# AIMS JOURNAL

## Implementing Better Births 1

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# AIMS

## The Association for Improvements in the Maternity Services

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Helpline 0300 365 0663 • helpline@aims.org.uk

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Journal Guest Editor
Jo Dagustun

Journal Production Team
Emma Ashworth
Debbie Chippington Derrick
Maddie McMahon
Shane Ridley

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Editorial

# Mission Better Births
# But just how do we do it?

*by AIMS Journal Editor, Jo Dagustun*

I'm going to start with an assumption: that everyone reading this Journal is already convinced that we can do far better by women and families in terms of improving the support available for them to make an effective and healthy transition to parenthood. For many of us, this is because we sit and listen to their stories. Or maybe we accompany them in some way through their maternity journey. And - based on those experiences - we are determined to do what we can to ensure that every woman and family has access to improved support, in the hope that the birth stories of the future will be very different indeed.

But that leaves us with a key question: collectively and individually, just what can we do to ensure that all women are better supported when pregnant, giving birth and adjusting to life post-birth? What can we do that is going to make a real difference?

Each reader will have their own answer to this question, reflecting the incredibly diverse range of activities that go on across the UK, day in day out, all intended to make birth better. These activities take place in a diverse range of settings, and are led by diverse groups of committed individuals. It is potentially made better in every meeting where people come together to grapple with a core agenda of maternity service improvement, whether they are focussing on research, policy or practice (or - even better - a combination of all three). It is made better when the service user voice is truly welcomed and respected as a crucial contribution to the debate. And it is made better daily with every competent and caring action on the part of skilled and compassionate health care professionals, working well together as a team.

With such diversity of activity it is easy to feel overwhelmed and wonder about one's own role. But if there's one message I'd like you to take from this Journal, it is to underscore that change for the better can be supported by every one of us, and indeed needs every one of us to be involved. We are all truly in it together. No longer can we be satisfied to rely on 'the establishment' to deliver a system that works for all. And nor can we sit back and simply expect compelling research findings, scrutiny reports or policy initiatives to be translated into frontline action.

**What can we do to ensure that all women are better supported when pregnant, giving birth and adjusting to life post-birth? What can we do that is going to make a real difference?**

In 2016, a report was published in England that was called *Better Births*. This report did not set out the full range of detailed improvement activity necessary to ensure better births for all; it focussed instead on offering a transformation agenda that would radically shift the way in which maternity services are organised, to underpin a safer and more personalised approach fit for the 21st century. It was a well-prepared report, drawing on a huge programme of work. But what do we traditionally do in the light of such maternity policy statements? After the fanfare, and a short period of implementation fervour, what then? In England, we are currently halfway through the proposed five-year transformation programme. Yet in many areas, a conversation that is truly open to the benefits of the Better Births transformation agenda is only just commencing.

Reflecting on the implementation of the 2007 report *Maternity Matters,* the *National Audit Office (2013)* stated that:

> *"The Department [of Health] did not fully consider the implications of delivering the ambitions set out in its strategy. The Department has failed to demonstrate that it satisfactorily considered the achievability and affordability of implementing the strategy, and it has not regularly or comprehensively monitored national progress against it."*

That was a damning indictment indeed. And it could be argued that the implementation landscape for Better Births is even more challenging: the financial pressures on our health service are intense, devolution has since progressed further (which offers key opportunities for local progress, of course, but also allows little national oversight of more poorly performing areas), and we now also have the intense demands and uncertainties of Brexit to contend with. So it is surely reasonable to ask: Is the proper implementation of Better Births even possible against this backdrop?

What we can be sure about is that the evidential base for Better Births is far stronger than that of its predecessor reports. Better Births reflects the quality improvement agenda across the NHS more generally. The transformation called for in Better Births - intended to deliver safer care and better outcomes for mother and babies - is highly congruent with the current political focus on improving safety across the health service. It is also notable that, at this time, we have a strong team at NHS-England, led by highly effective leaders such as Sarah-Jane Marsh and Jacqui Dunkley-Bent, who are determined to push forward this Maternity Transformation Programme.

On that basis, I would urge everyone reading this Journal to ask themselves what they can do to support this effort. I very much hope that the articles in this Journal will offer you new ideas and inspiration. This is such an important topic for AIMS that we are also devoting our next Journal to this theme (look out for Implementing Better Births Part 2 shortly). But for now, please find out how Better Births is being implemented in your area. Get involved in making it happen. I recognise that this is not always straightforward: we are each committed to specific initiatives, all important in their own right, and we each only have so much time to devote to improving birth. But so many specific initiatives would be much better served, I believe, in the context of a transformed service as envisaged by Better Births.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/better-births-vision*

Article

# Better Births Basics #1
# The Better Births vision

## The Essential Cut Out and Keep Checklist for Birth Activists

**Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.**

Given the vast agenda we have between us, all birth activists deserve a short-cut or two. In that context, the AIMS Campaign Team would like to suggest that you keep a written copy of the Better Births vision close-to-hand. (You can even learn it off by heart if you like!)

So often when we come across problems in the context of maternity care, whether in an MSLC/MVP meeting or on social media, we can find ourselves mired in argument, trying to justify why things should be different. And far too often, the energy to resolve the problem fizzles out before a solution is identified and put in place.

When such discussions arise, we'd like to suggest that it might be useful to keep in mind that the Better Births report - now being implemented across England under the title of the Maternity Transformation Programme - already does much of that explanatory work for us. So in the vast majority of cases, more debate just isn't necessary. It really is enough to declare that the Better Births vision, endorsed by NHS-England, supports the change you wish to see, thus opening the way to move straight onto a collaborative and focused discussion about possible solutions.

We'll give you an example. Recently, on social media, we came across a quote from a Dad who was clearly still reeling from being excluded from his wife's side after the birth of their baby. We have known for many years that too many families find themselves in this position. Taking the Better Births vision as our cue, we linked this problem to the part of the Better Births vision that talks about family-friendly services, and tweeted that:

*"Family-friendly mat services DO NOT exclude a woman's support network, except in highly exceptional circumstances. Wrapping care around us, not expecting us to fit into your model of care. That's what #betterbirths is about."*

For Better Births to stand a chance of being implemented fully, AIMS firmly believes that we all need to work together to remind people that Better Births is the agenda that we are supposed to be working on together. It's no longer a question of why or whether, it's all about the how and when. It won't be an easy transformation to deliver, we know that. But let's all play our part in changing the conversation, to at least have a hope of doing so.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/better-births-vision*

# Better Births Basics #2
# What's what and who's who?

- How is your local area doing with implementing Better Births?
- Are you in contact with your local MVP to ensure that implementation is going to plan? Do you even know who they are/how to make contact with them?
- Do you know which Local Maternity System you are a part of?
- Have you seen (and had a chance to comment on) your Local Maternity System's Better Births implementation plan?
- If you have a concern about the activity (or inactivity!) of your Local Maternity System, and want to take the matter further, who is your first point of call?

Better Births set a national ambition, an ambition that has been endorsed by NHS England. But, in the context of a devolved healthcare system in England, the responsibility for implementing Better Births rests fairly and squarely at the local level. So if - after reading the questions above - you feel like just turning the page at this point, please don't! In this short article, we'll give you the basic information about who's who and what's what to help YOU become an effective guardian of the Better Births vision in your local area.

## Multiple levels of engagement: a brief user's guide

Starting at the top - or at the grassroots level - we have every **individual stakeholder** of the maternity services: that includes every birth activist reading the AIMS Journal, as well as the key players in all this, the woman, her family and supporters, and the staff that keep our maternity services running. This is actually the Local Maternity System: you are already a part of it, whether or not you have noticed! Building on this grassroots level where a wealth of skill and expertise lies – NHS England is keen to ensure that every service-user across England should have access to **a local body that listens well to their ideas and concerns, and includes them in decision-making. This is typically a Maternity Voices Partnership** (an MVP). An MVP might cover the same area as your local CCG (Clinical Commissioning Group), as a group of CCG areas, or it might be organised around local provider sites (eg birth centres or hospitals providing maternity care): this varies across the country. Your local MVP might already be up and running, or it may be in the process of being set up. In any case, it is bound to need some more volunteer support from local birth activists. (Do note, however, that there is unlikely to be any remuneration for this role, however top quality your efforts! Following the three-tiered Patient and Public Voice (PPV) Partners reimbursement policy in place across the NHS, for example, only the service-user chair – and perhaps co- or vice chair if there is one – is likely to be remunerated; other volunteers are paid expenses only.)

Every MVP will be part of **a Local Maternity System (LMS)**. These cover areas that are usually much bigger than the typical CCG area, and there are 44 of these across England. To keep things simple, they generally follow the same footprint as the 44 existing **Sustainability and Transformation Partnerships (STPs).** These Local Maternity Systems are the brand new element of the local health service organisation. Recommended by Better Births, they seek to extend to maternity the benefits of a larger network to support individual commissioners and providers sustain and manage the transformation in services demanded. In terms of service-user input, every Maternity Voices Partnership should be invited to be part of the key decision-making body of their Local Maternity system (for example, by representing service users on the LMS Transformation Board): this is becoming a key site for maternity co-production, especially as CCGs think about combining their commissioning efforts. So if there isn't

already a local Maternity Voices Partnership in your area, then you will have to make a special effort to get involved in what's going on at the LMS level; you may also want to work with others locally to encourage the establishment of an MVP.

