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Implementing Better Births 2

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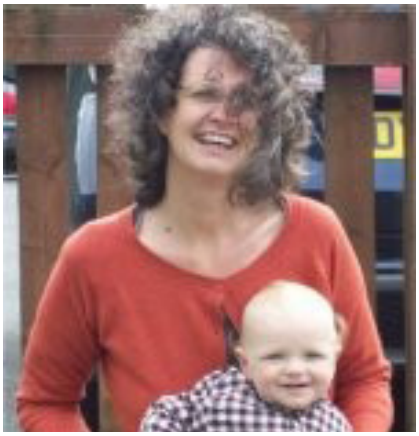
Implementing Better Births: working together to keep the Better Births Vision alive

by AIMS Journal Guest Editor, Jo Dagustun



Welcome to this AIMS Journal, Implementing Better Births Part 2, where we continue to discuss the implementation, across England and beyond, of the *Better Births* vision. This issue presents further perspectives on this topical issue and I hope that there is something here to inspire everyone.

Long-standing birth activist *Mary Newburn* reflects on Better Births in the context of the broader NHS reform agenda and offers some 'top tips' for birth activists. In terms of ensuring the perspectives of service-users are heard, *Laura James* and *Ceri Durham* offer us an insight into the potential for the new Maternity Voices Partnerships to contribute to the Better Births transformation agenda. In the context of the need for all local areas to provide women with choice around place of birth, *Cassandra Yuill* reflects on the first ten years of an urban freestanding birth centre in London, the Barkentine. And *Lyanne Nicholl* writes about the need for a greater emphasis on women's physical well-being post-birth.

I hope that readers will also be interested to read the regular features, from our book reviews to conference reports, birth stories and research briefings. All have been written with the aim of informing, inspiring and supporting you, as birth activists, to get on and do what you like doing best: working in collaboration with others towards improvements in our maternity services. We also take the opportunity to remember Clare Fisher in this issue – a midwife who truly understood the need for maternity service improvement – through the *obituary* written for AIMS by Beverley Beech.

It has been a privilege to work with each of these authors in bringing you this issue: all have a distinctive and important contribution to make. But I must admit that I have been particularly heartened to work with some of the new generation of birth activists represented here by Cassandra, Lyanne, Kirsten and Amy. AIMS is keen to provide a space for mutual support for birth activists across the UK: please continue to take the opportunity to utilise this Journal to introduce yourselves to each other, so that together we can continue to be a strong movement for change.

But before you get started on reading the articles in this issue, what is your experience of how well the implementation of Better Births is progressing? In line with the Better Births vision, are you starting to see positive changes in the organisation and delivery of maternity services? Are initiatives to extend women's choices, in line with existing national guidelines, panning out as you would hope? How are things looking locally in terms of the activity around meeting the key target of 20% of women being booked into a relational model of care by March 2019?

I would like to think that readers everywhere are seeing good progress. But maybe your local area, like mine, is at a rather wobbly stage, where early ideas about how to implement Better Births – and continuity models of care in particular – are looking increasingly difficult to pull off, and where fundamental questions are now surfacing about the affordability of Better Births? Or maybe you are in an area where service reconfigurations seem to be moving in a direction opposite to that intended by Better Births? Or perhaps you get the uneasy sense that nothing much is happening at all?

I was pulled up short recently when it was suggested to me that Better Births was indeed 'dead in the water'. I raised a quick auto-defence, based on the ongoing and

clear commitment within NHS-England to deliver on this agenda, as well as the efforts to implement Better Births on the part of many committed teams and individuals across the country. But this throw-away remark also got me thinking: just how widespread is such a perspective? Against the backdrop of severe pressures on the NHS and on our wider public services more generally, it is perhaps reasonable to assume that an ongoing focus on maternity service transformation is unlikely. Especially if what is frequently discussed in birth circles as 'a crisis in the maternity services' is simply a taken-for-granted part of the more general squeeze on public services for those outside these circles. If this is the case, then where is the ongoing political motivation for a sustained focus on improving maternity services? Has the window of opportunity for achieving the Better Births vision already passed us by?

We know that maternity service transformation ... as envisaged by Better Births ... holds the promise of widespread dividends, not just at the individual level, for individual women, babies and families, but also for society more generally. That is why it is so important. The improved outcomes – the improved lives – associated with the Better Births vision of transformed maternity services will surely relieve much pressure on wider public services, whether health, education or social care, and the nation's finances as well.

But that's exactly where organisations and individuals who have come to specialise – for the long term – in calling for improvements in the maternity services (and scrutinising improvement efforts) are key. We know that maternity service transformation, in its many different guises and as envisaged by Better Births, will take time to deliver, and that it holds the promise of widespread dividends, not just at the individual level, for individual women, babies and families, but also for society more generally. That is why it is so important. The improved outcomes – the improved lives – associated with the Better Births vision of transformed maternity services will surely relieve much pressure on wider public services, whether health, education or social care, and the nation's finances as well. As birth campaigners, we are thus uniquely placed to understand how important it is to ensure that the Better Births implementation agenda isn't simply written off as too hard but is sustained into the long-term.

We are now coming to a critical juncture for the implementation of Better Births. The next two or three years will be crucial. Reality is kicking in across the country about the sheer scale of the service transformation required, and commissioners and service leaders are becoming understandably nervous. Over the next few months, the implementation programme is likely to bring the leadership skills of Heads of Midwifery under the spotlight. How well will our current cohort of leaders, for example, be able to encourage and support our midwifery workforce to shift to a new way of working, one in which the offer of relational care for women is paramount? Will they be willing to give up traditional forms of management control, whilst implementing new models of team support, to enable new ways of working, which may be essential for true continuity models to flourish? But more of that in our future issues. Meanwhile, do please get in touch with your views and comments, whether just a few lines, a letter to the editor, or an article offering your own perspective on any of these issues. AIMS looks forward to hearing from you!

To print this article directly from AIMS, please go to *www.aims.org.uk/journal/item/better-births-part-2-editorial*

Implementing Better Births: What's the chance of Better Births?

By Mary Newburn

It's just over two years since Better Births[1] was published. Yet as many of us were part of engagement events and submitted evidence throughout 2015, by 2016, it already felt as though we'd been talking about some of the important game changers for many months. Not to mention that there had been previous policy commitments about woman-centred care since the early 1990s and the 'choice guarantee' since 2007[2]. But the latest, hoped-for, revolution – or transformation process – is really still only just beginning.

The Better Births vision for maternity, referred to as a 'five year forward view', has been developed alongside five-year plans for other health services. The idea has been to fundamentally change the way that health services function and contribute to improved quality of life for individuals, and therefore better health for the whole population. This will be achieved by planning comprehensively across 44 Sustainability and Transformation Partnerships; geographical footprints widely referred to by NHS managers as STPs. But the vision is still in the minds of the few, and needs to reach and be adopted by many before services really feel different in the far-flung boroughs and counties the length and breadth of England. (NB – Scotland, Northern Ireland and Wales have similar ambitions, some more developed, and some less so.)

Better Births in context: the NHS Five year forward view

The vision for maternity transformation is one part of a broader understanding of 21st century health and health service challenges, and identified solutions.

As people live longer health needs become greater and more complex. As medical technologies develop, the costs of delivering healthcare and demands on the NHS grow. How can more be delivered to people, for more years, without the bill shooting higher than can be afforded? Generally there has been an improvement in health generation to generation, thanks in part to improved standards of living and the success of public health programmes. But other changes – such as the commercialisation of highly processed and 'fast' food, linked to rising rates of obesity, more sedentary lifestyles, a recent resurgence of poverty and inequality, and high rates of mental health problems – mean there remain huge health challenges. Some might argue that the expectations of service users are higher. In maternity services, however, the needs of women often seem to be overlooked, despite positive stated ambitions.

There is a widespread view shared by policy makers, healthcare professionals and activists that services should be clinically effective, humane, respectful, involving and empowering. Yet, there is often tension between a medically-focused risk-reduction approach and a social model of care focusing on addressing mind/body and women's autonomy issues more holistically. As a society, people tend to complain more (and take legal action). As Kennedy said:

> *"The public are no longer prepared to be passive, trusting and grateful recipients of what is made available. They are no longer prepared to hope that their views will be fully reflected by the professionals. … That is not a criticism of professionals; it is just a reflection of the way the world has changed."*[3]

Social media and newspaper reporting does influence thinking. And some voices may be louder or more effective in gaining traction – including attracting the Health Minister's attention – than others.

Women and childbirth organisations like AIMS and NCT have been influential in maternity developments in the past. We need to continue to work to ensure that women have an effective voice today and in the future, too.

The bigger picture

In principle, at a high level of planning, many health service researchers, academic clinicians and policymakers agree that the aim is to:

- Develop a systems approach to service delivery, with networks of care;
- Provide more care away from (expensive) hospitals in local communities and at home;
- Integrate acute and community services better, connecting up health and social care, and addressing physical and mental health needs so the services are more holistic with fewer gaps;
- Focus on prevention and wellbeing, creating a real 'health service' that is not just about fixing illness;
- Promote public health (more favoured by the political left) and personal agency, so that people create their own health and sustain it (more favoured by the political right);
- Integrate services around service users;
- Research experience and measuring impact on 'outcomes', so that there is proper feedback to inform future planning.

This 'bigger picture' should work well, of course, for improved maternity services. Understanding that our work fits neatly within this context, therefore, can be a lever for change for activists.

... there is often tension between a medically-focused risk-reduction approach and a social model of care focusing on addressing mind/body and women's autonomy issues more holistically.

