THE MAGAZINE OF THE ROYAL COLLEGE OF MIDWIVES

midwives

VOLUME 26 / APRIL 2023

midwives

TURNING THE TIDE
A MENTORING SCHEME TO SHATTER GLASS CEILINGS

ON THE SAME PAGE
WORKING WITH FAMILIES TO UNLOCK THE GENOME STUDY

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APRIL 2023

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Birte Harlev-Lam, RCM executive director, midwife, says you're showing us the way

Welcome

Whatever job we do, there are some tasks we can do almost without thinking. We've been doing them so often and for so long that they come as second nature. Sometimes, though, it's important just to give ourselves a little check-in so that we make sure the way we've always done something is still the best way of doing it.

This is something that came out of our editorial board meeting earlier this year. The *Midwives* editorial board is made up of RCM members across the country, each bringing their own perspective of how and where they work. These midwives and maternity support workers (MSWs) help us shape the content of the magazine, telling us what they'd like to see more of – and what they'd like to see less! The conversation we had in January was fascinating as it challenged our thinking at the centre of the RCM.

The RCM is proud to be your professional association – and to champion the professionalism of maternity staff. It's perhaps because of this that we've shied away from publishing refreshers in the magazine. We respect midwives and MSWs, and the last thing we want to do is patronise you. But what we heard from the midwives and MSWs on the editorial board was that, sometimes, having a five-minute check-in, even on the things you've been doing for years, can be helpful. It might give reassurance that what you're doing is still best practice, or maybe it will help you find a better way of doing it. Whichever it is, it will help you deliver the best support to those in your care.

The way we care for pregnant women evolves

While the biomechanics of birth are as old as time, the way we support and care for pregnant women evolves and develops. We should never be closed to learning new ways of doing things: being a good midwife or MSW is based as much on curiosity and the desire to improve as it is on care. Most importantly, we should listen to the women in our care and respond appropriately.

So, in every issue of *Midwives*, we're going to include at least one skills refresher – something you can look at while you're having a coffee or waiting for the microwave to ding. Maybe it's even something you could use in a team training session. And if there are any areas that you think would be a good addition, do let us know at **Rebecca@midwives.co.uk.**

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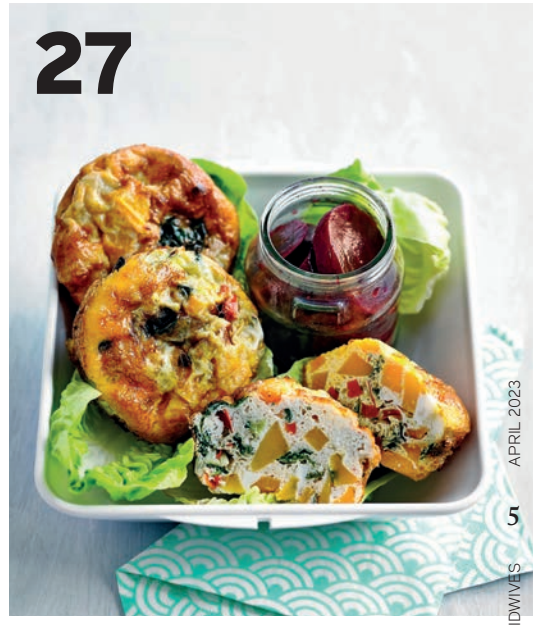
News

The longer read

Caring for you

Talking point



Voice of...

Skills refresher

External submission

In brief

YOUR PROFESSIONAL MIDWIFERY NEWS

Gas and air

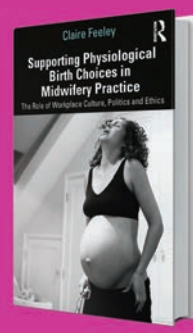
Some hospitals have suspended supplies of gas and air after it was found to pose health risks to midwives. Research shows that while inhaling gas and air (Entonox) in labour is safe for mothers and babies, long-term cumulative exposure may carry health risks. Over time it can affect the ability to absorb vitamin B12, damaging nerves and potentially causing anaemia or fertility issues.

The risk from Entonox is seemingly highest in older hospitals with poor ventilation. Dr Suzanne Tyler, the RCM's executive director, trade union, criticised the lack of investment in maternity unit buildings. She said: "Too many of the buildings that house maternity services are simply not fit for purpose. This issue has arisen because of poor ventilation in delivery suites and labour wards – but this is just the tip of the iceberg. We know of crumbling walls, ceilings being held up by props and even sewage flowing onto wards. These aren't cosmetic issues. We need to see proper investment in maternity services, including the bricks and mortar."

NHS England has been working with Trusts where gas and air supplies have been affected, and many hospitals are using temporary ventilation units to support staff safety.

READ

Supporting physiological birth choices in midwifery practice: the role of workplace culture, politics and ethics by Claire Feeley, published by Taylor & Francis



one to watch

TRY

For Stress Awareness Month try the Clementine app on **bit.ly/Clementine-register**

CELEBRATE

On 29 April, midwives and maternity support workers (MSWs) in Northern Ireland will celebrate International Day of the Midwife by doing the 5k Stormont and Waterworks Parkrun. Follow them at **#MidwivesActive**

IMAGES: GETTY/ISTOCK/SHUTTERSTOCK

Menopause

Out in the cold

The cross-party Women and Equalities Committee's report *Menopause and the Workplace*, which included a recommendation to make menopause a "protected characteristic" under the Equality Act, has been rejected by the government.

It is illegal to discriminate against protected characteristics, which include age, disability and race. In its response, the government warned of "unintended consequences, which may inadvertently create new forms of discrimination – for example, discrimination risks towards men suffering from long-term medical conditions". It rejected calls for a large-scale pilot of menopause leave in England, adding that it was not seen as being necessary.

The report's recommendation that the government produces model menopause policies to assist employers was also rejected. This would have given advice on flexible working, sick leave for menopause symptoms and provisions for education, training and building a supportive culture.

Many employers need guidance on how to frame a menopause policy for their workplace and what measures should be included, especially around reasonable adjustments.

The committee chair, the Conservative MP Caroline Nokes, said it was a "missed opportunity to protect vast numbers of talented and experienced women from leaving the workforce, and leaves me unconvinced that menopause is a government priority".

Work notice

The right to strike

The UK government's Strikes (Minimum Service Levels) Bill is, at the time of going to press, at the committee stage in the House of Lords (the first chance for line-by-line examination). The bill requires a "minimum level of service" whereby employers can issue a "work notice" stating which workforce they need. The effect is that employees named on the work notice lose their right to protection from unfair dismissal if they strike.

The government claims its aim is to reduce the amount of disruption to the public caused by strikes. However, unions agree it significantly curtails workers' rights, and Labour has said it will repeal the new measures if elected.

All devolved governments have expressed objection to the bill. The Welsh government stated that it is "rushed, lacks detail, interferes with devolved public services and is an attack on workers' rights and trade unions and will do nothing to resolve industrial disputes". It continued: "There is a risk that this legislation will make strike action more likely."

Read the TUC response at **tuc.org.uk/ProtectRightToStrike**

COVID-19 COMPLICATIONS

Research has found that COVID-19 increases the risk of grave illness and death in unvaccinated pregnant women. *The Guardian* noted: "Reports throughout the pandemic have highlighted how pregnant women are particularly vulnerable to the virus. But differences in how studies are done and the patients involved have made it hard to reach detailed conclusions about the impact of the disease, particularly in low-income countries, where few studies have been carried out.

"The latest research pooled data from more than 13,000 unvaccinated pregnant women reported in a dozen studies in as many countries. It aimed to reach reliable conclusions about the risks the infection posed to pregnant women around the world."

The study showed unvaccinated COVID-19-infected mothers are more likely to give birth prematurely and have their babies admitted to neonatal intensive care. Pre-term babies have a greater risk of lifelong health issues. Dr Emily Smith at George Washington University said: "The implications here are that it's really important if you are pregnant, or you're thinking about becoming pregnant, to get vaccinated."

Read the full article at **bit.ly/Guardian-COVIDrisk**

Read the study: **gh.bmj.com**

DARLING CLEMENTINE

The Clementine app aims to help users overcome stress, anxiety and poor sleep, and build up their self-belief. Named after the clementines that founder Kim Palmer would peel at work whenever she felt anxiety taking hold, it uses cognitive hypnotherapy sessions (from three to 26 minutes long) to help transform thoughts, feelings and behaviours for the better. Specifically aimed at women, these help users get to sleep or have a power nap, as well as prepare for, reset during and wind down after a shift.

One user commented: "NHS staff have messed-up circadian rhythms, so using the app to help you sleep in the day after a night shift is great." Another said: "A five-to-six minute session is perfect... when my to-do list is longer than my arm, it helps to ground me and restore some calm."

RCM members get a year's free subscription to the Clementine app. Visit **bit.ly/Clementine-register**

Working mums

Maternity leave

Careers After Babies research has found that of 848 mothers interviewed, 98% want to return to work after having a child but just 13% can make it work full-time, citing the cost of childcare and lack of flexibility from businesses as the reason.

It found that just 24% of women go back full-time after having children, and 57% of them leave within two years. The number of women in management roles drops by 32% after having children and the number of women in admin roles increases by 44%. 11% of women are forced to be stay-at-home mums when only 2% would do so out of choice. One respondent commented: "The cost of childcare is just far too high to make it worthwhile to work full-time or even three-and-a-half to four days a week."

The study's author Jess Heagren said: "There are barriers whichever way they turn – full-time childcare costs are unaffordable to the majority of women, but businesses aren't offering reduced hours either. Women make up 50% of the population and 86% of women will be mothers by the age of 40."

Read more at bit.ly/CAB-report

Repair device

Suturing support

Danish midwife Malene Hegenberger has designed a device to assist midwives and clinicians in carrying out the routine procedure of postpartum suturing by helping visualise the tear or injury and simplify the process and comfort during the repair.

After four years and many prototypes, she created the Hegenberger Retractor. Made from smooth plastic, the tool works by opening and expanding the vagina, allowing for a clear visual of the degree of the tear. It stays in place throughout the procedure.

Find out more at **hegenbergermedical.com/training**

MIDIRS Digest

1 Midwives' experiences of caring for couples having a stillbirth, Amy Farrugia, Rita Pace Parascandalo, Nathalie Craus

2 A student midwife's experience of bereavement care during the COVID-19 pandemic, Hannah E Carter

3 Managing perineal trauma in the community: a systematic review of women's experiences of postnatal wound care, Nicole Rajan-Brown

4 Impact of NICU dedicated lactation specialist on breastfeeding outcomes of extreme pre-term infants — an audit review, Lisa Conboy, Iby Chacko

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

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

midirs

IMAGES: BURGER/PHANIE/SCIENCE PHOTO LIBRARY/ALAMY

Research

Healthy eating support

Researchers at the University of Hertfordshire are calling for better information on diet and nutrition to be made available to expectant parents. Commissioned by the Food Foundation and funded by the Nuffield Foundation, the research collected the experiences of parents and expectant parents across the UK, as well as the views of professionals working within the healthcare, nutrition and food aid sectors.

Researchers found that while most expectant parents have a general awareness of healthy food, many are under-informed about the necessary nutrients and portion sizes or are confused by the range of different dietary advice. For example, the idea of 'eating for two' leads to misunderstandings about appropriate portion size; others pointed to the focus on the UK's obesity epidemic, with other consequences of poor diet being overlooked.

Overall, participants felt that pregnancy dietary guidance emphasised the foods to be avoided – such as soft cheese and raw eggs – rather than what foods they should be eating. The report also highlights the tendency for publicly available resources to focus on Western cuisines, with little consideration of cultural differences, despite the UK's diverse population.

Although the NHS provides websites and leaflets, parents did not always feel engaged by these and were more likely to seek information from more familiar but not necessarily professional sources – for example, social media or friends and family.

The findings underline the need for healthcare services to embrace online, accessible platforms that provide accurate and trustworthy information for expectant parents.

Read the report at **bit.ly/UHRA-report**

Slimming World and the RCM have created a website to support women before, during and after pregnancy. Visit **slimmingworld.co.uk/mums**

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What's on?

APRIL
STRESS AWARENESS MONTH

INTERNATIONAL CAESAREAN AWARENESS MONTH

7 APRIL
World Health Day
bit.ly/WHD-75

23 APRIL
St George's Day

28 APRIL
World Day for Safety and Health at Work

MAY
MENTAL HEALTH AWARENESS MONTH

1-7 MAY
Maternal Mental Health Awareness Week
bit.ly/MMHA-MMHAW

5 MAY
International Day of the Midwife
Get ideas on how to celebrate at bit.ly/RCM-midwifeday

15 MAY
Hyperemesis Gravidarum Awareness Day – see page 65

JUNE
SANDS AWARENESS MONTH
bit.ly/Sands-leap

18 JUNE
Father's Day

19-25 JUNE
Refugee Week
bit.ly/refugeeweek-theme

Working for you

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

RCM Northern Ireland

Pay consultations: Northern Ireland

In December, it was announced that a 4% pay award for Health and Social Care (HSC) staff would be implemented in Northern Ireland. At the time Karen Murray, RCM director for Northern Ireland, said: "This has taken too long – it changes nothing. Our members have also had a decade and more of pay freezes and stagnation."

A formal ballot of members was held in March, and 93.9% voted for industrial action short of a strike, based on a turnout of 55% of eligible RCM members. When asked if they were prepared to take industrial action consisting of a strike, 89% voted yes.

Karen said: "This is not just about pay – this is about our members standing up for better care for women and their families. The pressures on midwives, maternity support workers (MSWs) and other maternity staff are enormous and growing, but without the investment and resources to back them up. They are exhausted, burnt out and working above and beyond every day to care for our women, babies and their partners. They see no other option to highlight their exasperation and to focus attention onto maternity services."

The RCM Board agreed that members in Northern Ireland would walk out for four hours on 3 April and take action short of a strike during the week commencing 10 April.

RCM England

PAY CONSULTATIONS: ENGLAND

Following pay talks with the Westminster Government a new offer has been made to NHS staff on Agenda for Change contracts. While the revised offer isn't everything that was hoped for, it does provide a good base for this year's pay negotiations. The offer is: a non-consolidated award of 2% of an individual's salary for 2022 to 2023, on top of the pay increase of at least 4% they received for 2022 to 2023 last year, as recommended by the independent pay review body, worth at least £1,400. This means a newly qualified midwife received a 5.5% increase and those on the lowest salaries received a pay rise of 9.3%.

In addition, they will receive a one-off 'NHS backlog bonus', worth at least £1,250, depending on experience and pay band. The average midwife in pay Band 5 will receive £1,350.

For 2023 to 2024, the Government is offering Agenda for Change staff a 5% consolidated increase in pay, worth at least £1,065.

RCM members working in the NHS in England will receive an email with a link to the online consultation. The RCM, with all bar one of the unions representing NHS staff, is recommending members accept the offer.

IMAGES: GETTY / ISTOCK / SHUTTERSTOCK

RCM in brief

Get involved

Research prioritisation project

The project aims to identify the areas of maternity care that require more research and influence funding bodies and policy-makers to invest in filling these evidence gaps. The research team wants to include midwives and MSWs working in all areas, students and those who use maternity services. RCM members can take part in surveys, workshops or the project steering group, find out more at www.RCM.org.uk

TUC Women's Conference

At the March conference, the RCM put forward a motion calling on the Government to implement the recommendations from the All-Party Parliamentary Group on Baby Loss and Maternity's 2022 report. This asked for workforce planning to be based on the needs of women, time for staff to deliver more personalised care and safe staffing levels. A national strategy is also needed to support recruitment and retention.

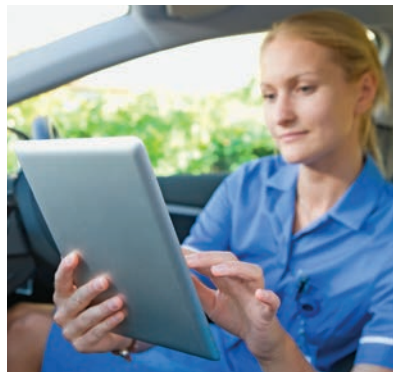
Its second motion called for protection for pregnant migrant women by reforming England's dispersal policy and scrapping NHS charging.

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

RCM Scotland

Pay consultations: Scotland

The RCM consulted its members in March on a revised pay offer from the Scottish Government. Members voted to accept a consolidated pay rise of around 6.5% for the 2023-24 pay year. This is on top of the imposed pay rise already in pay packets for 2022-23, meaning most RCM members will have received a consolidated 13% to 14% pay rise over a two-year period. This offer built on an earlier one rejected by RCM members in a consultation in December.



The deal includes the continuation of overtime payments for senior midwives, retaining the enhanced mileage allowances for staff using their cars for work and plans to reduce the working week to 36 hours with no loss of earnings. There are also firm promises from the Scottish Government on key issues including protected time for staff to undertake crucial ongoing education and training, when previously many people did this in their own time.

Jaki Lambert, RCM director for Scotland, said: "I'm incredibly proud of our members, who are prepared to stand firm for what they believe in. For them, supporting women and families always comes first, so to [have made] the decision to take industrial action is way outside of their comfort zones. This is a good deal that will very quickly push pay for a majority of our members significantly past the inflation rate. Importantly, though, it also comes with firm promises to address the real concerns of midwives and MSWs."

RCM Wales

Pay consultations: Wales

Planned strike action in Wales on 7 February 2023 was paused while the RCM consulted members on a revised pay offer of a consolidated 1.5% on top of the 4% pay increase recommended by the PRB, plus a non-consolidated 1.5%. The package of measures within the offer addresses other areas of concern including a commitment to look at staffing levels to address growing shortages and more flexible working.

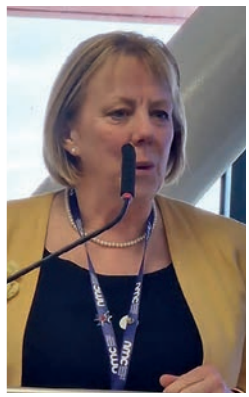
While members rejected the pay offer, the collective response of the majority of trade unions that make up the Welsh Partnership Forum – including the RCM – is to accept the offer. Julie Richards, the RCM's director for Wales, said: "There is a growing crisis in Welsh maternity services. We are losing midwives because they simply cannot sustain the effort they are having to make to ensure services are safe. The determination of our members brought the Welsh government back to the table. [Although it has] made it clear that there is no more money to improve the pay offer, hidebound as it is by the money it gets from Westminster, [it] has committed to improving the offer if more money does come through."

RCM Wales – St David's Day Conference 2023

For the first time since the pandemic, RCM Wales hosted the St David's Conference. It was fitting, then, that the theme was 'Moving forward, inspiring the future midwifery in Wales'.

The conference gave midwives, maternity support workers (MSWs) and students in Wales the opportunity to hear from speakers who addressed issues around supporting, retaining and nurturing midwives in their careers specifically for those working in Wales.

RCM Wales director Julie Richards and the Welsh government's chief midwifery officer Karen Jewell welcomed everyone before introducing keynote speaker Sue Tranka, chief nursing officer for Wales. Sue described how the strong midwifery voices in Wales are making history. There was a focus on inspiring leadership and having a strong workforce plan; the national work on the digital maternity system and the Maternity and Neonatal Safety Programme was highlighted.



