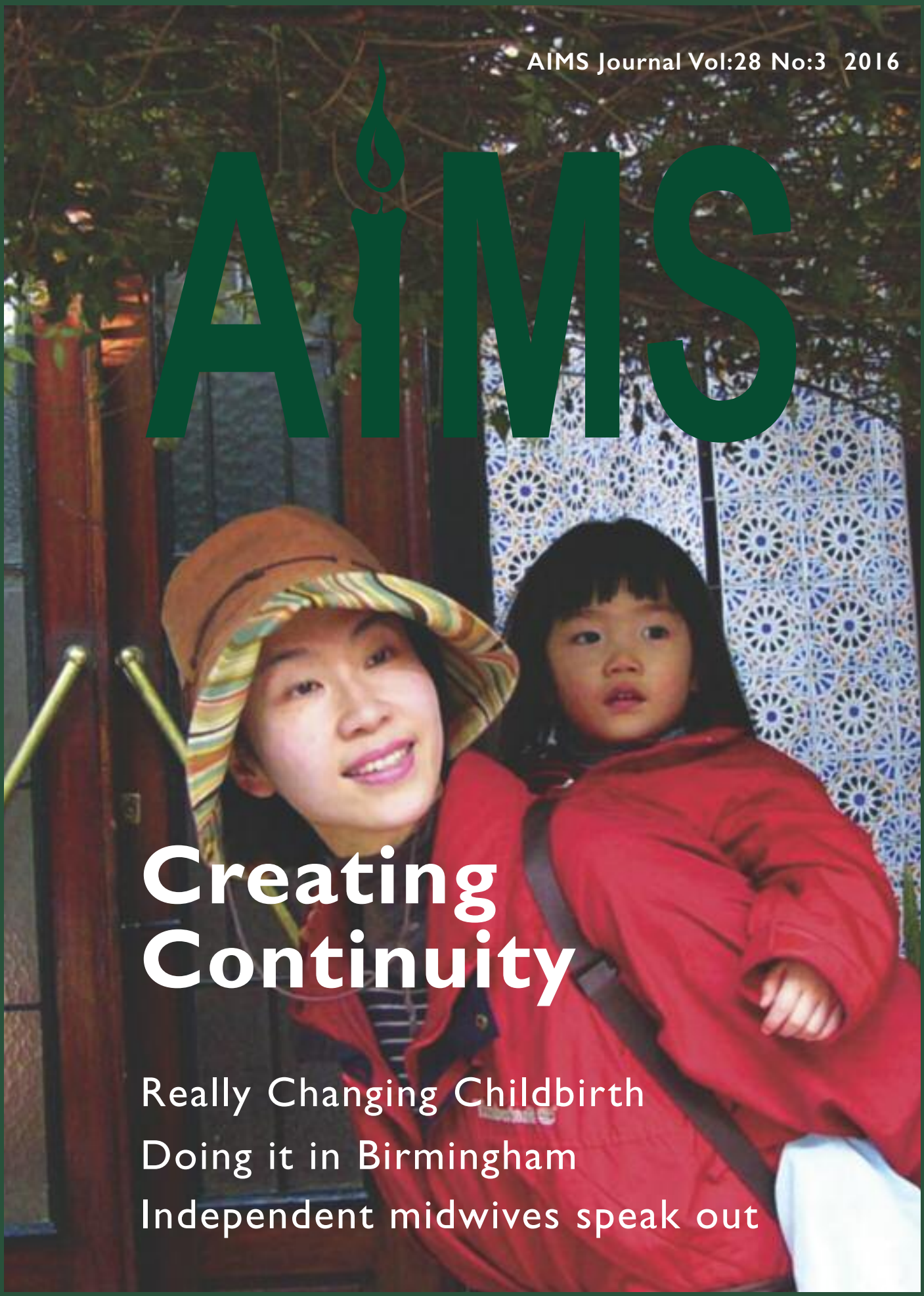
Association for Improvements in the Maternity Services

AIMS Journal Vol:28 No:3 2016

AIMS



Creating Continuity

Really Changing Childbirth

Doing it in Birmingham

Independent midwives speak out

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Diary

AIMS meetings

Saturday 21 November 2015, Cardiff

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

AIMS AGM and campaigning workshop

Saturday 24 September 2016
York

AGM 10.30 for 11.00 start

AIMS members only

Lunch 1.30 – 2.30

Please bring food to share

Workshop 2.30 – 6pm

Your chance to share experiences and to plan how we can bring about positive changes

(It would be helpful to let us know in advance if you plan to attend)

Please contact secretary@aims.org.uk for further information or if you wish to attend the AGM or send your apologies

Always check our website or contact us to confirm details as sometimes these change

ENCA Netherlands Symposium

Less is More
7 October 2016
Ede, Netherlands
With Ina May Gaskin, Debra Pascali-Bonaro and Raymond de Vries
for more details please email lessismoresymposium@outlook.com

Improving the Quality of Perinatal Mental Health Services

11 November 2016,
Hallam Conference Centre, London
Chaired by Elaine Hanzak
www.healthcareconferencesuk.co.uk/perinatal-mental-health-services-conference

Celebrating Continuity – Rhetoric into Reality, Policy into Practice

17 November 2016
Thackray Museum, Leeds

Following the successful event in London, AIMS, Neighbourhood Midwives, ARM, Positive Birth Movement, Sandwell and W Birmingham NHS Trust, with the support of RCM, bring you a second event exploring these issues.

Speakers include Baroness Julia Cumberlege, Kathryn Gutteridge, Lisa Common and Beverley Beech.

For more information please see www.celebratingcontinuity.org.uk

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

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AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

Vol:28 No:3
ISSN 1357-9657

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Printed by
QP Printing, London
Tel: 07593 025013

Cover Picture:
Akiko Kamura, carrying her baby Japanese style. See her article on page 13.

Contents

Pressing for change

Beverley Beech highlights some positive outcomes of AIMS campaigning

This journal issue highlights the crucial, central importance of continuity within maternity care with contributions from some of the people most associated with the campaign for excellent maternity services that include continuity of care and carer.

AIMS has argued for this concept for its entire 50 plus years. As well as arguing the philosophy, we also become involved in specific cases where the rights of women to make decisions about their own bodies and babies, and parents to make decisions about their children are called into question. In two recent cases the courts have ruled in favour of the rights of individuals.

The last journal highlighted the battle Jane Reeve had with Queen Elizabeth Hospital (QEH), King's Lynn and the Ombudsman's award of £1,000 in recognition of the hospital's failure to provide a home birth service (AIMS Journal,Vol 28, No2, 2016, p27).

The Ombudsman's final report made four recommendations to:

- make arrangement with neighbouring Trusts to provide the home birth service to those mothers specifically requesting it
- update the Ombudsman and Jane Reeve when the Trust have [sic] the home birth service re-instated or a suitable contingency in place
- apologise for the lack of choice available for the birth of her child
- pay a consolatory payment of £1000 in recognition of the failings

Mrs Reeve was overjoyed with this result: she felt this meant an end to the battle she had been fighting and freedom for other women to have the choice that should be available to them, however, she has yet to receive anything in writing from the NHS Trust QEH, and believes that women in the early stages of pregnancy are still being denied their choice of a home birth.

We have also been seriously concerned about events in Scotland, where under the provisions of the Children and Young People (Scotland) Act 2014 the Scottish government proposed a scheme whereby every child under 18 will have a responsible 'named person', such as a health visitor or teacher, who would be able to share information about the child and the family with a wide range of other people. Earlier this month our President, Jean Robinson, wrote to the Scottish Government about this provision asking, *'Where is the evidence for benefit, and lack of harm, from such a widespread and expensive intervention?'* AIMS also issued a statement (see www.aims.org.uk/pressReleases/namedPersonScotland.pdf for more information).

A group of charities and individuals launched a campaign, Say No to Named Person (No2NP – no2np.org), on the grounds that it would undermine parents' responsibility for their own children and allow state officials unprecedented powers to interfere with family life. No2NP appealed to the Supreme Court and on 28 July 2016 the Court unanimously overturned the provisions of the Act. Five judges, two from Scotland, determined that the Act was in breach of Article 8 of the European Convention of Human Rights, which guarantees the *'right to a private and family life'*. They announced that the Act had exceeded its powers by allowing public bodies to share personal and private information about children and parents without consent.

'The sharing of personal data between relevant public authorities is central to the role of the named person ... the operation of the information sharing provisions will result in interferences with the rights protected by article 8 of the ECHR.' (Para. 78). Because of the lack of safeguards the overriding of confidentiality is likely often to be disproportionate.' (Para. 100).

They concluded that,

'...the information sharing provisions of Part 4 of the Act are not within the legislative competence of the Scottish Parliament,' (Para. 106) and, furthermore, that *'...since the defective provisions are not within the legislative competence of the Parliament, they cannot be brought into force.'* (Para. 109).

The court said the aim of the Act, which is intended to promote and safeguard the rights and wellbeing of children and young people, was *'unquestionably legitimate and benign'*. However, *'The first thing that a totalitarian regime tries to do is to get to the children, to distance them from the subversive, varied influences of their families, and indoctrinate them in their rulers' view of the world. Within limits, families must be left to bring up their children in their own way.'* (Para. 73)

They also quoted a US Supreme Court judgment that states that, *'the child is not the mere creature of the state'*. (para 73).

The Supreme Court has invited the Scottish government to respond with proposals on how the legislation might be amended to make it compatible with article 8 – within 42 days. Worryingly, the Deputy First Minister and Education Secretary, John Swinney, insisted that an amended version would be *'implemented nationally at the earliest possible date'* and that the Scottish Government was *'absolutely committed'* to the policy and in the meantime, NHS England is forging ahead with their proposals for a national database. There is still a great need for vigilance despite the very welcome stance taken by the courts. We feel strongly that while children and all vulnerable people deserve protection that the best way to ensure this, for almost everyone, is not through authoritarian surveillance but by allowing and encouraging long-term, respectful and trusting relationships to develop between people and their professional support.

Beverley A Lawrence Beech

The future of maternity care

Julia Cumberlege talks about choice, safety and continuity of carer

When Changing Childbirth was published in 1993 there was little research concerning maternity services compared with today. We should be so grateful to the NPEU and other research centres who have found this an interesting and productive area. We are indebted to all those academics, research midwives and obstetricians who have provided us with robust evidence on many aspects of maternity care. They have worked tirelessly to provide us with the credible information we need, not least concerning continuity of the health professional looking after a woman and her baby(ies).

So much has changed in 25 years regarding society, the advances in conception with IVF a possible choice, the age of mothers giving birth, the condition of their health, the management of labour and the newborn, and so on. Nevertheless some things are so fundamental that they should not be cast aside as being old fashioned and no longer relevant. One such is the relationship and trust between the health professional and the woman.

Better Births, the most recent review of the future shape of maternity services in England, published in March this year, has not revisited Changing Childbirth since it is in the past and we must go forward. However, continuity of carer is one of those fundamentals that has emerged again and this time we have not only the obvious presumption that it provides safer care and enhances the woman and her partner's experience, but we have the evidence to prove it.

Throughout the extensive public engagement we undertook, women and their families told us they wanted to know the health professional, usually the midwife, who cared and advised them throughout their antenatal period, the birth and post-natal care. Continuity of carer was a major factor in ensuring they had a good experience. This is not rocket science. Surely it is obvious that in one of the most challenging experiences she will undergo she will want continuity of carer to help reduce any potential trauma. Relationships are crucial and not only for the woman and her family but for those professionals looking after her.

