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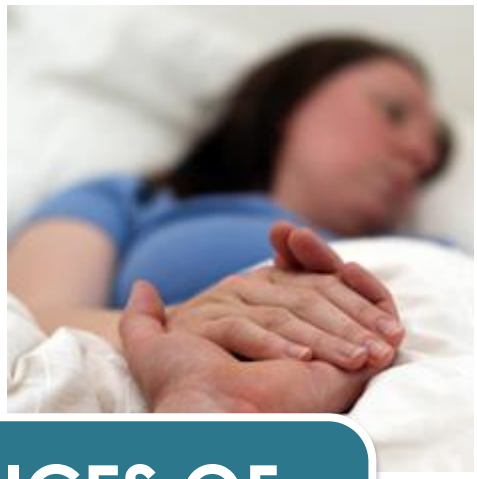

LISTENING TO THE VOICES OF MIDWIVES

Independent research for Birmingham, Solihull & Sandwell LINks

March 2013

Birmingham LINk MAKE IT HAPPEN! Local Involvement Network

Solihull Local Involvement Network

Sandwell LINk MAKE IT HAPPEN!

Acknowledgements

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We would also like to thank the volunteer researchers from Birmingham and Solihull LINks who formed part of our team and the midwives and the external midwifery academic who took the time to proof read the draft report and provide their comments.

Merida Associates is an independent research and development consultancy serving the public, voluntary and community sectors.

Disclaimer

This is not a definitive study of all maternity services provision across Birmingham, Solihull and Sandwell; it presents the views and opinions of a cross-section of professional midwives and stakeholders who work in those areas. The examples of practice mentioned in the report come from the people who chose to take part in the research and we have not been able to include everything we were told. They do not therefore reflect all current practice developments, innovations or changes being implemented by the various provider organisations.

Commissioned by
Birmingham, Solihull and Sandwell LINks

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Approved Consultant 2013 ncvo National Council for Voluntary Organisations

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Listening to the voices of midwives: Executive Summary

Local Involvement Networks (LINks) currently provide the mechanism for patient and public involvement in health and social care services. The three LINks organisations for Birmingham, Solihull and Sandwell have commissioned Merida Associates to undertake independent research on the experiences of midwives across for the three areas, following previous LINks research into the experiences of women accessing maternity services. The research team have undertaken a number of qualitative and quantitative research activities to enable the voices of midwives to be heard.

The report is structured thematically to reflect the key areas of interest of the LINks and to allow information from a range of sources to be cross-referenced. The main sections look at:

- *Providing safe care*
- *Providing quality of care*
- *Providing care for vulnerable and disadvantaged women*
- *Midwifery workforce*
- *Accountability and autonomy*

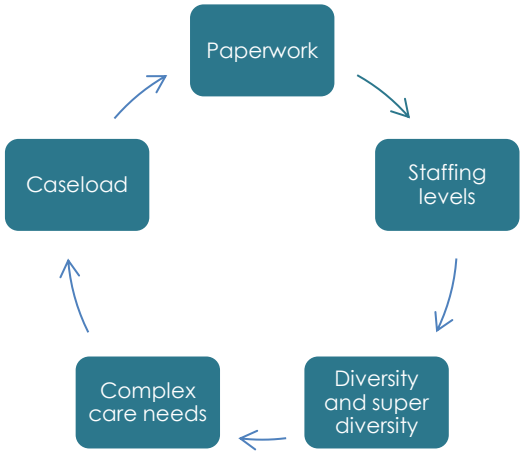
Findings

The following points highlight key learning from the research.

- **Time pressures**

Time pressures present the key obstacles to providing the highest quality of care. From midwives' perspective, lack of time means they are unable to do their job as well as they would like.

This diagram illustrates some of the more commonly agreed factors that exert time pressures on midwives.



- **Supporting vulnerable women**

Changes in population demographics and increases in the number of complex cases mean that midwives across the three Trusts are working with more vulnerable women than ever before. Midwives are doing their best to support vulnerable women with a caring and compassionate service but they recognise that they need more support, information and skills to do so more effectively.

- **Impact of super-diversity**

Midwives across the three areas, particularly but not exclusively in community settings, are developing skills and knowledge about the communities they work in, often very different on a geographical basis, which could enhance the quality of care in acute units.

- **Postnatal care**

Evidence from the research suggests that the area of maternity services most in need of attention in terms of improving the quality of care is the postpartum and postnatal period in acute units.

Anecdotal evidence from the research suggests that postnatal care in community settings varies between Trusts and also within Trusts.

The transition of care between community and acute unit or MLU settings, particularly postnatally, appears to be an area where communication between professionals can be limited.

- **Silo working and communication**

In services that cover large and varied geographical areas, there are incidences of 'silo working', with poor communication between settings which could impact on the quality of care for women at key service transition points. Some community midwives in particular identified transition points as crucial for supporting women in terms of continuity of care.

