No half measures
The risks of alcohol in pregnancy
EDITORIAL

5 ▶ CATHY WARWICK
The RCM’s chief executive reflects on the positives amid a challenging year.

HEADLINES

7 ▶ NEWS
Job shortages, money for breastfeeding... Midwifery stories hot off the press.

12 ▶ GLOBAL NEWS
The latest news from around the world.

13 ▶ IN FOCUS
The implications of a new report around the identification of FGM victims.

16 ▶ RCM NEWS
Midwife awarded, Cathy honoured... The RCM news and dates.

18 ▶ COUNTRY NEWS
RCM UK latest news for Northern Ireland and England.

19 ▶ ON POLITICS
Stuart Bonar describes the RCM’s efforts in Europe.

20 ▶ WORK LIFE
Amy Leversidge on providing evidence to the NHS Pay Review Body.

OPINIONS

23 ▶ ONE-TO-ONE
Hollie Ewers talks to Birte Harlev-Lam on her new role at NHS England.

26 ▶ FEEDBACK
Dietary recommendations and dispelling myths around electrical sockets.
29 ➤ UPFRONT
A vaginal breech birth.

30 ➤ ON COURSE
Getting the best out of mentorship.

31 ➤ TOP TIPS
Ten tips for newly qualified midwives.

33 ➤ CUTTING EDGE
Emma Godfrey-Edwards reviews the latest midwifery-related research.

34 ➤ HOW TO...
Conduct active management of the third stage of labour.

36 ➤ EBM
A summary of the papers in the latest issue of EBM.

39 ➤ ALCOHOL
A look at whether ‘safe’ drinking in pregnancy exists and how midwives can educate women on the dangers.

43 ➤ RCM AWARDS
The transformation that produced an award-winning team in North London.

44 ➤ RCM CONFERENCE
Highlights and key messages from the RCM Annual Conference in Telford.

46 ➤ PEARLS
The Perineal assessment and repair longitudinal study summarised.

48 ➤ INCONTINENCE
Ensuring women receive pelvic floor advice during and after pregnancy.

50 ➤ HOME BIRTH
Looking at the ethics of home birth based on the Birthplace study findings.

53 ➤ RCM BRANCHES
Increasing activity at RCM branches.

FOOTNOTES
56 ➤ EVENTS
57 ➤ COMPETITIONS
58 ➤ CROSSWORD
Staying positive

This year has flown by and has been full of debate and discussion about the state of our health services, how we provide the highest quality of care and how decreasing resources can provide for increasing need.

So what has this meant for maternity services? Choice, continuity and control (principles expressed in the Changing childbirth report 20 years ago) still underpin maternity policy, midwife numbers are holding their own, there is a slight shift towards more women giving birth outside of our obstetric services and, despite gloomy headlines, the number of freestanding midwife-led units has been maintained.

On the other hand, reconfigurations are creating larger obstetric units with little evidence as to the impact on services. Only 2% of women give birth at home despite evidence that, especially for low-risk multip, home birth is a positive, cost-effective choice. Postnatal care services are evaluated poorly as hard-pressed community midwives and MSWs struggle to provide even a minimum number of visits, which is not so positive.

With both good and bad news, how should the RCM’s members react as we head into 2014? Firstly, let’s stay positive. Our maternity services have midwives as their backbone, our policies are women centred, our regulatory system is robust and the multi-professional team gets on well. This is a far cry from situations in many other countries – we do not need to be fearful for women or our profession.

Secondly, let’s remember that the care women experience daily depends mainly on interactions with clinically based midwives and MSWs. Women value being treated with respect and kindness above all else and, regardless of the model of service delivery, if each midwife and MSW makes every contact one in which communication is positive, we can make things better – a smile goes a long way.

Thirdly, if we want to see positive improvements in maternity services in 2014, we must all recognise our individual and collective ability to influence change. We need the ‘powers that be’ to be on the same page, but continuity of carer will only happen if we embrace working differently. Midwife-led units will only thrive if we support them. Home birth services will only develop if we explain this choice positively to women. Women in obstetric units need us to promote normality. Evidence will only affect practice if we implement it.

In other words, let’s head to the end of 2013 recognising our own accountability for making UK maternity services even higher quality than they are already.
The RCM’s president Lesley Page has been awarded an international alumni award. She received the accolade for her pioneering work and influence in midwifery.

Lesley collected her award from the University of Technology Sydney, where she completed a PhD by publication.

Lesley said: ‘I was really proud and pleased to get the award and my feeling was that it wasn’t just an award for me, it was an award for midwifery.’

In her career, Lesley has managed to integrate policy leadership, research and development and being a practising midwife.

She helped establish the first legally recognised midwifery service in the health service in British Columbia in the 1980s, served on three national committees in the UK, and was deputy chair of the English National Board for Nursing, Midwifery and Health Visiting.

Lesley also wrote the influential book The new midwifery: science and sensitivity in practice, and has worked and lectured in 13 countries.
SPENDING CUTS

NEW FIGURES ARE ‘WORRYING’

Half of English regions have cut their spending on maternity services, despite the ongoing baby boom, according to new figures obtained by the RCM.

The statistics come following a parliamentary question by MP Andrew George.

They show that five of the English regions cut spending on maternity services in 2012-13. The East Midlands cut 15% of its spending in 2012. Spending fell by 6% in London and Yorkshire and Humber, while the North East and South West also had small cuts.

Figures show too, that the North East is the only English region meeting the recommended midwifery staffing levels.

The RCM recommends a midwife-to-birth ratio of 1:28 per year as a minimum, but the current average for England is 1:33.

Cathy Warwick, RCM chief executive, called the figures ‘worrying’ and said that ‘urgent attention’ is needed.

‘There is not one midwife practising today who has seen this level of births and demands on maternity services,’ she said.

‘I am constantly meeting midwives and far too often they are telling me of the unprecedented demands on their time and their struggle to deliver the safe, high-quality care they aspire to.

‘Health bosses are cutting spending blindly and we have yet to see the impact of this on staff numbers and on the care women are receiving.

‘We recognise many regions are working hard to improve maternity services but these figures show there is still much to do.’

There were some spending increases, including a 7% rise for the South East coast and almost a 4% rise by the east of England and South Central.

The North West and West Midlands have also seen very small spending increases over the past year.

JOBS SHORTAGE

NEWLY QUALIFIED MIDWIVES STRUGGLE

An RCM survey found recently qualified student midwives are struggling to get jobs for the third consecutive year.

The online survey was conducted in October and emailed to the RCM’s student midwife and newly qualified midwife members.

It found that 33% of midwives who had started looking had not yet found a job as a midwife, rising from 32% in 2011 and 2012.

Cathy Warwick, chief executive of the RCM, said: ‘The government argues that it has increased the number of student places to address the shortage of midwives.

‘However, given the findings of our survey, we do not believe that merely increasing the numbers of student placements is enough.

‘The government urgently needs to address funding for maternity services so NHS trusts and boards can employ more midwives, otherwise we are pouring taxpayers’ money down the drain and training student midwives who can’t get jobs.

This is such a waste of talent.’

In addition, 45% of midwives who had not yet secured a job had been looking for a post for more than three months.

Only 37% of the midwives who had not yet found a job were optimistic about their chances of securing a post as a midwife.

Despite these factors, 87% of recently qualified midwives said they would still recommend midwifery as a career.

One newly qualified midwife said: ‘More women seem to be high risk or have complex needs, which are often not being met due to time constraints and pressures on the ward.

‘I thought there would be plenty of job opportunities, but so far there have been none.’

The RCM calculates that there is a shortage of 4800 midwives, partly because the registered midwifery workforce is ageing.

MATERNITY FEEDBACK

FRIENDS AND FAMILY TEST FOR MATERNITY UNITS

NHS England has begun asking the Friends and Family Test (FFT) question in every NHS maternity unit across the country.

The FFT question, where patients are asked if they would recommend the same service to a friend or family member, has previously been in use on A&E and acute inpatient units.

NHS England will gather views at three points: in antenatal care, birth and postnatal care.

Jane Cummings, NHS England’s chief nursing officer, said: ‘Maternity staff work hard to provide excellent services for women across the NHS.

‘The Friends and Family Test provides an additional opportunity to capture feedback relating to maternity services.

‘It builds on the culture of responsiveness to women’s experiences of care in real time, encouraging swift interventions when required, as well as providing positive feedback for staff when things go well.

‘We are making sure that every pregnant woman or new mother has an opportunity to be heard.’

The first results for maternity services will be announced in January 2014.
PAY AND CONDITIONS

‘FACING THE THIN END OF THE WEDGE’

A survey shows an undercurrent of resentment about working pay and terms and conditions. A total of 36% of those surveyed said they often think about leaving their NHS trust, while 29% of those with less than 10 years’ service said they would look for a new job in the next 12 months.

A total of 36% of the respondents opposed performance-related pay. Less than half said that they felt a sense of belonging to their NHS trust, while more than half were dissatisfied with the recognition they received from their employer for ‘good work’ and the value placed on their work by their NHS trust. A total of two-thirds of the respondents opposed performance-related pay.

→ The online survey found that 33% of midwives who had started looking had not yet found a job as a midwife

MONEY FOR BREASTFEEDING

NEW STUDY UNDERWAY

Research on financial incentives for breastfeeding mothers is being undertaken by the University of Sheffield. The project – Nourishing Start for Health (NOSH) – has been designed to test the feasibility and deliverability of offering financial support for breastfeeding in the form of vouchers.

It is being trialled in areas of South Yorkshire and Derbyshire that have low six- to eight-week breastfeeding rates. It is hoped that offering vouchers to mothers will increase the prevalence and duration of breastfeeding.

However, Janet Fyle, professional policy advisor at the RCM, believes that financial incentives for breastfeeding are not the only solution. She said: ‘While we are not against financial incentives for the right reasons, there is a much bigger social and cultural problem here that needs to be tackled instead of offering financial incentives for mothers to breastfeed. ‘In many areas, including those in this study, there are generations of women who may not have seen anyone breastfeeding their baby, meaning it is not the cultural norm in many communities.

‘The motive for breastfeeding cannot be rooted by offering financial reward. It has to be something that a mother wants to do in the interest of the health and wellbeing of her child.’ Janet said that poor rates of breastfeeding in the UK are ‘a major public health issue and one of inequalities’.

Cathy Warwick, RCM chief executive, said: ‘Maternity staff are being required to work harder to meet the increasing demands of the service during the baby boom, including performing a growing amount of unpaid work. ‘While maternity staff remain committed to mothers and their families, I feel that the good will and kindness of midwives is being eroded and that our members are facing the thin end of the wedge.’

51% of women said gaining weight in pregnancy affected their self-esteem

225,000 pregnant women in need of health care in the Philippines, following typhoon Haiyan

45.6% flu jab uptake for frontline healthcare workers in 2012-13
The challenges facing midwifery are the same as 20 years ago, it is claimed.

The 1993 Changing childbirth report called choice, control and continuity of carer for the mother as the most important tenets of maternity care.

On the 20th anniversary of its publication, the report is said to be ‘as relevant today as it was then’.

The statement was made at a witness seminar held at the RCOG, which included many of the key figures behind the report discussing its legacy.

Sir Nicholas Winterton, former chairman of the Health Select Committee and honorary vice president of the RCM, said: ‘Changing childbirth is as relevant today as it was then. But we should be making further progress. It is unfinished business.’

Mavis Kirkham of the University of the West of Scotland said that the report ‘has had a profound effect on rhetoric, but not a profound effect on practice’.

The panel agreed that women’s choice, control and continuity of carer needs are not being uniformly met by current NHS maternity services.

Cathy Warwick, RCM chief executive, said: ‘At the time of Changing childbirth, all the groups came together with a government that was interested in making change.

'A major challenge today is knowing how to get leverage between working together with the government and NHS England to make change happen in a very different context to Changing childbirth. ‘I, for one, will be going away and thinking about how to make this happen.’

The Changing childbirth report was produced by the Expert Maternity Group.

It focused on the importance of midwives and reversed the policy that hospital is always the safest place for birth.

The NMC met its key performance indicator to impose 80% of interim orders within 28 days of receiving a referral.

In the past year, the NMC met its key performance indicator to impose 80% of interim orders within 28 days of referral.

It has also completed investigations within 12 months in 86% of cases, against a key performance indicator of 90%. The average time to complete investigations was 11 months.

The news comes in its annual reports, accounts and fitness-to-practise report, covering April 2012 to March 2013.

Jackie Smith, NMC chief executive and registrar, said: ‘These reports reflect a year of substantial transformation for the NMC as we worked to become a more effective and efficient regulator, focusing on protecting the public.

‘In the last year, we launched our corporate plan, introduced new Midwives rules and standards, rolled out a new risk-based approach to quality assurance and improved the information available to the public about midwives and nurses who have been suspended or have been struck off the register.

‘We also introduced voluntary removal and consensual panel determination, which have provided us with more efficient fitness-to-practise processes.

‘We are now focusing on maintaining progress and continuing to deliver the changes and become the regulator that patients, public and professions are right to expect.’

The NMC met its key performance indicator to impose 80% of interim orders within 28 days of receiving a referral.
MIDWIFE RESILIENCE

‘WARRANTS SERIOUS CONSIDERATION’

New research into the concept of resilience, funded and supported by the RCM, has been published. The research was undertaken by RCM professor of midwifery Billie Hunter, and Lucie Warren, research associate at the School of Healthcare Sciences at Cardiff University.

The study explored clinical midwives’ understanding and experience of resilience, and modelled the concept in collaboration with a panel of experts.

The authors said: ‘By understanding more about resilience, it may be possible to better nurture novice midwives and those experiencing workplace stress.