One woman told me she had encountered 42 people throughout the months before, during and after the birth. Others have told me how they were so weary at having to give the same information time and time again wasting everybody's time. The most poignant was the person who told me when asked how her first baby, born two years ago, was thriving now as a toddler, had to explain to so many different people that her baby had died soon after birth. She dreaded this inevitable conversation as she knew her notes would not have been read. Reading notes and sharing information is essential to ensure that women have a better experience and a safer birth. Women and midwives told us the notes are now so comprehensive, (and there is a question about if they really need to be so long and deep) that midwives who are busy have not got the time to read them before they see the woman. To this end one of our recommendations in Better Births is to introduce electronic records to be held by the woman and shared among professionals, with her permission. The childbearing generation of today are increasingly savvy and competent with new technology, many will tell you they have their lives on their smartphone and are amazed that the NHS is still in the last century.

In the Models of Care Workstream Soo Downe told the review team that prematurity is on the rise and millions of pounds are being spent on research to reduce it, but we already have a solution – continuity of care reduces prematurity by over 20%.

Jane Sandall et al 2016 in their research,[1] which was published in January this year, identified 15 studies involving 17,674 mothers and babies. It included women at low risk of complications as well as women at increased risk, but not currently experiencing problems. All the trials involved professionally qualified midwives and reliable methods were used to assess the quality of the evidence (no trials offered models of care that offered home birth). It showed fewer women had an episiotomy or instrumental birth when they had continuity of carer. Women's chances of a spontaneous vaginal birth were also increased and there was no difference in the number of caesarean births. Women were less likely to experience preterm birth, and they were also at a lower risk of losing their babies.

we know the value of continuity and that it is a type of care women would choose

So we know the value of continuity and that it is a type of care women would choose if it was generally available on the NHS; so far so good. But the crunch issue is not the 'what' and the 'why' but the 'how'?

Twelve hour shifts are the norm, but they are not sacrosanct, indeed they are a relatively recent development. We only have to look to Holland to see the success in community nursing of self-organising community nursing teams, where long shifts are long forgotten.

Research

Evaluation of satisfaction with care in a midwifery unit and an obstetric unit: a randomized controlled trial of low-risk women

Stine Bernitz, Pål Øian, Leiv Sandvik and Ellen Blix
BMC Pregnancy and Childbirth
DOI: 10.1186/s12884-016-0932-x
Published: 18 June 2016

Abstract

Background

Satisfaction with birth care is part of quality assessment of care. The aim of this study was to investigate possible differences in satisfaction with intrapartum care among low-risk women, randomized to a midwifery unit or to an obstetric unit within the same hospital.

Methods

Randomized controlled trial conducted at the Department of Obstetrics and Gynecology, Østfold Hospital Trust, Norway. A total of 485 women with no expressed preference for level of birth care, assessed to be at low-risk at onset of spontaneous labor were included. To assess the overall satisfaction with intrapartum care, the Labour and Delivery Satisfaction Index (LADSI) questionnaire, was sent to the participants six months after birth. To assess women's experience with intrapartum transfer, four additional items were added. In addition, we tested the effects of the following aspects on satisfaction; obstetrician involved, intrapartum transfer from the midwifery unit to the obstetric unit during labor, mode of delivery and epidural analgesia.

Results

Women randomized to the midwifery unit were significantly more satisfied with intrapartum care than those randomized to the obstetric unit (183 versus 176 of maximum 204 scoring points, mean difference 7.2, $p = 0.002$). No difference was found between the units for women who had an obstetrician involved during labor or delivery and who answered four additional questions on this aspect (mean item score 4.0 at the midwifery unit vs 4.3 at the obstetric unit, $p = 0.3$). Intrapartum transfer from the midwifery unit to an obstetric unit, operative delivery and epidurals influenced the level of overall satisfaction in a negative direction regardless of allocated unit ($p < 0.001$).

Conclusion

Low-risk women with no expressed preference for level of birth care were more satisfied if allocated to the midwifery unit compared to the obstetric unit.

The Buurtzorg system of Neighbourhood Care is truly impressive. It was started in 2007 with one team of four nurses. Today they have 9,500 nurses working in 850 independent teams with 45 staff in the back office (Chief Executives eat your heart out) with two Directors and 16 coaches. The coaches are important as they will advise and help those teams which have relationship problems within the team. The nurses care for 70,000 patients using electronic tablets in the patient's home. Writing up the record of the visit takes around 20 minutes and the notes are agreed by the patient. Clinical problems are referred to the appropriate clinical professional quickly and efficiently. Patient satisfaction scores are 30% above the average for traditional community nursing.

On our visit and quoted by others, is the power of the autonomy the nurses enjoy. They have the freedom to always put the patient at the very centre of care without top down direction or inappropriate management systems. They organise their diaries to fit with their lives and their patient's needs. Burnout is a myth. Recruitment is not a problem and sickness rates among the nurses have fallen by one third.

Of course maternity services are different from community nursing and Holland is not England but surely there are some good lessons to be learnt?

Not for a minute do I think continuity of carer is easy or can be done overnight, since it requires a complete rethink of the way we organise current services. Neither do I think it is too difficult or can be left on the back-burner. I know there are some remarkable midwife leaders in our service and this is a call to them. I also know there are midwives who are leaving the profession, disillusioned and sad to be leaving a service for which they trained and loved. In addition there are well-trained young midwives or those in training who cannot believe the way they are being treated. The phrase I hear too often is *'I love the work – I hate the job'*.

With labour wards working at, or even above, 100% capacity, with more difficult births, with many staff who are giving up and others who grit their teeth, knowing they have to keep going in a service that is unsustainable, we have to think differently, be creative and use imagination.

The two major themes running throughout Better Births are choice and safety. Continuity of carer is essential to achieve these twin goals, if we are to achieve safer and better births with the woman, her baby and her family at the centre of care.

With such compelling evidence continuity must be implemented to provide a safer service giving satisfaction to women and midwives alike.

Julia Cumberlege
Independent Chair
National Maternity Review

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Building together

Kathryn Gutteridge talks about what happens when women and midwives work together

As a midwife for some years now it is obvious to me that the greatest professional successes I have been involved in are because of the women who joined with me. If I reflect upon this then it is obvious that I have listened correctly to women's voices and joined with them in a journey to fulfil the work.

At the moment there appears to be a groundswell in maternity services supported by some key events that have raised issues around quality and safety. Morecambe Bay[1] demonstrated how a service could lose sight of those important features by not listening in earnest to families and therefore failing the very people they were supposed to care for. The recent Maternity Review[2] was commissioned to listen to families and to find out exactly what a high-class service should look like and how families should be at the heart of the process.

My view is that maternity care has suffered from many things, but one of the greatest failings is the lip service it pays to involving women and their families. For many years now there has been a requirement to involve patients and the public in health systems, this is no different in maternity with Maternity Services Liaison Committees being an example. However, as with many health agendas, there is a lack of understanding and clarity of how and who should deal with this.

History has also highlighted the impact of not involving people in their own care

If we look at the origin of the 'person-centred' approach in healthcare back in the early 1990s a change in perspective emerged. The Patient's Charter[3] then took this further and set out a number of rights for patients, including maximum waiting times and the right to have a complaint investigated. History has also highlighted the impact of not involving people in their own care. A successive number of reports commissioned, as a result of adverse events in health and social care, have concluded that in the majority of cases significant harm could have been prevented and financial cost saved if organisations had listened to those in their care.[4,5]

Maternity care is certainly considered to be a high risk area of health, as supported by the publication of Ten Years of Maternity Claims – An Analysis of NHS Litigation Authority Data.[6] The report showed that litigation overall had increased and the commonest areas of deficiency had an underpinning thread of failing to listen or involve women in decision making. Therefore, if women are turning to lawyers to find a voice, it would make absolute sense to involve women right at the start of changes or service development.

Where women and midwives work together a strong foundation is made with a certainty around the philosophy of care. When developing any service provision a great deal of work should precede this, with a focus upon local women and families. If the service to be developed is a midwife unit in a busy urban city then research has to include significant elements that need to be addressed prior to any physical work.

To ensure that the service is bespoke, and fits the women it is intended for, a consultation should be started with a wide spectrum of reach. This should encompass all aspects of the service proposal and comprise detailed questions that are to be addressed. A consultation should begin with a project plan that has a time frame and key objectives to fulfil; there should also be a governance framework that monitors the progress of this work.

Using social media to both advertise the consultation and collect opinions is a very easy way today to engage with women's views. This method can produce a large volume of data. However, it is important not to rely purely on electronic opinion.

Example of some key questions:

- What is the cultural diversity of service users?
- Who is the midwife unit for?
- Where will the midwife unit be situated?
- What transport links are established?

Ways of Reaching Women

There are many ways to conduct a survey or canvass opinion when a change is proposed, but the drivers should come from the women. If there is a steering group then this should include representatives from the women's community. This will ensure that throughout the development phase all of the information is validated by women. There should be a variety of events/methods to capture information which will inform the philosophy of a new service. This ensures the service is underpinned by systems and processes to suit local women. There are a few suggestions of how this may be done.

Birth Stories Listening Group

When women have given birth they will have a story to tell. This may have valuable information that can be fed back to midwives and doctors alike. In addition to this it gives women a voice and a platform in which they are heard. It is important to understand that many of the

stories will include difficult narrative but the essence is facilitation that does not evoke emotion one way or the other. It may also be useful to video these stories, with the woman's permission, so that messages can be shared throughout the service.

Targeting Groups

Working with a specific group of women gives the consultation team opportunity to collect views from less representative groups. These target groups may be young parents, women with mental health illnesses or socially deprived women. As you can imagine all of the suggested groups will have their own needs and birth outcomes. For instance, if working with young parents, it is a good idea to engage with both parents. Using a specialist midwife to access these groups is an option. For example, when developing Serenity Birth Centre, a young mother's afternoon was held with a team of midwives. The young women used the opportunity to see a range of birthing equipment and environments. All of their comments and ideas were captured for use in planning the service. In addition to this a young father's evening event was held, supported by a project worker from the local community. This was a great success where the young men were able to state what was important to them at the time of birth and their involvement throughout the childbearing episode.

If there are specific ethnic communities then this has to be investigated as part of the consultancy plan. In Birmingham there are many such communities, one example is the Somalian community. It is essential that respectful enquiry is made through community organisations and that a key worker is involved. This makes access to community members easier and again is vital in establishing a relationship of trust. In the consultation work to develop the Serenity Birth Centre it became obvious that Somalian women did not want to book at the maternity unit. When meeting with the Somalian Women's Group it was discovered that they felt misunderstood, that they were afraid of having caesarean sections and that they were also not in favour of other birth interventions. Once again a listening event was organised, with women sharing their birth stories and experiences. It was clear that we had not met the needs of a significant group of women.

It proved very useful to engage with community elders. As project lead I can remember thinking that if we could show the elders of the community the benefits of midwife-led care then the job of convincing women would be so much easier. In this case I managed to be invited to several mosques and holy buildings. I met with both women and men in respected community roles. I asked them how I could reassure them about the benefits of a midwife for most women and I learnt some valuable information.

The elders told me that many families still upheld the traditions of their birth countries, even though on the face of it young women and men were living thoroughly westernised lives. I heard that families were keen to educate their children to achieve greater potential but that in itself became a conflict when the child challenged the family values. I gave the elders the principles of what safe midwife care could achieve and invited them to a tour of the unit to explain how interventions might cause problems. This small piece of work had boundless consequences. The elders generally influenced every family within their religious community and they were able to reinforce the new pathways we were hoping to introduce.

a model of care that was designed to meet our families' needs

Conclusion

It is fair to say that there is no prescription to this process. It is repetitive and region specific. However, there are some rule of thumb principles that should be applied.

