



# standing up for high standards



Royal College  
of Midwives

How the RCM will support  
midwives, student midwives and  
maternity support workers (MSWs)  
if they have concerns at work

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# Introduction

Speaking up when you see something wrong at work is a professional duty – but it's easier said than done.

The RCM believes that all staff in maternity, whatever their position and wherever they are in their career, should feel able to speak out if they have any concerns about the quality and standards of care provided or if they suspect treatment or care will or has caused harm, or if they see cultures and behaviours that put colleagues or women at risk.

We think everyone has a responsibility to create the environment where issues and concerns can be raised without fear or favour. That starts with chief executives and flows down through leaders and managers to clinical teams.

In this guide, we set out why we think speaking up is important, how you might approach this in your workplace and what the RCM will do to support you.

## The RCM commits to:

- ▶ Supporting and encouraging members to use existing mechanisms within their employing organisations to raise issues confidently rather than anonymously.
- ▶ Providing guidance for members who wish to raise concerns.
- ▶ Promoting good working relations and lines of communication between midwife managers and RCM workplace representatives so that issues are raised in a climate of honesty and transparency.
- ▶ Facilitating forums for midwife managers, supervisors of midwives (Northern Ireland and Scotland, clinical supervisor for midwives in Wales and Scotland), professional midwifery advocates (England) and RCM workplace representatives to share with others, views, evidence, and perceptions about their working environment.
- ▶ Directing concerns brought to its attention to the most appropriate office holder and escalate if required.



# Legacy of shortcomings

We believe that our members go to work to do a great job while simultaneously providing a high standard of care. But it is undeniable that over the years there have been too many incidents where health services have failed, often because those who could see what was going wrong did not speak out.

From Mid Staffs to Morecambe Bay and more recently Shrewsbury and Telford, these cases have thrown a spotlight on the way that concerns about standards, systems and practice are raised and dealt with across the NHS. The 2022 Ockenden report<sup>1</sup>, and previous reports, has highlighted the need for consistent and transparent processes when escalating and acting upon safety concerns raised by maternity staff.

There must be continued support throughout the NHS for staff and students who wish to raise concerns. This need for a transparent and open culture was first recognised in Sir Robert Francis' Freedom to Speak Up Review<sup>2</sup> which set out 20 principles and actions aiming to create the right conditions for NHS staff to speak up, share what works right across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in the future. The review led to the establishment in England of Freedom to Speak Up Services in all Trusts<sup>3</sup>.

Organisational culture has been identified as a key factor in many recent maternity investigations. This has been shown through inadequate internal inquiries on maternal deaths, inability to escalate

concerns and staff voices not being heard at board level. These have played a pivotal role in system-wide failure.

The RCM has supported the recent Ockenden recommendations and encouraged Trusts and Boards to implement the immediate and essential actions. The RCM has developed a range of resources for our members to support them in developing systems to ensure serious incidents are thoroughly investigated, and lessons are learned but also in creating a positive workplace culture, in which all practitioners working in a maternity setting feel confident and supported to raise concerns and work collaboratively.

[RCM - Positive cultures workshop](#)

[RCM - The solution series 1. Improving maternity services](#)

[RCM Position Statement - Racism in the workplace](#)

[RCM - The solution series 4. Making maternity services safer. Nurturing a positive culture](#)

[RCM - I-Learn](#)



# Identifying the triggers for escalation

We recognise that there are huge pressures on midwives, maternity support workers and student midwives which may have an impact on safety, quality, compassion, or standards of care. In many units these have been amplified by working through the COVID-19 pandemic, but sometimes maternity staff just keep going despite the conditions around them. You may be the one who can spot and highlight concerns, including:

- ▶ Workloads too heavy to be undertaken safely with staff working above and beyond comfort levels.
- ▶ Tasks or roles inappropriately or unsafely delegated.
- ▶ Insufficient or inappropriate staffing to provide a safe service.
- ▶ Unsafe equipment or working environment.
- ▶ Weak governance arrangements and inadequate mechanisms for investigating near misses.
- ▶ Being expected or instructed to overlook concerns when you have a duty to raise such concerns.
- ▶ Reduced management and leadership support.
- ▶ Bullying or other undermining behaviors between or within staff groups.
- ▶ Racism, discrimination, or unconscious bias which is directed towards colleagues or women.