CLOCKWISE (FROM TOP LEFT): RCM Wales director Julie Richards; RCM president Rebeccah Davies; NMC senior midwifery education advisor Dr Jacqui Williams; the Welsh goverment's chief midwifery officer Karen Jewell listens to chief nursing officer for Wales Sue Tranka; and assorted conference delegates

Career development

Dr Jacqui Williams from the NMC spoke about the Future Midwife Standards and how they influence and support a midwife's post-registration journey. Caitlin Wilson, RCM professional advisor for education and career development, enlightened delegates on the new RCM Early Career Hub, Preceptorship Guide and future plans. Karen then chaired the 'Meet the Experts' panel, where midwives and MSWs shared their career journeys – MSW Jodie Foran's journey through the RCM Cardiff branch was inspirational.

There were professional networking opportunities in the exhibition stands, including the launch of the All Wales Midwives Journal Club (AWMJC) created by Sian Jones, practice development midwife and learning rep at Cwm Taf Morgannwg University Health Board. This is a collaborative project with MIDIRS that gives registered midwives and student midwives from across Wales the chance to meet up and access collaborative learning and professional development. Visit **midirs.org/awmjc** for more information.

Inspiring leadership

The afternoon session opened with Jon Wilks, CEO of the Institute of Health and Social Care Management, talking about high-performance leadership in tough times. The Health Education Improvement Wales (HEIW) educational and leadership team shared HEIW leadership offerings and resources, including a showcase of the Gwella Portal for Career Development.

RCM president Rebeccah Davies closed the conference, encouraging delegates to consider what actions they will take to progress their career development.

Music is rooted in the Welsh identity, so it was fitting to finish the day with Choirs for Good, a collective of 12 community groups who encourage singing for wellbeing. They sang out the conference as a huge thank you to everyone who works under pressure in maternity services.

Kirkup Report

Lacklustre response to safety

The RCM has expressed disappointment at the UK Government's lacklustre response to Dr Bill Kirkup's report into maternity services at East Kent Hospitals University NHS Foundation Trust. Gill Walton, RCM chief executive, said: "If anyone wanted evidence of how little this government cares about maternity services, they simply need to read its response to the Kirkup report. Fewer than 500 words and nearly six months after the report's publication ... [it] does little to address the Kirkup report's calls for greater investment in maternity services, or the recommendations around training and support for staff."

Staff shortage

Senior midwife survey

The survey of directors of midwifery and heads of midwifery paints a stark picture of chronic workforce shortages and challenges, with maternity services often only functioning safely because of staff working long and additional hours, which are often unpaid. It also shows a service that is haemorrhaging midwives at an alarming rate.

The loss of experienced midwives is also impacting the ability to support and train student midwives on their placements in the NHS: 72% said they were finding it either difficult or very difficult to recruit to vacancies, 72% reported calling in bank or agency staff nearly every day, and 78% said it was difficult or very difficult to ensure staff take their breaks and leave work on time.

The midwife shortage is also one that should never have happened, says the RCM. If the midwifery workforce had grown at the same rate as the NHS workforce over the last decade, there would be 5,000 more midwives.

The RCM's Dr Suzanne Tyler said: "Our worst fears about where we saw maternity services heading are becoming a reality, and the fault lies squarely at the door of successive Conservative governments. Improving pay, more investment and increasing the workforce are crucial."

The survey forms part of the RCM's evidence to the PRB for the 2023-24 pay round.

Member survey

PERINATAL MENTAL HEALTH

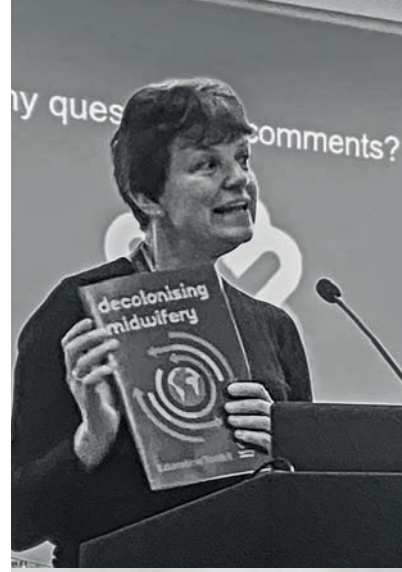
The RCM asked midwives and MSWs across the UK to help develop its perinatal mental health strategy. A member survey in March asked what was working well, what the challenges were and where the gaps were in the perinatal mental health care they provide. It will use the survey results to get a sense of perinatal mental health support across different areas, regions and nations to draw up a strategy to give midwives the tools and resources they need.

RCM director for midwifery policy and practice Sally Ashton-May said: "Perinatal mental illness affects one in four women during pregnancy and after birth, disproportionally affecting Black and Asian women. Clearly the impact of poor perinatal mental health can be devastating, yet access to support varies widely. That's why the RCM wants to inform the debate, support midwives and influence policy-makers and service providers to transform perinatal mental health care in the UK."

IMAGES: ALAMY

RCM Education and Research Conference 2023

A platform for midwifery researchers and educators to highlight their work and share the latest evidence and innovations in midwifery with members to advance practice



DAY ONE

RCM chief executive Gill Walton welcomed delegates, with a shout-out to students, noting that being interested in research was "key to the future of evidence-based midwifery practice".

Grace Thomas, director of WHO Collaborating Centre for Midwifery at Cardiff University, spoke about the challenges we all face, including the aftermath of the pandemic and the cost-of-living crisis. She encouraged delegates to "think globally, act locally", acknowledging the autonomy, regulation and strength of the profession in the UK. She said 300,000 women die from pregnancy-related conditions every year, overwhelmingly in low- and middle-income countries, but 80% of those deaths are preventable. Scaled up, the profession could save millions of lives by 2035. "If this was a pill, governments would be clamouring to buy it," she said. There is a need for advocacy at all levels, and the WHO Collaborating Centre aims to help scale midwifery across member states to improve care.

Continuing the conversation from last year's conference, Heather Bower, the RCM's head of education, chaired the session on 'Decolonising Education' to launch a new toolkit "to empower educators to challenge the implicit and explicit legacies of colonial perspectives". The project was initiated by students and has a wide range of stakeholders including sociologists and anthropologists, and it includes recommendations on recruitment, the curriculum and assessment.

Jayne Bekoe, RCM head of equality, diversity and inclusion, talked about the Race Matters initiative, which continues to "listen with intent", challenge discrimination and ensure quality of outcomes.

Sian McLaughlin discussed representation in recruitment: "In a lot of universities, global majority students aren't represented in the way that we want them to be." Open days, interviews and admissions are all opportunities to collaborate so that prospective students will feel safe. "Let's look at person-centred recruitment so we can see the values and potential of the applicants."

Sheridan Thomas said the diversity of faculty improves the feeling of safety among racially minoritised students, essential for difficult conversations that tackle discrimination – and only safe, confident

If you can say 'obstetric homeostasis', you can try harder with some of the students' names

CLOCKWISE FROM TOP LEFT: Heather Bower, Bernadette Gregory, Grace Thomas, delegates at the conference, Sheridan Thomas, CEO Gill Walton and Selena Palmer

IMAGES: RCM

students can become midwives who fight for equality.

Bernadette Gregory showed how planning and cocreation could make assessment more inclusive. "If you can say obstetric homeostasis, you can try harder with some of the students' names," she added. Selena Palmer added a student perspective. She agreed that students must feel safe to raise concerns, and pointed out that varied placement allocations were a way for students to experience diversity.

Dr Lisa Common presented on the £1.1m lottery funding to recruit apprentice maternity support workers (MSWs) to a two-year foundation degree apprenticeship with Nottingham University Hospitals NHS Trust to provide a new skills pipeline. However, it hasn't been plain sailing. Funding conditions restrict the types of work MSWs can do, and since apprenticeships combine education and employment, it can be tricky when students fail a module. Midwives also have to learn how to mentor their apprentices – but the reward is improved care in acute and community settings.

Applause welcomed Professor Katie Morris and Ana Gomez's overview of their £1.5m NIHR programme grant 'Chapter' study into improving postnatal childbirth-related perineal trauma. Katie pointed out that perineum repairs are more common than caesareans, yet there are huge evidence gaps in treatment and no definitive way to identify infections. The project aims to raise awareness, promote earlier identification and create a proper clinical pathway and tool to record postnatal exams, for what is currently the only bodily wound where those don't exist. Take part at bit.ly/NIHR-chapter

Jenny Cunningham and Dr Jude Field introduced delegates to the RCM Doctoral Thesis Collection, a resource for open-access research; showcased the RCM Small Research Awards as "a very first step for people to dip their toe safely into the research world"; and displayed the new RCM Maternity Research Map, which can help you connect with role models and researchers. They spoke about the RCM Research Prioritisation Project, a survey exercise aiming to uncover and maintain a top 10 list of priorities for research in order to influence funding bodies and policy-makers. Dr Dominique Mylod showcased interactive i-learn modules providing a grounding in research and ways to embed it in clinical practice.

Zepherina Veitch Memorial Lecture

Dr Laura Abbott began by asking: "Who has set foot inside a prison?" A few hands went up, but the majority had not. Yet prisoners, she explained, are seven times more likely to suffer stillbirths. "There has never been a more important time for prison midwifery. There's never been a more important time for midwives to be at the centre of all decision-making where pregnant women and new mothers are concerned ...

we must be willing to enter unfamiliar and uncomfortable spaces."

Conducting 260 hours of research in prisons, themes re-appeared concerning lack of comfort, food, access to medicine and facilities, humiliation and embarrassment. The descriptions of "institutional thoughtlessness" were damning – attendees gasped when hearing about untrained staff overseeing a breech birth in a prison cell, having refused to acknowledge the mother's insistence she was in labour and needed to go to hospital. The government has since introduced mandatory guidelines and Laura regularly feeds back to the Ministry of Justice team. Since her research, she has founded the Prison Midwives Action Group (PMAG) and Pregnancy in Prison Partnership International (PiPPi). She highlighted the power of qualitative research to create change and the importance of midwives advocating for the most vulnerable.

At the Zepherina Veitch Memorial Lecture Dr Laura Abbott spoke about her research into the conditions pregnant women face in prison

DAY TWO

Amy Corrigan, Holly Lovell and Jamie Morris offered an insight into their working lives as research midwives. Amy explained how midwifery skills were essential to running studies, particularly "having sensitive conversations with women and understanding what they are going through" when it comes to ensuring consent and communication with study participants.

Emilie Edwards lectures at Middlesex University and is passionate about raising awareness of neurodiversity in education and healthcare. She shared her personal story about being diagnosed with autism well into her career - diagnoses are more often missed in women. Working in the NHS could be sensorily overwhelming but Emilie excelled in academia and in community settings, away from busy wards. She benefitted from supervision where she felt safe to seek support. "Our student midwives really need this support in place," she said.

Emilie suggested starting points for educators to better support students with neurodiversity, such as signposting relevant services, providing diverse teaching methods and offering clear communication and feedback. She has helped develop a new i-learn module on neurodiversity in the workplace: bit.ly/ilearn-neurodiversity

The conference drew to a close emphasising the importance of collaboration. Royal College of Obstetricians and Gynaecologists' president Ranee Thaker discussed joint projects with the RCM: the National Maternity and Perinatal Audit, which will improve safety by streamlining services; Tommy's Clinical Decision Tool, a collaboration that will help standardise care by providing a web app to help assess the risk of preterm birth; the ABC programme; and the OASI Care Bundle on severe perineal trauma.

RCM's Gill Walton recalled how her journey into midwifery began by witnessing a protest against over-medicalised care at the Royal Free. When midwives began to question established practice and advocate for women's autonomy, it would strain the relationship between midwives and obstetricians, a relationship that fortunately has since evolved. "When you don't collaborate we know it goes wrong," she surmised.

The two colleges can now boast of sharing a building in SE1 and Gill hopes more professional bodies will work together – she noted that the Independent Maternity Working Group can help facilitate this. She called on midwives to build mutual respect and trust with others as leaders, researchers and educators.

Ranee agreed: "It's not obstetricians and midwives; it's maternity care. We look after one woman, and that woman just wants a safely-delivered baby and to be looked after well." This prompted one delegate to ask whether there might be a joint maternity education and research conference - to an enthusiastic response.

MORE INFO

For the full speaker programme and links to resources and further reading, scan the QR code

Welcoming the new RCM Fellows

Dr Helen Bedford

Helen's career spans midwifery practice, research, practice development and education, and she has held posts in Scotland and England. She has been a senior fellow of the Higher Education Academy since 2015 and is passionate about high-quality midwifery education. Helen has a particular interest in equality, diversity and inclusion, having been a steering group member and academic mentor for the Mary Seacole Awards.

She is currently lead midwife for education, the subject group lead for midwifery and midwifery team lead in the Department of Health Sciences at the University of York, contributing leadership and educational expertise to successes such as the Unicef UK Baby Friendly Initiative Achieving Sustainability in Universities Standards (Gold Award) and developing the UK's only integrated undergraduate master's in midwifery.

Dr Alison Callwood

Alison has a background in midwifery, nursing practice and education for health professions spanning 30 years. She gained her PhD in 2015 at the University of Surrey.

She is actively engaged in postdoctoral research exploring admissions to health profession education programmes, focusing on ensuring equity. She is a member of the Council of Deans of Health's Equity, Diversity and Inclusion Strategic Policy Group and UK Medical Schools Council Selection Alliance Multiple Mini Interview (MMI) Expert Group, a fellow of the Institute for People-Centred Artificial Intelligence (AI) at the University of Surrey, and senior fellow of the Higher Education Academy. Alison has been awarded multiple grants from UK Research and Innovation and has orchestrated the design and development of the first known online automated MMI system with principles of fairness built in.

Dr Suzanne Hardacre

Suzanne has been a registered midwife since 1998, with experience in all areas of midwifery practice. She worked as a midwife, senior midwifery manager and head of midwifery in Wales for many years before being appointed as director of midwifery in 2022.

Suzanne successfully completed her doctorate in advanced healthcare practice in 2022. Her research explored the experience of pregnant women being offered influenza vaccination during pregnancy.

She is passionate about helping midwives and maternity support workers realise their potential through training and development, acknowledging and celebrating achievement.

Thomas McEwan

Thomas has practised as a team midwife delivering caseload-based care, a senior charge midwife within a neonatal unit and an advanced neonatal nurse practitioner. He is head of programme for the Women, Children, Young People and Families Team within NHS Education for Scotland and has been a midwife since 1999.

He is the strategic lead for the Scottish Multiprofessional Maternity Development Programme and has additional responsibility for national midwifery, maternity and neonatal workforce and educational developments. He is an honorary advanced neonatal nurse practitioner within NHS Greater Glasgow and Clyde, undertaking clinical teaching around newborn examination. He is a board member of the Scottish Cot Death Trust and the consultant editor for the *British Journal of Midwifery*.

Dr Jacqui Williams

Jacqui is a very experienced midwifery educator and midwife. She has kept strong links with midwifery practice and regularly works clinically in a local Trust. She is passionate about the unique role of the midwife and women-centred care.

She is a senior fellow of the Higher Education Academy and has a particular area of expertise in quality assurance. Her educational interests are in open and distance learning.

Jacqui is also an experienced midwifery expert witness. Her doctoral work researched whether resilience develops in student midwives as they navigate the undergraduate midwifery programme. This work is currently being evaluated nationally.

She is senior midwifery advisor (education) at the NMC, ensuring that midwifery is considered in all the NMC's work. She works with a wide range of stakeholders to promote the adoption of midwifery standards and influence the maternity agenda.

We all know there's an exodus of midwifery professionals due to the pressure caused by staff shortages – and it's a Catch-22 situation. As Donna Ockenden once said: "You can't fill a bath with the plug out." So how can staff be better supported to stay?

a better way

"NHS midwives leaving 'horrific' understaffed hospitals to work in abortion clinics," read the headline in *The i* on 28 January 2023. "The British Pregnancy Advisory Service (BPAS), which runs more than 40 clinics, has told *The i* that a 'significant' proportion of former midwives who have joined them have no longer been able to cope in NHS hospitals, with poor pay and working conditions compounding staffing issues." Is this really the fate of maternity services in 2023, or can something be done to support midwives and maternity support workers (MSWs) better?

Yes, plenty, is the short answer. Liverpool Women's NHS Foundation Trust is a large stand-alone unit delivering approximately 8,000 babies each year. Its professional midwifery advocate and retention lead, Sarah McGrath says: "As is the case in many maternity units, we are having issues around midwife retention. Midwives are feeling undervalued, frustrated and not able to do the job they want to. This can lead to high levels of stress and anxiety, leading to periods of sickness, which are sometimes long-term."

Sarah has tackled this in two ways. "I have developed a wellbeing session on the mandatory study days. The session is around psychological safety, self-compassion and compassionate leadership," she says. "This is a chance for midwives to explore how they can look after their own mental health and discuss the help that is available. It is interesting to see during this session how little care and kindness we offer ourselves. I hope it helps the midwives to understand the positive aspects of self-compassion."

At the end of 2022 Sarah undertook a 'deep dive' into midwives' experiences while off sick. Among other things, the results showed that midwives felt isolated and guilty about being on sick leave, and had anxiety about their return to work and how they would manage once back. "I don't think this is unique to this Trust – I think these anxieties are common with anyone who is on long-term sick leave."

As a result, her second initiative offers staff on long-term sick leave a package of individualised support. "It could be a regular phone call, Microsoft Teams call or face-to-face meeting. It's an opportunity for the midwife to discuss how they feel and try to negate the feelings of isolation. It may enable them to return to work sooner than anticipated.

"I support them with their anxieties about returning to work – for example, by meeting up a week before in the canteen or being outside the entrance on their first day back and walking in with them. It might be as simple as an email to welcome them back.

"Some of the midwives felt that they needed ongoing support once they were back, so I plan to meet them as frequently as needed. I would also like to use this for midwives returning from maternity leave as the return-to-work anxieties will be the same."

Who cares for the carers?

In London, the focus is also on wellbeing. Josephine Oamen is a midwife and clinical site manager for the maternity unit at University College London Hospitals NHS Foundation Trust (UCLH). In 2020, in her roles as professional midwifery advocate, RCM health and safety rep and wellbeing champion, she launched a wellbeing room for maternity staff. "UCLH is a fantastic organisation that really tries to look after the staff, but we are a very busy maternity unit and when COVID-19 came it hit us hard. We had members of staff who became overwhelmed, so I wanted to do something to build their resilience and make them feel valued at work.

"I found out that there was a volunteer-run spa in the main hospital and I wanted to create something like that for us. I got in touch with the volunteer services and wellbeing coordinator for UCLH. I managed to find a room within our unit and we started with two therapists offering 15-minute massages and reflexology. I went around booking staff in and persuading their various clinical areas to release them."

ILLUSTRATION: LOU KISS

The initiative has grown, and there are now seven therapists, all final-year students in different courses, who give their time for free. They offer 12 to 15 hours of treatment a week including stress-relieving massage, aromatherapy, sports massage and shiatsu. Each session is 45 minutes.

