THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 25 / NOVEMBER 2022

midwives

PART OF THE SOLUTION
ACTING ON THE OCKENDEN REPORT

A HELPING HAND
PRECEPTORSHIP PROGRAMMES IN THE UK

BABY LOSS
BEREAVEMENT CARE AND WORKPLACE SUPPORT

The bigger picture

TAKING BACK CONTROL OF WOMEN'S HEALTH, RESEARCH AND CARE

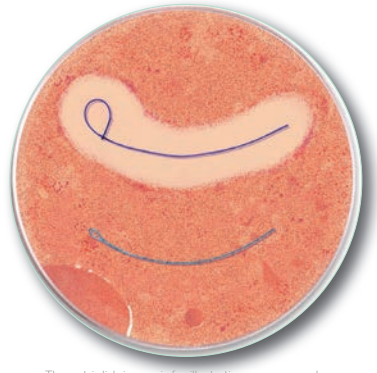
NOVEMBER 2022

Protect your **patients.**

Antibacterial protection that starts on the inside:

PLUS Antibacterial Sutures have been shown in vitro to inhibit bacterial colonization of the suture for 7 days or more and are effective against the most common organisms associated with SSIs[1-3]:

- ✔ Staphylococcus aureus
- ✔ 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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- ✔ **Self-anchoring** technology maintains closure without knots, **eliminating knot-related complications**[4]
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- ✔ While sutures and staples penetrate the skin and place tension on the wounded tissue, DERMABOND™ PRINEO™ Skin Closure System **redistributes tension in a uniform way**[#15]
- ✔ **No postsurgical dressings** may mean easier self-care for patients[16]

For complete indications, contraindications, warnings, precautions and adverse reactions, please reference full instructions for use.

*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).

ETHICON

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Johnson & Johnson Medical Limited, Baird House, 4 Lower Gilmore Bank, Edinburgh, EH3 9QP, UK

midwives

The official magazine of
The Royal College of Midwives
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0300 303 0444

Magazine subscription rates
(For non-members only, per annum)
UK £130
European Union £175
Rest of the world £185

Magazine subscription queries
Curwood CMS Ltd
+44 (0)1580 883844
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Printed by Precision Colour Printing.
Mailed by MAFMK

All members and associates of the RCM receive the magazine free.

The views expressed do not necessarily represent those of the editor or of The Royal College of Midwives.

All content is reviewed by midwives.

Full article references are available on request from magazine@midwives.co.uk

Midwives ISSN 1479-2915

Birte Harlev-Lam, executive director midwife at the RCM, says we must work together to mend maternity care

Welcome

Every woman should feel that they are properly supported, cared for and listened to by maternity staff throughout pregnancy, labour, birth and the postnatal period. As Dr Bill Kirkup's report points out, too often this was not the case at East Kent Hospitals NHS Trust.

The Kirkup report paints a picture of a difficult working environment and staff too frightened to raise concerns. This absolutely cuts to the quick of the RCM's ethos and values.

In 2019, we launched the Caring for You campaign to promote emotional support, as well as a workplace charter for employers to commit to meeting the health, safety and wellbeing needs of staff. This year, we've refreshed the campaign, with stronger commitments from the employer to comply with health and safety legislation, NMC Standards for Midwifery and Education, and to build relationships with RCM activists and branches so that members know they have someone fighting their corner.

The RCM has a long and proud history of supporting and empowering its members. Earlier this year, we published updated guidance to support midwives and maternity support workers who want to raise concerns. This is vital, and everyone involved in maternity care should be able to stand up for high standards.

We must work together to fix these toxic cultures that put lives at risk. The RCM has long called for greater provision for multidisciplinary teams – including midwives, obstetricians and anaesthetists – to train together to support better working practices, and it is working with the Royal College of Obstetricians and Gynaecologists to address this.

We must fix toxic cultures that put lives at risk

Without systemic change and – importantly – funding, maternity services will continue to struggle, and this is the second report this year to highlight that. But despite the recommendations of the Ockenden report being accepted in their entirety by the government, consistent progress has yet to be made.

We cannot have review after review, report after report, and nothing fundamentally changes. The RCM has no regulatory powers, but we can be there for our members, empowering them to speak up and speak out for their colleagues and the families in their care.

standing up for high standards

Your guide for raising concerns:

Step 1:

Talk to your local RCM workplace rep or your Regional/National Officer about your concerns to determine the best course of action.

Step 2:

Check your employer's policy on raising concerns so that you know the right route to take.

Step 3:

Be clear about the requirements of your professional code. Raise immediately with your Supervisor of Midwives/Professional Midwifery Advocate/Clinical Supervisor for Midwives or RCM representative if you are being asked to contravene your code.

Step 4:

Be clear about what you are concerned about and why.

Step 5:

Place your concerns on record - your RCM representative can help you with this.

Step 6:

Be prepared to have meetings to explain your concerns and determine the way forward.

Step 7:

If, having completed steps one to six you remain concerned, contact your local Freedom to Speak Up Guardian/Raising concerns champion.

Step 8:

If you are considering using the whistleblowing policy, seek support and advice from either your local RCM representative or Regional/National Officer.

Find out more here

Royal College of Midwives

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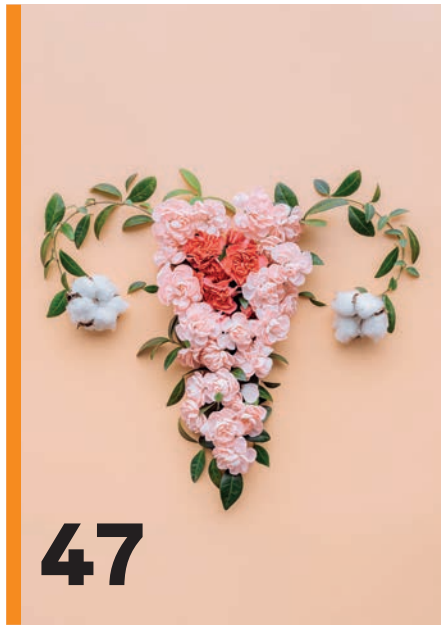
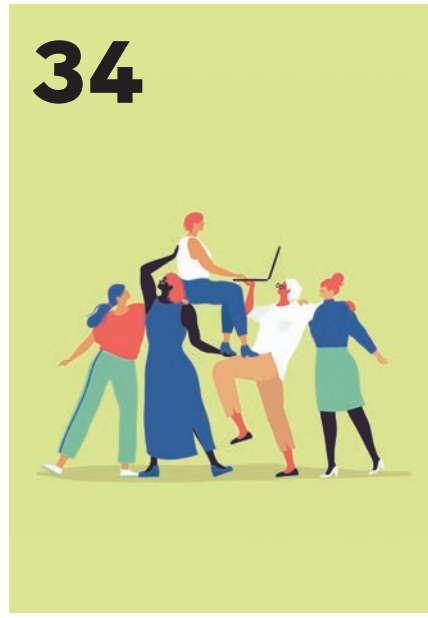
VOLUME 25 / NOVEMBER 2022

News

The longer read

Employment advice





Talking point

External submission

Voice of...

in brief

YOUR PROFESSIONAL MIDWIFERY NEWS

16 days of action to prevent violence

This year's 16 Days of Activism Against Gender-Based Violence continues the call for prevention and elimination of violence against women and girls. Women are more likely to experience domestic abuse than than men; according to the Office for National Statistics, 1.6 million women experience domestic abuse every year. And, while midwives and MSWs are trained to spot the signs of domestic abuse in the women in their care and signpost them to help, they are generally poor at recognising abuse in their own domestic situation and seeking help.

Women's Aid defines domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer.

Domestic abuse can include:

- Coercive control (a pattern of intimidation, degradation, isolation and control with the use or threat of physical or sexual violence)
- Psychological and/or emotional abuse
- Physical or sexual abuse
- Financial or economic abuse
- Harassment and stalking
- Online or digital abuse.

It is important to consider all of these elements as domestic abuse and not just physical or sexual violence. If you or a woman in your care is experiencing domestic abuse then there is help, visit **bit.ly/domesticabusehelp** for a comprehensive list of free, confidential UK helplines, live chat support, apps and safe spaces. It also provides guidance for employers on how they can support their staff.

VOTE

To vote on industrial action in England and Wales, please make sure your details are up to date. Visit **rcm.org.uk/login**

one to watch

READ

Systemic Racism, Not Broken Bodies, the charity Birthrights' year-long inquiry into systemic racism within UK maternity care at **bit.ly/birthrightsracialinjustice**

WATCH

Baby Lifeline's National Maternity Safety Conference sessions are available online for an £80 fee, visit **bit.ly/maternitysafetyconference**

IMAGES: ALAMY / ISTOCK / SHUTTERSTOCK

NHS pay offer

Industrial action ballot in Scotland

RCM Scotland balloted members last month on whether to take industrial action in light of the rejection of the government's 5% and revised 7% pay offer, which leaves experienced staff worse off. In the highest-ever turnout for an RCM pay consultation in Scotland, almost 90% of RCM members who voted said they wanted to be balloted on industrial action.

Jaki Lambert, RCM director for Scotland, said: "We have got to this point because the Scottish Government failed to address the crucial issues laid out in our pay claim earlier this year. We warned them that our members were at breaking point and that failing to deliver a pay increase that would match the rate of inflation could be detrimental to recruitment and retention. Many of our members feel undervalued and have had enough. They are already struggling with the rising cost of living and feel they've had no other choice but to make a stand in order for the government to wake up and listen."

A recent RCM survey of midwives in Scotland has shown that seven out of 10 midwives are considering leaving the NHS. A staggering half of respondents said they rarely had enough staff to provide safe care for women. Jaki added: "Even if our members do vote to take industrial action, I want to reassure women that staff will maintain safe services and women and their families can still expect the delivery of safe care. We will not ask our members to break their code of conduct. During previous strike action in other parts of the UK in 2014, services continued to be delivered safely and this will be the case if our members vote to take industrial action in Scotland."

NHS pay offer

Industrial action ballot in England and Wales

Midwives and maternity support workers (MSWs) working in the NHS in England and Wales will be balloted on industrial action from 11 November. This follows a month-long consultation that saw members overwhelmingly reject their governments' below-inflation pay award, with 75% saying they wanted to be balloted on industrial action. Two-thirds of eligible members in England and more than eight out of 10 in Wales took part in the consultation.

RCM executive director trade union Dr Suzanne Tyler said: "Midwives have only taken strike action once in 140 years. This is not something they take lightly. But they feel they have no other option to getting a fair and just pay award from their governments."

The RCM says if members vote in favour of taking industrial action, NHS employers in England and Wales will be given adequate notice of any type of industrial action. They will also work alongside RCM workplace representatives and maternity service managers to ensure there is cover during any work stoppages across and the delivery of safe care will not be compromised. The RCM says that, should its members vote for industrial action, they will not ask members to break their NMC code of conduct and safe services will be maintained.

LACK OF QUALITY CARE

The Care Quality Commission's State of Care report in October showed maternity care is falling below standard with 6% of NHS services (nine out of 139) now rated as inadequate and 32% (45 services) rated as requiring improvement. This means that the care in almost two out of every five maternity units is not good enough. Safe staffing was of particular concern, with only 6% of midwives saying there were enough staff in their organisation for them to do their job properly.

"Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised to reduce risk and help prevent tragedies from occurring. Furthermore, women from ethnic minority groups continue to be at higher risk of dying in pregnancy and childbirth than white women, and more likely to be re-admitted to hospital after giving birth," said the report.

bit.ly/cqcstatehealthcare

Air pollution

Toxic particles found in unborn fetuses

Toxic black carbon particles have been found in the lungs, livers and brains of unborn babies, meaning they have been breathed in by the mother during pregnancy and then passed through the bloodstream and placenta to the fetus. The joint study, published in *The Lancet*, was conducted with non-smoking mothers in Scotland and Belgium.

"We have shown for the first time that black carbon nanoparticles not only get into the first and second trimester placenta, but then also find their way into the organs of the developing fetus," said Professor Paul Fowler, at the University of Aberdeen.

Of particular concern is that air pollution is known to increase the chance of miscarriage, premature birth, low birth weight and impair brain development. The 36 foetuses examined in the Scottish part of the study were from voluntary terminations of normally progressing pregnancies between seven and 20 weeks of gestation. The findings are especially concerning because this window of exposure is key to organ development.

bit.ly/lancetairpollution

Indoor pollution

The health harms of everyday cooking and cleaning products

Scientists at Swansea University have launched a major study to discover how everyday indoor pollutants, such as those from cleaning products and cooking, affect the development and health of fetuses and children. In the UK, people spend on average 90% of their time indoors. The four-year 'Relating environment-use scenarios in pregnancy or infanthood and resulting airborne material exposures to child health outcomes' (RESPIRE) project has received £3.4m in funding from the National Institute for Health Research and UK Research and Innovation (UKRI) through its Strategic Priorities Fund clean air programme.

Cathy Thornton, professor of human immunology at Swansea University, said: "Our UK-wide collaboration will be the first to explore how pregnant women might respond differently to air pollution as a way of understanding the health consequences for their children." The study is designed to determine how air pollution exposures of pregnant women pass to the baby and affect organ development.

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

MIDIRS Digest

1 The National Maternity and Perinatal Audit: evaluation of care processes and outcomes to improve maternity care using a national audit tool, Alessandra Morelli, Kirstin Webster

2 Midwife responses to the 2021 NHS Staff Survey: what is it like being an NHS England midwife? Kate Jones

3 Complex ethical scenarios in maternity care: how do professional and personal values impact on decision making? Kelly Williams

4 The impact of midwifery staffing levels on breastfeeding rates in a North West National Health Service (NHS) maternity service, Ashley Lai Thom

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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IMAGES: ISTOCK / SHUTTERSTOCK

Menopause study

Stigma and no support

Landmark Study, the largest ever survey of menopausal women, has reveals a lack of basic support and a stigma that means the needs of menopausal women are being ignored in the workplace and by healthcare providers.

Carried out for the Channel 4 *Davina McCall: Sex, Mind and the Menopause* documentary, the study shows the majority of women (77%) find at least one menopause symptom 'very difficult', with women most likely to say they find sleeping (84%), brain fog (73%), and anxiety or depression (69%) difficult. For 23% of key worker women, their uniforms are uncomfortable given their menopause symptoms; 44% of women in employment say their ability to work has been affected and 52% say they have lost confidence. Despite this, eight in 10 menopausal women say their workplace has no basic support in place for them – no absence policies (81%) and no information-sharing with staff (79%). The study shows that 10% of menopausal and perimenopausal women who have worked during their menopause have left work because of their symptoms.