Most Local Maternity Systems will then be a part of a larger **strategic clinical network (SCN)** although some, such as the Greater Manchester and Eastern Cheshire LMS, cover a whole SCN area. Across England, there are 12 strategic clinical networks. These provide a helpful oversight of each LMS, and thus can be a useful resource for activists with concerns, for example, about their local LMS.

The next layer comprises **the regional teams of NHS England**, and there are five of these:: the North, the Midlands and East, the London, the South East and the South West regional teams. If you are struggling to find the right contacts at a more local level, these teams might be able to help signpost you, and it is useful to note that some of them are becoming increasingly active in supporting service-user networking across their regions.

Finally, there is the layer of the **National Health Service England, and other national bodies**, where national leadership for the implementation of the national Maternity Transformation Programme resides. At this level, *occasional reports on the overall programme to the NHS England* board might be of particular interest to activists, as well as the activities of the Stakeholder Council, on which AIMS is represented by its chair of Trustees, Debbie Chippington Derrick.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/better-births-basics-whats-what-and-whos-who*

# Better Births Basics #3 Some key national targets

*Better Births #1, 2 & 3 are compiled by the AIMS Campaign Team*

Within the wide-ranging Maternity Transformation Programme, there are inevitably a large number of individual areas for improvement. Indeed the many different areas of work, and targets in place, can become rather bewildering. But whatever your particular interest in an improved maternity service, there are a number of key targets that are both easy to remember and worth keeping in mind as your Local Maternity System develops and starts to implement its plans.

## 1. First, there are the key targets for reducing (certain) major adverse outcomes

At the core of the Programme is the Government's national ambition to ensure that the safety of maternity care is improved, as measured by a number of major adverse outcomes indicators. The measures that have been chosen for this activity focus are: the rate of stillbirth, the rate of neonatal death, the rate of maternal death and the rate of brain injury that occurs during or soon after birth.

The Government's ambition, *updated in November 2017*, is that the rates of each of these outcomes (measured against the 2015 baseline provided by the *RCOG Every Baby Counts programme*) should be **reduced by 20% by the end of 2020/21 and by 50% by 2025**.

## 2.This is underpinned, inter alia, by targets that seek to encourage increases in women's access to continuity of carer

One of the key enablers of a safer maternity care system has been identified as an increase in the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally. This will usually, but not always, be the woman's named midwife. *The national targets are: 20% by March 2019 and the majority of women by 2021*.

Thus by March 2019, at least 20% of women booking for maternity care should be booked onto a model of care that is effectively planned to deliver on the ambition that **services should be organised to ensure that a woman can expect to be cared for during pregnancy, birth and postnatally by the same midwife** (unless the woman chooses otherwise), with that midwife working in close partnership with other healthcare professionals to deliver an appropriately personalised package of care. The majority of women (ie a minimum of 50% of women) should be receiving this model of care by 2021.

### 3. And personalised care, including a woman's right to choose her place of birth, is also central

Women's calls for personalised care, including choice over when, how and where they give birth, are key to the Better Births agenda. With that in mind, NHS-England has introduced new headline measures to monitor the delivery of the Maternity Transformation Programme, including the national '4/4/20 by 2020' target. This target encourages Local Maternity Systems to focus on how they will increase their support for women to give birth at home, to give birth at a freestanding birth centre, and to give birth at an alongside birth centre (ie a birth centre that is co-located with an obstetric unit).

Based firmly on evidence that some women say that they do not recall being offered a choice of place of birth, the national *'4/4/20 by 2020' target* builds on the expectation that a more personalised approach to maternity care, and the availability of more choice with respect to local birth place options, will result in more women giving birth outside of an obstetric-led unit. By 2020, the national expectation is that 4% of women will birth at home (up from 2%), 4% of women at a free-standing birth centre (up from 2%) and 20% of women will birth at an alongside birth centre (up from 9%).

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/better-births-key-national-targets*

AIMS

## AIMS is looking for Volunteers

AIMS is run by a small team of volunteers, and we always welcome more! Please see the final page for a full list of areas that you might be able to help with.

### *Volunteer Website Birth Information Coordinator*

We need a volunteer to join the website team who will take responsibility for managing the process of getting the Birth Information pages onto the website. This will include seeking authors and liaising with them to get the pages written and keeping clear records about what is happening with each page.
It will also include having the pages checked, proofread and uploaded to the website; members of the existing team will also be available to do these tasks.
Although this is primarily an administrative task, there is scope for you to get involved in doing more than this.
We really need someone who is organised and can keep us on track.

### *Volunteer Administrative Assistant*

The scope is variable, but our priorities are:
Organising meetings; finding suitable dates, locations and finding venues.
Managing the production of Minutes and Agendas in collaboration with the volunteers, including ensuring copies were filed and circulated at the correct time.
Managing AIMS Programme of Events and making sure that volunteers are reminded of deadlines.

*But we also need help with:*
Identifying consultations deadlines (NICE, Dept of Health, RCM etc) and managing the collation of responses, circulating drafts and finalising and submitting responses.
Supporting volunteers with drafting, circulating and formatting letters....

For more information, and if you would like to volunteer for AIMS, we would love to hear from you! Our email contact is: volunteer@aims.org.uk

# The Consequences of Discontinuing Continuity

*A birth story by Emma Ashworth*

It was my booking-in appointment for my second baby, and I didn't want to be there. I didn't want to birth with the NHS, but I did want to ensure that I was "in the system".

"I'm just here to book - I'll not be seeing you after this", I said to the midwife.

"Oh OK Why?" She asked, in a genuinely polite and non-intrusive way.

"Because I'm having a home birth, so I'm getting an independent midwife," I answered, firmly.

Her response wasn't what I'd expected. My decision to birth at home with an independent midwife followed months of fighting for a home birth with my first baby, only to be let down in labour by the attending midwife who really didn't want to be there, ending up with an unwanted and unpleasant hospital birth. This time I was taking no chances.

"Oh do let us do it - we love homebirths!" replied my lovely, lovely midwife.

It turned out that the independent midwife that I'd wanted was pregnant at the same time as me, due a few weeks earlier I wasn't aware of others who covered my area (although it turns out that there are many!) so given the enthusiasm of my community midwife, I trusted her and decided to stay under her care.

I subsequently discovered that I had fallen on my feet with a midwife who was well known for being wonderful. Lorraine had a passion for supporting women and babies, and it shone through in everything she did. I had the comfort of being in her care throughout my pregnancy. This continuity of care from a midwife that I knew and trusted allowed me to open up to her about some of the fears that I was experiencing, preparing to birth my second child after the plans for my first birth were taken away by an unsupportive (different) Trust. I was able to explain to her what really mattered to me to achieve a safe and positive birth, and she grew to know me, and to know what went wrong before, so that she could support that without me starting again at every meeting. This continuity saved the NHS's time as I could go straight in with my new questions without starting my history from scratch with a new midwife, and it meant that when I reached the end of my pregnancy, I felt confident and supported in a way that I'd not felt the first time round.

## The best laid plans…

At about 2.30am one night I woke to feel my waters breaking. I woke my husband and scooted to the bathroom where it was clear that it was not just a leak, but all of my waters. I was 36 weeks to my (very accurate) dates, and 37 to my 12 week scan so in anticipation of labour starting soon my husband prepared the birth pool and we went back to bed.

In the morning, nothing further had happened, so we called Lorraine, who came and confirmed - not that confirmation was necessary - that my waters had broken. She did so by checking the pad that I was wearing, as I was now continuously and uncomfortably leaking fluid. She did this by checking my pad rather than by doing a vaginal examination, to reduce the chance of infection. We all hoped that labour would start soon, and she left expecting us to call her back that day.

48 hours passed and still no baby. Lorraine said that the hospital had asked me to come in for my baby to be monitored, which we agreed to, but it turned out that they actually had a different intention for me.

When on the ward I was first seen by a junior doctor who asked me to adopt the well-known heels together position. I asked her what she intended to do, and she replied that she was going to examine me to see if my waters had broken. I explained that they had, but she said that she needed to check. I explained again that my waters had broken, there was no doubt that this is what had happened, and that I didn't want to have a vaginal examination because of the risk of infection.

"But you have to", she said.

"No, I don't", I replied.

"But we're going to induce you this afternoon and we need to see whether your waters really have broken", she said.

"I'm not here to be induced though."

"But you have to be."

I made it quite clear that this is not why I'd come into hospital, and that I was not consenting to induction or examination, and she got quite cross and told me that she'd have to get her registrar to see me.

The registrar duly arrived and said, "I understand that you are refusing to be induced. Do you understand that you are putting your baby at risk?"

My husband and I then asked her exactly what that risk was, and how it compared to the risk of induction which was information that she was unable to provide us with other than "you'll get an infection", and eventually we were then passed to the consultant.

**When we get to know someone and build a positive relationship with them they are unlikely to be rude and coercive. When we've been able to have discussions about our own wishes, previous experiences and needs for our births, we are starting from a position of understanding and trust when things digress from normality.**

It was these types of interactions that we had wanted to avoid when we originally decided to hire an independent midwife. We so badly wanted the continuity with someone that we knew, and who knew us. When we get to know someone and build a positive relationship with them they are unlikely to be rude and coercive. When we've been able to have discussions about our own wishes, previous experiences and needs for our births, we are starting from a position of understanding and trust when things digress from normality. At the time when my body needed to relax, and my mind needed to believe in the people around me, I was feeling hugely stressed, attacked and isolated and totally lacking in trust of anyone. I could not have needed Continuity of Carer more than at this time, from a person that I trusted. Instead, having to deal with strangers who had led me, by their coercion, not to trust them, was devastating.

