THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 24 / MAY 2021

midwives

PREGNANCY INFORMATION: THE RISK OF SHARING VERSUS SCARING

HOMEBIRTH VERSUS THE PANDEMIC: DIFFICULT SERVICE DECISIONS

GOODBYE CASENOTE FOLDER, HELLO DIGITAL PREGNANCY RECORD

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RCM executive director for external relations Jon Skewes says it's time to value midwives and MSWs

Welcome

As a trade union, the RCM makes no apology for campaigning, influencing and negotiating for the contributions of our members to be well rewarded. During the past 10 years, in the jaws of economic austerity, that has been an uphill task. In some respects, NHS pay has been better ring-fenced than in other parts of the public sector. The negotiated 'three-year deal' that we are just coming out of restructured pay for many in a beneficial way. One statistic stands out though: midwives at the top of Band 6 are now seven thousand pounds worse off in real terms than they would have been in 2010.

They cannot clap you one week and insult you another

This is in addition to the long-term shortages of staff in maternity, the impact of caring for women and their families during the pandemic, and the very real risk – identified in so much research – that experienced staff will leave the NHS. If that happens to any significant extent, then the RCM's long-lobbied-for plans to invest in expanding maternity staffing to support quality and safety will be undermined. Our evidence to the NHS Pay Review Body (PRB) this year suggests that 38% of you have considered leaving.

What would address this issue? Policies on wellbeing, rest and recuperation and better local implementation of them, flexible working and improving workplaces. But valuing staff is the most critical.

That is why our 'Deliver a Decent Deal' campaign is so crucial and why the RCM has been engaging with members and politicians and in giving evidence to the PRB in the rest of the UK.

In Scotland, in the pre-election period, the RCM negotiated a significant offer that certainly sets the going rate, and is back-paid to December 2020. Members in Scotland have been consulted on this offer. In the rest of the UK, governments have decided to refer the level of pay increase to the PRB. We have given our evidence in detail, twice, and provided further information and research. Politicians, who have strung out the process, would be well advised to implement its recommendation in full. They cannot clap you one week and insult you another. If a headline increase of 4% is affordable in Scotland it must be in England, Wales and Northern Ireland too.

A significant and early pay rise for all members across the NHS is affordable, economically sensible, necessary and fair.

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[1]European observational study on 1718 children with Atopic Dermatitis, scientific poster European Academy of Dermatology Venereology 2011. Lipikar AP+M is a cosmetic product.

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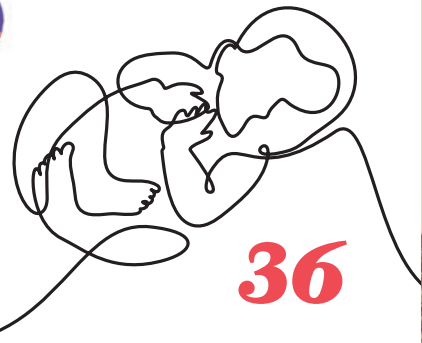


COVER ILLUSTRATION: CHU-CHIEH LEE / FOLIO ART

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Maternity voices

Using women's lived experience to inform and develop health services is key to improving experiences and outcomes. That's the aim of the government's 'call for evidence' to women, healthcare professionals and women's health organisations. They are being encouraged to share their experience via an online survey that runs until the end of May. The results will inform a Women's Health Strategy to improve the health and wellbeing of women across England.

RCM chief executive Gill Walton said: "We welcome this ambitious government-led plan to include women's voices in the development of such a large strategy. We know that placing women at the centre of their own care not only improves outcomes in pregnancy, but also improves a woman's experience of birth and maternity care."

This is why the RCM has launched its own Maternity Voice Network, which is aimed at improving women's experiences of maternity care. The network brings together women, midwives, maternity support workers and student midwives to inform and influence the RCM's work.

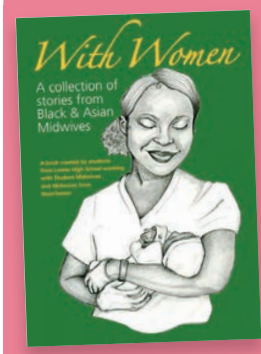
APPLY

Wellbeing of Women has partnered with the National Institute for Health Research to fund one Charity Partnership Doctoral Fellowship, Closing date is 15 July. Visit **bit.ly/NIHR_fellowships**

one to watch

READ

With Women is an RCM-sponsored book about midwives from black and Asian communities that will be sent to every school across Manchester in a bid to promote midwifery as a career choice. Read at **bit.ly/book_with_women**



SUPPORT

The RCM Wales/Welsh government-run annual leadership and development programme on 5 May saw presentations from five stand-out projects. **@MidwivesinMind** was chosen for its clever approach to supporting mental health

NHS Long Term Plan

Maternal mental health

NHS England has announced maternal mental health services for new and expectant mothers. The investment is part of the NHS Long Term Plan and will see 26 newly dedicated hubs set up across England with an ambition of bringing together maternity services, reproductive health and psychological therapy. The announcement is timely, given the increase in the number of mothers experiencing mental health problems since the pandemic began.

Birte Harlev-Lam, RCM executive director midwife, said: "For too long, women with pregnancy-related mental health problems have suffered with care and support often resembling a postcode lottery. Women suffered in silence and their problems deteriorated often so badly that they ended up needing care in a mother and baby unit miles away from their homes.

"It was only when crisis level had been reached that women were treated at these specialist units. Providing these services that are right for women, in the right places with trained healthcare professionals, which are properly funded, will save the NHS money in the long term and stop the toll it exerts on women and their families."

For more, visit bit.ly/NHSnewmumsmentalhealth

Health inequalities

Community support

A Maternal Mental Health Alliance report has shone "an important light on how the coronavirus pandemic has worsened existing health inequalities, particularly for women's mental health during and after pregnancy", said the chair of the Local Government Association's Community Wellbeing Board, Councillor Ian Hudspeth.

"Councils have adapted services to support new mothers and babies during the pandemic, offering virtual contacts and high-priority visits wherever possible, despite workforce pressures," he said. "Rising demand means it is essential that councils have what they need to support new and expecting mothers. This includes adequate funding to invest in the Healthy Child Programme workforce, as well as wider mental health support through suicide prevention work, substance misuse services and children's centres."

RECOVER, REWARD, RENEW: NHS EXODUS?

Exhausted and demoralised staff may spark an exodus from the NHS unless the government does more on support and reward. These are the stark findings of a report by the Institute for Public Policy Research (supported by the RCM). According to the *Record, Reward, Renew* report, one in four healthcare workers say they are more likely to leave the NHS due to a year of unprecedented pressure. This figure includes 8,000 midwives and comes at a time when England is already 3,000 midwives short.

Sean O'Sullivan, RCM head of health and social policy, said: "We are only just beginning to understand the impact this past year had had on the mental and physical health of NHS staff, including midwives and maternity support workers. While we've been encouraged by some measures put in to support staff wellbeing, it's clear from this report that it is barely scratching the surface.

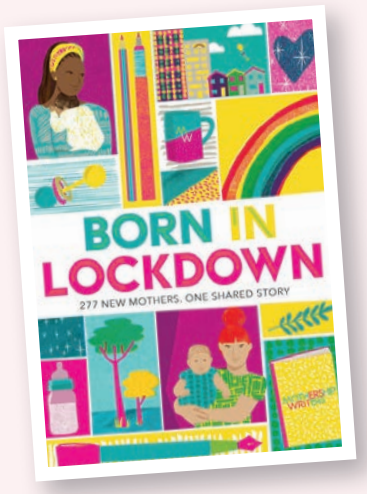
"Add to this the government's derisory 1% pay offer, and it's easy to see why staff are questioning their future in the NHS. We are running the risk of seeing hundreds of thousands of these incredible professionals walking out of our NHS doors and not coming back."

BORN IN LOCKDOWN

The result of a collaborative writing project set up by novelist Emylia Hall gives a voice to new mums navigating what is already a challenging time (but amplified by the pandemic).

Born in Lockdown is an unflinching and moving account of new motherhood during lockdown and contains stories and experiences that could possibly be upsetting or triggering for anyone who has been affected by pregnancy loss or the death of a baby or for anyone experiencing mental health concerns. It is a remarkable record of experiences from the mothers' perspective. The publication is free to download but there is a request for a donation to Sands. Visit mothershipwriters.com/borninlockdown

For bereavement support and to speak to a member of Sands, freephone 0808 164 3332 or email helpline@sands.org.uk
For mental wellbeing support, visit Mind or the NHS websites, or speak to your GP

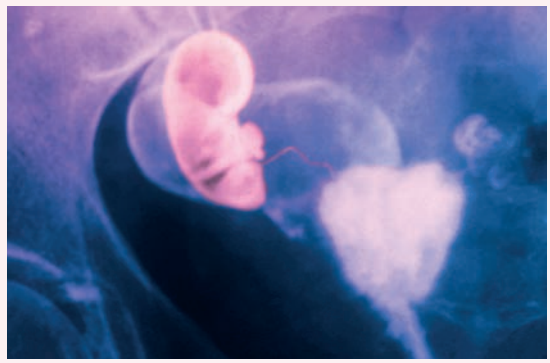


Ectopic pregnancy

The egg's journey

Ectopic pregnancy is one of the most common prenatal complications, yet its cause remains unknown. It affects 1% to 2% of all conceptions in the US and Europe and is the most common cause of pregnancy-related death in the first trimester.

Researchers at the Wellcome Sanger Institute have pinpointed a gene in mice that plays a key role in the egg's journey from the ovary to the uterus. When the gene Adgrd1 was deleted, the eggs remained stuck in the fallopian tubes. Dr Enrica Bianchi, first author of the study, said: "When Adgrd1 is suppressed, the flow oviductal fluid is not reduced and the egg cannot seem to move past the ampullary-isthmic junction."
The study was published in *Nature Communications*. See bit.ly/NatureBianchi2021



Awards

West Midlands innovation

The West Midlands Academic Health Science Network (WMAHSN) revealed the 15 winners of its Meridian Celebration of Innovation Awards.

The awards mark their commitment and drive to revolutionise healthcare across the region with new ideas, technologies and initiatives throughout the COVID-19 pandemic. Maternity service winners were: Implementation of the PIGF test at UHCW to rule out pre-eclampsia, which won the 'Above and Beyond' Adoption of Innovation Award; Gill Phillips, the creator of the 'Whose Shoes?' approach that ensures all voices are heard and reduces inequalities; and Nina Johns, for her remote monitoring solution for expectant mothers, which won the Meridian Innovation and Improvement Champion Awards.
Watch at meridianawards.co.uk

MIDIRS Digest

1 The use of Cultural Safety Huddle and Handover guides to improve care delivery for black, Asian and minority ethnic patients, Hannah Alice King

2 Making different choices – supporting pregnant women requesting care outside recommendations, Cate Langley

3 Respiratory illness, pneumonia and pregnancy: facilitating complex childbirth, L Sherriff

4 Midwives' compliance with the standard precautions of infection control in the maternity setting, Bernice Scicluna, Josephine Attard

5 'Including Dad': supporting men to feel prepared in their transition to parenthood, Shelly Higgins, Elizabeth Glyn-Jones

The above papers are published in *MIDIRS Digest*. Access them at *www.midirs.org*

Some *Evidence Based Midwifery* papers are reprinted in *MIDIRS Digest*. Visit bit.ly/EBMaccess

midirs

Traffic lights

Colour-coded triage

There is no standardised triage system in maternity care – but the Birmingham Symptom-specific Obstetric Triage System (BSOTS) is set to change that.

BSOTS comprises a brief, standardised assessment of women when they attend with unexpected clinical concerns, followed by clear guidance developed to help midwives and clinicians determine the clinical urgency in which women need to be seen. It allocates a colour code so hospital staff can see at a glance who needs to be prioritised. This ensures that variation in treatment and outcomes is minimal and that maternity triage departments are working cohesively.

An initial evaluation at Birmingham Women's and Children's NHS Foundation Trust showed that BSOTS increased the number of women seen within 15 minutes of attendance to maternity triage from 38% to 53%. The system also appeared to reduce the time between attendance to medical review for those who required it.

Dr Nina Johns, consultant obstetrician at the Royal Wolverhampton NHS Trust and co-creator of BSOTS, said: "Not only does it improve quality of care and the safety of pregnant women and staff, it also allows for better communication and creates a less stressful triage environment for staff."

BSOTS is now available digitally and has been adopted by 34 maternity units in the UK with a further 20 in the process of implementation, and 17 awaiting training.

BSOTS programme and training materials are available online for free via the Meridian Health Innovation Exchange. Visit bit.ly/BSOTStriage

New parent support

The best start for life

All prospective parents should be able to access a 'Best Start for Life' package of services that brings together the support available in their local area, to prevent families falling through the cracks.