‘Resilience is not about becoming tough or hardened, rather it is characterised by adaptability, self-knowledge and emotional awareness.

‘This study indicates that resilience is a complex phenomenon, which warrants serious consideration from clinical midwives, managers, educators and also researchers.’

A group of 11 midwives, who self-identified as resilient and each had more than 15 years’ experience of hands-on clinical practice, participated in online discussions for the study.

The findings of these were discussed with experts in midwifery workforce research and resilience studies.

The objectives of the study were to identify the factors considered to contribute to or act as barriers to resilience and to explore how the resilience of student and newly qualified midwives might be enhanced.

The report is available to download from the Cardiff University website.

OLDER MOTHERS

NUMBER INCREASING, FIGURES SHOW

Figures show that almost half of births in England and Wales are to women aged 30 and over. According to the Office for National Statistics, babies born in England and Wales in 2012 were most likely to have a mother aged between 25 and 34, with 57% of mothers in this age group. A further 23% of babies were born to younger mothers (aged under 25), while 20% had mothers aged 35 and over at the time of birth.

The number of births to mothers aged 25 to 34 was more than double the number to mothers aged under 25.

Overall, 49% of births were to women aged 30 and over. Nearly two-thirds (65%) of fathers were aged 30 and over.

Cathy Warwick, RCM chief executive, said: ‘This demonstrates very starkly the changing demographics of childbirth. Older mothers tend to have more complications and often need additional care from midwives and maternity services. This places additional pressure on time and resources.

‘These figures feed into the wider pressures on maternity services. Other issues, such as rising levels of obesity, are also leading to births becoming more complex,’ she concluded.

2014 SHORTLIST REVEALED

The shortlist for the RCM Annual Midwifery Awards 2014 and details of the ceremony have been announced.

There are three candidates shortlisted in each category, details of which are available on the awards’ website.

Louise Silverton, RCM director for midwifery, said: ‘We’ve had the biggest number of entries that we’ve ever had and they are incredibly varied, covering all sorts of aspects of care.

‘There was such a huge variety and it was extremely hard to sift them down to this level.

‘It is great that we are seeing new trusts applying and being shortlisted, and that we have received entries from all over the UK, which shows that all midwives and MSWs are trying to do something positive.’

The winners will be announced at a ceremony, hosted by Natasha Kaplinsky, in London venue The Brewery on 22 January.

The afternoon will start with a drinks reception and lunch, after which the winners will be named.

Booking for the ceremony is open now. There are special rates available for RCM members and group discounts for those who book a table of 10.

Louise added: ‘It’s a really great occasion. It’s a chance to celebrate midwives and MSWs and see how so many are going that extra mile to meet the needs of women and their families.’

For further details, and to book tickets, visit: rcmawards.com

For further details, and to book tickets, visit: rcmawards.com
Global news / Headlines around the world

SPAIN
Air Pollution Link to Low Birthweight

A European cohort study into ambient air pollution and low birthweight has found links between pollutants and reduced fetal growth.

The team of researchers was led by Dr Marie Pedersen from the Centre for Research in Environmental Epidemiology, Barcelona.

Overall, the study included 74,178 women with singleton deliveries between February 1994 and June 2011 across 12 European countries.

One of the researchers said, “We have shown that ambient air pollutants and traffic density are associated with increases in the risk of low birthweight at term and reductions in birthweight and birth head circumference.

‘Our findings suggest that in-utero exposure to ambient pollution in European urban areas could explain a substantial proportion of cases of low birthweight at term.”

TANZANIA
Schoolgirl Pregnancy Tests Details of forced pregnancy testing and expulsion of pregnant schoolgirls in mainland Tanzania have been published in a new report by the Centre for Reproductive Rights.

According to the report, school officials use these practices in an effort to prevent premarital sex and pregnancy. However, reproductive health education and services are minimal; only 11% of sexually active teenagers aged between 15 and 19 report using any form of contraception.

Evelyne Opondo, regional director for Africa at the centre, said: ‘If the Tanzanian government really wants to align with international human rights goals. However, executive director of the Action Group for Health, Human Rights and HIV/AIDS, Dennis Odwe, said that low staffing in health centres was affecting maternal health.

Statistics show there is one midwife for every 11,000 women in Uganda.
THE UK LEGAL framework for protecting young girls from undergoing female genital mutilation (FGM) has been in place since 1985.

But renewed commitment to tackling the crime on the front line has been shown in the form of a new report; the result of a coalition between royal colleges, trade unions and human rights organisation Equality Now.

Launched at the House of Commons on 4 November, the report, entitled Tackling FGM in the UK: intercollegiate recommendations for identifying, recording and reporting, makes nine recommendations for healthcare professionals.

It also says girls who have had their sexual organs cut should be referred to the police and other services.

The recommendations include treating FGM as a form of child abuse, implementing a national FGM awareness campaign similar to those highlighting domestic abuse and HIV, and holding frontline professionals accountable against agreed standards.

At the report’s launch, RCM chief executive Cathy Warwick said: ‘I really hope this report accelerates everybody’s work to try and prevent FGM happening.

‘What is being asked for really isn’t a lot – it is about everybody being aware of the problems that FGM causes and doing their bit to raise public awareness, and then to make sure that people who are letting this practice continue to happen are held to account.’

It is reported by the charity Forward that in 2007, 66,000 women in England and Wales are estimated to have undergone FGM, while more than 24,000 girls under 15 are potentially at risk of suffering the practice.

The UK law imposed in 1985 was updated in 2003 to extend rights beyond borders, with offenders facing a prison sentence of up to 14 years.

Keith Niven, detective chief superintendent of the Metropolitan Police Service, said: ‘This is a hidden crime – we have very few referrals to the police.

‘Girls are terrified of talking about this subject and they need to be empowered.’

Other recommendations outlined by the report include documenting and collecting information regarding FGM and sharing it systematically, identifying girls who are at risk and referring them as part of UK child safeguarding procedures, and reporting cases of FGM.

Speaking at the launch, MP Jane Ellison, parliamentary under secretary of state for public health, said: ‘We all know that no single change will automatically bring about an end to FGM in the UK.

‘I’m hoping with colleagues across government that we’re giving a very clear, political direction that this is not acceptable, that we expect people to take action and that we won’t, in any way, be looking to blame people that do want to speak out.

‘We have the will, we have the expertise. This is surely our time,’ she added.

Efua Dorkenoo, executive director of Equality Now, said that, while the UK is well on its way to developing a ‘joined up’ response to FGM, there is a need to ‘redouble our efforts’.

‘This is only the beginning,’ she said.

As a new report launches around the recognition and treatment of FGM victims by healthcare professionals, Midwives looks at the key recommendations.

A UNITED FIGHT AGAINST FGM

66,000 WOMEN IN ENGLAND AND WALES ARE ESTIMATED TO HAVE UNDERGONE FGM
**Headlines**

**RCM news / The latest stories**

**RCM NEWS AND DATES**

**CONFERENCE SUCCESS**

November saw another successful gathering of midwives, MSWs, student midwives and workplace representatives at the RCM Annual Conference in Telford. See pages 44-45 for a round-up of the conference highlights. Also, look into our brand new Education Conference, which is being held at the Institute for Education, London on 31 March 2014.

► Visit: rcm.org.uk/rcm-events

**RCM PUBLICATIONS**

There are now three new publications available to download from the RCM website, including Working with Birthrate Plus and Trends in freestanding midwife-led units in England and Wales 2001-2013 and the State of maternity services report 2013, which will be launching in December, so keep an eye on the website for the latest content and analysis from the RCM policy team.

► Visit: rcm.org.uk/rcm-events

**I-LEARN UPDATE**

More courses have been added including Genetics and genomics for midwifery practice, Coping with crying and Preventing non-accidental head injury. There’s never been a better time to log on, with over 40 courses covering a range of topics and all free to RCM members and certificated on completion.

► Visit: rcm.org.uk/ilearn

**RCM POLL**

How confident, on a scale of 0 to 10 (0 meaning ‘not at all confident’), do you feel about teaching pelvic floor muscle exercises to prevent incontinence?

► Email your responses to: colin.beesley@rcm.org.uk

---

**MARY SEACOOLE AWARDS**

**CLINICAL MIDWIFE IS HONOURED**

A clinical midwife has won a Mary Seacole Award of £6250.

Kate De Freitas, from Dartford and Gravesham NHS Trust, was one of three development award winners for her project, ‘Responding to a changing demographic horizon through the exploration and development of midwives’ cultural competency training’.

RCM director for midwifery Louise Silverton said: “These awards are groundbreaking in improving care for black and minority ethnic (BME) communities. They enable winners to showcase their talent and develop innovative midwifery and nursing leadership skills by improving safety, the service user’s experience and clinical effectiveness in midwifery and nursing practice and service delivery.’

The Mary Seacole Awards are open to all midwives, nurses and health visitors. The ‘development’ award supports projects that benefit the health needs of people from BME backgrounds.

**HONORARY RECOGNITION**

**UNIVERSITY REWARDS CEO**

Buckinghamshire New University has awarded RCM chief executive Cathy Warwick an honorary doctorate for her exemplary contribution to the midwifery profession as an expert and accomplished leader and negotiator.

Cathy said: ‘I am absolutely delighted to receive this award and would like to extend my thanks to the university for the recognition. In my working life, positive feedback from my fellow midwives and nurses has always meant a great deal. They are the best judges of my effectiveness.’

**WEIGHT MANAGEMENT**

**NEW RESOURCE**

We are delighted to announce the launch of a new website full of advice and health tips for women with one of our Alliance partners, Slimming World.

The resource has been developed following recognition that there are many confusing and conflicting messages about how women should manage their weight before, during and after pregnancy.

The new website provides clear information to improve the health of women and to help them pass on healthy habits and lifestyles to their families. Enclosed with this issue are five information cards with a link to the website, which can be given to women in your care.

► For additional copies of the card, visit: rcm.org.uk/college/about/alliance/slimming-world

---

**RCM website, including publications available to download from the RCM website, which can be given to women in your care.**

**Email your responses to: colin.beesley@rcm.org.uk**
NORTHERN IRELAND

TERMINATION GUIDANCE
Over the summer, I visited maternity units throughout NI where I listened to the views of RCM members before submitting our response to the latest Department of Health, Social Services and Public Safety’s (DHSSPS) guidance on termination of pregnancy in NI.

During my discussions with various midwives, I was struck by their professionalism and compassion for women who face the devastating news that their much-wanted baby has a serious and sometimes lethal fetal anomaly. The primary concern of the midwives I spoke to was the health and wellbeing of women and their families in very difficult circumstances. It is heartening to hear that the draft guidance is to be further revised and that the views of those providing direct care to women and their families are to be considered in any future guidance. We’ll keep you updated as matters develop.

DATES FOR THE DIARY
We recently held the 19th joint RCM/INMO annual conference in Dublin, which was extremely well evaluated by those who attended. Planning is now underway for the joint DHSSPS/RCM/RCOG/PHA/LSAMO conference on 27 March 2014, so put the date in your diary.

The RCOG has also invited midwives to attend the second conference on 27 March 2014, so put the date in your diary.

ENGLAND

FGM UPDATE
A consensus intercollegiate symposium on the critical issue of female genital mutilation (FGM) was held in London in September. The partnership includes the RCM, RCOG, RCN, Community Practitioners and Health Visitors Association and Unite, alongside other key stakeholders including the police. It aims to develop recommendations for health and social care professionals.

It is hoped that all professionals working with women, children and young people who are in the ‘at risk’ groups will be better educated and informed. The intercollegiate guidelines were launched in parliament on 4 November (see page 13). All midwives need to be aware of the recommendations and follow the guidance if we are to eradicate this practice.

BRANCH ACTIVITY
If you haven’t previously thought of how you might contribute to RCM activity in your local branch, then it’s time to speak to your local steward or to the team in the Ni office. The RCM is only as strong as its members and that’s every one of you. So, whether you attend an RCM event, volunteer as a steward or a branch officer or sit on a working group as an RCM representative, the RCM needs you. We’ll be taking the show on the road again in 2014 to discuss how you can all contribute to the work of the RCM. I look forward to meeting many of you and in the meantime have a lovely Christmas and New Year.

BIRTH CENTRE NEWS
Congratulations to everyone at Bradford Birth Centre, which has birthed 1400 women since opening in January 2013. HoM Julie Walker and the birth centre midwives say it’s the best place in the country to work.

PELVIC HEALTH
The RCM partnership working with the Chartered Society of Physiotherapists (CSP) on the importance of pelvic health continues. The publication of a joint statement about incontinence was well received and we are now working to review the current information for women. For more information and the CSP statement, see page 48.

GMTP
The Global Midwifery Twinning Project between Cambodia and England is more than halfway through. RCM volunteers have travelled to Cambodia’s capital Phnom Penh and to the provinces, where they have already made an impact on the Cambodian Midwives Association (CMA) in terms of capacity building.

Their advice, expertise, teaching and sharing of information has also made a difference to the CMA. I had the opportunity to visit the National and Child Health Centre in Phnom Penh and met some wonderful midwives in the clinical areas.

GMTP

Jacque Gerrard
Director
RCM England
Midwives make up 2% of the NHS workforce. In other words, for every 50 people who work for the health service, just one is a midwife. Despite being such a small proportion of the workforce, the RCM is an active voice in the health debate, punching well above its weight.

Take the party conferences, for example; this year, as in previous years, the RCM joined two other organisations to sponsor the health debate at each conference’s fringe. At the Liberal Democrats’, it meant we had the chance to quiz health minister Norman Lamb. At Labour’s, the speaker was Andy Burnham, the shadow secretary of state for health, and we had the chance to challenge him and pitch our ideas. Finally, at the Conservatives’, we heard from Stephen Dorrell, who heads the cross-party health select committee of the House of Commons. All three are key influencers in our national health debate.