We eventually saw the consultant, who was reasonably helpful and worked with us to create a plan which we were reasonably happy with. I asked what happened to women whose waters broke significantly earlier than term, and he explained the normal care plan which would be about combining avoiding risks of infection with monitoring the baby and mother, and considering induction if there was a sign of infection. My husband and I decided to choose this route for our baby despite him being almost at term.

We went home and started to research as hard as we could. We'd started from the position of knowing nothing about premature rupture of membranes (PROM) or its potential consequences, and were now trying to find out enough information to make an informed choice about the care of me and our baby. At the same time, we were trying really hard to ensure that our desire for a natural home birth didn't result in any decision which could potentially pose a significant risk to our baby. I use the phrase "significant risk" rather than just "risk" as no single choice is risk-free.

I checked my temperature every 3 hours, and kept a very close eye on my waters as they continued to leak (which of course continued, as they get re-made continuously for any sign of infection and there was never any indication of a problem, but any interaction with the hospital meant more coercion, more threats of dead babies from people we didn't know.

We eventually decided to have a hospital birth with IV antibiotics as at the time we could not find enough information about the antibiotics other than the consultant's recommendation. We were never advised of their risks. We did not think to ask for the antibiotics to be given at home, although some trusts do now offer this.

Eventually, 5 days after this all started I went into spontaneous labour. We went into hospital quite early as I'd wanted to use the birthing pool, and we arrived armed with a clear birthing plan. This included no continuous fetal monitoring, no vaginal examinations, no drugs, no augmentation, physiological birth of the placenta. The

midwife who took us on, who I had not met before that day, read through it and said that she was fairly happy with it all but that she would just like "a baseline reading on the monitor, for baby's sake", which didn't bode well for her actually respecting my needs. What she didn't know, because I'd not met her before, was my strong dislike of the monitor following an issue with it in my first birth. My own midwife, Lorraine, had been entrusted with my previous story but I had no desire to start telling it to a stranger and again I felt really sad and alone, wishing that I could have had Lorraine caring for me at this most vulnerable time. I agreed to the monitoring because the phrase "for baby's sake" was one that I was unable to rationally process due to the fact that I was in labour, but I hated it and removed it after 15 minutes.

Several hours later my labour was really getting very strong so I decided to get into the pool, which felt amazing and I commented that I felt that it had "gone back 4 hours". The midwife replied that in that case we should consider putting up a drip which totally confused me because I was just commenting on how lovely it was! My husband told her that this was all I'd meant, and explained that the drip would not be required, thank you (or words to that effect). Had this midwife been Lorraine, she would have known from our discussions in my pregnancy that of all things, artificial oxytocin was something that I wanted to avoid even if the only alternative was a caesarean birth.

Not much time later my lovely little boy was born gently in the pool. I loved how the pool created a barrier between me and these midwives that I'd never met before, despite my going through one of the most intimate moments of my life. If the midwife that I'd grown to know and trust through my pregnancy had been at the birth, I would never have had to even consider that I didn't really want to have strangers around me at this time.

In the months following Toby's birth we did more research, and I am now clear that I would have declined the antibiotics, had a home birth and watched him very carefully for the first few days. Even with the antibiotics, they had asked that my baby and I stay overnight so that he could be checked every 2 hours, but while we did stay, he was not checked at all because the postnatal ward was too understaffed. They didn't even know that this had been requested. They were yet more new people, yet another break in continuity. When I called the midwife to request that she do Toby's observations overnight, she laughed at me. She told me that I was worrying over nothing. She didn't know that we were only there because we had been told that our baby was at risk of dying from an infection if he wasn't under close observation by hospital staff for 24 hours post birth. She didn't know that my husband felt, as he put it, "bereft", after being forced to leave the two of us at the postnatal ward door when he was sent home, and that I was to suffer trauma for which I needed counselling to deal with the incident after incident of contradictory advice and pressure, and my lack of faith from then on in medical staff. A midwife that I'd never met, who had no idea of the terrible stress and anxiety of the past week, and who had no knowledge of the challenging decisions we'd made under appalling pressure, was now telling me that it was all for nothing, and that I was just being silly.

**The evidence tells us ... that a lack of Continuity of Carer through pregnancy, birth and beyond leads to worse outcomes for mothers and their babies**

The evidence tells us time after time that a lack of Continuity of Carer through pregnancy, birth and beyond leads to worse outcomes for mothers and their babies. It is not hard to see why women are left thrown from wave to wave of uncertainly and coercion, with no time to build a trusting relationship before being turned upside down by another tidal surge of change. Let's smooth the waters and ensure that the Better Births vision of Continuity of Carer is available to all women. As they say about doulas, if Continuity was a drug it would be unethical to not offer it.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal /journal/item/the-consequences-of-discontinuing-continuity-a-birth-story*

# Introducing Maternity Outcomes Matter: Tackling avoidable harm

*by Maureen Treadwell*

**Maternity Outcomes Matter (MOMS)** is a project that started in 2017, with the aim of reducing avoidable harm to mothers and babies which can occur during maternity care. The project is led by service users and charities and has a robust advisory body including an obstetrician, coroner, midwife, neonatal expert and GP. We are shortly to launch our website (www.maternityoutcomesmatter.org.uk) wh ere you will see the full list of our committee and advisory board members.

We thoroughly welcome plans in the NHS 5 Year Forward View to reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and to improve investigations and learning from incidents.

A key objective of the project is to support initiatives where the aim is to reduce stillbirth, neonatal death and maternal injury. Problems with care during labour, CTG training, management of perineal injury and rupture are recurring themes. The RCOG Each Baby Counts project is one example where real progress is being made in the identification of the root causes of brain damage and stillbirth. Making change happen is what matters. Invaluable recommendations of enquiries, such as that at Morecambe Bay, need to be implemented not just published! When things do go wrong, it is vital service providers exercise their legal duty to be candid, that they learn from their mistakes and above all say sorry to families. Service users and families have a powerful role in pressing for these changes.

Adverse outcomes are devastating for families, for NHS staff and for NHS budgets (litigation adds at least £600 to each birth). When the costs of ongoing treatment, special education and social care needs are factored in, the costs become almost incalculable. Families are not the only victims. Health care professionals who feel that they are even partially culpable for someone's death, suffering or disability carry a terrible burden throughout their life. It is clearly in everyone's interest to make maternity services safer.

We know that some women worry that too much focus on the small number of adverse outcomes will result in a huge rise in interventions that they may not want. This is a worry we understand because having as natural a birth as possible is very important to some women. However, intervening when intervention is neither helpful nor wanted is NOT safe practice. The difficulty is communicating risk so that women make informed choices. The problem, as we know, is that risk is not an absolute. Home birth for first time mothers is a perfect example. In absolute terms, the serious risk to the baby of a first-time mother with no complications at the onset of labour is 6 extra cases in a 1000[1] compared with hospital birth. Some women, however, weigh risks and benefits differently and are willing to take this small extra risk. Other women will regard any increased risk, however small, as one they are not prepared to take. Different women will make completely different decisions based on the same information but it is the individual woman's decision that matters. Ensuring that the information presented to women is robust, evidence-based and free from bias is the challenge. This is why we are so grateful to AIMS for giving us an opportunity to outline the project and develop a relationship, because we are determined to ensure that the MOMS project benefits all women and their families. If you would like further information please contact info@maternityoutcomesmatter.org.uk

*Maureen Treadwell is co-founder of the Birth Trauma Association, an organisation which both supports women who have had traumatic experiences in childbirth and campaigns to improve maternity services, www.birthtraumaassociation.org.uk. Born in Tower Hamlets, Maureen began campaigning for better maternity services in 1982, and has been a member of her local MSLC and Community Health Council.*

1. This figure of 6 cases per 1000 is the difference between 3.5 cases per 1000 for babies planned to be born in an OU and 9.5 cases per 1000 for babies planned to be born at home. It is derived from table 25 (p75) in: Hollowell J, Puddicombe D, Rowe R, Linsell L, Hardy P, Stewart, M, et al. (2011) The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth. Birthplace in England research programme. Final report part 4. NIHR Service Delivery and Organisation programme. Available at: *bit.ly/2NA6yTf*

# Implementing Better Births: The Long View

*by Margaret Jowitt*

We have the late Audrey Wise MP (1932-2000) to thank for the notion that in order to improve maternity services it would be useful to ask the users what they wanted. In the context of her work on the Health Select Committee, which led to the Winterton Report (House of Commons Health Committee, 1992), it was Audrey who suggested that, rather than listening only to the so-called experts, the committee should also listen to service users. Audrey's inspiration may have been Jane Lewis who, in the Politics of Maternity Care (1990)4, wrote that:

> *"…there has always been a gap between the perceptions and demands of women in respect to maternity policies and practices, and what has been offered by policy-makers and professionals."*

All previous enquiries had listened to 'the experts', i.e. obstetricians who overwhelmingly wanted women to give birth under their own expert care. The real experts in normal birth at that time were, of course, the community midwives, and thanks to Audrey Wise, the work leading up to the Winterton Report gave them the chance to share their expertise.