That's the hope of government advisor Andrea Leadsom, who is chairing a review of the experience of families during the first 1,001 days of their babies' lives. She has yet to secure funding for the 'family hubs', which pick up where Sure Start centres left off. Plans for the hubs include registration of births, services that offer breastfeeding and mental health support and the digitisation of 'red books'.

Angela McConville, NCT chief executive, said: "It's encouraging to see [...] health visiting, midwifery, mental health and breastfeeding support central to the plan, working at accessible hubs alongside public and voluntary sector services. [It] rightly aims to tackle the health and wellbeing inequalities that have been further exacerbated by the pandemic. The government's approach must be multifaceted: improving the direct services on offer for families; ensuring an infrastructure for those providing services in both the statutory and voluntary workforces; and addressing the poverty and hardship experienced by so many families."

Health minister Jo Churchill said: "This vision document sets out key areas for improvement to ensure every child has an opportunity to thrive and achieve their potential."

Visit bit.ly/1001criticaldays

What's on?

3-9 MAY
Maternal Mental Health Awareness Week
Join the conversation online using #MaternalMHMatters or visit perinatalmhpartnership.com

5 MAY
International Day of the Midwife
Join the celebrations at bit.ly/RCMIDotM

10-16 MAY
Mental Health Awareness Week
Visit bit.ly/MHAwarenessWeek2021

15 MAY
International Hyperemesis Awareness Day

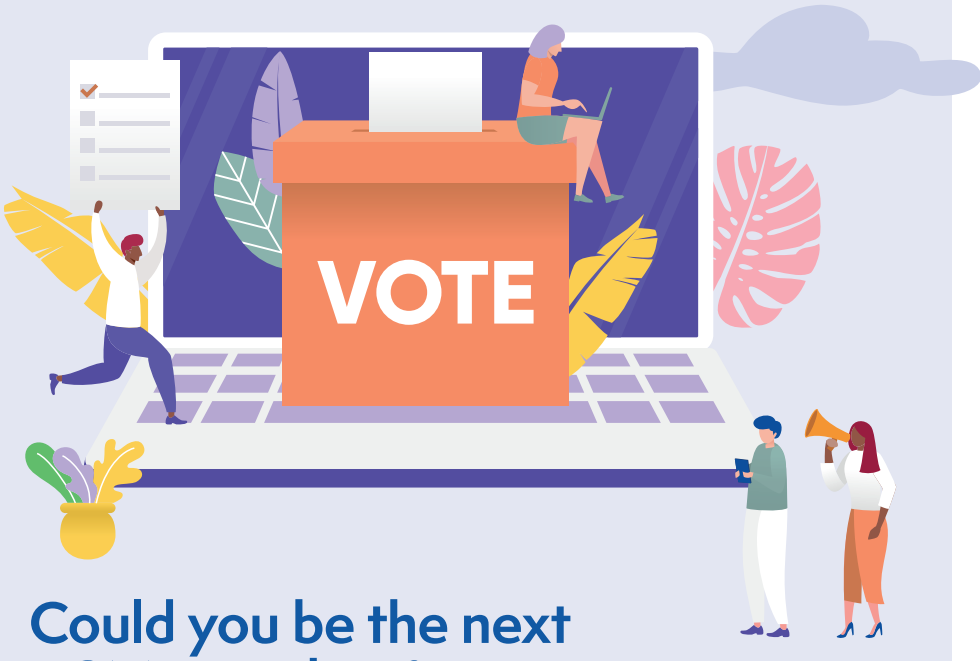
JUNE
Sands Awareness Month
Visit sands.org.uk

14-21 JUNE
Refugee Week, including World Refugee day on 20 June.
Visit bit.ly/RefugeeWeek2021

21 JUNE
Father's Day

Working for you

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



Could you be the next RCM president?

Nominations are now open for candidates for RCM president. Nominees must be practising midwives and make their submission by Friday 7 May. RCM members will elect their new president in June.

Gill Walton, RCM chief executive, said: "There aren't many jobs that come with the opportunity to inspire tens of thousands of your professional peers – but that's exactly the case for the president of the RCM. As RCM president, you get to meet members from across the country, share your experience and hear theirs too. I would definitely urge members to put themselves or colleagues forward."

The president is the ceremonial figurehead of the organisation, working closely with the chief executive and reporting to the RCM board. They serve for three years and may be re-elected for a further term of two years. The current president's term ends on 1 July, with the new president starting on 2 July.

You can find out more about what the role entails and the requirements to apply at bit.ly/RCM_President

MATERNITY PANEL APPOINTMENTS

In March, the Health and Social Care Select Committee announced its maternity panel members to scrutinise government commitments on maternity services. The four-person panel includes two senior midwives: Professor Soo Downe, professor of midwifery studies at the University of Central Lancashire, and Sarah Noble (pictured), associate director of midwifery at South Warwickshire NHS Foundation Trust.

Birte Harlev-Lam, RCM executive director midwife, said: "This is a major step forward in holding the government to account and making sure they come good on their promises. The RCM is, overall, supportive of the general direction of the government's maternity policy, but progress is patchy and stuttering. Too often policy statements are grandly announced then quietly forgotten, and we cannot let this continue to happen.

"We are also seriously short of midwives in England and maternity services continue to suffer from underinvestment. This is a strong and balanced panel with two hugely experienced and highly capable midwives on it. We now need to see that work begin quickly and in earnest so that our maternity services are supported to deliver even safer and better care for women."

Latest podcasts and webinars
The latest in the RCM's podcast series is 'Quality and safety', followed by 'Supporting members everywhere', which can be found at the podcast home hub at **bit.ly/RCM_podcasts**. Meanwhile, the latest in the RCM webinar series is 'health and safety', followed by 'Race Matters, one year on', which can be found in the webinars home hub at **bit.ly/RCM_webinars**

Twitter Q&A
The RCM, RCOG and Maternity Action continued to host live Twitter Q&As for pregnant women to allay fears about changes to services and appointments during COVID-19. The RCM also has an extensive advice section for pregnant women and their families on its website at **rcm.org.uk/coronavirus**

For up-to-date RCM and RCOG national guidance on pregnancy and COVID-19, visit **bit.ly/RCM_COVID-19**

Virtual royal visit
Her Royal Highness The Princess Royal, patron of the RCM, visited staff at South Warwickshire Foundation Trust's maternity unit, which last year won the RCM's Midwifery Team of the Year award. Accompanying HRH The Princess Royal on the virtual visit was RCM chief executive Gill Walton. Watch the video at **bit.ly/YT_royal_visit** or **bit.ly/SWFT_royal_visit**

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

RCM in brief

After Ockenden

Actions not words

The RCM has set out clear intentions and actions to address recommendations from the interim Ockenden review into maternity failings at Shrewsbury and Telford NHS Foundation Trust.

As part of its commitment to supporting members and the services in which they work, this month the RCM has launched a monthly 'solution series'. Each briefing will include evidence-based solutions and focused guidance for RCM members, other maternity staff and maternity services on key areas to improve the safety of maternity care.

The 'solution series' will include advice on how to develop systems for thorough investigation following adverse events so lessons can be learned and future incidents avoided, guidance on interpreting electronic fetal monitoring, leadership and creating a positive work culture.

RCM director of professional midwifery Dr Mary Ross-Davie, said: "The interim Ockenden review identified a number of key areas of concern. The RCM will do all we can to support NHS maternity services across the UK to address issues with systems, governance, culture, resources, training and staffing that impact on the safety of maternity care. The funding announcement from NHS England is something we have lobbied for and we will support maternity services to address some of these issues. The additional funding will enable backfill to release midwives to undertake multidisciplinary training and will ultimately boost midwife and obstetrician numbers.

"Strong midwifery leadership is key to tackling these recurring problems. More consultant midwives and specialist midwives are also needed to support quality improvement."

A new 10-minute i-learn module on the Ockenden review is already available for RCM members. The RCM, through its national network of officers, workplace reps and organisers will also be offering a range of online workshops on creating positive workplace cultures, escalating concerns and advice on the co-production of service improvement with women and families.

Technology

Digital edition

We've all had to embrace technology in ways we didn't imagine before the pandemic. Now *Midwives* is conducting an experiment to see if members would like to receive the magazine as a digital edition, rather than a paper version. The July issue will be digital, sent out via an emailed link. To receive it, please make sure your details are up to date: contact the RCM on 0300 303 0444, email enquiries@rcm.org.uk, or update your details via the My RCM portal.

Campaigning

Have your say on pay

The RCM is urging its members in Scotland to get involved with the formal consultation on the offer of a 4% pay increase from the Scottish government, following negotiations undertaken by the RCM and other NHS health unions.

The Scottish government has agreed to backdate the pay award to 1 December 2020, four months earlier than the 1 April 2021 due date. This is the result of the joint trade unions' campaign for an early pay award and is in addition to the one-off £500 payment made in February.

All RCM members in Bands 5, 6 and 7 will receive this increase and lower-paid Agenda for Change staff are expected to receive a flat-rate increase. For those in Band 8 and above, due to Scottish public sector pay policy, the offer won't apply.

As part of its 'Deliver a decent deal' campaign, the RCM has been campaigning for an early and significant pay rise for all NHS staff. Jon Skewes, RCM executive director for external relations and one of the lead negotiators for NHS Unions, said: "Lots of hard work and negotiations have happened to get to this point. An offer of 4%, which will also be backdated, is something the RCM has been lobbying and campaigning for. Sadly, the same cannot be said yet for our members in England, Wales and Northern Ireland."

TUC Women's Conference

Supporting vulnerable mothers

At the TUC's Women's Conference in March, the RCM warned that, without appropriate funding and support, vulnerable women experiencing disadvantage are at increased risk of poorer outcomes in pregnancy.

The RCM has previously urged the government to provide more training for midwives to offer more appropriate support to women who are in abusive relationships, have experienced childhood trauma or have mental health problems.

Women who have experienced severe or multiple disadvantage are at greater risk of complications during pregnancy, while a recent MBRRACE-UK report found that women living in the most deprived areas in the UK are 50% more likely to experience stillbirth or neonatal death.

Gill Walton, RCM chief executive, said: "Midwives can be extraordinarily effective in identifying needs and advocating for women. Many go above and beyond to support women in their care. Sadly, too often their effectiveness is hampered by a lack of resources, such as staff shortages which mean that midwives' time is stretched across all the women in their care and opportunities for training are postponed. As a result, women at their most vulnerable do not always get the care they need or deserve.

"That is why we are calling on the government to fund maternity services properly, to have the right levels of staffing and specialist midwife posts to lessen the risk to women and their babies.

"We have recommendations that can begin to tackle this issue, comprising of specialist midwives working on the frontline and women with lived experience, but without adequate funding for training and staffing we are fighting a losing battle."

THE STUDENT MIDWIVES FORUM (SMF)

Lisa Rollinson, SMF Midlands and East representative, writes...

Advocating for women and birthing people is a key part of being a student midwife and something that many of us do without a second thought. Standing up and speaking out for others takes courage and strength, especially when it goes against the norm. However, when it comes to advocating for ourselves, we seem to struggle: we're not sure who to turn to and what to do.

Being a student midwife isn't easy – we're constantly juggling university work while working long placement hours. We're also trying to balance our home lives and raise families, all while worrying about money. And then there are more complex issues, such as discrimination, racism and a lack of representation and support.

So who advocates for student midwives? Who can you turn to when you need someone to fight your corner? That's where the SMF comes in. The SMF is a group of 10 midwifery students from all over the UK who come together to discuss issues affecting student midwives, and bring them to the RCM.

The RCM aims to work effectively for its members by supporting and campaigning on what truly matters to student midwives. For example, in January the RCM and the SMF met with MPs to raise awareness of the Covid-19 pandemic effect on student midwives. They also petitioned for the implementation of financial and mental health support and workforce Covid protections.

Please reach out to your regional SMF representative if you would like to raise an issue, need support, or would just like a chat.

rcm.org.uk/influencing/student-midwife-forum

Staffing

Funding boost

The announcement in late March of a significant investment in "under-resourced and under-staffed maternity services" means that, from the next financial year (2021/22), maternity services in England will receive an extra £95.9m year on year.

A significant proportion of the funding will boost midwife and obstetrician numbers, and will also fund crucial joint training with midwives, obstetricians and other maternity staff.

Gill Walton, RCM chief executive, noted that it was something the RCM had been campaigning for, for many years and "acknowledges that they simply could not have continued ensuring safe, high-quality care with the pressures and demands they are facing".

The announcement contains funding for new senior posts, including seven deputy regional chief midwives, new regional chief obstetricians, and a national independent senior advocate to ensure consistency in maternity services across England.

Dr Edward Morris, president of the RCOG, said: "The Ockenden report acted as a wake-up call for the system and highlighted key areas where improvement was urgently needed, including an over-stretched maternity workforce with limited resources, and challenges in organisational functioning, culture and behaviour, many of which were further impacted under the strain of the Covid-19 pandemic.

