressures on the NHS."

Segregating waste is another vital measure

ON THE AGENDA

What you can expect to hear in the sustainability session at the RCM conference – from the speakers

Jo Frame, practice development midwife and chief sustainability officer's clinical fellow (FMLM 2022/23), will present the NHS England project on sustainability and net-zero work. She will use this to suggest small changes across the service that can bring about big change.

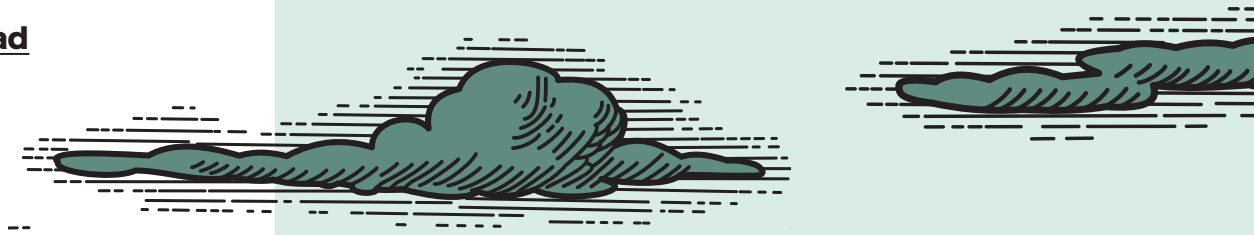
Alifia Chakera, head of the Scottish Government's pharmaceutical sustainability, health infrastructure and sustainability division, says she will highlight the socio-economic aspect of sustainability during her talk. "I will talk about Entonox mitigation and touch on the impact of inequalities," she says. "I think midwives need to advocate for the poorest women and their babies – they are the most in need of our care, compassion and advocacy."

Alifia will also call on midwives to get in touch with her, particularly in relation to her role leading on NHS Lothian's nitrous oxide project. "Midwives should get in touch with me and feel confident to ask, even demand, better care for new mothers and for themselves. Midwives need to be bold and ask for resources on many levels."

Find out more about the nitrous oxide project at **bit.ly/Anaesthetists-nitrous-oxide**

Manraj Phull, senior net zero delivery manager for the Greener NHS National Programme, NHS England, will present the work Greener NHS is doing to explore how the NHS can contribute to environmental sustainability and planetary health and assess the carbon footprint of maternity care pathways.

See more on socials at **@GreenerNHS**



It won't change overnight, but midwives are part of the climate solution

Bigger picture

Widening the lens on sustainability is also key to understanding how maternity services can make a difference, says Alifia Chakera, head of pharmaceutical sustainability within the Scottish Government, who will be speaking at the RCM conference (see *On the agenda*). "When you think of a baby's arrival, you, as a midwife, have an opportunity to affect the trajectory and wellbeing of (at least) two people. It's almost an invitation to improve the health and environment of both people for the rest of their lives and to create a better world at that juncture.

"We can do that by making sure their arrival is as non-toxic as possible and by creating a better delivery environment for the mother. Midwives are remarkable advocates."

Alifia urges midwives to harness this influence to demand resources. "It could be occupational health equipment, it could be monitoring, it could be better care of their [Entonox] pipeline or diversity of pain relief, from TENS machines to aromatherapy. Or bigger rooms so that dads or relatives can stay overnight and mothers don't have to be alone. They can advocate for all of these things that have a beneficial impact on the mother as well as the newborn."

The use of Entonox hugely increases the carbon footprint of midwifery services. As lead on NHS Lothian's nitrous oxide

GLOBAL CALLS TO ACTION

Two documents – from the PMNCH and ICM – highlight the urgent need for change

In November, the Partnership for Maternal, Newborn and Child Health (PMNCH) published an advocacy brief highlighting the need to prioritise women's, children's and adolescents' health (WCAH) in the climate crisis. It states that:

- climate change acts as a 'threat multiplier' to their health vulnerabilities by escalating social, political and economic tensions and inequalities
- newborns and younger children, including those unborn, are uniquely at risk because they breathe faster, have higher metabolic rates and are developing their immune systems, among other physiological, developmental and behavioural vulnerabilities
- at current rates, those born in 2020 will experience up to seven times more extreme weather events than those born in 1960
- the impacts of climate change on the pregnancy, perinatal and postnatal period include: stillbirth, preterm birth, low birthweight, impacts on feeding practices, respiratory diseases, congenital abnormalities, hypertensive disorders of pregnancy, gestational diabetes, impacts on mental health, malnutrition and reduced access to health services and family planning.

The brief makes recommendations for different stakeholders to ensure WCAH is better addressed in climate policies, financing and programmes. For healthcare professional associations these include: to collect data and measure the impacts of climate change on WCAH; to promote the health workforce's training on responding to climate emergencies, including by making climate change mandatory in health professional education curricula; and to work with governments and other stakeholders to reduce healthcare system emissions and provide mental health services in climate responses, especially for young people. View the brief at **bit.ly/PMNCH-WCAH**

Meanwhile, in January the International Confederation of Midwives (ICM) released an urgent statement on the resourcing of midwives and decisive measures to reduce carbon emissions. Signed by 59 professional organisations, the statement says midwives are critical to reducing the carbon footprint of reproductive and maternity services – therefore investing in a continuity model of midwife-led care is key to lowering carbon emissions.

This model, it states, is community-based, uses fewer resources in the short and long term and increases breastfeeding rates. It highlights the role of midwives as "trusted sources of information on sexual and reproductive health in communities" and as "first responders to the climate crisis", calling on policy-makers to: include midwives at climate and disaster response planning; ensure climate policy includes investment in sustainable models of continuous midwife-led care; and take "decisive and concrete action" to reduce carbon emissions overall. View the statement at **bit.ly/ICM-statement-carbon**

project, Alifia's work has demonstrated that much of this is driven by system loss and she's determined a pathway to aid mitigation. "The work is showing that we're probably wasting about 60% of Entonox, just through the way we deliver it," she says. "We need to improve the maintenance of these service units. And then maybe in three to five years, we might need to change how we supply it. It might be that we bring it closer to the service user.

"There are catalytic cracking systems, which need to become more affordable and efficient. In theory, you could clean the drug up as it is expelled and bring it back to the person. It's really about tidying up the methods by which we deliver it."

Another part of the NHS footprint, says Liz, "is the huge system that procures lots of medicines and equipment. It's about being able to influence those suppliers and providers about environmental sustainability, as well as being responsible for our own carbon emissions, and educating staff about creating a more sustainable healthcare system."

MORE INFO

Don't miss the RCM Webinar for International Day of the Midwife with Neha Mankani, a member of Women in Global Health, the PUSH Campaign's regional coordinator for South Asia and the head of the Midwifery Association of Pakistan's Karachi chapter. She will be discussing her work in camps for displaced persons or refugees and in communities that are poorly resourced and poorly served in terms of healthcare, and how these communities are affected by climate change and extreme weather.