Midwives reported that there needs to be better communication across all elements of the maternity service – wards, clinics and the community and better understanding of each other's roles.

- **Maternity Support Workers**

Working with Maternity Support Workers, and other support staff, in a team approach is widely seen as beneficial for both women and staff. Midwives that do not have opportunities to work with Maternity Support Workers, really appreciate the difference they make when they experience it first-hand.

- **Consultant Midwives**

Midwives identified the importance of Consultant Midwives. Research evidence suggests that there are few of these roles available with local Trusts and that some of them may be under threat during the re-alignment due to the implementation of the current Health reforms.

- **Autonomy and accountability**

Overall, midwives feel able to exert autonomy in the workplace, although some would like more support to do so. Midwives are accountable through CNST and they have a clear understanding of the accountability of their professional role, as signified by their registered status, and many are concerned about the risks and consequences of making mistakes, for the patients and for themselves, particularly less experienced midwives. Some Trusts are using CNST proactively to drive up standards of basic midwifery care.

- **Being involved**

Many midwives make time, often out of working hours and in addition to family commitments, to keep up-to-date with policy changes and service developments, to be aware and engaged with the changing environment around them. Many others are focused on supporting women while at work and find that, with working shifts, completing necessary paperwork, mandatory training and their own family care responsibilities, finding time to keep up-to-date is difficult. As a consequence they can feel disengaged from staff consultation processes and under-prepared when new policies and practices come into force.

Recommendations for provider Trusts

- Improve communication and team working
- Explore experience-led co-production[1] approaches to designing maternity care pathways
- Enable skill retention and professional development
- Listen to the voices of midwives
- Invest in effective, accessible IT systems and better equipment
- Enforce 'no tolerance' policies of violence towards midwives

Recommendations for the Maternity and Newborn Services Capacity Review Project

- Learn from the best – share good practice between Trusts
- Work together to improve recruitment and staff development opportunities, especially for people from BAME communities
- Trusts should share information to enable consistency across boundary lines

[1] *"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and carers. Where activities are co-produced in this way, both services and service users become far more effective agents of change" adapted from NESTA 2010 http://coproductionnetwork.com/forum/topics/what-is-the-definition-of*

Recommendations for commissioners (CCGs) and Public Health

- Work together to change public and professional perceptions around normalisation of birth

Recommendations for midwives

- Keep themselves up-to-date on policy and practice developments
- Actively engage in service re-design and improvement

Recommendation for new Healthwatch organisations

- Ensure findings of this research are followed up

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1 Introduction

This report presents the findings of an independent research project to explore the views and experiences of midwives working in Birmingham, Solihull and Sandwell, and makes recommendations for workforce support and improving services. The research was commissioned by the Local Involvement Networks (LINks) for the three areas and follows a previous LINks' study of women's experiences of maternity services in Birmingham and Solihull[2] to provide a fuller picture of both the delivery and receipt of midwifery care. The objectives of the research can be seen at Appendix 1.

The report is structured thematically to reflect the key areas of interest of the LINks and to allow information from a range of sources to be cross-referenced. The main sections look at:

- *Providing safe care*
  Midwives' experience of low-risk and high-risk care pathways
- *Providing quality of care*
  Midwives' reflections on the provision of care, including normalisation of birth, continuity of care, good practice, obstacles and solutions
- *Providing care for vulnerable and disadvantaged women*
  Reflections on the super-diversity of the population served across Birmingham, Solihull and Sandwell and the issues for midwives caring for women from different communities and with a range of complex health, social and economic needs
- *Midwifery workforce*
  Information on the make-up of the midwifery workforce in the 3 main provider Trusts that serve Birmingham, Solihull and Sandwell, the different models of team working, changing expectations of midwives, recruitment and retention issues and professional development and support
- *Accountability and autonomy*
  Midwives' reflections on being able to exert autonomy, the impact of CNST on practice, the impact of complaints and compliments on morale, the views of both experienced and newly qualified midwives

1.1 LINKs and Healthwatch

Local Involvement Networks currently provide the mechanism for patient and public involvement in health and social care services. They have statutory powers to hold service providers to account. In April 2013, these powers will transfer to new local Healthwatch organisations in Birmingham, Solihull and Sandwell. This report will form

[2] Lynch N. (2011) Women's Experiences of Maternity Services in Birmingham East and North and Solihull: Birmingham, Birmingham and Solihull LINKs

part of the transition documentation from LINks to the new Healthwatch organisations, with an expectation that they will follow up on the recommendations with maternity service providers.

