THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 27 / JULY 2024

GREATER THAN ITS PARTS
THE MIDWIFERY PRACTICE EDUCATION TEAM CAUSING A STIR

IT'S THE LITTLE THINGS
SIMPLE WAYS TO SHOW YOU CARE

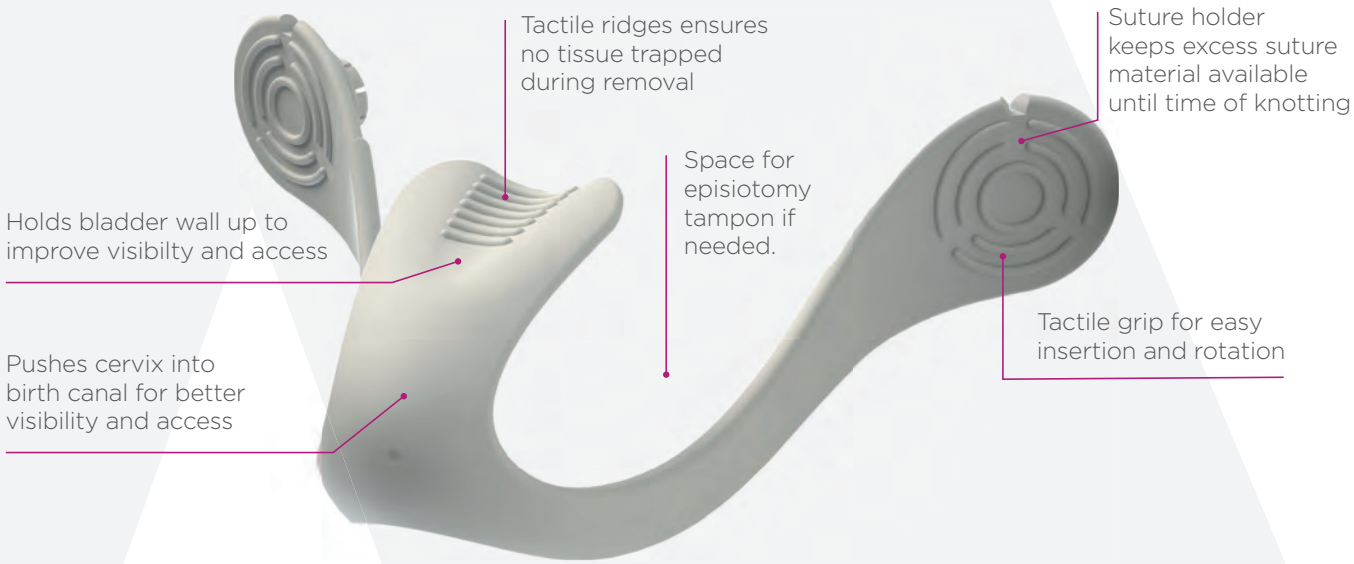
GREAT EXPECTATIONS
WHO'S REALLY IN FRONT OF YOU

Make maternity count

IT'S TIME TO FIX WOMEN'S HEALTH INEQUALITIES

Is the Hegenberger Retractor part of your **OASI care bundle**?

The recent **Birth Trauma Inquiry** highlighted as many as **10% of Obstetric Anal Sphincter Injuries are missed**[1]. The OASI care bundle recommends **systematic examination of the vagina and ano-rectum** even if the perineum appears intact.



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1. Thomas, K. (2024). *Listen to Mums: Ending the Postcode Lottery on Perinatal Care.* [online] Available at: https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf.

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The Royal College of Midwives
10-18 Union Street
London SE1 1SZ
0300 303 0444

Editorial
Editor **Rebecca Davies-Nash**
Director of communications
and engagement **Jo Tanner**
Editorial contributors
Juliette Asrup, Helen Bird
Cherry Casey, Kellie Smith

Editorial board
Sophie Halton-Nathan,
Jessica James-Hill,
Patrice McKenna, Brenda Murnion,
Kashmira Parekh, Ruth Sanders,
Angie Velinor, Victoria Wilkins,
Louise Woolams

redactive

Publishers
Redactive Publishing Ltd
Dallington St, London EC1V 0BH
0207 866 4050
Director **Jason Grant**

Advertising
midwives@redactive.co.uk
020 7880 6231

Design
Designer **David McCullough**
Picture researcher
Jessica Marsh

Production
Production manager
Aysha Miah-Edwards
aysha.miah@redactive.co.uk

Membership
0300 303 0444

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+44 (0)1580 883844
subs@redactive.co.uk

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RCM CEO Gill Walton welcomes the new Government and a chance for change

Welcome

I told our conference in May that I want to start a revolution in maternity services. I want midwives and maternity support workers (MSWs) to build on the good practice that is going on every day, in every service. There is so much you do that's incredible, and I want us to share it. I want us to regain our confidence and to lift our heads up. I want us to be proud of who we are and what we do. Every day, every single one of us makes a difference.

And that's the message we're also taking to the new Government. Within hours of his appointment, I wrote to the new health secretary in Westminster to remind him of his party's manifesto commitments on maternity care – and that we stand ready to work with him to bring about change.

Join us in our revolution to bring about change

During the election campaign, we put staffing, safety, student debt, estates and inequality front and centre – now all the votes have been counted and we have a new Government and Parliament, those are the issues we will continue to push for.

We cannot continue with services relying on your goodwill to plug staffing gaps. Our survey earlier this year found that you worked more than 140,000 hours, unpaid, in one week alone. We cannot have students giving up on the profession before they've even started because of the burden of debt; we cannot have midwives and MSWs opting for bank shifts rather than contract because of a lack of flexible working patterns; and we cannot sit back while Black and Asian women have significantly poorer outcomes than their white counterparts.

While the Westminster Parliament may only have responsibility for healthcare in England, these are issues facing every corner of the UK and will form the basis of our influencing work across all four nations. It's worth remembering that while the national parliaments and assemblies may decide how the money is spent, it's the Westminster Parliament that decides how much funding they get.

I am proud to be a midwife and to lead this college. That's why working with this new Government is vital. So, join us in our revolution – to restore pride in our profession, to build trust among the women and families in our care and to provide maternity care and midwifery education that is the envy of the world.

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.

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News in brief

FOR ALL THE LATEST NEWS AND VIEWS,

Priorities

RCM asks

As we welcome a new Labour Government in Westminster, now's the time to make maternity services a priority. The RCM has three key asks:

1 **Ensuring the right staff are in the right place, supported by education and training**

2 **Ensuring maternity services reflect the needs of the communities they serve and the staff that work in them**

3 **Building a profession that's fit for the future**

RCM CEO Gill Walton said: "Maternity services are a fantastic opportunity to shape healthier lives, for this and future generations, and it deserves investment of time, attention and resource. Midwives and maternity support workers (MSWs) do that day in, day out and we want to see that level of commitment from policy-makers."

Welcome the new RCM president

"Being a midwife is a huge privilege and the best job in the world. I will represent every member no matter their background or their role," says Sophie Russell, the newly elected RCM president. Read more at

EYES ON THE PRIZE

Health Education and Improvement Wales has been shortlisted in the NHS Wales Workforce Sustainability Award category for the development of a national labour ward coordinator framework. Winners will be announced in October.

Read more at:

I-LEARN OF THE MONTH

Maternity disadvantage assessment tool (MatDAT)

(Study time: 15 minutes)

MatDAT is a new standardised tool for assessing social complexity in maternity, based on women and birthing people's broad social needs. The i-learn course is a companion to the RCM MatDAT resource, introducing the assessment and planning tool.

Staffing

The right staff and the right support

A lack of flexibility and fairness around working patterns is forcing too many skilled and experienced staff out of midwifery – or to bank and agency roles, which are incredibly expensive for the NHS.

141,000

In just one week this year midwives worked an additional 141,000 unpaid hours

£112m

In England alone in 2022/23, NHS Trusts spent more than £112m on agency and bank midwives

The RCM is calling on the new Government to facilitate greater flexibility around staffing patterns, which recognise the needs of midwives and MSWs. Gill said: "The cost of understaffing in maternity care is huge. Sorting out shift patterns may not grab the headlines, but if we get it right it could be transformational."

Read more at:

IMAGES: SHUTTERSTOCK, RCM, RCM/KATE DARKINS

VISIT RCM.ORG.UK/NEWS

Student debt

3 for 3

If politicians are serious about improving maternity care, they need to lift the crippling burden of student debt in all four countries. The RCM is calling on the new Government to forgive student debt for those midwives who commit to work in the NHS for three years, matching their years of study. Unless this is addressed, midwifery will become less attractive, making the workforce crisis worse.

