Association for Improvements in the Maternity Services

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Caring for future midwives

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Diary

AIMS meetings

Friday 22 March 2016
Peterborough

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AIMS, Neighbourhood Midwives, Positive Birth Movement and Sandwell and W Birmingham NHS Trust
Celebrating Continuity – Rhetoric into Reality, Policy into Practice
13 April 2016
King's College Hospital
The conference will explore what the barriers and challenges are to this way of working and how to overcome them.
Speakers include:
Baroness Cumberlege, Independent Chair of the 2015 National Maternity Review and Lesley Page, President of the Royal College of Midwives
Sponsored and supported by the Royal College of Midwives
Early bird tickets: £66
Full price tickets: £84
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Please always check our website or contact us to confirm details as sometimes these change.

Chichester home birth
Home Birth: Inspiring Women
12 March 2016
Chichester
Stories to inspire, inform and build confidence in health professionals and parents.
Speakers include:
Ina May Gaskin, Sheena Byrom

Contact Mandy 02392 462786
www.chichesterhomebirth.org.uk

Birthrights
Policing Pregnancy
13 April 2016
Royal College of Physicians
Speakers include:
Elizabeth Prochaska,
Sarah Davies and Lynn Paltrow

www.tickettailor.com/checkout/view-event/id/32028/chk/1c27

Royal Society of Medicine
Maternity and the Newborn Forum
Safe high-quality maternity care: Learning from the Kirkup Report and other inquiries
17 May 2016
(day meeting)
Royal Society of Medicine
London

maternity@rsm.ac.uk

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

AIMS

Campaigning for better maternity services for over 50 years

AIMS

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Cover Picture:
Anjie BowenAnjie with Tina Perridge, her neighbourhood midwife

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National Maternity Review

The National Maternity Review, chaired by Baroness Cumberlege, has now finished its programme of national consultation and on the 30 December 2015 sent its findings and recommendations to NHS England for consideration and action.

Those with long memories will remember a similar exercise which took place in 1991 when the House of Commons Select Committee decided to investigate the issues in maternity care.[1] Those of us involved in campaigning for change were elated that, at last, the 'powers that be' had listened: our elation was short lived. Rather than accepting and implementing the report's recommendations in full, the government focused on 'choice', asked Baroness Cumberlege to establish Changing Childbirth and in 1993 published guidelines for implementation of selected recommendations, only funding the project for two years. Midwives enthusiastically set up case-load community midwifery groups but, over time, NHS management overloaded the midwives, causing burn-out and the disbanding of the majority of groups, then the money ran out. In 2003 another House of Commons Health Committee enquired into the state of maternity care and, once again AIMS gave written and oral evidence: this committee too called for change.[2]

So, is the National Maternity Review a case of re-inventing the wheel? Questions have been asked about the formation of the Review committee which was established without a public appointments system and appeared to have been rushed into being, probably as a result of the RCM's State of Maternity Services Report, the BirthPlace Study[3] and, finally, the Kirkup Report into Morecambe Bay's dysfunctional obstetric unit,[4] as well as changes to the role of supervisors of midwives under the auspices of the Nursing and Midwifery Council.

Furthermore, we now have a generation of midwives whose skills have been eroded by an obstetric based system that fails to recognise the importance of women having continuity of care throughout pregnancy and childbirth from a midwife they know. Student midwives no longer learn physiology, they rarely attend a home birth, and the majority have lost the skills of assisting a woman to birth twins or a baby by the breech. Skilled midwives, many of them in independent practice, have sometimes found themselves judged critically by their own profession when they have attempted to respond to women's wishes by reclaiming these traditional midwifery practices.

The criteria used by the Review to judge the provision of care is unclear but, our expectation is that it will be based on the following:

- Good quality research evidence
- Quality and safety based on the WHO definitions
- Recognition of women's human rights
- Valuing real woman-centred and supportive care
- Really respecting women's decisions
- Acting on the evidence given by the hundreds of women who have attended the regional meetings
- A commitment to act on the research evidence demonstrating the short and long-term benefits for all women, and especially vulnerable women, of community based midwifery care provided by case-load midwives.
- Implementation of the requirements of the NHS Constitution

The Birth Tank meetings, held all over England, revealed the numbers of enthusiastic, women, midwives, doctors and commissioners willing to create the kind of care that will really be women-centred and based on current research evidence. There is no doubt that Baroness Cumberlege is an enthusiastic supporter of midwifery care and a champion for change, but she is seeking to change a dysfunctional maternity service that is not fit for purpose, at a time when the Government is cutting funding in every direction; and at the National Maternity Review Birth Tank 3 we were told that 'there is no more money'.

We must wait to see whether the Report committee accepts the evidence that has been presented to it and whether the establishment will bite the bullet, and work for effective change; or nibble away at the cake and leave the users to be convinced that the crumbs on offer will be an improvement to the current dysfunctional system.

Beverley Beech and Gill Boden

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Exciting News from Wales

New Guidance in Wales says that 45% of women should have the facilities made available to them to give birth outside obstetric units. The Chief Nursing Officer for Wales has written to Health Boards to issue guidance linked to the Maternity Strategy. This guidance requires health boards to review services and invest in services to prepare and implement plans that are in line with the findings of the Birth Place Study and NICE Intrapartum Care Guidelines.

This innocuous and reasonable statement could transform women's experience of maternity care in Wales we await news about its implementation with excitement.

Potential for real change

Beverley Beech and *Gill Boden* talk about new opportunities for maternity care

Baroness Cumberlege has submitted her findings following the National Maternity Review, and we now await a response from NHS England.

Concerns were expressed that the formation of this review body was provoked by a need 'to do something' following the adverse publicity provoked by the Kirkup Report (see page 10) and, perhaps, the findings of the BirthPlace Study, as well as the lack of clarity in the appointment process. It was clear, however, that, when the appointed members travelled the length and breadth of England, seeking the views of everyone involved in maternity care, parents, midwives, obstetricians, paediatricians, health visitors, and anyone else who had an opinion, that there was a real desire for meaningful change to a system that is no longer fit for purpose.

The BirthPlace Study confirmed that fit and healthy women and babies were safer birthing at home or in free-standing midwifery units (FMU). The evidence for case-load midwifery care grows daily and the problems of our dysfunctional obstetric units continue to grow. While enormous publicity has been given to over-worked junior doctors there has been barely a mention of overworked midwives, who cannot give the kind of care they want and know that women need. Some women need an obstetrician but all women can benefit from traditional midwifery, where a midwife truly puts the woman at the centre of care: the evidence suggests that where there is a mutually caring and trusting relationship between women and their caregivers and where there is a supportive philosophy encouraging physiological, emotional and psychological process the outcomes are positive. Instead, we have a centralised, obstetrically led system that ignores good evidence, is based on fear, tick boxes, overwork and mutual distrust and where in 2015 the Care Quality Commission's survey[1] (page 3) found that 22% of women are still giving birth in stirrups.

'WHO states that 70-80% of women are healthy at the onset of labour even in countries with high rates of morbidity in the population.'[2] This means that midwives and doctors are causing damage to healthy women and babies.

But it is not only women and babies who are damaged by the system, so too are midwives. Many midwives leave the profession, either because they have been bullied or because they are no longer prepared to work in a system that is, in far too many areas, unsupportive and dysfunctional. The article on page 9 describes what can happen to those midwives who raise legitimate worries. Far too many superb, dedicated, and caring midwives within the system struggle to provide the kind of quality care they know women need, but are often afraid to speak out because of the kind of retribution experienced by this midwife and her colleague.

As Jenny Patterson has written on page 22, *'improving guidelines and pushing for excellence is worthless if midwives are not supported in achieving this along the difficult and often conflicting path between meeting guidelines and women's needs and wishes.'*

The National Maternity Review is yet another investigation into maternity care in a long line of enquiries. They invariably follow a pattern: a panel of 'experts' is appointed; everyone works hard to alert them to the issues; a report is published; the establishment eventually responds and we find, once again, that the real issues are not addressed, but token changes are agreed and we all sigh and accept the crumbs on offer.

On 13 November 2015, the Secretary of State for Health, Jeremy Hunt, announced new ambitions, *'to reduce the rate of stillbirths, neonatal, maternal deaths and intrapartum brain injuries in babies in England by 20% by 2020 and by 50% by 2030 to ensure England is one of the safest places in the world to have a baby,'*[3] despite, we understand, being advised that giving the NHS £2.24 million to fund yet more equipment will not work. He appears to ignore the evidence that continuity of community-based case-load midwifery care will have the greatest impact.

We know that Baroness Cumberlege is very supportive of the changes that so many knowledgeable lay people and professionals would like to see, but change for the better will only happen if NHS England and the Minister of Health actively support the recommendations we hope the report will make. Only time will tell.

We decided that this journal should focus on the problems midwives face, but also on some examples of good care that should be available to all women. Andy Beckingham (page 18) has eloquently proposed an alternative model to the current system. We hope that this review will make recommendations that will enable the kind of change that will properly respond to women's and babies' needs, but unless we, as mothers, parents, families, speak out and support the change that needs to happen the avoidable and unnecessary interventions will continue.

Beverley Beech and Gill Boden

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Caring for future midwives

Sarah Davies takes a look at trauma support for student midwives

Last year a psychotherapist colleague and I carried out a research study on the traumatic experiences of student midwives and how they were supported with such events.[1] We were keen to do the study because although some excellent research work has looked at midwives' experiences of trauma, there has been none to date on the experiences of students.

Research suggests that caring roles are associated with 'secondary traumatic stress', post-traumatic stress disorder and burnout. In relation to midwives, a literature review in 2008[2] concluded that midwives' empathic relationship with women places them at risk of experiencing secondary traumatic stress (p76), suggesting that this has harmful consequences for midwives' mental health and for their capacity to provide care for women. Recently a postal survey of 421 UK midwives with experience of a traumatic perinatal event found that a third of them were experiencing symptoms of post-traumatic stress disorder.[3] So it seems there is a very high level of unacknowledged distress amongst midwives, affecting the care they provide women and the support they can provide to student midwives.

For our study, we interviewed 11 student midwives who had experienced an incident they found to be traumatic. We deliberately chose not to predefine trauma, leaving it up to individuals to decide this for themselves. The approach was based on our understanding that trauma is 'in the eye of the beholder', as Tatano Beck has suggested in her research on women's traumatic birth experiences.[4] The traumatic incidents that students recounted to us all took place in the context of busy obstetric units. We discuss our findings in full elsewhere.[1] In this article I will be focusing on midwives' working conditions because in many places these in themselves constitute a form of trauma, and until these are improved, any other initiatives to support students will simply amount to tinkering around the edges of the problem.

Most of the students we interviewed reported that they found the busy overcrowded hospital environment distressing, with women 'pushed through a system that isn't based around them'. They witnessed fragmented care, lack of relationship, and task oriented work while the midwives attempted to 'process' women and 'get (them) out of the hospital'.