1.2 Context

The context for maternity care and support is changing as the Health and Social Care Act 2012 comes into force in April 2013. The new legislation abolishes Primary Care Trusts (PCTs) and transfers most commissioning powers to GPs, as Clinical Commissioning Groups, who will be responsible for commissioning maternity services. Strategic Health Authorities have also been abolished and Clinical Commissioning Groups will be supported by the National Commissioning Board, which will also commission primary care and specialist services. The Act forms part of a wider agenda of accelerating moves towards:

- Foundation Trusts with new 'freedoms' to innovate to improve quality of services
- Opening up the provision of health and social care services to 'Any Qualified Provider' within a mixed economy of welfare[3]
- Developing the right to challenge and right to manage options for employees and communities[4] and options for developing NHS mutuals or 'spin out' social enterprises, such as the One to One midwifery service in the Wirral[5][6]

Maternity services across Birmingham, Solihull and Sandwell have been re-configured in recent years and on-going changes to extend women's choices are being facilitated by the development of midwife-led units[7] and different ways of working. There is currently a Maternity and Newborn Services Capacity Review project in which provider Trusts covering Birmingham and Solihull are working with commissioners and patient representatives to develop a new approach to providing safe, accessible, high quality maternity services equitably for all women, making best use of available resources.

Most significantly, the profile of women accessing maternity services has changed[8] with more older first-time mothers, increases in multiple births, more women with long-term medical conditions being able to have babies, increases in obesity and diabetes and the growing super-diversity of communities across the three areas covered by this research. There is also a continuing baby boom in England, numbers of births have increased by 20% in the West Midlands between 2001-2011and the numbers of births were up again in 2012. This is set against a national shortage of

[3] Powell, M. (2007) *Understanding the Mixed Economy of Welfare*
[4] Localism Acts 2011/2012: Open Public Services: 2012
[5] http://www.onetoonemidwives.org/
[6] See Alcock et al: (2012) *Start-up and growth: National Evaluation of the Social Enterprise Investment Fund*
[7] Midwife-led units are small maternity units which are staffed and, in most cases, run by midwives. They offer a homely rather than a clinical environment. They are good at supporting women who want a birth with no or few medical interventions.
[8] King's Fund (2008) Safe Births: Everybody's business - An independent inquiry into the safety of maternity services in England

midwives and although there has been an increase in the numbers of full-time midwives in the West Midlands, and the numbers of midwifery training places have also increased, the Royal College of Midwives contends, based on calculations using Birthrate Plus, there are still not enough midwives to meet the increased demand[9].

Relevant to the findings of this report is the recent policy produced by the Chief Nursing Officer of the National Commissioning Board on the vision and strategy for nursing, midwifery and care staff to deliver *Compassion in Practice* (Dec 2012). This document describes how professional staff must work in partnership with patients to help them in making choices about their health and care, and supporting the implementation of 'no decision about me without me' by employing the 6Cs - care, compassion, competence, communication, courage and commitment. The strategy document identifies frontline staff as the 'change champions' for developing a new organisational culture based on the 6Cs, supported by strong and effective leadership. Together with the recommendations of the Francis Inquiry[10], this strategy provides a current and powerful context for putting patient care at the centre of delivery and creating an organisational culture that listens to patients and staff and responds to what it hears.

This report is timely in the wake of the Francis Inquiry report as it presents up-to-date information on the experiences of midwives providing services to women and families in Birmingham, Solihull and Sandwell. It indicates the competing pressures they face in providing high quality patient care, what works well in supporting women through the stages of pregnancy, birth and postnatal care and how they are responding to meeting the needs of an increasingly diverse and complex patient population.

1.3 Methodology

The aim of the research was to capture the experiences of midwives working in Birmingham, Solihull and Sandwell. The focus of the research was to gather mainly qualitative data with some quantifiable elements. To ensure the robustness of the research findings, a triangulated mixed methodology was adopted[11]. This involved undertaking a detailed online questionnaire survey to generate primarily qualitative data which could be subject to quantitative analysis[12]. This was supplemented by:

- A scoping focus group with midwives
- A series of follow up convenience sample telephone interviews[13] with midwives who had completed the online survey and self-selected to take part in more in-depth questioning

[9] RCM State of Maternity Services 2012
[10] Robert Francis QC (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*
[11] Cresswell, J. and Clark, V. (2011) *Designing and Conducting Mixed Methods Research*
[12] Tashakkori, J. and Clark, V. (eds) (2003) *Handbook of Mixed Methods in Social and Behavioural Research*
[13] National Audit Office (2012) *A Practical Guide to Sampling*

- In depth, semi-structured interviews with key stakeholders, as identified by the LINks Project Board, conducted by telephone or face-to-face
- A literature review of policy documents, academic research and practitioner journals, some provided by the LINks Project Board

Table 1: Number of research participants

Participants	Number
Online survey	181
Midwife interviews	20
Scoping focus group midwives	3
Stakeholders	10

Please note: midwife interviews were mostly self-selected from online surveys so 18 out of 20 midwives interviewed also completed an online survey. See Appendix 2 for a profile of research participants.

