THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

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midwives

VOLUME 24 / SEPTEMBER 2021

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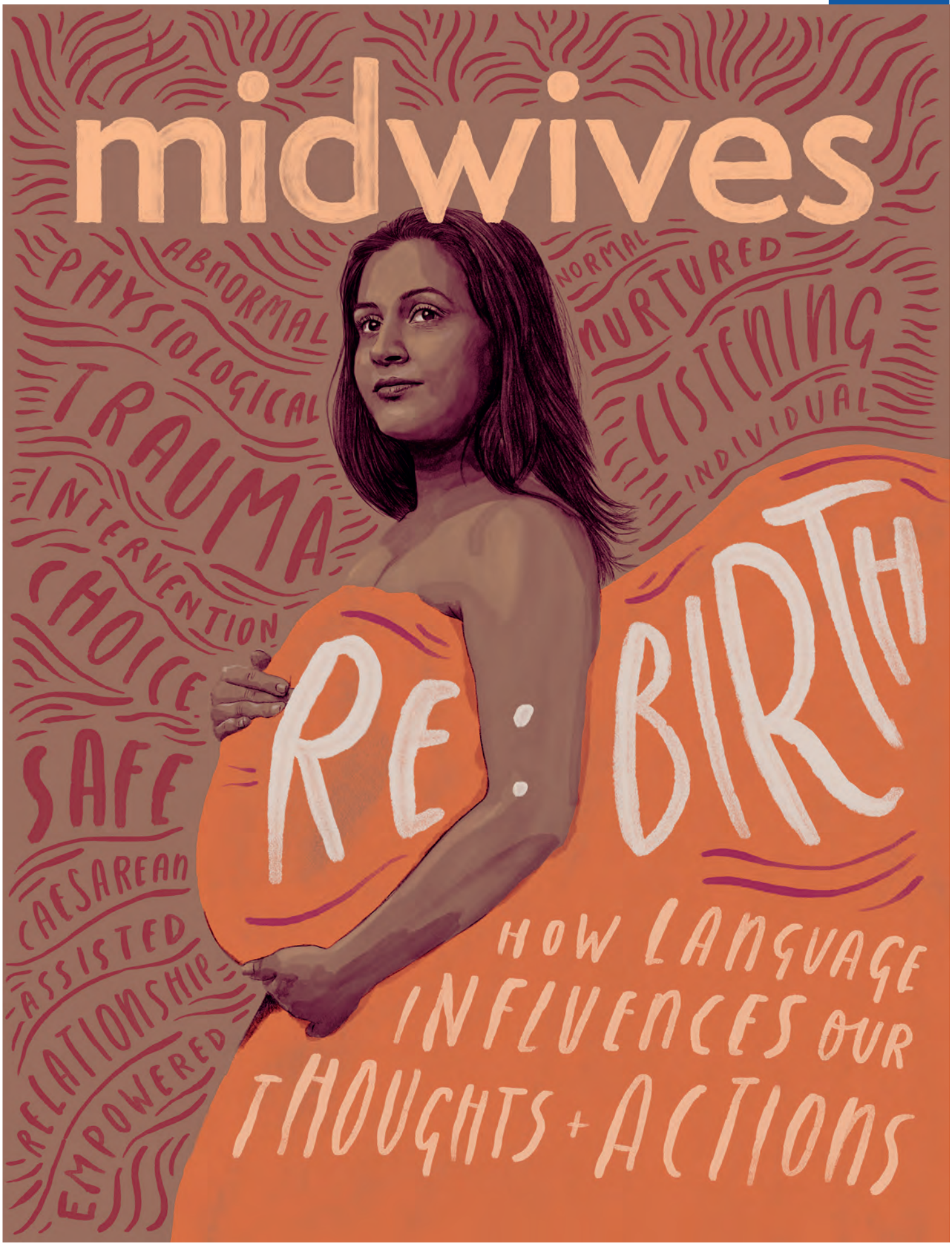

RE: BIRTH

HOW LANGUAGE INFLUENCES OUR THOUGHTS + ACTIONS

SEPTEMBER 2021

Birth Prep & Recovery

by Lansinoh

neu

75% of women said they were unprepared for the physical pain & recovery after having a baby.[1]

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1 Lansinoh (2021) Postpartum Survey. Internal Lansinoh report. Unpublished.

2 Bourdillon, K., McCausland, T., Jones, S. (2020) The impact of birth-related injury and pain on breastfeeding outcomes. British Journal of Midwifery. Vol 28:1.

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4 LDPE Recycle your magazine's plastic wrap – check your local LDPE facilities to find out how.

RCM chief executive Gill Walton stands up to bullying and abuse

Welcome

I'm really proud of the fact that we were one of the first royal colleges to share information for our members about COVID-19, all the way back in February 2020. Since then we have brought together the most up-to-date information for midwives, MSWs and the women and families in their care, from clinical guidance to posters for display in maternity units. We've worked with the media to amplify this advice and done the same on Twitter, Facebook and Instagram. It's been a brilliant team effort, not just within the RCM but also through our partnership with the Royal College of Obstetricians and Gynaecologists and others.

During the course of the pandemic, the guidance changed as more was learned, and we made sure we were always giving the best possible information to maternity professionals and the women in their care. In April this year, pregnant women were advised against having a COVID-19 vaccine because not enough was known about its safety, but now there is a huge body of evidence that it is safe for pregnant women and their babies. In July, amid worrying rises in the number of pregnant women becoming very ill with COVID-19, the RCM alongside NHS England and the RCOG encouraged pregnant women to get the vaccine. Following a round of TV and radio interviews, I became the subject of vile online abuse from anti-vaxxers accusing me of putting women and babies in harm's way.

While it was an awful experience, the RCM supported me with #IStandWithGill and called on fellow health organisations, trade unions and health and care professionals to do the same. But this isn't really about me – it's about you. The episode mirrors the rise in abuse that maternity professionals are experiencing and reporting across the UK because of COVID restrictions. Midwives and MSWs working in stretched services – who are giving it their all to help women, birthing people and their babies to have the safest, best-quality care despite the pandemic – shouldn't have to put up with abuse or aggression just for asking a visitor to wear a mask.

You are doing an incredible job – the RCM stands with you

You are doing an incredible job in the most difficult circumstances, and you have the right to be treated with respect and dignity. More than that, you have the right to feel safe in the workplace. If you do not, you must raise it with your head or director of midwifery and with your RCM rep. The RCM is there to support you too. The RCM stands with you.

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COVER ILLUSTRATION: PETER STRAIN

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Vaccination advice

Data is showing a concerning rise in hospital admissions for pregnant women unvaccinated against COVID-19. There is now a huge body of evidence that the vaccine is safe for pregnant women and their babies, and they are being encouraged to get vaccinated. It's understandable that pregnant women are hesitant about vaccinations, so the RCM and RCOG have produced resources to support maternity professionals' discussions with them.

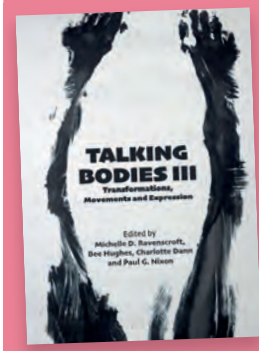
NMC chief executive Andrea Sutcliffe CBE said: "Our Code clearly sets out the importance of midwives' fully recognising their responsibility to provide pregnant women with support and accurate information. We encourage all pregnant women and their families to receive a COVID-19 vaccination."

Sarah McMullen, of the National Childbirth Trust, said: "We urge healthcare professionals to read the guidance on COVID-19 in pregnancy. Pregnant women should be prioritised as a vulnerable group."
Find out more at bit.ly/RCMVaccineFacts, bit.ly/MaternityVaccineGuidance, bit.ly/RCOGCovidGuidelines, and bit.ly/NMCCaringCode

LEARN
E-Learning for Healthcare has created a training package for perinatal postmortem consent to address the lack of standardised professional training on this sensitive topic. See **bit.ly/ELFHPortal**

one to watch

READ
Talking Bodies (University of Chester Press) is a collection of essays about how the body is perceived. Includes discussions on body awareness in midwifery and moving towards LGBTQ+ inclusive practice.



FOLLOW
In 1951, Henrietta Lacks was undergoing cancer treatment and unknowingly had cells taken from her that have since been widely used and proven crucial for biomedical research. Her family is seeking compensation. Follow the case at **bit.ly/HenriettaLacksInfo**

Screening programme

Tell SCID

From September 2021, the NHS newborn blood spot (NBS) screening programme will begin an evaluation of screening for severe combined immunodeficiency (SCID) in six centres in England.

SCID is a group of rare, inherited conditions that impair immune system development. Without early recognition and treatment, babies with SCID generally die before they reach one-year-old. In England, about one in 40,000 babies – roughly 14 a year – is born with SCID. About one-third of cases are diagnosed because of a family history, but the delay in identifying the remainder means babies are exposed to infections for longer before receiving treatment.

The SCID evaluation will take place in two-thirds of the country over a two-year period. In the areas taking part, screening for SCID will be offered as part of the existing NBS screening programme, using the same blood spot sample.

The evaluation will also support BCG vaccinations. From September, the BCG vaccine will only be offered to eligible babies from four weeks of age where a baby has a 'SCID not suspected' or 'SCID screening not offered' result because the BCG is a live vaccine and can make the treatment for SCID more complicated.

For more information, visit bit.ly/PHEScreening, bit.ly/SCIDScreeningNHS, and bit.ly/PHEScreeningBlog

COVID response

MBRRACE and COVID

In response to July's MBRRACE-UK report on COVID-related and associated maternal deaths in the UK, NCT's director of impact and engagement, Sarah McMullen, said: "We have profound sympathy for families with mothers who have died from COVID-19 while pregnant or having recently given birth. While we recognise the pandemic has been exceptionally challenging for caregivers, it is apparent there has been inadequate care for many women. Some were in need of an interpreter or advocate, which was not available; others were afraid even to engage with health services. As MBRRACE-UK points out, not all women are able to use online consultation or have the privacy to disclose their concerns. We call for real urgency in implementing the latest evidence-based guidance in this report."

For more, see bit.ly/MBRRACEReport

LOOK AFTER EACH OTHER

The RCM has joined health bodies in urging the public to keep COVID-19 transmission rates low by continuing to use masks on public transport and social distancing where possible.

Gill Walton, RCM chief executive, said: "Our maternity services and the wider NHS are still facing massive and increasing pressures, as rates of the new variant of the virus are rising. We have significant staff shortages that were there before the pandemic. These have been made much worse as many staff are off sick or self-isolating because of COVID-19.

"We also need employers to allow maternity staff and their NHS colleagues to work more flexibly. This will help to reduce unnecessary journeys and the possibility of passing on or catching the infection on public transport and in workplaces. This is particularly important for pregnant women."

A poll by the NHS Confederation showed that almost 90% of its members want the public to continue wearing masks in all healthcare settings. The RCM is also urging NHS staff to keep self-testing for COVID-19 even if asymptomatic, along with maintaining good infection prevention and control.

BREATHE EASY

A study by Cancer Research has show that, during the first lockdown, there was a 25% rise in the number of 18- to 34-year-olds smoking, resulting in more than 652,000 new smokers. The researchers, from University College London and the University of Sheffield, also found there was a 99% rise in people across all groups successfully quitting during lockdown. While NHS data shows smoking in pregnancy fell to 9.5% last year – the first time rates have dropped below 10% since records began, according to Action on Smoking and Health.

Clare Livingstone, RCM's professional policy advisor, said: "Investment in stop smoking services is working in some areas. Reducing smoking in pregnancy is key to reducing stillbirths and will also have real benefits for the health of women and their babies. That's why it is critical that they get the support they need to stop."

The RCM has called on the government to reverse public health funding cuts, which have seen many stop smoking services close.

SHARE YOUR STORY

Have you had a great idea for improving clinical practice? Have you found a way to improve care for women, birthing people and their families? Have you a tried and tested system for supporting your colleagues and your own wellbeing? Then let us know the amazing work you're doing at Rebecca@midwives.co.uk

Preterm birth

Due date

The health outcomes of preterm babies can be significantly improved by timely and appropriate interventions in women presenting with preterm labour. However, non-specific presenting signs and symptoms make that challenging.

A study from the University of Edinburgh, funded by charity Tommy's, has been working on how to predict when babies will arrive early. Current NHS standard tests only get it right in about one in five cases, so mothers are often hospitalised 'to be safe' and COVID-19 makes it even more important to avoid that.

Using a risk prediction model that included vaginal fluid fetal fibronectin concentration analysis alongside clinical risk factors improved the prediction of impending spontaneous preterm birth and was cost-effective in comparison to fetal fibronectin alone.

Jane Brewin, chief executive of Tommy's, said: "With 60,000 babies born prematurely each year in the UK, there's an urgent need for better ways to predict and manage that risk. Most mothers with signs of premature labour are still pregnant a week later, and this study shows the typical NHS tests aren't accurate enough. We urge the government to include these tests as standard in national maternity care guidelines, so that precious NHS resources can be focused on those most in need."

"There's an urgent need for better ways to predict and manage risk"

MIDIRS Digest

1 Experiences of being a midwifery student during these challenging times – Hauwa Hamza

2 Burnout – a personal experience – Iris Snowdon

3 What do women need to know about induction of labour? A co-creation approach to supporting women's experience of birth following induction – Sam Nightingale, Jane Coad, Elizabeth Bailey

4 Women's experiences of communication support in a maternity care setting: a literature review – Coralie Huson

5 Factor contributing towards women booking late for antenatal care in the UK – Hayley Billings, Nada Atef Shebl

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

Some *Evidence Based Midwifery* papers are reprinted in *MIDIRS Digest*. For full access to EBM papers, visit bit.ly/EBMJournal

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Health funding

Budget cuts

A partnership of leading women's health organisations has called on Hampshire County Council to rethink its plan to cut £2m per year from its public health budget.

In a letter, the One Voice Partnership – which includes the RCM, the RCOG, charity Sands and the National Childbirth Trust (NCT) – has called on the council to urgently re-evaluate the cuts. The RCM's Gill Walton said: "What's happening to public health budgets in Hampshire is happening elsewhere across the UK. We absolutely recognise the strain that local authority budgets are under, but slashing spending for some of the most vulnerable is a false economy. Cutting community nurses and health visitors by almost 50 full-time posts will reduce the support women and their babies need at a time when they need it most. We're all aware of the need to support perinatal mental health, yet these proposed cuts risk taking a vital contact point away altogether. Those who are most vulnerable will lose out. Supporting pregnant women, new mums and babies isn't a luxury – it's a vital investment."