Read more at:

Report

Birth trauma inquiry

The report by the All-Party Parliamentary Group and the Birth Trauma Association in May follows the UK's first-ever inquiry into birth trauma to which the RCM provided evidence in February.

The inquiry received more than 1,300 written submissions, with many harrowing stories prompting the then women's health minister Maria Caulfield to apologise for the Government's approach to maternity services.

READ THE REPORT

READ MORE AT

The RCM responded that safe staffing levels – so maternity staff have the time they need to give the care they want – has long been an issue. Solving the midwifery recruitment and retention crisis with practical solutions must be the number one priority for the new Government.

The Maternity and Newborn Safety Investigations programme reviewed the findings of 92 investigations in England. It highlighted 'work demands' and 'staff capacity' as key prohibitors to the delivery of safe care

WATER BABIES

Julia Sanders, professor of clinical midwifery at Cardiff University, led research into the safety of waterbirths for uncomplicated pregnancies. "In the UK around 60,000 women a year use a birth pool or bath for pain relief in labour, but some midwives and doctors were concerned that waterbirths could carry extra risks." Research from 73,229 records in England and Wales showed waterbirths were a safe alternative to births outside of water.

Read the POOL study at:

WELLBEING IN WALES

Health Education and Improvement Wales has published a *Best Practice Guide* for NHS Wales to help improve the health and wellbeing of all staff. It is welcomed by the RCM and reflects the commitment shown by all seven Welsh NHS Boards to the RCM Caring for You Charter.

Read more about Caring for You on page 14. Read the guide at:

UK's Chief Midwifery Officers in conversation: Caroline Keown, Karen Jewell, Kate Brintworth and Justine Craig, chaired by Birte Harlev-Lam

RCM conference

Under the banner of 'Energising excellence', this year's conference celebrated the incredible achievements of midwives, maternity support workers (MSWs) and students across research, education, practice and leadership

RCM CEO Gill Walton got the conference off to a roaring start by asking everyone to stand and cheer and applaud. She said: "Celebrating each other. It's something we just don't do often enough. And you know why. It's because we're too busy, because we've got to move on to the next thing. But feeling appreciated, and appreciating each other, is so important. Sometimes we have to tell ourselves to do it."

Pride and joy

Many of the sessions stressed the same spirit of celebrating the profession and ourselves. The UK's chief midwifery officers in conversation discussed the unique relationship that midwives have with those in their care, and the importance of "listening to the whispers so you don't hear the screams". In the same session, Karen Jewell got a round of applause for highlighting that MSWs are invaluable and should be your go-to because they know everything.

Carmel Doyle in 'Listening to words unsaid' referenced Gill's opening speech when she talked about her pride as a midwife and how we advocate for women because they can't do it for themselves in labour.

In one session, a question from the audience asked how we can challenge the "demonisation of the profession" that is happening in the media. The panel agreed that it can only be countered by celebrating the small things and the good things, and articulating what being a midwife or MSW is.

If anyone was in any doubt about how midwives can change lives, it was quelled by Wendy Warrington's Zepherina Veitch Memorial Lecture about helping pregnant women caught up in the Ukraine war.

Position of trust

The ability to make a difference to people's lives was echoed in many sessions.

RCM CEO Gill Walton

'Integrating trauma-informed care into practice' was a deeply emotional session that looked at experiences, complexities and behaviours that constitute trauma experiences (see p29), as well as the need for maternity staff to have support from vicarious trauma. Sophie Olson from the Flying Child shared how being a survivor of child sexual abuse had affected her pregnancy journey, including keeping professionals at arm's length. "It's still considered unspeakable," she said, so while many may not divulge abuse, they are still entitled to non-judgemental care. Jo Cull suggested asking about trauma as routine "rather than cherry-picking who we think might have experienced trauma" and said there needed to be better training on how to respond to the questions being asked, as well as more time to discuss things.

'Listening to words unsaid' explored lived experiences of poor perinatal mental health. Midwife Kerry Adekoya echoed the trauma session's message "Don't ever assume someone is okay" and said that she only knew how to get help for her intrusive thoughts of harm because she

PHOTOGRAPHY: CARMEN VALINO

Dr Yana Richens OBE, director of midwifery, Liverpool Women's NHS Foundation Trust

2024

MORE INFO

Watch selected speaker sessions from the main stage and delegate reactions.
Read Nic Ferguson's experience of speaking at conference.
To hear more voices from the conference, watch the delegate videos now.
Follow the QR code:

"No one is hard to reach and no one is a statistic"

was a midwife. Nafiza Anwar pointed out that cultural perceptions of mental health, stigma, language and mistrust are all reasons for non-engagement among the global majority. "No one is hard to reach and no one is a statistic," she said.

Inclusivity and equity

Many of the sessions highlighted health inequities. England's chief midwife Kate Brintworth noted that we all need to stay curious about the data – for example, if the stillbirth rate is lower than the national average, we still need to ask who it's happening to and why – and that it's in our power to change things.

Common neonatal assessment methods and first-person accounts laid bare how the global majority can feel invisible, ignored and dismissed by care that lacks compassion, dignity and respect. Asking for preferences and consent before proceeding are invaluable for building trust.

This was echoed in the LGBTQ+ speakers accounts. Student Midwives Forum member Nic Ferguson spoke in 'You don't lead alone' about how the LGBTQ+ community has higher rates of freebirthing because of poor experiences in medical services. To quote Maya Angelou: "Do the best you can until you know better. When you know better, do better."

The conference's message is to treat others as you'd like to be treated and set an example that sends out ripples of kindness. As Gill said: "What we do makes a difference. Statistically, we know that the outcomes for a woman who has been supported through pregnancy, labour and birth by a midwife are significantly better than for one who hasn't. But we also know that women are not statistics."

right to thrive

Maternity is a vital part of a wider conversation about the cost of women's health – and the even greater cost of ignoring it

Ask more than a million women and girls from 14 countries what they want most for their health and wellbeing and you can expect a great deal of variation. As the *Beyond the sum of our body parts* report from the White Ribbon Alliance discovered, whether it's adequate nutrition, high-quality healthcare, better education or more vocational skills, what women need to live well is multi-layered. One message prevails however, far too often women's voices are not included in the decisions made about their health and wellbeing – and their outcomes are suffering as a result.

"We know that funding for research into women's health is very low compared to other areas of health research," says Jaki Lambert, director of RCM Scotland. "And we know that a lot of [healthcare] evidence is based on men … yet we know there are specific conditions that impact women differently, like a heart attack." Typically, the heart attack symptoms people look for and recognise are those that present in a man, meaning women have not been receiving equitable cardiac treatment. If they had, according to research by the British Heart Foundation, the deaths of at least 8,000 women in England and Wales over a 10-year period could have been prevented.

And then there are sex-specific conditions such as menopause, which have been woefully deprioritised and under-researched, meaning many aspects of the condition remain a mystery. For instance, while hormone replacement therapy (HRT) has long been the most widely used intervention, there is still a lack of basic understanding of exactly how HRT interacts with a woman's body. And these gaps in our healthcare system add up to create a stark inequality: women, while living longer than men on average, spend 25% more of their lives in poor health.

Women's health plan, Scotland

Tackling this inequity is the aim of the Scottish Government's *Women's health plan*, for which Jaki currently sits on the oversight group. Kicked off in 2021, the plan "looks at health in a holistic

ILLUSTRATION: BETH GOODY

sense, from a life-course perspective, so that you're not looking at each individual issue as a single thing, but at all the touch points in women's lives where we have opportunities to maximise and promote health and wellbeing".

Maternity care is part of that life course and, as Jaki explains, "is often the point at which women for the first time in their lives have a regular interaction with the health service … yet it's not visible within wider Government policies and plans". This was particularly striking during COVID-19, she says, where "maternity had a hard time getting seen as an emergency service, [as] something that doesn't close its doors and doesn't work to convenient hours".

Put simply, maternal care is not given the priority it needs. Yet if we could turn this on its head the ripple effect would be huge. "Right now we're working in a reactive space," says Jaki. "But if children are healthy when they're born and go on to thrive, then straight away the future health of the population is better. It's the same for mothers. If they receive the right pregnancy care, then they recover well and they thrive. Waiting lists are shorter – there are fewer people at the front door of the emergency department."

Jaki continues: "If workplaces offer the menopause support women actually need, they are less likely to take early retirement." And all of this requires accessible, holistic services that routinely meet their health needs "rather than it being an exception". The *Women's health plan* had funding for three years, which expires this year, but "there is absolutely a willingness to continue this work". What has taken place so far "is a start" but until we reach a point of equity "there should always be a women's health plan".