The scoping focus group helped to shape the content of the online survey. The telephone interviews with midwives were conducted by the research team with support from two volunteers recruited via the LINKs Project Board. Volunteers received training in research methods and were supported throughout the research within the terms of best practice guidance on working with community researchers[14]. Midwives and all participants were promised anonymity to encourage them to take part and the research has been conducted under Social Research Association Ethical Guidelines[15]

Stakeholders were selected by the LINks Project Board and included senior management representatives from each of the 3 hospital Trusts providing maternity services across Birmingham, Solihull and Sandwell, a local commissioner of maternity services, a representative from a regional midwifery professional body and a stakeholder with a national view of developments in maternity services. These interviews provided policy, managerial and strategic context for the operational experiences of the midwives who took part in the research.

The online survey was designed by the research team in partnership with the LINks Project Board. It was piloted by the LINks Project Board who circulated it to a number of colleagues for testing, following which final revisions were made.

The risk of a low response rate from practising midwives was acknowledged at the beginning of the research and various strategies were adopted to maximise participation in the research. The LINks Project Board was keen to promote the research to midwives as a recognisably independent project and secured early

[14] Banks, S. et al (2011) *Community-based Participatory Research: Ethical Challenges*
[15] Social Research Association Ethical Guidelines (2003) http://the-sra.org.uk/wp-content/uploads/ethics03.pdf

support from the Nursing and Midwifery Council (NMC), the Royal College of Midwives (RCM) and the Royal College of Nursing (RCN) to promote the research in their e-bulletins and newsletters and via their West Midlands regional networks.

The research was promoted using social media on Twitter[16] and Facebook (WAITS). The survey link was uploaded onto the WAITS website[17] and it was circulated by email, along with a printable flyer, through a number of routes including Supervisors of Midwives, LINks Project Board networks and Heads of Midwifery in the 3 maternity provider Trusts.

The response rate was carefully monitored and regularly discussed with the LINks Project Board. When concern was expressed about the numbers of responses, additional marketing activity was undertaken. This included contacting Heads of Midwifery to offer on-site focus groups with staff. This was well received but focus groups were unable to take place within the original timeline for the project because of the effect of adverse weather conditions on the delivery of maternity services at the allocated time. As a result, the data capture time period was extended by the LINks Project Board and paper copies of the survey were distributed to all maternity units in Birmingham, Solihull and Sandwell, together with Freepost envelopes. This was a successful strategy for generating more survey responses.

A total of 193 people accessed the online survey, of these 12 were filtered out of the sample as they do not practise as midwives in Birmingham, Solihull or Sandwell. The number of responses analysed from the survey is 181. This is made up as follows:

Table 2: Online survey respondents by employer

Employer	Number of respondents	Percentage of sample that answered question
Birmingham Women's Hospital NHS Foundation Trust	38	22%
Heart of England NHS Foundation Trust	87	50%
Sandwell & West Birmingham Hospitals NHS Trust	37	21.5%
Birmingham Community Healthcare Trust	2	1.1%
Agency / Bank midwife	4	2.1%
Independent midwife	0	0%
Prefer not to say	4	2.1%
Other	2	1.1%
No answer	7	

No. respondents 174

[16] (Birmingham LINk/Merida/@WeMidwives/@WeNurses/RCN
[17] http://waitsaction.org/2012/12/listening-to-the-voices-of-midwives/

Table 3: Online survey respondents by setting

Setting	Number of respondents	Percentage of sample that answered question
Community	41	23%
Stand alone Midwife Led Unit	8	4.5%
Alongside Midwife Led Unit	12	6.5%
Obstetric unit	85	48%
Rotating to all areas of the service	19	10.5%
Other	13	7.5%
No answer	3	

No. respondents 178

The total population of midwives across the 3 main Trusts delivering maternity services in Birmingham, Solihull and Sandwell is 1032[18]. The survey sample of 181 is equivalent to17.6% of all midwives employed by the 3 Trusts. It is a strong sample that is robust to a confidence level of 95% with a confidence interval of +/- 6.6, which is in line with accepted research parameters[19].

The data gathered through the online survey and semi-structured interviews were systematically and comprehensively analysed following a three stage process:

Stage 1: **Immersion** - the process by which the research team becomes familiar with the collected data

Stage 2: **Categorising and indexing** - using a coding framework and key word searches to identify both commonalities and anomalies

Stage 3: **Thematic summaries** - by which the data and information is grouped around emerging themes.

The report sets out the integrated findings of the research against the identified themes, using quotations from midwives and stakeholders to illustrate common or significant individual points and charts and tables to present quantifiable data. All sources from the literature research are referenced in footnotes where they are referred to in the text. The findings have been discussed with the LINks Project Board, a number of midwives from across the three areas at a feedback session and reviewed by an external midwifery academic. Comments from these sources have been incorporated into the final report.

[18] Based on figures provided by BWHCT, HEFT, SWBHT

[19] *A confidence interval gives an estimated range of values which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data*. (Definition taken from Valerie J. Easton and John H. McColl's Statistics Glossary v1.1)
If independent samples are taken repeatedly from the same population, and a confidence interval calculated for each sample, then a certain percentage (confidence level) of the intervals will include the unknown population parameter. Confidence intervals are usually calculated so that this percentage is 95%.