The Institute of Health Visiting's executive director, Alison Morton, agrees: "These short-sighted plans, designed to cut costs, will cause harm and cost the council and wider society much more in the long run. Having the right support from highly trained health visitors who are specialist public health nurses has been shown to make a big difference to a multitude of health and social problems."

HEE review

Workforce trends

Helen Whately, the Minister of State for Care (pictured), has commissioned Health Education England (HEE) to conduct a one-off review long-term health and social care workforce trends. Sean O'Sullivan, RCM head of health and social policy, welcomed the review but said it should be an annual assessment: "This is a moving target and that demands that any assessment is looked at again with fresh eyes every year so that immediate and pressing gaps can be identified and dealt with. We had hoped that the Health and Care Bill would have incorporated such a role for HEE and it is disappointing that it falls short of what is needed.

"Maternity is ahead of the curve on this, following the Expert Panel review of safe staffing and the published Health Committee review of maternity service safety. This recommended increased investment of £200m-£350m in maternity services to eliminate staffing shortages, including current shortages of 2,000 midwives. We need that additional and immediate investment now to tackle the chronic understaffing and training issues that have blighted our maternity services."

What's on?

6-10 SEPT
Pride in the NHS week: bit.ly/NHSPrideWeek

10 SEPT
Virtual Pride – get involved on social media via @NHSLGBT, #OurNHSPeople, #OverTheRainbow, #NHSPride and #LookingAfterOurPeople

9 SEPT
Baby Lifeline Maternity Safety Conference: www.babylifeline.org.uk/conference-2021

13 SEPT
World Sepsis Day

OCTOBER
Black History Month. The theme this year is 'Proud to be'. The RCM is encouraging maternity staff to share what they're 'proud to be. Watch out for a month of activities and a webinar at www.rcm.org.uk

9-15 OCT
Baby Loss Awareness Week: bit.ly/BLAW2021 and bit.ly/MiscarriageBLAW

10 OCT
World Mental Health Day: bit.ly/MentalHealthDayUK

11 OCT
UN International Day of the Girl Child: bit.ly/UNGirlChildDay

Working for you

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

Too little, too late

The RCM has responded to the government's pay award to NHS staff in England of a 3% pay rise with dismay. Jon Skewes, RCM executive director for external affairs and an NHS union chief negotiators, said: "At least the limbo our hardworking members were left in by our shambolic government has ended. We are disappointed that maternity staff in England will not receive a headline increase of 4% like their colleagues in Scotland. Through our evidence to the Pay Review Body, we managed to secure more than the 1% proposed by the government, but again this is not backdated far enough or on par with the pay award in Scotland."

The RCM is to review the report in detail and talk to members before deciding its next steps. Meanwhile, "this pay award now needs to be paid to our members and all NHS staff as quickly as possible. They have waited long enough and any more delays will further erode morale and impact on recruitment and retention," Skewes added. "We will also be seeking reassurances [that] any pay increase will be funded centrally, and that trusts will not be expected to use other budgets to pay for it."

WOMEN'S HEALTHCARE STRATEGY

In response to the government's consultation on a Women's Health Strategy for England, the RCM has stated that women's voices should be at the centre of their care.

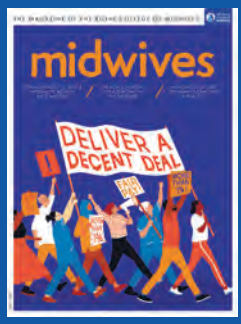
In a detailed and wide-ranging response covering issues such as mental health, the pandemic and education around women's health, the RCM notes that even within maternity services, where 99% of midwives are female, women still felt that their voices were not being heard. This is especially true for women from minority ethnic backgrounds – who are more likely to experience baby loss and maternal death – and those with disabilities.

Women have been actively involved in the RCM's response through its Maternity Voices Network. Birte Harlev-Lam, executive director midwife at the RCM, said: "There is a lot in our response and some of it is quite radical, but we need fresh thinking, new ideas and a better way of delivering healthcare for women that looks at the whole woman and is built around her. The government are bold in their statements about this consultation. We now need to see them be bold about really listening."

RCM in brief

Student welcome
Imperial branch ran a student enrichment week in early July. The programme involved talks on respecting others individuality from Benash Nazeem and Fiona Fairclough, positive cultures in the workplace from Linda Allan, understanding your payslip from Simon Purser, reducing risk from Judith Robbins, understanding research from Alison Perry and Katie Luxion, and myth-busting vaccinations from Alison Meinel alongside laughing yoga, bladder care, a cardio workout and a QCCH tea party. What an amazing way to welcome students!

Why not go digital?
Did you see the first-ever digital issue of *Midwives* magazine? Email us at tellus@rcm.org.uk



Didn't receive the magazine?
Make sure your contact details are up to date that you have 'opted in' for email contact.

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

Workplace practice

Flexible working

Plans for improved flexible working provisions for NHS staff in England, Scotland and Wales come into effect in September 2021, with similar measures expected to follow in Northern Ireland.

New contractual terms will allow staff to:

- Request flexible working from the start of their employment
- Make an unlimited number of applications for flexible working, instead of just one a year
- Submit applications without having to justify requests or provide specific reasons
- Managers must refer on requests that cannot be accommodated initially to ensure all possible solutions are explored.

Alice Sorby, RCM employment relations advisor, said: "Greater flexibility around working arrangements is crucial if we are to retain NHS midwives and maternity support workers and bring more into our maternity services. The sort of flexibility and better opportunities for work-life balance open to many outside the NHS need to become as mainstream as possible within it. This has though got to work for all NHS staff, including those on the front line delivering care every hour, night and day. For too long, NHS workers have been straightjacketed into a rigid working regime that means many who would stay in the profession have had to leave because of family and other commitments, and the same problems deter others from joining. The agreements outlined in June will go a long way to improve the working lives of our incredible health workers."

Workplace health

Thirsty work

A survey of RCM members in 2020 showed that over half (52%) say they feel dehydrated most or all of the time when at work; a problem exacerbated by PPE. Midwives, student midwives and maternity support workers have reported trusts and boards do not allow staff to have fluids on units and they are so busy they cannot take a break to drink. Maternity staff across the UK have said they often go for 11 or 12 hours on shifts unable to drink because of work pressures. The RCM has also received reports of staff contracting urinary tract infections because they are not getting enough fluids.

Dr Mary Ross-Davie, RCM director for professional midwifery, said: "We are appealing to those services to look after the health and wellbeing of staff. It's also about the safety of care. Even mild dehydration can start affecting performance and can lead to errors."

View the RCM's guidance on staying hydrated at bit.ly/RCMHydrationAdvice

Scrutiny panel

Jersey maternity service review

A review of maternity services has been published by Jersey's health and social security scrutiny panel. RCM national officer Vicky Richards said: "It is a really positive report for the future of Jersey's maternity services and the care it will be able to deliver for women, babies and their families. Midwives and their colleagues in Jersey are working incredibly hard to deliver safe and high-quality care. However, the system and buildings they are working in are not supporting them to do that as well as they would want. That is why this review is so important for them – and for the women on the island, whose choices around pregnancy and birth are limited compared with much of the UK. If the report's recommendations are taken on board, it will be a transformative step to better care for women and a more positive environment for maternity staff."

RCM i-learn

Scoring tool for documentation audit: midwifery outpatient antenatal care

Record-keeping is an essential part of midwifery practice and maternity care. All midwives should already be familiar with the NMC code and guidance on record-keeping. The use of a documentation audit tool can facilitate reflection and learning from practice. Midwives may wish to use this audit tool to support their reflections on documentation as part of their NMC revalidation.

RCM i-learn

See what's new in i-learn at bit.ly/ILearnCourses

VIRTUAL EVENTS

Re:Birth Listening Groups
Re:Birth is a collaborative listening project that hears the perspectives, thoughts and feelings of service users, maternity professionals and other birth workers about the language we use to talk about different types of birth (see pages 14 to 19). We would like to develop guidance and resources to support conversations in maternity care between healthcare professionals and families about the risks and benefits of different types of birth.

Since the 1990s, the term 'normal birth' has been the most commonly used phrase in the UK to describe an uncomplicated labour, alongside others like 'physiological', 'straightforward' and 'optimal'. However, we have heard from women and families that these terms can feel difficult, old-fashioned or judgemental. We'd like to invite you to an informal, friendly online group to hear different perspectives on these words and find common ground. Dates are as follows:

7 Sept 10am–12pm
21 Sept 12–2pm
28 Sept 6–8pm
12 Oct 10am–12pm
19 Oct 12–2pm
2 Nov 6–8pm

22 Sept Activists Conference: 'Together we can grow more'

24 Sept Flexible working rights in the NHS webinar

5-6 Oct Annual conference: 'Together we can'

15 Oct Working with the menopause webinar

27 Oct RCM Awards: for more, see rcmawards.com/2021-shortlist

For more, visit **rcm.org.uk/rcm-events**

Carer continuity

The RCM's stance on continuity of carer

We have been hearing from more and more of you as you have been voicing concerns about how continuity of carer is being implemented in your area. You have told us about the pressures that you and your colleagues are facing about the pace of change, the lack of consultation, the lack of account given for the pressures the service has faced in the past 18 months, the exhaustion of frontline workers and the safety of imposing these changes when services are so chronically short of staff.

Please be assured that the RCM has been listening and we are on your side.

We have been clear, ever since the publication of Better Births, that safe, sustainable implementation of continuity of carer is only possible with the right investment, safe staffing levels and staff engagement and support.

We are using our position regionally and nationally to raise these concerns and to influence the implementation processes so that the needs of midwives, maternity support workers and all maternity staff are considered along with the needs of women and families. The RCM has:

- lobbied for greater investment, particularly in staffing, at meetings with the Maternity Transformation Programme Board, the chief midwifery officer and the regional chief midwives, Health Education England (HEE) and government ministers
- testified to the House of Commons Health Committee on the extent of midwife shortages in England and the impact this is having on the ability of services to implement major change programmes, such as continuity of carer
- submitted joint evidence with the RCOG to an expert panel evaluating the government's maternity services policies. We advised the panel that services unable to provide safe staffing levels will not be able to safely introduce continuity of carer.

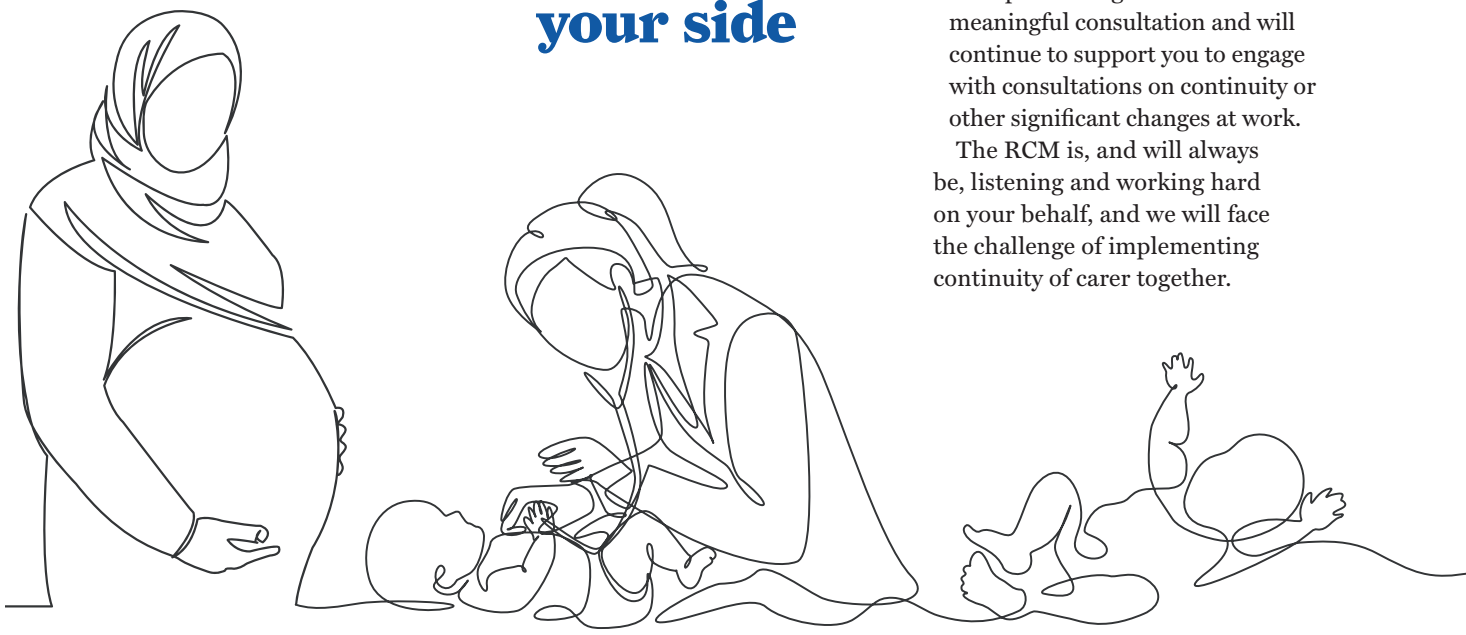
The RCM has been listening and we are on your side

There has been some progress, such as: the announcement of an additional £95m of funding from 2021/22, including an extra £47m to help with recruiting an additional 1,000 midwives; the 2022 NHS planning guidance, which makes clear continuity implementation needs to be phased in alongside the fulfilment of staffing levels and the need for maternity staff to recover from the challenges of the pandemic; and HEE's commitment to training an additional 3,650 student midwives in the five years to 2022/23. But it's not enough to alleviate the pressure on services.

So here's what the RCM will do:

- continue to pursue NHS England over uncertainty and ambiguity around implementation targets
- gather evidence on the extent to which continuity of carer is improving outcomes for women and families
- at a local level, RCM representatives and officers will continue to support you if you think your employer is trying to impose changes without meaningful consultation and will continue to support you to engage with consultations on continuity or other significant changes at work.

The RCM is, and will always be, listening and working hard on your behalf, and we will face the challenge of implementing continuity of carer together.