- ▶ Limited access to multidisciplinary training.
- ▶ Poor multidisciplinary team working.
- ▶ Limited access to supportive clinical supervision.

Raising concerns in these situations is the responsible thing to do. It is the early warning system which should give organisations an opportunity to put right issues of poor practice or wrongdoing at an early stage. The best organisations empower their staff to feel confident they can have a dissenting voice.



# Rights and responsibilities of NHS staff

Throughout the UK, the NHS expects that staff will work together so patients and those in their care and will come first in everything we do, and that staff will speak up when things go wrong.

The NHS terms and conditions of service handbook (Part 3 section 21: Right to raise concerns in the public interest) states: “All employees working in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.”

Each UK country has set out a framework in which patients have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff and in which staff will encourage and welcome feedback.

These can be found in:

- ▶ England: Freedom to speak up: raising concerns (whistleblowing) policy for the NHS<sup>4</sup>.
- ▶ Scotland: The national whistleblowing standards - Introduction to the Standards<sup>5</sup>.
- ▶ Northern Ireland: Raising concerns - A good practice guide for the Northern Ireland public sector<sup>6</sup>.
- ▶ Wales: All Wales procedure for NHS staff to raise concerns and raising concerns<sup>7</sup> about healthcare in Wales advice for healthcare workers<sup>8</sup> (Healthcare Inspectorate Wales 2021).

In 2022 the NMC and GMC refreshed their joint guidance on the duty of candour<sup>9</sup>. The guidance focuses on the professional duty of midwives and nurses to be open and honest when things go wrong. This duty extends not just to candour with patients, but also within organisations including the reporting and investigating of adverse incidents and near misses.



# England

The aim of the NHS Constitution in England (NHS England, March 2013 updated January 2021)<sup>10</sup> sets out the rights, pledges and responsibilities for patients, the public and NHS staff which the NHS is committed to achieve.

Among these is the right

 **“To raise any concerns with their employer, whether it is about safety, malpractice or other risk, in the public interest.”**

The NHS People Plan<sup>11</sup> states

 **“Many staff have felt unable to speak up... this is another area in which Black, Asian and minority ethnic (BAME)<sup>12</sup> staff have been particularly affected. We need to look beyond the data and listen to the lived experience of our colleagues. Making sure staff are empowered to speak up and that when they do their concerns will be heard...”**



# Northern Ireland

The Department of Health<sup>13</sup> in Northern Ireland has identified that public safety must be the first concern of everyone who works in or manages in healthcare. Effective care should place an emphasis on improving safety processes to prevent harm, and to improve the service user and carer experience.

This is set out in policies that guarantee all employees working in the NHS a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety, or any other serious risks they consider to be in the public interest.





## Scotland

The Patient Rights (Scotland) Act<sup>14</sup> aims to improve patients' experiences of using health by respecting the rights of patients and staff. It sets out a series of Healthcare Principles which all staff should consider, including avoidance of injury or harm.

NHS Scotland wishes to ensure that employees have the opportunity and confidence to raise concerns by requiring all health boards to have a whistleblowing policy.



**“A responsible attitude to whistleblowing helps each organisation to promote a healthy workplace culture built on openness and accountability. Encouraging staff to raise any serious concern they may have about malpractice or serious risk as early as possible, and responding appropriately, is integral to achieving this.”**



# Wales

NHS Wales has a legal duty and responsibility to protect the interests and wellbeing of its service users. The ambitions for the NHS in Wales are set out in A healthier Wales: our plan for health and social care<sup>15</sup>

Ensuring staff play a role in achieving this is set out in the All Wales raising concerns (whistleblowing) policy which requires



**“Healthcare organisations ensure that staff are supported by processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management.”**



# The Royal College of Midwives: championing the highest standards of care

The RCM believes that NHS staff should feel able to speak out if they have any concerns about the quality and standards of care being provided.