Collaboration – the key to implementing the Maternity Transformation Programme

The Maternity Transformation Programme's top line message is to both improve safety and make services more personalised. These two objectives can be unified or be in conflict with each other. As activists, we need to focus on 'win/wins' and constantly be talking 'both/and'. This is particularly important as we seek to develop broad alliances amongst the service-user community and make progress across a range of maternity improvement objectives. For example, taking an 'improve postnatal care' focus we need to BOTH improve support for breastfeeding women AND make sure that all women feel supported in caring for and feeding their baby. Thinking about pregnancy and birth, we need to BOTH introduce and sustain services and behaviours that enable physiological or 'normal' birth AND support women in making their personal choices. The push to reduce the number of stillbirths, has led to more and more women being 'offered' induction of labour at 40 weeks or as early as 38 weeks. But when does sharing evidence-based information (in this case, about the very small but real risk of stillbirth at term and beyond) become anxiety-provoking and undermining, or even coercive? Much work still needs to be done to explore this, with formal audit and research, including qualitative research and listening activities with women and families to learn from their feedback.

A few measures are so important that we all need to work to make them mainstream in NHS maternity services. Continuity of midwifery carer is one of these, and I am delighted to see that it remains at the heart of AIMS campaigning efforts. This BOTH reduces adverse outcomes AND it is reasonable to believe that the relationship enables women to feel more in control, better informed and respected. The Cochrane review of midwife-led continuity models[4] says that in addition to many clinical benefits, including significantly fewer baby deaths, women are 'more satisfied with their care' (Sandall et al, 2016).

A top priority for me is for more women to give birth in midwifery settings (at home, and in midwife led units), because women have been telling us for decades that access to giving birth in these environments makes a significant positive difference for them and their families. And we now have high quality comparative evidence on the benefits and drawbacks of planning for birth in different settings, which underpins the NICE Intrapartum care guideline CG190[5]. This issue is included in the NHS England 2018 Programme Update summary of priorities (below).

To print this article directly from AIMS, please go to *www.aims.org.uk/journal/item/the-chance-of-better-births*

Maternity Transformation Programme – Our Aims

- By working together nationally, regionally and locally we will transform maternity services so that by March 2021:
- We have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2025.
- All pregnant women have a personalised care plan.
- All women are able to make choices about their maternity care, during pregnancy, birth and postnatally.
- Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
- More women are able to give birth in midwifery settings (at home, and in midwife led units).

Source: Implementing Better Births: Programme Update, NHS England, March 2018[6]

What you can do: top tips for activists

It's easy to get bogged down in talking rather than action. So here are some tips to help you become a positive force for change.

- **Be focused.** If you want to make a difference to the kind of quality improvement projects undertaken by your local NHS trust or 'local maternity system', I would suggest you focus on one thing and really stick with it. Hold on, like a terrier, chasing it up relentlessly. Things take a long time to change in the NHS; often activists become fatigued and walk away.
- **Co-design and regular reporting.** All trusts and/or LMSs should have 'task and finish groups' (or similar) developing and monitoring progress with transformation plans. Find out what there is in your area and make sure the Head of Midwifery and/or consultant midwives are co-designing the needs assessment and strategy with service users. Ask them to report regularly to the MVP.
- **Have a plan; make progress**. To take the example of activism around place of birth, at least one women / service user advocate on every maternity voices partnership (MVP) should be an advocate for increasing the number of women giving birth in midwifery settings. This means knowing the current numbers and percentages having home births, and giving birth in your alongside midwifery unit (AMU) and freestanding units (FMU). If you don't know the numbers, or don't have all three options in your area, work out your

priorities and find others with influence to work with. Meet together and agree a project plan. See *How to make the most of your MLU* on the Midwifery Unit Network website.

- **Think creatively**. One option is for the place of birth 'task and finish' group to be combined with, or work closely alongside, the group overseeing increased continuity of midwifery carer. If midwives follow women, rather than staffing beds, there is scope to achieve more and better within the same budget.

- **Ensure women have high quality evidence**. A new decision support aid for choice of place of birth, approved by NICE and NHS England, has recently been published, based on the *Birthplace in England* cohort study findings and other studies included in the *Intrapartum Care review for NICE*. Is your area using it?

- **Take action.** Write letters and blogs, visit MPs' surgeries, and talk about your priorities on social media. For example, there is a shortage of midwives and we should all be aware of this and vocal about it. Poverty and social inequalities have a huge impact on stillbirths and poor health of women. Exercise your right to vote when there are elections!

- **Get connected; get inspired**. Don't work alone. Buddy up with fellow birth activists, for mutual support and encouragement. Network. Keep reading about what others are doing. Seek out free or cheap local events and conferences: birth activists deserve professional development opportunities too! Online, there are so many useful Facebook groups now, such as *National Maternity Voices* for those on MVPs and MSLCs, *MatExp*, the *Positive Birth Movement* and the *Midwifery Unit Network*. These are open to all. And there is more on Twitter. Start following one or two people, or groups, who you know and trust, and expand if you want to. (I have social media-free days, but still find out a lot that way and support others, too.) *Join AIMS*!

Achieving change is slow and often hard work. But change can, and does, happen. If local developments hit roadblocks, remind people of the bigger picture, the higher-level objectives for the NHS. We need to focus more on prevention. We should work as a whole integrated, transparent, learning system. We need to BOTH enhance positive well-being and mental health AS WELL AS safe physical services. The Maternity Transformation Programme is fully aligned with these overarching objectives, so keep working for its implementation with gusto!

Mary Newburn is a service user researcher and activist, trustee of the Positive Birth Movement, co-founder of the Midwifery Unit Network and former Head of NCT Research and Information.

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Implementing Better Births: Why Maternity Voices Partnerships (MVPs) are key

By Laura James

Since 1984, Maternity Services Liaison Committees (MSLCs) have been working away in the background of maternity care. These forums are made up of health care professionals, commissioners and the women who use the service, together with their families and other service-user representatives. They were created as a way of enabling women to be involved in shaping the maternity care provided for them, and strengthened during the implementation phase of Changing Childbirth.

Since MSLCs were established, there have been many examples of extremely effective, well-supported, committees making a real improvement to maternity care in their local area, from reaching out to seldom heard groups, designing information posters on how to personalise the birth space, to setting up online birth information hubs and supporting the development of a local perinatal mental health pathway. Confusion over which body was responsible for resourcing the MSLCs following the Health and Social Care Act (2012)[1], however, meant that some floundered due to lack of financial support or a lack of engagement, either from health care providers, commissioners, or service users.

With Better Births, there is a new focus on how to make such structures work more effectively, so that more service users can get involved in helping to shape local maternity services, through a co-production model. The "ladder of engagement and participation" model[2] based on the work of Sherry Arnstein, shows different forms and degrees of service user involvement. True co-production means the collaboration and involvement of service users in the design of services (rather than service-user involvement being limited, for example, to reviewing services once they've been developed).The idea of co-production with patients and their families is a common thread throughout the NHS. For maternity in particular, commissioners have received guidance on how they can meet their objectives of co-production most easily by setting up and maintaining an effective Maternity Voices Partnership. NHS Trusts are being offered incentives too to support the MVP initiative, for example through discounts in the cost of their contributions to the NHS 'insurance fund' (via the NHS Resolution Maternity Incentive Scheme). So with commissioners and providers everywhere (almost!) at the ready, now is the time for birth activists and service users to step forward and get involved, to ensure that the Better Births' call to put local Maternity Voices Partnerships at the centre of all planning for maternity services in England becomes a reality.

The NHS England resource pack for commissioners[3]– produced as a key part of the Maternity Transformation Programme – calls for:

* the 'establishment of independent formal multidisciplinary committees, [or] 'Maternity Voices Partnerships' to influence and share in local decision-making. (Department of Health 2017, p4)
* all women in the local area being able to participate in an MVP by giving feedback or becoming service-user members of an MVP (*ibid*, p16)
* existing MSLCs to change to become known as Maternity Voices Partnerships. (*ibid*, p17) (NB: MSLCs will continue in Wales, Scotland and Northern Ireland)

The resource pack also makes recommendations for the leadership, membership and funding of these Maternity Voices Partnerships. As with MSLCs, an MVP should be service-user-led, which should usually involve a service-user representative taking the role of chair, and at least one

third of its members should be service-users or service-user representatives. It states that the maternity commissioner is responsible for facilitating and organising the funding of the MVP, usefully giving a breakdown of what that funding may be needed for (including providing administrative support, remunerating the chair and providing childcare provision and travel expenses for service-user volunteers) (*ibid*, p18), in line with the Patient Public Voice partner reimbursement policy in use throughout the NHS. For some local areas, this transition to an MVP will require very little other than a simple name change for their existing MSLC. For other areas with a less effective or a non-existent MSLC the transition will require some careful planning, as well as a renewed commitment to partnership working.

Following Better Births, there is also one particular new role for MVPs: as well as continuing to work closely with their own local maternity commissioners and current providers, MVPs should be represented by their service-user chair at the new Local Maternity System level, ensuring that service users are also at the centre of the regional decision-making process. Better Births also expects that MVPs will henceforth 'play a lead role in capturing and interpreting local data' (*ibid*, p20-21). Whilst this has always been a key role for MSLCs, for most MVPs, this will require developing improved processes to gather service user feedback from a 'full range' of service users, including from those whose feedback has sometimes been more challenging to obtain, such as women and families who have experienced loss. All voices will be needed to inform local transformation activity, and the principles of diversity and inclusion should be core values of every MVP.

What makes for an effective MVP?

