THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 25 / SEPTEMBER 2022

midwives

BIRTHING LANGUAGE
HOW RE:BIRTH CREATED A CONSENSUS OF RESPECT

CARE AND REPAIR
REIMAGINING SAFETY AT WORK FOR ALL

BREAKING BARRIERS
IMPROVING AUTISTIC WOMEN'S CARE EXPERIENCE

We are one

HOW THE RCM IS FIGHTING FOR YOU AND THE FUTURE OF THE PROFESSION

SEPTEMBER 2022

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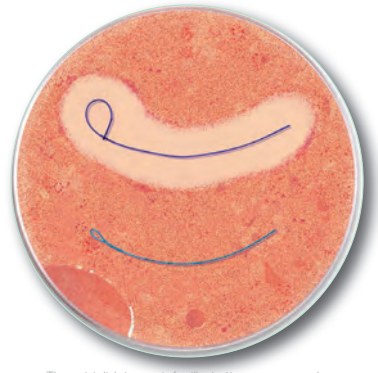
- Staphylococcus epidermidis
- MRSA
- MRSE
- Escherichia coli*
- K pneumoniae*



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

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*PDS™ Plus Antibacterial (polydioxanone) Suture and MONOCRYL™ Plus Antibacterial (poliglecaprone 25) Suture only. **Conclusions derived from pre-clinical data. ***Staphylococcus epidermidis, Escherichia coli, Staphylococcus aureus, Pseudomonas aeruginosa, and Enterococcus faecium. † conducted via video-conference or patient submitting photograph to discuss with HCP via teleconference. # Study performed ex vivo using porcine skin.

1. Ming X, Rothenburger S, Yang D. In vitro antibacterial efficacy of Monocryl Plus Antibacterial Suture (poliglecaprone 25 with triclosan). Surg Infect (Larchmt). 2007;8(2):201-207. **2.** Rothenburger S, Spangler D, Bhende S, Burkley D. In vitro antimicrobial evaluation of Coated VICRYL* Plus Antibacterial Suture (coated polyglactin 910 with triclosan) using zone of inhibition assays. Surg Infect (Larchmt). 2002;3(suppl 1):S79-S87. **3.** Ming X, Rothenburger S, Nichols MM. In vivo in vitro antibacterial efficacy of PDS* Plus (polydioxanone with Triclosan) Suture. Surg Infect (Larchmt). 2008;9(4):451-457. **4.** Ethicon, LAB100028658v3 STRATAFIX Knotless Tissue Control Device. Instructions for Use. Data on File. **5.** Ethicon, 100326296 Time Zero Tissue Holding - Competitive Claims Comparisons for STRATAFIX™ Knotless Tissue Control Devices vs Various Products. May 2015. Data on File. **6.** Ethicon, AST-2011-0210. Study to evaluate the tissue holding performance at time zero of DOLFIN PDS™ PLUS barbed suture sizes 1 and 2-0 vs dyed PDS™ II Plus suture sizes 1 and 2-0 in a continuous stitch pattern—Project DOLFIN 11822. July 2011. Data on File. **7.** Ethicon, AST-2011-0341. Performance testing of DOLFIN PDS™ PLUS size 3-0 suture—tissue holding 10 cm incision. August, 2011. Data on File. **8.** Ethicon, PSE 09-0204, project number 11822. Exploratory histological and biomechanical evaluation of DOLFIN following closure of the ventral abdominal wall in a porcine model at 7+/-1 days. July 2010. Data on File. **9.** Ethicon, PSE 10-0012, project number 11822. Model development: histological and biomechanical evaluation of 3-0 DOLFIN barbed suture prototypes, 3-0 Quill suture, and 3-0 V-loc suture at 7+/-1 days following closure of the ventral abdominal wall in a rabbit model. August 2011. Data on File. **10.** Ethicon, AST-2013-0603. Performance Testing of STRATAFIX™ SYMMETRIC PDS™ PLUS Size 0 & 1 Devices – Initiation Strength in Porcine Tissue. April 2014. Data on File. **11.** Greenberg J, Goldman R. Barbed Suture: A Review of the Technology and Clinical Uses in Obstetrics and Gynecology. Rev Obstet Gynecol. 2013;6(3-4):107-115. **12.** Ethicon, 06TR071 Study Report for in vitro evaluation of microbial barrier properties of DERMABOND™ ProTape, December 2006, Data on File. **13.** Ethicon, 20210201 Transparency of DERMABOND PRINEO R&D Memo. February, 2021. Data on File. **14.** Ethicon, LAB 0013100 Rev 6 - DERMABOND™ PRINEO™ Skin Closure System Instructions for Use Package Insert. Jan 2020. Data on File **15.** Ethicon, 100216627 Report for mapping strains in DERMABOND™ PRINEO™ Skin Closure System 22 cm (DP22) Comparative Study, August 2014, Data on File. **16.** De Cock E, van Nooten F, Mueller K, Tan R. Changing the surgical wound closure management pathway: time and supplies with PRINEO vs. standard of care for abdominoplasty surgery in Germany. Poster presented at: International Society for Pharmacoeconomics and Outcomes Research, 11th Annual European Congress: November 2008; Athens, Greece. (142179-200603).

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10-18 Union Street
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0300 303 0444

Editorial
Guest editor **Emma Godfrey**
Director of communications and engagement **Jo Tanner**
Executive director of trade union **Suzanne Tyler**
Editorial contributors **Juliette Astrup, Helen Bird, Jess Connett, Kathy Oxtoby, Janice Warman**

Editorial board
Kate Ashforth, Mary Caddell, Kate Evans, Sarah Fox, Alexandra Hawkins-Drew, Jayne Marshall, Sophie McAllister, Ruth Sanders, Angie Velinor, Louise Woolams

redactive

Publishers
Redactive Publishing Ltd
9 Dallington St
London EC1V 0BH
0207 866 4050
Director **Jason Grant**

Advertising
midwives@redactive.co.uk
020 7880 6231

Design
Lead designer **Nicholas Daley**
Picture researcher **Claire Echavarry**

Production
Production manager **Aysha Miah-Edwards**
aysha.miah@redactive.co.uk

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

We stand strong and united on pay, says RCM executive director of trade union Suzanne Tyler

Welcome

When it comes to pay, the time for change is now. Although the outcome of our member consultation on pay in England and Wales is unknown as I write, we have heard loud and clear that you are angry and demoralised by the award of around 4% for most midwives. But we don't know whether you feel willing or able to take the next step.

We do know that members in Scotland, where pay is determined differently, have given us a clear mandate to ballot for industrial action. They, alongside other health unions, have overwhelmingly rejected the 5% pay offer from the Scottish government. I applaud our RCM Scotland team and activists for the work they have done in engaging members.

In this issue, we're focusing on pay for midwives and maternity support workers (MSWs) – how we got here and what we can do together. I see no conflict between standing up for the highest standards of maternity care on one hand and believing that midwives and MSWs deserve fair pay for their work on the other. Although strikes are always a last resort, it might be the last weapon we have to bring those in power around the table. We are acting together with 12 other health unions – and collectively we are strong if we have your support.

We stand together to make things better

The RCM was forged by the solidarity between midwives. Another area in which we are united is safety, and the desire to see professional education in safeguarding women. But we have reached a point where, without enough midwives and MSWs who are able to work effectively, safety is severely compromised.

Not only are we losing staff to other jobs, but many who are staying are forced to use food banks and the hardship funds being set up by their employers. How can you possibly focus on delivering high-quality care when you're worrying about food and warmth for your family?

I'm as proud as ever that the RCM is a strong trade union as well as a powerful professional body. We stand together to make things better for women, for babies and for each other.

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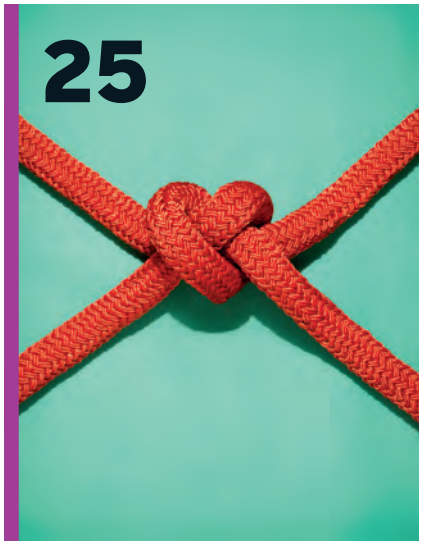

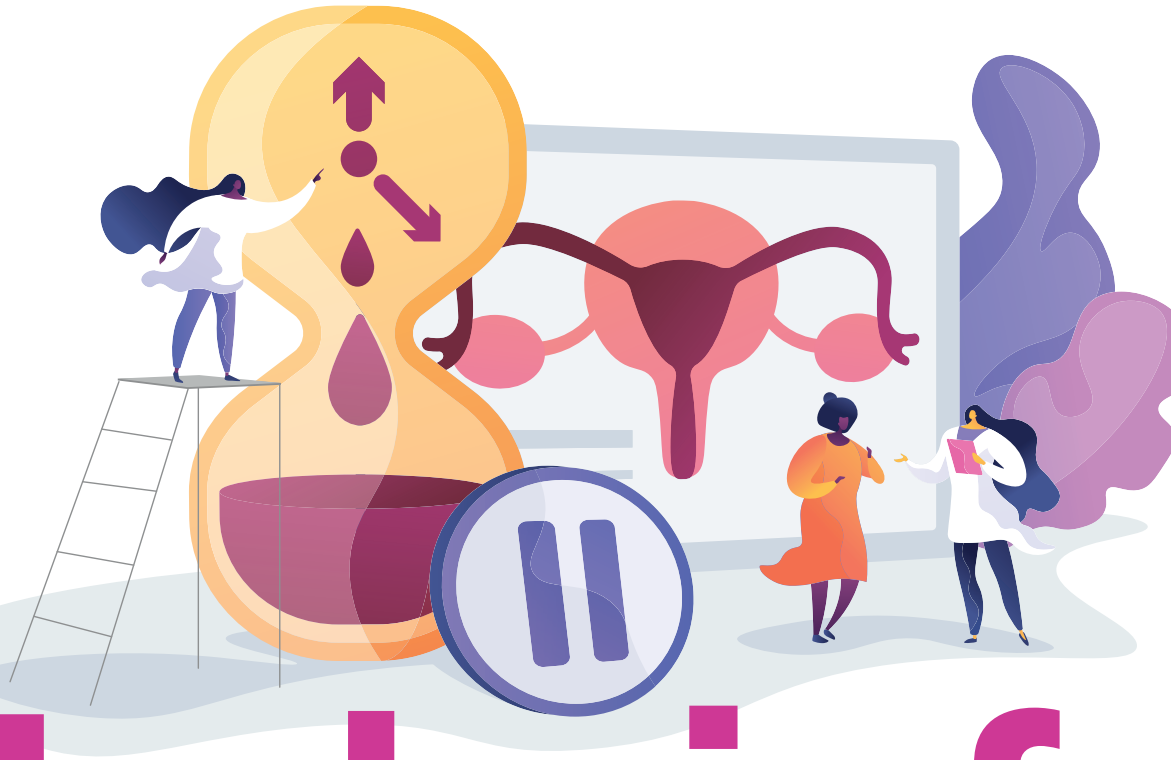

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Tackling the gender health gap

The government has published the first ever Women's Health Strategy for England, with the aim of tackling systemic underfunding, poor education and the chronic data gap related to female-specific health conditions. It will focus on fertility, pregnancy loss and endometriosis.

One of the strategy's key promises is to introduce a pregnancy loss certificate to recognise and better support parents in England who have lost a child before 24 weeks. Other commitments include £10m for breast cancer screening, improving IVF provision, and mandatory training in women's health for all undergraduate medical students.

The strategy builds on the existing work of the UK Menopause Taskforce and the Maternity Disparities Taskforce – which the RCM has been part of from the outset.

Birte Harlev-Lam, the RCM's executive director midwife, welcomed the government's commitment to improve care for women but called for more detail about how the strategy would be funded. "We need to see investment right through pregnancy and beyond to really make a difference to all women and to the safety and quality of their care," she said.

Birte added that the chronic shortage of midwives was causing the profession to "buckle under the strain", with even greater understaffing and underfunding among specialist services that support women who have lost a baby.

"Strategies are great, but they are nothing without the right staff, the right training and the right places to deliver them," she said.

For more, visit **bit.ly/womenshealthstrategy**

SUPPORT
October is Black History Month, and it has a new theme: Time for Change: Action Not Words. As well as celebrating the contributions of Black people, it's also a time to fight racism and reclaim Black history. **bit.ly/bhmonth2022**

one to watch

RECOMMEND
With Women, a book created by students from Loreto High School working with students and midwives from Manchester, and jointly produced with the RCM. More at **bit.ly/withwomenloreto**

COME TOGETHER
The first in-person RCM Annual Conference for two years will take place on 4-5 October at the ICC Wales in Newport. It's free to attend for all RCM members. **rcm.org.uk/rcm-events/2022/rcm-annual-conference**

IMAGES: ISTOCK / SHUTTERSTOCK

Data for 2021

Birth rates rise

The latest data from the Office for National Statistics shows that live births increased in England and Wales in 2021, bucking the long-term trend. The total fertility rate rose for the first time since 2012, and now stands at 1.61 children per woman.

The number of live births went up by 1.8% from 2020, with 624,828 babies born last year. Sadly, the number of stillbirths also rose, increasing to 4.1 per 1,000 total births compared with 3.8 in 2020.

The rising fertility rate has been driven by older mothers. In 2021, live births per 1,000 women fell for those aged 24 and younger, but for those aged over 30, rates climbed in every age group. The greatest increase was for those aged 30 to 34, rising from 102.5 births per 1,000 women in 2020 to 107 in 2021.

However, the data shows that a COVID-19 'baby boom' has not happened: birth rates in January 2021 – which would reflect conception during the first UK lockdown – were down by more than 10% from January 2020. The numbers rebounded in the later months of 2021, but were still lower than they were in 2019.

Select Committee report

Government lacks 'credible strategy' for NHS workforce crisis

A damning report by the House of Commons Health and Social Care Select Committee (HSCSC) has accused the Conservative government of having no strategy to tackle the greatest workforce crisis in the history of the NHS.

The report, published in July, puts the shortfall of midwives and nurses at more than 50,000. Understaffing "now poses a serious risk to staff and patient safety both for routine and emergency care", the authors wrote. "Most depressing for many on the frontline is the absence of any credible strategy to address it."

While the report considers the whole NHS workforce, staff shortages in midwifery are "particularly pressing". The HSCSC warned over a year ago that an extra 2,000 midwives were needed to operate at safe staffing levels; the government has yet to set a deadline to address the shortfall.

On the same day, a second report was published by the HSCSC's expert panel. This scrutinised the government's public commitments to the NHS and found them "inadequate" overall.

Seven commitments were considered across three main policy areas, and all of them were rated as either inadequate or requiring improvement. They include: ensuring the NHS and social care system has enough staff; supporting and developing the current workforce; and reducing the rates of bullying.

The RCM contributed evidence to both the panel and HSCSC report. Suzanne Tyler, the RCM's executive director of trade union, said: "This shows an alarming and deeply worrying picture of a government failing maternity services."

See **bit.ly/HSCSCreport** and **bit.ly/HSCSCpanel**

What's on?