2 Providing safe care

The context within which midwives are providing safe care is evolving. Although, in modern times, giving birth has been a safe process, much work has been done in recent years to improve understanding of what creates the right circumstances for the safe delivery of babies which have the best longer term outcomes for mothers and children. An independent inquiry by the King's Fund in 2008 into the safety of mothers and babies during the period of intrapartum care noted that the key features of maternity services of relevance to safety were:

- **Sudden transitions** although pregnancy and birth are normal physiological processes, unexpected emergencies can develop rapidly
- **Two lives** the fact that maternity services have to care for two or more lives (mother and baby or babies) simultaneously raises the stakes and sometimes – as with caesarean sections – may involve a conflict of interest between mother and child
- **Duration of care** maternity care is delivered over a long period, often in different settings and involving many professionals, ranging from midwives and obstetricians to social workers
- **Women's experiences** the quality of the birth experience can have lasting effects on mothers, babies and families
- **Changing demands** changes in the pregnant population have important implications for safety in maternity services[20]

More recently, the Birthplace research study confirms that giving birth is very safe, with a very low rate of harm to women and their babies. The study provides evidence that

- Supports the policy of offering low-risk women a choice of birth setting
- Planned births in midwifery units have the same outcomes for babies compared with obstetric units, with fewer interventions and around half the rate of caesarean sections for low-risk women
- For women having a first baby, a planned home birth increases the risk of harm for the baby, such as neonatal encephalopathy (caused by the baby's brain being deprived of oxygen before or during birth) or non-life threatening, but sometimes disabling, physical injuries to the baby's shoulder, and there is a fairly high probability of transfer to hospital during or immediately after labour
- For women having a subsequent baby, a planned home birth does not increase risk for the baby, and reduces the risk of interventions for the mother
- A third to almost a half of first-time mothers transfer from home and midwifery units to obstetric units[21]

[20] Kings Fund (2008) Safe Births: Everybody's business - *An independent inquiry into the safety of Maternity services in England*: London, Kings Fund

In Birmingham, Solihull and Sandwell, maternity providers are continuing to safely deliver ever increasing numbers of babies to mothers with more and more complex needs at the same time as transforming their ways of working to increase choice for women and promote normality in birth.

Trust providers covering Birmingham, Solihull and Sandwell have also been taking part in a regional initiative to reduce the number of stillbirths, which are a central indicator of patient safety and quality of care, and an essential component of the NHS Outcomes Framework[22]. West Midlands stillbirth rates have been consistently well above national rates for the last 50 years but in the last year they have dropped below the national average for the first time ever. The largest reduction in stillbirths was in Birmingham and Solihull, where the rate dropped by 38% in 2011 against figures for 2000-9. This sharp decrease is attributed to increased efforts in prevention, including the Community Growth Scanning project (CoGS), running since 2010, through which midwives have been trained to undertake scans in community settings to detect Fetal Growth Restriction, a major cause of stillbirth, earlier in at-risk pregnancies[23]. Care pathways have been agreed with clinical colleagues to respond to Fetal Growth Restriction once detected and there is consistency in approach to this issue across Birmingham, Sandwell and Solihull.

Evidence from midwives and stakeholders shows how by learning from research, good practice and national guidance they are putting in place measures to improve the birth experience and longer term outcomes of many women across the three areas covered by this study. In addition, the pressure of the high numbers of deliveries on the physical constraints of the existing maternity facilities, particularly obstetric labour and post natal wards, is also a driver for re-thinking birth pathways and options for early discharge postnatally.

Midwives participating in the research did not raise specific concerns, either in the survey or in interviews, about providing safe practice. What they did mention were concerns about having a lack of time, due to staffing issues, to deliver the quality of care they want to, difficulty in taking designated breaks during long shifts and poor or inadequate equipment. Some recently qualified midwives reported the need for more support and mentoring as they developed their confidence as newly qualified professionals. Midwives who reflected on the research findings felt all of these concerns taken together could indicate an environment within which mistakes could happen and safety could be compromised. They noted that midwives are unlikely to express concerns about patient safety to researchers as they would worry about being identified or putting their registration at risk, even when anonymity has been assured.

[21] NHS Confederation (2012) *Birthplace in England – New Evidence* Research Digest June 2012 Issue 3
[22] The NHS Outcomes Framework 2012/13, Department of Health, London
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf
[23] Perinatal Institute: Stillbirths in the West Midlands - 2011 Update. Sept 2012

2.1 Antenatal care

Women's journeys to a safe delivery generally begin with seeing their GP and then booking with a community midwife to be assessed. Interviewees suggest that, increasingly, community midwives are being supported to be better able to identify and appropriately assess risk and to offer women a care pathway that will best meet their needs. Some midwives reported that in SWBHT, for example, they have separated their low-risk and high-risk pathways, a move supported by their maternity services commissioner. Low-risk women have their antenatal care in the community and will be directed towards a Midwife-Led Unit (MLU) or a home birth as the normal route for delivery. Strict referral criteria have been put in place so that only high-risk women attend antenatal clinics at the hospital, where they access specialist support depending on their needs. The numbers attending at hospital have been reduced and also the structure of activities in the hospital clinic has been changed to reduce waiting times and increase flow.