"We are grateful to NHS England for accepting our recommendations for an increase in support in the number of staffing and resources required, particularly their acknowledgment of the vital role obstetricians play in providing safe maternity services. We also wish to thank NHS England's chief nursing officer Ruth May for working closely with us. This funding will go a huge way to creating a much more cohesive system."

Vaccination

AstraZeneca alternatives

The RCM sought to reassure its members, healthcare workers and vulnerable pregnant women following the news that people under 30 are to be offered an alternative to the Oxford-AstraZeneca vaccine.

Birte Harlev-Lam, RCM executive director midwife, said: "We can absolutely understand that young people, many of whom will be midwives, maternity support workers and other health and care professionals, may be concerned by this announcement.

"While the evidence shows that the benefits of the Oxford-AstraZeneca vaccine far outweigh the risks, the Joint Committee on Vaccination and Immunisation is exercising caution. If you are under 30 and have already received the first dose of the Oxford AstraZeneca vaccine, the JCVI has advised you should continue to be offered and take the second dose of the same vaccine. If you have concerns, contact your GP or vaccine centre."

IMAGES: AKIN FALOPE / ISTOCK / SHUTTERSTOCK

RCM FELLOWS

The RCM Education Conference in March saw the announcement of three new Fellows:

Grace Thomas
Reader in midwifery at Cardiff University, lead midwife for education and deputy director of the World Health Organization Collaborating Centre (WHOCC) for Midwifery Development – one of only two WHOCCs specifically for midwifery in the world. A midwife for more than 30 years, Grace moved into academia after working across a variety of clinical and managerial roles and as consultant midwife for 10 years. Follow Grace on Twitter **@graciee65**

Carmel Lloyd
Carmel has 40 years' experience in midwifery practice, education and regulation and leads the delivery of the RCM strategy and professional activity for education and learning for members. She is a member of the RCM Expert Clinical Advisory Group and the RCM editorial lead for *Midwives* magazine; she is a member of a number of external working and advisory groups for the NMC, Health Education England and NHS England and Improvement. Follow Carmel on Twitter **@rcm_carmel**

Dr Sally Pezaro
An academic midwife, research associate and hearings panellist for the NMC's Investigating Committee, and a steering group member of the Mary Seacole Awards programme. As an editorial board member of *Midirs, Evidence Based Midwifery*, the *British Journal of Midwifery* and the *International Journal of Childbirth*, she's keen to ensure that teaching remains research inspired. Follow Sally on Twitter **@SallyPezaro**

MAKING CONNECTIONS

The Bangladesh Midwifery Society, twinned with the RCM, has shown strong leadership during the pandemic rolling out a PPE programme and increasing member renewal rates

In Bangladesh, midwifery is a relatively new profession, only beginning in 2010 when the prime minister, Sheikh Hasina, committed to the training and deployment of 3,000 midwives across the country. Before this, women were cared for by traditional birth attendants, obstetricians and nurses – but there were no midwives trained to international standards. Since July 2017, the RCM has been working in a twinning partnership with the Bangladesh Midwifery Society (BMS), with the aim of helping the BMS to develop its organisational capacity and to advocate for both midwives and midwifery in Bangladesh.

Joy Kemp, the RCM's global professional advisor, says that the pandemic hasn't slowed progress. "I think the assumption from some people, perhaps even ourselves, was that the partnership would fizzle out, but we've gone from strength to strength – we communicate more now than ever before. Where the Bangladeshi team was struggling to have access to information and current evidence, part of the RCM's response to the pandemic was the development of an expert clinical advisory group, so we were able to use the evidence and knowledge being generated in the UK to really help the BMS to know how to respond."

It wasn't just reliable evidence-based information BMS members wanted, they were also crying out for PPE, especially as midwives were initially not prioritised to receive it in Bangladesh. "The few supplies of single-use PPE they did have were being washed and reused countless times, rendering them ineffective," she says.

Mahfuja Aktar Jhumu, vice-president of the BMS, adds: "At the beginning of the pandemic we had a lot of demand from midwives in different areas – government and private sector – asking for masks, hand sanitiser and all kinds of PPE. The BMS was providing it for them."

The good idea

This demand sparked the idea that the BMS could produce their own reusable cloth masks for members. Joy notes: "WHO issued guidance around how reusable face masks should be made where there was insufficient single-use PPE, so we talked to the BMS about trying to produce some. BMS were already trying to forge stronger links with maternity service users and women's groups in Bangladesh, so the partnership approached an organisation that works with disabled women."

Sharmin Shobnum Joya, the twinning project manager in Bangladesh, says: "We wanted to involve women's groups so we went to the disabled women's society in Dhaka, which provides work for disabled women, and they made the masks. Later they became so popular they asked me to allow them to make the design for sale because they're so comfortable."

Some 8,000 triple-layer WHO-standard masks were made in total and distributed along with other PPE items across 342 Upazila health complexes, 41 nursing institutes (where midwives are trained), to private sector bodies such as the Bangladesh Rural Advancement Committee (BRAC) and the Obstetrical and Gynaecological Society of Bangladesh (OGSB). "The masks were distributed from July onwards," says Mahfuja. "For the Mymensingh region, I received more than 1,500 masks, which I distributed to midwives and nursing colleges."

Asma Khatun, education secretary at the BMS, distributed 400 masks to student midwives in their final year of the three-year diploma in midwifery at BRAC University, sending them out to the seven academic sites across the country either by courier, or delivering them in person where possible. "These final-year students were practising in hospitals during the pandemic situation. They felt much better using these masks – more comfortable. The fabric is very soft and they are able to wear them for a long time – and, most importantly, they are reusable. They are very grateful, and there is great demand for these masks. When I distributed them, teachers or other members of staff would ask for them. People are still using them, and more masks are needed."

Raising the profile

The reversible masks, which have the BMS logo on them, were given out packed in a pouch with washing instructions and a leaflet about the BMS, along with the telephone number for the BMS information hotline, hosted by BMS Young Midwife Leaders (see panel on ▶

The masks, as well as BMS's leadership in the pandemic, have not gone unnoticed

ILLUSTRATIONS: CHU-CHIEH LEE / FOLIO ART

VIRTUAL VOLUNTEERING

RCM member volunteers have played an important role in the twinning project throughout. They have been skill-matched to help with specific projects – "be that developing ongoing midwifery education or implementing a midwifery audit tool to help improve the quality of care," says Joy. "Our volunteers are often senior midwives, but we can also offer aspiring midwife leaders early career opportunities to support their leadership development."

Once, that might have included one or two trips to Bangladesh a year. "Exchange visits haven't been possible during the pandemic, but remote twinning, or 'virtual volunteering', has continued, through video calls, to offer mentoring and support, including support with writing for publication." Sangita, one of the Young Midwife Leaders, has even joined the editorial board of *MIDIRS* and will be mentored by its editor, Sara Webb.

"Looking forward, we know we won't be travelling at least until the end of 2021 and probably beyond. However, we want to continue enabling RCM members to participate in this work and are currently exploring new models for virtual volunteering. We are particularly interested in hearing from midwives from the Bangladeshi diaspora community and any aspirational midwife leaders in the UK.

"The RCM's vision is to be a voice for midwifery locally, nationally and internationally, and we want more RCM members to have a global focus. COVID-19 has clearly demonstrated the world's interconnectedness. All healthcare workers need to be global citizens, whether we can travel or not, we must have the cultural competency and awareness both to work with and to care for people, whatever background and culture they come from."

page 18) for midwives and members of the public seeking advice and guidance about maternity care during the pandemic.

As well as distributing masks, the BMS provided other vital equipment such as infrared thermometers, negotiating the deliveries at each local level with hospital managers and health system managers, through the network of Young Midwife Leaders. The masks, as well as BMS's leadership during the pandemic, have not gone unnoticed, with both proving popular with other healthcare professionals and healthcare authorities.

"As I went into hospitals to reach the midwives, I had to give some masks as gifts to supervisors and local authorities also. I carried extra with me – that was part of the advocacy for the BMS," says Mahfuja. "I would give them to doctors too and encourage them to wear them and know the BMS. The masks were important because the BMS gained a good reputation by providing them.

"Midwifery is a new profession in Bangladesh, and midwives can face many kinds of problems when they are working in local areas. The UHFPO [Upazila health and family planning officer] and the doctors were inspired to help midwives after seeing the BMS distributing so many masks and PPE."

Strengthening membership

Sharmin agrees the masks have raised the profile of the BMS: "Now when I go to the Directorate General of Nursing and Midwifery, I see lots of people wearing our masks and because they have received them, they come to know about the BMS. I didn't have that advocacy material before. Now whenever I go to workshops or training, I take three or four – it's very helpful. During COVID, people have started to recognise the BMS. At the UHFPO meetings we are recognised for having done a lot of work during COVID."

Midwives and student midwives also

responded positively to the project, Mahfuja notes. “Many more midwives are now coming to us for support – instrumental support, administrative support – because the BMS has provided all kinds of PPE support. If they’ve got problems, they are asking for help from the BMS, which is the most important part of it. Last April and May, membership renewal was down to around 700 members. But when we started providing PPE, midwives really became interested in renewing again. The BMS offers grants and incentives and BMS members have been inspired by that but providing the masks has also inspired midwives to renew and enrol. At this point, we have just 3,262 members.”

“It has helped change our image,” adds Sharmin. “Students in the private and public sector are using them and there is great visibility.”

“We are attracting new members,” confirms Asma. “In the first quarter of 2021, I enrolled 198 new members from among the student midwives, and over the last two quarters I enrolled 700 new and renewal members, both students and midwives.’

“It’s just a fantastic win-win-win project,” says Joy. “It’s giving disabled women who are marginalised in Bangladeshi society an income; it has strengthened the links between BMS and maternity service users and has raised the profile of midwives with other health professionals, in the health systems and in the wider community; it has provided essential PPE and has given access to evidence-based information for midwives, women and their families; and it has raised the profile of the midwifery association.

“I feel incredibly proud of what they have done. The Young Midwife Leaders and BMS staff have worked so hard to overcome many challenges. This initiative has earned BMS so much respect. No other professional association has stepped up to this extent and whereas few people knew who

The wide provision of BMS-branded face masks is attracting new members

In the first quarter of 2021, I enrolled 198 new members from the student midwives

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YOUNG MIDWIFERY LEADERS

The twinning project is funded by the UN Population Fund (UNFPA), which works with partners, governments and policymakers to help build a competent, well-trained and well-supported midwifery workforce in low-resource settings. Strengthening professional midwives' associations is one of UNFPA's key strategies for supporting midwifery globally.

"The twinning of midwifery associations is also promoted by the International Confederation of Midwives as a means of mutual capacity building and reciprocal learning," says Joy. "We know that Asian women are twice as likely to die in childbirth in the UK compared with white women, and Asian babies are more likely to experience poor outcomes. Those with Bangladeshi heritage are under-represented in the UK midwifery workforce and there is potential for our project to positively impact these issues and for our international work to influence our work in the UK."

One of the objectives of the project is to develop Young Midwifery Leaders, and 26 midwives have already completed the programme. "Many of those midwives now hold senior positions in their workplaces, have been elected to senior positions in the BMS, or have taken up jobs at a policy making government level," says Joy.

Young Midwifery Leaders have distributed vital PPE and equipment such as infrared thermometers

midwives were, this has brought them huge recognition across the country."

What next?

With COVID cases now rising across Bangladesh, the mask project is set to be renewed, says Sharmin. "We're currently in the third wave, so in the second quarter we are planning again to start making masks and also providing sanitiser and soap."

The twinning project is funded to 2022 and likely beyond, adds Joy. "We will continue to work with the BMS through the third wave of the pandemic, and we will continue to work the new cohort of Young Midwifery Leaders taken on in January 2021.

"Rural women have been at greater risk of contracting COVID-19 by travelling to densely populated urban centres for sexual and reproductive health services. Other women have stopped accessing these services completely, risking unwanted pregnancies or death from unsafe abortions. Midwives are trained to provide these services at rural health centres, but sometimes don't have the equipment and other enabling factors to implement them. A next step is to offer refresher training to midwives and to help them address local system challenges, enabling them to take on this role and prevent COVID transmission."

The BMS and its midwives have come a long way in a few short years. While there are still challenges to be faced, as their leadership during the pandemic has shown, they are ready to rise to them.

