The Royal College of Midwives

MIDWIVES

AUTUMN 2015

The birth continuum
Where does normality sit?
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Editorial
Jon Skewes discusses strikes and the RCM’s affiliation with the TUC

News
New NICE nutrition standard

Country news
The latest from the RCM’s country directors

The big story
What will happen to supervision?

Global news
The headlines around the world

Your RCM news
New charity partnership; London Pride 2015

On politics
New manifestos for each of the UK countries

Your student news
Cake competition; Fear of Birth Conference

On employment
Pregnancy and maternity-related discrimination

One to one
TUC general secretary Frances O’Grady on the rewards of the union movement

MSW voice
An MSW advocate explains her role and why she loves what she does

Feedback
Members’ letters: midwifery as a vocation and the better births challenge

Your thoughts
A midwife and mother on the issues and challenges of assisted conception

Student voice
Why an elective abroad can prove to be an invaluable learning experience

Voice of a mother
A mother’s view on midwifery supervisors as a valuable resource for all

Research
Two lead authors summarise their latest work

How to...
Facilitate birth in water

EBM
The contents of the September 2015 issue

rcm.org.uk/midwives
Standing up for members

Two national strikes and the RCM’s affiliation with the TUC... Jon Skewes

comments on these memorable events.

Two historic steps have taken place to defend midwifery and RCM members. The first was our two national strikes. These had overwhelming member support and produced a settlement in England. In Northern Ireland, we are still working towards one. The action sent a message of which governments must take notice. They cannot just undermine midwives and MSWs and be confident that there will not be an effective response.

The settlement in England called for talks on the Agenda for Change pay structure. The RCM is at the centre of these negotiations and will want to reduce the time it takes to reach the top of pay bands. Nine years is too long, on equality and competence grounds, to reach the top of Band 6, for example. Equally, we are aware of pressure to undermine unsocial hours provisions. We welcomed the recent Pay Review Body report on seven-day working, which talked of the need for unsocial hours to be part of a wider negotiating agenda in the Staff Council.

Then the Chancellor’s budget capped pay increases at 1% for four years across public services. We will point out the hypocrisy of unfettered pay review for MPs producing 10% increases in one year with that of frontline NHS workers expecting 1% increases over four years.

The second historic step was taken by our Board, which determined that the RCM should affiliate to the TUC. We have been accepted and are beginning to participate and benefit. The TUC will help us to improve our influence on behalf of members (for an interview with TUC general secretary Frances O’Grady, turn to page 19). I now sit on its ruling body, the General Council and on the Public Services Liaison Group. We are already achieving additional influence. Firstly, the TUC is brokering representation deals to bring health unions into talks with local authority leaders as devolution to city regions in England takes off.

Secondly, a campaign is being launched by the TUC against the Trade Union Bill, which threatens the right to strike, however careful unions are about safety. Striking workers could also be replaced during the strike by agency workers.

In a situation where austerity and threats to professions are ever present, it makes sense to work with allies for greater influence. The RCM will be introducing motions on the value of midwifery and on pregnancy discrimination for the first time at the TUC’s 2015 Congress. This will stand up for our members, the profession, women and families.

rcm.org.uk/midwives
SMOKING

Stillbirth rate decrease following smoking ban

The number of stillbirths has dropped by almost 8% in England since the smoking ban was introduced, researchers have found.

There has also been a fall by the same percentage of the number of babies dying shortly after birth.

Researchers at the University of Edinburgh looked at information on more than 10 million births in England between 1995 and 2011.

Their findings suggest that almost 1500 stillbirths and newborn deaths were averted in the first four years after the law to prohibit smoking in public places was introduced in July 2007.

The team also assessed the impact of the smoking ban on the number of babies born with a low birthweight, which is linked to health complications in later life, including heart disease and diabetes.

More than 3000 fewer babies were born with a low birthweight of less than two and a half kilos, the researchers estimate.

RCM professional policy advisor Janet Fyle said the research shows that the RCM’s vigorous campaigning to ban smoking in public places is having a positive impact.

‘It remains the case, that exposure to cigarette smoke is detrimental to the health and wellbeing of pregnant women and their unborn babies,’ she said.

HEALTHY EATING

New NICE nutrition standard

A quality standard to help improve maternal and child nutrition has been published by NICE.

It aims to support improved nutrition for women before, during and after pregnancy (up to a year after birth), and for babies and pre-school children.

The quality statements in the standard set out the priority actions to enable better nutrition.

They include that pregnant women attending antenatal and health visitor appointments are advised how to eat healthily in pregnancy; women with a BMI of 30 or more following childbirth are offered a structured weight-loss programme; pregnant women and parents and carers of children under four years, who may be eligible for the Healthy Start scheme, are given information and support to apply; and women receive breastfeeding support from a service that uses an evaluated, structured programme.

IMMUNISATION PROGRAMME

MenB vaccine added

The meningococcal B (MenB) vaccine was added to the routine childhood immunisation programme in England on 1 September.

Public Health England (PHE) wrote to health providers, including those in maternity services, to advise on communication to parents.

PHE said it is of particular importance to offer clear advice about the recommended prophylactic use of paracetamol.

Advice on the use of paracetamol following MenB vaccination differs to previous advice on the use for post-vaccination fever, which may still appear on infant paracetamol packaging.

To avoid confusion, PHE has produced two leaflets, which provide detailed advice on paracetamol dosage and timings, as well as answering commonly asked questions.

The information on MenB vaccine and the use of paracetamol has been added to NHS Choices, together with the links to the patient information leaflets.
INFANT DEATH DATA
UNEXPLAINED DEATH IN INFANCY RISE

The latest figures from the Office for National Statistics reveal the first rise in unexplained infant deaths since 2008. The figures show 249 unexplained infant deaths in England and Wales in 2013, a rate of 0.35 deaths per 1000 live births. Previously, the rate had fallen steadily from 0.41 in 2008 to 0.32 in 2012.

The largest monthly rise in unexplained infant deaths was in February 2013. This coincided with a colder-than-average mean monthly temperature.

tinyurl.com/nj4lydw

30
Following childbirth, women with a BMI of 30 or more are to be offered a structured weight-loss programme

tinyurl.com/q9hfmhn

RCM DIRECTOR, GILLIAN SMITH
SCOTLAND

MATERNITY REVIEW:
NHS Forth Valley chief executive Jane Grant has been announced as the chair of the Scotland maternity and neonatal review. Jane has previously worked with the Women and Children’s Directorate in NHS Greater Glasgow and Clyde and the RCM in Scotland is delighted that she has accepted the role and looks forward to working with her.

The review was announced in February by minister for public health Maureen Watt. She emphasised that she was keen to reassure the public that the services currently provided are very good and safe, but changes to the birth rate, demographics, new best practice and guidelines suggested it was time to look at refreshing the current model of provision. The review will look at innovation and best practice and consider all of the available information and reports into the benefits of different birth settings, including relevant recommendations from the Morecambe Bay investigation.

It is timely that the review is running alongside the one in England, and I’m sure there will be opportunities to share information and ideas. It is intended that the report will be ready by summer 2016.

MUMS CHARITY: Many midwives will be familiar with Lothian midwife Linda MacDonald, who set up the Malawi Underprivileged Mothers (MUMs) charity. It is with great pride that Linda received an OBE in the Queen’s Birthday Honours for her work and will visit the palace soon. It is well deserved, however MUMs has come to an end. But, the education part of the charity has moved to ‘Smalls for all’, who collect underwear for women and children in Africa, and also put a number of girls through education. While the feeding station part of MUMs has moved to ‘Mary’s meals’, so much of Linda’s work will be continued.

MIDWIVES ACT: The preparations for the celebrations of the centenary of the Midwives Act (Scotland) are progressing well, and the RCM Scotland conference in Edinburgh on 16 October can now be booked online at rcm.org.uk/events. It promises to be a fantastic event with a service to take place the following day in St Giles’ Cathedral, Edinburgh. It will include a midwives’ choir and a midwife singing in Gaelic, with students reading a poem. A number of dignitaries will be sharing the day with us, so if you have not already registered, please do, for this once-in-a-lifetime opportunity.

I hope many of you have read the excellent article Labours of love in The Herald Magazine, in which Dani Garavelli features midwives from across Scotland, in particular the Lochgilphead, Campbeltown and Ayrshire midwives and the parents who took part, proudly presenting their newborns.

Carolyn Pallister, public health manager for RCM Alliance partner Slimming World, said: ‘Pregnancy is a time when women often feel vulnerable and unsure about the best way to manage their weight. Couple that with concerns for the health of their unborn child and it’s easy to see why women who are already struggling with their weight may feel they need extra support. Having worked in collaboration with the RCM to develop our policy on the best way to support our members in managing their weight during pregnancy, Slimming World is the only weight loss organisation to offer behaviour change support throughout every stage of the pregnancy, from pre-conception to postnatally.’

tinyurl.com/q9hfmhn

Following childbirth, women with a BMI of 30 or more are to be offered a structured weight-loss programme

rcm.org.uk/midwives
IODINE IN PREGNANCY

NHS savings from iodine supplements

New research reveals that iodine supplementation for all pregnant women could offer massive savings to the NHS.

The study, published in *The Lancet Diabetes & Endocrinology*, estimates that introducing iodine supplements to pregnant women could save the health service about £200 per expectant mother.

The researchers looked at clinical data across 1361 articles relating to iodine deficiency in pregnant women and the effect on IQ in their children aged eight to nine years.

They used eight articles to work out the monetary value of IQ points.

The study shows that, as well as the UK, the findings have implications for the 1.88 billion people in 32 countries with iodine deficiency worldwide.

RCM director for midwifery Louise Silverton called on manufacturers of pregnancy supplements to include iodine as a matter of course, adding that the importance of adequate iodine in pregnancy had been known for some time, with this study providing additional supportive evidence.

Louise added that while midwives advise women on eating well during pregnancy, with iodine being found in dairy as well as a variety of seafood, their intake may be insufficient.

'Some pregnancy supplements include iodine, but the time is right for all manufacturers to include the recommended level of iodine in their formulae,' she said.

[press.thelancet.com/iodine.pdf](press.thelancet.com/iodine.pdf)

DUTY OF CANDOUR

New guidance urges openness and honesty in health care

Midwives, nurses and doctors should know what is expected of them when things go wrong, and should have the support of an open and honest working environment, according to new guidance.

It adds that patients should also expect a face-to-face explanation and apology from midwives, doctors and nurses. It aims to help patients understand what to expect from healthcare professionals.

Developed in collaboration between the NMC and the GMC, *Openness and honesty when things go wrong: the professional duty of candour* builds on advice in the NMC code and *Good medical practice*.

Under the new guidance, midwives, doctors and nurses should speak to a patient, or those close to them, as soon as
Country news

RCM DIRECTOR, HELEN ROGERS
WALES

MATERNITY NETWORK:
The Maternity Network Wales has launched its new website bit.ly/maternitynetworkwales.

Features on the site include quick access to Wales and UK resources (for example, Welsh government policy documents and publications), all-Wales guidelines, current projects being undertaken by the Maternity Network Wales working groups, membership details (Maternity Network Wales and partner organisations), quick links to partner organisations, and the latest blogs and conversations on Twitter.

I would encourage all of our members to visit the site and see what is available to them.

BANGOR MIDWIFERY SOCIETY:
In June, Bangor University’s Student Midwife Society held a celebratory annual general meeting with a packed afternoon that reflected the success of the society over the past academic year. I was inspired by the enthusiasm and passion that all of the students displayed. It was a fantastic day, which ended on an extremely upbeat and fun note.

HYWEL DDA BRANCH MEETING:
The branch members held their first meeting in Cardigan in July with invited guest speakers, RCM chief executive Cathy Warwick and City University London’s professor of maternal and child health Christine McCourt (both pictured above). The day was organised by branch chair Sue Peterson, and was a fantastic opportunity for midwives to get together to celebrate and network over afternoon tea and cakes.

FGM:
A new report, published by City University London and Equality Now, shows the prevalence of FGM in England and Wales. The Welsh government supports a zero tolerance approach towards FGM and some excellent work is taking place here.

Midwives, in partnership with other agencies, have a clear role to play in ensuring that this unlawful practice no longer continues.

Detention:
A prison inspectorate report finds that Yarl’s Wood detention centre has contravened government guidelines by detaining pregnant women.

tinyurl.com/pct2v77

Patients should also expect a face-to-face explanation and apology

The guidance also says that they should not try to prevent colleagues or former colleagues from raising concerns about patient safety, while managers must make sure that if people do raise concerns, they are protected from unfair criticism, detriment or dismissal.

NMC chief executive Jackie Smith said: ‘We believe that the public’s health is best protected when the healthcare professionals who look after them work in an environment that openly supports them to speak to patients or those who care for them, when things have gone wrong.’

tinyurl.com/najyr7

‘Valuing diversity – embracing change’ is the theme of the 7th annual CNO’s BME Advisory Group Conference, taking place on 16 October in Birmingham.

tinyurl.com/pdm9lnx

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tinyurl.com/pdm9lnx
Supervision will leave the NMC’s legal framework, but the RCM is determined to ensure it does not disappear altogether. *Julie Griffiths* finds out more.

**LONG LIVE SUPERVISION**

Midwifery supervision will leave statute, that much is clear. The RCM is working hard to ensure that it does not leave the profession too.

Since it was announced that supervision would be taken out of the NMC’s regulatory legislation, its future has looked shaky. A review by the King’s Fund, *Midwifery regulation in the United Kingdom* (NMC, 2015) acknowledges this. It found that the current system is something ‘extremely important’ to most stakeholders, particularly midwives. But the same review says, once removed from the NMC, nobody else would take on the responsibility and stakeholders would ‘look to re-allocate the investment elsewhere’.

For RCM public affairs advisor Stuart Bonar, this is the crux of the issue.

‘If supervision is handed to employers to continue, then there will be very little left. If we just remove legislation and leave it to trusts then, in a few years’ time, we’ll find it has withered away. And, once it’s gone, it will be very hard to bring it back,’ he says.

Work is afoot to ensure this does not happen. The UK chief nursing officers (CNOs) have agreed to take on supervision as their responsibility. The Department of Health (DH) is leading a working group that includes the CNOs, which is putting together a proposal paper for the health secretary. RCM chief executive Cathy Warwick is also on the group.

‘The paper advocates some form of clinical supervision remaining. The paper is very good, though it is still a draft, but our comments on it were: “Where are the teeth?”’ she says.

The concern is that, once it is no longer mandatory, it will be difficult to enforce in tight economic times.

One route for ensuring supervision retains its importance is giving it to another regulatory organisation. David Foster, head of the nursing, midwifery and allied health professions policy unit at the DH, who leads the group, is checking with bodies, such as the CQC, to see whether this is a possibility.

But Jess Read, chair of the LSAMO UK Forum, who is also on the working group, wonders if supervision falls within their remit.

‘The CQC has got a clear line of enquiry and my understanding is that it is about monitoring, inspection and regulation of services against defined standards. It is uncertain as to whether those standards could incorporate the supportive elements of statutory supervision, such as the midwife’s annual review,’ she says.

Jess also wonders what authority the CQC might have if a trust did not bother with supervision.

The other challenge of CNOs taking over its responsibility is the possibility that the four nations develop different systems. Cathy feels this is a worry.

Already there is looking like a divergence across the UK. Cathy

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**WHAT THE RCM WANTS**

**Midwifery voice**

► The NMC may no longer be required by law to have a midwifery committee, but the RCM is pushing for continued guarantees that there will be a strong, distinct midwifery voice within the NMC.

**Regulation**

► The change may no longer require the NMC to produce the Midwives rules and standards. The RCM will fight to ensure that the midwife’s role continues to be protected.

**Supervision**

► There may be no legal requirement for the system of supervision to exist, but the RCM wants to ensure that the non-investigatory elements remain in place.
FAST FACTS
(NMC, 2014)

669
► incidents were investigated by LSAs in 2013-14.

875
► local action plans and 144 LSA practice programmes occurred as a result.

57
► suspensions and 73 NMC referrals also resulted from the investigations.

}says that there is ‘a very strong commitment to supervision being retained within the health service from devolved nations’. And England?’ This may be less apparent. However, in a recent speech in the House of Commons on NHS reform, health secretary Jeremy Hunt did say that changes would include ‘placing a greater focus on learning from reflective practice in staff development’. Cathy says that this sounds like a commitment to supervision, which is reassuring.

Aside from the desire and drive to make it happen, Carmel Lloyd, the RCM’s head of education and learning, says that it is likely that supervision will mirror health care across the nations. This has an impact on the profession’s leadership.

‘The other countries are smaller and there is more coherence among midwifery leaders. They meet and there is more networking. But that’s not the case in England. The reorganisation means there is not really that same midwifery voice,’ she says.

The LSAMO function will continue until the new system comes in, which may be a year, 18 months or two years. But the system has already started to fragment. Under the reorganisation in NHS England, the number of LSAMOs dropped from 10 to seven.

‘The LSA function is dismantling before anything is in place to replace it. I fear for professional leadership in the future,’ Jess says.

As well as working hard to ensure supervision is kept, the RCM is seeking to influence the wording of the text, which will remove the supervision element from statute. If it is done without careful wording, says Cathy, there is the potential to remove other important elements.

‘For example, in the same section, there is a definition of childbirth. If it’s taken out then, it needs to be somewhere else. We have a meeting with the DH lawyers and that will give us more clarity,’ she says.

In the meantime, the RCM is preparing itself in case there is a battle on its hands. It is continuing to lobby sympathetic MPs.

‘It is a movable feast at the moment,’ says Cathy. ‘Things should be clearer within a few weeks.’

DAY OF ACTION: Following the successful day of action in April, discussions have been held with the Department of Health, Social Services and Public Safety (DHSSPS) in relation to the 2015-16 pay deal for health and social care (HSC) staff. We will keep you updated as they progress. Hopefully, all RCM members who participated in industrial action have now submitted their claims for additional hours worked and received the extra payment in their June salary.

If you have had any problems, contact your local RCM steward.

Early analysis of the record cards kept by staff indicate that most midwives in Northern Ireland (NI) work an average of two extra, unpaid hours each week. As almost 70% of midwives in NI work part time, this is a clear demonstration of the extent to which maternity services rely on the goodwill of staff. The RCM has written to the newly appointed health minister Simon Hamilton seeking an early meeting to discuss pay and other issues of concern.

TERMINATION GUIDANCE: Although Mr Hamilton hasn’t been in the post long, he is progressing with some long-standing issues, including the publication of guidance in relation to the termination of pregnancy. The RCM has been assured that the long-awaited guidance will be published ‘shortly’. The DHSSPS has begun a review of the way that HSC services are commissioned in NI, and the RCM has contributed to this discussion with a report to be published soon.

CHILD DEATH REPORTING: The Donaldson report was published in January with the aim of examining arrangements for ensuring and improving the quality and safety of care provision in NI. The report doesn’t mention maternity services, however, it does say that the current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing more harm than good. It adds that it is distressing for families, burdensome for staff and is not producing useful learning.

Midwives caring for bereaved parents will welcome this, especially where it is known in advance that a baby will die shortly after birth. It’s hoped that the health minister will take these comments on board and amend the current reporting arrangements.