MVPs that are effective seem to have similar traits. They are adequately funded, have an engaged maternity commissioner who sees the value of these multi-disciplinary, collaborative forums, have clear terms of reference and have established effective ways in which the MVP can operate, with committee members having clear, well-defined roles. Often they have started out by identifying issues which are easily resolved, which make a difference to parents and staff alike, to build some early enthusiasm and to encourage others to join their successful team. Development days can also help MVPs develop as an effective team, and offer a dedicated space for the team to identify priorities, barriers and successes, and help with team-building and communication skills (Newburn & Fletcher, 2015[4]).

The MVP 'Unique Selling Point': three examples of where MVPs can contribute well to the maternity service improvement agenda

a) Walk the Patch

With feedback from service users as key to driving improvement, one approach used by many MVPs and MSLCs, is to "Walk the Patch". This has been proven to be a hugely important feedback-gathering exercise, and one that MVPs are uniquely able to undertake, given their privileged access to birth centres and obstetric units. It involves a (DBS checked and trained) service user visiting the maternity wards of their local unit (either midwife- or obstetric-led) and asking women and their families about their experiences. Traditionally, the questions are generic, "what did you like about the care you received/what would have made it even better?", although if there is a particular issue about which the MVP, Commissioner or Trust wants feedback, that can be incorporated. The responses are fed back to the MVP for discussion and action-planning as necessary. In some areas, women are encouraged to give the names of the staff that made a difference to their care, and this positive feedback is very much appreciated amongst the health care professionals.

There are many other ways of gathering service-user feedback that are productively used by MVPs, including holding informal coffee mornings and, increasingly, using social media to ask for feedback (which also publicises the work of the MVP). These are all really important sources of experience data for the MVP to review, alongside the Friends and Family Test data gathered by providers, complaints data and the annual service user experience survey data gathered by the Care Quality Commission.

b) Listening to seldom heard voices

MVPs can be the platform for innovative ways of engaging with local service users, especially those voices that have traditionally been 'seldom heard'. In the model terms of reference for MVPs (*http://nationalmaternityvoices.org.uk/toolkit-for-mvps/setting-up-an-mvp/mvp-resources/*) there is a section that really captures this idea well:

> *"Listen to, and seek out, the voices of women, families and carers using maternity services, even when that voice is a whisper. [Enable] people from diverse communities to have a voice."*

A great example of such engagement work is happening in Tower Hamlets, where a Mothers Support Group (MSG) is supported by a 3rd-sector community development organisation, Social Action for Health. This allows the feedback of local women from many different ethnic backgrounds to be heard effectively, including Bangladeshi, Indian Caribbean, African, Chinese, Eastern European and White British women. 923 local women's voices were heard in this way in Tower Hamlets between April 2014 and March 2015. As a group, the MSG identified key issues to take to the main MSLC meeting, as well as coming up with some suggested solutions. This 3rd-sector supported approach empowers local women from the most disadvantaged communities to share their maternity experiences and builds local women's capacity to influence and shape maternity services. With the support of the user chair and the committee's administrator, we have seen how individual women gradually develop confidence to feed back directly to the health professionals and commissioner at multidisciplinary meetings.

c) Driving positive changes on specific issues

Close working relationships between commissioners, providers and service users can lead to an MVP becoming a really productive forum to discuss improvement initiatives. In Reading, for example, women shared their experiences of having positive planned Caesarean births and then worked with an obstetrician, anaesthetist, consultant midwife and theatre manager to implement personalised planned Caesarean births. In Leeds, repeated requests for a dedicated bereavement midwife were rejected, until the MSLC (as was) set up an online survey about bereavement support for families. The findings of this resulted in a sub group being set up to make changes. This group, attended by service users and health care professionals, met every two months, to develop a plan of action. As a direct result of this group's work, there is now a dedicated bereavement midwife offering emotional support for women in pregnancy following a loss. The group also helped secure funding for the refurbishment of the bereavement suite, including a separate entrance so that women did not have to access it through the labour ward. Further examples of how MVPs have used feedback to shape services can be found on the National Maternity Voices website

Further resources

It has never been more important, more relevant, or easier for health care professionals and service users to get involved in co-production. The National Maternity Voices website for the national network of MVP chairs in England has a number of resources about how to set up an MVP from scratch or to revive a flagging MSLC, including further London Clinical Network guidance for commissioners[5]. There is also a very well-established Facebook group for MSLC/MVP chairs and service user reps to share best practices, highlight common issues and challenges and celebrate successes.

Get involved!

MSLCs have been working to improve maternity care in their local areas since 1984. The 'next generation' of MSLCs, known as Maternity Voice Partnerships (MVPs) in England, are a key part of the NHS-England Maternity Transformation Programme, and should help us deliver and sustain the transformed maternity service as envisaged in Better Births. Never before has there been such an opportune time for everyone, health care professionals and service users alike, to be involved in helping shape maternity services for the future. Why not come and join us? You can find your local MVP in England here, contact your local Clinical Commissioning Group or Head of Midwifery to see what's going on in your local area, or National Maternity Voices or the MSLC and MVP leaders and members Facebook groups to find out more about us.

Laura James is acting chair of National Maternity Voices, co-chair of the London MVP strategic group and former chair of Bromley Maternity Voices. She is also an NCT Practitioner and NCT VOICES facilitator.

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Implementing Better Births via MVPs: an interview with Ceri Durham

Since 2016, Ceri Durham (an AIMS trustee) has worked for a small grass-roots health inequality and community development charity, Social Action for Health, based in the East End of London. Much of Ceri's time in this paid role is allocated to supporting her three local Maternity Voices Partnerships (MVPs), and in this interview we have asked Ceri to reflect on whether the effectiveness of MVPs might be improved with the help of such 3rd sector organisations.

Ceri, can you tell us a bit more about Social Action for Health?

Social Action for Health (SAfH) is a community development charity which recognises that many answers to good health are not just about medical treatment, but rather about addressing social factors which influence health. It is well known that the poorer you are, the worse your health is likely to be, for example. This is as true in maternity as in other health matters.

What is your role?

I am one of SAfH's senior managers and head up the 'community research' programme. This includes speaking to women about their maternity care, and feeding that into local MVPs and the Local Maternity System, as well as working on a range of other projects.

SAfH is responsible for supporting three Maternity Voices Partnerships. Can you tell us more about that?

We are currently commissioned by the Clinical Commissioning Groups in the London Boroughs of Tower Hamlets, Newham and Waltham Forest to administer and facilitate the MVPs in these diverse boroughs. We facilitate and support the MVPs and aim to encourage and support genuine community involvement in the leadership and membership of them.

Do you have specific targets that you must meet?

Yes, we have targets. We are responsible for delivering to each contract and there are monitoring meetings every three months where the CCG assesses whether we have done what we agreed, to the required standard. We also produce a report for each MVP every quarter, evidencing what local women are saying about maternity care in their borough.

It sounds like MVPs are taken very seriously in your area, which is not necessarily the case across the country. Do you have any reflections on this?

We are very lucky to have senior commissioners and midwives who are very supportive and genuinely want women involved in all aspects of improving local maternity services. The SAfH team definitely view the MVPs as a key vehicle for women and professionals to work together to improve maternity services. MVPs have great potential for genuine co-production, with women as partners and leaders in shaping great maternity care.
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But even in our local area, there are tensions and confusion. For example, some see our role as the hosting of a patient consultation group, a complaints forum, or as a mechanism that can provide women 'on tap' whenever they need a woman's voice or to demonstrate service-user involvement. This can inevitably lead to frustration, and it is definitely work-in-progress. I think this confusion can be seen across the country, but I hope that over time, local MVPs will become more embedded in the overall decision-making process. This will represent a real shift in power and thus mean real progress.

To whom are you responsible?

SAfH is primarily responsible to the women and families whose voices we represent. They are telling us their story and trusting us to make a difference. So often we find that they deserve better from maternity services and we have a key role in making that happen. As a charity employee, I am also responsible to our board of trustees. As an organisation, SAfH is contractually responsible to the relevant Clinical Commissioning Groups.

Does having a common administrator mean that all 3 MVPs are very similar in set-up, activity and outcomes?

To some extent, the MVPs that we administer are very similar. We tend to recommend, for example, that things that work in one MVP should be considered by another. We have monthly meet-ups for the chairs, so that they can learn from and support each other. We are using a common MVP meeting format at the moment, which seems to work well.

All the current local chairs are quite new to the 'birth world'. As local service-users develop more of a sense of ownership of their MVPs, the format and operation of the meetings will start to vary more across each one. I am very excited about this. I would also like to move to a model where the MVP itself can have more awareness and control of a budget to get things done, but as yet we are some way from having these mechanisms in place.

What is the rationale for operating an MVP in this way, and is it really affordable?

Many MVPs operate at a lower cost than ours, either relying entirely on volunteers or paying a chair or other service-users to do everything. I don't think there is a perfect model. The rationale for paying us is for consistency, quality control and sustainability, as well as volunteer support and accessing our community networks and community development expertise. This ensures we have a wide range of voices sharing experiences with the MVPs and also bringing their expertise to the meetings to help shape the development of the maternity care in the area.

As part of this, we provide training and support to our local communities, so that they are really in a position to influence change. None of our current chairs had heard of 'Better Births' or the notion of a Local Maternity System before we started working together. I do feel proud of what we've achieved.

There are many MVPs which seem to operate brilliantly, facilitated by a team led by a service-user chair. But I have seen many occasions when a chair steps down and the MVP folds because there is no one to sustain it. As every service-user chair and representative knows, there is often a great deal of emotional energy involved in MVP meetings. Often, hospital staff are defensive where feedback is concerned, and women can get annoyed that providers do not seem to do anything in response to their feedback. Working with a third party, in a more structured way, can help take the 'personal' out of the equation.