- Know your community groups
- Influence the groups that hold the power
- Listen to the messages that women tell you when they have used the services
- Find out what the families need

In the overall development of both Serenity and Halcyon Birth Centres the consultative work led to a model of care that was designed to meet our families' needs. This was derived from women and families at different stages of their childbearing and life course. The main themes to emerge were that women wanted to have a clean, safe environment, a midwife who was kind and that their family was cared for too.

Not a great deal to ask for.

Kathryn Gutteridge
Consultant Midwife, Clinical Lead for Low Risk Care, Doctoral Student, RCOG Undermining Champion for West Midlands
(see www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/faqs/)

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Continuity of carer

Brenda van der Kooy explores the real barrier to implementation

The new National Maternity Review Report Better Births – Improving outcomes of maternity services in England[1] identified that continuity of carer is what is required to make a safer, personalised maternity service.

Over twenty years ago Changing Childbirth[2] called for women to have '*Choice, Continuity and Control*' and many pilot projects were set up with the hope these would be rolled out across the country. Yet today very few women receive care throughout pregnancy, birth and the post natal period from a known and trusted named midwife working in a small team. So what is the barrier to successfully changing the current fragmented midwifery care provision to a case loading model which provides continuity of carer? The answer is the underlying funding structure.

Burn out, the on-call commitment and difficulties with ongoing recruitment and retention of midwives on case loading teams are the most common reasons cited for the failure of caseload midwifery schemes. However, when examined closely these all stem from lack of funding.

Currently where the few continuity of carer models do exist they are expected to function within budgets based on income generated from the maternity tariff. To achieve this they rely on unrealistic demands put on midwives such as increasing maximum caseload numbers beyond 28-30 women per midwife per year (full time equivalent posts) plus back up for another 28 – 30 women, failing to remunerate midwives for the on-call commitment case loading inherently involves and requiring them to plug gaps in other areas of the service when required. This results in burnout, discourages other midwives from working in this way and is not mitigated by the increased job satisfaction midwives experience from knowing their caseload of women.

If continuity of carer in the maternity service is to become the norm instead of the exception more money needs to be invested upfront to achieve a sustainable roll out of caseloading models.

However, compounding the whole funding of maternity service issue is the fact that the existing tariff does not cover the actual cost of the current maternity provision. The House of Commons Committee of Public Accounts 2013/14[3] identified that NHS Trust providers of maternity care have to subsidise their maternity services from other more profitable departments within the organisation. This of course is not an option for midwifery only providers, as they don't have other profit making services available to them.

According to another new report Relationships: the pathway to safe, high-quality maternity care, from the Sheila Kitzinger symposium at Green Templeton College, Oxford,[4] current evidence suggests continuity of carer has a cost-neutral effect. In other words, it costs no more to provide than the current fragmented system of maternity care because it saves money from improved outcomes. It acknowledges, however, research is very limited on the financial savings from many other known improved health outcomes that comes from continuity of carer such as reduced preterm births. Where the research does exist, for example, improved breast feeding rates, it is impressive and amounts to millions of pounds of savings annually.[5] So the true situation is that continuity of carer will save the NHS very large sums of money indeed.

So the funding structure requires a shift of resources to invest in midwives to provide continuity of carer to achieve improvements in outcomes for mothers and babies and realise the huge short, medium and long term savings that it will generate. In order to protect scarce financial resources, it will be essential to ensure continuity of carer is measured as an outcome and payment to providers is attached to achieving this. This will provide an incentive for all providers to innovate to develop their own continuity of carer models that work for them and their midwives.

Failing to address the maternity funding structure to enable continuity of carer to be rolled out across the country is no longer an option. It is denying mothers and babies of improved outcomes and birth experience, wasting precious NHS resources and failing to achieve the huge savings from improved health and wellbeing of the future population.

Brenda van der Kooy

Brenda is a registered nurse and midwife and active campaigner for continuity of carer

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A much needed revolution

Mavis Kirkham explores some of the fundamental changes required for continuity

Don't underestimate the change required to achieve care grounded in relationships.

Continuity of midwifery carer results in good outcomes for mothers and babies and it is good for the midwives who provide that care.[1] The Cochrane review based on 15 trials and involving 17,674 women found that women at high and low risk of problems around childbirth who received continuity of midwifery care were 24% less likely to experience preterm birth, 19% less likely to lose their baby before 24 weeks gestation and 16% less likely to lose their baby at any gestation, when compared with women receiving medically-led or shared care. Women receiving this care also had fewer caesareans, more spontaneous vaginal births, fewer antenatal admissions, shorter postnatal hospital stays and their babies had reduced neonatal admissions.[2]

The positive spiral

Continuity of carer creates a virtuous spiral of relationship. Women get to know their midwife and, as trust develops, they feel increasingly able to discuss their worries with her. They feel safe in the familiar relationship at the centre of their care. Feeling safe produces profound changes in blood chemistry: the adrenaline surge produced by the threat of white coated strangers administering tests to women who feel they are on a conveyor-belt is replaced by the oxytocin enhancing experience of feeling nurtured and befriended.

Midwives invest time in learning about their clients and their problems because they will be providing future care and can be of ongoing help to them. These midwives' loyalties focus therefore on their clients and the small team of colleagues with whom they work.[3] This gives midwives job satisfaction and protects them from the uncertainties and fear associated with playing a small role in a large organisation where bullying and constant movement are normal. It also creates a community of practice which fosters learning.[4] Thus midwifery care can flourish and midwives can feel safe in their chosen area of work, rather than constantly meeting new clients and being threatened with being moved to other areas of work. Where midwives feel safe and protected from organisational threats they are thereby protected from frequent adrenalin surges and are rewarded with higher levels of oxytocin. Between carer and client oxytocin levels are highly contagious, thus the virtuous spiral continues. Even in emergency situations, the female responses of 'tend and befriend'[5] can be prioritised.

Obstacles and Contradictions

Prematurity and stillbirth are identified as major problems in this country. Research also shows birth by caesarean section to be linked with major non-communicable diseases in later life.[5] Given the positive outcomes outlined above, it is logical to assume that continuity of midwifery care would be welcomed and rapidly implemented as an important answer to major health problems, especially as this has been Department of Health Policy since 1993.[6] Yet this is not the case.

Relationship based midwifery care does not fit with modern NHS values and philosophies. It has often been said that if continuity of midwifery care was a drug it would be unethical not to give it to all childbearing women. As it is not a drug, no-one makes a profit from it and no multinational drug company has an interest in spending vast sums on advertising its good outcomes. Partly because of the efforts of the companies which produce drugs and technological innovations, such products are purchased and used to try to improve health outcomes. Staff costs, on the other hand, are seen as overheads which should be steadily reduced. Yet birth is about relationships and it is relationships which sustain people through major life events. Thus we see a major contradiction between the economic values of our society and its health services, and what we know works around birth.

Within the dominant mindset, efforts to counter prematurity and stillbirth seem still to focus on intensive monitoring of mother and baby and the search for a technical intervention, rather than seeking to foster the environment which best supports mother and baby together.

Centralisation, standardisation and market economics have been the dominant concepts in maternity care over recent years. Organisationally, NHS maternity care has been centralised into large units based on an industrial model where care is highly fragmented. Standardisation of services is seen as the way forward. The contradiction with the rhetoric of maternal choice is largely ignored. Indeed we have the ridiculous situation where, should women choose to decline some aspects of care, the midwife is likely to find she cannot proceed to the next computer screen which records the consultation.[6] NHS management thoughts seem to be focused on ever closer control of the workforce through prescriptive policies, guidelines, protocols etc, though wider management theory emphasises workers using their skills to the full and exercising the autonomy which links with job satisfaction.[7] Ironically many midwives leave midwifery because they cannot practice as to the best of their ability and make full use of their professional judgement.[8] At management level, there seems to be a fear of trusting midwives to do midwifery and to organise themselves in a professional manner. Yet, in other settings, this can work well with fewer managers and more clinical workers.[9,10]

Beyond the economic and management values that block efforts to implement continuity of care, I think there are deeper issues concerning power. Care based on technology and drugs makes women into patients and

staff into the active players around birth. For all the rhetoric around client choice women and midwives experience there is great pressure to go with the flow of the current model of care.[11] Where supportive relationships can develop, women feel safer and stronger and a good birth is the making of a strong mother. This is not the way to create compliant patients or consumers. Where midwives' loyalty is to their clients they will advocate for those women rather than being a compliant workforce. An alliance of stroppy women and stroppy midwives is not part of the script for the NHS in times of austerity, cutbacks and managerial dominance.

continuity of carer would not cost more

Money, fear and coping in the short-term

Research suggests that continuity of carer would not cost more because of shorter hospital stays and fewer tests and interventions[12] and because the flexibility of such care can match the input of midwives time to women's needs.[13] The long term savings resulting from the prevention of prematurity and later diseases have never been examined. NHS management is under great pressure to save money in the short term and we therefore see caseloads in existing continuity schemes increased to the point where the midwives involved can no longer provide good care and where their own health is threatened. Under such pressure neither management nor clinical midwives can plan for long term health improvement.

Women and midwives report fear and bullying within NHS maternity services as currently organised. With continuity of carer and small teams of self-organising midwives, this could change in a very positive direction. With the will to change, this could improve the wellbeing of all concerned and save money. Where does the will to change come from?

Major Change is Needed

So the introduction of continuity of midwifery care is not just a matter of organisational adjustment. It is a major change in the way care is organised and in the culture and values which underpin that care. The interests of the producers of drugs and technical equipment are dominant, so we spent vast sums electronically monitoring babies' heartbeats in labour and booking women for birth in obstetric units in the face of the research evidence that this is not in the best interests of most of them. We do not implement research which demonstrated the effectiveness of care grounded in relationships. It is evident that the values that underpin commercial organisations are not the right values for public services.[14,15] Midwifery and birth are rooted in relationships which flourish in a context of generosity yet the organisational context is one of meanness, doing more for less cost and these values are at the heart of government policy for the NHS.

With successive cuts in services, midwives battle on trying to provide good care but many are so overstretched with just coping that they cannot contemplate long term change. The culture of the service supports the status quo and this is reinforced by fear. As an innovator in a very different area of health care observed '*Culture has tremendous inertia… Culture strangles innovation in the crib.*'[16] Managers are required to '*internalise the market*'[17] and it is a rare midwifery manager who has the vision to look to the long term or who retains true midwifery values. These wonderful women are often bullied by general management.

Management values centralise, standardise and cut staffing. Yet we have the evidence that, for birth, small is beautiful, relationships are of crucial importance and, where relationships can develop, outcomes improve for all concerned. Change won't come from the vested interests within maternity services, or from tired and oppressed midwives. It will take tremendous pressure from outside the system, then an alliance can be built with midwives to bring about this much needed revolution.

Mavis Kirkham

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Time to stop fighting?

Vicki Williams asks us to think about doing something really radical

I am not asking anyone to roll over, play dead, or accept the path of least resistance; I'm proposing an alternative way of getting what you want.

This issue of the importance of continuity highlights a paradox at the heart of our work in AIMS, which is our awareness that encouraging women to fight for the birth they want especially late in pregnancy, means that the resulting stress hormones can potentially not only delay and disrupt the birth process but lead to the very outcome they wish to avoid. In our journal, our website and our helpline we try to help women to access the information they need to make the decisions which will give them the best chance of a healthy pregnancy, a birth that they will remember with feelings of joy for the rest of their days, and a sense of accomplishment and empowerment that will give them the optimal start to motherhood.

Government policy expects women to be offered a choice of place of birth and confirms the right for a woman to make informed decisions on how where and with whom she will have her baby, but often this gets lost in the service that is actually offered. Within AIMS we are very conscious of the need to fight for women's rights but also of the importance of creating the right environment for pregnancy and birth. I am advocating that we continue to fight for rights and high-quality, evidence-based care at an organisational level in the public arena so that women don't have to fight these battles as individuals. At the same time we need to forcefully draw attention to the importance of continuity, so that ideally the carer can become the woman's advocate.