For the first time this year, the RCM also attended part of the Green Party’s autumn conference, as the party has been very supportive of midwife-led care in the past. The Greens have an MP, a peer, two members of the Scottish parliament and two members of the London Assembly.

The RCM works hard to be heard in the political debate and we make sure that politicians know midwives’ concerns. We constantly remind them, for example, of the baby boom and the impact this has on the workload of midwives.

Another example of the influencing work we do is our annual State of maternity services reports. Two have already been published, winning television, newspaper, radio and internet news coverage; the third (the 2013 edition) is currently being written and will be launched in parliament in December.

It is perhaps for this reason that midwife numbers have risen by 1381 since the election, continuing an upward trend under the last government, compared to an overall fall in NHS staff numbers of 24,658 (both figures are full-time equivalent) over the same period (Health & Social Care Information Centre, 2013).

The attention of the RCM is now turning towards the next election, with polling day pencilled in for 7 May 2015. We are drawing up ideas for our own manifesto, which we can put to the parties and individual candidates up and down the country in the run-up to polling day.

We have some ideas, particularly about the importance of maternity care giving every child the best possible start in life, but we want to hear from you too. If you have ideas that you think we should be putting to the mainstream parties for possible inclusion in their manifestos, let us know. You can email me at: stuart.bonar@rcm.org.uk

Stuart Bonar
RCM public affairs advisor

For the reference, visit the RCM website.
Headlines

Work life / Amy Leversidge

PRESENTING THE FACTS

Amy Leversidge describes the evidence being put forward to the NHS Pay Review Body.

EVERY YEAR THE RCM SUBMITS evidence to the NHS Pay Review Body (PRB), which uses it to determine pay uplift for the following year. However, since becoming chancellor, George Osborne has not allowed the PRB to act independently and has demanded a pay freeze for two years, while capping the pay uplift at 1% for the next two years.

Despite the fact that the pay uplift of 1% is below inflation (representing a real terms pay cut), the Department of Health (DH), NHS Employers and the Foundation Trust Network want to return to a pay freeze. There are also calls, led by George Osborne, to end incremental progression.

In the RCM’s evidence to the PRB, we included our findings from our annual HoMs survey, which is sent to all HoMs in the UK. This year, the survey showed some very interesting results; in particular, how maternity units in the UK are struggling to meet the demands of the service, with HoMs frequently having to redeploy staff to cover essential services, calling in bank and agency staff, withdrawing ‘non-essential’ services and closing maternity units.

Additionally, the HoMs survey replicated previous years, revealing that there have been more cuts to training, and development opportunities are decreasing further with continued downbanding of band 7 posts. Around 40% of HoMs report that there have been incidences of bullying, harassment and abuse in their unit too.

As well as evidence from our annual HoMs survey in April, the RCM commissioned Professor Ian Kessler from King’s College London and Richard Griffin from Buckinghamshire New University to conduct independent research into attitudes to pay, job satisfaction, morale, commitment and career development opportunities against the backdrop of service reform and increasing demands. The research comprised a nationwide survey of members and two focus groups; one in London and one in the South West.

Some 1025 RCM members responded to the survey, which found that while the vast majority are highly motivated and committed to their roles, loyalty to their trusts is fragile and limited, and there is a high level of dissatisfaction with pay. Key findings revealed that 83.2% said they are ‘very dissatisfied’ or ‘dissatisfied’ with their last pay rise and 76.7% said they ‘strongly disagree’ or ‘disagree’ with the statement: ‘I am paid fairly considering the responsibilities of my job.’

In addition to feedback from our surveys, we also included evidence about the rates of inflation compared to the rates of pay in the NHS. The pay freeze started in April 2011, when retail price index (RPI) inflation was at a high of 5.2%. RPI inflation has come down since then but has stayed fairly consistent at around 3.2%, resulting in a continued devaluation of NHS employees’ pay, and with recent announcements by energy companies raising their prices, we are seeing a real crisis in the cost of living.

Furthermore, we highlighted how the costs of working have risen in the last year, with the NMC increasing its registration fee by 31.6% from £76 to £100. If midwives are unable to pay the registration fee, they will not be able to legally practise as a midwife.

Also, NHS employees have seen their pension contributions rise substantially, with the majority of midwives seeing their contribution rise from 6.5% to 9% in the last

→ Incremental progression cannot act as a substitute for an annual increase on basic pay.
two years, with a further increase planned in April 2014 to 9.3%.

We strongly argued that incremental progression cannot act as a substitute for an annual increase in basic pay. Incremental progression represents reward for increased skill and experience as agreed under the Agenda for Change framework.

The Francis report into the failings at Mid Staffordshire NHS Foundation Trust emphasised the importance of having an organisational culture that promotes high-quality care. Many research studies have shown that the more positive experiences of staff within an NHS trust, the better the outcomes for that trust, both in terms of patient care and financial performance – in particular, making savings through improving patient outcomes and staff sickness absence rates.

We also argued that maternity units are facing unprecedented challenges, with units understaffed and staff overworked. There has not only been a reduction in training, but in band 7 posts too, so there are fewer opportunities for talented midwives to progress and less leadership on the unit. Staff are not feeling valued, there are high levels of bullying, harassment and abuse, and perceptions of discrimination – particularly in London trusts. Staff are redeployed to other areas of work to cover essential services and units rely on bank and agency staff.

Improving staff engagement cannot only improve a trust’s financial performance through savings on litigation costs and sickness absence rates, but it has a direct impact on client outcomes. Midwives and MSWs have never been so challenged in their ability to provide high-quality and safe care.

Despite submitting strong evidence to the PRB, NHS Employers, the Foundation Trust Network and the DH have all included evidence arguing that NHS employees should be given a pay freeze for the next year. NHS Employers added to this by stating that, in their view, the changes to Agenda for Change that were agreed earlier in 2013 are ‘only a start’ to changing terms and conditions. Despite saying that the NHS staff are their ‘greatest asset’, the DH said that the 1% that the government has made available for pay would be best spent ‘modernising the national pay frameworks to ensure there is a better balance between pay, performance and productivity, rather than time served’. The Foundation Trust Network argues that there should be no pay award next year, but there should be ‘significant changes to pay, terms and conditions’.

Hopefully, as we (and the other NHS trade unions) have presented strong evidence to the PRB, they will award the 1% uplift as originally promised. However, what is clear is that the government and employers have not lost their zeal for cutting pay, terms and conditions in the NHS.

To read the RCM’s evidence to the PRB, visit: rcm.org.uk/college/support-at-work/pay

Illustration: Nick Radford

Amy Leversidge
RCM employment relations advisor
Thoughts, views and your feedback

Opinion

Birte Harley-Lam / One-to-one

Hitting the ground running

Birte Harley-Lam talks to Hollie Ewers about the first few weeks in her new role and what lies ahead.
One-to-one / Birte Harlev-Lam

With previous roles as director of midwifery, general manager of women’s and children’s services, HoM, strategic lead of maternity services and deputy director of nursing, quality and patient safety, it’s not hard to see why Birte Harlev-Lam’s 30 years of experience landed her a role in the newly formed NHS England as head of maternity and children’s services.

‘I’ve definitely had to hit the floor running,’ says Birte, who was one of the last few people to join the NHS England team after it came into effect in April.

‘There were a lot of people waiting for me to start, so it was very welcoming, but busy, as the same week I started in November, the National Audit Office report into maternity services was published. So a lot of what I’ve been doing has been looking through the report and thinking about how it impacts on maternity services in general. I’ve also had to think about how NHS England can respond to some of the challenges that’s set within it and what we need to do,’ she adds.

As the first major piece of work she’s been involved in, Birte admits she is still finding her way. A member of the nursing directorate of NHS England, headed up by chief nursing officer Jane Cummings, the remit of Birte’s team is to make sure that they work with all staff – midwives, nurses and care staff – to deliver high-quality, safe care to patients. ‘A lot of my work is around policy development strategy, but also providing professional advice to a variety of people – whether they are other NHS organisations, such as Health Education England, the Department of Health or even the senior team in NHS England. It’s an advisory role but it’s about identifying what we need to do and how we can work with commissioners to get good service specification.’

Since April 2013, NHS England has taken on many of the functions of the former primary care trusts with regard to the commissioning of healthcare services. Explaining NHS England’s role further, Birte says: ‘In a sense, it’s a commissioning body, although the actual direct commissioning of maternity services takes place at the clinical commissioning groups (CCGs). What we can do in NHS England, and within my clinical role, is provide professional support and advice to all maternity services. We can also provide professional advice to the CCGs. ’It’s also about having conversations with social enterprises, such as Neighbourhood Midwives and One to One, as well as with HoMs, and just finding out if there are any gaps in the services, so for example, we know with the shortage of midwives that actually quite often home birth services are suspended on an adhoc basis because of capacity staffing issues. So is that an area, perhaps, where social enterprise might be able to step in?’ she asks.

When questioned on the process of commissioning outside the NHS and whether it’s the right path for the NHS to take, Birte explains that the commissioning and buying of services now sits closer to where the care is being delivered, and how vital it is that, in maternity services, HoMs know who their maternity commissioner is within the CCG.

‘It’s important that they meet with them face to face too,’ she says, and that both the commissioner and HoM understand their local population, the demographics and what their population needs. ‘If they come together and talk that through, then between them they can decide what the services should look like and then I think it will work,’ she adds.

But does Birte envisage that commissioning could eventually lead to the privatisation of maternity services?

“I would like to see an improvement in outcomes, but I’d also like to see midwives step up and really see themselves as leaders and as holding the health of the nation in their hands”
‘I don’t think there’s a big risk that maternity services will become fully privatised,’ she says. ‘Not in the same way that you might have private surgery or gynaecology, for example, where you have elective surgery in big private hospitals. The reason behind that is to do with the cost of insurance and the risk that is associated with maternity services,’ she explains. ‘What I think social enterprises bring is they work within an NHS set up and they deliver care that compliments the NHS set-up, rather than a private service which is in competition.’

Fully aware of the other big issues facing maternity services, Birte agrees that staffing and capacity is a major one. ‘We know there is a shortage of midwives and that it’s not just about training more midwives but actually it’s more about whether there are the jobs available when they qualify, and about making sure that there is money to fund the jobs.’

More long-term concerns on Birte’s agenda include obesity and smoking, which she admits extend beyond just maternity. But, only a few weeks into her post, Birte has a strong sense of what she hopes to achieve. ‘What I’m hoping to see is that I’m able to support services to deliver improvements. That’s not to suggest that services are not delivering good care, because they are and we know that women are increasingly more positive and satisfied with the care they’re receiving, but there’s always room for improvement and that is my role – it’s about making sure we can have better health outcomes.’

One of the areas Birte sees where improvements in outcomes are needed in particular is the perinatal mortality rate in England. ‘We know that we have a lot of babies dying, either in pregnancy or in the first week after birth, and our numbers are higher than most of industrial Europe – certainly higher than Scotland, Wales and Northern Ireland – so there’s something we’re missing or not doing right and that will be one of the things that I’m definitely going to be looking at.’

When asked how she hopes she’ll make a difference, Birte thinks for a moment and answers: ‘I would like to see an improvement in outcomes but I’d also like to see midwives step up and really see themselves as leaders and as holding the health of the nation in their hands, because if we get care right for mothers and babies then that is really going to impact.

‘Midwives are very skilled. They are a tremendous talent and source of leadership, but I’m not sure that they always recognise it themselves. So, by the time I leave this post, if I’ve been able to influence more midwives to see themselves as leaders and as holding the health of the nation in their hands, because if we get care right for mothers and babies then that is really going to impact.

All about Birte
► Started her career as a general nurse
► Qualified as a midwife in 1987
► Became a SoM in 1997
► Completed an MA in health law with commendation at the University of Hertfordshire (2001)
► Director of midwifery at Royal Free Hampstead NHS Trust (2002)
► General manager, women’s and children’s services at Royal Free Hampstead NHS Trust (2006)
► HoM at Cambridge University Hospitals NHS Foundation Trust (2007)
► Strategic lead maternity services at NHS Midlands and East (2010)
► Deputy director of nursing, quality and patient safety at NHS England – East Anglia (January 2013)
► Head of maternity and children’s services, NHS England (November 2013).
Opinion

Feedback / Have your say

Midwives thrives on your letters and emails. Here is a selection of the ones that caught our eye this issue.

A CUTTING EDGE EXPERIENCE
I felt the need to write with reference to the article by Jan Wallis on dietary protein intake and gestational diabetes mellitus (GDM) (Issue 5 :: 2013) as a previous GDM woman.

I was first diagnosed during my third pregnancy, when I was two and a half stone heavier than I am now. I ended that pregnancy using insulin injections and with an emergency CS to a 4.15kg daughter, having struggled to deliver naturally.

When pregnant with my fourth child, I was much healthier and opted to follow a vegan diet. Although my glucose tolerance test result was only just over the acceptable level, my consultant classed me as a GDM woman once more, and throughout the pregnancy warned me that I wasn’t ‘allowed’ a home birth, waterbirth or normal birth, and that my baby would be huge.

I was the fittest and healthiest I’d ever been - I had a BMI of 24 and exercised regularly. I didn’t require medication once and this was the only one of my pregnancies where I was not iron deficient.

I was very pleased when, at 39 weeks, I gave birth to a 3.4kg boy within an hour of arriving on the antenatal ward, naturally and without pain relief. It was the easiest pregnancy and birth of all - I recovered incredibly quickly and lost my pregnancy weight in record time.

I attribute this wonderful experience to my healthy, vegan lifestyle, but have questioned ever since why my consultant and his team did not suggest reducing my intake of meat and dairy products.