Working in large centralised units, which have heavy obstetric presence (for example in 'ward rounds' on labour wards) leads to lack of autonomy for midwives who find themselves pressurised to adhere to obstetric guidelines, rather than responding flexibly to women's individual needs. From our study it was clear that this 'conveyor belt', industrial model approach is damaging for all involved:

'It sounds horrible, but you are like a machine, you just do the tasks that need to be done and the workload, you have to do it because of the pressures of managers, like they are just trying to get the women out of the hospital. It is like a conveyor belt. Being in that situation it does affect your practice and you do get stressed and you do feel like rubbish and half the time I can understand why the midwives don't want to come into work'.[1]

In this environment some students felt themselves coerced into practices that they felt were unethical. When this happened those students described feeling that they had betrayed women by not being able to stand up for them and ensure they were listened to. Admittedly these were students who reported experiencing trauma, so they cannot be considered representative of all student midwives, but such a culture has been repeatedly reported and analysed by midwife researchers[5,6,7] over the years, and again in a recent survey of UK and Irish midwives.[8] Lack of autonomy, lack of time, and powerlessness to care properly for women have been identified as important factors in why midwives leave the profession.[9]

Coming to similar conclusions as a large study on resilience in midwives,[10] our study recognises the demanding emotional work midwifery entails, and suggests that resilience in student midwives may be fostered through frank discussion, reflection and promotion of self-care. We recognise that we as midwifery educators need to support students to discuss and make sense of the distressing events that are an inevitable aspect of midwifery practice.[1]

However, building resilience in students and midwives, while a crucial aim, will only go so far if the environment in which they work is toxic. Michael West from the King's Fund blogged recently: 'there is a danger that leaders could use a health and wellbeing strategy as a sticking plaster, instead of addressing the underlying and pervasive structural and cultural causes of low staff morale... We are creating conditions in which the health, wellbeing and quality of life of those who have committed their working lives to the NHS are being profoundly damaged'.[11]

In 1999 Jane Sandall examined burnout and working patterns of midwives and found that control over workload, continuity of care and meaningful relationships with women were protective factors.[12] Burnout was associated with low control over decision-making and work patterns, low occupational grade and longer working hours.[13] Since that study was conducted, midwives' working conditions have deteriorated further. In the latest RCM staff survey three-quarters of senior midwives surveyed said they had to redeploy staff to cover essential services either very or fairly often, while vacancies for midwives were reported in three-quarters of UK units. Cathy Warwick CEO responded: 'Our maternity services are overworked, understaffed, underfunded and struggling to meet the demands being placed on them.'[14]

Midwives are currently working in unacceptable conditions which breach health and safety regulations. Indeed these conditions create the possibility for trauma. Physical damage, powerlessness and fear are three key elements in traumatic stress.[15] Long shifts (often on night duty) with inadequate breaks may cause physical damage; little control over organising off duty, and being moved by managers from area to area with little notice creates feelings of powerlessness; constant anxiety about making a mistake in a litigious culture means a climate of fear – all these elements contribute to a traumatic environment.

In such conditions it is likely that only the most resilient will be capable of providing consistently sensitive care for women as well as support for students and newly qualified midwives. I am moved by accounts from students of those midwife mentors who continue to function as skilled empathic midwives and powerful role models, despite working in a system that is 'at odds with their mission'.[16] However, staff attrition and sickness is high, and there is no doubt that some resort to the distancing and withdrawal strategies which are recognised responses to work-related stress and anxiety.[17] This has been called 'a perversion of care',[18] where feelings of guilt and anxiety at failing to respond to human need are covered up with routinised adherence to ready-made policies and protocols. Such a perversion of care will reverberate throughout women's lives, because a negative or dismissive attitude on the part of the midwife, as well as being stressful for students,[19] is a significant factor contributing to post traumatic stress for women.[20]

There are guidelines for safe staffing for midwifery.[21,22] But there appears to be no mechanism for Trusts to ensure they have adequate staffing, and no lines of accountability. One director of midwifery told the RCM staff survey 'As a head of service I feel powerless to affect change'.[23] Last year the House of Commons Public Accounts Committee reported that 'The Department (of Health) and NHS England struggled to articulate to us who is accountable for even the most fundamental areas of maternity care, such as ensuring the NHS has enough midwives'.[24] This lack of accountability is a direct consequence of the NHS Health and Social Care Act (2012) which ended the Secretary of State's duty to secure health services across England.

It is to be hoped that the current NHS maternity review[25] chaired by Julia Cumberlege will have some clout and as well as calling for continuity of midwifery care, will underscore the importance of increasing the number of midwives. Perhaps it will call for 'compassionate design' where the most powerful people in the organisation commit themselves actively to values that promote caring for staff as well as clients.[26] And a safety culture which adopts a positive approach, building on what goes right, as well as learning from mistakes.[27] But the review in itself will not be enough to mandate change. Such changes have been called for repeatedly, and promised by successive governments, with no improvement being made over the years. For example, despite a government guarantee that by the end of 2009 women in England would be able to choose where to have their babies, in 2012 only 4.2% had a full range of birth options.[28] Today, the remaining standalone birth centres in our area are under threat of permanent closure, while obstetric units regularly close (or 'deflect' – the new management-speak for temporary closure) due to bed/staff shortages. Increasingly women describe being told their planned home birth will be dependent on adequate staffing on the day.

The RCM's State of Maternity Services (2015) has talked of a 'retirement time bomb'; stating that the number of midwives in England aged 50 or over has doubled.[29] Newly qualified midwives need support from more experienced midwives otherwise the burden of responsibility is too great and many will end up leaving midwifery; all the resources put into training them, and all the sacrifice and effort they have put in, are wasted. As an anonymous midwife stated succinctly: 'The workforce is now divided into those who are going to retire shortly, and those who are going to be pushed out because working conditions are so poor'.[30] This is a serious problem that needs addressing urgently.

Concerted pressure must be put on the government to recruit the 2600 midwives that are needed

What can be done? Concerted pressure must be put on the government to recruit the 2600 midwives that are needed.[31] It can be pointed out that it makes no financial sense to skimp on midwives when maternity claims represent the largest payouts for clinical negligence in the NHS, 35% of the total.[32] But it will not be enough simply to recruit more midwives if at the same time they are haemorrhaging out of the profession because they are unable to do the work that they love: *'to keep our hearts engaged, we need attachment and relationships that grow in depth and value*'.[16] Midwives must be valued for their essential work, and strategies to retain them through improving their educational experience and working conditions should be implemented urgently.

The recent Lancet midwifery series contains powerful evidence on the value of midwives and their key role in public health globally.[31] It is unacceptable that despite the findings of this landmark work, midwives' skills and autonomy (upon which childbearing women's safety depends) continue to be undermined by inhospitable institutions and unsustainable working practices. Midwifery educators and mentors need to foster reflective spaces where students can safely process experiences, and be alert to the critical moments when extra support is needed.[1] At the same time, I believe the

time is right to bring together two strands of activism: pressure groups' activism for continuity of care, and trades union demands for increased midwives and improved working conditions. This approach could unite parents and midwives, creating a powerful force for change.

Sarah Davies

Sarah is a senior lecturer in midwifery at the University of Salford. She is a passionate believer in caseloading midwifery care.

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From the Archives...

In December 1976 AIMS sent a submission to the Royal Commission on the National Health Service. Its initial statement could be repeated today, almost:

'AIMS does not seek to further the cause of any particular method in obstetric care, but campaigns rather for the best practices to be established and made generally available, for the consumer's voice to be heard, and for a freedom of choice for prospective mothers as to where, when and how they may have their babies. AIMS regrets the current tendency to streamline into standardised patterns the essentially individual process of childbearing and the consequent lack of recognition of the mother's psychological needs at this critical times. To achieve the kind of maternity care that women want, we believe that NHS maternity services should aim to develop thus:

'To recognise that huge investment in buildings and technology has not brought about a corresponding improvement in perinatal mortality rates (B.Jnl.Obs. & Gynae, (83) 921-933), nor has it achieved consumer satisfaction (Sunday Times, 13.10.74; 20.10.74). A larger proportion of research resources should be devoted to the study of non-technological aspects of maternity and neonatal care, and comparative studies be made with those countries which achieve by differing methods (for example Holland and Sweden) very low perinatal mortality rates.'

Blowing the whistle

The story of a midwife brave enough to say that things were wrong for women in her care

Being a midwife is part of who I am – it's written throughout the centre of my body like a stick of rock. I am and will always be a midwife – truly 'with woman' and I am that midwife through the teachings and observations of truly inspiring midwives whose wisdom I absorbed like a sponge – to them I will be forever grateful.

Now time has passed and healing has begun, I can try and tell my story – not for resolution but to demonstrate how actions of NHS Managers have far-reaching consequences.

I was part of a team of eight midwives who ran an MLU in a rural area of England. We had a high home birth rate; we case loaded; we were very much part of the community – and we worked as a team, with no hierarchy, where a culture of mutual honesty and respect was the norm. Sadly our senior manager retired. A new manager was installed – a midwife whom we knew and had grave concerns about due to past history within the Trust. We quietly voiced our concerns, not for ourselves but for the women's unit, a special place, unique in fact.

Our concerns were realised quite rapidly in the form of a micro-controlling and aggressive management style that was totally foreign to the ethics of our unit. This situation was then further aggravated by the tolerance shown by management to colleagues who were not doing their jobs competently. One example of this was a midwife who had previously worked with the new manager and was blatantly manipulating the system. Several of us had seen timesheets that were incorrect: this was challenged and as so often is the case in the NHS was 'kicked into the long grass'. This midwife also had a reputation for bad timekeeping which had been highlighted for years by other teams, but nothing had been done. One day I had worked 24 hours on call and caught three babies – I was desperate for the day-call midwife to arrive for her 8am start, as a woman needed suturing and I was in no fit state to suture competently. At 8.45 when she had still not arrived, I rang and she had overslept for the umpteenth time. That was the turning point – I could no longer just 'do nothing' when a woman's standard of care is compromised. I will never forget that day – the husband went into the kitchen made me coffee and toast with Marmite and said 'Sit down and have a break. We are fine. We will wait. You can do this you just need to close your eyes for a bit.' It was such an act of kindness. I called another colleague in who was not on call and together we sorted the situation out. At 9.55 the day call midwife arrived to commence her shift. This was the day we decided to put our heads above the parapet.

Another midwife who had limited hearing (and had been transferred from an acute setting due to her having problems hearing in a busy delivery suite) had been causing much concern with the women, midwives and maternity support workers and, without a doubt, it was affecting her work. We tried to raise this issue with the manager as we had had written concerns from women. Again this was kicked into the long grass (some NHS managers are experts in this field). We had tried to help this midwife by taking on some of her caseload – actually this was a big mistake. It is important to remember there is a pathway you HAVE to go through when raising concerns, and this pathway directly protects the managers from addressing any concerns.

The situation deteriorated over a period of months and the manager refused to confront these two issues. Things came to a head when several incidents happened, which included a woman trying to access the unit (in advanced labour) who could not get the midwife to hear the bell or phone. She eventually drove to a nearby hospital and birthed there. A letter of complaint was received.

As a consequence of several such incidents – including this midwife's inability to hear the difference between fetal heart and maternal pulse – a fellow midwife and I decided to make two formal complaints about the potential dangers to which women were being exposed. All the other midwives were too frightened to write a letter. This wasn't just about the women, although they are always my first concern, but also about our jobs as any adverse outcome would affect our unit.

The immediate reaction by senior management to whom the complaints had been made (in line with Trust policy) was to accuse us of bullying and harassment and in one case we were accused of Disability Discrimination. I believe that this is how managers historically behave, to protect their own interests without tackling the root causes. They then started disciplinary procedures against us. A year of sheer hell commenced, I don't know how we survived and I thank the Lord that we had each other. Many a time I thought I could not continue and wanted it all to stop, I can understand why many whistle-blowers have taken their own lives.

Four hearings later and an enormous amount of suffering, for purely technical reasons, my colleague was sacked and I was transferred to an acute setting which was foreign to my philosophy and ethos. In my view disciplinary hearings within the NHS are judge, jury and executioner in which you are not allowed any legal representation. In fact, I wish I had been sacked – that would have been less of a punishment than the one I was given.

As for my co-whistle-blower, it is appalling to think that a midwife with thirty years of devoted service to women in the community, caring and very much loved by the local community lost her job, livelihood and raison d'etre because of management decisions taken, in my opinion, for protectionist reasons.