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RE:BIRTH
HOW LANGUAGE INFLUENCES OUR THOUGHTS + ACTIONS

How people birth has polarised opinion but, as Janice Warman discovers, the RCM is undertaking work that puts the focus back on the relationship between the women and the midwife

Some of the failings that led to infant and perinatal deaths at Morecambe Bay, and more recently at Shropshire and Telford, were attributed to maternity staff's pursuit of "a normal birth at any cost", according to the 2015 Kirkup Report and the first Ockenden Report, published in December 2020. There is significant pressure to review the use of the term 'normal birth', which has been seen as divisive, valuing a 'normal' delivery above all else.

In response, the RCM has launched Re:Birth, a collaborative project between midwives, obstetricians, other birth workers, charities and families to research the attitudes to types of birth and to hone the language used about it.

Dr Juliet Rayment is the research fellow of the Re:Birth project. She says it came about "because the RCM were increasingly hearing from service users that they were uncomfortable with some of the language being used in maternity care to talk to them about their birth and about what they might expect from their care and maternity services.

"One of the words that kept coming up was this term 'normal birth', which has a pretty long history within maternity care. It's something that is the foundation of what midwives' role and remit is – the scope of their practice. It is used very commonly by midwives in the same way that we talk about 'normal breathing' or 'normal blood pressure'; they would use it in a similar way to talk about a straightforward, physiological process. So, for a lot of midwives, it's an unproblematic, everyday word. But what they started hearing from some service users was: 'That makes me feel like I'm abnormal because I happened to end up with a Caesarean section or with forceps, because my birth didn't go quite how I was expecting'. So fundamentally, this is a listening project. We want to hear what service users think about the term 'normal birth', but also some of the other words that we use to describe different kinds of birth, such as Caesarean section or assisted vaginal birth."

Everybody's experience and perception of what is right for them is different

Individual experience

"Everybody's experience is different, and everybody's perception of what is right for them is different," Juliet says. "We always talk about having the right interventions in the right place at the right time. What's interesting is that we have a kind of birth system that doesn't always support physiological birth. Are we guilty of putting women into a system and promising them something where that's unlikely to happen because of things

ILLUSTRATION: PETER STRAIN

DEFINITION OF NORMAL BIRTH

The World Health Organization's definition of normal birth is: "spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy." One of a midwife's core roles is to refer women for obstetric help when they need it. Another, as outlined by the NMC and the International Confederation of Midwives, is to support normal birth.

that are outside of their control? There are a number of other terms that we might use instead of 'normal' – words such as 'straightforward' and 'physiological' are the two main ones, I suppose. One of the questions we're asking is: are there other words that would serve better?

"The Re:Birth project oversight group is made up of service users and representative organisations, obstetricians and midwives. I'm really pleased that there's such a diverse representation. And I'm especially pleased to see representatives from organisations such as Sands, the Birth Trauma Association and Make Birth Better – all are organisations that work with women who've experienced birth trauma in one way or another. The other group that I'm pleased to see is Five X More, which represents women from minority ethnic backgrounds. That's particularly important because black women have the poorest outcomes in maternity services in the UK." Juliet notes that this is an opportunity for everyone who really cares about birth to collaborate and to listen, to hopefully agree and offer some guidelines for health care professionals.

Dr Mary Ross-Davie, RCM's director for professional midwifery, agrees: "I am proud that the RCM is showing leadership within the maternity community to address this issue of language around birth. The Re:Birth project isn't just a project for midwives or about midwives. We have listening groups throughout the autumn – some in person, some virtual – for members (students, support workers, lecturers and midwives), obstetricians, other birth workers, service user representatives and recent service users to explore the language we use to describe birth. And we are using a variety of innovative virtual approaches to hear the views of everyone for the rest of this year and into the new year, so we can begin to build a shared language for the future. We hope that our members will get really involved, sharing their perspectives and also listening to the experiences of others."

Listening to voices

Emily Ahmed leads the RCM's Maternity Voices Network and brings the voices of service users, women and birthing people to the project. She agrees that language takes the emphasis away from the reality of the experience. "Midwives, or a maternity unit will say, 'Oh, that was a really successful birth; it was a natural birth', when often the woman, or the person that's in the centre of that, might well be really traumatised by it," she says. "I've met so many women who don't want to get pregnant again because they were so traumatised by a birth that the maternity unit might well have assumed was fine."

The Re:Birth project is a huge undertaking for the RCM, especially due to the size and scope of its membership. Shirley Cramer is independent chair of the project oversight group. "With 50,000 members in the RCM, you're going to have a range of views," says Shirley. "I think what we want is consensus around what are the right things to aim for and what's the right language to use to make everybody feel comfortable and included. Being genuinely independent, I can ensure

that everybody gets their say and that their input is important.

"Having a consensus that allows professional service users and families to feel comfortable and included also means that we won't be using either highly medical terms or terms that are loaded in any way, so we need clarity and something understood by everybody. If you looked at the reports over a number of years, there were poor relationships between midwives and obstetricians, there were poor outcomes and poor communications between staff on decision making, and between women and families in the care of the maternity services. We want to move away from that and from this misinterpretation that has been, for some people, 'normal birth at any cost'. That's the kind of thing that [former health secretary] Jeremy Hunt was concerned with."

I've met so many women who don't want to get pregnant again because they were so traumatised by a birth

Media attention

Addressing the focus on 'normal' birth is the one recommendation from both the Kirkup and Ockenden reports that the media has seized upon, rather than other safety issues such as chronic understaffing and underinvestment. At the Select Committee inquiry into maternity safety last year, Jeremy Hunt asked the RCM to denounce the idea of 'natural or normal birth'. "It's very emotive to talk about mothers and babies and to talk about babies dying and/or mothers dying," Shirley says. "It's a very emotional thing, so that probably makes good reading. Certain elements of the press absolutely will have characterised this in an overly simplistic way."

Emily notes that it's difficult to get a feel for whether midwives are really pressurising women into a 'normal' birth, because everybody's experiences are so different. "All the different midwifery units will have a different culture, so you'll have some people who will feel they would rather have a home birth and others who'd rather be on the maternity ward," she says. "For some people, being in a hospital feels safe and comfortable, with a more medical intervention style, while others feel much safer in a more informal, midwifery-led unit. I don't know what percentage of women feel that they've been able to have the type of birth experience that they want, but I suppose the important thing is that it's about an informed choice – that people can work together, they can speak with their healthcare providers, so that everybody understands what someone might want. It's hugely influenced by previous trauma: people's mental health and wellbeing, their previous experiences – not just their own birth experiences,

My hope is that we can use language that makes everybody feel safe

but those of their friends or their family – or the things that they've witnessed. I suppose my hope is that we can use language that makes everybody feel safe."

Emily agrees that the language currently used isn't intuitive or inclusive. "Calling something 'normal' indicates that something else is not normal – and nobody wants to feel that," she says. "You don't want the feeling that you're not normal, because it's all relative. I think it's less about what's normal, but more about what's the best: what's your optimal birth based on your previous experiences. And for somebody who may have had a traumatic experience, or has maybe experienced abuse, their optimal birth might be very controlled – perhaps a C-section – or it might be a well-supported home birth, or a water birth. It's about what that person needs – not what's 'normal', but what's optimal for that individual."

Personal choice and circumstance

However, this can change, Emily says. "It's what is the best thing for that person at that time. My first birth, with my daughter, I didn't have any pain relief; it was a water birth, there was no stress, it was so easy. It was a really good experience, but that wasn't because I did anything special. It was just because that was her birth, and that was what my body did at that time. But then when I had my son, he was back-to-back – it was crazy painful, and I wanted any and all medication that would help at that point. For me, the optimal birth for my son was with that support. It's what you need at that point and making sure that what is given is the care that you need.

"[The birth experience] is guided not just by science and data but also by [women's] own personal experiences and views, so it's about accepting that there is a such a special and beautiful relationship between midwives and women and their families.

"There is the best birth you can have, based on your circumstances, and the best and most caring support. You don't want to demonise anybody, because midwives are doing the best that they can; and the better that we can support and care for our midwives and our midwifery profession, and all the obstetricians and people around

that, we're enabling them to do what they want to do – which is to support families and women."

The midwife/birthing person relationship is at the crux of the issue. It isn't just about support: it's about good communication, an explanation of an individual's options, and the implications of those options, and enabling an informed choice. For this to happen, language is key. "It's an honest exploration of how we can use language, how can we have conversations that really support people giving birth, and the people that support them to do so. It's a listening project, and I think it's starting in the right place," says Emily.

The elephant in the room

As many factors contribute to a poor birth experience as to a good one, with a sense that this is really down to luck – and while there are a lot of things midwives can do to optimise the chances of having a straightforward birth, they can't make it happen, notes Juliet. "I think what's difficult is we give women the idea that they can choose to have a straightforward birth. But in the end, there is also luck and physiology and the system that you're birthing in and your care providers' own preferences or usual ways of working," she adds. "Research by Professor Soo Downe, published in *The Lancet*, suggested that most women would hope to have a physiological birth. This is significant when most of them don't, because you often then get all of that disappointment and regret and guilt."

Emily agrees: "It shouldn't be luck that you've got a lovely service, or that you're lucky to get a midwife, or that you're lucky that you understand the system. Everybody should be enabled to do that, especially women who don't speak English as a first language. There are so many problems, not just in maternity, but in healthcare and in society in general. We can't pretend that it's perfect because it's not, but we need to constantly be listening to people, because even though a midwife might want to give a woman the best experience, that midwife might not be supported enough or given the right experience herself to be able to make that happen. I don't know how midwives do it sometimes – they might not have been able to go to the toilet, they haven't had a cup of tea. We're making them work in situations under pressure, which is just not fair, and then we expect them to be really caring and take their time and give everyone options." It's a good point, and with chronic understaffing in maternity, couldn't this just be seen as another pressure on midwives?

"It's about balance and choice, and about not creating language that creates blame or language that makes anyone feel bad," says Emily. Perhaps if the language is right then it will relieve some pressure. Emily adds: "[The project] is a safe space for everybody: for healthcare professionals, for service users and for the voluntary sector organisations to come together and ask: 'what does this mean to everybody, and how can we make sure that everybody that's involved in the birthing process is supported and cared for?'"

It isn't just about support: it's about enabling an informed choice

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- Together decision making and consent can support intrapartum care
- Together we can use research to make pregnancy safer
- Together the RCM can lead and support our colleagues globally

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Agnes Agyepong

Head of Engagement, Best Beginnings

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Lisa Darrah

Midwifery Coordinator for Perinatal Mental Health and Social Complexity in Pregnancy, Belfast Health and Social Care Trust

Together we can support vulnerable women
6 October, 14:45-15:45

Dr Thomas Kitchen

Consultant Anaesthetist & Deputy Director of HHP Wales, Health for Health Professionals Wales

Together we can restore ourselves
5 October, 08:45-09:45

Rosemary Idiaghe

Consultant Midwife, Barking Havering and Redbridge NHS Trust. Queen's Hospital Romford

Together we can improve outcomes
6 October, 11:15-12:15

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THE ROYAL COLLEGE OF MIDWIVES

Check in&Chat

Jemma Hughes, third-year student midwife at Cardiff University, understands the importance of creating compassionate communities

Prior to the COVID-19 pandemic, the last large gathering I attended was a conference held by the Council of Deans of Health #150Leaders Student Leadership Programme. Gaining a place on the programme has, without a doubt, been a highlight of my midwifery degree, and the conference was alive with the buzz of inspiring talks, passionate conversations and the excitement for what the following year was to hold.

However, on the 11 March 2020, as I and other healthcare students from all corners of the UK were leaving the conference, COVID-19 was confirmed as a pandemic by the World Health Organization. At the time, we had no idea of what was ahead, and I left the conference inspired by my peers and ready to start putting a project together, to fulfil my place on the programme.

Now, whenever I talk to anybody there is a very clear distinction between pre-COVID and post-COVID life. It is impossible to ignore the changes we have navigated – and, even as things start to get back to normal, the differences that remain. However, it is from these changes –and from listening to Professor Michael West talk at the #150Leaders programme about the importance of creating compassionate communities – that my project was born, and I started to hold Check in&Chat sessions for first-year midwifery students at Cardiff University.

I found my own first year of my midwifery degree incredible, but I struggled. I loved caring for women, birthing people and their families, hearing their stories and developing my own skillset. However, my nerves commonly overwhelmed me. It was talking to my peers, sharing stories when things did not go quite to plan or I found something too much, that helped. We were all going through it together, and to know you are not alone makes such a difference.

Absorbing experience

I also clearly remember bumping into second and third years, hearing them talk about placements and what they'd experienced, and absorbing their tips. It was this sense of connectedness – of getting to know the faces that are going to be on placement with you, and that you are one day going to work alongside – that supports you in your first year. I became very aware the first-year student midwives would miss out on this. They were to have six months of online theory teaching before starting a placement.

I pulled a plan together on how Check in&Chat sessions could run and presented it to my tutors, who were incredibly supportive. It was my hope the sessions would somehow replicate the connection and communication that had helped me pre-COVID.

Initially, there were going to be just three Check in&Chat sessions between the start of the academic year and the Christmas holiday. They would take place on Zoom, would be facilitated by me and second- and third-year student midwives. They had a clear safeguarding and escalation process in place. My sister helped me create a poster to advertise the sessions. From the outset I wanted the Check in&Chat sessions to feel relaxed, informal and be centred around the idea of grabbing a cuppa and having a chat – something I believe is good for the soul.

The first Check in&Chat session was held in October 2020. The feedback from first years has both guided the sessions and blown me away. At the end of each session, I ran a poll to gauge the cohort's thoughts. There was enthusiasm for the sessions to continue past Christmas; to date, there have been six. I have worked with the first-year module leads to schedule sessions at points when there were likely to be more questions – for example, just before placements started or when there were exams on the horizon.

It has been exciting to read the feedback from a larger Google Form I sent out recently to understand the impact and sustainability of the project. The highlight has definitely come from seeing the first years believe that the sessions would be useful for future cohorts. Furthermore, the majority of the students said they would be interested in helping to facilitate the sessions as they become second-year students. What brings me the most pride is that the Check in&Chat sessions will continue once I am qualified, and that they will be in the safe hands of both the Cardiff Midwifery Society and those who have benefited from the sessions themselves.

Hopefully, the community I wished for from the Check in&Chat sessions will grow so that, pandemic or no pandemic, no one feels alone on their journey to become a midwife.