Sarah Buckley,[1] Kirstin Moberg and Michel Odent, along with many others, point out that adrenaline (our fight or flight hormone) and its stress counterpart, cortisol, are the antithesis of oxytocin, the hormone of love, healing, growing, calming and social connection. If that is the case, then anyone supporting pregnant women has a moral duty to help her reduce her stress levels and boost her love levels. That includes helping her to get the care that she needs without her having to fight for it or embark on the kind of research project worthy of a PhD, and in doing so spend her pregnancy in fight or flight mode instead of growing and healing.

Pregnancy should be a time of joy, expectation, planning, preparation, but for so many women it is anything but. There is plenty of evidence, mainstream allopathic, holistic, spiritual, for us to be able to say with confidence that stress in pregnancy is neither good for babies nor their mothers, and for that matter maternal well-being is likely to have an impact on other children within the family, the mother's intimate relationships, her relationships with her wider family and community. Put simply, pregnancy is not the time for fighting for what you want, and perhaps it is time that everyone, but especially the birth activists and care providers, actively supported women to stop the fight.

The evidence is clear, all the articles in this issue reflect that what women are asking for is a birth where they are well supported by carers of their choice, where they are able to determine what happens to them and their baby, where interventions are kept to a minimum and where social, emotional and hormonal disturbance is avoided. This kind of care is safe for babies and safer for the mothers who will care for them.

As it is very difficult to support emotional health for a child when you yourself feel battered, I would argue strongly, despite the fact that there is a dearth of studies looking at emotional health, and particularly the levels of postnatal depression and post-traumatic stress, that in the long-term an empowering, woman-led birth experience is also safer for children. Whilst it is becoming very clear that birth in a midwife-led unit is safer for babies and women,[2] it is vitally important that we also consider those women and babies for whom intervention or planned surgery is going to improve their chances of life or quality of life, and make sure that those women also decide what is and is not done to them.

With that in mind, I favour sharing Mary Cronk's assertive stuck record approach[3] rather than encouraging women to engage in battle. Teaching women how to calmly repeat their intentions and how to deflect negativity are arguably the most important tools we have. When coupled with techniques for improving women's confidence in their bodies and trust in the process, whether that is by education, techniques such as hypnotherapy or NLP (neurolinguistic programming), or something else, assertiveness is more powerful than arguing your case or trying to present enough evidence to professionals who really ought to have read it for themselves.

It is up to everyone to press hard for change, to educate, to ask questions and highlight research so that those who are pregnant simply don't have to.

Vicki Williams

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Continuity of mothering

Akiko Kamura looks at the enormous benefits of Japanese baby carrying

Every aspect of our lives has become so convenient, yet so commercial, and it's getting harder to maintain a healthy motherhood.

Have you ever tried knitting while carrying your baby on your back? Some people say, *'Yes, it works better when you stand up and rock, the nice thing is you actually give your baby the most heavenly moment. It must be a completely different feeling from being left alone in a cradle!'* The experts warn that it's essential to learn how to carry a baby correctly on your back. Carrying your baby in a high position (see photo opposite) is key; experts report that it doesn't damage the spine, as long as they carry the baby at the height that allows them almost to face baby directly. Most babies are very happy in that high position because they can watch what their caregivers are doing over their shoulders.[1]

This form of Japanese baby carrying is called **onbu** and it's different from the Western style derived from Africa. The baby is not carried on one's hip – instead it is carried on the upper part of one's back. It is said that when the lower body is evenly grounded by the weight of a baby, a mother can stand in a healthier way; she improves her sense of core and her spine is nicely aligned. In short, when we focus on our lower part it becomes easier to release ourselves from our head and be more intuitive.[1]

It takes time for you to feel comfortable with your baby on your back. It can be strange at first to get used to knowing how your baby is without watching: it's actually nothing special. Just like you used to try to sense where your friend was hiding herself when you played hide and seek, we can extend our awareness around our surroundings wider and deeper than we realize.

It's important that we don't interfere too much and we respect our babies' own time and space, babies can look up at the blue sky, or choose to learn by carefully watching you cook and knit. Children acquire social norms by watching what the caregiver does over their shoulders. They don't have to check the caregiver's expression or to ask permission. They don't need to know what the caregiver likes about the world or doesn't, which risks giving babies too much bias in exploring things. Onbu is a gentle, more open approach, which enables mothers and babies to become free.

In developed countries, our kids tend to be considered small adults and brought up with strict rules and discipline and mothers may feel constantly distracted by their children. Their mind is always preoccupied by worrying about their babies who are a certain distance away in a cradle, on a bed, on a sofa, on the floor, in a push buggy or in someone else's hands (like a baby sitter). However, if a mother can trust and feel comfortable that her baby is safe on her back, she is less likely to be stressed, and caregivers actually gain their own personal

space in the front part of the body. Yes, keeping a baby on our back stretches our ability to trust, but it's beneficial for both a baby and a mother, as I will explain later. The baby feels protected while the mother creates her own, non-disturbed zone. I don't mean to suggest a baby is disturbing, but we all need our personal space sometimes, right? Can you do your knitting while you carry your baby on your front?

Makiko Saito,[2] states that *'once we re-integrate the ability to sense things by focusing on our back, "a spinal sensor", we become so grounded that we are no longer bothered by subtle things, like comparing your child-rearing with that of other people. I believe that keeping an energy balance between the front and the back parts of the body is the best condition for motherhood. Within a sustainable balance between front and back you can make the best decisions for your children. A mother's front tends to be more occupied for longer as baby needs mother's milk anyway.'* That is the biggest reason I wrote this article. I want to invite people to bring more awareness to their backs, for better energy use. I believe keeping an eye on balance is important, if one part of your body is always busy then you can allow that part to rest while using the other part.

I am not saying everyone should use the piggy-back technique. This is just an invitation to create more space, more time, and more ways of communicating between babies and their caregivers. It may be a new approach for you but why not give it a try and see how your back can be warmed by your baby while the energy level at the front will be calmed. I know from my personal experience that this is indeed true. As you keep your baby on your back everything becomes much easier, soon you instantly know if your baby is about to sleep or is getting a temperature; by sniffing I could easily find out if my daughter was wanting to do a poo soon and by

sensing the movement I got that she needed a wee. So, when you read your baby's condition with your back's sensations, you may find you are trusting and relaxed, able to concentrate on some complicated handwork, perhaps filleting fish with a sharp knife. Another great thing about it is that your baby can learn from watching what you do and even learn how to cut fish properly (see photo above of a baby watching carefully how to cut fish). There is no doubt in my mind that a mother's back is one of the best spaces for a child to learn new things about our world.

I once saw my mother-in-law teaching my daughter over her shoulder. One summer day, my mother-in-law was carrying her granddaughter on her back and my baby was reaching out her arm to a green tomato. My mother-in-law gently, but very quickly, caught my daughter's small hand and invited her little fingers to pick a maturely red tomato. I was very inspired by watching the scene. It was done in the twinkling of an eye! And she managed to teach one important rule by using the experience of an actual movement. She was not facing my daughter but she softly guided her small hand to pick the right one instantly. My mother-in-law said to me later *'She still doesn't speak yet so we will have to be careful. It's all about timing. Introduce each new thing at the right time for your baby. How you teach them for the very first time is crucial. Remind yourself not to think too much in your head.'* I think what my mother-in-law was trying to convey was about distance (physical, symbolic or emotional). If a caregiver and a baby are inseparably attached, there is minimum distance and maximum time. There is no need for words to explain the reasons when you can easily direct the situation by your actual movement. I wonder when we lost the way of intuitive childrearing. Masayo Sonoda points out that Japan imported many child-rearing methods and 'commodities' from North America. There were three major elements that had a huge impact: The first one was a child-rearing practice to discourage babies from wanting to be held in order to be happy. Before the end of WW2, parents never ignored crying babies and always slept with their babies in the same room. The second one was the aggressive introduction of artificial milk. The third one was childbearing at institutions, a radical shift from home birth to hospital birth. These three major elements drastically changed the environment of childbearing and childrearing. Onbu culture, however, in recent years has been being reclaimed and the first onbu conference was held in Tokyo in 2014 and 2015. So, onbu re-emerges as a 'new' traditional mother-baby bonding style.

Lastly, Makiko Saito, one of the most influential birth educators and an Onbu expert, mentions the benefits of onbu. She has seen, over the last 20 years, that babies who have been carried are less likely to get hypothermia; have healthy abdominal conditions and show an incredible ability to hold onto their whole body sensations. Because a baby itself has to cooperate with caregivers to be carried the baby naturally develops a sense of balancing and holding which creates a strong core and a sense of healthy emotion, such as compassion and cooperation to work for one purpose.

Compared with 10 years ago in the UK, I joyously noticed, on buses, trains and in the park, many young parents had already started to keep their babies on their front (with slings and wraps). Babies are super happy being attached in any mode you prefer.

There will be so many reasons for us not to carry our babies too. Some are because of the stigma attached to the mothers having their babies on their back who might be seen as coming from a poor family background, immigrants or someone coming from 'outside' of the society. It's sad because having a baby on us has immense possibilities. It doesn't cost us anything and we can unconsciously bring our awareness to the other's feeling and other's sensation. We call it 'compassion' and it's a basic need of our human society. We express the attitude of knowing the others as 'reading the air'. Knowing others by a subtle movement or tone of the voice or verbally unexplainable sensation requires experience.

Mutual compassion is so needed in our society today. It sometimes seems as if we have completely forgotten to take care of others; 'feeling' a baby is taking care of the others and 'being' with a baby is an invitation to integrate ourselves into peaceful transition, *'My spine has become a sensor!'* exclaimed those mums who enjoy their 'onbu' lifestyle. They wink and add, *'you can do almost everything at your own pace while taking care of your baby. Isn't it great?'* If we can cultivate our inner core to 'sense' our babies we may never again use the excuse that we have no time for knitting!

Akiko Kamura

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Serving mutual interests

Christina Oudshoorn and *Mary McNabb* talk about transforming Dutch maternity care

Although long considered an enduring example of good practice, the Dutch midwifery and obstetric system is being transformed, to meet the interests of hospital obstetricians, insurance companies and governing financial interests.

The Dutch obstetric care system has three levels that cooperate over provision but function autonomously. Each year 85% of pregnant women start care at primary level with independently practicing midwives, or for 1% of women, general practitioners(GPs). Primary care is locally situated and extends from early pregnancy until the end of the postpartum period. Traditionally in the Netherlands, pregnancy and birth are perceived as fundamentally physiological processes and are characterised in this way, for risk selection and allocation of financial resources.[1]

Perinatal mortality

In 2008 the government appointed a Steering Group to undertake a comprehensive review of maternity services and make realistic proposals to reduce perinatal mortality. At the time, the Netherlands had one of the highest rates of perinatal mortality among European Union (EU) member states.[2] Since then, Dutch perinatal mortality rates have gradually declined and this trend has also occurred to varying degrees among other EU members states.[3]

The Steering Group report, A Good Start,[4] made specific recommendations to improve the organisation and delivery of prenatal and intrapartum care for all women and recommended more structured and seamless cooperation, in place of the distinct levels of care. The implementation of the recommendations was expected to lead to a 50% reduction in perinatal mortality within five years. However, the most recent mortality data suggest that this rather ambitious target has not been reached.

