

## **A response to the UK all party parliamentary group (APPG) report on birth trauma**

Dr Kirstie Coxon<sup>1</sup>, RM, PhD, University of Central Lancashire, School of Nursing and Midwifery, Preston,  
PR1 2HE Twitter @kirstie\_coxon

Dr Kerry Evans<sup>2</sup>, RM, PhD, School of Health Sciences, Queen's Medical Centre, Nottingham, NG7 2UH, UK  
Kerry.Evans1@nottingham.ac.uk Twitter @EvansKerryCAM

Professor Gill Thomson<sup>1</sup>, PhD, University of Central Lancashire, School of Nursing and Midwifery, Preston,  
PR1 2HE Twitter @gill\_thomson

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### **Introduction**

On 13<sup>th</sup> May 2024, the United Kingdom (UK) All Party Parliamentary Group (APPG) on Birth Trauma published a report detailing findings from a national inquiry into birth trauma (APPG, 2024). A similar inquiry, which reached many of the same conclusions as the UK report, was published in Australia, also in May 2024 (Select Committee on Birth Trauma, 2024). The UK inquiry was intended to understand better what is happening and identify ways to reduce birth trauma. Key recommendations include increasing numbers of midwives, obstetricians and anaesthetists, better retention of maternity care staff, a National Maternity Improvement Strategy and leadership from a maternity commissioner who reports directly to the UK Prime Minister.

It is perhaps worth considering how high resource countries such as the UK and Australia have reached a situation where maternity care is considered so problematic that inquiries of this nature should be needed. The UK Birth Trauma Inquiry report follows on from critical high-profile inquiries into UK maternity care (Kirkup, 2022, 2015; Ockenden, 2022), with others underway. These reports call for significant improvements in service quality and investment, which as yet have not translated into action

or had discernible impacts on women and birthing peoples' reports about their experiences of maternity care.

The need for this report is perhaps all the more surprising given that UK maternity policy has been firmly focused on improving compassionate care since 2016 (National Maternity Review NHS England, 2016), and that a national maternity and neonatal transformation plan is underway (Department of Health, 2023). An update to this work provides at least one reason for the evidence of continuing problems:

*'Our ambition of safer, more personalised, and more equitable care can only be delivered by skilled teams with sufficient capacity...However, NHS maternity and neonatal services in many [organisations] do not yet have the number of staff they need'. (NHS England, 2023) (point 11, page 4/9).*

Our editorial is a response to the UK Birth Trauma Inquiry report. Here, we consider some of the recommendations made in relation to antenatal, intrapartum and postnatal care, reflect on comparisons with other similar settings, and consider the implications of the report's proposals for practice and for research.

### **Antenatal care**

The APPG report recommends providing all women with opportunity to access good quality antenatal education that clearly explains what giving birth involves, what risks exist and the kinds of choices they might have to make during labour so that they can think these through beforehand. Antenatal education has been tasked with fulfilling numerous and sometimes conflicting priorities in UK maternity care. These include fostering social support networks, health promotion, caring for a new baby, outlining the risks associated with labour and birth, reducing maternal stress, informed decision-making, promoting self-efficacy, lowering rates of interventions and reducing health disparities (Çankaya and Şimşek, 2021; Dalton et al., 2018). Despite antenatal education being a core component of UK midwifery care for decades, there is surprisingly little evidence to inform the components, delivery and methods of evaluation; the most recent Cochrane review on this topic was published in 2007 (Gagnon and Sandall, 2007). The focus on antenatal preparation within the Report suggests a consensus view that this can prevent or reduce the likelihood of experiencing birth as traumatic, but the theoretical and evidence base is not yet established.

High quality research into antenatal preparation, including the extent to which this reaches marginalised communities, and those most likely to have poor birth experiences, is long overdue.