MORE INFO

Caring for You hub: bit.ly/C4Yhub Available in i-learn: Student survival guide, Promoting compassionate workplaces. RCM student midwives podcast: bit.ly/StudentMidwives

IMAGES: ISTOCK

FINDING SOLUTIONS

Learning lessons from failed and successful maternity services alike is crucial to ensure mistakes are not repeated and good practice is shared

The RCM's new Solutions series is aimed at supporting midwifery leaders and midwives to implement recommendations laid out in the Ockenden Review [of Shrewsbury and Telford] to improve the quality of care for women and their babies. Dr Mary Ross-Davie, the RCM's director for professional midwifery, said: "The detailed reviews of maternity services across the UK, and including the most recent interim Donna Ockenden review, have highlighted worryingly similar serious failings that must be addressed. As the largest professional body for midwives in the UK, the RCM has a duty to support midwives to be the best they can be – but we also know that it can be challenging knowing where and how to start." The Solutions series not only offers a place to start but also plots the practical steps needed to address the issues.

Solutions 1 Improving maternity: learning from reviews of maternity services

As well as safe staffing levels, the Morecambe Bay, Cwm Taf, and Shrewsbury and Telford reviews said the following were lacking: proper assessment and escalation; use of evidence-based guidance; continuous risk assessment and a clear escalation pathway; multi-disciplinary teamwork; a positive workplace culture; kindness and compassion for families in their care; and visible, positive leadership.

To begin to address these issues, it's important to know what a good system looks like. The Healthcare Improvement Studies (THIS) Institute framework sets out the seven key features of a safe maternity unit. THIS Institute undertook research using ethnographic methodology in a range of units – the seven features had been identified in one unit that had outstanding outcomes in relation to intrapartum safety. These seven features are: a commitment to safety and improvement at all levels, with everyone involved; technical competence, supported by formal training and informal learning; teamwork, cooperation and positive working relationships; constant reinforcement of safe, ethical and respectful behaviours; multiple problem-sensing systems, which are used as a basis of action; systems and processes designed for safety, which are regularly reviewed and optimised; and effective coordination and the ability to mobilise quickly.

By creating a self-assessment checklist and mapping these seven elements on to it, this

The Solutions series plots the practical steps needed to address issues

IMAGES: ISTOCK

Solutions instalment helps units to identify areas for improvement and provides a guide on how to begin that process.

Solutions 2 Making maternity services safer: the role of leadership

Most often, reviews of failing maternity services identify poor leadership. However, leaders do not fail alone. This guide identifies three core elements – context, capacity and capability – that need to be present for leadership to flourish. 'Context' defines the places of the head (HoM) and director (DoM) of maternity within a clear reporting and decision-making network, 'capacity' defines their duties and responsibilities, while 'capability' defines the skills, knowledge, experience and abilities of the HoM/DoM to meet these duties and responsibilities. A checklist enables leaders to map their understanding of their role against the three elements.

The new advice also outlines different leadership styles. Recent evidence rejects the 'command and control' approach in favour of compassionate, inclusive and collective leadership. A compassionate leadership style is one that attends to the concerns of colleagues, understands difficulties or concerns raised, empathises without letting this overwhelm the ability to lead, and helps by taking a thoughtful and intelligent course of action that is the most useful for colleagues. Inclusive leadership involves ensuring equality, positive diversity and that all voices are meaningfully heard. Collective leadership makes sure that the expertise, capability and motivation of team members are distributed within an organisation, enabling success to be shared. This Solutions instalment identifies nine practical steps that leaders can take to understand and improve their leadership role and style.

Solutions 3 Making maternity services safer: human factors

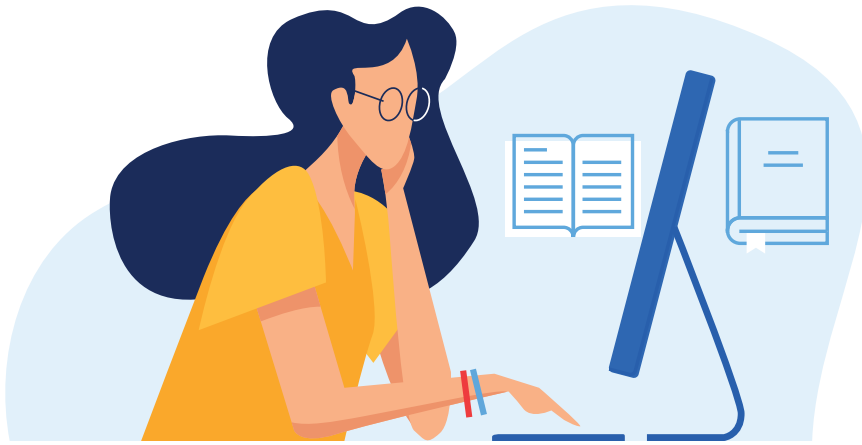
Everyone makes mistakes, but how can this be planned for and built into systems aimed at mitigating them? This instalment acknowledges the impact of a range of factors on safety and performance. These include: the ease of use of equipment and the training necessary to use it; environmental factors, such as noise levels and distractions; the impact of tiredness from working patterns; ability to take breaks; staff access to nutrition and hydration; workload-related stress and the need to multi-task; and team working practices, communication and leadership styles. These are known as human factors.

The above examples can be broadly separated into three elements – the job, the organisation and the individual – all of which influence human factor risks. Addressing these and acknowledging the role of human factors in safety is the work of the whole trust or board team. Organisations should foster an open and fair culture that encourages reporting of incidents so that everyone can learn from mistakes and near misses.

This Solutions instalment gives a checklist of key human factors and how to mitigate them. These include briefing the whole team, recognising factors that hinder individuals, and encouraging staff to speak up. The guide makes it clear that everyone makes mistakes and that these can be learned from – and that limiting risks caused by human factors is the whole team's responsibility.

MORE INFO

Access the RCM's short, practical series at:
bit.ly/Solutions1ImprovingMaternityServices
bit.ly/Solutions2MaternitySafety
bit.ly/Solutions3HumanFactors
Or access the i-learn modules at bit.ly/ilearnSafety, which cover the Ockenden Review and human factors in safety



Scaling K2

Nikki McNulty is one of two digital midwives at University Hospitals Coventry and Warwickshire (UHCW) tasked with digitising patient records successfully and at speed

UHCW is a large teaching trust, and 6,000 women choose to give birth here every year. The trust's documentation is paper-based, including the maternity department. A trust-wide Electronic Patient Record (EPR) project was being scoped, but this was paused due to the pressures of COVID-19.

In May 2020, we were notified that our Maternity Information System (MIS) was to be decommissioned on 31 December 2020. The MIS, known as 'Evolution', was our main reporting tool for local and national mandatory data, but it was not used clinically. We were challenged with continuing to use paper and manual counts for reporting, which was not ideal. So myself and my fellow digital midwife Patricia McGeown, together with obstetrician and gynaecologist Feras Izzat, formed a maternity EPR clinical team.

The decision was made to use K2 hardware that was already on our labour ward from a previous infant research study. Within a few weeks it was authorised as a full end-to-end K2 system maternity EPR. The K2 system is an electronic maternity health record for all clinical documentation. Its aim is to replace traditional paper pregnancy notes, in line with national guidance, and to enhance care and communication for women.

By June 2020, we were joined by Sharon

Coulson, a trust ICT K2 project manager. We had six months to complete process mapping, system development, localisation, and user acceptance testing and training.

Engagement

This project took place during the pandemic, and we used it to our advantage – shielding midwives lent us their clinical expertise for the localisation and user acceptance testing of the system.

Ward managers and staff were asked their opinion on what hardware they felt the wards needed – this meant K2 portal medical devices, workstations on wheels, PCs, laptops, dongles, card readers, additional monitors and large TV screens were ordered and installed.

Implementation was supported by a growing a network of other K2 sites, involving digital midwives from around England. We had regular virtual meetings that were invaluable in ensuring that we did not make similar mistakes and that we considered other implementation plans and ideas.

We opted for a phased approach whereby new pregnancies and all deliveries would be entered onto the system and the paper notes gradually reduced.

Training

The biggest challenge for this project was to ensure we had trained at least 75% of our maternity and neonatal staff. We had extremely dedicated midwifery practice facilitators who trained daily for the six weeks leading up to the launch date. Staff were rostered onto K2 training sessions to ensure enough people were trained, and were given dedicated time to receive their training.

We trained a team of K2 'super users' – staff from all areas within maternity – who received additional training and were given dedicated 'K2 floor walking' shifts for several weeks following the launch date to ensure staff had 24/7 access to support. During the launch period and for several months afterwards, we kept staff rostered in the same areas to minimise movement and thereby enabled them to learn to use the system well before moving them to another maternity department.

Go live

The K2 system successfully went live on 3 December 2020. Usually, a project of this scale – planning and implementing a full end-to-end system in a large trust – would take more than 18 months. We showed it is possible with a dedicated team and good project manager to do it in six.

Women now have online access to their own records through a web browser called 'My Pregnancy Notes', which works on any device. K2 provides a complete electronic record of their pregnancy journey, from antenatal booking to postnatal care. Clinicians and midwives can now document information directly onto the system, meaning they will have more time to spend delivering one-to-one care. The system also enables community midwives to access other trust ICT systems, which had formerly been challenging.

Going digital resulted in increased communication, improved safety and freeing up of time

Our next steps are to continue to develop the system to meet local and national requirements. We are now working on improving data collection for reporting and audits. Data analysis is an essential part of improving maternity care and contributes towards quality improvement. Therefore, we are working on data quality and continued K2 staff training to ensure documentation is recorded in a way we can analyse and report on. We also plan to engage with the trust's EPR programme, which is due to be launched in January 2022, because we'll be able to share the knowledge we've gained - for example, information on the community network and hardware, Wi-Fi black spots and so on.

As challenging as these digital implementations are, their success results in enhanced documentation and information reporting, increased communication with women, improved overall safety, and freeing up of clinicians' time – meaning they can focus on providing high-quality patient care.

MORE INFO

For advice on similar implementation, email nikki.mcnulty@uhcw.nhs.uk

RCM AWARDS 2021

CONGRATULATIONS TO OUR SHORTLIST

PARTNERSHIP WORKING

- **Sally Pezaro**, Coventry University Success in Co-Creating Educational Tools to Support Those Birthing with Hypermobile Ehlers Danlos Syndrome (Heds) and Hypermobility Spectrum Disorders (HSD)
- **Isabelle Bourton** and **Nina Khazaezadeh,** Guy's and St Thomas' NHS Foundation Trust, Caseload Midwifery - A Radically Holistic Approach
- **Suzy Hall** and **Lynn Bayes,** Lewisham and Greenwich NHS Trust, Partnership Working with Doulas
- **Milena Wezgowiex** and **Harriet Hickey,** Medway NHS Foundation Trust, Specialist Midwife Led Preterm Clinic
- **Hora Soltani** and **Frankie Fair,** Sheffield Hallam University, Partnership with Migrant Mothers to Improve Safe Perinatal Care-Making A Sustainable Impact

MATERNITY SUPPORT WORKER OF THE YEAR

- **Veronica Williams,** Guy's and St Thomas' NHS Foundation Trust
- **Candice Noonan,** Oxford University Hospitals NHS Foundation Trust
- **Vanessa Savage**, Royal Berkshire NHS Foundation Trust

EXCELLENCE IN MATERNITY CARE DURING A GLOBAL PANDEMIC

- **Kelly Parker** and **Didi Craze,** Brighton and Sussex University Hospitals Trust, Communications and Media Midwife. Innovative & Contemporary Job Role
- **James Harris** and **Victoria Cochraine,** Chelsea and Westminster NHS Foundation Trust, Chelsea and Westminster COVID Response- Caring During Crisis
- **Frances Rivers** and **Jackie Latimer,** Kingston Hospital NHS Foundation Trust, Supporting Homebirths During a Pandemic
- **Jane Coyne,** Greater Manchester Health and Social Care Partnership, Saving Babies Lives through the GM Smokefree Pregnancy Programme
- **Anne Richley** and **Claire Dale,** Northampton General Hospital NHS Trust, The Incredible Journey

THOMPSONS MEMBERS' CHAMPION AWARD

THOMPSONS SOLICITORS
STANDING UP FOR YOU

- **Imperial Branch**, Imperial College Healthcare NHS Trust
- **Zoe Meneilly,** Belfast Health and Social Care Trust
- **Cardiff Branch Committee**, Cardiff and Vale University Health Board
- **Haywards Heath** and **Brighton Branch**, University Hospitals Sussex NHS Trust
- **Sally Morgan,** Tameside Hospital

SLIMMING WORLD CARING FOR YOU DURING A GLOBAL PANDEMIC

Slimming World

- **Cardiff RCM Branch**, Cardiff and Vale University Health Board
- **Jacqueline Owusu-Ansah**, Imperial College Healthcare Trust
- **Pamela Galloway,** NHS Fife, Improving Staff Resilience
- **RCM Poole**, University Hospitals Dorset

JOHNSON'S EXCELLENCE IN MIDWIFERY EDUCATION, LEARNING & RESEARCH

Johnson's

- **Susannne Thomas**, Belfast Health and Social Care Trust, Royal Jubilee Maternity Hospital, SMARRT Pack; Supporting Midwives, Newly Appointed, Returning to Practice, Rotating Departments and Training
- **Juliet Wood** and **Laura Iannuzzi**, Bournemouth University, Zoom the Midwife Global Café
- **Jane Rooney** and **Lorna Gerrish**, Edge Hill University, Skills @ Home Pilot for Perineal Suturing
- **Sarah Fairbairn** and **Mary Bell**, Northumbria University, Online Transition of NIPE Education in Response to the Global Pandemic

WATERWIPES MIDWIFERY SERVICE OF THE YEAR

WaterWipes
THE WORLD'S PUREST BABY WIPES

Winners announced on the day

THE ROYAL COLLEGE OF MIDWIVES

RCM Alliance partners:

emma's diary · Johnson's · Slimming World · Pregnacare Vitabiotics · RCM Alliance Programme

Sponsors:

NMC Nursing Midwifery Council · THOMPSONS SOLICITORS STANDING UP FOR YOU · WaterWipes THE WORLD'S PUREST BABY WIPES