What do you think are the main downsides to having a 3rd sector organisation working alongside an MVP in this way?

There is an inherent conflict of interest. If the women say they want to prioritise one issue, but the commissioners want to prioritise another, we could be stuck between pleasing the person who pays us (the commissioner) and the women. This can also be a problem for other MVP models; our model might just make such tensions explicit, which is perhaps no bad thing! Another issue is that our involvement can translate as SAfH being seen as the service-user representative, which is not how we see ourselves.

Locally, we have tried to head-off both of these potential problem by having the MVPs focus on the outreach feedback we collect from local women. MVPs each collectively agree their priorities and use these to define the questions we ask in our outreach work and other improvement priorities. This is effective if you believe that the role of the MVP is co-production and that everyone has an equal voice at the table. For some people, however, this way of working is seen as pointless, because the perception is that women don't really know what the key issues are in birth, or in the provision of maternity care. I am sure you can guess where my personal view is on this spectrum!

In Better Births, service-user involvement via MVPs is imagined as a key part of the Local Maternity System framework. Did the MVPs you administer play any meaningful part in developing your local Better Births implementation plan, for example?

We are generally quite lucky in our area. MVPs are increasingly seen as a key part of the Local Maternity System. So, for example, we had some input on the Better Births implementation plan, and some of the chairs provided comments. We also conducted a surface level engagement exercise designed to help the Local Maternity System get user input. The problem is that the NHS often wants service-user involvement at very short notice, without any thought as to how this might be resourced in practice. We aim to help as much as we can – and we would rather provide basic input than there be no service-user input at all – but it can be very frustrating. Not all our chairs have the interest or expertise (yet!) to comment on strategy documents like this, nor the time in between family and other commitments.

To try and improve the input of the MVPs to the Local Maternity System, a women's experience sub-group has been set up. These meetings take place on a weekday morning during school hours – not at school pick-up time, when many of the Local Maternity Systems meetings had originally been scheduled – and in a central and accessible venue. A key part of our strategy is to support the MVP chairs to get involved at this less intimidating and slightly more user-friendly level, and for decisions made here to be passed to the main Local Maternity System for sign-off and implementation. The meetings are still relatively formal and full of 'policy-speak', but it is definitely a step in the right direction.

Many MVPs are trying to ensure a wider voice from a more diverse range of service-users. What advice can you offer to chairs and other MVPs trying to do this.

My first question is to always ask why you are wanting a more diverse voice. Not that you should not – far from it – but this will often tell you what you need to do. Very often, service-users find themselves stuck in an impossible predicament … the Head of Maternity (or whoever) wants input from people who are 'not the usual suspects'. At the same time, s/he wants input from people who are able to provide expertise on the subject and who actually understand the maternity system. These are, of course, the usual suspects!

I think sometimes it is also expected that people from different educational, social or cultural backgrounds will have totally different views. However, in my experience, all women want the same thing from their maternity services: compassion, dignity, and respect, underpinned by safe medical practice and midwifery care.

My top tip would be to think about your community and who you are not speaking to and just get out there. Get out there into your communities – and write down what you find. Very often, as far as the NHS is concerned, if it is not in a report, it is not happening. This way, even if a more diverse group of women are not attending the meetings, you know that their voice is still being captured. It can be very hard in practice to do this though, so use existing community groups and ask them to ask their attendees. Ask the leaders of the groups to come along to the MVP meetings to contribute and to represent their communities. If you are on social media, use that too. Capturing the voices – and showing what you do with them – is the first step. Slowly, you will build your wonderfully diverse and inclusive MVP.

If a fairy godmother was going to grant you one Better Births wish, what would it be?

Continuity of carer through pregnancy, birth and beyond! I honestly think this will make the biggest difference to making maternity services safer and kinder. At last, providers seem to have stopped moaning about continuity, and are trying to make some effort towards implementing the national March 2019 20% coverage target. Viva la revolution!

And finally, what has been your worst moment in this role?!

Being accused of making up the feedback we obtained from the outreach, because it did not reflect the local friends and family test feedback. Grrr...

Better Births at the Barkantine in East London: celebrating ten years

By Cassandra Yuill

Introduction

In recent years, choice of birthplace has been at the forefront of the conversation about improving maternity care in England. Better Births (NHS England, 2016) again emphasised the importance of choice of birth options, stressing the value of personalised care and advocated continuity of midwifery carer. Freestanding birth centres (named freestanding because they are not co-located with an obstetric unit), within a well-organised Local Maternity System, have the ability to provide women with straightforward pregnancies with safe and effective maternity care. In fact such centres have been found to have lower rates of intervention than both alongside birth centres and obstetric units (Birthplace in England Collaborative Group, 2011).

In May 2018, the Barkantine Birth Centre, located in the borough of Tower Hamlets in east London, celebrated ten years of operation. The centre has become a beacon for a social model of midwifery care, in which midwives understand and embrace women's autonomy and their role as the key decision-maker in their care. As more areas of England are looking to develop such free-standing birth centres, this article offers my reflections on our local successes and challenges.

The centre was planned and opened in response to the increasing population and growing demand for maternity care in Tower Hamlets, which is home to one of the most ethnically and linguistically diverse populations in England. A steering group, the Birth Centre Network, was established to plan the freestanding birth centre, subsequently applying for a grant to build the centre on an available floor of a GP health centre that was under construction. The plans were approved by the Trust Chief Executive, and the centre was opened in January 2008.

As the one of the first inner city freestanding birth centres in the UK, several groups of researchers have conducted studies on the centre. This article draws from the current birth centre research and The Barkantine Birth Centre: Celebrating 10 Years as a Community Hub, a recent report released reflecting on a decade of operation, to look at how the application of the Better Births policies is working on the ground in maternity services.

The philosophy of care at the Barkantine is to promote woman-centred birth by helping mothers to feel empowered and supported to give birth on their own terms, using their own resources.

A social model of care

The development of the Barkantine was guided by two core principles; the founding team wanted a birth centre where the social model of midwifery care could flourish and where midwives could provide woman-centred care. This social model of care recognises that the arrival of a baby is a socially and culturally significant occasion for women and their families. The philosophy of care at the Barkantine is to promote woman-centred birth by helping mothers to feel empowered and supported to give birth on their own terms, using their own resources. The centre offers women and their families a calm environment in which to birth, where they are disturbed as little as possible, combined with skilled and compassionate social and emotional support to help women cope with labour and birth.

Partnership in decision-making between midwives and service users is essential to determining a woman's care plan. Observational research of the centre found that there is a process that midwives use to build this partnership, so that

it becomes a key aspect of creating a woman-centred plan of care (Rocca-Ihenacho, 2017). For example, to develop this partnership midwives work hard to establish rapport with women in their care and to build a sense of trust and emotional commitment. The midwife provides information to the woman, including the pros and cons of different possibilities, and then discusses care options. This partnership element means that midwives can offer targeted support in order to facilitate a personalised plan of care.

The centre offers women and their families a calm environment in which to birth, where they are disturbed as little as possible, combined with skilled and compassionate social and emotional support to help women cope with labour and birth.

This model of social midwifery care is woven into the very environment of the Barkantine, which was purpose built. Midwives aim to promote co-ownership of the centre with women and their families by allowing mothers to have as many visitors as they choose and sharing the common areas (e.g. the kitchen and reception) with them, while providing a calm, home-like space. A study found that freestanding birth centres often act as a "protected space," in which features, such as nature-themed wallpaper, rocking chairs and comforting colour schemes, are used to evoke a feeling of home and a sense of wellbeing (McCourt, et al., 2016). The built environment is often constructed and organised in a way that supports physiological birth, and research suggests that there is an interaction between the physical environment and the work culture. At the Barkantine, this interaction has fostered positive collaboration between staff members (Rocca-Ihenacho, 2017).

Outcomes from the Barkantine

Over the last decade, 8,341 women have booked for their maternity care at the Barkantine, and 4,726 women have started their care during labour at the centre. Women who arrange their maternity care at the Barkantine, whether they plan to birth there or not, can receive antenatal and intrapartum care at the centre. At present, the staff do not provide these women with care during labour and birth if they choose to birth in a setting other than the Barkantine, which is an issue we need to address, in light of the continuity of carer agenda. In terms of mode of birth, of the women who started their care during labour at the centre, 81% had a spontaneous vaginal birth at the Barkantine, and 7% were able to achieve an unassisted vaginal birth after they were transferred to the nearby obstetric unit. Of those women who transferred in labour, 5% gave birth via caesarean section and 7% gave birth with the assistance of instruments (e.g. forceps or ventouse).

One key study (Macfarlane, et al., 2014a) found that women who booked at the birth centre were more likely to rate their care as 'good' or 'very good' when compared to those who were eligible for the Barkantine but booked at the Royal London Hospital (RLH). It also indicated that women who started their care during labour at the Barkantine were more likely to be cared for by a midwife they had already met, to have one-to-one care and to have the same midwife with them throughout labour (Macfarlane, et al., 2014a). Barkantine midwives always accompany women who require a transfer to the RLH and often continue their support during labour at hospital.