GMTP BOOK: The RCM Global Midwifery Twinning Project has ended, but volunteer midwife Áine Alam, who spent time in Uganda, was so inspired by her experiences that she has published a book, Teach, don’t tell: effective strategies for teaching midwives is aimed at midwives and midwife teachers in developing countries, and will feature as a competition prize in the next issue of Midwives.
At attempted murder charge

Munich prosecutors have charged a 34-year-old midwife with nine counts of attempted murder for allegedly giving blood thinners to women shortly before they were to give birth by CS. Her actions caused life-threatening bleeding, it is claimed. Prosecutors said that the German woman, whose name has not been revealed in accordance with privacy laws, allegedly acted out of ‘dissatisfaction with her work situation’. She has denied the charges. An investigation was opened in 2014 after a Munich hospital filed a complaint following one incident. Prosecutors found three other cases at the same hospital, and four more at another hospital where the midwife worked in 2011-12. They have also accused the suspect of administering drugs to another woman that induced such severe contractions that she needed emergency medical help. None of the newborns were harmed, they said.

Tanzania

Modern training

Traditional midwives are to be offered training by a school of nursing to help lower maternal deaths and curb the workforce shortage in rural areas. The Kibosho School of Nursing (KSN) has been given permission by the Ministry of Health and Social Welfare to provide the training. The KSN training department conducted research that discovered that about 350 midwives used only their birth experience to provide a service, something that led to the deaths of many newborns or mothers. KSN principal Devotha Shayo said the six-month programme will provide these traditional midwives with proper midwifery training to address this problem. Devotha added that many midwives who offered services in different health facilities received training some years back, but now needed modern intensive training to cope with the present maternal complications.

China

Pregnancy approval

A Chinese firm reportedly plans to ask its staff to seek approval before they get pregnant.

Workers at a finance firm in Henan Province were said to have been told they must apply for a ‘place on the birth-planning schedule’, and only if they had been employed for over a year. Those who become pregnant without approval risk a fine of ¥1000 (£102) and may also have to forfeit year-end bonuses and promotion or awards. The plan distributed by the firm suggested that only married female workers who had been with the company for more than a year would be allowed to conceive – and only within a specific period. ‘The employee must strictly stick to the birth plan once it is approved,’ the statement said. A spokesperson said the plan is a draft for employees to comment on.

New Zealand

Budget promises not met

The New Zealand College of Midwives fears that the government has not honoured a budget promise for community midwives. Budget 2015 specified new funding of NZ$4.882m for community midwives for ‘cost and volume pressures’. But then the ministry said only NZ$2.1m had been applied to cost pressures. College chief executive Karen Guilliland has written to health minister Jonathan Coleman to voice her concerns that the budget promise was being broken.

Medical newspaper *New Zealand Doctor* asked ministry National Health Board group manager Grant Pollard how the ministry would ensure community midwives benefit fully from the budget promise of NZ$4.882m. Mr Pollard said that the ministry was still considering how to apply this funding.

India

Midwives to do HIV tests

Midwives trained by the government are to carry out HIV tests on expectant mothers to diagnose the infection at an early stage.

The idea is to make testing more accessible in order to prevent parent-to-child transmission of HIV or AIDS. While such testing is often available in a hospital setting, it is less common in rural areas. Midwives will be trained by state and district AIDS control organisations to conduct rapid tests to check for the HIV virus. These are cold blood tests done through finger pricking.

Early diagnosis in pregnant women would enable interventions that may prevent the spread of the virus to the unborn child. India has the third largest population of HIV-infected people in the world, according to the United Nations.
midwives’ participation is key
—are you in?

Flu was responsible for 1 in 11 deaths among pregnant women between 2009 and 2012.¹

Your influence is key in helping pregnant women understand that vaccination can help protect them from serious illness and complications from flu, and in turn help reduce the risk of premature birth and low birth weight of their baby.

To find out how we can help you get the message across, visit www.flu-protect.co.uk

your influence can make the difference.

ABRIDGED PRESCRIBING INFORMATION

Legal category: POM

Package quantities and basic NHS cost:
Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90.

Inactivated Influenza Vaccine (Split Virion) BP
Refer to Summary of Product Characteristics for full product information.

Presentation: Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process.

Indications: Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age.

Dosage and administration: Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously.

Contraindications: Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection.

Warnings and precautions: Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunocompromised subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. Pregnancy and lactation: Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation.

Undesirable effects: Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema, anaphylaxis), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, encephalitis and Guillain-Barré syndrome. For a complete list of undesirable effects please refer to the Summary of Product Characteristics.

Marketing authorisation holder: Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP.

Marketing authorisation number: PL 6745/0095 Date of last review: February 2015

References:
1. Increasing influenza immunisation uptake in pregnant women, Resource pack for NHS organisations in HPA South East Region www.rcm.org.uk

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Sanofi Pasteur MSD; reporting form can be found at www.sqmsd.co.uk/AE or via telephone 01628 783291
RCM leadership event

Join our one-day RCM Leadership Workshop to explore how to influence policy and maintain effective partnerships, learn from one another and share knowledge and expertise.

The workshop, led by an experienced facilitator, will take place on 8 December in Bristol.

Delegates will consider how to build the essential professional alliances needed to deliver a high-impact maternity service.

They will explore the theories behind influencing and innovative teamwork and the issues around applying these theories in practice, as well as learning how to apply tools to work-based scenarios through working in action learning sets.

[Link: tinyurl.com/q2ys2k2]

NEW CHARITY PARTNER

The RCM is pleased to announce its chosen charity of the year, Women’s Aid, which is the national charity for women and children working to end domestic abuse.

Women’s Aid will remain the RCM’s charity of the year until the end of 2016, with the two organisations working together on joint projects to raise awareness.

Domestic abuse is a significant factor in the ill-health and mortality of mothers and pregnant women. It can have both a physical and emotional impact on the woman and can lead to miscarriage, low birthweight, ruptured uterus and pre-term labour.

Speaking at the launch, RCM chief executive Cathy Warwick said that Women’s Aid is a charity that will resonate with RCM members, who often deal with women who use their services.

She added: ‘Domestic abuse is abhorrent and we should be doing all we can to stop it. That is why this partnership with Women’s Aid is so important. Pregnancy can be a trigger point for the start of domestic abuse and midwives have a crucial role to play in spotting signs of it, and supporting women who are suffering from it.’

The charity relies on donations to carry out its work, so find out on the RCM website how to donate or host a fundraising activity.

[Link: rcm.org.uk/womensaid]

Honours for staff

More than 1000 people were recognised in the Queen’s Birthday Honours 2015, including two members of RCM staff.

RCM director for midwifery Louise Silverton was recommended for a CBE for services to midwifery and maternal and child health, while RCM professional policy advisor Janet Fyle was recommended for an MBE for services in tackling FGM.

Commenting, RCM chief executive Cathy Warwick said: ‘For the past 21 years, Louise has been a member of staff at the RCM and has held positions including deputy general secretary and director for midwifery. This honour is highly deserved, as Louise is a committed and motivated individual.

‘Janet’s commitment to the eradication of FGM is widely respected. Women who have suffered FGM are deeply grateful to her for her work, and in the midwifery profession, she is hugely respected for her courage in taking this very difficult issue forward. The RCM is delighted that she has received this award.’

PRIDE 2015

For the second year running, the RCM took part in the London Pride Parade in June.

Over 60 RCM members joined in the celebrations at one of the city’s biggest LGBT events.

An excellent time was had waving RCM flags in the carnival atmosphere – it certainly was a fantastic, life-affirming celebration.

Thank you to all the members who came along – we’re already looking forward to Pride 2016.

Stay up to date

If you don’t currently receive our emails, contact our membership team to check your contact details are correct, and stay updated with the latest news, articles and analysis. Call 0300 303 0444.
On politics

RCM PUBLIC AFFAIRS ADVISOR
STUART BONAR

Spending cuts and new manifestos

THE CONSERVATIVES WENT INTO THE last election promising to eliminate the deficit through cutting public spending, and, now elected, they are putting that into practice. We have already seen, for instance, the announcement that they will slash £200m from local councils’ public health budgets.

The RCM fears that this will have a damaging effect on important public health campaigns on obesity and smoking, which can impact on those using maternity services, as well as more directly relevant campaigns like breastfeeding. We believe that getting public health right can mean real savings in later years, and that these cuts are short-sighted and will end up with more money needing to be spent, not less. We hope this is not the start of a concerted campaign of cuts to public health and we will be vocal in opposing them.

While those of us in England can forget about electioneering and political campaigning for the moment, spare a thought for those outside of England. Before long, doors in Scotland, Wales and Northern Ireland will be knocked on, telephones called and leaflets stuffed through letterboxes, as the parties limber up for elections to the Scottish Parliament, National Assembly for Wales, and the Northern Ireland Assembly. With health a devolved matter outside England, the choices voters make will impact on the working lives of midwives and MSWs.

What is the RCM doing about it? We are going to be launching a manifesto for each part of the UK and asking parties and candidates to sign up to it. We did something similar at the general election and we saw every main political party support at least one of our manifesto priorities. We also found some new friends among those standing, with two-dozen of them elected to the House of Commons. Given that we lost some longstanding MPs who were happy to help our campaigning in parliament, it was a relief that some new friends made it into the Commons.

We have already spoken to midwives in Northern Ireland about what they would like to see from any post-election administration in Belfast, and we will be meeting midwives in Scotland and Wales soon, too. It is important that what we ask for in each manifesto reflects the issues most important to members locally, so if you live in either of those countries and want to let us know what you think, please email me at stuart.bonar@rcm.org.uk.

Finally, the RCM has joined a newly-formed group in Scotland that brings together people working in health policy for organisations representing NHS staff. RCM director for Scotland Gillian Smith is already well involved in the health policy debate, but this will provide another route to keep in touch with issues as they arise and seek to work with our NHS staff groups to influence developments at the Scottish parliament and in the Scottish government.

SPENDING CUTS AND NEW MANIFESTOS

MIDWIVES AVAILABLE ONLINE
The full Midwives magazine archive is now available online in PDF format for all members to access.

With some great articles from over the years, they are an interesting read for all members, especially those who have just joined the RCM.

Members must be logged into their RCM account to access the content, which is in the Midwives magazine section, under the ‘Learning & career’ tab.
NORMALITY IN MIDWIFERY CARE

CAKE COMPETITION AND STUDY DAY
A highly-detailed placenta cake (pictured, left) took first place in a competition at the Queen’s University Belfast Midwifery Society’s study day.

Several students created their own masterpieces and second place was awarded to an incredible cord prolapse cake, designed by three second-year students.

The study day focused on promoting normality in midwifery care with sessions run by the facilitator of the Positive Birth Movement in Belfast and a representative from Natal Hypnotherapy.

YOUR STUDENT NEWS
What’s new in the student world? Your chance to tell us where you’ve been and what you’ve been up to...

FEAR OF BIRTH
CONFERENCE SUCCESS
The overwhelming theme at the Huddersfield Midwifery Society’s Fear of Birth Conference was that fear of birth is almost becoming an epidemic. It was concluded that there must be improvements in continuity of care, while midwives need to reclaim midwifery, be kind, think about the language they use with women and their families, and ensure that care pathways are appropriate for women.

The conference, held in July, was attended by some 150 delegates, including midwives from across the country and lots of prospective students.

CHALLENGES AND CHANGES

STUDENT MIDWIVES’ CONFERENCE
RCM president Lesley Page (pictured below with students) gave an inspiring talk about the future of midwifery at the University of West London’s annual student midwives’ conference. The theme was challenges and changes in midwifery, which included talks about FGM and the new Pan London practice assessment document that comes into circulation in September.

Several students also presented topics, such as breast care and an innovative video they had made. There was something on the buddyng scheme, where new students are paired with more senior students for support in clinical placements, and one of the male students spoke about his experiences and the challenges he has faced during his training.

There was also the chance to celebrate successes from the previous year.

rm.org.uk/midwives
NHS ENGLAND REVIEW UNDERWAY
RCM chief executive Cathy Warwick has encouraged members to provide feedback on the latest maternity review.

She said comments received are being fed into the NHS England team.

There are currently four review workstreams including models of care, choice, levers and incentives, and professional culture and accountability.

International models of maternity care are also being explored and stakeholder events are taking place across the country.

Cathy said: ‘While it’s hard to predict the review outcome, it is clear there is a desire to ensure all previous policy recommendations for high-quality maternity services are implemented.

‘It’s also accepted that women should be at the heart of all care provision. So, let me hear your views on how you would like to see services change, and I will ensure your voices are heard.’

Find out more at england.nhs.uk
► Email feedback to angela.hulbert@rcm.org.uk

STUDENT ARTICLES
THE LATEST ONLINE
The RCM has an area on its website for student members to find the latest student-related news, information and articles, just bookmark the link below.
► rcm.org.uk/tags/student-ezine

NMC BOARD
STUDENT APPOINTED
Congratulations to second-year student Sarah Craig, from the University of Cumbria, who has been appointed as an NMC education board member. Her role is to bring in a student perspective in terms of the pre-registration requirements.
VITAMINS & NUTRIENTS IN PREGNANCY

Helping mums put government guidance into practice

Making it simple for mums

Mums often feel confused by the volume of advice they receive when they are pregnant. We spend a lot of time telling mums what they CAN’T do, when they crave positive, practical advice about what they CAN do. Educating mums about the importance of key nutrients in pregnancy and giving simple, practical advice about how to get them is one of the ways midwives can positively influence the health of mums and their babies and follow NICE antenatal guidance, as well as the new NICE quality standard on improving maternal and child nutrition.

Despite Department of Health recommendations of 400µg folic acid and 10µg vitamin D, mums are not supplementing daily

- Over a third of pregnant and breastfeeding women don’t supplement
- Less than half of pregnant women take folic acid supplements during pregnancy
- Many women begin pregnancy with low vitamin D status and use of vitamin D supplements in pregnancy is low

Why don’t mums take supplements?

They are confused. Over three quarters (78%) of pregnant women could not identify the two key vitamins the Department of Health recommend during pregnancy. More than two thirds don’t recognise the need to take additional vitamin D.

They forget. Approximately a third of women admitted to often forgetting or only sometimes taking their daily recommended supplements during pregnancy and breastfeeding.

They make them sick. A third of women say supplements have made them ill in the past. 80% of pregnant women experience morning sickness.

One nutrimum bar a day: A convenient way for mums to get the additional nutrients they and their baby need

nutrimum cereal bars replace mums’ daily tablet supplement making it easy for them to fortify their diet in pregnancy and breastfeeding everyday. One nutrimum bar (40g) per day meets Department of Health supplementation recommendations, providing 100% RNI of folic acid and vitamin D during pregnancy and 100% RNI of vitamin D during breastfeeding, as well as other key nutrients such as omega 3 (DHA), iodine and iron.

References

‘Midwives are not alone among public sector workers in terms of funding, staff levels and seven-day working issues. They are joining a movement, not an organisation’

The RCM has become the first royal college to join the TUC. General secretary of the TUC Frances O’Grady talks to Julie Griffiths about the challenges and the rewards of the union movement.

A suggestion that the new government has had a shaky start to its relationship with trade unions elicits a laugh from the TUC general secretary Frances O’Grady. ‘That’s the understatement of the year!’ she quips.

The government’s approach to unions in the few months it has been in power has been aggressive. The Trade Union Bill was announced, in which the threshold for participation in strike ballots will be raised to 50%, and public sector strikes will need the backing of at least 40% of those eligible to vote.

Frances says that she believes there are elements of the government that view the relationship with unions as ‘unfinished business’. ‘They want to replay old trends from the 1980s,’ she says. ‘One of the papers described it as the biggest attack on trade unions for 30 years’
and I agree. It is an affront to civil liberties. The government is out of line and out of touch with the British public.’

The government’s approach means that trade unions are facing a challenging time, as are workers who rely on their support. Frances says it is a time to come together in unity to fight.

In the summer, the RCM announced it would do just that by joining the TUC and thereby becoming the first royal college to be a member. Frances says she is delighted, and adds that there has been a myth that royal colleges cannot join the TUC and she thinks that this is why none have done so before.

‘There’s another myth that you can’t marry trade unionism and professionalism – that’s not true,’ she says. ‘We have a number of professional unions in the TUC, such as those for physiotherapists, journalists and pilots.’

The TUC has 52 affiliated unions, of all shapes and sizes, and represents nearly six million working people. As an organisation, it is not linked to any political party. Frances says that about 15 unions in the TUC family are affiliated to the Labour Party though.

**Changing landscape**

One of the biggest changes in the trade union movement since Frances became active is the influence of women. The previously male-dominated world has changed with membership now 50/50 split. Frances is the first woman to be general secretary of the TUC and she estimates that three in 10 trade union leaders are women.

One of the undoubted benefits of the RCM becoming affiliated to the TUC is the extra clout. ‘There is strength in numbers. The history of the TUC has shown this repeatedly,’ says Frances.

For RCM members, there are also benefits. Frances says that one of the biggest advantages is the access to learning. Unionlearn, which is part of the TUC, aims to assist unions in the delivery of this for their members, as well as managing the Union Learning Fund. Since 2003, more than 30,000 union learning representatives have been trained and more than 220,000 people each year have been given training and learning opportunities.

Joining the TUC is more than that, she says. It is about being part of a larger movement that fights for equal rights. Frances says that this is important at a time when, as well as trying to reduce workers’ rights, the government’s austerity measures mean that public services are under attack.

‘Midwives are not alone among public sector workers in terms of funding, staff levels and seven-day working issues. They are joining a movement, not an organisation,’ says Frances.

The movement has been of great benefit to women through the years. It has won campaigns on family friendly hours, equal rights for part-time workers and equal pay, among others.

‘If we hadn’t campaigned, then that wouldn’t have happened. That’s all credit to the trade union movement,’ says Frances.

**The future**

Yet trade union membership is in long-term decline with membership having peaked at around 13 million in the mid-1970s. The latest figures (Department for Business, Innovation & Skills, 2015) show
that by 2014, it had fallen to 6.4 million. Nevertheless, this still accounts for a quarter of all employees in the UK.

With the Conservative government in power, the union movement is facing an uncertain future. Frances is in no doubt that there are a number of challenges, but the TUC is ready for the fight. She plans to battle ‘these draconian and undemocratic measures’ every step of the way.

One of the things that rankles Frances is that, in spite of the government rhetoric that the reliability of public services are jeopardised by strike action, any industrial action is rare. Frances says that it takes a lot for members to strike.

‘A strike is a symptom, not a cause of a breakdown in industrial relations,’ she explains.

It is also a crucial bargaining chip for the unions. Without the right to strike, the power is all on one side of the negotiating table, Frances acknowledges.

This aside, it is also shortsighted of the government to try to eradicate this right, says Frances, because it solves nothing.

‘You can’t get rid of dissent in the workplace by introducing these measures,’ she says. ‘It won’t disappear.’

Those in the public services have plenty of reasons to dissent in the current climate. The TUC plans to continue lobbying to challenge the government’s austerity measures, which it sees as false economy. Frances argues that if more people have decent jobs, then there is more money from taxes and this means there is more to invest in public services.

‘We are campaigning for a fairer economy that works for working people, not just a few at the top,’ says Frances.

Given that the governor of the Bank of England, Mark Carney, has said that inequality and perpetual low pay is the greatest economic risk, this is a fight that goes far beyond the individuals involved. If those at the top increase their own pay without affording the same rises to staff, as is quite possible without trade unions, then the future looks bleak.

As Frances points out: ‘The trade union movement is not perfect, but the majority of the public see it as essential. If we don’t stand up for people, then who will?’

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Yvonne Dignam explains why she became an MSW advocate and what she hopes to achieve.

MY INTEREST IN LEARNING AND development has always been there – whether studying towards something or doing a course – so becoming an RCM learning rep was an obvious step. It is a way of gaining new skills, knowledge and information and passing it on to other MSWs, helping them to develop and gain confidence in learning and studying. I also flag up events, online learning and RCM i-learn to colleagues.