5 SEPTEMBER
England and Wales pay consultation closed

11-14 SEPTEMBER
TUC Congress

13 SEPTEMBER
World Sepsis Day

15 SEPTEMBER
Pensions Awareness Day

17 SEPTEMBER
World Patient Safety Day

22 SEPTEMBER
RCM Activists Conference

26 SEPT - 2 OCT
Black Maternal Mental Health Week UK

26 SEPT - 2 OCT
UK National Inclusion Week

4-5 OCTOBER
RCM Annual Conference

9-15 OCTOBER
Baby Loss Awareness Week

10 OCTOBER
World Mental Health Day

18 OCTOBER
World Menopause Day

24 OCTOBER
Diwali

Training places

Based in Tooting, London, St George's University Hospitals NHS Foundation Trust is a large teaching hospital with a maternity unit that cares for more than 5,000 women each year. We take great pride in promoting midwifery by delivering holistic woman-centred care to our diverse local community. Our enthusiastic and dynamic midwifery and obstetric teams work closely together, with a positive embedded multidisciplinary team (MDT) culture.

We strive to provide excellent clinical support and pastoral care to those who decide to join our vibrant maternity team. In line with this, we recognise the vital role our preceptee midwives and maternity support worker (MSW) colleagues play in the St George's MDT. Thus, we are proud to present new projects that we've developed: our revamped preceptorship programme, and our brand new maternity helpline and MSW programme.

Mark of quality

Our preceptorship programme was recently updated to respond to the needs of our Band 5 midwives, and has been awarded a CapitalMidwife quality mark. As a Trust, we are committed to supporting newly registered midwives, with a programme aimed at offering high-quality clinical training and pastoral care. In particular, we created four bespoke study days for midwives to learn in a friendly environment while sharing experiences with fellow preceptees. The feedback so far has been very positive: "I loved the study day: it gave me the opportunity to understand very important topics and to interact and get to know all my colleagues," one participant said.

We are also working with the CapitalMidwife consortium to recruit internationally educated midwives to our preceptorship programme and our thriving midwifery team. Also, we work in proud partnership with Kingston University to deliver our new MSW programme, to train and upskill our MSW colleagues to become Band 3s. It is offered to all our Band 2 colleagues in maternity and will support them to provide the best evidence-based care to women and their families. We are developing two different courses, which will run twice per year.

Almost all our current Band 2 colleagues are enthusiastic and positive about this chance to progress in their careers: "The opportunity for progression from Band 2 to Band 3 is one I'm grateful for. This course will allow me to develop my skills earning a chance to take on further responsibilities confidently and competently while supporting mothers and their babies," an MSW said.

Moreover, we are delighted to announce a new maternity telephone helpline for both expecting and new parents that provides direct access to support from our team of midwives. Parents can call 0208 725 2777 seven days a week for support and advice. We strive to provide easier access to the right maternity care. The feedback we've had so far is extremely positive.

The place to be

We are committed to meet the specific and individual needs of women who come from a wide range of social and cultural backgrounds. Our aim is to improve retention, enhance clinical support to midwifery staff whilst improving quality of care across our maternity service for all women and their families. We have several vacancies available across the service. Come and join us at St George's!

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Outstanding care every time

International collaboration

University embeds sustainability into midwifery course

A move to embed sustainability into midwifery courses at the University of Plymouth is leading graduates to take their first steps to becoming change leaders and practice innovators.

An international collaboration to produce evidence-based teaching and learning material began in 2014. The university's Sustainability, Health and Wellbeing Interest Group recognised how embedding climate change, health and sustainability into curriculums could motivate students to tackle the challenges that they will later find in their workplaces.

Now the idea is beginning to bear fruit. An annual sustainability prize is offered to third-year student nurses, and examples are emerging of former students applying their sustainability knowledge both in the workplace and to their own postgraduate research work.

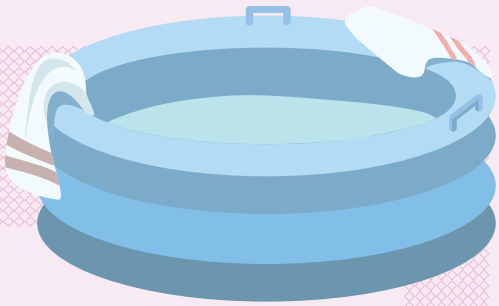
Midwifery graduate Sarah Cottell says the sustainability prize enabled her to explore the potential of breastfeeding as a sustainable healthcare solution.

The UK has one of the highest uses of formula per capita, while breastfeeding for six months could save up to 153kg of carbon dioxide per baby.

Sarah says: "In the UK, only 1% of babies are exclusively breastfed at six months, yet the benefits of breastfeeding include decreased risk of infections, obesity, asthma and diabetes. It costs the NHS around £48m to treat only five illnesses that are related to not breastfeeding for one year."

The university says Sarah's experience shows how a supportive learning environment can encourage further study and promote learning for both professional colleagues and patients.

It has now partnered with the international coalition, Health Care Without Harm, to work on the Health Care Climate Challenge.



Birthing pools

Review confirms benefits of waterbirths

Using a birthing pool during labour provides "clear benefits" for healthy mothers and their babies, with less intervention and fewer complications during and after the birth compared to labour and giving birth on land, a review of research concluded.

The study, which looked at more than 150,000 sets of mothers and babies, also found mothers who had a waterbirth reported higher levels of satisfaction with their birth experience.

Lead author Dr Ethel Burns, senior midwifery lecturer at Oxford Brookes University, said: "This research shows that it is just as safe for healthy mothers to give birth in water as on land.

"Water immersion is an effective method to reduce pain, making it a low-tech way to improve care quality and mothers' satisfaction with care."

The authors recommended that future research should include factors that are known to influence interventions and outcomes during and after labour or birth.

For the full study, go to **bit.ly/BMJOwaterbirths**

Hospital support

Better breastfeeding support could reduce social inequalities

Breastfeeding matters for children's cognitive development, while disadvantaged mothers who give birth at the weekend are less likely to breastfeed due to poorer breastfeeding support in hospitals, research suggests.

A study by University College London found that children born in 2000-02, whose mothers left school before age 17 and who were breastfed for at least three months, achieved higher scores in cognitive assessments up to age seven than those from similar backgrounds who weren't breastfed.

The findings also showed that among disadvantaged mothers, those who gave birth at the weekend were around six percentage points less likely to breastfeed for at least 90 days.

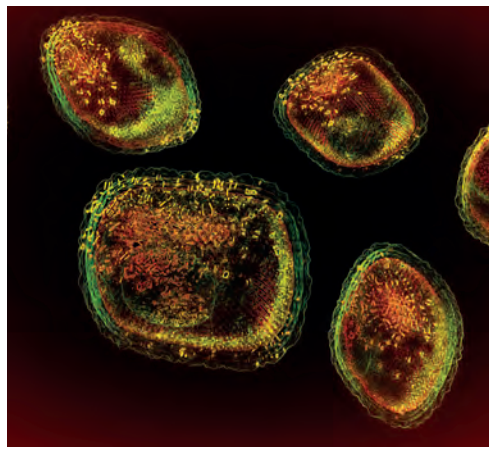
Co-author Professor Marcos Vera-Hernández said: "As core maternity services for low-risk births remain consistent through the week, our study shows that it is differences in support for breastfeeding at the weekend that makes the difference."

Read more at **bit.ly/UCLbreastfeedingsupport**

IMAGES: SHUTTERSTOCK / GETTY

New viral concern

Pregnant woman with monkeypox gives birth in US



The US has identified its first case of monkeypox in a pregnant woman, who has now given birth to her baby.

Dr John Brooks announced the news update on the disease by the Centers for Disease Control and Prevention (CDC) during a webinar hosted by the Infectious Diseases Society of America in July.

Dr Brooks, a medical epidemiologist at the CDC, said: "Thankfully our experience with children is small, so we'll be learning, unfortunately, as children do become infected. There has been a case of a pregnant woman who delivered. We know that infection can occur through placental transfer [but] in the case that we are aware of presently, it doesn't appear the virus was transmitted [to the baby]. The child received immune globulin [prophylactically] and both mum and baby are doing well."

According to the CDC, monkeypox is a rare disease caused by infection with a virus that is part of the same family that causes smallpox. Monkeypox symptoms are similar to those of smallpox, but it is milder and rarely fatal.

Get more details on monkeypox at **bit.ly/monkeypoxinfo** and watch the webinar at **bit.ly/CDCmpoxweb**

Reasons for reluctance

'Disapproval and disgust' stops mothers breastfeeding in public

A study of 17,700 pregnant women and mothers has found a general reluctance to breastfeed outside the home because of the potential negative reactions from strangers.

Researchers from Swansea and Cardiff universities examined existing data from OECD countries – largely the UK, US and Australia. Little evidence was found that women were routinely breastfeeding outside their homes; and for those who did, the experience was "uncomfortable".

Women who were young, from marginalised ethnicities or from deprived socio-economic backgrounds all reported higher levels of perceived surveillance and stigma.

The study also found that legal protections for breastfeeding in public were not well enforced. In the UK, under the Equalities Act 2010 it is illegal for anyone to ask a woman who is breastfeeding to leave a public place such as a cafe, shop or public transport.

Lead author Dr Aimee Grant said: "We urgently need the public to reframe their view of breastfeeding, so that it is understood as nutrition for babies, rather than a political or sexualised act by their parents. This means that the public should not stare, tut or make negative comments about breastfeeding babies."

Read more about the study at **bit.ly/breastfeeding_study**

MIDIRS Digest

1 How do maternity services support autistic women and birthing people now? What improvements could be made to help autistic people who are pregnant and giving birth and the staff who support them? Sara King

2 Exposing racial bias in midwifery education: a content analysis of images and text in *Myles textbook for midwives*, Mairi Harkness

3 'Normality' and the role of the midwife in statutory rules and midwifery textbooks in the UK: an analysis of the language, RCM project group

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

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

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IMAGE: SCIENCE PHOTO LIBRARY

Interactive perineal suturing workshop for midwives

Location: London Heathrow

Facilitated by a team of experienced midwives, the course is specifically designed for midwives, student midwives and junior obstetricians in a friendly and relaxed environment.

During the practical session, you will practice on a range of realistic models:

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- Subcuticular technique
- Interrupted suturing technique
- Basic knot tying techniques.
- Performing episiotomy and repair
- Infiltration.

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Course Fee: £190

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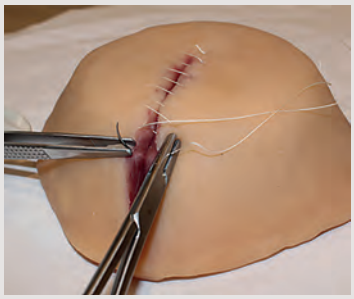
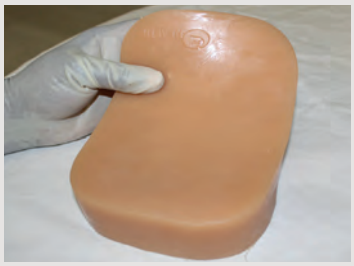


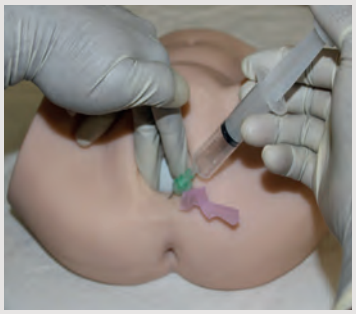
NEW PERI HEALTH FLESH-LIKE DOME SHAPED SUTURE PAD WITH MUSCLE AND SKIN LAYER

This suture pad is excellent for practicing all the different suturing and knot tying techniques with realistic feedback. Designed to repair the vaginal wall, perineal muscle, and the skin. You can create 8-10 incisions after the first incision has been sutured multiple times.
Price £114.95



PERI HEALTH FLESH-LIKE SUTURE PAD

Excellent for practicing all the different suturing and knot tying techniques with realistic feedback. Great for maintaining suturing skills following training.
Price £60.00



DUAL FUNCTION SIMULATOR

This realistic model is excellent for teaching vaginal/rectal examination, to diagnose buttonhole tear from the vaginal wall leading to the rectal mucosa. The buttonhole can be created anywhere along the posterior vaginal wall for training, as it comes intact. The simulator can also be used to teach infiltration prior to episiotomy.
Price £350

Working for you

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

'Unacceptable' pay offer could lead to strike action

The latest pay offers for NHS staff would see many midwives receive a 4% pay rise, while inflation hit 10.1% in July and is predicted to rise above 18%.

The RCM says any below-inflation pay rise "is unacceptable and won't cut it" and is now consulting with members about possible industrial action.

The UK government accepted all recommendations of the 2022 NHS Pay Review Body, which considered the pay of around 1.4 million NHS staff paid under Agenda for Change (AfC) for 2022-23. Pay increases will be backdated to 1 April 2022.

In England, the pay offer for Bands 2 to 5 and Bands 8 and 9 is a £1,400 wage increase, while Bands 6 and 7 staff will receive £1,561 and £1,834 respectively. This represents a 1.3% pay rise for Band 9, and up to a 7% pay rise for Band 2. The higher rates for Bands 6 and 7 equate to a 4% pay rise.

The offer is similar in Wales, with a £1,400 wage increase across most bands and a 4% rise for Bands 6 and 7. With the addition of the Real Living Wage top-up, workers on Bands 1 and 2 will receive a 10.8% pay rise.

Workers in Northern Ireland are yet to receive a formal offer as the Executive has not agreed a budget for 2022-23.

"We are disappointed [the Welsh government] has not listened to our warnings of the consequences of a below-inflation pay rise," said Vicky Richards, the RCM's national officer for Wales. "Dedicated and committed RCM members in Wales have been propping up maternity services and working beyond their hours – often unpaid – to ensure safe care is delivered to women and their babies."

She added members would view the offer as "an absolute insult" that would "further erode already rock-bottom morale".

The Scottish government has offered a 5% pay rise for all AfC staff above Band 2. The offer is slightly higher for the lowest-paid workers, peaking at 5.36% for Band 1. In the highest-ever turnout for a pay consultation in Scotland, RCM members overwhelmingly voted to reject this offer and will be formally balloted from 26 September.

The RCM is now consulting members in England and Wales to gauge the appetite for industrial action – up to and including strike action.

Suzanne Tyler, the RCM's executive director of trade union, said: "Industrial action is always a last resort, but midwives and MSWs are genuinely at the end of their tether. That is why we are consulting with them to see if they are willing to take industrial action. This consultation is a vital step in deciding whether to move to a statutory industrial action ballot and we need every member to raise their voice."

As in 2014, when members in England took strike action, the RCM would work with maternity units to put emergency cover in place and maintain safety standards during any industrial action.

IMAGES: ALAMY / SHUTTERSTOCK

RCM in brief

Save the dates

Event: RCM annual conference
Theme: Recover, Reflect, Renew: Setting the course for maternity services
Date: 4-5 October
Location: ICC, Wales
The two-day in-person event is free to attend for RCM members.
Book now: rcmconference.org.uk

Event: Black History Month: celebrating the diversity of cultures
Theme: Celebrating Black health and wellness
Date: 20 October (5pm-7pm)
Location: Hallam Conference Centre, London
The RCM's head of equality, diversity and inclusion Jane Bekoe will be in conversation with author, TV presenter, entrepreneur and stylist Candice Brathwaite. This event is free to attend for RCM members.
Book now: rcm.org.uk/rcm-events/2022/black-history-month-celebrating-the-diversity-of-cultures

Event: All Ireland Annual Midwifery Conference
Theme: Midwives – visible and valued
Date: 17 November (9am-4pm)
Location: Slieve Russell Hotel in County Cavan
Want to submit a poster?: Email niamh.adams@inmo.ie (closing date: 23 September)
Book now: rcm.org.uk/rcm-events/2022/all-ireland-midwifery-conference

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

RCM Scotland

Five-year plan created after huge survey response

RCM Scotland has published its Five Year Forward Plan, developed from the testimonies of members. The 2022 nationwide members' survey yielded a response rate of almost 40%, compared to just 1% to 2% in previous years.