"It's not just for the midwifery team," says Josephine. "All staff working within maternity can access it. Since we went live with a booking app last year, 300 staff have used the service. It's a small thing, but it gives people something to look forward to. It's not just about getting a massage – it's about us doing something to support staff and enhance retention. If someone is feeling stressed, down or just needs to rest, they can go to the wellbeing room – there are beanbags, a massage chair, artificial plants and big canvases on the wall; it's so calming, you feel like you're not even in the hospital."

In addition, Josephine and her team have launched a mindfulness drop-in session every Wednesday evening. "People are loving it," she says. "One doctor said it was the most beautiful thing ever offered to her at work – she came out feeling completely refreshed. I'm about to start a weekly yoga session too, and I've just got funding for a mural."

Josephine acknowledges it's been difficult and she's still fighting for the initiatives to be permanent, but she is a great believer that it helps staff feel valued. "I know from talking to staff that it makes a big difference to their morale and mental state – they are always looking forward to their next treatment."

Flexible working

Self-care initiatives at work go a long way to improving wellbeing and making people feel valued. But what happens when the pressures of juggling working hours with responsibilities outside of work get too much? Blackpool Teaching Hospitals has recognised the need for staff to have a better work-life balance and more options around flexible working. One of the ways they hope to achieve this is by staff self-rostering using their 'Allocate Me' app, which is being automated so that all shifts are staffed appropriately according to skill mix and need for that day. Continuity of care project lead midwife Justine Eadie says: "Once up and running we will have 130 midwives and MSWs doing their own roster. The ICU here at Blackpool has adopted this system and they report staff morale and retention has greatly improved. We are excited to be offering this and believe it will make for a happier and healthier workforce."

Meanwhile, at Lewisham and Greenwich NHS Trust, head of midwifery (HoM) Sue Chatterley introduced a rostering innovation to tackle unfilled bank shifts by making them open to offers. "We call it 'any hours' and it means that, rather than asking someone to do the whole shift, they say how long they want to work – even if it's just three or four hours. In any workforce you have those people who will always pick up extra shifts, but as we get busier and shorter staffed, they get tired. It's important to be able to share the load – with 'any hours', people who don't normally pick up hours have started to because it fits in with their work-life balance. We've really grown our available resource.

"I did some number-crunching and worked out we gained on average 150 hours a month with these hours between February and June last year – that's equivalent to one full-time midwife. In December alone, it was an additional 300 hours I wouldn't

When someone turns up mid-shift, the reaction is always 'Amazing – you're here!'

normally have had – equivalent to two full-time people."

Sue notes that some midwives will come during the school day or in the afternoon, or pick up hours at the weekend. A couple of midwives regularly start work at 11pm or midnight and stay until 5am or 6am. "I'd never ask anyone to work those hours – but it suits them because it means they keep everything they earn rather than paying for childcare. A couple of midwives on bank-only contracts told me they wouldn't have been able to stay in a job they love if it hadn't been for that degree of flexibility. And if they'd had to take a career break to prioritise their children, they're not sure they would have returned.

"Even when you can't cover the whole shift, it helps cover breaks and ensures colleagues are able to work safely. When you're really busy and someone turns up mid-shift the reaction is always 'Amazing – you're here!' So there's that instant validation too."

It supports retention, and Sue notes it's been easy to implement as the midwives just book the hours on the normal e-rostering system. The administration is transparent and visible, and everybody trusts it. Sue has written it up for the FutureNHS platform and it has been shortlisted to appear in the single delivery plan. "But when I've spoken to other HoMs and directors of midwifery, interestingly the conversations have not so much been about the logistics, but about 'allowing' people to choose. It is a scary concept as it requires trust. But the 'any hours' offer only applies to shifts that would otherwise remain unfilled, and the results speak for themselves."

Starting out

Evidence shows that a significant number of early career midwives (ECMs) leave the profession within the first two years of employment, and the peak point for attrition in the first year is six months post-qualification. New employees make decisions in their first six weeks about their long-term intentions to stay within an organisation.

At Newcastle upon Tyne Hospitals NHS Foundation Trust, practice development lead midwife Fiona Noble and retention and pastoral care lead midwife Emily Robson have set up a 'New to Post Bootcamp'. "Feedback revealed that training requirements in the preceptorship period were a source of stress and anxiety and, in some cases, contributed to delays in completing the programme and subsequent Band 5 to 6 progression," says Fiona. "This prompted a look at how we ensure new midwives feel valued, welcomed and supported to stay and thrive in our Trust."

The 'New to Post Bootcamp' is a rostered eight-day training programme for cohorts of four to seven midwives within the first six weeks of joining the Trust. The programme consolidates all training requirements aligned with the National Preceptorship Framework, Saving Babies' Lives, Unicef Baby Friendly Initiative and Ockenden Essential Actions and incorporates key preceptorship competencies. A wellbeing day provides a holistic approach to equipping the new registrants for their career with an emphasis on the emotional work that the role demands. Completion of the programme as a cohort cultivates relationships, peer support and a sense of team, enabling integration within the workforce – a key contributor to retention.

"One hundred per cent of Bootcamp attendees reported that the programme prepared them well for their preceptorship and provided clarity around what is expected of them. All felt well supported and knew where to access help, with many articulating the benefit of cohort completion in fostering supportive peer relationships," says Emily. "The comparison of previous preceptee experience and that of our ▶

ILLUSTRATION: LOU KISS

The skills and expertise late career midwives bring should never be underestimated

current cohorts suggests that the bootcamp is effective in providing a foundation of support, confidence and competence as midwifery professionals."

Wrap-around support

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), Elaine Merrills, matron for recruitment and retention, has been leading a project of recruitment, retention and pastoral support (including international recruitment), heading up a team including a lead midwife for recruitment and retention, two practice development midwives and professional midwifery advocates. She believes that supporting staff at all stages of their career is key.

"Historically, midwives at the Trust had to work a minimum of 18.75 hours; this did not fit in with midwives who had already retired and returned," says Elaine. "Midwives began to contemplate retirement due to the physical demands, as well as night shifts and to ensure their work-life balance. The value, contribution, transfer of skills and expertise that these late-career midwives bring to the workplace should never be underestimated. We were able to retain two late-career midwives by simply offering them a 15 hours per week contract with no night duty."

By contrast, she notes, ECMs often feel "overwhelmed and out of their depth" as they transition from student to practitioner. This is well evidenced in the UK WHELM study (RCM, 2017).

Noting that "preceptorship prior to 2021 was ad hoc at best," Elaine devised a robust preceptorship and rotation package and worked collaboratively with the local maternity network system to develop a system-wide preceptorship booklet. Aware that this generation has increased digital awareness and absorbs most of their information online and via social media, the team set up a WhatsApp group to provide instant support. She notes that only one midwife from this cohort of 17 left midwifery at six months post-qualification.

Once the retention team had grown, the 2022 cohort was treated to a comprehensive

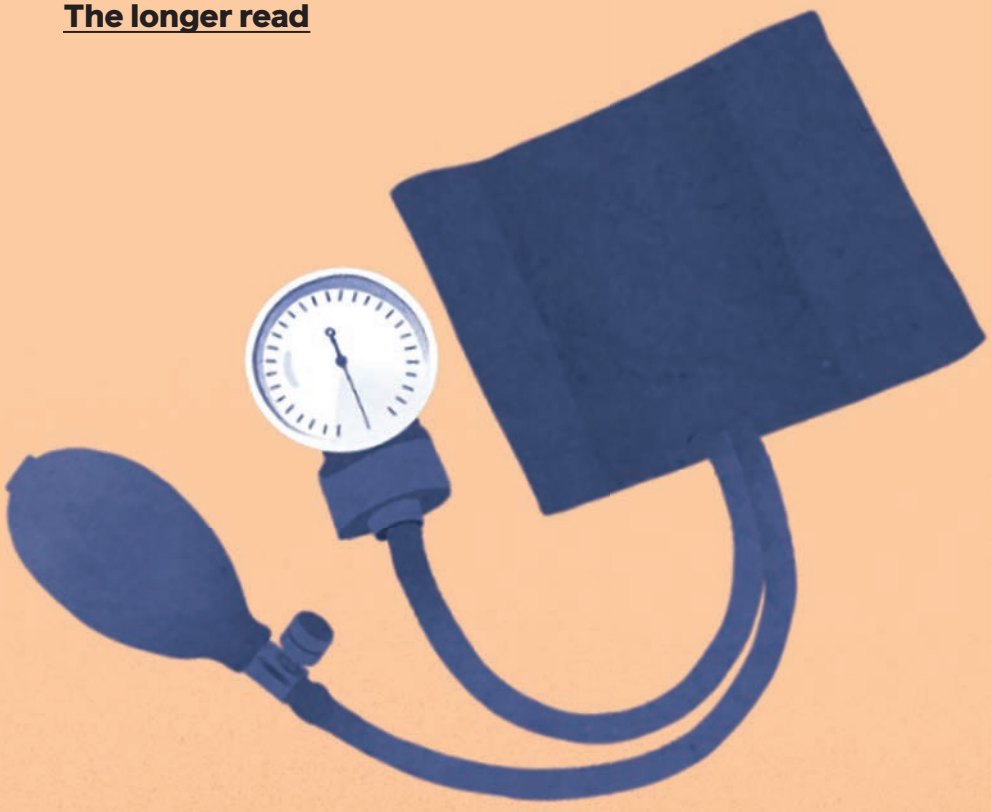
ILLUSTRATION: LOU KISS

RCM SUPPORT FOR ECMs

The workforce crisis has had a significant effect on midwives who are just starting out. When the RCM spoke to third-year student midwives and those in the first year of practice, it was clear that more support was needed.

The need for peer support featured heavily in these discussions. The early career midwife (ECM) discussion forum was launched in January (as part of RCM's i-learn, which offers more privacy than social media). All midwives in the NQM membership category will be auto-enrolled and their access will be active for three years. Anyone who has not been notified of this should call RCM Connect at 0300 303 0444.

The RCM set up a group led by Lynne Galvin, regional head for the north of England, to look at developing a bespoke membership benefits package. It was decided that this offer should extend beyond the early preceptorship period and would support members until their first revalidation. The ECM hub was also launched in January and can be found on the home page of the RCM website. It includes information on what a good preceptorship looks like (because this is when most ECMs feel vulnerable and need extra support to consolidate their learning and build their confidence), with some excellent examples from around the UK. The i-learn module on revalidation has been updated to give a better view of the process and hopefully remove some of the anxieties of those doing this for the first time. And there are three workshops in the pipeline that will look at how to continue with the values learned at university, how to embrace differences in the workplace, and leadership and supporting culture into the future. The role of the RCM learning representative has also been expanded to give pastoral support to ECMs.



plan of care: coffee mornings prior to the start date; a three-week induction period involving the multidisciplinary team; clinical skills days and essential training; a full year's rotation programme given to all; and annual leave allocated at their request. Importantly, Elaine says, "there has been zero attrition from this group of ECMs, who are now six months post-qualification."

Combined with 'life-friendly' working hours for midwives and MSWs from day one of their contracts, Elaine believes that they offer an enviable support system – so much so that four Band 6 midwives who left for geographical reasons soon asked to return and were able to do so without a protracted reemployment process. "We believe an investment in a maternity unit pastoral team is an investment into the maternity workforce," she says.

Retire and return

As Elaine noted, the contribution of experienced midwives cannot be underestimated. Their loss – whether that's through retirement or for other reasons – is causing the profession's attrition. In January, Health Education England (HEE), in collaboration with the Maternity Workforce Programme at NHS England, launched a new 'Return to Midwifery' initiative. It supplements the wider 'Return to Practice' programmes, which offer routes back into the profession for midwives, regardless of their length of time away.

Kerri Eilertsen-Feeney, lead midwife with the HEE's National Nursing and Midwifery Team, says the initiative offers personalised support and a streamlined route for midwives who still have an active NMC registration to return to practice. Interest can be registered through the NHS Careers website, and they will be connected with a local 'Return to Midwifery' contact. After a short screening conversation to make sure they're eligible, the contact will look at their range of previous experience and why they left, and consider what their needs might be in terms of learning, skills, competencies and knowledge. They will also consider the need for greater flexibility and more pastoral support. With a range of e-learning modules, each individual can build a bespoke package to address any training or knowledge needs that might have prevented them from returning.

Kerri explains: "We want to ensure they feel not only confident and competent, but also valued and cared for, so we create a personalised journey back into the clinical environment. Local recruitment leads are on hand to discuss the different types of roles that may be suited to them, including their preferred hours and location. Midwives have one-to-one conversations on their return, along with ongoing mentorship. Any other support they need can be developed at a local level. They might only have been away from practice for 12 to 18 months, but that can feel like a long time.

"Our aim is to bring as many midwives as possible back into practice through this initiative. Since we launched, we already have 15 back in post, and another 45 are in the initial stages of developing the package of support they need. I think that's amazing. There's also been interest in the formal return to practice course from those with a lapsed registration. These are all midwives who might otherwise have remained lost to the profession."

It's still early days, notes Kerri, but the work is also collecting feedback and evidence to help understand how to be more successful in bringing midwives back, and how to help them feel supported and valued so that they want to stay. "It feels good for them to want to come back into the profession they trained so hard for in the first place," she says.

Heather Irving is one such returnee. She took early retirement in 2020 and returned to work in the labour ward through an upskilling course at the Mid Yorkshire Hospitals NHS Trust at the end of last year. "I qualified in 1992, having started in the NHS as a nurse in 1984, and worked across all areas of midwifery, spending the last 10 years of my career in management. I had the option to retire early and took it. The plan was to go back, but in a more flexible way, with a better work-life balance. But the reality check came

ILLUSTRATION: LOU KISS

when I realised I wasn't very flexible in my skill set, having worked in an office for so long.

"While caring for women and families felt natural, I felt uncomfortable around the equipment and around the processes. To feel safe, I knew I needed some structure and support around me. This course was just what I needed.

"It started with a month of classroom-based learning covering key things like how to use certain equipment, or what it would be like to be back in theatre. After that came a two-month placement – doing 12.5- or 14-hour shifts as a supernumerary, which could have been extended if I'd wished. My mentor was a very experienced labour ward coordinator, herself retired and returned, which worked really well."

Heather then began a buddy system with a mentor on the same shifts, but not working directly with her. Finally, she's been working independently in the labour ward.

"The whole process has been tailored to me," she says. "I've felt very protected and listened to, but it hasn't been easy. It takes a long time to feel comfortable, and the work can be highly stressful and physically demanding. Flexibility is key. I came back on the minimum contract possible – 23 hours, or two long shifts a week, and I don't work nights; my manager has been very understanding.

"Everyone has been so welcoming. The biggest problem at the moment is numbers on the floor, so as someone coming back to make things easier, I feel very valued. And my colleagues have recognised that I have a lot of skills and knowledge from other parts of my midwifery life that I can contribute.

"I feel I have a lot to give, and I wanted to end my career as I'd started it – working clinically as a midwife, and working with women in a more personal, face-to-face environment. That felt right to me as soon as I started – I felt I'd come full circle."

These are all midwives who might otherwise have remained lost to the profession

Employment policy

In February, the RCM hosted a roundtable event with the Institute of Public Policy Research (IPPR) that included experts from the Royal Society for Public Health, Royal College of Obstetricians and Gynaecologists, Institute of Health Visiting and Association of Directors for Public Health, as well as Yasmin Qureshi MP, shadow minister for women, and Feryal Clark MP, shadow minister for primary care. The focus was on the first 1,000 days and making the link between good maternity provision and economic growth – how investment in keeping women healthy during pregnancy so they're able to resume work postnatally, addressing inequalities and investment in the maternity workforce are all important to the wider economy, as well as in their own right.

The event discussed, in no small way, the immediate importance of getting workforce policy right because the retention of staff is a constant challenge. Participants indicated there was a demotivated workforce due to a wide range of factors – including feeling undervalued and not having the resources to conduct the quality and quantity of care they would want. "People are being reduced to tasks," noted one participant.

The raft of solutions put forward included access to more family-friendly working hours, childcare costs that are more in line with working families' budgets (alongside better pay offers) and more routes into the profession, such as apprenticeships that would allow people to grow with maternity services. These measures would help attract new staff members while supporting those already in post. It was encouraging to see two ministers from the shadow cabinet embracing the advice of the experts around the table, and it promises a future workforce policy is fit for purpose.

But what about the present? What about supporting midwives and MSWs who are struggling now? The initiatives shown by Liverpool Women's NHS Foundation Trust, UCLH, Blackpool Teaching Hospitals, Lewisham and Greenwich NHS Trust, Newcastle upon Tyne Hospitals NHS Foundation Trust and DBTH, as well as HEE (to name a few), all show incredible innovation.

From wellbeing and self-care sessions to flexible working and autonomy in picking shifts that fit around lifestyles, none of the initiatives have funding or logistical demands and all are proving very effective in showing staff they are valued. If retention is an issue, these solutions are worth trying – because maternity staff shouldn't have to face leaving the job they love.

MORE INFO

HEE: Returning to midwifery
bit.ly/HEE-return

Listen to the RCM podcast 'You can't pour from an empty cup' which features UCLH's Josephine Oamen
bit.ly/RCM-self-care

Grab and go

Do you often find yourself unable to eat the lunch or dinner you've brought with you on shift for lack of time, relying on quick and easy snacks such as biscuits to keep energy levels up but feeling rubbish after eating them? Slimming World could have the answer...

From habit to hunger to boredom, there are lots of reasons you can find yourself reaching for snacks. Alex Clark, registered nutritionalist at Slimming World, advises how you can take control of your snack attacks and enjoy them without impacting your weight.

"Snacking can get a bad rep and be something we can feel we need to avoid. There's nothing wrong with enjoying a snack though. Choosing something healthy and satisfying can be beneficial for your weight, support your intake of important nutrients and maintain energy levels.

"It helps to be mindful of when you are snacking and work out what your common trigger foods are. Think about which snacks you are often tempted by and how you might be able to switch up your routine.

"Slimming World's Food Optimising healthy eating plan is packed full of filling foods that you can eat freely, meaning mealtimes are super satisfying so you're less likely to reach for unhealthy snacks. And our Free Foods list includes heaps of healthy snacks you can enjoy without impacting your weight."

However, if you feel as though you are surviving your shifts through snacks, Alex says there are plenty of ways to replace the biscuits and crisps with things that will be far better for you. Try these quick and easy recipes for snacks to take to work.

BEETROOT HOUMOUS WITH CRUDITÉS

Serves 1
Ready in 10 minutes

- ½ tsp cumin seeds
- 1 small garlic clove, crushed
- 1 cooked beetroot from a jar or vacuum pack
- 215g drained can chickpeas
- Juice of ½ lemon
- A small handful of fresh mint
- 2 tbsp fat-free natural Greek yoghurt
- Vegetable crudités, to serve

Dry fry the cumin seeds over a medium heat for 30-40 seconds or until toasted. Tip them into a food processor with the garlic, beetroot, chickpeas, lemon juice and most of the mint leaves and whizz to a purée.

Spoon into a bowl. Drizzle over the yoghurt, season to taste and stir to ripple the yoghurt through the houmous. Scatter over the remaining mint and serve with your favourite crudités.