Ultimately, says Lia, "midwives on their own cannot fix climate change. But increased access for women to midwifery care, including homebirth and midwife-led units, is directly linked to decarbonising care provision."

Midwives – and more women generally – also need to be present at the table when discussing climate crisis solutions. "Only one in four health leadership roles is held by a woman. The voices of midwives are desperately missing in national health leadership. It's not going to change overnight, but midwives are part of the climate solution," Lia adds.

"The responsibility of promoting and protecting health is at the core of all maternity care," says Jo. "By providing personalised care in collaboration with women, birthing people and families, midwives and wider maternity multidisciplinary teams are ensuring safe, high-quality, low-carbon care. And as we facilitate the birth of the future population, shouldn't we also be protecting the planet for them?"

IMAGES: ISTOCK, RCM ARCHIVE

Start of the journey

Thinking of midwifery research but unsure how to take the first step? PCAF can point you in the right direction

We know that research is an essential foundation to our evidenced-based practice in maternity care, so shouldn't midwives be the ones doing it?

While research may sometimes feel a million miles from the care we provide on a labour ward or in a busy clinic, it's informing everything we do. Have you ever had a great idea for how we could improve, streamline or update care? Or questioned something we do as routine? If so, you might be interested to hear about our journeys into research, and how it might inspire you to turn your ideas into your own research project.

Who are we?

We are a group of midwives from across England who are undertaking a pre-doctoral clinical and practitioner academic fellowship (PCAF). With a wide range of interests and experience, we are united in our aim of improving maternity services and the care we provide by wanting to conduct research at doctorate level. Whether you have heard of a pre-doctoral fellowship or not, we are keen to share our experiences, demystify our roles and support others taking the plunge into clinical academia.

What is a pre-doctoral clinical academic midwife?

The chief midwifery officer for England recently released a strategic plan for research (NHS England, 2023) highlighting the importance of embedding research within the role of the midwife. There are lots of opportunities to start a journey into clinical academia, with funding available at local, regional and national levels. One option is through a PCAF, working as a midwife jointly in clinical practice and academia, and preparing for a PhD.

Funded by a range of sources, including the National Institute for Health and Care Research (NIHR), the role provides protected time to develop a research area of interest, while also working clinically, typically over six to 36 months, full-time or part-time. This provides a chance to focus on the areas you are passionate about or time to develop your ideas for improving clinical practice and research skills.

How the role looks is very varied: some of us work one day a week on our research training and the rest in clinical practice; others work full-time or nearly full-time in research. The beauty of it is that we still work clinically in maternity services while developing our research skills and working towards improving care for women and birthing people and their babies. We have varied schedules, and a day in the life of a PCAF midwife may be clinical or academic focused. Working as a PCAF midwife provides protected time to develop your academic skills flexibly around your clinical commitments.

Alongside research and clinical work, fellows are supported by supervisors and mentors to develop their research, clinical skills and experience, and to prepare for doctoral research. You can tailor the fellowship to your individual needs and include a range of things such as master's modules, full master's programmes, short courses and clinical placements. Funding is also available to attend (and present at) national or international conferences, providing unique opportunities to network and hear about other research happening around the world.

After pre-doctoral clinical academic fellowships?

The next step along the clinical academic pathway would be to apply for funding for a doctoral programme. While this might feel like a scary feat, pre-doctoral fellowships give you an opportunity to develop your research project with support, as well as find your

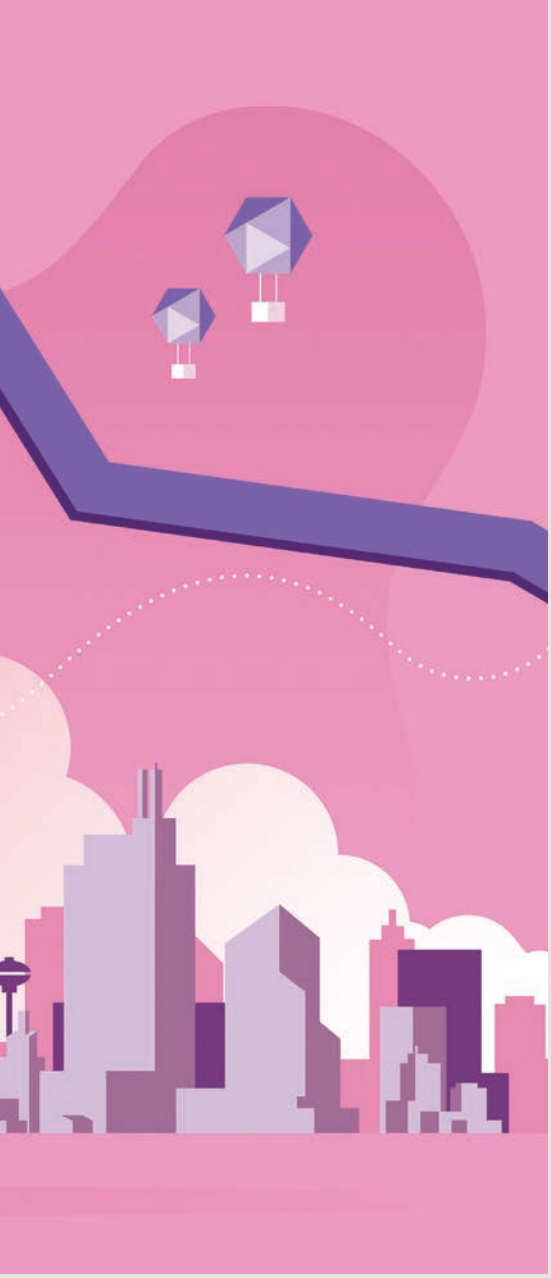


IMAGE: GETTY

network and supervisors. With timings of applications, you may be returning full-time to clinical practice after completing the pre-doctoral fellowship. This can provide an opportunity to apply the skills and learning from the PCAF to your clinical practice.

Why should I be a pre-doctoral clinical academic midwife?

Our individual areas of interest have stemmed from care that we have been involved in or problems we have identified as practising midwives. This is a great starting point for research and can be the first step in implementing change. We all know that being a clinical midwife is an incredible but immensely time-pressured role. The PCAF provides opportunity for protected time to focus on your own research alongside your clinical roles. You may feel like you wouldn't know where to start or that you haven't got the right experience to do research, but this is an ideal place to start on the pathway as a clinical academic.

What should I do next if I want to do this?

- Get yourself out there. Have a chat with colleagues, experts or your local networks to help form your ideas into a research project. This could be your local Board or Trust's research and development team, Research Champions, the NIHR Research Design Service or local and regional networks such as the NIHR Applied Research Collaborations. The RCM also has resources available to support you and your research journey.
- Consider your area of interest. Have a think about what subject or topic you would like to research further. Start by looking around you and talking to colleagues within the clinical area and go from here.
- Be brave. Reach out, network and get in touch with people. We are all more than happy to be contacted for support or to bounce ideas off – find us on X (formerly Twitter). Also, if there are names that keep cropping up who have done work in your area, get in touch. The RCM Research Buddy Scheme is also a great place to start with other small research grants that might get you started on the pathway.
- Take your curiosity and desire to improve midwifery services into research. Start with a small project, quality improvement or research internship and see if a clinical academic career could be for you.