> *"We have changed the way we work – women are down from a 3 hour wait to in and out in an hour"*

Generally, however, midwives report there can be a high number of 'do not attends' at antenatal appointments in acute units by high-risk women. Often the complexity they contend with in pregnancy can be social or economic as well as medical, and attending a lot of different appointments may not be easy. In those cases, some midwives are texting women who do not attend and arranging to see them in the community instead, making sure they are followed up and do not drop off the radar until they deliver.

Midwives from HEFT described how low-risk women can be seen in the community up until delivery and again postnatally, but high-risk women may be referred to a specialist clinic at booking and not seen again in the community setting until postnatal appointments. This can make it difficult to build a relationship so some community midwives also offer high-risk women 'social' antenatal appointments in the community to provide ongoing support and guidance, however not all have the time to offer this. The research did not reveal any evidence on how the transition between community and acute maternity services for high-risk women operates in SWBHT or BWH. Some midwives mentioned a move within HEFT to bring more flexibility into this system by assessing women at each antenatal appointment to consider if they could move to a different pathway, so women are not set on a pre-determined pathway at booking.

> *"Just because they may have some high risk factors doesn't mean they can't have a low risk pathway, with appropriate care and support"*

It is acknowledged that midwives need appropriate training and support to develop their service in this way; some report it has been customary practice for many to err on the side of caution, with patient safety to the fore, and to signpost women on to a high-risk pathway as a matter of course.

> *"It's very much needed, you know, to try and change things, because we're not giving women a chance, we're high-risking them before they've even become high risk."*

One stakeholder felt that wider dissemination and discussion of the evidence from the Birthplace research, along with in-house assessment training, would help to reassure midwives about the safety of low-risk pathways and normality in birth and enable them to develop a more flexible approach to individual women's needs.

> *"Midwives need confidence and the ability to exercise autonomy to do this"*

Issues can arise for community midwives when women they are supporting are booked to deliver their baby in another Trust. Accessing appropriate information and assistance from colleagues in another Trust can take a lot of time, particularly when, for instance, NICE guidance is interpreted differently by different providers. This can create confusion for women who could be told one thing by their community midwife and something different by hospital staff. One midwife suggested it would help if providers across the region could use the same criteria, or at least share their care pathways.

2.2 Intrapartum care

There have been recent re-configurations of maternity services across the three provider Trusts in order to offer women more choice about where they give birth, however the majority of women still give birth in hospital. Increasingly, more women are accessing Midwife-Led Units (MLUs), especially those located in hospitals; nevertheless each Trust has high numbers of women who are identified as high-risk for delivery, for a range of reasons explored in detail in Section 4 of this report, so the majority of midwives providing intrapartum care are working in acute obstetric units, which is reflected in the profile of midwives who participated in the research.

Although all three Trusts covering Birmingham, Solihull and Sandwell now have MLUs, they operate different criteria for women to be able to give birth in a MLU. This is a developing area but some interviewees felt the criteria for admission to MLUs was too rigid in some instances. It was suggested that it can take a while for a new MLU to 'bed down' and that, once established, experience suggests it will be able to open up and become more flexible to enable medium- and higher-risk women to

access it. For instance, at BWH where they have had an alongside MLU for some time, they have an 'opinion clinic' where women with some high-risk factors can be reviewed on an individual basis to see if they can access the MLU facilities, such as the birthing pools, for labour if not for the birth itself.

Some midwives are concerned that low numbers of women using MLUs might put them at risk of closure, when there might be women on the obstetric labour ward who would benefit from a low-risk, midwife-led delivery. Sometimes MLU midwives are sent to cover labour wards because their numbers are low and they see women who might be suitable for an MLU birth.

> *"Being able to go downstairs and work on the labour ward I can look and think 'Gosh there's some women here that are not actually high risk. Who's high-risked them, for what reason?"*

Some midwives noted that where there is a Consultant Midwife promoting normality within a Trust, there is a more flexible approach to the use of MLUs. They also noted that there are currently few midwives working at that level across the three areas of the study.

Interviewees commented that in Trusts where an effective triage system has been put in place for women arriving in labour, like BWH, they can be directed more easily to an appropriate low-risk or high-risk setting. This is in line with good practice identified by the Birthplace research.

The high level of women presenting with a range of high-risk factors can mean that they almost automatically trigger a high-risk pathway of care that leaves little room for women to choose their birthing options or for midwives to offer them choices.