Our workplace representatives and full-time officers will support individuals and groups of members to make use of the right channels for raising their concerns.

The RCM agrees that it is right to encourage professionals to be candid with patients, colleagues and those undertaking statutory responsibilities. We want to encourage reporting transparency to improve health outcomes. We want to see a culture in the NHS where those who shed light on wrongdoing do not fear for their careers.

The RCM will not normally act on anonymous letters making claims about individuals or organisations. Instead, to ensure that lessons are learned, and feedback is shared, we encourage all members to identify themselves when raising concerns at their organisation. Our workplace representatives and full-time officers are there to protect members who raise concerns.



**...we encourage all members to identify themselves when raising concerns at their organisation**

Members who formally raise their concerns with the RCM can be certain we will pass these to where they can be most effectively dealt with, and we will continue to escalate until we can get satisfaction on your behalf. Most commonly this will be the Head or Director of Midwifery services, but in some instances, it may be necessary to inform the Director of Nursing/Chief Nurse or even Chief Executive.

Where student midwives are undertaking a placement in the area giving rise to concern, consideration will be given to informing the NMC and their higher education institution.



External to the organisation, it may be necessary for the RCM to raise matters of concern with the regional chief midwife (England) or Chief Midwifery Officer (Scotland, Wales, and Northern Ireland)

The RCM is not an inspectorate and does not have the authority to investigate incidents or concerns. However, where we see or are made aware of concerns about quality or safety, we will work with members to help to resolve them, or if that is not possible, to escalate them.

Through its organising and engaging activities, the RCM often gains insights into professional cultures, clinical developments, and practice issues within organisations. Our staff will often be involved in advising and supporting maternity management and the clinical workforce as they address these issues.

Inspectorates such as the CQC in England now routinely ask professional organisations such as the RCM to share their insights, both positive and negative, before embarking on scheduled visits. This provides another opportunity for the RCM to raise concerns on behalf of members.



**...where we see or are made aware of concerns about quality or safety, we will work with members to help to resolve them...**

The RCM believes that where the NHS has the right number of properly trained, remunerated and well-motivated staff, it is more likely to see high standards of safe, effective woman-centred care. The RCM is a trade union and a professional organisation, which means that, at times, we will both represent individual members through formal processes, while supporting services to improve. There is no conflict of interest, as the RCM is ensuring that standards are raised across every aspect of maternity services.



# Guidance for midwives

It is important for all staff to feel safe to raise their concerns without fear of reprisals and to have the confidence that they will be listened to and taken seriously by their employer.

Every employer should have an executive director with responsibility for Freedom to Speak Up and a properly resourced Freedom to Speak Up Guardian and if necessary, a network of champions (raising concerns champion in Northern Ireland, whistleblowing champions in Scotland). There should be a robust and up-to-date policy on raising concerns at work and every employee should be aware of this. The policy should include information on contacting the local Freedom to Speak Up Guardian<sup>16,17</sup>.

RCM workplace representatives should be actively involved in formulating policies, procedures, and support mechanisms. These policies need to be communicated and publicised widely at regular intervals and be seen to work in practice. It is the role of the RCM workplace representative to help communicate policies to members and to help them follow the policy when raising a concern.

Staff are often not alone in the concerns they have, and others may feel the same, a collective response is often a more powerful way of ensuring appropriate action is taken.

If staff raise concerns collectively, victimisation and reprisal may be less likely.

## Professional accountability for midwives

Midwives and nurses must abide by the Nursing and Midwifery Council (NMC) code of conduct, standards, and guidance.

The Code: Professional standards of practice and behaviour for nurses and midwives (2015 updated 2018)<sup>18</sup>

Standards of proficiency for midwives (2019)<sup>19</sup>

Raising concerns. Guidance for nurses, midwives and nursing associates (2022).