After listening to women and other stakeholders, such as the RCM, the NCT, AIMS and the ARM, the 1992 Winterton Report3 was thus produced by the Health Select Committee of the Houses of Parliament. It had three main themes: the importance of continuity of care, the importance of offering women choice of provider of care and place of delivery, and the importance of the rights of women to have control over their own bodies at all stages of pregnancy and birth.

Moreover, it was stated in that report that "…the policy of encouraging all women to give birth in hospital can no longer be justified on the grounds of safety … it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions". The Association of Radical Midwives (2013) was justifiably proud of the praise for its own blueprint in this context. First published in 1986, ARM's Vision for the future of maternity care statement was updated in 20131, with copies given to everyone involved in the review which led to Better Births.

In response to the Winterton Report, the paternalistic conservative government of the day did not much like the idea of women having a say in their maternity care; it thus set up its own Expert Maternity Group under the chairmanship of Baroness Julia Cumberlege. However, the findings were much the same, in particular about the importance of choice for women. Baroness Cumberlege was passionate about listening to women and we now understand that she tried her very best to get the phrase 'continuity of carer' into her final report, Changing Childbirth (Department of Health, 1993)2, but was stymied by the Department of Health who thought it a step too far for a woman to have her own midwife. The Expert Maternity Group did manage to incorporate a suggestion that all women should have a 'named midwife', but when I was doing my research into women's experience of birth in the early 1990s I understood how hollowly this principle had been translated into practice in some areas, when an antenatal clinic proudly proclaimed to all attendees: 'Your named midwife is Sister …".

**The problem for the Establishment is that if you allow women to support each other – midwives to support women and women to support midwives – they might well gang up together against the System, declining interventions that are deemed necessary!**

The problem for the Establishment is that if you allow women to support each other – midwives to support women and women to support midwives – they might well gang up together against the System, declining interventions that are deemed necessary!

Changing Childbirth remained official policy right up until the publication of Better Births (NHS England 2016)5, this latest maternity review. But, as always, getting from paper to practice was the challenge. At the beginning, things looked to be going well. Shortly after Changing Childbirth was published, the Changing Childbirth Implementation Team was given 'pump priming' money and set about helping services in various locations to test different models of care. Various schemes were trialed around the country, most involving team midwifery where teams of midwives shared a 'caseload' of women. There were ten indicators of successful implementation, among them: women carrying their own notes; the concept of a named midwife; 30% of women having a midwife as lead professional; midwives having direct access to maternity beds (i.e. midwives as well as GPs would now be able to book a hospital bed for the birth); and equipping ambulances with staff to support transfer to hospital in an emergency. It was also established that at least 75% of women should know the person caring for them during their delivery.

Passionate midwives put their all into making it work. Pilot studies showed excellent outcomes and increased satisfaction for mothers, but the schemes were not rolled out across the entire service. Many were sabotaged by caseloads being increased to the point where midwives suffered burn out. Moreover, despite increasing workloads, the team midwives were often pulled into obstetric units when these units were short-staffed. Another common pretext for closing schemes was that services were 'inequitable'. It was simply not fair, the feeling went, that some women could have continuity of care while others only had access to the traditional provision. The answer to this conundrum was not to improve care for all women by expanding continuity of care schemes (as would seem to be the obvious solution) but to close those services which women preferred and valued.

Another of the success indicators of Changing Childbirth was that antenatal and postnatal provision for women with uncomplicated pregnancies should be reviewed. Women should receive the care they needed rather than services strictly adhering to the age-old schedules for universal antenatal and postnatal visits. The UKCC, the predecessor of the NMC, made the necessary changes to the Midwives Rules. Midwifery leader Mary Cronk warned us of the dangers of abandoning these schedules, and her predictions came true, much to the detriment of women and their midwives. A daily visit for ten days after the birth now seems like unheard of luxury and yet, having so little experience of caring for babies, many women need this now more than ever, and this is perhaps borne out by the rising number of women seeking to access such support (where they can afford to do so) from the growing birth doula sector. As community midwifery services were cut, this had a knock-on effect on the logistics of providing domino care and of enabling women to give birth at home. The changing ratios of community midwives to hospital midwives also meant that there could be fewer student placements in community midwifery. Staffing labour wards always took precedence over a planned home birth. Hospital needs trumped individual women's needs. Another adverse effect of Changing Childbirth was the exit of GPs from maternity care. The old GP units morphed into midwife-led units, and now that they had no doctors to champion them, it was up to midwives to keep these birth centres open. Birth centres struggled to survive in that context and were often replaced by alongside midwifery units, which again suffered as staffing the labour ward was prioritised. On the other hand, GPs no longer needed to fear being called out to a difficult birth. Transfer to hospital now became the standard response to difficulties in labour or after the birth.

The only Changing Childbirth scheme to survive well into the 21st century was the Albany practice, and the other King's midwifery team. The Albany was funded separately from the rest of the maternity service, with the money for the service being managed by the group itself; hence, its midwives were not managed by the Trust and could not be redeployed at will. Even the Albany was eventually closed with indecent haste, however, following a contrived audit after its champion at King's College Hospital, Cathy Warwick, moved on to become General Secretary of the Royal College of Midwives.

However, Changing Childbirth did endorse and insist upon the notion of choice, and the revolutionary concept that the woman should be at the centre of her care.

Meanwhile, there have been enormous pressures in the opposite direction to the Changing Childbirth agenda. Litigation costs, for example, had started to rise exponentially, and professional indemnity insurance (PPI) for obstetricians was becoming unaffordable. In 1995, therefore, the Clinical Negligence Scheme for Trusts (CNST) was established. The newly formed hospital trusts, who were funding the CNST, became paranoid about keeping their premiums under control. The way to do this, they believed, was to exert ever more control over birth, which meant more control over women and midwives. This again had the effect of derailing Changing Childbirth. Although 30% of women were supposed to have a midwife as their lead maternity professional, for example, more and more women were 'risked out' of midwifery care. The newly acquired choices in childbirth were now often denied on the grounds of safety.

## Looking forward in the context of Better Births: how can we avoid a repeat failure to implement?

In my view, the real battle is for the control of women, both mothers and midwives. Women are controlled in many ways, for example through the control of the time and place of their care. Putting expectant mothers in hospital at set times for consultant appointments, clinics and induction of labour, gives the hospital system control over them, rather than allowing for the healthy physiological process itself to be in control. The hospital sets limits in time and space so that it is able to plan its services for predictable events and prefers to plan its work over the normal working week. Whilst this is an understandable method of management, it is important to understand the inappropriateness of this method of control in the context of childbirth. Midwives are controlled in the same way: keeping them under surveillance by employing them in a set place at set times. This particular form of control has created a huge barrier to change: it is no co-incidence now that one of the greatest challenges of Better Births is how we encourage many midwives now used to a three 12hr days per week working pattern to realise the importance of working in a more responsive and flexible way, to meet the needs of birthing women. Control over midwives is also exerted by threats of referral to the NMC and, unfortunately, by peer pressure. Anecdotal evidence suggests that male doctors tend to support each other against bullying management behaviour, whereas women are more susceptible to peer pressure, be they doctor or midwife.

For me, the key to a better birth is to acknowledge that quality maternity care is based around the human relationship between the mother and her midwife, encapsulated in Better Births by the key recommendation to shift to a continuity of carer model of care for most women. NHS England want to see this in operation by 2021. But what is clear is that it will be even more difficult to implement this crucial element of Better Births now than it might have been in the 1990s. Midwives have become used to fewer longer shifts, and many prefer, or have at least planned their lives around, working this way. It may be easier for them to arrange childcare with this working pattern. There are fewer 'on-call' arrangements, which seem to be hated by many midwives. Some London hospitals rely on midwives who commute vast distances to work their three days a week because housing is so expensive in the capital. These are all explanatory factors in the difficulty in now switching to models of care that demand a certain amount of on-call working.

**... [if]we really want to improve birth, then we need to trust our midwives! If the Trusts look after their midwives, the midwives will look after the women, and the women will be in far better physical and psychological shape to look after their babies.**

In order to encourage midwives to work in a different way, so that they can forge relationships with women, midwives need to have control over their diaries: when and where they do their visits, how they fit their mothers in around their own family lives. Hospital managers will hate this loss of control and CNST may well suggest that they cannot properly calculate indemnity for midwives without set hours of working. Other midwives may find it challenging to give up the certainty of shift work.

If, however, we really want to improve birth, then we need to trust our midwives! If the trusts look after their midwives, the midwives will look after the women, and the women will be in far better physical and psychological shape to look after their babies. In the end, it comes down to women, midwives and other stakeholders being united and working together for the transformational change in the maternity services set out in Better Births. Let's work on this together!

*Margaret Jowitt has been working towards making birth a safer and more rewarding experience for mothers and their babies since 1991. In 1998, Margaret gained an MPhil for her research into Mothers' Experience of Birth at Home and in Hospital. Margaret is a published author, a birth-chair designer and a past editor of Midwifery Matters, the magazine of the Association of Radical Midwives.*

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## New AIMS leaflet available to order

We have a new AIMS leaflet, kindly designed for us by one of our members, Elly Gedye. This is an A4 tri-folded sheet, ideal for handing out at classes, conferences etc. You can order leaflets from the AIMS shop here: https://www.aims.org.uk/shop/item/aims-leaflets-pack-of-10


# Upcoming Events

## The AIMS AGM

This is on **Saturday 22nd Sept, 2018, at the Carrs Lane Conference Centre, The Church at Carrs Lane, Carrs Lane, Birmingham, B4 7SX**.