Think you're not quite ready for a pre-doctoral fellowship, but are interested? Have a look into a small grant such as the RCM small research awards, Health Education England or a local internship or Wellbeing of Women Entry Level Scholarship for midwives. While these aren't essential when applying for a pre-doctoral fellowship, they can certainly help get you on the right path.

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Hear me

Women who do not speak English are 25 times more likely to die in pregnancy, birth and the postnatal period. One midwife has made it her mission to find out why

My name is Maria Rowntree, and I have been a community midwife for eight years. It is an honour and a privilege to be someone who supports women and birthing people through their pregnancy journey, the occasional home birth and the postnatal period.

I have always been passionate about inclusion. I believe that in providing women-centred care, each engagement will be different as you are tailoring the care and being led by the woman's individual needs. Understanding both the social and physiological factors that may affect care or outcomes is what community midwives are skilled in. We are working within the woman's community; we are invited into their homes and trusted with some of the most intimate and personal information.

It is the understanding of how social factors can impact pregnancy and birth outcomes that has fuelled my passion for inclusive practice. There is so much emphasis on clinical procedures, pharmacology, holistic therapies and healthy lifestyles, but very little focus on how the care we provide sometimes excludes those who are not the majority.

During my time as a midwife, I began to realise that women who do not have English as their first language often had poorer experiences. The stories I heard and the evidence I found highlighted that women were not fully informed of choices, not giving informed consent to procedures, and not provided suitable access to important information to ensure a safe and healthy pregnancy. Family, friends and even children were being used in the place of professional interpreters. This is a national issue and is happening in most NHS Trusts and Boards.

Informed consent is a legal requirement of care and should come directly from the woman

Shocking disadvantages

Even though they are only 0.2% of the female population aged 16 to 49 (Office for National Statistics, 2021), non-English-speaking women represent 5% of maternal deaths (MBRRACE-UK, 2023): that's 25 times that of their English-speaking counterparts (according to my baseline data uncovered during the fellowship). A rapid review of intrapartum stillbirth carried out by the Health and Safety Investigation Branch found that 43% of cases were in women who did not have English as their first language. A freedom of information request by Maclellan et al suggests that of the recommended 13 to 16 maternity contacts for primiparous and multiparous women, interpreters are only accessed on an average of three occasions. There is guidance from the Government (the *Language Interpreting and translation: migrant health guide*) and NHS England (*Guidance for commissioners: interpreting and translation services in primary care*). Both state that a professional interpreter should always be offered and children should never be used as interpreters.

In many research articles, policies and guidelines, the reasons friends and family should not be used are often listed; however, a factor that is often overlooked is the issue of vicarious trauma to the family member when they are used as the interpreter. Their role changes from being a support to the woman to supporting both the woman and the practitioner. This puts them in a difficult position and affects their ability to help the mother make informed choices and give informed consent. Informed consent is a legal requirement of care and should come directly from the pregnant person unless in extreme circumstances – a fact that is often forgotten when not using professional interpreters.

The project

I wanted to improve the engagement with professional telephone interpreters to benefit women who did not speak English. I had an idea for a project but was unsure how to get it off the ground. Fortuitously, I came across the Dame Elizabeth Anionwu Fellowship of Inclusivity for Nurses and Midwives. The main criterion for the application was to create a change project at local level, providing background on why this change project was needed and the intended impact on care. I had all the background information and had read so much evidence already that the application almost wrote itself.

Initially I wanted to create a small credit card-sized tool that would fit on a lanyard and hold all the relevant information for accessing an interpreter, including the codes for the 10 most used languages at Trust or Board level. I created a survey for maternity staff to ensure that what I planned would be seen as useful. The

Inspirational speaker and leader Dame Elizabeth Anionwu

THE DAME ELIZABETH ANIONWU FELLOWSHIP OF INCLUSIVITY

The Fellowship was the first of its kind, and I was one of the first to receive it. I knew that I would get support and guidance to create my change project, and that was enough for me to consider the seven hours travel each day I attended. I hadn't realised all the other benefits. We had inspirational leaders such as Dame Elizabeth Anionwu, Joan Myers, Ruth Oshikanlu and Janet Fyle, among others. We would start each session with a semi-structured talk or discussion topic and watch a short presentation. Then the majority of each lesson involved discussions with Professor Calvin Moorley, the fellows and the guest speaker on the topic and learning from each other. We discussed ways to implement the learning or situations where that knowledge would have made a difference to how we dealt with scenarios.

Although that is a very basic description of the structure, it was far deeper than that. We began to understand the structure within the NHS, how to implement change, how to use language in ways to include colleagues and patients, how to effectively demonstrate inclusion, and how to identify and address situations of discrimination. We also were taught how to understand our own qualities and skills and how to share those in ways that benefit all. We also completed action learning sets, where we would present a personal professional issue or problem and address it together with the other fellows in a structured and guided way. I learned that it is okay to 'rock the boat, but remember to stay in it'.

Each day I attended (and I didn't miss a single session), I would leave in awe of who we met and inspired beyond belief. I believed I had found a place where my passion fitted and no longer felt I wanted to leave the profession. Participating in the fellowship helped me see a new career path – now I barely mention retirement and feel I am at the beginning of a new journey, hoping to start a PhD in health inequalities next year.

responses to the qualitative questions highlighted issues such as the need for training, best practice, suitable phones, difficulties accessing interpreters or a lack of female interpreters – and so my project evolved.

I also wrote step-by-step best practice guidelines:

- Request same-gender interpreter (usually an option after dialling)
- Introduce yourself and the situation to the interpreter
- Ask the interpreter to introduce themselves and you to the service user
- Check the dialect is correct for them (this is to simplify the process by asking each time, rather than trying to remember which languages have different dialects)
- Explain that the conversation is confidential, uses a professional interpreter and is at no cost to the service user
- Ask the interpreter to relay everything you say
- Check the service user consents
- Use simple English and avoid medical jargon
- Speak directly to the service user, keeping eye contact (you are relationship building)
- Give enough time to relay the conversation.

I took part in a video showing the use of telephone interpreters and the best practice guidance, which will be viewed by all maternity staff on their mandatory training. I was also successful at highlighting the issue of suitable telephones and new ones were provided for each area.

What have I learned?

Before joining the fellowship, I felt my time in midwifery was drawing towards retirement. Midwives have faced many challenges – the issues around staff shortages, COVID-19 and pay have taken its toll on many of us, when we simply want to be able to provide safe and effective women-centred care and to not spend our days off worrying about what the next shift may bring.