NECTARINE AND MINT PARFAIT

Serves 1
Ready in 5 minutes

- 1 ripe nectarine, sliced
- 1 tsp lemon juice
- Zest of ½ unwaxed lemon
- A handful of fresh mint leaves, shredded
- 100g fat-free natural Greek yoghurt

Put the nectarine slices in a bowl. Add lemon juice and shredded fresh mint leaves and toss together. Put the yoghurt in another bowl and mix with the zest of ½ lemon.

Spoon most of the nectarine into a clip-top jar or sealable pot and cover with the yoghurt mix. Top with the remaining nectarine to serve.

CRUSTLESS SQUASH MINI QUICHES

Serves 2 (makes 6)
Ready in 35 minutes, plus cooling

- 125g butternut squash, peeled, deseeded and diced
- 50g baby leaf spinach
- 1 roasted red pepper in brine from a jar, cut into small chunks
- 4 spring onions, sliced
- 5 medium eggs
- ½ tsp smoked paprika
- Low-calorie cooking spray
- Pickled baby beetroot from a jar, drained, to serve
- Lettuce leaves, to serve

Preheat your oven to 180°C/fan 160°C/gas 4. Put the squash, 2 tbsp water and some seasoning in a medium non-stick saucepan. Cover and cook over a low heat for about 5 minutes or until tender. Uncover, add the spinach and leave to wilt.

Cool slightly then stir in the red pepper and spring onions. Crack the eggs into a bowl, add the paprika, ½ tsp salt and some pepper and beat well with a fork. Spray 6 compartments of a non-stick muffin tin with low-calorie cooking spray. Divide the squash mixture between the compartments, pour in the eggs and bake for 20 minutes or until set.

Remove the muffin tin from the oven and leave the quiches to cool for 10 minutes. Carefully remove the quiches from the tin, running a round-bladed knife around the edge of any that need a bit of encouragement. Leave to go cold and enjoy with the beetroot and lettuce leaves.

COCOA, HAZELNUT AND DATE BALLS

Makes 8
Ready in 5 minutes, plus 1 hour to set

- 160g dates
- 80g hazelnuts
- 2 level tsp cocoa powder

Put all the ingredients in your food processor and pulse to combine, scraping down the sides if necessary. Roll the mixture into 8 equal-size balls and chill for an hour, or until set.

APRICOT, COCONUT AND LIME BALLS

Makes 8
Ready in 10 minutes, plus 1 hour to set

- 240g dried apricots
- 90g cashew nuts
- 2 level tsp desiccated coconut
- Zest of 2 limes

Put all the ingredients in your food processor and pulse to combine, scraping down the sides if necessary. Roll the mixture into 8 balls and chill for an hour to set.

These balls will keep in an airtight container in the fridge for up to a week or can be frozen.

All recipes are taken from Slimming World's collection. Join your local Slimming World group or sign up online for even more recipes, guidance and support. To find your nearest group, visit www.slimmingworld.co.uk or call 0344 897 8000.

Images: Slimming World/Hannah Rose Hughes, Lara Holmes, Alex Luck, Andy Warburton

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1. Journal of the American College of Nutrition, Vol.18, No.5, 487-489 (1999). **2.** L Brough et al. Effect of multiple-micronutrient supplementation on maternal nutrient status, infant birth weight and gestational age at birth in a low-income, multi-ethnic population. British Journal of Nutrition (2010), 104, 437-45. **3.** Agrawal, R. et al. Prospective randomised trial of multiple micronutrients in women undergoing ovulation induction, Reproductive BioMedicine Online December 2011.

2023-03-13_ADPRGPROFA4_RCM_E_2

COMMUNICATION CORNER

How do I... give difficult news?

Clare Worgan, head of training and education at Sands, offers her advice on everything, from the language to use to avoiding feeling overwhelmed yourself

It may seem kind to use euphemisms, but it's better always to use clear, factual language when giving bad news. At a time of shock and trauma, many parents tell us how they felt "brain fog" and how difficult it was to understand what they were being told. Overly medical language should also be avoided – clear factual language prevents confusion and additional distress.

Over time, as parents process what is happening, they may naturally use euphemisms as they talk about their baby and their experience. In these circumstances it's advisable to mirror the language the parents choose to use.

Often bad news is given in a clinical setting following a diagnosis, and after that parents should be cared for somewhere where they and wider family can sit down together and given as much time as they need. Ideally, this is a designated bereavement room, away from maternity wards and the sounds of other families and babies.

Reactions vary

For some parents the news may come as a shock, for others the news may confirm what they feared. Everyone responds differently to bad news – you may see anger, numbness and tears. The uniqueness of response means that the midwife must judge how to best support the parents. Some parents will have many questions and will need you to stay close by for support, while others will want to be left alone. Ask them what they need.

It is important to listen carefully to what's important to the parents. It's also important to answer all questions honestly. It is possible that the parents may have questions that you don't know or have the answer to. In these cases, always be honest. If you don't know, say so and let the parents know you will find out the answer for them.

Make the time to reflect on your practice and your emotional response

Grief is isolating

Many parents tell us it's the small things that make a difference: sitting with a mother who is crying or listening to a dad as he talks about his child. They are still parents, even though their baby has died, so acknowledging their parenthood is a kind thing to do. Asking about their baby's name or the baby clothes they have chosen to dress them in can bring great comfort.

Supporting grieving parents through the myriad of emotions can be rewarding; however, it can also be emotionally challenging. Make the time to reflect on your practice and your emotional response. Remember you are not alone – it can be helpful to have a debrief with a trusted colleague or use the support services available at your workplace or the Sands helpline (0808 164 3332 or helpline@sands.org.uk). Always remember to be as kind to yourself as you are to the families.

MORE INFO

Sands offers bereavement care training that includes the communication skills required to share difficult news with care and compassion. For details, visit **www.sands.org.uk/training**

IMAGE: GETTY

World in your hands

Each country brings a different set of challenges to midwifery, and the ICM has made it its mission to meet them

The International Confederation of Midwives (ICM), based in the Netherlands, has a vital role worldwide. It works to strengthen and support professional associations of midwives across the globe, representing midwives and midwifery to achieve common goals in the care of mothers and newborns. It works closely with the World Health Organization, UNFPA and other UN agencies; global professional healthcare organisations including the International Federation of Gynecology and Obstetrics (FIGO), the International Pediatric Association (IPA), the International Council of Nurses (ICN); non-governmental organisations (NGOs); and bilateral and civil society groups. The 140 members' associations represent more than one million midwives in 119 countries across the world.

Its vision is for "a world where every childbearing woman has access to a midwife's care for herself and her newborn" and "to advance the profession of midwifery globally by promoting autonomous midwives as the most appropriate caregivers for childbearing women". ICM sets global standards, determining the basic essential competencies of a midwife, explains its outgoing president Franka Cadée. "We are in the process of also becoming the organisation that accredits for midwifery education globally. We are hoping that in the future all midwifery schools will get ICM accreditation so we know that they are all at the same level."

◀ Franka with global partners at the UN National Assembly

ICM has a process called the midwifery services framework (MSF). "Countries can ask ICM to analyse their maternal health system. ICM finds a local person in each country, supported by them, to facilitate the process. We analyse it to see what is needed in that country and to be able to make the needed shift."

Difficult situations

The concerns ICM tackles are humanitarian, climate and, unsurprisingly, gender issues. Franka notes: "Research is showing that especially in humanitarian settings, for whatever reasons – be it war or be it climate change – midwives are key in providing sexual and reproductive health and rights care (SRHR). Often midwives remain when all other healthcare professionals flee.

"Midwives are mainly about prevention. For example, contraceptive care is crucial in these situations. We need to focus on having midwives in those humanitarian settings. It's really quite simple: if you make sure that a woman is able to get pregnant healthily, her child will have a good start to life. So midwifery is actually a core element of climate action."

Franka is stepping down as president this year after six years at the helm. Before this, she was treasurer of ICM for six years. In her previous role at the Midwifery Association in the Netherlands, she travelled widely, organising twinning projects for midwife organisations from countries including Sierra Leone, Morocco, Ghana, Iceland and the Netherlands.

Of her time at ICM, she is proud to have brought stability – though she is keen to stress that she did not achieve anything by herself. "I've managed to get people together to all work on the same thing. I think there's been a lot of uncertainty at ICM for a long time before I came – instability regarding finances and chief executives who came and went, and I think that caused ICM a lot of internal issues. That made it hard for us to set the strategy and then work it out because we all had other things going on.

"Stability has been really important for ICM. We've had the same president and the same chief executive for six years. The chief executive and I have a very similar vision, although we are very different kinds of people. I think that has really helped, as we have both kept our eye on the same ball."

"Often midwives remain when all other healthcare professionals flee"

The future

Six years on, Franka acknowledges ICM's role as the go-to organisation for global midwifery. "Every organisation that wants to work with midwives and midwifery wants to work with ICM, which is quite right because we are a reliable, hardworking and stable organisation." With this comes pressure, and she acknowledges that global pandemics, conflict and climate change will test the organisation to its core. "When you treble your staff, it can be the most dangerous time because you have to deliver, keep everyone aligned and stay as agile as you have always been. They are all over the world and we have to keep them aligned in our vision, with the same passion and the same mission.

"I hope that governments will listen to the evidence and see the enormous potential of the midwife-led model of care. I hope they change their system from the predominantly obstetric-led model of care. We urgently need to change the paradigm to a midwife-led model of care and the midwifery philosophy of care because that is much more sustainable, gender equitable and climate-friendly. It's much more focused on partnership and respect – and, most of all, it delivers better results."

ICM's first six twin countries. See **bit.ly/ICMtwintowin**

IMAGES: ICM/SHUTTERSTOCK

◀The presidents of the francophone midwife associations at a meeting in Ivory Coast

"There is great leadership out there at the moment, and it must be nurtured"

She feels the organisation's biggest struggle is helping people understand that the obstetric model of care is a patriarchal model. "Obstetricians are crucial – they are excellent at their job, which is taking care of women and gender-diverse people who are sick. But if you always look at people as having a risk, then you will find a risk. Let's all keep to our own expertise – midwives take care of all women, and obstetricians are called in when needed."

ICM congress

The 33rd ICM Triennial congress, in Bali, Indonesia on 11-14 June 2023, will be the first in-person congress in six years thanks to COVID-19. Its theme is the same as the International Day of the Midwife: *Together again: from evidence to reality*.

"It's a logical theme after not seeing each other for so long. I think it resonates with our members," Franka says. As ever, its purpose is to shine a spotlight on midwifery, as well as to inspire. Plenary sessions will include: realising the top demands of midwives – a pathway towards better pay and a happier, healthier midwifery workforce; and the last healthcare professionals standing – an exploration of the role of midwives in humanitarian and fragile settings.

"The congresses are crucial because we all need the strength and energy to be able to carry on," continues Franka. "There is great leadership out there at the moment, and it needs to be nurtured. There are lots of midwives and many countries doing fantastic things. In Bali, we can find each other and support each other to carry on. It's a big job. We're fighting huge patriarchal, hierarchical structures and gender issues. And for that you need a bit of soul food, so ICM Congress is that for us."

The council members will also elect a new board because, as ICM has professionalised, so too must the board. Part of this is a commitment to reducing the number of board members, as well as choosing them for their governance competencies and skills. The years ahead will be crucial.

"With the climate crisis, as well as conflict and the global growing disparity, the world will demand to change the paradigm. That can only be towards a midwifery model of care as it is more humane and more holistic," says Franka, and it's clear that she sees ICM playing a leading role in achieving this.

INTERNATIONAL DAY OF THE MIDWIFE

Set up by the International Confederation of Midwives (ICM) in 1992 with the purpose of highlighting the role of the midwife across the world, 5 May sees country-specific celebrations each year.

Many African countries hold huge gatherings, says ICM's Franka Cadée. "They'll have a special cloth made – a cloth for that year, or a cloth of their association – and all the midwives will wear it in different styles. They have big processions and make a lot of noise."

Latin Americans celebrate the day by taking to the streets, often dressed in red. They also celebrate the Feast Day of St Raymond Nonnatus, the patron saint of midwives, on 31 August.

North Americans and Europeans celebrate by making cakes and holding celebrations inside and outside hospitals. Many countries also organise conferences, which is where Franka plans to celebrate this year. "This May I will be in Portugal speaking at the midwife organisation's conference and we will celebrate the day together. I think the UK does it nicely, with all your cupcakes!"

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Midwife in a war zone

Wanda 'Wendy' Warrington travelled into Poland, then Ukraine, to offer support to pregnant women and their families

It was just three weeks after the war began. Many women, children and elderly people travelled for days to get to the border, and then had to queue in temperatures of -6°C. Seeing them standing for hours in sub-zero temperatures really affected me as a mother and grandma. All I could think was that I would hope someone would help my family if they were in the same circumstances.

As a registered midwife and nurse, I wanted to offer practical support, rather than sending aid from home. My family is Polish so I speak Polish fluently, and I thought my language skills would be of help. I arranged my own placement after looking at where I felt I would be most useful. I went to Przemyśl, a small town in Poland just 7km from the Ukrainian border. The town has seen a huge influx of displaced Ukrainian refugees fleeing the horror of the invasion. A humanitarian aid centre was set up at the town's disused shopping centre, and I was based in a mobile medical clinic in the car park.

The medical clinic was staffed 24 hours a day by Polish student paramedics, with support from volunteer doctors and nurses. I was the only midwife. When I asked about pregnant women, I was told there were none. I noted there was a cardiotocography machine (CTG) and then discovered no one knew how to use it. I made it my business to walk around the centre several times a day speaking to volunteers and people. I soon found pregnant women to whom I offered antenatal care and support.

Word spread of my work among the volunteers and professionals, and I was called to see women in Korczowa, where there was another centre for internationally displaced persons (IDPs). I also went to the train station where there was a mother and baby unit, which at the time was under police guard due to safeguarding issues.

I then moved to Medyka on the Polish-Ukrainian border as a volunteer for a charity. This saw me cross over the border into Ukraine to centres for refugees fleeing from the east of the country. There I saw pregnant women and undertook regular antenatal care while providing the women and newborns with everything they needed. I ensured that they were linked into the Ukrainian maternity system, which is mainly obstetric-led and fragmented due to women being displaced.

Scared and far from home

There was no typical day. I saw pregnant women and did full antenatal checks. Seeing the relief on their faces when they heard the fetal heartbeat was reward enough for me; it validated why I came to help. The stress and lines on their faces would visibly soften and the hugs and tears came. Women fleeing with their families

Since the war began Wendy has travelled to Przemyśl, Korczowa, Medyka, Kharkiv and Zaporizhzhia to help pregnant women and their families

with only what they could throw into a bag was poignant. They did not have time to think about the unborn baby or whether they could feel fetal movements when they were crammed into trains for up to 30 hours, nor when they had to queue to cross the border in freezing conditions. All I had time to offer was routine antenatal care before they headed off on coaches to other cities and countries.

I subsequently moved on to offering postnatal advice and support in the refugee centres. Then I travelled eastwards across Ukraine, including to the heavily hit cities of Kharkiv and Zaporizhzhia, with humanitarian aid and medical supplies (including donated fetal dopplers and a CTG, which I gave to a maternity hospital hit by missiles in Kharkiv).

I have spent more time in Poland and Ukraine this past year, with the longest period being four months. I took a career break from my substantive post and eventually resigned due to my commitments in Ukraine. I am now working as a bank midwife undertaking regular shifts at my former Trust in between visiting Ukraine.

My latest visit was on 17 February, and I went with donated dopplers, a CTG, baby scales, maternity packs and vitamins for the primary care clinics we've set up in the centres for IDPs. I also plan to deliver equipment to the last maternity hospital standing in Kherson, which was attacked recently.

My ethos has always been to deliver aid into the hands of the people. I can't say how long I will stay – if I am needed and can make a difference, I will continue. I have been offered the role of a legacy midwife at my Trust, and when I return I will be focusing on my experiences to support newly qualified midwives.

I am humbled to be able to offer some support to the internally displaced women, children and families of Ukraine affected by the horrors of this senseless war. Its impact and ramifications on future generations remain to be seen.

Seeing the relief on their faces when they heard the fetal heartbeat was reward enough

AWARD-WINNING WORK

Wendy won Best Midwife in *The Sun*'s Who Cares Wins Awards, hosted by Davina McCall and screened on Channel 4, and has appeared on BBC Radio 4's *Today* programme, as well as *Woman's Hour*, which you can listen to here: bbc.in/3Za8yWW Wendy has also been a steering group member for the RCM's work on homelessness.

FOLLOW ME

I have a JustGiving page at **bit.ly/JustGiving_Wendy** and you can follow me on Twitter **@wandathemidwife**. I'm also on Facebook under 'Wendy Warrington my Polish/Ukrainian journey'.

MORE INFO

For more on how to support those in Ukraine, visit the RCM website's dedicated section on the conflict using this QR code.

Heard and counted

In a bid to measure and improve the quality of care of pregnant and birthing women, a team of midwives in Scotland took a national approach and localised it – with inspiring results

Once in a while, a story of success acts as a reminder – amid testing times – of the positive impact midwifery can have. The Community West team at NHS Dumfries and Galloway, Scotland, have provided such a story through the Care Assurance initiative.

It's based on the Excellence in Care (EiC) approach which, according to Health Improvement Scotland, "aims to ensure people have confidence they will receive a consistent standard of high-quality care no matter where they receive treatment in NHS Scotland".

Laura Boyce, head of midwifery and quality assurance lead at NHS Dumfries and Galloway, has been involved in piloting the "local arm" of this approach in the community with support from EiC lead Karen Hamilton.

"Both initiatives are about delivering and monitoring the effectiveness of the care we're providing," she says. "But while EiC has some maternity measures, they don't tell us about the whole care journey. The local Care Assurance process is a far more detailed approach.

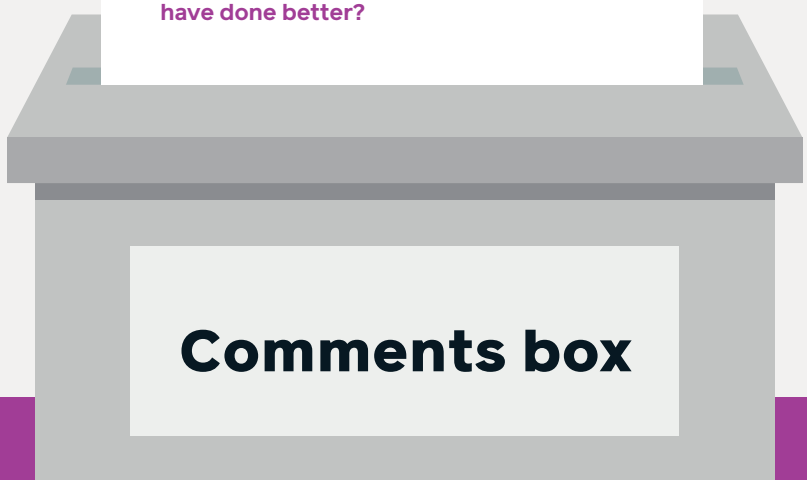
"We've started to look at our women's experiences through the pregnancy journey, in terms of receiving continuity of care, the relationship with their midwife and their birth plan. So now we can use that as live service user feedback and report it nationally, as well as locally.'

