THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 25 / MAY 2022

midwives

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RCM chief executive Gill Walton says the Ockenden Report must bring change

Welcome

The Ockenden Report, published in March, was sobering reading for all of us working in maternity care. I know that many of you will have found it – and some of the media coverage around it – very difficult. I certainly did. It is heartbreaking that it only came about because of the determination of families who were affected. We owe these families a debt that I fear can never be repaid. We owe it to them, and to each other, to work together to listen, learn and ensure that women and families are able to trust the care we give them.

This report must be a turning point

The report cited a poor working culture, where staff were afraid to raise concerns, as a key factor in many of the cases. The RCM has published guidance on how to raise concerns about maternity care and what staff should do if they feel they are not being listened to. All of us working in maternity services need to look around us and ask 'Is the care here safe?' If you have any concerns you need to have the courage to speak up and stand up for higher standards. Poor working cultures lead to a lack of timely and appropriate escalation, which compromises safety. This has to stop.

The review also identified workforce shortages as being a threat to safety. The RCM has been highlighting this for over a decade, calling on three successive health secretaries to invest not only in recruiting new midwives but in retaining existing ones. Long-term underinvestment in staffing has undermined midwives' efforts to deliver the safest and best care. It is not good enough that the government only pays attention in the light of a tragedy.

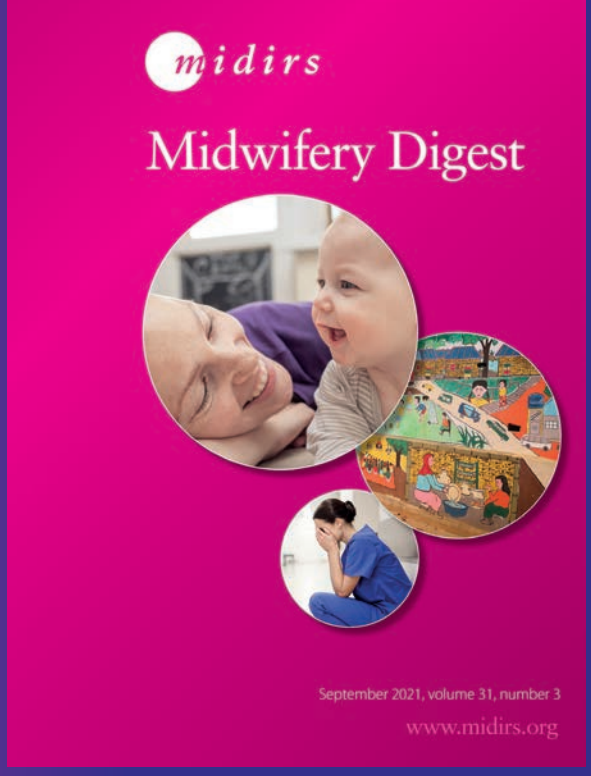
We welcome the Ockenden Report's focus on improving staff retention and its recommendation that newly qualified midwives should have a robust induction training programme. We also support its recommendation to ring-fence training budgets and ensure that those midwives who go on training courses are replaced. All too often our members tell us that crucial training has been put on hold because no one is able to cover their posts. We also welcome the endorsement of the RCM's long-held view that improving midwifery leadership is a key factor in improving safety. Midwifery leaders need the right level of influence, resources and staffing to be effective.

Our branches are not only the heart of the RCM, they also provide space to talk and share concerns – whether that's about Ockenden and the issues it highlights, or just to talk openly and honestly with colleagues.

Openness and speaking up are key to safety in our maternity services. It starts in the workplace, but it's also what we as the RCM do on your behalf: with employers, with policy-makers and with the government.

Write for us!

We are interested in you, your research, your studies, your individual experiences and insights as a midwife, student midwife or MSW.



As the RCM's information provider, we are passionate about providing midwives, student midwives and maternity support workers with opportunities to share and promote their work to the wider midwifery community.

MIDIRS Midwifery Digest **provides the perfect platform for you to share your knowledge and experiences with those caring for women, babies and their families during pregnancy, birth and the postnatal period.**

Our journal

MIDIRS Midwifery Digest is a quarterly, academic journal available in print or PDF format. Its sections cover the whole midwifery spectrum including: *Midwifery & Education, Pregnancy, Labour & Birth, Postnatal, Neonatal & Infant Care*.

Part of the Royal College of Midwives' portfolio of educational resources, the *Digest* is read by midwives and student midwives, but is also relevant to anyone working with pregnant women, new mothers, babies and parents.

Who writes for the Digest?

We accept original articles from midwives, students, MSWs and health care professionals involved in maternity care. Whether you are a clinician, a student, or a new or established author, we welcome your contribution. Our dedicated editorial team can advise and support you with your paper.

Your article can be used as evidence of continuing professional development and NMC revalidation requirements, demonstrating a commitment and interest in extending your own and others' knowledge.

Original articles published in the *Digest*, are added to the Maternity and Infant Care (MIC) database and can be accessed by subscribers. You are immediately sharing your work with an even wider audience and further contributing to the improvement of maternity care.

Submitting a paper

Depending on the content, articles vary between 1000 words for viewpoint/discussion papers to 3500 for research papers. Author guidelines and details of how to submit your article can be found on www.midirs.org.

For further information

For informal enquiries, questions or support with your submission, please contact MIDIRS Digest Editor, Sara Webb at: sara.webb@rcm.org.uk.

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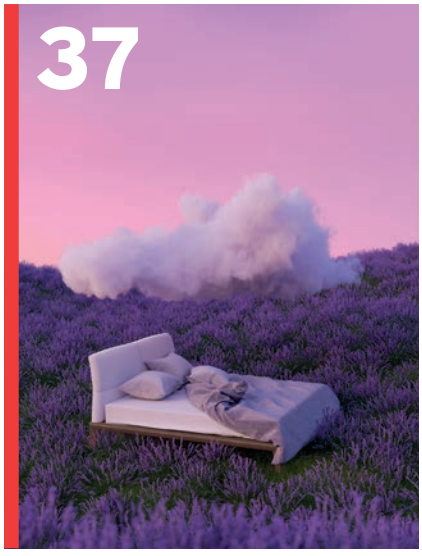


In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Funding boost

NHS England has announced £127m for maternity services across England to help ensure safer and more personalised care for women and their babies. More than £50m will be provided to Trusts across the country over the next two years to boost staffing numbers in maternity and neonatal services.

Around £34m will also be invested in local maternity systems, in culture and leadership development programmes and in supporting staff retention roles, and £45m of capital funding will be available to hospitals over the next three years to increase the number neonatal cots across England.

This is in addition to last year's announcement of £95m for maternity services in England to boost maternity workforce numbers with 1,300 new roles – 1,200 midwives and 100 obstetricians – alongside more training, development and leadership programmes.

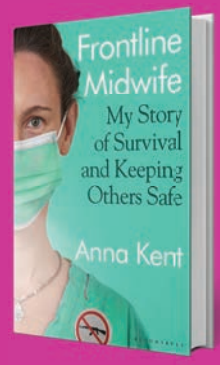
RCM chief executive Gill Walton welcomed the move and said: "For far too long, underinvestment has undermined our members' efforts to deliver the safest and best possible care for women and their babies. Right now, we are seeing midwives leave in their droves – we are losing talented professionals as they've had enough, while newly qualified midwives are turning on their heels because they do not feel supported or valued. It's crucial the NHS looks after the health and wellbeing of its staff to have any hope of recruiting and retaining them."

SUPPORT
@NoHungryStaff, fronted by *MasterChef* champion Saliha Mahmood-Ahmed, aims to provide hot, affordable and nutritious food 24/7 to all NHS workers.

one to watch

CELEBRATE
International Day of the Midwife: 5 May
bit.ly/RCM_IMD

READ
Frontline Midwife: My Story of Survival and Keeping Others Safe, by Anna Kent, follows Anna's volunteer work for Médecins Sans Frontières in South Sudan, Haiti and a refugee camp in Bangladesh.
bit.ly/Anna_Kent



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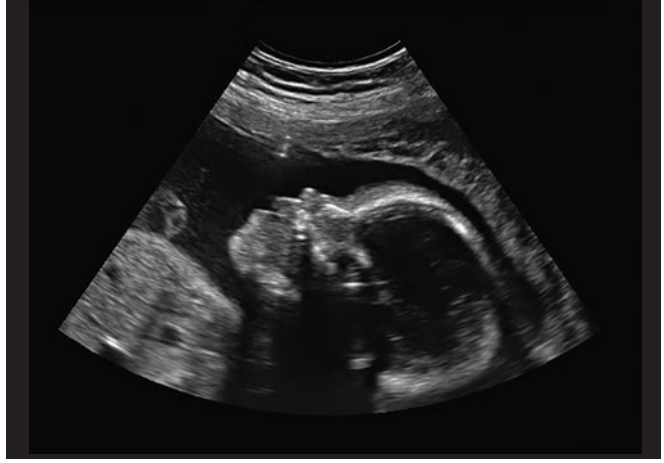

Ultrasound

AI scan

Perspectum Ltd, a company linked with the University of Oxford, is developing technology that uses artificial intelligence (AI) to analyse ultrasound images taken during women's 12-week scan and assess the placenta's volume and the blood vessels supplying it.

Although the placenta can be visualised using ultrasound, it is extremely time-consuming to measure it and all the tiny blood vessels supplying it, making this impractical for routine early pregnancy screening.

The University of Oxford has used machine learning to develop an AI tool, trained on thousands of ultrasound images where the placenta has been painstakingly marked out by hand, to automate the recognition process.

A pilot study of 143 women suggested the tool could differentiate between those with pre-eclampsia and fetal growth restriction. A new trial will test whether integrating this information into the existing NHS algorithm can further improve its accuracy. It aims to recruit 4,000 women who will be offered a placental ultrasound at their 12-week appointment, alongside routine care, and then follow up to see if the improved algorithm's predictions are correct.

Read more at **bit.ly/AIplacenta**

Metformin

Drug safety update

Following a European review, the product information for metformin is being updated to permit its use during pregnancy and the periconceptional phase in addition to or as an alternative to insulin, if clinically needed. Read more from the Medicines and Healthcare products Regulatory Agency at **bit.ly/metformin_pregnancy**

What's on?

MAY Maternal Mental Health Awareness Month

MAY HG Awareness Month
bit.ly/HGAwarenessMonth2022

3-5 MAY
Maternal Mental Health Awareness Week

4 MAY
World Maternal Mental Health Awareness Day

15 MAY
International Hyperemesis Awareness Day
bit.ly/HyperemesisAwarenessDay

JUNE Sands Awareness Month

20-26 JUNE
Refugee Week
refugeeweek.org.uk

21 JUNE
Father's Day

MIDIRS Digest

1 Reflection for validation: focusing on mental health, Mercedes Taylor

2 Big Birthas – the effect of being labelled 'high-BMI' on women's pregnancy and birth autonomy, Mari Greenfield, Amber Marshall

3 Civility training: a measured improvement to safety culture, Caroline Lacy, Caroline Walker, Anna Baverstock

4 A clearer view to COVID-19 domestic violence and abuse — gaining insight by using a visionary post-feminist lens, Jacqueline Richards

5 Factors that enable midwives to stay in the profession: why do midwives stay in midwifery? Dianne Bloxsome, Sara Bayes, Deborah Ireson

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/EBMjournal**

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book now

Join us for the return of RCM's annual conference, an in-person two day event across 4-5 October 2022 at ICC, Wales!

RCM conference

4–5 October 2022 – ICC, Wales

RECOVER, REFLECT, RENEW

Setting the course for maternity services

Royal College of Midwives

REASONS TO ATTEND

1. Network once again in person with colleagues, friends and thought leaders within midwifery
2. Two days of discussing the challenges faced and lessons learnt over the last 12 months with a look to the future
3. It is free to attend for RCM members
4. An interactive exhibition hall with over 75 exhibitors.

