RCM COMMUNITY

SUPPORTING OUR COMMUNITY OF MIDWIVES, STUDENTS AND MSWs

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How to lighten the hidden weight of caring

DREAM TEAM
Meet the maternity care assistants on a mission

QUALITY IMPROVEMENT
Don't lose heart if you're in a service under review

Digital care

TECHNOLOGY USE IN MATERNITY IS HERE, SO MAKE IT WORK FOR YOU

Volume 29 / January 2026

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1. National Health Service (NHS), Itching and intrahepatic cholestasis of pregnancy, https://www.nhs.uk/pregnancy/related-conditions/complications/itching-and-intrahepatic-cholestasis/ (last accessed December 2025)
2. Black MM, Ambros-Rudolph C, Edwards L, Lynch PJ. Obstetric and Gynecologic Dermatology. London: Elsevier Health Sciences UK; 2008.

MEN-304-1225 Date of preparation: December 2025

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COVER IMAGE: ALEKSANDAR SAVIC

Building a community

Improving working life

Amplify your voice

Inspire

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

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RCM CEO **Gill Walton** says safe care needs safe staffing

"We hear you loud and clear"

The new year has brought continuing pressure for many of you, facing staffing gaps and a system that often feels at odds with the high standard of care you strive to provide. Despite this, you are providing exceptional care, holding everything together and being there for women and families during the most transformative and emotional moments of their lives. Your commitment to safety, advocacy and compassion is nothing short of extraordinary and you should feel immensely proud.

We know that's not easy to do when you're under so much pressure. We know midwives work an estimated 100,000 unpaid hours every week just to keep services functioning, with 87% saying their units are not safely staffed.

We hear you loud and clear – and we're going to make sure the four governments hear you too. Urgent action is needed to address chronic understaffing in maternity services.

The fundamental issue is that you cannot deliver safe maternity care with exhausted and overstretched staff. We need action now, backed by ring-fenced, sustainable funding. Without safe staffing, care simply cannot be safe.

RCM representatives are supporting our members in the workplace to raise these issues with employers. These include breaches of the Working Time Regulations and Agenda for Change contracts that are there to protect both staff and those in their care from unsafe working conditions.

Our 'Safe Staffing = Safe Care' campaign launched in Parliament in January calls for dedicated, multi-year funding through a national maternity and neonatal action plan to end understaffing in hospital and community settings. In addition, it demands a maternity strategy that includes: protected learning time for cultural competence training, student supervision and essential CPD for midwives and maternity support workers; a director of midwifery in every trust and on every board, alongside sufficient consultant midwives; and urgent investment to improve poor maternity estates and working environments.

We are fighting for this because we know you can no longer carry the weight of the system on your shoulders. Please hear this: when the day feels impossible, it is not a reflection of your worth or your skill. Together we will bring change.

Turn on, tune in

It is clear that digital technology has a big role in maternity care – so let's make it work for you

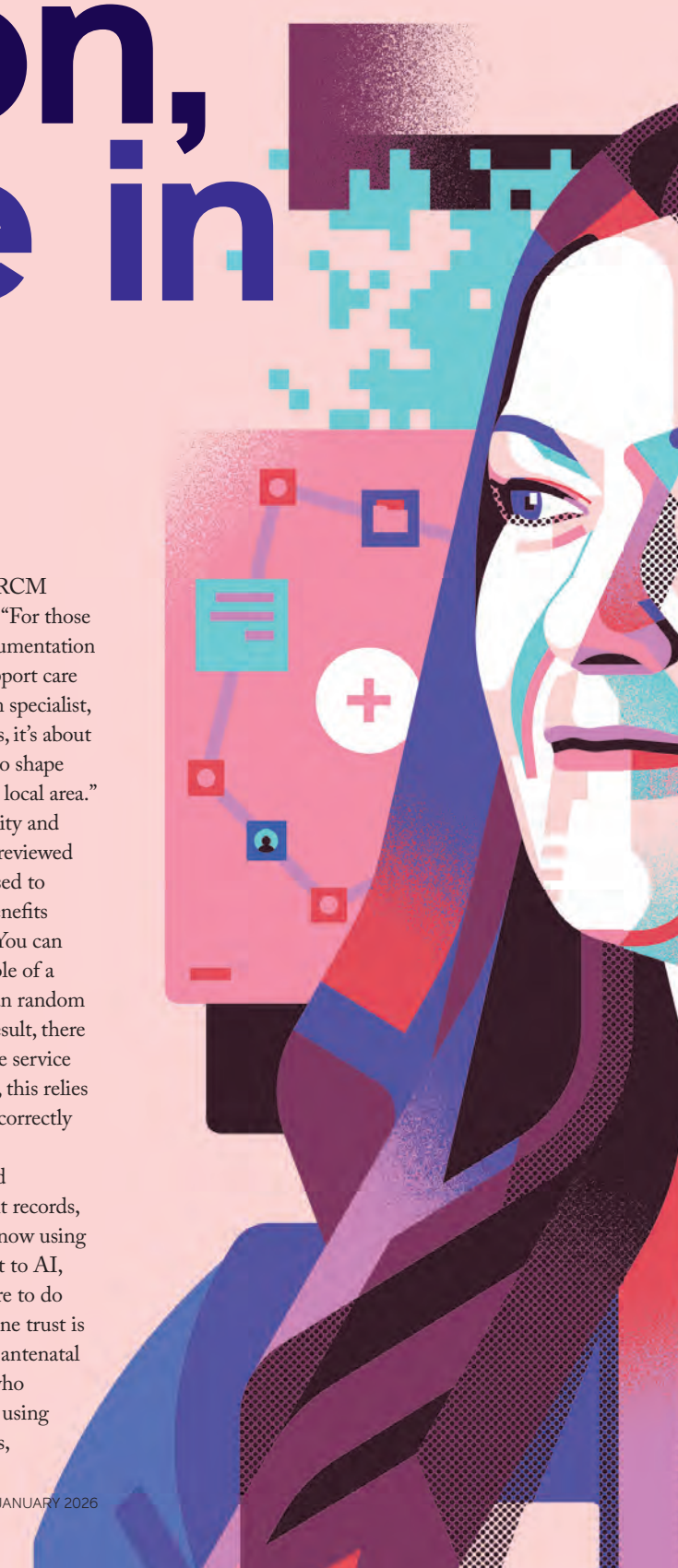


ILLUSTRATION: ALEKSANDAR SAVIC

When the NHS 10-year plan for England was published in the summer of 2025, transferring healthcare to digital was one of its three key shifts. "New technology will liberate staff from admin and allow people to manage their care as easily as they bank or shop online," the ambition read. While it sounds wholly optimistic, the huge strides made in Northern Ireland with the roll-out of its Encompass system and in Wales through an award-winning digital inclusion project certainly suggest that it is possible – and, what's more, it brings many benefits, as the countries' own digital strategies attest.

What digital maternity looks like

Digital use in healthcare can take many forms – from record-keeping and service users being able to access their own information, to digital triage efficiencies to meet service users' needs and artificial intelligence (AI) linking to additional care teams. "The use of digital tools varies across professional roles," says Doris Hayford, RCM professional advisor, digital. "For those in direct care, it's about documentation and using equipment to support care delivery. For professionals in specialist, operational or strategic roles, it's about interpreting collected data to shape service provision within the local area."

Doris notes that the quality and volume of data that can be reviewed in a digital format, as opposed to manually, is one of many benefits of digital documentation. "You can complete audits on the whole of a maternity service rather than random sampling of records. As a result, there will be a better review of the service provision." But, she stresses, this relies on the data being inputted correctly onto the system.

Having implemented and embedded electronic patient records, some trusts and boards are now using automation. This is different to AI, says Doris, and uses software to do day-to-day admin tasks. "One trust is using automation to cancel antenatal appointments for women who have given birth; another is using automation to send referrals,

make appointments and provide notifications for women who have been to A&E during pregnancy and 12 months prior, generating a safety risk report."