> *"High risk is a barrier to autonomy"*

However, some midwives described how they do advocate for women in high-risk settings in acute units and do their best to ensure, where possible, that women's wishes are considered and acted on, for instance in respect of interventions.

In SWBHT, interviewees acknowledge that the population they serve has high levels of particular risk factors, for instance anaemia, and they are tailoring their care pathways to offer more choice to women with that condition. However, across the providers covering Birmingham, Solihull and Sandwell as a whole, midwives report that there are proportionately higher numbers of Black, Asian and Minority Ethnic women on the whole in the high-risk acute units. Cultural and language factors may play a role here and are discussed later in this report (see Section 4).

It was also mentioned several times that women choose to give birth in hospital because they believe it to be a safer option. Low-risk pathways like the one being developed by SWBHT should help to begin the culture change necessary to correct this common misunderstanding. Pregnant women are, however, influenced by family, media coverage and other women's experiences, so change in attitudes will take time to filter through. For instance, it was reported, in some communities status is achieved by delivering hospital, especially if that is not an option in a woman's country of origin.

It was suggested that with fewer resources available in the future and when MLU care is being proven to be cost-effective by the Birthplace research, it may mean that low-risk women will be directed on to a pathway that does not include an automatic route into consultant-led obstetric care in hospital, but to midwife-led care in an MLU or at home as a matter of course. How this direction of travel would sit with the concept of patient choice when women might choose a hospital birth was not mentioned, however a commissioner did suggest that in commissioning for patient choice, informed women who choose a planned home birth against medical advice might be asked to sign a waiver of responsibility.

Midwives responding to the survey felt that the pressures on their time meant that they had less time to spend with individual women during labour and had to balance the needs of a number of women concurrently.

> *"Whilst providing intrapartum care on the delivery suite the midwife may be caring for two or three women at any one time. It makes it difficult to build relationships if you are in and out of the room, and the women do not receive as much care and support I believe they should have."*

2.3 Postnatal care

Interestingly, postnatal care was not mentioned much in the research in relation to low- and high- risk pathways. The general policy is to discharge low-risk women within hours of giving birth, if they have had no complications and this is what many women want. The prevailing view of midwives in delivery suites is that the pressure on beds is so severe that they feel obliged to move women to postnatal wards as soon as possible after delivery, to free up spaces for other women to give birth. While no specific issues about safety after birth were raised by midwives, there were comments about the inability to give the highest quality of care post-partum, as women and their babies needed to be moved. Similarly midwives on postnatal wards feel they are often being encouraged to discharge women as quickly as possible, again to free up beds, which reduces opportunities to provide child care education or support the establishment of breastfeeding. The concerns about quality of care are explored in Section 3.

"Minimal staffing levels often mean you don't have the time to spend as much time as you need to with women on the ante and postnatal wards. Due to competing demands and often caring for 10 woman and their babies can often mean the service you provide is 'short and sweet."

2.4 Differences in approach

The research identified a number of different approaches across the three areas that midwives and stakeholders who were interviewed think are good practice and which may be of interest for the Maternity and Newborn Capacity Review project. These include:

- Community midwives in Solihull (part of HEFT) have been involved in achieving a UNICEF Stage 3 accreditation for baby friendly services which sets common standards of care across multi-disciplinary teams. They have also been trained in the Solihull Approach[24] which supports practitioners to work with children and families and supports parents and to understand their child. This is also a multi-disciplinary approach, with professionals learning from each other
- Interviewees from SWBHT feel that in developing their low-risk pathway they have protected women and improved care and outcomes for women. It means that high-risk women can have a one-to-one team approach to support their individual needs
- BWH midwives identified a number of approaches including its home birth service and the triage system that has been developed for induction of labour. They have trained midwives to provide scans in community settings and they have increased feedback from women using their services
- HEFT has introduced a 'Fresh eyes approach' – where two people work together as a single unit and are able to monitor and help each other, supporting effective professional practice. Symon et al (2006) support this approach and note that what often prevents an adverse outcome in midwifery is incidental intervention by another practitioner. The process identifies areas that can lead to misinterpretation on CTG[25] tracings: fatigue, familiarity and limited knowledge[26]

[24] For Solihull Approach see http://communityservices.heartofengland.nhs.uk/default.asp?page=376
[25] CTG – Cardiotocograph – measurement of fetal heart rate
[26] Fitzpatrick T, Holt L. (2008) A 'buddy' approach to CTG. *Midwives* **11(5)**: 40-1, Symon AG, McStea B, Murphy-Black T. (2006) An exploratory mixed-methods study of Scottish midwives' understandings and perceptions of clinical near misses in maternity care. *Midwifery***22(2)**: 125-36

2.5 Supporting factors

A number of factors that support their roles in relation to care pathways have been identified by midwives during the research and are recorded here but this is not a definitive list.