I felt that the issue I was trying to address was not fully understood and I

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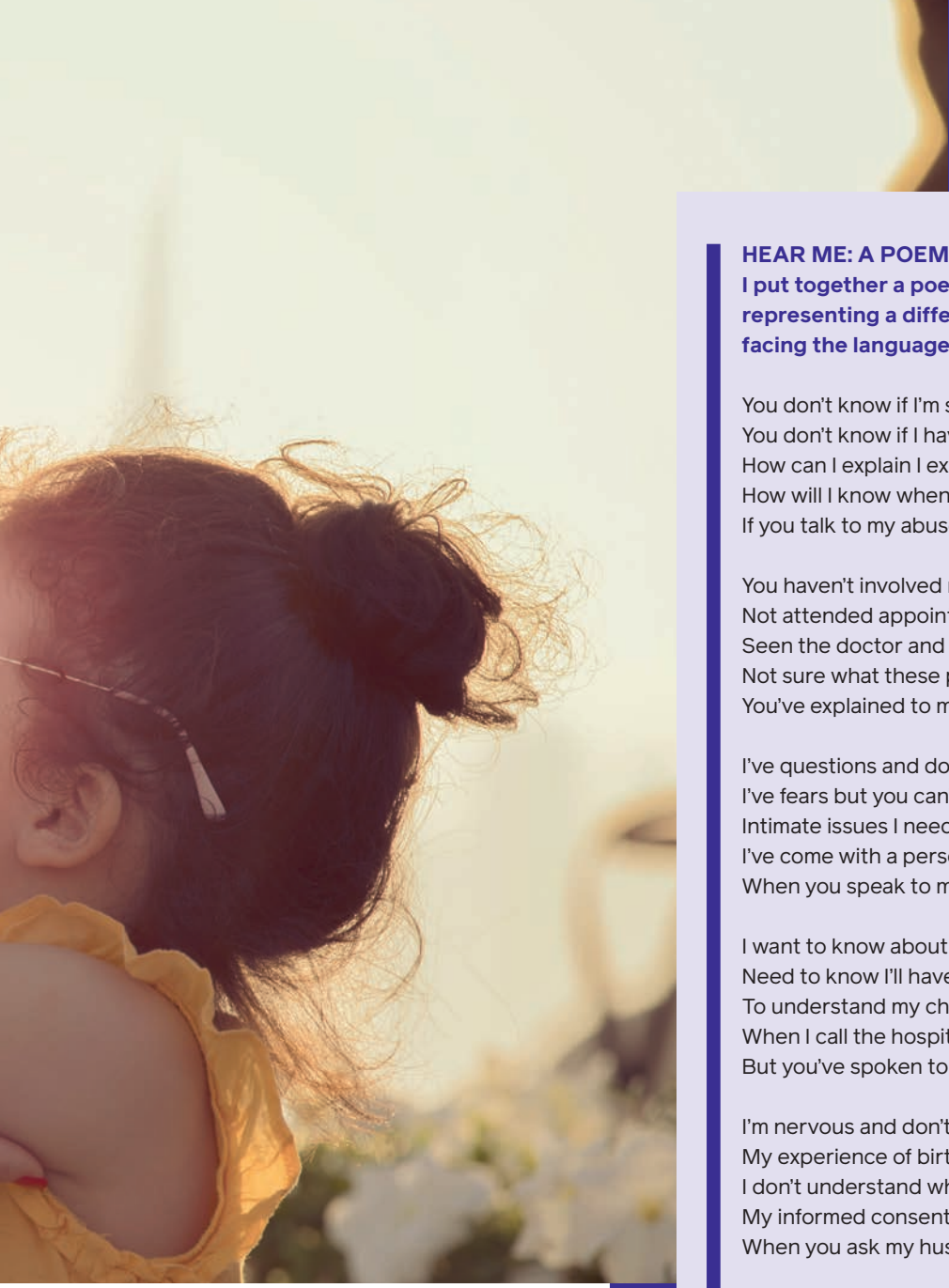

lacked the knowledge and skills to address it in a meaningful way. I felt that my passion did not fit into the overstretched and understaffed system in which I worked. I could not see another way out and I couldn't imagine not being a midwife. So retirement felt like my only option.

The fellowship and Dame Elizabeth Anionwu herself made me realise that passion doesn't have a retirement age. I am grateful I never gave up. I am grateful I didn't stop trying to get this issue seen and that I now have knowledge, skills and power to keep pushing this issue and get everyone talking about it.

Those women, their babies and their families all deserve to be heard, understood and cared for.

HEAR ME: A POEM

I put together a poem of real stories, each verse representing a different woman's experience when facing the language barrier.

You don't know if I'm safe in my home.
You don't know if I have freedom to roam.
How can I explain I experience harm?
How will I know when to raise the alarm
If you talk to my abuser to hear me?

You haven't involved me in choices of care.
Not attended appointments, didn't know when or where.
Seen the doctor and didn't understand the plans.
Not sure what these pills are in my hand.
You've explained to my child and not me.

I've questions and don't know the language to ask.
I've fears but you can't see beyond my mask.
Intimate issues I need to discuss,
I've come with a person I don't really trust.
When you speak to my neighbour and not me.

I want to know about birth, what to expect,
Need to know I'll have proper care and respect,
To understand my choice and make my birth plans,
When I call the hospital to know they'll understand.
But you've spoken to my partner and not me.

I'm nervous and don't know what lies ahead.
My experience of birth just fills me with dread.
I don't understand what you tried to explain.
My informed consent hasn't been obtained,
When you ask my husband and not me.

For when I am hungry, thirsty, or low,
Without an interpreter, how will you know?
If I am in pain or petrified by fear,
How will I know your concern is sincere?
If you talk through my family to hear me?

MORE INFO

To listen to The MAMA Podcast on Spotify, visit bit.ly/MAMApodcast

For more on Maria Rowntree's research, visit her profile on X (formerly Twitter) at bit.ly/MariaRowntree-tweet

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Complex cases

Kate Whatmough, maternal medicine team leader at King's College Hospital, has four inspiring examples of what good practice looks like in normalising the birth experience

Over the past couple of decades, the birthing population has become more complex due to increasing age, incidence of comorbidities and declining social determinants of health. The issue is becoming more widely recognised and reported – from Donna Ockenden at the RCM conference in 2022 to figures in MBRRACE-UK's *Saving Lives, Improving Mothers' Care* report (2022). Throughout the UK, midwives are seeing greater numbers of women and birthing people with complex medical conditions.

The issue is especially pertinent for maternity services based at tertiary referral hospitals, which now see large numbers of complex pregnancies each year. King's College Hospital in London is one of these units, with a service designed to provide care for

women and birthing people who require the most input.

The Ruskin maternal medicine specialist midwifery team was established at King's College Hospital's Denmark Hill site in 2001 with the initial aim to provide multidisciplinary team (MDT) working and continuity of care to mothers living with HIV. Over the two decades since, the team has evolved to care for a wide range of pregnancies where additional care is needed and that come under the umbrella of 'maternal medicine' with other complex needs such as type 1 or type 2 diabetes or physical disabilities.