For some women, information can help them to feel in control and confident in their abilities, aligning their expectations about labour and birth, decreasing apprehension and fear of the unknown (Borrelli et al., 2018; Diezi et al., 2023). Birth preparation which includes information about possible complications can provide women and partners with a 'toolkit' to draw upon if needed. Women are exposed to information about childbirth from various sources and the amount of information they receive and how it is interpreted is influenced by women's sensitivity to risk, their cultural and social backgrounds. Some may want to discuss the accuracy of what they read online but can be reluctant to ask questions due to embarrassment by lack of knowledge about what happens during labour. Antenatal education could provide opportunity to initiate discussions in a supportive, non-judgemental setting where women can receive support and encouragement from care providers and from each other.

The report recommends mandatory training on trauma-informed care for the maternity workforce.

However, as yet there remains a lack of definition and consensus for trauma-informed approaches to care that seek to reduce the negative impact of trauma for women with a history of adverse, abusive and traumatic experiences (Office for Health Improvement and Disparities, 2022). Principles outlined in the *NHS Good Practice Guide for Trauma-Informed Perinatal Care* (Centre for Early Child Development, 2021) recommend improving midwives' awareness of trauma symptoms, recognising how women with a history of trauma may present at any time during pregnancy or childbirth and providing consistent and compassionate care with the aim to prevent re-traumatisation. We also need to acknowledge that while some women may disclose previous trauma for the first time during pregnancy, for many, previous trauma remains hidden and is often undisclosed (Cull et al., 2023; Montgomery, 2013).

The focus on antenatal care in the Report reflects Ayers' (2017) view that research into antenatal recognition of predisposing factors provides a clear opportunity to intervene early, plan care to prevent trauma and harness positive support and individual resilience to prevent negative sequelae when pregnancy or birth is complex.

## **Intrapartum Care**

Moving on to intrapartum care, it is clear that specific practices are contributing to experiences of trauma during birth. Amongst those who responded to the APPG call for evidence, many had experienced forceps or other instrumental births, third- and fourth-degree perineal tears or emergency operative births (in-labour caesareans). Instrumental births are associated with feeling a loss of control during labour, (Anderson, 2017), and as the Report made clear, forceps use is much lower in other European countries than in the UK. The Report recommended that the OASI care bundle be fully rolled out in the UK (Gurol-Urganci et al., 2021), and a study to evaluate implementation of 'OASI 2' is currently ongoing (Jurczuk et al., 2023) but has not yet reported. A recent comparative study of thirteen high income countries showed that England had the highest use of forceps (11.2% for first births, 3.8% for second or subsequent births); other countries used ventouse more often, which is associated with lower rates of OASI (Seijmonsbergen-Schermer et al., 2020). The reasons for this comparatively high use of forceps is unclear, but taking steps to learn from other countries, and if feasible, safely reduce their use would be a progressive step. A further consideration is that instrumental birth is not something that women felt they had been able to fully consent to. Many reported that they were not told of the known short-, medium- and long-term impacts on birth recovery, or of the sequelae of OASIs and how these might affect continence, mental wellbeing, employment, ability to care for children, their partners, and their sexual relationships.

Recommendations to reduce or prevent traumatic birth experiences highlight the central role of effective communication, in particular during unexpected and unplanned events (Centre for Early Child Development, 2021). This includes providing clear explanations of interventions, the likelihood of possible outcomes and providing opportunity to discuss care options in advance. Given the complex often unpredictable context of childbirth, we need to understand how best to deliver straightforward information during pregnancy, which helps women and birth partners prepare for the numerous possible situations and decisions they may be confronted with without unduly causing anxiety and fear.

In common with previous reports on UK maternity care, the APPG Report found that women and birthing people do not feel listened to by staff. As in other recent policy statements, the Report calls for staff to respect women's choices. This is already part of UK NICE and WHO guidelines for pregnancy and birth (National Collaborating Centre for Women's and Children's Health [NCCWCH], 2007; National Institute for

Health and Care Excellence, 2021; NICE, 2023; World Health Organization, 2018) but maternity staff report that they under-prepared to discuss best evidence about risks and benefits for individuals (Begley et al., 2019; Clerke et al., 2023). This is also a cornerstone of professional practice; no clinician completes a pre-registration programme without a thorough grounding in communication skills. However, studies about midwives' reasons for leaving the profession demonstrate that staff want to provide good quality care but feel this is impossible under current constraints (Cull et al., 2020; Harvie et al., 2019). We therefore need to ask whether the problem is not that staff 'don't listen', but rather that staff *can't* listen, because they work in a chronically under-funded system that does not have the infrastructure to provide good quality, safe maternity care. This was to some extent acknowledged by the incoming Health Secretary, Wes Streeting, whose candid assessment on taking up his post was that '*the NHS is broken*' (Guardian Staff, 2024).