The plan sets out RCM Scotland's vision, where all midwives, maternity support workers (MSWs) and maternity care assistants (MCAs) feel valued, and can therefore give the highest standard of individualised care.

"This plan provides a broad framework to ensure all maternity care in Scotland is safe, sustainable and future-focused," said RCM director for Scotland, Jaki Lambert.

"Key to this is ensuring newly qualified midwives have a positive and supportive experience when they enter the profession, but we also want all midwives, MSWs and MCAs to feel heard."

In the survey, members reported feeling 'undervalued' and sometimes left out of decisions that affect their work. They also found opportunities for career development lacking.

To drive the plan forward, a strategic midwifery leadership group is being developed. This will be chaired by Scotland's chief midwifery officer and facilitated by RCM Scotland.

Jaki called on everyone involved to make the plan "a priority for improvement". She added: "Our measure of success will be our members reporting they are working in supportive workplaces, with compassionate cultures, where there is clear autonomy and ability to contribute."

Position statement

'No reputable evidence' for progesterone 'reversing' abortion

The RCM, RCOG, the Faculty of Sexual and Reproductive Healthcare and the British Society of Abortion Care Providers have released a joint position statement, following the investigation of UK doctors who prescribed progesterone to 'reverse' a medical abortion.

In the statement, the organisations assert there are "no reputable national or international clinical guidelines that recommend the use of progesterone to reverse the effect of mifespristone [medication used to induce abortion]". There is also "no evidence [progesterone] increases the likelihood of a pregnancy continuing".

A consultant cardiologist and consultant obstetrician were investigated by the General Medical Council after they offered patients progesterone as a method of 'abortion pill reversal'. The Medical Practitioners Tribunal Service placed interim conditions on both doctors in 2021, restricting their ability to practise. After the investigation concluded in May, no action was taken against either practitioner.

According to OpenDemocracy, only one randomised trial attempted to test whether progesterone interferes with mifespristone. The trial was halted after three participants experienced haemorrhaging requiring hospital treatment (Creinin, 2020).

Preceptorships

RCM lends support to NQMs

A new position statement, released in late August, sets out the RCM's belief that structured support should be provided to newly qualified midwives (NQMs) moving into their first jobs. Evidence shows this support or 'preceptorship' can improve NQMs' confidence and job satisfaction.

The RCM's position statement sets out nine guiding principles for preceptorships that are tailored to meet the individual needs of NQMs. These include clarity about the expectations employers have for skills development in different settings, the creation of flexible development plans, and individualised career progression opportunities.

Preceptorships should be offered in addition to an organisation's induction process and mandatory on-the-job training, says the RCM. This helps NQMs consolidate the knowledge and skills they need to meet NMC's Standards of Proficiency and grow their confidence to perform their role safely and competently.

Importantly, this has been shown to help combat attrition – vital in the current circumstances, with so many unfilled vacancies creating very challenging working conditions.

Fiona Gibb, head of education at the RCM, says that, although midwives are already highly skilled when they qualify, extra support in their first six months helps to embed and develop their learning.

She added: "We know that many midwives struggle in their first six months because they are not getting the support they need. This leads to burnout and mental health problems, meaning some will simply choose to leave. This is a tragedy for the midwives leaving a job they love, and a great loss to the NHS, which is already facing serious shortages."

The RCM also recommends that each NQM has support from the same preceptor during their first six months to provide consistency. There should also be protected time for reflection and debriefing.

Read the RCM's position statement at **bit.ly/preceptorshipfornqms**

Diversity

RCM outlines commitment to EDI

The RCM has joined forces with the RCOG in releasing a joint statement on the importance of diversity and inclusion in all areas of maternity and gynaecological services.

In the statement, both Royal Colleges commit to supporting staff members to feel able to be their true selves at work, and ensuring everyone can "thrive, feel included, valued and reach their full potential".

The statement reads: "We do not tolerate discrimination and harassment of any kind and we are committed to taking the necessary steps to tackle unprofessional behaviour. We encourage all members and staff to support their colleagues and call out bias, abuse, racism and discrimination."

These commitments to diversity and inclusion extend to those in the care of maternity services.

The joint statement asserts that delivery of care to everyone accessing services – women, gender diverse individuals and those whose gender identity may not align with the sex they were assigned at birth – must always be "appropriate, inclusive and sensitive".

Both organisations vowed to use inclusive language in communications, publications and patient information.

The statement ends with the organisations emphasising their commitment to providing a fully inclusive healthcare service that "does not stigmatise, one in which everyone feels they belong and has equal access to information and care so they can make informed decisions".

Read the full statement at **bit.ly/inclusivitystatement**

RCM podcasts

Pay deal top of the agenda

Delivering a decent pay deal is at the top of the RCM's agenda, according to RCM director of employment relations, Alice Sorby. On the RCM's August podcast, she and Lynn Collins, RCM director of field services, discussed the union's "disappointment and surprise" at the below-inflation offers, what is being done to secure members a decent pay rise and next steps for the pay campaign.

Meanwhile, plans are afoot to develop a new long-term strategy to reboot local activism, which is expected to launch in January.

Listen to the latest RCM podcast on Apple Podcasts or Spotify – just search RCM.

What's next?

The next episode is due out at the end of September. It will focus on the RCM's professional offering for members, with an update on the RCM's clinical and research work.

To access this podcast and the whole series so far, visit the RCM's podcast hub page at **bit.ly/podcasthubpage**

IMAGES: SHUTTERSTOCK

NEW MODULE

● Antiphospholipid syndrome (APS)

APS, also known as Hughes syndrome, is a rare condition in which the body produces antibodies that lead to an increased risk of blood clots, miscarriages and stillbirths. There is also an increased risk of hypertension, pre-eclampsia, fetal growth restriction and placental abruption. Women often experience delays in diagnosis.

This module will help you identify women who may need testing for APS, understand the treatment required, and support women with APS throughout their pregnancies. Around 70% to 80% of women who receive treatment will go on to have a successful pregnancy.

Study time: 20 minutes

READ THE ARTICLES IN THIS ISSUE AND WANT TO LEARN MORE? TAKE THESE MODULES:

● Maternity PEARLS – perineal repair and suturing

This video-based online resource is based on the work of the Perineal Assessment Repair Longitudinal Study (PEARLS), funded by The Health Foundation. The study identified training issues and variations in practice, and this resource was put together to make practitioners aware of best practice.

The resource includes anatomy, surgical techniques, episiotomy and repair, perineal trauma assessment and postnatal perineal care.

By the end of this module, you will:

- Understand the anatomy and functions of the pelvic floor
- Gain knowledge of basic surgical skills
- Understand the importance of assessment and classification of perineal trauma
- Gain knowledge in the immediate postnatal management of perineal trauma.

Study time: 3.5 hours

For more on perineal tears, go to page 28.

● Autism and pregnancy

This interactive module explores how midwives can support autistic women more effectively, by better understanding how autism can affect daily activities. It also provides an opportunity for reflection on midwifery practice.

Study time: 30 minutes

See article on page 36 on this subject.

book now

Join us for the return of RCM's annual conference, an in-person two day event across 4-5 October 2022 at ICC, Wales!

RCM conference

4-5 October 2022 - ICC, Wales

RECOVER, REFLECT, RENEW

Setting the course for maternity services

Great Western Railway

Delegates attending the conference can enjoy an exclusive rate when travelling by Great Western Railway to Newport

Newport Bus services

Just a five-minute walk from ICC Wales Newport, the bus services travel on the Chepstow Road

fflecsi bus service

Newport's brand new fflecsi 'on-request' bus service, ICC Wales is quick, easy and inexpensive to reach from any location across the city

visit: www.iccwales.com/getting-here for more details and help to plan your journey

Royal College of Midwives

Explore some of the sessions
Meet some of our speakers

Rumbi Mutema | Lisa Rollinson | Abbie Aplin

Standing up for high standards: using escalation process to keep services safe

This panel discussion will address what raising concerns means for midwives, maternity support workers and students in practice, and how they can safely raise concerns to improve outcomes for the women, babies and families they care for.

5 October | Stream A | 12.15 - 13.15

Sandra Igwe | Mark Williams

Challenging the stigma of perinatal mental health

In this session the speakers will examine the concept of stigma from their own unique perspectives. They will discuss the social and cultural influences on people seeking support for mental ill health and the experiences of accessing services, providing insight into how midwives and maternity support workers can step up to give support

5 October | Stream A | 09.30 - 10.30

Dr Patricia Gillen | Dr Paula McFadden

Health and well-being: exploring quality of working life and coping during the COVID 19 pandemic

This collaborative research project is led by Ulster University and supported by researchers from Queen's University Belfast, Bath Spa University and King's College London. This session will provide an overview of research findings across the duration of COVID, highlight the emerging themes, including midwifery-specific findings in comparison to other professional groups, and set out the recommendations for interventions

4 October | Stream A | 10.45 - 11.45

The RCM Conference is a sustainable event

Our programmes are digital only

Bring your own waterbottle to fill up on site

Public trasport is widely available to access the venue

free to book for RCM members

for this fantastic live event

@MidwivesRCM | #rcmconf22

rcmconference.org.uk


MORE PAY
RCM

we are one

Being a trade union member has never been more vital. *Midwives* celebrates some of the ways in which the RCM strives to be your voice, protect your values and fight for the profession's future – at a time when it feels most under threat

Against a backdrop of protests, strikes and threats of action across a wide spectrum of public sector workers, the 'summer of discontent' has served as a timely reminder why being part of an active trade union is so vital.

In June, thousands took to the streets of London for the TUC's rally over the cost-of-living crisis. The RCM was there – alongside many other unions – to voice its members' calls for action amid untenable working conditions, an exodus of midwives and maternity support workers (MSWs) and pay that falls way below the soaring rate of inflation.

"We had a lot of support for the rally," says London RCM organiser Lyndsey Wheeler. "Lots of our reps came out and marched with us, because they know that the fight is real and worthwhile.

"Our local reps are in a great position to empower our members to believe we are stronger together – and that if everyone stands up for what they believe in, we are more likely to win."

Better together

But why is a sense of togetherness helpful – and particularly in a professional context? Maria Kordowicz, a psychologist who works with health and social care organisations, says: "It's about strength in numbers. Feeling we are a part of something is important to us; it gives us a sense of connection to others and helps us to form positive relationships with colleagues and teams. It makes us feel like we can meaningfully contribute, and promotes deeper connections and respect."

But when support from fellow midwives could be just a text message away, what's special about being a member of a professional organisation?

"The ethos of the RCM is to help every midwife and MSW be the very best they can be at work every day," says RCM executive director of trade union Suzanne Tyler. "We recognise that staying up to date on clinical, policy and research developments is time-consuming, so our job is to make access to professional information and discussion as easy as possible.

"Our i-learn modules cover every element of CPD and can be accessed for free in members' own time and pace. Our website briefings cover all the developments in maternity services relevant to midwives and MSWs in their work. And our professional discussions in branches, local study days and workplace forums give our members a safe space to debate with colleagues, share best practice and keep up to date."

In testing times

A safe space to share with peers seems more important now than ever. Recent NHS Digital research shows that sickness absence rates for midwives were the third-highest among NHS staff in February, at 7.6%. The most reported reasons were anxiety, stress, depression or similar problems; these accounted for 23.4% of all NHS sickness absence during that month. And the NMC Leavers' Survey in March showed that former midwifery and mental health workers were more likely than staff in other areas to cite too much pressure as a reason for leaving.

The RCM's relaunched Caring for You campaign (see page 25) is there to support members during challenging times, says Suzanne. "It highlights what good employment practices look like; it's an opportunity to share best practice and to call out employers that are not investing in people. Initiatives include supporting flexible working; protecting and honouring adequate breaks during the working day; physical and mental health support; and ensuring staff stay hydrated and have

IMAGES: NEIL STEVENS

access to rest spaces and places to park," she explains.

"But the other feature is the peer support the community of RCM members can provide for themselves through our branches. For example, through study days, sharing healthy eating tips, thanking and acknowledging colleagues, providing a safe space to share concerns and building solidarity and friendship. Walking groups, picnics, quiz nights – all contribute to making coming to work more pleasurable and rewarding, despite the challenges our members face."

For the long run

But what about systemic change? How can the RCM and its members ensure the profession has a brighter future? Professional membership can act as a catalyst for real change, notes Suzanne. "The RCM is not just about members – it's about the profession and the practice of midwifery itself, informed by and responding to members' experience.

"Real change would be further reductions in stillbirth rates and smoking rates, and midwives influencing and leading on care for women throughout pregnancy in active collaboration with their obstetric colleagues. It would be more digital midwives supporting the introduction of new technology, better record-keeping and information transfer. It would be a strong midwifery voice at every level of NHS decision-making.

"Through active involvement in the RCM, midwives can shape and spread best practice and secure a bright future for the next generation of midwives and MSWs."

As the RCM continues to support midwives and MSWs in these challenging times, we look at some of the ways it's there for you, listening to your voices, understanding your plight and fighting your corner – for the welfare of women, families and the profession.

MORE INFO
Visit **rcm.org.uk/member-benefits** to find out more or call the RCM on **0300 303 0444**.

Elevating your voice

ACTIVISTS PLAY AN IMPORTANT ROLE IN THE RCM, RAISING ITS PROFILE AND ENGAGING WITH MEMBERS. RCM ORGANISER LYNDSEY WHEELER TELLS US MORE...

Who are RCM activists?
They are branch officers, workplace representatives and MSW advocates that are part of a network supported by regional/national officers and organisers, as well as RCM staff in headquarters and country offices. They're elected at local level and responsible for tasks such as addressing workplace issues, hosting learning events and celebrating midwifery locally.

Why do we need them?
"Having activists is important because we rely on them to amplify the voices of our members," says Lyndsey. "People are good at vocalising complaints and concerns behind closed doors, but not so good at ensuring these are heard by the right people or in the right places. Having activists to voice these concerns is key to bringing change. Becoming an MSW activist gives you the chance to fight for that change locally, but also to tap into good practice across the UK that can support it. Together we are stronger."

My path to activism:
"I was a Band 3 MSW and feeling very downtrodden because of the hierarchy within the NHS," explains Lyndsey. "Becoming an RCM steward raised my profile and my voice, but also the voices of MSWs I was working with. Becoming an RCM rep in particular exposes members to training they wouldn't normally get. Being part of the RCM shows MSWs it is working with other stakeholders and is advocating for them behind the scenes."

● **How do I get involved? Find out more at rcm.org.uk/activists-hub**

The RCM has more than

1,500

activists spread across 200 branches across four UK nations

Valuing MSWs

IT'S TIME THE MSW VOICE IS HEARD, THE ROLE BETTER UNDERSTOOD AND GREATER VALUE PLACED ON IT, THE RCM BELIEVES

Seen and heard

Keelie Barrett, of East Lancashire Hospitals Trust, recently became the first MSW on the RCM Board. She is also a health and safety rep in her RCM branch, and an RCM steward and branch chair.

It's great to have a diversity of viewpoints on the board. Now I can be the voice of my MSW colleagues – that's really important.

The RCM was an important voice during the creation of the Health Education England MSW competency framework. It's always been an advocate for MSWs to have real career progression, and that's where job evaluations come in (see right). It's about making sure job descriptions are accurate and correctly graded for what staff are doing.

Midwives' roles have certainly evolved; they now take on tasks that were traditionally done by doctors. With that in mind, the MSW role has also had to evolve, because we are there to support midwives. Given the current midwifery staffing crisis, we need to attract and retain every MSW we can.