You may ask why they want to destroy our unit – a 'gold standard unit' – which interestingly the HOM stated during the investigation was not an attribute she wished to have in

our Trust – that we were all to practise to a 'bronze standard' otherwise we showed up other teams for their lack of enthusiasm. But we only did what we felt was morally right to ensure the safety of women and babies in our care as the NMC advises, yet we were naïve: I think we are called 'tall poppies' and I'm proud to be one.

We do not regret any of our actions – we have to live with ourselves and if we have saved one baby's life then it has been worth it. The outcome for mothers was that the transfer rate to the obstetric unit, which had been 8-12%, swiftly rose to over 50%, and the midwifery unit was closed for a year.

My story and that of my co-whistle-blower unfortunately does illustrate that reporting fraud, inefficiency, incompetence and any other harmful misdemeanour by NHS employees to senior management, far from resulting in a resolution of the matter, more often results in the reporter being sacked or pushed or removed. The only way this will be resolved is to be able to report incidents to a totally independent body outside the influence of the management who have allowed the situation to exist in the first place. With an independent body people will feel confident to report, at present they don't and won't, they may get sacked then may lose their house – everything that is dear to them. So my advice is to be very careful about highlighting poor practice. Would I do it again? Not in the NHS, it's a juggernaut. But for that one baby or mother we may have saved due to being 'tall poppies' – I hope they are aware that a massive price was paid along the way.

To conclude in a message to my fellow whistle-blower, not only have I seen us in the depths of despair I remember the beautiful empowering births we had together and I am in awe of you. We truly know what sisterhood means. I will forever hold you in my heart.

A True Midwife

The Kirkup Report

This report was commissioned following the deaths of mothers and babies over a nine-year period at Furness Hospital Obstetric Unit. National press coverage focused on blaming the 'musketeer' midwives. The reality is more complicated.

One of the major points of the report was the dysfunctional relationships between all the professions working on the Furness Hospital maternity unit. The midwives / obstetricians / paediatricians were at odds with each other and the paediatricians were even at odds amongst themselves. The doctor responsible for the paediatricians at Furness Hospital apparently knew that they were inexperienced but did not give them suitable supervision. The RCOG report talks about bullying and says, *'there should be greater engagement with neonatologists and anaesthetists'*, but doesn't seem to me to deal with relationships between obstetricians and midwives. From my reading of the report Kirkup just accepted (possibly with some bewilderment) the excuses of the senior obstetrician that he couldn't stand up to the midwives at Furness Hospital

It wasn't reported anywhere in the media that the report highlighted a major problem arising from not transferring women in premature labour when they should have been. The (junior, not well trained or supervised) paediatricians then typically adopted a 'wait and see' policy with regard to the resulting premature babies. These babies were now at high risk and being cared for in an inappropriately low-level unit. The ones who did become very ill were transferred to a bigger hospital in a poor state. If they had been transferred earlier, ideally when the mother was in labour, there might have been a better chance of survival and recovery. Having taken in very ill babies, the special care baby unit in the receiving hospital was not surprised if the babies died, and reported accordingly to the Coroner.

This means that parents had to fight to get recognition that the deaths of their babies were not the inevitable, or even likely, outcome of what had been normal pregnancies in healthy women.

Following the Kirkup Report the RCOG commented, *'Strict protocols on risk assessment and patient pathways based on agreed national standards (including the capacity to treat high-risk patients and capacity to provide for emergency transfers) are needed in all maternity units.'* It appears that this is addressing the problem of transferring women in premature labour when the hospital they turn up to in labour is not equipped to deal with a baby of that prematurity. RCOG usefully suggests: *'At a wider level, programmes must be put in place to help up-skill community practitioners (in this case, GPs and midwives) in areas where the recommended levels of consultant-led care are difficult to achieve.'*

Furthermore, RCOG states: *'At a broader level, in geographically remote areas with small isolated communities, more emphasis should be placed on community-based midwifery and the development of primary care services.'*

There are many sensible recommendations about rotating and training staff, setting up 'buddy' systems, and also warnings about staffing levels and unfilled training posts.

Finally, RCOG states: *'The RCOG suggests that project teams consisting of a senior manager, an obstetrician, head of midwifery and patient representatives should be appointed to advise local Clinical Commissioning Groups on the population and workforce needs in catchment areas.'* One hopes that the patient representatives will be of women with experience of maternity care and not just a token woman who has been selected because she has had a baby recently.

Dorothy Brassington

It could happen anywhere

Maria C follows up her story

A few years ago I wrote an article for AIMS about a maternity service complaint I was going through.[1] It seems strange to me now that I chose not to name the Trust at the time. Perhaps I should have done because the Trust, University Hospital of Morecombe Bay NHS Foundation Trust (UHMB), is now regarded as a second Mid-Staffs after the recent damning findings of the Report into the Morecombe Bay Investigation.[2] Whilst the principle focus of the report were the multiple catastrophic events at Furness General Hospital, the Trust's maternity services and how complaints were dealt with as a whole were investigated alongside external organisations alerted to the problems:

'This Report details a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The result was avoidable harm to mothers and babies, including tragic and unnecessary deaths. What followed was a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed, and a series of missed opportunities to intervene that involved almost every level of the NHS.'

I didn't name the Trust at the time, or the hospital, the Royal Lancaster Infirmary, because I wanted to make the point the same problems could happen wherever care systems fall apart. Perhaps I should have just named them as an example of a rare, systematic, dangerous incompetence on several levels? I said in my first article[1] that in other threats to life police become involved but little did I know that I was dealing with a Trust that was actually to end up being subject to a police investigation.

I had endured five years of being told, through hundreds of emails, phone calls and letters of my complaint that my care had been normal, my life had not been put at risk and either way efforts were under way to improve their services. I could not reconcile this with my own experience of being left severely traumatised after going through what felt to me a near death experience whilst being refused help by several staff, countless times.

One of the prerequisites for the diagnosis of PTSD is that you have gone through a traumatic experience where you felt you (or a someone close to you) was going to die or suffer serious injury or you have closely witnessed trauma to someone else.[3] Because I left the hospital with no explanation of what had happened to me and the Trust refused for years to admit anything had gone wrong it took years for me to get a diagnosis and treatment I had required. If I had been in a train crash I could have at least explained to people I had gone through a traumatic experience and the PTSD would have been picked up quickly. Being told nothing had happened to me was seriously damaging to me and shows how a duty of care is important after leaving hospital and through complaints procedures. It was only the growing realisation that I was suffering from long-term post traumatic stress disorder (PTSD) and my belief that despite the disregard for my life I had experienced in their care, that my life mattered to me, that kept me going for the five years of the complaint.

At first I spent almost two years trying to get a reply from the Trust, and experienced delays (caused by the Trust) in going through the Healthcare Commission and Health Service Ombudsman (HSO) investigations for another three years. The HSO judged my care to be a case of 'service failure' and I finally got the evidence that my life had been in danger after losing half my blood volume in a massive obstetric haemorrhage and being left to cope with this unaided, refused even a glass of water, for a whole 24 hours. Only luck allowed me to survive that.

trauma remains as if it is part of the present

One of the reasons PTSD exists is because the brain fails to process a traumatic event into its normal memory so the trauma remains as if it is part of the present, so causing the effect of a broken record and constant triggers.[3] The Trust's behaviour in dealing with my complaint caused years of delays in my recovery. First, by leaving the hospital with no explanation of how serious things had become delayed my understanding of why I felt so traumatised and ill for a long time after discharge. In the months that followed I was unable to return to work and ultimately lost my job and my career. It took a couple of years to qualify for the PTSD treatment because I needed to justify a near-death experience. When I could get treatment it was the first stage of the recovery but was being aggravated by the volume of frustrating emails and phone calls about the complaint, which constantly triggered my symptoms.

The second stage of the recovery was when I got my complaint upheld by the HSO and a letter of apology from the Trust. The third stage of my recovery was having time to put that behind me and put back the time I'd lost with my family and luckily was able to build a new career. Now I have gone from being unable to enter the doors of a hospital without breaking down uncontrollably into tears and having a panic attack in public to only having my PTSD triggered if I need dental treatment or surgery. Even on gas and air dentists can't understand why my

heart rate stays so high after prolonged exposure to the gas. Whilst being given a general anaesthetic for a minor operation, again with my heart being routinely monitored the surgeon couldn't understand why my heart was racing so much and I failed to explain why I was panicking about a past event and I wasn't scared of him per se. All in all I have felt symptom-free for a few years now although I am aware I am still vulnerable to a relapse and have had mini-relapses in response to some stressful events.

Although I am now able to tolerate minor medical procedures, my general trust in the NHS had been drastically affected. I developed a solid belief that NHS care in this country was no longer what I had grown up to believe it to be and whilst excellent care was still there I needed to be wary of substandard care. To me it was a realisation that the NHS had irreversibly changed. I couldn't explain why, whether it was due to budget cuts, changes in expectations of nursing roles, training, staffing levels, whatever. I had managed to get rid of the irrational fears caused by PTSD but remained cautiously wary of future care. I had survived a physical test on my survival and felt extremely lucky. The psychological effects of the trauma and the experience of the complaint had left me feeling my spirit had crushed to almost nothing and I am grateful that somehow I have managed to come back from that. That was no coincidence though as I was lucky to have help through the unfailing advocacy of the Independent Complaints Advocacy Service (ICAS), GPs, councillors and supportive individuals in my new career, but most of all my family. I was truly blessed to have my youngest who was about four at the time, like a broken record constantly repeating 'I love you mummy' breaking through the numbness of the early days of trauma.

the release of this report has added another level of healing and closure

But the release of this report has added another level of healing and closure. It has helped me feel I shouldn't accept that the care I received in hospital, and throughout the complaint, is normal NHS and there are systems still there to make sure it is not tolerated or buried. Hearing it described as a 'second Mid-Staffs' makes total sense to me and allows me to believe it was as wrong as I felt it was and my fears weren't quite as irrational as I had been made to feel they were.

'Today, the name of Morecambe Bay has been added to a roll of dishonoured NHS names that stretches from Ely Hospital to Mid Staffordshire.'[2]

What I went through is absolutely and completely miniscule compared to those who have lost their beloved beautiful babies, wives and mothers at Furness General Hospital. On multiple occasions the five years of my complaint seemed to be a complete waste of time and just seemed to be more damaging to my health. It makes it worth it now to see my HSO investigation at least seemed to have contributed to the thousands of documents used in the investigation to understand what went wrong at Furness General Hospital.

But now it would be easy to shun and scandalise the Trust, and its many dedicated staff recognised in the investigation. Just like the Rotherham Child Abuse scandal, it is easy to be horrified at what has happened and think it is far removed from everything else.

'This Report sets out why that is and how it could have been avoided. It is vital that the lessons, now plain to see, are learnt and acted upon, not least by other Trusts, which must not believe that "it could not happen here". If those lessons are not acted upon, we are destined sooner or later to add again to the roll of names.'[2]

Indeed the report focuses on the errors of wider NHS services as well as the Trust. Despite the extremes of this case the same mistakes and cover-ups nobody, anywhere, can say 'it could not happen here'. The report recommendations should be read and taken extremely seriously by all maternity services, particularly this quote:

'To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.'[4]

Sir Liam Donaldson
quoted by Dr Bill Kirkup presenting the report

Maria C

1. AIMS (2009) Complaining about complaints. AIMS Journal Vol:21 No:1. pp5-7.
2. Kirkup B (2015) The Report of the Morecombe Bay Investigation. www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
3. www.rcpsych.ac.uk/healthadvice/problemsdisorders/posttraumaticstressdisorder.aspx
4. ITN (2015) Morecambe Bay report: failures of care may have led to deaths, says investigation chairman. Video link is available at www.theguardian.com/society/video/2015/mar/03/morecambe-bay-report-failures-of-care-may-have-lead-deaths-video

Post-traumatic stress disorder (PTSD) is currently defined by the NHS as *'an anxiety disorder caused by very stressful, frightening or distressing events.'* Thankfully it is now recognised that PTSD is not confined to near-death experiences, and also that women can experience trauma during childbirth.