Some of our exciting exhibitors you will see at the ICC Wales

- Antenatal Results & Choices
- Cardiac Services
- CMV Action
- Derma
- Happiest Baby
- Health Education England
- Health Education England's Genomics Education Programme
- Huntleigh
- LabourPains.com
- NHS Wales
- Nursing and Midwifery Council
- Perinatal Institute
- SIMBA
- Solihull Approach
- And many more...

free to book for RCM members
for this fantastic live event

@MidwivesRCM | #rcmconf22

rcmconference.org.uk

Working for you

Here's a round-up of what the RCM has been doing on behalf of its members this month

Actions from the Ockenden Report

NHS chief executive Amanda Pritchard, chief nursing officer for England Ruth May and national medical director of NHS England Professor Stephen Powis have written to NHS Trusts with a list of 15 immediate and essential actions (IEA) following Donna Ockenden's review of maternity services in Shrewsbury and Telford Hospital NHS Trust.

The actions support the report's four key pillars: safe staffing levels, a well-trained workforce, learning from incidents and listening to families.

The report includes a specific action on maternity continuity of carer (MCoC), that all trusts must suspend the provision of MCoC "unless they can demonstrate staffing meets safe minimum requirements on all shifts". The IEA has stated that "Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision."

It echoes the RCM's stance on MCoC: we have been clear, ever since the publication of Better Births, that safe, sustainable implementation of MCoC is only possible with the right investment, safe staffing levels and staff engagement and support.

Read Gill Walton's comments here: **bit.ly/MCoCclashingtruths**
For more, see: **bit.ly/RCMcontinuitystatements**

BLUEPRINT FOR NORTHERN IRELAND

The RCM is demanding improvements in maternity care for Northern Ireland's women. In a direct message to Northern Ireland's politicians ahead of Assembly elections in May, the RCM has asked them to get behind its blueprint to drive safety improvements. More midwives and greater investment in maternity services are also needed. Ring-fenced money for ongoing initiatives to improve safety in Northern Ireland's maternity services must also be put in place, says the RCM.

Karen Murray, RCM director for Northern Ireland, said: "The pandemic has laid bare the precariousness of our maternity services. It will not take much to tip them over the edge compromising the quality of care and there is no safety net. That's why investing in staffing and resources must be a priority for the next government.

"I am appealing to every MLA to put their weight behind our call and support us publicly to make our maternity services the best they can be. Midwives and their colleagues are working incredibly hard to deliver safe care for women, but we must all work together to drive up standards even further. This needs investment, it needs a clear and honest roadmap, and it needs political will and action."

IMAGES: ALAMY / SHUTTERSTOCK

TUC Women's Conference
The RCM told the TUC Women's Conference that the government must fix worsening staffing shortages in maternity services to protect safety of care. Alice Sorby, RCM director for employment relations, said: "We are heading into a vicious cycle of staffing shortage leading to burnout in staff, leading to them thinking of leaving, which will worsen shortages. The safest care cannot be delivered without the right numbers of staff, and we haven't had that in maternity for a long, long time." The RCM's shared workforce service staffing motion was passed at the TUC Conference.

The RCM also had a motion calling on the TUC to campaign for improvements in shared parental pregnancy leave, backed by charity Maternity Action. It called for a new policy that will give each parent individual leave, while keeping the existing rights of mothers to 52 weeks' maternity leave. It also said the scheme must be open to all workers because some on zero-hours contracts may not be getting access.

The RCM also made an amendment to an NASUWT and Royal College of Podiatry motion on women's health calling for better support for women in the workplace with health issues, including those going through the menopause.

Going digital again
After the success of our first digital issue last July, we will run another in July 2022. To receive your copy, update your details with RCM Connect and 'opt in' to email contact.

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

RCM in brief

Recruitment crisis

Pay Review Body evidence

The RCM delivered a stark warning to the NHS Pay Review Body in April that failing to deliver a decent, inflation-proof pay award will speed up the recruitment and retention crisis in maternity services.

Official NHS workforce figures for England showed that in the 12 months to January 2022 there were 410 fewer midwives than at the same point last year. This is on top of existing estimates of a shortage of over 2,000 midwives in England alone. In a recent RCM survey of heads of midwifery (HOMs) in England, 77% said it was becoming "increasingly difficult" to recruit to vacancies; 87% said they currently have midwife vacancies; and 61% said they had to call in bank or agency staff nearly every day. Nearly all those who responded (97%) said they rely on either a significant or a moderate amount of goodwill to run services.

This is borne out by the NHS' own staff survey which found that 83.4% of midwives reported working additional unpaid hours, up from 79% in 2020, and more than a quarter above the national average for NHS workers. The RCM has called for NHS employers to enforce a no-working-for-free policy and says overtime should be used for all hours in addition to contracted hours.

Alice Sorby, RCM director for employment relations, said: "Our members feel utterly undervalued by the government. Morale among staff is at its lowest, last year's pay award was late and by no means enough to keep up with inflation and the rising cost of living. We are at a tipping point.

"The reality is that this isn't just about fair pay for dedicated staff in maternity services, it's about ensuring the safety of the women and families that use them. Many midwives stayed in the NHS out of a sense of loyalty to their colleagues and to those women and families, not wanting to desert them during the pandemic. We feared that it was only a temporary halt to the exodus of experienced staff, and that fear is now being realised as we have seen a month-on-month drop in the number of midwives working in the NHS.

"Maternity services cannot and should not be run on the cheap, and certainly not by relying on staff working beyond their paid hours for free. It's not safe and it's not sustainable. Most midwives and MSWs are at the top of their pay band, and therefore will be entirely reliant on the 'cost of living' pay award that is within the Pay Review Body's gift."

Workforce Race Equality Standard

Discrimination still an issue

The 2021 Workforce Race Equality Standard (WRES) revealed the number of Black and minority ethnic staff experiencing discrimination from colleagues has risen since 2020. The RCM is calling for this to be tackled at organisational level in the NHS.

Worryingly, the report also shows one-third of staff believe their Trust doesn't provide equal opportunities for career progression or promotion for Black and minority ethic staff, the lowest percentage recorded since the WRES report was established in 2016.

RCM executive director, trade union, Suzanne Tyler said: "Significant inequalities not only still exist but are directly affecting the health, wellbeing and safety of midwives, maternity support workers and other NHS staff. The system is part of the problem and ending discrimination must focus on individual and organisational change."

Numerous reports have identified that Black, Asian and minority ethnic NHS staff are more likely to go through disciplinary processes, either locally or through a regulator. As part of the RCM's Race Matters programme, it has recently sought the views of its own Black, Asian and minority ethnic members who have been through or are going through disciplinary or capability proceedings, and from RCM workplace representatives supporting them. This will be used to inform and strengthen its work on supporting its members.

Pregnancy care for all

Migrant maternity charging

The RCM has called for an end to NHS charging of pregnant vulnerable migrant women over safety fears. The worry of having to pay for their care is stopping many women engaging with maternity services, which is especially concerning as many of them are in difficult and dangerous social situations. This includes dependence on exploitative relationships for survival, destitution and homelessness.

The RCM outlined its position on the care of vulnerable migrant women at an event at the Houses of Parliament in February. Clare Livingstone, professional policy advisor at the RCM and author of the RCM guidance, said: "A woman's immigration status should never be a deciding factor on whether she can access pregnancy care." Another major concern is that migrant women can be relocated at short notice (though not after 34 weeks). This can disrupt their antenatal care with potentially serious consequences. The RCM is calling for this to be changed to 20 weeks. After that, they should be settled into suitable accommodation in one place until after the birth and only when a GP or health visitor agrees mother and baby are fit to be moved. Clare added: "Maternity care is deemed 'urgent and immediately necessary'. This means all women in this country, regardless of their immigration status, are entitled to pregnancy care."

Read the Caring for Migrant Women guidance at **bit.ly/CaringforMigrantWomen**

BritishRedCross

BRANCH FOCUS

Bristol and District branch has donated £500 of its branch funds, plus an additional £255 from personal contributions, to the Ukraine appeal on behalf of all members. The money has been donated to the British Red Cross, through Tesco, which has pledged to match any donations received. Naomi, the branch treasurer, would like to say a huge thank you to all who contributed.

MAGGIE'S RUN

More than 80 staff members from **Swansea's Singleton maternity unit** took part in Maggie's Run/Walk 50 Event supporting Maggie's centres and raised a staggering £11.7k! Maggie's provides multifaceted services for families at their most vulnerable time. Midwife Julie Morgan received direct support from the centre three years ago when her daughter was diagnosed with bowel cancer, and she raised £730.

Claire Parkin said: "From a maternity team perspective, it's been such an important team-building time, given the challenges over the last couple of years. It's given us all a massive boost in morale. We have supported each other and have been hugely motivated by the wider Swansea community and online Maggie's group."

New research

RCM Education and Research Conference 2022

This year's conference saw a packed programme of sessions with respected academics and researchers covering topics from 'Improving the childbearing experience for women with obesity' (Dr Rowena Doughty, De Montfort University, Leicester), or 'What are UK nurses and midwives' views and experiences of using social media within their role?' (Anna Marsh, University of Bournemouth) to 'Increasing inclusivity in preregistration education to provide high-quality care for LGBTQI+ people' (Dr Freda McCormick, researcher, Queens University Belfast, and Dr Sally Pezaro FRCM, assistant professor, Coventry University).

The Zepherina Veitch Lecture this year was given by Franka Cadée, president of the International Confederation of Midwives in a timely reminder of the global role of midwives. Her lecture 'Life is not so much about how we fall, but how we get up again!' spoke to the challenges that face midwifery and about finding inner resilience to continue in a profession you are passionate about.

For the full programme, visit **bit.ly/RCMeducationconference**

NEW IN I-LEARN

RCM i-learn

- **Perinatal mental health** – Perinatal mental health
- **Care of migrant and asylum-seeking women** – Understanding asylum seekers and refugees
- **Women with multiple disadvantages and racial bias** – Health inequalities: the power of maternity care; Women and society
- **Multidisciplinary working** – Human factors: reducing errors in maternity care; Undermining and bullying behaviours (an RCOG and RCM collaboration)
- **Becoming an RCM workplace rep** – There are courses on Your rights to time off and facilities for trade union duties, Maternity rights at work, and GDPR for activists

Delivering care

Safe staffing?

The RCM has raised concerns that Trusts are staffing based on their budgets rather than on the levels needed. Birte Harlev-Lam, RCM executive director midwife, said: "Women and their safety are still not being put at the centre of care. If this was the case, we would see significant amounts of additional funding and real efforts to support, retain and recruit staff, and we are not. There is a black hole in the centre of our maternity services where more money and staff should be. I have no doubt this is undermining maternity staff efforts to deliver the safest and best possible care.

"We know also that many staff are still afraid to speak out when they know something is wrong for fear of reprisals and recrimination. We must flip this thinking on its head. Every workplace must have a culture that encourages and supports staff to raise their voice, and then acts on it, because they will be the ones delivering the safest care."

The RCM is also raising a red flag over concerns that regular reviews of staffing levels are not happening often enough. This is particularly crucial when making major service changes such as delivering more personalised care for women. Trusts and Boards should also have escalation plans that kick in when demands on services exceed their capacity to meet them, says the RCM.

More specialist midwifery roles that play a key part in delivering safer and better care for women are also needed. These offer additional and tailored support for women with more complex problems such as mental illness, and physical problems that can affect their pregnancy.

Northern Ireland, Scotland and Wales are also feeling the worrying impact of understaffing as pressures on services increase. Across the UK, these shortages have been deepened by several factors, including limited opportunities for flexible working. This is damaging the attractiveness of midwifery as a career option, says the RCM.