Make maternity count

In England, the 10-year *Women's health strategy* commenced in 2022. Last year it announced measures including spending £25m on developing women's health hubs

and creating greater IVF transparency, plus a new AI tool to identify early risks in maternity units. Earlier this year, secretary of state for health and social care Victoria Atkins announced that a key priority of the strategy would be continuing with NHS England's three-year plan for maternity and neonatal services. In Wales, there is still no dedicated women and girls' health plan, despite the *Women and girls' health quality statement* – the precursor to the country's 10-year strategy – being published in 2022, while Northern Ireland announced a three-year *Women's health action plan* would begin this year.

Effects of inequality

"Deprivation and ethnicity are key factors in determining maternal mortality and complications," says Professor Hora Soltani, who leads maternal and infant health research at Sheffield Hallam University. "And I don't think enough attention has been given to it."

Hora and her team's work focuses on addressing health disparities for mothers and babies from the most disadvantaged backgrounds, part of which involves understanding how issues such as maternal nutrition and obesity, infant feeding, perinatal mental health and vulnerability can all interplay. "For instance, when women are not well supported regarding nutrition and physical activity, there will be higher levels of complications ranging from exhaustion to anaemia or conditions such as gestational diabetes," she says. "When that's topped up with perhaps isolation, experiences of discrimination, potential trauma through their journey to the host country [for migrant women] and no support networks, it puts them in a vulnerable position to suffer from a combination of physical and mental health issues."

There is a complex but important relationship between all these different issues that mothers from disadvantaged backgrounds may face, says Hora, "and we don't have sufficient programmes in place to be able to identify where the problems are, in order to address it effectively and in a timely manner". Yet, in some instances, the solution is relatively straightforward. "One of the big issues that we have identified through research regarding mental health problems is that there is a lack of safe space to talk," she explains. "These women say: 'It is not just that I don't know where to go. When I try my GP, they put me off by the kind of questions they ask and their manner. It's in a rush and feels as if they want to tick the boxes – they're not interested in hearing my story.' And that sense of isolation perpetuates the situation."

The bigger picture

The UK has fantastic midwifery education, says Hora – something she is proud to be part

MORE STAFF NEEDED

The topic of birth trauma has reached the headlines this year, with an inquiry by Westminster politicians finding that mothers and babies going through painful, sometimes life-altering and often preventable ordeals has become "tolerated as normal". Led by Conservative MP Theo Clarke and Labour MP Rosie Duffield, the inquiry called for an overhaul of the UK's maternity and postnatal care, with the introduction of maternity commissioner being a key demand, alongside ensuring safe staff levels.

The Care Quality Commission's 2023 maternity survey found that availability of staff has to be a key area of improvement in maternity units, with 25% of people being left alone at some point during, or shortly after, the birth at a time when it worried them. And as the inquiry revealed, when mothers' voices were not heard, their needs not attended to and their babies not given the care they required, the results could be catastrophic. One of the RCM's key asks for the new Government is addressing the staffing crisis in maternity as a matter of urgency.

For a personal view of birth trauma, read page 33.

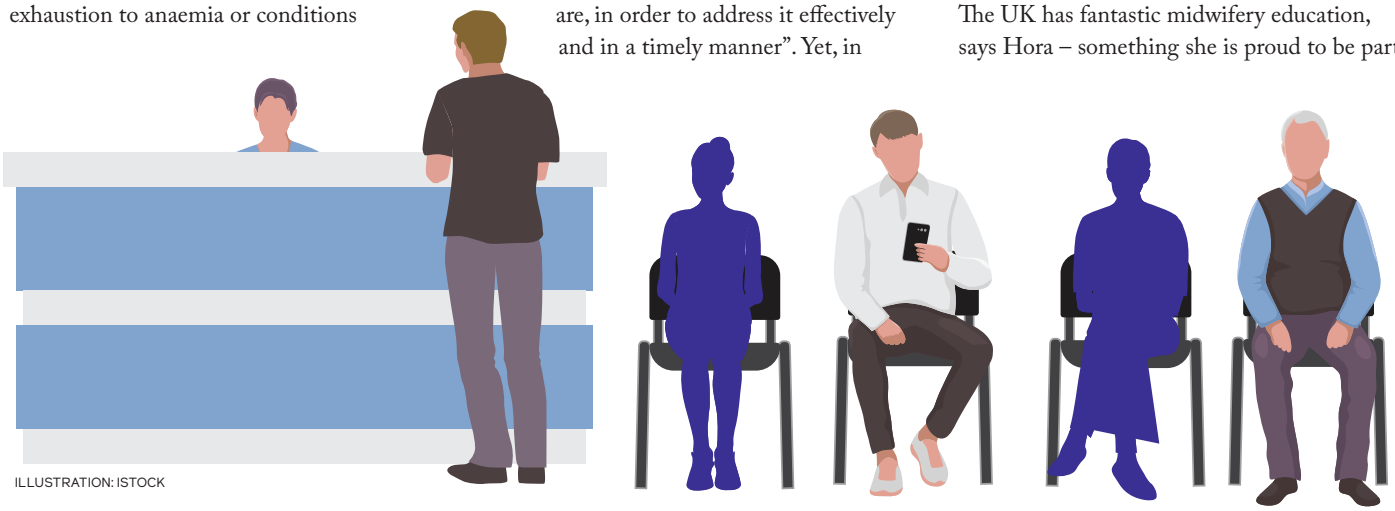


ILLUSTRATION: ISTOCK

of – but better training on cultural sensitivity and how to provide compassionate and trauma-informed care would help improve the experiences of the most disadvantaged women. But perhaps most importantly, she adds, our midwives and healthcare providers "need time in order to build a trusting relationship and rapport with these women, because that really matters to them". Time usually requires investment, and in May the Royal College of General Practitioners requested funding reform in order to better serve the areas of highest deprivation. Hora agrees that "the root cause of most issues seems to go back to deprivation". However, she warns that "we shouldn't lose sight of other factors like ethnicity if we're to ensure equitable access for holistic care".

Collaboration between services is vital in reducing social and health inequalities, which is one reason why the RCM has created the Maternity Disadvantage Assessment Tool (MatDAT). The toolkit, which launched in May and is currently in the early stages of being rolled out locally, offers a system by which midwives can assess and plan the care a woman needs. This goes from 'level one', where mother and child are thriving, to 'level four', where they are considered at risk of significant harm.

"It's a consistent approach," says Clare Livingstone, professional policy advisor at RCM. "And in that way it supports midwives … in taking account of the whole picture of a woman who may present with a range of circumstances and meet her individual needs accordingly." MatDAT will also assist midwives in making referrals or linking up with other agencies that may be needed, such as mental health services or housing support.

"Pressure on these services is enormous," says Clare, "and the resources available have been dwindling for many years now." But the first 1,001 days from conception in a child's life are the cornerstone for their future health, meaning a mother and child's healthcare absolutely has to be maintained throughout pregnancy and continued after discharge from maternity services. "We need to be confident that there's real continuity," she adds, "so if someone is receiving support from stop smoking services antenatally, for instance, that support is continued once the baby is born and is available for the whole family to improve the chances of success."

The Sure Start initiative offered a one-stop shop, says Clare, where women could see midwives as well as have access to mental health support, social support and support for children such as speech and language therapy. "The list was endless," she says, "but those have just disappeared in so many areas."

Joined-up services with professionals and the third sector all truly working together must become a priority, she adds, so there are no longer these gaps – in our healthcare system or indeed our society – "that women can just fall through".

FURTHER READING

Closing the women's health gap: a $1 trillion opportunity to improve lives and economies from the World Economic Forum: **b.link/WEF-gap**

Beyond the sum of our body parts: a call to action from women and girls from the White Ribbon Alliance: **b.link/WRA-body**

Women's health strategy for England from the Department of Health & Social Care: **b.link/DHSC-women**

RCM i-learn module *Health inequalities: the power of maternity care* (Study time: 45 minutes): **ilearn.rcm.org.uk**

Scan the QR code for MatDAT

It's the little things

No grand gestures, no showy prizes... a west Wales' Health Board has struck gold on much needed and appreciated initiatives to show the team how much they care

"The last Wednesday of every month we get together for a breakfast," says midwife Jennifer Pearce. "We put names into a hat and draw out five each time so it's fair and includes everyone." This is just one of the many Caring for You initiatives at Hywel Dda University Health Board (UHB).

It all began after COVID-19, when morale was low and there was an urgent need to counter the stress everyone had been under. It began as 'random acts of kindness', and soon spread to appreciation boards with 'thank yous' pinned to them and staff-nominated 'employee of the month' awards. "It's about the recognition. There are no prizes, we're not fundraising to buy gifts – it's the value of being recognised by your peers for the amazing work that you do," she says.