Giving birth in the Royal London Hospital (RLH) v the Barkantine: continuity of carer outcomes during labour

	RLH (%)	Barkantine (%)
Women cared for by a midwife they had already met	4.8	42.7
Women had one-to-one care throughout labour	51.0	87.8
Women had same midwife throughout labour	48.6	66.7

Source: (Macfarlane, et al., 2014a)

Another study from Macfarlane et al (2014b) found that women who booked at the Barkantine also benefited from this during the antenatal period. They were more likely to attend antenatal classes and find them useful, and they were less likely to be induced than those who booked at the hospital (Macfarlane, et al., 2014b). Finally, women who planned their birth at the centre were more likely to use a birth pool and reach the stage of "established breastfeeding", which means these women were breastfeeding beyond six weeks postpartum,

when feeding has been found to become less complicated and more routine (Macfarlane, et al., 2014b).

Challenges and the future of freestanding birth centre care

While the Barkantine has much to celebrate, creating and operating the centre has not been without challenges, and keeping it open sometimes feels like a triumph itself, against the backdrop of the other freestanding birth centre closures across England. Over the past year, for instance, the Barkantine has experienced a drop in the number of births (perhaps due to the opening of an alongside birth centre in the local hospital), but there is strong collaboration between local parents, staff and the wider Local Maternity System to ensure that the centre remains in operation.

Dr. Lucia Rocca-Ihenacho, a research fellow at City, University of London and former Consultant Midwife, is clear about the importance of centres like the Barkantine, and also the difficulties that freestanding birth centres (also known as freestanding midwifery units, or FMUs) face: "*At a time of industrialised maternity care, rising costs and unnecessary birth interventions, there is a need for maternity services and commissioners to truly understand the positive impact that FMUs bring to their services. FMUs are ideally placed to become the community hubs outlined in Better Births, offering a series of integrated services from maternity to social care. Many FMUs in the UK are now acting as a base for local community midwives offering continuity of carer; these midwives will increasingly need to work flexibly across boundaries between the community and the local hospital, and FMUs are an ideal local hub for these staff.*"

Operating integrated services in this way can be tricky, however, and it took the Barkantine a few attempts to get it right. Luckily, there is now a wider network of support for freestanding birth centres in the form of the Midwifery Unit Network, of which Dr. Rocca-Ihenacho is a co-founder. There is an increasingly strong national drive to share the philosophy of care offered by the Barkantine and similar freestanding birth centres. For the Midwifery Unit Network, this means conceptualising freestanding birth centres as part of mainstream care models, available to all women and getting a clear message out internationally: this model does work, and it could be introduced into maternity services worldwide to ensure equity of care and positive birth experiences for women and their families.

Do you want more information and support for your local initiatives? Please visit the Midwifery Unit Network: *www.midwiferyunitnetwork.com*

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Introducing Pelvic Uprising: tackling women's postnatal health issues

By Lyanne Nicholl

Abandoned, dismissed, unimportant, broken. These are words that crop up alarmingly frequently when you question women about their experience of postnatal care. This also comes close to my own experience after the birth of my son, three years ago. Although I recovered well and managed to avoid postnatal depression, the shock at my treatment within the health system led me to take a closer look at postnatal care. I was dismayed by the threads I read on mothers' forums and facts such as only 8.5% of the maternity budget is being spent on postnatal care. Over 10% of mothers are suffering postnatal mental health issues[1], including up to 7% developing PTSD[2] symptoms, and over 30-40% experiencing embarrassing or debilitating physical morbidities such as prolapse, dyspareunia and incontinence[3]. You don't have to be a rocket scientist to conclude that a lack of investment in new mothers is storing up considerable problems for the future. And beyond that, it drums a message very firmly into our heads – 'you don't matter'.

There is a casual disregard for women's bodies after they have given birth. Once baby arrives (hopefully in rude health) the focus immediately switches from the mother to the baby and never returns. This shift is so deeply ingrained in both mothers and health professionals, that mothers often just accept being treated like an afterthought[4]. We seem to forget that these broken, battered, stitched up women are the very same ones that then raise the children they have just carried and given birth to. Being able to provide a nurturing environment for their children to thrive is currently being compromised. We need to remember that these women – us – are still valuable individuals deserving of appropriate care to get back to optimal health. We need a postnatal revolution. For too long mothers have been conditioned to 'put up and shut up' and accept a 'new normal' which can dramatically affect their quality of life.

Too many post-birth issues are 'normalised'. Women put up with pain, discomfort, embarrassment and worse, because we are conditioned to accept that pregnancy and birth will have a negative impact on our bodies. We remain silent because all of the women before us remained silent. It is time for change. The message women should be receiving is that physical issues, especially pertaining to their pelvic floor, are common postnatally but they are not necessarily 'normal' and should be addressed by health professionals. Increasing knowledge of healing after birth is paramount to creating an environment where women feel valued, supported and confident to speak up. This should all take place within a holistic model and be woven into maternity care from your first contact with health professionals. I believe this would have significant positive impact on physical and mental health postpartum. The "new normal" should be a mother being supported to achieve optimal health for the long term. The mantra 'all that matters is a healthy baby' implicitly implies that you don't matter. Why are we not striving for a healthy mother too, mind, body and spirit? The two need not be mutually exclusive.

Progress is being made. There is momentum building amongst groups and organisations who, collectively and individually, are calling for change. We at @pelvicuprising are gathering evidence from women with lived experience and health professionals[5] and presenting it to MPs; @pelvicroar are calling for better pelvic health education across the board.

However, at present there is no standard multi-disciplinary care pathway for mothers postnatally. Services vary considerably across the country but, with postnatal care widely called the 'cinderella'[6] of the maternity services, the broad picture is that care is substandard and "not-fit-for-purpose"[7]. We have highlighted to MPs the need for a multi-disciplinary pathway, to address each woman's health needs holistically. This should include: continuity of carer; improved immediate post-birth checks; improved patient-centred birth debrief options; a 6 week GP check, thoroughly screening for physical and mental health issues; and referrals/signposting to women's health physiotherapists. Embedded in

all of this must be better information about pelvic floor health – from antenatal contact onwards. It is shocking how little women know about how to prevent the common post-birth issues which may affect them for the rest of their lives. Within all of this lies the silent message, the vital message that needs to be communicated: you matter.

The time is ripe for transforming birth and the postnatal period. To join the 'pelvic uprising' please do follow us on twitter (and our sister postnatal community on Facebook) and put yourself forward to join your local Maternity Voices Partnership. We need people all over the country who will ensure that women's optimal health – short and long term – after birth, becomes a key focus in maternity and postnatal care. Let's rise up!

Lyanne Nicholl is a freelance charity consultant.

Join us at Twitter: @pelvicuprising Facebook: Women's Postnatal Health Community

[1] *www.nhs.uk/conditions/post-natal-depression*

[2] *www.nature.com/articles/srep27554*

[3] *www.appgcontinence.org.uk/cmo-report-2014.pdf* - Page 124

[4] *www.mumsnet.com/campaigns/better-postnatal-care*

[5] GPs, Midwives, Obstetrician/Gynaecologists, Mental Health practitioners, Colo-rectal surgeons, Women's Health Physios, Pilates instructors and Osteopaths

[6] *www.nct.org.uk/sites/default/files/related_documents/1fox-postnatal-care-still-a-cinderella-story-17-.pdf*

[7] *www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf*

Conference Report: The Northern Maternity & Midwifery Festival

By Amy Fairbrother

In June this year, I attended The Northern Maternity & Midwifery Festival at Old Trafford in Manchester. As a new volunteer for AIMS, an aspiring birth doula, and a self-proclaimed birth-nerd, I heard about this free-to-attend event and just had to see what it was all about! Similar events have been held up and down the UK, with upcoming one-day events in London, Leicester, Manchester, Cardiff and Edinburgh. (For more information on future events, visit the Maternity & Midwifery Forum page.) As I had not attended before, I was a little apprehensive and unsure what to expect, but, with such a welcoming crowd, I had nothing to worry about. I knew the event was aimed predominantly at midwives and student midwives, and although I was one of very few doulas present I didn't feel out of place at all

Prior to the event we were able to view a list of the exhibitors online. We were also given the agenda in advance so that we could think about which sessions we might want to attend. Most of the stalls in the exhibition were very informative, some gave out free samples and the baked goods stall was a big hit! The event was very well organised, although there was a coffee shortage! But I wouldn't want to attempt to find enough coffee for over 2,000 midwives, would you?

After having a wander around, we were ushered into a large lecture hall to be greeted by Sue Macdonald, Midwifery Consultant and curator of the event. She did a wonderful job, making us all feel welcome, enthused and ready to soak in all

the information on offer throughout the day. After the opening speech, we all stayed seated for talks on positive birth, respectful relationships in maternity services and a parents' perspective on life after stillbirth.

Milli Hill, the founder of the Positive Birth Movement told us all about this network of support that is aimed at making birth a positive experience. **The Positive Birth Movement is exactly what it says – it seeks to spread positivity in birth and breaks down those negative views about certain ways of birthing.** Milli explained what the movement offers to families, such as antenatal discussion groups, where birth stories can be shared and women's options and rights can be discussed. Milli stands by the view that "a healthy baby isn't all that matters" and that there is no 'right way' to have a baby: it comes down to how each woman can get the best birth for her and her family. As a doula, I feel that this is such an important point to get across. Milli's talk inspired me to seek out my local Positive Birth Movement meetings in Manchester and to get involved with them.

David Monteith, the founder of the charity Grace in Action, gave a talk about his own personal experience of stillbirth. The only note I wrote during this talk was "amazing!" because I was completely absorbed by what David had to say. The way he told his story with laughter, heartbreak, and utter honesty about the subject of death brought everyone to tears. His experience is such an important one. He told us of the moment the midwife tried to hear the baby's heartbeat and couldn't find one. He told us how they were given the option to give birth to their baby in a birth pool, in hospital, and how important that was for him and his wife. His wife was also given the option to be given medication to stop milk production, which she declined and she instead donated 20 litres of breast-milk to a human milk bank! This is a path that not everybody would choose, but having the choice is so important. His main message in the talk was that stillbirth is still birth, and that the element of choice is still just as important. He also highlighted the importance of caring for the whole family, not just the mother, which is an incredibly important message.