The team of eight Band 6 midwives and one Band 7 has excellent working links with the MDT and provides care both in our midwifery-led antenatal clinics and our MDT clinics. These are split by speciality: diabetes, HIV, haematology, liver, epilepsy, cardiac, rheumatology and IBD. We also provide labour and postnatal care for our case load of service users.

As recognised by many publications, including MBRRACE-UK's report and the Ockenden report (2022), we hold MDT working relationships as one of the most important factors for the safety of the families we care for. We therefore have long-established relationships with obstetricians, obstetric physicians, doctors, consultant midwives and the wider midwifery teams within the Trust. Engaging with these teams and collating the expertise they provide holds the largest benefit towards ensuring the safety of our service users as they plan towards labour and birth.

Even within these complexities, there are certain cases that require a further level of thought and input from the MDT, usually requiring an extra level of planning and organisation prior to delivery.

Adapting the environment

'A' is paraplegic and a wheelchair user who came to us after becoming pregnant with her first baby. Our primary concern was for her access and mobility to all areas of the maternity service. We spent time pointing out all the accessible routes to clinics, the maternal assessment unit and the labour ward to ensure she could access these services when they were required.

Secondly, we had to consider equipment in clinical spaces. A was able to transfer from her wheelchair to a bed as long as this was at a similar height, therefore we ensured her antenatal appointments were always in the clinical room that had the palpation couch with electronic adjustable height.

It became evident that she would require extra planning around her birth. We were aware from early on in the pregnancy that she felt an elective caesarean birth was right for her specific circumstances. To ensure that we were prepared, an MDT meeting alongside representatives from the labour ward, the postnatal ward, the obstetric team, the anaesthetic team, the consultant midwife team and the moving and handling team took place. Our main consideration was the mobility of A both during and after her elective caesarean birth.

Discussions centred on the availability of equipment and rooms and the training of staff. As it was elective, we could reserve a side room for her on the postnatal ward that was able to accommodate extra equipment. We were able to hire a hoist and sling that the practice development midwife spent time training the postnatal ward staff how to use (as it was likely A would be unable to self-transfer after surgery), plus a commode as it was thought that A would be unable to use her wheelchair to reach a bathroom after

Midwives are seeing greater numbers of women with complex medical conditions

surgery. A named senior midwife was made responsible for hiring all mobility equipment that was required and ensuring it had arrived for the correct date. We then followed with a second MDT meeting closer to A's delivery date to ensure all was in place.

Complex comorbidities

'B' is a third-time mother who had a booking BMI of 75 and a weight of 209kg. She developed gestational diabetes early on in the pregnancy and was transferred to our team for complex care planning. It became evident that the maximum load on the couches in our antenatal clinics were lower than B's weight. We discussed options for antenatal fetal monitoring. She was advised and accepted to have regular ultrasound scans, but that it was unsafe for us to auscultate her during an antenatal appointment. We advised that NICE guidelines do not recommend auscultation at each appointment; instead we concentrated on discussing fetal movements at each meeting.

When it came to birth planning, as B had already had two spontaneous vaginal deliveries, we felt confident this pregnancy would conclude the same way. We called an MDT meeting with representatives from the labour ward, the postnatal ward, the obstetric team, the anaesthetic team, the consultant midwife team and the moving and handling team. We ensured that B had received an in-depth review from both the obstetric team and the anaesthetic team regarding the birth. As she had two recent uncomplicated vaginal deliveries, we were happy to proceed with discussions regarding what extra equipment she may need. Again, a senior midwife was named as responsible for sourcing, in a timely manner, a bariatric bed, wheelchair and armchair. We also discussed sourcing an inflatable mattress that would help raise B from the floor in the case of collapse.

A complex issue that was identified from the MDT meeting would be how to monitor the wellbeing of baby during labour and delivery via CTG. It was unlikely that a CTG transducer would be able to consistently monitor the fetal heart

due to maternal habitus. We concluded that the use of a fetal scalp electrode would be preferable; however, in the early stages of labour when the cervix was not dilated enough to utilise this, we may have been unable to accurately monitor fetal wellbeing. The consultant obstetrician discussed this concern in full to inform B's choice on how to proceed, and she understood and accepted the concerns. She went on to have an uncomplicated vaginal delivery.

Care outside the guidelines

'C' is a multiparous woman who had been diagnosed with epilepsy as a teenager. Her specific type of epilepsy manifested as tonic-clonic (grand mal) seizures, though she had not experienced a seizure in eight years. She was prescribed lamotrigine to help control her symptoms and this had been effective. C's first labour was induced – it resulted in prolonged labour and forceps, a process she found quite traumatic. When discussing plans for labour and birth, C stated she was considering a waterbirth in the midwife-led unit (MLU).

This request is considered 'out of guidelines' as the obstetric team advise against pool birth where there is a history of epilepsy.

The chance of an epileptic seizure in labour is approximately 1% to 2% of all women and birthing people known with epilepsy. The seizure frequency prior to pregnancy predicts the frequency during pregnancy and the risk during labour. In a woman who has not had a seizure during pregnancy the risk of a seizure in labour is 1% or less (Bhatia et al, 2017; Bromley et al, 2016; Morrow et al, 2006). Having a tonic-clonic seizure during a pool birth puts the individual at risk of drowning or injury to herself when labouring in a plumbed-in pool with hard surfaces.

As it had been eight years since C had last had a seizure, we felt this reduced her chance of seizure during labour to 1% or less; therefore she was referred for counselling by the consultant midwife. During this appointment, the risks were discussed in full alongside preventative factors such as continuing to take her lamotrigine during labour and ensuring she was well rested prior to embarking on a pool birth, as tiredness contributed to the occurrence of her seizures. C also always experienced an aura prior to a seizure, which would give both her and the midwives an opportunity to act during labour. After considering the information she was given, C began planning a waterbirth on the MLU.

To ensure adequate planning, the team organised an MDT meeting to ensure all professionals were aware of the plans being made. We invited our practice development midwife, who increased the amount of pool evacuation drills she ran leading up to C's due date. We also discussed sourcing floats to help protect C in the event of a seizure in water that could then be used to support any future maternal collapse in water. C went on to have an uncomplicated but unplanned homebirth.

Supporting normality

'D' is a first-time mother who had been diagnosed as HIV positive during a routine sexual health check a number

of years previously. She was taking daily anti-retroviral therapy (ART) and her viral load had been undetectable, therefore untransmittable, for some time. During her antenatal appointments, D expressed that she was very keen to breastfeed her baby.

To prevent the transmission of HIV infection during the postpartum period, the British HIV Association considers the complete avoidance of breastfeeding as the safest way to feed baby in cases where the mother is HIV positive. However, its most recent guidelines state that women and birthing people who are virologically supressed with good adherence on ART should be supported to breastfeed if they chose to do so (2020).