With obesity ever on the increase, I feel it is imperative that more women are influenced to rethink their diet and exercise regimes. This is not to discourage women from enjoying food, but to train them to make small changes with a view to keeping themselves and their babies healthy, now and in the future. As the world’s natural resources are declining and the human race increasing, it makes sense to lean towards eating a more plant-based diet.

I would love to see more research in this area for healthcare professionals to use in their evidence-based practice. Thank you for highlighting this subject.

Leah Wise
Student midwife

SHOCKING MYTHS
I am writing in the hope that you will be able to help dispel the long-standing myth that socket covers for electrical outlets protect babies and young children.

It’s widely believed that children can poke their fingers into power sockets unless covers are used, but UK sockets are required by law to have three design features that make them inherently safe. These are: having apertures too small for baby fingers, automatic shutters to prevent objects being poked in, and live parts being positioned deep inside the socket. Using additional unapproved measures reduces safety rather than increases it.

Caroline Haslett, the first female vice-president of the Royal Society for the Prevention of Accidents and a prominent electrical engineer, served on a 1944 government committee to report on the post-war electrical needs of the country.

They concluded that ‘to ensure the safety of young children it is of considerable importance that the contacts of the socket outlet should be protected by shutters or other like means’.

This resulted in the BS 1363 socket, produced in 1947, and, ever since, the UK has benefitted from the safest sockets in the world.

Yet the belief persists that these plug-in covering devices are essential to protect our children from shocks. Actually, no cover has the correct dimensions to safely fit into a BS 1363 socket and there is no standard or regulation.

Does this matter? Yes, because covers increase the risk of electric shock and oversize pins damage sockets, leading to overheating and fire when the socket is used.

The technical regulations manager of the Institution of Engineering and Technology has written: ‘Socket outlets to BS 1363 are the safest in the world and have been since they were first designed in the 1940s. Socket protectors are not regulated for safety, therefore, using a non-standard system to protect a long established safe system is just not sensible.’

Please help to dispel this myth. To learn more, visit: fatallyflawed.org.uk

David Peacock
Co-founder, FatallyFlawed
Hannah Stone / Upfront

**BREECH POSSIBILITIES**

Midwife **Hannah Stone** recalls her experience of a vaginal breech birth.

On a night shift, a phone call came through to the labour ward explaining that a woman had arrived at the birth centre contracting strongly. It was her first baby, her waters had broken and there was a history of precipitate labours in the family. She was 8cm dilated and the baby was breech.

I arrived at the birth centre as the second midwife and things had moved on – the woman had an urge to push. We now faced the question: to transfer or not to transfer? Although the presentation of the baby wasn’t typical, it was not necessarily abnormal, as some may believe, but it did mean that we were outside of the birth centre guidelines.

The evidence regarding the safest mode of delivery for breech babies is not clear cut, but the majority present at term in a ‘frank’ or ‘extended’ breech position, with legs extended at the hip and feet by the head. It is known that this type of breech is preferable if aiming for a vaginal birth. The buttocks alone were clearly felt on vaginal examination, so as far as we could determine, this baby was favourable to deliver vaginally.

An ambulance crew was present and we were aware that if we did not decide to transfer, we would need them to stay, but if they left, it would force our hand.

The other midwife and I talked through the pros and cons of transferring the couple into the main hospital. Was it safer to transfer, despite the fact that all things pointed towards a progressing labour and birth, and risk her delivering in the ambulance where we did not have much space or access to a clear area for resuscitation? Or, was it safer to stay put and remain quiet and calm, paying attention to the descent of the baby’s bottom and those sometimes very subtle cues that tell us, as midwives, that things are going either the right way or deviating off our preferred path?

The hospital was advising that we go in and the SoM and the consultant on call were informed of the situation. Despite their support, the pressure over our heads felt very heavy. Ultimately, it was the couple’s decision and it was our duty to be open and honest, and to provide them with all the information to make their choice.

Being in the room with a reassuring fetal heart and a labour that was progressing quickly meant we were not surprised when the couple said they wanted to stay. As a midwife, being there with what you know and being comforted by what you see helps you to stay focused and calm. That night, there was a strong desire to focus and attune to what I knew was reassuring – the baby gave us the cues we needed; all we had to do was make sure we didn’t miss them.

After an hour or so of pushing, a Mauriceau-Smellie-Veit was performed, and mother and baby sat together and proved to us all that breech birth is possible. I’m not saying that all breech babies should be born vaginally, nor am I implying that they should all be delivered via CS. I believe that if we have an otherwise low-risk mother, in spontaneous labour that has progressed rapidly, then isn’t it worth considering?

As I sipped my cup of coffee later on, I was truly satisfied and proud, not only of what we had faced together, but also of what we had achieved.

Hannah Stone
Midwife, Royal Hampshire County Hospital
You arrive at your new placement area thinking you’ll be able to show off your newly attained skills. But this confidence can soon give way to the realisation that your new mentor may not have the same approach as previous mentors. Each midwife is an individual with their own unique practice based on a number of factors. This variety should be embraced rather than met with apprehension, but it is sometimes easier said than done.

Mentors work hard to assess clinical abilities and, naturally, students strive to exhibit competent skills and knowledge when working together. An example of where students may feel uneasy adapting to a different approach is in the management of the perineum. The hands-on or hands-off technique during the second stage of labour is widely debated (Downe, 2011).

Studies into this element of the second stage are ongoing and, accordingly, there is a variation in approach by midwives depending on the situation and the preference of the woman in labour (Steen, 2012). In discussions and reflection with student colleagues, this is one of the points in which anxiety is keenly felt. Have you had time to discuss your mentor’s approach? What are the woman’s birth preferences? Which technique do you feel comfortable practising?

Your initial thought could be that your mentor will practise a similar technique to previous mentors and, while being assessed, you merrily demonstrate recently gained skills. This can be that moment when your heart sinks, as you realise your mentor advocates a different technique to you. They may correct you and wonder why you’ve not displayed the ‘right’ technique.

It is a good idea to debrief afterwards to explain the rationale for your preferred method. If there’s time, a quick chat about their preferred clinical techniques is useful, although if you feel strongly about a certain method – for example, using a hands-on technique for management of the perineum – discuss the evidence and combine this with their guidance.

Continuous communication with your mentor is key to preventing confusion and misunderstanding. You may hope that your mentor will guide you, so that you can repeat their technique and be assessed accordingly. However, it is important not to rely solely on your mentor to show you their preferred methodology – researching evidence and questioning clinical skills techniques is time well spent. It may also be useful to compare your experiences with those of your student colleagues, to find out about the methods and approaches they have learnt during their clinical placements.

Experiences of mentorship within clinical placements vary greatly and can affect the student learning experience (Prevost, 2011). However, elements of this variation in experience and approach to clinical skills may be advantageous. The benefit of working with different mentors is the breadth and depth of clinical skills that students are exposed to. And, as the women we care for are diverse, the variety of skills taught by mentors should be considered an aid to learning and development.

Embracing and critically analysing different approaches to clinical skills develops with each new placement, and hopefully those heart-sinking moments will become less frequent.

Bronwen Ryan
Student midwife
Kingston University

For references, visit the RCM website.
Top 10 tips for newly qualified midwives

1. **Go where the job is**
The sooner you get a job after qualifying, the better – even if it means moving somewhere new, although the practicality of this will depend on family commitments for some.

2. **Build a support network**
Probably the most important thing to do is to get good people around you and try to keep in touch with your classmates – it’s good to know people who are going through the same thing as you.

3. **Don’t practise beyond your capacity**
Sometimes this is easier said than done with the demands on services. But you need to remember that you are accountable for what you do and what you do not do.

4. **Don’t be afraid to ask questions**
No one thinks you’re stupid and you’re not expected to know everything. Asking questions will show that you’re keen to learn and improve.

5. **Keep studying**
Life-long learning is necessary for your professional development, and keeping up to date with new developments in midwifery will help you deliver evidence-based practice.

6. **Make friends with the staff**
Be friendly with all staff you meet, from the shift lead to the support staff, and become part of the team. You need them on your side and communication is key.

7. **Get to know the RCM**
Keep involved with what the RCM is doing for its members and for maternity services as a whole.

8. **Feel privileged**
Keep the passion for what you do going and, even if things get stressful, remember why you want to be a midwife.

9. **Focus on care**
Keep women-centred care at the heart of what you do, enabling and facilitating women’s choices to help give them positive birth experiences.

10. **Stay positive**
A positive mental attitude, a smile and being kind are important and can make all the difference.

► Thanks to Charlotte Elliott and midwives on Twitter for providing these tips.
On focus

On Midwifery

Current and completed midwifery research

Emma Godfrey-Edwards / Cutting edge

Continuity of care vs fragmented care

The researchers in this study assessed the clinical outcomes and costs of care for caseload midwifery compared to standard hospital maternity care within two teaching hospitals in Australia.

Standard care was based on a fragmented system, which lacked continuity of care throughout pregnancy, birth and postnatally.

The aim was to establish whether caseload midwifery care might reduce interventions – most notably CS – reduce costs and increase women’s satisfaction.

In this unblinded, controlled, parallel group trial, 1748 women aged 18 or over and less than 24 weeks pregnant at their first booking visit were randomly assigned to one of the two care systems – 871 were allocated to caseload care and 877 to standard care.

Unlike previous studies, this trial included women irrespective of their risk factors, although it excluded those who planned to have an elective CS, had a multiple pregnancy, or planned to book with another care provider.

Most of the primary clinical outcomes – women who had a CS, an instrumental birth, or an epidural during labour – did not differ between the two groups, and neither did the neonatal outcomes of Apgar scores, preterm birth and neonatal intensive care admission.

The proportions of unassisted vaginal birth – another primary maternal outcome – were 4% less in the standard care group than the caseload group (487 [56%] vs 454 [52%]; p=0.08). However, there was a drop in the proportion of women electing to have a CS before the onset of labour in the caseload group (69 [8%] vs 94 [11%]; OR 0.72, 95% CI 0.52-0.99; p=0.05).

The authors found that there was also an overall decrease in CS across both groups from the pretrial proportion of 29% (in one site) to 22% in the study population.

The most significant outcome of the trial was the reduction in the total cost of care per woman in the caseload group by AUS$566.74.

The authors concluded: ‘Our results show that for women of any risk, caseload midwifery is safe and cost-effective.’

Emma Godfrey-Edwards
Editor, Midwives

For women of any risk, caseload midwifery is safe and cost-effective
As explained in last issue’s How to (Baker, 2013), the third stage of labour is the period from the birth of the baby to the birth of the placenta and membranes (WHO, 2012; Begley et al, 2011; NICE, 2007). It comprises two distinct clinical approaches: physiological and active management.

Active management is recommended for all women by WHO (2012), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) (ICM and FIGO, 2006; 2003). However, NICE (2007) recommends that women at low risk of postpartum haemorrhage (PPH) who request physiological management should be supported, while the RCM (2012) and a Cochrane review (Begley et al, 2011) recommend that women should be given information on the benefits and risks of active and physiological management to support an informed choice.

There is no general agreement regarding the individual components of active management (WHO, 2012). Consequently, there are many variations in its management (Downey and Bewley, 2010; Winter et al, 2007). Active management does not rely on the woman’s body to produce oxytocin to contract her uterus causing the placenta to separate from the uterus wall and for her to birth the placenta. Instead, a prophylactic uterotonic drug (exogenous oxytocin) is given to the woman to induce contractility of her uterus, to make the placenta separate from the uterus wall quicker. Prophylactic uterotonic drugs are a key component in the reduction of PPH (WHO, 2012; RCOG, 2009). Other components of active management include clamping and cutting the cord and controlled cord traction (CCT).

During the antenatal period
The midwife needs to discuss with the woman her different care options regarding the third stage of labour. This will enable the woman to make an informed choice between physiological and active management.

Conducting active management
During an active third stage of labour, the midwife needs to continually observe the woman, monitoring her blood loss visually and how she feels and behaves (assessing for signs and/or symptoms of excessive blood loss), to ensure that the wellbeing of the woman and her baby is not compromised. The midwife also needs to ensure that the woman has an empty bladder (a full bladder can prevent the uterus from contracting effectively).

With the birth of the baby’s anterior shoulder, or as soon as practicable after the birth of the baby, a prophylactic uterotonic drug is administered by the midwife. The drug is given into the woman’s quadriceps muscle. The WHO (2012), a Cochrane collaboration (McDonald et al, 2004) and NICE (2007) recommend intramuscular oxytocin.

Where cord clamping is not delayed, the uterotonic drug should be administered early. Immediately after the drug is given and the baby is born, the umbilical cord is clamped in two places and cut between the clamps. One is applied to the cord, about 3cm to 4cm from the baby’s abdominal wall. A swab or gloved hand is held over the cord as it is cut, to prevent any...
mess from blood oozing from the cord. Once the cord is cut, the maternal end of the cord – often clamped with artery forceps – is placed into a sterile receiver close to the woman’s vulva (Harris, 2012). NICE (2007) advocates early cord clamping less than one minute after birth. However, the RCM (2012), WHO (2012), Resuscitation Council (UK) (2011), the RCOG (2009) and a Cochrane collaboration (McDonald and Middleton, 2008) recommend delayed cord clamping, because of the benefits to the newborn.

Where cord clamping is delayed by one to three minutes, the uterotonic drug should not be administered until the cord has stopped pulsating and has been clamped (McDonald and Middleton, 2008).

Once the umbilical cord has been clamped and cut, the midwife should place her non-dominant hand over the woman’s fundus and await signs of a contraction and signs that the placenta has separated from the uterus wall. When the uterus has contracted and signs of placental separation are evident, CCT is applied. The uterus is guarded by placing the non-dominant hand above the symphysis pubis, with the thumb and fingers stretched across the abdomen, palm inwards and pushing the contracted uterus upwards (Harris, 2012; Johnson and Taylor, 2010).