Given the current midwifery staffing crisis, we need to attract and retain every MSW we can

Earn your worth

Job evaluations of MSWs have begun at the Shrewsbury and Telford Hospital NHS Trust. RCM president Rebeccah Davies tells us more.

What? Job evaluations for MSWs can be done collectively, or on a case-by-case basis. An MSW's role may vary from area to area; some will have received extra training to undertake a specific role or use specialist equipment. So, one size does not fit all. But matching the job description with the NHS Employers national jobs profile means the correct banding can be applied.

How? If an MSW feels they have enhanced skills and are working beyond their pay band, they have the right to request a formal job evaluation from their manager, who would send a submission form to the organisation's Agenda for Change team. An independent panel then evaluates the request. If the job is matched to a higher band, the MSW will be paid at the higher rate. Workplace representatives or activists can support you in this process.

Esther Cassidy

Midwife, Royal Jubilee Maternity Hospital, Belfast Trust, and workplace rep, RCM Belfast Branch

I value the RCM because it's my union – it supports me in my workplace, and fights for fair pay and improved working conditions for all members. For me and for all midwives, the RCM is working at all levels to effect positive change – for us and for the families we care for.

Zoe Meneilly

Lead midwife, Royal Jubilee Maternity Hospital, Belfast Trust, and chair, RCM Belfast Branch

My role is to promote what the RCM does for branch members; to make the branch active and dynamic, and responsible, responsive and visible in the workplace; and to let members know all the things we can do to support them – from workplace representation to helping them develop their career and their learning. It includes highlighting fun social events and activities to bring us together as a community, and detailing how members can reach out for support if they're struggling.

We hear you: Scotland's story

JAKI LAMBERT, DIRECTOR FOR RCM SCOTLAND, EXPLAINS HOW A STAFF SURVEY IN A SINGLE BOARD SNOWBALLED TO HEAR THE VIEWS OF MIDWIVES NATIONWIDE – AND HOW THE RESPONSES FORMED THE BASIS OF THE RCM'S NEW FIVE-YEAR PLAN

How did the survey roll-out happen?

The board at NHS Greater Glasgow and Clyde (GGC) undertook the survey as it was facing challenges. The RCM supported it, and it had a huge response – over 61%. In some previous UK-wide surveys, just 1% to 2% have responded. Then members told us they wanted a survey across Scotland.

What was the nationwide response rate?

Almost 40% of our members responded, and three-quarters of those gave us incredibly detailed responses.

How did it feel reading about their views and experiences?

It was devastating to read: members were crying on their way to work or on their way home, not feeling safe in their ability to practise, or provide the care they wanted to. It really drove me to make sure the response was heard and we did something with it.

What did you do with the responses?

We took what we heard and analysed it. We asked: what structures do we need to ensure every midwife feels they have a voice?

Tell us about the five-year plan.

It was launched on 25 August. We've examined our policies to determine what should be happening but maybe isn't. Previously, there's been a lack of professional perspective when recommending policies. So we will now have a strategic midwifery leadership group that represents groups from every part of the profession. Whether they're early career, managers or team leads, members will know their voice is getting represented. And the group will be chaired by the chief midwife in Scotland – so we've got really good support.

What needs to happen in midwifery?

We need every midwife to feel they are a leader, not that leadership is something that happens to others. We need to make sure that's embedded, but we can't do that without recognising where midwives are now and their feelings about the cultures and environments they're working in.

THE FIVE-YEAR PLAN: KEY THEMES

The RCM's ambition for Scotland All midwives, MSWs and maternity care assistants should feel valued and able to give the highest standard of individualised care. They should have safe workplaces with supportive cultures.

Key themes of the plan include:

- **Career structure:** all maternity staff should have access to a career structure across all pillars of practice and feel they have opportunities to develop
- **Compassionate leadership:** all should see themselves as leaders; opportunities for, and access to, leadership roles must increase; and a midwifery leadership structure is agreed
- **Workplace culture:** all must feel psychologically safe
- **Safe staffing levels,** with clear quality measures for maternity services.

Kirstie Woolner

Midwife, Royal Infirmary of Edinburgh, and RCM workplace rep

In these increasingly tough times, I like knowing I can be there to support midwives. It's good to know someone has your back! I enjoy working with colleagues in many different areas and coming up with new ideas.

Claire Massey

Interim clinical nurse manager, NHS Fife, Kirkcaldy

The RCM in Fife recently supported midwives through a pay dispute. I personally was glad of my RCM membership. I felt supported and well informed by our rep Mary-Ann Gillon. The process was lengthy, but Mary-Ann provided regular updates.

CASE STUDY

Fighting your corner

JENNY* FOUND THAT IN TIMES OF PROFESSIONAL TRAUMA, THE RCM WAS THERE TO SUPPORT AND ADVISE HER

"It happened instantly when I started, but for months I dealt with it on my own," says Jenny of the racist bullying she endured at her former workplace. "When you start, you don't want to be labelled as troublesome."

But very quickly it was apparent to Jenny that she was being singled out and subjected to scrutiny. "I was beginning to get panic attacks and asthma attacks because I felt so trapped," she recalls.

After talking to family members and fellow midwives about what she was going through, Jenny sought help and advice from the RCM. Professional policy advisor Clare Livingstone, who was working as a regional officer during the pandemic, was assigned to the case.

"We logged the case with ACAS on the grounds of racial discrimination," says Clare. "Then we received witness statements from other ethnic minority members of staff, current and past, who said they'd been treated differently as well. Things weren't right."

Having instructed Thompsons, the RCM's solicitors, and a barrister to take the case to tribunal, Jenny and Clare were warned the odds of winning weren't high. "Thompsons were very honest and said 'we don't believe you have a better than 50% chance of success' – which is normally our threshold for taking cases that far," says Clare. "But the RCM believed in supporting Jenny, who had been so badly treated. And we decided the case was worth putting our weight behind."

During lengthy delays in the tribunal process, Jenny's employer made various offers to settle out of court. "None of them were acceptable to her or to us," recalls Clare. Then, just before the hearing, they offered a substantial sum, which Jenny decided to accept.

How does she look upon such a traumatic experience now? "I feel the scale has tipped towards positivity about the outcome," says Jenny. "The RCM was more than supportive and went with me all the way.

"Had I not had Clare, I would have given up. She was never biased; she always gave me a balanced view."

All members can be sure the RCM's advice will be completely confidential, Clare adds. "Sometimes there is a reluctance to come forward as staff can be made to feel as if it's their fault. But if they feel they've been racially discriminated against, that's something the RCM will not tolerate."

Jenny's advice to other members in a similar situation is clear: "Get the RCM on board very early. It may feel like you're troubling people, but do not suffer in silence and keep them in the loop constantly."

*NAME HAS BEEN CHANGED

Jodie Foran

Stop Smoking maternity care assistant, Cardiff and Vale University Health Board (UHB)

Since becoming an RCM member, I found so many learning opportunities that I hadn't realised were available. I discovered what felt like a team or club of like-minded colleagues who were keen to encourage and motivate me to become more involved and then go on to become an activist so I could do the same for others. I've gained knowledge around pay scales and banding and how to challenge it, I've connected with midwives and MSWs from various other branches across the country, and shared experiences and advice that's helped me to gain the confidence to progress in my career.

Maryanne Bray

Lead research midwife, Cardiff and Vale UHB, and secretary and workplace rep, RCM Cardiff Branch

Being an activist in a vibrant and engaging branch enables members to see RCM representatives around different areas within maternity. It also lets them voice any comments, concerns or suggestions and increases engagement from members and senior management. There has always been a strong focus on the Caring for You campaign alongside trying to improve staff morale, support and retention.

For the future

SUPPORTING RESEARCH IS INVESTING IN THE PROFESSION'S FUTURE. RCM RESEARCH ADVISORS JUDE FIELD AND JENNY CUNNINGHAM TELL US MORE

Research improves our practice and is fundamental to almost everything we do, but it can feel daunting or difficult to get more involved in contributing. That's why, back in 2020, the RCM launched its Research and Development Strategy 2021-2024.

About the strategy

It provides a framework to embed research-mindedness throughout the profession and fits with the aspirations of the NMC's Future Midwife Standards (2019).

The RCM wants to empower midwives to take an active role in research, which can lead to important changes such as the removal of routine episiotomies or highlighting the benefits of waterbirths.

Whether it's a small step or a giant leap, the RCM is here to support you.

At the Hub

You'll find a range of great resources on the RCM's Research Hub – from information on research-related careers and support, to links to RCM-supported studies, ideas for funding and our monthly newsletter.

Buddy up

The Hub is also where members can access the RCM's new Research Awards Buddy Scheme, which offers you the support of a buddy while you complete an application to one of the RCM-supported research awards – the Wellbeing of Women Entry Level Scholarships, or the Iolanthe Midwifery Trust Jean Davies Award, which opens for applications in December (see box). Our buddies are all previous award winners and are available to support your ideas. Forms to join are available on the Hub.

Recruiting for studies

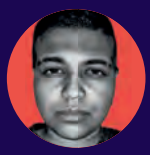
The RCM is keen to support midwives with their own projects too – we regularly host in-progress studies on the Hub and post on social media to help involve people in them. Projects currently looking for midwife participants include: a study seeking to understand service provision for women with multiple long-term conditions, and research on ultrasound scanning in detecting breech presentation at term.

In the pipeline

Watch out for the Thesis Collection – a platform for midwives to showcase their academic work and a source of open access midwifery-generated evidence for everyone to use. If you have a PhD, get in touch so we can include your thesis.

Get in touch

We're spreading the word at RCM branch meetings about the importance of midwifery research and the work we do. If you think we could support you or your work, contact us at research@rcm.org.uk, or talk to us at the RCM annual conference on 4-5 October in Cardiff – we'd love to meet you.



Afsana Ahad

Maternity support worker, St George's University Hospitals NHS Foundation Trust

The RCM has helped me to better understand my role and realise I am in the incorrect band, despite the skills I have and the work I carry out. Being a member has made a difference because I feel supported, and it has encouraged me to do other things out of my comfort zone. I choose not to settle for less and always push for more.

Catherine Cargill

Student midwife, Croydon University Hospital; former MSW, currently MSW advocate and learning rep

I provide information about work conditions and advocate for members generally – helping with things such as appraisals, pay grades, signposting to training, workshops and conferences. I am a listening ear, providing encouragement and practical support.

Find us on Twitter at **@djennymidwife** and **@JudeField**

RESOURCES

Research and Development Strategy 2021-2024
bit.ly/RCMRandD
Standards for midwives – The Nursing and Midwifery Council
bit.ly/NMC_Standards
Research Hub
bit.ly/RCMresearchhub
Research Awards Buddy Scheme
bit.ly/RCMresearchbuddy
Wellbeing of Women Entry Level Scholarships
bit.ly/WoWscholarships
Iolanthe Midwifery Trust Jean Davies Award (entries open in December)
bit.ly/IMTJeanDavies
Current studies
bit.ly/RCMcurrentresearch

Care and repair

The newly refreshed Caring for You campaign is more important than ever, Jess Connett writes

When Caring for You first launched in 2016, Lynn Collins – now RCM director of field services – was working for the TUC. A rep came to talk about it, Lynn remembers: "When she said, 'We're running a campaign to get access to drinking water,' I thought she was talking about an international campaign in a developing country. But she was talking about maternity units in the north-west of England."

The issues were fundamental, but fixable. The campaign saw members across the country supported by local reps to develop and implement plans to improve their own working conditions. From flexible shifts to care boxes and funding for new break rooms, countless small actions helped midwives and maternity support workers (MSWs) to prioritise looking after themselves.

But since the COVID-19 pandemic, chronic short staffing, low morale, inflexible shifts and greater scrutiny following the Ockenden report have made working conditions tougher than ever. In response, Caring for You has been refreshed. A new employers' charter was launched in May, and the RCM is influencing national decision-makers to embed Caring for You into top-level policies. The whole campaign has had an important change of focus.

Healthy environment

"The solution is not just for the RCM to bring cans of pop into work," Lynn says. "It's about employers taking their responsibilities seriously. Everyone should have the right to work in a healthy and safe environment – and a safe working environment is safe for women and babies."

In February 2016, shortly before Caring for You launched, NHS England published the *Better Births* report. This presented a seven-point vision for the future of maternity care, including personalised care for every woman giving birth and better multidisciplinary working.

Better Births followed on the heels of the Kirkup report (2015), which found "avoidable harm" had caused the deaths of 11 babies and one mother at University Hospitals of Morecambe Bay NHS Foundation Trust, at a time when England had higher maternal and infant mortality rates than both the EU and OECD averages (Papanicolas et al, 2019). Between 2013 and 2015, 47% of Care Quality Commission (CQC) inspections of maternity services had led to safety assessments that were either "inadequate" or "needs improvement" (Cumberlege, 2016).

With some services working at 100%

IMAGES: GETTY

Making time for staff

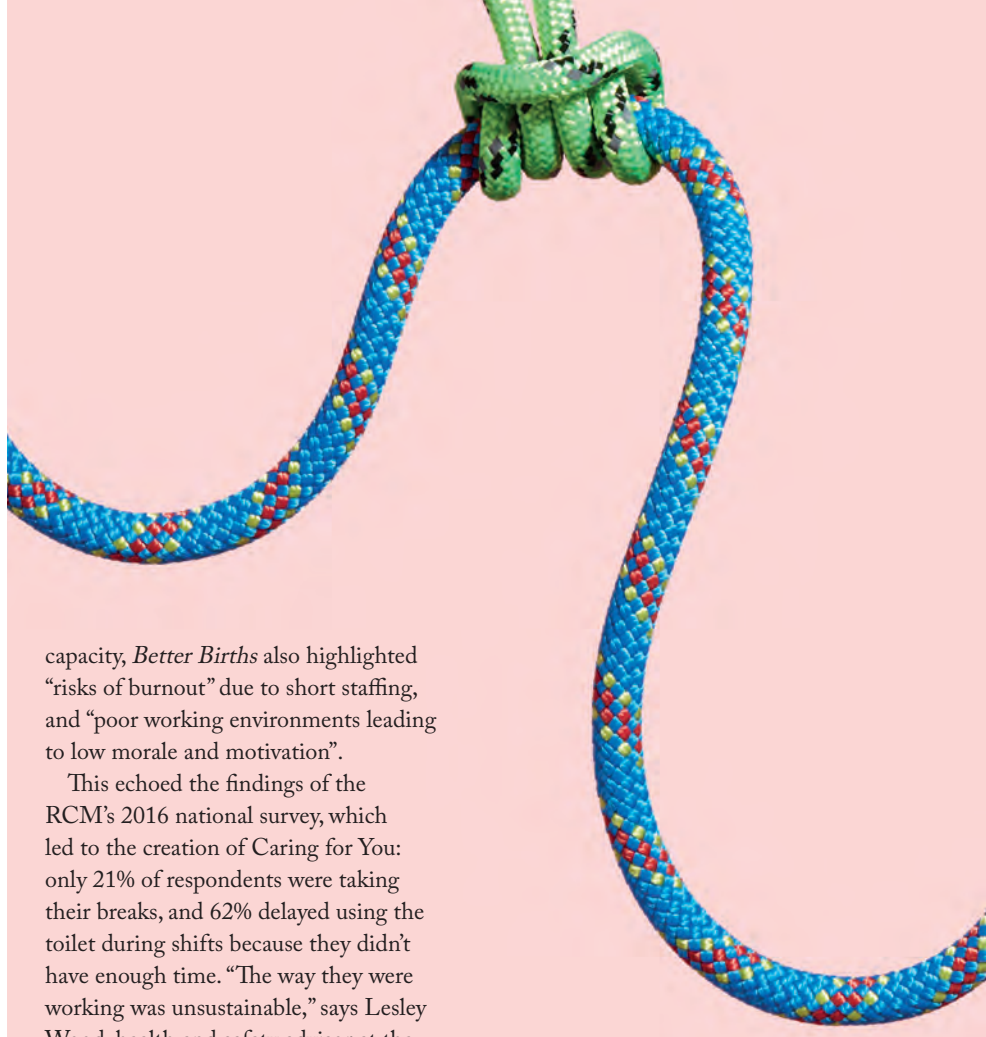
BEV O'CONNOR IS HEAD OF MIDWIFERY AT SAINT MARY'S OXFORD ROAD SITE, MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

"When we first signed up to the Caring for You charter, our first priority was to support our Band 6 workforce. Our Band 5 midwives get a great preceptorship package, but the Band 6s needed some extra support. We worked with a local university to facilitate resilience training courses, ran supported wellbeing days and Band 6 away days for the teams.