EXCELLENCE IN BEREAVEMENT CARE

- **Judith Cutter** and **Jessica Holmes**, Cardiff and Vale University Health Board, The Rainbow Bereavement Service
- **Sian Ness** and **Beth Towsey**, Mid and South Essex NHS Trust, Excellence in Bereavement Care
- **Daryl Mallis** and **Myra Kinnaird**, Scottish Health Professionals Bereavement Network (pregnancy & neonatal loss), Bereavement Networking: Benefiting Staff and Families
- **Victoria Owens** and **Hannah Gardener**, Swansea Bay University Health Board, The Gift- A Beautiful Birth and a Beautiful Death

PREGNACARE STUDENT MIDWIFE OF THE YEAR

Vitabiotics Pregnacare

- **Jemma Hughes**, Cardiff University
- **Emily Davis**, Sheffield Hallam University
- **Beatrice Bennett**, University of Nottingham
- **Tracey James**, University of South Wales
- **Eilidh Cole**, University of the West of Scotland

INNOVATION IN MATERNITY CARE

- **Lisa Darrah** and **Sinead McFarlane**, Belfast Health and Social Care Trust, SWAN Team
- **Sarah Gregson** and **Shazia Nazir**, Maidstone and Tunbridge Wells NHS Trust, Birth Planning Infographics to Support Informed Choice
- **Sophie Kelleway**, North West London Maternity Transformation Programme, Supportive Signposting in Maternity
- **Amanda Mansfield**, The London Ambulance Service NHS Trust, Promoting Safe Conversations when Maternity Emergencies Arise - The Development of a "Midwives Communication Card" to Enhance Communication with Ambulance Services when Requiring a Transfer from a Free-Standing Birth Centre or Home Birth

RCM RACE MATTERS AWARD

- **Benash Nazmeen**, Bolton NHS Foundation Trust
- **Patricia Mugwangi**, Dartford and Gravesham NHS Trust
- **Fatima Ghouch**, Northampton General Hospital NHS Trust, Midwives for Change: Our Journey Around the Race
- **Sara Sardarizadeh**, St George's Hospital

NMC EXCELLENCE IN PERINATAL MENTAL HEALTH

NMC Nursing Midwifery Council

- **Kate Allon**, Darent Valley Hospital
- **Katie Potton**, NHS Fife, Delivering Excellence in Perinatal Mental Health
- **Fiona Laird** and **Mellissa Jhagroo**, North Middlesex Hospital, Case Holding Women with Perinatal Mental Health Collaboratively
- **Zara March**, Royal United Hospitals NHS Foundation Trust
- **Annmarie Thomas**, Swansea Bay Health Board, Becoming a Perinatal Mental Health Specialist Midwife
- **Ilaria Harrison** and **Alaine Holland**, University Hospital Coventry and Warwickshire, Complex Continuity Team for Perinatal Mental Health and Vulnerabilities

RCM LEADERSHIP AWARD

- **Grace Thomas**, Cardiff University, Compassionate Leadership in Midwifery Education
- **Jane Coyne**, Greater Manchester Health and Social Care Partnership, Saving Babies Lives through the GM Smokefree Pregnancy Programme
- **Heidi Ottosen**, Oxford University Hospital Foundation Trust
- **Kayleigh Wdowczyk**, North Manchester General Hospital, Leadership of a Midwife Ultrasound Scan Team and Service-Helping to Save Babies Lives in Greater Manchester
- **Naomi Plant** and **Holly Toyne**, United Lincolnshire Hospitals Trust, Ongoing Training Provision Through a Pandemic

WATERWIPES TEAM OF THE YEAR

WaterWipes THE WORLD'S PUREST BABY WIPES

- **Lisa Darrah** and **Sinead McFarlane**, Belfast Health and Social Care Trust, SWAN Team
- **Jenny Carter** and **Vicky Robinson**, Guy's and St Thomas' NHS Foundation Trust and King's College London, Preterm Surveillance Clinic
- **Polly Kay** and **Nick Kametas**, The Hypertension Clinic, King's College Hospital
- **Barbara Strawbrigde** and **Paula Morrison**, Northern Health and Social Care Trust, Continuity of Midwifery Care
- **Deirdre Gill** and **Fiona Clarke**, Western Health and Social Services Trust, OASIS

MIDWIVES' MIDWIFE OF THE YEAR

- **Susanne Thomas**, Belfast Health and Social Care Trust
- **Tania Pearce**, East Surrey Hospital
- **Emma Mckay**, Hywel Dda University Health Board
- **Noella Aers**, Maidstone and Tunbridge Wells NHS Trust
- **Harriett Burke**, Maidstone and Tunbridge Wells NHS Trust
- **Lorraine Hawkins**, Milton Keynes University Hospital
- **Frances Arrowsmith**, NHS Highland
- **Shona Hamilton**, Northern Health and Social Care Trust
- **Sarah Smith**, University of Derby and Burton Hospitals NHS Foundation Trust
- **Sarah Blackwell**, University Hospitals of Leicester NHS Trust
- **Sarah Hookes**, NHS Wales Shared Services Partnership

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Each Baby Counts Learn & Support

The RCM and RCOG's Mandy Forrester, Ann Morling, Susie Crowe and Nimarta Dharni explain a national programme to help maternity units build the right culture, behaviours and conditions to enable effective clinical escalation

Numerous reports have indicated that an improved culture in all aspects of maternity services will help create better care and outcomes for women and babies. Around 700,000 babies are born in the UK every year. The vast majority are born safely, but more than 1,000 babies die or suffer a brain injury during or shortly after term labour. Many of these cases are preventable.

Each Baby Counts Learn & Support (EBC L&S) is a joint initiative from the RCOG and the RCM, and is funded by the Department of Health and Social Care. Twelve midwives and four obstetricians from 16 NHS trusts across England were recruited and backfilled for one day per week. Known as local development leads (LDLs), these 16 maternity professionals have received training in clinical leadership, safety thinking, quality improvement and behavioural science as part of the EBC L&S programme.

The project evolved from recommendations made by the RCOG's Each Baby Counts (EBC) initiative, a national quality improvement programme that was launched in 2015 to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. EBC and other maternity reports have all identified clinical escalation as a key contributory factor in cases of unintended harm. EBC L&S aims to help maternity units build the right culture, behaviours and conditions to enable effective clinical escalation.

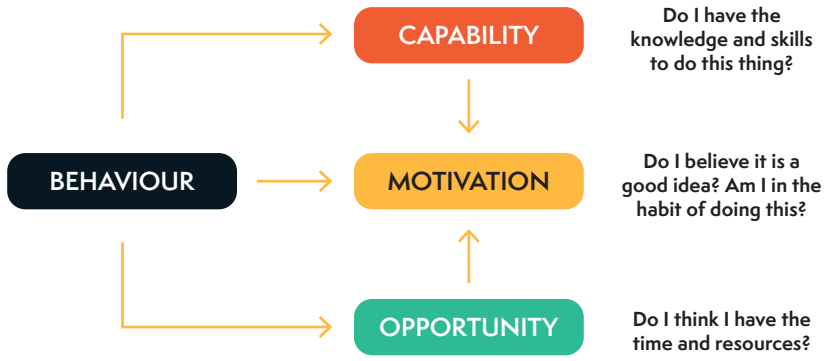
Identify, communicate, act

The Each Baby Counts Progress Report (2018) outlined a three-stage approach – 'identify, communicate and act' – to safe and effective clinical escalation. 'Identify' involves recognising any deviation from a normal birth and developing an appreciation of risk factors; 'communicate' involves using structured communication, a flattened multidisciplinary team hierarchy, and developing assertive escalation and receptive action abilities; while 'act' entails making an appropriate and fast response, using appropriate infrastructure and staff.

Each LDL undertook detailed diagnostics in their respective units to identify the areas needing change.

COM-B FRAMEWORK OF BEHAVIOURAL INFLUENCERS

The 16 LDLs identified numerous barriers to effective clinical escalation in their home NHS trusts. These included: a lack of clarity in role regarding to who to escalate to; the use of vague language when communicating; and getting negative responses to escalations.



Michie et al, 2011

Using multiple methods, involving consultations with staff and women – as well as making observations of clinical escalation and practice, and reviewing local Healthcare Safety Investigation Branch reports – barriers and facilitators were collated. These were mapped onto the COM-B framework (see box), a widely applied behavioural science model to help understand and develop strategies to change practice.

Three is the magic number

To address these, three intervention techniques were co-designed with the LDLs. These are currently being tested across intrapartum care settings in the LDLs' 16 home units, with monitoring and evaluation taking place. 'Identify – Communicate – Act' is being used as a platform for implementing and testing proposed improvements.

The three key strategies to improve clinical escalation are:

1. Team huddles for each shift aim to establish psychological safety and team working by enabling everyone to have a voice, flattening the hierarchy, checking in with incoming and outgoing staff, and making sure everyone knows who to escalate to for that shift.

2. The use of concise safety-critical language to communicate clinical escalation concerns. This uses the 'Advice, Inform, Do' model, a systematic and structured communication tool to help people ask for advice or to inform or to achieve a response, using the phrases 'I need advice', 'I need to inform' or 'I need you to do'.

3. Teach or treat is a learning conversation technique. 'Teach' involves responding kindly and appropriately to escalated concerns, such as: "tell me what you think and why; I'll do the same and we can discuss". 'Treat' involves finding a remedy for a situation, using language such as "let's take action to the clinical escalation".

The EBC L&S Programme has three planned outcomes:

1. A final report outlining the findings from the evaluation of the EBC L&S programme in terms of the training and development of LDLs. It will also outline their experiences and insights into implementing of the quality improvement process in their units.

2. The creation of a refined version of the L&S programme within a digital toolkit that reflects the core components that enabled LDLs to complete the quality improvement work. It will be used as a guide for others. For example, the refined version will include leading change, undertaking a behavioural approach, setting up a home team, and key safety concepts.

3. A clinical escalation toolkit incorporating the intervention strategies developed and tested as part of the L&S programme. This will be shared with maternity teams with recommendations for successful implementation and monitoring.

MORE INFO

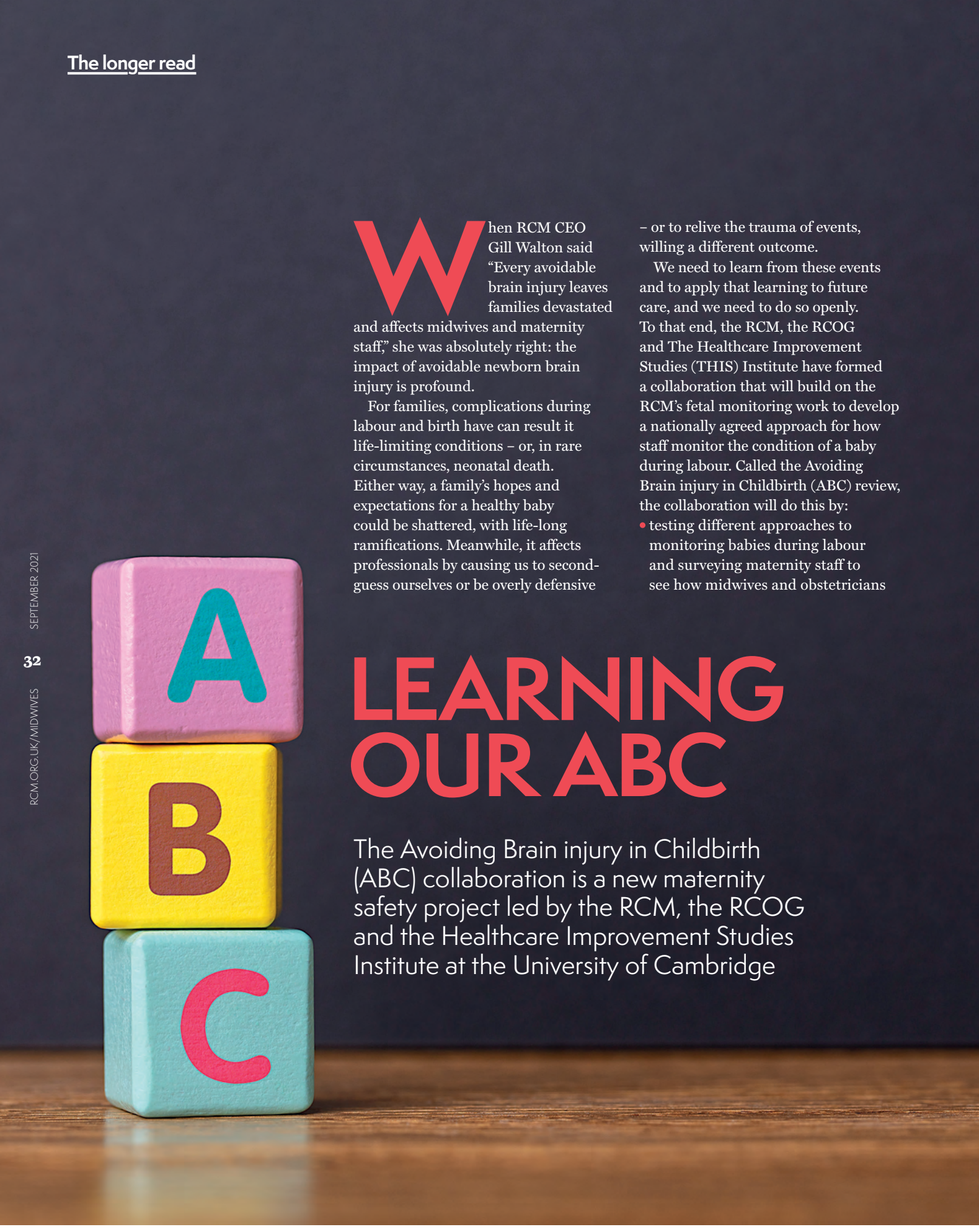
Email ebc_learnandsupport@rcog.org.uk

The behaviour change wheel: bit.ly/behaviour_change_wheel

PARTICIPATING UNITS

- Leeds Teaching Hospitals Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Norfolk and Norwich University Hospital NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- Medway NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals of Morecambe Bay
- Chesterfield Royal Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Royal Wolverhampton NHS Trust
- West Hertfordshire Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust

IMAGES: ISTOCK



LEARNING OUR ABC

The Avoiding Brain injury in Childbirth (ABC) collaboration is a new maternity safety project led by the RCM, the RCOG and the Healthcare Improvement Studies Institute at the University of Cambridge

When RCM CEO Gill Walton said "Every avoidable brain injury leaves families devastated and affects midwives and maternity staff," she was absolutely right: the impact of avoidable newborn brain injury is profound.