This is something that's apparent with the student celebration day this year. Jennifer says: "We've displayed the students' final-year project posters and invited the staff and lecturers to come and see them. It's a really good way to showcase their hard work and welcome them to the profession."

Far and wide

Building a sense of belonging is easier said than done. The Health Board for the west of Wales covers Carmarthenshire, Ceredigion and Pembrokeshire and has a population of nearly 386,000 people. Its headquarters is based in Hafan Derwen, St David's Park, Carmarthen. With such a huge geographical

area to cover, including remote and rural communities, it's hard to see how the team fosters a sense of community and belonging.

"It is hard," notes Jennifer, "but that's why it's important. We make sure we include everyone and try to do things that translate well on the social media groups. For example, we had a sunflower growing competition and we handed out seeds. Everyone was posting pictures of these huge sunflowers that they'd grown – it was great."

It's a given that, when it comes to cake, maternity means business. Jennifer says that Hywel Dda UHB took that to another level: "We did a cake delivery for International Day of the Midwife (IDM) this year for the other units – it meant travelling for more than an hour just to take them cake."

Including everyone

Jennifer stresses the fact that it isn't just for the maternity team – the Caring for You initiatives are open to all. "We don't leave anyone out, as it helps during stressful shifts because there's camaraderie." It makes for respectful working where everyone is acknowledged and appreciated.

"We had a doctor from overseas who didn't have family here, so we decorated the staff room and celebrated his birthday – he was nearly in tears. We just wanted him to feel like it was a home from home.

"In fact, we want everyone to feel it's a home from home. That's why we have sanitary products in toilets and shampoo and shower gel in the showers for staff. We also have a wellbeing champion for each staff group."

At each unit, teams held 'wellbeing walks' around the grounds during shifts for those who were able to. It was especially therapeutic immediately after COVID-19 when there was a need to go out into the fresh air and shake off the stress of the shift, even just for 10 minutes. While the regularity of the walks has waned, the teams are still encouraged to have lunch or even a cup of tea outside to boost wellbeing, weather permitting.

Jennifer also made a connection with a local alternative therapy school to come in and offer treatments. "Because they are students who need to practice to pass the course, they can come in and offer treatments such as reflexology for free or a discounted rate. It's a simple yet lovely thing to be able to offer staff members." At one point, she notes, they even had a rounders team, though keeping it going with everyone across such a wide area proved too difficult.

Celebrations

Less difficult to organise are events such as IDM, Maternity Support Worker Celebration Day, Easter, Christmas, Halloween and Valentine's Day. "We like to decorate the staff rooms and chip in for snacks and refreshments – for example, during the summer we have ice lollies in the freezer. We also always make sure that what is there is shared with the night shift." Jennifer notes that they make up hampers for Christmas and give away Easter eggs, all from staff donations. "It's incredible really, the generosity."

This year, she did something a little different for IDM. "We organised for therapy dogs to come into the hospital for staff. It gave us all such a boost."

Hywel Dda UHB has captured the essence of Caring for You with kind and thoughtful gestures that show everyone that they are valued.

MORE INFO

RCM i-learn module *Promoting compassionate and supportive workplaces* (Study time: 30 minutes)

Find out more at **rcm.org.uk**

Pass notes

Professional advisor for education at the RCM Ruby Handley-Stone shares her 10 tips for students handing over the midwifery society

Are you a student midwife approaching qualification? Have you been involved in your midwifery society, or 'mid soc'? If so, you may be considering how it will continue without you and your peers.

Having good communication between outgoing and incoming members is an essential aspect of running a society, more so when key members are leaving – for example, if you have a final-year student who acts as the chair/president of the society, or if a new member is elected. So, here's how to ensure a smooth handover to the next cohort:

1 Make sure your mid soc election date is set far ahead of the final-year students' last day of term.

2 Once election results have been confirmed, put each successful student in touch with a current member to arrange a meeting or email discussion.

3 All key members of the mid soc should complete a handover outlining key information and achievements from this academic year.

4 Provide all important details to your new mid soc members, including passwords, email addresses, finance codes and membership fees, if applicable.

5 If you have a mid soc email address, make sure to remind the new chair to add new contacts to the mailing list and remove those who are leaving, and provide them with a full list of other contacts accumulated during your time on the society.

6 Be sure to update all social media accounts and logins, including posts informing members of the newly elected individuals with photographs if possible.

7 If you own or use any storage space for mid soc event items, remember to give new members access. You should also hand over an inventory, with the details of any large items such as tables and screens.

8 During the verbal handover, outline each member's role and their details, particularly the roles of chair/president and treasurer. Include the main tasks involved in each position.

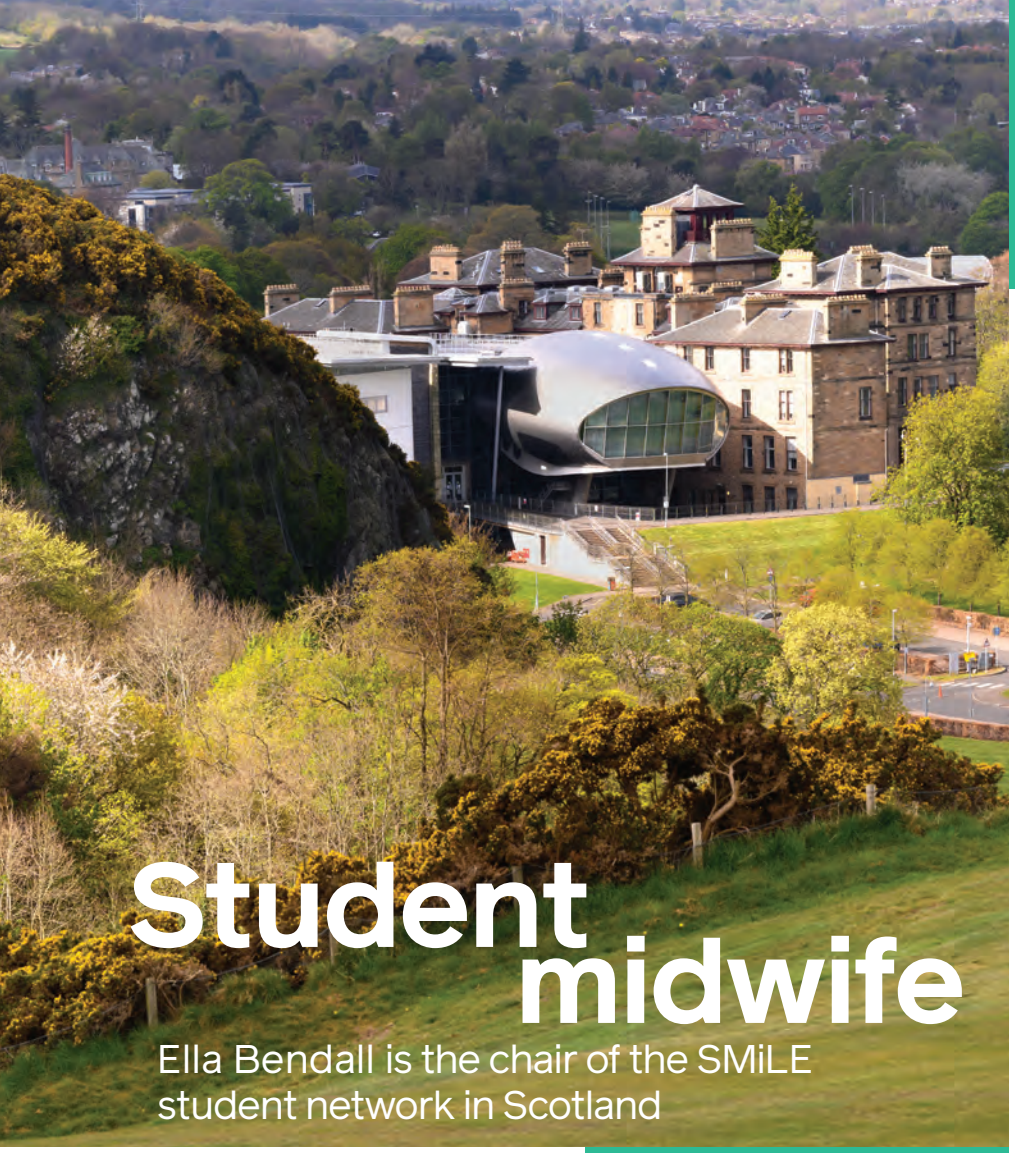
9 In your handover, include a list of tasks to complete in preparation for the next academic year and any ideas you may have for the succeeding group.

10 Ensure new members have an overview and diary of all previous events undertaken throughout the year, so that they can plan accordingly for next year.