Jemima Olchawski, Fawcett Society chief executive, said: "333,000 women have left the workplace as a result of their symptoms. Do we really think we can afford to disregard these women with all the talent, potential and experience they bring to our workplaces? What's so frustrating is that this is completely unnecessary. Our research shows that providing flexible working options, training for managers and support networks would hugely benefit women and in turn, encourage them to stay in the workforce."

Four out of five would quit the NHS over concerns about their pay – NHS staff survey (June)

What's on?

7 NOV
National Stress Awareness Day

17 NOV
All Ireland Midwifery Conference bit.ly/rcm2022irelandconference

21-27 NOV
Carbon Monoxide Awareness Week

24 NOV
#MSWcelebrationday2022
See page 30 for a rundown of the celebrations

25 NOV
White Ribbon Day
whiteribbon.org.uk

25 NOV- 10 DEC
16 Days of Activism Against Gender-Based Violence

30 NOV
St Andrew's Day

5 DEC
International Volunteer Day

CQC report

Racial inequality in care

The Care Quality Commission State of Care report has once again highlighted "deeply embedded" racial inequalities in maternity care.

Tracey Bignall, senior policy and practice officer at the Race Equality Foundation and member of the Racial Justice Inquiry into Maternity Care led by Birthrights, said: "It's a tragedy that little progress seems to have been made ... We are particularly concerned that removing the 2024 target effectively means continuity of care has been scrapped as a way of reducing inequalities in maternal mortality. We know this is largely due to the recruitment crisis in midwifery, but instead of tackling this problem head on, it appears to have been swept under the carpet. We continue to see evidence of disproportionate deaths, with Black women more likely to be readmitted in the six-week postpartum period than women of other ethnicities. It's crucial that the state of care is not continually left to deteriorate by the government. Action is needed urgently."

Working for you

The RCM's first in-person annual conference for three years was held on 4 to 5 October to a packed ICC in Wales

Audience members saw a wealth of thought-provoking speakers

DAY ONE
Welcome

RCM president **Rebeccah Davies** and RCM chief executive **Gill Walton** were joined on stage by the Welsh minister for health and social services, **Eluned Morgan**, to welcome delegates.

Eluned painted a picture of maternity services in Wales, discussing the maternity vision, preceptorship programme, national retention offer and the WHO Collaborating Centre on Investment for Health and Wellbeing (bit.ly/nhswaleswhocc). The conference hall erupted with applause when she noted that the Pay Review Body pay offer had been accepted but no one was backing down from the battle. "It's scandalous that bankers get bonuses while frontline NHS staff get nothing," she said.

Gill talked about the pressing issues of the staffing crisis, burnout and safety and how the RCM was fighting its members' corner. "We can't just moan from the sidelines – we must bring about positive change," she said. "We do that by campaigning for the right to workplaces that are safe, safe for you and safe for families." She called on the RCM's 50,000 members to vote in the ballot on industrial action over pay and conditions and "make a noise so loud that it can't be ignored."

Avoiding brain injury in childbirth

The THIS Institute's **Dr Lisa Hinton** and **Dr Jan van der Scheer** and the RCM's consultant midwife **Wendy Randall** discussed the innovative, collaborative approach of the ABC project. The cost of legal claims is significant – 10% of claims made against the NHS are for maternity care, and they account for 60% of costs. Lisa pointed out that normal fetal heart rate patterns are predictive, but abnormal ones are poor predictors of problems and that there was a need for better assessment. Two to three families a day suffer injury from intrapartum care, and this project offers a standardised approach to assessment and care (see thiscovery.org/project/abc).

"How many times have you heard in practice 'Is the CTG okay?'" asked Jan. "This is not right – we should be asking 'Is the baby okay?'"

Recover, reflect, renew

The theme of this year's conference was discussed first by **Dr Patricia Gillen** and **Dr Paula McFadden** in 'Health and wellbeing: exploring quality of working life and coping during the COVID-19 pandemic' and then in 'A UK perspective on post-COVID-19 maternity services'

PHOTOGRAPHY: CARMEN VALINO

Speakers included Carina Okiki (top centre), Candice Noonan (bottom right) and Gill Walton (bottom left). Elsewhere, delegates enjoyed physical therapy sessions and champagne with colleagues

by **Ruth May**, chief nursing officer for England, and **Maria McIlgorm**, chief nursing officer for Northern Ireland. Obviously, maternity services couldn't be paused for the pandemic, regardless of the pressures on them, Maria said. "We led the way for how services operated during the pandemic. I'm proud of but not surprised by how midwifery rose to the challenge."

Ruth echoed the sentiment that everyone had adapted to the challenges of appointments and visiting and she thanked everyone for "their collective leadership and for not closing your doors". Both said the workforce recruitment and retention challenge needed to be met by investment, training, by there being more options for "wannabe midwives" who don't have the qualifications, preceptorship frameworks and by more midwives in executive, decision-making posts.

Decolonising the midwifery education curriculum

This session, supported and chaired by the Student Midwives Forum, saw **Jane Bekoe**, **Dr Claire Clews**, **Carina Okiki** and **John Pendleton** discuss efforts to address the gaping holes in maternity education. Carina noted: "Conversations can be uncomfortable, so that's why it's important to explore that together."

A survey of Black, Asian and minority ethnic student midwives found that many felt as though midwifery was "an exclusive club" that they couldn't join or speak out against because they were too easy to identify, and that their inclusion on the course was a tick-box exercise. Many had said they were the only brown person in the room both at university and on placement. Many also noted that lecturers didn't recognise "cohort tribalism" or the unconscious bias of the teaching – only Black and brown students noticed, while one in 20 cited racial harassment as a reason for not continuing studies. Jane discussed her work on the RCM's Race Matters campaign, "a project to actively listen and promote change – through actions not words". She drew attention to the mentoring campaign, among other initiatives, which was launched in response to a noted lack of development and progression and a lack of visibility in leadership roles.

High-quality bereavement care is everyone's business

Candice Noonan, bereavement MSW (and RCM award winner), **Nicola Welsh**, CEO of Held in Our Hearts, and Sands head of training and education **Clare Worgan** all advocated understanding the individual nature of the loss. Candice said that it was important to listen to the wishes and birth plan of the parents and make sure it is communicated to the whole team. She said: "Advocate for women but sometimes just being there allows them to advocate for themselves." Nicola discussed the advances in keepsake packs that are available including culturally specific packs such as 4Louis' Ibraheem's Gift for Muslim parents (4louis.co.uk/ibraheems-gift). Clare said one in four pregnancies was a miscarriage and therefore the importance of good-quality bereavement care cannot be understated. She discussed the range of resources and training available to ensure midwives and MSWs can support families through tragedy.

We are in this together

Gill Walton joined forces on stage with RCOG president **Dr Eddie Morris** and, via video link, **Donna Ockenden** to discuss mutually respectful relationships and supportive workplace cultures. Little wonder that the last session of the day drew everyone's attention.

Donna began by discussing the challenges facing services – as stated at the very start of her report into baby deaths at Shrewsbury and Telford – that a lack of funding, a lack

I'm proud of but not surprised by how midwifery rose to the challenge of the pandemic

of safe staffing and a lack of a coherent plan was compounding issues in maternity: "You can't fill a bath with the plug out," she said. She noted that maternity was facing more complicated pregnancies due to a rise in older mothers, a rise in mothers with a BMI of 25 and above and a rise in social deprivation: "The use of food banks has risen 81%." All of which adds to the pressures on staff and reinforces the urgent need for investment in the workforce. She good-naturedly corrected session chair Giuseppe Labriola for describing the 15 "recommendations" in her report, pointing out that they were "ideas" for how we can better coordinate and support services.

Gill and Eddie asked how, in pressurised services, can 'working together' happen? "On the shopfloor by obstetrics and midwifery having each other's backs," said Gill. Eddie pointed out what a privilege it is to take care of a pregnant woman "because this is the person that essentially the whole hospital is scared of".

On a serious note, he said maternity is the "Cinderella service because the hospital ethos is based on maternity consuming its own smoke. That's wrong, if there's smoke that means there's a fire and can't be ignored by the rest of the organisation."

Gill agreed that the report had changed the view of maternity and that it would be "a very brave director that didn't listen to maternity now".

Following the Ockenden report, both Gill and Eddie discussed the forming of the Independent Maternity Working Group to be a "critical friend" in translating, planning and putting into practice the report's immediate and essential actions. Gill also said that anyone considering leaving the profession should "talk to someone first because there are better times ahead".

Anyone considering leaving the profession should talk to someone first because there are better times ahead

Only 32% of services provide training on cultural competency and therefore have little comprehension of the cultural differences of experience and expectation for new mothers. "Black women only tend to access perinatal mental health support via the criminal justice system," she said, to gasps from the audience.

Mark Williams gave equally powerful testimony documenting his experiences of poor mental health after becoming a father. He spoke of his loneliness and difficulty bonding with his baby alongside dealing with a partner going through postnatal depression, compounded by an inability to talk about how he was feeling which

Speakers and RCM staff, clockwise, from top left: president Rebeccah Davies with Gill Walton, Joan Walker and Ann Thomson; DrJoan Myers; Birte Harlev-Lam; Nicola Walsh; Mark Williams.

DAY TWO
Challenging the stigma of perinatal mental health

Sandra Igwe, founder of the Motherhood Group, gave a powerful talk on her experiences of recognising, addressing and accessing help for postnatal depression as a Black woman.

"How could I open up to a system that had caused me trauma and pain and didn't have my best interests at heart?" she asked.

expressed itself as anger and destructive behaviour. He noted that suicide rates were high for men, especially in the perinatal period, and said not enough care is given to father's experience.

"Just have a conversation with the father," he urged delegates. "It takes five minutes and it could save lives."

Thriving not just surviving in the workplace

Dr Joan Myers brought down the house with her positivity in this session on creating supportive and caring workplaces. "You have the power to change the atmosphere in a workplace," she said, relating anecdotes about telling jokes to civil servants to lighten the mood: "No matter what someone's status or role, they are still people."

And her advice on dealing with someone who is difficult was to "show kindness because it confuses them!" She also made the point that if you know your own value then you don't have to worry what people think of you, this doesn't mean acting in isolation but that your confidence helps support others and enables you to "bring people along with you."

As a career mentor she advised delegates to write a plan of small steps that lead you to where you want to be.

Standing up for high standards

RCM director for maternity reform **Abbie Aplin**, consultant midwife **Rumbidzai Mutema** and student midwife **Lisa Rollinson** discussed what raising concerns means for midwives, MSWs and students in practice. All noted that workplace culture needs improvement and that mistakes highlighted in maternity safety reports are simply not being learned from. Guardians who should be the end of the process when nothing else has been acted on are reporting a year-on-year increase in reports. Rumbidzai said: "When we raise concerns it shouldn't be about individual blame, it should be about learning" and for that reason the support for the person raising the concern is vital because "a great deal of thought has gone into that action." Lisa spoke of the experience of student midwives in raising concerns. "What happens if the person you need to escalate those concerns to is the same person they are about?" she asked.

Abbie noted that the change must come from the bottom up, and that civility, kindness and psychological safety should be at the core of every workplace. "This is our time to make it better," she said.

Duty of candour

This session looked at how to have open and honest conversations especially when things go wrong. RCM executive director midwife **Birte Harlev-Lam** stressed the importance of saying sorry and being honest when something has gone wrong – it can give families answers and help them move on.

The NMC's **Verena Wallace** agreed, saying that it is in section 14 of the Code and that it is important for colleagues to hear too so that it can be learned from.

The conference drew to a close with a focus from Birte and RCM executive director trade union **Suzanne Tyler** on everything that delegates had heard over two days about the challenges facing midwifery and the opportunities. They outlined what the next steps are for the RCM to support its members and the role that individuals can play in driving change. As Suzanne commented: "These are exciting times ahead – let's get active!"

PHOTOGRAPHY: CARMEN VALINO

the bigger picture

ILLUSTRATION: BETH GOODY

Women's health has been neglected for years, under-researched and under-funded, and it's women who have paid the price. But things are changing

"Most of recorded human history is one big data gap." In her 2020 book *Invisible Women*, Caroline Criado Perez invites readers to imagine a world where your phone is too big for your hand, your doctor prescribes a drug that is wrong for your body and, in a car accident, you are 47% more likely to be seriously injured. "If any of that sounds familiar, the chances are you're a woman," she writes.

Compiling case studies, stories and research from across the world, Caroline exposes the data bias that exists "in a world designed for men" – and how it means half of the population is systematically ignored.

It's no different for women's health. Nicola Slawson writes in *The Guardian*: "Less than 2.5% of publicly funded research is dedicated solely to reproductive health, despite the fact that one in three women in the UK will suffer from a reproductive or gynaecological health problem. There is five times more research into erectile dysfunction, which affects 19% of men, than into premenstrual syndrome, which affects 90% of women." Furthermore, she says: "Women's bodies were seen to be too complex due to fluctuating hormones,

so clinical trials often excluded them." Until the 1990s, that is.

Despite 51% of the UK population being women (Office for National Statistics, 2022) women giving birth to every human on the planet, just 2.1% of public funding for medical research went towards women's reproductive health and childbirth according to the latest available data (UK Clinical Research Collaboration, 2018). "Research into women's health has traditionally been a Cinderella discipline," says Professor Louise Kenny, executive pro vice chancellor, health and life sciences at the University of Liverpool. "But we all get onto the planet via pregnancy; it's the one common denominator. So it's always amazed me that we haven't prioritised this for research."

Jeremy Barratt, head of research at Wellbeing of Women (WoW), agrees that women's health has long been neglected. "It's not spoken about enough. Often the topics are considered taboo, and they only affect women – so they haven't been spoken about publicly. In general, that's meant a lack of support for women's health and inevitably, that means nowhere near enough funding has gone to support research. Endometriosis only gets a fraction of the research budget that's gone into diabetes in the past – yet it affects the same proportion of women [Endometriosis UK]."

Lasting legacy

And it doesn't stop there: last year, it was revealed that 41% of UK medical schools do not have mandatory menopause education on the curriculum (Menopause Support, 2021). Dr Sofia Cerdeira, academic clinical lecturer at the Nuffield department of women's and reproductive health and lecturer in medicine at the University of Oxford, says there are more drugs being developed for rare disorders like amyotrophic lateral sclerosis (ALS) – which affects four in 100,000 people – than for pregnancy. The problem? Pregnancy is seen as a "self-limiting condition", Sofia explains, meaning it's "not so profitable to industry" and therefore there's a "lack of economic incentive for research funds".