For families, complications during labour and birth have can result it life-limiting conditions – or, in rare circumstances, neonatal death. Either way, a family's hopes and expectations for a healthy baby could be shattered, with life-long ramifications. Meanwhile, it affects professionals by causing us to second-guess ourselves or be overly defensive – or to relive the trauma of events, willing a different outcome.

We need to learn from these events and to apply that learning to future care, and we need to do so openly. To that end, the RCM, the RCOG and The Healthcare Improvement Studies (THIS) Institute have formed a collaboration that will build on the RCM's fetal monitoring work to develop a nationally agreed approach for how staff monitor the condition of a baby during labour. Called the Avoiding Brain injury in Childbirth (ABC) review, the collaboration will do this by:

- testing different approaches to monitoring babies during labour and surveying maternity staff to see how midwives and obstetricians

currently identify when a baby is in distress during labour
- interviewing women and their birth partners on these varying approaches based on their personal experiences
- agreeing on a clear process to monitor babies and record readings during labour, with a flowchart guide to decide when to escalate a case to the wider multi-disciplinary maternity team
- developing a nationally agreed approach to delivering babies via caesarean section when there are complications with the positioning of the baby.

Partnership working is the key to improving safety for women and their babies

Funding

While no one can put a price on human life, avoidable newborn brain injury has a significant impact on NHS finances. Though just one in 10 claims settled by NHS Resolution in 2018/2019 were for maternity cases, they accounted for half of the compensation awarded. It's therefore fitting that there is significant government funding for the review.

Minister for patient safety Nadine Dorries announced £2m for the first phase of the programme. The funding will be used to survey maternity staff and parents and test out best practices for monitoring and responding to a baby's wellbeing during labour, as well as those for managing complications with a baby's positioning during caesarean section. This will inform and develop a nationally agreed approach for how staff monitor the condition of a baby during labour.

The Department of Health and Social Care has given an additional £449,000 to the RCOG to enable it to collaborate with stakeholders across the health sector and gather data to develop a new workforce planning tool. The tool is to be made freely available to NHS Trusts across the country next year. It will aim to provide maternity staff with a new methodology that calculates the numbers, skillsets and grades of medical staff required within individual maternity units based on local needs.

It will also help Trusts tackle inequalities by taking into account local factors such as birth rates, the age of the local population, the socio-economic status of the area and geographical factors, as well as making it possible to calculate the number of obstetricians at all grades required locally and nationally to provide a safe, personalised maternity service within the context of the wider workforce.

Finally, it will be able to identify innovative ways of working to better utilise the current workforce, and help maternity teams gain a better understanding of the factors that promote a safe and positive culture and how these can be rolled out nationally.

Joint initiatives

Gill notes that: "Partnership working is the key to improving safety for women and their babies. This funding will enable the RCM and RCOG in partnership with the Department of Health and Social Care to firstly review approaches to monitoring babies during labour and ultimately with more multi-disciplinary training in this area will go towards improving safety for women and their babies. Crucially, this review will also include the voices and personal experiences of women and their birth partners to enable maternity to inform better, safer care."

The RCM and RCOG are longstanding collaborators and are already involved in a number of initiatives, including Each Baby Counts + Learn and Support and the forthcoming collaboration with birth charity Tommy's to identify and support women with higher-risk pregnancies.

We know there's often a risk of 'initiative-itis' among the workforce, which is why these programmes have been designed to dovetail with each other to provide a bigger picture. That way, midwives and obstetricians can get the right training, guidance and support to improve outcomes. And it is with gratitude that the RCM and partners acknowledge that this work would not be possible without the maternity workforce's involvement – monitoring, adapting, reporting and striving to provide the best care possible.

MORE INFO

Get involved at bit.ly/ABC_Homepage
Watch at bit.ly/ABC_Launch_Video
RCM safety podcast at bit.ly/RCM_safety_quality

IMAGES: ISTOCK

A DIFFERENT APPROACH

Geraldine Lucas and Emma Douglass of the University of the West of England and Lynsey Daniels at Devon Partnership NHS Trust discuss how to support women with learning disabilities through pregnancy

Midwives support a small number of women with a learning disability as part of their practice. A learning disability is defined as a "significant reduced ability to understand new or complex information and to learn new skills, with a reduced ability to cope independently". Women with learning disabilities have additional needs through pregnancy, birth and beyond – and, with the right support at the right time, can have positive pregnancy experiences. However, women often face challenges in accessing appropriate support.

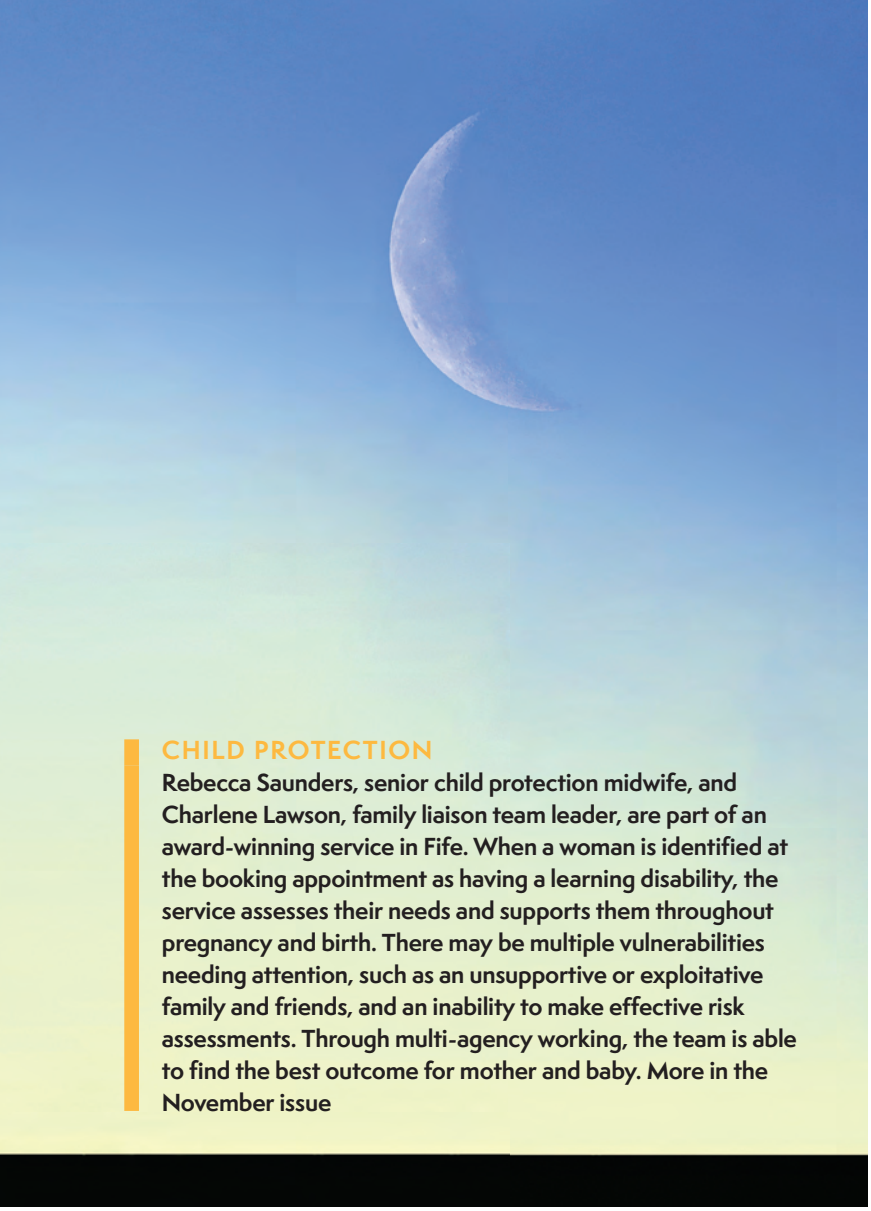
Case study

Lottie, 35, finds out she is pregnant at her Annual Health Check (AHC). AHCs are offered to all people with learning disabilities as they are more likely to have health issues and less likely to seek and receive good quality healthcare. Lottie is 22 weeks pregnant and had no idea she was carrying a baby. Lottie does not know much about pregnancy; she doesn't know how the baby will leave her body as she received minimal sex and relationship education. Lottie does not have a wide support network and is scared of telling her mother for fear that she will get into trouble. None of Lottie's friends have had babies and she doesn't use social media.

The GP gives Lottie some leaflets containing lots of words and no pictures, which she cannot understand. A midwife appointment is booked. Lottie has to go to a busy hospital. She doesn't know if she is allowed to take somebody with her and doesn't like busy places with lots of noise, so she fails to get to the appointment on time.

As services strive to implement continuity of care models, this will facilitate the delivery of woman-centred antenatal care for Lottie and provide an important opportunity for maternity services to re-evaluate the needs of pregnant women who have learning disabilities. Research indicates that the full care needs of pregnant women with learning disabilities are not being met, with women reporting negative maternity care experiences. Small-scale studies have found that midwives face difficulties in meeting the needs of those with learning disabilities, often feeling poorly informed and ill-equipped.

In *Midwives' experience of caring for women with learning disabilities – a qualitative study*, midwives reported receiving a lack of training on



CHILD PROTECTION

Rebecca Saunders, senior child protection midwife, and Charlene Lawson, family liaison team leader, are part of an award-winning service in Fife. When a woman is identified at the booking appointment as having a learning disability, the service assesses their needs and supports them throughout pregnancy and birth. There may be multiple vulnerabilities needing attention, such as an unsupportive or exploitative family and friends, and an inability to make effective risk assessments. Through multi-agency working, the team is able to find the best outcome for mother and baby. More in the November issue

learning disabilities and faced significant time constraints, which left them feeling they could not spend the necessary time with the women to meet their pregnancy needs. The midwives felt unsupported in their attempts to deliver adequate care, speaking about a lack of accessible support for pregnant women with learning disabilities. They were left feeling responsible to fill the gaps in service provision. The midwives were dedicated in delivering adequate care to help give women with learning disabilities a positive experience of childbearing. They felt a safeguarding process (child protection) was an inevitable part of the pregnancy experience of women with learning disabilities, yet were aware that the right support at the right time could improve parenting capacity.

In line with the Department of Health and the Department for Education and Skills' *Good practice guidance on working with parents with a learning disability*, Lottie can expect early professional support to identify her needs for this pregnancy, including a sensitive discussion on her own role in her care. Lottie's assessed needs should also be made in line with clear frameworks, and she should receive a clear explanation from the midwife and other professional staff on the assessed outcomes and what they mean for her own care.

The midwife can support Lottie by identifying her communication needs and finding out whether she would like anyone to support her at antenatal appointments. As accessing appointments and information has been described as more challenging, the midwife could discuss more flexible options.

NHS England and NHS Improvement have discussed using personalised care and support plans during pregnancy that aim to take account of a woman's support needs. As part of the Equality Act, Lottie's midwife should consider any reasonable adjustments that might need to be made.

NICE advocates using information gained at the antenatal appointments to support antenatal education. The midwife will need to ensure any information provided to Lottie is in an appropriate format that she is able to understand, for example, explaining why a symphysis fundal height measurement is being made. Charity Best Beginnings says the uptake of antenatal classes is reduced among women with learning disabilities, and midwives must consider accessible ways for these women to receive this information. This is especially important for Lottie as it appears she has not had access to important reproductive information and requires this to empower her for labour and birth. SNIP (special needs in pregnancy) midwives might, for example, put on special classes for women with learning disabilities if they have a few women who are pregnant at the same time.

People with learning disabilities generally have poorer health outcomes. The midwife should explore Lottie's wellbeing at each appointment and gather information on the medical history of Lottie and her family, and sensitively explore the father's medical history, if known. Early collaboration and inter-agency working by the midwife will ensure Lottie's care is tailored and delivered within the wider multidisciplinary team. This is pivotal in achieving high-quality care while meeting Lottie's needs and ensuring safe outcomes for her and her baby.

FURTHER READING

Best Beginnings advice on parents with learning disabilities: bit.ly/BBLearningDisabilities
Good practice guidance on working with parents with learning disabilities: bit.ly/LDGoodPractice
Change, a charity supporting parents with learning disabilities, has produced a book with pictures for pregnant women. See bit.ly/LDParentingBook
Working together to safeguard children: bit.ly/InteragencySafeguarding

IMAGE: IKON

#NotSoNICE

When NICE's induction of labour draft guidance was released for consultation, it wasn't what anyone was expecting – and the response was overwhelming

Few things have caused such a stir as NICE's draft guidance for induction of labour, which was released in May this year.