Recently, I added the role of MSW advocate to my portfolio. Last year, I was involved in the MSW focus groups in Wales and enjoyed being able to share experiences and information with other MSWs from around the nation. It made me realise how different the role is across the country. When the MSW advocate post came up, I thought it would give me the opportunity to contribute to the ever-changing role of MSWs and, more importantly, ensure the voice of the MSW is heard.

The MSW role is still new to some people, who aren’t sure about us and even feel threatened. I believe this is because they don’t know enough about the role. As an MSW advocate, I intend to promote the role to every member of staff involved on the maternity unit, no matter what they do – from the domestic to the physiotherapist. It’s also important to make student midwives aware of the MSW role from early on in their training, so they know what we are able to do and, crucially, what we are not.

The RCM membership is open to all MSWs. They have their own area on the RCM website, their own membership, and are kept up to date with everything through newsletters and Midwives magazine. An added bonus is should you require representing at any time, because of workplace problems, then it would be by someone who understands the role and the area of work. Another benefit is the exclusive members-only i-learn section of the RCM website, with new courses added regularly.

I’ve been told many times that I should do my midwifery training, but, as much as I admire midwives and their work, I’m happy in my role as an MSW. By being involved in the advocate role and that of learning rep, I’m furthering my career in my own way, while simultaneously helping to develop a role that I’m passionate about. MSWs need a voice and someone to go to for guidance and peer support. As an advocate, I hope I can be that person.
A way of life

ANNA MERRICK, FIRST-YEAR STUDENT MIDWIFE
King’s College London

My mother is poised, standing behind the camera and ready to click, when she stops and comes over, straightening my little red cape. I stand to attention; beaming with the pride for a profession I know nothing about. The camera flashes, and the moment is captured forever. That’s what I remember and feel when I look at this picture (right) of me aged six.

Fast forward 13 years, and it’s a dark and drizzly autumn evening in central London, I’m arriving promptly to the postnatal ward, for the first of four consecutive night shifts. My uniform is folded neatly, my ‘tool-bag’ of equipment all labelled and ready for action. I change into my outfit – an off-white, blue striped dress with ‘King’s College London’ embroidered in bright red onto the chest. My mother showed me how to iron, press the collar, and fold it correctly. Adjusting my fob watch as she had adjusted my dressing-up outfit years ago, I am ready, wearing the same smiling pride.

I am a 19-year-old first-year student midwife from rural Dorset, embarking on the last shifts of a ten-week block of clinical placement. The postnatal ward has been my favourite area of the year so far, where my intuitive, ‘hands-on’ skills of true midwifery care have really started to develop. I find myself answering all the call bells, removing all the cannulas I can get my hands on, talking with the women so that they feel more confident in feeding their newborns. A particular 4am call bell stands out – a new mother and I can’t help but quietly laugh at the hilarity of trying to get her baby to latch on to the breast in the middle of the night. We get there in the end, both of us now clearly masters in breastfeeding, and peace in Bay 7 is restored.

People always seem to ask my friends and I why we decided to become midwives. It is a question that was thrown at us regularly in interviews, where words seemed to fail me, and just about everyone else. Instead, emotion is what answers. There was no defining moment, no sudden realisation. It was as if it was always there, patiently waiting in the background. There were ways of drawing it out of its instinctual hiding place – books, documentaries, work experience. But as I walk back to the tube station on that glorious Monday morning, as all the other commuters sit emotionless, unknowing, on their way into work, I can feel it; an irrepressible, overwhelmingly strong feeling of gratitude and happiness, pride and excitement, all mixed into one. There is an overarching feeling that this is where I am meant to be. Yes, that’s it. We are drawn into midwifery – it edges its way into our lives, written subtly on the history of all our backgrounds until it finds us, quite clearly, and demands to be heard. Clichéd as it is, this is a vocation – a way of life.

I am tired and the night has been demanding. Yet the sun is shining, and here I am, on the cusp of a career that encapsulates intimacy, privilege and compassion. I pause. Breathe. Exhale.

I am going to be a midwife.
Rising to the better births challenge

ANN HIGSON, MIDWIFE
North Manchester General Hospital

I would like to respond to your article in What does better births look like for you? in Midwives Spring 2015. It is very difficult to break away from the TV image of women lying down on beds to labour and give birth. Society has done a great injustice to women where birth is concerned by allowing programmes like One born every minute, where women’s faith in themselves to birth their young is eroded week after week.

Research has shown us (Lawrence et al, 2009) that women who remain mobile and adopt positions that they are comfortable with during labour have less analgesia and labour much quicker. The mobile elements found on most CTG machines today are not just there as a fancy add on, they are there to be used to help keep women in charge of their labour by staying off the bed. Hand on heart, how many midwives reading this can say they have ever used the mobile CTG attachments or have strived to keep women off the bed while obtaining a necessary CTG trace in labour?

If we are truly going to obtain better births for our women, then we have to start with the basics, often lost when working within a busy hospital obstetric unit. Normality is often the last thought on our minds as we strive to follow all the guidelines and protocols available to ‘keep women safe’. Once a woman is in labour from an induction then we have the power to stop any further interventions that may cascade her into an operative birth.

The US has obstetric nurses in their obstetric units and they seem to be nothing like midwives. The internet is full of unhappy women who feel they have been violated by hospital care received in labour. ‘Obstetric rape’ is often the cry from these women, who are desperately trying to reclaim the lost art of birthing within the doctor-led services available in the US today. This is one model of care that we must strive to stay well away from by supporting midwives to look at their practice and reflect. Am I being truly ‘with woman’?

Student midwives are our future and yet the number of students who pick up the very bad habit of calling contractions ‘pains’ to women really drives me crazy. I once mentored a student, well into her second year, and she had never laboured or birthed a woman off the bed. This was all she had ever seen and she was quickly becoming an obstetric nurse without her even knowing that there was a choice.

Women need knowledge. We can give them this knowledge during parentcraft classes that teach them how to labour as nature intended – relaxed and confident, giving them the choice of mobilising or simply sitting on a comfy chair or birth ball. When was the last time you even saw a birth plan, have women simply given up writing them as they learn to expect the carnage they see on TV?

Better birth is an achievable choice for most women going into labour today with the right support from their midwife. The article asks for strong midwives, confident in the simplicity of normal birth, let’s rise to this challenge and make a difference today.
EMOTIONAL BAGGAGE

Women who have had successful fertility treatment can face numerous emotional challenges during pregnancy, labour and beyond, as Katie Eaves explains.

As a midwife, I am very aware of the psychological and physical issues that women, pregnant by assisted conception, face. The reason? I have been through several intracytoplasmic sperm injection (ICSI) fertility treatments myself. Fortunately, one was successful, but my experience has taught me that the journey for women who have battled infertility is very different from those who have not. There is often a misconception that they are fine emotionally since they are pregnant and, therefore, the problem is resolved. But this can be far from true.

These women can go into pregnancy emotionally exhausted. They have had no chance to recover from what could have been years of stress and, sometimes, depression in the attempt to become pregnant, and the pregnancy can prompt more difficult emotions. For example, feelings of anger at the difficulty they have experienced, not to mention the stress of financial worries and relationship strains. Physically, women may feel unwell after treatment because the drugs can cause unpleasant side effects and, because the conception was assisted, these women can lack confidence in their body’s ability to carry a baby. Add in anxiety about losing a baby after years of trying to conceive, and it can be overwhelming. It can be even worse for those who have previously experienced miscarriage.

As women approach full term, confidence does not necessarily improve. Together with the consequences of needing numerous interventions during treatment, it can affect labour. Sometimes, treatment procedures are painful and uncomfortable and many women cope by emotional detachment, which may work well for undergoing treatment but, during labour and birth, women can find it hard to be in tune with what their body is telling them to do. It is important that midwives acknowledge and promote confidence and normality in childbirth, as complications can only add to their emotional burden.

Even when the baby is born, stress may continue. The elation of a new baby may be replaced by anxiety about the newborn’s wellbeing. This is hard at a time when the woman believes she should be happy and relieved. Other difficult issues could be related to donor egg or sperm, which women don’t often tell midwives about. For some, breastfeeding becomes problematic. Women may lack hormones required to produce sufficient milk, as this could be the reason for infertility in the first place. They need to be supported and encouraged to enjoy and bond with their baby.

By providing the right care, midwives could make a difference and help to improve pregnancy, birth and breastfeeding outcomes, as well as a woman’s psychological wellbeing after an assisted conception pregnancy.

Katie Eaves, midwife, Royal Sussex County Hospital

WHAT CAN MIDWIVES DO?
- Acknowledge the journey these women have been on prior to pregnancy. (Offer counselling and promote forms of relaxation or alternative therapies, such as acupuncture and aromatherapy.)
- Encourage mothers to express any anxieties and reassure with accurate information, assessment and monitoring.
- Promote normality and confidence for these women to carry a baby through pregnancy, to labour normally, and with parenting skills.
Welcoming NIPT and the Harmony™ Prenatal Test Into Your Practice

Cell-free DNA testing (cfDNA), or non-invasive prenatal testing (NIPT), has been welcomed into the practice of prenatal care worldwide. Increasingly popular with healthcare professionals and patients alike, NIPT has become a standard option among midwives. And no wonder – with its superior performance over traditional screening methods for Trisomies 21, 18 and 13, the Harmony™ Prenatal Test delivers an exceptionally low false-positive rate with proven accuracy as a primary screen in pregnant women of any age or risk category.1-13

How the Harmony™ Prenatal Test Works

The Harmony Prenatal Test analyses small fragments of DNA, known as cell-free DNA (cfDNA) from the fetus and placenta present in maternal circulation. A maternal blood sample can be analyzed as early as 10 weeks gestation and any time throughout the pregnancy.

Using a unique targeted approach called DANSR™, the test analyzes specific chromosomes of interest and precisely quantifies fetal DNA, which allows exceptionally accurate results.5 Ensuring that a sufficient amount of fetal cfDNA (fetal fraction) is present is widely considered to be an important quality metric for NIPT to minimize the likelihood of a false-negative result. The Harmony Prenatal Test also incorporates maternal age and gestational age into its risk assessment using the FORTE™ algorithm, to more clearly distinguish high and low risk results.5

Exceptionally Validated NIPT

The Harmony Prenatal Test is supported by clinical studies of more than 22,000 women of all ages and risk categories, showing detection rates for Trisomy 21 (Down Syndrome) greater than 99% and false positive rates of less than 0.1%.1-10 Data published in the New England Journal of Medicine show the superiority of the Harmony Prenatal Test over the traditional first trimester combined screening for Down Syndrome in the general pregnancy population.1

In addition to correctly identifying cases of Down Syndrome in the study, the Harmony Prenatal Test also reduced false positive results by over 90-fold.1 In contrast, 5% of conventional FTS tests returned a high-risk result while the pregnancy was unaffected (false-positive result) and failed to detect one out of five affected pregnancies.1 False positives can lead to further invasive, diagnostic tests such as chorionic villous sampling (CVS) or amniocentesis with associated risk to the fetus, as well as anxiety for patients and their families.

How to Incorporate Cell-free DNA Testing into Your Practice

It is important to remember that NIPT is not diagnostic, but rather a very accurate screening test. A patient with a high-risk result should be counseled that the pregnancy may be affected, but diagnostic testing is required for diagnosis.14 It is also important to note that data have not been submitted to or evaluated by Federal regulatory agencies and the test is not for sale as an In Vitro Diagnostic (IVD) in the US or the EU.

Cell-free DNA testing is a considerable advance in prenatal screening. Implementation should include pre- and post-test counseling regarding the scope of the test and proper interpretation and follow up of screening results. To learn more about the Harmony test, visit www.harmonytest.com

References

first heard about the opportunity of an elective placement when I was attending university open days. I immediately knew that I wanted to travel abroad for mine and the place that held the most appeal was Africa.

One of the main reasons that I wanted to do this was to witness and experience situations that would not occur in the UK. I thought that, if I could handle those sorts of experiences in a minimalistic environment, then it would give me greater confidence in dealing with situations in the UK with the support of a multidisciplinary team and easy access to high-tech equipment and drugs.

When the time came to organise the placement, myself and three other student midwives in my year contacted Work the World, a company that arranges medical placements abroad. Before we knew it, we were departing from Edinburgh airport and heading for Tanzania.

The four of us worked for four weeks on a labour ward in Arusha, which is a city of 416,442 in the north of Tanzania. While the experience was challenging at times, it was invaluable.

The labour ward consisted of an eight-bed bay with only a few shower curtains hanging for privacy and three rooms with two beds in each. The women were supposed to be transferred to these rooms once they had reached 8cm, however, we didn’t see this happen. The women gave birth in the bay, on show to others around them and sometimes at the same time.

This often made challenging situations even more stressful. Some of the challenges I faced were pre-term labour, undiagnosed breech, eclamptic seizures and stillbirths.

We also had to deal with the obstetric theatres closing for a day because they had run out of sterile gowns but, thankfully, no one else needed an operative delivery that day. The midwives would frequently leave us on our own so we often had to handle these difficult situations ourselves.

There were also a lot of instances where some of the practices we saw were outdated and, worse than that, unsafe. For example, instead of using an amnihook to perform an amniotomy, the midwives would use a broken oxytocin ampoule. As a result, I had a lot of practice saying ‘no’ and, in the process, learned to become more assertive. This is hard to do as a student midwife, but it is an invaluable skill.

Despite the challenges, I learnt so much while in Tanzania and I would definitely recommend an elective to other students considering it. The experience gave me a huge confidence boost to know that I am capable of working independently in a highly pressurised environment, adapting to whatever situation faces me.

Chloe Pearson, third-year student midwife, Edinburgh Napier University
SUPER SUPERVISORS

Sophie Fletcher on the underused resource of midwifery supervisors.

When I told my husband that I was writing an article on midwifery supervision, he was puzzled. ‘What do you have to do with supervision?’ he asked. We have two children and, for both, we went through the system without any idea of the existence of supervisors, or that we could request their help in making our experience better.

It wasn’t until I started working with other women that the question, ‘Have you spoken to the supervisor?’ would be dropped into conversation every now and again. Who was this mysterious supervisor and what did she do? Then I met a few and they were wonderful – generous with their time, compassionate, knowledgeable but, above all, approachable. They were a gateway for choice and the guardians of normality. I saw them help women believe in themselves and feel supported in their choices even when they conflicted with hospital policy.

When I suggest to a friend or a client that she can talk to the supervisor, there is often initial reluctance to go above her midwife in case she gets in trouble. But, once she understands the role of a supervisor, she feels much more confident in what to expect and less intimidated about making that contact.

I’m not sure whether hospitals and communities differ in how they present the option of talking to a supervisor, but I do know that nearly every woman I have encountered has no idea they exist, nor how they can be helped by them. How can such a wonderful service remain undiscovered by the vast number of women who could benefit from it?

As midwives, you are in the best position to spread the word about the benefits of supervisors. Tell women about them, use them well yourselves, make midwifery supervisors so vital that the case is won. Make it so that you, and the midwives who follow you, can support women confidently and safely as protectors of choice and normality.

I’m trained as a supervisor in a therapeutic capacity and I know how important supervision is in keeping my clients and my supervisees safe. As women, we need supervisors who have experience of midwifery, and are secure in their own ability to support women’s choices, whatever they are. For a midwife, good supervision can prevent burnout and is the key to workplace resilience.

To grow in your profession, you must have the courage to step outside your comfort zone. Imagine your comfort zone as a circle with you in the middle. At first the circumference of your circle might be small, from toe to heel. But each time you step outside it, the circle becomes bigger until it is so big you can dance around it. As midwives, you will always be learning, and that means sometimes stepping outside of your comfort zone, but your supervisor can help you to make that step confidently. Maybe one day you will be helping other midwives to step outside of their comfort zone.

Sophie Fletcher is a clinical hypnotherapist, author of Mindful hypnobirthing and mother to two boys.
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Date of preparation: June 2015. Fult-286
Lower back pain and pelvic pain during pregnancy is common. In fact, over two-thirds of pregnant women experience low back pain and almost a fifth experience pelvic pain. Some women can put up with the discomfort but, for others, the pain is too great. Many women self-medicate by purchasing over-the-counter medication. This is concerning, as there is no robust evidence to indicate that any of the common analgesics are 100% safe during pregnancy. This being the case, there is a need to consider non-pharmacological treatments, such as complementary and alternative medicines (CAM). We know the use of CAM during pregnancy is becoming increasingly popular in the UK, but the evidence of its effectiveness is limited.

Therefore, a research team set out to evaluate and summarise the current evidence on the effectiveness of CAM in managing lower back pain and pelvic pain in pregnancy.

The systematic review included randomised controlled trials (RCTs) only. Eight databases were used to search for relevant literature including the Cochrane library, PubMed, MEDLINE, AMED, Embase, Cinahl, Index to Thesis, and Ethos. The databases were searched from inception to July 2013.

Studies were selected if they met certain criteria. These were that they were written in English, were RCTs, a group one therapy (professionally organised alternative therapies) or group two therapy (complementary therapies), and reported pain reduction as an outcome measure. Study quality was reviewed using risk of bias and evidence strength was checked by using the Cochrane Grading of Recommendations and Development Evaluation (GRADE) tool.

Eight studies were selected for full review. They included two acupuncture studies with low risk of bias that showed both clinically important changes and statistically significant results. There was also evidence of effectiveness for osteopathy and chiropractic. However, osteopathy and chiropractic studies scored high for a risk of bias and there were considerable methodological issues with them.

Generally, the application of the GRADE tool indicated that the overall strength of the evidence across the studies for using CAM in the management for low back pain and pelvic pain (LBPP) in pregnancy is limited.
The vast majority of women would prefer to give birth without receiving medication for pain relief. One of the most popular natural alternatives is self-hypnosis. To learn how to use self-hypnosis, women usually receive training during the antenatal period and practise the technique using a CD.

So far, few studies have been done to test how well self-hypnosis works in this context and whether women who use it require fewer pain-relieving drugs. The SHIP (Self-Hypnosis for Intrapartum Pain) trial set out to answer these questions by recruiting a large number of women into a randomised controlled trial.

A total of 680 women were recruited at three different hospitals in the north west of England. Approximately half of these women (343) were randomly chosen to receive self-hypnosis training in addition to the usual antenatal care provided by the hospital. This group is referred to as the intervention group. The remaining 337 women received only the antenatal care offered by the hospital and are described as the usual care group.

The self-hypnosis training included two teaching sessions given by a qualified midwife with experience of using the technique in a maternity setting. Husbands or birth partners were also invited to the training sessions, which were given when women were 32 weeks and 35 weeks pregnant. The training included a CD that women were asked to listen to every day from 32 weeks until the birth of their baby.

The research team collected information on a variety of different clinical and psychological outcomes, with a particular focus on the use of epidural analgesia, which is the most commonly used form of pain relief for labouring women.

Following analysis, the team found there was no significant difference in epidural use between the intervention group (27.9%) and the usual care group (30.3%). The team also found there were no significant differences in the use of other pain-relieving medications between the two groups. However, when compared to the usual care group, the women in the intervention group had a bigger reduction in their scores on fear and anxiety about childbirth between late pregnancy and two weeks after the birth of their babies.

The authors of the study concluded that antenatal self-hypnosis training made no difference to the use of epidural analgesia during labour and birth. The impact of self-hypnosis on women’s levels of fear and anxiety warrants further investigation.

Kenneth Finlayson, senior research assistant, midwifery studies, SHIP trial coordinator, School of Health, University of Central Lancashire

Randomised controlled trial of self-hypnosis for intrapartum pain

Ciara Close, research fellow, Centre of Public Health, Queen’s University, Belfast

and pelvic pain during pregnancy was very low. The evidence was limited, however, this does not mean a recommendation for practice is forthcoming. Because the number of good-quality and robust studies was so severely restricted, it becomes impossible to make evidence-based recommendations. Before any recommendations can be made in this area, there is an urgent need for more well-designed large RCTs.