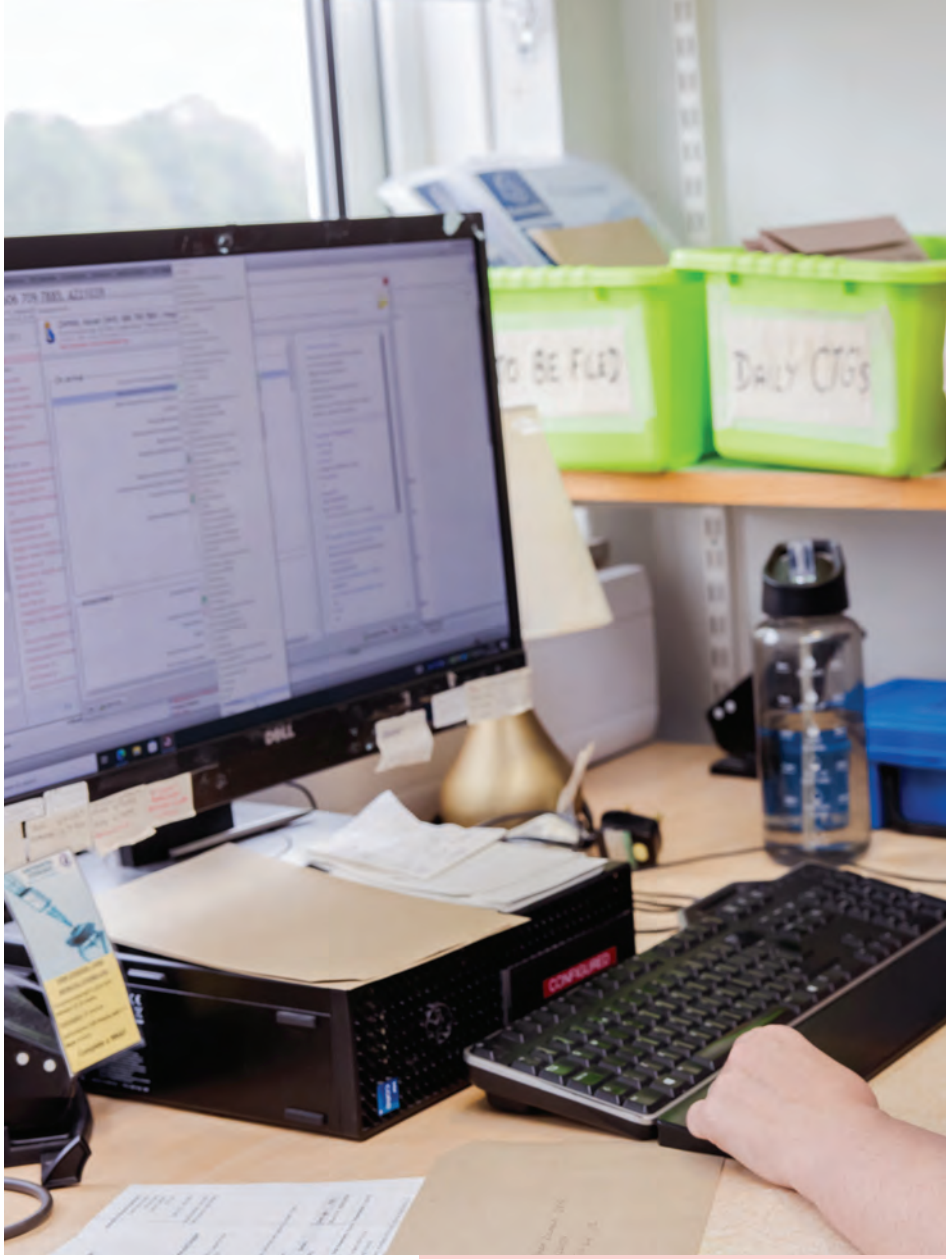
AI tools can also offer highly useful data to pregnant women and those who care for them. The Tommy's app, which gives a prediction as to the risk of preterm birth, pre-eclampsia or pregnancy-induced hypertension, is being used in several trusts, says Doris. "But it's really important that we recognise it is a tool. The clinician's experience and judgement is the real decider; the AI tool should be used in conjunction."

In a bid to create and share best practice, Doris set up the Digital Midwives Network Forum for RCM members. "The aim is to provide a safe, supportive and inclusive space for digital midwives to collaborate, share ideas and experiences and drive digital transformation in maternity care," she says. The first RCM digital symposium, she adds, is set for April this year. "I am mindful that there's a lot going on within the digital transformation landscape, so this event is to explore the future of maternity care in the light of the NHS England 10-year plan – because the plans will filter into the other three countries."

There are challenges, though, in implementing the digital roll-out. Doris points to factors such as staff confidence in using the systems and digital exclusion that affects service users. According to the Digital Poverty Alliance, digital poverty affects 13 million to 19 million people aged over 16, with unemployed people thought to be two to three times more likely to be affected. Encouragingly, work is being done to redress this (goodthingsfoundation.org).

Digital inclusion

In 2025, the chief nursing officer for Wales and RCM Wales Quality Improvement Award went to the digital inclusion maternity databank. This is led by Cheri Lewis, senior



midwife for clinical informatics at Cwm Taf Morgannwg (CTM) University Health Board.

Developed directly from the work of digital midwives in NHS England (who created the Connected Care model), rather than treating data and connectivity as a useful bonus, the initiative treats them as essential enablers of care.

Cheri says: "We were interested in how we could translate that thinking into the Welsh context, where we do not yet have fully digital maternity records but were already seeing issues with women accessing tools such as GROW 2.0 and other online services.

"Digital access has increasingly become a precondition for full participation in maternity care and, without safeguards, it risks widening existing health inequalities.

"CTM is an area of high deprivation and national data indicates that a significant proportion of people either lack home internet, rely on pay-as-you-go data or frequently run out of data."

The system is intentionally simple and was not difficult to implement. "A brief 'digital inclusion' section is embedded in the existing self-referral process. Responses to Connected Care questions generate a flag and the digital midwifery team then manage follow-up, eligibility confirmation, SIM allocation and data entry. Because the work is led by the digital midwives, it sits largely in the background and does not add to the day-to-day workload of frontline midwives in clinic or on the ward," she says.

Cheri notes that the main challenge involved is changing the mindset – from seeing digital access as a matter of personal consumer choice to recognising it as a shared social responsibility and a determinant of health. They did short, focused, awareness-raising sessions with the staff to help "explain why we were asking about digital access and how to approach those questions in a non-judgemental, routine way".

Now the SIM databank has been embedded, the next phase of work involves extending the model to include devices for the "small but important subgroup of women with no personal device at all". Cheri is on a mission.

Joined-up working

As Cheri notes, digital working involves a mindset shift among maternity professionals – despite the many benefits offered by digital systems, achieving staff buy-in requires work. Doris agrees that the challenge includes confidence. "Research has shown that being confident to use digital tools like social media does not determine your

"Some of the biggest challenges were around culture change rather than learning the new system"

confidence with digital health or e-health within the profession."

Step forward the South Eastern Trust, which in November 2023 paved the way for Northern Ireland by going live with the Encompass system. It creates a single digital care record for every citizen who receives health and social care. "The staff felt they were the test users for the whole system," explains Karen Gray, lead midwife for the nursing and midwifery digital and information practice team.

The implementation process brought teething problems, staff training was a challenge and not long after 'go-live' it was recognised that it needed to be fine-tuned, Karen says.

Competence

Digital misinformation

Misinformation spread through social media is one negative effect of the digital age. Many women, understandably excited or anxious in the early stages of pregnancy, are sold the idea of early access to information about their baby through private ultrasound scans – often through ads or posts on their social platforms. Some want 'souvenir' scans for early pictures and videos of their baby to share; some seek reassurance around the baby's health before the 12-week NHS scan; some wish to know the baby's sex ahead of 20 weeks.

But, as many stories in the press have shown, the high-street clinics offering pregnancy scans come with no guarantee that the scan will be conducted by a trained sonographer who knows how to read and interpret it. This puts unborn babies and their mothers in danger, the Society of Radiographers (SoR) warns. It says its members have seen examples of pregnant women being incorrectly diagnosed with serious health conditions and given dangerous advice. Others have been sent to hospital after being informed of an abnormality, only to find their baby was healthy.

In November, the SoR called for 'sonographer' to become a protected job title in the UK, meaning only those who are properly qualified and registered with a regulatory body would be allowed to use that job description. It offered the following advice for maternity professionals to share with those in their care:

- The NHS requires ultrasound practitioners to have a UK-recognised qualification or comparable qualification to undertake the Fetal Anomaly Screening Programme
- Users of services outside of the NHS should be aware that it is possible to practise sonography without any form of regulation or even, in some cases, without a qualification and adequate training
- Pregnant women should be advised to check that the person conducing their scan is a qualified sonographer (CASE*-accredited programme or equivalent) or on a register and which one, so this can be checked before attending an appointment. This is particularly important if the ultrasound service is being used to check the development of their baby
- The Care Quality Commission (CQC) also has information about choosing a baby scan clinic. The SoR has developed competencies for ultrasound practice that can be used to ask questions about the level of service offered, along with the education and training of staff.