"Saint Mary's has a great team of RCM reps, who tour the unit displaying information and speaking to midwives and MSWs about available support. Our reps are a relatively new team who are really enthusiastic. We work very closely with the RCM and are planning more "roving rep" tours to listen to staff, hear how they're feeling and find out what support they want.

"Staff say that they want to be involved and kept informed about quality improvements including staffing, recruitment and new initiatives. We recently put up a poster about staffing to explain how many new midwives have been recruited, what the sickness absence rate is, what the maternity leave rate is, and the recruitment plans for the future. We want our staff to be happy in work. If staff are happy, our women and families are happy.

"We are very proud of all our maternity workforce and our service. We receive positive feedback about our staff, and that supports job satisfaction. We are doing this job because we care: it's a privilege to be a midwife."



capacity, *Better Births* also highlighted "risks of burnout" due to short staffing, and "poor working environments leading to low morale and motivation".

This echoed the findings of the RCM's 2016 national survey, which led to the creation of Caring for You: only 21% of respondents were taking their breaks, and 62% delayed using the toilet during shifts because they didn't have enough time. "The way they were working was unsustainable," says Lesley Wood, health and safety advisor at the RCM. Lesley has been involved in Caring for You from the very start. She saw real successes when the campaign was embraced by a whole unit – as at Saint Mary's Hospital Maternity Services, part of Manchester University NHS Foundation Trust.

Saint Mary's was the first of 140 maternity units to sign the original Caring for You charter. The team, working across three sites to provide maternity services in Manchester, participated in the Speak Out Safely campaign, started staff engagement forums, drew up action plans to tackle workplace issues around staff retention, and involved HR leads as well as operational managers in Caring for You. "It became a full team effort, looking at what they could do and improving things in the trust," Lesley says. "Saint Mary's is a really good example of going from good to great."

Deteriorating conditions

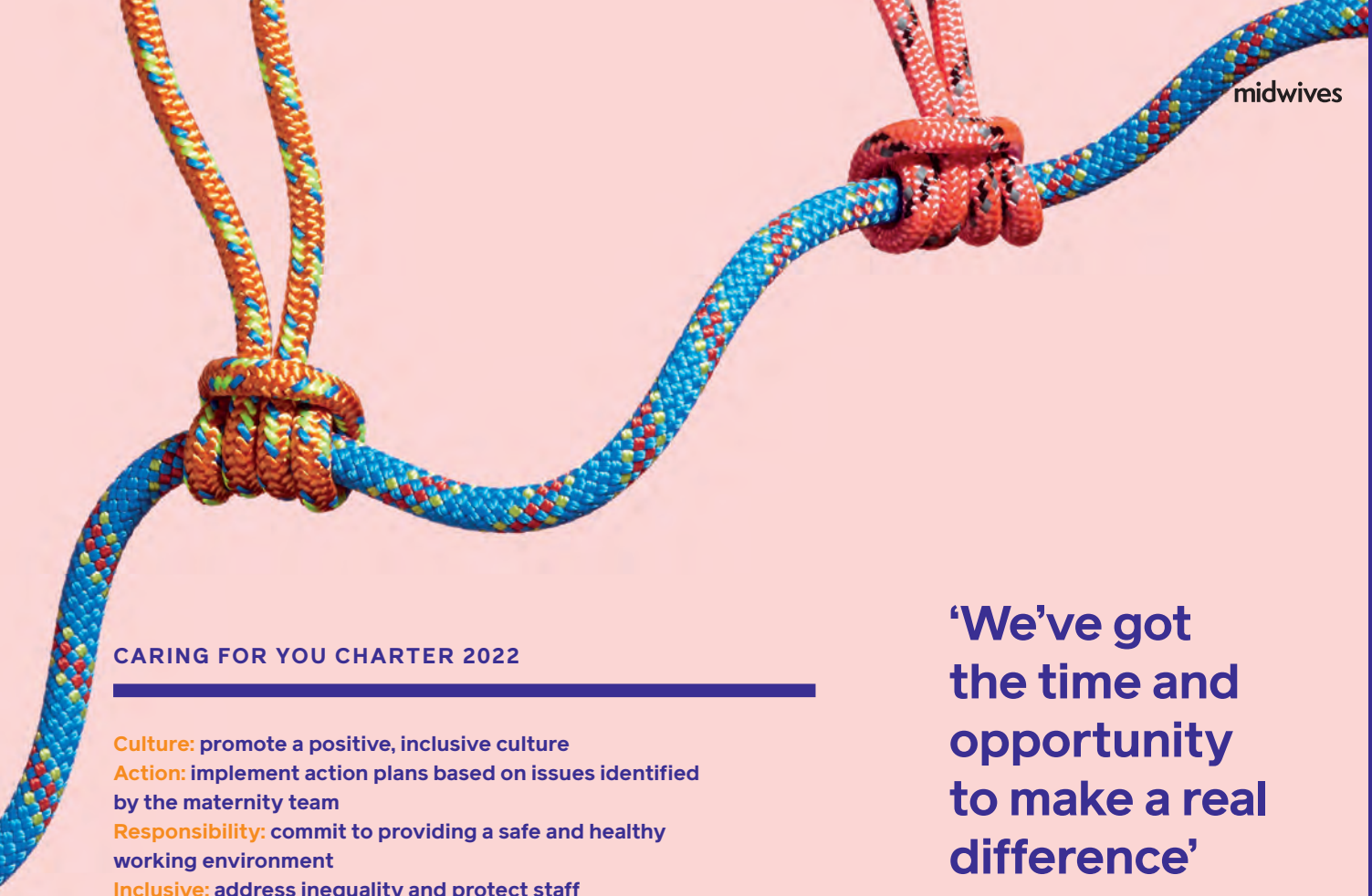
Following the *Better Births* report, change was incremental but positive: between 2016 to 2019, the CQC (2021) found "year-on-year improvement" for women giving birth. But by March 2020, pre-pandemic staffing issues, compounded by COVID-19 self-isolation laws, meant that one in five midwife roles were vacant (RCM, 2020).

While other parts of the NHS shifted resources to battle the pandemic, maternity services had to keep running. Working conditions worsened. In the 2020 RCM national survey, nearly 90% of respondents said they delayed using the toilet on shifts due to a lack of time.

"It makes me feel angry," says Lynn. "Angry as a trade unionist, because for most of my life I've been bargaining for basic health and safety rights at work. But I'm also angry as a woman. I think every woman who goes into hospital to have a baby would hope their midwife would be able to support them in the best possible way. And they can't do that if they're not getting a regular break, if they can't remain hydrated, if they can't go to the toilet."

The worst of the pandemic may be over, but the upheaval is still being felt. The number of midwives working for the NHS in England – which had grown year-on-year since records began

IMAGES: GETTY



CARING FOR YOU CHARTER 2022

Culture: promote a positive, inclusive culture
Action: implement action plans based on issues identified by the maternity team
Responsibility: commit to providing a safe and healthy working environment
Inclusive: address inequality and protect staff
Nurture: work positively to embed flexible shift patterns
Good to great: monitor and evaluate progress

in 2009 – dropped between 2020 and 2021 (Bonar, 2022). Numbers also fell every month between July 2021 and February 2022 (Bonar, 2022). It's hoped that overseas recruitment will fill the gaps, but 57% of midwives responding to the 2021 RCM national survey said they were considering leaving the NHS over the next year.

"Members cannot continue to work in situations where staffing is so low and so inflexible," says Lesley. "We have to hold employers to account. It's all well and good our members being reminded to look after themselves, but when there's nobody to relieve them, they can't do anything about it.

"This is causing harm to members both mentally and physically. It's not just about taking breaks: members report that they are unable to provide the high standards of care to women due to inadequate staffing and, in some trusts, lack of equipment. It is totally unacceptable."

The new Caring for You charter asks NHS trusts and health boards to uphold their duty of care. This includes compliance with health and safety legislation, NMC standards, the NHS People Plan and NHS People Promise. Employers also commit to concrete actions, including flexible shift patterns, protecting staff from bullying, and creating a "positive, inclusive culture where staff feel valued, respected and invested in".

At local level, workplace reps will be able to access toolkits and resources through the RCM website, and the RCM will provide training that will empower them to ask for changes in their workplaces. Employers will sign the charter and commit to tackling specific issues raised by midwives and MSWs, and the results will be fed back to the RCM to learn from.

The wider view

"The work we are doing on Caring for You dovetails nicely with the work other UK national teams are undertaking," Lesley says. This includes the National Maternity Health and Wellbeing Taskforce in England, which the RCM is part of; and Scotland's Five Year Forward Plan for the profession – both of which will give guidance for supporting health and wellbeing in maternity services.

The ultimate aim is to embed Caring for You into NHS health and wellbeing policies at national level. An employer's commitment to the charter would become part of their duty of care to the midwives and MSWs they employ.

"We've got the time and opportunity to make a real difference," says Lesley. "Maternity services have been under such scrutiny and employers are realising that things do have to change. There is a real commitment from all four countries, and all the NHS strategies.

"With our experience from the start of Caring for You in 2016 – the issues that it's raised, the conversations we've had, the improvements we've seen – it really will lead us onto improving actual working conditions."

'We've got the time and opportunity to make a real difference'

MORE INFO
Find out more, including resources and the employers' charter, by visiting **rcm.org.uk/caring-for-you-hub-home**

Silent trauma

Childbirth-related perineal trauma is a common condition and can have devastating effects. But a new study supported by the RCM aims to optimise and standardise women's care, Kathy Oxtoby writes

After having her first child by caesarean, Dawn wanted a natural birth for her second. "I wanted the experience of skin on skin with my second baby," she says. The birth, in 2020, was natural – and fast, just six minutes long. However, "there was a lot of complex tearing," she says. "And the urethral tear was the worst."

Dawn, who lives in the Midlands, was "stitched up quickly" in the delivery room as she was losing a lot of blood. Sore and in pain, she was discharged by the hospital the next day, and discharged by her midwife the following week, who advised that Dawn's many stitches would take time to heal.

But Dawn developed an infection, and the urethral tear failed to heal for over a year. During that time, she says the only advice she received from her GP about treating the infection was to bathe her wound in salt water. Fourteen months after giving birth, and now pregnant with her third child, a referral to a perineal specialist clinic last year by her antenatal community midwife led to her finally receiving the care and treatment she needed.

Reflecting on her experience, Dawn says: "I shouldn't have been discharged by my midwife until my stitches had healed. There is a lot of missing aftercare for mothers. It feels like we've been deserted, and that we are expected to heal with no issues. And at my GP surgery, perineal trauma feels like a taboo subject."

Each year in the UK, 80% of women who give birth vaginally – amounting to 450,000 women – experience childbirth-related perineal trauma (CRPT) (Health and Social Care Information Centre, 2015; Smith et al, 2013) – a term which refers to tears or cuts to tissues, muscles and skin around the bladder, vagina and perineum.

Kim Thomas, chief executive officer of the Birth Trauma Association (BTA), says: "A woman who has a forceps birth is three times as likely to experience a third- or

IMAGE: ISTOCK

fourth-degree tear as a woman who has a non-instrumental vaginal birth.

"Other factors that raise the risk for perineal trauma include ventouse birth, a long second-stage labour, and a baby weighing more than 4kg. Women giving birth for the first time are also more likely to experience tearing, as are older mothers and ethnically Asian mothers."

Dr Sara Webb is RCM head of midwifery information and research services, and honorary research fellow at the University of Birmingham. She says CRPT is "a natural part of vaginal childbirth and needs to be treated with the same specialism as other childbirth outcomes.

"It also needs to be repaired quickly and effectively. If the wounds aren't treated, women can be left with pelvic floor problems, such as incontinence, or psychological problems," she says.

Women who sustain CRPT can develop a wound infection, wound dehiscence, granulation tissue, pain, sexual dysfunction, psychological or social problems, and pelvic floor dysfunction, explains Sara. Sometimes the pain in the immediate postnatal period causes women to stop breastfeeding.

While information on how frequent or serious these complications are is not collected, "we know that 15% of readmissions to hospital after childbirth come from perineal wound problems, costing the NHS £2.4m a year," says Sara (NHS Improvement, 2017-18).

Hospital episode statistics data for emergency readmissions following childbirth in England (April 2007-March 2017) show that 36,687 women were readmitted within 42 days of birth due to perineal wound breakdown (excluding obstetric anal sphincter injury) (NHS Improvement, 2017-18).

"Wound breakdown is the most serious outcome of abnormal healing, so these figures represent an underestimate of the women with complications," says Sara.

A recent report, *Birth injuries: the hidden epidemic*, finds that injuries leading to pain and incontinence significantly affected women's ability to work, exercise, and maintain normal social life (BTA et al, 2022).

Women surveyed on birth injuries reported reduced body confidence and self-esteem, and problems in family relationships (including with children). Significantly, 85% of respondents reported that their mental health had been affected by their physical injuries.

Constant pain

The impact of birth injuries can be "devastating for women, and can include constant pain, and both urinary and faecal incontinence or urgency", says Kim.

"Women often become depressed, and feel unable to have a normal sexual relationship with their partner. They may develop post-traumatic stress disorder (PTSD). They may also have to give up their job, and some feel unable to go outside for any length of time in case they experience urgency," she says.

Kim says a "striking feature" of the narratives of survey respondents is how common it is for women to be dismissed or not believed when they reached out for help – sometimes described as "medical gaslighting". Some survey respondents felt delays worsened the harm, or reduced their chances of making a full recovery.

Women often feel despairing, thinking they will never get the help or support they need

"Women often feel despairing, thinking they will never get the help or support they need, and believing that they will have to go through the rest of their lives experiencing pain and incontinence," says Kim.

Dawn recalls: "For the 14 months I was living with the effects of CRPT, every day I worried about my condition. But none of the healthcare professionals I saw seemed to care. I felt abandoned after I was discharged by the hospital, and by my midwife."

Sara says national maternity surveys demonstrate that there is an ongoing trend in women being discharged from hospital sooner – 77% within two days of birth (CQC, 2021). They are also seeing their community midwife less – 25% receive two visits over a shorter time period than the recommended maximum of 10 days (CQC, 2018). And 53% of women are not receiving enough information about their own recovery, national maternity surveys show (CQC, 2018).

Sara says that, as well as a lack of postnatal support, there is "insufficient CRPT training and guidance for practitioners, particularly regarding ongoing care". While guidelines and standards of education exist for midwives and doctors for management of third- and fourth-degree CRPT, which involve the anal sphincter, the majority of CRPT is first- and second-degree – involving vaginal mucosa and perineal muscles – and repaired by midwives, she explains.