There are also cultural and historical factors at play, suggests Louise. "Unfortunately, we are still dealing with the legacy of what I glibly call the patriarchy.

Just 2.1% of research funding went to women's reproductive health

ILLUSTRATION: BETH GOODY

My research journey

Two midwives discuss their journey to research

Anna Marsh
lead midwife for antenatal clinic at University College London Hospitals NHS Foundation Trust and MRes student at Bournemouth University

All of my work is about social media and midwifery. I was in clinic, having a conversation with a woman about how scared she was of birth, even though she'd never had a baby. I thought, what's influenced you to have that fear? I fell into research from ideas and problems that I had in the clinical workplace. I got chatting to some academics about it. They were really supportive and helped me on my journey.

Research isn't as scary as it seems. We know that having an evidence base is essential for providing high-quality midwifery care, so why shouldn't midwives be doing the research? Getting involved doesn't mean the end of your clinical practice – in fact, the two can work very nicely together – and it can be a really rewarding way of improving the care and outcomes for women and their babies.

Historically, the grant-funding bodies are largely made up of men. And women were absent from the table when priorities were being set, decisions were being made, funding was being allocated.

"Secondly, we all live in the legacy of thalidomide. This catastrophe probably set women's health and pregnancy research back several generations. Because of that, and other complexities, women of reproductive age have been largely excluded from research for ethical reasons."

But this is slowly turning around, it seems. Taskforces have been created and several organisations, including the WHO, FDA and MHRA, are pushing to develop strategies to include pregnant and lactating women safely in research, says Sofia.

"Happily, I think the world has caught up with my belief that it's unethical to exclude women – and by definition, babies," Louise adds. "We know how critically important those first 1,000 days are in terms of setting your later life health trajectories. So I think ethically it's irresponsible and morally inexcusable not to research within pregnancy or the neonatal period."

Addressing the gap

Organisations like WoW are working hard to bring women's health further up the research agenda. The studies it funds cover menstruation to fertility, pregnancy and birth, the five gynaecological cancers, the menopause and much more. "We're advocating for women, girls and babies and women's health across the life course, trying to get it in people's minds and spoken about openly; trying to get people to donate so we can fund more research," Jeremy adds. "We're also trying to get the government to be more involved and to put more budget towards women's health funding. And we're working with any organisation that shares our passion to improve the health and wellbeing of women and girls by investing funds in research – such as the NIHR, Scottish Government, the Royal Colleges, other charities and industry – and forming new research partnerships to try and leverage more funding."

Indeed, collaboration is crucial to addressing the research gap. Sometimes, the data is there; it just needs to be communicated more clearly, suggests Marian Knight, professor of maternal and child population health at the University of Oxford and lead for MBRRACE-UK. "We've been counting women's deaths and describing the fact that there were more women dying who were Black than white for a long time. But nobody's ever really been doing anything about it. I put it front and centre on an infographic in 2018 – and an amazing number of Black women's groups and others have developed lots of initiatives and become incredibly powerful advocates, and there's been an all-party parliamentary group set up for Black women's health.

"Many other people helped to make sure the message got to people's ears. My job is to work closely with the lay writing group to make sure those messages are coming out in a digestible and understandable format – with that human aspect behind them."

By women, for women

An important effort to improve equity is the Women's Health Strategy for England, launched by the Department for Health and Social Care in July. Based on a call for evidence that received almost 100,000 responses, detailing women's experiences of

Judith Cutter
consultant midwife for public health and vulnerable families at Cardiff and Vale University Health Board

As part of a team I developed a midwife-led early postnatal contraceptive service in 2017, which led to being awarded a Wellbeing of Women/RCM/Burdett Nursing Trust first into research scholarship. This enabled me to evaluate the service, which has since evolved and provides midwives with an opportunity, through training, to develop their skills and knowledge in postnatal contraception. This is so important for helping women to space their pregnancies and avoid unintended pregnancy and interventions that may carry both physical and psychological risk.

For me, research plays an important part in developing services to benefit the women and families that use them. It can inform change by providing the evidence needed to improve safety and practices within the NHS. When I talk to student and newly qualified midwives, they express a fear of research, which might be due to limited exposure. Involving midwives in the research process will help allay these fears and encourage midwives to be confident in participating in research that contributes to the evidence-based care they provide to women and their families.

WOW'S RESEARCH AND WHY IT MATTERS

1972

Wellbeing of Women (WoW) establishes the importance of taking folic acid during pregnancy

1974

Various projects funded by WoW establish the vital role of ultrasound in pregnancy in monitoring the health of the baby in the womb

1982

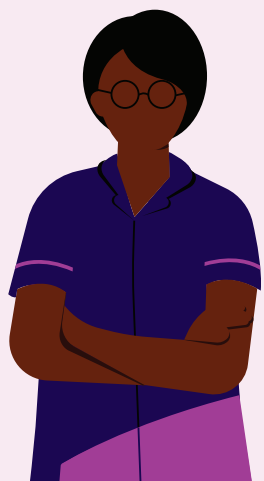
Researchers suggest that not all women need a routine episiotomy – a procedure that was widely used previously

1991

WoW begins research that leads to discovery of the link between HPV and cervical cancer

2012

The Birthplace cohort study has many significant findings – including that midwifery-led units are safe for babies and offer benefits for mothers



ILLUSTRATIONS: BETH GOODY

the health sector and how they thought it could be improved. The resulting strategy outlines the 10 key changes the government is calling for, including more research about women's health conditions, with women involved in it.

On the strategy's launch, women's health ambassador Dame Lesley Regan, who is leading its delivery, said: "We need to make it as easy as possible for women to access the services they need, to keep girls in school and women in the workplace, ensuring every woman has the opportunity to live her life to the fullest potential.

"This strategy is a major step in the right direction, listening to the concerns of women, professionals and other organisations to tackle some of the deep-rooted issues that we know exist."

In line with the strategy's aims, WoW is advocating to involve more women in research and to include more people from all under-represented groups. "It needs to become standard practice to include a diverse population when we're carrying out research – and make sure there is also better representation in the research community and in decision making," says Jeremy.

Nurturing curiosity

Midwives, then, are ideally placed to become involved in research – and it's important that they do, says Dr Jude Field, RCM research advisor. "We need to grow our knowledge base. That's one of the components of a profession – that it can show that it's got its own, specialist knowledge base."

It's also about creating a more equitable pool of researchers within the field, according to fellow RCM research advisor Jenny Cunningham. "Midwives are under-represented as research leaders. There's a lot of maternity research going on, but it's more often led by doctors than midwives.

"It's also really good for your professional development, and you can really drill down to what's important to midwives and to

HOW TO GET INVOLVED

Keen to dip your toe in the research pool but not sure where to start? The RCM's Jude Field offers these tips.

- **Get in touch with a research midwife in the R&D department at your Trust or Health Board and ask for a brief chat about their work. This will give you an idea of the experiences of someone working in that world – even if it's not the world you're in at the moment**
- **Find out what trials are being run locally to you and learn more about them**
- **If you want to go further than a conversation, try to arrange a shadowing opportunity with a research midwife, where you could discuss trials, consenting participants, and so on. We're all doing our NMC revalidation and this would be a great piece of CPD**
- **Outside your Trust or Health Board, you could make contact with your nearest university that has a midwifery research department: on the Research Hub (see Resources), you'll find a list of all the midwifery and maternity professors in the UK.**
- **You can always contact Jenny and me for advice or information about research: jenny.cunningham@rcm.org.uk and judith.field@rcm.org.uk**

women. Maternity research should be an interdisciplinary exercise; not just midwives or just doctors," Jenny adds.

So why aren't more midwives involved? Barriers do exist, particularly given the profession is a female-dominated one. "When you're thinking about research careers, typically the time when you're having to get your own funding to become an independent researcher is when you'd be having children, which immediately leads to a potential disadvantage," explains Marian. "So we need to think about our fellowship and funding processes to make sure we're bridging these gaps to make sure we're not penalising women who work part-time."

Another challenge is that academic posts for midwives who wish to continue in clinical practice can be few and far between. "But there is work going on to try to map those opportunities across England, potentially across the UK," says Jude. "Jenny and I are doing our small part with the RCM to address that." Of course, understaffing also creates a barrier, Jenny adds. "And if you haven't got role models around you in your local Trust or Board, you may not think to apply for funding or know how to apply. This is where the RCM can help, in terms of bringing equity to the process."

Fortunately, there are many different ways of getting involved in research, Jude assures (see panel, left). "You don't have to be working on a trial, you don't have to be

Research is about investment in yourself as a professional

doing a PhD or master's project. There are always studies looking for midwives and their experiences in practice. Mostly we're talking about clinical practice, but not always – expertise is also needed across education, management, leadership and other avenues.

"Equally, studies are always looking for women or families to be involved as participants, so midwives can certainly play a part in advertising those opportunities, because it all helps to build our practice and knowledge."

Curiosity is a hugely useful trait, Jenny adds. "You think, how could that have changed, or be done differently? It's why many midwives like working with students – because it makes them think about their practice, which is really beneficial."

Making change happen

Perhaps there's a fear that research is a far-off concept; words on a page that can't make a real difference to what's happening on the ground. Many would surely agree: if the research itself is a slow process then translating it into meaningful change is slower still. For Professor Basky Thilaganathan, clinical director at the Tommy's National Centre for Maternity Improvement, of which the RCM is a core partner, it is all too familiar. "Research in itself will not save a baby tomorrow, so you need to take the best evidence and make it happen.

There's a fundamental gap between research coming out and guidance coming out – and people changing the way they practise and being able to deliver the guidance at the coalface. As a health system, we don't change very easily," he adds.

However, believing that change is possible – and critically needed – the Tommy's multidisciplinary team are trialling a software medical device that identifies women at the highest risk of stillbirth or preterm births and provides healthcare professionals with clinical decision support to ensure those women "get the right care at the right time".

While agreeing there is often "an implementation gap", Marian says researchers can do more to prevent their findings from getting lost in the ether. "There are structures in place now, within the NIHR, to make sure the research is implemented. But that will only work if the researchers are thinking about designing it to be practically implementable in the NHS from the start."

Ultimately, research, says Jenny, is about "shining a light on a bigger picture". It's also an investment in yourself as a professional, and in the future of your profession. And it is worth getting involved, given the impact research can have (see timeline on page 18) – even if your contribution seems small.

"When something takes a long time, the best time to start was yesterday; the second-best time is today; the next best time is tomorrow," Louise concludes.

RESOURCES

- Find out more about the RCM's new Small Research Awards at **bit.ly/rcmsmallresearchawards**
- Save the date – the RCM's Education and Research Conference takes place on **28 to 29 March 2023** in Birmingham (venue TBA)
- Take advantage of the RCM's Research Buddy Scheme, which was launched earlier this year to support more midwives to apply for the larger RCM-supported research awards. Find out more at **bit.ly/rcmbuddyscheme**
- Take a look at some research case studies for inspiration at the RCM's career framework: **bit.ly/i-learncasestudies**
- Use the Research Hub, where you can see all the resources and information the RCM offers around research: **bit.ly/rcmresearchhub**

ILLUSTRATION: BETH GOODY

Part of the solution

Six months on from the publication of one of the furthest-reaching reports into maternity safety, we review the Ockenden report, the actions taken so far and the barriers that remain

When the final report of the Ockenden review of maternity services at the Shrewsbury and Telford Hospital NHS Trust landed in March 2022, it presented, as review chair Donna Ockenden put it, a "once-in-a-generation opportunity to improve the safety and quality of maternity service provision".

Her report contained 15 'Immediate and Essential Actions' (IEAs – see box overleaf), ranging from systemic shifts to granular details, and were welcomed by professional organisations, including the RCM, and accepted by the secretary of state for health and social care.

What was needed next, said Donna Ockenden, was for "the 'whole system' underpinning maternity services" to commit to implementation of all the IEAs "with the necessary funding provided".

Workforce planning

Investment is key for workforce planning. The Ockenden review was clear about the need for a fully funded multi-year settlement for maternity and neonatal services. While a £127m funding boost for maternity care was announced earlier in the year, it fell short of the £250-300m uplift recommended by the House of Commons Health and Social Care Select Committee in June 2021 and endorsed by the Ockenden report.

IMAGE: ISTOCK

RCM chief executive Gill Walton says: "Our lobbying continues around funding and workforce planning, which is critical to the ability of the workforce to deliver safe high-quality care and support themselves through training and development.

"We've also relaunched our Caring for You campaign (bit.ly/rcmcaringforyou) because we know midwives are struggling – they're burnt out and leaving the profession.

"While we're pushing NHS England for a long-term workforce plan, we also need them to think about what they can do in the short term to support the workforce. That includes getting enough MSWs, clerical staff, phlebotomists and others into services to allow midwives to do what they need to do."

Sean O'Sullivan, head of health and social policy at the RCM, agrees: "Recruiting and educating new midwives will take time, but what we can do in the meantime is train existing staff, which is not only good for services, but when staff feel they're being developed and invested in, they're more likely to stay."

Abbie Aplin, RCM director for maternity reform, says the RCM is already in conversation with Band 7 midwives about what they need, following the recommendation around additional labour ward training.

Newly qualified midwives need to feel invested in too and Ockenden specifies the need for robust preceptorship programmes. The RCM's preceptorship position statement sets out best practice and makes recommendations to Trusts and Boards on implementing strong programmes (see bit.ly/NQMpreceptorship and page 34 for more).

Safe staffing

In October, joining with baby loss charity Sands, the RCM warned that the severe shortage of staff in maternity services is putting mothers and babies' lives at risk. The report on maternity and neonatal staffing by the All-Party Parliamentary Groups on Baby Loss and Maternity (see page 40), painted a bleak picture of understaffed and overstretched services – again highlighting the urgent need for more investment.

Sean notes that the staffing situation has worsened with the number of midwives in post this year "actually 500 to 600 fewer than last year." That's on top of the longstanding shortfall of more than 2,000 midwives. Government instability certainly hasn't helped, says Sean: the cabinet is on its third health secretary since the Ockenden report was published and, while the RCM has sought a meeting with each, that is yet to happen, he says.

The IEAs were explicit that safe staffing levels are a prerequisite for midwifery continuity of carer models, and that all Trusts must review provision and suspend further roll-out unless they can "demonstrate staffing meets safe minimum requirements on all shifts".