MORE INFO

New downloadable resources for mid socs are coming in autumn 2024. Stay posted for useful documents designed to help support your midwifery society at **rcm.org.uk**

PHOTO: ISTOCK



Student midwife

Ella Bendall is the chair of the SMiLE student network in Scotland

The RCM set up the Strategic Midwifery Leadership Group (SMiLE) network in Scotland in 2022. It's a professional network bringing midwives and strategic stakeholders together to share experiences, make changes within the profession and develop their careers. The different networks, including students and early career midwives (ECM), filter information to the strategic group to develop midwifery services in Scotland.

I heard about the SMiLE network in my role as president of the midwifery society at Edinburgh Napier University (picured), where I'm completing my master's degree. The RCM was looking for representatives from universities in Scotland to join the student network. I wanted to get involved to meet other student midwives and learn from them. It's a great opportunity to get to know people from other universities who will be your future colleagues.

IMAGE: SHUTTERSTOCK

This piece of work shows that the student network has the ability to make real changes in Scotland

The student network meets every few months to discuss the issues that midwifery students face in Scotland. We represent student midwives at our own universities and share their concerns. This helps us to better understand what the student midwife experience is like, and the changes people want to see.

Speaking up

Initially, I thought the student network would be at the back of the queue when trying to raise issues affecting midwives in Scotland, but our voices are given equal weighting and importance. For example, we highlighted the financial hardship of student midwives at a roundtable at the Scottish Parliament in May 2024. We also put together a survey to send to student members and shared the findings in a report, gaining media coverage.

This piece of work shows that the student network has the ability to make real changes in Scotland. We'll hopefully be able to shift the culture of thinking around student finance.

As well as chairing the student network meetings, I attend meetings with the leadership group. It is looking at how the different SMiLE networks can work together more to develop the profession. For instance, on the RCM's Student Celebration Day in June, the student network and ECM network raised awareness of the different options available after qualifying.

I enjoy being the chair of the student network. It's good for both my personal development and future career. It has been hectic at times, especially when I was doing my elective placement for my course and writing the report about student finance, but everyone in the network is very supportive and engaged. We all work together.

MORE INFO

To hear from the chair of the ECM SMiLE group, visit **rcm.org.uk/midwives-magazine**

Job profiling

Alice Sorby explains why job evaluation is so important

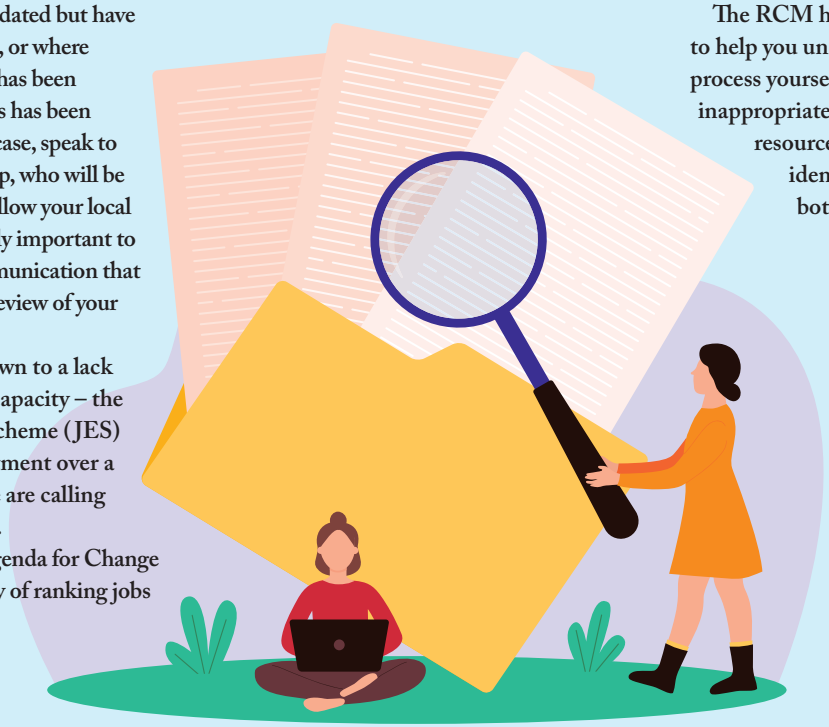
Q: I think I'm on the wrong Agenda for Change job band – what should I do?

A: Find your job description and job specification, then check whether it accurately reflects your role, responsibilities and the level of education and training required. If not, ask your line manager to update your job description. This then goes to a job matching panel to assign a pay band to it. A job matching panel comprises the employer and staff-side representatives employed in the NHS Trust/Health Board.

We know of situations where staff have challenged their banding and asked for job descriptions to be updated but have been met with pushback, or where a rebanding application has been requested but the process has been protracted. If this is the case, speak to your RCM workplace rep, who will be able to support you to follow your local internal process. It's really important to keep a record of all communication that you have regarding the review of your job description.

Any delays can be down to a lack of local job evaluation capacity – the NHS Job Evaluation Scheme (JES) has seen a lack of investment over a number of years and we are calling for this to be addressed.

JES underpins the Agenda for Change pay structure – it is a way of ranking jobs by knowledge and skills, and ensures equal pay for work of equal value. Every job description that is created for Agenda for Change staff must go through a process of job matching against a nationally evaluated profile. Where a job cannot be matched to a profile, local evaluation will need to be carried out. These are done in partnership with the job matching panel. Panel members must have been JES trained. It would be great if more RCM members were involved in job evaluation, so speak to your local branch if you are interested.



Updating the roles

The RCM is a member of the NHS Staff Council's national Job Evaluation Group (JEG), responsible for keeping the JES up to date – this includes developing new job profiles and updating existing ones.

JEG is reviewing the nationally evaluated nursing and midwifery profiles following a request from the RCM and the RCN. The profiles haven't been updated for many years and in that time roles have evolved significantly. The review ensures that the suite can be applied effectively to all the different and varied midwifery and maternity support worker roles, they reflect current clinical practice and deployment, they clearly show the differentiation between the bands and they identify specialist roles that are more difficult to match. See the evidence RCM has submitted to this ongoing review at b.link/RCM-JE

The RCM has a *Job evaluation toolkit* to help you understand the job evaluation process yourself and identify and challenge inappropriate banding. JEG has produced resources to support job profile identification that can be used by both you and your employer.

MORE INFO

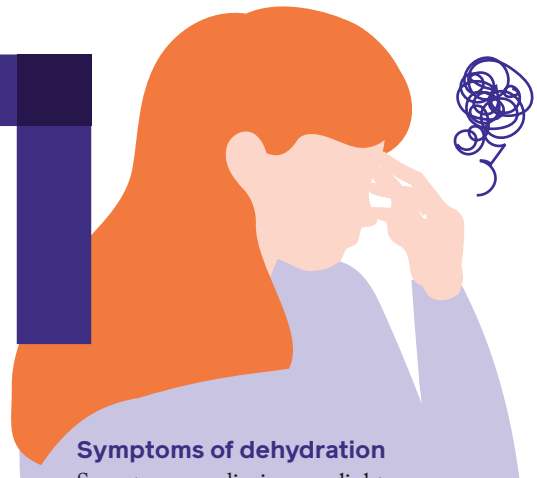
JEG's *Nursing and midwifery national job profile review*: **b.link/JEGreport**
RCM's *Job evaluation toolkit*: **b.link/RCM-JET**
NHS job evaluation handbook: **b.link/NHS-JEH**

ILLUSTRATION: ISTOCK. PHOTO: KATE DARKINS

Stay hydrated

Each year, RCM member surveys show that a worryingly high number of you feel dehydrated most or all of the time, have little opportunity to stop and drink, skip meals at work most or all of the time and delay using the toilet due to lack of time. Dehydration can cause weakness and confusion, not to mention have a serious effect on long-term health

1



Symptoms of dehydration

Symptoms are dizziness or light-headedness, headache, tiredness, dry mouth, lips and eyes and passing small amounts of urine infrequently (fewer than three or four times a day). Thirst is not a good indicator.

2

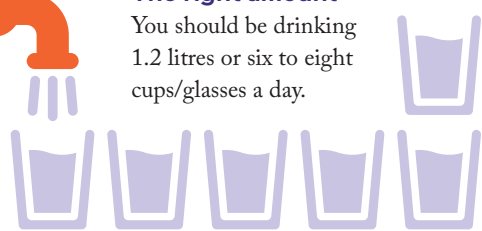
Need for fluid

You may need to drink more fluids than normal if you're in a hot environment and physically active for long periods.

3

The right amount

You should be drinking 1.2 litres or six to eight cups/glasses a day.



4

What to drink?