Please email secretary@aims.org.uk if you plan to attend or wish to send apologies.

## Wales & South West Maternity & Midwifery Festival

When: 20th September 2018#
Venue: Cardiff City Stadium, Leckwith Road, Cardiff CF11 8AZ
Cost: Free
www.maternityandmidwifery.co.uk

# Implementing Better Births:

## Continuing the campaign for continuity of carer

## A call to action!

*by the AIMS Campaign Team*

AIMS has long campaigned for a shift in emphasis in the maternity services to one that offers truly woman-centred care, anchored around the key midwife-woman partnership. AIMS believes that maternity care founded on that mutually respectful and trusting one-to-one relationship is crucial to achieving our shared goals of effective and safe maternity care. Forming a relationship with a primary carer creates a secure basis for care even when birth becomes complicated and demands a multi-professional approach.

Whilst AIMS is therefore delighted that the Better Births recommendations around continuity of carer form a key part of the national Maternity Transformation Programme, the AIMS Campaign Team is also clear that there is no room for complacency. Rather, there is a continuing need for local birth activists to work to ensure that this transformation is delivered across the country. The local implementation phase of this campaign is crucial. If we fail at this stage, we may have to campaign for another generation for this opportunity.

Thus AIMS is calling on local campaigners to take action to secure this promise of continuity of carer for women and families in their local areas. Each area will be different in terms of how this model can best be matched to local needs. And every area will be different too in how we best engage in this work: campaigners will need to be creative in terms of how they campaign, taking into account what's already happening locally. In some areas, it might be most effective to work with an existing Maternity Voices Partnership, for example: maybe you could offer to sit on the partnership as the 'continuity of carer' champion? In other areas, it might be worth talking directly to the leaders of your local maternity system, to understand how implementation is being facilitated at that level.

### Priorities for action

1. ***Find out what's going on, and then get involved in the development and scrutiny of your local plans for implementing continuity of carer. Are these plans realistic? Are they sustainable?***

* **Are we setting up schemes that are designed to fail?** We know that burn-out has been a major factor in previous attempts to implement continuity of carer schemes. So given the casemix envisaged for any given continuity team, do the numbers of women to be cared for seem realistic, or do they just seem too high? If the casemix is made up of many women whose care needs will be particularly time-consuming, for example, you will want to query how the caseload allocation has been modified to reflect this. (Usual allocations tend to be within the range of 28-40 women per midwife per year, depending on casemix, for a full caseloading continuity model.) It is also worth scrutinising carefully any plans for non-geographically based caseloading teams: do they allow for enough time for midwives to travel between appointments?
* **Do local managers understand what is meant by true continuity of carer?** Is there a good commitment to the notion that continuity means continuity across pregnancy, birth and postnatally? If you hear your local service already muttering about the likelihood that intrapartum continuity will not be achieved - because midwives will have to attend case conferences as a priority, for example - it is important to check that the local managers really understand the model of care that is required!
* **Working with the TWTs (Those Willing to Try).** Do local managers seem to be building on the enthusiasm of those local staff who are keen to work in a continuity model (with all of the changes that this will make to their work/life balance), or are there signs that reluctant staff members are being drafted in to work in the initial continuity teams?

***2. Scrutinising local maternity services decisions: are they***

***designing-in continuity of carer for the future, or making it less likely?***

* **Focus on new staff recruitment.** A key barrier to the rapid implementation of a continuity of carer model is that many staff have become accustomed to working in a non-continuity model, and have built their non-work arrangements around this. This is not an easy matter to untangle. In order to tackle this structural problem for the future, AIMS suggests that it is really important to scrutinise how new staff are being recruited. It may well be that the majority of new midwifery staff, for example, are not yet being allocated immediately to a continuity of carer team model of working. But if they are not being recruited on the basis that this is the policy objective for the local service, then this is simply storing up problems for the future, making continuity of carer for most women within the next ten years less (rather than more) likely in your area.
* **Putting short-term planning into a broader context.** How do the decisions being made now in terms of the creation of continuity of carer teams either help or undermine the straightforward further rollout of the continuity of carer model? You will want to scrutinise carefully, for example, the new structures that are being put in place to meet initial continuity of carer targets, and to think about whether they really make sense given your longer-term ambition. Let's imagine an end-point goal, for example, where your whole area is covered by mixed caseload continuity teams of staff. If that is where you hope to get to, but you are starting out with a couple of continuity teams that are taking on specific groups of women from across your whole area (for example, women with existing mental health issues, women who are particularly vulnerable for other reasons, or maybe even a cohort of women who are keen to be supported to birth at home), then you will need to take into account the eventual disruption of the dismantling of these teams as you move over time to a more geographically-based team structure. Good design now must be informed by a longer-term context which is your local vision of where you are trying to get to: initial implementation plans cannot be sensibly considered in isolation.

## How can we help you?

The AIMS Campaign Team is here to support local activists every step of the way with this campaign, so please don't hesitate to get in touch with us via email at campaigns@aims.org.uk if you have any questions or would like some advice.

As part of this work, the AIMS campaign team would also like to build up a picture of how continuity of carer is being planned and implemented across England, or at least what it feels like from an activist perspective. This will really help us as we continue with our national campaigning work and as we collaborate with parallel campaign efforts being led by other groups and individuals. So please get connected with us if you are working on this issue in your own local area, so that we can all keep in touch.

You can also help us by sharing information such as tips about what campaigning strategies are working well in your area and what doesn't work so well. And tell us what support you would find helpful. We look forward to hearing from you, and we look forward to us all supporting each other on this key issue.

To print this article directly from AIMS website, please go to *https://www.aims.org.uk//journal/item/better-births-call-to-action*

# Physiology Matters: A letter to Doctor Joseph B. DeLee

*from Celine Lemay*

*As a practising midwife and long-time AIMS member, I realise that maternity is colonised by the biomedical perspective. This is evident in the discourse and the organization of care. Historians of obstetric medicine consider Dr J. DeLee, an American gynaecologist, as the father of modern obstetrics. As I read his renowned 1920 article, I felt that I wanted to talk to him, both as a midwife and as a woman who has given birth three times. This letter – a flight of fancy if you will – is the result: it is what I want to say to him – and his followers – almost one hundred years later. The letter was originally written in French, as the prologue to my first book (2017).*[1]

Dr. DeLee,

I have just been reading the article you published in the American Journal of Obstetrics and Gynecology in 19202 , almost a century ago. It is that well-known article that so heavily influenced the practice of obstetrics in Western medicine.

At that time, you lamented the numerous difficulties linked to childbirth and you noted the high level of morbidity and mortality among mothers and babies during birth. According to you, very few women could emerge from the childbearing process unharmed. To give birth was to put their lives and those of their unborn babies in danger. Because you recognized the presence of pathologies, you proposed nothing less than to redefine childbirth itself as a pathology.

In your view and in the name of science, you proposed that all births should henceforth take place in hospital under the care of a specialist doctor and be considered as a "necessary" medical surgical procedure. You also argued that we should put birthing women under anaesthesia, systematically cut their perineum and use forceps "preventatively" in order to accelerate the second phase and get the baby out of the uterus.

You declared that midwives were not qualified to attend births and that we should even denounce their approach of favouring vigilance and patience.

Your words still resonate today in the mentality of much modern birth practice, entirely dominated by the potential of pathology, with fear so well concealed under the notion of "risk". The impact of your claim has been to obscure childbirth physiology, to justify numerous systematic interventions and to encourage a surgical conception of childbirth. Technological possibilities have made this model ever easier and more seductive, as much for healthcare providers as for many women.

**I am keen to give you some good news regarding childbirth. Scientific research in human biology has confirmed that pregnancy, birth and breastfeeding are normal physiological processes of the female body. Doctor DeLee, childbirth is not a pathology.**

Doctor DeLee, nearly 100 years later, I am keen to give you some good news regarding childbirth. Scientific research in human biology has confirmed that pregnancy, birth and breastfeeding are normal physiological processes of the female body. Doctor DeLee, childbirth is not a pathology. The mother and the baby have innate and complex capacities of mutual regulation, endogenous competencies to accomplish the process of childbirth.

Furthermore, healthcare based on the promotion of physiology reduces not only interventions but can generate

a cascade of physical, psychological and social benefits for the mother/baby dyad. Fundamentally, it is a question of placing confidence at the heart of maternity care. Women are capable of carrying and bringing a child into our world. Certainly we must act with patience and prudence, respect and kindness to ensure that women give birth with their own power and dignity.

Doctor DeLee, midwives are not part of the problem. They are part of the solution. The journal The Lancet, already renowned and respected by the medical community of your time, has now demonstrated clearly the importance of midwives to global maternal and child health, in its key series of papers investigating midwifery and its role in improving key health outcomes (2014).3

One hundred years later, it is time to trust women and the childbearing process. Our new century is beginning to pick up this essential thread… for the future of our humanity and our world.