Birte added: "Staff are working even harder and then harder again to continue delivering the safest possible care. They can only do this for so long before they and the system relying upon those efforts breaks, and I think we are close to this. We must once and for all see governments really solve maternity staffing shortages and invest in services now and for the long term."

IMAGES: KATE DARKINS / SHUTTERSTOCK

100 years of progress

Joy Kemp, RCM global professional advisor, celebrates the legacy of International Day of the Midwife

Celebrated every year since 1991, International Day of the Midwife (IDM) provides an opportunity to highlight the difference that midwives can make in the world. IDM on 5 May recognises midwives' unique professional role and achievements while advocating for adequate investment. The theme for this year is '100 years of progress', celebrating the 100th birthday of the International Confederation of Midwives (ICM). The ICM represents 143 midwives' associations (including the RCM) in 124 countries across every continent. Together, these associations represent more than one million midwives worldwide.

Midwives' associations such as the RCM play a vital role in bringing midwives together with a collective voice. They lobby for midwifery to be integrated into health systems around the world, drive up standards for high-quality care and education, and advocate for better pay, better working conditions and professional development. As mainly women-led civil society organisations, they are also advocates for gender equality and for women's rights.

The 2030 Agenda for Sustainable Development, adopted by all United

Nations member states in 2015, provides a blueprint for the wellbeing of people and the planet. At its heart are the 17 Sustainable Development Goals (SDGs), which are an urgent call for action by all countries – both developed and developing – in a global partnership. Midwives provide a link between these goals, offering direction and dexterity in the dynamic drama of the world.

Although 'leaving no one behind' is a key concept underpinning the SDGs, some countries – and certain groups within individual countries – are being left behind. Midwives make a vital contribution towards changing this: we have the potential to avert two-thirds of maternal and neonatal deaths and stillbirths (UN Population Fund, 2021; World Health Organization [WHO], 2019).

However, there is a global shortage of almost one million midwives, and many women across the world have no access to midwifery care – despite this being considered a basic right.

Global work

International engagement is at the core of the RCM's vision. The RCM has a dedicated international team, and belongs not only to the ICM but also to the European Midwives Association and the European Forum of National Nursing and Midwives' Associations, in which it holds key positions.

The RCM is also closely involved with the WHO Midwifery Collaborating Centre at Cardiff University and with WHO Europe. This regional engagement ensures that the UK is in step with its European neighbours regarding midwifery education and regulation; it informs parallel work done in the UK.

As well as being a professional association, the RCM is also a trade union and is connected to the international trade union movement through its affiliation with the Trades Union Congress and its links with the International Trade Union Confederation and the European Federation of Public Service Unions. These links strengthen the RCM's voice on equality and employment rights, and provide RCM workplace representatives with a wider range of development opportunities. Most recently, the RCM has joined with trade unions worldwide in condemning the Russian invasion of Ukraine and in showing solidarity with Ukrainian healthcare workers.

IDM enables midwives and those who support them to recognise their global citizenship

As well as international networks, the RCM has its own global twinning partnerships, such as the most recent five-year partnership with the Bangladesh Midwifery Society and previous partnerships with midwives' associations in Cambodia, Nepal and Uganda. Partnerships such as these can be powerful catalysts for positive change, providing platforms for advocacy and gender empowerment as well as supporting sustainable organisational development.

The COVID-19 pandemic has threatened progress to global development goals and has heightened inequalities. The crises in Ukraine, Syria and Afghanistan demonstrate the challenges of providing high-quality sexual, reproductive, maternal and newborn healthcare in areas of conflict and mass human migration; women (including midwives), adolescent girls and newborns are especially vulnerable in humanitarian emergencies. Climate change is now recognised as a health emergency, with the NHS responsible for over 5% of the UK's total carbon emissions. In the UK, urgent action is needed to improve care for mothers and babies from Black, Asian and minority ethnic backgrounds, and care for those living in more deprived areas. Maternity staff of colour also face racism, discrimination and prejudice in the NHS.

Push Campaign

Despite these challenges, there are opportunities for strengthening midwifery over the next decade. The ICM's Push Campaign aims to accelerate progress on reducing maternal and neonatal mortality, advance sexual and reproductive health rights, address key barriers to women's leadership in the global health workforce, and shift underlying gender norms that undervalue women's rights, lives and work. The WHO has set priorities for midwifery education, jobs, leadership and enabling service delivery; these mirror the RCM's own manifesto for better maternity care. During 2022, the RCM will be developing its international strategy, determining how best to maximise its contribution to these global endeavours.

IDM provides an opportunity for midwives, and those who support them, to recognise their global citizenship and to raise their voices in solidarity for more investment in midwives. Greater investment will give every woman, birthing person and their families access to high-quality, respectful care from a midwife. And that's something we should all celebrate.

MORE INFO

RCM (2019) *Strengthening midwifery leadership: a manifesto for better maternity care*: **bit.ly/RCMmanifesto**

2030 Agenda for Sustainable Development: **sdgs.un.org/goals**

Push Campaign: **pushcampaign.org**

IMAGE: GETTY

Care outside guidance

Lia Brigante, RCM policy & practice advisor, discusses the RCM's *Supporting women seeking care outside guidance* and why it's important to respect choices

The notion of woman-centred care has been at the heart of RCM policy and at the core of maternity policy in the UK for decades. We know that personalised care is safer care, and that having choice and control improves clinical outcomes for women and their babies.

Midwives have a key role as advocates and facilitators of women's choices, particularly when women and families have to negotiate fragmented and under-resourced healthcare systems.

The RCM's *Supporting women seeking care outside guidance* provides midwives, many of whom are working in different models, with guiding principles to facilitate personalised care and women's choices – including when those fall outside clinical recommendations. It is underpinned by the principles of consent as a fundamental right of individuals and by the changes in UK law following the landmark ruling of Montgomery vs Lanarkshire in 2015.

With confidence and safety

In my clinical career, I have worked in a Trust with an established 'OutWith' guidance clinic run by a consultant midwife. The clinic not only enabled women with medical and social complexities to be supported with personalised care planning by a consultant midwife, but it also enabled midwives at all stages of their careers to be supported to provide out-of-guidance care confidently and safely. The mantra from the multi-disciplinary team is 'we may not recommend it, but we will support it'.

This supportive environment taught me a lot and enabled me to mentor and guide junior colleagues and student midwives to improve their skills in counselling women and supporting their choices.

In my first year as a caseload midwife, I cherished the support I received by senior midwifery coordinators as well as my own caseload colleagues when called out to an out-of-guidance homebirth. It has enabled me to help other midwives, often skilled and experienced in obstetric-led settings, to support women at higher risk to birth at home or in a midwifery-led unit.

However, it can be very difficult for midwives in certain circumstances, particularly if there is a conflict between duty of care and the wishes of those in their care. The *Supporting women seeking care outside guidance* looks to address those barriers. It was developed by the RCM, with input from an independent advisory group of experts on the topic, from consultant midwives to academics.

If we listen to women and trust them to make informed decisions – even if they are decisions we would not make for ourselves – we will improve outcomes and ensure safer care. It is important to remember that women are more likely to access and engage with services when their physical, emotional, psychological and social needs are met and respected.

MORE INFO

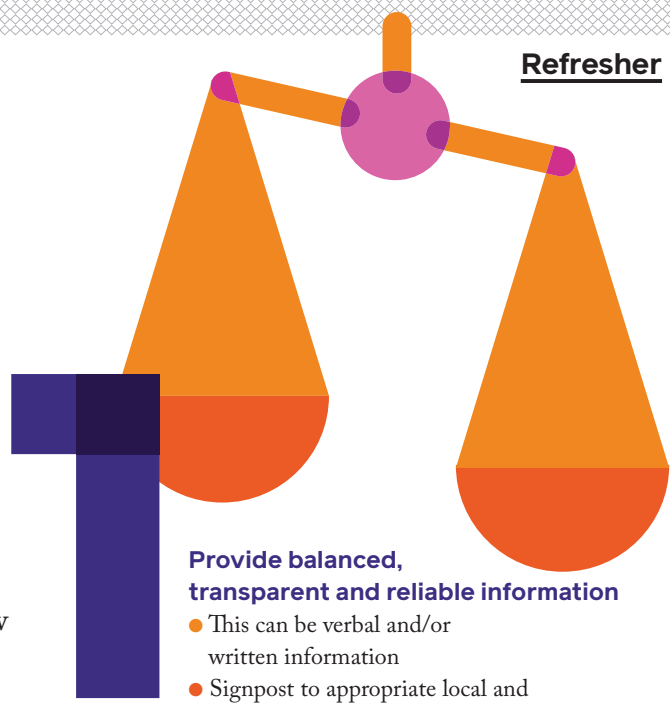
Download the guide at **bit.ly/RCMoutside**

The Montgomery v Lanarkshire ruling can be read at **bit.ly/MontvLan**

IMAGE: ALAMY

Informed decision-making

Women value midwifery support when they make a range of decisions. However, it can be difficult to know how to support informed decision-making. There is a link between safety and a culture of maternity care that listens to and respects the preferences and decisions made by women and families. That's why the RCM has produced a guide to help.



1 Provide balanced, transparent and reliable information

- This can be verbal and/or written information
- Signpost to appropriate local and national guidance and organisations
- Refer to specialist colleagues if required
- Avoid sharing your personal opinion

2 Ensure understanding

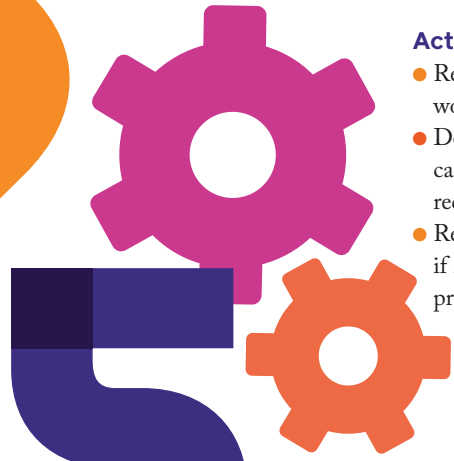
- Provide easy-to-read publications if required
- Provide professional translation services for written and verbal information if required

3 Facilitate the decision-making process

- Consider using a decision aid
- Encourage the woman to ask questions
- Understand that in many situations decision-making is an ongoing process

4 Be an advocate for women and families

- Support the woman as she makes her decision, including if you are not acting as the lead caregiver



5 Act on the decision

- Respect the woman's wishes
- Do not provide any care without first receiving consent
- Refer to colleagues if required in order to provide personalised care

MORE INFO

Download the RCM's *Informed Decision-Making* guidance at bit.ly/RCM_IDM

STRONGER TOGETHER

The Lambeth Early Action Partnership (LEAP) is a success story that shows just what can be achieved with fully funded, safely staffed services

IMAGE: GIACOMO BAGNARA

LEAP is made up of parents, early years practitioners, nurseries, children's centres, Lambeth Council, the National Children's Bureau, NHS Trusts and local community organisations. Its aim is to have a positive impact on diet and nutrition, social and emotional wellbeing, and communication and language outcomes for children aged 0-3. In turn, it aims to influence broader policy and practice through learning about what works. Formed in 2015, LEAP is being funded by The National Lottery Community Fund for 10 years as part of the 'A Better Start' initiative and is hosted by the National Children's Bureau.

Nina Khazaezadeh was instrumental in setting up and securing the funding for the LEAP continuity of carer team. She says: "I was involved in this project from its inception as a consultant midwife in public health, and have continued supporting and overseeing its implementation and progress over the years as a head of midwifery for Guy's and St Thomas' NHS Trust before I moved to the regional team last October.