MORE INFO

For more on the RCM's work in Bangladesh, visit rcm.org.uk/promoting/global
Don't forget International Day of the Midwife on 5 May – visit rcm.org.uk and join the celebrations
Join the ICM's virtual congress in June: internationalmidwives.org

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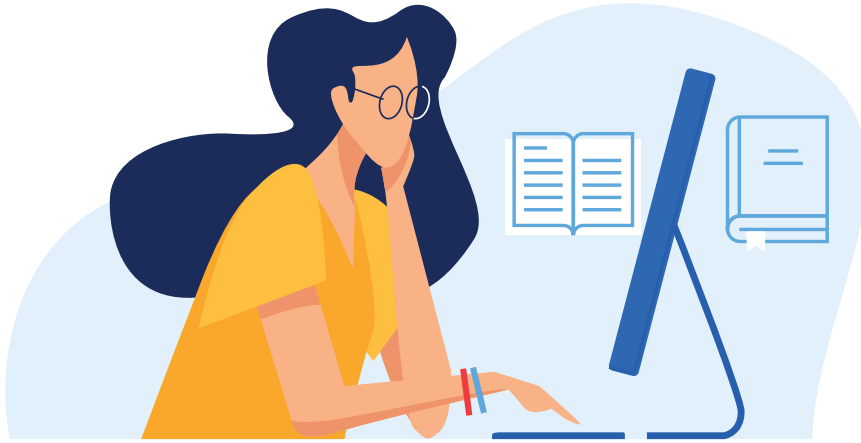


Digitising pregnancy records

The casenote folder's days are numbered, says Coralie Rogers, digital lead midwife and reducing inequalities lead in the Better Births Team, Lancashire and south Cumbria

In Lancashire and south Cumbria, we are implementing a single maternity system across the four trusts within our local maternity system (LMS) – specifically the single pregnancy record to improve information sharing and women's experiences. The system will support the key recommendations of Better Births to deliver a high-quality, safe, woman-centric and accessible service.

We are rolling out a full, end-to-end online system that records all aspects of a woman's pregnancy, through to birth and early parenthood. There will be many advantages for women, families and health professionals involved in providing care and to the maternity services.

Benefits for women

Currently, women need to bring their folder to each appointment – each visit, antenatal appointment and scan – and more and more pieces of paper are clipped into the folder, alongside handwritten notes. Should any paper fall out, important information can be lost with no back-up. Should women forget their folder, there is no access to the information, and any new paper generated from the visit will be entrusted to the woman to put in the folder. So-called 'baby brain' means that forgetting to do this is quite likely.

However, there is no chance of information loss when it is stored in a 'digital folder' on the

cloud. The notes are easily accessed by healthcare professionals and the women themselves through something as simple as a code and a smartphone. Should the woman present in an unexpected emergency at another hospital, her notes will be there. Should a woman need to move at short notice (because she's fleeing domestic violence or has unsettled immigration status), her notes will be accessible. By downloading the Maternity Notes and Baby Diary apps, women have access to their maternity record on a PC, tablet or smartphone whenever they want it.

The app allows women to interact with their own records in ways they haven't before, accessing information and making informed choices about her care and that of her baby: for example, finding out about maternity care providers and self-referring directly into the service of their choice without having to wait for an appointment to see her GP first. The app shows week-by-week information – what should be happening to her and how her baby is growing. It also sends e-leaflets at the relevant time in the woman's pregnancy – for example, birth choices or induction of labour – and can be set up to send notifications (and reminders) of appointments.

The app enables her to create her own personalised care plan she can share with her midwife and, together, design an individual care pathway. Women will also be able to write a confidential pregnancy diary within the app that is not accessible to the midwives without explicit permission.

Benefits for maternity teams

The notes being kept in one place and made accessible to the healthcare team is invaluable. Digital notes offer clarity – there are no issues with handwriting legibility or notes falling out.

There's also no need to spend the appointment reviewing a stack of paper, because the on-screen record has a searchable function to make finding salient information quicker. This frees up time for better engagement, it cuts the time asking a woman the same questions she has been asked before and creates more time to spend listening to her. Research suggests that electronic records could increase the time spent by midwives in providing direct care from 30% to 70%.

The navigation is key. No more rifling through a folder of papers – the information is filed in tabs so is easier to find. Important elements, such as rhesus status, are displayed at the top of the screen and alert clinicians each time they open the record. The record is integrated with other hospital systems so important results of blood tests or scans are readily available without delays due to filing. This information can be shared (with appropriate permissions) with other providers of maternity care if a woman has to access services elsewhere in an emergency, which means nothing is missed.

The app allows women to interact with their own records in ways they haven't before

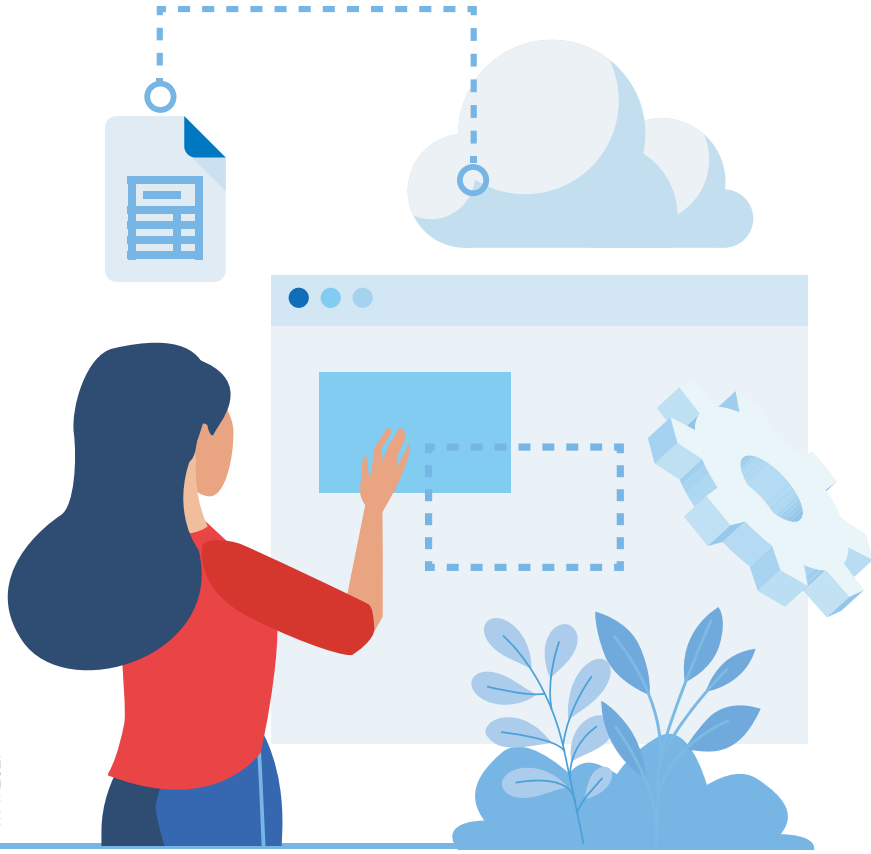
Equally, there is the ability to filter and hide sensitive information from routine enquiries if the woman isn't alone. Instances of this include keeping confidential any disclosures of domestic violence if the partner is present or disclosure of previous pregnancies or terminations from current partners.

Challenges for maternity teams

Local guidelines and management plans are embedded within the system to support decision-making and communication between teams and the women in their care. It also improves safety, as no records are lost or illegible, which makes guidelines easier to follow. The data is auditable to ensure returns of national and regional data requirements, but it also helps to identify local trends and customise care based on local need.

Some of the major advantages for the trust or board is that the data available meets and exceeds the requirements for national and local reporting. It is one of the 'golden threads' that enable the effective implementation of many of the Maternity Transformation Programme workstreams.

The system will also enable greater workforce mobility – no need to relearn a new system each time you move jobs. Training takes about two days, including practice, but the system is



intuitive and easy to learn. And it is paper-free, reducing costs and admin time.

With all of these benefits you'd be forgiven for thinking that moving to digital is a no-brainer. But it's never that simple. Moving a heavily paper-based system to digital is a big step and requires a great deal of staff confidence. Training and practice is the answer – but releasing staff from clinical commitments will always be a challenge. If there is time, plan it into the duty rotas as soon as possible and keep staff informed regularly with what is happening and when.

In Lancashire and south Cumbria, we've been working towards standardising processes across four separate providers – no mean feat considering that, historically, trusts and boards are separate entities with many different processes and, to a certain degree, there's a spirit of competitiveness. Even within a trust or board, different disciplines are used to working in silos even though everyone is working towards the same goal. It's helpful to impart things that worked well and learnings from the process.

MORE INFO

The project is in its going-live phase at the time of writing. If you would like advice on how to implement a similar in your health board or trust, please email coralie.rogers1@nhs.net

IMAGE: SHUTTERSTOCK

TIPS FOR SUCCESS

- A digital midwife in each trust/board is essential to bring together all key stakeholders
- Get teams out of their competing trust/board silos straight away. Early collaboration is the key, especially as everyone is working towards the same goal
- Use the Teams space, or similar, to bring people together and get them talking
- The group procurement worked well – everyone wanted the same thing and being in a shared, neutral (Teams) space facilitated great discussion and achieved agreement
- The trusts started their going-live process separately, but regular collaboration early on was incredibly helpful to share those tips, ideas and how to avoid the pitfalls. Next time I would provide space earlier to share those ideas at the beginning
- Engage early with the wider multidisciplinary team – radiology, GPs and so on – so that they also have an opportunity to shape how they want the system to interact with their services
- Plan every detail and keep issue logs for everything
- Train staff from different trusts/boards together. The training system is very similar and working 'across borders' helps with the discussions and aligning of pathways.

EXPLAINING YOUR PENSION

Regional officer Lynne Galvin demystifies NHS pension schemes and entitlement

Q: I'm confused about my pension entitlement as there seem to be different schemes running and different ages from which I can draw my pension...

Yes, because of a number of reforms over the years, there are three schemes, known unimaginatively by the dates they were launched. The 1995 and 2008 schemes are final salary schemes, which pay a pension for life based on your final salary and years of service. The 2015 scheme is different because it is based on an average of your earnings throughout your career. It is known as a 'career average revalued earnings' or CARE pension. The 1995 scheme is the only one that automatically entitles you to a lump sum on retirement.

Pension contributions from members are between 5% and 14.5% and based on your annual pensionable salary (the income that you get from the NHS, excluding overtime payments unless otherwise stated) the rates were fixed from 2015 to March 2021. These are currently being reviewed. Employers also contribute to your pension at a current rate of 20.6%.

You will only be paying into one scheme; however, you may have another that is frozen and protected. This is dependent on when you joined the NHS. If you joined before 2008 you are in the 1995 scheme with a normal pension age of 60. (If you joined before 6 March 1995 and have not had a break in service of more than five years, you will have Special Class status and can take your pension at 55 without reduction.) If you joined after 2008, that scheme has a pension age of 65. Any new starters from 2015 have a pension age equal to state pension age – 66 to 68 dependent on your year of birth.

When the 2015 scheme was introduced, it applied to new starters and some existing pension scheme members. However due to a recent court ruling, existing pension scheme members who were changed to the 2015 scheme can, at retirement, choose to have their old pension rate reinstated for seven years (between 2015 and 2022) before it then goes to the 2015 rate.

From 1 April 2022, all members of the NHS pension scheme will move into the 2015 scheme. Benefits accrued in existing 1995 and 2008 schemes will be frozen and preserved. You could still retire on the benefits that are frozen in these schemes at the retirement age for them. Your existing 2015 scheme could then be frozen until you reach the retirement age for it, or taken early with a reduction.

GETTING ADVICE

Check your pension status and payments via your electronic staff record system or access your 'Total Reward Statement' (TRS) at nhsbsa.nhs.uk (England and Wales). This video explains the TRS: bit.ly/TRSexplained The NHSBSA website provides fact sheets and videos to explain the differences between the three schemes, or speak to your regional or national officer.

What if?

Lia Brigante, RCM quality and standards advisor and consultant midwife trainee at Guy's and St Thomas' NHS Foundation Trust, and Alice Sorby, RCM employment relations advisor, discuss how working in MCoC affects pay and pensions

Midwifery continuity of carer (MCoC) is on course to become the central model of maternity care, benefiting women, birthing people and their families. It can also benefit midwives and maternity support workers (MSWs) by enabling them to work more flexibly. Key to the success of MCoC is the early engagement and support of staff throughout any proposed changes to working practices. As part of the development of MCoC teams, midwives and managers may be considering the adoption of an inclusive salary. An inclusive salary may have several benefits, including supporting more flexible working arrangements and decreased paperwork for individuals and their managers. However, for the model to be successful it is important to ensure staff are paid equitably; that no one is made financially worse off in comparison to a midwife or MSW in an equivalent role being paid according to standard arrangements. The likely fluctuation in demand for services in MCoC teams means that it is difficult to find a blueprint percentage and ensure that staff do not suffer a detriment working in this way. A new publication, part of the MCoC *What if?* series, aims to address in detail the different approaches to pay for MCoC teams and how those may affect pensionable pay.

The *NHS Terms and Conditions of Service Handbook* (Agenda for Change) sets out the contractual basis for remunerating midwives and MSWs for unsocial hours working and overtime, as well as principles for agreeing on-call arrangements locally. It is not mandatory to apply an inclusive salary when developing continuity teams. The *NHS Handbook* provisions enable continuity teams to work successfully without any changes necessary, however, the RCM has developed the following 10 principles to guide discussions and decisions when an inclusive salary is being considered by maternity teams.