Those experiencing PTSD often re-live the event through nightmares and flashbacks, and can have feelings of isolation, irritability, guilt, problems sleeping or difficulty concentrating. Symptoms are often severe enough to have a significant impact on the person's day-to-day life. PTSD can be disabling, but fortunately treatment has a high success rate. If you think you are affected help is available.

To be or not to be?

Beverley Beech takes a look at what women want from supervision

In December 2014 the Ombudsman's report on Midwifery Supervision and Regulation questioned the value of statutory supervision of midwives. His report commented on the failure of supervision at Morecambe Bay to identify and act on poor midwifery practice and expressed concern about the conflicts of interest between the regulatory and supervisory roles of Supervisors of Midwives. This is something AIMS has been concerned about for a very long time.

Supervisors of midwives are midwives who have undertaken extra training to support midwives, promote excellence in midwifery and protect women and babies from poor practice: they can be an invaluable source of support for those women whose decisions differ from the conventional provision of care.

In the present climate of understaffing and over-medicalised birth, supervisors of midwives exercise a great deal of power; but are also constrained by their employment regulations and Trust policies. Too many excellent, competent, midwives who have been truly supportive of women centred care have been referred to the Nursing and Midwifery Council, often for the most spurious of reasons.

In 1998 Clare Fisher made a formal complaint about a series of investigations, comments and general bullying. Her colleagues questioned the wisdom of this, as they feared she would be victimised, and that is precisely what happened. In contrast, the NMC took no action for bullying and mal-administration against Gillian Harris, the lead SoM at Carmarthenshire NHS Trust, who vigorously pursued unjustified complaints about Clare Fisher to the NMC, and who was subsequently promoted and retired on a pension.

In 2014, following subsequent appeals to the Ombudsman, Clare was exonerated. *'The unfair treatment and maladministration outlined in the DTR remains unremedied. It has caused Ms A significant hardship and injustice over a prolonged period. The failures have affected her career and reputation, caused her to practice in England and have caused her personal anguish...'* He recommended that Clare be awarded £75,000 damages.

In 2013, six years after being illegally suspended by an LSA Midwifery Officer, Val Beale, Julia Duthie was finally exonerated by the Nursing and Midwifery Council who were required by the Court of Appeal in 2012 to reconsider three allegations of misconduct. The judge overturned the other allegations.

These are but two examples of a number of women-centred, skilled midwives with unblemished records who have appeared before the NMC only, eventually, to be exonerated after years of prevarication and stress.

One of the problems is the supervisory process which, once set in motion, appears to develop a will of its own. The supervisors are not accountable and the procedures do not allow for any appeal and, all too often, the midwives are told that they are not allowed to speak to anyone about their alleged failings. The Trusts have no right to impose this restriction but, unfortunately, the midwives invariably comply until it is too late and they are on the treadmill.

There are hundreds of supportive, knowledgeable, and skilled supervisors of midwives out there giving the kind of support and encouragement that enhances midwifery skills. In her article 'Supervision – where now?', on page 14, Tania Macintosh looks to the future and how midwifery supervision could be developed to bring women and midwives together and offer the support and safe space to empower both midwives and women.

So many women, who make decisions that are challenging to the medical orthodoxy, may spend months battling to get the kind of care they want; it can be a lonely and anxious time, not knowing what to expect and whether the support they need will emerge. Very regularly women contact our helpline because they want maternity care that is unusual: this is often a home birth or a VBAC but could be a 'gentle' caesarean section or some specialised advice for a medical condition. It is rare that an appeal to a supervisor of midwives does not solve the problem, by supplying personalised care which responds to the woman's wishes at the same time as providing reassurance for her own midwife.

Sometimes the situation is a very urgent one where the 24 hour availability of supervisors is key: one example last year in South Wales involved a woman who had booked a home birth for her first baby; had declined ultrasound scans; was thought to be six-weeks post term and was put under considerable pressure to accept an induction. When she declined this, two social workers arrived unannounced at her door, demanded to be let in and cross-examined her about the safety of her birth choices. The woman was alone at the time and very alarmed and upset. An immediate phone call to the LSAMO completely transformed the situation: the referral was withdrawn, good midwifery care provided and her baby was born safely and happily at home. It was just as well that she had refused an induction, as her baby was nowhere near six weeks overdue. It is hard to imagine how to handle such a situation without supervisors of midwives making themselves available to women.

While midwives work hard to support and empower women we also have a responsibility to support and empower them. It is only by developing supportive networks of women that we will be able to encourage and promote the kind of woman-centred care we want.

Beverley A Lawrence Beech

Supervision – where now?

Tania McIntosh explores the issues facing midwifery supervision

Midwives are unique among health practitioners within the UK in having a long established and statutory framework of supervision under the governance of the Nursing and Midwifery Council (NMC).

As midwifery supervision changes, we must explore how supervision works brilliantly as support for midwives and for the public, together with the issues and pitfalls that can make it work very badly. Historically supervision has tried to do too many contradictory things. Once these threads are unravelled it is possible to explore how supervision might be re-imagined for the future to provide the framework to protect midwives and the public and to help them to realise their common goals.

Statutory supervision of midwives dates back to the Midwives Act of 1902 which developed a regulatory framework for midwives[1]. Supervision was carried out on behalf of the Central Midwives Board, the new regulatory body for midwives. Neither supervisors nor members of the Board had to be midwives. Most were doctors and their role gave them oversight and control of a potentially competitor profession. Supervision in its first iteration was designed to coerce and control rather than to support.[2]

Contemporary supervision is intended to protect the general public by providing support to every practising midwife in order to ensure safe practice.[3] On an individual level this takes the form of face to face annual reviews between the midwife and her supervisor, who is also a registered midwife. Ad hoc support and advice is also offered as required. Supervisors support midwifery provision within a Trust or area by being on call to offer advice and help in challenging circumstances. However, alongside this role as clinical support, midwifery supervision carries a regulatory remit. Supervisors can be called on to investigate the practice of an individual midwife where concerns are raised. It is this aspect of the role which has been found wanting and puts at risk the whole concept of supervision in midwifery. The Kings Fund was commissioned to review midwifery regulation following concerns about the quality of midwifery supervision at Morecombe Bay NHS Foundation Trust following a series of clinical incidents.[4] Their report, which was accepted without demur by the NMC, was that midwifery regulation as it currently stands is not proven to be efficacious and should be dismantled.

When supervision doesn't work

The reasons why supervision was originally developed and the ways in which it has mutated give clues as to how and why it might not work. The most fundamental issue is the duality of the supervisory role. The individual supervisor is challenged with being both supporter and investigator, roles which are mutually exclusive and hard to separate. The intention is that the supervisor providing support to a midwife should not be the supervisor who conducts any investigation. In practice with small supervisory units the roles are blurred in concept if not in fact. Supervisors speak powerfully of their role as supporters, allowing midwives safe spaces to reflect and grow[5] but this nurturing role is not the one that most midwives see or experience in their working lives.[6] The very title 'supervisor' conjures up images of surveillance and control, not of nurturing. This disjoint between theory and practice is exemplified by the status of the supervisor within an organisation. Historically they were above and beyond the midwives they supervised and their role included oversight of personal as well as professional lives.[2] More recently midwifery supervision was viewed as another string to the managerial bow and supervisors were very often also the line managers of those they supervised. This meant that 'support' could easily, and accidentally, be replaced with a managerial need to make sure everyone was toeing the organisational line. It also means that supervisors were not outside the system, able to be impartial, but very much part of it.

supervisors were not outside the system

Current critiques of midwifery supervision may even have strengthened supervisors in the belief that they need to investigate rigorously and to be seen to be investigating. Anecdotal evidence suggests that midwives are being referred for formal supervision where before Morecombe Bay any issues may have been dealt with more informally. It could be argued that this is a good thing, that it was a lack of rigor which caused problems in the first place and that the public need more protection than supervision was offering. In this reading more investigations signifies success. But it all depends on how and why they are done. In the modern NHS the intention is to move past a culture which blames individuals to one which looks at the ability of the organisation to learn and improve. Midwifery supervision focuses right back down on the individual and returns us fairly and squarely to the blame game. Learning in these cases is confined, if it takes place at all, to the registrant who was at fault and the search for wider gains is lost.

This all implies that supervision fails because it is punitive and one sided, punishing the individual and protecting the organisation. There is another linked way in which supervision can fail, however, and that is when investigations are performed within that small coterie. In this case transparency and honesty is potentially lost to

the need to protect colleagues and friends from a system that is seen as harsh.

When supervision works

Supervision has been a hostage of its antecedents and of the risk-driven managerial focus of the NHS. However, there are sparks of something more positive in contemporary supervision. As might seem obvious, this mainly revolves around the supportive role of the supervisor. When supervision works it protects the public by giving midwives a safe space in order that learning may take place and for the development and deepening of lines of communication between midwives and with women. Duerden[7] reflected on the power of supervision to support decision making in midwifery. She suggested that in this situation the supervisor performed a myriad of interlinking roles including sounding-board, role model and advocate. These all rely on an open and honest relationship between midwife and supervisor reflecting core NHS values around such things as candour and courage.[8] By directly supporting the individual midwife the supervisor indirectly supports the public. Warwick[9] described the value of supervisors in supporting change and in working with midwives delivering team based caseload models of care. More recently the One to One service on the Wirral has used models of supervision which privilege honesty and open dialogue; discussion and decision is based on the triad of woman, midwife and supervisor.

The idea of supervisor as supporter and advocate appears uncomplicatedly positive, but the more 'punitive' side of supervision can also have powerful strengths. Davidson and Raynor[10] wrote about the experience of being under supervised practice following an episode of poor clinical practice and an investigation. For the individual midwife to be deemed to need 'retraining' in some aspect of practice can be a huge blow to confidence. This blow can itself be detrimental to learning and growth indicating the uphill battle some midwives face psychologically to rebuild their confidence and their practice after an investigation. Davidson and Raynor turned this on its head by reflecting on the power of supervised practice to give space for reflection and learning and to allow the midwife to step back from the coal-face and actively to engage with what it means to be a confident and competent practitioner. Done well supervised practice can make, rather than break, a midwife.

In the future?

Debate around midwifery supervision has intensified since Morecombe Bay. Following the Kings Fund report the NMC recommended the dismantling of supervision and legislation is being developed to make this a reality. As yet the post-supervision landscape is foggy, with little sense of what will replace it. The pulling apart of the regulatory/investigatory function from that of advocacy and support are certainly overdue. It is to be assumed that regulation will remain with the NMC in some capacity leaving the four countries of the UK free to develop their own versions of clinical supervision for midwives.

There are many examples of clinical supervision in other health professions.[11] Midwives remain unique, however, in that they work with a population who are generally well and who are able to exercise a high degree of autonomy in decision making around their care. The power of clinical supervision arguably lies in its ability to bring together midwives and women outside the administrative framework of the NHS. Doe[12] has suggested that supervisors could support women more directly through the use of social media. Gowers (personal communication) reflects on the power of story-telling among midwives and supervisors. This reinforces ideas of courage and honesty, but also highlights the need for midwives to have a safe space to reflect, to listen and to learn.

To reflect this change in emphasis a strong signal would be sent by abandoning the name 'supervision' to something more redolent of support. This would remove any lingering sense that the role has a punitive function.