It is a view shared by the RCM, which has been supporting members struggling with its implementation. Sean says: "While we know the benefits and evidence to support it, there needs to be sufficient staff in both the continuity team and the core services to ensure they're safe. We're pleased that NHS England has written to services to say they are no longer required to meet continuity targets, so they'll have more autonomy to determine what they do locally."

OCKENDEN'S IEAs

1. Workforce planning and sustainability
2. Safe staffing
3. Escalation and accountability
4. Clinical governance – leadership
5. Clinical governance – incident investigation and complaints
6. Learning from maternal deaths
7. Multidisciplinary training
8. Complex antenatal care
9. Management of women at high risk of preterm birth
10. Labour and birth information
11. Obstetric anaesthesia follow-up
12. Postnatal care
13. Appropriate bereavement care
14. Clear pathways for neonatal care
15. Supporting families

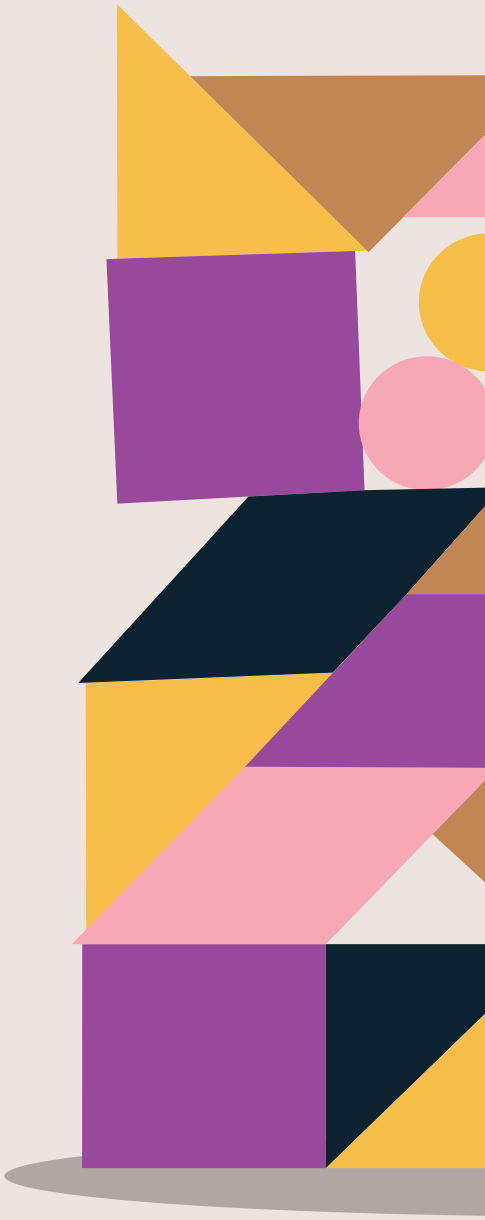


IMAGE: ISTOCK

The NHS is one of the safest places in the world to give birth, but Ockenden proved there is more to do

Escalation and accountability

As well as launching the statement on preceptorship in response to the Ockenden review, the RCM also created a four-part 'Solution Series' to support midwifery leaders and midwives in implementing interim recommendations laid out in the Ockenden review to improve the quality of care. "It puts all the guidance and information in one place, making it slick and easy to use," adds Abbie, "because we know maternity leaders have a massive agenda of safety initiatives they're trying to implement."

The RCM's Solutions Series provides evidence-based advice, with a focus on learning lessons not only from failed services, but also on what can be learned from successful services. It covers improving maternity services, the role of leadership, the human factor and nurturing a positive workplace culture. The detailed reviews of maternity services across the UK highlight worryingly similar serious failings, and the latter seems to be a recurring issue.

Ockenden's IEAs state the need for a clear path for professionals to escalate their clinical concerns regarding a woman's care. The RCM's Standing Up for High Standards gives clear, practical steps to raising and escalating concerns. It is naturally part of the RCM's remit to support staff experiencing a negative workplace culture. As Gill notes, "It's important that when staff feel they can't deliver safe care, they are empowered to speak up and speak out. Standing Up for High Standards and the Solution Series are aimed at helping staff on the front line speak up when things are not right, and strengthening their leadership skills at every level, so that they can advocate for women and families."

The Independent Maternity Working Group

An important legacy of Ockenden will be the new Independent Maternity Working Group (IMWG), co-chaired by Gill Walton and Dr Edward Morris, president of the Royal College of Obstetricians and Gynaecologists (RCOG).

Abbie is working across the RCM and RCOG as part of the IMWG. She explains: "This group is providing advice and guidance, ensuring the IEAs are implemented in way that is workable and sustainable in services, and that improves the safety of women and babies and works for all those delivering maternity care.

"Its remit is to act as a critical friend to those who have responsibility to fund and implement

the IEAs. That includes advising on how the planned activity of existing programmes will achieve them, and crucially, what revisions might be required to ensure they are relevant to the current maternity system and can be achieved."

Gill says the group has an important role in being "the voice of the front line, testing the priorities and plans. People working in services are the ones who really know if innovations and recommendations are possible now – and if they're not, what they need in place to make them possible."

The working group will also act as "a collective voice to amplify the case for change", says Abbie, and to "spread best practice and gain evidence of the opportunities and hurdles, using our experience and expertise to support the entire system, from policy-makers to clinicians.

"There has been good work delivering quality improvement despite everything going on, even in COVID-19 times. And we have got to take steps to improve working conditions to stop the mass exodus of staff that's taking place – things like more flexible working, something the RCM has encouraged."

Multidisciplinary training

Co-working is also key, explains RCOG president Dr Edward Morris: "The RCM and RCOG continue to deliver a number of programmes that are contributing to improving maternity safety and that align with the recommendations made within the report.

"These include the development of a workforce tool to allow the benchmarking of obstetric medical staffing nationally and enable services to determine what safe staffing looks like, and the ABC programme, which aims to improve fetal monitoring and improve the management of impacted fetal head at caesarean section, and our guidance for the hiring of long-term locum doctors."

He adds: "The NHS is one of the safest places in the world to give birth, but Ockenden proved there is still more that can be done to ensure that we continue to improve maternity safety and offer a high standard of care to those who access maternity services across the UK. We will continue to support our members and ensure the government commits to funding for maternity staffing and training as a priority."

Ring-fencing a proportion of maternity budgets in every unit for training is an IEA where progress appears to have faltered. Sean notes: "We're hearing that little of that is happening – even things like mandatory training on safety is being cancelled or in some instances moved online, due to staff shortages, and that has an implication for the safety of services."

Gill says this simply isn't good enough: "We must have a really robust funding structure and workforce plan in order to do what is immediate and essential.

"Staff know this. They also know how it feels not to be able to deliver the care they want to. Yet they still try, in the face of adversity, to deliver excellent maternity care. The RCM will continue to do everything we can to support midwives and MSWs – through strengthening our branches to speak up for the local workforce, and by being their voice at a national level, to get them the resources they need to provide safe, high-quality care.

"The system has failed maternity services for many years, but I want this to be the last time these reports are seen in this country. I absolutely believe that together we can make a difference and provide the hope that we all need."

While ultimately it is NHS England and the Department for Health and Social Care that have the power to implement the Ockenden actions, the RCM, working with the RCOG and others, continues to be part of the solution.

MORE INFO

For more on the Independent Maternity Working Group, visit
bit.ly/independentmaternityWG
RCM's Solutions Series
bit.ly/RCMsolutionseries
RCM preceptorship position statement
bit.ly/NQMpreceptorship
RCM Standing Up for High Standards
bit.ly/RCMstandingup

IMAGE: ISTOCK

Driving change

Stuart Bonar, RCM public affairs advisor, asks: what does it take to make a government take notice?

Q: I took part in the trade unions march in June to demand better pay. The mood was so uplifting that I really felt that government had to take notice. But now I don't feel it has, and with the publication of another maternity safety report (the Kirkup review), I'm feeling demoralised that maternity services will not get the investment that we need. What can I do?

A: The RCM lobbies ministers on behalf of its members on matters such as pay, safe staffing, recruitment and retention, employment rights and so on. We have found that if MPs have been speaking to their local constituents, they are more aware of the issues and are more invested in trying to solve them. The single most effective way to get the government to take note of the investment needed in maternity services and support fair pay for staff is to meet with your local MP. If this sounds daunting, it isn't – and here's why.

Firstly, you don't have to go alone – you can go with colleagues from your branch. Secondly, it isn't Prime Minister's Questions: no one is going to put you on the spot and no one is trying to catch you out. You are simply giving information to someone who is your representative in Parliament; moreover, an MP should welcome the opportunity to meet their constituents.

Prepare by thinking about what your main points are and support these with examples of your personal experience. For example, if you are saying that maternity units are understaffed then tell your MP of instances where you have seen this in practice, how often it happens and what you and your colleagues have to do to help cover the gaps. You've mentioned the Kirkup report, and the issues around maternity safety weigh heavy on everyone – your MP will be particularly keen to understand how staffing levels have a significant impact

The most effective way to get the government to take note of the investment needed in maternity services is to meet with your local MP

HOW TO GUIDE

Get your MP's contact details from the 'Find Your MP' page on the UK Parliament's website. Input the MP's name, your postcode or the name of the constituency and all their available contact information should pop up.
Call their office and tell them that you are a constituent, that you are a local midwife or maternity support worker, and that you would like to have a meeting with the MP to discuss your concerns. If you are going as a group, let them know.
If there is a group of you, work out in advance who will be the main person speaking on your side, or perhaps divide up the points you want to get across between different people.
Give your own experiences of the issues you're raising – remember this is a person who doesn't know your working life as well as you do and you have to help them to understand what it's like. At the end of the meeting, ask your MP what actions they plan to take and ask them to keep you updated on their progress.

on safety. Tell them how you and your colleagues are covering extra shifts to try to ensure there are the right numbers of midwives on duty, but that also means people can't go home and get the rest they need. Or if you want to discuss your pay, give them examples about the cost of living and how it is affecting you (NHS staff are worse off now than they were only a few years ago – because prices have risen faster than pay. The RCM is urging MPs to sign Early Day Motion (EDM) 199 calling for a significant and fair pay deal. See video link, right). It is causing many people to consider leaving the profession, which will plunge staffing levels even further into crisis.

This kind of personal experience strengthens what you have to say. Different MPs have different styles: some may ask lots of questions, others may want to focus on listening to what you have to say. It is important to tell them what it has been like to work in the NHS during the pandemic – they are unlikely to understand the true extent of the difficulties you faced, and it will give them a better idea of the true value of your role.

Finally, think about what you would like them to say what they will do about the issue that you've raised. It is useful to have them commit to do something after the meeting. For example, ask them to write to the secretary for health and social care and the chancellor of the exchequer to ask on your behalf for a decent pay rise for NHS staff, for investment in the numbers of midwives joining the profession, or support for newly qualified midwives and those who may well be considering leaving the profession. Ask for your MP to let you know what the secretary of state or chancellor said when they reply. You can also request a further meeting to follow-up on your local MP's progress with the issues you have raised. Finally, MPs also have a lot of pressures on their time so it's important to thank them for taking the time to meet with you and listen to you.

The MP's job is to hear, understand and represent the concerns of their constituents. The vast majority of MPs will welcome the opportunity to speak with you, and it is the single most effective thing you can do to push for change.

IMAGE: SHUTTERSTOCK

MORE INFO

If you need any guidance, or you just want to let us know that a meeting is happening or what an MP had to say, email us at **publicaffairs@rcm.org.uk**
Sands is petitioning Parliament to fix the maternity staffing crisis. Sign here: **bit.ly/sandsstaffingcrisis**
Watch Stuart discussing EDM199, a Parliamentary petition for a fair and significant pay rise: **bit.ly/RCMEDM199**

Job evaluations

The 2004 Agenda for Change said there should be job evaluation for every role to standardise responsibilities and ensure equal pay, but has this changed anything?

