

# Our Proposals for Change A New Era in Maternity Care

## BACKGROUND

Increased medical intervention in recent years has not demonstrated the promised impact on the stillbirth rate or maternal mortality.

- The maternal death rate remains significantly higher than the rate in 2017–2019 – even excluding deaths from Covid [1].
- The stillbirth rate decreased from 4.1 per 1000 in 2021 to 4.0 per 1000 in 2022 but remains higher than in 2019 at 3.8 per 1000 [2].
- Over a 30 year period the stillbirth rate has reduced from 4.3 per 1000 to 3.8 per 1000 [3].

Women are more dissatisfied with their care than ever and more women are experiencing long term trauma [5,6]. There is no clear evidence that the benefits of increased medical intervention in recent years outweigh the risks to the well being of mothers and babies.

The broader context of women's lives have a significant impact on their well-being and that of their baby.

- Black women are 4 times more likely to die when compared with white women.
- Asian women are 2 times more likely to die.
- The most deprived women are 2 times more likely to die than women who are least deprived

Multiple disadvantages increase the likelihood of a poor outcome for women and babies. Maternity care can mitigate this through targeted midwifery care but without a more comprehensive approach to tackling inequalities these differences will be difficult to reduce significantly.

ARM frequently hears that midwives and obstetricians are fearful of getting things wrong and practice defensively to the detriment of women and babies. Consideration is only given to the immediate situation without thought for longer term implications (e.g. impact of induction before 39 weeks on the child's development [4]).

## DEVELOPING AND SUPPORTING MIDWIVES

### EDUCATION

- Reintroduce the bursary that enables more mature students to enter the profession
- Increase students' exposure to physiological birth
- Recognise that newly qualified midwives are novices and need appropriate support to develop

### RETENTION

- Adjust and improve pay to meet inflation rate
- Ensure safe working environment – staff are entitled to an appropriate work life balance and protected breaks
- Improved maternity leave package
- Well-resourced professional development that enables midwives to support women

### REGULATION

- Disband the NMC in response to recent report – huge backlogs, punitive approach, bullying and systematically racist culture
- Replace with new Midwifery Council that oversees Fitness to Practice cases
- Eradicate the systemic bias against black & brown midwives and independent midwives
- Develop a No Fault Compensation Scheme

## SUPPORTING WOMEN AND FAMILIES

### CURRENT CARE

- Women experience a tick box service
- Main focus is on risk management
- Lacks genuine continuity of carer
- Fails vulnerable women
- Inflexible guidelines dominate decisions
- Lacks genuine informed consent
- Physiological birth is currently very difficult to access

### WOMEN HAVE THE RIGHT TO

- Have their autonomy respected
- Develop a relationship with *one* trusted midwife
- Be provided with evidence (positive and negative) about all their options in a format they can understand
- Decline any test or treatment
- Decide how and where they birth
- Be provided with a birth environment that supports physiological processes
- Receive positive and skilled support with infant feeding
- Have supportive and sensitive care at all stages

### MODEL OF CARE

- Continuity of carer has been shown to improve outcomes for all women and in particular for disadvantaged women [7]
- Recognises the value of midwife-mother relationship in protecting women and promoting the adoption of healthy choices
- Listening to women is best facilitated by a genuine continuity of care model



Scan to find your local group and get involved in helping shape the future of maternity

Because  
Midwifery  
Matters

## WORKLOAD & RETENTION

In recent years, the real-terms workload carried by midwives has increased considerably. To take just one example: induction of labour. In line with the Saving Babies' Lives Care Bundle, we offer earlier induction to women whose babies are suspected of fetal growth restriction and those who present with reduced fetal movements near their due date. More hospital trusts offer to induce labour routinely at 7 days after a woman's due date, rather than the 12 days as was previously the case.