By their very title midwives are expected to be 'with woman' during the childbearing year. In order to give to women and to provide strength, support and advocacy, midwives themselves need a place where they can be supported. Peer-to-peer clinical support should be 'with midwife' rather than 'with management' or 'with organisation'. By supporting and empowering midwives we can support and empower women.

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My name is Imogen

Imogen Jenner reports on her experience of bullying in the NHS

I have been a midwife for a while now and I have seen and heard bullying within NHS maternity services on a regular basis: I used to go home quietly and say nothing until I became the victim.

Several years ago I was appointed as a senior midwife. I was told by a very senior member of the team to 'sort out the area you are allocated to, I trust you to just organise it and be passionate'. I decided to buy a book about management and find out how the area was organised, my mission was to get to know the staff and to take my time. Within three days I was pulled by my uniform sleeve in front of all my colleagues by my line manager who asked me 'have you said you are going to "sort me out"?' I was horrified but stated clearly that I would never say such a thing. This incident was only the beginning, the tip of the iceberg and, to cut to the chase, I eventually became too unwell to work.

Some of the things that happened to me included being told by two supervisors of midwives that I might get struck off after I'd challenged poor care; being put on the rota to do three weeks of nights despite being appointed to a Monday to Friday post; being victimised, shouted at and finally downgraded. I became depressed and was off work for several months, at one point I was so ill that I stayed in bed for almost four weeks: my family became my carers.

Fast-forward several years, I am now recovered and to my surprise I am still working as a midwife: I still see bullying happening but following my own experiences I am able to make a stand against it. I am not in possession of any superpowers and some days I go home upset but I accept help from my family and colleagues and I report it. I don't blame some of the midwives who try to bully me, I feel they are trapped in a culture and I try to raise awareness by challenging language used at handover and also by questioning unrealistic workloads; I liaise with the RCM and I'm compiling a letter to the Maternity Service Review committee. Notice how I said, 'try to bully me', I have gained resilience.

The courageous act of displaying one's own moral values and beliefs takes determination and energy and can be exhausting. Imagine being the only member of staff to speak out in a shift handover on the subject of language and the kind of response this generates.

Midwives are special people, present at the birth of a child, the beginning of motherhood and family life: they are responsible for educating women and families on pregnancy and parenthood and helping to alleviate and address fear of birth. Midwives' roles are varied and encompass the whole of pregnancy, the postnatal period and far beyond.

To be a midwife is to be responsible

My aim as a midwife is to start each new day with a fresh mind, full of hope, knowledge and passion so that I can embrace my role and support families as well as my colleagues. I aspire to treat each day differently but to maintain consistently high standards of compassion. I see each woman and family as individuals and practice evidence based holistic care.

I would like to add that I do see brilliant examples of excellence within my place of work. I visualise the Pareto principle [the 80/20 rule] and think perhaps 20% are bullies and 80% are not. My senior managers are very receptive to my words and thoughts and take me seriously; this is a huge move in the right direction to dissolve bullying within midwifery. The RCM is also reigniting their campaign against bullying and undermining behaviour; newly qualified midwives are taught about the effects and signs of bullying and women are definitely becoming more assertive. So would I go through it all again? My experience has made me stronger and able to deal with bullying against others; I am feeling more positivity in the air and aware of drives to embody compassion within maternity services. There is increasing teamwork and positive debate between midwives and obstetricians.

Unless we all speak out and realise that we are caring for the world's sisters and brothers there will be no reduction in bullying. We must be gentle with one another, we must stand still and speak slowly, we must consider the way we move and the way we act. So I'd like to ask all midwives 'What is your aim as a midwife?'

To be a midwife is to experience a glorious and beautiful vocation. Now is the time to name the issues and build cultures that care for women, babies and families and value staff, so that we sow seeds of kindness and goodness to all.

Imogen Jenner

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Further Help

If you have been affected by reading this, here are some contact numbers and resources – please do not be alone seek help, talk to your friends and family or contact the AIMS helpline.

The National Bullying Helpline – 0845 22 55 787
www.nationalbullyinghelpline.co.uk
email admin@nationalbullyinghelpline.co.uk

RCM/RCOG joint toolkit – www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/undermining-toolkit/

Unison – www.unison.org.uk

ACAS – 0300 123 1100

Too busy to be nice

Hayley Huntoon shares her frustrations at the lack of resources available

Yesterday a man came to me livid with frustration 'this is not good enough' he told me 'my daughter has been waiting hours to be seen.' He went on to tell me 'it isn't you. It isn't the other midwives, the care has been impeccable but the situation just isn't good enough.'

I know. I agree. I have shed too many tears over a career I could not love more because there is nothing I can do. What he didn't know was that heartbreakingly this is a daily occurrence in my life as a midwife. What he didn't know was that actually yesterday was a rare Saturday off for me yet I had come into work so that my amazing colleagues could have a break from their 13-hour shift: a break they won't be paid for whether they take it or not, but that they physically need as human beings. I had come into the unit so that women like his daughter could be seen: so that our unit could be open to women who needed our skills as midwives, doctors, health care professionals; women who were in labour; women whose babies weren't moving much; women who were concerned about their own wellbeing.

Five maternity units in my region have been closed over the weekend

Five maternity units in my region have been closed over the weekend: these women need our care. We are literally being worked to the ground. I am watching amazing midwives leave a profession they love because the workload and stress is too high.

The NHS is run on good will, but there is only so much we can take. We joke at work that midwives don't need to eat; to rehydrate; to empty our bladders or to sleep. Let us look after ourselves so that we can look after our women and our future generation of children.

Over the past four years I have missed Christmas days, New Year's days, family birthdays and countless nights out. I had a good education and did very well at school; I am 22; I have held the hands of women through the most emotional times of their lives. I have dressed Angels we have had to say goodbye to; I have supported women to make decisions that empower them; I have been scared myself, tired, stressed, emotional every day. Yet I am not and will not be paid well like my friends who have chosen business careers. I am not offered pay rises for my efforts or successes. I don't care because I get something more valuable than that from what I do. I love what I do. I'm passionate about what I do, that's why I do it: but I do care that we are the ones who are being threatened with further cuts, further strain.

I am regularly met by stunned responses from women and their partners to the situation they watch me working under, but enough is enough. I have shed too many tears over a career I love; missed too many meal breaks; not physically been able to care for too many women the way I wanted to; spent too many days off in work; lost too much sleep over the stress I am under; watched more of my colleagues than I could count (myself included) be signed off work with stress in the early years of their career; watched too many good midwives leave careers they love. This is not humane. Let's change this.

Hayley Huntoon
Hayley is a newly qualified midwife working in a busy consultant-led maternity unit

Quotation Corner

In 2005, the World Health Organisation challenged health practitioners not to ask, 'Why don't women accept the service that we offer?' but to question, 'Why don't we offer a service that women will accept?' Let's stop trying to criminalise women's choices or bully them into submission and let's start trying to understand why those choices are made. We need to put in place responsive, sensitive maternity care systems that cater for the individual. And we need to remember and respect that birth for a mother is more than the everyday medical event that is for an obstetrician.

Dr Hannah Dahlen
Professor of Midwifery, University of Western Sydney

View the full article here:
www.ethics.org.au/on-ethics/blog/april-2015-(2)/part-two-'but-your-child-might-die'-the-right-to-d

Dear Baroness Cumberlege

Andy Beckingham writes to the Maternity Review Team

Dear Baroness Cumberlege and the Maternity Review Team,

I write to you as a Consultant in Public Health with a particular interest in maternal health in the UK (and also in low-income countries). Over some years I have studied the wider maternal health, and particularly the approaches that might prioritise women's choice and satisfaction ahead of professional preferences and the medicalisation of childbirth.

I would firstly like to support the request by Birthrights UK – who I know have also written to you – to make the fundamental principles of respectful care a priority in your investigation of maternity services. All the national and international evidence I have studied in order to design maternity care programmes and to assist with maternal death reduction in India points to the conclusion that care quality improvement and the achievement of good satisfaction rates and low unnecessary intervention rates will only be achieved if women's preferences and respectful care are placed at the centre of all care planning. In the UK, they are not. Absolutely not. They are often paid lip-service, while managers and obstetricians determine priorities, which are more about 'risk management' instead, and which have resulted in the largely unnecessary medicalisation of birth in the UK. This has been an especially sad thing for me, working in low-income countries, where I would have liked to recommend a UK approach to maternity care. Instead I have only been able to recommend a few limited UK models that had managed to resist NHS bureaucratisation, or independent midwifery services' approaches.

The first Cumberlege Report back in the 1990s was hugely well-received. Unfortunately it was then largely undermined by authoritarian NHS management driven from the centre to implement a 'performance culture' that has squeezed sensitivity, listening, and choices for women into the margins. I have seen it replace the first Cumberlege report's emphasis on sensitive care, with performance targets instead, and with hostile work environments that made sensitive care an 'extra' – when occasionally possible. This has sadly been reinforced by many obstetricians. As a consultant I would normally use less emotive language. But in this case, the erosion of the best aspirations of midwives by an NHS management culture over many years makes me think it is best to simply state what a dreadful thing has befallen maternity services, stifling many of their efforts to improve care.

Over two decades we have seen maternity care become a punishing work environment, where midwives often don't want to work. We have also seen 'choice' become a token set of Trust PR statements that are meaningless when women say they want more natural birth and home birth, only to be told that those aren't available, or that the professionals know what's best for women, and sadly, sometimes blackmail about 'what's best for your baby'. Many midwives now choose not to work in the NHS because they can't provide woman-centred care there. This tends to drain the NHS of staff who want to provide woman-centred care. Their loss to the NHS will allow the culture of not listening to and not addressing the concerns of women, to go even more unchallenged, especially with a top-down belief that those who work in maternity care should dictate how maternity services are delivered and planned.

Birth centres may have been one environment that has been more resistant to corrosion by bureaucracy, and might be studied as a useful model.

Since the really positive and welcome recommendations of the first Cumberlege Report were largely undermined by an NHS management system and clinicians who believed they knew much better than women, I would like to recommend that this new Maternity Review anticipates that the same could happen again, and takes steps to resist and mitigate that in your recommendations.

Secondly, however, I would like to propose an excellent alternative to the prevailing NHS model for maternity care. A 'gold standard' for maternity care already exists in the UK. I would like to recommend that your maternity review considers how the Albany model – once widely applauded, but now closed by bureaucrats – might be proposed as a new way of working that could be built upon, expanded, and might ultimately replace the current NHS model in some geographical areas. Women and midwives living in those areas might be consulted about whether they would like (a) the standard NHS service or (b) a community-based service based on the Albany model. This would, for once, offer women real choice.

The Albany was a maternity service that provided woman-centred maternity care in South East London. Their good outcomes far exceeded anything I have seen achieved by other services. Their episiotomy rates were probably the lowest seen anywhere. Women who wanted home births had home births, and in very large numbers. Satisfaction among the women whose maternity care was provided by the Albany was astonishingly high. Care safety was very high, despite misguided attempts by unaccountable individuals to discredit them. At the same time, and most remarkably, these outcomes were achieved among a very disadvantaged population, having an important countering impact on health inequalities. This model is now well-known around the world as the 'gold standard' internationally, not just for the UK. It is important to also point out that the Albany service operated without the cumbersome and punitive NHS-style management system. Staff were happy to work there. Unlike many maternity services in the NHS, they had top-class staff retention rates. This could well offer your Maternity Review an alternative model to

recommend for the wider provision of maternity care across the UK. It could be NHS-funded, but use its own much more benign management approach, focusing primarily on choice for women. Just like the original Albany model in London, it could be contracted by the NHS, without fears about privatisation, since it is a 'public interest' model too.