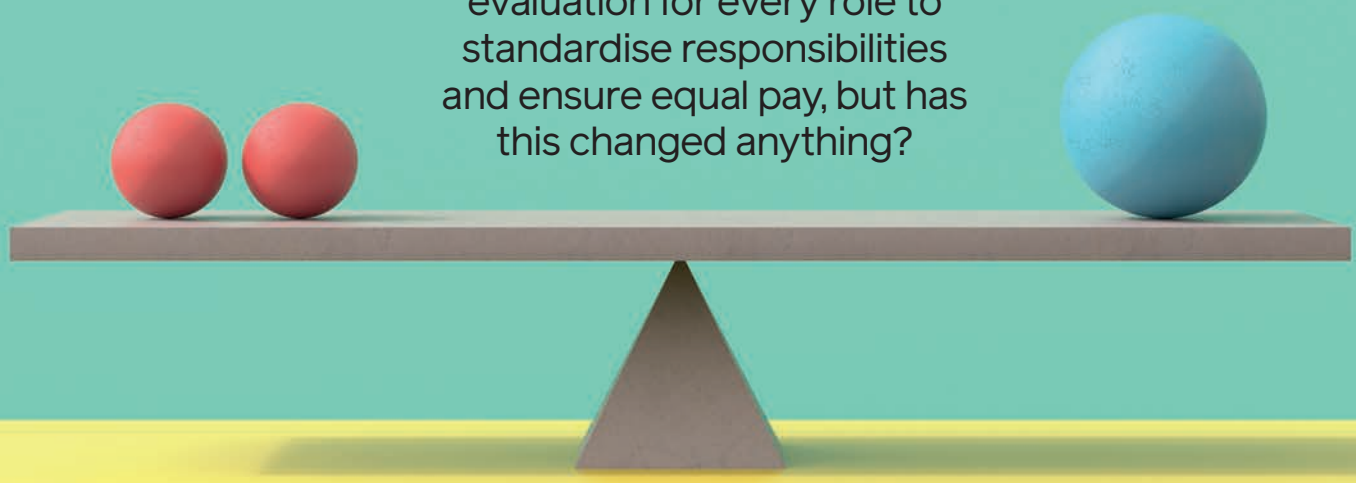
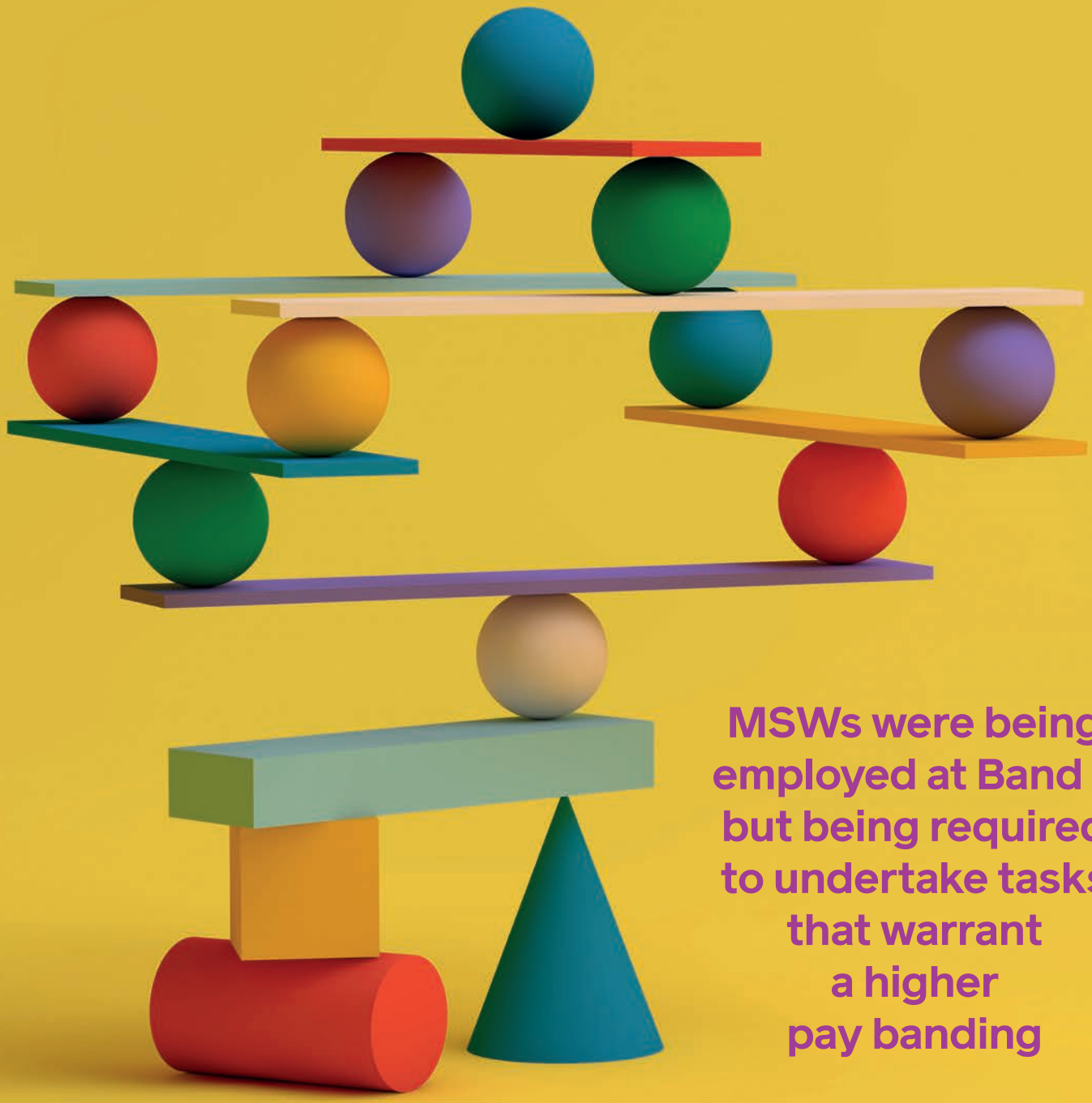


IMAGE: GETTY

Most NHS jobs are banded by being matched to a job profile that has been through the NHS Job Evaluation Scheme and has been scored and banded. The RCM is a member of the NHS Staff Council's national Job Evaluation Group (JEG), which is responsible for the development of new job profiles, updating existing job profiles, deciding the banding of new posts, reconsidering the banding of existing posts that have changed significantly, and ensuring that trainers and the nationally approved training courses are up to date.

Ann Fordham, regional officer in southeast England, says the task of evaluating job roles and matching them against existing profiles across the UK is huge and ongoing. "There are new roles being created in response to the changing landscape, such as digital midwife or clinical governance roles. The current review of midwifery profiles may result in new ones being created.

"In 2018, during MSW Week, the RCM began hearing from MSWs that they were going above and beyond their roles and banding and pay, so we used a Freedom of Information [FOI] request to NHS Trusts and Health Boards to find out whether each MSW job description has been through the job matching process. The discrepancies were quite marked."



MSWs were being employed at Band 2 but being required to undertake tasks that warrant a higher pay banding

Across the UK, 50% of NHS Trusts and Health Boards were unable to provide the job matching analysis to accompany job descriptions for Band 2 posts. England was the worst offender, with 57% of NHS Trusts unable to provide the job matching analysis. In Wales, the figure was 50%, while Scotland and Northern Ireland Health Boards provided 100% of the job matching analysis documents for Band 2 posts.

Are you being paid fairly?

Meanwhile 41% of NHS Trusts and Health Boards were unable to provide the job matching analysis to accompany job descriptions for Band 3 posts. England was worst again, with 48% of NHS Trusts unable to provide the job matching analysis; in Northern Ireland the figure was 75%, while Scotland and Wales Health Boards were able to provide 100% of the job matching analysis documents for Band 3 posts.

The fact that the RCM had raised the FOI request was widely covered in the media and its 'Are you being paid fairly?' campaign raised awareness. "Suddenly you had MSWs approaching the unions and their employers to say 'We want our roles evaluated because we know that the same role in a different unit is paying more or has responsibilities that differ from our own,'" says Ann. "It was empowering."

IMAGE: ISTOCK

MSW CELEBRATION DAY

The RCM continues to focus on the development of MSWs and to celebrate their integral role in maternity care. This year the theme is 'Supporting our MSWs', and the RCM will continue to highlight MSW banding and job profiles, to push for fair pay (rcm.org.uk/pay-hub) and call for employers to sign the new Caring for You charter, with fresh commitments on health, safety and wellbeing, as well as rejuvenating its working relationship with RCM activists and branches.

Here's how you can get involved:

- **Ask MSW colleagues how they are and about their training needs**
- **Hold Caring for You events inviting MSW members or advocates to talk about their roles**
- **Share events and celebrations on social media using the hashtag #mswcelebrationday2022**
- **Explore the suite of learning materials for MSWs, including i-learn modules, webinars and podcasts**
- **Check out our dedicated MSW celebration tile on the website.**

A review of a significant sample of the Band 2 job descriptions found that 90% were being required to undertake tasks that required a level of knowledge that should have been matched to a Band 3 or 4 job profile. "It was a common theme that MSWs were being employed at Band 2 but being required to undertake tasks that warrant a higher pay banding," says Julia Chandler, regional officer for the south of England. "Band 2 is about personal care – ensuring wards are tidy and well stocked, helping women to the showers, that type of thing – versus clinical care at Band 3: canula or catheter removal, blood pressure observations, and so on. Staff undertaking tasks that they don't have the level of knowledge for is not only unsafe but it opens NHS Trusts and Boards up to an equal pay claim."

JEG consequently reviewed the profiles, ensuring the language and examples were clarified, leaving no one in any doubt about the banding distinctions. The clarified profiles are making a difference. "There are plenty of examples from around the UK of an uplift from MSWs on Band 2/3 based on the profiles," says Ann. "The Job Evaluation Toolkit has given people a process and the profiles have given people leverage – the uplift is gaining momentum."

Julia agrees. "It's important to know what you're entitled to. I suggest you check what your Trust/Board is doing, attend branch meetings and elect an MSW advocate. Check job descriptions and ask for them to be matched – significantly, they should be matched in partnership with the union as there's a lot of outsourcing of job matching taking place that isn't always in line with JEG training and certainly isn't transparent. It's a worry because it needs to be done with the unions and if it's wrong, it can go to grievance. I also suggest MSWs have regular meetings with managers in the same way other roles do, to keep them in the loop about the job roles."

Call for evidence

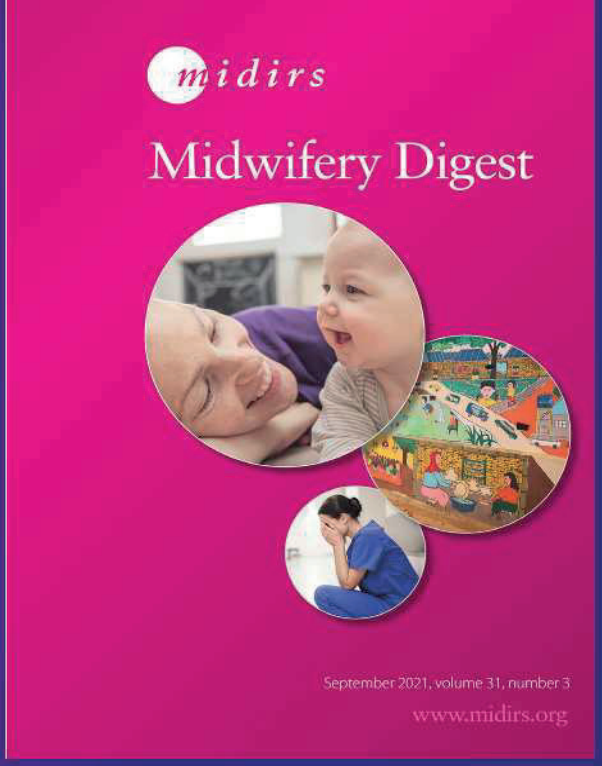
There is currently a massive Job Evaluation Scheme review of nursing and midwifery roles taking place (last done in 2011) for Band 4 and upwards. A call for evidence and digital questionnaire has already gone out with a deadline on 1 November, but the channels to give information will remain open. The whole process is likely to take two years. As Ann notes: "The point is to mitigate against unequal pay and job expectations across UK. You can only match against a good job description, which is why the profiles are important: more people need to get the job matching training from their Trust or Board to ensure the job matching is a robust process, done in partnership with employers and staff."

MORE INFO

All job profiles can be found at nhsemployers.org
The RCM believes that MSWs are a vital part of maternity teams across the UK and want to make sure that the voice of MSWs is being heard in maternity workplaces. Please speak to your RCM branch representatives about becoming your RCM branch MSW advocate.
bit.ly/mswadvocates

Write for us!

We are interested in you, your research, your studies, your individual experiences and insights as a midwife, student midwife or MSW.



As the RCM's information provider, we are passionate about providing midwives, student midwives and maternity support workers with opportunities to share and promote their work to the wider midwifery community.

MIDIRS Midwifery Digest **provides the perfect platform for you to share your knowledge and experiences with those caring for women, babies and their families during pregnancy, birth and the postnatal period.**

Our journal

MIDIRS Midwifery Digest is a quarterly, academic journal available in print or PDF format. Its sections cover the whole midwifery spectrum including: *Midwifery & Education, Pregnancy, Labour & Birth, Postnatal, Neonatal & Infant Care.*

Part of the Royal College of Midwives' portfolio of educational resources, the *Digest* is read by midwives and student midwives, but is also relevant to anyone working with pregnant women, new mothers, babies and parents.

Who writes for the Digest?

We accept original articles from midwives, students, MSWs and health care professionals involved in maternity care. Whether you are a clinician, a student, or a new or established author, we welcome your contribution. Our dedicated editorial team can advise and support you with your paper.

Your article can be used as evidence of continuing professional development and NMC revalidation requirements, demonstrating a commitment and interest in extending your own and others' knowledge.

Original articles published in the *Digest*, are added to the Maternity and Infant Care (MIC) database and can be accessed by subscribers. You are immediately sharing your work with an even wider audience and further contributing to the improvement of maternity care.

Submitting a paper

Depending on the content, articles vary between 1000 words for viewpoint/discussion papers to 3500 for research papers. Author guidelines and details of how to submit your article can be found on www.midirs.org.

For further information

For informal enquiries, questions or support with your submission, please contact MIDIRS Digest Editor, Sara Webb at: sara.webb@rcm.org.uk.

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HIB/76/0222

Date of preparation: February 2022

A helping hand

Fiona Gibb, RCM's director for professional midwifery, says the impact of a successful preceptorship should not be underestimated

Every midwife was newly qualified once. Some may recall the first time they put on their uniform or celebrated as they received their NMC registration pin, while others may remember how they felt on their first shift. One thing that stays with most is how they were supported by others to transition to qualified practice.

Newly qualified midwives (NQMs) are proficient at the point of registration; they have been assessed and confirmed competent over several years and approved for entry to the register by the lead midwife for education. However, the transition to newly qualified practice is still a rite of passage for all – like getting your driving licence but still feeling nervous the first time you take to the road on your own.

Preceptorship is an enhanced period of support to help new midwives in their first post following qualification. It is not a retest or re-assessment of capability, but a structured period of further development to promote confidence and relational belonging into the team to achieve positive cultures. It should complement a formal induction and orientation and is in addition to the mandatory training that all staff complete. The impact of a successful preceptorship should not be underestimated in promoting job satisfaction, as well as improving the recruitment and retention of midwives.

Best practice

There are excellent examples of preceptorship across the UK. The new RCM position statement, published in August this year, was shaped by speaking to many of those involved in developing transferable best practice. Some NQMs actively chose employers that advertised structured programmes. Heads of midwifery acknowledged the high proportion of Band 5 midwives in their workforce and the importance of supporting and retaining midwives during these early years, when midwives are most likely to leave the profession (Health Education England RePair, 2018).

What was clear was that best practice examples used consistent and individualised approaches that recognised individual learning needs, the place of work and rurality, the needs of the individual country region or organisation, and whether the NQM had practised in that location or model of care as a student. They recognised the abilities of NQMs to work across the scope of midwifery practice and provide support to develop and embed all skills across care settings and models of care (including midwife-led settings).

With midwifery vacancies across the country and high numbers of midwives leaving the profession, we cannot be complacent that graduates will stay in the area in which they were educated, or even take up employment as a midwife at all. Employers must ensure that their area is an attractive place to work, and supporting midwives at the start of their careers is the essential first step to recruitment and retention.

It's like getting your driving licence but still feeling nervous the first time you take to the road alone

NHS Grampian, Scotland

Lead practice educator Nicola Mackay explains that NHS Grampian aims to invest in new midwives at the earliest opportunity. Its recruitment open day this year included representation from a variety of clinical midwifery teams, NHS Grampian 'We Care' team, practice, education and the new Baird Family Hospital. There were also tours of clinical areas, refreshments and goodie bags. "The questions were provided to the candidates ahead of the interview, allowing them to discuss considered answers during the interview and demonstrate their knowledge," says Nicola.