Ten principles

1 NHS trusts and health boards are able to agree local variations to standard NHS terms and conditions, such as annualised hours, paying for unsocial hours and on-call on a prospective, rather than retrospective, basis. Employees must not be at a disadvantage (paid less than their actual hours worked) through these arrangements, and policies for monitoring should be in place to ensure this isn't the case. Whilst it is recognised that NHS foundation trusts have additional freedoms, as set out in Annex 11 of the *NHS Handbook*, the principles set out in this document still apply.

2 It is imperative that any variation to terms and conditions must be negotiated and approved by recognised trade unions through local staff sides.

3 Midwifery departments looking to introduce any of the above changes when developing continuity teams should engage the RCM through the relevant regional or national officer. The regional or national officer will then liaise with the RCM at a national level to ensure that the *NHS Handbook* is not undermined, and that midwives and MSWs do not suffer a detriment (made worse off compared to a midwife/MSW in an equivalent role being paid according to standard arrangements).

4 Detailed modelling should be undertaken in advance of any proposals and shared with trade unions and staff.

5 A risk assessment and benefits analysis of proposals should be carried out in partnership with the RCM and other recognised trade unions.

6 The MCoC model has the potential, demonstrated in research, to improve a range of outcomes for maternity service users. Any such improved outcomes are also of benefit to the organisations providing care. Organisations may therefore consider recognising this potential through developing payment and uplift proposals that could incentivise staff to work in this way.

7 Proposals should be clear and transparent as to what is included, for example, whether an uplift is inclusive of on-calls alone, or on-call plus unsocial hours.

8 A fundamental change to terms and conditions must be subject to both individual and collective consultation with affected staff.

9 Any change that is agreed and implemented must be subject to a joint review process and equality impact assessment.

10 An audit trail should be kept to evidence staff remuneration under the new arrangements and what would have been received if no change to terms and conditions was made, to ensure there is no detriment or equal pay risk (considering both remuneration and pension implications).

These 10 agreed principles could reduce administrative burdens, ensure that any changes to working terms and conditions do not leave midwifery professionals financially worse off, and support the transition of teams to the new models of working. The RCM has been working with NHS Employers to develop future joint NHS Staff Council guidance. At the time of writing, discussions on such guidance have also been taking place in Scotland within the Scottish Terms and Conditions Committee.

The MCoC model has the potential to improve a range of outcomes for women and birthing people, as well as providing better ways of working for maternity staff. Any such improved outcomes are also of benefit to the organisations providing care at every level: from happier staff to better staffed services. The success of MCoC however, is dependent on maternity teams being engaged and supported through the changes to their working practices and pay.

The RCM has developed the 10 principles to guide discussions and decisions

MORE INFO

Access the *What If?* series from rcm.org.uk, or follow on Twitter @lia_bri and @AliceSorby1

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1Juan C. Vazquez. Heartburn in pregnancy. BMJ Clin Evid. 2015; 1411

*Care should be taken when recommending medicines for use in pregnancy as medicines can cross the placenta and may affect the fetus.

Louise Webster

A MIDWIFE

Starting a new job is stressful, but in a pandemic it's worse, says Louise Webster

In August 2020, I started a new job in a new trust. I've always been confident, but that walk up to the hospital and into the unit was more nerve-racking than my first day after qualification.

I knew who everyone was at my previous trust, so it wasn't a problem when we all started having to wear masks, but the practice has made it hard for me to get to know people in my new workplace. How am I going to learn who everyone is? How can I tell a consultant from a registrar, or a senior house officer from an anaesthetist?

Masks also change people's perceptions of each other. Our inability to see someone's facial expressions when they are talking to us can change how we interpret their words. We have to speak with our eyes – and, after a long and busy shift, they can show our fatigue. I mean, how many of us have told the women we're supporting that we promise we're smiling behind our masks?

I've been at my new trust for more than six months now, but I still don't know who many of the midwives working alongside me really are, let alone the doctors.

I discussed this issue with some of my friends in the profession. Louise Nuttall, a fellow midwife, said: "I've realised that when a woman finally removes a mask after you've only ever seen her with one on, it dawns on you that you've made up a completely different face from the one she actually has."

I thought: how true that is. I've probably done the same with many of my colleagues. Even when we can remove our masks, I still won't really know who they are.

They can't see me smiling – and that makes a huge difference

Sabrina Scott, a healthcare assistant in gynaecology, started working at a trust after compulsory mask-wearing had begun. She told me: "I've only ever known working with people in masks. It will be so nice to see what everyone actually looks like."

Midwife Andria Lewis said that she lifts her mask, at a safe distance, in order to introduce herself, thereby ensuring that women and their birthing partners know what she looks like behind it.

Even though she knows all her colleagues in her unit, community midwife Jennie Warren told me that she still misses "smiles when I greet women when entering their homes. They can't see me smiling either – and that can make a huge difference."

In March 2021, I was included among the extra 1.7 million people who were asked to shield and stay away from work for four weeks. I now feel I have to start all over again. So please bear with all new members of staff and students in your trusts, because the masks have added to our anxiety.

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THE ROYAL COLLEGE OF MIDWIVES

Emotional rollercoaster

An NHS-wide approach to wellbeing has been accelerated by the pandemic. The good news is that there's a greater awareness of mental health and no longer a stigma attached to seeking help. In fact, it's encouraged

Whether you're on the front line caring for pregnant women and new parents, managing staff or in an essential role supporting women and families, it's fair to say that you've been facing a very challenging time. The pandemic has meant we've all had to work differently, under intense pressure, and we've had to consider our own health and safety in ways that we've never had to before.

It's resulted in a higher incidence of stress and anxiety than normal, and that's a heavy burden to carry.

Have you taken the time to consider how you are feeling? If so, have you taken the time to imagine asking for help?

NHS England and NHS Improvement have established a support package for all NHS workers (though some elements are country-specific) in the hope of creating a 'wellbeing culture'. It's a package of emotional and practical support that includes apps, phone lines, virtual therapy sessions, resources and one-to-one guidance. The programme encourages you to seek out help in the form that best suits you. Moreover, the initiative is keen to stress you are not alone in needing support and that the pandemic has been an emotional rollercoaster for everyone.

Caring for YOU

Phone

There is a confidential, free phone line for NHS staff running from 7am until 11pm, seven days a week. It is operated by Samaritans, with trained advisors who can help. If you've had a bad day, are feeling worried or have a lot on your mind, it's good to talk. Call 0800 069 6222 or, if you feel more comfortable using a text messaging service, text FRONTLINE to 85258.

There is also a specialist, confidential bereavement support line. It operates between 8am and 8pm, seven days a week, and is also free. Operated by Hospice UK, the lines are staffed by qualified, trained bereavement professionals. Call 0300 303 4434 for support.

Virtual counselling

Sometimes there's nothing more therapeutic than having a good old moan with your colleagues. 'Virtual common rooms' were set up with this purpose in mind, to share frustrations and experiences with 10 of your peers. In partnership with NHS Practitioner Health, the one-hour sessions are hosted by an experienced and approved professional who shares coping strategies and provides a confidential, safe space to reflect on events. Check events.england.nhs.uk for details.

The Association of Christian Councillors (ACC) has developed free counselling services offering up to 10 sessions either online or over the phone. Despite the organisation's name, the service is open to people of all beliefs, or those with no religion, and you can also asked to be matched on ethnicity. Visit acc-uk.org

#LookingAfterYouToo offers frontline staff free individual coaching support, seven days a week. It is a space to process experiences and offload, and helps you develop practical strategies to cope. The idea is to give primary care for those providing primary care. Access the support at people.nhs.uk/lookingafteryoutoo

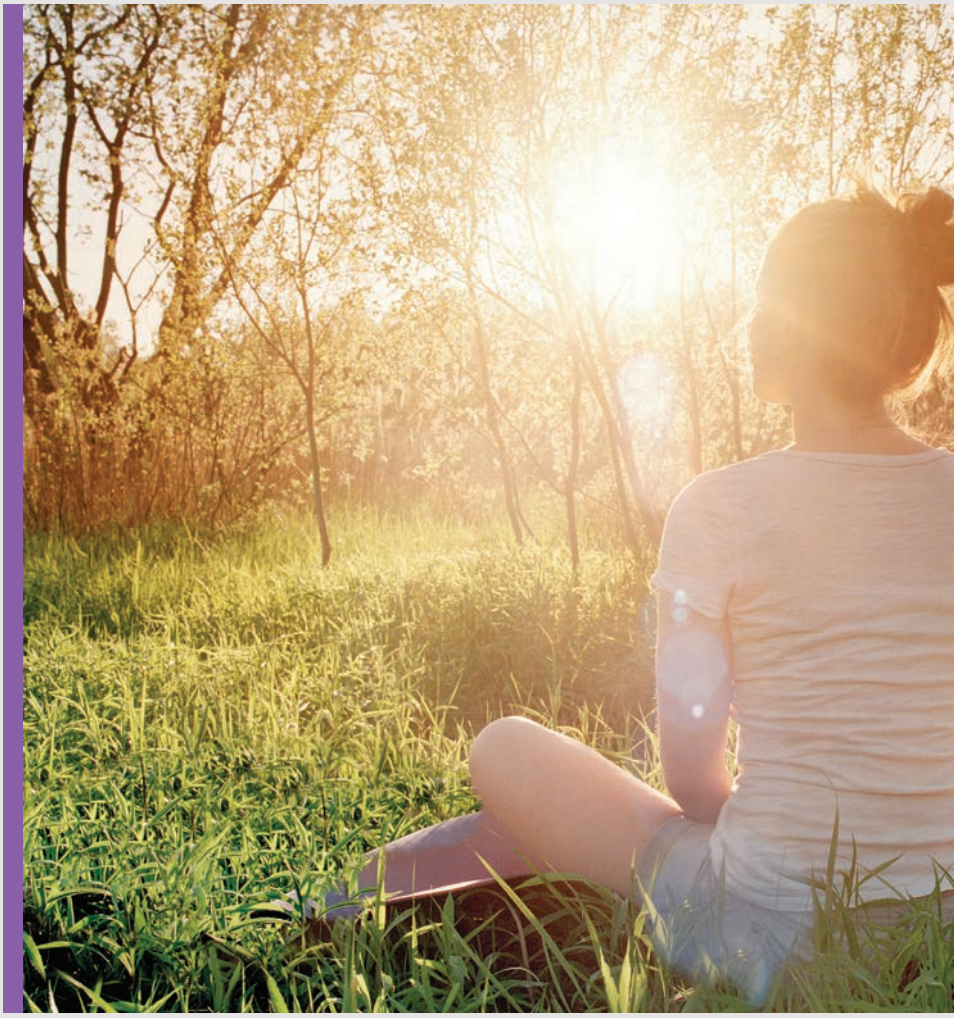
Project5.org is offering free, one-to-one sessions for NHS staff with accredited clinical psychologists and mental health experts. It is a chance to talk and find solutions to longer-term issues. Access the online booking system at project5.org

Apps

NHS People was providing resources and access to wellbeing apps before the pandemic. Popular ones focus on sleep, mindfulness and relaxation techniques alongside daily mood boosters. Headspace, Unmind and Sleepio are the most famous but the full list is available at people.nhs.uk/help/support-apps

NHS England and NHS Improvement have partnered with Liberate Meditation. This app is curated for, and by, those from black, Asian and minority ethnic communities. It offers mindfulness that is culturally sensitive and a more diverse selection of meditations. The app aims to reduce anxiety and promote better rest, as well as offering advice on how to cope with a situation where someone is unintentionally racist. The app can be found at people.nhs.uk/help/support-apps/liberate-meditation

#StayAlive app is a suicide prevention resource for those who may be worried



IMAGES: ISTOCK / GETTY

You are not alone. The pandemic has been an emotional rollercoaster for everyone

that someone they know is considering suicide, or for anyone experiencing a crisis themselves. It takes strength to admit suicidal feelings, so the app offers a gateway to help, in a way that is not intimidating and goes at the person's own pace. Available on the App Store.

Brightsky is a free-to-download app that provides support and information for anyone in an abusive relationship, or those concerned about someone they know. It is available in Polish, Punjabi and Urdu. Available on the App Store.

Resources

Health and wellbeing guides are available at people.nhs.uk/all-guides. The short guides aim to improve your working life by helping you manage your emotional life, for example, learning personal resilience and running your own 10-minute pause space.

Financial worries are regularly the cause of sleepless nights, so the Money and Pensions Service is offering financial wellbeing events alongside its own guidance and tools.

Place2Be has a resource programme for keyworkers and their children that comprises three webinars and an 'art room' pack for parents, carers and children to craft together while working through anxiety, recovery and self-care.

Leadership

Through short, themed and interactive online sessions, NHS leaders can understand the principles of leading compassionately. Through Leadership Support Circles, managers at all levels and across disciplines can find a reflective space to share experiences.