As current maternity policies already recommend personalised care and informed decision making (Department of Health, 2023; National Maternity Review NHS England, 2016), understanding what matters most to women and planning care on that basis is already a de facto requirement, although one that seems rarely achieved. The UK *Montgomery vs. Lanarkshire* ruling confirms that it is also a legal requirement to inform pregnant women of any material risk that may affect them when seeking lawful consent, but the evidence from this and other national review reports makes it clear that women often do not receive information that reaches even the legal threshold prior to complex or instrumental births. The policy and legal framework are therefore already in place to make individualised, sensitive maternity care routine; we must conclude that a lack of NHS staff and a history of under-investment prevent this from becoming a reality.

### **Postnatal care**

In view of the evidence that so many women and partners report traumatic birth experiences, many of the UK Report conclusions and recommendations are designed to improve access to suitable services. For example, the Report highlights inequities within the newly formed maternal mental health services (MMHS) (mandated within the NHS long-term plan) (National Health Service, 2019) but stops short of recommending how these should be addressed. It is also important to emphasise that even within MMHS

that received available funding (i.e., the 'early adopter' and 'fast follower' funding streams), service needs often exceed capacity, leading to long waiting lists, frustration, and arguably enhancing perinatal mental health problems. If birth trauma and its concomitant sequelae are to be taken seriously, this needs to be reflected in services that are sufficiently resourced to ensure women and birthing peoples receive timely access to needs-led care.

A further pressing area to consider within postnatal provision relates to inequities faced within minoritised ethnic communities. The Report highlights a commitment to tackling inequalities via the use of interpreters, however although welcome, we argue this is insufficient to address the widespread disparities in this area of healthcare. As reflected in a series of MMBRACE reports, and in common with the Australian Report, women from minoritised ethnic communities face poorer maternal and infant health outcomes (Knight et al., 2023, 2022, 2016) and are at increased risk of poor perinatal mental health (Prady et al., 2021; Womersley et al., 2021). However, despite these increased risks, ethnically minoritised women and birthing people are less likely to access support due to barriers operating at the individual (stigma, lack of awareness), organisational (inadequate resources), sociocultural (language, cultural barriers) and structural (lack of clear policies) levels (Webb et al., 2023).

While this evidence signifies the need for services to be more accessible, there are related challenges of current mental health systems not serving the needs of marginalised populations. Cultural adaptations (e.g., in language, culture and context) to 'recommended' interventions may help optimise their compatibility and efficacy. For example, a culturally adapted Interpersonal Therapy and Cognitive-Behavioural approach proved feasible, acceptable, and efficacious in the treatment of post-natal depression in South Asian women (Husain et al., 2023, 2021). Overall, however, there is limited evidence of the effectiveness of culturally safe adaptations or modifications for interventions in perinatal populations – this is an area where urgent attention is needed.

Another area where further work is required relates to the training of healthcare staff. First, the recommendation of mandatory trauma-informed training for maternity staff should be expanded to General Practitioners (GPs). GPs are the professionals who are potentially most likely to see postnatal women and birthing people with poor mental health problems. It is therefore crucial for these