"The LEAP programme's overall objectives are to improve early childhood development. The evidence suggests that the key areas of nutrition, social and emotional factors, communication and language development have a significant impact on long-term life chances and outcomes and are crucial to reducing health inequalities; midwives are critical in realising the above aims. I have always believed that public health is integral to the midwife's role; as midwives, we have the potential to enhance health during and beyond childbirth and reduce the health inequality gaps in the early years.

"Midwifery is a gateway into supporting and improving health outcomes for women and birthing people, but it also has a tremendous

influence on the next generation. During the early stages of the project, what one mother said to me at one of the stakeholder events has stuck. She lived in a high-rise flat and could see the green park outside, yet she felt isolated. She didn't feel able to go out because of her fear that she may not be safe. Hearing her comment was very poignant and strengthened my belief that these families needed support throughout their childbirth journey and that midwives played an integral part in integrating families into their local communities."

Making a difference

At the heart of LEAP, and at the beginning of each child's journey, is its maternity team. Professor Eugene Oteng-Ntim at Guy's and St Thomas's is the LEAP project's consultant obstetrician. As a professor of obstetrics with an interest in public health, he was working with deprived communities in Peckham when the public health team at Lambeth asked him to help with the pitch for the funding from the National Lottery.

The project's results have been impressive. LEAP covers four council wards in inner-city London, where more than 90% of residents are in the two most deprived quintiles of the English Index of Multiple Deprivation (IMD) and the population is ethnically diverse.

Fetal outcome is affected by social deprivation and parental ethnicity. In 2016, 25.9% of all stillbirths in the UK occurred in the most deprived IMD quintile compared with 14.9% in the least deprived, with a similar distribution for neonatal death.

Eugene headed a two-year study, which showed a significant fall in the number of preterm births for women allocated to caseload midwifery compared with those who received traditional midwifery care (5.1% vs 11.2%). The study showed that a model of caseload midwifery care implemented in a deprived inner city community improves outcome. This data trend suggests that, when applied to targeted groups (women in higher IMD quintiles and women of diverse ethnicity), the impact of intervention is greater.

"What lessons can we learn?" asks Eugene. "One is we need to address inequality. And secondly, prematurity is a significant part of infant mortality. Reducing infant mortality is a significant factor in terms of neurological development, so you reduce the lifetime cost or impact on brain development, as well as physical development, and you improve social and emotional wellbeing. You improve communication and therefore you improve the child's readiness for school by the age of two, which may improve their chances of success by age 11, and therefore improve their life chances later on."

> **It was the first time in my midwifery career that I really felt that we could give this kind of wraparound support to people**

Caseloading care

Rachel Smith is the LEAP caseload team's midwifery practice leader, and cites an example of how the caseload team is able to help someone with significant needs through the LEAP project: "We had a woman who was from a Black and minority ethnic group, who we know are up to four times more likely to die during pregnancy and childbirth. She had significant mental health issues, particularly with depression, and she was finding it difficult to leave the house. Due to this, she had fluctuating attendance for antenatal care. Because of the flexibility in

the way that we work, we were able to offer to see her at home. Had it not been for the caseload team, she probably would have had minimal attendance to midwifery care, and therefore may have been at risk of undiagnosed complications. However, because we were able to offer care in the home setting, she still had access to midwives in a way that was comfortable to her.

"In terms of her mental health, we were able to support her with other LEAP services such as the Parent and Infant Relationship Service (PAIRS) and give her the opportunity to integrate herself into the community once her mental health had improved and she felt ready to do so.

"She had a teenage son, but he lived in the Caribbean and she was very new to the country. When she arrived, she didn't know anybody. With support from LEAP, her mental health improved, and she was able to access services within the community that meant she had the opportunity to make friends and take her child out more to meet others.

"We direct our midwifery service towards those who need us most – typically women who are considered to have vulnerabilities. This takes into consideration a number of factors, including: women with pre-existing mental health conditions; asylum seekers or refugees; women who are experiencing or have a history of domestic abuse; or women who have had social care involvement, either currently or previously."

Awards nomination

The LEAP caseload team has been making great strides, so much so that it was shortlisted for the 2021 RCM Partnership Award. "It was an honour to be recognised for the work that we've been doing. The RCM awards gave us a platform to showcase our efforts and the impact it's making for the women we care for. It was really lovely to be recognised for what we're promoting and achieving," says Rachel.

"Every summer, we contact all the women that have had a baby with us within the preceding year and invite them to come and have a picnic," she continues. "The turnout is always very good, and it's lovely because we get to see all the children and women we've helped care for. When we last saw them, they were newborns, and now they're crawling, which is wonderful."

Carla Stanke is public health specialist for LEAP. She notes that, "Our remit is to deliver a portfolio of services to improve outcomes for pregnant women and their children from birth until their fourth birthday. The remit was never to replace what's currently on offer by Lambeth Council, but rather to enhance it, specifically within the areas of LEAP.

"From a public health perspective, I'm living my dream – to be part of such a really thorough, comprehensive public health programme."

Carla cites continuity of care as a significant part of LEAP's success, but something that's only possible because the project has adequate funding and staffing levels. "What's special about LEAP's continuity of care is that it's given to women who live in particularly socio-economically deprived parts of London."

LEAP director Laura McFarlane agrees. "We based a lot of our thinking around the gaps in provision for families'" she says. "One example is that we recognised that there was very little provision in the parent-infant mental health space in Lambeth. So we developed PAIRS, a psychotherapeutic support service. What we wanted to try and demonstrate is that offering a community of care model to those women would enhance their experience and improve their outcomes.

"We've had an opportunity to talk to some civil servants from the Department for Education and the Department of Health and Social Care. One of the things that they were really

interested in is how are services linked together, because early years is such a diverse and complex system.

"We've got a very strong monitoring evaluation and learning framework, so we've got very high-quality data. We've built a data platform, which is located in Lambeth Council. And we're hoping that they will continue that as part of the borough-wide collection of data."

RCM's policy and practice advisor Lia Brigante is consultant midwife for the LEAP Social prescribing project MyVillage. She says: "MyVillage is another very exciting project. Midwives refer women to MyVillage, which focuses on providing social support to those women who are more vulnerable from a social perspective, across the perinatal period. They are provided with a link worker, a social prescriber and are referred to volunteering group activities – for example, learning gardening. We have a befriending service for young mums, so they can meet each other. There are cookery classes and teaching advisors, and a range of sports, all available for free in the community. There are doulas for women who don't have a birth partner – for example, they might be a refugee arriving here who is completely isolated."

Issy Bourton, LEAP caseload team leader, likes "the fact that it was a targeted area, working with a population of families who lived in the highest level of deprivation, and that there was this gateway to all these other fantastic services that we're running. It was the first time in my midwifery career that I really felt that we could give this kind of wraparound support to people. Not just through the continuity of care that we were providing to all women in their pregnancy and postnatal periods, but for women that had additional needs – whether that be relating to their mental health, or the kind of support that women look for when pregnant, or wanting to get to know people in the area.

"We finally did have the resources and the opportunities for families to get more of the support they needed,

ONE VOICE AND FIRST 1,000 DAYS

Both the One Voice and the First 1,000 Days projects aim to create a better start in life. The RCM, along with the RCOG, is a founder member of One Voice, which brings together organisations working across maternity and postnatal care and support. Its purpose is to represent the voices, experience and expertise of parents and professionals. The RCM also worked on the *First 1,000 Days* report, which argues that the 1,000 days from a child's conception until two years of age are crucial for public health.

Sean O'Sullivan is RCM's head of health and social policy. "If we can speak with one voice across those elements, it makes us much more powerful and influential," he says.

"Last year, we lobbied Hampshire County Council when it was planning to cut a lot of health visitor and school nurse posts. We put in a response to the consultation. The council has now withdrawn those plans to cut posts. Obviously, it wasn't just down to us and certainly I think the Institute for Health Visitors was key, but having organisations like ours coming in to lend support could certainly have helped matters."

The *First 1,000 Days* report came out in 2019. "We had representatives who attended some meetings of an all-party parliamentary group and fed views in, and we were very supportive of the report and its findings and recommendations," Sean says.

"The RCM recognises the importance of giving infants the very best start in life and that maternity services have a key contribution to make that better in preconception care, pregnancy, labour, birth and postnatal care.

"The better the care is, the better the outcomes are for the child. If you then have good services kicking in during the period between when they're born and two years of age and beyond, that's obviously critical."

and the support that was designed for them. Another thing that really made it different for me was the location. Working out of the Children's Centre as midwives has been really revolutionary. Just having that kind of community-based care, making pregnancy less of a medical event and more of a normal event in people's lives."

Community care

Sheila O'Connor runs the Community Activity and Nutrition Programme. "The aim is to support women with their health – their diet and activity," she says. "It's eight weekly sessions with a health improvement facilitator, and we look at a different topic each week. The aim is to help women make small changes that are going to be good for them and good for their baby in terms of ensuring that they get a complete balance of the right types of foods.

"After the weekly sessions, there's a follow-up appointment with me, so we get the feedback, which is obviously important, and see how they've enjoyed the programme. We can also use this to signpost to other LEAP services, and we see them again at six months postnatally, to see how they're getting on.

"One woman really took on all the changes and recipes from the handbook, and got the whole family involved. They gave up takeaways and saved money. They were a large family and the children helped with cooking. They picked a different recipe each time."

Working out of the Children's Centre as midwives has been really revolutionary, making pregnancy less of a medical event

Victoria Craig runs the Baby Steps programme, which was written by the NSPCC. "It's a six-week antenatal programme with a three-week postnatal element to it. We contact them directly with a letter to take part in classes that fit with their due date; we keep the due dates in each group within about four to six weeks of each other.

"The groups are small, with around 10 women, and there's a manual for what's covered in each session, such as healthy eating and staying healthy in pregnancy. It also looks very much into the strains a baby can put on your relationship and other factors in your life, and tries to find ways to strengthen those relationships. We break after six weeks and we invite them back for a further three sessions when their babies are usually about six weeks plus."

Victoria remembers one woman in particular: "She was an asylum seeker and from Community Activity and Nutrition I could see that she really needed support, so I got her into Baby Steps too. That way, even before the classes started, we were giving her support. She was moved out of the LEAP area to a hotel. But she had good support and she attended all the classes. When I first met her, her mood

They know they are providing gold-standard midwifery care while being in control of their working conditions and schedule

was really quite low. She had been moved a couple of times, but she came back for the postnatal visits. It took her an hour and a half from north-west London, and she got on the bus, because she was so proud. She was a completely different person and just so pleased."

Increased satisfaction

One thing becomes clear from everyone you speak to that is involved with the project is their sense of satisfaction. LEAP is a model of mutual respect and good working relationships between agencies and professionals. When a woman presents with additional care needs, whether that's mental health concerns or poor diet and nutrition, the professionals are able to do more than simply refer her to another service – they know exactly who to speak to and make the personal introductions to provide wraparound care.

The project's funding means that it is also safely staffed – something that we all know has great significance. As Rachel comments, "Working within the UK maternity system right now is hard for everyone. Staffing issues are a continuing problem and effects everyone involved. LEAP has been supportive throughout this process and has allowed us to maintain maximum continuity. Luckily, due to this there has not been burnout within the team, but we are aware of the ongoing difficulties the NHS faces. I believe continuity of care provides the utmost job satisfaction within our current climate, and despite the circumstances we've been able to offer women the care they deserve."

In addition to better obstetric outcomes and improved wellbeing being reported by the women in their care, midwives report good job satisfaction, good relationships with multidisciplinary colleagues – and even happiness. As Lia comments: "The LEAP midwives have full autonomy and control over their work lives as well as a sense of belonging to the team; they feel valued and respected by their colleagues as well as the wider LEAP family. They know they are providing gold-standard midwifery care to women and their families while being in control of their working conditions and schedule. This contributes positively to the midwives' improved job satisfaction and low turnover within the team."