*CASE – Consortium for the Accreditation of Sonographic Education

RESOURCES
Read the CQC guidance at **b.link/CQC-scans-guidance**
Find the SoR competencies at **b.link/SoR-US-competencies**

"It's important to make everyone feel heard and part of the process"

"The training needed to be developed in partnership with those who would be using the system – and the system itself needed the same input. We all recognised things needed changing – and quickly – as the other go-live dates approached."

"Some of the biggest challenges were around culture change rather than learning the new system," continues Karen. Community teams going into homes with laptops felt it could be a barrier to being 'with women', and there was a concern that if they didn't know how to use the system properly, it would give a poor reflection to the women they were caring for. "In the early days many community midwives fell back on using notes because it was in their comfort zone, what they've always done," she says.

Her aim then was to increase staff confidence in using the system. 'Superusers' were appointed, taking part in quarterly sessions that were fed back to the teams. "I found with some, once they got a better understanding of the benefits, they were more inclined to learn. With the go-live date looming, the attitude was a mix of panic and excitement. The feeling was that we've got this forever, so we need to get it right. Everyone pulled together to make it happen."

Karen shared the learning from her trust's go-live with the other trusts, highlighting the importance of communication and preparation. In June 2024, Belfast became the second trust to roll out the system; by December that year, Northern Trust had followed suit; and then in May last year, Southern and Western Trusts went live together. Karen's secret to getting everyone on board? Listening and adapting to their needs. "It's important to make everyone feel heard and part of the process."

The road ahead

As digital tools and, in time, AI become more embedded in maternity care, there is an opportunity to improve safety, experience and outcomes, Cheri believes. "But that will only be realised if we recognise that digital access itself is part of our duty of care.

"We have a social responsibility – and, I would argue, a moral obligation – to ensure that digital transformation does not create or entrench new health inequalities. By getting digital support right in pregnancy and the postnatal period, we can not only improve care for women and babies now, but contribute to longer-term digital confidence and connectivity for families and communities."

MORE INFO

For more on the RCM Digital Midwives Forum, visit **b.link/RCM-DMN**

And for more on digital midwifery, visit **b.link/RCM-digitalmidwifery**

It's good to talk

RCM director for Scotland Jaki Lambert says she has felt gaslit when trying to get midwifery's voice heard on the political stage – and now suddenly everyone wants to talk

Jaki Lambert
RCM director for Scotland

How often do we feel that the voice of our community is not heard? It's as if we are a niche speciality, rather than the biggest intervention in the life of everyone either pregnant or born in Scotland.

Midwifery has always advanced because our community – colleagues and allies – has fought for it. We have seen opportunities to learn, to help and to improve, and we've not let them pass us by.

From Mrs Quintin Smith from Lanarkshire, who set up the Scottish Midwives' Association in 1917 that had 400 members within a year, to her successors spanning research, education, practice and union, opportunities to advance have always been brought about by passionate maternity professionals. Therefore, it's important to grasp the opportunity for midwifery in Scotland that's in front of us.

Maternity taskforce

Following urgent debates in the Scottish Parliament, a maternity and neonatal taskforce was announced in October that would determine the scope and need for a review of maternity in Scotland. We feel a significant amount of frustration hearing this, because it isn't as if we don't know the issues already and have the solutions.

The letter from the Scottish Government in November said it would review the themes from the eight inspections that will be completed by March. Yet, these inspections are focused on acute care rather than the whole system. We already know community midwifery is under-resourced, and we cannot risk improvement for acute care being taken yet again from community. The RCM opposes any midwife being called to cover the labour ward while on call, yet we know this is happening more since the inspections started. We also know that without the prevention in communities, the pressure in acute will keep growing.

"Opportunities to advance have always been brought about by passion"

The taskforce will also look at specific areas of rural care. Again, we know that that's like playing whack-a-mole with services rather than looking at the whole system. We have to meet care needs wherever families access care. We badly need a model for smaller hospitals integrated within the wider system. We have said we need to learn from other countries – such as Northern Ireland and Wales – with evidence-based clear methodology and solutions, putting families at the centre with rapid timescales for improvement. What we don't need are endless reviews and recommendations that reduce trust, psychological safety and the capacity to provide care.

Cabinet secretary for health Neil Grey pledged to "turbo-charge" action to reduce maternity workforce issues at the SMiLe25 (Strategic Midwifery Leadership Group) conference in November, and we intend to hold him to his word. Now, more than ever, we must use our voices to make change.

MORE INFO
Read more about the SMiLe conference at **b.link/SMiLe25con**

IMAGES: SHUTTERSTOCK, KATE DARKINS

Professor Dunkley-Bent (left) and speakers

The annual All-Ireland Midwifery conference took place in Armagh in November, with a fantastic line-up of speakers on midwifery leadership, regulation and practice

All Ireland

The RCM and the Irish Nurses and Midwives Organisation (INMO) jointly hosted the 2025 conference with the theme 'Maternity care: recognising challenges and building on success'.

Professor Jacqueline Dunkley-Bent, chief midwife for the International Confederation of Midwives, opened the conference with her keynote address on how "strengthening midwifery leadership enhances high-quality midwifery care".

The day provided an insightful line-up of speakers, from Imelda Aylward's talk on the Kilkenny Postnatal Hub to Angela Dunne's 'Evidence to support maternity care policy in the republic of Ireland'. Workshops covered initiatives such as supporting women with complex social needs from Lisa Darrah and 'Strengthening Communities: Establishing Holistic Midwifery Services to Address Health Disparities in Disadvantaged Populations' from Julika Hudson. It was also a great opportunity for colleagues from across Ireland to catch up, and to share knowledge and ideas.

RCM director for Northern Ireland Dr Dale Spence said: "For more than 30 years, the RCM and the INMO have worked closely together to deliver our annual joint conferences. We were delighted to see so many midwives, student midwives and MSWs [maternity support workers] coming together from all over Ireland.

"We're delighted to see so many midwives, student midwives and MSWs coming together from all over Ireland"

"This provided an opportunity for them to share their professional experiences and best practice so they can learn from each other.

"This year's programme acknowledges the challenging circumstances in which midwives work, but aims to highlight positive ways in which, by working together, we can improve the care women and babies receive."

Professor Dunkley-Bent said: "I left incredibly inspired after hearing so many exceptional speakers share their experiences and innovations in advancing midwifery services for women, babies and families ... their passion and commitment to improving maternity care were evident throughout. It was also wonderful to reconnect with colleagues from Birthrate Plus, the NMC and AIMS, whose ongoing contributions to maternity services continue to make such a difference."

Congratulations too to the poster competition winner Ursula O'Dea and project team at Belfast Trust for the poster 'Turning babies, turning outcomes: moxibustion for a safer birth'.

Dr Spence (left) and Professor Dunkley-Bent (right) with students

PAY PARITY

The RCM team in Northern Ireland sends its heartfelt thanks to all midwife and MSW members, supported by RCM national officer Anne Wilson, for their efforts in securing victory in the fight for pay parity. We welcome the health minister's eleventh-hour announcement, which means that you will receive the promised pay rise, fully backdated to April 2025.

Members have told us they are eager to gain more knowledge and confidence to better support one another and the communities they serve – and this conference is the perfect place

St David's Day conference

Our home for this year's St David's Day celebration and RCM Cymru conference will be the Swansea.com stadium, formerly the Liberty Stadium, in the heart of Swansea, Abertawe. We are delighted to be rotating across Wales and linking with Swansea Bay branch and Swansea University Midwifery Society to help host the day.

This year's theme of 'Building Communities' sits close to our hearts. It reflects the growing commitment among midwives, maternity support workers (MSWs) and midwifery students to strengthen connections – with each other, with the people we care for and with the wider midwifery community.

One of the three pillars of the new RCM strategy is 'building our communities' and the day is intended to encourage open dialogue, increase understanding and share our experiences of supporting the diverse communities in maternity that we care for daily in our work. Additionally, we are going to showcase the amazing work that is already taking place here in Wales.

This year's event has a programme of sessions and speakers who bring insight and experience on key issues about communication, the changing workplace and equality, diversity and inclusion. The day will create a safe and supportive space for everyone working in maternity services across Wales to reflect on their practice, explore professional development opportunities and consider how we can all contribute to improving the birthing environment for everyone.

"Let's celebrate what makes us unique and what brings us together"

Sessions will include:

- Building Branches: the Swansea RCM Experience – a practical look at how local branches can grow, thrive and support their members
- Building Digital Communities – exploring how online spaces can strengthen midwifery networks and peer support
- The Welsh Language and Workplace Cultures – celebrating and embedding Welsh identity in maternity services
- Launch of the RCM Cymru Manifesto – setting out our shared vision for the future of maternity care in Wales
- Supporting the Development of our Global Majority Workforce to provide a better service for the future.