After these plenary talks, and some refreshments, we chose from a range of seminars. There was plenty of choice, and I opted for the ones that intrigued me the most. I started by hearing from Skye Rolfe, the midwifery lead for One-to-One (North West) Ltd on the topic of reclaiming homebirth. **It was really uplifting to hear, via Skye's presentation, from women who have used the One-to-One service and had a wonderful experience and also to hear from such happy midwives who completely love their job and have such a passion for providing continuity of care.**

Next **I attended a talk delivered by Dr Rehana Jawadwala who is the founder of Chester-based MummyYoga.** Dr Rehana told us about the benefits of exercising during pregnancy, using the analogy of trying to run a marathon without doing any training beforehand. **The last seminar was delivered by Pete Wallroth telling the very personal story of how his wife died from cancer soon after the birth of their first child, and the fear and struggles he faced during a subsequent pregnancy with a new partner. As a result of his experiences, Pete founded, and is the chief executive of, the charity Mummy's Star.** For those of you who don't already know, this is a charity that supports women and their families affected by cancer during or soon after pregnancy.

There was also an element of self-care involved during the afternoon at the festival. During our lunch break I received a free taster session of Reiki. Later, I attended half an hour of wellbeing tantalisers, where I was guided through mindfulness breathing and other relaxation techniques. This was a lovely lesson on how busy maternity workers can take a little time to look after themselves. It underlined how important self-care is when in a position of caring for others. **With these sessions, and Maggie O'Brien's talk at the beginning of the day on respectful relationships in maternity settings, it was clear how important it is to make and keep happy midwives in the NHS, because if the staff are content then they are more likely to provide excellent care and create positive birth experiences for their service users.**

For me, the most important part of the day was listening to the talks from Milli, Pete and David. It's truly inspiring to hear service users educating staff on what they love about maternity care and how things could be improved, and the maternity care staff in the audience really seemed to respond well to this opportunity. I believe that it is incredibly important for birth workers to hear these stories and learn from them, and to constantly strive to provide a better service for women and their families. This was a resounding message throughout the day, but especially from these three when talking about their own experiences, both the positives and negatives. These are the people – service users - who should be our guiding voice and lead the way to better maternity care..

Birth Story: My three very different experiences of becoming a mummy

By Kirsten Mitchell

When I was little I wanted to be a midwife. I did well at school and went on to do my A-Levels. When I was 17 I applied to go onto a midwifery course but didn't get accepted and I was devastated. I decided college wasn't for me and got a job as a trainee building inspector. My parents were really disappointed and tried to talk me back into college. To please my Mum, I applied for the Project 2000 nursing course and got a place at Bury. My Mum and Dad were delighted but a little less so a month later when I told them I was pregnant. I was 19, and my dreams of being a midwife were replaced by the reality of becoming a mum.

I had a lovely pregnancy, although the baby was a little too comfortable and I was induced at 42 weeks. It was quite traumatic and after 42 hours in labour my baby became distressed and was born by emergency caesarean. He weighed a rather impressive 10lb 11oz. He was the most beautiful thing I had ever seen, and I named him Sam. Even though I was a young mum, I was excited to be a mummy. I wanted to do everything right, I had really wanted to breastfeed, but no one spoke to me about it. My mum had been the first one to hold Sam whilst I was still in theatre, and she had been handed a bottle which she gave to him without question. Two days later I was up and about and I tried to get him latched on. I remember the midwife popping her head around the curtain and saying "Oh, look at you breastfeeding, clever girl". She didn't ask me how I was doing and the next day, with bleeding nipples, I asked for a bottle for him and that was that.

Maternity leave was very different 21 years ago, and when Sam was 5 months old I went back to work full time. Sam went to a childminder and my mum and dad helped out. I bought my first house when I was 22 years old. It was tough. I was skint but Sam and I were happy.

Six years later I met Gareth and two years after that we got married. Gareth wanted more kids but I was happy with Sam. I had a bit more money and we were able to get a car and go on holiday for the first time. But one morning I just woke up and thought "I want a baby now". After becoming pregnant accidentally with Sam I expected it to happen overnight. It didn't, it took nearly 4 years. Plus lots of tests and a few rounds of clomid.

In December 2011 I found out I was to be a mummy again. I had a lovely pregnancy, but this baby didn't want to come out either. I was induced at 41 weeks and 5 days, and our baby girl arrived by ventouse with a little help from some surgical scissors. She was amazing, she was a little smaller than Sam at 8lb 12oz but she was the double of him. We named her Daisy. This time around it was different, the midwives were really supportive about breastfeeding and Daisy latched on the minute she was laid on my chest. I was over the moon. It wasn't plain sailing with Daisy's feeding though. As soon as we got home I started to struggle and Daisy didn't feed well. The support I had received on the postnatal ward at North Manchester wasn't reflected in the community and one midwife told me I should give up if it was making me feel so bad. Things got worse and Daisy was diagnosed with silent reflux. She was constantly crying and in pain. I gave up with the breastfeeding. I just couldn't cope. I was miserable and dreaded Daisy waking up for a feed. I put her on formula and she got worse. When she was 6 months old, Daisy was diagnosed with a severe allergy to cow's milk protein, she was prescribed a hydrolysed milk and she changed overnight. I finally had the happy smiling baby I knew Daisy was, and I started to enjoy her properly.

We talked about having another baby and we knew we would like one more. We also knew we could potentially have fertility problems again so we put it to the back of our minds as something we would talk about next year. The day after Daisy's 1st birthday I found out I was pregnant.

Everything was going well, we were excited if not a little shocked and I felt pretty good.

That Christmas whilst visiting my in-laws in Ireland I experienced some heavy bleeding, I was just over 22 weeks pregnant. I was admitted to the maternity unit at a small local hospital on Christmas Eve. The baby was happy and my scan was fine. I was kept in for 24 hours as a precaution. Two days later we sailed home, and I decided to get checked out at the Maternity Assessment Unit at North Manchester. I'm Rhesus negative, and as I was still bleeding a little I just wanted to be seen by someone at home. All was well and I was sent home. A week later I woke up to a pretty big bleed, I was 24 weeks pregnant. I rang the hospital and they told me to go straight to MAU. I wasn't too worried and I told Gareth to stay at home with Daisy and that I would ring him. The midwife checked the baby's heartbeat. All was well but she wanted the doctor to examine me "to be on the safe side". The doctor came in and examined me and I knew straightaway we were in trouble. The midwife very gently told me my cervix was dilated and she could see the baby's membranes. The next few hours are hazy, I remember ringing Gareth and being taken to the delivery suite, I remember somebody mentioning steroids for the baby's lungs, then they started talking about moving me somewhere else. I was confused. I remember thinking 'do they actually think the baby might come now, because they must be crazy, a baby doesn't arrive at 24 weeks because it would die and why would my baby die?!' Very soon, I was on my way to Oldham hospital. The next few days were crazy: labour ward, scans, plans, antenatal ward, change of plans, labour ward, antenatal ward again. The Neonatal team came to visit me: they explained what would happen to the baby after birth.

Everyone talked about what would happen to the baby when it arrived but no-one talked about what our role would be, particularly mine. I did at times feel a little out of the loop regarding my care. The midwives were busy. Other than to do my observations I saw very little of them.

Five days later my waters went. I asked for a section as I thought it would be easier on the baby. The consultant told me she didn't think it was worth the risk to me, as there was only a slim chance of our baby surviving. That was hard to hear. I was in labour for three hours. I was very lucky and was cared for by an amazing midwife, Sue. I don't know how she got me through the birth but I couldn't have done it without her. She was kind, caring, supportive and very calm.

The NICU team were in the room as they had promised, and our baby boy, Tom, came into the world feet first without a sound. He weighed 1lb 7oz. A lot of what happened next is a blur for me and it has taken a long time for me to able to process it. The only word I can use to describe Tom's birth is traumatic! I could see people working on my baby but I couldn't see him. I know I lost a lot of blood and I remember that Sue was very worried. Tom was resuscitated for quite a long time and I know that we came very close to losing him. I managed a little peep at him and then he was gone, whisked off to the place that would be our home for months.

I was totally unprepared for the neonatal unit, so many machines and beeps.

I was even less prepared for seeing Tom properly. He looked nothing like a baby: his skin was red and see through, his eyes were fused and he didn't look like he belonged to me. I didn't feel that instant rush of love that I had felt for my other two children. I didn't want to pick him up and snuggle him. I felt fear and pity. Pity for him, this poor little person going through unimaginable intervention. I felt broken.

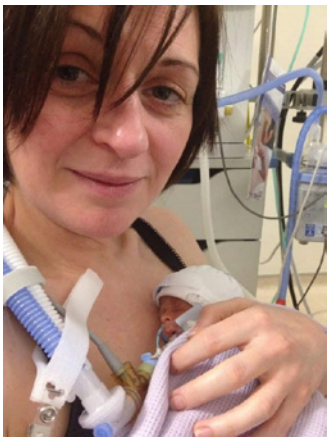
Physically, I was pretty well after Tom's birth, although I was bleeding pretty heavily and kept asking the midwives to check, as I was sure it was too much. They insisted it was normal and they spoke to me about going home. I couldn't believe it! We had spent 5 days locked away in our little safe haven on the antenatal ward, only letting my Mum & Dad and my kids visit us and now they wanted me to go out into the world where everyone was carrying on as normal. I was shell shocked. However, I went home and I was glad to get back to my other kids, and my bed. I soon got into the routine of balancing expressing, spending time with the other two and being at the hospital every minute I could.