Yours sincerely
Céline Lemay

*Céline Lemay PhD, anthropologist by academic background, has been a practicing midwife for more than 30 years. She is also a senior lecturer in midwifery at the Université du Québec à Trois-Rivières, and a current council member of the College of Midwives, Québec (l'Ordre des sage-femmes du Québec).*

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# Campaign update: Is the NMC fit for purpose?

*by the AIMS Campaign Team*

## Change at the NMC: why is this important to AIMS?

AIMS recognises that a large number of taxpayer funded national bodies are key to driving improvements in the maternity services. AIMS is keen that each of these bodies plays its part effectively, and that they work in partnership with us and other stakeholders to achieve this. This is central to our primary mission of campaigning for better births for all.

Regarding the regulation of individual healthcare professionals, AIMS considers that the body of regulators working under the umbrella of the Professional Standards Authority (PSA) (including the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC)) plays a key role in undertaking ongoing quality assurance and regulation of the maternity services via their regulation of individual professional staff.

Effective and efficient regulatory bodies are vital for safeguarding maternity service users and AIMS on behalf of all maternity service users, and dependent on the volunteer resources we have to carry out this task thus seeks to keep their activities under close review and to campaign for improvements to the maternity-related regulatory system as necessary.

## The NMC: the renewed case for change

Regarding the NMC in particular, AIMS notes the publication in May 2018 of the *PSA's Lessons Learned Review* reporting on their investigation into the Nursing and Midwifery Council's (NMC's) handling of the Morecambe Bay cases together with the recent resignation of the NMC's chief executive, Jackie Smith.

AIMS is founded on the principle that the actions of service-users are key to maternity service improvements, and AIMS pays tribute to the affected families, who were
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not only instrumental in the setting-up of this investigation, but who have been steadfast in their determination to ensure that lessons are learnt from the deaths of their family members in what has become known as the Morecambe Bay scandal.

The Nursing and Midwifery Council (NMC) exists to play a key role in the regulation of the maternity services, and effective and efficient regulation is vital for the safeguarding all maternity service users. In that context, the highly critical nature of the Lessons Learned Review is of great concern to AIMS. It is also of concern to AIMS that the methodology of the performance review process carried out annually by the PSA does not seem to be sufficiently attuned to picking up the major concerns about the NMC which have been well-known and publicised in the media and social media during the last few years.

AIMS notes that the 'Lessons Learned' report from the PSA is not the first critical report of the NMC's operations, and in this context recalls concerns about the functioning of the NMC that date back many years (and that have been regularly covered in the AIMS Journal). AIMS is clear that improvements in the performance - and changes to the deep-seated culture and poor communication habits - of this regulator are long overdue and that such improvements would make an important contribution to the ongoing improvement in the maternity services in the UK.

### The NMC and the way forward

Following the Lessons Learned Review, AIMS therefore looks forward to scrutinising the detailed action plan as it emerges from the NMC, which should set out how the NMC will address the many criticisms set out in the Review, as a step towards restoring - and indeed warranting - renewed public confidence in its operations. We are also keen to know more about the process for appointing a new chief executive.

AIMS of is of the view that it may be, however, that only wholesale reform of the regulatory structure, involving significant changes to the organisation of current regulatory functions, will deliver the objective of having in place a midwifery regulator which both the public and professionals can trust.

This is in line with proposals put forward by the PSA, which suggests that a shift to a 'super-regulator' is a sensible way forward, to ensure the efficiency and effectiveness of all regulators in the healthcare sector. Certainly, there is much evidence that the NMC has never worked well enough for maternity service-users (nor for midwives) and it may be that a significant redesign of the regulatory sector is the best way to achieve the clear improvements needed. In that context, we look forward to the next steps following the *Department of Health's recent consultation exercise* on reforms to the regulatory system to ensure "better and more responsive healthcare professional regulation". *The AIMS response to that consultation* can be found on our website. But whether the NMC remains, or whether the regulation of midwives is taken on by a new or existing organisation, AIMS is strongly of the view that all the recommendations of the Lessons Learned Review must be fully implemented.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/physiology-matters-dr-delee*

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# Keeping babies 'Born In Salford'

## *An update on maternity provision for Salford women*

*by Amy Prodgers*

On the 19th April, as a member of the University of Salford Midwifery Society, I was invited to attend the opening of the Ingleside Birth and Community Centre in Salford. The weather performed its own blessing and the sun shone on Oakwood Park to reveal the hidden greenery of post-industrial Salford. The Ingleside mansion is a Victorian listed building left to the people of Salford in 1936 by the Pilkington family, along with extensive grounds which now function as a public park. Finding a new use for the building has been a subject of concern for local people in recent years, and its conversion into a birth centre has managed to achieve an ongoing public function for the building.

The refurbishment has successfully created modern
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birthing spaces whilst preserving the building's beautiful original features, most notably the unique and varied windows. Each of the large, airy birth rooms has a generous-sized birth pool, and in the largest room the doors open to reveal the lush trees and birdsong of the surrounding park. The centre also hosts community spaces to enable use of the facilities beyond that of birthing women to other members of the locality, as campaigned for by local people. It is hard not to be impressed by the tranquil rooms and settings, and its potential to be transformative. However, as an individual whose personal history has traced the decline of maternity services in Salford, the day also brought with it a great sense of what Salford has also lost.

Until November 2011, Salford had a full range of maternity services delivered from Salford Royal Hospital, still affectionately known to Salfordians as 'Hope Hospital'. The unit was an early adopter of the UNICEF Baby Friendly standard, and only a year before its closure was listed as one of the Care Quality Commission's top ten maternity units. Babies had been born on the site since 1882, and on hearing of the closure, the people of Salford took up the fight to keep their babies 'Born in Salford'.

Despite the campaign, the maternity unit was closed in November 2011. (See Davies and Rawlinson (2012) for a discussion about the closure of the obstetric-led unit at Salford Royal, as part of Greater Manchester's maternity reconfiguration programme.) However, one positive outcome from the relentless campaigning of women, midwives, and local politicians was the retention of a freestanding midwifery unit, so that the women of Salford were still able to give birth in the city. When this later closed in September 2017, the women of Salford were left with no other choice but home birth if they wanted to give birth in Salford.

Their only other options were to use four hospitals outside of Salford: North Manchester General Hospital, Royal Bolton Hospital, St Mary's Hospital in Manchester, and Warrington Hospital. The opening of the Ingleside birth centre in Salford thus offers a welcome improvement to this situation. It is notable, however, that at the opening event women travelled from other areas of the region to see the facility, and there have been discussions around the centre being used by women across Greater Manchester and Eastern Cheshire. It remains to be seen whether the centre will focus on serving the people of Salford, or whether the needs of others will begin to overwhelm those of the local community.

My journey into motherhood shadowed these changes to maternity services in Salford. In December 2006, shortly after the birth of my first child at Salford Royal, the 'Making it Better' consultation into maternity services in Greater Manchester recommended the closure of the unit. By the time I had my second baby two years later, an appeal against this decision had failed, and the campaign focused now on establishing a freestanding midwifery unit in Salford, and was successful with this. With my third baby, the fight was to retain this freestanding unit in Salford. Involved in the campaign as part of the Salford Maternity User Group, I forged strong friendships and alliances with my colleagues and was supported by some amazing midwives and midwifery lecturers.

It was painful at times; our low as a user group was finding out about the proposed closure of the freestanding midwifery unit on reading the Manchester Evening News, despite having been part of the consultation. We would have at least expected to have been told of this decision directly! In the pause provided by a series of angry letters to the newly established Clinical Commissioning Group (CCG), the political climate in maternity services had changed enough for plans to start being made for a new birth centre, and with our experience of childbirth deemed too distant, a new group of women were enlisted to provide their views.

There has been a notable absence of discussion about this impassioned fight to retain services in Salford as part of the celebrations opening Ingleside. For some, it seems the campaigns to retain services in Salford were overshadowed by the 'success' of Greater Manchester's maternity and neonatal service reconfiguration (Making it Better). As Dowler, Heritage and Wallis (2012) wrote in the Health Service Journal:

*"When the neonatal intensive care unit and maternity services at Salford Royal Foundation Trust finally closed in November, it seemed almost to pass without comment. Local papers did not report angry protests. There were no indignant statements in Parliament. You would not have known that a few years previously the closure was so controversial a serving cabinet minister – Hazel Blears – joined a demonstration against it."*

However, Salfordians are pragmatic people. In Rebecca Long-Bailey MP's speech at the opening of Ingleside, she was applauded for her iteration of Tony Wilson's famous quote about Manchester, "we do things differently here". The unfortunate truth for Salford is that, shadowed by our more powerful Mancunian neighbours, we have no choice but to do things differently. We did fight, and we did retain services. However, the fragmentation of care in Salford has had catastrophic consequences for the provision of services. In terms of financial strength, Salford CCG's power is diminished by this four-way split and our Salford voice has become weakened. Alongside the creation of the Ingleside Birth and Community Centre, other services in Salford have slowly ebbed away, passing almost unnoticed: breastfeeding peer support services, the antenatal clinic and scanning services from Bolton Foundation Trust at Salford Royal, and an acupuncture service highly valued by women suffering hyperemesis and pelvic girdle pain.