The Dutch Society of Obstetrics and Gynaecology (NVOG)

Following A Good Start the NVOG responded by publishing a position paper on the need to abandon the divisions between primary, secondary and tertiary care. The NVOG's main argument was that a unified model of care would lower perinatal mortality, by reducing risks to women associated with divisions in the old system. While recent studies have highlighted a strong relationship between socio-economic deprivation and increased perinatal mortality in the Netherlands, the ongoing debate over the relative safety of midwifery vs obstetric-led care has fuelled a much larger interest in small differences in birth related perinatal and neonatal mortality in pregnancies at term.[5]

In contrast to the situation in countries with a longer history of routine hospital based obstetric care, there has been little research in the Netherlands, on maternal and neonatal morbidity associated with caesarean sections and pharmacological interventions during labour and birth.[6] The use of epidural analgesia has increased dramatically since 2004, and caesarean sections have risen from 2.5% in 1970 to 16.6% in 2014. This trend runs counter to the evidence based WHO guidelines, in 2015 that have clearly demonstrated the absence of any health benefits to either mother or baby when caesareans section rates exceed 10%.[7]

In June 2011 the Ministry of Health directed the National Health Authority (NZa) to advise on incentives and constraints affecting cooperation and data transfer between obstetric and midwifery led care. The task was to show the influence of funding and the role of the health care provider. Outcomes of care; rising referrals from primary to secondary care; differing levels of obstetric interventions in the two levels and views of women were totally excluded. The advice reinforced the view that current divisions between primary, secondary and tertiary care should be abandoned, to solve existing problems. This organisational approach gave priority to cooperation and shared responsibility of professionals (NZA, 2012), despite recommendations to place '*women in the centre of care*'.[4]

Endorsed by A Good Start and the NZA, the College for Perinatal Care (CPZ) has become an important partner and motor to coordinate and facilitate the proposed innovations to enhance inter-professional cooperation in maternity care.

Midwives welcomed the A Good Start report in good faith

Midwives and women

Midwives welcomed, in good faith, the A Good Start report. The Royal Dutch Organisation of Midwives (KNOV) and a consumer group provided input.

For the majority of midwives, working in primary care, the proposed abolition of the divisions between primary and secondary is a direct threat to their livelihood. A total of 1988 (63.1%) of Dutch midwives work independently. Two thirds have financial shares in independent practices or work independently as locum practitioners. Only 5.9% of Dutch midwives are

employed by midwifery practices.[8] In order to stay in business, by serving women in primary care, these midwives need to reject the proposals for an integrated system, since it is a medical model of shared care that will diminish their autonomy and entrepreneurship.

In 2011 the KNOV advised members during a national, general meeting to go along with integrated obstetric and midwifery care despite the opportunity to modify the existing midwifery model of care. The KNOV's support for the integrated system indicated its compliance with a medical paradigm.[9] Women activists were ignored. Confusion and chaos ensued as questions were asked to secure the autonomy of midwives and women. Voting was postponed and during a subsequent meeting, a majority of members voted for the KNOVs suggested option.

As a result of this decision, a small group of women and midwives woke up and rallied for autonomy, by challenging the KNOV.

Involvement of women in care related projects is still very new in the Netherlands. Ouderschap (Parenthood) was an official adviser to the A good Start project but was not a strong voice for women. Lawyers and women of the Bynkerhoek Institute of Law asked a different group of birth activist (Birth Movement) to join the organisation of the groundbreaking International Human Rights in Childbirth Conference in The Hague in 2012. This conference drew attention to the case of Ternovsky in Hungary and discussed all aspects of the Dutch birth system and the meaning of 'women centred care'. This event united activist groups, as well as midwives and doctors who fully understand the physical and emotional problems associated with a medicalised model of maternity care.

CPZ

The CPZ sees its role as stimulating innovation at local and regional level and uses the structure of the Obstetric Collaboration Platforms (VSVs). The VSVs are local platforms without any legal status, where specialists, midwives, GPs and maternity care organisations, voluntary work together to further the quality of maternity and obstetric care continuum. They have been charged by CPZ with developing an integrated structure of obstetric and midwifery care, to fit the specific needs of local women, including a financial structure and instructions on how to divide the budget.

By their nature VSVs are highly varied; some are well structured and successful, others act as playing fields for power groups to implement their own agenda whilst others are very inactive and unresponsive.[9] More recently consortia have been established, to stabilise regional medical power and groups of midwives have formed cooperatives, to strengthen their position in local or regional VSVs.[10] Meanwhile the KNOV has set up pilot studies to test the proposals made in A good Start and act as negotiator with involved organisations.

Current situation

During negotiations in 2015 about evidence-based changes in the Dutch Selection System, the NVOG proposed to abandon the selection of risk system. The position of the NVOG is that selection of risks is not necessary in an integral structure of practice. Instead, all women, regardless of health status, are to be discussed by local VSVs. The KNOV was unable to accept this view and decided to withhold its cooperation. To do otherwise would have meant losing the autonomy of midwives and choices for women. The NVOG was furious about the refusal and left the negotiations.

However, a back door action was taken by the KNOV to remain on speaking terms. The NVOG, other organisations and the KNOV started discussions about another aspect of the plan, to create a national maternity standard of care. The document was agreed upon by all partners except the KNOV because it clearly represents a medical approach to maternity care.

The latest NZa report, a Quick Scan and Policy Letter on integrated obstetric and midwifery care signalled increasing costs and medicalisation in running pilots.[11] After discussion in the Second Chamber, MP Dik-Faber came forward with a motion '*to prevent increasing medicalisation and costs in an integral model of obstetric and midwifery care*'. The motion was accepted by the majority and the Minister of Health will carry it into effect.

At the end of January 2016, three organisations – the Clara Wichmann Institute, the Dutch Women's Council and the Birth Movement – sent a letter to the Minister of Health. They fear that while making the new plans, little attention has been devoted to women's interests. The new system will make it very difficult for pregnant women to change from one midwife or hospital to another or make her own choice on place and way of giving birth, particularly since the integrated model of care will be financed by an integral insurance tariff for pregnancy and parturition, from 2017.

In their letter, the organisations have voiced concerns about the randomness that is likely, as the changes will be left largely to individual regions. They demand that a number of issues concerning obstetric and midwifery care in every region should be guaranteed, such as respect for women's self-determination, free access to midwifery led care facilities in medium risks situations, hospitals offering a physiological approach to birth, with easy access to a

broad range of non-invasive practices and non-pharmacological methods of pain relief; alternatives to hospital care (such as home births and birth centres supervised by midwives): free choice of a professional and place of birth.

The groups have called on the Minister to carry out a review and conduct solid research before the whole system is changed. Following the letter women and midwives started a petition and within six weeks 10,000, mostly women, had signed. With 40,000 signatures women and midwives will have a democratic voice in parliament.

The latest news is that the KNOV has decided to join the protest and reject the national standard of maternity care. At this point, the outcome for women and midwives in primary care is highly uncertain but the political nature of the issues at stake are much clearer than five years ago.

We are very grateful to Gré Keijzer-Landkroon for her help, trust and inspiration.

Christina Oudshoorn and Mary McNabb

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Information and consent

Birthrights highlighted the following example in their advice about consent and the Montgomery case.[1] It is a concise example of what women should expect from an informed consent discussion.

'Far from threatening doctors with more claims, proper disclosure of risks should protect the medical profession from litigation and lead to patients bearing responsibility for their own decisions. Respect for patient autonomy means that patients take responsibility.'

An example: post-dates induction

'Post-dates induction provides a useful example of how informed consent ought to work in practice.

'The obstetrician must make time for a genuine dialogue with the woman. Hospital information sheets on induction are not a sufficient basis for making informed decisions. During the dialogue, the doctor cannot not simply impart facts or hospital policy without taking account of the woman's particular situation and wishes for the birth.

'The conversation must be personalised – it would differ between a first-time mother and a woman who has already had children; or between a woman who wants to give birth vaginally and a woman who is concerned about vaginal birth.

'The obstetrician should explain the risks of exceeding her due date using accurate and comprehensible information that does not put undue pressure on the woman (stating only that 'your baby might die' would not be considered sufficient information).

'She should then be told of 'any material risks' of induction to both herself and her baby. It is obvious that most women would wish to know the likelihood of success and failure of induction in that clinician's experience at the hospital in question, and the risks should induction fail. These will include fetal distress, assisted birth, with consequent potential for perineal trauma, and emergency caesarean section.

'The obstetrician should suggest alternative courses of action, including waiting for natural labour to begin and elective caesarean section.'

How often does this happen?

From our experiences at AIMS we have noticed that this 'discussion of risks' also frequently appears to exlude the risks of forceps delivery to the baby, which was a significant factor in the Montgomery case.

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AMUs for all who request

Sue Learner reports on a talk by Kathryn Gutteridge on providing services as requested

In June 2016 Midwife, Kathryn Gutteridge, was invited by North Bristol Trust's Lead for Normal Birth Midwife to speak to obstetricians and midwives about the Serenity Birth Centre (AMU) in Birmingham. With a sound philosophy and appropriate guidelines Kathryn has led the way to enable women with certain pregnancy issues, who request to use the birth centre, to be able to do so.

During Kathryn's authoritative, data-led, experience-based and clear presentation I saw at first hand, by the response of some senior obstetricians, who controls our Maternity Services. Shock and horror were displayed that a woman with twins, and another woman with Type 1 diabetes, gave birth at the Serenity Birth Centre. There was disbelief that 100% of women with a BMI of more than 35, who asked to use Serenity Birth Centre, used the centre throughout labour and gave birth there. There was surprise that 94% of women with a previous Caesarean Section, who asked to use Serenity Birth Centre, successfully gave birth there. Also it was considered irresponsible that the baby of a woman who had Type 1 diabetes went home with its mother, on approval of the neonatologist, within hours of the birth.

But it was acknowledged by one or two consultant obstetricians that *'...it is important to support women'. 'These figures show the importance of this....'* and *'...our system does not offer flexibility'*. On the other hand one doctor questioned: '*If we encourage this* (that is give full support to these women) *all other women will follow*'. Midwives cheered '*That's the whole idea'* and *'you mean that they should lose their freedom of choice?*'

So for women to control their own pregnancy and labour we need to give women back their power by deeply respecting their decision from wherever it has come; by supporting their pregnancy and facilitating how, where, and with whom they wish to give birth; by acknowledging that continuity of care allows for support of a woman's decision which may sound madness to another clinician.

As midwives, by considering ourselves the guardians rather than the managers of pregnancy and labour we can support women and offer them flexibility. The resulting reduction of interventions would in turn be in the interests of women and their families. This will happen in North Bristol Trust thanks to a birth centre midwifery team which has dynamic and tenacious leadership that promotes normal birth.

Sue Learner
Sue is a registered midwife, practising independently in Bristol.

A room in the Serenity Birth Centre

From chains to charter

Denise Marshall looks at improving perinatal care and support for women in prison

Twenty years ago, the situation of women giving birth in custody came to public attention when Beverley Beech filmed a woman from Holloway prison, shackled in labour. Now, Birth Companions is launching a Birth Charter for perinatal women in prison in England and Wales[1] and, once again, there is a focus on this group of women and babies.

In February, David Cameron called for an urgent rethink of their treatment in custody; a few weeks ago, in The Archers radio drama (BBC Radio 4), Helen Archer gave birth and is now a mother breastfeeding in prison and the closure of Holloway prison is imminent.

Let's go back to the end of 1995 when Annette, in prison for a stealing a handbag, wrote to Beverley Beech about the indignities that she was experiencing as a pregnant woman in prison. She asked if Beverley could be her birth partner. Beverley came to the hospital with a concealed camera, and, with Annette's permission, filmed part of her labour, highlighting the shocking practice of shackling women in labour. After the footage was shown on Channel 4, there was public outrage and the matter was discussed in Parliament.