FOR THE JOURNEY

Talking to service users is a huge part of how the Care Assurance system is measured, as Jenny Rendall, senior charge midwife at NHS Dumfries and Galloway, explains. "The first few questions are about the woman's relationship with her midwife. I'll often explain exactly what the question means. I've got lots of comments boxes."

The questions asked include:

- **Has it been clear to you who your midwife was?**
- **Has it been easy for you to contact her?**
- **Have you seen your named midwife plus up to one other midwife for your scheduled antenatal care?**
- **Have you had the chance to make a birth plan with your midwife yet?**
- **How do you feel about your birth plan? Does it reflect how you feel about your risks, needs and wants for labour?**
- **Have you had an opportunity to discuss a place of birth during the pregnancy?**
- **Were you offered any antenatal education? Specifically, have you been aware of conversations around health promotion topics? For example, around stopping smoking, drinking alcohol when you're pregnant or safe exercise during pregnancy?**
- **Are you aware of the pain relief options for during labour?**
- **How do you feel about the education you've received? Has it been tailored to your needs and wants?**
- **Do you feel prepared for birth?**
- **Have you had an opportunity to discuss postnatal care options?**
- **Have you been offered information advice about feeding your baby and do you feel enabled to make an informed choice?**
- **[To the partner] Do you feel as involved as you might like?**
- **What do you [the partner] think we might have done better?**



IMAGES: SHUTTERSTOCK

Giving women a voice

It is needed because feedback – of all kinds – is invaluable, Laura explains. "We had no other mechanisms of receiving women's feedback in real time, other than through the complaints procedure, because we didn't have a maternity services liaison committee at that point. So for us, it was about identifying positives and the areas to celebrate, as well as the areas to share and enhance care – rather than just being reactive to complaints."

The emphasis is very much on continuity of carer, which is a cornerstone of *The Best Start* report – Scotland's five-year maternity and neonatal plan published in 2017. "All women will have continuity of midwifery carer from a primary midwife," it states. "The primary midwife will have a buddy midwife who can support her and provide cover for annual and other leave and by a small group of local community midwives."

So how does the Care Assurance scheme work and determine whether women have received the continuity of carer they're promised? "A call is made by the senior charge midwife around the 36-week mark," says Laura – when women are given the opportunity to answer a series of questions about the care they have received up to that point (see *For the journey*, left).

The decision to contact women at this point in the pregnancy – as well as on the questions themselves – was an important part of the design process, explains Jenny Rendall, senior charge midwife at NHS Dumfries and Galloway.

"I spent a couple of years playing about with the questions, testing them on people

It was about identifying positives, rather than just being reactive to complaints

and looking at the results," she says. "I discovered that if you speak to women too late, then you miss an opportunity to correct anything that they're not particularly happy about. But if you speak to them too early, then sometimes they haven't had enough contact with their midwife yet."

Jenny also made the decision to try and speak to a woman from each midwife's case every month, to ensure feedback is evenly distributed across the team. "It gives you a really good picture of what the midwives are doing, what kind of care they deliver and what it feels like to be in their care," she adds.

A postnatal contact is currently being piloted, Laura confirms – while the team is also looking at implementing it for acute areas to ensure an even wider view of women's care journeys.

Investing in better

The process has been streamlined by inputting the data – which was initially recorded on paper – digitally, using Microsoft Forms. "Jenny can just run through the form and complete it as the conversation is happening," says Laura. "Installing it allows us to build up each case on case – and slice and dice the data from Excel downloads. And we can use the data for graphics for posters, or to glean individual or team feedback."

Investment in training has been minimal due to Jenny currently being the primary point of contact for the women. "We looked at disseminating it down so it would go within the teams themselves, but we weren't sure whether that would negatively alter women's openness to responding to the conversation," Laura explains. "Generally we provide training around what Care Assurance is and what the standards are – that's all done in-house."

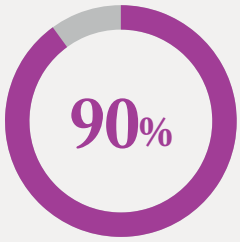
There is the obvious question of how the feedback on individuals is shared with them, and Jenny has to frame any negative comments as areas for improvement. "I try to deal with each one around the time of doing the call so it's not forgotten about," Jenny explains. "I do a little email – and I realise emails aren't always the best way to do things – but I tend to keep it quite short. 'This is what the woman this month said; here's what she said was good,' or, 'Unfortunately, she might have liked to see a bit more of this.' I try to be positive about it. I think if women aren't particularly happy that something hasn't been done, I can say that the midwife will be in touch about a birth plan, a tour of the hospital or some workaround preparation for birth.

It gives you a good picture of what the midwives are doing, what kind of care they deliver

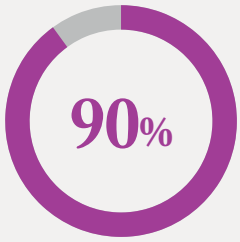
IMAGES: SHUTTERSTOCK

KEY STATS

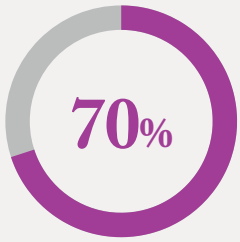
The Community West team reported the following results from the Care Assurance initiative between March and December 2022:



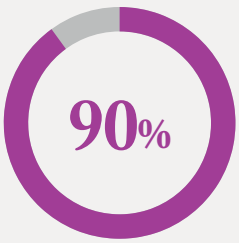
of the women received planned antenatal care from their midwife or one other



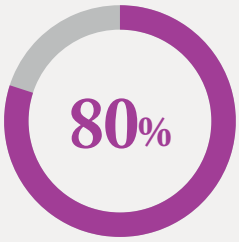
of the women had a wellbeing assessment completed within a week of booking. The women felt that it addressed strengths and worries



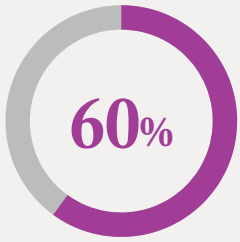
of the women said that they were aware of who their named midwife was



of the women had the opportunity to make a birth plan with their midwife, which they felt reflected their individual needs, risks and wants



were offered advice and information on breast and bottle feeding. These women said that they felt supported and able to make an informed choice



of the women contacted specifically mentioned how happy they were to have care from one midwife

100%

November 2020 to April 2021 – the average number of women who received continuity of carer. The rate of 100% has now been sustained for six months

51.5%

January to October 2020 – the average number of women who received continuity of carer

It's about making it a better experience for the women."

Women seem glad of the opportunity to share their views, Jenny says. "I don't think a woman has ever said to me, 'I don't want to give you any feedback.' And it's a useful discussion. Hopefully, we can come up with a positive for the woman, whatever her negatives have been. They are aware that this feedback will be used to shape the service going forward and many of them are going to use this service again."

Similarly, it's improving the experiences of the midwives at both an individual and team level – particularly since the feedback received has been largely positive, Laura confirms.

"The team are totally invested in it because they all get monthly data back, which shows them their reports where they've had continuity rates and what the birth outcomes for the women are." The feedback from the women and data that the midwives receive via their manager can also be used for the midwives' one-to-ones and revalidation, Jenny adds.

The Community West team's successes have been shared and celebrated more widely too. "Jenny spoke nationally with the heads of midwifery and we've presented it locally to other directors to show them what we've done," says Laura. "We put posters into local competitions and national ones – because people getting the recognition out of it is the thing that keeps driving it to scale up.

"Often you don't hear about things unless there's a problem. So seeing the data and how it's shared and celebrated is such a nice thing as opposed to being in a negative mindset – it totally changes your focus on the team."

MORE INFO

Scottish Government (2017) *The Best Start: a five-year plan for maternity and neonatal care*: **bit.ly/gov-fiveyearplan**

Interactive perineal suturing workshop

Location: London Heathrow

Facilitated by a perineal specialist and a team of experienced midwives. The course is specifically designed for midwives, student midwives and obstetricians in a non-judgmental and a relaxed environment.

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

- How to handle surgical instruments
- Continuous non lock technique
- Subcuticular technique
- Interrupted suturing technique
- Basic knot tying techniques.
- Performing episiotomy
- Repair of 2nd degree tear/episiotomy
- Infiltration

DATES:

20th May 2023
27th May (Limited spaces)
10th June (Limited spaces)
24th June 2023
22nd July 2023
23rd September 2023
28th October 2023
25th November 2023
16th December 2023

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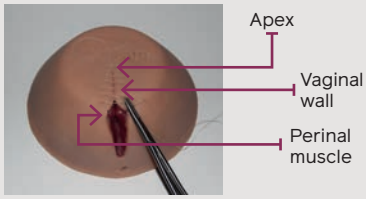
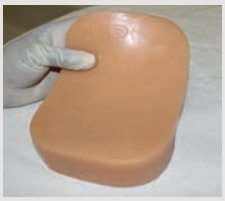


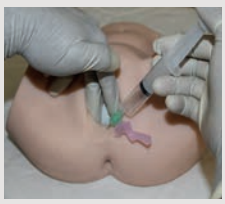
NEW PERI HEALTH FLESH-LIKE DOME SHAPED SUTURE PAD WITH MUSCLE AND SKIN LAYER

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



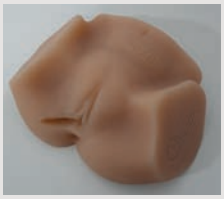
PERI HEALTH FLESH-LIKE SUTURE PAD

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



DUAL FUNCTION SIMULATOR

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



3D INTERNAL STRUCTURE

- The high-quality material gives realistic feedback during suturing
- It is designed for suturing the vaginal wall/ perineal muscle and the skin
- It is also designed for practicing continuous non lock, subcuticular and interrupted techniques.
- The model is made of high-quality material which allows repeated suturing.
- The wound area is reinforced to improve the tear strength
- Very stable during suturing.

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Turning the Tide

This initiative to fight racial discrimination via mentoring is making waves with midwives and MSWs

In October 2021, the RCM, in partnership with the Turning the Tide Oversight Group, launched a mentorship scheme to support Black, Asian and minority ethnic midwives and maternity support workers (MSWs).

The scheme links senior and experienced NHS professionals with midwives and MSWs of colour to provide support, networking and guidance to help them progress in their careers. The programme grew from the 2020 *Turning the Tide* report, which recommended targeted mentoring to tackle racial discrimination in the profession.

Dr Gloria Rowland
IS CHIEF NURSING AND ALLIED HEALTH PROFESSIONAL OFFICER AT SOUTHWEST LONDON INTEGRATED CARE SYSTEM AND AUTHOR OF THE *TURNING THE TIDE* REPORT

The vision is to develop a mentorship programme that meets the personal or career developmental needs of any Black and Asian staff. While other programmes force you to accept a mentor assigned to you, we had the idea to make it more like a dating site: mentors put profiles up and mentees can review them and choose ones they feel will be able to help them – they can act on their own initiative.

We have already seen a drastic improvement in the number of Black, Asian and minority ethnic people in leadership positions. When we started Turning the Tide, there were seven across the UK in head of midwifery (HoM) or director of midwifery (DoM) roles; now there are close to 20, and people of colour in consultant midwife, deputy HoM and other leadership roles too.

Of course, other factors contribute to this. However, I know that most people who have come through Turning the Tide have moved up the career ladder. One mentee – with a PhD – had been at Band 6 for years, and recently finally got a Band 8 role and fellowship. For me, this shows mentoring works.

What I want is for people like me to be able to sit back and let those who are rising leaders mentor others coming up behind them so that this spreads out even further. For me, as the first Black African HoM in the UK, it was a lonely place. But that isn't what they'll experience, and in years to come it will get even better.

It is also really important that this should have a knock-on effect on maternity care. We know in some areas, in London especially, the leadership doesn't represent the population they serve. Having the right diversity will also help move the health inequalities agenda forward because staff of similar backgrounds, who have a better understanding of the sociocultural needs of women from Black and Asian backgrounds, will be in decision-making positions – improving health outcomes for those communities.

What's more, our white colleagues mentoring through the programme are enjoying and benefiting from what they're experiencing and learning; they will disseminate that, and that has a ripple effect on the wider culture, reducing racism and discrimination.

I really encourage midwives and MSWs to engage with this process. And I want to thank the RCM for believing in it and acting in partnership with us to make this a reality.

IMAGE: SHUTTERSTOCK

Abigail Griffiths-Golha

IS A MIDWIFE AT HOMERTON HEALTHCARE NHS FOUNDATION TRUST AND A MENTEE

The Turning the Tide mentorship programme spoke to me because over the past four years I have had interviews for promotion without success. I have been qualified for 10 years, with experience of working in all areas of maternity. I am a qualified professional midwifery advocate, I demonstrate leadership behaviours in the roll-out of initiatives that support all team members both clinically and with reflective practice. I am currently on a master's programme in enhanced midwifery.

Feedback from my failed interviews all centred on what I did well: excellent presentations, knowledge of the subject, strategic overview, passion for the role and focus on staff wellbeing. However, only once was an area to improve on identified. This was very frustrating. Due to the lack of robust feedback, it is challenging not to feel there is an element of bias at work. I have a mixed-heritage background, and I look Middle Eastern, Mediterranean or south Asian. I very much feel 'other'.

For me, the mentorship has been incredibly valuable. I was first interested in working with my mentor because I grew up in the area where she is now the DoM. She has a lot of experience in all areas of practice, which is something I really respect. We discussed recently how complex discrimination is, and that maybe culture should be included within a learning unit. Whatever it is, it has had a negative effect on me personally and has affected my professional progression.

Having access to a senior, clinically experienced midwife in a mentoring capacity has undoubtedly been very rewarding. In recognising and acknowledging my concerns without making excuses or brushing my thoughts and feelings under the carpet, she has made me feel heard.

Reflecting with her made me realise I am not doing anything wrong. Being acknowledged by a DoM for your capacity as a leader in a Band 6 role is incredibly validating. She does not indulge me and focuses very much on 'what next' – moving things forward, and supporting me to keep doing this and that, broaden my horizons and think big.

It is a very positive experience. I feel it would be great if initiatives such as Turning the Tide were to evolve and progress into supporting the mentoring of middle management in how to be mindful and honest on the motivations behind their decision-making processes.

Heidi Beddall,

DIRECTOR OF MIDWIFERY AT BUCKINGHAMSHIRE HEALTHCARE NHS TRUST, IS MENTORING THREE MIDWIVES, INCLUDING ABIGAIL GRIFFITHS-GOLHA

The *Turning the Tide* report landed with me really powerfully because it shone a spotlight not only on the health inequalities experienced by women, but on

the issues facing Black, Asian and ethnic minority staff – not only their experiences during the pandemic, but also how they felt overlooked for opportunities and not always believed by managers. Another issue highlighted in the *Turning the Tide* report is how few midwives of colour are in the most senior roles – a pattern reflected across the NHS generally.

I've been very fortunate – I've had a great career and opened a lot of doors of opportunity, but reflecting on this report I began to think: did those doors open more easily for me because I'm white? Do I get more opportunities than my counterpart midwives from ethnic minorities? That didn't sit comfortably with me. At the launch of the *Turning the Tide* report, Dr Gloria Rowland asked for interested colleagues for support; I volunteered and became a member of the oversight group.

I feel incredibly privileged to be part of this and to be able to make the contribution I want to make, and to be an active practitioner of change rather than a passive recipient of all these reports detailing the inherent racial inequalities within the NHS. Being one of the few white people involved in this project – in the minority rather than the majority – has changed the optics for me, and hearing about people's lived experiences has been very powerful.

It feels very good to be back mentoring people again – to give really dedicated time and to be responsive to their individual mentoring needs. It is incredibly positive to see my mentees' confidence growing and to see them feeling able to open those doors of opportunity for themselves. I am benefiting enormously from reverse mentoring too.

It also keeps me grounded in terms of what's happening on the shop floor; after listening to what their needs and experiences are, I can go away and consider whether we're doing the right things by colleagues where I work.

Almost 30% of mentees have achieved career progression already. The Turning the Tide oversight group won the *HSJ* NHS Race Equality award in November 2022 for this and other work undertaken to address the recommendations of the report.I hope we will see these aspirational leaders and experienced midwives gain confidence and make the progress they are looking for in their careers.

Having access to a clinically experienced midwife in a mentoring capacity has been very rewarding

IMAGE: SHUTTERSTOCK

Edith Kumi-Poku IS A SENIOR MIDWIFE AND RCM STEWARD AT BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST AND A MENTEE

The Turning the Tide mentorship programme began as I was returning to work from long-term sickness and starting six months of non-clinical duties. Before I spoke to my mentor, I'd set out some objectives, but after our conversation I wrote new ones that would help me get more from the work I'm now doing in clinical governance and as an RCM steward. I want to grasp as much as I can while I'm here.

I was also in a pickle about my career stance – I didn't know where I wanted to go and what I wanted to do. My mentor Kit Oriakhi helped me set objectives; we talked about the training, and how if I want to apply for Band 7 roles, she's available for interview prep. It's clarified the courses I want to take and the roles I want to go for. And if I'm not sure about something, professionally or personally, or if there's a clash and I'm not happy with where I stand, I can contact Kit any time.

The mentorship programme is like a train – you collect information and you move it along. When Kit made me aware of an increase in CPD funding, I managed to get the lead for education at our Trust to come and speak to maternity about it because we hadn't been made aware. That's helped other staff apply for courses.

I've also started to mentor another midwife through the Turning the Tide programme. I'm learning a lot myself, because the way things are done in her maternity unit is completely different to us, and she qualified years after me so she's been taught differently. As a mentor, you don't have all the answers – you take what you have learned and what other people have learned, put it in a mixing bowl and come up with solutions.

The issues Turning the Tide addresses have been going on for years – so few Black, Asian and minority ethnic midwives break through that glass ceiling and they have to fight hard to do it. But things are changing, in my Trust especially. Both the HoM and DoM, who've been recently appointed, are from ethnic minority backgrounds, and so are some consultant midwives, ward managers and professional midwifery advocates. It means more people of colour are now going for those opportunities because they know they have a chance.

More people of colour are going for opportunities because they know they have a chance

IMAGE: SHUTTERSTOCK

Kit Oriakhi,

HEAD OF EDUCATION, PROFESSIONAL DEVELOPMENT AND WORKFORCE FOR NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS AT NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST, IS MENTORING TWO MIDWIVES, INCLUDING EDITH KUMI-POKU

I think the timing of Turning the Tide was perfect. George Floyd and Black Lives Matter was a moment in time that we will always remember – it ignited an awareness, and Turning the Tide captured that. It's no longer just about having conversations: it's about what we can actually do to alleviate this, starting with baby steps. That's why I fell in love with it. It's wide reaching; it's not just about midwifery, or women in that space from ethnic minorities. This is a movement with so many allies – including the RCM.

I have had mentors in my career – colleagues and professional friends who supported me, although always informally – and this was an opportunity to pass that on. As a mentor, you wear different caps – you are the person your mentee needs you to be in that space. That might be a guide, a confidant, a role model; you might be signposting, offering opinions and ideas, or act as more of a sounding board.