When in 2011 I designed the pilot education and training programme for India's first 'UK-style' midwifery service, I drew on the Albany model for its basis. We couldn't have been more fortunate in our recruitment of Becky Reed, ex-Albany Centre, to come out to South India to provide the core midwifery ethos and model, by mentoring our trainees. Becky's Albany model became the main principles that our trainee midwives put into practice. Four years on, these midwives – who are now qualified – manage the majority of intrapartum care for women with low-risk pregnancies for one of India's most influential and high-quality maternity hospitals. Under this ethos, inspired by the original Albany ethos, women are encouraged to make choices about their care in labour and childbirth, and – unlike what often happens in the NHS – these choices are honoured, and helped to happen. Breastfeeding rates within the first hour of birth reached almost 100% following Becky's intervention. A qualitative study has shown that these midwives in India have all retained the 'Albany' principles of woman-centred care and choice for women. A second recent study shows extremely high satisfaction rates among the women they assisted in childbirth. A third study shows that intervention rates are much lower, and perineal integrity rates higher, than among women attended by doctors. The safety rates were extremely high. And just like in Peckham where the Albany originally operated, these women in India include many very disadvantaged women. With not a single maternal death among 3000 births.

Although we have not yet subjected this 'international transplant' of the Albany model to a randomised controlled trial, it does seem very clear that this 'gold standard' Albany model has huge potential to transform maternity care into woman-centred care that offers choice for women. In India, this adaptation of the Albany model holds enormous potential to radically improve maternity care and reduce morbidity and mortality. I thus recommend it to your Review to propose it as a serious alternative to more mainstream, and far less successful models in the UK.

On this basis, when you are formulating your recommendations and planning to put UK-wide improvements into practice, may I also suggest that you engage Becky Reed in leading some of the practical development of national midwifery improvement.

Finally, I would like to recommend that a better regulatory approach to maternity care that fosters woman-centred care instead of persecuting it, is seriously needed in the UK. Might a more effective regulatory body replace the Nursing and Midwifery Council? May I suggest that you consider recommending its replacement with a slimmed-down – and accountable – version of regulation that would focus on promoting good quality woman-centred care and choice for women instead?

Sincerely,

Andy Beckingham FFPH
Consultant in Public Health
UK and Hyderabad, India

ENOUGH

Today I am saying ENOUGH!
ENOUGH to the lies women are told about their 'incapable' bodies
ENOUGH to the bullying and coercion they experience when they say 'No'
ENOUGH to the trauma that scars them and those who love them for life
ENOUGH to ignoring the scientific evidence AGAIN and AGAIN and AGAIN
ENOUGH to the power middle class men hold when it comes to women
ENOUGH to the PTSD that is rising in childbirth and the rising rates of suicide
ENOUGH to the horror stories that strip women of their hopes and dreams
ENOUGH to the impersonalised care we give, knowing we can do better
ENOUGH to a system focused on itself, not women, despite the mission statements
ENOUGH to anxious babies looking for love in their haunted mother's eyes
ENOUGH to our money spent on causing harm in health care, not preventing it
ENOUGH to weak leaders and politically correct tiptoeing around the issue
ENOUGH when we know better
ENOUGH when we know how
ENOUGH when we know why
ENOUGH when it can change now
ENOUGH!
ENOUGH!
ENOUGH!

by Hannah Dahlen

Bonding and Wellbeing

Rosemary Mander asks 'support by whom?'

The benefits to mother and baby of good support during the childbearing cycle are too familiar to bear repetition.

Suffice it to say that what women and midwives have known for centuries was, in the late twentieth century, endorsed by research evidence. So I learned with eager anticipation of the establishment of UKPEA (UK Prenatal Education Association - www.ukpea.org). This new charity, with a focus on perinatal psychology, seeks to enhance the experience of mothers and babies by facilitating a strong attachment for parents. Such splendid ideals are to be achieved by drawing on a strong research evidence base. The importance of women being able to access good support during pregnancy and after the birth cannot be over emphasised. So the arrival of this charity onto the childbearing scene is more than welcome.

UKPEA has, very sensibly, embarked on its mission by undertaking a research project, which endeavours to demonstrate the ongoing need for such support and to establish UKPEA's research-based credentials. The research project[1] comprised an online survey, involving 1438 childbearing women, using a questionnaire to investigate women's state of mind.

So far so good.

The background and the theoretical basis rely on the work of Goecke,[2] whose wide-ranging study of depression in childbearing serendipitously identified an association between attachment in pregnancy and postnatal depression (PND). The negative correlation led Goecke and colleagues to an assumption of cause and effect – that poor attachment or bonding leads to PND. This is not a safe assumption, as a depressed pregnant woman may find difficulty relating to her unborn baby.

Rachel Gardner's summary of the research project details the findings. Although she claims that the questionnaire reached 'a wide variety of women', the snowball technique which it used carries a risk of bias. That Gardner eventually found that the sharing of the questionnaire could 'no longer be tracked' meant that she did not know where or to whom it was being sent. This is a particular problem for readers because information is lacking about the sample, such as age, childbearing experience or even respondents' gender. The data is numerical, but analysis, such as for significance, is lacking. Some of the figures are surprising, such as that only 18% of women reported feeling 'worse' after the birth. Further, the women's experience of feeling anger (p3) is presented as serious, but without any indication that anger was unusual for the women.

The researcher highlights the problem of what she calls 'medical professionals'; a phrase clearly intended to include midwives. The data are difficult to follow because there is (p3) a subset of 647 women with no indication of their characteristics. Of those 647 women, 172 reported isolation or loneliness and 'more than half' of the 172 stated that professional support, care or compassion was lacking.

That these women were unable to find the support they sought and needed is a sorry reflection on the milieu in which women experience pregnancy and birth. The women whose partners, parents, friends are unavailable to offer support should be able to find that help from the midwives and others who offer maternity services.

So what has happened to the midwife's ability to respond to women who are feeling vulnerable?

The answer to this question may be found in the findings of a survey by the Birth Project Group (BPG).[3] While the UKPEA survey collected only data from women, the other side of the coin, midwives' views, were accessed by the BPG study. The BPG paints a very clear picture of midwives who are keen to provide women with the standard of care which they know to be necessary. This includes education and psychosocial support, as well as a high standard of clinical midwifery care.

The midwives told the BPG, though, of practising within a system which prevents them from caring appropriately. They are prevented by understaffing, by bullying, by poor management and by a blame-ridden environment. The midwives were all too clear about what they know to be necessary for women, especially those who are more needful. Their main focus, though, is on safety and avoiding the incidents which endanger not only the childbearing women, but also their own futures in midwifery.[4]

The blame for a service which does not meet the needs of childbearing women should be laid where it belongs. This is at the door of a political system which assumes that well-meaning midwives will tolerate stringencies to the point where their own welfare is jeopardised.

It is clear that UKPEA do an admirable job of providing support for vulnerable women, but they have not campaigned strategically. To improve the situation for women the problem also needs tackling at its roots by campaigning beyond the interpersonal and taking political action addressing our hostile maternity system.

Rosemary Mander

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Andrea Roslyn Robertson

16.02.1948 – 28.04.2015

In the UK we had Sheila Kitzinger, in the USA they had Doris Haire and Elisabeth Bing and in Australia they had Andrea Robertson. As Andrea was much younger than the other three, her death in her 60s was entirely unexpected.

Andrea worked as an Occupational Therapist in both Australia and New York and after the birth of Jamie and then Jenny she became active and very vocal in consumer maternity groups. She was President of Parents Centres Australia from 1978–1984 and appeared on Australian TV, wrote for newspapers and magazines and generally put forward the case for gentle, loving and respectful birthing options.

Andrea established ACE – Associates in Childbirth Education in 1985. This was an educational consultancy which provided workshops for midwives and other health professionals and antenatal teachers. Her teaching methods were dynamic, her research knowledge was prodigious. She brought to Australia speakers and lecturers who were internationally recognised and took them all over the vast country.

As one of her speakers I really appreciated her knowledge of what it is like to be a key note speaker. Her secreting away of your lunch on a plate ahead of the queue so that you didn't starve to death. Her knowledge of her speakers preferences so that whenever I had a day off it was when we had reached a place with wildlife and lovely flora. Her generosity so that whenever Giles and I went to Australia we always stayed with her in her lovely flat overlooking the city. We were planning a visit this year but now that she has gone it is too sad to go.

Having established training courses for antenatal educators in Australia both face to face and on line Andrea travelled all over the world presenting workshops on how to provide antenatal classes for midwives, doctors and antenatal teachers. She was always on the move. Whenever she came to the UK she stayed with us in London. How we looked forward to her visits. Fun, full of beans and a wonderful cook. She always took over the cooking of the dinner, glass of wine in one hand, spatula in the other she cooked interesting and innovative meals with the minimum of ingredients.

Andrea wrote many best selling books on Childbirth. Preparing for Birth sold 260,000 copies, other titles include: Teaching Active Birth, Making Birth Easier, Empowering Women and The Midwife Companion. The Australian College of Midwives made her an Honorary Member because of her contribution to Midwifery Education and Practice.

Andrea died suddenly and unexpectedly at home. Her son-in-law was staying with her so was able to organise ambulances and hospital admission. She is and will be sorely missed, both by those of us who loved her as a friend but also by hundreds of pregnant couples and midwives whose lives she touched.

Caroline Flint

At the heart of normality

Midwife at the heart of normality – being with women in childbirth, Southern General, Glasgow, 16 January 2015

This was a well attended, well thought out and presented study day for midwives in Greater Glasgow and Clyde area, organised by Lisa Allan, Community Midwife, Glasgow and Liz Miller UWS lecturer. It was a wonderful range of experienced and interesting speakers – Hilary Patrick, Evelyn Frame, Yvonne Bronsky, Mary Ross Davie, Helen Shallow, Maureen McSherry, Geraldine Butcher and Gillian Smith, with a focus on the quality of relationship between midwives and women.

Yvonne Bronsky emphasised the need to make the quality of care count, regardless of the building or environment.

Mary Ross Davie presented her powerful findings from her SMILI study in 2013.[1] Mary's research clearly showed that the continued presence of a supportive midwife during labour, whom the woman trusts and with whom she feels safe, leads to improved outcomes in terms of reduced intervention, increased normality and satisfaction. Even though the women and midwives had not met prior to labour, many midwives developed this trust and relationship through rapport, often created by good 'banter'. Mary highlighted, from several studies across the world, that women tell us they want the presence of a positive, calm, kind carer; to be treated with respect as an individual, informed and involved in decisions and to receive praise and encouragement.

Geraldine Butcher presented her award winning work within her Fear Clinic in Ayrshire and Arran. The source of women's fear of childbirth is varied and sometimes unknown, but includes other women's stories and not trusting staff. Within my work as a midwife I also see previous difficult birth experience as a major source of fear. Geraldine highlighted communication between women and midwives as one of the top issues.

Helen Shallow engaged us in discussing scenarios, exploring ways in which we might communicate with women in response to their wishes. This challenged us to really focus on the language we use, both verbal and bodily, as well as our understanding of our autonomy as midwives. We explored how we might maintain autonomy which can be particularly challenging when dealing with policies, which are inherently 'guidelines'.

For me, the thread which wove throughout, was that the way we are present and relate to women is not an additional 'nice extra touch', but is fundamental to the well being and outcome for both mother and baby. This presence and good relationship is core to, and must be embedded within, excellent clinical care.

However, on hearing examples of poor relational care, perhaps harsh words, impatient behaviour by the midwife, or inappropriate expression of stress to the women, I'm prompted to ask, 'but why do midwives behave like this?'