For a short while, a spotlight was shone on one of the most marginalised groups of people in Britain, women in prison, resulting in change for women who were pregnant and giving birth in custody: they were no longer to be handcuffed, once they were in labour. Childbirth campaigner Sheila Kitzinger called together north London antenatal teachers and midwives to talk about what else could be done for the women in Holloway and, out of this meeting, Birth Companions was born.

There was a desire for change from the prison as well. The Prison Governor agreed that Birth Companions could start immediately, supporting women at birth at the Whittington hospital. I had just begun as an antenatal teacher in the prison. Every Tuesday, the pregnant women would pile in, sometimes sitting on laps, there could be twenty women or more. Birth Companions volunteers came each week to meet women, offer birth support and do birth plans. It was very unlike other antenatal classes. As well as the usual hopes and fears about birth and becoming a parent, women worried about being unlocked in time to get to the hospital for birth and whether officers would be in the room with them when their baby was born. Would they get a place with their baby on the Mother and Baby Unit (MBU) or have to separate after the birth? Most women had other children at home and shared their sadness about being apart from them. Some women had only discovered they were pregnant once in custody, so were coming to terms with this, as well as the shock of being in prison. Women, who spoke no English, came with another non-pregnant prisoner who interpreted discussions about choices in labour and baby feeding. What was striking was how much some women wanted the


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information and support to give their baby the best start possible in this difficult situation. Also, how relieved women were to know they could have a birth companion with them, and would not be giving birth alone. Some women did have family but worried whether they would be called or arrive in time. The groups gave space for women to support each other and the strength of this peer-support was sometimes quite incredible.

Over the years, Birth Companions continued to work with women in Holloway in a trauma-informed way, being woman-centred and providing a safe space in the harsh environment that prison can be. There was a Birth Companions antenatal group (after mine closed due to budget cuts), an early parenting group on the MBU, and a breastfeeding supporter who could work with women during pregnancy, early parenting and also with women who were separated from their baby and wished to express milk. Birth Companions also began to work with women after release in London, and in Bronzefield and Peterborough prisons. The birth companions I worked with, as well as the courage of some of the women in prison, inspired me.

One woman wrote, about the antenatal group:

'I felt a huge amount of support. I was able to share my experiences with the other girls and the birth companions without fear of judgement. I was never asked why I was here and for the two hours of the group I didn't feel I was in prison. It just felt like we were all mums looking forward to our new

arrivals with no stress.'

This woman did not get a place on the MBU but was supported to express milk for her baby:

'They gave me the right amount of advice and support which encouraged me to give it a try, which I loved. I didn't have my son with me unfortunately but they taught me to express so my son could still benefit, which is the best thing I ever did.'

Women in prison continue to be a vulnerable and small minority (fewer than 5%) in a system designed for men. Most women in prison have experienced emotional, physical or sexual abuse (53%, compared with 27% of men) and 31% have spent time in care, based on Ministry of Justice 2013 figures. Most women have substance or alcohol misuse problems before coming into custody and physical and mental health levels are worse than any other recorded group.[2] Statistics are not collected for pregnant women but it is estimated that over 600 receive antenatal care and 100 give birth in custody each year. Many more women have recently been released, are on bail, are electronically tagged (Home Detention Curfew), serving community sentences or have a partner in prison, and are affected by this during the perinatal period.

Now, 20 years later, Birth Companions has launched the Birth Charter and we hope again, that something will change. The Birth Charter is based on our work with approximately 1,500 women (mainly in Holloway) at different stages of pregnancy, birth and early parenting and what they told us about their experiences. It was a huge piece of work but we wanted the Birth Charter to be thorough and to reference relevant research. We also had input from the Royal College of Midwives and Unicef UK Baby Friendly Initiative. In theory, women in prison are entitled to the same standard of maternity care and choice as women in the community but, for reasons that can be complex, this is not always the case. The Birth Charter sets out fifteen recommendations that would ensure equivalence of care and could form the basis of a Prison Service Instruction (PSI) for Perinatal Women in prison. An existing PSI covers what happens for mothers and babies who go on to prison Mother and Baby Units but not what happens for pregnant women or for mothers and babies who do not get a place together on a MBU and are separated (approximately half of women do not apply or are refused a place with their baby in prison).

Since Annette was shackled in labour, some things have changed for the better but others have not and experiences vary enormously. Some very dedicated prison staff make a real difference to the women they work with. For some women, coming to prison provides respite, away from an abusive partner or from living on the streets. Getting a place on a prison MBU can enable women to make a new start with their baby. There are some real success stories, a testament to what can happen when support is there at this crucial time. Many women stay in contact with us and are quoted in the Birth Charter. A woman we supported at her birth told us:

'I was fortunate to go back to the Mother and Baby Unit at Holloway and three weeks later to a mother and baby rehab. Thanks to support I completely turned my life around and have been clean six years this year.'

Other women felt their baby was also being punished while they were pregnant in prison because of experiencing unnecessary stress, particularly around their MBU place.

'The not knowing [about whether or not I had a place on the MBU] *was making me ill, was making me anxious, just making me so frustrated ... I came to prison in May and I was told it's a 2/3 month process. I sat the Board* [and got my place at a MBU in another prison] *and I still didn't go.'*

The Birth Charter addresses ways in which stress for pregnant women in prison can be reduced and calls for officers to have clear guidance and appropriate training. There are too many instances of women being handcuffed during scans, officers staying in the room (uninvited) with women during medical consultations, active labour and when women are having skin to skin or breastfeeding after the birth. It is difficult for women to be assertive while in custody and, although medical staff do ask officers to step outside or remove restraints in these situations, not all staff are aware of the woman's rights around this.

The Birth Charter includes many examples of good practice in prisons, which are sometimes lost when staff change or budgets are cut. From 1998, women in Holloway received excellent maternity care from midwives from the Whittington hospital who ran clinics in the prison three times a week. This minimised the need for women to go out to hospital during pregnancy, handcuffed and accompanied by uniformed officers on their way to clinics, and women felt safer and less stressed. For years there was a mobile phone in Holloway that women could use to speak to a midwife on labour ward for advice. An officer would hand the phone to a woman in her cell, giving her access to a midwife, as she would have in the community, and then speak to the midwife to confirm transfer to hospital, if that had been the advice. This system no longer exists and so pregnant women in prison discuss bleeding, headaches, waters breaking and early contractions with officers and in-house nursing staff, instead of a midwife, to negotiate going out to hospital (despite the Nursing and Midwifery Order (2001) Article 45[3]).

Things in Holloway prison were far from ideal but a huge amount was learned there and all the expertise from staff, external agencies, therapists and others should not be lost. Birth Companions is hoping to work with the Prison Service and individual prisons, using the Birth Charter as a basis for improving care for this group of women and babies. We are also developing modules with the Royal College of Midwives on their virtual learning platform. So, as well as being the end of an era, the closure of Holloway could also mark be the beginning of a more consistent and enlightened approach for women and babies affected by the Criminal Justice system.

Denise Marshall
Group Co-ordinator for Birth Companions

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Jacob

Emma Ashworth tells the story of 'risk' and an independent approach

My third child, Jacob, was three when I was asked to do a presentation of my birth story to an audience of midwives as a home birthing, water birthing high-risk woman. It was only then that I realised that the NHS had classed me as 'high-risk' during my pregnancy with him. Not once was the term mentioned by my midwife, not once did I have anything but absolute faith in myself and my baby, and not once did it even cross my mind that I was 'high-risk'.

This doesn't mean for a moment that the 'risks' (to use common, but flawed terminology) were glossed over or ignored between me and my midwife. On the contrary, we discussed them at great length as I needed to understand them and to make my decisions from a position of knowledge. It simply means that I was considered and cared for as a healthy woman with a healthy baby who had specific and personal considerations that were relevant to my pregnancy, birth and beyond.

Here is my 'high-risk' list: previous PROM (prolonged rupture of membranes) and slightly early baby (born at just over 36 weeks after 5 days of PROM), previous PPH (post partum haemorrhage), high BMI, aged 39. Of all of these, the only one to cause me any concern was my previous PPH. There's nothing more likely to really focus your mind on your next birth than watching your blood flow away from you as you lose consciousness. I was very, very keen to work out what the possible causes might have been, and what could be done to reduce the risk of it happening again.

Jacob's birth was planned as a home birth. I chose to have an independent midwife with Jacob because I wanted to know who I was having as my midwife, and my husband and I to make our own informed decisions rather than having to navigate NHS guidelines which may not be suitable for us as individuals, and in our own personal circumstances.

With my previous baby, Toby, we had experienced amazing care through my pregnancy from a lovely NHS midwife, and getting to know and trust one midwife was hugely reassuring and it filled me with confidence. Unfortunately, when my waters broke a little early in that pregnancy and my labour didn't start, I was taken away from the midwife that I trusted and thrown into the hospital system which is when the fighting began. *'You have to…'. 'No, I don't. Please explain your advice so I can make my decision.' 'But you have to…' 'No, I don't. Please talk to me so that I can understand.' 'But your baby will die…' 'Now I have lost trust in you, I don't know where to turn and I am terrified. This is not helping me to go into labour and neither is it helping me to know what is best for me to decide.'*

During my pregnancy with Jacob, my independent midwife, Debs, and I would spend much of the time that she was able to give me talking about my experience with my previous son, Toby. I had been frightened by the PPH experience that I had with him. I needed to understand why it might have happened and what could be done at home if it were to happen again. As well as talking to Debs, I used the AIMS book Birthing your Placenta to learn more about the physiological processes of how the placenta is released.

Over the course of the time that I spent in antenatal sessions with Debs I decided that I understood what was likely to have caused the PPH that I experienced after birthing Toby and rather than making me more fearful, which can so often happen when women are just told that they are at higher risk of something happening because it happened before, I was able to take back some control of the situation. I was able to change most of the triggers for PPH by controlling my environment. The lights would be dimmed, I would be warm, dry and covered if I came out of the pool. My oxytocin bubble would be protected with people that I trusted. I knew that there are some aspects of PPH that are entirely uncontrollable and I understood what could be done at home to help with that if necessary, and what I'd need to

transfer in for. I understood, I was in control of what I could be and I knew what would happen if things happened that I couldn't control.

I hear women who are told that because they've had a previous PPH, they're at high risk of another, so they must birth in hospital. Birthplace (2011) showed that women who plan to birth in hospital have a significantly higher risk of a PPH needing a blood transfusion than women who plan to birth outside the hospital. There seems to be a faulty logic in telling women that they need to birth in the place which is most likely to lead to the situation that they are trying to avoid in the first place! Most importantly, midwives are not given the time with the women that they care for to get an understanding of that individual woman's fears and wishes. There is no time to build up a trusting relationship, and even if that does happen, it can be for nothing when the woman has to take her chances with someone she has never met when she is at her most vulnerable, at her birthing time.

In the end it took 1 hour 50 minutes for the placenta to arrive, just 10 minutes less than it took for Jacob to be born after my waters broke. That was all fine, there was no pressure as there would have been in hospital and I know my midwife was watching me like a hawk so I could relax. I know I'm very sensitive to oxytocin release stopping after birth which messed up the placenta delivery for my older two, and this time it worked like a dream, just slowly.

The placenta was intact and lovely and I enjoyed watching Debs check it over and she showed me all the different parts, and we took some photos. Some time later I wanted to get out of the pool, so I did.

I didn't dress Jacob for ages, not even in a nappy, I don't think I did until we went to bed that night. I just laid on the sofa holding him against my breast allowing him to feed when he wanted and just stroking him and smelling him. He'd not been dried off or cleaned and he had a lot of vernix and I felt that it was important to allow him to keep that smell that he knew and not to bath or rub him down. He was very calm and lovely and happy.