One of my mentees has been transitioning from one role to another, and in that relationship I was in the role of a professional friend, providing a safe space for her to speak openly about issues and concerns in a way she wouldn't have been able to do with her line manager. I was just actively listening, not judging.

At the centre of both my mentoring relationships is reflection; I'm holding up a mirror to allow them to make sense of situations. I'm also a guide, offering advice and a range of options, and helping them think them through. It's been helpful for me too – through mentoring, and being so immersed in those conversations, I have built my active listening skills.

My mentees are strong characters, and I'm proud of them both. I hope our relationship is as satisfying for them as it is for me, and that our conversations are impactful in helping them progress, be it vertically or horizontally.

My hope for this programme is that it is sustained. We are creating a community that allows people to see what is actually attainable – that roles they felt were never within their reach are actually achievable with the right support. As they go on to mentor others, this creates a domino effect.

Gemma Poole IS A NEWLY QUALIFIED MIDWIFE (NQM) AT NOTTINGHAM UNIVERSITY HOSPITAL AND AN NHS CLINICAL ENTREPRENEUR. WITH A BACKGROUND IN ENTREPRENEURSHIP AND HEALTH AND SOCIAL CARE EDUCATION, SHE DESIGNED A PROGRAMME TO DELIVER INCLUSIVE ANTENATAL EDUCATION WORKSHOPS TO HELP TACKLE HEALTH INEQUALITIES FOR BLACK AND BROWN SKIN WOMEN AND BIRTHING PEOPLE. SHE IS ALSO A MENTEE

We have all the data showing why Black and brown skin people are more likely to die in their maternity journey, and with my training and education background I could see the gaps behind that inequality.

I took the fundamental aspects of how maternity services are falling short in supporting Black and brown skin people and put them into a business plan to deliver a series of co-produced community projects addressing health and social inequalities in tandem, giving people the skills and tools to overcome barriers. With that, I was chosen from more than 300 people to join the NHS Clinical Entrepreneur programme.

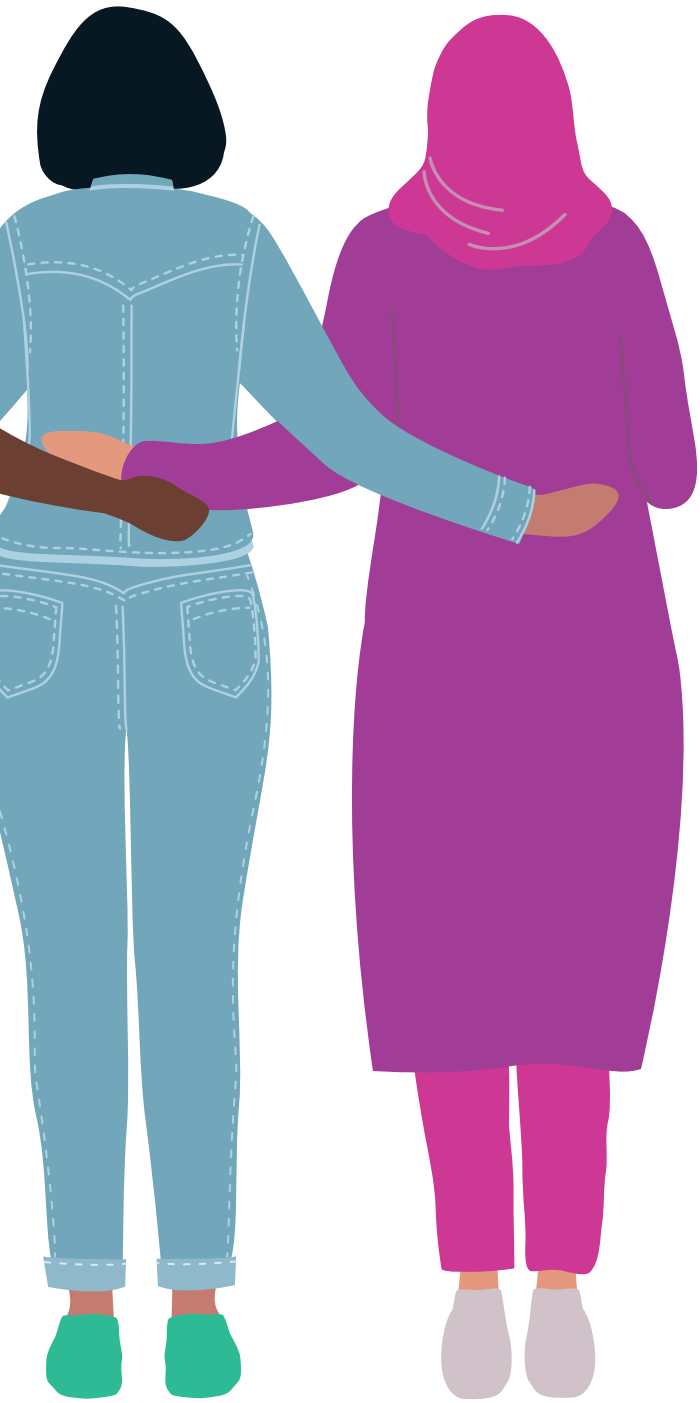
The reason I approached Jacqui Williams through the mentorship programme was because I needed someone influential to help me with this project. The mentorship programme supports the progress of Black and brown skin people to higher positions – but for me it's a tool to ensure people on the ground can get a better service.

I knew Jacqui held a particular lens in terms of understanding the landscape of maternity services and being able to access different groups, so it was a good match for me. But from our first conversation it quickly evolved.

I was only thinking about developing the project and getting it to where it needed to go, but the questions Jacqui asked helped me identify some areas of personal development. I am severely dyslexic, and that has affected my confidence. Jacqui gave me some tips and a series of tasks to practise to help me improve my presentation skills, which have been incredibly useful.

As a testament to this, I was chosen to co-host the NHS Clinical Entrepreneur Programme Big Pitch event in London – the first midwife to do so. Jackie Dunkley-Bent was on the stakeholder panel and we spoke about encouraging innovation within midwifery to improve recruitment, retention and save lives.

I love the concept of the mentorship programme, and we need to spread the message. I would urge anyone interested to go for it – even if you don't know how it will make a difference, be open-minded and say yes to every opportunity.



Jacqui Williams,
SENIOR MIDWIFERY EDUCATION ADVISOR FOR THE NURSING AND MIDWIFERY COUNCIL, HAS TWO MENTEES, INCLUDING GEMMA POOLE

It's an arrangement that you can tailor to your mentee's needs, which I like. It's meeting the mentee where they are and letting them take the initiative. I think it's very important that this process begins with the mentees choosing their mentors, because by being proactive and taking ownership they will choose a mentor who suits them and can get the best from it.

It can be incredibly powerful for a mentee to share with you where they are right now and where they want to go – and that pathway might not be linear. As a mentor, you haven't necessarily got all the answers. You can be a sounding board and a conduit to other people – I always have my eyes and ears open for people and activities that could be useful to them, and I'm quick to say: "I don't know much about that, but I know someone who does."

This is a safe space to talk. They can share things they might not feel able to share with others. That said, I do encourage mentees to share aspirations with their line manager and signal that they're interested in doing more. Doing those extra things gets you noticed, and people start viewing you differently. I can have confidence in them, but ultimately they need to have confidence in themselves and take steps to build that.

One of my mentees is looking for a big change in her career and is applying for substantial funding for an external project based around inequalities, which could have real potential. It's about helping her come to her own decision, and if she goes down that route, I can go into more detail with how to approach the application and prepare for the interview, that sort of thing.

This programme is about supporting the development of Black and Asian maternity workers – but there are benefits for mentees and mentors. Throughout my career, while I've thought about who I was up against for roles, I've never had to consider ethnicity and racism because of my own background. As a mentor, I've had conversations I wouldn't normally have had that have illuminated this issue for me.

I really hope this programme makes a difference. The proof will be in what happens to these cohorts, and we need to map their future trajectories.

I would urge anyone interested to go for it – be open-minded and say yes to every opportunity

IMAGE: SHUTTERSTOCK

Gillian Godwin
IS A RESEARCH MIDWIFE AND PROFESSIONAL MIDWIFERY ADVOCATE

I got to know about Turning the Tide mentoring through the RCM website. As an RCM member, I had taken advantage of some of the training and webinars provided for free to members before.

As the programme is specifically aimed at Black, Asian and minority ethnic midwives and MSWs to assist in career development and progression, I felt it would help me find my path in my new role as a research midwife. I hadn't taken an active interest in research before – it was a new experience and very different to clinical work, hence I felt it would be good to have unbiased support.

Early on in my career I have had to overcome several hurdles to become the midwife I am today – being of a minority background, training as the only Black midwife and overcoming a language barrier. These and similar problems contribute to the inequalities of midwives. With this program I was hoping to help gain a better understanding of the hurdles and how to overcome them.

I was able to choose my own mentor. I made my choice from a long list of midwives with years of experience in different areas of midwifery. I focused on a mentor who had experience and skills in my desired field. The programme was easily accessible and flexible, which made it more suitable for my busy schedule. I chose my mentor due to their profile. The mentor I chose was my age, had young children but vast experience in research, and was also from a Black, Asian and minority ethnic background.

My mentor was very friendly, understanding and proactive. Our sessions were conducted via Zoom at a time convenient for me and we always had an agenda prior to our meeting. At times it was difficult to find a suitable time for

I have had to overcome several hurdles to become the midwife I am today

us both, but my mentor was very flexible to accommodate my busy schedule.

I had no sense of direction before our sessions, but now I know where I am headed and what path I want to take. I realised that lack of opportunity very often comes from a lack of knowing what support is available. With the mentoring programme, I have gained knowledge of grants and awards available to Black, Asian and minority ethnic midwives. It has also given me the confidence to commence my master's degree, which I would have labelled as impossible before.

My mentor would send me links to learning opportunities in between meetings and kept encouraging me to reach out and build up my confidence. This has motivated me to keep reaching out to her, despite our mentoring sessions having concluded. It has also led to me now being an RCM learning representative.

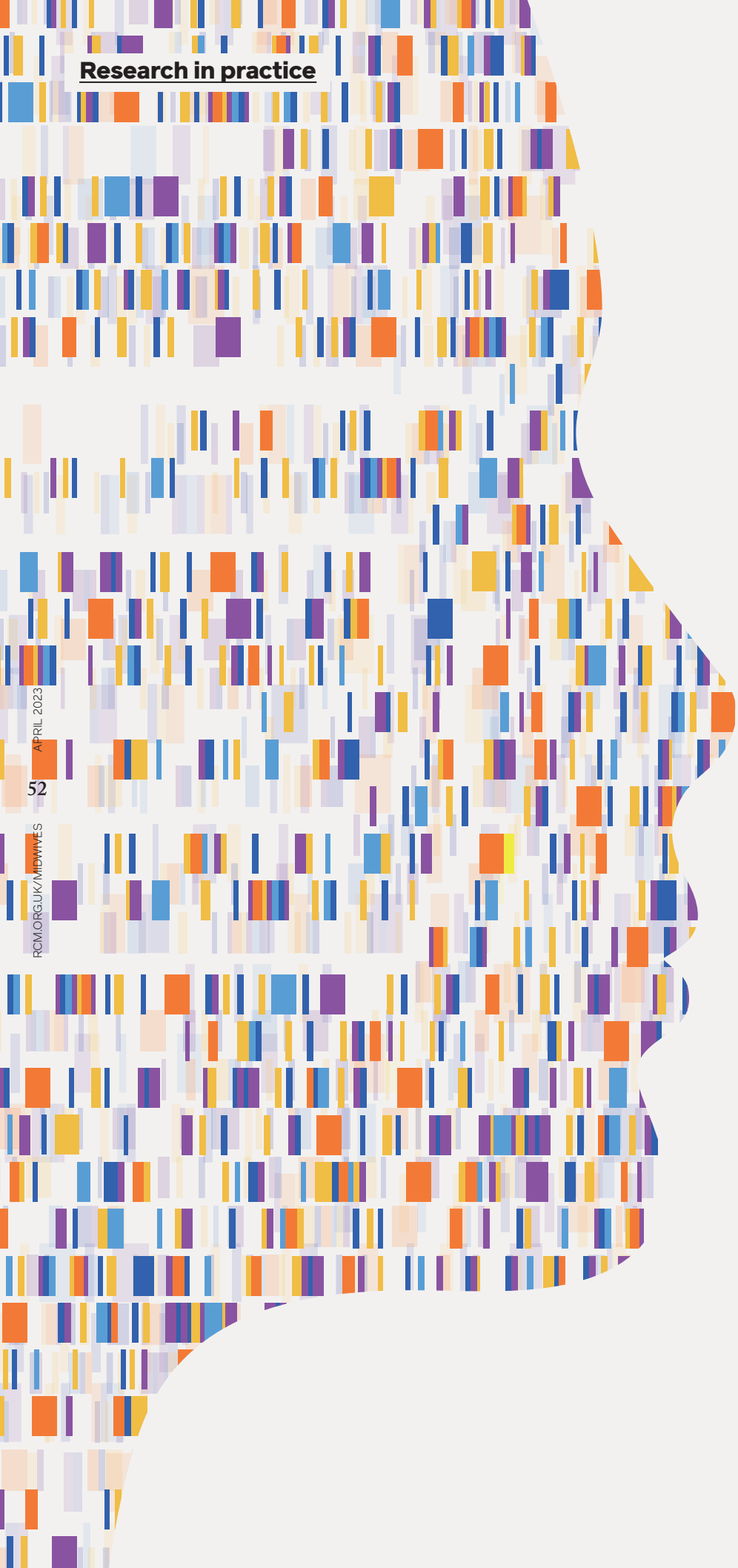
The programme widened my horizons on approaching staff who are able to help me achieve my personal career development goals, and not feel too scared or inadequate to ask for support. With my mentor I am able to be myself and be completely open and honest about my fears, goals and aspirations without having to say what others want to hear.

I firmly believe that this programme will help non-Black, Asian and minority ethnic staff gain a greater understanding of the lived experiences of Black, Asian and minority ethnic staff, and hence change common practices and treatment of them.

I also hope that many more midwives will take up this brilliant opportunity. I think it will increase the confidence of Black, Asian and minority ethnic staff to reach out, and give them equal opportunities in their career development, opening the door for constructive communication.

I am delighted to have been part of the mentoring programme and I continue to support the initiative to fight for better opportunities for Black, Asian and minority ethnic midwives.

IMAGE: SHUTTERSTOCK



On the same page

Midwives' ability to give new information to families about the DNA of their babies can be vital to survival, both pre- and post-partum

Genomics research can identify genetic variants, leading to new ways to predict and prevent disease. Those working in midwifery have a critical role in this science because of their interaction with families. That's why those undertaking genetic research are keen to get midwives up to speed on the research and involved with how it affects families.

Later this year, the Genomics England-led Newborn Genomes Programme will launch, sequencing the genomes of up to 100,000 newborns in England. It will cover up to 25 NHS Trusts, where every eligible parent would be approached.

It is spread across urban and rural areas, with a diversity of ethnicity and levels of deprivation.

Its three aims are outlined by Amanda Pichini, clinical lead for genetic counselling at Genomics England:

1. To evaluate the utility and feasibility of being able to screen newborns for a large number of rare genetic conditions, which are childhood-onset and can be treated in the NHS.

2. Being able to understand how the baby's DNA and health data could be used for wider health research – which could help to develop new treatments and diagnostics – and help Genomics England understand more about genes and health.

3. To understand public attitudes about the potential risks and benefits of storing that baby's genome over a lifetime. Is there the potential of going back to ask different questions of stored genomes, for example, if they get sick when they're older?

Information and care

Midwives are crucial to discussing a variety of tests and helping parents to make informed decisions during pregnancy, many of which involve genetics or genomics. Those discussions might arise at the booking appointment, when asking about family history, when discussing first trimester screening, if something comes up on a scan that might suggest a potential genetic condition, or when talking about newborn screening that might pick up a genetic condition.

You don't necessarily need to understand the in-depth science and technical aspects of genomics, but it's important to know enough to facilitate informed decision-making, knowing when to act on red flags and signposting to other specialists as needed. It's also important to use empathy and communication skills when it comes to discussing difficult news with parents.

Knowledge of basic genetics has enabled midwives to explain genetic fundamentals

The study comes with funding to support the delivery of the programme and results – and that includes staff, who would be helping to consent and enrol parents.

"We know how stretched midwives and other NHS professionals are, and we have been working closely with the NHS to understand how we can deliver the study with these workforce pressures in mind," says Amanda. "It's going to be important that midwives are aware that this study is happening and what it is aiming to do so they can signpost parents to more information and someone they can talk to about the study in more detail."

Currently in the UK, babies are screened for nine rare conditions through the newborn blood spot screen or heel prick test.

Screening for conditions

The study will enable Genomics England to look for about 200 more conditions, using genome sequencing. Amanda says: "It's important to focus on those conditions where there are treatments or interventions that could be done in the NHS in early childhood. That would help improve the lives of those babies and families."

Midwives are already involved in genomics, says Donna Kirwan, lead midwife for genomics in the Genomics Unit, NHS England and NHS Improvement. From a practice perspective, she notes, they are already delivering genomics in maternity services as the analysis of some tests, unbeknown to them, relies on genomic technology to deliver speedier and more accurate results.

"Knowledge of basic genetics has enabled midwives to explain genetic fundamentals, such as the autosomal recessive [AR] pattern of inheritance associated with conditions such sickle cell and thalassaemia, cystic fibrosis and other AR conditions that are offered as part of newborn blood spot screening. So midwives' track record of genetic conversations has set them up well to become competent and confident in harnessing genomics."

Genomics in practice

Donna notes: "In fulfilling the requirements for the [NMC's] standards of proficiency, midwives need some knowledge of genomics, but not at great depth – they are not expected to be experts in the science. It's still crucial to explore health beyond the booking history to ensure every care pathway touchpoint is optimised, as we know that

IMAGE: SHUTTERSTOCK

sometimes women forget or hold back information that could prove useful for genomic interpretation."

Her advice is not to overthink the situation and not to work in isolation, but to "forge relationships with other specialities and work in partnership. Midwives know so much more than they think. Reach out to the RCM i-learn platform, the suite of resources developed by the Genomics Education Programme and the RCOG's Genomics Taskforce."

Donna says there is a keenness from midwives for the work. "I attended the Festival of Genomics in London last month, where we held a nursing and midwifery genomics roundtable event. It generated a healthy debate about genomics within the professions and clearly highlighted their enthusiasm for it. The word is getting out there, and with the advent of the new genomic strategy and direction from the NHS England nursing and midwifery genomics team, there is a great opportunity to embed genomics in routine practice."