professionals to be able to recognise the signs and symptoms of trauma and to prevent a misdiagnosis of depression. This would help to reduce inappropriate medication being prescribed, with associated cost savings for the NHS, as well as enabling women and birthing people access to appropriate treatment. Second, in the UK, maternity professionals who are predominately white have been found to lack confidence in identifying poor mental health in ethnic minority populations and are less likely to ask minoritised ethnic women about their mental health compared to white women (Harrison et al., 2023). These issues could be tackled by additional mandatory training in unconscious bias and culturally competency. Thirdly, services need to provide training to practitioners working within the NHS Talking Therapy services. The development of MMHS has ensured a clear pathway for women experiencing moderate to severe mental health difficulties due to birth trauma and perinatal loss provided by staff that have specialist training and experience. Although women experiencing mild to moderate difficulties can access NHS Talking Therapies services, these practitioners lack perinatal training, particularly in the areas of birth trauma and loss. Trauma responses for perinatal populations are often different to those experienced by the general population. For example, the focus of the trauma – often the baby – is an ongoing reminder in families' lives; parents may also wish to plan for a further conception following a traumatic childbirth event, or perinatal loss, all of which require a family-focused and relational focus and that requires an understanding of maternity care practices and provision. Bespoke training to upskill these professionals aligns with the APPG recommendation of universal access to specialist support, whereby individuals can receive support that is tailored to their perinatal needs, irrespective of where it is provided.

The APPG report ends with a section dedicated to what 'good' might look like in maternity. It is important to recognise that many women and birthing people do report that they receive good care, and feel they were provided with information to inform decisions during pregnancy and birth (Care Quality Commission, 2023). It is easy to lose sight of this when we read of the distress and suffering caused to some, and of evidence in both the UK and Australian reports showing the burden of poor care falls disproportionately upon those who have pre-existing physical and mental health conditions, experience complex or emergency care during birth and those who are already been disadvantaged by structural factors including racism, socio-economic inequality and many other forms of marginalisation. Universal

principles of compassionate care have a significant impact on maternity experiences and should be an 'always' event in maternity care. The report highlights significant failings through active neglect of women's needs, women's concerns being ignored and being treated with unkindness during periods of vulnerability. The determinants and barriers to compassionate and respectful care require urgent attention for the same of all women, partners and maternity care staff.

## References

Anderson, C.A., 2017. The trauma of birth. *Health Care for Women International* 38, 999–1010. <https://doi.org/10.1080/07399332.2017.1363208>

APPG, 2024. Listen to Mums: Ending the Postcode Lottery on Perinatal Care: A report by The All-Party Parliamentary Group on Birth Trauma. All Party Parliamentary Group on Birth Trauma, London UK.

Begley, K., Daly, D., Panda, S., Begley, C., 2019. Shared decision-making in maternity care: Acknowledging and overcoming epistemic defeaters. *Evaluation Clinical Practice* 25, 1113–1120. <https://doi.org/10.1111/jep.13243>

Borrelli, S.E., Walsh, D., Spiby, H., 2018. First-time mothers' expectations of the unknown territory of childbirth: Uncertainties, coping strategies and 'going with the flow.' *Midwifery* 63, 39–45. <https://doi.org/10.1016/j.midw.2018.04.022>

Çankaya, S., Şimşek, B., 2021. Effects of Antenatal Education on Fear of Birth, Depression, Anxiety, Childbirth Self-Efficacy, and Mode of Delivery in Primiparous Pregnant Women: A Prospective Randomized Controlled Study. *Clin Nurs Res* 30, 818–829. <https://doi.org/10.1177/1054773820916984>

Care Quality Commission, 2023. 2022 Maternity survey Statistical release, NHS Patient Survey Programme.

Centre for Early Child Development, 2021. A good practice guide to support implementation of trauma-informed care in the perinatal period. NHS England and NHS Improvement, Blackpool and London, UK.