LEAP shows what is possible with the right funding. If only its 'gold standard' of staffing, multidisciplinary working and holistic care for women and babies was able to be replicated throughout the UK.

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1. McNulty et al. BMC Medicine (2019) 17:196 Children of mothers taking folic acid throughout pregnancy scored significantly higher on cognitive development at age 3 years and word reasoning at age 7 years, compared to those in whom folic acid supplementation was stopped after the first trimester.

2. L Brough, GA Rees, MA Crawford, RH Morton, EK Dorman (2010) Br J Nutr. 2010 Aug;104(3):437-45 **3**. Agrawal, R. et al. Prospective randomised trial of multiple micronutrients in women undergoing ovulation induction, Reproductive BioMedicine Online December 2011. **4**. A beneficial effect is obtained with a daily intake of 200mg DHA in addition to the recommended daily intake of omega-3 fatty acids for adults.

***Nielsen GB ScanTrack** Total Coverage Value and Unit Retail Sales 52 w/e 29 January 2022. To verify contact Vitabiotics Ltd, 1 Apsley Way, London, NW2 7HF. †For more information on this research, please visit www.pregnacare.com/mostrecommended. ‡Vitabiotics has received the Queen's Award for Innovation on two occasions, in addition to twice for International Trade.

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Sea change

Funded by the Mary Seacole Development Award, Amanda Firth has been studying midwives who care for migrant women with perinatal depression

Why focus on this area of midwifery care? Because perinatal depression is the most commonly diagnosed perinatal mental health condition in the UK and is estimated to affect around 15% of the general maternity population. However, research also shows that less than 50% of women in the general maternity population will receive a formal diagnosis and clinical support for their symptoms. Women may present with symptoms such as persistent low mood, apathy, lethargy, change in appetite, withdrawal from social situations, feelings of inadequacy, shame, guilt and hopelessness.

Some women are at greater risk of not having their symptoms recognised by healthcare services. Women from ethnic minority backgrounds with symptoms are less likely to present to healthcare professionals, and even if they do, they are less likely to receive a formal diagnosis. Some sectors of the population are even more vulnerable in this regard, particularly asylum-seeking and refugee women using UK maternity services. Rates of perinatal depression in asylum-seeking and refugee women may be up to four times higher than the general maternity population, yet they are also among the least likely to receive effective clinical help for their symptoms.

According to national clinical guidance, asylum-seeking and

IMAGE: GETTY

refugee women are maternity service users with complex social needs, which puts them at a higher risk of maternal and neonatal morbidity and mortality. Many (but not all) of the women in this category have fled dangerous situations in their home country such as war or persecution. They may have faced a difficult migration journey and they may also be experiencing post-migration stressors such as social isolation, financial issues, housing problems, complex and slow migration applications and difficulty communicating in a new language. All of these factors may negatively influence a woman's perinatal mental health.

Although national guidance highlights these additional risk factors, it states that there is not enough evidence to make any recommendations about how midwives should most effectively support asylum-seeking and refugee women with symptoms of perinatal depression. Therefore, this research project sought to explore this topic more deeply.

Amplifying the voices of women and midwives

One-to-one interviews were undertaken with 14 NHS midwives in England, most of whom held specialist roles where they frequently cared for migrant women. Midwives were asked about their experiences of identifying and supporting women with symptoms of perinatal depression. Twenty women also participated in one-to-one interviews to explore their experiences of discussing their mood and mental health with midwives, and to consider how this could be done more effectively.

The midwives and women described navigating a maternity system that treated them the same as any other midwife or woman; the system did not recognise that to effectively support asylum-seeking and refugee women's mental health requires additional resources for midwives and services. This decreased the likelihood that the women would disclose or be able to effectively discuss their mood.

Language barriers

Language barriers were the biggest factor affecting whether a woman could disclose low mood to her midwife. Most women wanted to use an interpreter, but felt that it was the midwife who decided whether interpreting services were necessary. On the whole, women felt happy to discuss their mental health with midwives, but were impeded by lack of access to appropriate language support.

"My midwife didn't ask if I wanted an interpreter. It would have been good, honestly. I understand mostly but I cannot always explain it in words"

Midwives described the complexities of trying to arrange interpreters for women, which took a significant amount of time and resources. Although midwives favoured the use of face-to-face interpreters to discuss mental health, they frequently had to rely on telephone-based services. Barriers to using telephone-based services such as Language Line or The Big Word included: only having a male interpreter available; a poor telephone line, which made it difficult to understand what was being said; and the absence of non-verbal communication, which made it difficult to assess how effective the communication was.

When interpreters were used to translate depression screening tools, both women and midwives had concerns over the accuracy of the translation of mental health vocabulary.

Lack of time

Midwives suggested that their employers supported the notion of giving women longer maternity appointments in theory, but in reality their caseload was so large that they were unable to provide extended appointment times. This meant they had to care for women with a complex social history while trying to address language barriers and support their physical and mental health in an appointment of the same duration as those afforded to women in the general population, which wasn't enough. Many midwives were forced to adapt their practice to be able to see the volume of women in the time available to them, which led to asylum-seeking and refugee women receiving less care than midwives wanted to be able to provide.

Women were perceptive of midwives' busyness and described not wanting to be an additional burden to their workload, which prevented women from disclosing

Language barriers were the biggest factor affecting whether a woman could disclose low mood

any depressive symptoms. Both midwives and women agreed that the ability to spend longer with women would encourage them to discuss their mental health.

"If they can talk a little bit longer with us, because I know they are busy and they are doing a lot… If they can ask a little more and then start to ask questions, we will answer"

Falling through the gaps

Midwives were frustrated that symptomatic asylum-seeking and refugee women frequently fell through gaps within NHS systems or were passed between services. Midwives felt that women often did not meet the Western diagnostic criteria for referral into services because women did not fully understand the questions asked during mental health screening. They perceived that the women were frequently turned away from NHS services because their symptoms were deemed to be more of a migration-related stress rather than perinatal mental health concern, which left midwives with the responsibility of finding other sources of support within the voluntary sector. Midwives felt that they were letting symptomatic women down by not being able to find a service that would effectively support them.

Supporting midwives

A small number of midwives worked in well-developed services, but most midwives felt relatively isolated in their role. The emotional labour of supporting this population of women appeared to be invisible to most midwives' employers. They suggested that formal supervision would give them a chance to effectively debrief and develop skills to more effectively

Specialist training on migration and mental health was almost absent for most midwives, who try to source training in their own time

support women's mental health. Specialist training on migration and mental health was almost absent for most midwives, with midwives trying to source and attend training in their own time. Midwives were frustrated by this, alluding that the skills needed to support asylum-seeking and refugee women were not acknowledged by their employers or at a national level in clinical guidance.

"I think if I'm honest with you it feels a bit tick-box; you know, this is something that we need to be seen to be doing… if it was going to be taken seriously, there would be time and money put in to ensure that we were trained"

Implications for practice

For midwives to be able to effectively recognise and support symptoms of perinatal depression in asylum-seeking and refugee women, there must be system-level changes in midwifery, which must include recognition that:

- It is essential to address language barriers if midwives are to effectively discuss perinatal mental health with women
- Failure to address language barriers increases the health inequalities experienced by asylum-seeking and refugee women using NHS maternity services
- Midwives need to be facilitated to spend a greater amount of time in appointments with asylum-seeking and refugee women, particularly when there is a language barrier
- Multi-disciplinary working between maternity and perinatal mental health services needs to improve so that women do not fall through any gaps in service provision
- Midwives need access to formal support structures (such as supervision) and training to enable them to effectively assess and support asylum-seeking and refugee women's perinatal mental health.

This Mary Seacole Development Award research, titled *Midwives who care for asylum seeking and refugee women with symptoms of perinatal depression*, is part of a wider PhD project and additional findings will be published in the coming months.

The full Mary Seacole Award report for this project can be read at **bit.ly/MSA_research**

The RCM's position statement on caring for migrant women can be found at **bit.ly/RCMmigrantcaring** and a pocket guide can be found at **bit.ly/RCMpocketguide**

RESEARCH AND MIDWIFERY

I am a midwife and senior lecturer in midwifery at the University of Huddersfield with a passionate interest in addressing health inequalities for maternity service users. I wasn't always interested in research and in my early career I didn't envisage that I would one day would become involved in it.

Yet practising as a clinical midwife influences your perspectives. I noticed that so much of the research that underpins our midwifery practice isn't actually conducted by midwives, yet midwives are perfectly placed to undertake research. We are degree-level graduates and experts in our field but what we often lack are the opportunities and mentorship to begin that research journey.

I applied for and was fortunate enough to be awarded a Mary Seacole Development Award, aimed at healthcare professionals such as midwives who want develop research skills and receive research mentorship. The awards focus on addressing health inequalities in the UK for service users from ethnic minority backgrounds, which aligned with the aim of my own research project.

Numerous funding opportunities are out there for midwives, and we need to ensure that midwives know about them and feel supported to consider midwifery research as a viable and attractive career option.

MORE INFO

For more information on the Mary Seacole Awards, visit **www.maryseacoleawards.co.uk**
For more details on available research opportunities, visit the RCM Research hub at **bit.ly/RCMResearchHub**

The importance of maintaining skin-to-skin contact for mum and baby during the COVID crisis

Expert midwife, Marie Louise, in partnership with WaterWipes, the world's purest baby wipes, shares her advice and the benefits of skin-to-skin contact, as part of Kangaroo Care Day, while navigating the COVID-19 pandemic.

Skin-to-skin contact and kangaroo care, is a key element in maternity, neonatal and premature baby care. Immediate and ongoing skin-to-skin contact provides both physiological and psychological benefits to all newborn neonates.[1]

Research shows that skin-to-skin contact immediately after birth is hugely important in helping newborns adjust to life outside the womb, supporting mothers to initiate breastfeeding, as well as helping them both develop a strong bond.[1] It is also linked to regulating baby's breathing, heart rate, oxygen levels and temperature, and decreasing the chance of postnatal depression.[2]

How has COVID-19 impacted immediate skin-to-skin?

The coronavirus pandemic has resulted in the implementation of hygiene measures that focus on limiting infection rates, which includes some changes to how parents might engage in skin-to-skin. This can cause additional worry and confusion for new parents.

Changes including social distancing, lockdown and isolation have created challenges and further complications for many families. A Royal College of Midwives report stated that together, they pose a risk to immediate, close and loving contact between the mother and newborn infant, as well as with the other parent and wider family.[3]

In the same report it is noted that some instances, mother-baby contact has been reported as being reduced or stopped. 40% of UK infant feeding services in a recent (unpublished) survey reported that staffing has reduced because of the COVID-19 pandemic, and 30% report that parental access to neonatal units is 'very restricted'.[3]

How can healthcare professionals support new mothers during this time?

Guidelines from the Royal College of Midwives encourage healthcare professionals to support parents with skin-to-skin, and states that separating healthy and non-symptomatic mothers and babies should be avoided to help reduce anxiety and fear. Visual face-to-face interaction with parents is also important for newborn brain development.[3]

The World Health Organization advises that mothers should continue to share a room with their babies from birth and be able to breastfeed and practice skin-to-skin contact – even when COVID-19 infections are suspected or confirmed.[4]

Despite the restrictions caused by COVID-19, healthcare professionals should support new parents to do skin-to-skin, and parents should be reassured that skin-to-skin is still encouraged, safe to do and has numerous benefits for both mother and baby.