**... my enthusiasm for ensuring maternity services are informed by women is ... the key to ensuring that maternity care is woman-centred. However, this means ensuring that we understand what women want, whether or not they are one of the vocal few who will be part of campaigns...**

I am now a Student Midwife, but my enthusiasm for ensuring maternity services are informed by women is not diminished; this surely is the key to ensuring that maternity care is woman-centred. However, this means ensuring that we understand what women want, whether or not they are one of the vocal few who will be part of campaigns. Returning to my letters from the proposed closure, I was reminded that as the Salford Maternity Services User Group, one of our major concerns was that our views as a group of mainly white middle-class women did not represent those of the women of Salford. At the opening of Ingleside, Baroness Cumberlege, who led the National Maternity Review, spoke passionately about harnessing the skills of working women in Maternity Voices Partnerships (MVP). The professional woman invoked by Baroness Cumberlege do exist in Salford, but I would question whether they are representative of Salford. 70% of Salford residents live in areas of significant social deprivation, and only 20% are in professional level employment, compared to 50% of the South East. It is a challenge for a Salford MVP to represent the voices of such a diverse group of women, and a creative approach needs to be given to engagement. The division of care in Salford caused by the 'Making it Better' reconfiguration adds to this challenge. Not only must we work to try and find this voice, we must also try to communicate this to four different NHS Trusts. Should Salford attempt to do this through its own MVP or should Salford women try to represent their voices as part of existing MVPs in these trusts? Whatever way is chosen, ensuring the perinatal needs of Salford women are met seems a formidable task.

In many ways the opening of Ingleside is a triumph; to have retained services in Salford is an achievement which seemed unlikely just four years ago. However, in his speech at the opening, Salford's Mayor, Paul Dennett, claimed that Ingleside will continue to enact the Pilkington legacy for the people of Salford. It is clear the beautiful building will have the power to attract women from outside the area to use the centre. However, to act as a legacy for Salford, Ingleside will need sustainable targets for births and a supportive staff base. It must endeavour to offer services that benefit women from Salford beyond those whose low risk status will enable them to birth there. Having community midwifery services located at Ingleside seems of little added value to local women who have continued to access community midwifery in local GP surgeries and Children's Centres. The possible co-location of perinatal mental health services is a more promising addition. What is clear is that the campaigning zeal of the women of Salford must not end here. We must continue to press for services which meet the needs of Salfordians rather than allowing the marketisation of maternity services to obscure the needs of the most vulnerable.

*Amy Prodgers is soon to graduate from the University of Salford, where she was this year's winner of the university's Student Achievement Award for Midwifery Programmes.*

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To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/maternity-provision-salford*

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# Introducing the Make Birth Better Network

## *Networking to address the birth trauma challenge*

*by Emma Svanberg and Rebecca Moore*

The number of social media references to the Make Birth Better campaign and network are growing, and you might be wondering what it's all about. Make Birth Better has grown from a small post on Instagram to a network of over 40 people. Together, we form a collective, working to raise awareness of the impact of birth trauma, to encourage trauma-informed care throughout maternity services and to offer support and training to others working with women and their partners who have been traumatised by birth.

The Make Birth Better campaign began when Emma Svanberg, who often uses social media to raise awareness of perinatal mental health problems, wrote on Instagram about the difference between PTSD after birth and postnatal depression. As a result of the responses received, many of which outlined women's traumatic experience of birth, she invited women to send her their birth stories. Over 70 stories were then analysed, and the key themes (which can be found at https://www.makebirthbetter.org/findings) reflected themes already well established in existing birth trauma research. These provided a starting point for Emma to consider what changes could be made to a woman's maternity journey to promote a more positive experience of birth, something which will now be explored more fully with the Network.

Whilst doing this, Emma connected with Rebecca Moore, a perinatal psychiatrist specialising in birth trauma – who founded an annual Birth Trauma conference (the next will be held in January 2019). Rebecca also campaigns for greater awareness of birth trauma and was hoping to set up a network of organisations and people from different personal and professional backgrounds to promote trauma-informed maternity care. Together, Emma and Rebecca have pulled together over 40 people who hope to bring their shared experience to the group - parents with lived experience, peer supporters, health and mental health professionals, research academics, as well as organisations such as AIMS, the Birth Trauma Association, the Positive Birth Movement, the Association for Infant Mental Health and Birthrights,

The Network has already held two meetings and is developing its mission statement and initial objectives. While meetings have so far been held in London, network members are located throughout the UK and we hope to address this in the future. The initial goal for the Network was to develop the Make Birth Better website to provide a comprehensive resource for parents, professionals and services. This launched on 1st July and has been well received by parents and health care professionals. Our next goal will be to collaboratively create a model of a trauma-informed maternity journey, which services can draw from in their own practice.

As a group of people from many different backgrounds, we hope to offer a broad perspective on birth trauma, pulling together some of the brilliant work that is going on around the UK. By connecting professionals, third sector organisations and those with lived experience we can raise awareness, campaign, offer training, create resources and enable a platform for all views. As well as these activities, the Network also hopes to support its members as they
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champion this key issue in their own work. Please do visit the website and share it among colleagues and friends, and let Emma or Rebecca know if you are interested in being involved.

### More about the Network founders

*Dr Emma Svanberg* is a Chartered Perinatal Clinical Psychologist with a special interest in birth and the transition to parenthood, writer and Perinatal Mental Health Advisor for the Positive Birth Movement.
*Dr Rebecca Moore* is a Consultant Perinatal Psychiatrist, with a special interest in birth trauma and PTSD after birth. She organises an annual birth trauma conference and writes, blogs and speaks about mental health in the perinatal period.

Details of network members can be found on the Make Births Better website, where you can also request to become a member and add local birth trauma services to the Make Birth Better map which can be found here *www.makebirthbetter.org/gethelp*

### Some definitions: what do we mean by birth trauma and trauma-informed maternity care?

Although for all parents birth is a huge life event, some can be left feeling traumatised by their experience. It is believed that 1-3% of women meet the criteria for PTSD after birth; many more are left with distress but do not meet diagnostic criteria. *The Birth Trauma Association* suggests that as many as 200,000 women a year in the UK may feel traumatised by their birth.

A difficult or traumatic birth occurs when women - or their partners- find some aspect of their birth traumatic, distressing, and/or fearful. It's not what happened that is important, but how you felt at the time.
Trauma-informed care in maternity services would encompass an awareness of the roots of a traumatic response, including the importance of compassionate care for patients and adequate support for staff, as well as offering additional support to those who might be more vulnerable (such as those with a previous history of trauma).

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Conference Report

# ENCA Meeting 2018, Sanski Most, Bosnia and Herzegovina

*by Debbie Chippington Derrick*

Ceri and Debbie at ENCA

ENCA, the European Network of Childbirth Associations, was founded in 1973 on the initiative of our German partners, with the aim of sharing experiences of campaigning for improvement to maternity services across Europe. The first meeting was held in Frankfurt that year, attended by representatives from 13 countries. AIMS was a founder member and the second meeting was held in the UK in 1974. Beverley Beech was the original AIMS contact with ENCA, and has attended meetings each year, with other AIMS members also attending the meetings from time to time. I had the privilege of attending two previous meetings, the first in Paris in 2015 and then in Portugal in 2017. This year, Ceri Durham and I represented AIMS at the meeting, and we were pleased to be accompanied by Beverley, who attended and spoke at this 25th Anniversary set of meetings.

The meeting took place over three days, and we made good use of our time together, starting on the meeting agenda on the drive to the conference venue from the airport (shuffling seats on the bus so we could reach the microphone and make sure everyone could hear!) Most of the ENCA representatives were accommodated at the Centar Fenix (www.centar-fenix.com), an NGO which has

been supporting pregnant women and their families, and the elderly, since 1997, and this arrangement enabled lively discussions to continue throughout the weekend.

Attending the meeting were representatives from 14 countries: the UK, Ireland, Greece, Netherlands, Germany, Croatia, Luxembourg, Spain, Czech Republic and Poland, from Slovenia and Serbia (both new ENCA members) and from our second-time hosts, Bosnia and Herzegovina. Representatives from other ENCA member countries (Bulgaria, Italy, Portugal, Romania, Slovakia and Turkey) were unable to join us this year. We had also thought that the Hungarian representative, Agnes Gereb, was unable to join us, but during the conference on Saturday the door opened and in she walked! The proceedings of the conference came to an abrupt stop and dissolved into rounds of applause and cheers, with people rushing to hug her. I think there were quite a few people in the room with tears in their eyes. For so many of us, of course, Agnes symbolically represents a key raison d'etre for such international collaboration.

ENCA meetings generally take place around a conference or event on the Saturday, organised by the host country. Member countries provide country reports in advance of the meeting, which prepares the ground for a good discussion of issues of concern to different countries, and for a discussion about how we should collaborate further.

The conference itself comprised many interesting presentations, including a focus on just how we disturb human birth and the consequences (Elisabeth Geisel), on whether birthing autonomy might be associated with a shorter labour (Fatima Klempić Dautbašić), on the short and long-term impact on women and babies of the cascade of intervention (Beverley Beech), on the culture of 'either episiotomy or c-section' in Europe (Daniela Drandić), and on women and power (Anna Zdral). A choice of workshops followed, covering Rebozo, butterfly touch massage and birthplans.