I had some food and we all just chatted – it was so lovely. My friend arrived armed with champagne, cakes and some lovely baby vests and got her first cuddle. Debs cleaned up although there was really no mess at all – and Philip got our children from the neighbour. Debs cut Jacob's cord short and sealed it with a tiny Sterifeed cord ring rather than the huge and uncomfortable plastic clips. Eventually we went up to bed and my family was snuggled up together at about midnight, so utterly different from in hospital where my husband had to leave me, bereft, and go home alone. I'd hated the postnatal ward and to be together with my family was just amazing.

Jacob's birth was an extraordinary experience and I would do it every day. I desperately want to do it again. I envy anyone who may be able to! However it was seven years in the making and it took two less than perfect births to get there. I took everything I'd learnt from my first two boys and added into it seven years of research and more than anything a wonderful midwife. A wonderful midwife who I was able to work hand in hand with, as equals and with trust in each other. Knowing and trusting your midwife works both ways. She knew that she could trust me to tell her if I had concerns because I knew that I could trust her to hear me and understand me.

Continuity of carer: we know that it leads to healthier babies and mothers. This logically leads to healthier families. But, done properly and with the rightful respect for the autonomy of the midwife it leads to happier and healthier midwives as well.

Emma Ashworth

Where is the support?

Jeanette Stevens shares her experience of the effects of home birth service suspension

It was a lovely Friday afternoon in May 2015 that I found out that I was expecting my third baby. I will always remember it well as it was the very same Friday on which we celebrated my husband's grandad turning 100, so good tidings all around!

There was no doubt in my mind that this baby too, as our son and daughter had, was to be born at home. I could imagine for no other place for me to give birth as my two previous births at home had been amazing, relaxing and very empowering.

My first, a son named Jensen born in 2012, arrived here at home using the then still active home birth team from Queen Elizabeth Hospital in Kings Lynn. No issues with the maternity service nor the birth as it was straightforward, quick and without any intervention. I remember the midwives just standing by at the sideline and it made it much more private, especially as once he was born they left us to it and soon it was just our recently expanded family of three alone in the house. Magical.

Our second baby, a daughter named Penelope, born in 2014, arrived at home too without any intervention, pain medication or other assistance. However when I was 32 weeks pregnant the QEH suddenly withdrew its service for home births and cited low staff and budget as a reason for their temporary suspension. It was a dreadful couple of weeks as the QEH left us hanging, offering us no alternative other than the birth facilities at the QEH, where they only have an obstetric-led maternity ward. A far cry from the birth we had had with Jensen. I recall many tears being shed, feeling very nervous and afraid of possibly having to go to hospital.

Devastated is perhaps the most accurate description of how I felt and it was very disheartening to imagine that my daughter wouldn't be born at home. I made contact with Elizabeth from Birthrights and Beverley from AIMS, and with their guidance and advice I felt a bit more empowered and ventured down the route of hiring an independent midwife. Not a cheap option, but we were getting no help from our local NHS services. We still kept pressure on the QEH and the local CCG to reimburse us or assist, however all our correspondence fell for deaf ears. We had the local MP contact them on our behalf, did countless newspaper articles, and went on BBC news and the radio. We campaigned endlessly but the hospital did not budge at all. I went into labour a day early with my daughter but was reassured as I knew I had my independent midwife, Nicky Garrett of Iceni Independent Midwifery booked, she was wonderful and had been a pillar of support the last five weeks running up to the birth.

Fast forward to this joyful day in May, and despite the fact that it should have been the most wonderful day I suddenly realised that we faced another uphill battle with the QEH and CCG to assist us in achieving something that should be our right, to birth our child at home. The home birth service was still suspended – I knew as I had not stopped campaigning for its reinstatement. I thought though (naively) that given us knowing well enough in advance that we could work with them to allow for them to either subcontract an independent midwife or for the CCG to allocate a sum of money for me to use to hire an IM myself – something which is possible using guidelines laid out. I would soon learn that it would be a long and painful battle again, one that no expectant mother should have to embark on in order to have her choice upheld.

The day I had my 12 week scan I sent off a letter to the CCG and the QEH respectively – both pre-prepared with the ultimate statement that I would not be going to hospital so could they please advise how they were to provide maternity cover for me. Sounds simple enough and one would think that 28 weeks would be sufficient for them to make some sort of arrangement, that was, however, not to be the case. I was met with a *'we have no home birth service available so your option is to birth in the hospital ONLY',* every single counter argument which I raised was either ignored or just answered with that same statement. As a matter of fact, the QEH took three months to respond to my letter despite me chasing them constantly – disgraceful given that I was on a strict timeline – the baby wasn't going to wait just because they chose to be slow. Perhaps they did it deliberately as they knew I would run out of time? Elizabeth stepped in again to try and help and we had a solicitor assist with penning the letters and also raising more legal pressing questions and going down routes of which I was unaware. I had three meetings with the hospital, every single time we asked how they would support us they just stated they had no home birth service. Not very reassuring and it gave me a sense that no one cared. Both my son and daughter had been quick labours so we raised the question from the beginning how they could justify us risking a lay-by birth with them refusing us assistance at home. No response. Ever.

We went down the route of trying to get the CCG to allocate money to us, however, by the time the CCG responded they claimed this procedure would take too long as a medical plan needed to be made and this required 12 weeks. 12 weeks which they would have had had they started it when I wrote to them following my 12 week scan. They even had the audacity to state that I had never asked directly for this service. Apparently asking *'what can be done to assist me'* is not sufficient, you, as an expectant mother, have to understand the loopholes and procedures yourself and tell them what can be done!

The QEH were no better as they claimed that as I wanted a home birth they could not facilitate an

independent midwife as they would not get paid, thus not have the money. This turned out to be false as we contacted the CCG and they said this could be facilitated. However then the QEH put forth more excuses, one after another was shot down and another put up. It was tiring and hurtful as it felt as if though they truly didn't care.

In early January we had another letter saying that the most recent arguments which we had raised could not be met for various reasons and we simply ran out of time to pursue it any further and I, personally, was done. I didn't want to get any more upset so, despite having no funds for hiring an independent midwife, we contacted the IM who supported our daughter's birth. I felt at ease, ready, still angry at the QEH and CCG, but as they obviously had no care for my wishes nor the safety of my child we felt this was the only route we could take.

On January 26th I went into labour at 10.05 PM. My husband heard me potter about upstairs and came to check on me. I told him to ring the midwife as the second contraction hit. And when I say midwife, we both knew we'd be calling upon the independent midwife. Not once did we consider calling the QEH who had denied us the right to a home birth and clearly said several times that should we call, we would be sent an ambulance or be asked to travel to the hospital. I had no desire to be arguing with them about this whilst in labour, I had only the birth of my son in mind and wanted it to be peaceful and safe. Having a mind full of anguish, uncertainty and worry was not going to facilitate that.

Turns out that the argument which we had raised with them about us not wanting to risk a lay-by birth was a very true one, as less than 55 minutes later our third baby, a son who we named Lucien, arrived – caught by my husband – unassisted. Or as some would call it, freebirthing. Not by choice, and not something I would want to do again. It was, however, amazing, and extremely empowering to greet this little person with no other assistance than my husband. It was, I should note, no fault of the IM that she wasn't there for the labour, we rang her immediately but she is based an hour away (the QEH is 20 minutes away). She arrived 20 minutes after our son Lucien had arrived, found us all snuggled up on the sofa and later told me that she felt bad to be intruding on such a special moment as we looked so at peace. A piece of peace which she facilitated as she gave us the reassurance to have a home birth. She might not have made it for the birth but she tried and wanted to, and she was there afterwards to assist with the afterbirth and check that we were both well.

Birth is such a special moment, a moment which may not mean much to anyone else but one you will forever remember. It is appalling that women are being denied a right to choose. Queen Elizabeth Hospital in Kings Lynn will, in September this year, have had their service suspended for three years and there are no signs of the service being reinstated or alternatives offered.

Jeanette Stevens

AIMS Comment

This article is deeply sad. It is an account of the undermining of a woman's right to stay at home and insist that someone comes out to her. AIMS suspects that her notes could contain a very interesting record of the Trust's reasons for the decisions made.

AIMS is concerned that approaching this problem within a more formal legal framework may actually be giving Trusts the loopholes they have been looking for, whereas the AIMS 'stand your ground and make them come to you' approach has proved effective in the past and is less easy to just ignore.

As Jeanette did not phone the hospital when she went into labour, because she did not trust them she had made other arrangements, we do not know what would have happened if she had insisted that she was staying at home and would decline an ambulance transfer. Would QEH have actively told a woman to freebirth? Would they have tried to insist on a transfer to hospital after the birth? We simply do not know. What is clear is that all Jeanette really wanted was a midwife to know and trust who would support her when she birthed her baby in the place of her choice.

The previous AIMS Journal – Vol:28 No: 2 – drew attention to the award by the Ombudsman of £1,000 consolatory payment to Mrs Jane Reeve who had a similar experience.

Both Jane Reeve and Jeanette Stevens were able to engage an independent midwife and one might speculate that the staff were aware of that possibility and waited to see what would happen, thereby solving the problem without the Trust having to do anything creative at all.

Many women, however, are not able to pay for private care or do not have an independent midwife within reasonable travelling distance. Those who intend to birth at home need to make it very clear to the Trusts that they have no intention of coming into hospital or engaging an independent midwife; and they expect the midwife to come when they call.

Midwives have a professional obligation to attend when called and it is wise to remind a Trust of this fact and that should any untoward event occur as a result of their failure to send a midwife the family will take legal action.

Were that to happen the Trusts would be faced with a fee far larger than £1,000.

It is unacceptable, however, that any woman is subjected, in the latter stages of pregnancy to the stress this uncertainty of support generates.

Lui's Birth

Rosie Jones tells her water and hypnobirthing story

Lui Allen Greensmith – 8lbs 4oz – swam into my arms in the 'good karma pool' in our dining room on April 3 2016 at 7.41pm. This was my second hypnobirth – but my first home birth – both beautiful life affirming experiences that will stay with my until my last breath.

I felt like a lioness – invincible, primal and so ALIVE in that moment when I scooped him up and brought him to my chest. I was the first person to touch him! The indescribable joy and triumph of 'I did it!' and the intense rush of love as I felt the weight of his body on mine. As with my first birth, hypnobirthing gave me the confidence and self-belief to trust in my body. I did not need pain relief – just the loving support of my wonderful partner Seb, and knowing that I would soon be meeting my beautiful boy.

This is my birth story... It was a week before my 'due date' and although I had been having surges in the early hours of the morning for over a week, I had got used to them fading away by day break. My daughter Mei was born at 41+1 so I was feeling relaxed – it was just my body practising and gearing up for the big event still, I thought, a few weeks away. I was also convinced that as with Mei, my labour would begin in the middle of the night. The weather was fine so we decided to go to Crystal Palace park for a walk. We were not more than a few hundred metres from the car when I suddenly became aware of my surges (with hindsight they had been coming and going sporadically throughout the morning but I had not given them much thought). I told Seb. He said he thought we were a few weeks away still (I was 39+1) and asked whether we should keep going. I said yes and then a few steps later changed my mind. I was finding it difficult to walk and I could feel the baby had moved down. I wanted to go home, it was time to go home and rest and get things ready...

it was time to go home

We got home around 1pm, after a detour to the deli to buy some bits for lunch. Seb joked that I would need the energy if our baby boy was really on his way that night and if not we could just enjoy a nice lunch – he came back to the car laden with sausage rolls, ham, lovely bread and brownies! During lunch my surges continued to niggle away which surprised me. It was Sunday afternoon – I was so sure that they were going to fade away and start up again properly that night. After lunch Seb put Mei down for her nap. Seb and I then discussed what to do next. We decided to see whether we could send Mei over to a friend's for a play date with her little boy so I could rest and Seb could get everything ready in case the baby decided to come that night. Fortunately she was home so Seb got Mei ready to walk her round after her nap.