About WaterWipes

WaterWipes, the world's purest baby wipes, contain just two ingredients, 99.9% water and a drop of fruit extract. WaterWipes are now 100% biodegradable wipes and also 100% plant based and compostable wipes*. They have been validated by the Skin Health Alliance as being 'purer than cotton wool and water and are so gentle they can be used on premature babies. For more information on WaterWipes, **please visit the WaterWipes Healthcare page.**

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Helen Rogers

An RCM country director

Helen Rogers was a midwife until she saw an opportunity to become an RCM rep – and she's never looked back

More than 30 years ago, I made the mistake of going to a branch meeting where they needed a steward. The rest, as they say, is history. At the time, I was a midwife working in a unit with good management and I was lucky to be mentored by a very experienced steward. All of which gave me good insight into how things worked and meant that I felt very confident about supporting members.

They were very different times: we didn't have smartphones or mobiles, and if I wanted to speak to my regional officer (RO) I would have to ring London HQ to arrange a phone call. Now workplace reps (WPRs), ROs and national officers are often members of WhatsApp groups, in constant communication. WPRs are unsung heroes. They have facilitated time for their trade union duties but I know they always do more hours than they should.

A six-month secondment came up for an RO role covering north-east Hertfordshire. I handed in my notice as a midwife and went for it. It was long hours and a lot of travel but I loved it. I represented midwives and made a difference – getting people what they were entitled to, calling out poor employers and supporting midwives through professional issues. In my early years, I covered everywhere in Portsmouth, Southampton and the Isle of Wight before eventually settling into a permanent patch in the South West.

To anyone considering a WPR role: just do it

I applied for the role as RCM director in Wales as a six-month secondment too. The confidence from my previous roles stood me in good stead – especially as the role involves a willingness to work together with professional bodies such as the NHS leaders and key stakeholders such as the Welsh government. Professional respect, remembering your purpose and your boundaries are vital. As a clinical midwife, I could never have imagined that I'd have a working relationship with the minister for health and social care or even the first minister for Wales.

I'm leaving the role this year, but the challenges I see ahead are the ones that have always been there: financial constraints, training, education, safety and ever-increasing demands on maternity services. The biggest challenge will be around leadership: we need more consultant midwives, directors of midwifery and heads of midwifery. We need respect for the breadth of responsibility those roles carry and bespoke training. Wouldn't it be wonderful to get to a point where advertised posts are oversubscribed?

My advice to anyone considering a WPR role is to just do it. You don't know what opportunities lie ahead or where it will take your career. Clinical midwives and maternity support workers can often feel alone, so it's about standing up for them, supporting them, showing them they aren't alone and that someone is on their side – everyone deserves that. I've loved every minute of it.

Thank you

Robert Ingersoll once wrote "we rise by lifting others"; midwife Sarah Moir's blog thanks those who've lifted her

THANK YOU to all the mentors who supported me throughout my midwifery training, and all the students who have questioned me since. From how to put on sterile gloves, take blood pressures and check urine samples, to measuring bumps, and how to differentiate between a head and a bottom; thank you to the midwives who taught me clinical skills, and who showed me that while practice may sometimes make perfect, no midwife ever is.

To the midwife who taught me, mid nightshift, that it's easier to butter toast with the back of a spoon than a plastic knife; those who show no judgement when I plough my way through a box of Celebrations; and to those who ensure my water bottle is always refilled.

Thank you to the midwife who taught me the benefits of having a staff shower, and the reason that Crocs are the best shoes. To those who laugh at my sweaty scrubs after hours spent leaning over a birthing pool and those who've wiped my brow when I'm sitting sterile under a suturing lamp.

Thank you to the passionate midwifery lecturers, who share their research, the evidence and the knowledge that has guided my practice. From the midwife who proofread my master's thesis at 4am on a rare quiet night shift, to those who put up with me endlessly going on about things I've "read somewhere…"

THANK YOU to the midwife who promised me I would learn to like tea; that I would survive thanks to a strong cup; and to all those who have made me them.

Thank you to the midwife who taught me to bring spare knickers and socks to work.

THANK YOU to the midwife who subtly handed me a fresh pair of scrubs when a busy shift without a break led to me bleeding through my trousers, and to the midwives who turn off the lights in the staff room when I've fallen asleep upright on the sofa.

Thank you to the midwives who taught me it's okay to cry – and who showed me the best hiding places to do so.

THANK YOU to those who take the time to explain why, to those who I am confident in seeking a second opinion, to those who take over when required.

Thank you to the midwife who assured me that everybody makes mistakes, that we are all human and we can only ever do our best.

THANK YOU to all those who've come to my aid at the sound of an emergency buzzer, who have taken and given direction and have provided the most necessary of debriefs.

Thank you also to those who put their trust in me, those who seek me out when they question their own judgement, to those whose faith builds confidence in others.

Thank you to the those who work tirelessly, passionately and without judgement to improve working relationships and friendships. Thank you, midwives.

Thank you to the midwives who've told me I've got make-up down my face, leaked pen all over my uniform or meconium up my arms. Thank you to all those who followed it up with "we've all been there".

Feeling inspired? Send your 'thank you' notes to Rebecca@midwives.co.uk
Read more from Sarah at sarah.moir.co.uk

IMAGES: SHUTTERSTOCK

Pieces of the puzzle

Final-year student midwife Harriet Laing has invented a puzzle that helps families to visualise their mental health and how to support it

As part of a public health module in the second year of study at Coventry University, we were tasked to create an artefact to help spread public health messages to the families we work with. I wanted to create a tool to support women and their families in discussing mental wellbeing in pregnancy. It would help them identify the potential impact a new baby could have on their life, and the resulting ripple effect on mental health.

Mental health and wellbeing are a priority within maternity service. Research conducted by the Royal College of Obstetricians and Gynaecologists in 2017 found that one in five women develop mental illness during pregnancy and the 12 months following birth. It also found that 81% of women surveyed reported that they experienced a maternal mental health problem, two-thirds of whom experienced low mood, while half of these women reported anxiety and a third reported depression. While three-quarters of survey respondents had no previous history of mental illness. Tragically, maternal suicide remains the leading cause of direct death within the first year after birth, and the fifth most common cause of maternal death during pregnancy and puerperium.

That's why I decided to create a mental health puzzle to be used as a primary prevention tool as well as supporting secondary intervention with service users who have pre-existing mental health concerns. The

puzzle includes eight different factors that affect mental wellbeing, inspired by the NHS's 'five steps' approach.

Mindfulness

Research suggests mindfulness activities such as colouring and completing puzzles have a positive impact on mental wellbeing, improving behavioural regulation, psychological symptoms and emotional reactivity. The mental health charity Mind recommends puzzles and other tactile activities to assist with mental health problems, both to practice mindfulness and while experiencing crisis. The puzzle was designed to be used within a parent education setting to encourage connections between other expectant parents to support the development of a sense of community within the session.

NHS FIVE STEPS TO MENTAL WELLBEING

1. Connect with others
2. Be physically active
3. Learn new skills
4. Give to others
5. Pay attention to the present

bit.ly/NHS5stepswellbeing

The puzzle is a visual representation of good mental wellbeing. Within the session, groups would be formed to complete the puzzle together and discuss their relationships with the factors present. Sleep is universally affected by the arrival of a new baby; as part of the session, these pieces would be removed. A discussion would occur about how lack of sleep affects mood, communication, diet, exercise and relationships; each piece would be removed in turn to reveal significant gaps in the mental wellbeing picture. This becomes a visual representation of how new parents become more vulnerable to everyday stresses following changes to lifestyle in pregnancy and puerperium. The group would then discuss coping strategies to build these pieces back in to complete the puzzle, encouraging couples to consider ways to prepare antenatally to reduce the impact on mental wellbeing.

Holistic approach

The puzzle has been designed using a life-course approach to health. Pregnancy is a period of transition; positive steps to improving health and wellbeing at this point may improve outcomes for women and their families. It is designed for women to use both within a parent education setting to discuss mental wellbeing with their peers, while accessing professional and peer support. It is also for use at home with their partners, children and wider family to encourage discussion. It serves a secondary purpose to educate families on the importance of mental wellbeing because half of all lifelong mental illnesses start before 14 years of age. Early intervention with families could save £5.2bn per year and improve outcomes for children in health, education employment and relationships.

The puzzle has purposefully been designed with large print and minimal text to encourage independent conversation and ensure accessibility. The minimal text is also appropriate for families with limited English language skills. The individual words can be easily translated, while further information is accessible via web links printed on the back of the puzzle pieces, including NHS, Mind and Change For Life web addresses. One piece features the telephone number for Samaritans should service users find themselves in crisis. The piece is subtle and small enough to keep in a purse or pocket to have to hand if needed.

The puzzle is designed as a physical game, but I'm looking into how it can be made into an app and how to access funding so it can be rolled out in wider maternity service. I think it has the potential to help people, and I hope to use this tool as a newly qualified midwife to help families access appropriate support in their transition into parenthood.

Half of all lifelong mental illnesses start before 14 years of age

IMAGE: GETTY

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Lavender blue

Kate Allon, specialist perinatal mental health midwife at Darent Valley Hospital in Kent, and Debbie Johnson, senior midwifery lecturer at the University of Greenwich, London, believe mothers with mental health conditions and suffering sleep deprivation can be better supported

Many women of childbearing age live with severe and enduring mental health problems. In UK maternity services, additional focus has been placed on perinatal mental health, especially for those women identified as being at increased risk of post-partum psychosis. Women with severe mental health conditions such as bipolar disorder are at a higher risk of postnatal psychosis when sleep-deprived. And as we are all aware, childbirth is typically associated with sleep disruption; in fact, it has been suggested the common factor of both non-puerperal mania and postpartum psychosis is the lack of sleep and disruption of circadian rhythm before an episode.

'Lavender Mothers' is an initiative to implement a sleep hygiene programme on the postnatal ward for women at higher risk of postpartum psychosis. Any women who has previously experienced psychosis or bipolar disorder is classed as being suitable to be a lavender mother – named after the sleep-promoting plant.

Identifying women with prior mental health issues allows healthcare professionals to give extra support in the postnatal period to try and aid a restful night's sleep. It was also hoped that using the word 'lavender' to identify this group of women would reduce the risk of stigmatism, which often surrounds mental health.

Lavender Mothers

The initiative aims to reduce the amount of time women are woken in the night, thus reducing their psychosis risk. Sleep is crucial in preventing a decline in mental health or a psychotic episode; this doesn't mean the women should sleep all night without caring for their baby, but where possible they should have periods of unbroken sleep. And reducing sleep deprivation during the perinatal period may offer a cost-effective method for preventing, and potentially treating, postpartum depression and psychosis (see box).

Introducing the sleep programme to a busy NHS maternity setting required some changes in practice to facilitate the

IMAGES: ISTOCK

service. It is acknowledged that women with a risk of major postpartum mental health issues should have a written plan for their management, including risk reduction strategies, which may include allocation of a side room (if safe and practical to do so) or helping to feed the baby overnight.

High-risk women should also have a care plan agreed for the neonate immediately after delivery for non-invasive baby observations such as temperature, breathing and heart rate. These observations must be carried out every four hours for 12 hours post-delivery to screen for neonatal withdrawal to psychotropic medication (to be performed without disturbing the mother) and they do not include invasive testing such as blood tests or intravenous antibiotics.

Labels without stigma

Under the initiative, a laminated lavender sign is attached to the door or curtain to make all practitioners aware of the woman or birthing person's consent and circumstance. This is not used to segregate or stigmatise women with mental health conditions. In addition, with consent, a sticker is added to the front of her notes that she is a Lavender Mother under the care of the consultant obstetrician and lead in perinatal mental health. The sticker has details of the woman's consultant and a picture of a lavender flower, but no further details about diagnosis or treatment to promote discretion and confidentiality.

This sticker again helps midwives and healthcare professionals identify the woman as someone who may need extra support in the postnatal period to help achieve a period of unbroken sleep. This sticker also shows consent for all routine observations to be completed on the baby without waking the mother and, as mentioned, does not include invasive tests.