The NMC states that:

**“As a nurse, midwife or nursing associate, you have a professional duty to put the interests of the people in your care first and to act to protect them if you consider they may be at risk. Where we use the term in your care throughout this document, it is used to indicate all of those people you come across or know about because of your work as a nurse, midwife or nursing associate, not just those people you deliver specific care for or have direct clinical or managerial responsibility for.”**



So, what do you do if there is a conflict between what your employer expects you to do and what you believe is in the best interest of the women and people you are caring for? What should you do if your employer's instructions or expectations place you at risk of breaching your professional code? First, be clear about your responsibilities under your professional code.

Any expectations or instructions that compromise compliance with your professional code must be questioned, challenged and, if necessary, refused. This cannot be left to other members of staff or to the RCM representative; they must be raised by the individual who has the concern. It is, however, sensible to take advice before taking action if you can. You are personally accountable for your acts or omissions, so failure to act appropriately could ultimately lead to a charge of professional misconduct. If you consider there is a risk of immediate harm, then you must report your concern to the appropriate person immediately.

Raising concerns can be very challenging. A midwife, student midwife, MSW or midwifery manager may have concerns which are not shared by colleagues, or colleagues may be fearful of raising concerns. Raising concerns means verbally and in writing, bringing to the attention of your immediate line manager the issue or situation which you are worried about.

If raising concerns does not have the desired result or you do not see appropriate action, you may need to make use of your

organisations whistleblowing policy. We advise you to exhaust the internal procedures first. It is important to be clear about the legal protection available to those who raise concerns. Healthcare workers who whistleblow have a statutory protection from victimisation through the Public Interest Disclosure (Protection) Act and the Public Interest Disclosure (Northern Ireland) Order. This legislation protects all employees, workers (including students on workplace training) contractors, trainees or agency staff who make a disclosure in good faith.

If you are considering whistleblowing, we strongly advise you to contact your local RCM representative for advice and support with this procedure. They can help you draft letters as it is extremely important to keep a paper trail setting out clearly what your concern is and what you hope to achieve.



**If staff raise concerns collectively, victimisation and reprisal may be less likely.**



# Step by step guide to raising concerns

## Step 1:

Have a discussion with either your local RCM representative or your Regional/National Officer about your concerns to determine the best course of action. This may be to approach your immediate line manager, matron or Head /Director of Midwifery about the concerns you have.

## Step 2:

Find a copy of your employer's policy on raising concerns in the workplace to guide you.

## 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/RCM representative if you are being asked to contravene your code.

## Step 4:

Be clear about what you are concerned about and why:

- ▶ What evidence do you have?
- ▶ Is this an individual or collective issue?
- ▶ Has the issue already been raised and not dealt with?

## Step 5:

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

- ▶ Set out what you wish to achieve - be clear.
- ▶ How can you work with your employer to address the concerns?

## 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



# Guidance for maternity managers

We know that being a midwifery manager is a tough job, often feeling caught between corporate responsibilities and loyalty to your staff teams, and always with the safety of the service in mind.

Midwife managers may face additional pressures when their staff raise concerns, and they too must comply with the requirements of the NMC Code. The NMC<sup>18</sup> places a duty on nurse and midwife managers to promote “an open work environment in which staff are accountable and encouraged to raise concerns about the safety of people in their care” which “will help identify and prevent problems and will protect the public”.

Other requirements will be set out in your job description and in local arrangements for clinical governance. Senior managers now have specific standards, developed in each country, they are expected to comply with; for example, in England, standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England<sup>20</sup> have already been published and in Wales a new Code of Conduct for NHS managers is currently in preparation.

Health Education England, NHS Employers and the National Guardian's Office all provide useful resources and training for staff on raising and handling concerns in the NHS. NHS employers from board level down are expected to provide a working environment that promotes high quality safe care by ensuring appropriate allocation of resources and a culture which welcomes staff or patients to speak out if they believe patient safety is being compromised.

The RCM promotes good working relationships and lines of communication between midwife managers and workplace representatives and will support them to work through issues and concerns in partnership.





# Guidance for student midwives

The NMC guidance on raising concerns encourages students to inform their practice supervisors/assessors or academic link if they have any safety concerns during their placement, including if they think a colleague is putting someone else at risk or a pregnant woman is unhappy with their care<sup>21</sup>.