Water, lower-fat milk and sugar-free drinks all count. Be aware that drinking tea and coffee isn't as effective as they flush fluids out of your system. If you don't like the taste of water then try adding fruit to your water bottle.

Little and often

The key is to drink regularly throughout the day. If breaks are an issue, then try regularly sipping small amounts to stay hydrated.

5

MORE INFO

All midwives, student midwives, maternity support workers and midwifery managers should be aware of the evidence relating to the serious impact of dehydration on health, mood and cognitive ability. If your work situation is not allowing you to stay hydrated, inform your RCM health and safety representative or contact RCM Connect.

Scan QR code for video

Trauma-informed care

Maternity professionals need to understand the impact of psychological trauma on women in the perinatal period and respond in a sensitive and compassionate way

Psychological trauma has been defined as "an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social and emotional wellbeing". This can include previous birth trauma or pregnancy loss, adverse childhood experiences or current abuse.

During pregnancy and the perinatal period, women may revisit past experiences of trauma. Some women feel a loss of control as their body changes, while some aspects of childbirth can be triggers such as close proximity of a relative stranger and feeling exposed during procedures or examinations. Women can often disclose previous abuse or trauma for the first time in maternity services. However, trauma is often hidden and may never be disclosed.

The Centre for Early Child Development in Blackpool, with support from Birmingham University and the University at Buffalo, has produced *A good practice guide to support implementation of trauma-informed care in the perinatal period*. It identifies four areas that can help improve care for those with trauma:

- **Compassion and recognition** – trying to understand how the person is feeling and reflecting what you hear back can help them feel seen and understood. For example, you could say: "It sounds like you are really worried – that makes sense to me."
- **Communication and collaboration** – relationships are built on trust, respect and collaboration. This will help individuals understand their options and make informed decisions about their care. Be attentive and non-judgemental, use language that is sensitive to trauma and avoid use of jargon. Remember this includes those with learning difficulties or English as an additional language. Often the impact of trauma can be experienced through a sense of powerlessness, so always explain what you are about to do and ask the person if they are ready and okay.
- **Consistency and continuity** – linking up staff and services will help them to feel supported through each stage of their care.
- **Recognising diversity and facilitating recovery** – it is important to recognise cultural, historical and gender vulnerabilities. Consider how best to meet the needs of individuals, such as those whose immigration status is uncertain, have English as a additional language, have a learning difficulty or are accompanied by a carer. Think how this may present challenges for that individual to disclose or discuss trauma. Remaining curious and asking people about what is right for them will foster a sense of safety, trust and understanding.

READ
A good practice guide to support implementation of trauma-informed care in the perinatal period at **b.link/trauma-guide**

ILLUSTRATION: ISTOCK

Greater than the sum of its parts

The midwifery practice education team at Northern Ireland's Southern Health & Social Care Trust (HSCT) has seen huge improvements in recruitment and retention

"We're a bit different," admits consultant midwife and team lead Jen McKenna on what sets the Southern HSCT midwifery practice education team (MPET) apart. "I'm sure others demonstrate some of the same attributes, but we haven't come across anybody else quite like us."

Previously a midwifery lecturer at Queen's University Belfast, Jen places a strong value on education. "During COVID-19, as we were responding to emergencies and new ways of working, education and training was one of the things that was deprioritised," she says. "So, when I joined the Southern HSCT, I was delighted that the senior team in maternity services wanted to put the focus back on education and training." Alongside Jen, the MPET comprises clinical skills midwife Katrina McCullough, practice development midwife Donna King and fetal monitoring midwife Donna McLoughlin. "We found a little space to create an education hub within the clinical area and promoted the fact that we are now a team rather than just individual specialist midwives."

Initiatives introduced by the MPET include:

- a closed social media group for maternity care staff that highlights upcoming training and conferences
- a monthly focus on one component of corporate and midwifery mandatory training, with audited staff completion rates
- 'hot topics' requested by staff
- multidisciplinary study days
- real-time emergency drills that incorporate learning from governance processes and 'InterSim' – interprofessional simulation with multidisciplinary teams that incorporates team-working, human factors, systems thinking, communication, leadership, escalation and psychological safety
- a three-day induction programme and 18-month support programme for new midwives.

Staying power

The investment in support and training is paying dividends. Between 2019 and 2021, the Trust recruited just 58% of the annually required number of midwives, while the retention rate for newly qualified midwives (NQMs) at one-year post-registration was 74%. For 2023, says Katrina, those recruitment requirements have been achieved, all the outstanding vacancies from

PHOTOGRAPH: RCM, KATE DARKINS

previous years are now filled and the retention rate of NQMs stands at 97.5%.

Katrina's role focuses on new midwives, enabling them to develop their clinical competencies, as well as providing pastoral and psychological support to grow as professionals. The role was created to address the challenges around recruiting and retaining NQMs, who currently comprise 18% of the Trust's midwifery workforce. "It's recognising that those first 18 months are really challenging, particularly post COVID-19," Katrina says. "We're all involved in the induction programme to try and give them a really good start and make them feel they're a part of this Trust."

Regardless of experience, education is ongoing, explains Donna McLoughlin. "Staff need reassurance around keeping women and babies safe. That's why we have good training – both electronic and face to face."

Jen adds: "When people are good at their job and have personal and professional confidence and competence, they enjoy the job more. That's how we keep our retention rates high: people are enjoying what they do because they're skilled, competent practitioners. Education underpins everything."

THE BEST POSSIBLE START

Band 5 and 6 midwives from Southern HSCT explain how the practice education team has helped them get the best possible start in the profession – giving them the drive to stay in it.

AOIFE EANNETTA

[Band 5]:

"In your first few years as a midwife, you're laying the foundations. Having as much support as I could get was really important. [Where I trained] was a smaller unit and they would have cared for a lot of women with universal care needs only, but I wanted the experience of more complexity. A dedicated midwife looking after Band 5s is a big support when you first start out."

GEORGIA CAMPBELL

[transitioning from Band 5 to 6]:

"When you move on to Band 6, it's a scary prospect – you're going into a busy maternity area so people don't have the time to show you where things are. So having that induction and knowing that a person is there if you're ever stuck was very good. I trained with Craigavon as a student midwife and staying on was a no-brainer. There was never a thought that I would work with any other Trust."

NIAMH MCALLISTER

[Band 5]:

"In our first week, we had an induction and were introduced to the roles that everyone had. This meant if you had any questions, you knew who to go to. Even with the online training, you have that one person you go to. Katrina is always asking me how I'm doing, so you have someone looking out for your wellbeing as well. I don't understand why [all Trusts] don't have it."

NICOLE O'BRIEN

[Band 6, continuity of midwifery carer team, Sapphire]:

"When I first qualified, being able to run through things step by step in real time was so valuable. When that emergency happens, you can automatically take yourself straight in there. The midwifery practice education team is always very reassuring. And if there's learning to be done from it, they're happy to talk you through it, because we're all here to be the best practitioners we can be."

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RCM Awards 2024

The RCM Awards 2024 will take place on Friday 18 October 2024 at The Brewery, London – Celebrating, rewarding and sharing outstanding achievements in the midwifery profession across the UK this year.

Join us for a glamorous Awards lunch, including a welcome drinks reception, followed by a delicious three-course lunch, entertainment from our host and the Awards ceremony itself.

Shortlist announced 23 July 2024

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Winners announced: 18 October 2024

