Written evidence submitted by the Royal College of Midwives to the Independent Chief Inspector of Borders and Immigration

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THE ROYAL COLLEGE OF MIDWIVES

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Written evidence submitted by the Royal College of Midwives to the Independent Chief Inspector of borders and immigration on Asylum Accommodation.

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Introduction

The Royal College of Midwives (RCM) is the professional organisation and trade union that represents almost all the midwives in the UK. The RCM is the voice of midwifery, providing excellence in representation, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

We thank the Independent Chief Inspector for the opportunity to comment on asylum accommodation, and dispersal, in respect of the needs of pregnant women and new mothers.

The specific clinical needs of vulnerable women are well defined in the NICE guidance for antenatal care.[1] Previous enquires into maternal death have found asylum seeking, pregnant women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population.[2]

Unique vulnerabilities exist for migrant mothers recently coming to the UK, some without support networks, with little or no English, who have been trafficked, or victims of slavery/ torture, and those whose status has become more vulnerable after relationship breakup or from overstaying. Midwives and maternity systems must adapt to meet the needs of these women and their babies in order to improve health and wellbeing and reduce health inequalities. Vulnerable migrant women may be in contact with other non-NHS services or in receipt of services which will greatly impact her physical and mental health. As a

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[1] NICE (2010), *Pregnancy and complex social factors* , CG110. https://www.nice.org.uk/Guidance/CG110

[2] Confidential Enquiry in Maternal and Child Health. 2004. *Why mothers die 2000–2002. The sixth report of the confidential enquiry into maternal deaths in the UK*. London: Royal College of Obstetricians and Gynaecologists; Poverty among refugees and asylum seekers in the UK: An evidence and policy review Jennifer Allsopp, Nando Sigona and Jenny Phillimore. Iris Working Paper Series, No.1/2014. https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2014/working-paper-series/IRiS-WP-1-2014.pdf

consequence, these women must be cared for holistically, with midwives having a good understanding of the wider social and economic opportunities and constraints on them and their children.

There has been extensive research and lobbying in recent years around the needs of pregnant women and new mothers in the asylum system. The RCM has welcomed the efforts of many charity and voluntary organisations, including our midwifery and maternity support worker (MSW) members, to bring substandard conditions and practices to light.

The Home Office has been in a process of updating is Healthcare Needs and Pregnancy Dispersal Policy since 2012. The latest 2016 version has positive opening statements in regards to the importance of safeguarding health and wellbeing of pregnant women and new mothers which is great to see. However, it still has shortcoming in regards to handovers of care, the categorisation of the care always required by asylum-seeking women. It isn't clear how the guidance is being operationalised, with many of its protocols depending on the behaviour and resources of contractors. We would like the Inspector to look at the Home Office's 2016 guidance, its communication with stakeholders and its implementation to see if progress can be made.

For our response to this call for evidence, we have used information from a series of focus groups with midwives to discuss the needs of women with complex immigration status. We also collaborated on a guide for midwives caring for women with asylum claims in partnership with Maternity Action[3] which we will also use to highlight what we see are the needs of this specific group of women. Lastly, we have consulted midwives who care for pregnant women and new mothers who are housed in Initial Accommodation to inform the Inspector of conditions following the Home Affairs report was published 13 months ago.

Clinical care needs of women with asylum claims

As a general rule, all asylum seekers can be deemed to have high risk pregnancies from early in the pregnancy due to a combination of their housing, poor nutrition, poor previous access to health services and access to NHS services now, and stress from a lack of security and social support. Some will have serious medical and psychological problems from being victims of violence and discrimination, which has led them to seek asylum in the UK. Further, BAME women in the UK in general are at a higher risk of complications during pregnancy.

In particular:[4]

Destitution and homelessness

- Infants of women who are homeless have a significant risk of low birth weight, and low birth weight babies have a significantly higher risk of morbidity and mortality.

Sub-optimal antenatal care

- The aim of antenatal care is to monitor and respond to risk factors, signs or symptoms that may affect the health of the mother and baby.

[3] See www.maternityaction.org.uk

[4] Maternity Action and RCM (2015). Housing and financial support for pregnant women who have been refused asylum: a briefing for midwives and other health professionals. https://www.maternityaction.org.uk/wp-content/uploads/ma-asap-briefing_v4.pdf

- Starting antenatal care during later stages of pregnancy (known as 'late booking') is strongly associated with worse outcomes for mothers and babies.
- It also prevents the development of trust between the midwife and pregnant woman which can mean women are less likely to disclose issues in their life which will impact the care they need.