Unless we have the human side of midwifery correct, the relationship, presence, rapport and trust between women and midwives, we will, as Mary Ross-Davie's work shows us, continue to have avoidable poor outcomes. I strongly suggest that improving guidelines, and pushing for excellence is worthless if midwives are not supported in achieving this along the difficult, and often conflicting, path between meeting guidelines and women's needs and wishes.

Every midwife must feel safe, knowing they can trust and rely on peers, management and other disciplines to provide a positive working environment conducive to enabling midwives to give the required time and quality of care: adequate staffing; appropriate working hours and timely breaks; the ability to ask questions, seek help or support without fear of ridicule or being chastised; the ability to come to work without fear, achieving good job satisfaction without undue stress and exhaustion.

Midwives enter this profession passionate about good care for women. The consequence of time constraints, policies, increasing expectations and understaffing leaves midwives stressed to breaking point as shown by the Birth Project Group 2014 survey on midwives experience.[2] Midwives are then unable to provide optimum support and may lash out in inappropriate ways and as Mary's work show, outcomes suffer.

This study day provided an excellent opportunity to not only hear about innovative work, but to explore how we might use this knowledge and awareness: it strengthened my growing awareness of the importance of building real practical, support for midwives that enables them to remain healthy and well and emotionally strong, so they can, in turn, be the amazing support and presence which women not only want, but need. This is not an optional extra, or 'the icing on the cake' it is a fundamental basic ingredient.

I was invited to attend this study day to present two break out sessions using wellbeing and resilience techniques based on Capacitar practices. I offer this work as a means for women and midwives to discover simple, yet effective ways for managing stress, anxiety and fear. This day confirmed for me that it is essential we find ways to enable midwives to care for themselves and be supported in their very valuable work.

Jenny Patterson

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Promoting normality

Physiological birth: Promoting normality, Royal College of Obstetricians and Gynaecologists, 11 September 2015

'Making the transition from an industrial model of maternity care to a social model of care'

It was an inspiring and thought provoking day with 14 compelling speakers debating how it is that despite the available evidence we do not have social models of care that support normal/physiological birth.

The theme of the day was listen, listen to women, listen to colleagues, don't undermine or coerce women or each other and build relationships that are meaningful and mutually respectful. Even when birth is 'normal' women can be traumatised by the way midwives and / or obstetricians treat them, and this can have a profound and long-lasting effect.

Lesley Page, President of the RCM, opened the conference comparing Call the Midwife which portrays a 'social model' of care, where compassion and connections are fundamental with One Born Every Minute, showing an 'industrial model' with system-based care.

Deb Pittman President of the New Zealand College of Midwives and Associate Director at Northland District Health Board told us about the legislation in New Zealand that underpins and supports women and care givers in 'Partnership, Participation and Protection': where women have an absolute right to make an informed choice.

Tracey Cooper, consultant midwife, shared her PhD work on women's and midwives perceptions of a midwife's role. Tracey described different types of midwives; 'doing' midwives, 'cyborgs' who use equipment, technology monitoring and measuring and connect with women and babies through machines, such as ultrasound and cardiotocograph (CTG),and 'being' midwives, 'goddesses' who were 'with women' able to support physiological birth in all areas, and how women felt more supported and empowered by 'being' midwives.
clok.uclan.ac.uk/2404/2/CooperTthesis-hardbound_final_collated.pdf.

Carolyn Hastie, Senior Lecturer of Midwifery Southern Cross University Australia, discussed bullying in obstetrics and midwifery and the effect this has on physiological birth: she gave some shocking statistics, 50% of midwifery students dropout, and 25.5% of health workers suffer with mental stress. Carolyn suggested that to 'grow' students and midwives who are strong, support each other and are able to be present with women, we should stop 'Turf War', ask who is the most appropriate person to care for the woman, build a sense of self, have courageous conversations and stand up for peers not present.

Sheena Byrom, midwife consultant and author, recommended the the building of virtuous circles by means of social media and gave the example of @hannahtizard and @JennytheM who have had an amazing response on Twitter with their Blood to Baby and Skin to Skin campaigns.

Ellie Durant, midwife, who runs www.MidwifeDiaries.com gave us some coping strategies, 'Simple Achievable Solutions': saying 'adrenaline is contagious – we need to be calm and confident'; we need to share positive birth stories; to be aware of the language used with women and each other on the labour wards as it can be disempowering for women and midwives and to be flexible, adaptive and as physically fit as you can be.

Rebecca Schiller, co-chair of Birthrights and doula, argued that policy will only change when every clinician and organisation treats each woman as an individual, with compassion and respect.

Kate Brian, author and journalist specialising in infertility, told us how continuity of care with known midwives enabled her to have the birth that she wanted, which is unusual after an IVF pregnancy, when often women have lost faith in their bodies and are frequently labelled as high-risk as their baby is seen as 'precious'. I was so privileged to be Kate's midwife, and it was lovely to hear her talk about how her relationship with her midwives enabled her to have the confidence to birth her babies.

Mark Harris, midwife, talked (very animatedly) about the presence and participation of fathers, what men can do to combat the paternalism in the RCOG and the testosterone-filled birth, by creating connections and communications with their partners.

Emma Jane Sasaru, NHS infant feeding worker and doula who runs Unfold your Wings, raising awareness of Postpartum PTSD and Birth trauma, told us powerfully what it felt like to be separated from her baby in NICU. After being told that everyone was too busy to take her to see her baby, she literally dragged herself to see her baby, she missed her meals and when finally someone checked her HB it was 4.1. The feelings of being forgotten, the lack of choice and consent and the use of language, has had a profound and long lasting effect.

Virginia Howes, independent midwife, shared a story of a woman who choose to have her baby at home knowing that her baby would not survive; she talked about how this birth reduced the woman's emotional pain, how she was kept safe and had a positive birth experience.

Finally conference organiser **Jodette Holly** got a standing ovation when she read **Hannah Dahlen**'s Enough which is printed on page 19.

Jackie Moulla

Jackie worked as a caseload midwife for eight years and knows how trusting relationships empower women and midwives. She now spends much of her time with women and their partners talking through and unpicking their birth

Considering a home birth

Belinda Ambrose shares her story

After two very 'medicalised' hospital births following regrettable decisions made on limited information, the thought of experiencing a third birth in a hospital environment marred by interference and intervention, filled me with dread.

Attending a course in Natal Hypnotherapy led by NHS head midwife Sue Turner proved to be a pivotal point in my birth preparation plans. It was after being somewhat enlightened; finally really understanding why things went so wrong that I became determined to have my third baby at home.

After getting my husband 'on board' with my decision following our workshops with the 'hippies and hippos' as he affectionately called us, at 35 weeks into my pregnancy I casually mentioned to community midwife Judy Freeman we were planning to have the baby at home. I was expecting to be met with resistance and prepared for an argument, only to be met with positivity and enthusiasm for my birth choice: my previous obstetric history and age (I was 43 when I eventually had my third baby) didn't appear to be obstacles to achieving what I so desperately desired – a drug-free, non-medicalised and 'hands off' birthing experience.

Of course I researched as much as I could the history and safety of childbirth at home. Since birth has been 'taken over' by modern medicine, doctors and the risk of litigation, everything has changed, and now fear is a major contributing factor preventing more women from choosing home birth. These anxieties are often further reinforced by the people that make up your circle of influence. I can't tell you how many women I have encountered who have been put off the idea of a home birth by partners/husbands who even flatly refuse to discuss the option.

I was astonished to find out that in our area of Northumberland (at that time) only around 12 babies out of 170 were born at home annually, I was told that it was owing to a lack of awareness that home birth is a safer option for the great majority of women. If you do fall outside the 'low risk' category you can still plan for a home birth in many situations, as I did.

Planning our home birth was like a military operation: it was imperative for me to put in substantial physical and mental preparation. I visualised the birth and the outcome on a daily basis, there was no place for focusing on negativities or outcomes other than the perfect birth. Of course, I had considered all emergency situations but having been fully informed and reassured, I put it all out of my mind and concentrated on achieving a successful home birth.

Planning our birth also required considerable team effort, from Charles (hubby) assembling the birth pool, 'learning his lines' and supportive procedures from Natal Hypnotherapy; to Mum knowing how to administer herbal tinctures, to my other young children being adequately prepped on how 'birth looks and sounds'. Even the midwives were given a birth plan including everything from candlelight and gentle music to how long I wanted the cord to remain attached and what I wanted to do with the placenta after a physiological third stage of labour.

simply wait until she was ready to be born

As my 'due date' came and went, I declined a membrane sweep and community midwife, Charlie Pickney reassured me that the alternative option of daily monitoring was available and to simply wait until she was ready to be born providing baby was thriving. She even told me she started dreaming (in her sleep) about defending my decision not to have labour induced going up against opposing views of the hospital obstetricians!

According to scan dates I was 10 days 'overdue' when my baby arrived – my LMP date calculated by NHS midwife, Ingrid was exact and B was born on that date.

As my labour began, I quietly went about waking the children, feeding them and getting the household generally organised. With 'all the ducks in a row' I sat on my birthing ball, in the dark, breathing through the contractions going over my affirmations and looking forward to the journey ahead. The contractions started increasing in frequency and intensity and I felt it was time to step into the birthing pool, inhaling essential oil Clary Sage which had been dabbed onto a cotton ball.

As part of my birth plan, I was adamant I wanted to keep internal examinations to a minimum and would prefer none at all – at the end of the day, the baby was going to come out, and I didn't want to have any distractions that would break my focus. After what seemed to be a very short and stress-free labour with my wonderful birth team supporting me, I literally breathed the baby out and little B arrived wide eyed and lying beautifully at the bottom of the pool. I was mesmerised and it only occurred to me to pick her up after being prompted by Judy to do so! As I held our little baby in my arms with my family around me, I felt completely elated. To be able to crawl into my own bed with my newborn baby and my family close by in familiar surroundings was magical. It was without doubt the best decision I made: the right birth choice, the best home birth team.

Belinda Ambrose

The battle for Cordelia

Jane Reeve shows just how difficult it can be to get support

With the birth of my first daughter, in November 2012, 12 minutes after my arrival at the hospital, came the clear knowledge that future babies would be born at home. Who would have guessed that such a clear and simple decision could lead to so much distress and dismay?

December 2014 found me with an appointment with the local midwife service to prepare for the birth of my second child. The midwife, who knows me and already knew my intentions, announced, 'Before you ask, we do not have a home birth service. It was suspended in 2013.'

And so the first blow was struck!

The midwife, helpfully, advised me to contact an independent midwife and to write to Stephanie Pease, Head of Community Maternity Services for the Queen Elizabeth Hospital King's Lynn.

In the meantime, I was very fortunate to find and book an excellent independent midwife and I found that the QEH had been having discussions about commissioning the services of independent midwives temporarily. This led me to the belief that funding would probably be available, that the home birth service would be reinstated and to an easing of my concern. Appeasement?

Cordelia Reeve

Birthrights, contacted for advice, proved to be very supportive throughout the ensuing battle for an NHS funded home birth as it became abundantly clear that the home birth service would not be re-instated before my my baby was due to be born, confirmed by Stephanie Pease who also refused to answer the question, 'Will the NHS foot the bill for my home birth?' The battle lines were drawn and on their side was the passage of time. Allies had to be found.

the CCG put in writing that commissioning home birth service from an alternative provider was not safe

Letters were written: three to staff at QEH King's Lynn, and the Clinical Commissioning Group (CCG), Maternity Services Liaison Committee (MSLC, Health Watch and my local MP. QEH gave a curt and dismissive response, acknowledging the request as reasonable but indicating that I should have my baby in hospital or pay for my IM's service, as the CCG's policy was not to commission IMs to provide this service. Incredibly the CCG put in writing that commissioning home birth service from an alternative provider was not safe. This allegation had to be refuted, The Royal College of Midwives and the Nursing and Midwifery Council were both unable to influence my case directly but Cathy Warwick of the RCM confirmed she would take up the issue as part of the NHS England Maternity Review using my case as an example.