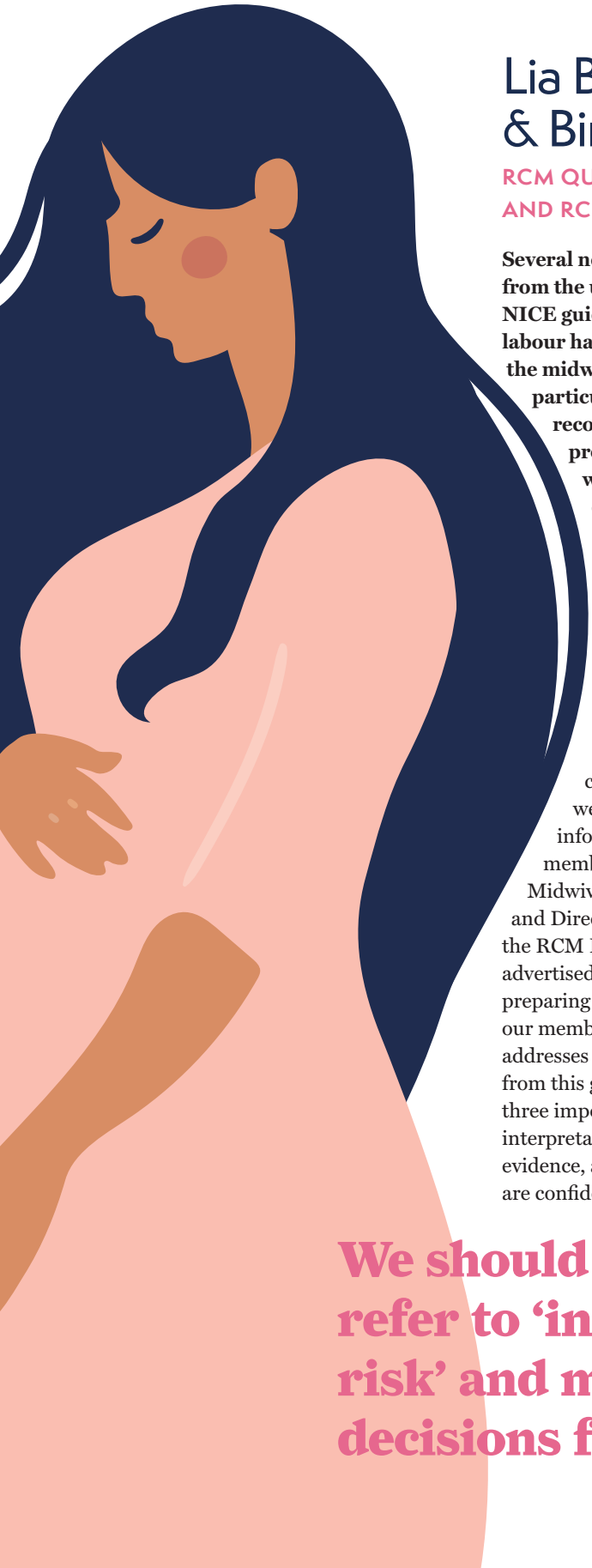
Specifically, this paragraph was a major point of contention: "Consider induction of labour from 39+0 weeks in women with otherwise uncomplicated singleton pregnancies who are at a higher risk of complications associated with continued pregnancy (for example, BMI 30 kg/m2 23 or above, age 35 years or above, with a black, Asian or minority ethnic family background, or after assisted conception)." That month, social media feeds were awash with comments such as "so my body is broken because it isn't white?" and "'Offering' induction based solely on race is just another example of systemic racism."

Many were also quick to point out that the evidence for the guidance was not only flawed but clouded by the authors' views: "We can't find any evidence for why these people have poorer outcomes, but think inducing all of them would probably fix it, based on our own knowledge and experience, so we decided to pop that in – how can NICE guidance committees get away with doing this?"

The consultation on the draft guidance closed in early July, and the RCM was among the many professional bodies and individuals to respond.

MORE INFO
Read the draft guidance in full at bit.ly/NICEmaternityguidance

IMAGES: ISTOCK



Lia Brigante & Birte Harlev-Lam

RCM QUALITY & STANDARDS ADVISOR AND RCM EXECUTIVE DIRECTOR MIDWIFE

Several new recommendations from the updated draft 2021 NICE guidance on induction of labour have caused concerns in the midwifery community. In particular, the implication of some recommendations – on service provision, the midwifery workforce, safety, long-term clinical and psychological outcomes for women and babies, and the experience of care for women and their families – did not seem fully considered.

The RCM is a registered stakeholder for all NICE consultations related to maternity care. When this consultation opened in May, we set up a working group to inform our response by consulting members via the RCM Consultant Midwives Forum, the RCM Heads and Directors of Midwifery Forum and the RCM Professorial Group. We also advertised on social media that we were preparing a response and welcoming our members' views. Our final response addresses several issues emerging from this guidance, and focuses on three important aspects: methodology, interpretation and transferability of the evidence, and service implication. We are confident that NICE will take those comments on board before finalising the guidance.

Midwives have the privilege to care for women and families at a life-changing event, which means the care we provide needs to be informed by the very best evidence available and should not be limited to randomised controlled trials, as seems the case with this guidance. There are some good observational studies, as well as qualitative reviews, that can offer data on the long-term outcomes for women and babies – including the impact on their mental health and their experience of care. Offering earlier induction of labour to all healthy women will affect their experience of labour and birth, and limit the options available to them in terms of place of birth and midwifery-led care at home or in midwifery units.

Women should be informed that the body of evidence on the gestational age beyond which continuing the pregnancy may pose any additional risks to mother and/or baby is contradictory. Nevertheless, there is some evidence that, although small, the risk of stillbirth or perinatal death in the first week of life may increase with expectant management between 41 and 42 weeks, approximately from less than 1 per 1,000 pregnancies to 4 per 1,000.

We should provide this information to women in clear absolute risk terms, developing infographics from the body of research evidence, and enable women to decide what's best for them in their individual circumstances. We should not just refer to 'increased risk' and make decisions for them, as this guidance suggests. We should provide women with the information and evidence based on their personal

We should not just refer to 'increased risk' and make decisions for them

circumstances, including risk, so that they can make an informed decision. There is a recommendation to offer women declining induction the opportunity to 'revise their options weekly'.

We need to be careful we don't stray into coercive behaviour but rather remain focused on personalised evidence-based and informed care. According to the NMC midwifery standards, all midwives "in partnership with the woman, use evidence-based, best practice approaches to plan and carry out ongoing integrated assessment, individualised care planning and evaluation for both the women and the newborn infant, based on sound knowledge of normal processes and recognition of deviations from these".

To provide safer care, we need to provide truly personalised care and refrain from blanket approach recommendations. Offering induction of labour at 39 weeks to all women falling in the so-called 'high risk' bracket is not evidence based, particularly when women fall in this category just because they have an increased BMI, are aged over 35 or are from an ethnic minority group. Black, Asian, mixed and minority ethnic (BAME) women face a constellation of biases when accessing maternity services, often experiencing poorer quality of care and lower satisfaction. Introducing an intervention singling out women on ethnicity alone when there are likely to be large differences in health status and values within their group could itself be considered discriminatory. There are a number of initiatives, including training and support, to reduce racial inequality and promote culturally sensitive care in maternity services that would be more effective.

There is already evidence suggesting that women can feel pressurised into accepting an induction and therefore detailed, evidence-based discussion is essential to support women to make the choices that are right for them. They must also be made aware that they can change their minds at any point and will be supported in doing so by their midwives and maternity team.

Nikki Darby

HYPNOBIRTHING INSTRUCTOR AND VOLUNTEER DOULA WITH SUPPORT PROJECT MATERNITY MATES AND TRAINEE BREAST FEEDING COUNSELLOR

It makes me really angry and upset that they brought out these draft guidance to suggest that a group of women and birthing people from the BAME community, or people with a BMI of over 30, or those with assisted pregnancy, or people over the age of 35 should be induced. Imagine how many women and birthing people that would need to be induced?

We know that induction quite often leads to a cascade of further interventions. And there's a really high proportion of women and birthing people that will end up with a C-section, who can then end up traumatised. It's just not the birth that they wanted and what they deserved.

The guidance says that in the absence of evidence, the committee made recommendations based on their knowledge and experience. We know that black women are five times more likely to die in childbirth, so why not investigate that and find out why that's happening? Otherwise, this is just sticking a plaster over something.

It seems absurd and hugely racist to suggest that only white women and birthing people can safely carry their babies to full term. If you're a black woman who has decided to wait until you're 37 to have your baby, and you have a BMI of over 30, you're going to be ticking three boxes.

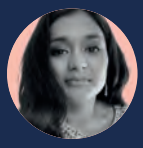
I can just imagine in the future sitting with the mums that I'm supporting and consultants saying 'Let's get that induction booked in' and maybe them not having the confidence to challenge why that's being recommended to them.

That's when the Maternity Mate sat next to them could suggest some questions to ask. And then we can talk about it afterwards, we won't have to make a decision immediately – we can look at the evidence together.

But without us being there, if the pregnant person in this meeting doesn't have somebody who knows their rights they'll probably just sign on the dotted line and agree to it because it's a doctor – it's the 'white coat syndrome'.

Some studies now suggest that there's a link between the synthetic oxytocin given during induction and postnatal depression. We'll have a lot of traumatised, unhappy families who are being left with the consequences of the actions of the NICE guidelines and hospital policies.

I don't think people should be coerced and be told their baby is at risk if they continue with their pregnancy, because that's an unfair burden to place on anybody's shoulders.



Fazia Rehman

MIDWIFE; RUNS THE RAHAM PROJECT TO SUPPORT ETHNIC MINORITY FAMILIES

These guidelines are taking a very short-term view, completely downplaying how birthing people feel about the experience of the induction of labour and how it actually impacts them in the long term. As south Asian women, we are taught 'you must do as you're told.'

We grew up in a community where it's very patriarchal, very male dominant, where men are the protectors and providers, and women are the homemakers and mothers. If somebody in healthcare, coming from a position of authority, tells south Asian women: 'We believe your baby might die, you have to do x, y or z', we will. We may not even question the suggestion.

When mothers turn up before an induction of labour, they often don't always know what it entails. More often than not, when I talk to mothers after an induction, they will say: 'I wish I had not done that; I did not realise it would be that painful. I did not realise it would take that long.'

The fact that we know black and brown women are more likely to die or have babies that die – that's the snippet of information that will probably be given to all parents. The reasons behind why we think they die will not.

Inducing BAME women is just trying to put a plaster over the fact that there are deeper-rooted issues as to why women and babies in our communities die. It effectively says: 'There are issues that we acknowledge, but actually we're not going to take the time and value to invest into these communities to find out what these issues are, to look at and fix the root causes.'

There is a huge shortage of midwives in the UK. I really would like to see more midwifery care. I'm a true believer in the ethos of continuity of care. But with the number of women we have, and the lack of midwives we have, it's proving difficult to implement our belief.

What I really want to see is for us to create a culture to prioritise providing time to families. As well as time, I'd love to see a huge investment in prioritising antenatal education.

When mothers turn up before an induction, they often don't always know what it entails

Deborah Longe

LABOUR WARD AND QUALITY IMPROVEMENT MIDWIFE

We should focus on the root cause of the negative health outcomes in the BAME community rather than inducing these women earlier and essentially trying to shorten the period of time they may be experiencing health inequalities in relation to pregnancy. It's almost trying to take a shortcut, saying once women are no longer pregnant, then they're no longer our responsibility. And then whichever health inequality they're facing has to be dealt with outside of maternity.

The recent MBRRACE-UK Report states the importance of individualised care, especially for BAME women. In my experience as a midwife, one common health inequality in my demographic is the language barrier. Women who don't speak, read or understand English should be supported in understanding their care and helped to make informed choices.

Health inequalities are also due to socio-economic factors. Women should be supported during their pregnancies to access financial help when needed. They also need more support in making a suitable environment for them to be able to raise their babies.

Another area that we could look at is safeguarding. Some women tend to be in vulnerable positions during their pregnancies. We should let them know that their voice is heard and that they're valued. For example, the Maternity Voices Partnerships encourage women to talk about their experiences and what they'd like out of maternity services.

I think as midwives we're empowering women to ask questions. I certainly do in my clinical practice, where I explain the rationale and the reason behind decisions and encourage women to ask questions. We're really trying to encourage that relationship of transparency and empowerment. You need to be taking that extra step to make sure that they understand and are making informed decisions.

We should let women know that their voice is heard and that they're valued

What we need at this stage from NICE is support to understand the evidence behind this guidance, and hopefully the assurance that they take into consideration the voices of midwives, doctors and women.

Hopefully, we can move forward with an agreement to do the best thing for our women – as we have always done – as well as with other maternity care issues we'll be facing in the future. It'd be nice to know that we're working collaboratively for the best outcomes for our women and their babies.

MORE INFO

The consultation ran from 25 May to 6 July 2021. Read the RCOG, doctors and Tommy's responses at bit.ly/RCOGlabour, bit.ly/BMJLabour and bit.ly/TommysLabour

Bolanle Adebayo

A STUDENT MIDWIFE

Bolanle Adebayo is on a mission to highlight the lack of representation within the midwifery curriculum and its teaching materials

I'm a student midwife in Ireland just starting my fourth and final year. It is normal for me to see a diverse population whenever I step out of my house, and yet it is abnormal for me to see this represented during my lectures. I have written to different professional bodies to highlight the lack of representation within the midwifery curriculum – more precisely, the anatomical models and clinical diagnosis descriptions or images used to educate future midwives.

Given the stark differences in maternal mortality rates between certain ethnic groups (highlighted in the 2019 and 2020 MBRRACE-UK reports), representation is needed more than ever. Is it possible that the failure to account for the diverse population during midwifery education plays a role in mortality rates?

I asked fellow midwifery, dentistry, medicine and nursing students in Ireland for their own observations. Most reported that they only ever saw Caucasian anatomical models, that there is a lack of representation in the way skin conditions and symptoms are described in teaching materials, and there's an absence of cultural competency workshops or modules.

The companies producing anatomical models mainly (only) make Caucasian skin tones, and these are even being used in places such as Africa and Asia. I looked at the anatomical models of three Irish suppliers, and here is what I found:

- Medguard Healthcare – only its 'Baby Care' models offer multiple skin tone options. The 'Model of Female Breast' "depicts common diseases like mastitis", but only on Caucasian skin.
- Medstore Medical – of the 11 gynaecological models I looked at, not including the uterus and pelvis, all were Caucasian.
- Shaw Scientific – models only represent a Caucasian population.

Is the situation so normalised that it isn't questioned?

Does this reflect a lack of demand for non-Caucasian skin tones – or is this situation so normalised that it isn't questioned? I recently visited Tanzania and was shocked to notice that they have the same issue with educational models and shop mannequins. I pointed this out to a local and he admitted that he hadn't even noticed!

We, particularly students, need to recognise the issue. Then we need to speak out consistently so that universities prioritise it. I'm still shocked by universities' claims to "address exclusionary practices (such as the lack of diversity reflected in reading materials) and embed principles of diversity, equality and inclusion", or to "commit to social justice by achieving a fair and equal representation for all". How can social justice be promised when healthcare students are only being taught how to care for Caucasian bodies? How can you claim to produce professionals are equipped to provide safe, quality care when your teaching material only covers one group? I believe there is a willingness to make a change, but we're going to have to keep demanding it.

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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.

ON YOUR SIDE

Gerard Stilliard, head of personal injury strategy at Thompsons Solicitors, discusses changes to small claims

Q: I'm a community midwife and rely on my car for visits. I was recently injured in an accident, but instead of being able to get free legal help, I'm having to deal with the other driver's insurance company myself. What can I do?

Historically, any injury claim with a value above £1,000 saw legal fees being paid by the person responsible for your injuries. The government has changed that for road traffic accidents (RTAs) and increased the limit to £5,000. Since nearly 80% of RTAs have a value less than the new limit, thousands of people injured through no fault of their own will have to fight insurers on their own, as you've discovered, or pay legal fees up front.