At the same time, with the dominant hand, the midwife should either grasp the cord clamp near the woman’s vulva or wrap her fingers around the cord near the vulva. Traction is then applied upwards, following the curve of Carus (Deneux-Tharaux et al, 2013; Harris, 2012; Tiran, 2012). As the placenta is birthed, the midwife should stop guarding the uterus with the non-dominant hand and receive the placenta with it, teasing out the membrane (Johnson and Taylor, 2010).

Consequently, the position of the uterus during CCT remains unchanged, reducing uterine inversion (Deneux-Tharaux et al, 2013). However, at present there is no evidence to support guarding the uterus to prevent uterine inversion (Harris, 2012).

CCT is best applied with the woman in a semi-recumbent or sitting position, with the dominant hand applying CCT close to the vulva (Harris, 2012). As the cord descends, the midwife’s grasp on the cord should be moved up to remain near the woman’s vulva (Johnson and Taylor, 2010). CCT may also be applied before signs of placental separation and descent have been seen (Tiran, 2012; McDonald, 2009).

If resistance is felt when applying CCT, stop applying it, relieving pressure from the dominant, then non-dominant hand. The midwife should wait for a minute before attempting CCT again, ensuring the uterus is contracted (Johnson and Taylor, 2010).

The time the placenta is birthed should be documented by the midwife in the woman’s labour notes. NICE (2007) recommends that the placenta should be birthed within 30 minutes in active management of the third stage of labour.

After the placenta has been birthed, the midwife should assess the wellbeing of the woman, the condition of her uterus, amount of blood loss, pulse, blood pressure, and the condition of the genital tract to identify any birth trauma. Findings should be documented in the client’s notes.

The woman should be assisted into a more comfortable position and soiled linen removed. The midwife should stay with her and the baby until the observations are within the normal range and the wellbeing of both is assured.

The placenta and membranes are then examined to ensure that they are complete and have no abnormalities. The total estimated amount of blood loss from birth should be recorded and the placenta and equipment disposed of correctly.

There are many similarities and differences in both physiological and active management of the third stage of labour. Midwives need to be competent and confident in promoting and conducting both, enabling them to provide safe care, as well as allowing the women they care for to make an informed choice.

Karen Baker
Midwife at Calderdale Birth Centre, West Yorks

For references, visit the RCM website.
The latest research

Evidence Based Midwifery is the RCM’s quarterly journal featuring in-depth research. Here is the summary of contents from the most recent issue – December 2013.

Looking through the research lens at the challenges facing midwives delivering evidence-informed antenatal education

Marlene Sinclair

Technology-based learning may have advantages over a traditional educational setting; however, development of face-to-face education has a unique role to play, this editorial argues. It states that it is important for new midwives to value both the evidence from randomised controlled trials and what technology has to offer in the application of evidence.

A realist evaluation of a normal birth programme

Purva Abhyankar, Helen Cheyne, Margaret Maxwell, Fiona Harris and Christine McCourt

This paper illustrates drawing upon a realist evaluation to assess a complex programme to support normal birth. It also describes in detail the process of conducting a realist evaluation, methods used, steps in data analyses, challenges encountered and the approach adopted to overcome them.

Motivating pregnant women to eat healthily and engage in physical activity for weight management: an exploration of routine midwife instruction

Mary Jane Brown, Marlene Sinclair, Dianne Liddle, Alyson J Hill, Janine Stockdale and Elaine Madden

Exploring how midwives instruct women on healthy eating and exercise, this study finds that the motivational potential of routine antenatal instruction is yet to be fulfilled. The type and frequency of goals communicated to women varied considerably depending on the individual midwife, with no apparent standardised procedure being followed.

A preliminary survey of the use of complementary and alternative medicines in childbearing women

Catriona Jones, Julie Jomeen and Ola Ogbuehi

Findings from a project designed to explore complementary and alternative medicine (CAM) activity within a local childbearing community in the north of England reveal that a number of women are engaging with different forms of CAM. The authors voice concern that a small proportion of women are using CAM without letting their midwife know.

Obesity, pregnancy outcomes and caesarean section: a structured review of the combined literature

Andrée Dignon and Tracy Truslove

This literature review found that there is evidence of an association between elevated BMI levels and the subsequent risk of CS. Furthermore, it clearly demonstrates that as the BMI of the woman increases from obese to morbidly obese, the likelihood of CS as an emergency procedure also becomes greater.

Australian maternity health professionals’ experience of an e-learning fetal surveillance package

Samantha Davies, Yvonne Hauck, Sara Bayes, Terri Barrett and Joan Jones

The provision of e-learning packages for health professionals is gaining acceptance. This paper aims to determine knowledge improvement, retention and user experience with a computer-assisted fetal surveillance package (K2MS) in Australia. It was found to be an effective and relevant means by which to educate clinicians. However, strategies are needed to ensure that those in rural and remote areas can successfully access K2MS.
No half measures
The risks of alcohol in pregnancy
Midwives are on the front line in the battle to educate about the dangers of alcohol in pregnancy. But are they well enough equipped to broach the subject? And are the guidelines clear enough? Helen Bird investigates.

‘I don’t want it on my conscience.’ These reported words of a Liverpool bartender to a pregnant woman who had ordered a small glass of red wine sparked media frenzy earlier this year. And, while the bar in question quickly apologised on behalf of its staff member, the story highlighted the issue of whether safe drinking in pregnancy really exists.

The guidelines dictate that ‘safe’ comes in the form of one to two units of alcohol, once or twice a week, although avoidance while trying to conceive and during the first trimester is recommended (NICE, 2008). But the RCM’s advice is for women to abstain completely throughout their pregnancy, thus eradicating any risk to their health or that of their baby, as professional policy advisor Janet Fyle explains: ‘The government talks in units, but different places measure alcohol differently, which is why we say that the best thing to do is abstain.’

It is this dual message that can be perceived as confusing, by midwives and, therefore, the general public. Rachel Towell, drug and alcohol specialist midwife at Newcastle’s Royal Victoria Hospital, sees first hand the effects that chronic use of such substances can have. But the absence of a clear message is blurring the lines, she believes. ‘The messages we’re giving out are very mixed. The RCM’s stance is nil and that is our stance in Newcastle – we use the slogan “alcohol and pregnancy don’t mix”.

‘But with the Department of Health guidelines, we’re still looking at: “You should not drink; however, if you choose to drink, you should drink no more than one to two units no more than once or twice a week.” It’s contradictory – it doesn’t make any sense,’ she says.

And the evidence seems to suggest that many women do choose to drink during pregnancy. A recent study carried out in Norway shows that 16% of women consumed ‘light’ alcohol (0.5 to two units, one to four times per month) in the first trimester and 10% in the second trimester (Stene-Larsen et al, 2013). Perhaps more worryingly, the figures for binge drinking, defined as five units or more in a single session, were 12% and 0.5% respectively.

On UK soil, it appears to be a similar story. Research published in Obstetrics &
Gynecology (McCarthy et al, 2013) looked for a link between maternal alcohol consumption in early pregnancy and four pregnancy outcomes — small for gestational age, reduced birthweight, pre-eclampsia and spontaneous preterm birth.

Aside from the slightly surprising results of the study — no association was found between drinking up to 15 weeks and these four outcomes — the researchers were struck by the number of participants who drank during pregnancy. Fergus McCarthy, a specialist registrar in obstetrics and gynaecology and lead researcher on the study, says: ‘Something we found surprising was the degree of consumption — we were all quite amazed at the prevalence of alcohol use in pregnancy.’

Of course, the reasons behind this would be subject to an entirely separate area of research, but Rachel believes that the stresses of modern life could be to blame. ‘The women that we see coming through with higher levels of alcohol use are stereotypical, middle class professionals that drink quite reasonable amounts weekly to cope with the stresses and burdens of everyday life and work,’ she says. Coupled with the absence of a clear message to abstain from alcohol, and a culture that is ‘very much dictated by alcohol’, the temptation is perhaps too difficult for some women to resist, Rachel adds.

But, Fergus warns, just because the dangers of alcohol in pregnancy don’t necessarily manifest in immediate, adverse birth outcomes, there are far more serious, long-term health implications that are not covered by this research. ‘Although we might not need to be worried about preterm delivery, pre-eclampsia or altered birthweight, alcohol, without a doubt, as shown by other studies, has neurocognitive developmental effects,’ he says. ‘Therefore, we should continue to recommend to avoid it in pregnancy.’

Susan Fleischer, founder of the National Organisation for Foetal Alcohol Syndrome (NOFAS) UK, cannot stress this point enough. Having adopted a girl with brain damage thought to be caused by alcohol, Susan considers the issue to be close to her heart. When it comes to the advice midwives should give around alcohol consumption, Susan, who also founded the international medical advisory panel on fetal alcohol spectrum disorders (FASD), is very much in alliance with the RCM in its ‘no alcohol, no risk’ stance. ‘The bottom line is, we can’t predict which women will be affected, so we say as soon as a woman knows she’s pregnant, she should avoid alcohol for the remainder of her pregnancy,’ she says. ‘Why play Russian roulette with your child? You can’t guarantee anything.’

But she is quick to warn against an alarmist approach, which can cause undue concern. ‘We don’t want to panic women who have had a couple of drinks,’ she says. ‘We have a lot of women who call up and say, “I was drinking at the beginning of my pregnancy – should I get an abortion?”’

On the other side of the coin, however, are those women who appear to look for validation to have a drink while they’re pregnant. Rachel says that, in some cases, the advice that midwives give will be ignored, or at least diluted down, because ‘women will hear what they want to hear’.

She also cites generational differences as a reason for women believing they will be ‘fine’ to drink alcohol in pregnancy. ‘My mother was told to drink a glass of stout every night when she was pregnant because of the iron benefit, which we now know is not true, but that was the information given at the time,’ she says.

But, despite facing so many obstacles, are midwives well enough equipped to broach the rather personal topic of alcohol use with women and educate them about its dangers? Fergus believes his study (McCarthy et al, 2013) served to highlight shortcomings in this area.

### Drunk in pregnancy

#### THE FACTS

71% of mothers who drank before pregnancy received some sort of information about drinking during pregnancy.

Women in Northern Ireland (80%) and Scotland (77%) were the most likely to receive information about drinking.

Among those who received information about drinking, the most common source of information was from a midwife (31%).

62% of those who drank before pregnancy said they had been given general information about the effects of drinking alcohol on the baby.

36% said they had been given information on how to cut down or limit the amount they drank during pregnancy.

29% said they had been given information on stopping drinking alcohol completely.
ALCOHOL

The media will dilute and distort the facts. This is particularly true regarding ‘safe’ measures of alcohol, says Liz. ‘The way that it gets confusing is because often one to two units gets reinterpreted as one or two drinks,’ she says. ‘Some women don’t realise that one glass of wine could have as many as three and a half units.’

It seems that the need for a single, strong message around alcohol in pregnancy is clear. Rachel observes that obtaining support and treatment for far more dangerous substances, such as heroin, is easier than for alcohol. ‘It’s very easy to get someone into treatment for drug addiction. I don’t think we’re quite there with alcohol,’ she says.

In other parts of the world, such as Australia and New Zealand, the ‘nil’ stance on alcohol is stricter – or perhaps simply clearer – and is therefore adhered to more readily. While women in these countries, as in the UK, enjoy freedom of choice, the guidance they receive is such that most make the choice to abstain, and this is widely accepted as the social norm.

Rachel concludes that clarifying our guidelines is key. ‘I think if we gave the right messages, people would not necessarily listen all the time, because who does – we all do things that aren’t good for us – but if you’ve got the right information, you can make that informed choice.’

For references, visit the RCM website.

PHOTOSHOT

Women who drank during pregnancy

Women who drank before and gave up during pregnancy

WOMEN WHO DRANK BEFORE AND GAVE UP DURING PREGNANCY

35% Northern Ireland

35% Scotland

39% Wales

41% England

WOMEN WHO DRANK DURING PREGNANCY

58% Northern Ireland

59% Scotland

55% Wales

48% England

Source: Infant-Feeding Survey 2010

‘I think that we, as healthcare providers, have to look at our own practice,’ he says. ‘Obviously we’re quite bad at advising women or even asking women about their alcohol consumption and discussing cessation during pregnancy. ‘We’ve always considered pregnancy to be an ideal public health opportunity for us and we’re obviously doing a relatively poor job of that.’

Rachel agrees that, in spite of the guidelines that are in place, she’s aware of midwives bending the boundaries. ‘I’m still hearing midwives, not necessarily in my area but in others, telling women: “You’ll be fine, have a drink,”’ she says.

‘As health professionals, we’re still arguing among ourselves as to what is acceptable. What do we expect women to do? We have to sort it out as professionals first, and get that clear, concise message out to women and their families.’

Thankfully, there are resources out there to help midwives communicate the key messages to women. Liz Burns, public health development advisor for alcohol within Manchester Mental Health and Social Care Trust, has worked with local midwives to develop visual aids, as well as a ‘no alcohol = no risk’ campaign that launched in 2008 in female pub toilets.

The visual aids, Liz tells Midwives, are designed to support the conversation between frontline staff and women when they are carrying out alcohol screening. ‘The format gives midwives options of where to go in the conversation,’ she says, admitting that it isn’t always an easy topic to approach.

But Janet believes that the best approach is to be non-judgemental and to give unbiased advice. ‘Midwives should not act as social police,’ she says, ‘but they have to find a way of discussing public health issues with women.’