Stress

- There is evidence of a physiological link between stress and mechanisms triggering labour. Stress increases the risk of preterm delivery, and chronic stress may be an important component of some preterm births.
- Domestic abuse and post-traumatic stress disorder (PTSD) are also linked to preterm births. Asylum seeking women are at higher risk of PTSD than the general population.
- Women experiencing severe stress have a significantly increased risk of mental health problems during pregnancy and may find it difficult to engage with healthcare services and to attend appointments. Continuity of care is critical for women with these problems because the delivery and postnatal period will predispose such women to further mental health problems.

Specific migrant and Black, Asian and Minority Ethnic health risks

- Pregnant asylum seekers are significantly more likely than the general population to have untreated or undiagnosed medical complications which give rise to adverse pregnancy outcomes.
- Maternal health outcomes for BAME groups in the UK are also significantly worse than for the general population with maternal mortality rates up to six times higher than those of White British women.
- The Confidential Enquiry into Maternal and Child Health 2007[5] recommended that all pregnant women from less developed countries should have a full medical assessment and history at antenatal booking or soon after.

The above risk factors are often interlinked. Maternity care for all asylum seekers should therefore include all the recommendations for care of women with high risk pregnancies. As a group likely to have high risk pregnancies, they should also be advised against taking any long distance travel during pregnancy.

Midwives' caring for women with precarious immigration status

As part of a wider project of improving public health through midwifery, we held focus groups with midwives and maternity support workers (MSWs) to ascertain the needs of pregnant women with precarious immigration status. We also explored what midwives needed to provide care, and what barriers were preventing this.

Midwives and MSWs in the focus group expressed their frustration about starting to develop a relationship with a woman, only for her to be dispersed and lose continuity of carer.

> M1G6: I found the Home Office useful for housing her but they did just uproot her and move her away at extremely short notice, away from continuity of care and the only support she had established - us and other local services …. Often they get moved to different cities before we get to grips with their care planning. They must

[5] Lewis, G (ed) 2007, *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom.* London: CEMACH.p225

> have very disjointed care because we don't always know where they've gone. We don't always get reassurance from someone that the [new] local midwives will be notified…

They also found that direct contact with accommodation providers could be difficult:

> M5S7: It (their housing solution) depends on what stage of the immigration / asylum process; G4S are our housing providers for asylum seekers. They are a nightmare to contact, very slow to respond via email regarding certain issues. Not always that helpful, however this week they were quite good.

A strong emphasis was put on the vital importance of knowing what services - statutory and voluntary - are available locally, and the importance of good working relationships across services in order to provide the care women needed. Participants spoke of midwives and others going above and beyond, an example of the NHS 'picking up the slack' or being the gatekeeping to other services. Housing is just one piece in this puzzle, and we would like the Inspector to look at the impact on other services, like the NHS, when housing or a sense of security is substandard:

> M4V6: I also have a good relationship with some women who have a business fixing buggies and prams. I ask for the ones they would like to donate - I have been lucky to give clothes bundles and Moses baskets for those who have no money or are unable to access these items.

> M1G6: My amazing colleagues luckily had fantastic knowledge of the local area, and our MSW [maternity support workers] has a folder full of local services to refer people to. She contacted a local legal aid service which was the most help. They helped her apply for asylum and got everything started. A large part of our MSW role is social support, and assisting people with language barriers to apply for financial help or to phone other services. I'm aware she uses the web to apply for emergency funding or maternity pay with some of our clients. She tends to do this sort of thing as she has time and clinics allocated to it… Ultimately [one woman] accessed every service she could, and was amazed she could use the library to go on the Internet for free, and go swimming for free! There was a happy ending to her story

> M4V6: It's a tough one. Sometimes I wangle them staying on the ward for the night until early then next morning when they have to go to the housing office ASAP.

> M5S7: I've signposted people to the organisation Shelter if they are homeless, or the city council, or Citizens Advice Bureau

Home Affairs Committee report January 2017

The Home Affairs Committee report into Asylum Accommodation, especially the care of pregnant women and new mothers Initial Accommodation (IA), makes for sobering reading. The RCM fully supports the recommendations of the Committee which we believe are sensible measures to take to safeguard the health and wellbeing of pregnant women and new mothers.