This St David's Day, let's celebrate what makes us unique, what brings us together and how we build midwifery communities that truly reflect the values we live by every day.

BOOKING INFO

The St David's Day Conference takes place 27 February, from 9.30am to 4pm. Scan the QR code to book your ticket.

IMAGES: RCM/KATE DARKINS

Dream team

Maternity care assistants **Sue Petrie** and **Kelly Croudace** of NHS Grampian have developed both the role and a thriving service in Scotland

Kelly and Sue have defined and developed the MCA role

Sue Petrie qualified as a maternity care assistant (MCA) in 2009, then worked as a healthcare support worker at Dr Gray's Hospital, Elgin, until 2021. After this she began to work in the community in Elgin and Moray as an MCA after a refresher course.

Kelly Croudace qualified as an MCA at the University of the West of Scotland this year. Before that she was a healthcare support worker at the Women's Health Clinic at Dr Gray's Hospital. She now works with the community midwives in Elgin and Moray, and has been working on an updated skills passport for Band 2, 3 and 4 MCAs.

Together, they have exploded the myth that MCA is a support role with no career path or ambition. They have defined and developed the role for MCAs (with a third member, Britney Todd, currently doing her training) and shown how to lead a service for the benefit of those in their care.

PEEPs

It all began two years ago. Sue found women who were trained in the Parents Early Educator Programme (PEEP), most of whom were nursery nurses, and contacted them for an initial meeting.

From there the meetings snowballed, with them finding venues and funding as

there was no budget available at the time. Later they built alliances – such as the one with Action for Children – to train more practitioners, support the administration of classes and ensure that more women across Moray have access to the PEEP training.

It was a five-week programme, but they have now added a sixth week to do a parenting class, which is for birthing partners as well. The course has capacity for five classes per week, with about eight women and partners attending each class. The benefits are huge – not least because the MCAs are able to support the midwives offering much-needed extra services.

Maternity team

"The role is working alongside the midwife and not below them," explains Kelly. "We are all part of the team. There are things we can offer because we have more time – we don't have antenatal classes to run like the midwives. For example, we can offer breastfeeding support; women can need more than the standard visit, so we can help support positioning and mental wellbeing. We're lucky in that our midwifery team appreciate us – and they miss us when we are not there."

When they are doing the classes, they deal with a range of different needs. For example, one woman was anxious about coming out and joining groups, so they went to her home. "We love seeing women making connections, bonding with their babies and learning how they can get to know their baby," says Kelly.

"So much of the role is amazing and fulfilling in its own right"

MCA career path

In all departments, roles are always evolving. For some the changing nature of the MCA role has been an adjustment. "When I first joined the team, they thought we were stealing their work," says Sue. "But we are just there to support them. We work well as a team. It's important to us that we're working alongside them, so all the women can get what they need.

"There is so much of the role that is amazing and fulfilling in its own right. If you want to, you can go up or you can expand your role horizontally."

Healthcare support workers are used to making beds and doing basic housework, but the MCA role offers much more clinical involvement – including baby observations and learning about women's health. "We've worked hard to get where we are, to learn our clinical skills, and we are willing to learn more," says Kelly.

Playing it forward

They both had their reasons for going into the maternity services. Sue's youngest son had problems when he was born. Her husband was in the Army; however, the military hospital wasn't able to help so she was cared for in a civilian hospital. "He was too poorly to fly to the UK. I was away from home and my family, but I had the support of trained staff in a German hospital. I had never thought of going into the health profession before, but I wanted to give back the support I was given."

Kelly had her son in the first lockdown. "The care I got was second to none. Because you were on your own, they really were there for you and made sure you were supported. The community midwives really nurtured me.

"This is part of what drives me – making sure that women are heard, drawing out the confidence they already have and getting them to do what they already know."

READ

Sue and Kelly did a flash talk about the PEEP classes and their benefits for service users at the SMiLe conference – to find out more about the SMiLe MCA network, contact **sharon.allison@rcm.org.uk**

IMAGES: UNP

Skills

The NHS Scotland Skills Passport

Kelly has been working on an updated skills passport for Band 2, 3 and 4 MCAs. When she started her training last year (2024) at the University of the West of Scotland, the passport hadn't changed since Sue had first done her training.

"Jaki Lambert [RCM director for Scotland] did a Teams call with my uni class and said she was hoping to develop the role and asking current students to get involved. I and one other – Claire Rehr from NHS Highland – volunteered," says Kelly.

They went to RCM HQ in Edinburgh and met with Dr Tom McEwan, Head of Programme for the Women's, Children, Young People and Families team in NHS Education Scotland. "We discussed what new roles and skills we bring and Tom was able to pull it together within the Four Pillars of Practice," says Kelly.

The NHS Scotland Skills Passport provides a record of the skills and competencies in order to support a student to achieve the MCA. Its recent update includes:

- **defining the roles for each band, so the new passport is broken down into level 2, 3 and 4 to align with the Agenda for Change banding 2, 3 and 4**
- **following the Four Pillars of Practice**
- **clarifying information for managers and supervisors in how the passport should be used**
- **listing common extra duties that can be undertaken with additional training and which level it would be appropriate for**
- **facilitating and supporting continuity of care**
- **adding of Parentcraft/PEEP classes.**

RCM Awards 26

Secure your place at the RCM Awards

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The RCM Awards 2026 will take place on Friday 6 Feburary 2026 at The Brewery, London - Celebrating, rewarding and sharing outstanding achievements in the midwifery profession across the UK this year.

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

Winners announced: 6 February 2026

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The future is now

The RCM Education and Research Conference 2026, 18-19 March, helps connect and strengthen our maternity community and champions the wellbeing of women and families

The conference is a great way to highlight the vital contributions of midwives, student midwives and maternity support workers/maternity care assistants working in education and research. Alongside the Excellence in Education and Research 2026 Awards winners and the much-anticipated Zepherina Veitch Lecture, this year's programme includes:

- Andrew Darby-Smith leading the 'Transforming maternity training through mobile, AI and VR' session
- Dr Aimee Grant leading the 'Creating autism-affirming maternity care' session and joining the panel discussion 'Participation in research' to cover how to involve communities in research
- Hannah Rayment-Jones speaking on 'Understanding the impact of immigration status on maternal and child health'
- The 'Mapping the future: career development in maternity care' session covering the career framework and seeing the launch of two RCM publications for lead midwives for education and consultant midwives to help support and improve education and research for the future of maternity practice.

scan

The Midwifery Education Blueprint

Heather Bower, RCM head of midwifery education, says: "Based on the evidence from our 2025 Freedom of Information request to all universities, we are also developing a *Midwifery Education Blueprint* that follows the guiding principles for midwifery education. These are:

- High-quality education grounded in safety, compassion and evidence
- Strong collaboration between regulators, education institutions and clinical practice partners
- Consistency, fairness and transparency across all elements of education and learning
- Dedicated support for students, educators and the wider workforce so that everyone can succeed and thrive.

"We've identified 'asks' for the NMC, for universities and for practice learning providers to strengthen outcomes for midwifery education, also enablers for success and how these might be achieved."

Small Research Awards

Every year, the RCM Small Research Awards supports members to undertake a research-based activity that could benefit them in their career or maternity care – such as making connections with others in research, deepening their knowledge in a particular area of practice, or developing a brief or service evaluation proposal. The Small Research Awards winners will be announced at the close of the first day of the conference. Hear from previous winner Katie Handley, clinical lead for maternal and child health at Genomics England, who is working on the Generation Study (a groundbreaking research initiative aiming to sequence the genomes of 100,000 babies to identify and treat rare genetic conditions), at *b.link/RCM-research*

BOOK

For more on the conference programme and to book your place, scan the QR code

IMAGES: RCM/KATE DARKINS

Promising beginning

For early career midwives, the first year in practice should see you off to a flying start in your midwifery career – but for some the support is lacking. Here's what you can do

"Having a good relationship with my preceptor who I could go to when I was needing to check something and who would remind me that I was doing well when I was overly self-critical. Being able to see my work and abilities reflected from her perspective was very helpful."

"A lack of support, no induction, no check-ins, being in charge and alone less than a month into the role, no discussion re expectations of the first year in practice and rotations. Shifts and on calls being changed with no consent or being told."