Unfortunately, as is often the case with public health issues, the media will dilute and distort the facts. This is particularly true regarding ‘safe’ measures of alcohol, says Liz. ‘The way that it gets confusing is because often one to two units gets reinterpreted as one or two drinks,’ she says. ‘Some women don’t realise that one glass of wine could have as many as three and a half units.’

It seems that the need for a single, strong message around alcohol in pregnancy is clear. Rachel observes that obtaining support and treatment for far more dangerous substances, such as heroin, is easier than for alcohol. ‘It’s very easy to get someone into treatment for drug addiction. I don’t think we’re quite there with alcohol,’ she says.

In other parts of the world, such as Australia and New Zealand, the ‘nil’ stance on alcohol is stricter – or perhaps simply clearer – and is therefore adhered to more readily. While women in these countries, as in the UK, enjoy freedom of choice, the guidance they receive is such that most make the choice to abstain, and this is widely accepted as the social norm.

Rachel concludes that clarifying our guidelines is key. ‘I think if we gave the right messages, people would not necessarily listen all the time, because who does – we all do things that aren’t good for us – but if you’ve got the right information, you can make that informed choice.’

For references, visit the RCM website.
Engaging hearts and minds

A transformation has taken place at a North London maternity unit. Fiona Laird explains how they did it and won the RCM’s Bio-Oil team of the year award.

Feedback from the Picker Institute Maternity Survey in February 2010 rated the North Middlesex University Hospital (NMUH) as the worst maternity unit in the country for treating women with dignity and respect.

Concurrently, 62% of maternity complaints were associated with staff attitude, not poor clinical care, while staff sickness rates were high.

Under the HoM’s leadership, the senior midwifery team (SMT) critically analysed the underlying issues and developed a multifaceted approach to address them. The aim was to improve women’s experiences in a sustainable and measurable way. Three new innovations were piloted in the following six months.

Maternity teams

To improve team building, all maternity staff – from consultants to cleaners – were allocated into six coloured teams and given a coloured name badge to make them visible to women and their families. Staff could achieve points for their teams in numerous ways, including receiving positive feedback from CARE rounds.

CARE rounds

These involved a daily round of the maternity ward by a wide cross-section of the maternity multidisciplinary team, who each visited the women in their four allocated beds on a weekly basis. Women were asked for feedback via the CARE questions (below), and to give a mark out of 10 for each one. They were also asked: ‘Would you recommend us to a friend?’

The CARE questions:

- C: Women are asked to discuss their overall maternity care during the antenatal, intrapartum and postnatal period
- A: Women are asked how the attitude and behaviour of the staff was towards them
- R: Women are asked if they were treated with dignity and respect
- E: Women are asked if everything was explained clearly in an appropriate and timely manner

Feedback

Feedback from each woman was left on the ward in the CARE rounds folder. The forms were collated at the end of each week and the HoM would write a letter to each member of staff, giving them positive feedback and awarding them points for their team. Letters were also written if feedback was negative, and if staff received three adverse letters in three months, the HoM and SoM would see them personally.

Overall results from CARE rounds were published quarterly in the maternity newsletter, Pregnant Pause. Monthly team results were also published to announce the winners, and staff who earned the most points for their teams were celebrated.

Results

Following a CQC unannounced visit and review of maternity services, NMUH was fully compliant in all standards and received a positive report. Complaints reduced overall by a third and those about staff attitude reduced by 50%. Staff sickness also reduced by 50% and reported incidents regarding staffing issues, poor documentation, staff injury and guidelines not being followed reduced.

In July 2012, for the first time, 100% of women said they would recommend NMUH to a friend, and since November 2011, the rate has not fallen below 88%. For the past year, NMUH has maintained the lowest CS rate in the sector, as well as a one-to-one care in labour rate of more than 90%.

Although there is more work to do by engaging the hearts and minds of our staff, women and their families, a transformation has taken place. It is up to all of us to ensure that it is not only sustained, but improved upon. We want to be able to always say: ‘We are a family fit to look after your family.’

Fiona Laird
Head of midwifery, North Middlesex University Hospital
More than a thousand people flocked to the RCM Annual Conference 2013, held in Telford in November. The two-day event featured a raft of top politicians, experts and policy-makers and was chaired by journalist and presenter Nina Hossain.

Among the speakers were the MPs Dr Dan Poulter, parliamentary under secretary for health, and Andy Burnham, shadow health secretary. Midwifery research was unveiled, discussed and debated at the main conference and the student and workplace representative conferences, which ran concurrently.

The topics ranged from understanding genetics and genomics, to anxiety and fear of birth in modern society.

Cathy Warwick, RCM chief executive, delivered the opening address to a packed main hall.

She said that, while the past year has been tough for the profession, ‘UK maternity services are in good shape’.

She added: ‘Midwives, student midwives and MSWs have a huge amount to be thankful for.’

There were a number of announcements that were made at the conference, including the news that the government will provide funding for improving birth units and a commitment for more resources and increased education in order to help women with mental health issues.

Debate and Q&A sessions took place, giving the audience the chance to quiz panels and speakers on a range of topics.

There was even an interactive dramatic presentation, with drama learning development group Steps performing a piece that questioned resilience in midwifery.

Away from the stages, groups of delegates had in-depth discussions about conference news and developments, with the debate continuing on social networking sites.

The final speaker of the conference was RCM president Lesley Page, who delivered an emotive speech to close the conference and thanked all who had attended.

Midwives, student midwives and MSWs have a huge amount to be thankful for.’

The two-day event featured a raft of top politicians, experts and policy-makers and was chaired by journalist and presenter Nina Hossain. Among the speakers were the MPs Dr Dan Poulter, parliamentary under secretary for health, and Andy Burnham, shadow health secretary.

Midwifery research was unveiled, discussed and debated at the main conference and the student and workplace representative conferences, which ran concurrently.

The topics ranged from understanding genetics and genomics, to anxiety and fear of birth in modern society.

Cathy Warwick, RCM chief executive, delivered the opening address to a packed main hall.

She said that, while the past year has been tough for the profession, ‘UK maternity services are in good shape’.

She added: ‘Midwives, student midwives and MSWs have a huge amount to be thankful for.’

There were a number of announcements that were made at the conference, including the news that the government will provide funding for improving birth units and a commitment for more resources and increased education in order to help women with mental health issues.

Debate and Q&A sessions took place, giving the audience the chance to quiz panels and speakers on a range of topics.

There was even an interactive dramatic presentation, with drama learning development group Steps performing a piece that questioned resilience in midwifery.

Away from the stages, groups of delegates had in-depth discussions about conference news and developments, with the debate continuing on social networking sites.

The final speaker of the conference was RCM president Lesley Page, who delivered an emotive speech to close the conference and thanked all who had attended.

Midwives, student midwives and MSWs have a huge amount to be thankful for.’

The two-day event featured a raft of top politicians, experts and policy-makers and was chaired by journalist and presenter Nina Hossain. Among the speakers were the MPs Dr Dan Poulter, parliamentary under secretary for health, and Andy Burnham, shadow health secretary.

Midwifery research was unveiled, discussed and debated at the main conference and the student and workplace representative conferences, which ran concurrently.

The topics ranged from understanding genetics and genomics, to anxiety and fear of birth in modern society.

Cathy Warwick, RCM chief executive, delivered the opening address to a packed main hall.

She said that, while the past year has been tough for the profession, ‘UK maternity services are in good shape’.

She added: ‘Midwives, student midwives and MSWs have a huge amount to be thankful for.’

There were a number of announcements that were made at the conference, including the news that the government will provide funding for improving birth units and a commitment for more resources and increased education in order to help women with mental health issues.

Debate and Q&A sessions took place, giving the audience the chance to quiz panels and speakers on a range of topics.

There was even an interactive dramatic presentation, with drama learning development group Steps performing a piece that questioned resilience in midwifery.

Away from the stages, groups of delegates had in-depth discussions about conference news and developments, with the debate continuing on social networking sites.

The final speaker of the conference was RCM president Lesley Page, who delivered an emotive speech to close the conference and thanked all who had attended.

Midwives, student midwives and MSWs have a huge amount to be thankful for.”

The two-day event featured a raft of top politicians, experts and policy-makers and was chaired by journalist and presenter Nina Hossain. Among the speakers were the MPs Dr Dan Poulter, parliamentary under secretary for health, and Andy Burnham, shadow health secretary.

Midwifery research was unveiled, discussed and debated at the main conference and the student and workplace representative conferences, which ran concurrently.

The topics ranged from understanding genetics and genomics, to anxiety and fear of birth in modern society.

Cathy Warwick, RCM chief executive, delivered the opening address to a packed main hall.

She said that, while the past year has been tough for the profession, ‘UK maternity services are in good shape’.

She added: ‘Midwives, student midwives and MSWs have a huge amount to be thankful for.’

There were a number of announcements that were made at the conference, including the news that the government will provide funding for improving birth units and a commitment for more resources and increased education in order to help women with mental health issues.

Debate and Q&A sessions took place, giving the audience the chance to quiz panels and speakers on a range of topics.

There was even an interactive dramatic presentation, with drama learning development group Steps performing a piece that questioned resilience in midwifery.

Away from the stages, groups of delegates had in-depth discussions about conference news and developments, with the debate continuing on social networking sites.

The final speaker of the conference was RCM president Lesley Page, who delivered an emotive speech to close the conference and thanked all who had attended.

Midwives, student midwives and MSWs have a huge amount to be thankful for.”
Top five moments

1. Eminent 84-year-old natural birth campaigner Sheila Kitzinger simulated an orgasm onstage in her address to students.

2. 820 signatures were added to a petition to provide midwives in developing countries with motorcycles.

3. In the final session, student midwife Charlotte Williamson performed an a cappella version of Sister Sledge’s hit song We Are Family.

4. The findings of a study on resilience in midwifery revealed that owning a dog could help alleviate stress.

5. Rapturous applause when Dan Poulter was grilled on why MPs are able to get pay increases while frontline NHS salaries are frozen.

Tweet talk

@SMLindseyHughes
Had a fab day at my first ever #RCMconf13
- Found it so interesting and exciting as a 1st year student #motivated @MidwivesRCM

@junicho
@David_Cameron i really hope you are paying attention to the @MidwivesRCM conference and the cutbacks to our maternity services #disgraceful

@JuWray
@MidwivesRCM excellent Billie Hunter & Lucie Warren paper, food 4 thought #RCMconf13 will get the report

@DawnNiAodha13
@MidwivesRCM Thanks for the great updates today for those of us unable to attend! Some interesting topics raised.

@rhiann_russell
Had a great few days in Telford for the RCM conference @MidwivesRCM thank you @ShaunnaLeigh4 for being my room buddy!!

@crystalkiru
Such an inspirational day and definitely worth travelling all the way from Devon, thank you so much @MidwivesRCM #RCMconf13

@melanie_fitz01
@MidwivesRCM President @LesleyPageRCM first on the dance floor! Simply magnificent!

@JulieBambridge
@DeniseRCM been an amazing day, great interaction with #studentmidwives, @MidwivesRCM team have been wonderful :) #RCMconf13

@ClaireCroxall
Amazing talk from Jane Grant about pregnant asylum-seekers and detainees #RCMconf13 @MidwivesRCM

@Hana_StudentMid
#RCMconf13 nxt yr: let’s smash through to 500 st/mws at conf!! & have a flash mob/record brake? :) thoughts #studentmidwives @MidwivesRCM
Pearls of wisdom

Midwifery consultant Sue Macdonald summarises the Perineal assessment and repair longitudinal study.

Background
Birth associated perineal trauma affects millions of women and correct assessment of trauma and effective repair are crucial clinical skills. The Perineal assessment and repair longitudinal study (PEARLS-QI) aimed to test whether a standardised, cascaded education and training programme for midwives and obstetricians improved local implementation of evidence-based practice in perineal assessment and repair and reduced maternal morbidity. The team, which included researchers from Birmingham University, Staffordshire University, King’s College London, Bournemouth University and the RCM, obtained funding from The Health Foundation. Full ethics committee approval was granted.

The study included an initial survey of current midwifery practice, which indicated a low rate of use of evidence-based perineal suturing methods (Bick et al, 2012); a Delphi study indicating what women considered were priority outcomes in terms of health and recovery following perineal trauma (Perkins et al, 2008); and a project exploring the experiences of the research facilitators.

Methods
PEARLS-QI was an innovative, pragmatic matched pair cluster randomised controlled trial (RCT) with 22 participating UK maternity units, matched into 11 pairs. HoMs were initially selected to ask if their units wanted to be part of the project. A total of 24 units were initially selected, though two units were subsequently excluded due to delays in securing relevant local R&D approvals. Each unit identified one or more midwives and/or obstetricians to be responsible for cascading the standardised training intervention, promoting the study locally and collating data. Each maternity unit was matched with a similar unit – in terms of size, birth rate and staffing. Each unit was unaware of the identity of their paired unit. In each pair, one unit was randomised to receive the PEARLS-QI intervention early (group A) or late (group B). The facilitators from each unit allocated to groups A or B attended a ‘train the trainers’ event, during which the PEARLS-QI team demonstrated a ‘hands-on’ training package, which included information on the anatomy of the pelvic floor muscles and perineal body, suturing methods and materials, basic surgical skills and issues relating to postnatal perineal care. The content was also included on an innovative DVD that was provided to each unit, together with an episiotomy repair trainer. The facilitators, who were provided with a leadership package, were then tasked with organising and rolling out the training intervention in their units.

Figure 1 illustrates the study progress. Data were collected at three time points. Baseline demographic and obstetric data were collected prior to implementation of the PEARLS-QI intervention (phase 1). Main trial data were collected following implementation of the intervention, and the clusters randomised to receive it early were compared with the matched clusters that did not receive it at this time (phase 2). To assess sustainability of the effects of the PEARLS-QI intervention, data were collected following implementation of the intervention in the other cluster in the matched pair (phase 3).