Coaching and mentoring is also available through confidential, one-to-one, virtual sessions that cover everything from leading through the pandemic to finding ways to stay resilient and overcome day-to-day challenges. Details can be found at people.nhs.uk

Fun

Tickets for Good has partnered with NHS England and Improvement to give discounted or free tickets to UK events, such as music or comedy shows, as a way to say 'thank you' to those working in the NHS, especially through the pandemic. Sign up at nhstickets.org and once lockdown measures are eased, an evening out with colleagues could be just what the doctor ordered.

People Plan

As part of the NHS People Plan, there is an ambition to empower the entire workforce to value and improve their own health and wellbeing, thus improving the care they give others, creating a 'wellbeing culture'. In England, this has taken the form of pilots that have been analysing the existing physical and mental health needs of staff, rolling out initiatives, measuring the affects of the initiatives and sharing what's working.

NHS Education for Scotland

This site shows key resources to support the mental health and wellbeing of you and your staff members. It includes sections on managing stress, coping and resilience. bit.ly/NHSESmentalhealth

NHS Wales

The interactive site takes you through a range of wellbeing resources, toolkits and guidance, including videos, financial advice and bereavement support. heiw.nhs.wales/covid-19/

HSC Northern Ireland

Alongside the mental health resources and information, this site promotes Take 5 against Covid #CompassionateCare. These are important steps to not allowing the uncertainty of the situation to overwhelm us. Visit bit.ly/HSCNIstaffhealth

IN SAFE HANDS

Heather, a volunteer on the COVID-19 vaccination programme in Scotland, explores how kindness can be shown through body language

The events of the past year have made most of us reflect on how once we'd almost unconsciously reach out to shake someone's hand or embrace a loved one – and on how much we miss such contact. Of all our senses, touch represents the most fundamental expression of compassion. It has the power to convey emotions such as fear, reassurance and gratitude in the briefest of moments.

I am a qualified midwife, but, like many healthcare workers, I'm also supporting the COVID-19 vaccination programme. In recent months I have met so many people in my role as a vaccinator. I greet each visitor to my station with a smile from behind my mask and usher them in with reassuring words and a open-handed welcoming gesture.

For a short time, they allow me into their lives. A large proportion of visitors have left their homes for the first time in months to come for their vaccine. I can see the tension in many, fearful of injections and overwhelmed at being out after such a long confinement. It's instinctual for me to reach out and give them comfort. I'll often pretend that I need to roll their sleeve up further just so that

"Have a heart that never hardens and a temper that never tires and a touch that never hurts" – Charles Dickens

IMAGES: GETTY

they can feel my reassuring touch on their arm and sense that they're in safe hands.

A giant of a man arrived at my station. Although he was elderly, he was 6ft 5in tall and looked as strong as an ox. He was quite a presence, if not a little intimidating. Yet he averted his gaze and spoke only when he had to. He sat down, still and tense in his seat, and I could see that his eyes were tightly shut. He was petrified. With his head lowered, he whispered: "I'd rather take a punch in the face than have an injection."

I leaned in and quietly told him to open his eyes. I explained that I was a pro at this and asked him to breathe slowly in time with me: in… and out.

As a midwife, I know that when we focus on our breathing, our brains are distracted from scanning for danger. It made sense to apply the mindfulness technique here. I moved my hand up his arm and instructed him to continue breathing slowly while I arranged his sleeve. I gave him the vaccine while resting my other hand gently on his arm. He was still breathing at the same rate when I squeezed his hand and told him that it was done. He squeezed my hand right back for a few moments and tears welled up in his eyes, but I could feel the tension melting away. Then he nodded and asked whether I could be around for his next visit. I asked him if he was asking me out on a date and said that I'd check my diary.

A moment of connection

Not long after the gentle giant departed, a couple approached my station. Another elderly man, dressed beautifully in a tweed waistcoat and flat cap, was accompanied by a younger woman – a daughter or a carer perhaps? There was a great warmth between them as she guided him over with her hand on his arm. She was his interpreter, as it turned out that he was both deaf and blind. I invited them to sit down and watched as she signed carefully on his hand to tell him to feel for the chair behind him. As he sat there, I wanted to reach out to him compassionately and let him know that he was in good hands. My reliance on eye contact and warm words to reassure him were of no use here.

I took a breath and asked the interpreter to sign my name and tell him that I was really happy to meet him. He signed back that he was excited to be getting his vaccine. All that time, I sat patiently watching as she moved her fingertips across his palms, 'speaking' to him through touch. I simply couldn't let my first touch be that of a needle, so I asked the interpreter if she could help me to say hello. She placed my fingers across his hand. He smiled when he felt that they didn't belong to his interpreter. He cupped his hands around mine and felt my fingers, the backs of my hands and my palms. It was an incredibly powerful moment of connection that helped both of us to relax.

I explained through the interpreter what I was doing and waited until he indicated that he understood. After his injection, he smiled and reached out towards me with open hands. I placed my hands in his and he squeezed them warmly. I will never forget the moment that we 'spoke' to each another – it was a truly humbling experience.

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THE PEAR STUDY

Caroline Taylor plans to help pregnant women make more informed choices about healthy eating, but she needs your assistance first

We all know that a nutritious diet is crucial for a healthy pregnancy. Pregnant women have so many questions: Should I eat for two? What about starchy foods? Is it okay to consume eggs? Cheese? Fish? Peanuts? Coffee? We're surrounded by so much nutritional information that it's sometimes hard for us to know what to rely on.

Midwives are in a special position of trust as providers of reliable guidance for pregnant women. But do midwives have access to the right resources? And how can they deliver dietary information in a way that will ensure that their advice will be followed? The PEAR (Pregnancy, the Environment And nutRition) Study, run by Dr Caroline Taylor and Dr Lucy Beasant at the University of Bristol and funded by the Medical Research Council, aims to answer these questions and more.

There is a lot of guidance available about what pregnant women should consume to stay healthy, but less about the foods they should eat less of or avoid entirely – which is the focus of this research. It includes an online questionnaire asking midwives practising in England how they source nutritional information and provide it to pregnant women. The study also features a questionnaire asking postpartum women about all the dietary guidance that was available to them, whether it came from their midwife or any another source. To gauge the effectiveness of that advice, it will also ask about their antenatal diet and how it differed from what they consumed before their pregnancy.

To obtain more detailed information, we'll then invite a smaller number of midwives and postpartum women to participate in an in-depth phone or video call.

Get involved

There are three stages in the research that require input from midwives:

- To ensure it fully answers our research questions, we need to refine the first questionnaire so that it contains all of the questions that midwives would consider relevant and all of the answers that anyone taking that survey would want to select. This will be done via a phone or video call.
- Once the questionnaire is finalised, we'll ask midwives to fill it in online.
- Finally, we'll ask a small group of midwives who took the survey to engage in an online or phone discussion to give us more details about how they provide nutritional information to patients – and their ideas about improving this aspect of their work.

To participate in any of these stages, you'll need to be a registered midwife providing antenatal care in England. We're recruiting for stage one now. Once that's complete, the questionnaire will be opened to more volunteers.

Your contribution will be crucial in helping us to make recommendations on the dietary guidance, especially on foods to consume less of or avoid, provided to pregnant women.

MORE INFO

For further information, visit pearstudy.com or email pear-study@bristol.ac.uk

IMAGES: GETTY

ON A JOURNEY

Caitlin Wilson, the consultant midwife leading the implementation of continuity of carer at Worcestershire Acute Hospitals NHS Trust, reports on the project's progress

My trust's continuity of carer (CoC) journey began in late 2017 when, like all of its equivalents in England, it was challenged to improve its provision of maternity care by introducing new service models. We started from the point of having no CoC provision beyond the occasional home birth. Implementing the new approach would therefore require us make transformational changes.

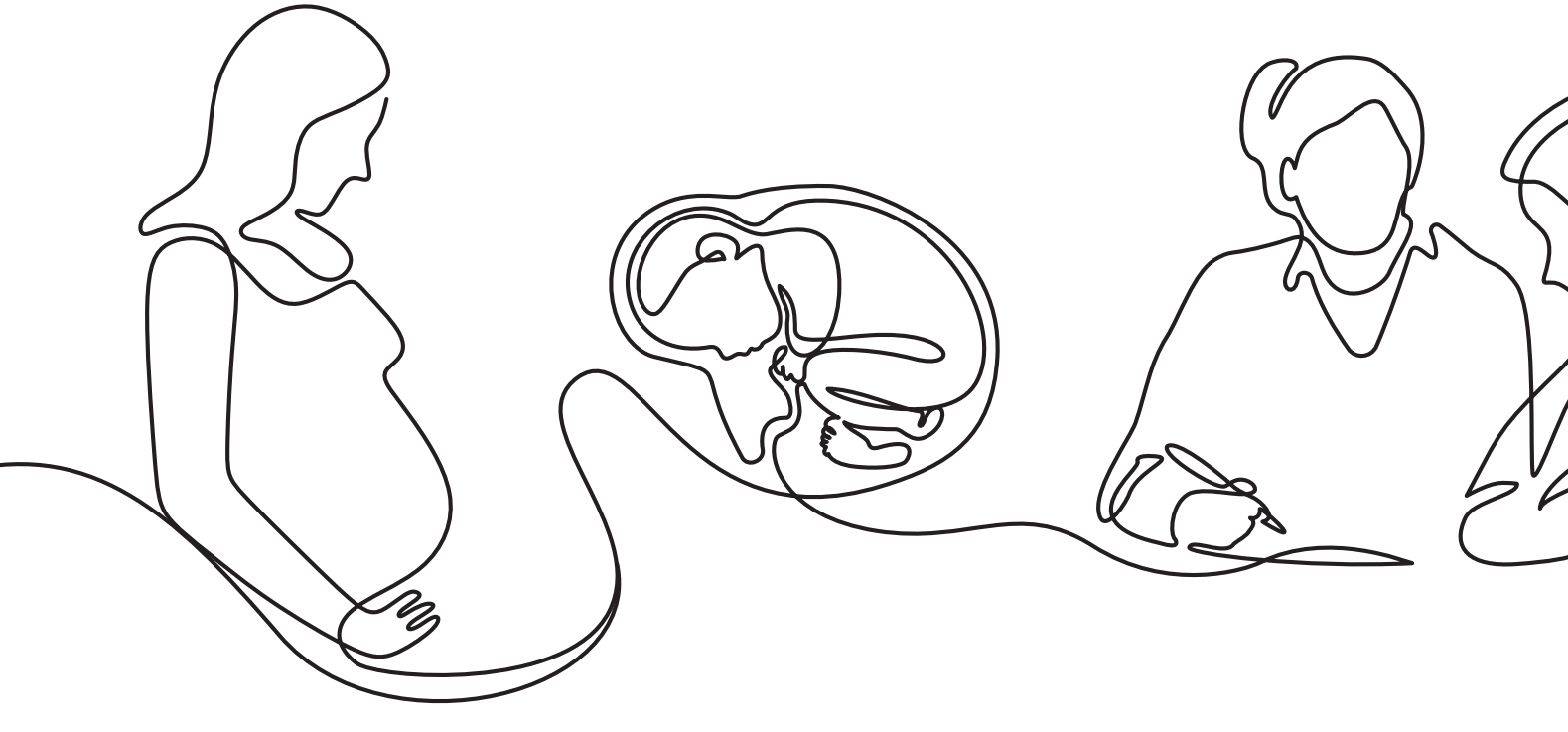
A comprehensive review of our services found many areas of good practice, highlighting our dedication to local families, but it also showed that our provision of CoC, as described by NHS England, was negligible. Our goal was clear from the start: to embrace the changes required and implement the recommendations of Better Births by adopting new service models that would improve outcomes for all patients and the work/life balance of all staff.

We surveyed users of the local maternity and neonatal system in early 2018, asking them about their expectations. More than 10% of our birthing population responded. Their feedback largely matched the findings of Better Births, with women wanting to know the midwives caring for them, especially during childbirth.

Action plans

Over the spring and summer of 2018, we held staff engagement events with the aim of dispelling long-held myths about CoC and forming a shared vision of what it would be. These sessions explored a variety of possible models. Staff from the birth centre devised their own one, creating two teams that would work on a shift basis. In January 2019, they started piloting their new approach.

In February 2019, two newly formed CoC teams began two months of phased development. One team was based in the city of Worcester while the other was focused on rural communities in the county. Both handled mixed-risk caseloads in areas that were aligned with lower-layer super-output areas (LSOAs) – regional subdivisions created to improve statistical reporting in the NHS. By the following month, 20%



CHALLENGES

- Strengthening the coaching support as per Buurtzorg model
- Integration of MSWs
- Adapting to the new ways of working, flexibility and teamwork
- Increasing student experience
- Strengthening our consultant obstetric links to enhance communication and referrals.

We will engage with all services to review our process and systems as this has never been done at scale before, and the whole system needs to adjust and adapt and learn to work differently.

of service users in Worcester had been booked on to a CoC pathway.