"However, education standards for midwives in training only state initiation into performing an episiotomy and repair of CRPT – the standards do not cover ongoing care of CRPT, particularly in the community," she says.

Despite the issue's importance, says Sara, "GPs and midwives say they lack confidence, knowledge and training on how to assess and treat CRPT, as there is little research or guidelines in this area."

IMAGE: ISTOCK

However, now this seemingly neglected area is the focus of a new four-year study, supported by the RCM. Launched this May, the Chapter Study is being undertaken by a group of women, public, midwives, doctors and academics who have come together with the aim of improving the care of women following CRPT (University of Birmingham, 2022).

The study was conceived by Sara when she was specialist perineal midwife at Birmingham Women's Hospital in 2018. "CRPT care is a core component of routine postnatal care but there is a recognised deficit in this area from healthcare providers, stakeholders and women," she says. "There is no validated CRPT wound assessment tool, and no guidelines or research-based care pathways for management of complications of CRPT. In my specialist role of caring for women with CRPT complications, I decided to change this."

Putting the team together

Sara worked with Katie Morris, professor of maternal fetal medicine at the University of Birmingham, to build a multidisciplinary team to develop her original idea, and succeeded in getting funding from NIHR in 2021. Katie says: "By standardising and optimising the care of women with CRPT, we hope to improve their recovery, their ability to care for, bond with and breastfeed their baby, reduce inappropriate antibiotic use, ensure high-quality care if complications arise and improve long-term outcomes. This will positively affect the lives of more than half a million women a year in the UK."

The study features four interlinked research areas. These involve: a cohort study; linking data between primary and secondary care routines; qualitative research with women and midwives to capture their experiences and views; and working with women and a team of midwives and multidisciplinary health professionals to develop tools to assess CRPT and its associated postnatal care pathway.

The Chapter Study is being undertaken to improve the care of women following CRPT

The public will be involved "at every stage of the study", says Sara. "It is only through understanding the outcomes and experiences from women who suffer from CRPT that we will be able to improve care and care pathways.

"Women tell us that they support our research. We will set up a programme advisory group of six women and their partners who will be involved throughout. They will advise us how best to recruit women to research, guide us on the use of tools, advise how the results are shared, and help shape the future direction of

research into CRPT."

The study's findings will be shared with key organisations, including the RCM and RCOG as well as others such as the NCT and GPs. "We will target wider networks such as health visitors and physiotherapists, and work with stakeholders to promote further research and develop future guidelines and policies," says Sara.

The RCM is a stakeholder in this study, says Sara, "because of our commitment to improve maternity care – not only the physical outcomes for women, but also in being at the forefront of service improvement innovation."

Sara is co-applicant and research lead for the wound tool development study area and represents the RCM on the project management group. "This is a perfect opportunity for the RCM to have a much fuller involvement within this vital programme of work – I'm ideally placed to provide the research team with my clinical and research specialisms and also to ensure the programme remains in compliance with RCM goals and objectives," she says.

Sara says this programme of work has been wanted by women, midwives and doctors for many years: "We are delighted to be working towards providing evidence-based assessment tools and care pathways to improve outcomes for all women who have CRPT. And we will be keen for many NHS Trusts to take part and help us with the study – by working together, we will improve care for all women nationwide."

MORE INFO

Look out for further announcements about the Chapter Study and how your hospital can become involved. For further information, email **chapter@contacts.bham.ac.uk** or follow **@Chapter_Study**

RCM research hub: **bit.ly/RCMresearchhub**

'I'm using my experience to help others'

RACHEL, FROM YORKSHIRE, IS A CHAPTER STUDY PATIENT AND PUBLIC INVOLVEMENT (PPI) MEMBER

In 2018, my birth was induced, with a forceps delivery. I felt my labour was sped along, and my views and values weren't supported. I bled heavily, but was told there wasn't any significant tearing. The next day I had faecal incontinence. My midwife and obstetrician reassured me that "these things happen", and I was discharged without further examination.

The next day I was examined at home by a midwife, who said I had a bad infection. She arranged for a hospital assessment, where I learned a third-degree tear had been missed. As I had an infection, it was unable to be repaired immediately. Instead I had surgery to create a temporary stoma.

I still have that stoma. It became long term because I received insufficient information from healthcare professionals about what my quality of life would be like if it was reversed.

Not being listened to has left me with a permanent sense of foreboding. I was 'gaslit' for so long by the medical profession, it feels like my brain has been rewired not to trust.

I'm using my experiences to help others, which is how I became involved in the Chapter Study. I see my PPI role as really positive – being able to share my experience of CRPT, knowing it will be valued and form part of research. This comprehensive study will bring together existing and new evidence, and involve those with lived experience. I hope it will motivate people to bring about change.

I'm involved because I was left powerless and without a voice. The Chapter Study is a constructive and powerful way to reclaim my voice. And I'm involved so that when my boy gets older he will be proud of me, knowing I fought for the voices of women who have experienced CRPT to be heard.

CHAPTER STUDY TIMELINE

Jun 2022 - Oct 2023: Context exploration and awareness of problem
Jun 2022 - Feb 2024: Data synthesis
Jul 2024 - Sep 2025: Resource development
Apr 2023 - Dec 2025: Integration, synthesis, dissemination, impact and future development

Taking action on pay

As the fight for better pay reaches a critical point, the RCM is ready to take action, director of employment relations Alice Sorby explains

Following the resounding rejection of the Scottish government's offer of a 5% pay increase, at the time of writing, the RCM had just announced that it would ballot members working in the NHS in Scotland on industrial action. Two-thirds of RCM members working in Scotland turned out to vote on the pay offer, and 90% of those that had, rejected it.

Unlike the rest of the UK, the Scottish government chose to negotiate directly with the RCM and other health trade unions through the Scottish Terms and Conditions Committee rather than participate in the NHS Pay Review Body (PRB) process. The PRB makes recommendations on pay for the rest of the UK.

Just before the summer parliamentary recess, governments in England and Wales announced they would accept its recommendation of a £1,400 consolidated pay award for most Agenda for Change NHS staff. For the top-step point of Band 6 and all of Band 7, the amount is adjusted to equate to a 4% increase. Because it is a pay award rather than an offer, it will

IMAGE: SHUTTERSTOCK

be implemented.

In Northern Ireland, the health minister Robin Swann confirmed he would accept the PRB's recommendation, but said that he couldn't move forward without an agreed budget.

Real-terms cut

The RCM consultation among members in England and Wales to establish strength of feeling and willingness to take action on pay closed on 5 September. The outcome was unknown as *Midwives* went to press, but the RCM Board's decision about whether to move to a statutory ballot would be guided by the strength of feeling evidenced in that consultation.

Despite the different mechanisms for deciding pay, what the RCM wants for all its members is clear: an inflation-busting pay increase that absorbs the impact of rising costs and starts to make up the pay that members have lost over the past decade.

We also want to see an urgent retention package put in place, the details of which can be found on the RCM's pay hub (for more information about this, see below).

Clearly, the pay offer in Scotland and the award in the rest of the UK does not meet the RCM's demands – and with inflation currently at 10.1%, it is a pay cut in real terms. With increases in annual grocery bills averaging more than £400 over the past year (Butler and Inman, 2022) and research estimating that more than 15 million UK households will be pushed into fuel poverty by next January (Bradshaw and Keung, 2022), fair pay is vital. It is not only key to recruiting and retaining staff but also to make sure NHS workers do not have to choose between heating their homes and putting food on the table.

Last resort

Midwives and maternity support workers (MSWs) did not cause the cost-of-living crisis and they shouldn't have to pay for it. As the value of wages falls, big company profits are up – 34% for the biggest non-financial firms, according to the Institute for Public Policy Research (Jung and Hayes, 2022). Meanwhile, in March, City bonuses were at their highest level on record (Kollewe, 2022).

The RCM Board never takes a decision to move to an industrial action ballot lightly. Strike action is always the last resort, but the strength of feeling among midwives and MSWs at the moment cannot be underestimated.

However, if members do vote to take action, we would not allow women or babies to be put at risk.

The NMC code does not prohibit midwives from taking part in lawful industrial action. When RCM members took strike action in 2014, we maintained safe services. RCM workplace representatives worked effectively with managers to ensure there was cover during the stoppage, which is intended to be similar to the cover on a bank holiday.

We believe the treatment of NHS staff will affect care because staff that are demoralised cannot deliver the quality of maternity services that users deserve. It's time for governments to listen to midwives and MSWs and pay them fairly by delivering a decent deal.

Fair pay is vital. It is not only key to recruiting and retaining staff but also to make sure NHS workers do not have to choose between heating their homes and putting food on the table

MORE INFO

Read more about the RCM's pay campaign at **rcm.org.uk/pay-hub**

IMAGE: SHUTTERSTOCK

Don't miss out on free legal support

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Breaking barriers

Dr Aimee Grant, who recently led a review on autistic women's breastfeeding experiences, tells *Midwives* how support for this group of mothers could be improved

Just three years ago, Dr Aimee Grant was diagnosed as autistic. The delay wasn't unusual: many women and girls don't receive a diagnosis until they're well into adulthood – if at all. But when it came, Aimee's longstanding research interest in pregnancy and early parenthood meant the progression to her recently published paper seemed natural.

"It made me start thinking: what do we know about autistic people's experiences of breastfeeding? And is it different to a general population of mothers? We [Aimee, along with Dr Sara Jones, Professor Amy Brown, Dr Jennifer Leigh and Kathryn Williams, research director of Autistic UK] gained a little bit of funding, which was just enough to get us started."

The team undertook a review of existing research in the area, which was scarce. "There were eight studies included," says Aimee. "We also included blogs and things that people had written online. So we took all of the information and pulled it together for the 300 women that were involved."

The findings, she explains, were multi-layered – and prompted the authors to make a number of recommendations for healthcare professionals (see box, right).

Lack of understanding

"Before even thinking about feeding the baby, there were real barriers within maternity services in terms of health professionals who didn't understand autism, whose communication wasn't very clear," notes Aimee. "Or sometimes they weren't

very pleasant, and made women feel bullied. Bad experiences during antenatal appointments meant that many autistic people weren't feeling confident about staff supporting them before giving birth; they didn't have a lot of trust in the services."

A lack of knowledge and understanding about the needs of autistic women was at the root of the challenges they experienced. "Autistic people are quite clear and direct with communication, which is sometimes mistakenly interpreted as rude," says Aimee. "But other factors suggested they weren't being believed by the health professionals when they reported their experiences of things.

"That could include all the way up until birth: one participant talked about how the staff didn't believe that she was about to deliver – even though she was – because they didn't understand her presentation of pain."

Feeding challenges

After a birth in hospital, autistic people can experience a number of sensory and emotional challenges over and above those undergone by neurotypical new

Autistic people can experience sensory and emotional challenges

mothers. From the bright lights and noise, to being touched by or having awkward conversations with healthcare professionals, autistic mothers can feel 'dysregulated', Aimee explains. "They would normally know exactly what to do to make themselves feel better and get back to their normal level of arousal. But they have a new baby that needs a lot of attention, so their strategies for reregulating aren't always available."

Regarding infant feeding, the review highlighted many typical barriers that mothers across the UK can face, says Aimee; for example, "that they didn't get enough support, or got conflicting information". But it also revealed additional hurdles faced by many autistic mothers. "To get support from the infant-feeding team, you might need to make a phone call. But phone calls are much more difficult for autistic people. When they are dysregulated, some autistic people find it difficult or even impossible to speak. So in the early days, the challenges of a difficult birth, a baby that they're struggling to feed and cries a lot could make that phone call a step too far."

Improving outcomes

How can midwives and MSWs improve their support of autistic women in everyday practice? A huge difference could be made through up-to-date training delivered by autistic people, Aimee believes. "Health professionals don't have good training about autism – and the training they do have is sometimes based on quite outdated beliefs, which can make it hard for staff to believe that the 'normal-looking' person in front of them is autistic."

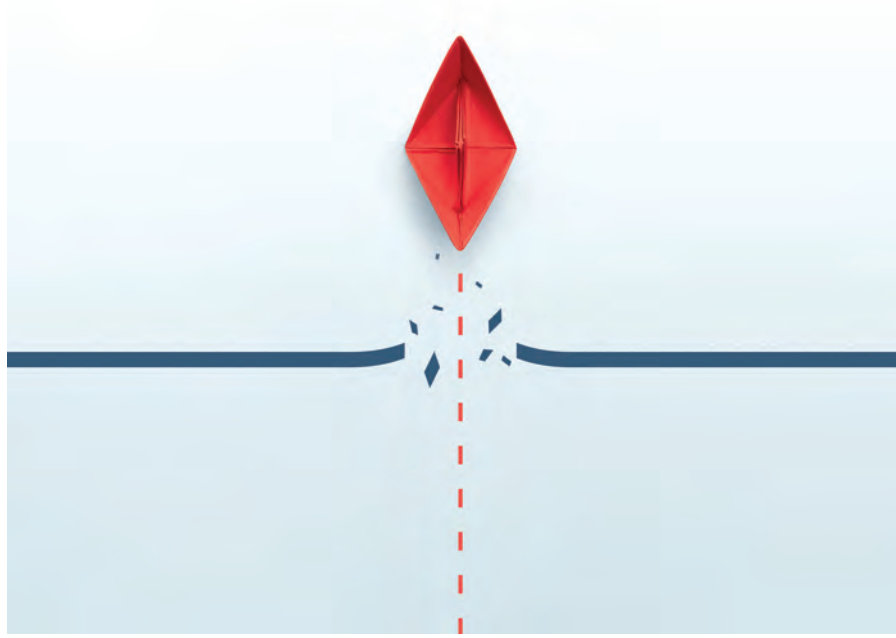
Smaller measures could also improve autistic women's experience of care. "Communication should always be clear

AUTISTIC WOMEN'S VIEWS AND EXPERIENCES OF INFANT FEEDING: A SYSTEMATIC REVIEW OF QUALITATIVE EVIDENCE

Publication: *Autism*
Background: Around 1% to 2% of the population is autistic. Recent work highlights that autistic mothers are more likely to feel stigmatised and misunderstood by health professionals. Pregnancy and birth can also cause sensory challenges.
Aim: To explore autistic women's experiences of infant feeding.
Findings: Maternity and infant-feeding services lacked an understanding of autistic needs, and were often inaccessible when autistic mothers already felt a loss of control and lack of social support. Determination to breastfeed was often high, but sensory challenges, pain and interoceptive differences (exacerbated by a lack of support) made it impossible for some.
Conclusion: The review identified multiple barriers to breastfeeding among autistic women, and few facilitators. Accessibility measures should be introduced urgently to help autistic women meet their breastfeeding goals.
Recommendations:
- Communication should be clear, direct and specific and followed up with written information
- Mothers should not be touched without explicit consent
- Staff should receive training and tools related to autism, but this also needs to be specific to infant feeding and able to be individually tailored
- Autistic mothers should have named infant-feeding support providers to avoid having to repeat their needs to staff
- Communication/sensory guidance should be included in handheld notes and the red book for all mothers, which would prevent autistic mothers from having to regularly reassert their needs.