Has your research been published recently? Would you like your summary to appear on these pages? Then contact Midwives editor at emma@midwives.co.uk

MORE READING


Randomised controlled trial of self-hypnosis for intrapartum pain

The vast majority of women would prefer to give birth without receiving medication for pain relief. One of the most popular natural alternatives is self-hypnosis. To learn how to use self-hypnosis, women usually receive training during the antenatal period and practise the technique using a CD.

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A total of 680 women were recruited at three different hospitals in the north west of England. Approximately half of these women (343) were randomly chosen to
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*This claim is based on a home placement test with 85 UK mums (2012).
Facilitate birth in water

Although there are some accounts of waterbirths that occurred in ancient times or in various cultures, it did not emerge as a widespread practice until the 1980s and 1990s (Dekker, 2014; RCOG and RCM, 2006).

A total of 34% of women giving birth in England plan to use water or a birth pool for coping with pain during labour, while staying in the water to actually give birth is not as common, with just 8% of women doing so (CQC, 2013).

Using water immersion in the first stage of labour may help the woman to feel more comfortable, as it facilitates freer movement and may empower the woman to feel more in control during contractions (NCT, 2010).

For those who do give birth in water, the mother is immersed throughout and, following birth, the baby is brought to the surface and into its mother’s arms. The baby’s body remains in the water, with the nose and mouth above the surface. A waterbirth may be followed by the birth of the placenta in or out of the water (Nutter et al, 2014).

Planning waterbirth

If the waterbirth is to be at home, the midwife and woman should have a conversation about the available resources, such as whether the hospital will supply a pool or whether she needs to hire one (1).

There should be a discussion about which room has adequate space to both house the pool and allow the midwife sufficient access.

Home pools generally take about 30 to 60 minutes to fill, but larger birthing pools can take longer.

Hospital and birth centre pools are subject to stringent infection control protocols and, while this is not the case with home pools, there are still guidelines. Water must not remain in the pool longer than 24 hours, unless a filtration cleaning system is fitted (Health and Safety Executive (HSE), 2013). In June 2014, Public Health England (PHE) temporarily advised against the home use of birthing pools with built-in heaters and recirculation pumps, potentially filled up to two weeks in advance of the birth, after a case of Legionnaires’ disease was identified in a baby born in this specific type of pool. It said: ‘These systems contain pipework and consequently may harbour biofilm that can be difficult to remove during cleaning and could be the source of Legionella during any subsequent use.’ PHE (2014) recommended that heating systems to heat or maintain the temperature of the water should not be used. Such systems are not necessary and present significant infection control risks. Furthermore, PHE (2014) and HSE (2013) suggested that everyone...
using the pool should shower before entering the water to reduce the risks of infection further.

Other issues to consider are additional equipment required – such as a large strainer and bath thermometer – and how the pool will be filled and emptied, as well as the maintenance of the correct water temperature. Obviously, there must be adequate hot water and electrical supply to facilitate the use of the pool for both labour and birth.

The midwife facilitating the waterbirth must be knowledgeable, competent and confident and, where appropriate, should seek additional support and training. The midwife needs to possess the right skills, confidence and knowledge to support the woman (RCM, 2012).

If the waterbirth is planned to take place in a hospital, the woman needs to be aware of pool availability in her local birth centre and labour ward. Every attempt to facilitate the woman’s choice must be made (RCOG and RCM, 2006).

**Using the pool**

Evidence suggests that a woman may benefit most from the pool when her cervix has dilated to 5cm or greater (NCT, 2010). However, some women have been observed to benefit much earlier, as they relax and progress quickly to an active second stage when they have the freedom to move buoyantly in water (Dekker, 2014).

Contraction patterns were previously thought to become less frequent in water, but underwater continuous fetal monitoring has provided evidence that they are the same, in or out of the water. It was, in fact, the mother’s different response to contractions in the water that prompted the belief that they were less intense (Harper, 2006).

For water immersion to be effective, the depth of the water must cover the woman’s abdomen, reaching the level of her breasts, when she sits or kneels (2). Thirty minutes of deep water immersion releases the maternal hormone oxytocin (Harper, 2006). Evidence
suggests that the chemical and hormonal impact of immersion takes effect after 20 minutes and peaks at around 90 minutes (Harper, 2006).

Labouring in water, compared to on land, has also been found to reduce the stress hormones catecholamines, which inhibit oxytocin and labour progress (Ohlsson et al, 2001).

A change of environment, such as getting out of the pool and walking around, is recommended after about two hours of initial immersion (3). Getting back into the water after 30 minutes then reactivates the chemical and hormonal process, causing a sudden and marked increase in oxytocin, which influences contractions (Harper, 2006) (4).

The midwife can use this time out of water to make an evaluation of the woman’s progress. It is crucial that the midwife manages the labour and birth in accordance with NICE (2014) guidelines, while ensuring that there is minimal interference with the woman.

The midwife will monitor the temperature of the woman and the water hourly, to ensure that neither becomes too hot – the temperature of the water should not be above 37.5°C – or cold, and to ensure that the mother is not becoming pyrexial, which could have an adverse effect on the fetus (NICE, 2014) (5).

**Physiology of normal birth**

The midwife should use her skills and knowledge of the physiology of birth to facilitate a positive birth experience. These include the same signs of progress as an out-of-water birth, such as checking how the woman looks and sounds, her mood and how the environment is affecting her.

During the second stage, the baby should be born completely under the water with no air contact until the head is brought to the surface, because air and temperature changes may stimulate breathing and lead to water aspiration (Nutter et al, 2014) (6). It is important that the midwife avoids excess cord traction as she helps the mother or partner to guide the baby’s head out of the water because, as is the case with a birth outside the water, there may be an increased risk of the cord tearing from unnecessarily rapid or extra forceful traction on the umbilical cord as the baby is lifted (Schafer, 2014).

After a physiological first and second stage of labour, the mother may opt for physiological expulsion of the placenta and membranes. The midwife should be skilled in physiological management of the third stage and can expedite this by promoting skin-to-skin contact between mother and baby and early breastfeeding (Begley et al, 2010; Marin Gabriel et al, 2010; Fahy, 2009).

The mother may choose to remain in the pool for a physiological third stage. Studies have shown that postpartum blood loss is significantly decreased after waterbirth (Dahlen et al, 2013). However, if a woman decides to have active management of the third stage, she will be encouraged to leave the pool.

Waterbirth is a safe and positive experience for women with lowered intervention and perineal trauma (Dekker, 2014). The use of water encourages a woman-centred approach to care, complements the normalising agenda and is an important consideration in terms of maternal choice (RCOG and RCM, 2006).

Dr Valerie Finigan, midwife, and Diane Chadderton, community matron, Pennine Acute NHS Hospitals Trust
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Here is the summary of contents from the most recent issue – September 2015.

1. The future role of technology in the healthcare industry
   Marlene Sinclair

   The research community faces a new future, as it prepares to make research impact more visible and collaboration with industry more acceptable post-REF2014, argues this editorial. Mobile health care is the future and the electronic health record that was talked about 25 years ago is now a reality, it states. The use of apps for all aspects of maternity care is becoming more and more popular and ‘generation z’ are becoming older and more sophisticated users of technology.

2. Tapping into authentic presence: key components arising from a concept analysis of online breastfeeding support
   Maria Herron, Marlene Sinclair, W George Kernohan and Janine Stockdale

   The internet is widely used by women to guide infant-feeding decisions and practice, but there is no clear understanding of women’s self-directed use of the internet to support breastfeeding. This paper aims to conceptualise online breastfeeding support and opens the doors for research investment.

3. Thai cultural influences on breastfeeding behaviour
   Lesley Dornan, Marlene Sinclair, W George Kernohan, Janine Stockdale, Varangthip Khumthyanakorn and Pikul Suppasan

   The aim of this study is to identify the contextual and cultural influences that are communicated through breastfeeding instruction within a Thai setting. It finds that the maternity staff take pride in what they term ‘the Thai way’ of breastfeeding and this was indicative of a specific cultural identity. The authors argue that cultural influences are inextricably linked to individual and national goals.

4. Pre and post survey findings from the Mind ‘Building resilience programme for better mental health: pregnant women and new mothers’
   Mary Steen, Mark Robinson, Steve Robertson and Gary Raine

   A sample of 108 pregnant women and new mothers returned a pre and post survey questionnaire on the Mind ‘Building resilience for better mental health’ project. Analysis shows that the model promotes engagement in positive activities and helps to build social connections and reduce social isolation. The authors claim that learning some coping strategies about mood and mind helps pregnant women and new mothers to build resilience to stay well.

5. Blokes talking with blokes: feasibility of a ‘dads-only’ session within an Australian parent education programme
   Yvonne Hauck, Christopher Cooper, Lucy Lewis, Renae Gibson, Fiona Ronchi and James Foley

   A feasibility study was undertaken to determine the acceptability and influence of a fathers-only education session, facilitated by a male midwife, on parents’ anxiety, depression, stress and parenting confidence. Feedback on content around parenting and lifestyle, plus infant care and men’s preferred resources, may assist in the provision of father-inclusive parent education, the authors state.
You are invited to the Zepherina Veitch Memorial Lecture presented by Professor Mary Renfrew

Thursday 10 December
The Royal College of Obstetricians and Gynaecologists, London

The RCM invites you to this prestigious event which presents the best and most topical in midwifery evidence and thought leadership from Professor Mary Renfrew. Named in commemoration of Zepherina Veitch (1836-1894), a pioneer of modern midwifery and founder of a predecessor institution of the RCM, it continues her spirit of challenge and reform and commitment to the advancement of the midwifery profession.

Professor Mary Renfrew will discuss the Lancet Midwifery Series (of which she was a co-author), which provides a framework for quality maternal and newborn care that firmly places the needs of women and their newborn infants at its centre.

This evening event will bring together senior guests from government and media, together with our Board members, honorary fellows and vice presidents. The evening also includes the presentation of our RCM honorary fellowships by the President and will be followed by a networking drinks reception.

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NORMAL BIRTH: WHAT DOES that term mean to you? A ‘normal delivery’, according to a consensus statement from the Maternity Care Working Party (2007), must involve a spontaneous start to labour, spontaneous progress without drugs, and a spontaneous birth.

But, if there were a poll, the chances are that a number of different definitions would crop up. There would be overlap, of course, but also distinct differences; purists may describe it as physiological from start to finish, while others may say a vaginal birth without use of instruments.

Hannah Bielby, a third-year student midwife at Bangor University, says: ‘It depends what you define as normal. I don’t know what the definition is.’

In training, the best way to experience normal birth is at home or a midwife-led unit (MLU), because nobody interferes, she says. Once on the labour ward, it becomes a looser term.

However, following on from events at Morecambe Bay, where the ‘pursuit of normality’ had tragic consequences, there has never been a greater need to agree on a definition. The first conclusion of the Kirkup report (2015) was that maternity care exists in a context where the majority of those using it are ‘going through a sequence of normal physiological changes’. It says that safe care depends on ‘maintaining vigilance for early warning of any departure from normality’.

But when there is no universal agreement on normality, then how can one spot a departure from it?
Some women are in labour for two hours and for others, it’s 26 hours. Both are normal. So long as they are progressing then that is good. It takes as long as it takes.
Definition
Psychologist Voula Grand says that having no agreed definition causes all sorts of difficulties locally and nationally. ‘It is very hard to set clear goals that will be met if everyone has a different definition. When an individual defines normal then they are basing it on their own experiences and that of their family and friends. It is subjective,’ she says.

It is made trickier by the fact that an accepted sense of normal shifts from culture to culture and across time, says Voula, who is founder of consultancy Grand Shearman. What was considered normal in the 1950s is not the same as now. Voula says that, in the world of psychology, normal is defined by the frequency of occurrence.

‘Normal is what happens to most people, statistically speaking. If you want to test the intelligence of 100 kids to find normal, you map it out. If the average is 50 then there’s a line on the bell curve to show that, then another line on either side so we can say that anyone who comes between 30 and 70 is normal. Everything else is rare,’ she says.

But, of course, maternity statistics vary so much from one trust to another that this method of defining normal may not help.

In fact, taking a broad-brush approach is unwise. RCM chief executive Cathy Warwick says that midwives try to ensure every woman has as normal a birth as possible and this is right because unnecessary interventions have the potential for harm. But the care needs to be individualised.

‘Where the whole thing goes wrong is when midwives and other professionals take what we know from evidence, which is based on wide populations, without personalising it to individual women. And they do that outside relationship-based care, so women get these blunt messages that normal birth, whatever that is, is better than a CS without ever considering whether that is actually true for that individual woman,’ she says.

Continuity of care
The starting point of the whole process must be the woman. This is where continuity of care is so crucial, says Cathy. ‘A conversation needs to take place with the woman from which a pathway of care emerges, rather than a tick-box exercise that immediately puts women in one box or another and sets them off on a particular pathway,’ she says.

Her hope is that the NHS maternity review for England, which began work in April, will make the changes needed to realise this. It is charged with producing proposals to shape the future of maternity services across the country.

Chaired by Baroness Julia Cumberlege, the review has been asked to consider UK and international evidence on safe and efficient models of maternity care,
including MLUs; ensure the NHS supports and helps women to make safe and appropriate decisions for their maternity care; and support NHS staff, including midwives, to provide responsive care.

The midwifery profession is represented on the review panel by Cathy Warwick; Annie Francis, chief executive of Neighbourhood Midwives; and Sarah Noble, consultant midwife at Birmingham Women’s NHS Foundation Trust. Morecambe Bay parent, James Titcombe also sits on the panel. The review is timetabled to produce its report by the end of the year.

Cathy says that, at present, maternity services are not set up to place the woman at the centre. Instead, maternity care has focused on institutions and the needs of staff, as much as on women giving birth.

Independent midwife Mary Cronk agrees. In fact, she puts it in even stronger terms.

‘Maternity services are not giving a service. They should be observing and supporting women but, instead, they try to dictate,’ she says.

Her view is that the system has decided that all women should have a certain number of contractions in a minute and have a labour that lasts a specific length of time. This is nonsense, says Mary.

‘Some women are in labour for two hours and for others, it’s 26 hours. Both are normal. So long as they are progressing then that is good. It takes as long as it takes,’ she says.

Now in her 80s, Mary worked in the NHS for 30 years until, frustrated by the ‘prescriptive system’, she left to become an independent midwife. She only stopped working three years ago, when arthritis in her hands forced her to give up.

Mary’s unconventional career poses the question of whether aspiring to ‘normal’ is always the best approach. She became a pioneer of birthing breech babies at home, which was not the norm.

‘Hospitals criticised me for it, but I criticised them for not making services available to women. If a woman was in hospital with a breech then they’d begin intervention from the start, not when it became necessary,’ says Mary.

When she looks back over a career spanning five decades, Mary has no doubt about how things have changed.

‘We have become afraid of normality. We need to sit back and observe and it no longer happens. Now, it varies from hospital to hospital depending on who is in charge,’ she says. ‘The woman and the midwife should be in charge.’

**The evidence**

Mandy Bellenger, a community midwife in Cornwall, who has just set herself up as an independent, says that the problem is wider than maternity services. She says that there needs to be a change in society, which has come to see birth as something fearful and medical.

‘We should be highlighting birth as a very normal life event, not to be feared. We need to let women know that their bodies have the innate ability to birth,’ says Mandy.

Schools need to send out the right messages to the parents of the future, she believes, which may mean re-evaluating the sex education curriculum. In the meantime, the best way to establish normal birth for women is to have a named midwife who gives one-to-one care throughout childbirth.

‘A substantial body of evidence now exists showing that care provided by midwives in one-to-one models contributes to high-quality and safe care with significant benefits for both the mother and her baby,’ she says.

That evidence includes the Birthplace in England Research Programme, commissioned in 2007, which was the largest study of its kind into low-risk women giving birth in different
settings. The study collected data for more than 64,000 low-risk births and found that those giving birth in freestanding or alongside midwifery units had fewer interventions and more normal births than in obstetric units (Birthplace in England Collaborative Group (BECG), 2011).

Then there was a Cochrane review of 13 studies into midwife-led care, published in 2013 (Sandall et al, 2013). This found that women were less likely to experience instrumental births, epidurals, or episiotomies when giving birth under midwife-led care, than under doctor-led care, or where care was shared between a number of different health professionals. The studies, which covered more than 16,000 women, also found higher rates of spontaneous vaginal births under midwife-led care.

Guidance has now changed to reflect this, with updated NICE guidelines on intrapartum care (NICE, 2014), published at the end of 2014, confirming that giving birth in midwife-led care is as safe as a hospital birth for low-risk pregnancies.

Yet just 46% of women having a first baby in an obstetric unit had a normal birth, according to Coxon (2014) and the Birthplace study (BECG, 2011). That figure rises to 62% in an alongside unit and 70% for those at a freestanding midwifery unit. It is 67% for those at home.

Inevitably, if normal birth – that is, a labour that starts spontaneously at or around term and is physiological from start to finish – is becoming rarer, especially in hospitals, then new midwives will find it harder to get the experience of it. Yet each student midwife needs to have 40 signed off to qualify, which again begs the question, how is normal being defined?

Newly qualified midwife Jude Jones wondered the same thing when she was studying at Salford University in 2013. When she talked to her peers, she discovered that the experience varied enormously across the five trusts that hosted student placements. To drill down a bit further, she surveyed 98 midwifery students at Salford, finding one third-year student had only 16 normal births while eight had over 40. One out of 34 first years had no normal birth experience, while another had 19, most of them home births.

A continuum
The RCM aims to address this disparity across maternity services in its Better Births Initiative, which was launched in May last year. It is raising awareness of health inequalities in maternity services and promoting service design to reduce them. It also wants more access to the midwifery-led continuity of carer model, as well normal births for most women and normalisation of birth for all.

For many, it is the normalisation element that is most important. After all, the flip side of normal is abnormal.

Soo Downe, professor in midwifery studies at the University of Central Lancashire, says language is important. ‘Women don’t like the binary of normal and abnormal,’ she says. ‘We want both “safety” and “positive birth”.’

Soo points out that while it is true that a physiological approach gives the greatest

Seeing birth on a continuum means that it is not a failure to transfer a woman from one unit to another, or transfer care to a consultant or obstetrician.
The likelihood of both safe and positive, this is not possible for all women.

‘Where it can’t be physiological or where women find it psychologically problematic then we have to make it as normal – in the societal sense – as we can,’ says Soo.

Sarah Gregson, consultant midwife at Maidstone and Tunbridge Wells NHS Trust, says normalising is crucial. She has been at the forefront of normalising medical births and believes that small changes can make all the difference to the parents’ perspective. For example, having immediate skin-to-skin with a baby after birth in an operating theatre can transform the birth experience. So too can asking if it is possible to delay cord clamping and cutting.

‘Those are just two very small examples of ways that midwives can make a difference in helping a birth to be more normal, but not every unit up and down the country is practising those things. I find that really sad,’ says Sarah.

‘It’s about having that professional dialogue with an obstetrician, sometimes a haematologist, sometimes an anaesthetist, if someone is really sick. It is making sure we are all on board and challenging each other in a good way on what is really necessary, and what isn’t, making sure the woman is involved with that and making sure that where we can make things more normal, we do.’

Service redesigns are important too, though not without challenges. When Sarah’s trust moved from two high-risk units to one, with the creation of a new standalone MLU, it was a big shift for the public and staff.

‘This was a major change, particularly for our local population to understand what that meant, and for a number of professionals to understand that a standalone midwifery unit is actually good for women rather than a downgrade to the service they are receiving,’ explains Sarah.