The sticker denotes that, in prior agreement with the mental health team, that a side room should be offered postnatally if available and, where possible, the women should have help with her baby overnight by a relative, partner or maternity support worker. If available, a side room allows the woman to sleep; midwives will not wake them to make observations on the baby unless they are invasive tests or if there is something wrong. The side room also stops cleaners and Bounty workers knocking and disturbing them without first speaking to the midwife caring for them.

Making plans

Individual care planning takes place prior to the birth, with the perinatal mental health midwife and the consultant obstetrician discussing the sleep hygiene project, the baby's arrival and how to maximise rest while caring for a baby.

A plan of care is clearly outlined with the woman, which includes a feeding plan while in the unit. Women who choose to breastfeed will be encouraged to express milk during the day for nighttime feeds; other options are to use formula for night feeds, or they can ask to be woken only when necessary to feed.

The sticker identifies who the woman's perinatal mental health care coordinator is and how to contact them; this is aimed at promoting better information-sharing between professionals and the wider multidisciplinary team. It acts as a prompt for postnatal midwives to notify the woman's care coordinator of the birth and it prompts the midwives to realise the women will need 28-day postnatal care. The woman's mental health care coordinator will be notified again before discharge to help women have a seamless transition of care through mental health teams and maternity.

Sleep is crucial in preventing a decline in mental health or a psychotic episode for mothers at risk

The initiative was piloted three years ago and has proved so beneficial that it has been embedded in the unit and is working well. Women are now quickly identified as being at higher risk of relapse in mental health when they come in for birth, which prompts midwives to check for the women's mental health care plans and assess what medication they may be taking.

Feedback from the women themselves has been overwhelmingly positive, with many reporting that they have felt "well looked after" and "really supported", with all those involved in their care party to the same information so that postnatal care runs smoothly. One new mother commented that it was a relief to know that she had space to rest. Lavender Mothers is a simple yet effective system to help those with poor mental health to get a better night's sleep and hopefully a better start in the postnatal period.

FINANCIAL CONSIDERATIONS

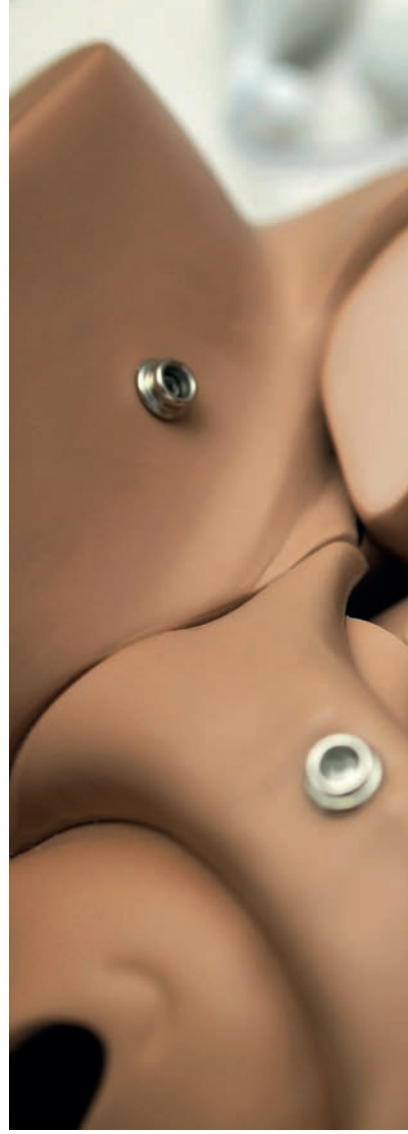
Perinatal depression, anxiety and psychosis create a combined long-term cost to the UK of £8.1bn per year. The cost of a mother and baby bed on a specialist mental health unit is £684 per day.

On average, a woman with new onset puerperal psychosis will spend 6-12 months in the care of specialist services following an episode. This has a staggering cost to the NHS of at least £124,488 per case for every six-month stay.

The proposed Lavender Mothers project is a fraction of this price (3% annually) in comparison with the potential cost (per day) of just one woman becoming mentally unwell during the postnatal period. This covers the cost of the stickers for one year for womens' notes, and no extra staff were required to fulfil this role as identification and support of mental health conditions is part of the midwife's role and remit.

Bridging the gap

Yeovil District Hospital researchers Bea Chubb, Becky Cockings, Emma Symonds and Janine Valentine plus Vanessa Heaslip of Bournemouth University set out to identify and tackle implicit bias in training



In 2021, the MBRRACE-UK report into maternal deaths revealed that there has been no statistically significant change in disparities of outcome for Black and Asian women since 2014; Black women are four times as likely to die during pregnancy or shortly afterwards than white women, while Asian women are almost twice as likely to die.

There are also disparities in infant mortality. Stillbirth is more than twice as likely in Black families than in white families, and Black babies are 43% more likely to die during the first month of life. Also, Asian families are 60% more likely than white families to experience stillbirth and neonatal death.

Targeted initiatives to reduce stillbirth and neonatal deaths, such as the Saving Babies Lives Two Care Bundle, have had more of an impact for white families, and the reasons for this are likely multifaceted. Fewer than one in three UK Trusts or Boards provide training on clinical signs of deterioration for Black, Asian and minority ethnic women and babies, nor do they provide cultural competency training.

Most training, textbooks and guidelines have pictures of exclusively white skin, as does the APGAR tool. Within many Trusts and Boards, there are no resuscitation mannequins that reflect Black women or babies. This can potentially affect midwives' ability to recognise, assess and care for women and babies from Black, Asian and minority ethnic groups.

Training gap

The authors undertook a quality improvement project that aimed to design, implement and review a training package that would address the issue of poor assessment of babies from Black, Asian and minority ethnic groups by using appropriate resuscitation mannequins. Implicit bias, stereotyping and inequalities were also discussed. Pre- and post-training surveys were developed to establish baseline knowledge and the impact of the training package.

The training was well evaluated by participating midwives, with 98% saying they had gained new knowledge and understanding. However, as positive as this is, it highlights worrying gaps in midwives' knowledge on issues related to race, diversity and health inequities prior to the training. Significantly, 98% stated they will change their practice – this included hands-on care, the language they use and the advice given to parents.

The dangers of unchecked and unchallenged bias have been evident since research by Clark and Clark in 1939. Despite this, our project identified that 38% of midwives had not heard of implicit bias before receiving the training.

Midwives have a responsibility to provide equal opportunities and eliminate discrimination; continued poor awareness of implicit bias and its effect on the safety of those in our care must be understood in order to provide families with the safe and personalised care they are entitled to. The training midwives receive must support them to do this.

Current training provision is not able to do so – this is highlighted by

IMAGE: ALAMY

Ledger et al (2021), who found that less than a third of healthcare Trusts and Boards provide cultural competency training, or training to understand clinical signs in Black, Asian and minority ethnic women and babies. Not only could this oversight in training be described as institutional racism, but it could also be a contributory factor in the poor outcomes for women and babies.

Recognising the signs

The death of a three-month-old baby boy, despite the mother's concerns, in September 2018 showed that important clinical signs – including assessment of colour and rash – were missed. Following this tragedy, a Healthcare Safety Investigation Branch report recommended that the Chair of the NHS system-wide paediatric observations tracking programme should ensure resources are

Most training textbooks and guidelines only have pictures of white skin

produced to include examples of Black, Asian and minority ethnic children demonstrating signs of serious illness. It could be argued that using 'pink' as part of the assessment in the APGAR score at birth perpetuates a culture that does not recognise or see babies from Black, Asian and minority ethnic groups – some babies will never be pink. As such, the 'colour' aspect needs adapting to appropriately assess colour in all babies.

Sigurdson et al (2019) describe disparities existing at all levels – structure, process and outcome – within neonatal units that disadvantage Black babies. Therefore we are excited that one of the next steps with our project is to scale up the training to include neonatal nurses. The training will also incorporate signs of unwell women from Black, Asian and minority ethnic women as well as babies and further discuss bias and the importance of personalised care, listening to women and their families at the centre of this.

The authors believe implementing a training package addressing the issue of assessment of Black, Asian and minority ethnic mothers and babies, alongside encouraging midwives to understand and work with their own biases will improve outcomes for families. While we recognise the reasons for inequity are multifaceted, ensuring midwives assess their own biases and are aware of the potential for institutional racism is crucial.

MORE INFO

How conditions present in Black and brown skin: **bit.ly/MindTheGapHandbook**. For more on the training, email **Bernadette.chubb@ydh.NHS.uk** or **Rebecca.cockings@ydh.NHS.uk**

On your side

Workplace reps – stewards, health and safety, learning and MSW advocates – are the RCM's front line, supporting, advising, representing, sharing information and caring while working alongside members

IMAGE: SHUTTERSTOCK

Midwife Mary Ann Gillan has been a steward for the RCM Fife Branch for five years

My motivation is getting people a fair deal and advocating for them. In the past 10 years I've seen the RCM be more active as a union, standing up for the rights of members and having a stronger voice, and that made me want to get more involved.

I think members don't always realise what we do behind the scenes: attending staff-side meetings, working with other unions, attending area partnership forums with management, ensuring compliance with Agenda for Change and any up-to-date terms and conditions. As stewards we have input and can influence for the benefit of our members.

For example, over the past two years we've had a huge issue in Fife with staff not being paid correctly for annual leave dating back to 2008 – but, working with other unions, we were able to come to an agreement for the back pay owed.

We also have a good relationship with the assistant director of midwifery and the head of midwifery who support the Fife Branch and really want to engage with the RCM. They listen and respond to our concerns to stop things escalating – that's a vital part of the role.

I wish people came to me more. I can raise something and they don't have to put their name on if it helps. I don't like to think of staff sitting there concerned and worried and wondering who could give them advice.

Reps are unique in being able to support midwives and maternity support workers (MSWs) in issues relating to their practice – as a midwife myself, I have better understanding.

I think members don't always realise what we do behind the scenes: as stewards we have input and influence

Community MSW Sarah Richards, at Imperial College Healthcare NHS Trust, became an RCM Steward and an MSW advocate in August 2020

I have a disability and I'm a single parent, so I didn't know what I could bring to the table. But I was isolating because of COVID-19, so I thought I'd try something new.

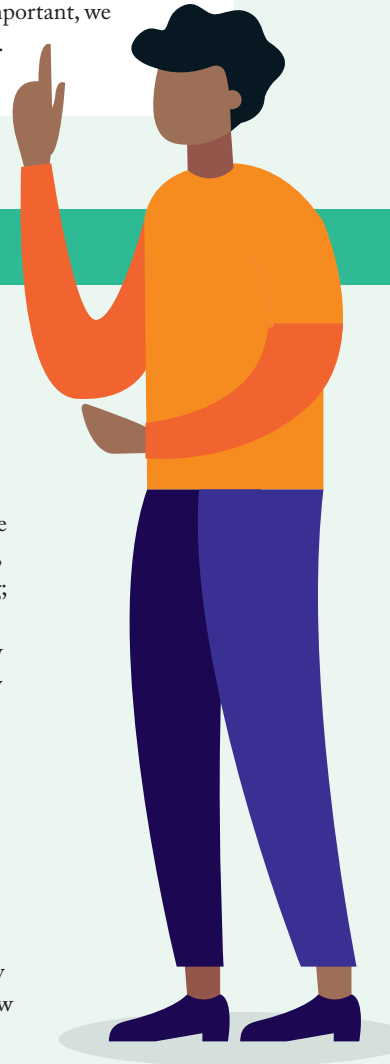
I did all the training I could because I was a complete novice, and there was a whole world of things I needed to be able to do in order to support members as a steward.

That nervousness has gone now with the massive amount of support I've had from the branch, from the regional officer and from RCM organiser Lyndsey Wheeler. I can call them any time and they will get back to me the same day; I am never alone.

I have learned to read a lot – policies, guidelines, steps in place. I will meet with a member, find out what the issue is and, importantly, what outcomes they want, then go and do my research and get support if I need to.