Tom was doing pretty well, or at least was stable. He did have some problems with his lungs and when he 12 days old he was moved to St Marys. This was hard for me. It was strange hospital and I missed the staff at Oldham. However the staff at St Marys

were great and I got my very first cuddle when he was two weeks old. Tom began to have a fairly smooth ride at last. Of course we had many setbacks and he gave me lots of 'heart attacks'.

I was still bleeding heavily. I had seen the community midwife who insisted it was normal as I was expressing. [Ed: It is possible that this advice was based on the notion that retained placenta was unlikely given Kirsten's success with expressing milk, as placenta retention can negatively impact milk supply.] When Tom was 9 weeks old, I told his nurse that I was having to change my pad every hour. She marched me straight down to antenatal and I asked for a scan. Unfortunately the scan showed retained placenta, and two days later I had surgery. It was stress I could have done without and I did feel a little angry that I hadn't been taken seriously.

Tom came home after 127 days in neonatal care. He was on home oxygen and it was hard. I was diagnosed with Post Traumatic Stress Disorder and my mental health saw some dark times. It has been a long road and the scars remain but I am in a good place now. Tom is doing so well. He is happy and healthy and he starts school in September. I could never find the words to thank the all people who were involved in our journey and given us the chance to watch our little boy grow up. I feel blessed to have my three very wonderful children.



A year after Tom was discharged from the neonatal unit, Kirsten set up Spoons, a parent support group for other families using neonatal care services at Oldham and North Manchester hospitals.

Spoons is a registered charity – see their website at *www.spoons.org.uk/* for more information.

Kirsten also now sits on the parent advisory group for the Greater Manchester Neonatal Network with some of the people who were responsible for Tom's care.

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Obituary: Clare Fisher

(28 September 1963 - 22 June 2018)

By Beverley A Lawrence Beech

When considering the requirements for a good midwife Clare Fisher filled the bill – and then some. She was kind, caring, tough, principled and formidable, and loved and respected by the women she attended, many of whom were cared for by Clare as an Independent Midwife.

Clare was not afraid to stand up and speak out when she saw bullying, poor practice, or injustice. Having been a Ward Matron by the age of 27, Clare qualified as a midwife in October 1993. After making a complaint about bullying, Clare found herself suspended from duty, later from practice – and subjected to numerous unwarranted referrals to the Nursing and Midwifery Council (NMC). Clare had planned to write the second part of her experiences when she retired in September (see Beech, 2009 for the first part) fearing that writing it before removing herself from the register would lead to further reprisals. She has asked Roo, her partner of 30 years and husband of just 3 weeks, to finish the story on her behalf.

When executives of the Healthcare Inspectorate Wales (HIW) belatedly investigated her concerns they were horrified. A 500+ page report (see summary below) vindicated Clare's concerns and complaints. Three times the Public Services Ombudsman for Wales ruled in Clare's favour. On the last occasion the Welsh Government, acting for HIW, was forced to pay substantial compensation – and even then
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they attempted to offer a derisory settlement whilst insisting on a 'gagging clause'; an offer that was met with a typically forthright response from Clare. To the end she believed the stresses of her treatment by the Local Supervising Authority (LSA) in Wales, the HIW, and the NMC had profoundly affected her health – and that no amount could properly compensate her for that, or for the damage to her family.

She maintained that the NMC was a body 'unfit for purpose', lacking insight into their own failings. She had made powerful enemies in Wales but found powerful supporters – such as Professor Paul Lewis (former Chair of the NMC Conduct and Competence Committee), and well-respected midwife, Mary Cronk (who praised Clare for providing a gold standard of midwifery care). In turn she provided support and advice to others. For the last six years of her life Clare practised as a midwife in Oxford where her skills, wacky humour, and commitment to women, were valued and finally appreciated within the NHS. Those parents whose births had been enriched by Clare's attention never forgot and will never forget.

Clare loved gardening, riding her bike, holidays with her family in France and Terry Wogan. Above everything she treasured her family – her husband Roo, and children: Adam, Olly, Josh, Jack, Phoebe and Ella. Her retirement in September was to be their time, family time, a time that has so cruelly been snatched away.

Clare died of Metastatic Adenocarcinoma of the Gallbladder and I have no doubt that the years of stress that she was subjected to by the combined activities of the LSA, Health Professions Wales and the NMC was a significant factor. Clare will be a huge loss to midwifery which sorely needs midwives of Clare's calibre if the profession is not to turn into obstetric nursing.

Beverley A Lawrence Beech is a long-standing birth campaigner and past Chair of AIMS.

References

Beech, B A Lawrence (2009) Clare Fisher – The Welsh Witch-hunt AIMS Journal 21 (3): 6-9

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Clare Fisher – The Healthcare Inspectorate Wales' Findings

AIMS volunteers were saddened to hear of the death of midwife Clare Fisher, who died on the 22nd June 2018. It seemed that Clare was eventually getting the justice she deserved in 2013, when the Health Inspectorate Wales (HIW) published findings into the actions of the Local Supervisory Authority (LSA), actions which caused this woman-centred midwife so much harm.

The report was nothing short of damning, raising, amongst other issues, the fact that the LSA failed to keep adequate records, failed to provide information and to communicate effectively, failed to identify and manage conflicts of interest, failed to act within the timescales set out in their own guidelines and failed to operate openly and transparently.

The HIW was unable to confirm that Clare Fisher was treated fairly, nor that staff were impartial, and they stated that 'The LSA's actions in this one case was neither professional nor accountable. This has been to the detriment of the midwives involved (most notably Clare Fisher herself), public protection, and the reputation of the LSAin Wales.' They go on to say that '… The failures in this one case are extensive. …'.

While the review may have given Clare some relief before her death, the fact that she was forced to go through such a terrible supervisory experience should raise concerns with anyone who supports woman-centred midwifery, and strengthens the determination of AIMS to continue to work in partnership with others to keep the performance of UK maternity-service-related supervisory bodies under close scrutiny.

Health Inspectorate Wales' Findings (2013). Midwife CF: Desk top review of HIW 's actions. Full report. July 2013, p1-520.
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Research in Focus: Introducing the Access to Research scheme

By Jo Dagustun

Although there is now a rapid shift towards academic research articles becoming available online on an 'open access' basis (which means that they are freely accessible to anyone with an internet connection), there are still a significant number that are not free to access online. For students and academics, this is very rarely a problem, as their access to a wide range of academic journals is guaranteed through their institution's library subscription arrangements. NHS employees are also often able to access scholarly journals through their organisation's libraries.

But this poses an obvious gap in provision for anyone without recourse to such institutional access. Whether members of the public, independent researchers, small charities, patient advocates or prospective students wanting to develop a research proposal, the cost charged via academic journal publishers for an individual article can be significant (and has to be paid upfront, whether or not the article turns out to be useful). In the past, some people have found creative work-arounds to this problem (e.g. accessing a university library through enrolling for the cheapest course available, or taking a part-time job in a university to secure library access). But more generally, citizen access to research has been limited. Which is rather bizarre when one considers that the vast majority of the research reported in these academic journals is funded by taxpayers around the world, via taxpayer-funded research councils or universities.

In the UK, the Access to Research scheme has been designed to address this issue. Originally offered as a two-year pilot, this scheme continues to offer members of the public free access to a wide range of academic journal articles via their local public library, based on a growing set of agreements between academic publishers and public library services.

Using the scheme is very straightforward. There is no need to register. At home, you simply search for the Access to Research website (*www.accesstoresearch.org.uk*), agree to their terms and conditions and then search the database to locate articles that you are interested in reading. If an article is open access, you can read it immediately. If it is not, you can in any case read the abstract (or brief summary). Confident that the articles you want to read are available, the next step is then to pop into your local library to access the full article on a library pc. All UK local authorities are able to opt their libraries into the scheme for free, so if yours doesn't provide this service, just let them know that you want it!

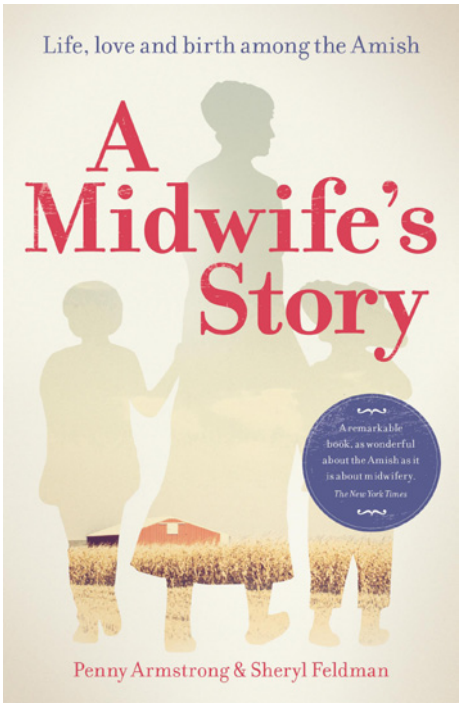
I have accessed a number of key maternity-related articles via this scheme, and I really recommend it. Its usefulness will doubtless decline over time, as more and more journal articles become free to access, and thus available direct from the publisher's website. But even if you are seeking to access articles that are already freely available, the one-stop shop nature of this portal is convenient and effective, and I find the university-quality search engine really useful. Why not give it a try? I can guarantee that you'll find something interesting to read once you start searching: my latest find was a fascinating article dating back to 2003 discussing the potential benefits of continuity of care across the whole healthcare system, just the night before the same team hit the national headlines with their most recent work!