The risk of vertical transmission (from birthing parent to child) of HIV, if there is good adherence to ART in the parent and anti-retroviral prophylaxis in the baby, is between 0.06% and 0.13% (Larsen et al, 2019; Mofenson, 2016; Hudgens et al, 2013).

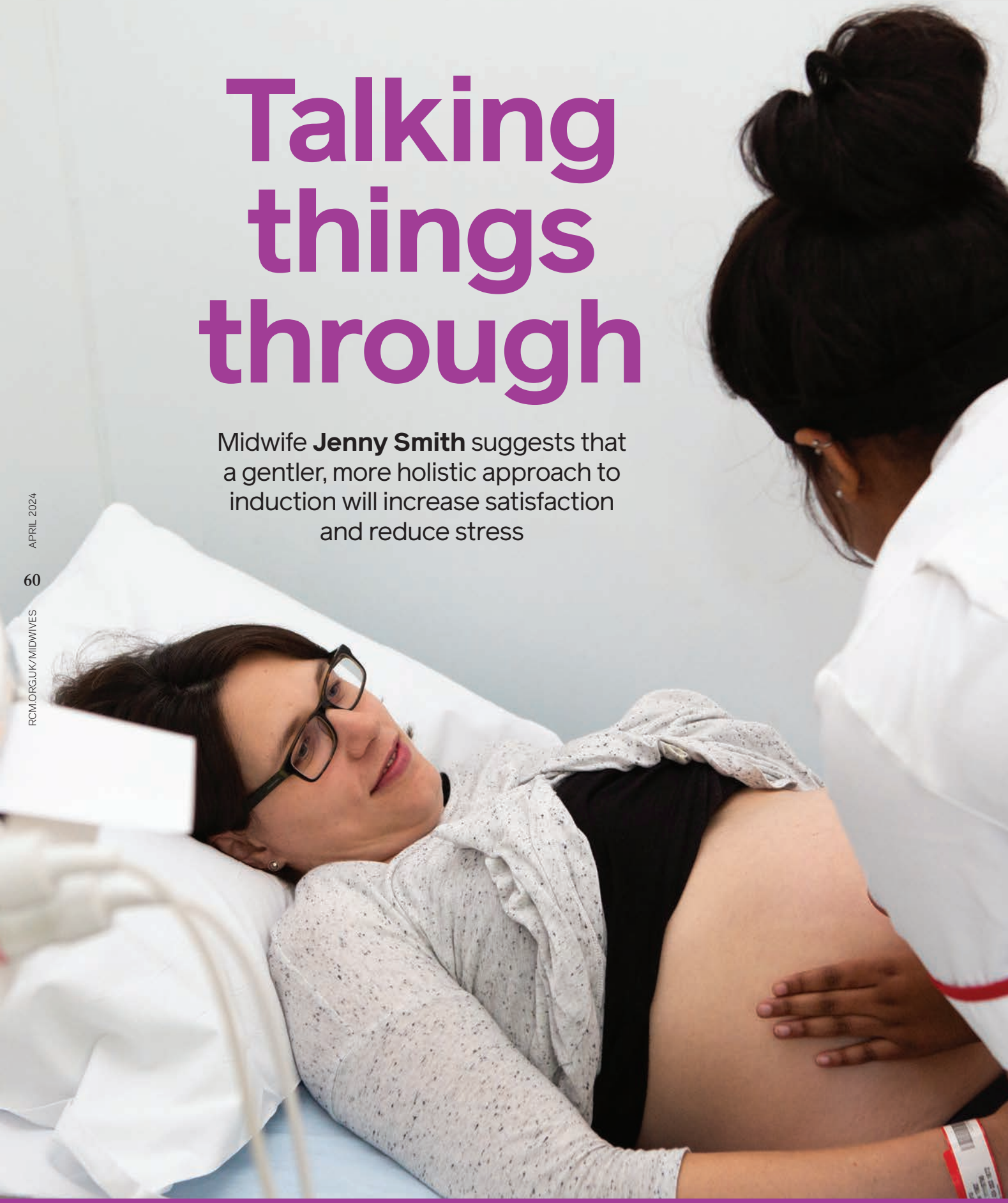
In order to help inform D's decision, the above was discussed with the specialist midwives, the HIV consultant and the paediatric HIV specialist. After consideration, she chose to proceed with breastfeeding her baby and a robust plan was put in place to reduce the chance of vertical transmission as much as possible. This plan included breastfeeding for a maximum of six months to reduce exposure to the HIV virus; to stop breastfeeding if the mother experiences bleeding nipples (that may then be ingested by baby); exclusively breastfeeding because formula milk is thought to inflame the lining of the gut and therefore make absorption of the HIV virus more likely; monthly testing of maternal viral load until breastfeeding is concluded; and monthly testing of baby for HIV by the paediatric team. D went on to breastfeed her baby for a period of three months and baby tested negative for HIV at their six-month and one-year follow-up.

As maternal medicine begins to take more of a central role in midwifery, we feel it is important to build specialist teams within services that are able to concentrate and dedicate time into working alongside the wider MDT, improving our knowledge and forging good working relationships – all of which will benefit the women and birthing people in our care.

IMAGES: SHUTTERSTOCK

Talking things through

Midwife **Jenny Smith** suggests that a gentler, more holistic approach to induction will increase satisfaction and reduce stress



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While it is recognised that much has changed to improve the birthing experience for those with vaginal and planned caesarean births, there remains a disparity when it comes to induction of labour. Many women have expressed a feeling of disappointment and dissatisfaction regarding this aspect. This is concerning considering that, in the UK, as many as one in three women are offered an induction.

What is 'business as usual' for midwives can be a frightening and overwhelming experience for women. Can this process be made better for those giving birth, without adding to midwives' workloads? I believe it can.

What are your feelings about induction?

Many women don't really know what induction involves. I've supported women who view it as a medical process at odds with their hopes of having a 'natural' birth experience. I've found that discussing it thoroughly in the first instance covers a lot of ground – not least because women are able to build it into their birth plan and feel comfortable with it.

I've found that asking her questions about how she's feeling, how her pregnancy is going and her feelings about birth is a good way to put her at ease and show her that you are putting her at the centre of her own care.

Explaining what the induction stages are, what each involves, why it is done, and the advantages and disadvantages prompts the women to discuss their own feelings about it. It also gives us a better understanding of how the process is viewed by those in our care.

I've found that following these conversations, women are less fearful of induction, are more inclined to include it in their birth plans and even feel empowered by it, as this comment from Harriet shows: "I had a difficult birth with my first son, who was eventually helped out with forceps, and I took quite a few months to recover. He was a large baby and was 12 days beyond the due date.

"During my second pregnancy, we kept a close eye on the growth of the baby as I was nervous about having the same experience.

"I talked with Jenny about the options of having an induction before the due date from the second half of the pregnancy. I was keen to have as natural a birth as possible.

"I was induced three days before Christmas. The first few hours were very calm – I spent some of it reading a book. It was nothing like the first birth.

