Royal College of Midwives

Response to the Women and Equalities Committee Inquiry - Unequal impact? Coronavirus and the gendered economic impact

July 2020

The Royal College of Midwives' response to Unequal impact? Coronavirus and the gendered economic impact

Royal College of Midwives

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, 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. The RCM welcomes the opportunity to respond to this consultation.

The Royal College of Midwives
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The COVID-19 pandemic has impacted on women and men in different ways. Although it appears men are more likely to die after having contracting COVID-19, women are more likely to report struggling with their mental health, and they are more likely to have had their employment impacted, and their caring responsibilities increased. As such it will be necessary to consider the unique impact of COVID-19 on women, and to proactively develop responsive strategies.

1. **Mental health**

   Even prior to the pandemic, we knew that up to 20 per cent of women experience mental health problems in the perinatal period.[1] Maternal mental illness is also a leading cause of maternal death.[2] Mental health problems during pregnancy can have a harmful impact not only on the woman but also have been shown to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences.[3] In 2014, the LSE Centre for Mental health estimated that the annual cost of perinatal depression, anxiety, and psychosis carry a long term cost to society of about £8.1 billion for each one-year cohort of births in the UK.[4]
   Although the impact of this pandemic on maternal mental health is yet to be properly evaluated, we know that the pandemic has created a particularly challenging climate for pregnant and postpartum women. The COVID-19 pandemic has caused women to experience additional anxiety, specifically

around the impact of social isolation resulting in reduced support from family and friends, the potential for reduced household finances, and major changes in antenatal and other NHS care e.g. from face-to-face to telephone contact; as well as limits on visitors and on home birth services.[5] In these circumstances, some women will feel they need to turn to substance misuse to cope. The requirement to isolate in such tense circumstances has also caused a spike in domestic violence which may cause women to miss appointments or otherwise reduce help seeking behaviours.[6]

In addition, although initial data suggested no increased risk of infection and morbidity among pregnant women compared to the general population, some studies have reported that pregnant women are at risk of having more severe disease.[7] Preterm deliveries are also reportedly more common, and maternal and neonatal mortalities have been reported.[8] These uncertainties are likely to add to women's anxieties.[9]

As such, although it will take time to generate empirical evidence, it is safe to speculate that pregnant women are at increased risk of developing mental health problems such as depression, anxiety, and post-traumatic stress symptoms. This must be considered in light of the existing maternal mental health caseload in the UK.

Prior to the outbreak of COVID-19, the RCM called for all NHS trusts in England to employ maternal mental health specialist midwives so women can get the support they need. This is now more important than ever. Midwives have a unique opportunity to identify women who are at risk of, or are suffering from, perinatal mental illness, and to ensure that these women and their families get the care they need at the earliest opportunity.[10] It is also increasingly suggested that midwives play an important role in the provision of mental healthcare beyond screening and referring, and are well placed to provide counselling interventions.[11]
The RCM additionally supports the Maternal Mental Health Alliance in their calls for adequate provision of specialist perinatal mental health services (inclusive of both specialist perinatal mental health community teams and inpatient mother and baby units). While we are pleased that new funding was

announced for specialist community multi-disciplinary perinatal mental health services in 2019,[12] we support MMHA's call to ensure this funding is not misspent by CCGs, to address outstanding areas of need in Scotland, Wales, and Northern Ireland, and to ensure women and families have access to specialist multi-disciplinary perinatal mental health services as part of an integrated care pathway.[13]

Finally, the RCM urges the Committee to consider the mental health impact of the pandemic on healthcare professionals who are women. As the only trade union for midwives and maternity support workers in the UK, the RCM represents a workforce that is 99% female.

During the pandemic 57% of our members have told us the crisis has had a negative impact on their mental health. If midwives and MSWs are to care for women's mental health needs, more must be done to safeguard their mental health, particularly in light of the fact that even prior to the pandemic only 26% of midwives reported having time to take a break and 64% reported feeling unwell due to stress. The RCM calls for sustained support for midwives mental health including the establishment of 'wobble rooms'[14] and continued availability of counselling and other assistance.