The RCM recognises that this may be difficult for you to do as a student and RCM workplace representatives will help and support you to raise any concerns that you have.

Universities also have a responsibility to ensure midwifery students understand their responsibilities and appropriate policies for dealing with issues raised.



# Guidance for maternity support workers

Although not a regulated profession, MSWs have a responsibility just as any other member of staff to raise concerns and the earlier guidance will be useful for you. The RCM recognises that as a group MSWs may feel less confident and more vulnerable in raising concerns. Therefore, MSWs should take advantage of RCM membership and make use of the support of local RCM representatives to raise any concerns.

Each of the UK countries has issued guidance for support staff:

- ▶ England - Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England<sup>22</sup>
- ▶ Northern Ireland - While there is no specific guidance for MSWs in Northern Ireland the guidance contained within Section 21 of the Agenda for Change Handbook applies to all HSC staff and all Trusts have local policies in place which apply to all staff including MSWs<sup>23</sup>.
- ▶ Scotland - Code of Conduct for Healthcare Support Workers<sup>24</sup>
- ▶ Wales - Code of Conduct for Healthcare Support Workers<sup>25</sup>



# References

1. This reference should now read Final report of the Okenden review (2022) Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust  
[Ockenden maternity review - Ockenden report](#)
2. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Francis Report  
[UK Government publication - The mid Staffordshire NHS foundation trust public inquiry](#)
3. Francis R. (2015). Freedom to speak up review  
[Freedom to speak up review](#)
4. NHS Improvement NHS England (2016). Freedom to speak up: raising concerns (whistleblowing) policy for the NHS  
[NHS England - Freedom to speak up policy](#)
5. Independent National Whistleblowing Officer (2021). The national whistleblowing standards. Introduction to the standards  
[National Whistleblowing Standards All Parts](#)
6. Northern Ireland Audit Office (2020). Raising concerns. A good practice guide for the Northern Ireland public sector  
[NIAO - Raising concerns](#)
7. Health Inspectorate Wales (2021). Raising concerns about healthcare in Wales: advice for healthcare workers  
[HIW - Raising concerns about healthcare in Wales](#)
8. Public health Wales (2020). Procedure for NHS staff to raise concerns  
[PHW - Procedure for NHS staff to raise concerns](#)
9. Nursing and Midwifery Council (2022). Openness and honesty when things go wrong: the professional duty of candour  
[NMC - The professional duty of candour](#)
10. UK Government (update January 2021). The NHS Constitution - England  
[NHS Constitution for England - UK Government](#)
11. NHS England (2021). We are the NHS: People Plan for 2020/21  
[NHS England - We are the NHS](#)
12. Although the RCM no longer uses the term BAME this has been included when directly referencing NHS documents
13. Department of health, social services and public safety (Northern Ireland) [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)
14. UK Government (2011). Patient Rights (Scotland) Act  
[UK Government - Patients Scotland Act 2011](#)
15. Welsh Government (2018). A healthier Wales: our plan for health and social care  
[A healthier Wales: long term plan for health and social care | GOV.WALES](#)



# References

16. NHS England (2021). Guidance for boards on freedom to speak up in the NHS Trusts and NHS Foundation Trusts  
[NHS England - Guidance for boards on freedom to speak up](#)
17. Health Education England (2021). Freedom to speak up programme  
[HEE -Freedom to speak up programme](#)
18. Nursing and Midwifery Council (2018). Professional standards of practice and behaviour for nurses, midwives and nursing associates  
[NMC - The Code: Professional standards of practice](#)
19. Nursing and Midwifery Council (2019) Standards of proficiency for midwives  
[NMC - standards of proficiency for midwives](#)
20. Nursing and Midwifery Council (2022). Raising concerns. Guidance for nurses, midwives and nursing associates  
[NMC - Raising concerns guidance for nurses and midwives](#)
21. Professional Standards Authority (2013). Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England  
[PSA - Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England](#)
22. Skills for health (2013). Code of conduct for healthcare support workers and adult social care workers in England. Funded by the Department of Health  
[Skills for Health - Code of Conduct for Healthcare support workers](#)
23. NHS Employers (updated July 2021). The NHS terms and conditions of service handbook, Section 2021  
[NHS Employers - Terms and conditions of service handbook](#)
24. NHS Scotland (2009). Code of conduct for healthcare support workers  
[NHS Scotland - Code of conduct for healthcare support workers](#)
25. Welsh Assembly Government (2011). Code of conduct for healthcare support workers  
[Welsh Assembly Government - Code of Conduct for Healthcare Support Workers](#)