COVID-19 disruption

After months of planning, two more teams were to start operating in the north of Worcestershire in March 2020, but the coronavirus crisis struck the UK, causing much uncertainty across maternity services. Only one team got under way, while the birth centre's pilot came to an end, having been found to be unsustainable during the pandemic.

In September 2020, two further CoC teams were able to start work, bringing the total up to five. All of these are operating in LSOAs, focusing on socially vulnerable groups such as migrant and traveller communities.

We have rolled out one team in March 2021 bringing us to six CoC teams. One team focuses on people from black, Asian and minority ethnic backgrounds in the north of the county started work. This means that 35% of our service users are now booked on to a CoC pathway.

Positive results

Our project is gathering momentum, as further CoC teams in other parts of Worcestershire are under development. The continuity midwives have themselves been championing this way of working. Service users in the county have reported that the new model is improving outcomes for all concerned.

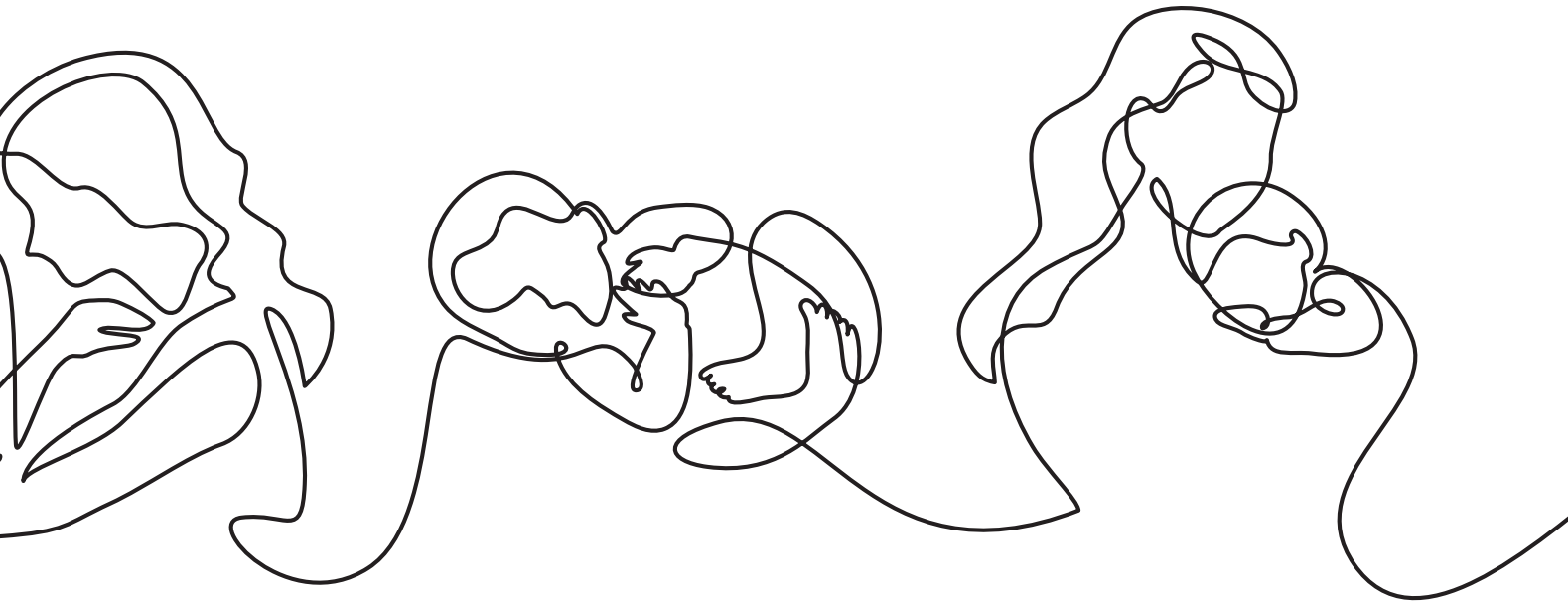
Midwives are forging true partnerships with the women in their care that are built on trust. Most CoC teams have eight midwives working to an annual midwife-to-patient ratio of 1:36. All of the teams include newly qualified practitioners, some of whom are achieving all of their Band 6 competencies under this model. All Band 5 midwives in these teams have a bespoke development plan. Just as we wrap care around our women and their families, the programme is wrapped around newly qualified midwives' needs.

Pandemic aside, the project has not been without its challenges. Team members have had to adjust to working both autonomously and cooperatively. Given that they haven't been expected to work this way before, it has taken many of them a while to get used to it.

Nonetheless, as they learn new methods, midwives are embracing the self-determination that's making the CoC teams so successful. Communicating the workload to colleagues and the wider service has not been easy, but projects are in place to support this as continuity develops. This has been an incredible journey for our services so far. And, with national support, it will continue.

MORE INFO

If you would like advice on implementing CoC, email caitlin.wilson1@nhs.net
For further information, download the RCM What if? guides from bit.ly/WhatIfMCoC



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

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

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

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

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

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

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

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

How can healthcare professionals support new mothers during this time?

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

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

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

About WaterWipes

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

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Homebirth vs the pandemic

When the pandemic struck, most homebirth services were forced to close. For those that didn't, there were significant staff safety considerations. For those that did, there was an awful sense of failing women in their care. Here are two sides of the story

IMAGES: SHUTTERSTOCK

Emma Chambers

ASSOCIATE DIRECTOR OF MIDWIFERY, EAST SUSSEX HEALTHCARE NHS TRUST

The ethical dilemma I faced when making these decisions was traumatising

Planning and responding to the pandemic has been a significant challenge. Initially, the impact on morbidity and mortality for pregnant women, new mothers and babies was not known – which made the early weeks and months of the pandemic especially difficult to navigate, causing high levels of anxiety for pregnant women and staff.

In March 2020, my trust received a communication stating that the ambulance service was unable to guarantee a response to maternity calls within the usual timeframes. With the support of the trust's executive team, I made the difficult decision to suspend out-of-hospital birth services until the ambulance service was able to provide a timely emergency response again. We were then unable to restart the service as soon as ambulance support was provided due to health and safety and infection control concerns for midwives working in women's homes for long periods of time. The ethical and legal dilemmas of this decision-making were extremely complex.

As a midwife with many years of practice, mainly within community settings and birth centres, and as an independent midwife supporting women's choice and autonomy, the ethical dilemma I faced when making these decisions was traumatising. I was acutely aware of the importance of choice of place of birth and the impact that its removal would have on the birth experience and mental health of some women and their midwives. The suspension of homebirth services certainly led some women to feel forced into making the decision to 'freebirth' when they would not have previously; they cited the feeling of safety during birth in their own home, as well as the risk of COVID-19 infection transmission in hospital. Consequently, the concept of autonomy was removed for these women, and those having to give birth in a hospital environment instead of at home.

Between a rock and a hard place

During the suspension of services some members of our community teams were very keen to provide homebirths, particularly once ambulance support was restarted. However, some midwives were genuinely frightened about working in homes, especially for the long periods sometimes spent at homebirths. This conflict was very difficult to

resolve; the information about COVID-19 was evolving quickly and continuously, including the contributing risk factors, PPE requirements and transmissibility of the infection. I did not want to place any member of my team at risk, but equally I did not want to remove choice and autonomy from women. Each trust maternity service was expected to make its own decision regarding out-of-hospital birth provision. This led to confusion and disparity for women as neighbouring trusts were offering different services for complex reasons.

MORE INFO

Equality and Human Rights Commission: bit.ly/EHRCwhatwedo

Human Rights Act 1998 [United Kingdom of Great Britain and Northern Ireland]: bit.ly/HRA1998

During this period, I faced unpleasant and unprofessional behaviour from a service-user group, I was threatened with personal legal action, formal complaint and referral to the NMC. I was accused of violating women's human rights (Article 8: Respect for your private and family life in theHuman Rights Act (HRA) 1998), but at the same time I was trying to protect my team's health and safety and human rights (Article 2: Right to Life). Following assessment using the Exception to the Human Rights framework, the suspension was found to be legal, necessary and proportionate (Equality and Human Rights Commission, 2019).

In an attempt to find solutions to these issues, I tried to ensure regular engagement and communication with my team and personal communication with affected women. We quickly developed robust risk assessments, documents explaining to families the expectations during homebirth, and processes to allow midwives the ability to decline homebirth if they did not feel safe. With these tools, midwives felt more able to offer homebirth and the service was restarted.

In the second wave, services were again suspended in December 2020 due to a lack of ambulance capacity, but were immediately restarted once this capacity became available.

The pandemic has been the most challenging period of my career. I am sure most – if not all – NHS staff would say the same. I have had to make decisions I would never have believed I would make, decisions that have significantly impacted women, their families and the staff working within our services. I have learnt a great deal, seen incredible altruism and humanity, but also the inability of some to consider the health and safety of others alongside their own wishes. All of these behaviours have been within the context of a new and threatening situation and can be understood. Being pregnant during the pandemic must have been frightening, frustrating and confusing, but as COVID-19 could potentially affect the health of everyone, being a midwife at this time has been the same!

Frances Rivers

HOMEBIRTH LEAD MIDWIFE, KINGSTON HOSPITAL NHS FOUNDATION TRUST

On my way to a homebirth at 5am in the middle of last year's lockdown, I sent a plaintive WhatsApp message to a colleague: "Are you awake?" Minutes earlier, as I was setting off to attend the birth, I had received a call from another family letting me know that their baby was also on the way. Two homebirths at once is not unheard of, but moments later, my phone went a third time. It was the maternity unit – another woman had called, also booked for a homebirth, also in labour. A flurry of phone calls and messages later – including that wake-up call to a team member who leapt out of bed within minutes to help out – and midwives and equipment had been dispatched to three homes. By mid-morning, all the families had welcomed their new arrivals safely and were enjoying celebratory cups of tea and cuddles on a very special VE day.

Providing a homebirth service during a pandemic has proved to be – like managing all aspects of maternity services this past year – fast-evolving and challenging. As the virus spread, many women expressed fears about coming to hospital, about who might be able to support them at their birth, and about childcare arrangements with lockdown restrictions in place. Those concerns triggered an unprecedented interest in homebirths, making the last 12 months Kingston Homebirth Team's busiest on record.

"I decided that in lockdown, as our house had become an office, nursery and gym, why not a birth centre too?" explains Jane Pettman, whose waterbirth was attended by members of the team last year. Just like Jane, women who might never have considered a homebirth found themselves asking whether it might be possible. The number of women requesting a homebirth increased by more than 60%. As a result, our homebirth rate for women living in the area now regularly sits each month between 4% and 5%, more than double the national rate of 2.1% – although that statistic pre-dates the pandemic. National birth figures for 2020 will be released later this year and will reveal whether our rise in homebirths has been mirrored across the country.

With demand soaring from March 2020 onwards, we took on the challenge to increase our homebirth service provision while still providing safe care and protecting our staff. Guidance published last year by the RCM and RCOG on providing midwife-led births in a pandemic suggested that homebirths may reduce infection transmission rates and pressure on hospital services. But it all depends on staffing capabilities. That's why regular consultations between the director of midwifery, community midwifery matron, consultant midwife, the homebirth and community midwives, local ambulance service and the families themselves have driven our response.

Early on, we decided to continue with in-person at-home care for all scheduled antenatal and postnatal appointments, to ensure safe outcomes and allow the involvement of family members.

"It's been really wonderful to be able to support women in their choice for a homebirth during the pandemic. By continuing to see women in their homes, wearing full PPE, we've been able to maintain some normality for these women at such a vulnerable time," says homebirth midwife Sarah Graham.

As the virus spread, many women expressed fears about coming to hospital

When the ambulance service told us during the first lockdown they could no longer guarantee safe response times to emergency call outs, the service was briefly suspended. Women were redirected to the birth centre and offered continuity from the homebirth midwives.

Second wave

During the January lockdown, when COVID cases threatened to overwhelm health services once more, ambulances faced extraordinary pressures. Reluctantly we briefly suspended the service again, but were able to restart after the local maternity system (South West London) agreed to fund a short-term contract with a private ambulance provider. It enabled us to transport women safely from home to hospital if the need arose. The idea had been instigated by other trusts in the capital as an innovative way of providing safe transfers, without calling on the ambulance service. In the event, we only used the private service once as hospital transfers are not common.

Now that we are emerging from this latest lockdown with a vaccine programme in full swing, homebirth numbers show no signs of decreasing. We've responded by enlarging the number of midwives on the team, including a placement for a preceptee midwife. And we work collaboratively with the wider team by increasing the number of midwives on call during peak activity periods.

"As a team we've really pulled together to support each other during busy periods, as more and more women consider homebirth as an option," says homebirth midwife Lucy Hooper.

Like other services, we've had to embrace the virtual world. Our Instagram (@homebirthkh) is regularly updated with stories and statistics. What was once a monthly get-together at the hospital for families interested in homebirth is now an online 'Meet the team'. It has proven so popular, with attendance more than double what it used to be, we're likely to keep it that way. Families join us on a Saturday afternoon from their sofas to listen to birth stories and ask us questions.