For her, the number one factor in affecting the normalisation of birth is the culture among staff. When the MLU was introduced at Sarah’s trust, obstetricians held mixed views. Now, 1500 births later, obstetricians are behind the centre.

‘What has convinced our medical colleagues is not me saying that it’s lovely there and the women really like it, but actually seeing the hard data of what happens to a woman coming to a midwifery unit – providing she is low risk and she is suitable for coming here – compared to a low-risk woman who goes to a hospital,’ says Sarah.

Gill Walton, director of midwifery at Portsmouth Hospitals NHS Trust, argues that the emphasis should be moved away from ‘normal’ and towards normalising the mother’s birth experience, whatever and wherever it happens to be.

‘My view really strongly is that you can’t split women into low risk and high risk,’ she says. ‘It is a continuum.’

Seeing birth on a continuum means that it is not a failure to transfer a woman from one unit to another, or transfer care to a consultant or an obstetrician, she says.

‘That is the right thing to do. It is appropriate care for all those women, normalising their experience as much as possible,’ says Gill.

Catherine Cummings, HoM at NHS Fife, agrees that normalising all birth is the way forward. It relies on the whole maternity team, from hospital porters to consultants, looking for the best outcome for the woman, her baby, and the whole family, and putting them at the centre of care.

‘Who’s got the right to say what normality is?’ she asks.

Catherine says that, regardless of how a woman births, it is about choice and support with the midwife helping her to make informed decisions and facilitating wherever possible.

‘For a woman it should be an optimum birth, so maybe we should just say “birth”.’ Perhaps she has a point.
The award-winning event in the midwifery calendar – this year’s RCM Annual Conference 2015 is not to be missed. Make sure you join us for your professional update as we explore this year’s theme ‘Better Births: Leading the Way for Maternity Care’ on 10-11 November.

Reasons to attend:

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Programme highlights include:

- How to make the case for maternity care – Question Time-style debate with speakers including Michael Macdonnell, head of strategy, NHS England, Professor Marcus Longey, Welsh Institute for Health and Social Care and Professor Jacqueline Dunkley-Bent, director of midwifery and divisional director of nursing for women’s and children’s services, Imperial College Healthcare NHS Trust
- Reducing stillbirth with a panel led by Catherine Calderwood, Scotland’s chief medical officer
- Maternal mental health with leading psychiatrist Alain Gregoire and Mary Ross-Davie, education projects manager, midwifery and reproductive health, NHS Education for Scotland
- Hear Dr Bill Kirkup CBE, chairman, Morecombe Bay investigation, Dr Umesh Prabhu, medical director, Wrightington, Wigan and Leigh NHS Foundation Trust and Rebecca Schiller, co-chair, Birthrights on improving safety.
Expert speakers include:

- **Mary Ross-Davie**, education projects manager, midwifery and reproductive health, NHS Education for Scotland
- **Karen Guilliland**, chief executive, New Zealand College of Midwives
- **Dr Debbie Carrick-Sen**, Florence Nightingale chair in clinical nursing and midwifery practice research, Heart of England NHS Foundation Trust
- **Dr Bill Kirkup CBE**, chairman, Morecambe Bay investigation
- **Sara Denham**, research fellow and midwife, Robert Gordon University and NHS Grampian
- **Professor Jacqueline Dunkley-Bent**, director of midwifery and divisional director of nursing for women’s and children’s services, Imperial College Healthcare NHS Trust
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Visit rcmconference.org.uk/programme to find out more.

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- **Interactive session on the continuity of care** with speakers **Professor Gwendolen Bradshaw**, director of quality enhancement and standards, School of Midwifery and Reproductive Health, University of Bradford, **Rebecca Schiller**, co-chair, Birthrights and **Octavia Wiseman**, community midwife, King’s College Hospital NHS Foundation Trust
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- **Keynote speaker**: **Professor Denis Walsh**, associate professor in midwifery and postgraduate director of research and knowledge transfer, University of Nottingham, on working with evidence

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Since the publication of the Morecambe Bay investigation report, I have been following the responses to it with interest. This is due partly to a feeling of responsibility for the investigation, as you’d expect, but also partly to a strong sense that there are important lessons drawn that should not be lost.

Most have been positive. It seems to me that there is general agreement that there were major failures of care which were poorly dealt with, that people suffered unnecessarily, and that changes are needed to address the shortcomings that allowed this to happen.

Some responses, however, have been less clear-cut, perhaps reflecting less acceptance of some aspects, or debates that have not yet been fully resolved. I’d like to reflect on the three that stand out to me.

**Error and accountability**

Errors that harm patients occur in every healthcare system, and I have said consistently that individuals should not be blamed for error. This is important: we know that the prospect of blame makes people reluctant to report errors, which prevents the identification and correction of their root causes. Some commentators have extrapolated from this to suppose that I mean that individuals were blameless victims of a defective system. This is not so.

The unspoken contract that applies to all of us
who work for the NHS is that we owe the public a duty in return for their understanding that errors will occur. To discharge that duty, we must be honest with those affected, and we must investigate causes and learn lessons to prevent recurrence. When individuals conceal and deny errors, fail to learn and, as a result, repeat the same mistakes, they break that contract and forego the right to remain blameless. That was the line that was crossed at Morecambe Bay.

Of course, this does not apply to everybody who worked in the unit. But a significant minority cannot be exonerated, and if we try to fudge this as entirely a systems failure, we will miss a significant point.

**Team working**

Effective teamwork is central to maternity care. The breakdown in working relationships at Furness General Hospital contributed significantly to what happened. It began, in my view, with a loss of mutual trust that subsequent events made worse, and which became fatal to effective team working. Many of the report’s responses suggest that a lack of trust between professional groups is not confined to Morecambe Bay. If so, this is a sad state of affairs when the overriding objective should be what is best for patients.

We have an opportunity now to look at the reasons why mutual trust may become eroded, and how best to ensure that it does not. I believe that one factor lies in the way that we train staff in relative isolation. Other enterprises, which depend on close collaborative working, emphasise training in the team settings that reflect people’s work in practice. I believe that a similar approach should be more widespread in the NHS.

**Normal childbirth**

The investigation’s finding on the part played by the inappropriate application of normal birth has generated more debate than any other. To be clear, the description of its pursuit as being ‘at all costs’ was not mine; it was what was said to the panel by a midwife at the trust. We found many instances where action was not taken in response to actual or potential problems, while staff persevered with normal birth. Sadly, some of those instances resulted in preventable harm, including deaths. In talking to interviewees, it was clear that what motivated them in the first place was their enthusiasm for normality; they thought, as they told us, that they were doing what they were supposed to be doing to promote the policy.

There is a warning here that is more widely applicable, and in looking at the broad range of responses, I am concerned that it is being downplayed and may be lost. Of course it is inappropriate to over-medicalise what is, for most, a normal physiological process. But it is wrong to either ignore warning signs or to treat everyone as if they were at low risk. When I hear comments implying that even considering risk is inappropriate or that it closes down the birth experience, I can’t help remembering the midwife who told us that ‘bad things happen in maternity, people just have to accept it’. The avoidable loss of babies – and mothers – is not, in any reasonable estimation, a price worth paying so that risk can be sidelined.

We have to find an approach to this policy that is based on evidence and on the views of service users – properly and objectively informed – and not on polarised and sometimes dogmatic opinion. I believe that there is a real need for leadership on this from the royal colleges and senior professionals. As long as messages remain mixed, the potential remains for others to think that they too are doing what they are supposed to do by underestimating or ignoring risk, with disastrous consequences sooner or later.

**Conclusion**

The most worrying remark that I have heard is ‘it couldn’t happen here’. This reflects a view, which may be quite widespread. It may be unlikely that all of the factors will line up in the way that allowed the problems at Morecambe Bay to remain undetected for so long. It seems to me extremely likely, however, that other units will show some of the problems set out in the report, and a number will show more. The short answer to ‘it couldn’t happen here’ is ‘yes it could’; once more would be once too many, given the opportunity we have to draw the proper conclusions from what happened and act accordingly.

Given the right commitment where it is needed, I am optimistic that we will.

To read the full report, visit tinyurl.com/pzh82ah
Investing in services to members

The RCM’s ambition is that members should be as proud of their organisation as they are of their profession.

In recent years, we have embarked on a ‘responsiveness’ initiative that aims to ensure the RCM is accessible, visible and active throughout the UK. The first step was the development of RCM Connect – giving members a single point of contact for accessing advice and information 24 hours a day, 365 days a year. In the month before it went live, we received 1379 calls. Nearly 30% of these went unanswered because we didn’t have the capacity to deal with them. In the same period in 2014, we received 3399 calls – a 150% increase. The average waiting time is now just 20 seconds and feedback has been overwhelmingly positive.

In 2013, we appointed an additional organiser to cover the north of England and we now have part-time organisers in Wales and Scotland supporting local activities, events and recruitment. The result is a resurgence in branch activities. This year, we have appointed a new project worker to specifically develop our offer, services and engagement with MSWs. We’re investing in staff outside London too, by equipping them with the latest technology, ensuring they can contact and serve members while ‘on the move’.

The next stage of our plan is to shift resources away from bricks and mortar into increasing our visibility throughout the UK. We want to make sure that we are flexible enough to meet you at your workplace and to respond when you need us most. Therefore, the RCM has taken the decision to close the office in Leeds at the end of this year, with all functions transferring to the remaining four UK RCM offices. By doing this, we will be able to hold workplace reps (WPRs) training days, study sessions and engagement events in a much wider range of locations and venues that are convenient and local to you.

This year, the RCM plans to meet members in face-to-face events on 600 separate occasions. We will come to branch meetings, unit events and to meet you and hear about your priorities and concerns. So far, we are on target with some 299 RCM events held between January and June.

The resources saved will be reinvested in additional training courses for WPRs, a new membership system and in connecting with members.

We now have increasing numbers of members organising local study sessions, skills updates and training events. We have also increased the number of stewards, health and safety reps and learning reps. The experience of industrial action in England and Northern Ireland has shown how effective the RCM is when we harness the energy and commitment of our members.

There remains much to do and we continue to strive to improve. We’ll keep you informed of the changes and we welcome your feedback via rcm.org.uk/form/contact-us on how the RCM can continue to improve the services we provide.
Birth injuries to newborns can occur as a result of the birthing process, especially in the event of shoulder dystocia, use of instruments, or due to the size and position of the baby. Clavicle fracture is one of the most common injuries in newborns, occurring in 0.35% to 2.9% of births (Linder et al, 2012; Lurie et al, 2011; Sauber-Schatz et al, 2010; Uhing, 2005). Yet, 40% of clavicle fractures remain undetected at the time of discharge from hospital (Paul and Williamson, 2012; Uhing, 2005).

The implications of missing the diagnosis can mean further trauma, because parents were not advised on gentle handing of the baby and, in turn, child protection procedures can be triggered when the injuries are noticed after discharge.

If further education and training were provided to health professionals, it may become easier to diagnose the condition. Then, instead of experiencing upsetting difficulties, the parents could receive an explanation, advice and reassurance.

Risk factors and clinical presentation
Newborn clavicle fractures can occur following vaginal and CS deliveries (Lurie et al, 2011). Shoulder dystocia is associated with clavicle fractures, but there are other independent factors that may put a baby at increased risk (see table above) and health professionals should remain aware of these.

Where concerns arise that there may be an injury – and it is often midwives who first notice it – the

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### Risk Factors for Sustaining Clavicle Fractures in Neonates

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<tr>
<th>Fetal factors</th>
<th>Maternal factors</th>
<th>Delivery features</th>
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<tr>
<td>Birthweight over 4.5kg</td>
<td>Maternal diabetes</td>
<td>Shoulder dystocia</td>
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<tr>
<td>Length at birth of over 52cm</td>
<td>Increased maternal age</td>
<td>Prolonged second stage of labour</td>
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<td></td>
<td>Increased maternal weight</td>
<td>Use of oxytocin during first stage of labour</td>
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<td></td>
<td>Vaginal breech deliveries</td>
<td>Instrumental deliveries</td>
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Clavicle fractures can be easily missed, leading to further problems. Midwives can help avoid this by spotting it soon after birth, or actively looking for it if there are risk factors.

Managing neonates with clavicle fractures
baby will be assessed together with a review of the birth circumstances and risk factors. This will be followed by a thorough physical assessment by a neonatal medical professional or advanced neonatal nurse practitioner. Clavicle fractures are usually unilateral, but bilateral clavicle fractures are also possible (Kanik et al, 2011). The most frequent clinical findings are decreased movement of the ipsilateral arm, palpable spongy mass – which may only become palpable after the first day of life – crepitus on palpation of the fracture site, tenderness on palpation or on passive movement, discoloration over the site of the fracture and unilateral absent Moro’s reflex (Paul et al, 2013; Paul and Williamson, 2012; Kanik et al, 2011; Mavrogenis et al, 2011; Uhing, 2005; Reiners et al, 2000).

**Diagnosis**

Diagnosis usually follows a clinical examination. However, in some cases, the findings can be subtle and the clavicle fracture may not be apparent when the neonate is examined soon after birth. So, there is a need for midwives to reassess the neonates with risk factors before discharge from hospital and, later, by the community midwife during home visits to increase the detection rate. Radiological imaging is suggested to confirm the clinical findings and this will also serve as a medico-legal ↘
Condition: Clavicle Fracture

Diagnosis can be challenging because other conditions can mimic a clavicle fracture (see table below).

Management

Once a diagnosis has been made, treatment is usually conservative, as callus formation typically allows spontaneous resolution within two to three weeks. An important aspect of the management is parental reassurance and education. Parents should be advised to handle their baby gently, not to lift up the baby by pulling on the arms from a lying down position, and to avoid lying the baby down with the involved shoulder bearing weight on the affected side, even when breastfeeding. They should also be given advice with regard to the expected healing time; this will enable them to seek medical advice in a timely fashion if there is suspicion of delayed healing.

It is extremely important that neonatal clavicle fractures are carefully documented in the medical notes and the 'red book', where available, for future reference. Notes should include the side and site of injury. Hospital midwives should ensure that the fracture information is communicated to community midwives, health visitors, and the GP because, although rare, complications can occur. Non-union is one possibility, which will need orthopaedic intervention, or osteomyelitis of the affected clavicle, which will need prolonged antibiotic treatment (Valerio and Harmsen, 1995). More common complications include difficulty breastfeeding on the side of fracture and associated brachial plexus injury (Reiners et al, 2000) where spontaneous recovery occurs in 75% to 95% of cases (Foad et al, 2009).

Neonatal clavicle fracture is a relatively common birth injury, but initial newborn examination may fail to detect it, so repeat examination in high-risk groups is suggested. Early diagnosis will enable explanation, reassurance, and monitoring of healing time, and meticulous documentation will prevent unnecessary child protection procedures.

Eleanor Katie Rogers, fourth-year medical student, University of Bristol, Sarah Bolger, practice development midwife, Western Sussex Hospitals Foundation Trust, and Dr Siba Prosad Paul, specialty trainee in paediatrics, Year 8, Bristol Royal Hospital for Children, Bristol
BABYWearing – Carrying an infant in a sling – is a simple solution for many parents, but research shows that the benefits for parent and child are more than just practicality.

For preterm or low-birthweight neonates, the benefits of babywearing – known as kangaroo care – have been well researched. Rather than in incubators, babies spend the majority of their time in a sling with their primary caregiver, ideally their mother. Research shows that these babies regulate their breathing and temperature well by remaining skin-to-skin, and that breastfeeding rates are also improved (Gregson and Blacker, 2011).

These positives also apply to the healthy full-term neonate. The research that shows skin-to-skin

Carrying a baby close is as innate to humans as other mammals. As well as being practical, it has many other benefits as Jessica Smart explains.
There has been an implication that carrying babies frequently spoils them. However, views are changing.

Positive for baby and mother
Babies who suffer with colic in the early weeks can cry for hours, particularly during the evening, and they find comfort in being rocked in an upright position (Akter, 2012). A correctly supportive sling should hold baby upright and reduce their discomfort, as well as giving the parent their arms free on long evenings. Babies without colic benefit too.

An insecure attachment in a parent’s early infancy can contribute to increased levels of anxiety and emotional problems when becoming and being a parent themselves, which can influence mother and child bonding, as well as wider difficulties within family relationships (Steen et al, 2013).

Sling safety
Safe and ergonomic carrying is important so as to maximise comfort for both child and wearer, facilitating the ideal position for the body. An ergonomic sling should hold the legs with the knees higher than the bottom. For the first few months, legs will be no wider than hip width, until the baby is able to wrap their legs around the wearer, forming an ‘M’ position. This position supports healthy hip development and optimises comfort (Graham et al, 2015). Some carriers may only support from one knee pit to the other for a short period of time. In most babies this will cause no harm, but for those who suffer from hip dysplasia to be beneficial is overwhelming (Moore et al, 2012) and, immediately after birth, it is common practice. But it is just as beneficial as time passes. Babywearing encourages frequent time for skin-to-skin during the day, which has shown to improve the rates of breastfeeding in the early months (Piscacane et al, 2012). It also gives fathers an opportunity to connect with their newborn in a nurturing capacity. The sling mimics a womb-like environment; they are held tightly and securely across their whole body, and their positioning means that they can listen to their parent’s heartbeat.

BETTER
Thigh is supported to the knee joint. The forces on the hip joint are minimal because the legs are spread and supported, and the hip is in a more stable position.

NOT RECOMMENDED
Thigh not supported to the knee joint. The resulting forces can exacerbate existing hip dysplasia.

THE HIPS GUIDELINE FOR CARRYING A BABY
(Rosie Knowles, Sheffield Sling Surgery)
and misalignment at the hip joint, a narrow base can exacerbate these issues and so a wider-based carrier, or one that can be adjusted, is optimal (Fettweis, 2004). The Pavlik harness used for these children holds the hips in this same ‘M’ shaped position (Ardila et al, 2013) and so a wide-based carrier is ideal in these circumstances and can help bonding and comfort with a harness in situ.

Babies should also be facing inwards towards their parent at least until they have good head control. Forward facing should only be advised in a carrier that supports the child’s legs and hips ergonomically, only for short periods and while awake. Hip and back carriers are good options as the child gets older.

Whatever sling is used, the baby should have a clear and visible airway with their chin off their chest. The baby should have a supported back, be upright and high enough on the chest that they can be clearly seen and there is no airway risk from the breasts. Recorded fatalities (BBC, 2014) from slings have been due to carriers that do not facilitate these essential safety checks, either from serious user error or from ‘bag’ style slings in which a baby is placed in a cradle position, causing them to curl up within, this could restrict the airway and is potentially very dangerous. While some instructions offer a cradle carry position, this is not advised without experience and awareness due to it not meeting ‘TICKS’ guidelines (see images).

Most areas now have access to a ‘sling library’ where users can hire carriers for a small fee to try out different styles. They are also great resources for getting advice from trained babywearing consultants. Details of local babywearing libraries or consultants can be found at slingpages.co.uk

Jessica Smart, midwife and babywearing consultant, Worthing Hospital

THE TICKS GUIDELINE FOR CARRYING A BABY IN A SLING

- **TIGHT**: Slings and carriers need to ensure the baby is hugged close. Slack fabric may mean the baby slumps, which hinders breathing, and hurts the carrier’s back.

- **IN VIEW AT ALL TIMES**: The mother should always be able to see the baby’s face by glancing down and the fabric should not require opening.

- **CLOSE ENOUGH TO KISS**: The baby’s head should be as close to the mother’s chin as possible.

- **KEEP CHIN OFF THE CHEST**: There should always be at least a finger width under the baby’s chin to ensure breathing is not hindered.