The Brewery, London

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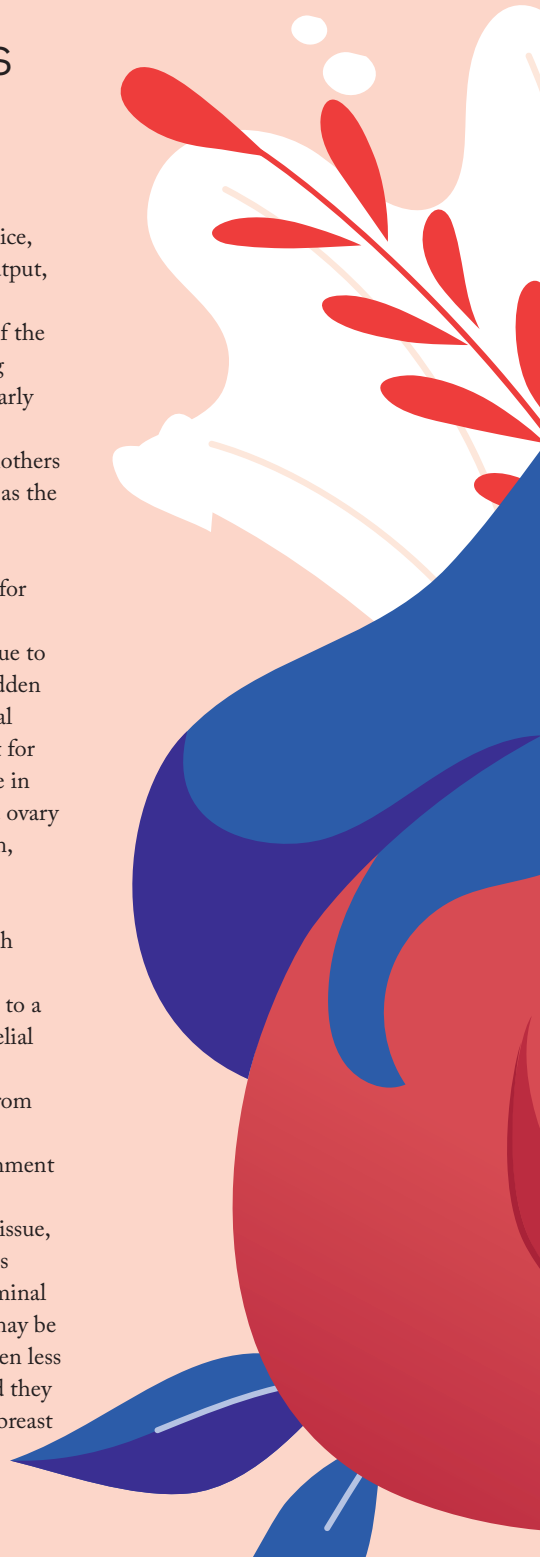
Food for thought

Jaspreet Garcha, infant feeding lead midwife at University Hospitals Coventry and Warwickshire NHS Trust, considers how high BMI affects breastfeeding



Worldwide obesity has more than doubled since 1980 and, according to the NHS Information Centre, approximately half of women of childbearing age have a high body mass index (BMI) – that is, a BMI of between 25 and 29.9, which is described as overweight, or between 30 and 39.9, defined as obese.

There appears to be a correlation between increasing maternal pre-pregnancy weight and declining rates of breastfeeding initiation and duration, irrespective of the nation of study. A systematic review investigating the relationship between maternal obesity and breastfeeding found that 15 out of 16 studies demonstrated decreased breastfeeding initiation rates among women with a high BMI compared with those in a healthy BMI range (between 18.5 and 24.9). This encompassed studies from Denmark, Australia, the US and the UK.

Having a high BMI pre-pregnancy is a major risk factor for complications for women's health during pregnancy, childbirth and postnatally. Those with a high BMI are more likely to have an induction of labour, lengthy labour, instrumental delivery, caesarean birth or postpartum haemorrhage, which are all risk factors for delays in stage II lactogenesis.

Late lactation

For the majority of mothers, stage II lactogenesis will occur within three days postnatal. However, 58% of women with a high BMI experience a delay in onset of lactation. This delay may reduce the mother's confidence and make her more likely to think that her milk is insufficient for her baby. It also puts babies at an increased likelihood of suboptimal weight gain, jaundice, hypoglycaemia, reduced urine and bowel output, and other associated symptoms related to insufficient milk intake. This could be one of the many factors that make high-BMI lactating women more likely to cease breastfeeding early and introduce formula milk feeding. These findings are echoed by the experiences of mothers with high BMI, who state insufficient milk as the reason to stop breastfeeding.

According to research, there are a myriad of reasons for delayed onset of lactogenesis for those with a high BMI. One theory for the delay is the accumulation of progesterone due to excess maternal adiposity disrupting the sudden drop in progesterone following birth. Several studies suggest that insulin is a requirement for stage II lactogenesis, therefore an imbalance in insulin may influence the timing. Polycystic ovary syndrome is associated with hypothyroidism, elevated androgens, insulin abnormalities and insufficient milk supply, and this often occurs alongside obesity. Complications such as induction of labour via artificial oxytocin hormone or caesarean birth could be linked to a reduction in oxytocin-stimulated myoepithelial cell contractions around the alveoli. Those with a high BMI are more likely to suffer from postnatal oedema, adding extra fluid to the breasts and potentially making infant attachment more difficult.

Physical factors such as additional body tissue, larger breasts, flattened nipples due to excess adipose tissue in the breast, increased abdominal circumference and reduced area in the lap may be a contributing factor. This could make women less flexible in their approach to positioning and they may need to prop the breast or hold excess breast

Tactful ways to incorporate weight discussions can affect breastfeeding success if provided in a coordinated, meaningful way

tissue away from the infant's nose. These factors may also contribute to those with a high BMI feeling self-conscious and being more likely to initiate mixed feeding.

Societal judgement

A US Pregnancy Risk Assessment Monitoring System (PRAMS) study showed that mothers with raised BMI are less likely to experience pro-breastfeeding practices compared with mothers with a healthy BMI range. They had lower chances of staff members providing breastfeeding information, lower chances of staff members helping them, lower breastfeeding rates in the first hour after delivery, less likelihood of being given community support contact and reduced incidence of rooming with their babies. They were also less likely to be instructed by staff to feed babies responsively. These results indicate a need for healthcare professionals to have further education about the effect of obesity as a risk factor for delayed lactogenesis and reduced initiation and duration of breastfeeding.

Healthcare professionals are in an optimum position to reinforce positive relationships, facilitate open channels of woman-centred communication and instil confidence in mothers' abilities to breastfeed their babies. Tactful ways to incorporate weight discussions can affect breastfeeding success if provided in a coordinated, meaningful way. For example, this could include discussing with parents antenatally how stage II lactogenesis may be delayed in the first few days after birth, or how breastfeeding mothers with a higher BMI are more likely to experience perceived insufficient milk supply and positioning difficulties. This can work to provide realistic expectations and reduce the likelihood of unnecessary bottle supplementation.

It really comes down to maternity professionals. As midwives and maternity support workers, are we aware of the compounding, underlying physiological factors and emotional barriers that these women face? Are we offering compassionate woman-centred care to support them to achieve equitable feeding outcomes? Are we aware of our own biases and how they could potentially impact on interactions we have with women? To provide the best start for mother and baby, isn't it time we offered better breastfeeding support?

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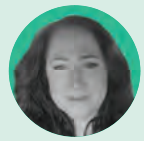
Great expectations

It's important to support the person in front of you and not who you think they are or should be. Not everyone fits the mould and behaves how you expect them to. At antenatal appointments, they may seem angry or uncommunicative. They may challenge or disregard your advice or reject your care. But this isn't about you. They may be dealing with things that you can't imagine. So how can you help when you aren't sure what you're dealing with?



Claire Spencer
CLINICAL AND CARE PROFESSIONAL LEAD FOR MATERNITY IN LAMBETH AND MIDWIFE AND BREASTFEEDING COORDINATOR AT GUY'S AND ST THOMAS' NHS FOUNDATION TRUST. SHE CO-DEVELOPED THE RCM MATERNITY DISADVANTAGE ASSESSMENT TOOL (MATDAT)

The Lambeth Early Action Partnership (LEAP) is one of five 'A Better Start' partnerships funded by the National Lottery Community Fund, which aims to improve the life chances of babies, young children and families. LEAP developed a multidisciplinary health team to support local implementation of the Healthy Child Programme, and from this the MatDAT was born.

As the two midwives working within this multiprofessional team, it became obvious to Octavia Wiseman and I that we didn't have the same language for classifying social risk factors as, for example, GPs or health visitors did with their safeguarding levels.

We were doing the same work – we were gathering each woman's story and all the complexities of her life to build up a picture of the support she had and what she needed. But as midwives we tended to keep it as a narrative. We didn't have a way to categorise the level of support needed that could then be shared with and understood by other professionals.

We set out to create something that was maternity specific. There are four levels. We know women at level 4 are well supported, with referrals to social service or perinatal mental health teams for example, but this is a really good tool to pick up those women who don't meet the thresholds (those at level 2 or 3) at the right time in their journey to help them give their children a better start.

The care planning tool comes next. It goes through every aspect – what a woman and her partner can do for themselves, and what their GP, health visitor or local authority can do – all of it specific to the local support services. In Lambeth, for example, we can refer to Better Start workers who are fantastic at supporting with English courses, benefits and housing. The idea is to make it as systematic as possible – a midwife can go through the list and clearly see what signposting, referrals and contacts to make.

We know women with social complexities will most often have not just one but many. And these together are the wider determinants of health, so it is so important we involve other health and care services, sharing that responsibility and the emotional load. We can't fix everything, but we can walk alongside families through difficult circumstances.