These two very different accounts from early career midwives (ECM) are highlighted in RCM Scotland's *Five years on* study. They show not only how experiences can vary, but what a difference having good support can make.

The RCM is determined that those starting out should get the support they need to thrive.

Help transitioning from student to ECM can be found at the RCM's ECM Hub, which has resources, information, financial and wellbeing advice and links for networking and joining the branch community. An RCM learning representative can also offer day-to-day advice and support in the workplace.

A fundamental part of the transition from learning to confident, autonomous practice is through guidance from an experienced mentor on what should be a structured and well-run preceptorship. This should complement a formal induction and orientation period in your workplace. Third-year student members will be familiar with the RCM's *Preceptorship guide*; it is invaluable for answering any questions you may have, helping you to get the most out of your preceptorship and laying out what you can do to make sure the programme meets your needs.

IMAGE: ISTOCK

Speaking up

Culture of care

The survey specifically looked at what quality and culture mean to early career midwives. While most felt well supported and there was generally high confidence in delivering quality care, more than half had seen gaps in quality of care due to staffing concerns, workload, poor morale and care being fragmented. The majority felt confident to raise safety concerns, but a shocking 87% had witnessed negative behaviours affecting team culture.

It is important that you have a positive experience as a new midwife in an organisation. If you have a concern, you must raise it with: an RCM steward or learning representative; a preceptorship or retention midwife; your line manager; your local freedom to speak up guardian (*nationalguardian.org.uk*); or your professional midwifery advocate (Eng) or midwifery supervisor (Wales and Scotland). The RCM has guidance on standing up for high standards at *b.link/RCM-HighStandards*

Focus on Scotland

Five years ago, Scotland didn't have a preceptorship programme for newly qualified midwives. In 2020, the RCM published a report from its First Five Years Forum called *Developing a preceptorship programme for early career midwives in Scotland*. It made a clear case for a structured, consistent programme and was a key influence in Scotland's Preceptorship Framework in 2023.

The report had five recommendations:

- Individualised career progression options
- Clarity about expectations of skills development
- Protected learning and supernumerary time
- Named preceptor and defined support network
- Development of a national programme to provide a consistent approach to skills development.

In 2025, the RCM, keen to see what progress had been made, surveyed ECMs on what quality and culture meant to them and what more needs to be done to support future midwives in Scotland.

The *Five years on* study was presented at the SMiLe (Strategic Midwifery Leadership) conference in November. It tells of a community that is striving to make things better with limited resource – it showed success, but also areas that needed improvement. For example, 44% of ECMs said that they were unclear on what was needed to promote to Band 6, and only 30% reached Band 6 in their first year of practice.

The RCM has set out with Education Scotland what still needs to happen. That is:

- For individualised plans to be updated throughout the year considering personal need and career aspirations
- For every ECM to have an identified person on each shift and access to clinical supervision, as well as networks at local and national level
- For clarity throughout re expectations and timescales to attain Band 6 and feedback from the preceptor
- For protected learning and supernumerary time
- For manageable workload, job satisfaction and a culture of kindness so that ECMs feel safe and proud of the care they give.

READ

RCM Scotland's *Five years on* study **b.link/RCM-5yearson**
RCM's *Preceptorship guide* **b.link/RCM-PreceptorshipGuide**
Scotland's Preceptorship Framework **b.link/Scot-preceptorship**
Preceptorship Framework Northern Ireland **b.link/NI-preceptorship**
Once for Wales Preceptorship Framework **b.link/Wales-preceptorship**
England's National Preceptorship Framework for Midwifery **b.link/Eng-preceptorship**

Alexandra Clark
registered nutritionist

Slimming World

Evidence-based lifestyle support and healthy weight management has been Slimming World's mission since 1969. Alexandra Clark, registered nutritionist at Slimming World, explains what that means for maternity

Feeling good

Since 2012, Slimming World and the RCM have been alliance partners, sharing mutually beneficial information to support members as well as those in their care to make healthy lifestyle choices. The importance of eating healthily during pregnancy and following birth can't be understated, though it's much easier said than done. Compassionate support is essential.

This is what Slimming World offers. Working closely with the RCM, we've refreshed our policy for how our pregnant members and maternity professionals work in collaboration. The goal remains the same, not to promote weight loss – it is to support healthy eating and provide advice and encouragement. From now on, pregnant Slimming World members will bring a letter to antenatal appointments that explains our pregnancy support. A midwife signature is no longer required. Slimming World members are encouraged to keep talking with their midwife throughout their pregnancy journey.

The healthy eating plan itself, 'Food Optimising', has always been based on up-to-date nutrition science and is centred around everyday foods. Our members are encouraged to fill up on nutritious, low-energy dense foods including rice, pasta, noodles, grains, poultry, fish, lean meats, plant-based proteins, eggs, beans, lentils, fruit and veg.

As well as these, we encourage our members to enjoy measured, daily portions of foods containing essential nutrients to help ensure a balanced diet – these are called 'Healthy Extras'. A focus on healthy fats has been incorporated with the creation of a new 'Healthy Extra' category, including measured portions of unsaturated oils and avocado.

Finally, included are the foods that are least satiating and high in energy density (such as crisps, chocolate or sauce with a meal), previously called 'Syns' now renamed 'Swips'. We'd had feedback that the word Syn led to feelings of shame around these foods, which was never our intention. Being able to enjoy your favourite foods without guilt makes it easier to stick to and make lasting changes.

Pregnant Slimming World members are supported to enjoy a varied diet and to take the advice of their healthcare team. Slimming World is proud to continue supporting mums-to-be and working in collaboration with the RCM to encourage healthy eating, active lifestyles and safe weight management during pregnancy.

Salmon sushi bowl

For more information, visit Slimming World's and the RCM's website for advice and support before, during and after pregnancy: **slimmingworld.co.uk/mums**
For more information on the alliance partnership, visit: **rcm.org.uk/alliance-partners**

IMAGE: SLIMMING WORLD/ANDY WARBURTON

On the record

Filming scans, appointments and births is becoming more prevalent, so how do you ensure your professional privacy without preventing the wishes of those in your care?

During COVID-19, filming and recording of consultations was a way to involve partners who couldn't be there in person. The practice has continued to grow in popularity as a way to have personal keepsakes, to help with recalling information given at an appointment, to assist if there are language barriers or to share with family and friends – or even a social media following. Whatever the reason, it poses questions about the privacy of maternity staff who have the right to consent to being filmed at work.

Some NHS trusts and boards have their own policies on filming and recording, although these may not be specific to maternity services. That's why the RCM has created a position statement to support workplace representatives and members in responding to questions and issues if they arise.

Principles for recording during appointments, scans and births

- Recording and filming can be undertaken positively and legitimately, but should be discussed in advance between women and birthing people and the maternity team
- It should be agreed to by all parties with a full understanding of the implications – this should include a plan for any emergency situations that might arise during birth and the potential for wider sharing of recordings beyond those directly involved
- Recording should be unobtrusive and not prolong or interfere with the purposes of the appointment or the professionals at work
- No recording of other people using the service must be made without their explicit consent
- It is vital that recording is done openly, responsibly and with respect.

Can I refuse to be filmed/recorded?

You have a reasonable expectation of privacy while at work, so the service user should ask for your consent before filming or recording. If the recording is solely for their personal use, it is unlikely that you can refuse; however, there are legal implications if it is then shared online. It is best to have a discussion with the person who is requesting to record to understand their reasons, while also explaining any objections you may have.

Birthrights advises service users: "The staff caring for you have the right not to be filmed in a way that would identify them if they don't want to be. However, if filming your birth is important to you then the trust [or board] should try to facilitate it."

IMAGE: SHUTTERSTOCK

READ
Download the RCM position statement at **b.link/RCM-recording**
The British Medical Association has developed guidance including how to respond when someone asks to record their appointment and what to do if a covert recording is posted online. Visit **b.link/BMA-recording**

Why Hibitane™ Obstetric Cream Should be on Your Trolley

It's the chlorhexidine based lubricant with a formulation that's been helping to prevent risk of infection for over 60 years.

- ✓ Chlorhexidine is a highly effective antiseptic and antimicrobial.[1]
- ✓ Effective against a wide range of Gram negative and Gram positive vegetative bacteria, yeasts, dermatophyte fungi and lipophilic viruses.[1]
- ✓ Use of chlorhexidine solution has been shown to reduce early neonatal and postpartum infections.[2]

Available as a single-patient-use 50ml bottle

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Obstetric Cream

- Licensed for use in Obstetrics and Gynaecology.
- Widely used by Healthcare Professionals during physical internal examinations, during labour and delivery.