# Useful links and resources

1. Care Quality Commission (CQC)(England)  
[www.cqc.org.uk](http://www.cqc.org.uk)
2. Health and Safety Executive  
<http://www.hse.gov.uk>
3. NHS Employers (2021). Workforce Race Equality Standard  
[NHS England - Race Equality Standard 2020 report](#)
4. Regulation and Quality Improvement Authority  
[www.rqia.org.uk](http://www.rqia.org.uk)
5. Royal College of Midwives (2021). Position Statement: Racism in the workplace  
[RCM - Racism in the workplace position statement](#)
6. Royal College of Midwives (2021). The Solution Series:4. Making maternity services safer: nurturing a positive culture  
[RCM - The solution series 4. Making maternity services safer. Nurturing a positive culture](#)
7. Royal College of Midwives (2016). Undermining and bullying behaviours in the workplace i-learn course.  
[RCM - I-Learn](#)
8. Royal College of Midwives (2020). Promoting positive cultures - creating a strong team  
[RCM - Positive cultures workshop](#)
9. Royal College of Midwives (2021). The Solution Series 1. Improving maternity: Learning from reviews of maternity services.  
[RCM - The solution series 1. Improving maternity services](#)
10. THIS Institute (2020). 'For Us' Framework.  
[This Institute - Seven features of safety in maternity units. For 'Us' framework](#)
11. Trust Development Authority (NHS TDA).  
<https://www.england.nhs.uk/>
12. UK Government (2015). The report of the Morecambe Bay investigation.  
[UK Government - Morecambe bay investigation-report](#)
13. UK Government (2013). The Public Interest Disclosure Act.  
[UK government - Public interest disclosure act](#)
14. Whistleblowing helpline (2014). Raising concerns at work. Guidance for workers and employers in health and social care  
[Whistleblowing helpline - Raising concerns at work](#)



# Useful links and resources

## Wales

1. Health Inspectorate Wales: Responsible for all NHS-funded care (including independent hospitals) 029 2092 8850  
[www.hiw.org.uk](http://www.hiw.org.uk)
2. Welsh NHS Confederation  
[Welsh NHS Confederation](http://Welsh NHS Confederation)
3. Department for Health and Social Services (Wales) English 0845 010 3300 Welsh 0845 010 4400  
[Health and Social Care Workforce Strategy - HEIW \(nhs.wales\)](http://Health and Social Care Workforce Strategy - HEIW (nhs.wales))

## Scotland

1. Care Inspectorate 0845 600 9527  
[www.careinspectorate.com](http://www.careinspectorate.com)
2. Healthcare Improvement Scotland  
Edinburgh 0131 623 4300 Glasgow 0141 225 6999  
[www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)
3. The Scottish Government 0131 556 8400 or 0845 7741 741  
[www.scotland.gov.uk](http://www.scotland.gov.uk)
4. The National Confidential Alert Line  
[www.gov.scot/policies/health-workforce/](http://www.gov.scot/policies/health-workforce/)

## Northern Ireland

1. Regulation and Quality Improvement Authority Northern Ireland 028 9051 7500  
[www.rqia.org.uk](http://www.rqia.org.uk)

## Crown Dependencies

1. Jersey States of Jersey, Health and Social Services Department 01534 442 000  
[www.gov.je](http://www.gov.je)
2. Guernsey States of Guernsey, Health and Social Services Department 01481 725 241  
[www.gov.gg](http://www.gov.gg)
3. Isle of Man Isle of Man Government, Department of Health 01624 642 608  
[www.gov.im](http://www.gov.im)





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