"All new graduate midwives [NGMs] also attend an NGM welcome day," she

continues. "This is an opportunity to celebrate the beginning of their careers with their peers and new colleagues, as well as gain invaluable information from a variety of speakers throughout the day. A minimum of two weeks' supernumerary period is offered. During this time the NQM will work the same working pattern as their Flying Start supervisor. This aims to build a strong relationship that will span the entire preceptorship year and assist the new graduate midwife to integrate as part of the team."

Flying Start NHS is the national development programme in Scotland for all newly qualified nurses, midwives and allied health professionals, to be undertaken in the first year of practice. It's designed to help support the transition from pre-registered student to qualified, confident and capable health professional (bit.ly/flyingstartNHS).

"From the beginning we discuss a personalised progression plan with the NQMs," says Nicola. "It is individualised to the preferences of their professional development and the experiences they wish to gain. We aim to provide the opportunity to gain experience of providing antenatal, intrapartum and postnatal care during their early career. A knowledge and skills self-assessment tool provides a template to guide discussions with line managers. This helps inform the decision-making process to identify any areas they would like to develop. Some NQMs have also shared that it is a useful tool to aid reflection and that they get a sense of achievement when they see how many areas they sign off as feeling competent in.

"One of the successes that we are most proud of at NHS Grampian is Connect 5, an NGM support platform that really connects the Band 5s. Support takes many forms and is individual. The aim of Connect 5 is to ease the transition from student to registered practitioner while fulfilling five emotional concerns as humans: appreciation, affiliation, autonomy, role and status. Its objectives are to engage in open, meaningful dialogues without hierarchical barriers to discussion; to provide a person-centred network that maintains vitality and resilience to support a healthy workforce; and to interlink professionalism, shared

IMAGE: IKON

experiences and companionship to promote reflection, self-care and learning.

"We have found coming together with peers in a safe space has been one of the biggest benefits," she adds. "These sessions are offered at regular intervals throughout preceptorship. Content includes Connect 5 check-in, looking deeper into the feelings of our new graduates, self-recognition and relaxation, and protected time to invest in Flying Start."

Once for Wales Preceptorship Framework

Nerys Kirtley, Karen New-Phillips and Vicky Richards note that there were disparities between NQMs' experiences in Wales. "It was apparent that many different preceptorship programmes were being delivered within Health Boards across Wales, and some had none at all," says Nerys. "NQMs will only flourish and grow in supportive environments – to keep attrition low, it is imperative to provide this. The Once for Wales Preceptorship framework (OfWPF) was developed as a supportive tool for all Health Boards to achieve effective preceptorship programmes across Wales, encompassing principles that would enable NQMs to develop the unique skills and competencies required of a Band 5 midwife, but also the time for consolidating and developing confidence."

To create the framework, a task and finish group was assembled that included student midwives, NQMs and midwives from across Wales, with

IMAGE: IKON

different backgrounds and expertise. Stakeholder events explored good preceptorship programmes alongside the challenges of developing a framework that was fit for purpose for all Health Boards in Wales. "It was also important to identify how we could develop mechanisms of support for final-year students to strengthen and support the transition to NQM," Nerys says.

"Collaborative working was essential and embraced by the lead midwives for education and heads of midwifery within Wales. Once all ideas were gathered, including examples of best practice and experiences of current NQMs, the task and finish group developed the OfWPF. Online roadshows were then arranged to explain the framework to all midwives in the Health Boards.

"To enable equity, 13 principles were developed as the minimum requirements for Health Boards. These included two weeks' supernumerary time, named preceptors, identification badges and regular meetings. Pre-qualifying placements were organised for all students in the Health Boards they accepted employment in, allowing for smoother transitions. Structured induction weeks were organised at the beginning of employment where all mandatory learning, skills training and employment procedures were delivered before the NQMs would commence any clinical work.

"The opportunity to attend two Once for Wales Forums were also in the principles. The forums put the emphasis on NQMs taking the lead and sharing best practice, but they also provide a safe area for them all to discuss experiences across Wales.

"The OfWPF encourages professional practice by keeping a record of progress, allowing for individualised support packages to be given to each NQM. This is an ever-evolving document and is updated yearly, structured around the four pillars of the NMC Code and compassionate leadership.

"There were many challenges that the NQMs faced, including reduced staffing levels and high acuity, which impeded some of their supernumerary time. However, they evaluated that they were still supported well. The forums gave them an insight into all NQMs experiencing very similar challenges. They also said that they were safe spaces for discussion and sharing to learn from each other.

"Our aim to develop a supportive preceptorship framework that is fit for purpose and futureproof across all Health Boards in Wales was fulfilled. We will continue to improve the framework using qualitative data collected from evaluations from NQMs."

Supporting midwives at the start of their careers is essential to recruitment and retention

Liverpool Women's Hospital, England

Judi Smith, preceptorship lead for Liverpool Women's Hospital, notes that the rising numbers leaving midwifery pose a significant threat to the safety of services. To mitigate this, her Trust mandated a robust retention strategy and – as a significant proportion of those considering leaving midwifery are under 30, having worked in midwifery for less than five years – an organisational commitment to the support for NQMs.

"Focus group discussion provided qualitative data which identified issues that negatively affect our NQMs," she says. "We know they stay when they feel valued, safe and supported. Through our social media platforms, we provide a community of support, inclusion and friendship. We host coffee and cake events prior to employment, we incorporate team-building exercises into our induction, and hold regular celebration events to increase a sense of belonging with recognition and reward embedded throughout.

"NQMs find the transition to autonomous practitioner challenging. Preceptees have a two-week off-site orientation with dedicated teaching from specialist midwives and multidisciplinary teams before they start in the clinical area. As dedicated preceptorship leads, we provide managerial, pastoral and clinical support with seven-day cover for the initial weeks of each new rotation, and a protected supernumerary period with a 'buddy' for support and guidance.

"We work with wellbeing coaches and a psychology service to support the emotional wellbeing of all our midwives. Leadership is key to creating to the culture of an organisation and promoting emotional safety. Early career midwives have a unique perspective, so we actively encourage them to come forward with ideas – we want to ensure their voice has power.

"Our programme is continually evolving but the data so far is good: 100% retention of our current cohort of NQMs at 12 months, a reduction in work-based stress, improved morale, confident staff and a reduction in incidents. We have just expanded our team with another two new preceptorship leads as we welcome our largest cohort of NQMs to date."

The step from study to practice can seem like a frightening leap, and preceptorship programmes offer a gentle bridge between the two. These three examples of preceptorship approaches in the UK have in common the desire to support NQMs to become confident autonomous practitioners in an environment where they feel nurtured and valued.

Shared Voices Network (SVN) chair

Emma Taylor wants to hear from you so you can help shape the RCM's new SVN

The RCM's new Shared Voices Network will bring together RCM staff and members, external stakeholder groups and service users so that we can ensure the RCM's vision and work programme has service users at its centre and are informed by these perspectives. The aim is to have a collaborative approach that will strengthen the RCM's work by ensuring that all the relevant views have been considered in the early stages.

I have been involved in amplifying maternity service user voices for nearly a decade. I joined my local Maternity Voices Partnership as a parent rep eight years ago and have been part of its core team for the past six years, vice-chair for two and chair for four. I have also held national service user representation roles including on the Improving Prevention and Public Health workstream of the Better Births Maternity Transformation Programme, and with the Maternity and Neonatal Safety Improvement Programme's Smokefree workstream. I am also the south-east maternity team's

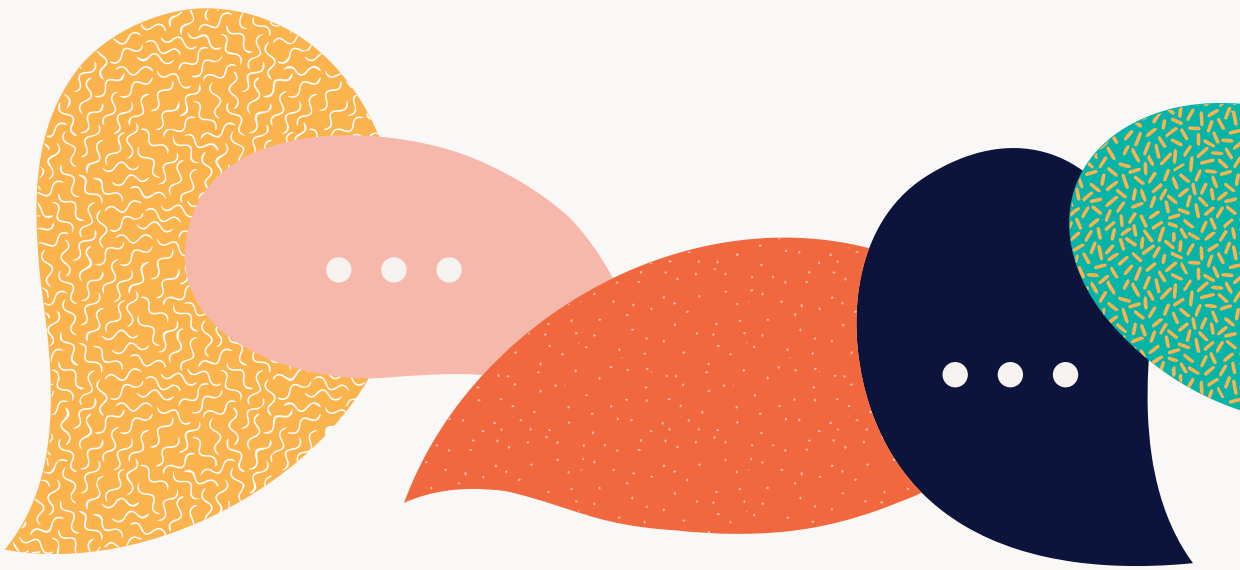


IMAGE: ISTOCK

service user voice and MVP network lead, a post I've held since November 2020, and a director of National Maternity Voices. That's a long-winded way of saying that I love bringing service users' voices into discussions about things that affect them.

I am tasked with scoping and creating this new network and creating a space where service user perspectives are available and listened to in the context of the RCM's work. I don't see my role as being about representing service users myself, so much as facilitating service users and stakeholders to be able to get involved in conversations where needed.

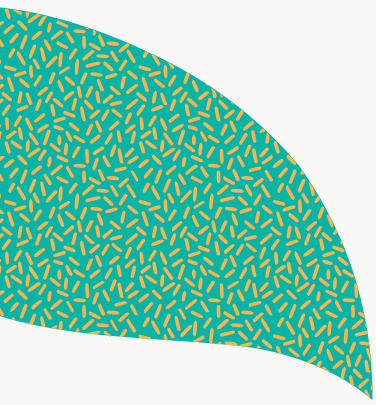
Gathering views

I've been talking to staff from all departments at the RCM including from the devolved nations, I've begun to identify themes across the needs of the different areas of the College's work. The aim is to ensure that the SVN supports and feeds into those, as well as offering a gentle, constructive challenge.

We will also be creating a database of service users and stakeholders who are happy to collaborate on projects, so that RCM staff can bring in service user voices to any piece of work easily and quickly.

Member voices are key in helping to decide what the SVN will look like, what it will do – I have been holding listening sessions since early autumn, inviting members to join a series of conversation groups online. I also attended the RCM conference in October, talking to as many members as I could on all things SVN. I will always be open to hearing people's thoughts and ideas, no matter what stage we are at in the process. Co-production often involves circling back and doing more listening because it is a constant process of refining.

I hope that the SVN will transform the way that the RCM works and in so doing, make long-lasting positive change to how maternity services look in our four countries. I also would love to influence the way that government thinks about maternity. Because the RCM is a four countries organisation, it is in a unique position to help raise up standards of maternity for all four countries. I aim for service user voice to be embedded in the culture and practice of the RCM, and for RCM members and service users to feel fully included in the RCM work.



I hope the SVN will make long-lasting positive change to how maternity services look

CREATING THE MATERNITY SERVICES OF THE FUTURE

In 2016, authors of the Better Births report had a vision: to create maternity services that were safer. All maternity policy in the UK focuses on more personal and kinder care for the women and families accessing maternity services. As the expert voice of midwives and MSWs, the RCM hopes its new Shared Voices Network will act as a facilitator of collaboration between service users, midwives, student midwives and MSWs. As chair, Emma Taylor will bring together those voices and facilitate conversations, drawing on personal experience and involving a diverse range of organisations and groups. Together, Emma and the SVN will establish a new model of working with service users and RCM staff and members, ensuring the RCM places women and families at the centre of its vision.
Read more at bit.ly/sharedvoiceschair

MORE INFO

If you would like to be part of this project, email me at **emma.taylor@rcm.org.uk**
I want to hear from RCM members, what you think the network should do and how it could help you in your work, because you are key to this and we need to hear your voices.

Baby loss support

Baby loss is a difficult subject, made more so by a lack of workplace policies that treat grieving parents with respect and care. For midwives and MSWs it can be especially difficult to return to work, as RCM professional advisor Heather Bower notes on page 43, many don't return, or take sickness leave and become subject to sickness policies. This in turn exacerbates the maternity staffing crisis, the subject of a recent All-Party Parliamentary Group (APPG) for Maternity call for evidence.

The APPGs for Maternity and Baby Loss have joined forces to press for urgent action on the immediate and catastrophic maternity staffing shortage. Their recent report cited reduced time to speak to parents and advise them when something had gone wrong, or simply to prepare them for parenthood, and, in general, just less time for compassion to be shown. The staffing crisis also brings a shortage of specialist maternity staff trained and available to support families. Some families have been left in the hands of staff inexperienced in bereavement care and not referred on for support such as psychological support, due to lack of time.

A recent Bereavement Care Audit by baby loss charity Sands found that 12% of Trusts and Boards across the UK had no bereavement specialist working in the maternity service. And for those that do, the charity estimates that each bereavement specialist has just two hours' working time to dedicate to each death, including all aspects of the role for supporting families directly.

Clea Harmer, Sands chief executive, comments that the report "paints a worrying picture of NHS staff having to make the choice between supporting a bereaved mother or caring for a mother giving birth to a living baby, often rushing between the two leaving no time for personalised, compassionate bereavement care. Good quality bereavement care is vital for parents who have lost a pregnancy, or whose baby has been stillborn or died in hospital during the first weeks of life."

Every parent whose baby has died deserves not only good bereavement care but also good workplace support.

There is a link between severe maternity staff shortages and safety

Sean O'Sullivan, RCM head of policy

"The RCM answered the APPG on Maternity's call for evidence on safe staffing by asking RCM members what impact staff shortages is having on services, safety and care, including bereavement care. The APPG aims to inform policy to ensure safer practice and better experiences for staff and service users so it was right that members should be able to feed into that.