Clerke, T., Margetts, J., Donovan, H., Shepherd, H.L., Makris, A., Canty, A., Ruhotas, A., Catling, C., Henry, A., 2023. Piloting a shared decision-making clinician training intervention in maternity care in Australia: A mixed methods study. *Midwifery* 126, 103828.  
<https://doi.org/10.1016/j.midw.2023.103828>

Cull, J., Hunter, B., Henley, J., Fenwick, J., Sidebotham, M., 2020. "Overwhelmed and out of my depth": Responses from early career midwives in the United Kingdom to the Work, Health and Emotional Lives of Midwives study. *Women and Birth* 33, e549–e557.  
<https://doi.org/10.1016/j.wombi.2020.01.003>

Cull, J., Thomson, G., Downe, S., Fine, M., Topalidou, A., 2023. Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis. *PLoS ONE* 18, e0284119. <https://doi.org/10.1371/journal.pone.0284119>

Dalton, J.A., Rodger, D., Wilmore, M., Humphreys, S., Skuse, A., Roberts, C.T., Clifton, V.L., 2018. The Health-e Babies App for antenatal education: Feasibility for socially disadvantaged women. *PLoS ONE* 13, e0194337. <https://doi.org/10.1371/journal.pone.0194337>

Department of Health, 2023. Three year delivery plan for maternity and neonatal services (Policy). Department of Health, London, UK.

Diezi, A.-S., Vanetti, M., Robert, M., Schaad, B., Baud, D., Horsch, A., 2023. Informing about childbirth without increasing anxiety: a qualitative study of first-time pregnant women and partners' perceptions and needs. *BMC Pregnancy Childbirth* 23, 797.  
<https://doi.org/10.1186/s12884-023-06105-3>

Gagnon, A.J., Sandall, J., 2007. Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*.  
<https://doi.org/10.1002/14651858.CD002869.pub2>

Guardian Staff, 2024. Wes Streeting says NHS is broken as he announces pay talks with junior doctors. The Guardian. <https://www.theguardian.com/society/article/2024/jul/06/wes-streeting-nhs-broken-announces-talks-junior-doctors#:~:text=The%20new%20health%20secretary%2C%20Wes,was%20%E2%80%9Cnot%20good%20enough%E2%80%9D.>

Gurol-Urganci, I., Bidwell, P., Sevdalis, N., Silverton, L., Novis, V., Freeman, R., Hellyer, A., Van Der Meulen, J., Thakar, R., 2021. Impact of a quality improvement project to reduce the rate of obstetric anal sphincter injury: a multicentre study with a stepped-wedge design. *BJOG* 128, 584–592. <https://doi.org/10.1111/1471-0528.16396>

Harrison, S., Pilkington, V., Li, Y., Quigley, M.A., Alderdice, F., 2023. Disparities in who is asked about their perinatal mental health: an analysis of cross-sectional data from consecutive national maternity surveys. *BMC Pregnancy Childbirth* 23, 263. <https://doi.org/10.1186/s12884-023-05518-4>

Harvie, K., Sidebotham, M., Fenwick, J., 2019. Australian midwives' intentions to leave the profession and the reasons why. *Women and Birth* 32, e584–e593. <https://doi.org/10.1016/j.wombi.2019.01.001>

Husain, N., Kiran, T., Shah, S., Rahman, A., Raza-Ur-Rehman, Saeed, Q., Naeem, S., Bassett, P., Husain, M., Haq, S.U., Jaffery, F., Cohen, N., Naeem, F., Chaudhry, N., 2021. Efficacy of learning through play plus intervention to reduce maternal depression in women with malnourished children: A randomized controlled trial from Pakistan ☆. *Journal of Affective Disorders* 278, 78–84. <https://doi.org/10.1016/j.jad.2020.09.001>

Husain, N., Lunat, F., Lovell, K., Sharma, D., Zaidi, N., Bokhari, A., Syed, A., Tomenson, B., Islam, A., Chaudhry, N., Waheed, W., 2023. Exploratory RCT of a group psychological intervention for postnatal depression in British mothers of South Asian origin – ROSHNI-D. *Acta Psychologica* 238, 103974. <https://doi.org/10.1016/j.actpsy.2023.103974>

Jurczuk, M., Thakar, R., Carroll, F.E., Phillips, L., Meulen, J.V.D., Gurol-Urganci, I., Sevdalis, N., 2023. Design and management considerations for control groups in hybrid effectiveness-

implementation trials: Narrative review & case studies. *Front. Health Serv.* 3, 1059015.