It is important to note that although it is clear that midwives and MSWs struggles with mental health can be attributed to pressures at work, midwives and MSWs mental health is also likely to have been impacted by other factors which are impacting women in general. For example, Ipsos Mori and the Fawcett Society have found that women were more likely to have taken up additional caring responsibilities during the crisis and were more likely to report struggling to stay positive.[15] Women are also more likely to have had their employment affected by the pandemic.[16]

2. Employment

McKinsey estimates that during lockdown, around 7.6 million jobs were at risk of permanent layoff, temporary furloughs, and reductions in hours and pay.[17] They also found that the risks are highly skewed: people with the lowest

incomes are the most vulnerable to job loss. As women are one-third more likely to work in lower paid sectors like retail and hospitality,[18] and more likely to work part time, their employment was most likely to be affected.

This finding was further confirmed in a cross-country study conducted by Cambridge, Oxford and Zurich universities, in which it was revealed that women in the UK are four percentage points more likely to have lost their job than men. This gender gap in job losses persisted even when the researchers controlled for education, occupation and regional location within each nation.[19] The researchers identified increased caring responsibilities, for example home-schooling, as a possible cause for the gender gap in job losses. Another cause is likely to be generalised sex discrimination, and pregnancy and maternity discrimination.

In 2016, the UK Government asked the Equalities and Human Rights Commission (EHRC) reveals that approximately 1 in 9 mothers (11%) were dismissed; made compulsorily redundant; or treated so poorly they felt they had to leave their jobs. If this figure is scaled to match the population, this means as many as 54,000 women are being forced out of their jobs every year. To address these figures, the EHRC made a series of practical recommendations. Four years later, the UK Government is yet to act on a single one.

Due to the economic downturn triggered by the pandemic, organisations like Maternity Action are predicting a wave of unlawful discrimination and unfair redundancies as businesses ‘adjust’. A recent TUC survey found that more than one in four pregnant women have experienced discrimination or unfair treatment at work since the COVID19 crisis began including being singled out for redundancy or furlough.[20]

For this reason, the RCM has joined Maternity Action in calling for the Government to adopt the Pregnancy & Maternity (Redundancy Protection) Bill recently introduced by Maria Miller MP. Miller’s Bill would see the current, inadequate law replaced with a new framework of protection for pregnant women and new mothers. Most notably, the Bill would prevent employers

from making a woman redundant from the time she notifies them she is pregnant until six months after the end of her maternity leave, including those who experience stillbirth or miscarriage. This change would represent an enormous step forward when compared with the current system, under which women are forced to shoulder the burden of challenging an unfair dismissal at an Employment Tribunal – a process which often costs in excess of £10,000.[21]

Miller's Bill represents and an elegant solution to a complex problem. If it is not adopted, significant work will be required to ensure women are not unfairly discriminated against in the coming months.

Better protections are also necessary to protect pregnant healthcare workers including midwives. When the pandemic broke out, there was significant confusion over the rights of pregnant healthcare workers whose work may put them at risk. Anecdotally, the RCM heard that many NHS Trusts were unaware that, as employers, they were required to conduct a risk assessment for pregnant workers, and where their work posed a risk, to offer the employee suitable alternative work or suspend them on full pay. This lack of understanding caused considerable stress and may have placed some workers at risk. More must be done to ensure NHS and other employers understand and comply with their obligations to pregnant employees.

3. Domestic violence

As mentioned above, measures to control the spread of COVID-19 including social distancing measures have exacerbated risks for domestic violence survivors, the vast majority of whom are women. Isolation has also increased barriers to support and changes to the format of midwifery (and other health care) appointments from face-to-face to primarily virtual have made assessment for women experiencing domestic violence more difficult.[22] In the first three weeks of the pandemic the number of deaths from domestic abuse more than doubled. Further, Women's Aid reports 67% of survivors who are currently experiencing abuse said it has got worse since Covid-19 and 72% said their abuser had more control over their life.[23]

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Health professionals, including in particular midwives, play a vital role in intervening in domestic abuse cases by providing a window of opportunity for survivors to disclose and be offered a referral into specialist support. Every year nearly half a million survivors of domestic abuse seek assistance from medical professionals.