"The responses make for difficult reading. They paint a bleak picture of services that are understaffed, overstretched and letting down women and families as well as maternity professionals.

"The report, published in October, shows maternity staff are under intense pressure, feeling burnt out, conflicted that they aren't able to give the level of care they would like to, and are in constant fear that things are being missed. The report makes a clear link between the severe shortage of staff in maternity services and safety. As one obstetrician notes: 'Sometimes I come onto my shifts and instead of 13 midwives there are seven or eight! It is no wonder that things go wrong when every midwife is doing two people's jobs.'

"The RCM will not relent in pressing the government for urgent action and investment for the sake of our members and for families."

Read the report at **sands.org.uk/appg**

IMAGE: SHUTTERSTOCK

Raffaela Goodby
CHIEF PEOPLE OFFICER, BIRMINGHAM WOMEN'S AND CHILDREN'S NHS TRUST

Birmingham Women's and Children's NHS Trust has been shortlisted for a HPMA (Healthcare People Management Association) Award for Partnership for its approach to colleagues who experience baby loss – 10 days' paid leave for the mother and up to five days for the partner (see panel, right). Raffaela has been integral to this approach.

"The RCM was key both in terms of helping us ensure the language was inclusive and sharing experiences of members affected by baby loss. Real-life stories were central to how we developed the policy: our launch video included the story of a midwife who'd lost a baby, alongside input from one of our professors in miscarriage research and our director of midwifery.

"The response has been incredible – the press release was clicked on seven million times. We've had other NHS Trusts, police forces, councils and private businesses come to us and pledge to follow. It will affect 280,000 employees across the country so far – and that's just the ones we know of.

"The most powerful impact – and one that I didn't expect – was from people sharing their stories, even from 20 and 30 years ago: people who'd had a miscarriage and not felt able to talk about it, or been disciplined for taking time off sick, or started bleeding at work and had to go back on shift, not knowing if they'd lost their baby.

"It's not just been about providing paid leave; it's also tackling the stigma of miscarriage – and that is so powerful. It's given people permission to talk about so many things that affect women: heavy periods, menopause, domestic violence and sexual assault too.

"The 10 days' leave, and five days for partners, is the crux of the policy. We were really clear that our policy extends to partners and intended parents in the case of a surrogacy. It is inclusive of baby loss at any stage for any reason, including abortion. There is still massive stigma around that, but as a women's centre that cares for a lot of women facing abortion, that was important to us.

"We've also adopted the 'Smallest Thing Charter', which means we offer additional maternity and paternity leave to parents when their baby is born prematurely, from the birth up to the point when they had intended to take their leave.

"Our Trust is 82% female, the only women's and children's Trust and a Tommy's specialist centre, it felt so important to us to do this – as our chief executive Sarah-Jane Marsh said: 'If not us, then who? If not now, then when?'

"We would love to see all NHS Trusts and Boards adopt this, and I will personally support anyone who wants to progress."

Real-life stories were central to how we developed the policy

The baby loss policy at Birmingham Women's and Children's NHS Foundation Trust (BWC)

BWC became the first Trust in the NHS to offer a package of support for staff who experience baby loss, which includes periods of paid leave, in July 2021

The policy offers the following to those that experience pregnancy loss:

- Up to 10 days' paid leave for the person who was pregnant and up to five days' paid leave for the partner. This includes, but is not limited to, miscarriage, stillbirth, abortion, ectopic pregnancy, molar pregnancy and neonatal loss. This is not dependent upon gestation of pregnancy or length of service
- Paid time off for appointments linked to pregnancy loss: for example, medical examinations, scans and tests and mental health-related interventions
- A promise that all requests to work flexibly following a bereavement will also be treated with understanding and sensitivity.

The Trust also adopted the Smallest Things 'Employer with Heart' Charter to offer staff whose baby is born prematurely additional support, including:

- Extended leave at full pay until the estimated date of when maternity leave was due to commence and two weeks' paid leave for partners of premature babies, allowing paternity leave to be taken later
- Support when returning to work following the birth of a premature baby with consideration given to flexible working arrangements.

Heather Bower

RCM PROFESSIONAL ADVISOR, EDUCATION. SHE IS PART OF A MULTIPROFESSIONAL BABY LOSS WORKING GROUP CHAIRED BY SANDS, WITH REPRESENTATIVES FROM ROYAL COLLEGES, CHARITIES, HEALTH TRUSTS AND NHS ENGLAND, AMONG OTHERS

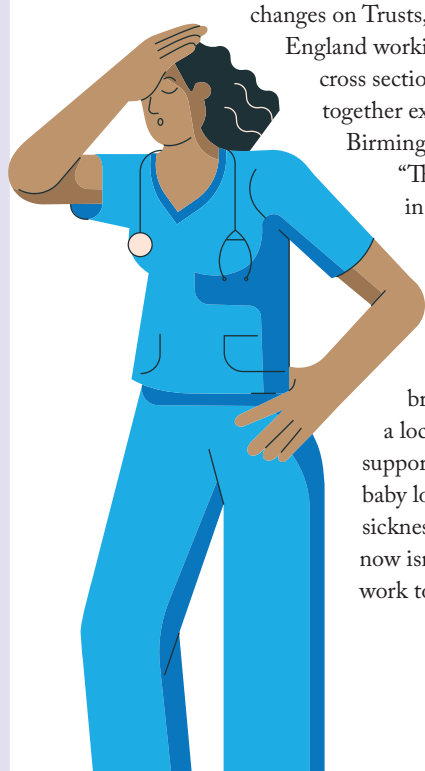
"Our overarching aim is to look at how we support NHS professionals who have experienced pregnancy loss or baby death, acknowledging the unique challenges for colleagues continuing in their professional capacity, and identifying their needs and how they might be met. What we want to do is to get this on the agenda at a national level.

"At the moment there is no policy in place for the way in which healthcare professionals are treated following the loss of their baby. If you experience the loss after 24 weeks you are entitled to maternity or paternity leave – but there is no legal entitlement before that. We want to see recognition that, whatever the stage of pregnancy, a loss is still a loss. You need time to grieve and try to come to terms with it, especially if you're going back to work in a healthcare setting, even more so as a midwife, or someone working in a gynaecology ward or neonatal unit for example. I know some midwives who never went back after they lost a baby – they found it too difficult – but perhaps with the right support they could have. It's so important to have those conversations.

"What we are hearing around the table is that the approach is variable across the NHS – some people are treated sympathetically and given time off, others take sickness leave and become subject to sickness policies. We'd like to see any baby loss, regardless of gestation, treated separately, more akin to bereavement than sickness leave.

"Without legislation it might be difficult to impose changes on Trusts, but within this group we have NHS England working at a national level, and a wide cross section of stakeholders – we can bring together examples of good practice, such as in Birmingham, and make recommendations.

"The RCM is also really invested in this work. This is very much a hidden issue and something likely to impact midwives, who are predominantly women. The RCM can also play a role through its regional officers and branch activists raising the profile at a local level – they will also be the ones supporting members who have experienced baby loss and are confronting the existing sickness and HR policies. What is in place now isn't adequate, and there is a lot more work to be done."



IMAGES: SHUTTERSTOCK

Clare Worgan
HEAD OF TRAINING AND EDUCATION AT BABY LOSS CHARITY SANDS

"When we surveyed bereaved parents about returning to work, almost half said they didn't feel supported by their employer. The main themes we heard were that their employer didn't discuss paid leave with them, even if they were entitled to maternity or paternity leave, and they didn't experience a compassionate workplace where they could have additional time away for sick leave or any appointments they needed.

"They also told us that they weren't asked about their baby – that no one acknowledged the life-changing trauma they'd been through and that can be very isolating. For bereaved parents working in health services, particularly those returning to maternity care when they are still trying to process what's happened to them, it can be particularly challenging.

"We've heard shocking stories from midwives and obstetricians about the lack of compassion when they return to work – not even being able to leave a shift to attend appointments or scans – often due to pressure from their line manager and the pressure on the service.

"It can be challenging for managers to know how to support staff going through pregnancy loss or baby death. It's quite an emotional subject and many people don't know what to say or worry about saying the wrong thing. Guidance and training for managers is vital to give them the confidence and tools to build a supportive workplace. Sands offers training and advice both around employment policy, and around what to say, what to ask, what language to use. Signposting support services for bereaved parents is also vital.

"We hear from many people who experience a miscarriage and, because there is no statutory leave, have to battle for time off. That extra battle is so unfair on top of what they are trying to process. While we don't want to assume that everyone will want or need that time off, there definitely needs to be that flexibility for them to choose what's right for them.

"There is a mixed bag out there in terms of policy and practice. Having a policy around baby loss, separate to the maternity and paternity leave policy, is the first step to take. Because it shows an employer is compassionate and understands the impact, it allows staff to talk openly about their experiences. That has a huge impact on changing the culture of an organisation."

Many managers don't know what to say about baby loss or worry about saying the wrong thing

Sands offers training and HR support for employers looking to improve their baby loss policies and staff care. Visit **sands.org.uk/training**

Janet Ballintine

LABOUR WARD COORDINATOR AND RCM ACTIVIST AT BIRMINGHAM WOMEN'S AND CHILDREN'S NHS TRUST (BWC)

Janet has been pivotal in developing and launching the BWC baby loss policy, including advising on the language used and how they engaged with colleagues who had suffered a loss.

"This was something I'd wanted to happen for a long time. Our workforce is predominantly women, many of whom are at an age where they might get pregnant. We know one in four pregnancies end in miscarriage, so there was a big gap to be addressed.

"To give an example of why this policy is vital, I once represented a member at a hearing who'd had a lot of periods of absence – she was an excellent midwife, but her employment record didn't look good, and she was at risk of losing her job. She finally opened up to me about what was going on and revealed she'd had nine miscarriages over several years. This is still such a taboo – women are suffering miscarriages in silence.

"The previous policy was a minimum of three days, up to five at a manager's discretion, for any kind of bereavement. But I was aware of the first-hand experiences of several members who didn't want to have those difficult conversations with managers after they'd lost their baby. This new policy takes away any quibbles – they are entitled to a minimum of 10 days and can ask for more if they need.

"I know in the past that colleagues will have gone to their GP to get signed off, but then felt that their loss and grieving were never acknowledged. This policy also shows them their employer understands and acknowledges what they're going through.

"We have got to be able to have these conversations – we work with women, we advocate for women, but sometimes we can forget that our colleagues are also women, and we need to be advocating for them too – their loss and pain is real.

"I went through the draft policy line by line, and because I was able to give examples from real-life experiences of RCM members, they took it all on board. There wasn't anything I asked they said no to. From start to finish it took just six weeks."

Lauren Petrie

FORMER BEREAVEMENT MIDWIFE, NOW MATRON FOR INPATIENT SERVICES AT WEST HERTFORDSHIRE HOSPITAL, A GUEST LECTURER AT KING'S COLLEGE LONDON AND A MEMBER OF THE ALL-PARTY PARLIAMENTARY GROUP ON BABY LOSS

Her daughter Jada was stillborn in 2013. Lauren began her midwifery training in 2015, after raising thousands to open a special room for bereaved families at Queen Charlotte's and Chelsea Hospital where she gave birth – 'Jada's room'.

"When I started my midwifery course, I asked when the lectures on stillbirth would be I was told we only had one session - a three-hour lecture in year two. Rather than feeling reassured that I wouldn't have to think about it, I was shocked – I believe this is why midwives are coming into the profession feeling scared and not equipped to provide bereavement care.

"So I asked if I could speak to the students. I started with a one-and-a-half-hour talk, and the feedback was so good the session was extended to a half-day session the following year. I wrote a training package in my second year and the students now have two and a half days over the course of a three-year degree.

"Students start in year one with a soft introduction to pregnancy loss including memory making. In year two and three we delve into a range of subjects including antenatal diagnosis, clinical intrapartum care, decision-making, palliative care, postmortem consent, grief, risk and governance – linking bereavement into other mandatory modules and preparing students for qualification.

"From the clinical considerations, to how they can adapt their language when a woman is birthing a baby that has died, the training gives them the practical tools they need. The training is unique as it has a two-pronged approach. I can tell them 'In this moment, this is how I felt as a mum', and 'This is what you can do as a midwife to help.'

"If we want to see a wider cultural change, we have to look at what we are doing in education. Most student midwives are still having one three-hour session in three years, which minimises the importance and prevalence of bereavement care. It needs to be higher on everyone's agenda."