The word is getting out, and there is a great opportunity to embed genomics in routine practice

Life-saving work

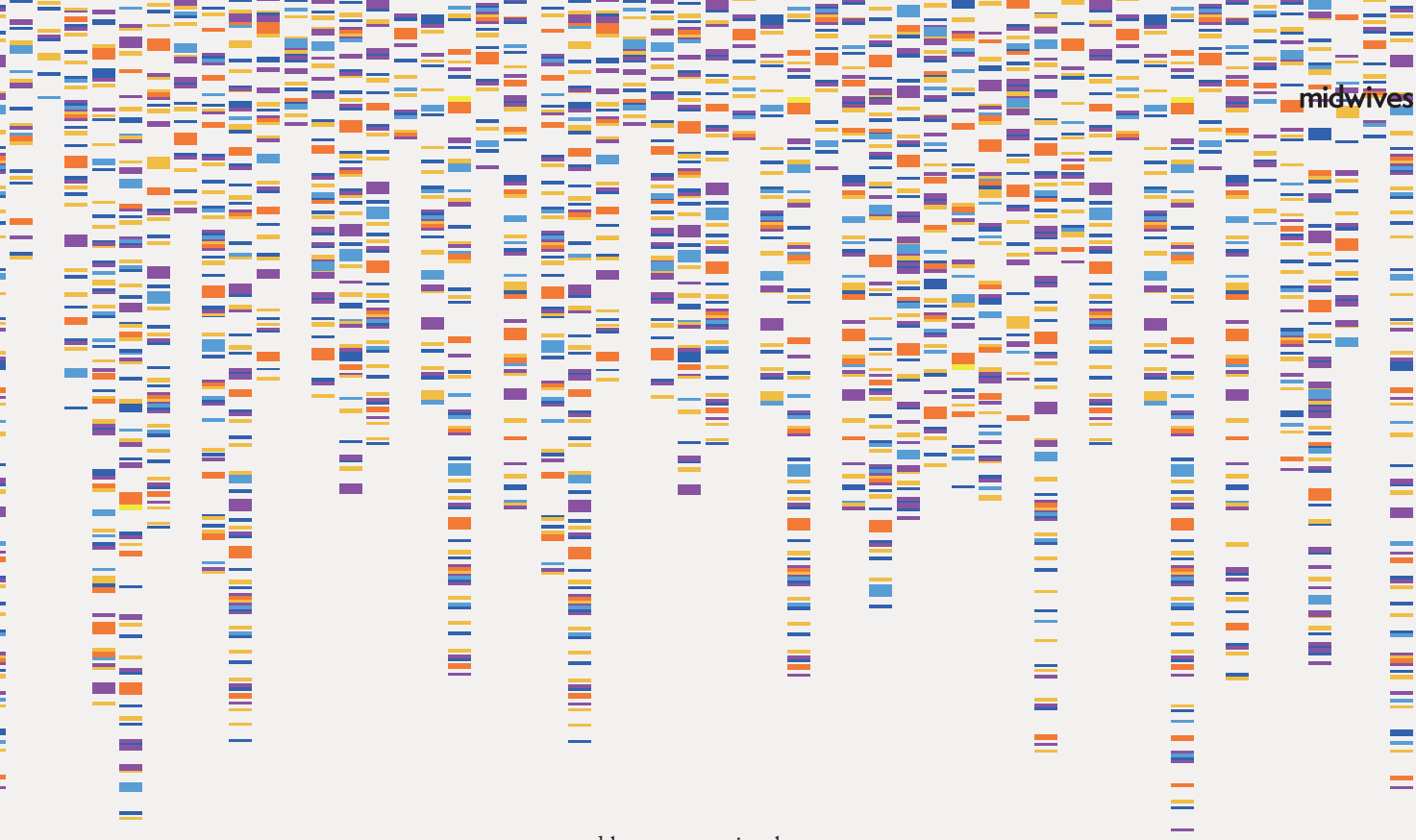
Reuben, a five-day-old baby, was admitted to hospital because he was fighting for his life. After running several tests, doctors discovered that he had lethal levels of ammonia in his blood. By using rapid postnatal whole exome sequencing, they found he had a genetic change in his CPS1 gene.

In normal circumstances, the CPS1 gene breaks down nitrogen in our system to prevent the build-up of ammonia to toxic levels. However, in Reuben's case, the CPS1 gene change caused the gene to malfunction and so an accumulation of nitrogen made him ill. The result directed doctors to medication to suppress the problem. After spending two and a half months in hospital, he went on a waiting list for a liver transplant to cure the condition.

In another example, Oscar's mother Siani had had retinoblastoma, a cancer of the eye, as a child, so non-invasive prenatal diagnosis (NIPD) was done early in pregnancy, a test that can determine with almost 100% accuracy if a baby will develop the disease. Doctors discovered that Oscar had a change in the RB1 gene. As soon as he was born, they started chemotherapy and then laser therapy on the affected eye. He lost the sight in that eye, although they avoided having to remove his eyeball. His sight remained perfect in the other eye – and the potential spread of the disease to his brain was averted.

Genomics education

Professor Kate Tatton-Brown is clinical director and head of programme for Health Education England's Genomics Education Programme. She is also leading on the education and training required across the MTD (a database that allows for browsing of genes) for the whole genome sequencing research study. "Our remit is to upskill, at scale and pace, the



entirety of the healthcare workforce to adopt genomic medicine," she says. There are four pillars to the programme:

1. To identify what the NHS workforce needs. What are those education and training requirements?

2. To build networks across the country to join everyone up to try to optimise communication, to share good practice and to get that flow of information across the country.

3. To help educate and develop the NHS workforce.

4. To increase awareness of genomics across healthcare.

The programme is underpinned by a Patient Advisors for Genomic Education (PAGE) group.

The Genomics Education Programme has been developing GeNotes – 'genomic notes for clinicians'. It is a two-tiered resource. Tier 1, 'In the Clinic', is focused on the point of patient care. Just before seeing a woman, during the consultation or just after, a clinician can access Tier 1 in order to understand who is eligible for testing, what genomic testing to request and how to organise the testing for that woman.

In addition, Tier 1 will support the clinician to interpret and feed back genomic results. Tier 2, 'Knowledge Hub', acts as an encyclopaedia and includes resources around conditions, genes, inheritance patterns, genomic technologies and communication resources. The resources have a flexible structure, with a range of different media, including text, images, narrated slide decks, infographics, filmed interviews and animations.

Hooks for learning

Tier 1 resources are speciality-specific, while Tier 2 resources are shared between all the specialities. There are 11 working groups in GeNotes, representing different specialities. One of those working groups is for fetal and women's health, co-chaired by Donna for midwifery and Dr Jess Woods for obstetrics and gynaecology.

Kate says: "Having accessed Tier 1, that practical part of the resource, midwives may then realise: 'This is really interesting, I'd like to know more about this.' They can then start extending their learning, following links or 'hooks for learning' in Tier 1, to create a bespoke learning journey in Tier 2.

"We know that's a really powerful way to facilitate engagement with genomic learning."

Midwives have always had a central role with women and families, and the new genome study speaks to that connection. For the science to save more lives, however, it needs midwives to do what they do best.

Amanda Pichini Clinical lead for genetic counselling at Genomics England

Donna Kirwan Lead midwife for genomics in the Genomics Unit, NHS England and NHS Improvement

Professor Kate Tatton-Brown Clinical director and head of programme for Health Education England's Genomics Education Programme

IMAGE: SHUTTERSTOCK

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Saolta
Grúpa Ollscoile Cúram Sláinte
University Health Care Group

Are you interested in working in the West and North West coast of Ireland?

The Saolta Health Care Group in West and North West of the Republic of Ireland is looking to attract Midwives, Neonatal Nurses and Gynaecology Nurses to join our teams in each of our Maternity and Gynaecology units.

The Saolta University Health Care Group provides acute and specialised services across six hospital sites.

Maternity and Gynaecology services are provided in 5 of these sites as part of a Clinical Network with tertiary level care provided in University Hospital Galway.

By joining our team you will be working with highly trained professional and support staff, working in a culture of learning, with excellent opportunity to develop and improve specialist skills, knowledge and training with clear pathways for professional development and promotion.

The salary scales for staff midwives and nurses are €32,542to €49,417 with additional benefits from qualification and unsocial allowances . Employees are also eligible to join the HSE pension. We are committed to providing high quality services in line with the National Maternity Strategy in Ireland and international best practice

Location of the post: We have openings on all sites for whole time and part time employment with opportunities for promotional posts and career progression available

- University Hospital Galway. Co. Galway.
- Letterkenny University Hospital Co Donegal
- Mayo University Hospital, Co Mayo
- Portiuncula University Hospital, Co. Galway
- Sligo University Hospital, Co. Sligo

Contract type: Permanent
Specialised Areas: Inpatient and Community Midwifery, Ambulatory Gynaecology, and Neonatal Intensive Care (level 1 & 2)
Banding: Staff and Senior Grades for Midwives and Nurses (equivalent to Bands 5 – 7)
Start date: ASAP following successful interview

Informal inquiries to:
Ms Siobhan Canny, Group Director of Midwifery
email: **siobhan.canny@hse.ie**

Please submit CV and cover letter detailing your experience, speciality area of interest, hospital preference to **resources.human@hse.ie**

ANTT

Aseptic non-touch technique (ANTT) aims to prevent microorganisms from hands, surfaces or equipment being introduced into a susceptible (key) site, such as an intravenous device, by the identification and protection of the key parts of a procedure.

The longer key parts and sites are exposed to the environment, the greater the potential for inadvertent contamination. Key parts therefore must remain protected until the point of use – for example, by leaving the sterile packet on a urethral catheter until the point of insertion, or caps on syringes.

Create a suitable working environment. If the procedure is performed at the bedside, ensure no cleaning or bed-making in the area for at least 30 minutes beforehand (as it contributes to airborne contamination). Ensure windows are closed and no fans are on.

2

Clean the trolley/tray with detergent and water, dry and then disinfect with disinfectant wipes or spray. The surface must be thoroughly dried afterwards. Sterile packs should be checked for expiry dates and to ensure there is no evidence of damage or moisture penetration.

3

Open and prepare equipment on the tray/trolley. Keep all equipment within its packaging. Identify key parts.

4

Put on a single-use disposable apron and decontaminate your hands with alcohol hand rub.

5

Decontaminate your hands again and put on sterile gloves if required.

6

Following the procedure, remove gloves, aprons and other PPE, and dispose of waste. Clean the trolley/tray and environment, and decontaminate your hands.

Trailblazers

Empowering leaders and tackling health inequalities: the Mary Seacole leadership development programme

In 2020 the Florence Nightingale Foundation began a new partnership with Health Education England (HEE) and the Mary Seacole Trust to offer an annual leadership development programme for midwives, nurses and health visitors, with the shared aim of empowering healthcare professionals to tackle health inequalities, particularly for minority ethnic communities.

The Florence Nightingale Foundation works to improve outcomes and patient experience through building nursing and midwifery leadership capacity and capability, while the Mary Seacole Trust exists to raise awareness of the life, work and achievements of Mary Seacole, the 19th-century Jamaican-born nurse who overcame racism and injustice to nurse soldiers during the Crimean War.

These two impactful organisations, each sustaining the legacy of an extraordinary woman, came together to deliver this programme, which celebrates the life of Mary Seacole while underpinning the values she lived and worked by.

Open to registered nurses and midwives at Band 7 and 8a working in NHS-commissioned services in England, this six-month programme

is delivered through virtual and in-person sessions and one-to-one mentorship. It is designed to support participants to enhance their leadership skills and enable them to develop and implement a Quality Improvement (QI) project targeted at addressing health inequalities in their own service.

The bespoke programme focuses on building self-awareness and exploring personality preferences, values, attitudes and blind spots, helping participants to develop their personal leadership style and become more effective and authentic leaders.

Among the key experiential elements is a Royal Academy of Dramatic Arts (RADA) Mentorship Day focusing on the development of 'presence and impact'. The programme also covers areas such as negotiating and influencing, personal resilience, communication and report writing, and the methodology, principles and practice of QI – equipping those on the programme to formulate and deliver plans that contribute to improved outcomes, especially for people from ethnic minorities.

The first cohorts have now graduated and, after pandemic-related delays, came together for a shared celebration day in December last year. This end-of-programme event provides an opportunity for graduates to share their experiences and present their QI projects, which so far have ranged from smoking cessation to improving health outcomes for homeless people and enhancing the effectiveness of same-day emergency care. There are currently two cohorts of 20 undertaking the programme, and applications for the next round open in the summer, ready for a start in early 2024.

Hazel Manzano,

MATRON IN THE NEONATAL SERVICE, WAS AMONG THE FIRST COHORT TO GRADUATE FROM THE MARY SEACOLE PROGRAMME

The programme helped me enhance my self-awareness, and to be more authoritative and authentic as a leader. We did eight days of training, including a day at RADA and a Residential Leadership Workshop by Leadership Academy, which helped me to 'own my space' and have the confidence to communicate and be influential in any setting. Coming from the Philippines, my culture is much more to sit back, listen and wait for permission to talk, rather than push myself forward.

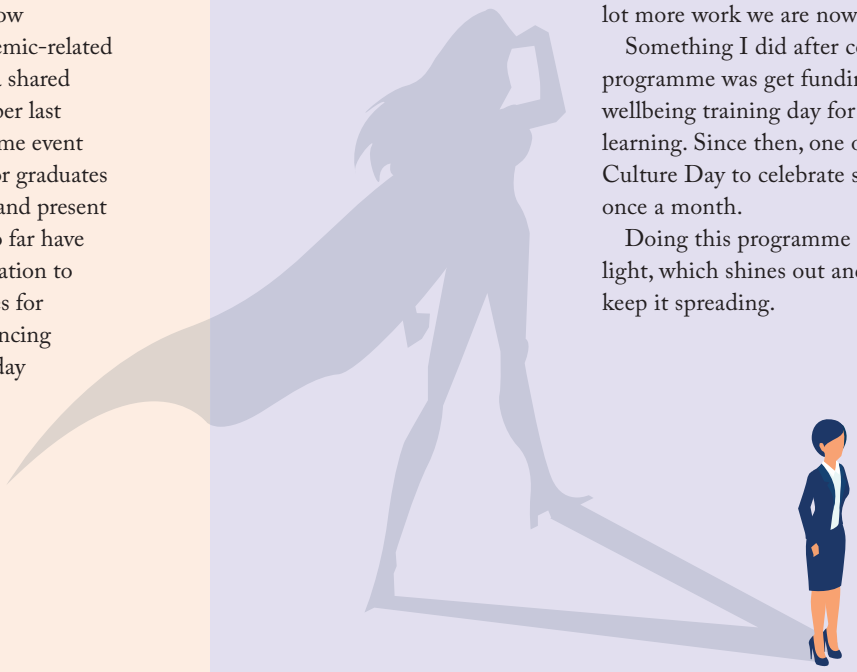
It's also embedded in me the rethinking and reframing of how I approach leadership. It's much more about coaching – shaped around the person and the team you're leading and inviting solutions from them. It's a slower, more collaborative process, but the return is so much greater. I have also learnt to take time for myself – to find that safe space to refuel, refresh, recharge and restart, and thus return as a better leader.

As part of the programme, I undertook a QI project related to improving health inequalities, both to benefit my service and patients, and as a tool to develop my leadership skills. We're in one of the most deprived boroughs of London and are one of the worst performers in terms of smoking cessation, so it's an important focus for the Trust. I identified a gap around neonatal screening for household smoking – there were 60% with unknown maternity smoking data among preterm admissions to our unit.

We did a baseline staff survey around confidence and competence to have those conversations sensitively with families. We've formed a stakeholder group looking at how we take this forward in terms of training and interventions – for example, we have new stickers for the discharge checklist to indicate that smoking cessation support has been signposted. There is a lot more work we are now doing around this.

Something I did after completing the programme was get funding for a leadership and wellbeing training day for my team to share the learning. Since then, one of them has created a Culture Day to celebrate successes and birthdays once a month.

Doing this programme has been like lighting a light, which shines out and lights up others, who keep it spreading.



IMAGES: SHUTTERSTOCK

Norma Barbosa,
A MIDWIFE CURRENTLY SECONDED TO A ROLE AS LEAD MIDWIFE FOR CONTINUITY OF CARER AND PERSONALISATION AT NHS NORTH CENTRAL LONDON INTEGRATED CARE SYSTEM

One of the main things the programme has given me is the confidence to express my views, and to know that what I have to say is relevant. It's built my understanding of the value of networking and how we can achieve more together. And it's helped me understand myself, the strengths and weaknesses of my personality type and how I can relate to others. I feel I have been given all the tools to flourish.

When you are a Florence Nightingale alumna, people see you through different eyes. It opens up opportunities – myself and many of my cohort have been able to take the next step in our careers as a result. I most likely wouldn't have applied for my current position without having done the programme. I wouldn't have had the confidence in my knowledge and skills.

I also want to support and encourage others. I met so many inspirational colleagues and I saw that leadership is natural in all of us – but maybe people coming from certain backgrounds or specialities don't feel like it's for them. At my Trust, we have an alumni group that helps others interested in applying for leadership courses, so you can see that ripple effect.

My QI project was based around a mother and baby app, which was co-produced with women and families in northwest London, and rolling it out across the four Trusts in north central London. The app provides reliable information for women and birthing people throughout their pregnancy journey, along with information about local maternity units and services. It also includes a section where they can create a personalised care and support plan.

We know maternal and neonatal outcomes are not the same across women from different ethnicities and backgrounds, and more personalised care can help address those health inequalities. This was a way to tackle this, by helping women make informed choices with a tool that supports discussions with healthcare providers. By doing the course at the same time as undertaking this project, I was able to put the tools I learned straight into action, managing the challenges of working across four Trusts with different personalities and competing priorities.

When I look at my leadership journey, I know this was the beginning – it's given me the foundations to achieve more, and the confidence to know that I can.

I most likely wouldn't have applied for my current position without having done the programme

Dian Bates,
A DIABETES AND OBESITY SPECIALIST MIDWIFE AND PROFESSIONAL MIDWIFERY ADVOCATE

When I started the programme, I had my QI project all mapped out. I was going to create a one-stop clinic, but when we came to that part of the course and talked about finding the 'baseline', I couldn't do it. I spoke to the QI lead at work and realised what I had was a clinical improvement project – not quality improvement. That really set me back.

I wanted to improve outcomes for women with gestational diabetes, so I went through all my audits to find the gap and saw that the majority of women ended up on medication.

For a lot of the women, I see there is a language barrier and they are in difficult circumstances. Even when you have a link worker who can translate, sometimes the message doesn't come across. I decided to build a universal visual board, working across the multidisciplinary team, using pictures of common foods – it doesn't matter what language you speak or where you're from, you can see and understand the difference between simple and complex sugars.

Knowing how to run a QI project is something I'm very proud of. The board has been commented on by the executive team, CQC inspectors and by the women and their partners. I'd like to see it rolled out in every Trust across north central London.

Another part of the programme was mentoring – which was the best thing ever! A mentor doesn't give you the answers; they help you look from a different angle. It's like you've stepped out of your body and can see yourself and what you're capable of clearly.

This programme has taught me that when we are united, as the organisations are, it becomes a ripple that creates movement

My mentor introduced me to a conference where I presented my project, and from there someone invited me to speak at an international conference. I've also written a blog for the RCM. I mean, wow!

This programme has taught me that although we are living in a world that may not be politically correct all the time, when we are united, as the Florence Nightingale Foundation and Mary Seacole Trust are, it becomes a ripple that creates movement. That was only a dream for Mary Seacole in the 18th century.