Often health professionals are the only statutory service to come into contact with both the victim and perpetrator. They hold critical information around the safety of the family and can make a significant difference in intervening earlier and ultimately preventing a homicide from happening. Evidence shows however that more often than not these opportunities are missed and health professionals are not appropriately equipped to respond to domestic abuse. Pathfinder is the first national health project to take a systemic approach to transforming the health sector's response to domestic abuse.

It combines all elements of good practice from acute, mental health and GP practices settings into a comprehensive model response to domestic abuse. From the work of Pathfinder, we know that a systemic approach to responding to domestic abuse in health is needed in order to make sustainable and meaningful change. A whole health approach to domestic abuse goes beyond training and stand-alone interventions. This requires a change in the culture of health services and a strategic, funded commitment to implement the necessary structural changes to embed this work.

The RCM has joined a number of likeminded organisations in calling for the Government to establish a comprehensive health response to domestic abuse. This will entail:

1. DHSC to ensure that all health services (including Trusts and CCGs) provide a strategic commitment to responding to domestic abuse. This must be done by requiring Board-level commitment to domestic abuse survivors by setting up
a. Specific DA governance structures
b. Comprehensive domestic abuse strategy and internal policies

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c. Effective and comprehensive data and information sharing systems

These strategic structures and processes are critical and will set the foundations to ensure this work is sustainable and embedded in all areas of the health system.

2. Sustainable and significant government investment is required to ensure that all key elements of best practice interventions in health are implemented consistently across all CCG areas. This will address current geographical discrepancies in services and responses. It will ensure that no matter the geographical location or area of the healthcare system where the patient presents, they will receive an effective and safe response. There are a number of evidence-based and good practice interventions covering primary care, acute and mental health. They are integral components of a whole health response.

3.Sustainable funding is required for high-quality, specialist training of all healthcare professionals, including online resources that can be easily accessed during the current crisis. Sustainable funding also needs to be provided to ensure referral routes are in place for patients. As outlined by Agenda in the Ask and Take Action Briefing Paper , there is a need for public authorities to ensure frontline staff in our public services are making trained enquiries into domestic abuse. Tiered and mandatory training around domestic abuse should be set up in all Health services. Training should include specialist content on how to identify, respond to and refer both survivors and perpetrators of domestic abuse in acute, mental health and primary care settings, as well as embed specialist workers within health settings. The training delivered should be trauma-informed and should take an intersectional approach.

4.An increase in funded quality-assured programmes for health professionals to refer perpetrators into underpinned by research and evidence. Interventions such as the evidence-based programme Drive can demonstrate what can be achieved when adequate resources are invested in this area of work.

5. A long-term public health campaign to challenge public attitudes to domestic abuse.

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6. Representation from mental health services on the Domestic Abuse Commissioner's advisory panel, in addition to the wider health service representation.[24]

In addition, the RCM believes strongly that more must be done to support our female NHS workforce who disproportionately experience domestic abuse. In 2016, a SafeLives report on domestic abuse services in hospitals revealed that 44,825 (87%) female NHS staff reported experiencing domestic abuse.[25] Our own survey in 2018, further revealed that 82% of surveyed midwives and MSWs reported experiencing domestic abuse during their working lives.[26]

As such, the RCM calls for:

1. All NHS Trusts/Health Boards to develop specific policies to support staff who are victims of domestic abuse, aligned to existing guidance from the NHS Staff Council developed in 2017. Local policies should be developed in partnership with staff side representatives, with detailed commitments to provide special paid leave, adjustments to working arrangements and safety considerations if appropriate.

2. NHS Trusts/Health Boards should provide and publicise confidential domestic abuse support services for affected staff, including access to IDVAs, external counselling and legal services as appropriate.

3. NHS Trusts/Health Boards should ensure that all managers and supervisors are trained on domestic abuse issues, so that they can recognise signs of domestic abuse in their staff and confidently undertake their safeguarding obligations.

4.NHS Trusts/Health Boards should ensure that staff at all levels are trained on domestic abuse issues and made aware of relevant workplace policies as part of their induction programme and continuous updating and are made aware of support services.[27]

Conclusions

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We thank the Women and Equalities Committee for the chance to contribute to this conversation and urge the committee to make ambitious recommendations to government which take into account the above comments.

Source

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