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Derma UK

Abbreviated Prescribing Information for Hibitane™ Obstetric Cream
Presentation: Hibitane™ Obstetric Cream is a cream containing Chlorhexidine Gluconate 1% w/w. **Indication:** An antimicrobial preparation for use as an antiseptic and lubricant in obstetric and gynaecological practice. **Dosage and Administration:** Apply liberally to the skin around the vulva and perineum of the patient, and to the gloved hands of the midwife or doctor. **Contraindications:** Contraindicated for patients who have previously shown a hypersensitivity reaction to chlorhexidine. However, such reactions are extremely rare. **Warnings and Precautions:** For topical application only. Keep out of the eyes and ears and avoid contact with the brain and meninges. Local stinging and/or chemical burns have been reported following off-label use of gauze packs soaked in Hibitane™ Obstetric Cream and left intra-vaginally for prolonged periods. **Undesirable Effects:** Irritative skin reactions can occasionally occur. Generalised allergic reactions to chlorhexidine including anaphylaxis have been reported but are extremely rare. **Package Quantities:** 10 x 50ml and 250ml bottle. **Pharmaceutical Precautions:** Store below 30ºC. **Basic NHS Price:** £49.00 (10 x 50ml) and £22.00 (1 x 250ml).

Legal Category: GSL. **Marketing Authorisation Number:** PL 19876/0009. **Marketing Authorisation Holder:** Derma UK Ltd, Toffee Factory, Ouseburn, Newcastle upon Tyne, NE1 2DF, UK. "Hibitane" and "Derma UK" are registered Trade Marks.
Date of Revision of Text: January 2024

Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Derma UK on +44 (0) 191 375 9020.

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

HIB/114/0325
Date of preparation: March 2025

Quality improvement

"Increasingly, families are writing to us to tell us how good their experience was – which is fantastic for staff"
Kathryn Greaves, director of midwifery, Swansea Bay University Health Board

In August 2025, the health secretary appointed Baroness Valerie Amos to chair the new National Maternity and Neonatal Investigation (NMNI) to understand the lived experiences of women, babies and families in England at all stages of the maternity and neonatal care pathway.

It is the latest in high-profile reviews of maternity services throughout the UK – The Renfrew report in Northern Ireland, the Wales independent review and the taskforce being set up in Scotland (see page 11) – that showcase the need for quality improvement, as well as setting out what that looks like.

Amos' NMNI would conduct 12 local investigations of maternity and neonatal services in NHS trusts and develop and publish one set of national recommendations to drive the necessary improvements. By December, her interim findings made for difficult reading.

"Nothing prepared me for the scale of unacceptable care that women and families have received, and continue to receive," she said, "the tragic consequences for their babies, and the impact on their mental, physical and emotional wellbeing. This naturally raises an important question: with so many thorough and far-reaching reviews already completed, why are we in England still struggling to provide safe, reliable maternity and neonatal care everywhere in the country?"

Gill Walton

RCM chief executive

Baroness Amos' report paints a deeply distressing picture. Every woman and baby should have a positive experience of maternity care. Yet too many have experienced devastating consequences from systemic failings.

Midwives are committed to safe, compassionate, woman-centred care, but

IMAGE: SHUTTERSTOCK, ISTOCK COMPOSITE

chronic understaffing and inadequate resources are undermining their ability to deliver it.

The RCM has been raising concerns for years about these issues, the lack of urgency to improve maternity services and the absence of ring-fenced funding for improvements.

Baroness Amos is right to ask why change has been "too slow" when 748 recommendations have been made over the past decade. The government already has the evidence it needs. It knows the scale of the challenge and the solutions that will make the biggest difference.

We now hope to work constructively with the government through the Maternity and Neonatal Taskforce to ensure these findings lead to meaningful action. The RCM's 'Safe staffing = safe care' campaign is amplifying this message in the halls of government to demand action. Women, families, midwives and maternity teams have waited long enough for the safe, high-quality maternity services they deserve.

Kathryn Greaves

Director of midwifery, Swansea Bay University Health Board

"Talk to your colleagues and your leaders. It is possible to make changes and come out the other side"

In 2023, an independent review was commissioned by Swansea Bay University Health Board in response to a range of significant concerns about the safety and quality of maternity and neonatal services provided.

I started in July 2024 with the review already underway, so my role was to coordinate a service response. I saw a highly motivated, compassionate team, who had been facing significant staffing challenges. While they appeared swan-like and composed, underneath they were working at an unsustainable pace to deliver improvements. There was no director of midwifery (DoM) before I came into post, so part of my role was managing expectations about what was safe to do over what timeframe. There was also the challenge of where maternity and neonatal services sat within the organisation and the level of board scrutiny – a lot of early work focused on strengthening board-level understanding of perinatal services.

The report into our service raised the same issues seen elsewhere – it described a system in need of change and the importance of listening to women and families. For those working in the service, however, it felt very personal. One of the hardest things for midwives was the amount of commentary in the media and social media, and the fact we couldn't just come back in some instances and say, "that's not true." We had to use our internal reporting and benchmark against other services as the safest, most professional and clinically credible way to rebuild confidence.

Focus on staff

Staff were working with huge dedication, so the ongoing commentary was painful. Feeling judged by people without the full facts is incredibly hard. A major focus therefore had to be staff wellbeing. We now have a staff experience, workforce and retention plan. Staff engagement – understanding what matters to staff, what we do well and

IMAGE: SHUTTERSTOCK, ISTOCK COMPOSITE

where we need to improve – has become 'business as usual', which is hugely positive.

Another big positive has been board engagement – governance has improved, we have a perinatal committee reporting directly to the board, and board members see our data monthly. We've seen how important the role of DoM has been throughout. When Health Improvement Wales inspected us following the reopening of our birth centre and home birth service, staff reported that having a DoM telling their story, channelling the noise and steadying the ship helped them feel safe again. That has resonated with me through all of this.

The focus on maternity triage since the review has also been hugely beneficial. We now have a triage modelled on the Birmingham Symptom-specific Obstetric Triage System and we're supporting other services in Wales to understand how we achieved this. We are currently modelling a 24-hour midwife-led triage line, due to go live this year, with the medical workforce in place to back it up. Again, while painful, this level of scrutiny has elevated the urgency around what maternity services need and shifted health board priorities accordingly.

Staffing has been central to improvements. We have recruited to our Birthrate Plus and, with strong board support, over-recruited to account for a younger workforce and frequency of maternity leave. A lot of work has also been done around culture. Quality improvement and mandatory training are multidisciplinary and we are now talking about a perinatal service as a collective. We're not perfect – but we're on the right path.

Listening to women

We're also working in a positive, more structured way to engage with women and understand what the service means for them and what they'd like to see. We have established several clinical forums that pass developments to the Maternity and Neonatal Voices Partnership. We are 'storming and norming' – brainstorming ideas with women through the partnership, using quality improvement methodology to implement changes, then analysing whether they deliver the expected improvements.

"Feeling judged by people without the full facts is incredibly hard. A major focus therefore had to be staff wellbeing"

We have also implemented the NHS Core Questionnaire, delivered via push notifications to women at different stages in pregnancy, with questions on triage access, responsiveness, reassurance and listening. We're triangulating experience and outcome data. The Core Questionnaire also allows us to intervene early, addressing concerns during pregnancy, and improve women's experiences before discharge.

We know we won't always please everyone, but increasingly families are writing to us to tell us how good their experience was – which is fantastic for staff. It has been tough, but they are beginning to see the impacts of their work for mothers and babies. They are committed to each other too. Now, we're all doing a walking challenge raising money for a cancer charity – things like that only happen when staff feel engaged and confident. Our RCM branch has been pivotal, particularly through its monthly 'think tank', where anyone can bring ideas forward. Staff also have access to an independent 'Guardian' service, providing a safe space to raise concerns.

My message to those in other services going through this would be to not sit in isolation. Talk to your colleagues and your leaders. It is possible to make changes and come out the other side. Although it has been uncomfortable, seeing how the learning from our report is influencing national policy-making, and knowing others are benefitting, we feel grateful to our families and our staff for sharing their experiences. Ultimately, it is all for the good.

READ

Read Wales' independent review at **b.link/SwanseaMaternityReview**
Read Baroness Amos' interim findings at **b.link/NMNI_findings**

“I’ve never believed leadership is done from behind a desk”

It’s very clear why Roslyn Bullen-Bell, director of midwifery for Jersey, received the Government of Jersey Award for Excellence in Leadership

My approach to leadership has always centred on being accessible, present and genuinely connected with the people I work alongside. I’ve never believed leadership is something done from behind a desk; it’s something lived, shared and demonstrated in real time with your team. From the moment I arrived in Jersey, I set out to build a culture where people felt seen, heard and supported.