Each woman recruited had a study entry form completed by the attending midwife or obstetrician and was offered a questionnaire on discharge to be completed at 10 to 12 days postnatal. If women returned the questionnaire, a second one was posted at three months postnatal for completion. A period of three months was allowed for the PEARLS-QI training intervention to be cascaded in all units (clusters).

All women sustaining a second-degree tear or episiotomy were eligible for inclusion. The primary trial outcome was percentage of women with pain on activity at 10 to 12 days postnatally, with secondary outcomes including wound infection, use of pain relief and implementation of evidence-based perineal repair.

Analysis was based on summary statistics at cluster level, using paired t-tests. This method of analysis takes into account the clustered design of the trial.

Results
A total of 3681 women were recruited over the period of the study – 1470 to group A and 2211 to B. There was no significant difference in mean primary outcome (pain on activity at 10 to 12 days postnatally) between units when outcomes were assessed at phase 2 of the study (0.7%, 95% CI (-10.1%, 11.4%), p=0.89), with the overall percentage of women (ignoring clustering) being 77% and 74%.

However, noticeable improvement was seen in implementation of evidence-based perineal management. A significant reduction


was noted in mean percentages of women reporting wound infections and needing suture removal in the early intervention clusters.

**Discussion**
Implementing and cascading multi-professional training within units was associated with a significant improvement in adherence to evidence-based perineal repair practice and some of the women’s reported outcomes when assessed following the main trial intervention at phase 2. The findings have major implications both for in-service training and initial pre-registration education programmes for midwives and obstetricians. Work to complete further analysis is underway.

One of the most valued elements of the training intervention from facilitators was the PEARLS DVD. As it was part of an intervention, it could not be circulated outside the trial. Nevertheless, feedback from facilitators was that this was an important component of the training intervention. In response, the research team obtained further funding from the Health Foundation Shine initiative to further develop the learning package into an online learning programme to enable clinicians to develop their knowledge and skills.

An e-learning version of the PEARLS-QI intervention (MaternityPEARLS) is now available through RCOG’s StratOG and the RCM’s i-learn e-learning suite. With more than 400,000 women sustaining perineal trauma during childbirth each year in the UK, the clinical importance of this study cannot be underestimated, particularly if viewed in relation to its potential global benefit.

**Conclusion**
PEARLS-QI was the first RCT to assess the impact of a ‘hands-on’ training package on implementation of evidence-based perineal trauma management and some clinical outcomes important to women. The findings show that a standardised training package with supportive information for women impacted on implementation of evidence-based practice, highlighting the need to improve clinical education to support evidence-based perineal management.


For references, visit the RCM website.
Evidence suggests that approximately 19% of women have urinary continence problems following childbirth (Labrecque et al, 2000), and it is likely that many more women are affected but are too embarrassed to seek help. By capitalising on women’s general receptiveness to public health messages during and immediately after pregnancy, the joint campaign from the RCM and the Chartered Society of Physiotherapy (CSP) aims to reinforce the message among midwives that pelvic health is a key public health issue. The reasons and recommendations to maternity service providers have been set out in a joint position statement, which can be viewed on the RCM website.

Among the key recommendations is that all women should be given evidence-based information and advice about pelvic floor muscle exercises (PFME) and an opportunity to discuss pelvic care with a qualified healthcare professional. It also calls on maternity service providers to develop clear standards and a referral pathway to specialist physiotherapy for women who are at risk of developing problems related to pelvic floor dysfunction.

Bladder and bowel dysfunction caused by pelvic floor damage can be severely distressing and disruptive to women’s lives, potentially affecting personal relationships and their ability to work and look after young children.

‘For women with incontinence, their whole day is planned around being able to access a toilet. This is a very powerful message: if we don’t pick up on this issue and embrace pelvic health, these problems will continue into older age and probably cause worse problems,’ says RCM director for England Jacque Gerrard, who has been leading on this work with the CSP. It is not only the physical impact on a

A new joint venture between the RCM and the Chartered Society of Physiotherapy aims to ensure that all women receive pelvic health advice during and after pregnancy, as Louise Hunt explains.

Preventing pelvic flaws
woman’s quality of life: one study found that women who experience urinary incontinence following childbirth are nearly twice as likely to develop postnatal depression (Sword et al, 2011).

Mary Steen, professor of midwifery at the University of Chester, says it is important that midwives connect the physical with the potential psychological consequences and think about all the issues around a woman’s wellbeing and quality of life.

‘Most continence problems do resolve during the first couple of weeks following birth, but midwives should be checking antenatally if everything is ok with bowel and bladder function, not just at booking in, but as they build up a relationship with the woman, because it is a sensitive subject. They have got to be proactive and reiterate on a few occasions that if a woman thinks there is something abnormal, not to be afraid to seek help,’ she says.

The joint work builds on the pelvic health advice that midwives currently provide, with a focus on equipping them with the knowledge to deliver PFME during the antenatal and postnatal periods.

The collaboration has been driven by women’s health physiotherapists, who see a need for a more preventive approach to pelvic health, since many of the women they treat with continence problems already have long-term damage that could have been avoided with timely advice and early intervention.

‘The teaching of pelvic floor muscle exercises during pregnancy tends to fall between different health professionals,’ says CSP professional adviser Ruth ten Hove. ‘Even if some people are being told about these exercises, they often don’t get the information at the right time or realise they have to carry on doing them. It is really important that this becomes part of normal practice.’

Physiotherapists have the expertise to deliver this training, but with just 650 specialist physiotherapists in women’s health, ‘there are simply not enough to teach pelvic floor exercises as a preventative measure’, Ruth says.

‘There is not an interface between physiotherapists and pregnant women unless there is a problem. Midwives are the key profession working with pregnant women, but they have also said they need more training to confidently deliver pelvic health education.’

To this end, the RCM, along with the CSP, is developing new resources for midwives to use with clients that will be available in spring 2014 on the RCM’s i-learn platform. They will cover the basics of what midwives need to know in anatomy, function and dysfunction of the pelvic floor, including PFME and when to refer women to specialist physiotherapists. There will also be a video featuring the case study of a woman affected by incontinence.

Patient information leaflets are also being developed that will be available to download from the NHS Choices website, which midwives can use to signpost women as part of antenatal discussions.

Mary says: ‘Many maternity services already provide patient information on pelvic health and exercises, and there are lots of examples of good practice out there. But there will be variation in how pelvic health advice is given because of midwives’ workloads and resources. These will be additional, evidence-based tools that midwives can use.’

In the meantime, the benefits of early intervention in PFME teaching for combating pregnancy-related continence problems or prolapse later in life are well documented. For example, a recent systematic review published in the British Medical Journal (Markved and Ba, 2013) concluded that pelvic floor exercise training during pregnancy and following childbirth can prevent and help to treat urinary incontinence. In addition, the NICE (2006) guidance for treating stress incontinence recommends PFME as a first line of treatment.

The collaborative goal has so far been well received by HoMs consulted by the two bodies, but Jacque acknowledges the challenges its implementation will incur. ‘Midwives can see there is a need to do this work and we will incorporate more pelvic health into our workload. But, with the current midwife shortages, we will be stressing the societal cost of not treating incontinence early enough, which is £117m a year for the NHS (Imamura et al, 2010), as part of our call for 5000 more midwives.’

Jacque’s key message to midwives is to take on board the importance of disseminating information on good pelvic health to all women in their care. ‘My aspiration is that this message takes on the same resonance as skin-to-skin contact and breastfeeding,’ she says.

To view the joint RCM and CSP statement, visit: rcm.org.uk/college/policy-practice/joint-statements-and-reports

For references, visit the RCM website.
The recent Birthplace study (Birthplace in England Collaborative Group (BECG), 2011) has demonstrated that, for nulliparous women, a planned home birth carries increased risk for the baby. For these women, the risk of adverse perinatal outcomes at home was 9.3 per 1000 births, in obstetric units 5.3 per 1000 and at freestanding birth centres 4.5 per 1000. While these findings are statistically significant for a first-time mother-to-be, home births are still relatively safe.

With some areas of the country having higher home birth rates than others, it’s clear that the study may have shown different results if individual areas had been compared, although this could potentially be affected by possible delays and inconsistencies in transfer systems throughout the UK. In comparison, for low-risk multigravidae women, home birth was the safest option, with the risk of adverse perinatal outcomes at 2.3 per 1000 births.

Globally, there has been contradictory evidence surrounding the safety of home birth (Ecker and Minkoff, 2011). Studies from the US and the Netherlands demonstrate that this contradiction may be linked to different social attitudes and healthcare provision (Wax et al, 2010; de Jong et al, 2009; Martin et al, 2007; Pang et al, 2002). Current NICE guidelines (2007) support home birth as a choice for low-risk women, prompting discussion over whether future guidelines should continue to support home birth for low-risk nulliparous women, or whether this support should be withdrawn, as well as considering the ethical principles influencing this discussion.

**Background and legal issues**

Most cultures throughout history have birthed at home, and in many countries this remains the case (Cohen, 2008; Tew, 1998). The NHS Acts of 1946 and 1949 clearly outlined the legal obligation for midwives to attend home births; however, the 1969 Act lacked this clarity (AIMS, 2011). Incongruity now exists between a midwife’s ethical and legal obligations. Women have a legal right to emergency birth support at home; however, if their employer does not provide this service, midwives are not legally responsible for attending (NCT, 2012), though I’m sure every midwife would believe they have a duty of...
care to the woman if she contacts them in labour. Nevertheless, if a midwife refused care based on birthplace she may be accused of disrespecting the woman’s autonomy. Providing care may uphold the principles of beneficence and non-maleficence; for example, the baby may need resuscitating, requiring the skills of a trained professional.

**Unassisted or ‘freebirth’**
Some women birth without a midwife, whether a result of precipitous delivery or by choice, placing both herself and her baby at risk. It is unlikely that many women would have the ability to resolve obstetric emergencies, such as shoulder dystocia or postpartum haemorrhage. However, Foster and Lasser (2011) state that making a judgement without understanding the influence of the woman’s cultural background may demonstrate a lack of respect for autonomy. If a woman chooses unassisted birth, the midwife must respect her decision. Parker and Dickenson (2001) state that in these circumstances, a midwife may abide by the principle of beneficence by remaining aware and available to the woman, enabling the midwife to satisfy any sense of moral or ethical obligation.

**Physical considerations**
A woman’s own home may be more comfortable than hospital, giving her freedom to move and eat at will and providing a sense of control. If she remains at home her labour will not be artificially augmented, thereby reducing risks of instrumental delivery (BECG, 2011). The postpartum infection rate is lower in women who birth at home, due to the unfamiliar pathogens present in hospital (Horn, 2010). A woman may suffer more harm from hospital-acquired infections than any potential morbidity at home (Thompson et al, 2006). However, serious perinatal morbidity or mortality may be less preferable.

Furthermore, women who live in extreme poverty may appreciate the space, comfort and privacy of hospital, and some women may not want to birth at home because of the associated ‘mess’. For these women, non-maleficence may not be upheld by asking them to birth at home.

**Impact on physiology**
According to Dick-Read (2004) and Odent (1994), labouring in relaxed settings allows the body to create endorphins (natural analgesics), reducing the necessity for opiate drugs and epidurals, encouraging active birth (Balaskas, 1994). If endorphins are not created in sufficient quantity and opiates are used, many cross the placenta, affecting the baby’s nervous system, respiration, thermo-regulation and breastfeeding ability (Jordan, 2010). Beneficence is therefore demonstrated by supporting the mother to labour in an environment best suited for natural endorphin production. Due to the advantages of breastfeeding, any practice, including home birth, that increases breastfeeding rates may be considered beneficent (UNICEF, 2012; Johnson and Daviss, 2005).

**Psychological factors**
Some women fear hospitals because of previous negative experiences. This may render entering hospital for something as natural and normal as birth implausible. For other women, although being in a natural environment may help alleviate fear,
a hospital environment may provide feelings of security. According to Gaskin (2011), fear may prevent progression of labour and in some cases lead to intervention.

Supporting a woman to birth in the environment she feels most secure demonstrates beneficence. Some women may experience a sense of security in a hospital, for example, if they have experienced domestic abuse. Others may feel more secure in proximity to doctors and operating theatres. It may demonstrate beneficence to provide a hospital birth for these women.

Cultural, social and personal beliefs
Home birth may be something a woman feels she should do in order to conform to her cultural, social and personal beliefs. For example, a woman may come from a family where the majority of the women have birthed at home. She may feel compelled to maintain this tradition and hospital birth may create a sense of failure. Although the intrapartum transfer rate is higher for nulliparous women, having attempted home birth may reassure the woman that she did all she could. This may help prevent psychological repercussions, such as postnatal depression, that are associated with unexpected birth outcomes (Astbury et al, 1994). Conversely, if the woman birthed at home and there were adverse perinatal outcomes, this may also lead to postnatal depression and other psychological disorders. In this instance it is difficult to differentiate between actions that uphold the principles of beneficence and non-maleficence.

Large cities are home to many different nationalities, including asylum-seekers, refugees and illegal immigrants (Townshend, 2010). Some of these women come from cultures where hospital birth is less acceptable. A study on Bolivian women demonstrated that one reason they preferred not to attend hospital was embarrassment, for example, when asked to ‘open their legs’ to strangers (Otis and Brett, 2008). Women raised in British culture may consent to this, but for the Bolivian women in the study, the embarrassment and perceived lack of dignity was significant enough to prevent hospital attendance. If autonomy was respected and these women were supported at home, this may uphold the principle of non-maleficence due to reduced emotional harm.