The government has developed a new Official Injury Claim portal and has published a 64-page guide, but that has been described as absurdly complex – most claimants will give up after page two. In an unequal fight against a well-funded insurance industry, we anticipate that those who have no choice but to fight on alone will end up being browbeaten into taking what they can get.

The RCM's CEO, Gill Walton, described it as "an unnecessary and unfair strain on those who need help, not hindrance". In fact, the RCM and Thompsons campaigned against the reforms. This has resulted in 'vulnerable' road users being exempt from these changes, but sadly not those such as community midwives and other frontline workers. Without the luxury of working from home, these workers will be at a greater risk of road accidents – having to tackle this new portal as a result.

So the RCM has made the decision to meet the cost of getting members help, rather than stop providing a service for minor claims that can run into thousands of pounds or pass the costs on to members. And rather than being left on your own to fight the insurers, you will have trusted union lawyers to help you through the legal process.

Gill said: "It is neither fair nor realistic to expect people who have little or no experience with legal documents to go up against insurers who will use every trick in the book to avoid paying up."

Thompsons agrees. The government kept emphasising during the passage of these changes through parliament that the systems injured people would need to deal with were going to be straightforward and simple. The reality is that the new system is anything but, and gives free reign to insurers who will face no sanctions if they muck injured people about.

MORE INFO

Contact the RCM's legal service on **0808 100 7776** to talk about what to do next or visit **bit.ly/ThompsonsSmallClaims**
The RCM and Thompsons are proud to provide comprehensive legal cover for RCM members and their families. For more information, visit **thompsonstradeunion.law/RCM**

Standard bearers

Deputy HoM Kerry Williams and assistant chief nurse Carol Bradley discuss an assessment and accreditation system improving maternity safety at University Hospitals of Leicester NHS Trust

The need for quality, safety, improvement and assurance in maternity services is as important now as it ever was. The Ockenden Report and Morecambe Bay investigation highlighted issues such as staff not having the right skills or knowledge, poor risk assessments and the failure to learn from incidents.

The drive for change in maternity is fast paced, with a key focus on quality, safety and robust processes to ensure women, birthing people and their families are receiving the best possible care. A key component to this success is high-quality leadership. There is no national standardised preparation or education framework for ward managers and matrons starting out on their leadership journey. Their development relies heavily on learning from peers in the profession,

but this can fall into the 'how we've always done things' category.

There are also no standardised processes for quality and assurance for the maternity ward environment. This contributes to a variation in quality of service – and, in turn, high levels of panic and anxiety for maternity staff when regulators undertake inspections. In response to this, the University Hospitals of Leicester (UHL) NHS Trust revisited the Nursing Assessment and Accreditation System (NAAS) for maternity in order to provide a structure for assessment and practical plans for improvement.

How it works

The NAAS was originally introduced at Salford Royal NHS Foundation Trust in 2008 as a way to assure patients were receiving high quality nursing care. The NAAS quality improvement framework provides a 'ward to board' channel, and is designed to create a culture of safety as well as monitoring performance around quality of care. The ward is assessed on how it complies with high standards of communication, accountability, teamwork and leadership, thereby placing patients at the centre of care provision.

The NAAS improvement framework provides a 'ward to board' channel

The assessment process is unannounced and each ward is assessed against a number of standards, with each standard being red, amber or green (RAG) rated. When the standards are combined, an overall RAG rating is produced for the ward. A ward's re-assessment depends on overall improvement and the subsequent rating given.

The accreditation was originally set up to align with clinical indicators as well as local and national drivers, which provides evidence that the trust is meeting required standards of care. This will also provide assurance for external regulators such as the Care Quality Commission. Following an assessment, the ward manager, matron and head of nursing are responsible for formulating a ward improvement plan. They also ensure the plan is tracked and disseminated to all members of the ward team. The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole will provide the board with comprehensive information regarding care delivery within the organisation.

NAAS in maternity

It is important that clinical excellence is recognised by leaders and regulators; it is also key that healthcare professionals are given the tools to ensure quality and standards of care are measurable.

Evidence suggests high-performing hospitals have the following characteristics:

- a positive organisational culture with a focus on excellence – staff are recognised for good work and a safety culture is promoted
- receptive and responsive senior leaders, who are visible and strive for quality and improvement. They also listen to teams and value their input
- effective monitoring of outcomes and performance – the data is used for continuous feedback, improvement and goal setting.

The NAAS is a standardised tool that has been designed to measure ward performance in relation to some of these characteristics, making use of an internal assessment process. This has been used positively not only to improve standards of care within nursing but also to strengthen assurance processes throughout departments and organisations. We decided to adapt the NAAS to make it relevant to local and national maternity care indicators and roll it out across the maternity service at UHL.

What we did

Assessment and accreditation was launched for nursing across UHL in August 2019, and a maternity tool was subsequently created and launched in 2020. The maternity tool consists of 13 standards; each one is made up of a number of different elements, such as:

- quality and safety
- infection prevention and control
- safeguarding
- infant feeding
- medication safety

IMAGES: GETTY

- pressure-area care
- person-centred care
- communication and safety culture, etc.

In our experience, the assessment process enables continuous improvement, reduces unwarranted variation and empowers midwives to drive quality improvement. It also allows success to be celebrated and shared across the organisation.

The maternity assessment tool was built in partnership with senior leaders and shared with the regional chief midwife for comment and validation. It is reviewed annually to ensure that current learning from concerns, complaints and incidents are reflected within the assessment process to support a culture of shared learning across the trust.

What have been the results?

Implementation of the tool has been a success and maternity staff have engaged with the process. Ward managers initially carried out a self-assessment to ascertain a realistic baseline of the award they were likely to receive and understand the standard expected within their area.

The RCM highlighted the widespread low morale within maternity services in November 2020 and discussed the impact this is having on midwives in practice. Stretched services with significant staffing shortfalls are affecting safety and quality of maternity care. As a result, the RCM has called for action not only on midwifery staffing to be resolved but also for trusts to equip their teams with the resources and support they need to provide safe and personalised care.

Improving midwifery staffing levels within maternity continues to be an ongoing challenge and this undoubtedly affects the care provided. Assessment and accreditation makes it possible to monitor the quality of care closely, ensuring an improvement process is in place where wards fall below the 'green' standard. However, it is also important to consider the impact of the process on an already stretched service.

Given the pressures midwives are currently facing, it was necessary to address any concerns or anxieties, and staff were invited to provide feedback about the process. The response from midwives was very positive – here are some of their comments:

"It was a brilliant experience and highlighted areas to improve to enable us to give a high standard of care as a ward. It is also highlighted the importance of team working in order to achieve this level of care."

"It has given us focus and determination to improve the care and environment for women and babies."

"Assessment and accreditation improves the standard of care on the ward and as a result will improve outcomes for women and babies."

"Although the ultimate is to achieve the highest standard of care possible for women, it generated a positivity that was a real boost for every member of staff on the ward. We all received praise from the

The assessment process enables continuous improvement and empowers midwives

ward manager, who had put so much time and effort into achieving an amber award. This reinforced what all members of the team already knew, and that is we do work best when we work as a team. The enthusiasm that preparing for accreditation created has inspired us all to want to work together towards ultimately achieving a green rating."

What's next

To date, all maternity inpatient areas have been assessed at each acute unit within UHL. One ward achieved a red rating while the remaining wards achieved amber. The red ward was reassessed 13 weeks later and upgraded to amber status. This demonstrates the commitment from the teams for quality improvement, and all wards are now working hard to achieve green status.

The assessment and accreditation results are reported on the quality and safety metrics scorecard across the trust, and a report is made quarterly via the trust's senior nursing and midwifery board. Our aim is to provide evidence of consistent quality and to ensure women receive a high standard of care within our service. It is important that our staff are supported to provide excellence in care, that this is recognised, and that they work in an environment where there is a culture of safety and where they are supported to speak up and report any concerns.

Embedding a process of assessing excellence will also attract staff to the maternity service. This is because they will know that they are supported in providing high-quality care to women and that we encourage an open and honest culture.

Our next step is to design and implement an intrapartum tool using quality evidence, key drivers and findings from national reports and regulators. However, one of the main drivers will be how we listen to women and ensure they feel in control of their care and supported to make informed choices. It is then our overall goal to be the first maternity unit in the country with 'blue' ward status in all clinical areas.

MORE INFO

More on the NAAS can be found at: bit.ly/NAAS10years

SALFORD'S NAAS LEGACY

The Northern Care alliance has adopted the NAAS system across several sites: bit.ly/NorthernCareNAAS

In Scotland it is also known as the Care Assurance and Accreditation System (CAAS). NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Ayrshire & Arran is an example of a bespoke Scottish model: bit.ly/ScotlandCAAS

Are all emollients the same?

Eczema, also known as atopic dermatitis, is a diagnosis that is greeted with dread, particularly if the patient is a child. Emollients have an important role in the treatment of the skin condition, either alone or to supplement other treatments.

Eczema is a chronic, inflammatory, itchy skin condition that often develops in early childhood and is either episodic or continuous. It can lead to damage of the skin barrier and alteration of its components, which makes the skin more susceptible to irritants and allergens that can worsen the condition.

Eczema can clear or improve during childhood or persist into adulthood. Some children will go on to develop asthma or allergic rhinitis. Although eczema is not always recognised by healthcare professionals as being a serious medical condition, it can have a significant negative impact on quality of life for children and their parents or carers.

In a new paper on eczema in the under-12s, NICE says: "Emollients should form the basis of atopic eczema management and should always be used, even when the atopic eczema is clear. Management can then be stepped up or down, according to the severity of symptoms."

NICE recommends the use of emollients whether the condition is mild, moderate or severe, along with other treatments – including corticosteroids – as needed. Emollients should be used for moisturising, washing and bathing even when the skin is clear, replacing soaps and detergent-based wash products.

A new double-blind study* tested two products, CeraVe cream and CeraVe lotion, against three commonly prescribed emollients in patients with dry, eczema-prone skin. The two CeraVe products were

CeraVe delivered sustained hydration

the only ones capable of sustaining clinically meaningful improvements in skin moisturisation for 24 hours. The study concluded that the sustained moisturisation imparted by the CeraVe cream/lotion lessens the need for more frequent application.

The CeraVe cream and lotion both delivered sustained, clinically relevant increases in hydration of the stratum corneum (the outer skin barrier) that lasted more than 24 hours after a single application. In contrast, the three referenced emollients delivered marginal changes that did not reach a clinically significant level.

This means that the health of the skin can be improved with once-daily applications of the test products instead of the two to four applications per day recommended for traditional emollients.

There is a high volume of prescriptions for traditional emollients. This data suggests that many patients would benefit from improved skin moisturisation and a reduced therapeutic burden by switching to one of the test products.

A recent study by Cabout et al. found that, over six years, use of an effective evidence-based emollient in atopic dermatitis resulted in more than six months without flare-up compared with no moisturiser, and more than 35 days without flare-ups compared to other referenced emollients**

Most doctors will suggest using the simplest treatment first. Prompt and regular treatment with evidence- based emollients may avert the need for further medication. Always take the advice of a doctor.

The patient's preference is key, and patients should be given the option to choose the most suitable emollient to their use. Some of these evidence-based emollients are not available on prescription, therefore the option to purchase an evidence-based emollient should be suggested to patients.

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* An investigation of the skin barrier restoring effects of a cream and lotion containing ceramides in a multi-vesicular emulsion in people with pry,eczema-prone, skin: the RESTORE study Phase 1. ** Cost effectiveness of emollients in the prevention of relapses in atopic dermatitis, published in Clinical, Cosmetic and Investigational Dermatology, Dove Press.

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EMAIL MEDICAL.UKI@LOREAL.COM FOR MORE INFORMATION AND SAMPLES

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Peripartum cardiomyopathy

Many women feel tired and out of breath in pregnancy, but for **Mel Bucknell,** her exhaustion was potentially life-threatening

In October 2017, I gave birth to my second child via planned caesarean section (due to my first being a caesarean). I was 29 at the time and had a mostly straightforward pregnancy. Looking back now, I can recall feeling unable to easily walk up the stairs at about 36 weeks and not being able to run at all without feeling really puffed out. I put this down to being pregnant and already having a two-year-old at home.

A few days after the birth, I started coughing and feeling generally unwell – I was very tired, I had a racing heart and I was sweating. At the time I thought I had a fever related to my cough. But in early December, on a visit to hospital with my newborn (who had an infection), I still had a terrible cough and felt unwell. The ward nurses kindly looked after my baby while I went to A&E for an electrocardiogram (ECG) and chest X-ray. It was deemed a chest infection and I was given antibiotics. I remember feeling like I was going to pass out while walking back to the ward.

A few weeks later I started to cough up pink mucus, so my GP sent me to A&E for more tests. One of the nurses noted my high heart rate and asked about my cough, general health and when I had my baby. An ECG machine was brought in to look at my heart – at this stage I was really confused.

The scan showed that my heart was really struggling, so I was transferred to the coronary care unit. I was in shock. All I could think was that I needed to get home to feed my baby and that my milk was overflowing! On the ward, I was hooked up to machines – my resting heart rate was 135. I was given furosemide and kept in for the next few days. We discussed potential heart transplants, the risk of dying and that I had to stop breastfeeding. It was really distressing.

I have been under the care of the heart failure team ever since, adjusting to a variety of medicines and a new way of life. I have gone from an ejection fraction of 10% to 40/45% and have been gently exercising, which has helped hugely. I will be on medication for life and have been told that having more children is not an option, which I'm sad about. But my focus is on managing this condition and warning others. I wish I'd listened to my body – I may have been able to address this earlier and been in better shape for it now. But if I can tell my story and help others spot the symptoms, then there's happiness in that.

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Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Derma UK on +44 (0) 191 375 9020.

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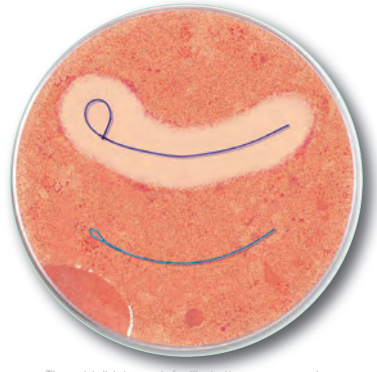

The petri dish image is for illustrative purposes only; zone of inhibition testing results can vary.

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