This for me is a great accomplishment for the two organisations in a time when equality and diversity are under the microscope like never before. I am proud to be one of the first intakes of this new course.

IMAGES: SHUTTERSTOCK

Font of knowledge

Kate Knightly-Jones and Charlotte Gibson discuss advanced midwifery practice and how it can be bettered by the formation of a community of practice

As a consultant midwife, I have spent more than a decade exploring the issue of advanced practice in midwifery; my master's dissertation noted that to understand what it is, we must first reflect upon what we mean by a midwife's role. I wonder now if this is even realistic within the context of the current NHS climate, where the demand on maternity services is higher than ever and resources are being stretched to capacity. There was, and remains, a longstanding correlation between the changing context of healthcare and the development of advanced practice roles.

Roles essentially encompass the things that we as individuals and professionals value – they are underpinned by a purpose, and driven by a need. Advanced practice is the ability to recognise the values underpinning these roles and see what is needed to drive those roles.

An advanced practitioner needs to identify their key core values – for midwives, this had been the promotion of normality (Charlton, 1996; Rogers, 2010; Sisto and Hillier, 1996). But with this core value being contested in the wake of Better Births, the Ockenden report and the Kirkup report across social, professional and political platforms, we are subsequently seeing a shift towards safe and personalised care as the core values of a midwife's role.

Professional evolution

Perhaps one of the strongest arguments for defining advanced clinical practice in midwifery can be best explained with the example of the consultant midwife. When the consultant post was first introduced in the UK in 2000, there were not enough candidates who had the required level of professional development to undertake the role. A profession can only advance if it acknowledges and promotes the value of advanced practice roles.

In 1999, for example, the National Council for Professional Development of Nursing and Midwifery (NCNM) was set up in Ireland to implement, regulate and evaluate the clinical career pathways for nurses and midwives wishing to progress towards specialist and advanced practice (Begley et al, 2010). The NCNM determined what the "appropriate level of qualification and experience" is for those in such posts.

Conversations continue in the UK with the RCM relating to validating similar career pathways – for example, the consultant midwife trainee programme (Rogers, 2010). While the accreditation of advanced practice roles has its advantages – including progressive clinically-focused career pathways, reduction in role confusion, the regulation and provision of a benchmark for practice making it easier to evaluate the role in terms of impact on

health services, and cost-effectiveness – there are some distinct disadvantages to the Irish model. For example, in Ireland it is the post that is accredited rather than the individual. This has ethical implications – what happens to those midwives when they cease to work in that post? Do they automatically stop working at this level of practice? Such dilemmas can also be seen with midwives who undertake post-registration education.

The traditional view that advanced clinical practice is predominantly a nursing issue, which largely relates to autonomy, is now outdated. The view that 'a midwife is a midwife, is a midwife' is too simplistic (Downe, 1999). Essentially a midwife's role consists of a balancing act between the old and the new, between the maintenance of the core role and how the collective profession adapts to the context in which it practices.

Health Education England's (HEE) recently published Advanced Clinical Practice in Midwifery Capabilities Framework (2022) defines it thus: "Advanced clinical practice in midwifery will ultimately support midwives to develop to an advanced level of clinical practice through education and training, while contributing to the provision of safe and personalised care for childbearing people and their babies."

Advanced practice in practice

Midwives across the UK have embarked on a path of advanced clinical practice (ACP) in midwifery and taken up trainee posts across a variety of settings. There is a vast landscape of ACP practice from triage, high-dependency unit care and mental health to antenatal care, diabetes and community. This is encouraging and it's important to support that with the next step – community of practice.

A community of practice (CoP) describes an ideological shift from a cognitive-based model of learning to more of a social-based one – and one that forms a repository for best practice and knowledge (Wenger, 1998). The sheer expanse of the NHS

The traditional view that advanced clinical practice is predominantly a nursing issue is now outdated

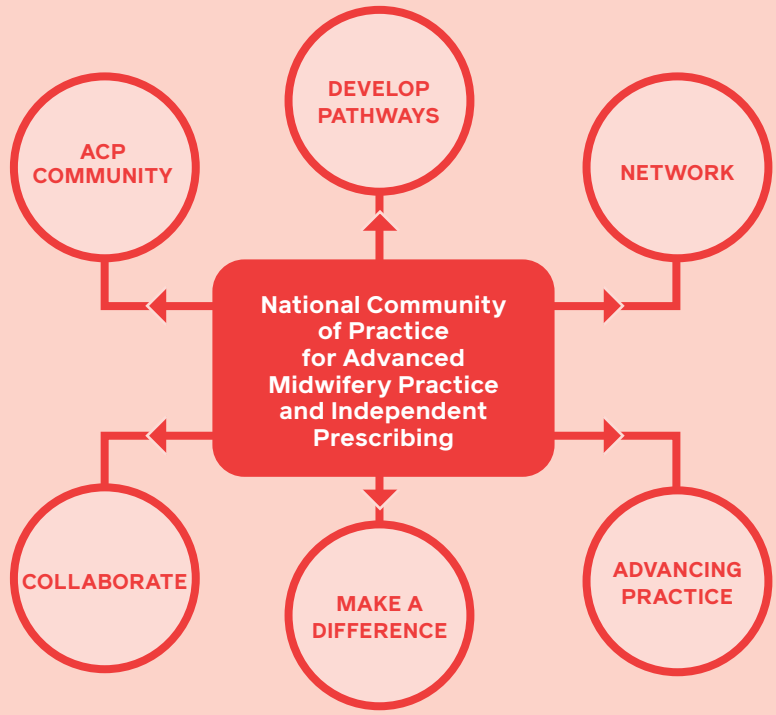
offers unlimited opportunities for CoP and promises enormous advantages.

While Midwifery Independent Prescribing and Advanced Midwifery Practice are playing an increasingly important role in the NHS and its aim of modernising the maternity service and better promoting continuity of care as part of Better Births, how this is actually implemented across different trusts can vary considerably.

Therefore, the ability to share experiences within our CoP gives us a plethora of information such as frameworks and guidance, educational resources and even job descriptions to identify and critique the similarities and differences across different Trusts and Boards: what is working optimally and what is not (and perhaps even why not).

Ultimately, a CoP can provide an exciting and novel opportunity to collaborate with others. It can be distinguished from the age-old concept of 'networking' in that it is not just focused on refining the means of communication between different individuals or communities, but is instead active and purposeful by design.

It offers them, in the absence of one omnipotent font of knowledge, a source of many – those who are responsible for our continued learning, knowledge and development in such specialist areas. It will be an active repository of knowledge carefully built, maintained and refined by our community of practice that will advance the profession.

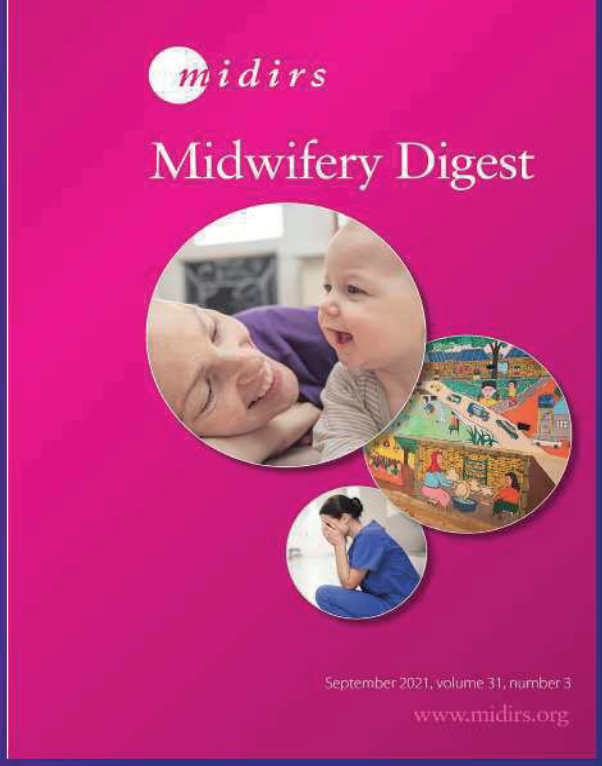


▲ National Community of Practice for Advanced Midwifery Practice and Independent Prescribing visual strategy

IMAGE: GETTY

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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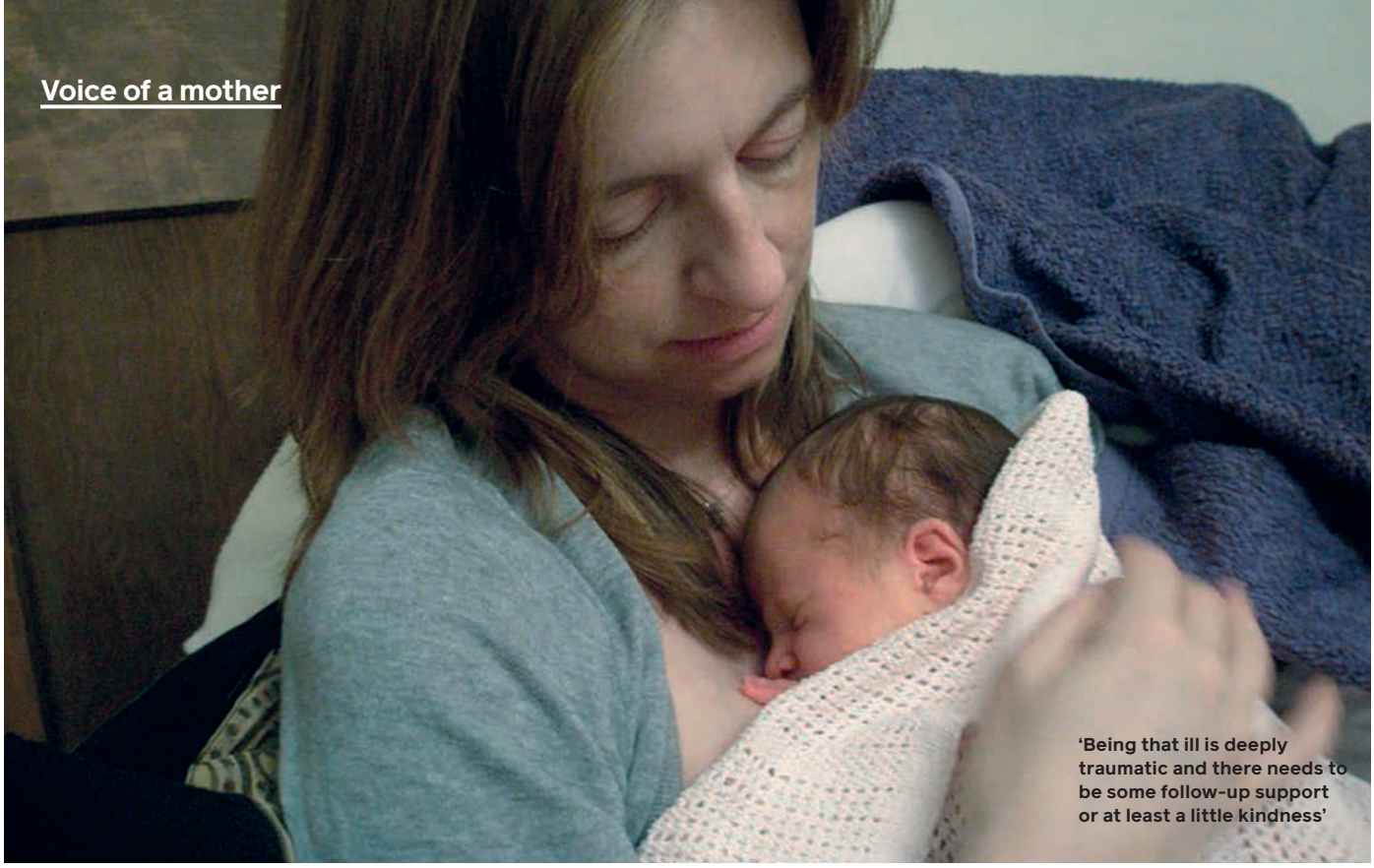


'Being that ill is deeply traumatic and there needs to be some follow-up support or at least a little kindness'

Post-traumatic stress

Hyperemesis gravidarum may have ruined Claire's pregnancy, but it was the lack of support afterwards that was the real blow

Weirdly enough, two months before I was pregnant, I'd listened to a BBC Radio 4 *Woman's Hour* dedicated to hyperemesis gravidarum (HG). So, when six weeks into my pregnancy I began to experience dizziness and vomiting, I knew what it was. My GP wasted no time in beginning anti-nausea injections every three days. It was hard to cope with the idea of taking medication for nausea, after the legacy of thalidomide. But the GP made it clear that I needed help; he said, "your baby will be okay, but you're in for a rough time."

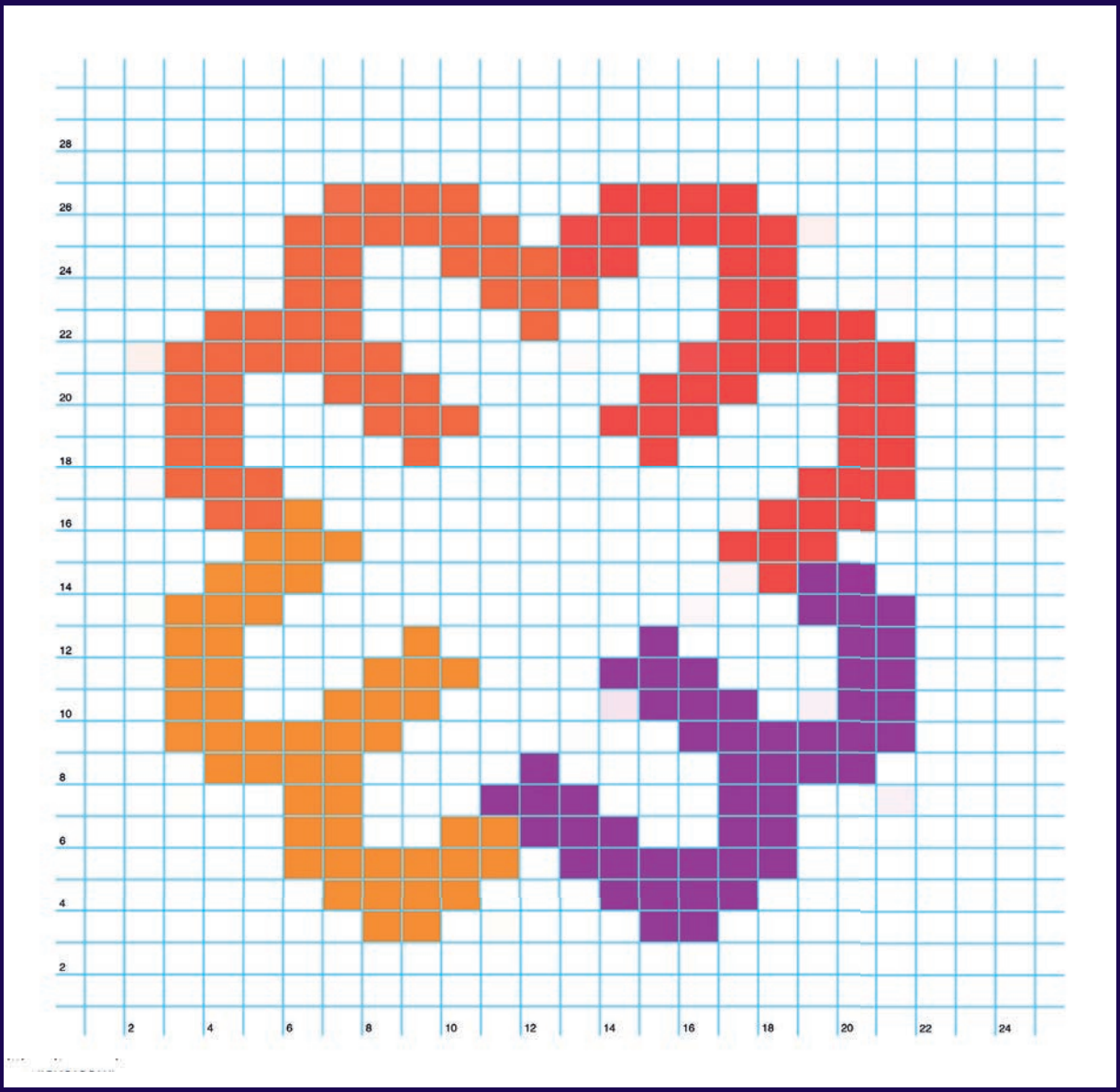
And he wasn't wrong. I had to tell my boss early on because I couldn't go to work. I couldn't keep anything down – even water. The injections just didn't work and I was so dehydrated that the GP advised me to go to A&E. I was admitted for two days and put on a drip. When I was discharged, I was told to try eating dry toast and ginger biscuits, which is laughable. I was given a huge bag of anti-sickness medication to take three times a day, which worked. I was still sick every day, although it felt more controlled and there were periods when I could function. I was able to go back to work part-time and sometimes used a walking stick.

The midwifery care was great, everyone was helpful – though I never saw the same person twice so had to recount everything each time. As the pregnancy progressed, I developed hypertension and preeclampsia; at my last antenatal appointment I was admitted to hospital and induced. My healthy daughter was born by caesarean, but I was a wreck. At 5ft 7in, I weighed 51 kilos, I was physically and mentally exhausted – and now I had a new baby. Worse, I was told off because I couldn't breastfeed (I wasn't producing) and no one would help me bottle feed her. I checked myself out and spent much of the first year struggling and on antidepressants. When I encountered health visitors and the NCT, I was made to feel a failure for not being able to breastfeed.

There was a sense of 'you're all better now' but you're not – far from it

As well as the physical repercussions, HG is mentally debilitating and no one takes that into account. There was a sense of, 'you've had the baby so you're all better now.' But you're not – far from it. The thing is, being that ill is deeply traumatic. There needs to be some follow-up support or at least a little kindness. I never had another child because of it.

Knit for IDM



Maternity teams are a crafty bunch, so for this year's International Day of the Midwife, we've come up with a new challenge for you. Yes, it's time to get your cross-stitch kits, your knitting needles and your crochet hooks out and create your own handcrafted RCM logo!

The pattern here can be increased in size, so if you want a Gyles Brandreth-style woolly jumper, just multiply each stitch by four, five or even 10 if you want to go super-size! If it's just an adornment for a bobble hat, scaling it up by a couple will probably do the job.

We're sure there will be some clever crafters out there who will be able to do wild and wonderful things – and we'd love to see them. So if you've created a pillar box topper, or made lots of hats for newborns, or even created a delicate IDM tapestry, please share your pictures on social media, tagging in the RCM and using the hashtag #RCMCreates.

Multi-professional human factors training

Maternity Simulation Game

Unique simulation encourages communication, collaboration and situational awareness.

Recreates a maternity department focussing on intrapartum areas to simulate everyday challenges and emergencies.

Invented by senior midwives to address key recommendations from Ockenden and MBRRACE including

- Staff who work together must train together
- Trusts must mandate annual human factor training
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Flexible training tool for staff, managers and students.

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Up to 16 people ***60 - 90 minutes*** ***Self-managed*** ***No external support needed***

What does it cost?

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