"It took around 10 hours from the induction start to my daughter being born. We practiced some of the hypnobirthing techniques we'd learned and, after my first experience, I couldn't believe when my daughter arrived how easy it could be. No tears and no stitches. We even hosted 15 people for Christmas Day a few days later!

"My third pregnancy was very similar to my second. Again, I discussed the benefits of induction with Jenny and [the induction followed] a similar pattern. For the third delivery I didn't even have time to request an epidural.

"I've been a strong supporter of the benefits of induced labour ever since."

A gentle approach

It's understandable that women feel apprehensive about birth, especially if it is their first. They don't know what to expect and are looking to you for guidance, support and kindness. I feel that induction is an area where we can overlook the women's perspective because, for us, it is routine. As a consequence, women often report feeling rushed in the conversations, under pressure when decisions have to be made and threatened by the risk of having a stillborn baby. If I was a woman facing my first birth, apprehensive about what was going to happen, this approach to induction would compound the fear I was feeling.

A gentler approach is to discuss induction during the latter weeks of pregnancy at an antenatal appointment to allow them time to process the information.

A proper explanation of induction procedures, choices and wishes will reduce stress

I suggest the following:

- explain why an induction of labour is recommended – everything from postdates to deteriorating clinical conditions, as well as maternal choice or mental health
- explain that it is done in the three steps so they can agree to all
- explain the methods used and what each involves, so they can choose what they feel most comfortable with. I believe that women should be given a choice of their induction method
- give them some context on current thinking when making a choice as to whether to accept an induction or not – for example, the ARRIVE study
- ask their opinions and if they have any questions or concerns.

This approach was taken with Robyn, who says: "As an older first-time mum I was aware of the increased risks of stillbirth in letting my pregnancy go past my due date. Induction was a logical choice for me as it gave me the chance of having a vaginal birth.

"I knew there was a potentially increased risk of assisted delivery or caesarean birth with induction, but with 30% of first-time mums ending up with a caesarean birth anyway, I felt I had nothing to lose – plus a better chance for my baby.

"For me, having discussions early on in my pregnancy about my specific situation and risk factors allowed me to think things through in my own time and make a choice I was happy with, not a rushed decision at the end.

"This was instrumental in setting expectations and helping me choose a safe birth plan that I was happy with, making the birth of my daughter a hugely positive and wonderful experience."

Things we can do to help

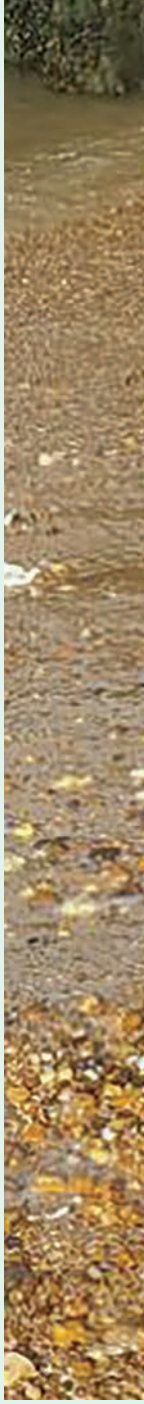
Given the reported widespread dissatisfaction with induction, these types of positive experiences really stand out. While some things are out of our hands, such as potential delays to the labour ward due to bed availability and staffing and the complex infrastructure of hospital design (if all inductions were in single rooms, birth experience satisfaction would increase dramatically), there are some things that aren't:

- as we know, an antenatal stay in hospital is likely, so I encourage women to bring a "bit of home" with them to make it more pleasant
- if we're able to, offer all birth partners a reclining chair, they can get some rest and support their partner
- make fetal monitoring checks and drug rounds more flexible, so that sleeping women are left so
- include birthing balls, mats and beanbags with flexible lighting in birthing areas to help support relaxation during the early stages of induction and labour so women aren't in a tired and agitated state before the birth has begun
- employ greater use of telemetry devices to support greater mobility. This is especially important if the woman's birth plans included a birthing pool, for example – women can feel devastated that their hopes and plans for birth have been prevented just because they are now undergoing induction. It contributes to the feeling that it's an overly medicalised process and one they have no say in.

Given that induction is just as much a part of the birth experience, shouldn't we be treating it with the same consideration? Having a proper explanation of procedures and conversations about wellbeing, choices and wishes is both a respectful approach and one that will increase satisfaction and reduce stress, leading to a better birthing experience. And that benefits everyone.

FURTHER READING

Watch a video from Jentle Childbirth Foundation at: **jentlechildbirth.com**
Read the ARRIVE study at: **bit.ly/ARRIVE-study-2018**



Duty of care

Negligence, racism and homophobia all contributed to a harrowing birth experience for Lisa and Wendy

Wendy: I was 43 when I was pregnant with Jamie. As a PE teacher, I'm very fit and active. There were no problems in pregnancy and no health concerns, though they were very keen for me to be induced because of my age.

Lisa: We asked to see data that was being used to support this. When we did, Wendy was by their own metrics in better health than a 25-year-old woman. So we asked: "If you take Wendy's age out of the factors, would she still need to be induced?" They said yes because it was policy.

We asked, what if we refused induction? They said we'd lose our place at the birthing suite – not that we'd asked for that anyway. They said when you call up for the ambulance there may not be a space for you. They also scared us about the health and safety of our baby.

Wendy: We didn't want to take any risks, so even though I had no labour signs, we went in on Jamie's due date for the induction as we'd been told to do. Once I'd had the first one, we thought we'd be allowed to go home. That's when they said we couldn't leave, but no one had told us that beforehand.

We weren't on a ward. It was just a room like A&E, with curtains around each bed and people coming and going. Lisa didn't even have a seat – she perched on the edge of the bed. We were like that all afternoon and all night. There was strip lighting so I couldn't sleep. No food or water came, so Lisa had to go and get something for us. They said we had to stay in for observation, but no one came.

The next morning, I was seen by the shift change of consultants. The first thing he asked was: "So what time have you scheduled your caesarean birth?"

We said: "But we're not having a caesarean birth."

He responded: "But it's easier."

This was a shock. Once he realised we didn't want that, he said: "Right, that's it." It felt like they'd washed their hands of us.

Lisa: At some point they moved us to a ward. I was acutely aware of midwives consulting other women's male partners about what was happening and some weren't even that interested, yet we were just left. If you're there for that length of time, you see every shift change – each time a different consultant and each time a different course of action. The assumptions that we'd be having a caesarean birth were the same though. We even asked for it to be put in the notes for them to stop asking us. They still did.

Wendy: By that point we'd had enough – we'd been there more than two days. We decided to leave, though we were told to be back in for a set time the next day. Then we went home and I slept. The next day we went back as

Wendy and Lisa with their baby boy Jamie

instructed. There were still no signs of labour. By that point I think it was the third or fourth induction.