- **SUPPORTED BACK**: An upright carry should mean the baby is held close to the mother with their back supported in its natural position, with its tummy and chest against the wearer. A baby in a cradle carry should have their bottom in the deepest part, so the sling does not fold them in half.
In the UK, there are almost 785,000 live births each year\(^1,2,3\), and in around 40 per cent of these, the mother will experience constipation while she is pregnant\(^4\). Added to this, between 25-35 per cent of pregnant women will develop haemorrhoids\(^5\). In many cases, these conditions could be avoided by simple lifestyle changes to increase fibre intake, particularly wheat bran, and fluid intake. This article shares research findings and clinical guidance to help prevent and, where necessary, to relieve these troublesome conditions.

**FACTORS CONTRIBUTING TO PREGNANCY CONSTIPATION**

The increased incidence of constipation during pregnancy is thought to be due to a range of factors; both hormonal and mechanical (see Figure 1). Rates of constipation are highest in trimester one (35%) and two (39%), and drop slightly in trimester three (21%)\(^2\). Hormonal factors appear to have a greater influence, compared to mechanical changes, as pregnancy progresses. For a non-pregnant population, a low-fibre, low-fluid intake, together with reduced mobility, increases the risk of constipation\(^6\). Low fluid and fibre intakes are therefore likely to also be significant contributing factors to these conditions during pregnancy.

**POTENTIAL IMPACT OF CONSTIPATION IN PREGNANCY?**

The prime concern for women suffering from constipation during pregnancy is discomfort. However, straining to defecate can damage the pudendal nerve and impair the supportive function of the pelvic floor musculature\(^7\), and it appears that constipation is as important a cause of pelvic floor damage as obstetric trauma\(^8\). Raising fibre intake is therefore important not only for quality of life, but also to help maintain the integrity of the pelvic floor.
FOCUSING ON DIETARY FIBRE

Nutrition guidelines for pregnancy (e.g. NICE 2010) advise increasing intake of dietary fibre, and particularly wheat bran as a first line approach to prevent or alleviate symptoms of constipation. However, how much fibre and which foods to advise is not specified.

Clinical guidelines around the globe recommend wheat bran as the most effective solution to an irregular bowel habit and constipation. Bran is simply the coarse outer covering or coat (seed husk) of the cereal grain. Wheat bran has greater laxative effects compared to other cereal bran hence its specific recommendation in clinical guidance.

The laxative effect arises from wheat bran’s high water absorption and stool bulking effect: 1g of wheat bran absorbs over 5 times its weight in water, giving a 5g increase in stool weight. Analysis of decades of research has led to the approval of two health claims for wheat bran, which are permitted for use in the UK, and across the rest of Europe “Wheat bran fibre contributes to a reduction in intestinal transit time” and “Wheat bran fibre contributes to an increase in faecal bulk”.

HOW MUCH FIBRE AND FLUID SHOULD WE ADVISE?

Research among constipated, pregnant women is sparse with just one intervention study carried out in the past 30 years. During that study, women on average just 18g fibre daily, considerably lower than recommended for adult women is to consume 30g fibre daily, with no specific increase for pregnancy.

Current intakes of fibre in the UK are low. The new recommended intake for pregnancy, and could often be avoided by simple lifestyle changes. Clinical guidelines advise increasing fibre, particularly wheat bran, and fluid intakes during pregnancy.

IMPLICATIONS FOR PRACTICE

Most women in the UK are consuming too little fibre and fluids and are therefore likely to start pregnancy with mild, but unrecognised, constipation. The influence of pregnancy hormones on gut motility can, for some women, result in problems with regularity and constipation right from the earliest days.

TACKLING THE PROBLEM

The most reliable way to identify a high fibre food is to check the nutrition panel, and look for ‘wholemeal’ or ‘wheat bran’ in the ingredients list. By law ‘high fibre’ foods must contain at least 6g of fibre per 100g, and those with at least 3g fibre per 100g are a ‘good source’. The words ‘wholegrain’ on packaging provides no indication to fibre status, and some foods stating ‘wholegrain’ are low in fibre.

It appears that the average pregnant woman would benefit from an increase in wheat bran fibre of at least 10g per day, accompanied by an increase in fluid intake.

TABLE 1: COMMONLY CONSUMED SOURCES OF WHEAT BRAN

<table>
<thead>
<tr>
<th>Food</th>
<th>Wheat bran fibre per 100g</th>
<th>Wheat bran fibre per typical portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Bran Cereal</td>
<td>27g</td>
<td>11g</td>
</tr>
<tr>
<td>Wholemeal Spaghetti</td>
<td>3.5g</td>
<td>7.7g</td>
</tr>
<tr>
<td>Wholemeal Tortillas</td>
<td>6.4g</td>
<td>2.6g</td>
</tr>
<tr>
<td>Bran Biscuits</td>
<td>16g</td>
<td>6g</td>
</tr>
<tr>
<td>Bran Flakes</td>
<td>15g</td>
<td>6g</td>
</tr>
<tr>
<td>Wheat Pillow Style Cereal</td>
<td>11.6g</td>
<td>5.2g</td>
</tr>
<tr>
<td>Wholemeal Pitta Bread</td>
<td>6.2g</td>
<td>3.9g</td>
</tr>
<tr>
<td>Wholemeal Flour</td>
<td>9.0g</td>
<td>2.7g (1tbsp)</td>
</tr>
<tr>
<td>Wholemeal Bread</td>
<td>5.0g</td>
<td>2.5g</td>
</tr>
</tbody>
</table>


KEY POINTS

1. Constipation affects approximately 40% of women during pregnancy, and could often be avoided by simple lifestyle changes.
2. Clinical guidelines advise increasing fibre, particularly wheat bran, and fluid intakes during pregnancy.
3. Most women need to increase wheat bran fibre intake by around 10g per day to help minimise or avoid constipation in pregnancy.

References:

11. Anti M et al. (1998) Water supplementation enhances the effect of high-fiber diet on stool frequency and laxative consumption in adult patients with constipation. Gut 42: 168-172
18. Adib et al. (1998) Water supplementation enhances the effect of high-fiber diet on stool frequency and laxative consumption in adult patients with constipation. Gut 42: 168-172
R EVALIDATION WILL BE MUCH EASIER when it becomes habit. One of the things that was difficult was the need to do it all in eight weeks.’ These are the words of Lynne Pacanowski, director of midwifery and head of gynaecology nursing at Guy’s and St Thomas’ NHS Foundation Trust, which was one of 19 sites across the UK to pilot revalidation earlier this year. Her words should be of some comfort to the first set of midwives who will go through revalidation in April 2016 – if it is achievable, albeit challenging, to get it in done in a couple of months, then it is certainly possible in a longer timeframe.

The pilots involved 2100 participants who were testing the system before the NMC makes a final decision about the model in October. Guy’s and St Thomas’ had 313 people participate, 6% of whom were midwives – 3% single registration and another 3% dual registration. Timings were tight with midwives needing to collate their portfolio and have held their meeting with their confirmer within a two-month timeframe. In spite of the ambitious deadline, initial findings were that revalidation was achievable and realistic.

**Pros and cons**
Midwives have an advantage over their nursing colleagues because of the current annual requirement of submitting their intention to practise (IIP).

‘This is like a mini-revalidation each year and I was able to use much of that for revalidation,’ says Lynne.

But that is not to say it was without challenges. Lynne points to several areas of confusion. One was a lack of clarity around feedback. Some participants in the pilot opted to carry out a survey on colleagues – a valuable source of feedback for those with limited client contact. However, asking peers, managers and direct reports on how your working practice reflects the NMC code may result in five pieces of feedback covering four domains of the code, but it does not mean the job is done.

Lynne says: ‘Even though you may get more than five responses to the survey, this only counts as one piece of feedback because it is one source.’

There was also confusion around the role of the
confirmer. The NMC requires midwives to have recorded at least five reflections and have had a professional development discussion about it with another NMC registrant. Lynne says there was confusion about how this should work in practice. ‘There is room for different interpretations. I did some headlines for my confirmer and planned to expand on them in our discussion, but she had expected to read all my reflections before we met,’ she says.

**Areas of concern**

For midwifery practice leader Anne Cobell, revalidation felt repetitive. She says that she meets her SoM each year to reflect on her practice then does some more reflection in her appraisal. In her view, revalidation was doing it all again, but in a different format.

As someone who is organised, she already keeps her CPD and feedback together in one file; she spent eight hours one Sunday pulling it together and writing her five reflections, making links to the four areas of the code. She was one of a small number of participants chosen at random to provide additional information to the NMC. This was a frustrating and time-consuming task, she says.

‘I’d already filled out the NMC templates, printed them for the portfolio and then discovered I had to type it all in again. Some of it I could photograph with my iPad and upload, but others I couldn’t. That was really frustrating and I thought the NMC could have sorted that type of glitch before the pilot,’ says Anne.

The biggest area of concern for her is the lack of guidance around dual registration. Anne is determined to remain dual registered but, in spite of having gone through the pilot, says it is still unclear as to how she does this.

She was not alone with this complaint and the NMC is to produce detailed guidance on the scope of practice, which will address this.

In fact, in response to all the feedback from pilots, the NMC is to simplify the guidance for midwives and nurses, clarify the role of the confirmer and develop additional materials for employers.

**Valuable learning**

The trust itself has learned from the pilot experience and how best to manage the process when it starts for real. For example, there was uncertainty about whether revalidation could dovetail with appraisals. In Lynne’s case, the two were combined and the meeting was long – more than two hours.

But Julie Hamilton, head of nursing revalidation and regulation, thinks that this is partly due to it being the first time and expects the length of time to reduce drastically. She also did her appraisal with revalidation and the meeting took no longer than other years. The trust has decided, like many others, to have the confirming conversations in the same meetings as the appraisal.

‘Otherwise, people are away from the clinical area two or three times a year rather than once,’ says Julie.

She says that linking the two makes reflection an essential component of professional development on a yearly basis and embeds the NMC code into everyday practice.

‘But it does need to be very clear that the reflective discussion is not about performance management; it’s about professional development,’ she adds.

One thing on which they all agree is that it is never too early to start preparing for revalidation. Lynne’s advice is to think ahead, even if revalidation is not due for some years.

‘My number one message would be: get organised. If you have a study day, write it down and link it to the code. We learned that, when it becomes business-as-usual, revalidation will be much easier.’
Fear of childbirth among women is an issue about which midwives have an awareness and sensitivity (Dahlen and Caplice, 2014). But what about the fear and anxiety experienced by midwives themselves? In recent years, there has been increased research into their experience, illuminating some of the difficulties that midwives face on a day-to-day basis (Davies and Coldridge, 2015; Hunter and Warren, 2013). Many of the problems are connected to the environment in which they work, whether that is a specific unit or the broader healthcare culture. For example, recent investigations into NHS failures of care have resulted in midwives receiving mixed press, which has an inevitable effect on morale (Mander, 2014).

The Birth Project Group aimed to find out how much a midwife’s practice is affected by the stringencies of the recent and current healthcare environment. It put together an online survey, focusing on midwives’ perceptions of their practice environment, and comprised open and closed questions to glean midwives’ genuine feelings. The survey began with an invitation to UK and Irish midwives and midwifery students on social media and professional publications in 2014. The respondents were sufficiently enthused by the topic to answer questions in detail and at length. Fear was a recurring theme in the answers to the open questions. It seems to manifest itself in three different forms.

**General anxiety**

The first is general anxiety, which appears to be widespread. One respondent said: ‘There is a culture of fear… I feel [I’m] walking on egg shells when I go to the unit, you never know what you’ll walk into, there is always a frisson of fear somewhere.’

Heightened awareness is crucial to effective practice and is a highly satisfying aspect of midwifery. However, midwives who work in an over-stretched environment may feel nothing but tension and react to potentially complicated conditions with increased anxiety because their emotional resources are drained by challenging day-to-day practice. Thus, anxiety and tension aggravate demanding situations.

Some respondents could see the long-term effect of this. One said: ‘If we support midwives and value them, we will succeed in providing excellence. If we wear them out, stress them beyond what is reasonable – and create a culture of fear – we will pay the price in patient care.’

When asked what factors inhibited the ability to practise optimally, one midwife replied: ‘Staff, protocols, expectations, size of unit, power of obstetrics. Most of all, fear.’

Qualitative findings from an online survey show the extent to which midwives are practising in fear.
Variety of fears
Some midwives responded with a series of concerns, reflecting a variety of fears. They indicate the breadth of concerns that the midwife must endure while seeking to provide care and encouragement to women. Unsurprisingly, low staffing levels caused problems. One midwife explained that it is stressful because of tasks left undone, and fear has become a near-constant companion.
‘Fear of untoward occurrences; fear of litigation; fear of burnout; fear for my health; fear of making a mistake,’ she said.
Many of the midwives reflected on what has been termed ‘the vicious cycle of understaffing’ (Donohoe, 2015). This cycle is perceived to result from current economic stringencies on top of past neglect of midwifery staffing levels. It carries adverse implications for women and their babies, as well as for midwives’ health and careers.
One midwife said she fears a serious clinical incident occurring and being blamed for something out of her control because of staff shortages. Another explained the effect it has on her when she is trying her best in a system with severe shortcomings.

I feel constantly disheartened, apologising to women for things I am unable to provide during my shift

‘It is sad to leave every shift knowing that you haven’t been able to do enough and being too scared to follow up a woman due to the fear that somewhere else in the service care has fallen short. The only reason I’m still working in this environment is fear for what would happen if any more of us leave.’
This vicious cycle can be linked to attrition from the profession and sickness absence. One midwife described how patient satisfaction goes down while staff stress levels go up. She said that the fear that something – or someone – will be missed means that the increasing levels of sickness become self-perpetuating. It is apparent that fears compound each other, both for individual midwives and more widely.

Specific fears
Other respondents articulated specific fears, such as encountering certain colleagues in a climate of unacknowledged behaviours that reinforce intimidation. One described ‘the prevailing obstetric culture of fear’. There was recognition that fear was an impediment to effective midwifery practice. Some saw the solution as becoming more assertive. One midwife said: ‘Fear is the greatest barrier to me practising as the midwife I would like to be. If only we would all find the courage to speak out when we are understaffed and feel overwhelmed, management would need to listen.’
This need for assertiveness, sometimes termed ‘resilience’ (Hunter and Warren, 2013), was identified by other midwives as fear of ‘tall poppy syndrome’ – the fear of standing out from the crowd.
Blame and bullying were both serious causes of concern among respondents, some of whom were able to express remarkable insight, even sympathy, for the bully.
‘There is a fear of bullying by managers, themselves bullied by their managers because of financial pressures,’ said one.
Fear is the greatest barrier to me practising as the midwife I would like to be

A specific, widely expressed anxiety related to the effects of stringencies on the standard of maternity care. Midwives recognised that poor staffing jeopardised their own health and career. One said: ‘I feel constantly disheartened, apologising to women for things I am unable to provide during my shift. I also live in fear that the job I once loved will come to an end because I am unable to provide the standard of care women deserve.’

The qualitative data from the survey reveals the depth of midwives’ anxieties. Many of these result from the economic stringencies being levelled at the health service and maternity services, in particular. However, they also reflect the steady stream of reports published since the beginning of the century and their neglect (Healthcare Commission, 2006).

**Professional anxieties**

The data throw a different light on the concept of fear in a maternity unit. Until relatively recently, fear was seen as unique to the childbearing woman and a possible reason for medical intervention. Attention is now moving to those attending the woman; research is identifying the extent to which the carer’s bad experience mirrors or parallels the woman’s (Davies and Coldridge, 2015). Fear and professional anxieties experienced by the midwife were the focus of Hannah Dahlen and Shea Caplice’s qualitative study (2014). But the Australian respondents and researchers concentrated on clinical problems. Mortality, morbidity and near misses monopolised the anxieties that were expressed by the midwives. Only 132 fears (17%) related to the practice environment were expressed. The reasons for this are uncertain; it may relate to the Australian population or the healthcare system. While these clinical concerns will be experienced by midwives in the UK and Ireland, as well as Australia, they are likely to be aggravated by a clinical environment that has become disagreeable to the point of verging on hazardous.

The significance of the fear articulated by midwives and students should not be underestimated. Although clearly different from the woman’s anxiety, the midwife’s fear will be perceived and exert an iatrogenic form of stress, which is likely to interfere with the woman’s physiological experiences, such as birth and breastfeeding (Ewing, 2010). Thus, the trauma of a woman’s difficult childbirth experience further traumatises those attending her (Davies and Coldridge, 2015), manifesting itself in an escalating cycle of despair.

The data show midwives’ part in this vortex. Their fear of certain phenomena presents a threat to optimal practice. They also articulated their fear to behave in certain ways that, although daunting, were known to be necessary. The midwives were able to adopt a particularly long-sighted position and talk about their fears for midwives’ health, their careers and the future of maternity services.

Isn’t it time that management listened?

The Birth Project Group, Scotland and Ireland.

For more information, see tinyurl.com/oldxdxf

I live in fear that the job I once loved will come to an end because I am unable to provide the standard of care women deserve
Hydrating is about drinking eight glasses of water per day
False. Total daily water intake is the sum of water content coming from all beverages and foods. Plain water is fine, but consuming a wide variety of drinks can help in achieving the recommended daily intake. In addition, foods with a high water content – such as fruit, vegetables and soups – can also make a significant contribution.

Caffeinated drinks dehydrate you and should be avoided
False. Caffeine is a mild diuretic, but most caffeinated drinks will result in a positive fluid balance: the caffeine content is low and the water they contain will more than match any losses. There is a danger of becoming more dehydrated if you cut out caffeine-containing drinks and do not replace them with something else.

Dehydration occurs only when the temperature is high
False. Water losses will be greater with a high environmental temperature, but may also be increased by other factors. Any physical activity, especially in dry air, will increase the rate of water loss from the body. Gastrointestinal diseases (vomiting, diarrhoea) also increase water and salt loss.

The European Food Safety Authority (EFSA) (2010) has defined adequate water intake for women at two litres per day, so this is how much is needed
False. It is important to remember that the adequate intake (AI) is the amount that is estimated to meet the average need of any population. This means that half of the population need less, but half need more. Meeting the AI is a good starting point, but you may need more or less and your needs will vary from day to day. If you are active, or bigger than average, or if the weather is warm, you will probably need more than average.

During pregnancy and breastfeeding, women’s hydration needs are higher
True. Increased water needs in pregnancy arise because of the weight gained (typically 10kg to 15kg), the higher energy demand, the increase in blood volume, the formation of amniotic fluid and the increased water losses that result from morning sickness.

For pregnant women, EFSA recommends the same water intake as non-pregnant women, plus an increase in proportion to the increase in energy intake (300ml/day). For lactating women, EFSA recommends adequate water intake of about 700ml/day above the AI of non-lactating women of the same age. Mild dehydration does not affect milk supply, but moderate to severe dehydration may have an effect, including changing the composition of the milk and decreasing the amount produced. Dehydration can also add to feelings of tiredness at what can be a very stressful time.

The reference for all facts stated in this article is:

A consumer survey by the European Hydration Institute suggests that there are common misconceptions around hydration. Here are responses to some commonly-held perceptions.
In just over a year, Abbey Birth Centre (ABC) in Chertsey, Surrey, has grown in reputation and success. It opened its doors in May 2014 and, by the end of the first year, had seen 507 babies born there, even though it had only anticipated 360 (ASPH, 2015). In the same time, the number of waterbirths has tripled (ASPH, 2015). In April 2014, there were 13 waterbirths in the service; in April 2015, it had risen to 38 (ASPH, 2015).