One of the first things we had was ‘Time to Chat’ every Wednesday – a simple but powerful idea. It’s a completely open space where staff can drop in, raise concerns, share suggestions, ask questions or simply talk. It’s informal and relaxed, yet it has become one of the most valued fixtures in our week because staff know it is a safe place to speak without judgement. Alongside this, I prioritise visibility: joining handovers, walking through the unit, spending time in clinical areas and having genuine conversations. Being present shows staff that I’m not just leading – I’m listening, learning and fully invested in their experience.

Jersey is unique. It has the warmth and closeness of a small island while still demanding the highest standards of clinical care. Because the service is smaller, you can truly get to know each member of the team – not only what they do, but who they are. That closeness allows for deeper trust and quicker, more

IMAGE: GARY GRIMSHAW – UNP

meaningful improvements. One of the most rewarding parts of working here is seeing, day by day, how positive leadership can influence morale, practice and outcomes.

Culture of kindness

When I first arrived, one of the clearest priorities was establishing a culture of kindness and psychological safety. Staff shared that they didn't always feel able to speak up, raise concerns or challenge poor practice. There was no 'Speak Up Guardian' and that absence had left a real gap. That was addressed quickly by establishing a 'Guardian' and embedding psychological safety training for everyone including midwives, obstetricians, maternity support workers and administrative teams. We wanted to build an environment where speaking up is normal and expected, where people feel valued and protected, and where learning replaces fear. The transformation has been remarkable. Staff now tell me they feel confident voicing concerns, offering feedback and stepping forward with ideas. That shift has completely changed the tone of the service.

> **"We wanted to build an environment where speaking up is normal and expected"**

Another major challenge was the lack of leadership stability. The service hadn't had a permanent leader for some time and, understandably, staff were worried about what the future would look like. It was important to be honest with them from day one that I had moved my life to Jersey. My family came with me, and one of my daughters joined the island's health service as an assistant clinical psychologist. Staff could see that I was here to stay and that stability has made a tremendous difference. We now have a fully recruited workforce with all permanent consultants, bringing continuity, confidence and pride back to the team.

Learning and thriving

We also transformed the way we approach incidents and learning. Previously, these discussions were often closed and hierarchical. Some staff found them intimidating or unhelpful. Today, they look completely different. Everyone is invited and the focus is on reflection, learning and growth, not blame. We talk openly, share insights and support one another. No one is left to face an incident alone. This has created a culture where learning is celebrated and the team operates with shared purpose and mutual respect. Our weekly risk meetings reflect this philosophy – they are open, collaborative and constructive. Being able to speak honestly and without fear has strengthened teamwork immeasurably.

Alongside cultural change, we have implemented major service improvements. One of the most exciting milestones was the opening of our new maternity unit. This is a modern, safe and welcoming environment designed with families and staff in mind. We now provide both midwife-led and consultant-led care, offering genuine choice and ensuring that women receive the right care at the right time. It has been fantastic to see how proud the staff feel of this new space and how positively families have responded.

Empowering people

If I were to offer advice to others, it would be this: truly get to know your staff. Understand their aspirations, their pressures, their strengths and what brings them joy in their work. Build psychological safety through trust, consistency and kindness. Culture cannot be imposed – it must be nurtured.

Kindness, for me, has always been the foundation. When people feel valued, they grow. Over the past few years, leadership development has become a priority. When I arrived, none of the leaders had completed formal leadership programmes. Now many are undertaking RCM leadership pathways and the Florence Nightingale Leadership Programme. Watching them develop confidence, clarity and pride in their leadership identities has been one of the most rewarding parts of my role.

Being nominated for the Excellence in Leadership award was incredibly humbling. It told me that staff feel the difference we've created together. They want someone who leads with openness, vision, compassion and a commitment to change. But this nomination isn't about me – it's about all of us.

I grew up in the north of Scotland, inspired by my aunt, a nurse midwife who adored her job. I know she's proud of what we've built here and so am I.

Pfizer | ABRYSVO® Respiratory Syncytial Virus Vaccine (bivalent, recombinant)

Respiratory Syncytial Virus (RSV)

What is RSV?

RSV is a highly contagious virus that infects the lungs and breathing passages and is one of the most common viruses that cause coughs and colds in winter.[1,2]

The impact of RSV on infants

Infants aged less than 6 months are at risk for serious respiratory illness with complications such as **bronchiolitis and pneumonia, which can lead to hospitalisation.**[2,3]

It is estimated that each year in England, RSV in infants under 6 months of age is responsible for:

64,570 (2017)[4]
GP appointments

15,126 (2019)[5]
RSV-associated hospitalisations

Symptoms of RSV infection*

The symptoms of RSV can be hard to distinguish from other respiratory illnesses.
These symptoms can include rhinitis (runny nose, sneezing or nasal congestion), cough and occasionally a fever.[6]
In young infants, <6 months old, symptoms of RSV may present as:[3]

- **Irritability**
- **Decreased appetite**
- **Decreased activity**
- **Difficulty breathing**

* This is not an exhaustive list.

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Find out about how RSV maternal vaccination helps protect babies

1. Vaccination of pregnant woman[7]

2. Pregnant woman generates antibodies against vaccine antigen(s)[7]

3. Antibodies travel through the bloodstream to the placenta[7]

4. Antibodies are pumped into the placenta by FcRn proteins[7]

5. Foetus receives antibodies, which circulate in the foetal bloodstream[7,8]

6. Antibodies can help offer a newborn baby protection from birth through 6 months of age[9]

Vaccinating pregnant mothers with ABRYSVO:[9]

ABRYSVO is indicated for:[9]

- Passive protection against lower respiratory tract disease caused by RSV in infants from birth through 6 months of age following maternal immunisation during pregnancy.
- Active immunisation for the prevention of lower respiratory tract disease caused by RSV in individuals 60 years of age and older.
- Active immunisation for the prevention of lower respiratory tract disease caused by RSV in individuals 18 through 59 years of age who are at increased risk for lower respiratory tract disease caused by RSV.

The use of this vaccine should be in accordance with official recommendations.

Scan to learn more about ABRYSVO.

Scan the QR code for ABRYSVO▼ Prescribing Information.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in Google Play or Apple App Store. Adverse events should also be reported to Pfizer Medical Information on 01304 616161.

FcRn = neonatal crystallisable fragment receptor.

PP-A1G-GBR-0444, Decemember 2025

virus-rsv-symptoms-transmission-prevention-treatment/respiratory-syncytial-virus-rsv-symptoms-transmission-prevention-treatment

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Jennifer Clarke
regional officer and lead for residential training

Heidi Booker
activist

Wearing too many hats?

Regional officer and lead for residential training **Jennifer Clarke** and activist **Heidi Booker** say there's a hidden cost of caring that shouldn't be ignored

In caring professions such as healthcare, midwifery, social work and emergency response, the emotional toll of continuous exposure to suffering can be profound. Known as compassion fatigue, it refers to the physical, emotional and psychological exhaustion experienced by individuals who are persistently exposed to others' trauma and distress. Over time, this sustained empathy can erode a person's wellbeing, motivation and job satisfaction.

Compassion fatigue, often termed the 'cost of caring', develops gradually as emotional demands exceed an individual's coping resources. Unlike burnout, which typically results from chronic workplace stress, compassion fatigue is directly linked to empathic engagement with others' pain. It's unsurprising then that midwifery professionals are particularly vulnerable. Ironically, the same qualities that make healthcare workers effective – empathy, compassion and emotional connection – can become risk factors when these emotions are continually stretched without time for recovery.

Prolonged exposure to difficult births, trauma, heavy workloads and poor working atmospheres such as limited managerial or peer support and poor organisational culture will obviously also increase the risk.

Those going through compassion fatigue will commonly experience emotional numbing, irritability, physical exhaustion and a diminished capacity for empathy. It is essential that organisations such as the NHS and individuals recognise and address this hidden occupational hazard.

For activists and learning and workplace representatives this is key: recognising the signs in others and in yourself and putting in place ways to help.

What you can do

So in what ways can you help? Well, recognising the growing prevalence of compassion fatigue, some NHS teams have implemented innovative wellbeing initiatives. Strategies include music therapy, which is playing music or the radio in

clinical areas during the day, at a desk or in communal areas at low levels. This doesn't interfere with workflow, but it does help maternity staff and those in their care to feel more relaxed as it replicates a 'normal' home environment.