As soon as Seb left the house with Mei my surges intensified and started coming closer together. Suddenly I realised I really was in labour! It was 3 o'clock. I was excited and struck by how clever our bodies are – now I was no longer distracted by Mei – and knowing she was safe and happy playing with a friend – the baby was coming! Seb got home about 3.20 and as he did my phone rang. He had rung the midwives on the walk home and they were already calling me to have a chat and assess the situation. While speaking to them I had a particularly intense surge which left me unable to speak. I remember my midwife then saying to me, '*OK, I'm hanging up now and I'll be there in 20 minutes*.' My surges continued to increase in intensity and frequency so when she arrived at 3.45 I was already draped over my birth ball focusing on my up breathing. After a quick chat and examination she confirmed that I was 7cm and it was time to start filling up the pool! Big grins all round – we had only been walking in Crystal Palace a few hours before!

The next few hours then became a bit of a blur. Seb filled the pool for me and I was able to get in by around 4.30 which was a huge relief. The warmth of the water was bliss and helped me to rest between surges which were building and become stronger with each one. At 5.30 our supermarket delivery arrived, much to everyone's hilarity (perhaps not to the delivery man's!) At 7.17 there was a sudden downpour followed by thunder and lightning outside. It was almost like an announcement that our baby boy was on the last leg of his journey as shortly after this my waters finally broke and at 7.41 he swam free to meet us! He was beautiful and bigger than I expected – 8lbs 4oz of chunk! But despite this I suffered not a single tear.

At 10.20 Seb was able to go and pick up Mei while the midwives tucked me and Lui into bed. By 10.45pm all of us were snugly tucked up in bed – in the course of about 4.5 hours we had gone from being a family of three to four in the comfort and safety of our own home. While my surges at the very end of my labour were incredibly intense and all encompassing, at no point did I feel fearful or out of control. All the hypnobirthing practice paid off. I loved how clear headed and present I felt without pain relief and how supported I felt by Seb and my midwives.

It was one of the most powerful and fulfilling experiences of my life and I would do it again tomorrow in a heartbeat.

Rosie S Jones

Reviews

One Man's Medicine: an autobiography of Professor Archie Cochrane

By Archibald Cochrane with Max Blythe
Cardiff University Cochrane Centenary Edition, 2009
ISBN 978-0954088439

In AIMS we have many occasions to bless the name of Archie Cochrane as the Cochrane reviews are so extremely useful in the field of maternity services. I certainly have waved a printed out copy of a Cochrane Review in difficult meetings with health professionals as a kind of trump card.

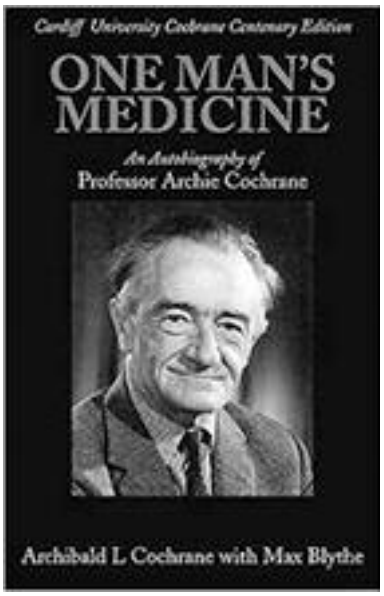
Cochrane himself wasn't particularly interested in childbirth but the Cochrane Collaboration, (which began in 1992/3) was preceded by a systematic review of pregnancy and childbirth, and went on to include more than 20,000 unpaid collaborators from 100 countries, so that posthumously Archie Cochrane has been recognised as being remarkably influential in health politics and a champion of the idea of looking for evidence on which to base health care.

This paperback is an edition published by Cardiff University to mark the centenary of his birth, the original was published in 1989 shortly before his death. It has additional contributions by Sir Richard Peto and Sir Iain Chalmers who are now able to evaluate his lasting contribution to the world of health care, which is now so firmly required to be evidence based.

His early life is interesting as an introduction to the man he would become, if fairly unremarkable, but becomes increasingly dramatic. Setting out for a career in clinical medicine and research in 1927, he was distracted by the Spanish civil war and interrupted his studies to spend time with a field ambulance unit, then spent four years as a POW medical officer in the German prison camps of World War Two. In desperation, in really dreadful conditions of semi starvation, which he describes calmly but with feeling, and with prisoners who were riddled with disease, he started to collect data and run simple trials and surveys to inform his work.

After the war he turned to epidemiology and evidence based-care. There is a suggestion that he was burnt out from caring, and in a fascinating aside explains that, as he had a private income, he was able to enter epidemiology which, at that time, did not carry the merit award that bumped up and roughly doubled the salaries of his clinical counterparts.

Some of the details are noteworthy. As I said, his work was not in the field of maternity, in fact his main interest was pneumoconiosis, but at one stage, while challenging the consensus that early diagnosis leading to early treatment was always in the patient's interest, he confesses a trick that he played on his colleagues. He was concerned to find out whether hospital treatment had better outcomes than outpatient and home treatment and to study cost effectiveness. He was randomising the place of treatment for ischaemic heart disease, as the cardiac consultants were sure that expensive coronary care units were saving lives. Preliminary results showed slightly more deaths in the group treated in hospital so he reversed the figures. The doctors felt vindicated and said emphatically that he must stop the trial at once, allow no more home treatments and that his research was unethical. He then said that he had made a mistake and the higher death rate was in the hospital care unit. He waited to see whether they would insist on closing coronary care units but there was silence. No-one involved in the arguments against home births mounted by doctors will be surprised by this.



Gill Boden

Beyond the Sling: a real-life guide to raising confident, loving children the attachment parenting way

By Mayim Bialik
Pinter & Martin, 2014
ISBN 978-1780661957

I loved this book, it is such a child and family friendly approach to bringing up children! As parenting books go it is a rare combination of personal experience and research-based evidence. Bialik has lived, whilst parenting her own children, the research she is advocating. It creates a book that makes attachment-based parenting seem really accessible, fun and achievable. She says some interesting things, and nothing especially controversial, she simply puts parenting into her academic arena as a neuroscientist and evaluates it. Even her less mainstream-familiar chapters, such as the one on elimination communication, are grounded in research as well as personal evidence.

I agreed and identified with pretty much everything Bialik says, and I suspect if she were to turn up at a parenting group near me we would be friends!

I did find the language and style a bit 'American' and in some places quite directive, despite Bialik saying that she won't be 'preachy', but I think that is largely a cultural difference in style, combined with her evident enthusiasm for the subject, rather than Bialik opting for the 'my way or the highway' approach favoured by some parenting guides.

Whilst some of the concepts might be written off in some circles as a bit 'hippy' everything said in this book comes with a wealth of quality evidence to support it, and I would recommend it to any new parent whether they are planning that style of parenting or not.

I loved what she said about breastfeeding, especially how strongly she stresses the importance of surrounding yourself with good support. Even though the organisations she talks about operate a little differently in the UK, the principles are the same, and looking for local support is worth it on every level!

My only major worries about the book are both in the chapter on 'keeping your relationship strong'. Firstly, Bialik is separated from the father of her children, although they do seem to have a shared-parenting relationship that would be envied by many separated parents! My concern here is that as one of the well-used criticisms of child-centred parenting is that parents need time away from their children and mothers should take responsibility for the marital relationship, it would be a shame if this book's message were to play into this view. Secondly, and this is interestingly the part where I have found most disagreement amongst child-centred parents, is her firm assertion that sex is not possible when sharing a family bed with a child. Views on this subject, as well as personal experiences, seem to be more varied than over any other topic covered in the book, topping even the chapter on nappy-free babies! The general consensus is that babies sleep through anything, toddlers can be moved if necessary, and if a child is going to wake up and disturb you they will, wherever they are sleeping, even if you have locked your door…

Vicki Williams

Why Your Baby's Sleep matters

By Sarah Ockwell-Smith
Pinter and Martin 2016
ISBN 978-1780665450

Sarah's book, part of a Why It Matters series of essential evidence-based guides to pregnancy, birth and parenting, by Pinter and Martin, is described as 'science-rich yet easy-to-read' which just about sums it up. She is rightly, in my view, critical of the baby sleep industry and 'sleep experts', many of whom are medical doctors who appear to have little knowledge of living with babies and any notion of mothering.

I particularly liked her pen-portrait of possibly the first expert, Dr. Luther Emmett Holt, a pediatrician who advocated a rigid parent-led feeding schedule, making babies cry regularly to exercise their lungs and teach them not to be manipulative. His ideas presumably influenced the famous Truby King, who ushered in what she calls 'the parent centric years', 1890 – 1949. She tracks the rise of the 'child-centric years', 1940 – mid 1980s, with the psychoanalytic views of Bowlby and Winnicot followed on by Spock and Penelope Leach then links the resurgence of the parent-centric attitudes which have re-emerged since 1980 with social changes including a rise in female employment.

the evidence for how babies actually sleep is set out clearly

This resurgence is bolstered by Dr Richard Ferber, an American pediatrician who is author of an infamous book, Solve your Child's Sleep Problems published in 1985 which remains a perennial best seller: his name gives rise to the word 'Ferberisation', or 'cry it out', advice which is echoed by Gina Ford author of the Contented Little Baby Book.

In Why Your Baby's Sleep Matters the evidence for how babies actually sleep and what to expect is set out clearly in a way that will help new parents. It also covers naps, night weaning, coping with tiredness and SIDS, and the lack of evidence for the current advice against co-sleeping and bed sharing.

One point I found particularly fascinating was the suggestion that the prevalent view that the 'Back to Sleep' campaign was responsible for drastically lowering the rate of cot deaths doesn't fit all the facts. An increase in breast-feeding, a decrease in maternal smoking, more awareness of how to co-sleep safely and a gradual decline in early weaning also accompanied the decline in SIDS.

There is a section on how mothers have managed their babies in the past and around the world. A example with lovely quotes compares Mayan mothers' cultural practices with North American mothers, where the Mayan mothers had no complaints about night feeds since they breast fed while asleep in most cases and expressed 'alarm, dismay, pity and sadness at the idea of the infants sleeping alone'.

The book finishes with stories from mothers, which remind me of the pleasures of being the mother of a new baby. I enthusiastically recommend this book for any new parents.

Gill Boden

How you can help AIMS

AIMS became a Charity in 2014. It still has no paid staff – our committee and volunteers give their time freely. All monies raised go towards providing women with support and information.

If you are not already a member, you could join

As a Member, your benefits include four AIMS Journals a year and access to the AIMS Members Yahoo Group. You will be able to stay in touch and have more of a say in what AIMS is doing. You will receive updates from committee meetings and early notice of events such as AIMS talks, as well as being able to contribute to discussions of current issues.

Visit www.aims.org.uk

If all our Members just encouraged one other person to join, we would double our membership and income!

Christmas Cards

Consider sending AIMS Christmas cards this year and help us raise funds
We are still selling our very popular Nativity Scene, Snowbaby and Wise Women.

These cards are available for only £3 for 5 or £5 for 10.

A really easy way for everyone to help AIMS is to order cards and notelets from our website www.aims.org.uk and consider giving the new canvas bag or mugs for presents.

A big thank you, whatever you can do!

Remember the

AIMS AGM

and campaigning workshop

Saturday 24 September 2016

York

10.30 for 11.00 start

Please contact secretary@aims.org.uk if you wish to attend or send your apologies. For more information please email talks@aims.org.uk