Alexandra Bell, ABC’s team leader, says that the testimonials from women are increasing the popularity of the alongside birth centre: ‘In the last 10 weeks, we’ve had 130 babies and we’re now getting out-of-area bookings, as women have heard about it from friends or sisters and they want to come here.’

The success is all the more special, because the birth centre was a decade in the making. Before ABC, all low-risk women gave birth on the obstetric-led labour ward at St Peter’s Hospital, unless they were having a home birth. The labour ward comprises seven rooms, one pool room and three home-from-home rooms. Senior midwives – in particular, clinical midwifery manager Theresa Spink – were keen to offer low-risk women an alternative. It was argued that a birth centre would reduce the likelihood of intervention, with the associated risk and costs, and improve outcomes and the experience for mothers and babies. Of course, such a service develops midwives’ skills and competence in spontaneous vaginal birth, which enhances the culture of normality within the wider maternity service and community.

Theresa’s determination paid off, and five years ago, it was agreed in principle that a birth centre could be built. Once the money had been found, a £1.5m budget was set and the work began.

The centre, which has four rooms – three with active birth pools – is staffed by a core team of eight Band 6 midwives, who provide 24/7 care to women. There are two midwives on every 12-hour shift who are supported by Alex, a Band 7 midwife team leader, during office hours from Monday to Friday and the community midwifery service. The community midwives rotate into the birth centre once or twice a month as part of their role. ‘If we’re super busy then we speak to the bleep holder for support and, if that is not possible, the community midwife

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**TOP TIPS FOR SETTING UP A BIRTH CENTRE**

- Be patient
- Have a vision
- Keep your passion
- Have flexibility
- Be persistent
- Get support from senior management
- Celebrate every win.
who is on-call for home births will come in. We have no MSWs yet, but if numbers keep increasing then we will look at that,’ explains Alex. The numbers seem likely to rise since the centre has just revised its definition of ‘low risk’ for the third time since opening in order to include more women. For example, women who were on medication for depression were previously excluded but are now permitted, and the BMI limit was 30 initially but this has now been raised to 34.9. Obviously, more women will now be eligible for the birth centre, though the various individual risk factors are always explored to ensure it is appropriate.

Alex explains: ‘Often, risk is not clear cut. So we have a traffic light system of green, amber and red – green is no barrier at all and red means women need increased monitoring and so are not eligible. For amber, we meet and assess their individual situation.’ For those for whom the birth centre is not possible, the wider team support these women to plan for the positive experience they want on the labour ward. So it is helpful that the staff there are increasingly taking the view that normal birth is possible for more women than they previously thought.

One of the barriers to setting up the centre was the challenge of implementing a philosophy of normal birth alongside a high-risk obstetric unit. Ashford and St Peter’s Hospitals NHS Foundation Trust has a high-risk population and, as it has a level three neonatal intensive care unit – the only one in Surrey – it receives in-utero and ex-utero referrals from a wide geographical area. Inevitably, this affects the maternity culture locally. This is not only among obstetricians but midwives too. It is an ongoing challenge, though Alex points out that it is not unique to their service.

‘We are dealing with this every day. Much of it is a mindset. There can be a view that a woman’s condition precludes normal birth but, in most cases with medical conditions or risks, they can still have one. This belief is beginning to be challenged more since the birth centre opened,’ she says.

Alex adds that, in achieving high numbers of normal births in the centre, the ABC team are changing views in the wider maternity service and embedding the philosophy. As those in the hospital hear about the success of the birth centre through presentations of results and word of mouth, the more encouraged they are that normal birth is possible for many women.

‘We’ve increased our expectation of normality here and on the labour ward. People are seeing that normal birth really does work – it does happen where women just come and have a baby.’

Pain relief at ABC comprises the birthing pool, gas and air and one-to-one midwife care. Such is the power of midwives’ care that Alex describes it as pain relief. The personalised care on offer makes a world of difference. Women who have never before had a baby can find it a terrifying experience because they do not know what ‘normal’ means. Someone who has the time and expertise to reassure an anxious mother, provide tips and guidance on how to cope and give her a ‘metaphorical’ cuddle, makes it a different experience from that on the labour ward where it can be more challenging and often much busier, says Alex.

‘The midwives understand the process of normal labour and can support women in the right way. Women almost need permission to be ok and the midwives give them that.’
A S MIDWIVES WILL KNOW, INFLUENZA is an acute viral infection of the respiratory tract that is highly infectious and spread by respiratory droplets, aerosols and direct contact with infected respiratory secretions (Lau et al, 2010). The infection is often of sudden onset with fever, chills, sore throat, dry cough and congested nose. For most healthy individuals, the disease is self-limiting, though complications of influenza infection include otitis media, bronchitis, secondary bacterial pneumonia and, rarely, meningitis and encephalitis. Although it can happen all year round, most flu infections in the UK occur in an eight- to 10-week period during the winter.

Influenza viruses can be classified into A, B and C strains. Flu A strains are subject to unpredictable changes to their surface proteins. If a small change occurs, this is known as antigenic drift, while a major change is called an antigenic shift. Where this happens, and a new sub-type of influenza A virus occurs, large outbreaks and pandemics may occur as there may be little or no population level immunity to the virus. Influenza B strains cause less severe disease and smaller outbreaks. Influenza C virus causes relatively minor symptoms and is not included in influenza vaccines.

Those with diabetes, immunosuppression or chronic heart, respiratory, liver, renal and neurological disease are more likely to suffer complications of flu. Also at increased risk are those under six months old (Zhou et al, 2012; Coffin et al, 2007; Ampofo et al, 2006; Poehling et al, 2006) and the elderly (Zhou et al, 2012; Thompson et al, 2004; 2003).

In addition, flu during pregnancy carries particular risks to both the pregnant woman and the unborn baby. Influenza infection in pregnancy is associated with an increased risk of miscarriage, premature birth and low birthweight (Mendez-
One in 11

- In 2009-12, one in 11 UK maternal deaths in pregnancy was due to flu (Knight et al, 2014).

Five times

- Pregnant women with flu are five times more likely to have a stillborn baby or for the baby to die in the first week following birth (Immunisation Scotland, 2014a).

44.1%

- In 2014-15, 44.1% of pregnant women in England received a flu vaccine – a rise of 4.3% on the previous year (PHE, 2015; 2014).

10 days

- It takes about 10 days until someone is protected against flu after the jab (Immunisation Scotland, 2016).

Talk to GP

- If a pregnant woman gets flu, NHS Choices advises they talk to their GP as soon as possible as there’s a prescribed medicine that can reduce risk of complications. But it needs to be taken very soon after symptoms appear (NHS Choices, 2014).

13 times

- In 2009, pregnant women in Australia and New Zealand who had pandemic influenza were 13 times more likely to be admitted to hospital with a critical illness than non-pregnant women who had flu that year (The ANZIC Influenza Investigators and Australasian Maternity Outcomes Surveillance System, 2010).

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Figueroa et al, 2011; Pierce et al, 2011). Maternal morbidity and mortality from flu is higher in pregnant women compared with non-pregnant women (Pebody et al, 2010) and this risk is worse if the woman has existing risk factors, such as diabetes (WHO, 2012).

Between 2009 and 2012, one in 11 maternal deaths in pregnancy in the UK was due to flu (Knight et al, 2014).

Flu jabs

As a result of the unpredictable and changing nature of influenza viruses, annual immunisation against flu is recommended for pregnant women. The annual vaccines are based on recommendations from WHO and usually contain two A strains and one B strain (trivalent), although in recent years, an additional B strain has been added to some vaccines (quadivalent).

In the UK, there are two main types of influenza vaccine. The inactivated (killed) intramuscular influenza vaccine made from surface proteins is widely available and is suitable for use in pregnancy. While common side effects of inactivated influenza vaccine include pain at the injection site, low-grade temperature and aching muscles, the vaccine cannot cause the disease against which it is designed to protect. The intranasal vaccine, introduced as part of the national children’s influenza immunisation programme, is a live (attenuated) vaccine and is not suitable for use in pregnancy. Inactivated influenza vaccine in pregnancy reduces the risk of infection, prematurity and low gestational weight (Omer et al, 2011). It also provides the neonate with passive immunity to influenza for the first few months of life (Eick et al, 2011; Poehling et al, 2011; Benowitz et al, 2010; Zaman et al, 2008) and is effective in preventing flu and hospitalisation among infants whose mothers were immunised in pregnancy (Dabrera et al, 2014). Inactivated influenza vaccine was first recommended for all pregnant women in the UK in 2010 and can be given safely at any stage of pregnancy with no evidence of increased risk of adverse pregnancy outcome in vaccinated women (Regan et al, 2015; Keller-Stanislavski et al, 2014; Tamma et al, 2009).

The midwife’s role

During the influenza season 2014-15, 44.1% of pregnant women in England received a flu vaccine, which is an increase of 4.3% on the previous year (Public Health England (PHE), 2015; 2014). Midwives have an important role to play in ensuring pregnant women, the fetus and newborn baby are protected against influenza. Depending on local commissioning arrangements, midwives may administer the flu vaccine as part of antenatal care or, signpost the woman to her GP to receive the vaccine.

Influenza vaccine is normally available from September each year and immunisation of women with existing pregnancies should start when the vaccine is available. Those women who become pregnant during the flu season can also be offered the vaccine throughout the season. Additionally, pregnant women who have reached 28 weeks’ gestation can be offered the pertussis vaccine to protect the baby from whooping cough in the first months of life. Ideally, this should be given between 28 and 32 weeks’ gestation, but can be administered up to 38 weeks (Davies et al, 2012).

As the method of gathering data on uptake of both influenza and pertussis vaccines in pregnancy is via general practice clinical information systems, any vaccines given as part of antenatal care should be communicated to the woman’s GP.

It is recommended that midwives have the vaccine themselves to further reduce the risk to women and neonates in their care. In addition, antiviral medication can be accessed during periods of high prevalence of influenza-like illness. While antiviral medication is not a substitute for influenza immunisation, it can be used for the prophylaxis and treatment of influenza infection.
The length of postnatal stays is declining, women are unhappy and hospital admissions for neonates are increasing. **Juliette Astrup** explores the situation.
OF ALL THE CHANGES in postnatal care over recent decades, perhaps the decline in how long women stay in hospital after birth is the most dramatic. In 1975, two-fifths of women having babies at NHS hospitals in England stayed in for a week or more. Now, the majority – almost 60% – are home within one day (Health & Social Care Information Centre (HSCIC), 2015a).

Over the last 15 years alone, the mean length of stay has dropped from 1.8 days to one day for a single spontaneous birth, and 3.5 days to 2.4 days in the case of instrumental deliveries. For single CS deliveries, the average length of stay has more than halved from 5.7 days in 1998-99 to just 2.2 days in 2013-14 (HSCIC, 2015b; 2000).

So what is driving the trend, and how is it impacting on women and babies?

Few would argue that pressure on resources isn’t a big factor – especially in England, where the RCM estimates a current shortage of 3000 midwives. As chief executive Cathy Warwick explains: ‘We have certainly got evidence from our HoMs surveys over the years that they are having to pull midwives from community-based work and postnatal ward work into labour wards on a very significant number of occasions.

‘Downward pressure on beds across the health service is made particularly acute in maternity services, where a rising birth rate, and women with complex needs, has already put pressure on beds.’

She adds: ‘Women who don’t have a really desperate need to stay are getting sent home earlier than may be best for them.’

Financial issues
As well as staffing pressures, there is also an issue with the tariff – the amount clinical commissioning groups pay for postnatal care.

‘It is an area of care which is very undervalued and there isn’t really an incentive for trusts to increase care in that area,’ adds Cathy.

The RCM’s 2013 survey of mothers, carried out as part of its Pressure Points campaign for better funding and resources for postnatal care, reported that only 29% of mothers felt able to stay in hospital as long as they wanted (RCM, 2014a). Almost one in 10 felt rushed out before they were ready, and 31% said they were ‘keen to get home, but also felt unsupported and not quite ready to leave’ (RCM, 2014a).

NCT policy advisor Rosemary Dodds says: ‘Some women want to be at home, if they have plenty of support there, and they can rely on contacting a midwife if they need to. Others do feel rushed out before they are ready.’

She adds: ‘We also hear that many women are not receiving the information, emotional support and care that they need.’

The NCT’s (2010) own survey found 42% of women who had hospital births felt that there were sometimes or never enough midwives to provide them with the level of support they needed, while 57% said they did not get all the emotional support they needed in the first 24 hours.

While some women may not feel supported in the hospital environment, it’s also true that many simply want to get back to their families and their own homes. The National Perinatal Epidemiology Unit’s (NPEU) 2014 national maternity survey found most women (68%) thought their length of stay in hospital was ‘about right’, while only 12% said it was too short, and 15% thought it was too long.

Flexible care
Long hospital stays, along with daily midwife visits, are, in most cases, simply a thing of the past. Cathy Warwick recalls her time as a young midwife when it was ‘written in tablets of stone’ that women who went home early received two visits a day up until three days, and daily midwife visits until 10 days after birth. While that flexibility is right, she says: ‘The difficulty is when you take away these bureaucratic rules at a time when resources are constrained you can end up with nothing. It is a dilemma.'
...and it is tempting to argue for the reintroduction of minimum standards, but we shouldn’t have to do that – we ought to be giving care based on what women need and want, not a fairly arbitrary legal requirement.

“We need time to sit down with a woman following birth and work out what she is going to need postnatally – and then deliver it. Unfortunately, as our Pressure Points campaign shows, we are a long way away from that.”

Getting it right for women and babies at all stages is clearly the aim, yet repeated surveys of new mothers have shown they feel consistently less positive about postnatal care than other parts of their maternity care (NPEU, 2014; 2010; 2006).

Of course, that isn’t just a reflection of their time in hospital – indeed for women giving birth at home, none of it is. NICE guidelines divide the postnatal period into three time bands – the first 24 hours, between days two and seven, and from eight days up to eight weeks after birth (NICE, 2006). Most postnatal care happens outside hospital. But, echoing the decline in the length of hospital stays, is a decline in the number of midwife home visits. The average number has fallen from five in 2006, to 3.1 last year (NPEU, 2014; 2010; 2006). While most respondents in the 2014 survey (71%) felt they had enough postnatal home visits, almost a quarter (23%) would have liked more, especially first-time mothers (NPEU, 2014).

The RCM’s Pressure Points campaign report (RCM, 2014a) calls for ‘serious attention’ to be given to whether three visits is an acceptable average ‘and whether it is capable of offering safe care, in the context of early discharge from hospital and increasing readmission rates of mother and babies, increasing infection rates and postnatal morbidity.’

**Continuity of care**

Continuity of care is also an issue here. There is a wide body of evidence to support the practice, including a 2013 Cochrane review (Sandall et al, 2013) of 13 trials involving 16,242 women, which compared those who received midwife-led continuity of care, with shared or medically-led care. It found midwife-led care was associated with significant benefits for mothers and babies, and had no identified adverse effects.

However, the latest NPEU (2014) survey found a third of women saw three or more different midwives during the postnatal period, and 40% had not met any of the midwives who had made home visits before. Similarly, the Pressure Points survey found just 4% of mothers had full continuity of care antenatally, through labour and postnatally (RCM, 2014a).

Debra Bick, midwife and professor of evidence-based midwifery practice at King’s College London, says: ‘Continuity of care is really important. If you’ve got a midwife who has seen someone through pregnancy and knows their history, they haven’t then got to start again with three or four different midwives.’

She adds: ‘If you have a midwife you know and are comfortable talking to, you are more likely to mention any problems.’

For Debra, midwives are also being ‘hindered by the definitions of the postnatal period’. She adds that ‘there is no evidence base at all to support women being discharged from maternity care at six weeks’. She was involved in the 2002 trial of more than 2000 women in the West Midlands, which redesigned postnatal community care. The trial group, who had their health and care managed by midwives over a longer period, with GP contact only when required, saw an improvement in women’s mental health at four months postpartum, which persisted at 12 months, compared to a control group that received normal care.

Debra adds that ‘the whole model of postnatal care is not fit for purpose’. For her, it is a ‘missed opportunity’ to improve the lifelong health of women and babies.

‘If we do get it right there are really great benefits for long-term health,’ she says.

**Minimum stay**

So how important a factor is postnatal stay in hospital in the health of mothers and babies down...
In the UK, NICE (2006) recommends: ‘The length of stay in a maternity unit should be discussed between the individual woman and her healthcare professional, taking into account the health and wellbeing of the woman and her baby and the level of support available following discharge.’

While there is no doubt about the importance of postnatal care overall, particularly in respect of breastfeeding rates and maternal wellbeing, a Cochrane review (Brown et al, 2009) found policies of early postnatal discharge didn’t appear to have had adverse effects on breastfeeding or maternal depression, in the case of healthy mothers of term infants who were offered at least one midwife or nurse home visit. Although the authors conclude that the existing evidence was too limited to draw firm conclusions to support the practice.

But is there evidence of an impact on the health of newborns? Dr Rod Jones, statistical advisor at Healthcare Analysis and Forecasting, believes so. He points to the fact that over the past 15 years, neonatal and perinatal emergency admissions have risen from around 15,000 in 1998-99, to over 43,000 in 2013-14 (HSCIC, 2015b; 2000). The number of babies presenting with neonatal jaundice has more than trebled in that time, and there were two and a half times as many admitted with feeding problems in 2013-14 than 1998-99 (HSCIC, 2015b; 2000).

Based on his own statistical analysis of Hospital Episode Statistics data, he adds: ‘From 2004-05, the neonatal admission rate per 1000 births shot right up in almost a straight line – and beyond 2004-05, the average postnatal length of stay shot right down in an almost inverse relationship.

‘Neonates are getting readmitted in alarming numbers and unless something is done then that’s just going to get worse and worse.’

Safety in numbers

There is no ‘magic bullet’, says Cathy Warwick, who rejects the idea of prescribed lengths of stay, but says having enough midwives to meet existing guidelines is crucial.

‘We need to recruit and retain midwives and commissioners need to commission postnatal care in adequate quantities to fulfil the needs of the population,’ she adds.

‘I don’t think the solution is necessarily to expand the postnatal length of stay for all women, but we need to make sure that women who would like to stay, and need to stay, can. And women who can go home, and choose to do so, should have appropriate support in the community to prevent them having to come back into hospital. In policy terms, postnatal care needs to be properly valued.’

MORE FIGURES...

10% to 15%
- The number of mothers who experience postnatal depression (NICE, 2006).

2 to 8 weeks
- The time in which midwives should have given new mothers information on the availability, access and aims of all postnatal peer, statutory and voluntary groups and organisations in their local community (NICE, 2006).

66%
- The percentage of postnatal maternal deaths taking place in the first week after birth (Nour, 2008).

66%
- The percentage of women who said they were always treated with kindness and understanding in hospital after the birth of their baby (CQC, 2013).
How life can take a turn

From midwifery in Manchester to helping homeless children in Mombasa, Gayle Woods tells Hollie Ewers about life after retirement and the journey she has embarked on.

‘What we’re doing now was never something that we’d thought about – it was purely because we felt a real calling to go out there and help,’ says Gayle. She is referring to the charity Gap Kenya that she, and her husband Paul, set up to help homeless children in Mombasa. The drastic decision to retire early and sell their home came as a result of what they witnessed on a family holiday to Kenya in 2011. While on a trip into the city they came across the street children, many of whom actually live on the dumpsites of Mombasa, lying on the pavement and being totally ignored by passers-by. The sight of these children really touched their hearts and so they made it their mission to help them.