Another strategy is 'Never Event' time-outs. Never Events technically should never happen but do. After these events doctors routinely pause and reflect; however, midwives and maternity support workers (MSWs) are never encouraged to do the same, even though it is essential to help process what happened. Even if it wasn't a Never Event, taking five minutes to reflect as a midwifery team after any incident or difficult birth is good practice as the ripple effect of it will be widely felt.

Check-ins and check-outs are used routinely among many hospital trusts and boards. These are simple step-by-step solutions to check in with colleagues (as well as check in with yourself), to process emotions and to put the day into context to prevent emotional overload (see *The 'Going Home Checklist'*).

Even small changes – such as creating poster-free restrooms to provide visual and mental calm – can improve the working environment and promote mindfulness. Most of these practices are already happening across clinical areas, but sadly this good practice is not shared. Many maternity professionals believe we no longer have the time or staff to implement changes.

IMAGE: SHUTTERSTOCK

RCM branches

These approaches align with evidence suggesting that reflection, peer support and self-care practices are effective in mitigating the impact of compassion fatigue. Creating structured opportunities for emotional decompression helps sustain both personal wellbeing and professional compassion. RCM branches are a good starting point. They can play a vital role by offering awareness campaigns, peer support initiatives and wellbeing workshops to help members identify early warning signs and seek help proactively. Encouraging open discussions about emotional resilience reduces stigma and fosters collective coping strategies within midwifery teams.

The 'Going Home Checklist'

- Take a moment to think about the day
- Acknowledge one thing that was difficult about the day – and let it go
- Consider three things that went well
- Check on your colleagues before you leave – are they okay?
- Are you okay? Seek support from representatives, colleagues and senior managers if not
- Now switch your attention to home to rest and recharge.

Doncaster and Bassetlaw Teaching Hospitals

We polled colleagues at the RCM Activist conference: they highlighted some good ideas that branches can implement quickly and easily such as tea rounds, local therapist visits, walk arounds, drop-in sessions, visits from therapy animals and leadership training.

Workplace reps can make sure that midwives and MSWs are included at a policy/guideline level to ensure that these simple steps can become routine.

Compassion fatigue is not a new phenomenon, but this modern understanding of it provides insight into its causes and consequences. Healthcare professionals must not ignore the warning signs, and organisations must prioritise emotional health as part of safety and care quality initiatives.

By fostering empathy for caregivers as well as for those in their care, the NHS and professional bodies can build a culture of compassion that sustains everyone.

FIND OUT MORE
Find out more about Caring for You at **rcm.org.uk/caring-for-you**

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The Baby Blues and Post-natal Depression

THE ASSOCIATION FOR POST NATAL ILLNESS

This short, informative leaflet is approved by Midwives, Health Visitors, Community Practitioners, GP's and Perinatal Psychiatrists.

The leaflet is appropriate for all newly delivered women and ideal for Ante and Post-natal Clinics and Maternity Wards.

Thanks to a generous legacy we are able to offer this leaflet free to health professionals in quantities of 1,000, 2,000 and 5,000.

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Please ring 0207 386 0868 between 10am and 2pm on weekdays or email: **info@apni.org**

Please quote: **RCM COMMUNITY** when ordering

The Baby Blues and Post-natal Depression

One in two women experience the Baby Blues after giving birth. This leaflet explains why you may have mood swings after your baby is born and offers practical information and advice about the Blues and Post-natal depression.

Victoria White thought that she had experienced postnatal depression, but it was something else

Understanding the difference

Following the birth of my eldest daughter nine years ago, my senses were overloaded, my cognitive functions felt like they had gone missing and I lost all ability to regulate my nerves and my emotions. It sounds like an account of postnatal depression and anxiety, but what happened a few years later led me to reconsider.

When my daughter was five, she was diagnosed with autism, then latterly with ADHD. I began to look at my own experiences through a lens of neurodivergence, and I received my own diagnosis of autism and ADHD at the age of 41. This was unsurprising to me in many ways, yet it is something that I am very much still processing.

Reflecting on my perinatal experience, I think there are several areas of support that I would have benefitted from, had my neurodivergence been known about.

Sensory processing

I struggled with the hospital environment from a sensory perspective, particularly the lighting, noise, smells, food and bed linen texture. I found it hard to share a space with other parents, babies and their visitors due to all the sensory input they brought. It would have been beneficial to access a private room or to have been supported to reduce the sensory stressors in my environment.

Communication

I find it difficult to recall information that has been provided verbally and prefer to have information written down, which I can review multiple times at my own pace. I found our antenatal classes particularly challenging due to the social anxiety of a large group setting coupled with the lack of written information, which I had to seek out myself via books and websites. Processing information during labour was also incredibly challenging.

> **"I received my diagnosis of autism and ADHD at the age of 41"**

Executive functioning

Demands on the brain's day-to-day management system increase during the postnatal time, making it harder to carry out tasks and meet daily obligations. I often hyperfocus on topics, and at the time became overly fixated on sleep schedules and breastfeeding, which contributed a lot to my anxiety. Support to access quality information would have helped.

Mental health

I felt isolated because my experience as a new mum seemed so different to my peers and my mental health suffered. Reassurance and validation of my experience would have made a huge difference to my mental wellbeing.

These are all areas where many neurodivergent people report experiencing differences, and that's why I think it's important to raise awareness. Under the Equality Act 2010, neurodivergent people have a legal right to access maternity care in an equitable way. The starting point is understanding those differences.

READ

Victoria is the founder of Neurodivergent Birth CIC and author of *Why Neurodivergent Birth Matters*, published by Montag & Martin. She also hosts The Neurodivergent Birth Podcast. Visit **ndbirth.com**

RCM i-learn module *Neurodiversity in the workplace* (study time: 40 minutes): **b.link/RCM-neuroworkplace**

CoppaFeel!

The charity is encouraging all midwives and maternity support workers (MSWs) to raise awareness of breast cancer with those in your care – and to check yourselves too

Facts

Around 2,500 people under the age of 40 are diagnosed with breast cancer every year in the UK and more than 200 pregnant women a year in the UK may be diagnosed with breast cancer during their pregnancy or up to two years after birth. Pregnant women are more likely to be diagnosed at stage 4.

Trust

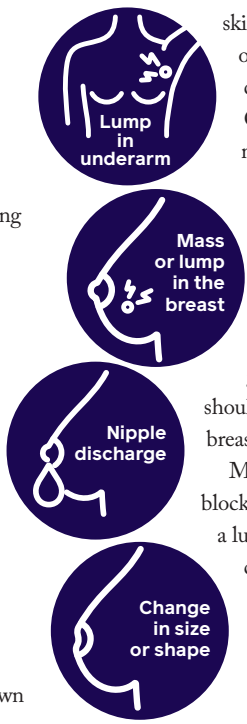
As midwives and MSWs, you are in a trusted position to encourage women to check themselves regularly during pregnancy and after birth – especially if you are giving breastfeeding support – and to tell them what to be aware of.

All women are encouraged to check their breasts every month and know what is normal for them. However, there are so many changes in the body during and after pregnancy (for example, breast density and nodularity increases) that it can be difficult to keep track.

So here are some things to be aware of:

- Skin changes such as puckering or dimpling, like orange peel
- Unusual lumps and thickening
- A rash or crusting on or around your nipple*
- A sudden, unusual change in size or shape
- An unusual lump or swelling in your armpit or around your collarbone
- Liquid coming from the nipple
- Constant, unusual pain in your breast or armpit.

* Changes to the colour, which can look different depending on your skin tone. On black skin, the area may go darker than the surrounding area. You may notice small spots in the area or changes in the colour, like purple, yellow or grey. On brown skin, the colour change may be more of a dark red. The area may also go darker than the surrounding area. On white skin, the colour change may look pink or red.



Pregnant women with breast **symptoms persisting more than seven days** – such as a breast lump, skin distortion or nipple discharge not clearly because of pregnancy-related galactorrhoea (flow of milk) – should be referred to a diagnostic breast clinic for urgent assessment.

Many lactating women experience blocked milk ducts that can present as a lump. Inflammatory breast cancer can often be mistaken for mastitis, so any lump perceived to be a blocked milk duct that does not resolve within seven days should be urgently assessed.

Remember, early detection is the best defence. So, encourage service users to get it checked out if they notice any of the above changes. And don't forget yourselves, check regularly and check often – men, that's you too!

scan

MORE INFO

Scan to download resources specifically for pregnancy (created in collaboration with Tommy's) and resources for health professionals

IMAGE: COPPAFEEL!

Drapolene® Cream

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Recommend at every nappy change to prevent and treat nappy rash

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