A midwife said she could see that I was just not dilating enough, so she broke my waters in the hope that it would speed things up. She also put in a catheter. I've got quite a high pain threshold from playing a lot of sport and until that point I'd had no pain, then suddenly there was. It got more and more intense. The monitoring machine was going crazy, but nobody came in to check on us for five hours.

On the third day, there were two maternity support workers (MSWs) who were bringing us food and were incredibly kind, though each time they did they would do a Christian blessing over me. They were well-meaning, but it was inappropriate.

They said we had to stay in for observation, but no one came

We'd not experienced homophobia in maternity until this point. I mean, clinics often asked for my husband's details, but as soon as I said "my wife" people apologised and adapted. It was fine.

However, there was a midwife who came in on that third evening. She just looked Lisa up and down, gave her the filthiest look and refused to talk to us.

Lisa: I felt so awkward that I introduced us, saying it's our third day and asked how's it looking – that sort of social glue. She didn't respond. She filled in the chart, put it down and walked off. Then we were left for hours, with Wendy in pain and no one to help. Having an emergency and being left in that room, it was inhumane.

Things had started going wrong that evening, so I went out to find someone. There were about six or seven midwives

just standing around the station, chatting and giggling. I asked if someone could please come as I thought Wendy needed help. They said, "yeah, we'll be a minute," and so I went back to the room and waited. An hour later, I went out again. This time the midwife refused to help because she was going on her break.

There was a culture of fear on the night shift and no one else dared help us. We saw nobody for hours. I was saying there was something wrong with the catheter – no one checked on it, no one looked at it, no one helped. When the midwife eventually came in, she said something homophobic. The awful bit was that I couldn't react or challenge her because there was no one else. I needed to work with her to make sure Wendy was okay. It was awful.

In the morning, when the new shift of consultants arrived, she knew I would complain so made a point of being in the room with us, talking about what she'd done and talking to Wendy like they were best friends. This was all complete lies to pretend that she'd been caring for us. She was hateful.

Wendy: I was in such pain. The contractions I could handle but the catheter felt like someone was cutting me from the inside out. Lisa kept saying there was something wrong, and eventually a consultant listened and took it out. There was immediate relief – it turns out it had been put in the wrong place.

Lisa: I had expectations of how Wendy should be treated, based on how I would expect to be treated. Yet, and I haven't experienced this as a white woman, there's an idea that as she's a Black woman she's more able to manage the pain. I really had to fight to get them to react as they should have done.

That morning at the handover, there was another set of people not listening. Because I'd seen her decline – from being perfectly fine to really, really unwell – I had to demand to speak to the medical director before anything got done. Then suddenly they couldn't prescribe enough pain medication. We were left on our own for nearly four days and then they threw everything at us. When it became clear that the baby was in distress too they rushed us into theatre.

Wendy: By that point I had had so many drugs that I wasn't totally clear on what was happening. I remember a slight pinch and then I heard Jamie cry. I remember them handing him to Lisa, but I don't remember any of what followed.

Lisa: They had the caesarean birth curtain up so Wendy couldn't see what was happening. She was just chatting to the anesthetist about camping and about a certain tent – she kept telling the anesthetist that it would change their life. Even though it was an emergency surgery, everything seemed fine – they seemed to struggle with cutting and getting him out, but then there he was. The midwife checked him over and handed him to me, then asked where his clothes were.

It was a major procedure, so how is it possible that there are no records of it?

Suddenly an alarm went off and at least four or five doctors came running in. For the longest time, they were trying to stem the bleeding and they all looked worried – everyone, even the assistants coming in.

That was the first point it occurred to me that Wendy might die in childbirth. I had been standing away from her to give them room. I went over to her, showed her Jamie and put him on her chest – he breastfed straight away, it was incredible. Wendy was quieter though. It was terrifying. Once they got the bleeding under control, we were sent back to the ward and discharged after two days.

Wendy: It was an awful experience from start to finish. I have had so many problems with the separation of my abdominal muscles from the surgery and no one's taken it seriously. As someone who loves sport and is a PE teacher, it restricts my ability to exercise and has chronically affected my work and my lifestyle.

I've repeatedly asked for my medical notes and the only thing I've been given is a discharge note of Jamie's birth – they said there was nothing else. It was a major procedure, so how is it possible that there are no records of it?

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1. Journal of the American College of Nutrition, Vol.18, No.5, 487-489 (1999). **2.** L Brough et al. Effect of multiple-micronutrient supplementation on maternal nutrient status, infant birth weight and gestational age at birth in a low-income, multi-ethnic population. British Journal of Nutrition (2010), 104, 437-45. **3.** Agrawal, R. et al. Prospective randomised trial of multiple micronutrients in women undergoing ovulation induction, Reproductive BioMedicine Online December 2011.

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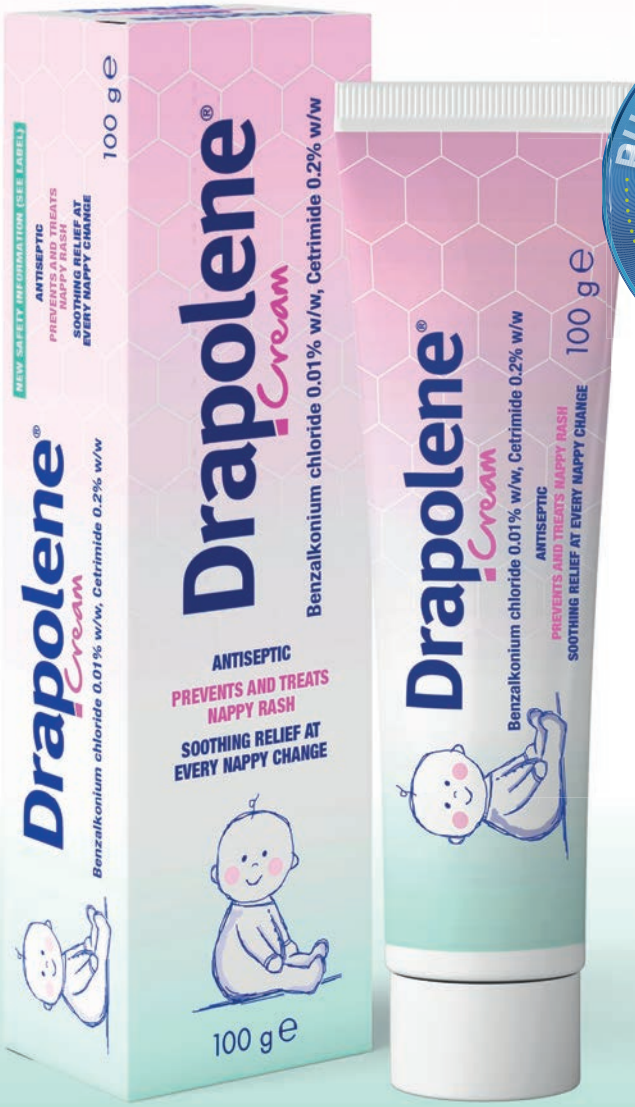

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