They set up their charity, which works in three ways. It runs a feeding programme giving the street children bread and juice, there is a day care centre called Stepping Stones, which the children attend on a daily basis and are given two meals, showers, are able to wash their clothes and have some teaching and recreation. There is also a small home where children, who wish to leave the street, are cared for by foster parents Timothy and Brigid, and attend school – their fees are paid for by the charity. At present, eight children reside at the home, but Gayle says the charity’s dream is to set up multiple homes to accommodate even more vulnerable children who have to fend for themselves on the streets.

Transferrable skills
While her role at the charity is, in many ways, far removed from her life as a midwife, Gayle has found her midwifery skills to be very transferrable. Having worked as a community midwife in Tameside for 16 years, in 2010, she moved to Knowsley as a public health midwife and was working with some of the most vulnerable and disadvantaged women and families in the community. So, although she is now a long way from Merseyside, she is still working with vulnerable members of society.

‘I use many skills from my midwifery career, although it’s not literally hands-on delivering babies,’ says Gayle. ‘I do a lot of teaching with the kids, so my skills from teaching the parent education classes to parents-to-be, such as doing lessons plans and presenting things, I’m now using for the children and young adults.’

However, Gayle has had experiences of the maternity services at the local hospital. ‘One
of our young street girls, Rukhia, became pregnant at 15 and I had the privilege of delivering her baby in a car on the way to the hospital,’ says Gayle. ‘It was really strange, because I was a community midwife, so I always had everything in my boot, but when I was there I had nothing – I didn’t even have a pair of gloves. But it wasn’t difficult because there wasn’t too much hands-on. I just wrapped the baby up really quickly and we set off for the hospital again.’

Gayle’s experience of Coast Provincial General Hospital in Mombasa and its midwives was ‘eye-opening’. ‘The baby was whisked away on arrival and placed in a cot along with another baby, neither of which were given any form of identification,’ remembers Gayle. She adds that the hospital regularly pushes two beds together and has three mothers and their babies sharing the space. In another experience of the maternity ward, while visiting a friend, Gayle was alarmed at the broken windows and birds flying around, while cats were freely roaming about and ‘licking stuff on the floor’.

**Success stories**

The birth of Rukhia’s baby, named Abigail in tribute to Gayle, was back in 2013, and since then Gayle says that both mother and baby are doing well. ‘She was part of our project, but she has since moved on and now lives with her aunt. She has a little bit of work locally, and is caring for Abigail, who is doing brilliantly.’

Rukhia was taken on by Gap Kenya as she was just one of the many young homeless girls who end up pregnant, because they are forced to sleep with some of the older men on the dumpsites in return for protection and shelter at night. It’s girls like Rukhia that Gayle hopes to begin more work with on her return to Mombasa.

‘We are hoping we can locate another day care centre near the dumpsite and begin a service where these girls can be offered free contraception, advice about the risks of HIV and STDs, and we can encourage them to be screened and begin treatment if required,’ says Gayle. ‘We also hope to offer some form of training, so that these girls can find work to enable them to leave the dump and support themselves and their babies.’

Rukhia’s is not the only success story of the charity. Gayle and Paul have been able to help many children, despite the fact that Paul has been quite unwell and they have frequently had to come back to the UK for treatment. Regardless of this, the couple have kept up their fundraising spirit by getting local schools in Tameside involved with sponsored ‘odd shoe days’ and teaching the children about the work they do to help the street children of Kenya. They were even featured as part of the council’s Proud Tameside campaign.

‘We’re trying to raise funds for a minibus at the moment, so we can transport the really young children from the dumpsite to Stepping Stones until we are able to sort out a centre nearer to the dump,’ Gayle says. And as soon as Paul is well enough, they plan to head back to Kenya for the long term and carry on their work helping the most vulnerable children in Mombasa.

For more information about Gap Kenya, or to donate to the charity, visit gapkenya.com and facebook.com/gapkenya
Some 60 years ago, Granny would ask me to cut her fingernails. Her sight was failing, and arthritis made it difficult for her fingers to cope. Her nails were gnarled, striated with age and difficult to trim, perhaps because these were hands that had served. The once capable hands of midwife and nurse Rebecca Martha Todd, 1868 to 1965, now depended on me. Granny would test the cut nail with a finger and sometimes ask for a smoother cut.

There is a photo of Nurse Todd (see above), dating from about 1902, that shows her as a handsome woman of 34 years old arrayed in a nurse’s uniform of the time, with a pinafore and cloak. She is flanked by two well-dressed children wearing similar clothes, coats with fur collars and buttoned high boots. These are her daughters.

The whole setting, together with the image of Doric columns in the background, is designed to portray a successful and prosperous family with a Victorian middle-class image. Yet, it is doubtful whether the profession of midwife and nurse would have been considered any more than upper working class at that time.

The photographer’s address is something of a giveaway. It is Bow East, that is, the heart of London’s East End, which was unequivocally working class. It is there that my grandmother pursued the profession of midwife from the age of 17 to 71. During that time, it has been estimated that she attended some 14,000 births.

The East End

My grandmother worked for most of her life in Bethnal Green (see box). In Victorian times and well into the 20th century, the East End contained some appalling slums. This is portrayed in the television series Call the Midwife, which shows midwifery in transition from the most
basic of medical services, if any existed at all, to the incomparable improvements introduced by the Labour government’s NHS.

But, of course, a television series can only sketch what it was like to live in those days. There was poverty, pain and brutality in many households. Drunkenness was common, men routinely beat their wives, birth control was unknown, and abortion, as well as being dangerous, was a crime. At the same time, it was a world where extended families stuck fiercely together for survival. In those days, many families would have been unable to pay for the services of a midwife, but I don’t believe my grandmother would ever have refused anyone on that account.

Nothing is remembered of Nurse Todd’s first husband, by the name of Evans, who was the father of her two children. We assume that he died because she married again and divorce was uncommon in those days. The second time, she married a policeman, just like Chummy in Call the Midwife. In those days of no telephones, policemen would carry messages of importance, such as summoning a doctor or a midwife, and this may be how they met.

Constable Todd would eventually desert his wife, leaving London for Devon. When she heard of his death in 1942 in a town called Beer, teetotal Nurse Todd remarked: ‘How appropriate!’ So it seems that alcoholism contributed to their separation. However, Granny’s teetotalism did not prevent her from smearing brandy on my lips just after I was born. I was not breathing, but the brandy made me cough. It was apparently a midwife’s trick and, in my case, it worked.

**Entrepreneurial midwife**

My grandmother does not seem to have suffered unduly from the loss of a second husband. She was a great entrepreneur, renting out shoes and boots for weddings and funerals. She bought the shoes from Darnel’s Warehouse in Shoreditch, where they gave her a discount, and my brother remembers going with her to buy shoes. As well as her shoe business, she owned an eel-pie store on Cambridge Heath Road, and she came to own a shop that sold ice-cream, and a house that she rented out. These were considerable accomplishments for a woman alone, and one can only wonder at how she found the time, not to mention the resourcefulness, to do it.

Besides her work as a midwife, she also prepared corpses for burial. It was said of her, with Cockney humour, that: ‘She got them coming and going.’ She was clearly a respected member of the community, because she sponsored the introduction of two doctors from Ceylon (now Sri Lanka), Doctors Fernando and da Silva.

In another similarity with Call the Midwife, my grandmother had contact with charitable nuns working in the East End, where they may have been the only service available to the poor. The two Sinhalese doctors were both Catholics, so perhaps it was her relationships with these people with whom she worked that influenced her faith, because in 1935 and quite late in life, she converted from being a Methodist to a Catholic.

From the early 30s onwards, she lived at our family home in Bethnal Green, at a time when it was still fairly common for grandmothers to live with their families. She still gave her consultations, where my brother remembers her sitting at a roll-top desk with a Gladstone bag at her side, asking someone: ‘When are you due, dear?’ before recording it in a ledger book. She lived to the age of 97 but, in her last years, she was afflicted with arthritis and increasing blindness, and her complaint was ‘I am no use to anyone’.

Midwifery is one of the oldest professions, and the most useful. I am awed by the thought that those hands, whose nails I had cut, had been the first hands to touch so many babies even before the mother’s embrace. Bringing a baby into the world is the earliest, most basic and most precious expression of human touch, one that defines what it is to be human.
Designs for birth

An ongoing theme of the Better Births Initiative is trying to achieve quality midwifery care for all women regardless of the specialist care they require. Rupa Chilvers provides an overview of the recently completed scoping project with the Design Council.

WAYS OF IMPROVING the birth experience is not a new discussion yet, after years of debate, we still don’t have all the answers.

A scan of the literature shows that the discussions in the 1960s and 1970s concentrated on the acute setting with talk of medical requirements, such as infection control and the need for obstetrics’ proximity to general theatres.

In later decades, this changed to conversations about the optimal environments for midwife-led units (MLUs) and birthing rooms and centres. There is now a wealth of literature emerging about birth spaces, with practitioners considering links between women’s influences and levels of satisfaction (Hammond et al, 2013; Fourer et al, 2010). However, translating some of these research findings to the acute setting is not easy.

The researchers found that there were some repeating themes, such as women receiving too much information at booking, and that tours of the units help put women and their partners at ease at birth. Some of the transitions highlighted including moving between stages.

The chance for women to have a life-enhancing experience is possible if care is conducted with an open and honest dialogue.
A MIDWIFE’S VIEW

Ruth Sanders is a midwife working in East Anglia and is interested in how co-design can be used to improve the experiences of women and families in maternity care. She was invited to join the RCM working group and contribute to the discussions about next steps. She provided insight into the midwife’s perspective on what the design researchers had found. Here is her three-point round-up of the project findings:

● 1. The project found that decision-making about place of birth is raised at a time that suits the schedule for care rather than individual women’s needs. This meant that interactions become ‘robotic and scripted’. Midwives stated that two-way interactions aren’t feasible because they don’t have the ‘luxury’ to explore all of the questions women may come with. This was particularly important at key moments, including the booking appointment, it being the longest contact time during the antenatal schedule and the basis on which the midwife-mother relationship is founded.

● 2. While safety, continuity, familiarity and cleanliness were voiced, what was exciting to me was the changing nature of women’s discussion about environment. Because birth place is raised so early, discussions of risk are explored and women acknowledge the impact this has on options of birthing environments. Women are noticing the MLUs and delivery suites as separate entities and the conversations about risk and space arise with the divide being noticed between the two settings.

● 3. Women perceive MLUs as ‘comfy’ emphasising lighting, music, access to pools and active participation. This was where midwives were present but ‘left us to it’ and assistance was close by. Perceptions of delivery suites however, focused around pain relief, and types of intervention. Parents considered the MLU ‘nice’ but that delivery suite was ‘the right thing to do’ depending on pregnancy risk.

My reflections upon future practice is that continuing to emphasise MLUs as the place for normalcy disregards the work midwives continue to do in obstetric environments where most UK births take place. The chance for women to have a life-enhancing experience is possible if care is conducted with open and honest dialogue exploring genuine choices about women’s wishes from the outset. If we don’t do this, we have nothing more than a cursory overview of individual women on which to base their needs and requirements. Perhaps a better birth is when a woman is being given an equitable opportunity for midwifery expertise to facilitate as physiological a birth as possible regardless of space and risk. After all, the element which remains the same in all spaces is the presence of a midwife.
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To apply please visit our website or contact Tahmina Islam, Recruitment Advisor on 01708 435 000 ext 3298.
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Cost: £140
T: 07957 412676
E: info@perihealthlondon.com
W: perihealthlondon.com

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Location: The Reminiscence Centre, Blackheath, London
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W: bit.ly/1HIktLK

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15 OCTOBER

‘The journey from harm to norm’ – conference topics will include reducing interventions, bullying and undermining behaviours, VBAC and birth choices, hypnobirthing, staffing levels, keeping birth normal.

Location: Armagh, Northern Ireland
Cost: £75 for midwife members, £55 for student members, £100 for non-member midwives, £85 for non-member students
T: +353 1 664 0648
E: jean@inmo.ie
W: tinyurl.com/nlqmupb

PREVENTION OF GROUP B STREP INFECTION IN NEONATES: THE WAY FORWARD IN THE UK

3 NOVEMBER

This one-day conference will bring together leading UK experts to explain how group B strep disease occurs and what can be done to prevent it. Hear about new developments, prevention strategies, legal aspects and controversies and join the debate.

Location: Brunee Gallery, SOAS, London
Cost: Early bird until 22 September – £35 for midwives and non-clinicians
W: GBSCconference.co.uk

50 SHADES OF NORMALITY

28 NOVEMBER

This conference is an exploration into the world of normality. Speakers include Dr Amali Lokugarnage, Clemmie Hooper and Janet Balaskas, with RCM director for midwifery Louise Silverton as chair. The event will also include a debate on pain-free labour as a myth, as well as a raffle with some great prizes.

Location: Newham University Hospital Education Centre, London
Cost: RCM members £50, non-members £60, students and HCAs £40 (lunch included)
E: whippss-branch@hotmail.com
W: tinyurl.com/q4n3yyn

CEREBRA ANNUAL CONFERENCE

3 DECEMBER

Titled ‘Every baby matters: ensuring better outcomes for preterm and low birthweight babies’, this conference is for all midwives, obstetricians, neonatologists and neonatal nurses wanting to prevent pregnancy-related brain injury in babies before and after birth.

Location: Royal Society of Medicine, London
Cost: Early bird rate £95
T: 01267 244325
E: rachels@cerebra.org.uk
W: cerebra.org.uk

RCM AND INMO ALL IRELAND ANNUAL MIDWIFERY CONFERENCE

15 OCTOBER

‘The journey from harm to norm’ – conference topics will include reducing interventions, bullying and undermining behaviours, VBAC and birth choices, hypnobirthing, staffing levels, keeping birth normal.

Location: Armagh, Northern Ireland
Cost: £75 for midwife members, £55 for student members, £100 for non-member midwives, £85 for non-member students
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50 SHADES OF NORMALITY

28 NOVEMBER

This conference is an exploration into the world of normality. Speakers include Dr Amali Lokugarnage, Clemmie Hooper and Janet Balaskas, with RCM director for midwifery Louise Silverton as chair. The event will also include a debate on pain-free labour as a myth, as well as a raffle with some great prizes.

Location: Newham University Hospital Education Centre, London
Cost: RCM members £50, non-members £60, students and HCAs £40 (lunch included)
E: whippss-branch@hotmail.com
W: tinyurl.com/q4n3yyn

CEREBRA ANNUAL CONFERENCE

3 DECEMBER

Titled ‘Every baby matters: ensuring better outcomes for preterm and low birthweight babies’, this conference is for all midwives, obstetricians, neonatologists and neonatal nurses wanting to prevent pregnancy-related brain injury in babies before and after birth.

Location: Royal Society of Medicine, London
Cost: Early bird rate £95
T: 01267 244325
E: rachels@cerebra.org.uk
W: cerebra.org.uk
COMPETITIONS

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

UP FOR GRABS

BOOK

WIN ONE OF FIVE COPIES OF A BEGINNER’S GUIDE TO CRITICAL THINKING AND WRITING IN HEALTH AND SOCIAL CARE (SECOND EDITION)

From approaching a subject to writing essays or a dissertation in health and social care, this guide takes you through every stage of becoming a critical thinker. Each chapter tackles a different aspect of critical thinking and shows how it’s done using examples and simple language. This second edition is updated with more references, online resources and critical appraisal tools. It is an essential read for students and qualified healthcare staff alike and was highly commended in the BMA Medical Book Awards 2012.

Worth £21.99 each

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BOOK

WIN ONE OF THREE POTS OF EMU BALM

If you’re on your feet all day and suffer with back pain, frozen shoulder, muscle aches, arthritis, sciatica or even sports injuries, and you’re frustrated with taking tablets, there is an alternative. Lorem’s 100% natural Emu Balm, which harnesses the power of Emu Oil blended with essential oils for pain relief, reducing inflammation, improving blood circulation and relaxing tight muscles.

It is so gentle, it can be used, quite safely, on the most sensitive of skins and for all ages.

For further information, visit loremcare.co.uk

Worth £24 each

HOW TO ENTER

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

► The closing date is 7 November. Winners are drawn at random. Only one entry per household will be accepted. The editor’s decision is final.
CROSSWORD

Test your wits on this midwifery puzzle...
How many did you get right?

ACROSS

1. Type of obstetric forceps (7, 6)
8. Producing milk (9)
9. Minimally invasive surgery and interventional techniques (acronym) (5)
10. Musical composition played by nine people (5)
11. Jewish feast celebrated on first night of Passover (5)
15. Shaped like a cone (5)
17. A dead fetus in the uterus becomes so (9)
18. People who examine X-rays (13)

DOWN

1. Relating to the coordination of nerves and muscles (13)
2. Fine, hair-like projection, arising from a mucous membrane (6)
3. Type of surgical knife (6)
4. Gave his name to a graduated glass tube for estimating amount of albumin in urine (6)
5. Innermost membrane which envelops the fetus (6)
6. City on Mudanjiang River in China (6)
7. Pathogenic bacteria (13)
12. On ..., feeding when the baby is hungry (6)
13. Relating to the spine (6)
14. Visual indicator on a computer screen (6)
15. Ketchup (US) (6)
16. A growth that forms under the skin (6)

Answers: Crossword 19

LOOK OUT FOR THE ANSWERS IN THE NEXT ISSUE
A strong body of existing and emerging research suggests that multisensory stimulation—or the concurrent stimulation of tactile, olfactory, auditory, and/or visual stimuli—benefits the social, emotional, cognitive, and physical development of babies.

A baby’s brain creates up to 1.8 million new synaptic connections per second, and a baby’s experiences will determine which synapses will be preserved. Stimulation is essential early in development; within the first 3 years of life, there is rapid development of most of the brain’s neural pathways supporting communication, understanding, social development, and emotional well-being.

Stimulating multiple senses sends signals to the brain that strengthen the neural processes for learning. Through consistent multisensory experiences, research shows that babies gain healthy developmental benefits, such as reduced stress in healthy and preterm infants and better quality and quantity of sleep in healthy babies, as well as improved weight gain which led to earlier hospital discharge in preterm infants.

Everyday experiences in a baby’s life can develop and stimulate his or her senses and provide parents an opportunity to nurture their baby’s ability to learn, think, love, and grow. A simple ritual of bath time and massage is an ideal opportunity to create a multisensory experience. Bath time provides an opportunity for increased skin-to-skin contact (touch stimulation) and direct eye contact, as well as the introduction of new textures, sights, sounds, and smells that can stimulate a baby’s tactile, visual, olfactory, and auditory senses. The sense of smell, in particular, is directly linked to emotional memory; a mother’s scent can help soothe a crying baby, while a pleasant scent during bath time is shown to promote relaxation in both baby and parent.

A ritual that includes a warm bath followed by massage with a gentle skin moisturiser and a mother’s scent can help soothe a crying baby; as well as opportunities for multisensory stimulation, there is more to be done to translate this research into everyday practice. By encouraging parents to view everyday rituals, such as bath time and massage, as opportunities for multisensory stimulation, experiences can be created that can contribute to a lifetime of healthy development.

For more advice and information, please contact jbhcppointcontact@its.jnj.com

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UK/088/5-17-475

References:
You want your mums-to-be to be confident when it matters...

So why not tell them about NCT – working with you to improve parents’ experience of antenatal education and preparation for parenthood.

87% of mums-to-be feel more confident about their labour and birth, and 81% more confident about feeding their baby, after taking part in an NCT antenatal course.¹

And now they have a choice of courses: our classic NCT Signature antenatal course, or our new lower-cost option, NCT Essentials antenatal course – from only £70.

New mums, dads-to-be and partners get practical information and emotional support from trained professionals, access to our online evidence-based information and their own ready-made peer support network.

Come and find out more about how we can help:

www.nct.org.uk/tellmemore