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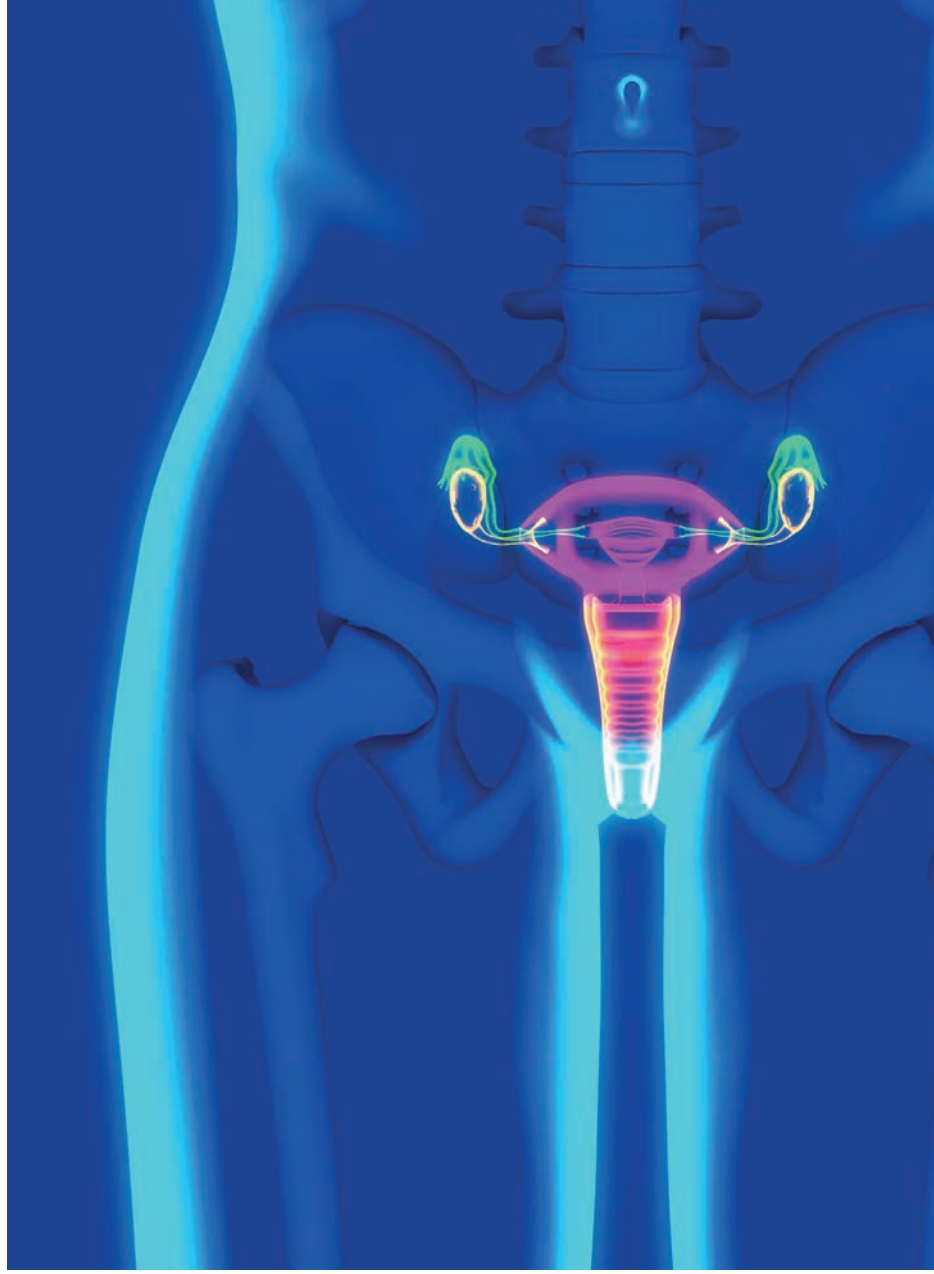
Family planning

Joanne Cull, Wellbeing of Women doctoral fellow at the National Institute for Health Research and Dr Abigail Easter, senior lecturer at King's College London, undertook a systematic review of factors influencing the implementation of post-placental intrauterine device insertion services

A gap of at least 18 to 24 months is advised between birth and next pregnancy, as short pregnancy intervals are associated with a range of serious maternal and neonatal risk factors, including low birthweight, maternal anaemia and preterm labour.

Post-placental intrauterine device insertion (PPIUD) entails the insertion of an intrauterine device (copper coil) or intrauterine system (Mirena or Jaydess coil) immediately after either vaginal or caesarean birth and has been shown to be safe, effective and convenient for women and compatible with breastfeeding. However, despite the benefits, PPIUD is not yet widely offered in the UK. The postpartum period is a time when women are particularly at risk of unplanned pregnancy and may find it challenging to access contraceptive services

IMAGE: ISTOCK



due to the demands of their newborn; this has been exacerbated by COVID-19.

A 2019 report by the Royal College of Obstetricians and Gynaecologists (RCOG) stated: "Post-pregnancy contraception should be a key part of the maternity pathway… NHS England, NHS Scotland, NHS Wales and Health and Social Care Northern Ireland must embed immediate post-pregnancy contraception maternity pathways and support for all women." A systematic literature review was conducted to identify barriers and facilitators to PPIUD implementation; these included women's perceptions. Twenty-one papers from four continents were included in the review.

Service challenges

Implementing PPIUD services requires the coordination of multiple professional groups and departments and is, therefore, subject to the logistical complexities of planning, support from external organisations, staffing and workload challenges. Hofler et al (2017) observed that "The complex implementation process involves many steps across several departments": for example, pharmacies must order devices and make them accessible on obstetric units, electronic health records need to be updated to support documentation, and patient counselling materials must be developed.

In an example in Scotland, staff training in postpartum contraception and routine antenatal contraceptive counselling was introduced two years before PPIUD service introduction. Research was carried out demonstrating demand and need for the service; this provided justification for the introduction of the service and influenced the culture of the maternity unit towards providing contraceptive services. PPIUD was then initially introduced at elective caesarean sections; vaginal PPIUD was then trialled at the smaller of two maternity hospitals, allowing the process to be tested before introduction on a larger scale.

The review identified two specific staffing challenges: high staff workloads and maintaining sufficient numbers of staff trained in insertion. The ability to maintain PPIUD services after the initial rollout was impacted by staff turnover and leave, leading Cooper and Cameron (2018) to conclude: "Ongoing investment in PPIUD training and education will be essential to ensure a sustainable service." Strategies to ensure ongoing training included adopting a 'train the trainer' model, or partnering with academic institutions, non-profit organisations and device manufacturers to offer training. The review also identified that clinical champions and external support, including by government bodies and implementation teams, appear to be critical to successful implementation. To date, this support has not been offered in the UK, and instead Trusts and Boards have been attempting to implement PPIUD on an ad hoc basis themselves with varying levels of success and sustainability.

What do women think?

Past experience was a key determining factor in contraceptive choice. Respondents to studies had little knowledge of PPIUD or the IUD more generally and were hesitant to adopt an unfamiliar method of contraception (Huber-Krum et al, 2019; Willcox et al, 2019; Carr et al, 2018; Robinson et al, 2016; Bryant et al, 2015). Where women had limited knowledge of PPIUD, their attitudes were based on what they had heard from

IMAGE: ALAMY

family, friends and the wider community.

Participants in all studies reported concerns around potential side effects. Some of these concerns are rooted in myth, such as the belief that the IUD can cause sterility or cervical cancer or migrate to another part of the body. There was a widespread misconception that early postpartum use of the IUD is dangerous, or that contraception is not necessary until menstruation has recommenced. In contrast to the common worry of women in western countries that contraception will lead to weight gain, women in Africa worried it would lead to weight loss. Respondents to several studies worried about the impact of PPIUD on their sexual relationships (Huber-Krum et al, 2019; Willcox et al, 2019; Robinson et al., 2016). Concerns included the effect of prolonged bleeding, pain for themselves and their partners during intercourse, sexual incompatibility after insertion, or that the method would reduce their libido. Impact on lactation was also important to women. Huber-Krum et al (2019) noted that fear of side effects often prevented women choosing PPIUD, and Bryant et al (2015) stated: "Regardless of whether they were using the IUD, a pervasive theme that affected decision-making was fear. Almost all of the women expressed specific fears about the IUD… Fear was often reinforced by what was read in the consent form which contained basic information on rare risks of IUD insertion, including uterine perforation, expulsion and pregnancy."

Contraceptive counselling

Women who trusted their healthcare provider and were satisfied with the quality of counselling received were more likely to choose and continue PPIUD. Advance information and advice on what to expect in the first weeks after insertion appears crucial. Huber-Krum et al explored this issue in detail in their 2019 study in Tanzania. The researchers found that women who were provided with information about potential problems, proactively followed up and supported to manage side-effects, were more likely to continue use of the method. Conversely, some study participants who had experienced expulsion were frustrated that they had not been adequately counselled about this risk and the subsequent mistrust prevented them from choosing to have another IUD inserted.

Some women were concerned that healthcare providers would be reluctant to remove the PPIUD on request. Crucially, these issues may not be commonly addressed in contraceptive counselling and women may not have the confidence to bring them up. Issues of reproductive justice around clinicians' biases and device removal were commonly raised in these papers and the review has highlighted the importance of applying a reproductive justice framework to PPIUD implementation and monitoring.

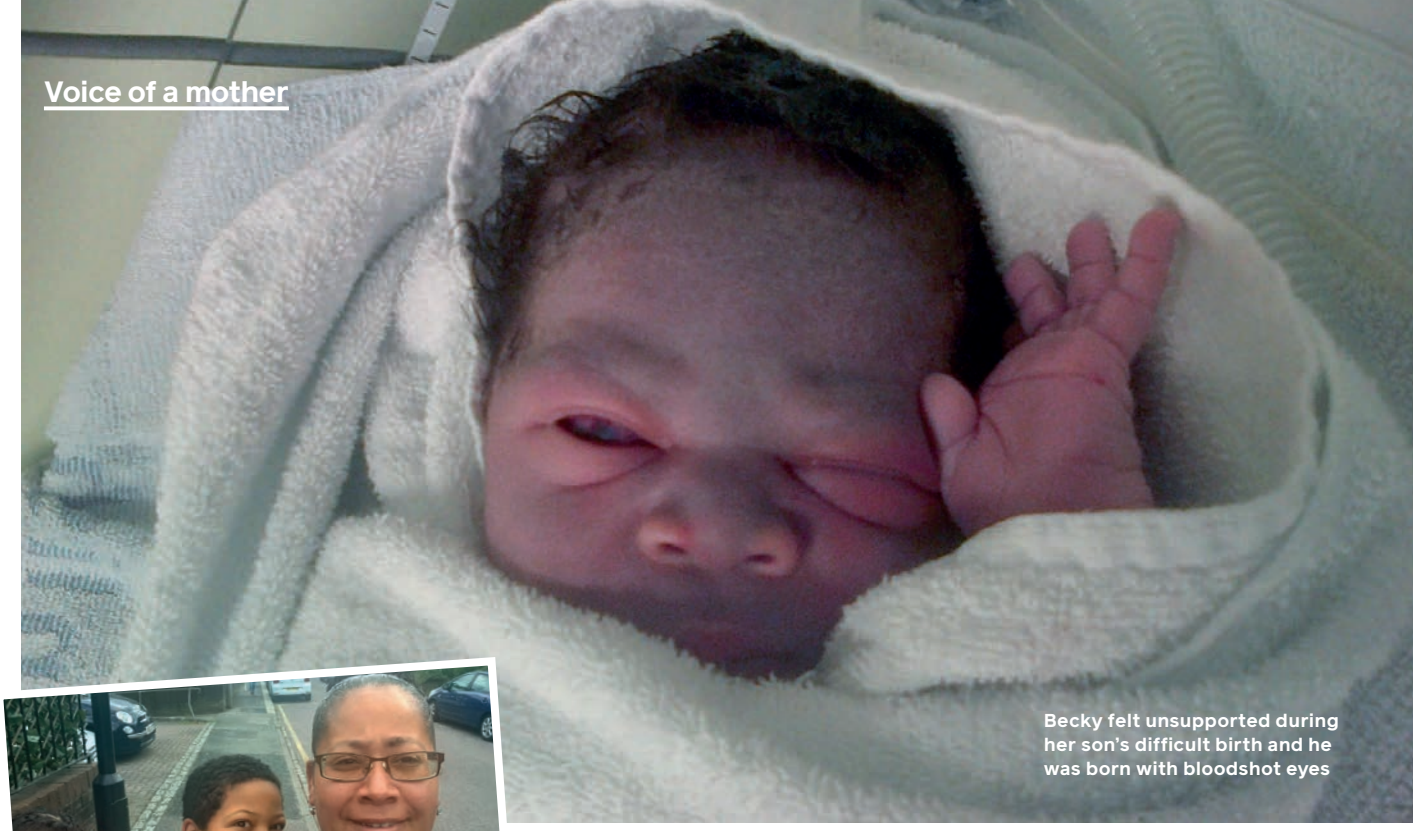
For women, contraceptive counselling should be timely and thorough, with particular attention paid to providing information on common concerns about the IUD, including its impact on sexual relationships. Including partners in counselling may increase uptake and services should be designed with reproductive justice in mind to allay fears about women's autonomy over their own bodies.

Meanwhile, units wishing to implement PPIUD services should anticipate that this will be a complex and time-consuming process and prepare accordingly, seeking opportunities to collaborate with other organisations. Implementation is most likely to be successful where it is supported by government policy and organisations such as national obstetrics and gynaecology societies.

Ongoing staff training will be necessary to maintain a sufficient pool of staff who are able to counsel, insert devices and help with complications. Whether in a formal 'champion' role or not, individual staff who are enthusiastic about PPIUD can have a significant positive impact on implementation. Finally, data monitoring and analysis can be used to advocate for continuing and expanding PPIUD services.

PPIUD is safe, effective and convenient for women, yet it is not widely offered in the UK. Acting to overcome the barriers identified in this review can aid successful implementation of PPIUD schemes and give more women contraceptive autonomy.

Women who trusted their healthcare provider were more likely to continue PPIUD



Becky felt unsupported during her son's difficult birth and he was born with bloodshot eyes

Hear me

When Becky went into labour with her third child, she didn't expect the experience to be so traumatic

I knew I'd gone into labour at around 7pm after my third sweep, but it wasn't until 3am that the contractions increased and were coming quickly. My sister and my husband came to the hospital with me. This was my third birth (I'd previously had a miscarriage at 23 weeks that I'd been induced for and had to deliver), so I thought I knew what to expect – but the pain was different, and that made me worry.

At the hospital, I kept feeling the urge to wee. I'd scramble to the toilet with a bursting sensation, but instead there was just a 'hot rod' of pain. The midwife ignored my pain and barely acknowledged me. I kept asking her to check what was happening, how dilated I was and so on, but she refused. She spoke quietly and I couldn't hear her – especially as the gas and air seemed so loud. I said I couldn't hear her, but she made no effort to speak louder. I just wanted her to check what was happening and she wouldn't – she said she knew best, that I wasn't in labour because my waters hadn't broken. I kept saying I was, but she said: "I'll tell you when you're in labour!" I knew something was definitely wrong.

My husband and sister both couldn't bear seeing in me in such pain while no one did anything. They both tried to get the midwife to do something, but she refused. They continued to challenge her that she wasn't listening to me or giving me anything for the pain. My sister, who's a mother of four, could no longer watch and had to leave the room.

Eventually, I checked and there was a lot of fresh blood. That's when the midwife leapt into action, though she still wasn't helpful; she was more panicked than anything else. I asked if I should push because I wasn't feeling any contractions, and because of the pain I could no longer hold the baby in, but she said: "If you want to push, then push." I asked, if I push now, would I damage the baby? She answered: "Just push on your next contraction." I couldn't wait because of the pain, so I said a quick prayer in my mind, gripped onto the bed and started pushing. I still hadn't had any pain relief, even though I was begging.

She said I wasn't in labour because my waters hadn't broken

When he was born, the cord was round his neck, he was purple and his eyes were bloodshot. Because I'd just pushed and had no contractions, my arms had no strength left to hold him. After the consultant had checked and things had calmed down, I didn't want the midwife to think I'd been rude, so I said: "I'm sorry I asked you to speak up, I just couldn't hear you." She nonchalantly said: "Don't worry, I've had that said to me before. People act all kinds of way when in labour." As if I had been her worst patient. I couldn't believe it – she couldn't see that she had caused a really awful experience. But I've put it behind me and count my blessings with my beautiful children.

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