<https://doi.org/10.3389/frhs.2023.1059015>

Kirkup, B., 2022. Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation. HMSO.

Kirkup, B., 2015. The Report of the Morecambe Bay Investigation: an independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013.

Knight, M., Bunch, K., Felker, A., Patel, R., Kotnis, R., Kenyon, S., Kurinczuk, J., on behalf of MBRRACE-UK., 2023. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21. (Confidential Enquiries into Maternal Deaths and Morbidity). National Perinatal Epidemiology Unit, University of Oxford, Oxford.

Knight, M., Bunch, K., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S., Kurinczuk, J., 2022. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20, MBRRACE. National Perinatal Epidemiology Unit, University of Oxford, Oxford.

Knight, M., Nair, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Brocklehurst, P., Kurinczuk, J.J., 2016. Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14, MBRRACE-UK. NPEU, University of Oxford, Oxford.

Montgomery, E., 2013. Feeling Safe: A Metasynthesis of the Maternity Care Needs of Women Who Were Sexually Abused in Childhood. *Birth* 40, 88–95. <https://doi.org/10.1111/birt.12043>

National Collaborating Centre for Women's and Children's Health [NCCWCH], 2007. (2007) Intrapartum Care: Care of healthy women and their babies during childbirth. Clinical Guideline 55. Royal College of Obstetricians and Gynaecologists (RCOG) Press, London.

National Health Service, 2019. The NHS Long Term Plan. NHS, London.

National Institute for Health and Care Excellence, 2021. Shared decision making NICE Guideline, NICE guideline 197. National Institute for Health and Care Excellence.

National Maternity Review NHS England, 2016. Better Births; Improving outcomes of maternity services in England A Five Year Forward View for maternity care (Report of the National Maternity Review).

NHS England, 2023. Update from the Maternity and Neonatal Programme, NHS England Board meetings. NHS England.

NICE, 2023. Caesarean birth: NICE guideline 192. <https://www.nice.org.uk/guidance/ng192>

Ockenden, D., 2022. Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Ockenden Report - Final. Department of Health & Social Care.

Office for Health Improvement and Disparities, 2022. Guidance Working definition of trauma-informed practice. Office for Health Improvement and Disparities, London, UK.

Prady, S.L., Endacott, C., Dickerson, J., Bywater, T.J., Blower, S.L., 2021. Inequalities in the identification and management of common mental disorders in the perinatal period: An equity focused re-analysis of a systematic review. PLoS ONE 16, e0248631.

<https://doi.org/10.1371/journal.pone.0248631>

Seijmonsbergen-Schermer, A.E., Van Den Akker, T., Rydahl, E., Beeckman, K., Bogaerts, A., Binfa, L., Frith, L., Gross, M.M., Misselwitz, B., Hálfhánsdóttir, B., Daly, D., Corcoran, P., Calleja-Agius, J., Calleja, N., Gatt, M., Vika Nilsen, A.B., Declercq, E., Gissler, M., Heino, A., Lindgren, H., De Jonge, A., 2020. Variations in use of childbirth interventions in 13 high-income countries: A multinational cross-sectional study. PLoS Med 17, e1003103.

<https://doi.org/10.1371/journal.pmed.1003103>

Select Committee on Birth Trauma, 2024. Birth Trauma. New South Wales Parliament Legislative Council, NSW, Australia.

Webb, R., Uddin, N., Constantinou, G., Ford, E., Easter, A., Shakespeare, J., Hann, A., Roberts, N., Alderdice, F., Sinesi, A., Coates, R., Hogg, S., Ayers, S., 2023. Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare. *BMJ Open* 13, e066703.

<https://doi.org/10.1136/bmjopen-2022-066703>

Womersley, K., Ripullone, K., Hirst, J.E., 2021. Tackling inequality in maternal health: Beyond the postpartum. *Future Healthcare Journal* 8, 31–35. <https://doi.org/10.7861/fhj.2020-0275>

World Health Organization, 2018. WHO recommendations: intrapartum care for a positive childbirth experience. World Health Organization, Geneva.

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