Read the full study at bit.ly/autismbreastfeedingreview

IMAGE: SHUTTERSTOCK



AIMEE COMPILED THESE POINTS TO HELP HEALTHCARE PROFESSIONALS UNDERSTAND ABOUT AUTISM:

- **Not all autistic pregnant people will be diagnosed, as women are typically undiagnosed. Unpublished research from Swansea University has found that 0.8% of pregnancies in Wales were to people diagnosed as autistic, while around 2% of people are autistic.**
- **Not all autistic pregnant people will tell you they are autistic, because many have had negative experiences with health professionals. This means it's best practice to offer support to all, regardless of whether they're diagnosed.**
- **Autistic people are not all the same, but in general will communicate differently to neurotypical people and will find aspects of the sensory environment painful.**
- **Best practice for caring for an autistic person includes not sitting close to them and always giving clear explanations before any touching or treatment occurs.**
- **If someone tells you they are autistic, ask: 'What can we do to make being here easier for you?' or 'Is anything bothering you?' If patients are in the department for longer than an hour, check frequently.**
- **Autistic people often 'mask' their traits in healthcare settings. This means ignoring the difficult sensory environment around them and trying to behave and communicate in a neurotypical way to gain acceptance from staff. Masking is very energy-intensive, and is associated with shutdowns/meltdowns in the short term and depression/self-harm in the long term. So it's important to accept autistic communication styles even if you think they're rude, or questions feel disingenuous.**

and direct," says Aimee. "And if, for example, you've demonstrated a particular breastfeeding hold, that should be followed up with some written advice, or even a link to videos on YouTube or the NHS Trust website that the mother can go back and look at again."

Another issue reported by several women in the study was being touched and having their breast grabbed by health professionals trying to help them to breastfeed, "which isn't best practice to breastfeeding support in general", Aimee adds. "So our advice would be never to touch a woman without getting her explicit consent – and that's even more important for an autistic woman."

Listening and learning

Taking autistic women's descriptions of their experiences seriously is another important measure, says Aimee, as she recalls an account from a participant in a different study: "She said her letdown reflex felt weird – like she had an old-fashioned phone ringing in her breast. Rather than dismissing what they say, it's about accepting it and trying to talk about things that could help. I think there's something about being believed that would be really helpful in developing a rapport with women."

In Wales, where handheld notes are soon to go digital, there's "a real opportunity" to include extra information about women's needs, says Aimee. "People could have something in there that says 'These are important things about me'. And that could work for whatever condition they have, although we'd need to make sure that midwives had enough time to read the information, and had the knowledge and skills to know how to support autistic people."

We urgently need healthcare to become more accessible for autistic people without delay. "Health professionals are doing the best they can with very limited resources. But we know that autistic people have worse physical health, worse mental health, we go to casualty twice as much as neurotypical people and the suicide rate for autistic people is nine times that for non-autistic people – because we don't get our proper care needs met."

MORE INFO

Find out more about masking at **bit.ly/autisticmasking**
To read more about shutdowns and meltdowns, go to **bit.ly/autistic_shutdowns** and **bit.ly/autisticmeltdowns**

IMAGE: SHUTTERSTOCK

Powys Teaching Health Board – Head of Midwifery & Sexual Health

Are you an inspirational leader in Midwifery looking for your next opportunity to improve the Health, Care and Wellbeing of Women, children and families? Look no further, Powys Teaching Health Board has the role for you.

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Apply today at https://pthb.nhs.wales/working-for-us/ with reference number 070-PTHBHOM-0922, closing date is the 16th October 2022. Find out more about our service, our organisation and our county here https://pthb.nhs.wales/midwifery-jobs.

About Midwifery Services in Powys

As Head of Midwifery and Sexual Health Services in Powys you will lead our Sexual Health and Midwifery Service in the county and be a key commissioner of maternity services for our residents from neighbouring organisations.

You will be a strong professional leader, who is confident in understanding 'what good looks like' for the patients of Powys.

You will have a passion for delivering high quality services and leading and motivating high performing teams. Influencing and working with partners and the ability to build effective and respectful partnerships across organisations and geographical boundaries will be at the forefront of your skill-set.

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Powys is proud of its midwife-led model of care.

About Sexual Health Services in Powys

Sexual health Services in Powys offer a range of different support from accessing Long-Acting Reversible Contraception to support with Gender Identity. We encourage innovation and you will be a key driver in the development of this service moving forward.

Get in touch

We would love to have an informal chat with you about the role, or arrange a visit to our services.

If you would like to arrange a chat or a visit, please contact:

Claire Roche, Executive Director of Nursing and Midwifery at Claire.Roche@wales.nhs.uk

Or Louise Turner, Assistant Director of Women and Childrens Services at louise.turner@wales.nhs.uk

Birthing language reborn

The RCM's Re:Birth project has helped to create a consensus on respect

The RCM launched the Re:Birth project in 2020 in response to the controversy around the word 'normal' when applied to birth. This pioneering research brought together those who work in maternity services with service users and others working in the field of pregnancy and birth to develop a better understanding of this complex area and seek to build a consensus around a shared, respectful way of discussing labour and birth.

Over the course of 18 months, thousands of people from across all four UK nations were consulted. The process was guided and supported by a project oversight group, involving representatives of many different groups and organisations, bringing a wide range of views.

Now that the Re:Birth report has been published, *Midwives* hears from members of the oversight group about the project, its findings and why it is so important.

Dr Juliet Rayment

RCM RESEARCH FELLOW, WHO WORKED ALONGSIDE DR MARY ROSS-DAVIE, PREVIOUS RCM DIRECTOR FOR SCOTLAND, TO DESIGN AND RUN THE PROJECT

We began by inviting collaborators with a diverse range of views to join the oversight group. We wanted to be challenged and ensure a balanced perspective. It was an example of how you can have a calm, respectful conversation between people who disagree, and we were proud to provide a platform for that conversation.

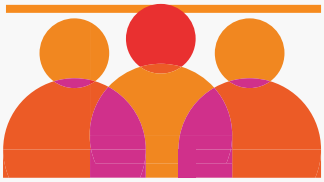
The project had an amazing response: almost 8,000 people took part. What was surprising was the incredible variety – nothing was clear cut. So even while 'normal birth' was the least preferred term, 40% of people still didn't mind it.

It showed the response to language is so personal, but we found agreement around the principle that language should be descriptive, accurate and non-judgmental. And that rather than having a default word, women wanted to be listened to and for health professionals to personalise their language accordingly. It was also clear that language can be unintentionally misunderstood. For example, health professionals might not be making a judgement when they use the word 'normal' – they might be using it in the way they might say 'normal' blood pressure – but that might not be how it's heard.

There is no perfect term – but the language used in clinical notes and records needs to be consistent. In our final survey, we presented five vignettes of common types of birth to poll the population about specific preferred terms. The preference for 'spontaneous vaginal birth' was a bit of a surprise – it's not the easiest term – but for the first time, we know how the maternity community thinks and feels about the language we use.

Re:Birth project

WHO TOOK PART?



7,822

PEOPLE PARTICIPATED IN TOTAL, WITH:

- **110** in the listening groups
- **764** in the voices survey
- **6,948** in the final survey

72% (5,512) were from a white British or Irish background

12% (935) were from an ethnic minority

Shirley Cramer CBE

INDEPENDENT PROJECT CHAIR

I was very happy to become involved – I loved the idea of a collaborative project and it seemed to me that bringing everyone together to get into the details was the only way to come to some consensus.

We didn't go into this thinking we needed to settle on set phrases – we wanted to understand everybody's point of view as well as what was needed to improve the experiences of women and families, and help healthcare professionals too.

The oversight group was really important in giving different professionals and different groups input into the process. The online listening groups then helped confirm the issues around women's experiences, which informed the whole project.

What emerged was that women's experiences were often very different to what healthcare professionals might think; what maternity workers may see as a happy 'normal' birth may have been quite traumatic for the mother, while an unplanned caesarean might have felt to the mother like a positive experience.

The need for personalised care and personalised language was really highlighted, and while there is no single answer, there is a way into thinking about it. The '5 As' (see panel on page 43) provide a protocol for healthcare professionals to follow that will lead to fewer misunderstandings and more happiness.

Nothing is perfect, but this study has given us an indication about the terms the majority will be happy with – for example, 'birth' rather than 'delivery', 'planned' and 'unplanned' caesarean rather than 'elective' and 'emergency'. The preferred terms are clear and easy to understand for women as well as healthcare professionals. It's a shared lexicon, and that consistency makes it safer.

It's my understanding that the recommendations will be fed back as guidance for trusts, and many of the organisations represented on the project oversight group have also been keen to share them. It isn't just an academic project – it will have value in the real world.

Elizabeth Duff

NCT SENIOR POLICY ADVISOR

I was really pleased to be invited to take part and to see this was a well-designed research project, bringing in as many voices as possible and sparking respectful discussion and debate.

Quite a few people were surprised by the survey results and the words that rose to the top. For example, it was interesting that 'straightforward birth' wasn't a popular choice and that 'natural' came out as more popular than 'normal'. But 'spontaneous vaginal birth' is a very clear phrase, and one that most service users and professionals would be comfortable with.

However, it's not about telling anyone what they must say. What I hope is that professionals take on board the message about listening to women and making sure the language used isn't alien to their individual experience. At the NCT, we aim to help expectant parents understand the terms likely to be used and support them in decision-making, so it's great to have this broad consensus.

There is a real need for clarity and accuracy where you have different professional groups working with women and families – and, where possible, positivity too. For example, there was a lot of discussion around the negative impact of phrases such as 'failure to progress', 'lack of maternal effort' and 'incompetent cervix'.

Having a baby is a massive learning curve, and women want to really understand everything being said to them. It's also a time of heightened anxiety and sensitivity; we know from many studies that the language used during labour and birth can have a big impact; if parents feel inappropriate words have been used, it stays with them.

I think it's also important to understand that this report isn't the last word; language is fluid and will continue to change.

Re:Birth report

WHO RESPONDED TO THE SURVEY?

2,885
were women who have given birth and their 'birth supporters'

3,732
were midwives, student midwives and maternity support workers

403
were obstetricians and obstetric anaesthetists

799
were 'others', such as doulas, antenatal educators and researchers

Clea Harmer

CHIEF EXECUTIVE OF SANDS

When parents experience the death of their baby, the words said to them at that time may become etched in their minds, forming part of their only memories of their baby – it is so important to get the language right. So, it was essential the views of bereaved parents were taken into account, especially as they are so often a 'hidden' group.

The language of birth had become very contentious; connections with Morecambe Bay, Shrewsbury and Telford tainted it, overlaying other meanings – it was incredibly divisive and triggering. It actually made talking about birth very difficult, which was disempowering for midwives; the very sense of who they are, what they are there for, was being chipped away at. That's why it was so good to see their unique role restated at the start of the Re:Birth report.

It was brave for the RCM to grasp the nettle and tackle this. They have held the space for women and helped find a consensus and a way forward. They should be very proud of that.

What has come out of it is, in many ways, stating the obvious – that language shouldn't be value-laden, unclear or ambiguous, or seem complicated – but until now, that has never been acknowledged. I like that the set of preferred phrases are like building blocks that can be combined – so for example, an 'induced labour', followed by 'birth with forceps'. The clarity that provides is brilliant. Another wonderful thing was that everybody was clear that a woman gives birth – she isn't 'delivered of a baby'.

The final report needed to be nuanced; it acknowledges it was more important to reflect what we heard than come out with something simple and directive. At Sands we teach people to mirror the bereaved parents' language. The Re:Birth project came to the same conclusion: listening to the woman in front of you is at the heart of person-centred care.

Soo Downe
PROFESSOR OF MIDWIFERY STUDIES AT THE UNIVERSITY OF CENTRAL LANCASHIRE

My research area has always been the nature of normal physiological labour and birth, so I think one of my roles in the Re:Birth project was to bring all those years of thinking about this topic. I also have a lot of international links, including, with colleagues, contributing several reviews to the World Health Organization (WHO) on their maternity guidelines. In the papers for the WHO, we found most (though not all) women around the world were reported as saying they generally preferred labour and giving birth without clinical procedures if all was well, and many used words equivalent to 'normal' or 'natural' for this.

I think that the Re:Birth team did a brilliant job of squaring the circle by recommending that 'spontaneous onset/labour/vaginal birth' should be used at a reporting level, but that, at an individual level we should use the language the woman/birthing person uses, including 'normal' if that is what they prefer. Indeed, I would be concerned if the term becomes unusable by convention – it's a short step away from this to believing that labour and birth itself are undesirable.

I did find it interesting that more than half of those surveyed in Re:Birth preferred or didn't mind the term 'natural birth', which could be seen by some to be even more absolutist than 'normal birth'. Around 40% of respondents said they preferred or didn't mind 'normal labour and birth' – and there was no one term that was suggested that wasn't offensive to somebody, which illustrates the complexity of this topic.

I look forward to seeing the '5 A' recommendations put into practice, provided this is done in the spirit of the report: that is, that when it comes to individuals, no language should be off the table, depending on what each person prefers.

The '5 As'

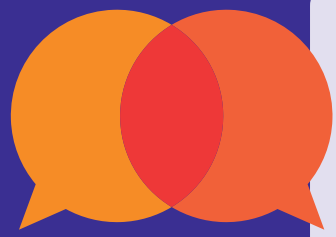
Health professionals should consider these 5 As when talking to women, birthing people and their families, but what are they?

1. ACKNOWLEDGE

Acknowledge the woman's previous birth experience – or whether this is her first time. Acknowledge a previous birth independent of mode of birth. If she has had a previous loss, this should also be acknowledged.

2. ASK

How would the woman describe a birth she has had – or would like to have, if it's her first? Her feelings are as important as the technical terms, so listen to how she talks about her experience and preferences.



3. AFFIRM

Check with the woman the language used in your notes to describe any previous birth. Does that description feel right to her? Is there another term she would prefer to describe it?

4. AVOID

Try not to make assumptions about her choices – for example, if there was a previous caesarean birth. Don't make your own interpretation of what you think her experience might have been, or impose terminology on her.

5. ANNOTATE

Record the woman's own description of her previous experience of birth as fully as possible, and her preferences of language and terminology.

Re:Birth report

WHAT DID IT FIND?

There were three words that dominated how midwives, obstetricians and other health professionals hoped the women they cared for would reflect on their labours and births:

Mavis Afriyie

A MIDWIFE, COMMUNITY TEAM LEADER AND PROFESSIONAL MIDWIFERY ADVOCATE AT LEWISHAM AND GREENWICH NHS TRUST

As the only shopfloor midwife on the oversight group, I felt it was really important for me to be part of the project. Everything we talked about is key to what I do every day as a community midwife; conversations with women about the kind of birth they want is an essential part of my role and very close to my heart. I'm also interested in disparities in experiences and outcomes, especially for Black and Asian women, so I felt I brought that element to the group too.

From talking to women, the common theme is that they want a safe experience for themselves and their baby – but what does that look like for each individual? What is 'normal' for one woman is very different for another, and one woman's choice or experience shouldn't be made to feel wrong.

Listening to women and language is absolutely key, and Re:Birth is about moving that language in the right direction so that women feel comfortable in defining and describing the birth that they want.

With staff shortages and the pressures midwives are under, it can feel as if there are even more changes to implement – but this is really important. These are small changes that can go a very long way. As we hear in our listening clinics, if women feel there is something about their birth they don't understand, or they feel their wishes haven't been respected, or even if they haven't felt reassured, it can be a traumatic experience.

I really like the '5 As' – it's vital for midwives as advocates to affirm women's wishes, avoid making assumptions, and document what they want. These are things we are already doing, but we need to think about tailoring our language, and making this an even more important part of individualised care.

Susie Crowe

CONSULTANT OBSTETRICIAN, REPRESENTED THE BRITISH INTRAPARTUM CARE SOCIETY ON THE PROJECT OVERSIGHT GROUP

I think we don't talk enough about how we, as maternity professionals, make women feel – and language is a very important part of that; what you say and how you treat a woman can make or break their birth experience. This project was a great opportunity to engage with women and birthing people to make sure the language we use is what they want, not just what we want.