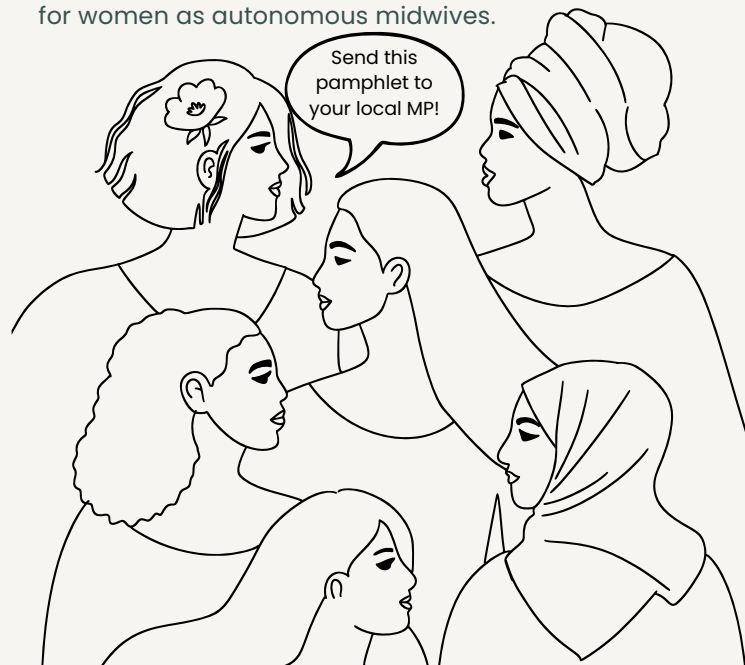
This substantially increases the workload on antenatal wards. It also increases the workload on labour wards due to longer labours and increased requirements for epidural pain relief. Women with induced labours are more likely to experience other complications, such as emergency caesarean sections and/or haemorrhage. This increases their postnatal requirements in both length of stay and intensity of care provided. And so, a whole cohort of women who may have laboured under their own steam and spent 12 hours in hospital may now spend 5 days or more.

While the inflation in midwives' workload has increased considerably, there has been no matched increase in staffing. Simultaneously, if we look at the way our profession is esteemed by politicians by using the pay rates they set as a proxy, the drastic salary erosion since 2010 has not inspired confidence in our worth-as-perceived-by-others.



## MIDWIFERY EDUCATION & TRAINING

Midwifery needs to have a diverse workforce and attract mature students and mothers with life experience to train as midwives. ARM is committed to bringing back the bursary which is a non-income assessed personal allowance that covers the whole three years of study that allows those with dependents to avoid getting into debt. At the moment, most midwives are coming into the profession straight out of school. Since they are younger and may have less life and work experience, they are more easily institutionalised and less likely to challenge and question common practice of their colleagues and system. This may make them more likely to act as obstetric nurses following orders instead of advocating for women as autonomous midwives.



## MODEL OF CARE - CONTINUITY OF CARER

There is extensive evidence demonstrating that this is the best model of midwifery care for women [7] and had been recommended by multiple reports over the past decades including Better Births (2016). It facilitates the midwife-mother relationship, enabling women to speak about what's important to them in their childbearing journey, and has better engagement with hard to reach groups. In particular, women who experienced care within this model reported more positive experiences during pregnancy, labour, and postnatally. Outcomes for women and babies are better on a range of markers such as; breastfeeding rates, reduced likelihood of experiencing a caesarean section or instrumental vaginal delivery, and more likely to experience a spontaneous vaginal birth. Additionally, there were cost savings in the antenatal and intrapartum period.

High quality maternity care is an investment in the future. If we value maternity care as a society, we need to invest accordingly.

## TRAUMA

Midwives are expected to provide compassionate care as part of our role. Many midwives experience trauma within the workplace, both directly and vicariously. And many have mostly been expected to 'get on with it', without being able to fully process traumatic events. When midwives aren't supported to process this trauma, the sympathetic (fight/flight/freeze) nervous system is activated which makes it impossible to show compassion to others. This has a direct impact on those who are being 'cared' for, leading to trauma to the women and families.

**Cared for midwives care for women.**



**INCREASE IN WORKLOAD**  
**DECREASE IN SATISFACTION**