FIND OUT MORE
Access the RCM MatDAT at
b.link/RCM-MatDAT

Lorraine Farrow
SENIOR EDUCATOR, LEAD FOR TRAUMA-INFORMED CARE IN MATERNITY, NHS EDUCATION FOR SCOTLAND

It's important to understand the impact of trauma and how it can manifest – for example, experiencing overwhelming emotions and using coping mechanisms that are risky or unhelpful, such as substance and alcohol misuse. I used to be an advanced specialist midwife for substance misuse, and now I lead pathfinding projects into how organisations interpret and understand trauma-informed practice principles and education needs.

It involves a whole-system approach looking at every point of contact for families – environment, interaction, documentation and communication. We have agreed three priority areas for the pathfinding: organisational and cultural readiness, workforce development, and approach to screening and assessing individual needs. By cultural readiness, I mean: how do policies cover such things as aggression and challenging behaviours? How are different traumas recognised and responded to? Scotland has seen a huge shift in responding to trauma, with clinical psychology now embedded in maternity services. Cultural readiness also covers what practice and policies are in place for workforce wellbeing, supervision and reflective practice to deal with any negative effects of supporting families.

Workforce development considers the training needs. When you're supporting those with trauma or mistrust, the fight, flight or freeze response can kick in. There can be disengagement and people put up barriers, including giving inaccurate information that may only be discovered later, or they can be defensive or argumentative. The best way to deal with it is to stay calm. Ask to speak to them in a private area and perhaps say: "Let's see why you are feeling how you're feeling and how we can help you." It's also important to explain why you're asking the questions you're asking so families don't disengage from the process that is meant to help them.

Thirdly, there's the focus on how maternity staff screen and assess individual needs. I am working with families, looking at how their interactions with the service are approached, documented and supported, and what needs to change. Their experiences are incorporated into the way we improve processes and communication.

The National Trauma Transformation Programme has created eLearning modules for those in practice, which cover different elements of trauma-informed care. For students, we're seeking to get this embedded in the courses. We also have monthly coaching sessions for staff in pathfinder Board areas. The principles of trust, safety, choice, collaboration and empowerment without judgement offer a chance to improve birth experiences.

FURTHER READING
eLearning available at
b.link/Turas-NTTP
Getting It Right For Every Child (GIRFEC):
gov.scot/policies/girfec

IMAGES: SHUTTERSTOCK

Yasmeen Akhtar
SPECIALIST MENTAL HEALTH MIDWIFE AT BARNSLEY HOSPITAL NHS FOUNDATION TRUST. SHE RECEIVED THE RCM'S OUTSTANDING CONTRIBUTION TO MIDWIFERY SERVICES: PERINATAL MENTAL HEALTH AWARD ALONGSIDE HER COLLEAGUE MELISSA ADDY

Having seen women with low-level mental health issues such as anxiety and depression get missed, only for their mental health issues to get worse, I wanted to provide services within midwifery to nip those in the bud. We brought together a package of tailored services, including one-to-one support, group sessions and antenatal classes for women with anxieties around pregnancy and birth.

Five years ago, we started our support group 'Mums understand Mums', or MuMs for short. Now, 30 women meet every Wednesday with a midwife (myself or Melissa), an MSW, a volunteer, someone from the health visiting team and someone from the children's centre.

Women dealing with anxiety and depression, fears around birth or fears they won't be able to look after their baby are referred to us. We focus on wellbeing and building confidence, from encouraging bonding with bump to supporting attachment with baby, empowering and supporting these women until their babies are six months, and working with other services to ensure support continues beyond that point.

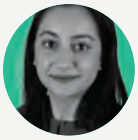
Care wraps around the family; we might help a woman understand benefits entitlements if she has money worries or, if her partner is struggling, connect him with support services for dads. Another key is peer-to-peer support. Women can feel very isolated, but at MuMs there is a room full of people who have struggled with the same things.

There is still so much stigma around mental health, especially during pregnancy. It is so important that we normalise it for women if they are brave enough to tell their midwife what they are feeling. We provide mental health training for all midwives, MSWs and doctors, because if we can capture and support women with low-level mental health issues we can stop them from escalating.

We provide mental health training for all midwives

If a woman comes into hospital for an appointment but leaves before seeing a consultant, we might say she's 'a DNA' or 'not engaging'. However, it might have been that she felt so anxious in that busy hospital waiting room that it was overwhelming. Supporting her might be as simple as suggesting distraction techniques – adult colouring, listening to music or looking through photos.

With an increasing public focus on mental health, this is a good time for midwives to think about how we develop and tailor our services. There are lots of different ways you can do it. It doesn't matter if it's just you – one person can create a ripple effect.



Dalvir Kandola

FORMER LECTURER IN MIDWIFERY AT THE UNIVERSITY OF LEICESTER, CONSULTANT MIDWIFE AND LEAD FOR INCLUSIVITY AT UNIVERSITY HOSPITALS OF LEICESTER

Maternity services have been under review and, unfortunately, it's been quite negative. To address some of the findings, we need to listen to the people who use our services to inform improvements. But how do we ensure the voices we seek represent the diverse population that we serve?

Service users who use PALS (patient advice and liaison services) or fill out feedback tools about their care are mostly English-speaking and middle class – they know they have the right to feedback and have a good standard of written English. Debi Bhattacharya [professor of behavioural medicine at the University of Leicester] and I reviewed evaluations of maternity experiences and to what extent they recognised diversity.

The maximum score possible from the cultural competency tool is 20, yet our results ranged from zero to eight, with a mean of 3.34 – falling well below the ideal. In relation to diversity of participants, all studies reported their participants were female, only 30% reported sexuality, only 30% reported religion and none reported on the neurodiverse status of the participants.

There's a lot to learn from this. It is important that literature reviews are not just stored in a database, but are used to provide tangible and practical results. I've produced a tool for our services in Leicester based on research and feedback from our Maternity and Neonatal Voices Partnership. It is a guide for staff who wish to collect feedback from service users, and this can then be used to help ensure the process and design of the services is culturally competent and supports diversity.

The Birth Trauma Inquiry report earlier this year recommended a national roll-out for standardised post-birth services, such as Birth Reflections, to give all people a safe space to speak about their experiences in childbirth. It led me to review our services in Leicester and question who uses them locally.

Data informs us that the service is underused by certain population groups, so we need to consider how we can make it more inclusive. We are looking at various options – one solution I've implemented is to ensure all community midwives inform families about the service at point of discharge to the health visitor and how to make contact. Our new perinatal website also allows for the information about Birth Reflections to be translated into many different languages (written and audio).

When it comes to making changes in relation to inequalities in care, it will take time to see the results. This can be difficult when trying to demonstrate the effect you are having. I find it helpful to remember that, at times, I am changing lives in places and spaces I can't even see yet.

MORE INFO

For more on Birth Reflections, visit **b.link/LMS-wellbeing**

Read the Birth trauma inquiry report at **b.link/BirthTraumaReport**

RCM i-learn module *Autism and pregnancy* (Study time: 30 minutes): **ilearn.rcm.org.uk**

This module covers how midwives can support autistic women through the journey of childbirth more effectively and provides an opportunity for reflection on midwifery practice.

Striving for better care

Sheila Brill's traumatic birth left her daughter with disabilities and her with PTSD – it should have been very different...

I had a traumatic birth experience with my baby in 1993. As a result of poor multidisciplinary working and communication, my daughter Josephine suffered a catastrophic brain injury due to hypoxia and had a lifetime of pain and suffering. She was profoundly disabled and needed 24/7 care for the whole of her life, which lasted only 23 years.

Josephine passed away in 2017 and I began writing our story. Surprisingly, in spite of my daughter's awful start and enormous challenges, the outcome of publishing *Can I speak to Josephine please?* has led to my deeper understanding of the midwifery profession and the difficulties it faced at the time – and, shockingly, that it still faces.

Mothers and babies will continue to be in danger in an understaffed environment, but I've learned that it's not just about numbers. Competent, well-trained midwifery teams need to be properly supported so that they have good communication skills, time to be kind and an enduring will to show the care and compassion that is needed.

Spread the word

What happened during my birth experience was preventable, and it is for this reason that I am hoping my story reaches as many maternity professionals as possible. I'm pleased to say that at a book event at the University of the West of England, Bristol, it was announced that *Can I speak to Josephine please?* would be a core text on one of the midwifery modules. It's comforting to think that midwifery students will take the learnings from what happened in my birth experience and apply those to their future practice.

This is vital because, as the Care Quality Commission's 2023 maternity survey found, plenty of women are not being listened to or are being left alone during or just after birth. This can be worrying and have tragic results. One mother whose son was born with hypoxic brain injury said: "My life will never be as it should." If the next generation of midwives can read my birth experience, then Josephine's voice will be heard.

READ

To order *Can I speak to Josephine please?* visit **b.link/Brill-Josephine-book**

Follow Sheila on X (formerly Twitter) at **@sheilabrill**

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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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