Another month passed before the CCG replied, simply reiterating the previous letter about safety and refusing to foot the bill. Frustration was mounting on my side and no satisfactory conclusion was forthcoming. I did have, however, final responses which allowed me to lodge my still on-going formal complaint with the Ombudsman. Here was the necessary ammunition for my continuing battle.

AIMS has been a constant ally, Beverley Beech provided the strongest possible support, writing to the Chief Executive of QEH highlighting the enormity of their shortcomings in maternity services. The burden of distress is somewhat reduced by the intervention of wonderful allies.

Five days after my 'due date' I had my routine appointment with a different community midwife who asked if my induction had been booked. When I confirmed that I would not be induced as I was having a home birth, she immediately changed her attitude, becoming very supportive of my wishes.

Now, the next form of attack was to be subjected to the 'essential' daily attendance at the DAU for CTG monitoring. I was continuously pressured to accept induction and regularly regaled with the risks of prolonged pregnancy. Nothing was ever said about the risks of induction. Despite huge concern expressed over

I created the ambience I had planned

placental health, I was not offered an umbilical Doppler scan which would have given an idea of the risk of hypoxia and I said that I wanted to have this scan at 43 weeks if my baby had not yet arrived.

A hiatus in the battle now occurred during a beautiful, peaceful, albeit completely intense interlude in this whole narrative. I created the ambience I had planned with my Tibetan Mantra and yoga incense, minimised lighting and, with my tens machine switched on, I began my labour until, with my IM in attendance, just two hours after I knew I was in labour, my daughter was born. She was perfect and beautiful. My placenta showed no signs of ageing, which totally vindicated my decision not to be induced and to bring my daughter into the world in the safe comfortable surroundings of her home where she was introduced to her sister within minutes of being born.

QEH King's Lynn subjected us to further atrocious treatment when we were forced to present our 2-day-old daughter to the hospital for her paediatric assessment. The appointment we were given was at 9.30, we were finally seen at 12 noon. This, I suppose, could be considered as punishment for tenacity in the face of adversity. The letter of complaint about such poor care received yet another dismissive response that appointment times are not guaranteed.

We are living in 2015. How can we allow the choices we make as we prepare for motherhood to be dictated? Having the birth experience of our choice should not be a battle.

The most important part of this episode in my life has been the safe birth of a perfect, healthy child. Each and every individual community midwife who has been in any way responsible for my care has been efficient, caring, supportive of my wishes and encouraging. Each of the decision makers has been negative, unhelpful and obstructive.

My battles with NHS QEH, they believe, are over. After all, I have my baby now and will be far too busy to concern myself further with these issues.

My battles are mostly lost ... BUT the war is not over.

Jane Reeve

Reviews

Breast Intentions

by Allison Dixley
Pinter & Martin Ltd.
ISBN-13: 978-1780662152
RRP £11.99

As someone who has followed Allison Dixley aka The Alpha Parent (interesting choice of name in the first place) sporadically online, I was very interested and apprehensive at the same time about what her book would have to offer. Well, the book did not disappoint, and I was most definitely right to feel apprehensive. Visually, this book appeals to me, though (and I am getting personal here, as Allison does throughout the book) I was not keen on the pink shiny blouse Allison is wearing in the inside cover photo. Thematically, I found the book extremely appealing and intriguing, having witnessed woman to woman sabotage with regards to mothering on more occasions than I'm able to count.

I started to read this book as soon as I got my hands on it, expecting to read it voraciously and quickly, either nodding along in agreement or getting quite shouty over my cup of Roibos tea. Not so. Instead I found myself fighting through the chapters and feeling cross and frustrated about the subject matter and the fact that I had promised to review it. It is fairly heavy going (though that might be due to English not being my first language) and reads more like a thesis on the psychological factors contributing to breastfeeding cessation rather than a book potentially geared towards mothers with an interest in breastfeeding. I'm actually not sure WHO exactly the book is geared towards. Mothers? Breastfeeders? Psychologists? I'm assuming NOT formula feeders. Or indeed 'failed' breastfeeders.

Dixley's premise is that all mothers know they should breastfeed and the overwhelming majority of women can do so physically. Therefore mother's who decide not to or 'fail' at breastfeeding, do so due to making (mostly silly) excuses and really ought to have tried harder. Yes. It is apparently that simple. Women who succeed with breastfeeding are 'black swans', 'diamonds in the rough' and the 'positive deviants of this world'. This premise is then supported from various angles with psychological theory, and the book ends on an over 50-pages-strong reference list.

Now, the ironic thing is that I somewhat agree with many of her points. In her opinion, maternal personality traits have a great predictive value over breastfeeding success for example and the psychological constructs are very interesting to get your teeth into. However, her choice of language and way she gets her opinions and facts across is often offensive and feels deliberately controversial for the sake of it. Not only to the 'failed breastfeeders' she so disapprovingly talks about but also others who are able to see that life is not black and white and that kindness and support go a long way when it comes to human interaction. Phrases and statements such as 'Hypoplasia sounds like the noise a baby makes when it farts in the bath', 'This triggers major butt hurt...' and '...milk deficient sob stories...' amongst other gems feel out of place in a book that seems almost academic.

controversial for the sake of it

It is not all bad however. Oddly, in her concluding chapter, Dixley alludes to all the positive things that can happen with regards to breastfeeding if we nurture women's body confidence and that she would like solidarity and success to reign, despite not showing either solidarity OR nurturing capability in the first part of the book. Another pertinent point that comes across in the conclusion is the importance of honesty with regards to decision making as well as owning one's decisions.

The epilogue of the book is a manual on how to own your breastfeeding journey which many prospective mothers may find helpful. I personally appreciated Dixley's advice of 'Unfuck your habitat' aka 'Finding your tribe' which is more than helpful in many facets of parenting and indeed life.

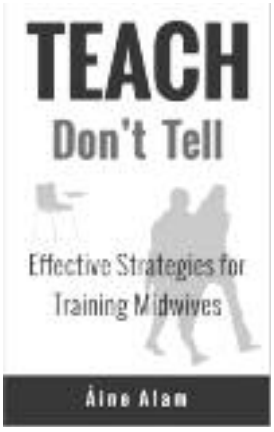
So, in conclusion, an interesting book, in more ways than one. If you are a kind person and suffer from blood pressure issues you may want to proceed with caution. Same if you have painful baggage from your own breastfeeding journey. You may just about cope if you are a 'positive deviant of this world' though.

Debs Neiger

Teach don't tell

By Áine Alam
Panoma Press Ltd 2015
ISBN 978 1909623897
RRP £12.99

This is an excellent and accessible short book exploring teaching strategies for training midwives both in the UK NHS education model and traditional birth attendants in developing nations. Every educator, mentor, trainer of birth attendants, companions and support staff should read this book!



Teach Don't Tell is not a recipe book, nor a step-by-step 'how to' guide, it is an exploration if philosophies, ideas and strategies for facilitating learning in the classroom and arguably more importantly, in practice. This book shows the reader how to enable others to learn in a way that encourages them to fully utilise their knowledge and skills. It is a strategy that has the power to revolutionise not only training, but care itself, through modelling effective support.

What you will find between these covers is an insight into a model of teaching that skills and empowers in a way few other education books do. The author, Áine Alam, draws on her many years of midwifery experience and her research into work-based learning to encourage the trainer to be 'with student', modelling the 'with woman' approach from the very core.

This book does rely on the reader having a basic depth and breadth of both the skills required and knowledge of how people learn, but the approach taken to presenting her ideas is quirky, fresh and gets results. She explains concepts such as the 'novice to expert continuum' in a way that is supportive and empowering at every level of competence. That is refreshing on its own!

I particulrlarly liked the chapter on education theory, where Alam encourages the reader to imagine sitting down to dinner with some of the greatest philosophers and education theorists in history and listening to their discussion. For me the result of that exercise was profound, and rather than tell you what I got out of it, I would encourage anyone who is interested in learning, at any level, to read the book and try it for themselves.

There are some areas of repetition, but, having read the book a couple of times, I am inclined to suspect that is a deliberate effort to encourage internalisation of those concepts, as the book is clear that modelling, practise and repetition are key to effective learning.

Other chapters I found most fascinating were the chapter on the concept of understanding, exploring and evaluating how rituals feed the difference between information and knowledge, and how rituals and jargon encourage 'gatekeeping' and the chapter on 'making the invisible visible' – talking your thinking in order to pass on the whole skill rather than simply teaching the process.

This book is a great start towards breaking down the barriers to knowledge, the tendency towards 'gatekeeping' that has been a part of our medical hierarchy for so long, and for me this is the best bit of the whole book. It really looks at where the knowledge needs to be, that is with the women and those caring for them, and works on ways of putting it firmly into their caring hands.

Vicki Williams

Funding the new AIMS Website

A huge THANK YOU to all of you who have made donations. We have raised just over £1000; but we still need to raise another £5000 to pay for this piece of work which is now underway.

So far donations have been personal ones, but we hope that over the next couple of months many of you will be able to undertake some fundraising activities. We already have a few promises of sponsored events or supper evenings (with and without Mircobirth or VBAC film screenings). Donate at mydonate.bt.com/charities/aims

Ideas can be found at www.aims.org.uk/?fundraising.htm and it would be great if you could share your plans and ideas on the AIMS Members Group (groups.yahoo.com/neo/groups/aimsukmembers/info).

Celebrating Continuity

Rhetoric into Reality, Policy into Practice

Wednesday 13th April 2016

A one day conference in London

key speakers:

Baroness Cumberlege Independent Chair of the 2015 National Maternity Review

Lesley Page President of the Royal College of Midwives

Whether you are a woman expecting a baby, a commissioner or a chief executive choosing and providing local services, or a midwife, student midwife or doctor giving care; whoever you are or whatever your role, Celebrating Continuity is the most important maternity care conference of 2016 and is not to be missed.

While the evidence, policy and demand for more continuity of carer models has never been stronger, in today's fragmented and overburdened maternity service, the reality of having a midwife you know and trust can feel further away than ever. The opportunities to practice in this way are few and far between and, where they do happen, they often start out in a burst of energy and hope and then either fall at the first hurdle or are gradually eroded over time.

This conference will explore what the barriers and challenges are to this way of working and, most importantly, how we can overcome them.

It recognises that there is a shared interest in finding a range of different solutions – some of which may look very different from the way care has been delivered in recent years and it seeks to answer the question – does providing more continuity for women automatically have to mean additional burnout and increasing stress for midwives or is there a way to make it a win-win for everyone?

With the 2015 National Maternity Review about to publish its report, it is time to challenge the attitude that says continuity of carer on a grander scale is simply unachievable and to introduce some new thinking about how to bring it into mainstream practice in innovative ways which can be both sustainable and scalable.

Come and hear some inspirational stories of how and where continuity of carer models are already happening. Get immersed in challenging but positive debates about the issues and take part in interactive sessions exploring the solutions. Most importantly, come away at the end of the day with some practical actions and next steps about how to make it happen in your area.

Whoever you are, we need YOU to bring your enthusiasm and ideas to share, as well as your concerns and challenges to solve. Together, let's make history!

Organised by a collaboration of:

Association for Improvements in the Maternity Services (AIMS) • Neighbourhood Midwives • Positive Birth Movement
Sandwell and West Birmingham NHS Trust – home of Serenity and Halcyon Birth Centres
Sponsored and supported by the Royal College of Midwives.