Conclusion
While NICE guidelines (2007) support the provision of home birth for nulliparous women with low-risk pregnancies, the recent Birthplace study (BECG, 2011) suggests that this group is at increased risk of adverse perinatal outcomes. Some low-risk nulliparous women may choose home birth, despite this increased risk. While the reduced risk of adverse perinatal outcomes for hospital birth may appeal to some, other priorities may be paramount.

Consideration must be given to each individual woman’s circumstances, taking into account physical, physiological, psychological, cultural, social and personal issues. The application of Beauchamp and Childress’ (2009) biomedical ethical model uncovers dilemmas between a midwife’s legal obligations and the moral-ethical rationale underpinning care.

It is important to note that the Birthplace study (BECG, 2011) has some limitations. It is a cohort study, generally considered a lesser evidence level to systematic reviews and randomised controlled trials (Ho et al, 2008). Cohort studies have the advantage of being able to examine multiple outcomes (used in this study), calculate relative risk, incidence rates and confidence intervals, but are subject to selection bias and loss-to-follow-up (Grimes and Schulz, 2002). Notwithstanding these limitations, the Birthplace study (BECG, 2011) appears to have been rigorously conducted and is already influencing organisations such as the NCT (2013). Considering the ethical issues, the study design and the stated increased risk of adverse perinatal outcome, future NICE guidelines should continue to support home birth for low-risk, nulliparous women.

Jenefer Fraser
Newly qualified midwife

Jenefer, who was a third-year student at the University of Leeds at the time of writing this feature, would like to thank senior lecturer Dr Janet Holt and associate lecturer Ian Townsend for their academic support in writing this article.

For references, visit the RCM website.
Reinventing and engaging

Some struggling branch officers may disagree, but the evidence says RCM branches are on the up, according to RCM head of organising and engagement Denise Linay.

Back in the early noughties, there was a strong feeling that branches had had their day. Branch officers were struggling to get members to attend meetings and, increasingly, branches were lapsing into a moribund state.

The RCM was not alone, with other trade unions experiencing similar levels of inactivity. In response, the RCM commissioned a review into whether anything could be done to reverse the trend. It concluded that there was little to be gained by providing additional resources to branches and that the RCM should direct its attention to supplementing current branch activity with a range of other initiatives, including regional events and electronic communications.

Consideration was also given to whether branches are increasingly reinventing themselves and becoming more creative

Branch network to host learning events, or the introduction of the role of RCM organiser, which is supporting branches. Or it may be that RCM members are becoming more aware that having a strong branch is essential to resist an attack on pay and conditions. Whatever the reason, it is an exciting development.

In response to this increased activity, the RCM reviewed its funding of branches in 2012, with an overall uplift and additional funds if the branch covered a number of workplaces.

We are currently undertaking a long overdue review of the resources for branch officers and have strengthened the processes that support branch activity. In 2014, the RCM is launching a campaign to raise awareness of the RCM branch, so look out for more details next year.

THE BELFAST BRANCH

On 24 September, 41 RCM members attended the Belfast branch event, ‘Investigation perspiration’. A number of speakers, including an obstetrician, were invited to talk about the range of investigations a midwife may face during their career.

Student midwife Suzie Smyth said: ‘It was great to hear such honesty and it really brought the theory we had learnt in the classroom to life. I left the event with more knowledge and feeling less scared of the process, but with a deepened appreciation of reviewing and evaluating practice.’

RCM member Angela Flanagan described it as ‘the most relevant’ event she had attended this year, while Philomena Cole, who had never before attended a branch meeting, said she would definitely attend future events.
# Events and courses, competitions and crosswords

## Footnotes

### Events / Dates to remember

<table>
<thead>
<tr>
<th>Event</th>
<th>Dates and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>International hands-on workshop in perineal trauma 2014</td>
<td>11 January, 1 March, 28 June, 13 September, 1 November</td>
</tr>
<tr>
<td></td>
<td>Third- and fourth-degree perineal tears and episiotomy: hands-on workshop. Course directors are Abdul Sultan and Ranee Thakar.</td>
</tr>
<tr>
<td></td>
<td>Location: Croydon University Hospital</td>
</tr>
<tr>
<td></td>
<td>Cost: £500 including textbook and DVD; £270 without DVD.</td>
</tr>
<tr>
<td></td>
<td>T: 020 8401 3000 ext 4768</td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:michelle.lawrence@croydonhealth.nhs.uk">michelle.lawrence@croydonhealth.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td>W: perineum.net</td>
</tr>
<tr>
<td></td>
<td>RCM interactive i-learn event</td>
</tr>
<tr>
<td></td>
<td>A great opportunity to find out how the RCM's online learning resource i-learn can help you in your daily practice. There are two sessions to choose from: 10am to 12pm or 2pm to 4pm.</td>
</tr>
<tr>
<td></td>
<td>Location: Queen's University, Belfast (Training Room 2, The McClay Library).</td>
</tr>
<tr>
<td></td>
<td>Cost: Free</td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:annemarie.oneill@rcm.org.uk">annemarie.oneill@rcm.org.uk</a></td>
</tr>
<tr>
<td></td>
<td>W: rcm.org.uk/college/campaigns-events/events/uk-country-events</td>
</tr>
<tr>
<td>The Florence Nightingale Foundation Annual Conference 2014</td>
<td>27-28 February</td>
</tr>
<tr>
<td></td>
<td>The two-day conference includes speakers, exhibitions and 28 masterclasses across six workstreams.</td>
</tr>
<tr>
<td></td>
<td>Location: Queen Elizabeth II Conference Centre, London</td>
</tr>
<tr>
<td></td>
<td>Cost: Early bird price: £249+VAT (only available until 20 December), £299+VAT from 21 December.</td>
</tr>
<tr>
<td></td>
<td>T: 01772 767782</td>
</tr>
<tr>
<td></td>
<td>W: florencenightingale.glasgow.co.uk</td>
</tr>
<tr>
<td>The Association of Hypnobirthing Midwives' practitioner training</td>
<td>31 March to 3 April</td>
</tr>
<tr>
<td></td>
<td>30 June to 3 July</td>
</tr>
<tr>
<td></td>
<td>Train to be a hypnobirthing teacher and run your own classes.</td>
</tr>
<tr>
<td></td>
<td>Location: London</td>
</tr>
<tr>
<td></td>
<td>Cost: £450</td>
</tr>
<tr>
<td></td>
<td>T: 07591 070474</td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:hypnobirthing@hotmail.co.uk">hypnobirthing@hotmail.co.uk</a></td>
</tr>
<tr>
<td></td>
<td>W: ahbm.co.uk</td>
</tr>
<tr>
<td>Deborah Robertson’s breastfeeding specialist course</td>
<td>May 2014 to April 2015</td>
</tr>
<tr>
<td></td>
<td>One Saturday or Sunday per month</td>
</tr>
<tr>
<td></td>
<td>Format is 12 study days (70 hours) plus optional homework (50 hours). Suitable for professional breastfeeding practitioners, lay volunteers or IBLCE lactation consultant exam candidates.</td>
</tr>
<tr>
<td></td>
<td>Location: London</td>
</tr>
<tr>
<td></td>
<td>Cost: £85 each month</td>
</tr>
<tr>
<td></td>
<td>W: breastfeedingspecialist.com</td>
</tr>
<tr>
<td>The Association of Hypnobirthing Midwives' promoting normal birth and hypnobirthing conference</td>
<td>19 June</td>
</tr>
<tr>
<td></td>
<td>Speakers include Professor Soo Downe, Sheena Byrom, Louise Silverton, Debby Gould, Julie Frolch, Shawn Walker, Judith Flood and Angela Leach.</td>
</tr>
<tr>
<td></td>
<td>Location: Guy’s Hospital, London</td>
</tr>
<tr>
<td></td>
<td>Cost: £75 including buffet lunch and complimentary copy of the Hypnobirthing book by Judith Flood.</td>
</tr>
<tr>
<td></td>
<td>T: 07591 070474</td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:hypnobirthing@hotmail.co.uk">hypnobirthing@hotmail.co.uk</a></td>
</tr>
<tr>
<td></td>
<td>W: ahbm.co.uk</td>
</tr>
<tr>
<td>Catherine Graves hypnobirthing teacher training diploma course</td>
<td>22-25 January, 27-30 March, 14-17 August</td>
</tr>
<tr>
<td></td>
<td>London</td>
</tr>
<tr>
<td></td>
<td>20-23 February Bristol</td>
</tr>
<tr>
<td></td>
<td>3-6 April Evesham</td>
</tr>
<tr>
<td></td>
<td>2-5 June Glasgow</td>
</tr>
<tr>
<td></td>
<td>14-17 July Manchester</td>
</tr>
<tr>
<td></td>
<td>Learn from a leading specialist hypnobirthing trainer and her team on the UK course chosen by midwives. ‘The home of hypnobirthing’</td>
</tr>
<tr>
<td></td>
<td>E: hypnobirthingcentre.co.uk</td>
</tr>
<tr>
<td>Michel Odent study day</td>
<td>1 March</td>
</tr>
<tr>
<td></td>
<td>The Hypnobirthing Centre is delighted to have Michel Odent at its study day, talking on birth and the future of homo sapiens.</td>
</tr>
<tr>
<td></td>
<td>Location: King’s College, London</td>
</tr>
<tr>
<td></td>
<td>Cost: £75; students £57 (including lunch).</td>
</tr>
<tr>
<td></td>
<td>T: 01264 731437</td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:admin@thehypnobirthingcentre.co.uk">admin@thehypnobirthingcentre.co.uk</a></td>
</tr>
<tr>
<td></td>
<td>W: thehypnobirthingcentre.co.uk</td>
</tr>
<tr>
<td>Unique aqua-natal courses for midwives</td>
<td>March (date TBA)</td>
</tr>
<tr>
<td></td>
<td>Designed for the community and hospital midwife, this intensive, practical and theoretical course provides the knowledge and coaching skills to lead a community-based aqua-natal exercise class safely and effectively.</td>
</tr>
<tr>
<td>The Association of Hypnobirthing Midwives’ pract [omising normal birth and hypnobirthing conference]</td>
<td>19 June</td>
</tr>
</tbody>
</table>
UP FOR GRABS

Here’s a chance to get your hands on some great giveaways with our free prize draws.

WIN ONE OF FIVE COPIES OF THE STUDENT’S GUIDE TO BECOMING A MIDWIFE

Now updated to include the latest NMC Midwives rules and standards, and a brand new chapter on the midwife and public health, this comprehensive resource provides a wide range of need-to-know information for student midwives.

The textbook encourages evidence-based practice and has a strong focus on normal birth. There are case studies, words of wisdom from practising midwives and a range of activities and self-test questions throughout, making it easy to learn and understand key concepts.

The student’s guide to becoming a midwife is the ideal companion for students throughout their course.

HOW TO ENTER

► To enter these competitions, email your name, address, telephone and membership number, clearly stating which competition you are entering to clare@midwives.co.uk

► The closing date is 8 January. Winners are drawn at random. Only one entry per household will be accepted. The editor’s decision is final.

WIN ONE OF THREE CALL THE MIDWIFE 1000-PIECE JIGSAWS

We Brits love a snippet of nostalgia and fans of the hugely popular BBC drama Call the Midwife will love the latest jigsaw puzzle from Gibsons, which captures the heart-warming atmosphere of the show.

This new, 1000-piece puzzle showcases actress Jessica Raine (who plays central character Jenny Lee) cycling in her midwife’s uniform through streets swathed in drying laundry, as well as snapshots of the show’s other popular characters.

Based on the memoirs of Jennifer Worth, Call the Midwife tells tales of hilarity and woe from the midwives and nuns who dedicated their lives to helping care for some of London’s poorest families in post-war Britain.

WIN ONE OF 15 COPIES OF A MIDWIFE’S COMPANION CD

A midwife’s companion is a highly effective self-hypnosis CD, specifically designed for midwives to help them feel more relaxed, in control, motivated and able to deal with the daily stresses of the profession.

The calm and reassuring voice of Maggie Howell (UK clinical hypnotherapist and founder of award-winning Natal Hypnotherapy) will guide you through relaxation, deep breathing and visualisation exercises, followed by positive suggestions to help you manage stress on a day-to-day basis.

Listening for half an hour will help take you into a relaxed, quiet state leaving you refreshed, calm, confident and ready for the next day. What’s more, it will give you safe and effective skills to help you manage your emotional wellbeing and gain coping strategies to deal with difficult situations.
Footnotes

Crossword / Puzzle

Test your wits on this midwifery-focused puzzle... How many did you get right? Look out for the answers in Issue 1 2014.

ACROSS

1. Relationship of fetal head to maternal pelvis (13)
6. ----tensive, blood pressure within the normal range (5)
7. Amount of lochia towards the end of involution of the uterus (5)
8. Archaic name for the nipple (3)
9. Rapid rise in body temperature, producing shivering (5)
11. Containing osmium, used in medical instrument-making (5)
12. ------ tunnel syndrome, may occur in pregnancy (6)
13. Relating to the heart (6)
15. Mixture of a solid with a liquid (5)
17. Small town near Seymour, Victoria, Australia (5)
19. Not young (3)
20. ----- cell mass, develops into fetus and amnion (5)
21. Grooves between placental lobes (5)
22. Catecholamine released from adrenal medulla (13)

DOWN

1. Prevention of pregnancy (13)
2. -----stasis, maintenance of stability, as in body temperature (5)
3. Culmination of sexual excitement (6)
4. Place or site (5)
5. Adrenaline, for instance (13)
10. Micro-organisms (5)
11. Foramen -----, opening between two atria of fetal heart (5)
14. Salt solution (6)
16. Covering or sheath (5)
18. Ordinary; normal (5)

Crossword 11: Jan Wallis

Notes

Last issue’s answers