The findings of Re:Birth were as I expected, in that there really is no universality around this, but what was made visible during the listening groups were the potentially very damaging effects of language – I don't think everyone really understood that before. This project drives that understanding forwards.

With preferred terms it was interesting that some of those choices were so marginal – the preference for 'unplanned caesarean birth' and 'in-labour caesarean birth' was almost the same. We were pragmatic and opted for 'unplanned' as the counterpart to 'planned caesarean birth', but there were concerns, particularly among the obstetricians, that 'unplanned' might sound chaotic or haphazard – when even in the most pressing emergency, planning and training is in place.

While I have some reservations about that, I am completely in favour of the rest of the recommendations. The big thing now is how we put them into practice – not just among midwives and obstetricians, but also among GPs, health visitors and other healthcare professionals.

We are all so used to saying certain words, but we have to be ambitious. It's going to start with the RCM and RCOG changing the wording in their guidance, and then we need to use every means possible – magazines, conferences, social media – until we hit the tipping point. For me, that's also about making sure there is joint ownership – midwives and obstetricians – and more obstetric champions out there as well.

Dr Jen Jardine
REPRESENTED THE RCOG ON THE PROJECT OVERSIGHT GROUP

There has been controversy surrounding the language of birth for many years. The Re:Birth project set out to address some of the concerns and to provide an evidence base around the language people feel it is appropriate to use within maternity services.

This is an area traditionally led by midwives. But it was really important for both professions to be in agreement, so the RCOG was pleased to partner on the project and provide a representative for the oversight group.

The aim was to better understand how we can have conversations with women while accurately reflecting their experiences and giving value to their own understanding. While the project has set out some particular terms, what's more important is the approach; the '5 As' – which were wholeheartedly agreed upon by everyone – provide a structure for what many in maternity services do already, and remind people to do it consistently, in every context.

This is a really challenging time for the NHS and maternity services in particular, so it's vital this isn't used as a stick to beat people with. I wouldn't want to see someone berated for using a slightly different term – it's about empowering them to use language that will both get across what they want it to, and ensure women feel listened to and have a good experience.

My one hope for this project is that it advances the goal of better communication, both between maternity professionals, and between maternity professionals and women.

The RCOG is working on implementing the findings of the Re:Birth project throughout its projects and guidance.

Re:Birth report

WHAT WORDS USED BY HEALTH PROFESSIONALS HAD A NEGATIVE IMPACT ON SOME WOMEN OR WERE 'DIFFICULT' FOR THEM TO HEAR?

- 'Approve'
- 'Normal' labour and birth
- 'Vaginal birth'
- 'Help' or an 'intervention'
- 'Failure' or 'emergency' – for example, 'failed home birth', 'failed induction', 'failed forceps'
- 'Query maternal effort'
- 'Failure to progress'
- 'Delivery' and 'section'

34

The number of synonyms identified by listening group participants for the term **'normal birth'**

IMAGES: SHUTTERSTOCK / ISTOCK

Maria Booker

PROGRAMMES DIRECTOR AT BIRTHRIGHTS

There has been a background atmosphere about some terms used in maternity service for some time, particularly 'normal birth', which had become associated with Morecambe Bay and the idea of people pushing an ideology of birth without interventions 'at any cost' – a phrase which came out of the Kirkup report.

So it was really important the RCM took this on and came up with a way of steering people towards a more positive conversation. The fact that they developed a robust in-depth approach, bringing in views from across the maternity community, will stand this in good stead.

What was surprising was the variety in how different groups understood certain terms. I hadn't really appreciated the obstetricians' views on what the word 'unplanned' meant to them for example, so it was necessary to have that debate and unearth those things.

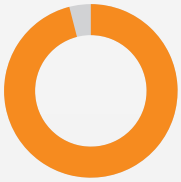
And while we need clinical terms to describe something accurately, there is also an emotional layer to them, as we heard in the listening groups – we need to ensure those terms don't have negative connotations for women and birthing people.

The greatest area of consensus was around individualised care, which as a charity we strongly advocate. We want people to have choice and for their choices to be supported and respected, and language is so important in that. A conversation with a woman or birthing person can be completely thrown if it begins 'so I see last time you had a straightforward birth' and that doesn't reflect their views or experiences. Language can open doors or shut them – it's the key to women feeling listened to.

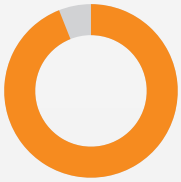
I hope midwives and healthcare professionals across maternity will engage with this report and reflect on their practice, with lots of discussion and dissemination. I would love to see it put into action – it would make a huge difference to maternity care.

Re:Birth Report

WHAT TERMS WERE PREFERRED IN NOTES, RESEARCH AND AUDIT?



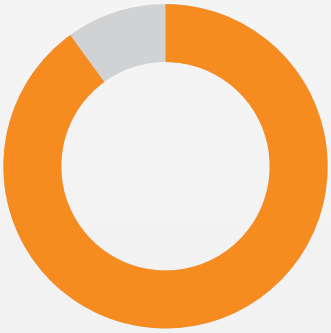
96%
of midwives



94%
of obstetricians

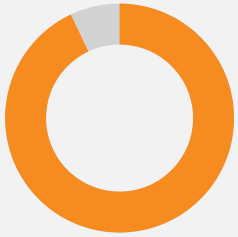
preferred the term **'spontaneous vaginal birth'**, compared with **81%** of service users

99%
of midwives and obstetricians favoured the use of **'induced and augmented labour'**, compared with **78%** of service users



'Birth with forceps' was universally preferred by

>90%
for all **4** groups in the final survey



93%
of respondents preferred or did not mind **'birth by caesarean'** and **'caesarean birth'**

95%–99%

of each group preferred **'planned'** to describe an **'elective'** or **'pre-labour'** caesarean birth

MORE INFO
To read the summary report from the Re:Birth project, go to **bit.ly/RCMRebirthreport**

The Lullaby Trust's Jenny Ward gives advice on how to ensure babies can sleep safely

The sudden and unexpected death of a baby is a terrible shock, and one of the most devastating things that can happen to a family – but we know that its occurrence can be reduced. The effect that safer sleep advice has had on the number of babies dying suddenly and unexpectedly is well known; since the launch of the Back To Sleep campaign in 1991, the number of babies dying has been reduced by 80%. Despite this, sadly babies still die suddenly and without cause, with almost 200 succumbing to sudden infant death syndrome (SIDS) every year.

Safer sleep advice needs to be given to all families, but information from the National Child Mortality Database over the past few years has confirmed which ones are the most in need of targeted advice and support. For example, babies that are more likely to die of SIDS are: those that were born prematurely or at a low birthweight; babies born to young parents; those whose parents smoked during pregnancy and/or after the birth; babies born into households

IMAGE: SHUTTERSTOCK

living with multiple deprivation and vulnerabilities, including substance misuse; and those sleeping in an unsafe sleep environment. The RCM has been working with The Lullaby Trust to ensure safer sleep messages reach these families in particular.

This work has involved developing a detailed RCM document to guide midwives and maternity support workers (MSWs) when providing safer sleep advice to families in the antenatal and postnatal period. Alessandra D'Angelo, professional and policy advisor at the RCM, led the development of the guide, titled *Safer sleep guidance for maternity healthcare professionals*. It provides an overview of the main risk factors for SIDS, and provides clear and up-to-date advice for healthcare professionals to give families on how they can reduce those risks.

Pregnancy is a key opportunity for midwives and MSWs to talk to families about safer sleep, as well as to inform and support their decision-making process about their baby's future care. They can identify specific risks, both modifiable and non-modifiable, for that family's baby.

Early intervention could help families make lifestyle changes and care decisions with safer sleep in mind, such as how to make their baby's sleeping environment safer or smoke-free. This is particularly important with socially disadvantaged families and others at increased risk of SIDS, as it can provide a personalised approach and ensure a plan of care is in place before the baby's arrival.

All carers – including parents – need clear, personalised advice on how to reduce the risk of sudden unexpected death in infancy (SUDI) for their baby; midwives and MSWs should provide verbal and written advice that is revisited at different times and that is consistent with the latest evidence.

To support you, a number of resources from The Lullaby Trust and the RCM are available for free online. The RCM's *Safer sleep guidance for maternity healthcare professionals* provides guidance on how midwives and MSWs can reduce the risk of SIDS. Meanwhile, The Lullaby Trust's *Safer sleep: saving babies lives – a guide for professionals* is written for all professionals working with families with young babies. It is specifically aimed at helping professionals to effectively convey safer sleep information to parents. The guide emphasises the vital importance of having open, non-judgmental conversations with parents about safer sleep, including bed-sharing, and provides suggestions that will help when having difficult discussions.

The Lullaby Trust has a wide range of other resources on its website, including safer sleep factsheets, animations and online presentations. It also provides free safer sleep training sessions for midwives working in England, Wales and Northern Ireland, and runs SIDS and safer sleep training sessions for other professionals and practitioners. Whatever the situation of the families you are supporting, there is advice and resources available to help provide safer sleep advice for them.

Alessandra D'Angelo led the development of the RCM's guidance on safer sleep for babies

RISK FACTORS FOR SUDI

Age
Babies under one year old are most at risk – especially during the first six months of life

Birthweight
Rates of SUDI are higher in low birthweight babies (less than 2,500g/5lb 5oz)

Poverty
Deprivation has been linked to the occurrence of SUDI, and the risk is higher for babies in families of lower socioeconomic groups

Prematurity
Preterm babies (born after less than 37 weeks' gestation) are at four times higher risk of SUDI compared with babies born at term

Smoking
- Babies are at greater risk when a mother smokes during pregnancy or if there is smoking in the home
- The risk of SIDS is up to four times higher if a parent that smokes bed-shares

Sleeping habits
- Unsafe sleep position (prone, side)
- Sleeping in a car seat, bouncy chair or baby carrier
- Co-sleeping in hazardous circumstances, particularly on a sofa or armchair

Drugs and alcohol
Bed-sharing with a baby when a parent is under the influence of drugs or alcohol increases the risk of SIDS by 18 times

Source: *Safer sleep guidance for healthcare professionals*

IMAGE: SHUTTERSTOCK

Early intervention could help families make lifestyle and care decisions with safer sleep in mind

Understandably, families who have experienced the sudden and unexpected death of a baby are often very anxious when they have another child. The Lullaby Trust's Care of Next Infant (CONI) programme is a bereavement support scheme that provides emotional and practical help to bereaved families during the early months of their new baby's life. Midwives play a crucial role in identifying when expectant parents have experienced SIDS or SUDI and are anxious about this subsequent pregnancy.

The Lullaby Trust has produced new resources that can be used by midwives in the antenatal period, in the areas of the UK where the CONI programme is offered to parents. The new resources consist of a free easy-read card to act as a memory aid for midwives antenatally, which can then be given to the expectant family.

The cause of SIDS remains unknown. However, we do know how to reduce the risk of it occurring and which families are most vulnerable. Together, the RCM and The Lullaby Trust are working to reduce inequalities faced by new and expectant parents and save more babies' lives.

RESOURCES

- The RCM's *Safer sleep guidance for maternity healthcare professionals*: **bit.ly/safersleepguidance**
- The Lullaby Trust's *Safer sleep: saving babies' lives: a guide for professionals*: **bit.ly/Lullabysafersleepguidance**
- Free SIDS and safer sleep training for midwives: **bit.ly/SIDStrainingmidwives**
- SIDS and safer sleep training for other professionals: **bit.ly/SIDStrainingprofessionals**
- New CONI antenatal resources for midwives: **bit.ly/LullabyCONIresources**

A critical moment

The instinctive actions of a midwife saved Emma Ogles from a life-threatening bleed. She tells *Midwives* about the experience

Emma suffered from bleeding after giving birth to Amelia

Having tea and toast after giving birth to my daughter, Amelia, I was more than ready for a rest. I was in labour for 24 hours and felt exhausted. I woke with an intense pain in my lower back. It was so strong that I had to roll onto my side, but as I did, we heard an almighty splash.

The last thing I remember is asking my husband if someone had turned a tap on, before I passed out and hit the back of the bed. The splash was my blood, which had pooled inside me and flooded out as I turned over.

My husband ran into the corridor and shouted for help. The next thing I remember is being slapped around the face by the matron and having my legs held in the air as I was brought round.

I'd lost a significant amount of blood, and was told I was going into surgery. I had to sign an agreement that I might have to have a hysterectomy as a result.

Life-saving decision

Rewind to my labour, which started at home. My contractions were regular and strong, but on arriving at hospital I noticed fresh blood and clots in my underwear.

This wasn't normal, the midwife told me. Deciding to err on the side of caution, she cross-matched my blood. It's a decision for which I'm eternally grateful.

Amelia was born successfully via ventouse. Thankfully she was well, but I felt uncomfortable. Discovering a small pool of blood in my bed, the midwife told me this was normal.

But then came the massive bleed no-one was expecting. In surgery, I had five transfusions with the blood that was cross-matched by the midwife earlier. I was in surgery for two hours and lost over four litres of blood. Once on the intensive care ward I was unable to care for Amelia as I couldn't move, and I stayed in hospital for three more days.

I was in surgery for two hours and lost over four litres of blood

Lessons to learn

The midwives gave us amazing care while I recovered. But it was the scariest experience we'd ever had. If my midwife hadn't made that instinctive decision, there wouldn't have been any blood available for my transfusions. During the surgery, my husband heard one of the surgeons tell a midwife that more blood was 20 minutes away, yet I'd have only survived another 10.

That I had to read and sign an agreement before going into surgery still bothers me. I'd lost so much blood that I couldn't focus, let alone understand the words. I've suggested that women need to be made aware of the document at midwife appointments so they can read and understand it before they are in labour. I've been told it's not customary to discuss all possible operative procedures – but I believe this needs to change.

The best outcome is our healthy, happy little girl. But each pregnancy is so individual, and it is vital for midwives to follow their instincts.



manx care
Kiarail Vannin

Would you like to be part of a midwifery team where you can provide **continuity of care** throughout a woman's pregnancy and birth, from antenatal and delivery through to postnatal care? Would you like to work in a midwifery team that is **central** to the Island's community? Are you an **enthusiastic**, **friendly** and **proactive** midwife who wants to contribute to the success of the team?

Join us as a Midwife on the Isle of Man

- You'll be working with a **friendly** and **supportive team** who are committed to delivering a quality service
- Support for **your career goals** and **development**. You will have regular opportunities to discuss your aspirations with your line manager, and we offer a coaching and mentoring service open to all employees. If you are a newly qualified registered midwife, we are able to offer you **a supportive preceptorship programme**
- **Competitive** salary and annual leave entitlement. Annual leave starts at 27 days + 10 public bank holidays. Extra days leave may be available for candidates with service within the UK NHS
- Enjoy the **fantastic lifestyle opportunities** the Island has to offer – walking, diving, sailing, mountain biking and great beaches
- **Free car parking** on-site at Noble's Hospital and we also have a subsidised canteen
- We know changing jobs can be daunting at times, so we have a **buddy scheme** at Noble's. If you're successful, we'll pair you up with a buddy who can show you the ropes and help you settle in here
- Paid interview expenses and a **relocation package** of up to £7,000 are available, with an additional incentive payment scheme and support towards housing costs
- An excellent **training and development** opportunities - We operate a well-resourced education and training centre where we provide opportunities for professional learning and CPD

For further information about working as a Midwife on the Isle of Man, **scan the QR code** or call **01624 651052**

Manx Care hold the following Care Values which reflect the culture we are aspiring to create:
Commitment and Passion
Accountability and Reflection
Respect and Inclusion
Excellence and Innovation

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