During the further ENCA meeting on Sunday, we made plans for better sharing of news across the network via social media, and discussed how we might better share information and statistics, as well as campaigning information and strategies. We also decided that the topic for the next International Week for Respectful Childbirth (IWRC) (13th-19th May 2019) would be "The power for birth is in you". For more information see *www.enca.info/international-week-for-respecting-childbirth*

There was so much of interest and importance during the weekend. The conference and meetings certainly provided lots of inspiration for our own national campaigning efforts. One highlight for me was to hear about the recent Spanish campaign, 'My body is not a toy!' I would wholeheartedly recommend a look at the set of powerful images developed for this campaign on the Spanish association's website (www.elpartoesnuestro.es), a website that incidentally translates well into English using Google translate!

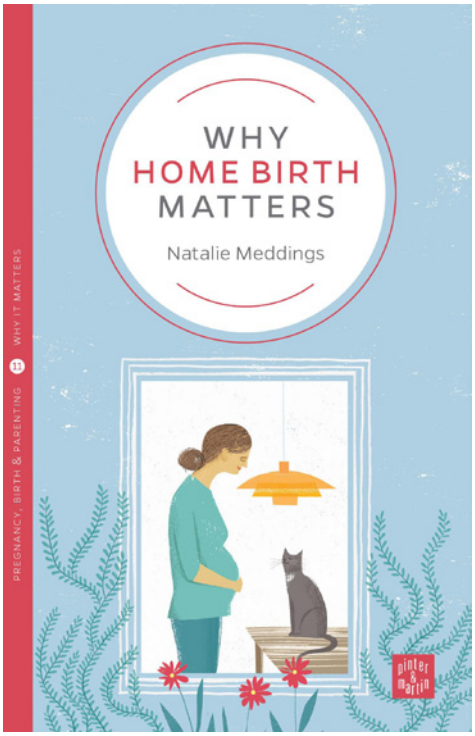
The next ENCA meeting is planned for 24-26 May 2019 in Zagreb, and we are looking at whether we can host the 2020 meeting in the UK which would also coincide with AIMS' 60th Anniversary. Meanwhile, the AIMS trustees and volunteers will ensure that we continue to collaborate with our European colleagues, and we look forward to contributing to the International Week for Respectful Childbirth in 2019. I would also encourage readers to take a few moments to look at the ENCA website (*www.enca.info*), and to get in touch with AIMS if you have any thoughts about how we can make the most of our membership of this vital European network of childbirth activists.

To print this article directly from AIMS, please go to *https://www.aims.org.uk/journal/item/enca-meeting-2018*

## Why Home Birth Matters

*by Natalie Meddings*

*Published by Pinter and Martin, 2018*
*RRP: 5.99*




The next best thing to Natalie Meddings coming to talk to you about staying at home to have your baby is to read her book. It is as though she is sitting beside you, talking you through the options and what will happen – all very matter-of-fact and not at all scary. In this small book, she manages to explain – quite simply – how birthing at home works. To do this, Natalie has gathered together midwives who know about home birth, and the book has plenty of quotes giving useful information from a variety of perspectives.This book meets the criteria that AIMS has developed for selling and publishing books under the AIMS banner: accessible, short books on topics of key concern to women. It is available to purchase in the AIMS online shop.

Importantly, Natalie highlights that society in general isn't up-to-date with its thoughts about the safety of childbirth at home. In the popular imagination, Natalie explains, the 'clinical framing of birth as a linear sequence' has taken the place of thinking about the natural flow of birth, implying that hospital is safer than home, when in fact, research shows how safe and beneficial homebirth is for most women.

Chapter 6 (The Build) is a very poignant reminder that moving into the birthing state is as important as the birth itself. The body is preparing itself for birthing this baby, and the mother needs to feel safe. Natalie encourages us to remember that the last few weeks of pregnancy should be for rest, listening to your body and obeying that nesting instinct. Just as eloquent is the Chapter 7 on the birth itself. Listen to Natalie telling you about the stages of birth – she is a wise woman.

Finally, in the last chapter, there is a wonderful dialogue between a midwife and a mother. If only every midwife and every woman could have this conversation together!

I was so thrilled to read this book. When I finished it, I wanted to be able to give it to every pregnant women I met. So I'm doing the next best thing – I've arranged for AIMS to sell it in our online shop and it has become part of our Book Bundles. Please buy it and pass it to every pregnant woman you know! Whether or not a home birth is for her, there is much support and learning to be had from a quick read of this very accessible book.

*Shane Ridley*

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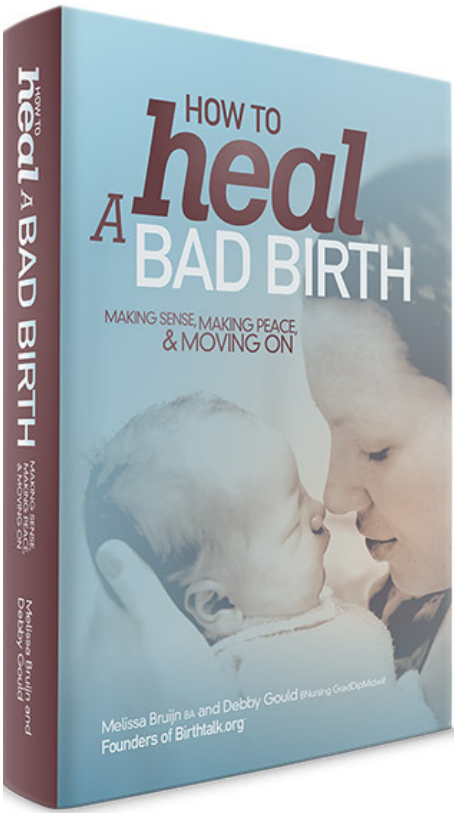
# How to Heal a Bad Birth

*by Melissa Bruijn and Debby Gould*

*Birthtalk.org 2016*
*RRP: £24.95*

Even after a straightforward well-supported birth, you can have a mix of emotions. When things didn't go as planned, or care providers were not being supportive, you can come out enmeshed with strong feelings that are not easy to put into words nor explained. And it's not always easy to find people to talk to openly about your birth, without their own emotions, experience and judgments getting in the way.




After my recent medically straightforward but psychologically traumatic birth, my friend recommended this book. It took me months to feel ready to pick it up and to start to confront what had happened. But when I was ready to do so, I found the gentle language very soothing: it was like talking to a sensitive, open minded and understanding friend.

I like the authors' definition of a bad birth, where a woman may feel powerless, confused, fearful, isolated or abandoned, unacknowledged or unheard, or her innate knowledge about her body and her baby disregarded. It can apply to any mode of delivery. The key is how a woman is treated. Spot on.

Whilst the paperback is fairly chunky, I found the ebook version great to read on the go. The bite size chapters make it an easy book to pick up and find relevant topics. It's a safe way to explore your emotions at your own pace, guided by decades of compassionate expert experience. The ebook version has links between related chapters, so you can jump between them easily. It is great for reading on the go and for marking sections to work on later. The substantial free ebook sample will help you decide if it's for you.

This is the most comprehensive, practical, honest and constructive book I have read on birth trauma. I wished I had started reading it earlier, but it's never too late to take the healing journey and move forward with life, with more understanding and love for ourselves. I would wholeheartedly recommend it to anyone who has had a bad birth, or is supporting someone who has, to make sense of the experience, decide upon a course of action and move on.

*Beth Whitehead*

**A complete listt of books reviewed by AIMS can be found at www.aims.org.uk/general/book-reviews**

# The AIMS AGM

This is on **Saturday 22nd Sept, at the Carrs Lane Conference Centre, The Church at Carrs Lane, Carrs Lane, Birmingham, B4 7SX**.

Please email secretary@aims.org.uk if you plan to attend or wish to send apologies.

Details of AIMS meeting can be found on the events page of the new AIMS website so you can easily check out whether there is a meeting near you *www.aims.org.uk/events*

# Volunteering with AIMS

*www.aims.org.uk/volunteering*

### Write for AIMS

We are looking for writers with knowledge of maternity issues for the information pages on our website, our online journal and books. This might be a campaign themed piece, an information piece, or maybe a book review. Perhaps you would like to be an author of an AIMS book. At its heart, AIMS is there to provide very high quality, unbiased, women-centred information and if you would like to be a part of this, we would love to hear from you.

### Helpline

We are looking to expand our helpline team. The helpline is run solely by lay volunteers and does not offer medical advice, but volunteers do need to have a good knowledge of maternity issues to be able to share information, for instance, on up to date research. Many helpline questions are focused on a woman's right to decide her place of birth or how she gives birth so an understanding of human rights in childbirth is also useful, although training and mentoring will be given and volunteers will be supported every step of the way.

### Press Relations

AIMS would like to be more proactive with interactions with the press, and a volunteer skilled in press relations would make this possible.

### Responding to consultations

AIMS responds to a wide variety of consultations, and people to add to the team to help support this work would be hugely valuable, and allow us to ensure that women's voices are heard more widely.

### Technical support

Helping less tech-savvy volunteers with tasks such as setting up their AIMS email, helping us with Google Docs and Groups which we used for sharing document and communication.

### Running workshops, speaking at conferences and running AIMS stands

AIMS is often asked to speak at events, to run workshops, and to have stands at events and our volunteer team cannot reach them all. If you have speaking skills, or if you would like to run a stand, please do get in touch!

If you would like to volunteer for AIMS, we would love to hear from you! Our email contact is: volunteer@aims.org.uk