Over the past 12 months we've had great results: 88% of women who laboured at home with the team had a homebirth, and 97% of women who laboured at home with the team had a vaginal birth. First-time mums make up about a quarter of our caseload and despite increasing numbers, our transfer rates to hospital have actually fallen.

Achieving such results in the midst of a global pandemic has reaffirmed our team's belief in the benefits of physiological birth and continuity of carer. As our students and newly qualified midwives queue up to spend time on the team, the wider service can only benefit from the impact on their practice in years to come.

But ultimately, the women themselves best sum up what it's been like. Chloe Cox had her second baby at home with the team in September. She says, "I feel so grateful and incredibly lucky to have had access to such care, which really is the definition of what woman-centred, holistic care should be."

MORE INFO

If you would like advice on how Kingston was able to continue the service, please email frances.rivers@nhs.net

A question of WRISK

Information sharing – or scaring? A project to review the communication of risk during pregnancy found worrying inconsistencies

Women find themselves subject to a wide range of messages about how to eliminate or manage a multitude of public health risks. Increasingly, midwives are delivering these messages to women who are pregnant or planning a pregnancy.

As part of antenatal care, midwives and sometimes maternity support workers (MSWs) are responsible for advising women about diet, smoking and substance misuse, managing their weight, monitoring their emotional and mental health, exercise, managing pre-existing conditions and medications, and building attachment to their growing fetus, as well as learning to monitor their baby's movements and other pregnancy symptoms. Family, friends and parenting groups contribute their own (sometimes contradictory) opinions.

Meanwhile, reporting of 'latest study findings' introduces an ever-expanding range of risks to avoid and benefits to seek out – from avoiding air pollution to eating more broccoli. Scientific findings are written into press releases designed to achieve the greatest impact, which are often distorted into scaremongering newspaper headlines.

The sheer weight and intensity of these rules may be leading to unintended negative effects, including on the one hand excessive anxiety (which women are advised to avoid!) and, on the other, a failure to appropriately prioritise serious risks to maternal health. Antenatal appointments can be so packed with information that isn't relevant to the person in front of you, that opportunities to personalise the conversation and discuss some of their worries or concerns are missed. Risks are not always communicated in a way that reflects or explains the evidence base and its limitations, and messages are not always constructed in ways that acknowledge the context of women's lives or their capacity to weigh up risks in relation to their own circumstances.

Borne out of these concerns, we started the WRISK project, a Wellcome-funded collaboration between the British Pregnancy Advisory Service (BPAS) and Cardiff University, supported by the RCM, which aims to better understand and improve the communication of risk relating to pregnancy. More than 7,500 women have spoken to us about their own experiences of risk messages and pregnancy through a survey and in-depth interviews, and we have also undertaken work to understand how pregnancy-related risk is portrayed in the media.

Women with higher BMIs

Women with higher BMIs experienced a great deal of risk messages, and many felt stigmatised throughout their maternity care. Several women in our survey and interviews felt that although they knew they were overweight there had been little discussion of their journey to become pregnant. One woman had lost six stone in the 18 months prior to her pregnancy, yet this was never acknowledged and the focus remained on the fact that she was still overweight. It is vital that midwives and MSWs take time to explore the individual circumstances of women and give real praise for personal achievements.

Pregnant women with higher BMIs were routinely subject to dehumanising messages throughout their care. For example: "No one looked at me like an individual but instead just a number on a scale," said one. Another felt she "didn't deserve to be pregnant", and another was "not good enough… because of my size". One of our participants was present for a conversation about how staff would handle her body should she

become incapacitated during labour: "I accept that there is also the risk of the idea of my body as a large object. In itself, it poses a risk to staff who are handling my body. That is a very depersonalising way to think about yourself. I feel quite strongly that risk needs to be considered in private and not in front of me."

The failure to quantify or contextualise risk was a source of anxiety for women. One says: "I was constantly being told I was at a higher risk, but no one could tell me by how much." This is an important consideration for healthcare providers who care for women with overlapping and intersecting risks; it is impossible to tot them all up neatly into one figure, and even if it was, that is a heavy burden for women to carry.

Women we spoke to felt that they had their choices restricted due to their weight, particularly in relation to birth. They were told they had to give birth in 'high risk' units where their options around waterbirth, or even their ability to be active in labour were restricted. However, women often just wanted an explanation or two-way conversation as to why something was not possible: "It has not really been explained very well and there's no one really who has actually said, 'Do you know what? We will try and do that for you' or 'We'll work with you on that, because it's what you want.' That's the only sad part where I've struggled, because the only thing I ever actually wanted was a waterbirth."

Alcohol and pregnancy

Current advice on alcohol consumption in pregnancy stems from the former England chief medical officer's guidance that pregnant women abstain from alcohol entirely. While most women don't drink alcohol once they know they are pregnant, this advice has been challenged on the basis that it is insufficiently nuanced or unrealistic.

Our research found that women are generally happy with the precautionary approach when it comes to alcohol, but they wanted an honest conversation about the evidence of harm, particularly regarding low levels of alcohol, so they were able to make up their own minds about the occasional drink. We also found that women felt an enormous amount of anxiety and guilt if they had drunk alcohol before they knew they were pregnant, even more so if they experienced a pregnancy loss and blamed themselves.

Some women we spoke to felt that the advice they received on alcohol (and other substances such as tobacco) was at the expense of other conversations that were more relevant to them. For example, some women we spoke to drank little to no alcohol before they were pregnant, and others were practising Muslims. For them, the time spent in conversations about alcohol could have been spent talking about something else.

Other concerns relating to alcohol highlighted in our research was how this advice has led to the encouragement of social surveillance – other people's sense that they are entitled to comment or interfere: "Yes, in the second and third trimesters of both pregnancies, I did have an occasional glass of wine. If I was out when I was visibly

pregnant, I felt a bit weird about doing that in a pub, for example. I definitely felt like people were judging me."

Use of medication

Conflicting advice and a lack of health professionals' knowledge about the risks and benefits of medication, particularly around the perceived safety of antidepressants and treatments for hyperemesis gravidarum, caused significant distress for women.

Several experienced 'gatekeeping' of medications by healthcare providers. Despite clear guidance of prescribing for hyperemesis from the RCOG, one sufferer was told that "there is nothing you can take for that". She implicitly trusted her midwife and felt unable to seek help elsewhere in case what was then recommended was not safe for her baby. When she changed trust, she found that medication was available and was upset she had been allowed to suffer for so long.

Women themselves, and healthcare professionals responsible for their care, sometimes struggle to balance and prioritise competing risks. For example, the latest MBBRACE-UK maternal mortality report highlighted cases of women who had been inappropriately discouraged from taking medication for epilepsy because it might be harmful to their baby.

We also heard from women who had stopped taking prescribed medicines without seeking advice from their doctor or midwife because they were concerned about the impact on their baby. Some women were hospitalised as a result, including one woman who was hospitalised after she stopped taking asthma medication. Others 'struggled' to cope with debilitating pain from conditions such as pelvic girdle pain and 'got by' on paracetamol when they had been prescribed more effective pain relief. We found that it isn't simply enough to prescribe women the medication they need – they need to be properly counselled, not just on the risks but on the benefits too. Some women talked about how their midwives supported them to decide whether to continue with long-standing prescriptions for antidepressants during their pregnancy, recognising the benefits they might bring during a time of great change and balancing these against the known risks.

Concerns have also been raised about a tendency to extend pregnancy risk messaging and caution around medication to all women of childbearing age, regardless of their pregnancy planning intentions. For example, it has been argued that restrictions on the use of sodium valproate for treatment of epilepsy for women and girls of childbearing potential, regardless of whether or not they are pregnant or planning a pregnancy, indicates that "the potential for pregnancy has now become a dominant consideration when treating women". Pregnancy prevention programmes, mandated for medications such as Roaccutane, have been difficult for people to navigate during the pandemic and particularly frustrating for women whose 'risk' of pregnancy is extremely low.

No continuity

The challenges in negotiating a complex risk message landscape disproportionately affect women who have pre-existing conditions, such as depression/anxiety; who develop conditions in pregnancy, as is the case with women suffering from hyperemesis gravidarum; or whose circumstances mean that they are more vulnerable or marginalised in other ways. Teenage mothers had a distinct

experience of risk messaging throughout their pregnancy. They felt that they were given instructional, directive advice, including during the intrapartum period: "…then when it came time to push, I told her this is how I wanted to be – on all fours – and she started shouting at me, telling me that's not how I was doing it. I was to get up on my knees and hold on to the back of the bed."

One younger mother recalled how she felt that her midwives delivered partial advice, omitting information about the risk of obstetric injury they did not think was relevant: "Oh, you're young, you won't have to worry about that sort of thing. Third-degree tears normally happen to older ladies." This was of little comfort when it happened to her.

Media headlines

While many women we spoke to took media headlines with a pinch of salt, mother-blaming in the mainstream media contributes to a culture in which women feel they are held responsible for any and all ills that befall their children. When we read headlines about the latest study findings, they become taken for granted facts that go unchallenged. Very few of us have time to track down the original study and interrogate the methods even if we have the skills to do so, and we certainly can't expect pregnant women to do this every time they read a newspaper headline.

However, we should not just be focusing on these headlines themselves, but looking at research on pregnancy and consider whether we are even asking the right questions. A recent review into the pregnancy research landscape found that the issues really important to women, such as the prevention and management of mental health problems, or the safety of medications in pregnancy, are not areas that receive the most attention, or funding.

Public health risk messaging is an essential role of midwives and MSWs, but we suggest it is failing to meet the needs of many women. At policy level there appears to be little consideration of the potential for public health messages to result in anxiety and distress – ironically, emotions women are advised to reduce. Midwives and MSWs have a duty to ensure information is accurate and evidence-based. Too often, women were incorrectly informed that safe effective treatments for pregnancy-related conditions, particularly for hyperemesis gravidarum, were not available, and women were not provided with appropriate information on safe medication use for ongoing conditions.

The challenge for midwives and maternity support workers who provide any risk message in pregnancy is to ensure this is provided in a way that makes women feel encouraged, valued and respected in accordance with their individual needs, lifestyle and circumstances. Pregnancy is an opportunity for women to make positive changes to their lifestyle that will benefit themselves and that of their baby.

MORE INFO
Visit wrisk.org

CONTRIBUTORS

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Ginger biscuits

15 May is HG Awareness day. Here's why that's important

"Despite the HG they were worth it": Rebecca with her boys

I am one of the 1% to 3% of women who suffer hyperemesis gravidarum (HG to its friends) in pregnancy. And while many women suffer nausea and vomiting, this particular disorder takes things to a whole other level.

At around six weeks, I noticed an unpleasant taste – acid reflux. Within days this had become a permanent nausea, and retching was swiftly followed by full-on vomiting. I was advised to take a well-known indigestion brand, which worked for two days before I began vomiting that up too. I couldn't stand the smell, taste or sight of food or drink, even water. I spoke to my GP, I spoke to midwives at appointments, I spoke to hospital staff, and no one seemed to understand quite how debilitating it is to have 24-hour sickness. I was advised to eat ginger biscuits.

At one antenatal appointment, the midwives noted that I was dehydrated and had ketones in my urine. I was swiftly sent to hospital and put on a drip for a few days. A kindly consultant suggested I try ginger biscuits. I was discharged with anti-sickness tablets – after a day I brought those up too. At 20 weeks, mercifully, the sickness lessened and, through a random series of events, I discovered that chilli sauce helped me keep food down. I covered everything in chilli sauce and at 42+ weeks had a beautiful 10lb baby boy.

My second pregnancy, when I was experiencing nausea and vomiting again, I thought: 'It's okay, I've got this'. Turns out, I didn't. The chilli sauce did not work. I went through endless days and nights of unrelenting nausea and vomiting – I couldn't sleep, I was exhausted, I couldn't keep anything down, I was admitted to hospital for dehydration, I was sick at work constantly and, much to my and my colleagues' horror, without warning. My throat was so raw that at one point I was vomiting blood. The 20-week mark came and went and I felt no different. Weeks rolled into months and still no one could do anything for me. Every time I spoke about it at appointments the response was a sympathetic face, the suggestion to eat little and often... and had I tried ginger biscuits? At 40 weeks exactly, my beautiful 9lb baby boy arrived and I celebrated with food.

I couldn't stand the smell, taste or sight of food

HG was hell. I experienced prenatal depression and considered both termination and suicide, though writing this now I can't believe it. My story isn't unique – ask any HG sufferer and they'll say the same. So here's the point: as midwives and MSWs you can help. Understand this is an endurance test, don't say "It'll pass" but offer anti-sickness medication – a variety to find one that works, offer interventions before crisis point, check on the woman's mental health and please, please, don't ever suggest ginger biscuits.

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Revision Date: April 2021

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