We have consulted with midwives who care for women – mostly those on Section 95 support – in an IA in London about what they think has changed since the Report was published just over a year ago. For context, a caseload audit found:

- 46 per cent of women had not accessed antenatal care previously
- 72 per cent required an interpreter
- Only 43 per cent required no mental health referral – 9 per cent had a severe mental health illness requiring a perinatal psychiatric referral and a further 38 per cent had a mild to moderate condition requiring referral to GP/IAPT or a migrant NGO.

In response to the Committee's recommendations, the midwives have noticed improvement in some areas but many others remain substandard. Midwives are continuing to work around barriers the best they can by using their knowledge of social and community services as the focus group quotes above illustrate.

Transport for pregnant women and young mothers to access to medical appointments has improved. Midwives report there is now a system of retrospective authorisation and payment for same day transport on clinical advice. Midwives are notified when a pregnant women arrives into IA and all pregnant women whatever gestation are offered initial comprehensive midwifery assessment to provide earliest identification any issues and planning of effective care. The midwives report the Home Office policy of not dispersing women in late-pregnancy or the postnatal period is being adhered to.

However, for wider medical conditions, screening is more difficult: there is not universal coverage for health screening in IA so it is not possible to detect all health issues. A dedicated in-hostel medical screening service would be beneficial particularly when people only stay in IA for less than 48 hours.

Women in the late stages of pregnancy do not get their own rooms, but these are provided once their babies are born.

There is no designated indoor or outdoor children's play area in this IA, few toys or activities. Families are encouraged to take children to local external facilities and groups.

Women receive three basic meals a day but there is questionable nutritional quality to meet the needs of pregnancy or lactation. Fresh fruit and vegetables are lacking, and restricting food to meal times only means breastfeeding mothers are not getting what they need. Midwives report that their repeated arguments to improve this have fallen on deaf ears.

There is still mixed-sex accommodation, which is distressing for women who have experienced violence. Midwives report that women feel afraid to walk the corridors to use the bathrooms at night, and would like to see more provision for women-only areas or times. It is still difficult to access specialist support for torture survivors due to specialist charitable support organisations being over-subscribed.

There is still variation in the quality and availability of baby baths, baby cots, slings, with most relying on charities for these basic needs. Only this week, midwives working in this IA have noticed new bedding, mattresses and Moses baskets being provided to women for their babies. This is a great improvement but also illustrates how things can change in IAs from day to day. Before this, the midwives reported women were only receiving second-hand Moses baskets with used mattresses which are not easily certified as safe (used mattresses in poor

condition are linked to increased risk of Sudden Infant Death Syndrome[6]), so the new sleeping materials delivered this week are a great safety improvement.

Midwives report that there are unsafe infant feeding practices, as women don't have access to sinks, sterilisation equipment or facilities to boil water. Basics, like washing-up liquid to clean equipment, are missing. Kettles are not allowed in rooms so formula feeding mothers are expected to visit reception (day or night) to collect hot water to make up feeds.

Most worryingly, midwives are still reporting that when women are dispersed, they are given little, if any, notification. Often it is dependent on the woman having access to a phone to contact the midwives directly. This is not in keeping with clear recommendation from the Committee to improve the communication between midwives in different areas of the country to ensure seamless care. Midwives try get around this by using paper notes - including scan and blood results, instructions to register with GP and contact details for previous midwife.

England has a clear national ambition to improve continuity of carer for women, which has specific benefits for women and babies in reducing pre-term birth and miscarriage. Considering that asylum-seeking women have a higher risk of these outcomes, more effort must be made from the Home Office to improve coordination between healthcare providers. The RCM would like to see the dispersal of pregnant women and new mothers as an absolute last resort so women can continue with the same carer, during the antenatal, intrapartum and postnatal periods.

Overall the RCM believes there is evidence of improvements to asylum accommodation recently, showing that the Home Affairs committee report has had an impact. But some of the fundamental issues of temporary accommodation - with interrupted care, limited funding, the involvement of government and voluntary sector organisations and a population with complex needs - are yet to be resolved. We hope that further progress can be made from your Inquiry and we would welcome any further engagement with organisations and maternity staff as you see fit.

The Royal College of Midwives
4 March 2018

[6] See https://www.lullabytrust.org.uk/safer-sleep-advice/mattresses-and-bedding/