A Midwife's Story: Life, love and birth among the Amish

by Penny Armstrong and Sheryl Feldman

3rd Editio,n, Pinter & Martin, 2017
RRP: £9.99

I first read this book in the late 80s and it inspired my sister (then living in an Amish-settled area of Maryland) and me to take a road trip to Lancaster County in Pennsylvania to visit the Amish country where Penny Armstrong worked. Thirty years on, it has the same effect – the glimpse it gives of the land-focussed, seasonal and sustainable life of the Amish people is tantalising and increasingly relevant. Of course, the Amish lifestyle raises as many questions as it answers, not the least of which is its patriarchal basis. But one is still left with the feeling that, whilst the Amish may have held on to the bathwater as well as the baby, they nonetheless have a message for the world.



Widespread homebirth, quiet support for midwives, community support for new families and young children, universal breastfeeding, acceptance of unavoidable perinatal bereavement, calm and quiet approaches to labour are all part of the Amish way and described in this book. The Amish narrative is interlaced with Penny Armstrong's own story of becoming a midwife and then becoming a midwife to the Amish of Lancaster County. It is a relatively short and easy read, and again left me wanting more, especially to know more about the inner lives of the women whose birth stories it tells.

I am glad that Pinter & Martin have decided to reprint "A Midwife's Story", as it is an interesting account both of becoming a midwife and then how a midwife becomes part of the life of a specific community. Being the midwife to a defined population, living among and being available to that population ("Call the Midwife" also illustrates this) is something that has become sorely tenuous in most parts of the UK. The ideal of "Better Births" is to re-establish these links, and this book demonstrates why community-focussed midwifery is so important and mutually beneficial for midwives and families.

Reviewed for AIMS by Deborah Hughes

Confident Birth

by Susanna Heli

1st Editio,n, Pinter & Martin, 2012
RRP: £9.99

Confident Birth is a little gem of a book. The author is an experienced doula and physiotherapist and the book, translated from her native tongue (Swedish), is based on her own experiences in Sweden and includes nuggets of wisdom gleaned from teachers in her life. Her method of building confidence in giving birth is based upon four tools of Breathing, Relaxation, Sound and Power of the Mind – all of which she talks about in detail in the book, including how she came to understand their power and effectiveness. Susanna reassuringly guides expectant parents on a journey of non-judgement and self-compassion (all feelings are allowed), talking them through what the sensations of labour feel like,

and how we can either get locked into negative cycles or positive ones in response to the intensity of birth. In her words "to protect against fear and stress during labour it is necessary to build a foundation of trust". Pertinently, she also explains that "panic and extreme fear should be seen as the most severe complications of labour, and great effort should be put in place to try and avoid these feelings".

The reader learns how positive psychology impacts on the body, kickstarting the 'reward system of the brain', and about the beneficial hormones, such as oxytocin, that are released when women are able to make the switch from responding to labour with fear to finding a way to relax and allow the birth to become stronger. She talks about the benefits of soundless breathing and explains why that is more effective than shallow or very noisy breathing; how massage and experiencing a feeling of heaviness can help relax the parasympathetic nervous system; how making low deep noises from the belly can help a woman to access strength; and how using simple words such as 'yes' or 'open' can have a powerful effect. In my own experiences of giving birth, I can identify how I have instinctively been using these tools for myself, and how powerful it is to say 'yes' to the birth, to the growing intensity. When I read the part about using a low deep voice I also had some funny flashbacks to a time at a birth I was supporting as a doula. I and the mama growled together through about half an hour of contractions, like bears or who-knows-what wild animal! I'm sure the staff thought we were mad, but it absolutely worked to switch from high pitched panicky cries to deep guttural sounds!

The book is full of such stories which illustrate the difference and shift in a woman's ability to cope with labour once she switches from feeling panicky to being guided to use coping tools. This helps the reader to understand the principles in action and have confidence that they work!

Susanna talks readers through the intensity of contractions, putting them into a context as something that is easier to endure when you recognise there is no need to be afraid, and that the pain has a purpose and that purpose is very normal and functional. She describes how, "Pain during childbirth is very different from the pain caused by an injury or trauma and doesn't have to involve suffering… destructive pain signals injury, while pain during labour tells the story of physical transformations in your body".

This is a very practical and straightforward book which, whilst discussing the emotional, does not stray into the realms of the spiritual dynamics of birth, so will appeal to those who don't want to read anything too 'hippy'. It also stays clear of birth politics, power dynamics, birth plans, or feminist issues (something which keeps the book neat and tidy from one perspective but perhaps leaves it slightly lacking if you like to look at those aspects of birth).

Whilst this is a great little book in so many ways, I do have a couple of tiny criticisms. Firstly, it is very much designed with straightforward birth in mind, so is fine if you have a completely straightforward vaginal birth. There is nothing to help readers that don't fit neatly into that bracket, and nothing about the maze of choices for mothers either side of normal physiological birth at full term. If birth takes a turn, there's no comfort, no explanation of how to carry that confidence over to the operating table, or other such non-ideal scenarios. I also found that, particularly in the first half of the book, Susannah had a habit of finding ten different ways of making the same point using the same words in a different order, which made them feel more than a little repetitive, and I felt a more brutal edit would have resulted in the same message being communicated to readers and spared us having to read quite so many pages. You could probably cut this book down by 30 pages or so, without losing anything.

In spite of these small niggles, it really is a gem of a book. It is one I will definitely keep in my doula library and have already lent out a copy to one of my antenatal clients, who went from being very set on hospital birth to choosing to give birth at home, which she did beautifully. A combination of positive education from different teachers in real life and book form. Such is the power of positive stories, and this book is full of them!

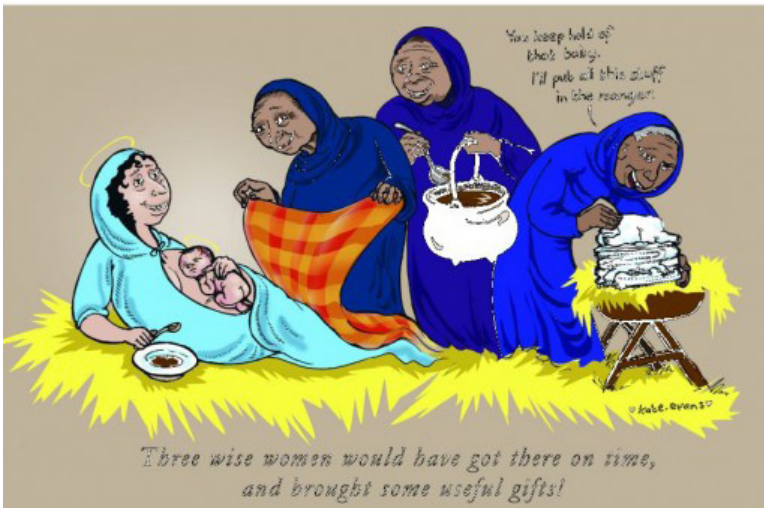
Reviewed for AIMS by Paula Cleary

AIMS Christmas Cards

Did you know that AIMS sells Christmas Cards? We have three in our range: a seasonal SnowMotherandBaby scene, a very popular nativity scene depicting the midwife being called away to the labour ward (!), and a wise women scene.

These high-quality cards are available in packs of 5, priced at £3 per pack. The messages inside the cards are 'Seasons Greetings' (inside SnowMotherandBaby and pink-edged nativity scene) and 'Merry Christmas and a Happy New Year' (inside the Wise Women card).

Buying our cards is a really easy way to help AIMS.



Order from *www.aims.org.uk/shop* and consider giving an AIMS canvas bag, mug or books for presents.

AIMS
There for your mother
Here for you
Help us to be there for your daughters

Join AIMS – Become a Member

AIMS has supported its work through membership since shortly after its founding in 1960. Membership is fundamental to our ability to undertake campaigns for improvements to the maternity services, produce the online AIMS Journal and birth information pages and to run the AIMS helpline. Until the end of 2017, membership was required to receive our printed Journals but since then the Journal has been available to all online, making it possible to share this vital information with a much wider audience. Although this removed the costs of printing and posting, membership is crucial to ensure that AIMS can continue its work to support women and their families to have a better and safer pregnancy and birth. By being a member of AIMS you are directly helping other women and families. AIMS is its members, and if you are also able to contribute your time to volunteer, you could make even more of a difference! *Click here to see our volunteers page.*

If you cannot afford the full amount then please contact us about a reduced rate; equally if you can afford more we will be very grateful to receive an extra donation.

Membership Options

- Annual Individual Membership £26 (£25 if setting up a standing order. You will be invited to join the AIMS discussion group and get involved with AIMS activities. We send you regular newsletters with updates about the AIMS Journals, campaigns and other information.

- Annual Organisation or Group Subscription £32 (£30 if setting up a standing order). You will be sent information about each AIMS Journal by email which you can distribute to your group or organisation.

Payment Methods

- Online: Become an individual member or set up an organisation or group subscription by clicking here.
- Standing Order: Please email membership@aims.org.uk sending a copy of your completed standing order form.
- Cheque: Please email membership@aims.org.uk to arrange to send a cheque.

Join the AIMS Mailing list

Members will get regular Newsletters, but if you don't want to become a member of AIMS, you might be interested in joining our mailing list. This will keep you informed of AIMS and other events that may be of interest, as well as information about AIMS Journals, books and website content. We may also include information about maternity issue and campaigns that may be of interest. You can sign up to the list *here*