I also meet with the head of midwifery and I'm on 17 working groups covering disability, policy, guidelines and ways of improving services and staff conditions.

As an MSW advocate, my biggest driver is raising awareness around speaking out. MSWs can feel 'less than' or 'lower than', as I did once – but I want them to know we are important, we are valued and we have to speak up.



MSW Stephen Hiles is a maternity IT coordinator, branch secretary, steward and MSW advocate at Northwick Park, London

Because I'm not a midwife I thought I couldn't be a steward. But, although I can't represent midwives if there is a clinical issue, I can do this role. I absolutely love it. We are the link between the shop floor and management. I am here to listen and to help, and if I can't help, I will find someone who can.

It is a big responsibility, and that can be intimidating – but the RCM equips you with an abundance of material, knowledge and back-up; the support system is phenomenal, but you never know that until you step forward.

As branch secretary I am engaged in the day-to-day running of the branch. In my role as MSW advocate I am a voice for MSWs – if they have a query, need validation, or if they just need someone to hear them.

As a steward too I am often just there for people who want to let off steam – they don't need to raise anything officially. But likewise, if they do have an issue, we are the first port of call. We can give advice, or, if they want us to, represent them in a meeting; we're there to help and support our members – how much help and support they receive is up to them.

There are more than 200 members at our branch, but the vast majority haven't opted in to receive emails from the RCM, so it's hard for us to get in touch. We need members to engage, or how can we know what they want and how can they know what we have to offer?

Midwife Lorna Duncan has been an RCM steward in NHS Tayside for three years

I thought it just meant being a bit vocal and standing up for our rights – I didn't appreciate before how much I would be involved with. I am the only rep in our hospital area; I have 7.5 hours a month for union duties, but it could be a full-time job! I can't believe the amount of learning opportunities I've had, and the people I've met through this. It is interesting work – I think that's why I've been able to recruit two more stewards from among our community midwives.

I've looked after mums and babies for a long time, and I wanted to do something for midwives. I've seen them leaving, I've seen them sad and disillusioned – and I wanted to do something to help them stay. I am that link between the union and the members, bringing help to midwives on the shop floor.

One of the biggest things I've been involved with has been organisational change and the move to continuity models. Management was trying to do that without enough midwives, and with very little engagement. With help from the regional officer, we were able to get them to delay implementation and go back to the beginning, work more with midwives and follow the right processes.

We need members to engage, or how can we know what they want?

Midwife Jayne Frank is a learning rep and chair of the RCM Cardiff Branch

My primary role is organising learning and development events. I started with 'breakfast and learn'. I'd heard the phrase 'lunch and learn', but working in maternity 'lunch' doesn't really happen, so we did breakfast, catching people at the beginning or end of their shift.

I am a fetal medicine specialist midwife, so I began with what I knew and invited my lead midwife to come in and present. We had 10 attendees for the first one, then it snowballed – we were doing one or two 'breakfast and learns' a month, with 30 or so people attending, including from other disciplines – doctors, support workers, nurses, physios – some of whom wanted to present. It was really beneficial.

After COVID-19 hit we went virtual and now we're hybrid, holding live sessions that people can attend, live stream at home, or watch later – some get hundreds of views. It's about what appeals to members and on-the-hop learning – if there are any changes to the management of a particular condition, for example.

We put on formal learning events too. Recently we were able to get funding from the Welsh Union Learning Fund for a training course run by the charity Birthrights focusing on facilitating a woman's right to informed choice and consent; we're currently offering an aromatherapy course in collaboration with another Welsh RCM branch. We also do a lot to promote the RCM's iLearn modules, regularly highlighting and sharing them with members.

It's all about promoting the value of learning by signposting colleagues to a variety of different learning opportunities both professional and personal, while promoting good practice by encouraging, assisting and supporting members with their learning needs. The Cardiff branch is a community I'm so proud to be part of.

Midwife Ann Saunders has been an RCM steward in Swansea since 1991 and is a former chair of the RCM's Welsh Board

As a rep, you are often an intermediary between the member and management – you can collaborate with each other to get the best for that person. It doesn't always work, but you're trying to find that middle ground.

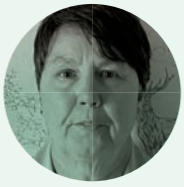
It means that care is better. If midwives aren't aggrieved, then women benefit from that. That is part of what I do every day, because when staff are unhappy, you see it in the dashboards, complaints go up, you start having to do statements – one thing can't be divorced from the other. It's like a pebble in a pond – it affects everything, unless you can stop that pebble going in. Grievance procedures don't benefit anybody; I try to avoid going down that route unless there is a serious issue that needs addressing.

Being a steward teaches you to have an all-round appreciation of an issue – you might not agree with something, but you can see why it's happening. You become more aware, better at reading people and situations.

You develop a good relationship with the managerial strata – who are often members as well. If you're not banging on the door every day, then when you have an issue they will listen. You learn to never go into a meeting without preparation and to never just go in with a problem but to also have a solution – it's very difficult for people to turn you away.

Grievance procedures don't benefit anybody – I try to avoid them

MSW Sally Morgan is a steward, MSW advocate and the branch chair at RCM Tameside



I spend a lot of my time introducing myself to new starters, making people aware of training opportunities, organising events and trying to get members involved in the RCM – organising celebrations for International Day of the Midwife and MSW Week for example.

I attend regional training days – updating, sharing ideas, networking. I like to have the knowledge so I can do my role properly and support members. Not being a midwife, I can't represent midwives with clinical issues, but I can represent them with other things – sickness reviews, for example.

A lot of it is about visibility – letting people know you're there and can support them, whether they want to have a bit of a moan and feel better for it, or if something needs to be escalated and resolved.

Morale is so low across maternity at the moment; it's important to let members know they're not alone. I really want to help people – when colleagues are happy and morale is good, it passes on to women and families; when we're at our best, we can give our best. The role we play as workplace reps is important. Staff really need that go-to person. And I really enjoy it – I've been doing it so long I just consider it part of my working life.

Midwife Toni Wood is a steward and chair of the RCM North Wales Branch, which covers three maternity units across an area ranging from the Welsh border (Flintshire) as far west as Anglesey

We're a small but active branch and I have the opportunity of working two days a week for the union. This allows me to work in partnership for our members. My duties include participating in organisational meetings to share the voice and concerns of members. I participate in workforce meetings and attend the women's board meetings as well as the staff-side forums with the rest of the union reps.

One of the day-to-day things that keeps me busiest is attending sickness reviews with members. Often people don't come to me soon enough; I am always surprised when members don't realise how much the RCM can help them.

I attend staff-side meetings, workplace partnership meetings and team leader meetings. My role is to pass on the views of staff and share information back – keeping communication flowing in both directions. People can come to me with things they feel they can't raise elsewhere. I can help make change feel a bit less scary, and go into the places where there are issues. I hear the stories from both sides, and can help people meet in the middle, or suggest solutions.

I tend to go down the 'coffee and a chat' route rather than the formal route. One of the things I really like about the job is the human touch, and how much people seem to benefit from knowing they're being listened to.

MSW Ana Galvez Romero is the branch health and safety rep and MSW advocate at Guy's & St Thomas' NHS Foundation Trust

I love giving a voice to people who have been overlooked in maternity services – for example, when the Trust was giving bonuses to midwives only and MSWs were overlooked, we were able to raise that and make the point all staff should be looked after and rewarded in the same way, regardless of their grade – we have all gone through so much together during the pandemic. We fought the good fight and managed to get bonuses for MSWs as well.

There is also the issue, at least in my Trust, that MSWs don't have any prospect of development except moving from Band 2 to Band 3. So last year I gathered all the relevant information for the Trust to be able to offer the new MSW apprenticeships and let the practice development midwives know – and now our Trust is offering MSWs the opportunity to undertake the apprenticeship.

It feels wonderful to be able to help so many people and address concerns they've had for years. I have had so much training and so many networking opportunities too – it is a great experience, personally and professionally.

I have only just completed my training as health and safety rep, but it is quite a different role. I have a legal duty and a responsibility to raise any issues related to health and safety that I am made aware of. For example, we've been having complaints that the birthing pool is not ergonomic and midwives are straining their backs – that is something that needs to be escalated and addressed.

MSW Chrissy Walsh, RCM steward and MSW advocate at Imperial College Healthcare NHS Trust

I have always been passionate about trying to improve wellbeing and speak up for staff, so when I completed my membership I applied to be a steward there and then, and later became an MSW advocate too.

I have really embraced having a platform and a budget to be able to show members there's more to the RCM than just paying their fees every month. When COVID-19 hit, we created 'Caring for You' packages of coffee, cake and goodies to keep staff going. For the International Day of the Midwife (IDM), my kids created a butterfly logo – which has now become our branch logo. We use it on branch merchandise – the proceeds go into our wellbeing kitty. We've also organised massage sessions, bought TheraBands and provided stretching sessions to teach staff how to use them, as well as stocked fruit bowls on each unit.

For IDM and MSW Week we host a week of training opportunities, wellbeing sessions and finish with a celebration – and we launched the first enrichment week to recognise our students last year too.

As RCM steward I've become involved in the staff-side and partnership meetings; I am part of consultations and working meetings, able to voice concerns and share how changes affect working practice. As an RCM branch we're here, alongside members. We know what's going on and we understand – who better to represent you?

Midwife **Noreen Robinson** is an RCM steward for the RCM Greater Glasgow and Clyde Branch, within one of the biggest health boards in the UK

A lot of the time I take the role of a counsellor – I have people phoning me up all hours of the day and I will try to allay their fears, and do as much for them as I can. Sometimes they need just a friendly face, or someone advocating for them, making sure everything is done by the book.

It can be stressful, and as stewards we feel spread a bit thin at the moment. But I get a lot of satisfaction from what comes back; members are so thankful and that gives me a lift. I feel I've achieved something.

I still do clinical shifts, as do my colleagues, so we see the issues ourselves – the disillusionment and frustration. We organised a staff survey to hear members' views. The response rate was very high – staff poured out their hearts, and to see it written down in black and white was upsetting.

The survey results were collated in January and now we're in the process of meeting different groups to see how we can work in partnership with management to improve working conditions and staff morale. It won't be a quick fix, but I hope we can make some things better.

I would encourage younger midwives and MSWs to take on RCM branch roles. It's improved my communication and my confidence; it's opened doors and I've learned about and experienced things I would never have thought of before.

The support is there – you just need to access it

Midwife **Claire Sayan** has just completed a nine-month secondment to the RCM as a regional officer for Yorkshire and Humber, and is now returning to her former role, picking up the reins as an RCM steward for the Sheffield branch too

I became a steward in 2018 because I hate injustice of any kind and I was passionate about people having a voice. This role has allowed me to channel my energy in a positive way and it's given me a different view on working together to find solutions.

An important part of the job is keeping the dialogue open between midwives, directors of midwifery and heads of midwifery, feeding back to them all the time rather than letting things build up and blow up. It's also vital to have midwifery representatives on local staff-side partnership forums at a Trust level.

As a regional officer you work directly for the RCM overseeing all the workplace reps – the stewards, the health and safety reps, the learning reps, the MSW advocates. You also sit on different groups and have a regional oversight, which allows you to be better informed to negotiate and challenge.

For example, when some Trusts in my region were managing long COVID-19 badly, I could use an example of what was happening in another Trust to encourage them to change their approach.

We are there when things go wrong, to represent someone in a disciplinary hearing or sickness review, but we are also there for branch meetings, webinars, training, advice, or as a shoulder to cry on, as well as to share with members what the RCM is doing for them at a national, regional and local level.

If people engage all the time, not just when something goes wrong, it allows us to be proactive rather than just reactive. That support is there – you just need to access it.

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

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