- Good teamwork and support, which is in line with the recommendations of the Safe Births[27] report
- A shared philosophy of believing in women's ability to birth and facilitating this process
- "*Midwives rotating to the birth centre feedback how their experience has helped bring back their passion (for) normal midwifery and confidence. This environment is conducive for women and families to feel relaxed and safe in our care.*" Also, community midwives rotate into acute units at least once a year in some Trusts, to refresh their skills, and some of them think it would be good for acute unit midwives to rotate to the community annually, to see the other side of midwifery which many, so it is reported, consider to be a soft option
- Computerised record-keeping system at BWH, with all observations being written up in real time and accessible anywhere in the hospital – "*works well if women become high-risk and have to transfer to the delivery suite*" (although it should be noted that one person thought inputting data in a low-risk setting was disruptive for the women)
- Midwives in BWH have found that now that they are trained and encouraged to perform sweeps that less women require induction of labour

[27] King's Fund (2008) Safe Births: Everybody's business - An independent inquiry into the safety of maternity services in England

3 Providing quality of care

For midwives participating in the research, the main area where they feel further improvements can be made is in quality of care, particularly on delivery suites and postnatal wards, but also in the community. The common obstacle across these settings to providing the level of care they would like to is time constraints caused by high numbers of women, many with complex needs, and shortages in staff due to a range of factors. The issues around time constraints are explored later in the report. In this section we look at the areas where quality of care has improved and some of the areas where midwives would like to be able to do more.

3.1 Normalisation of birth

When it comes to improving the quality of care provided by maternity services, a recent Royal College of Midwives (RCM) guide[28] explained how whereas in the past the driver had been to increase safety, more recently a key driver of change has been '*the desire to increase choice for women through pregnancy, birth and in postnatal care'*. In addition there has been '*widespread support to increase the normal birth rate, in the belief that normal birth offers good outcomes for women and babies and is a more effective use of resources'*. This normalisation agenda is supported by The Birthplace,[29] an important national perinatal epidemiology study which provides evidence that for low-risk pregnancies birth is equally safe in all settings, including home birth[30]. A key finding of the study was that interventions during labour were substantially lower in non-obstetric unit settings; a finding which has given license to the reconfiguration of services in settings other than obstetric units in some areas.

Among the stakeholders and midwives interviewed there was general, although not universal, approval of the drive to promote normalisation of birth. One stakeholder commented that promoting normality '*really should be integral to every midwife's role. It might not be to some but technically it should be.'* A few dissenting voices saw the normalisation agenda as a trend that is currently popular with professionals, but not necessarily with women who may see the acute unit as safer option.

> *"We have to think what women really want in our pathways. So not just current trendy things. So 'low tech births' is something coming from LINks and the like but in our experience what a lot of women really want is a medical unit."*

[28] Jameson, Hannah, 2012, *Innovation and Improvement in Maternity Services.* London, RCM in association with the Involvement and Participation Association (IPA) (p1) (p2)
[29] Brocklehurst P. et al, 2011, *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study,* BMJ 2011; 343:d7400
[30] excepting first-time mothers who have a higher risk of transferring into an acute unit with a planned home birth

A more representative view of the midwives and stakeholders interviewed, and those who responded to the survey, was that it is important to keep reaffirming the philosophy of normalising birth and midwife-led care. Midwives recognise that some women, for instance from migrant communities, perceive home birth as being only for women who are too poor to have access to a hospital birth, and others think that it is only for middle-class women, and see these factors as a challenge for practitioners to overcome, through educating and reassuring women about the safety of midwife-led care, rather than a reason to change the strategic direction. Concerns were raised by midwives interviewed that birth was still over-medicalised, and some commented that the increase in the number of women with, for example, diabetes and high blood pressure, leads to birth being medicalised. One interviewee commented that '*promoting normality empowers midwives*.'

There was a mixed picture in terms of whether midwives who responded to the survey felt that normality is currently promoted at their workplace, for example:

- One HEFT midwife felt she has noticed over the ten years she has worked at the Trust some of the people who were promoting normality previously have left
- It was suggested that maternity services at City Hospital and Birmingham Women's Hospital are more flexible than some other units because they have Consultant Midwives promoting normality
- Several respondents described how their Trust promoted normality through providing opportunities for water births, aromatherapy and hypnobirthing
- When asked about the extent to which they felt able to promote natural birth through their work (see Chart 4 in section 6) just under half the respondents (73 out of 155) said they felt they were fully able to do so, and a further 37 said they were mostly able to do so. This seems to indicate quite a high level of confidence in this aspect of the midwife's role

Stakeholders reported that at SWBHT the strategic direction is focussed on providing normality. Their birth centre's strap line is 'Your birth in our home,' and the centre is keen to provide women with a really homely environment. They feel that the environment can change birth experiences and shift the focus from a very medicalised model of care to a midwifery-led and women-centred model. One SWBHT member of staff commented '*our outcomes data speaks volumes*.' The same member of staff felt that midwives in SWBHT were responding well to the changes in approach and the drive towards normalisation of birth and were happy about it, a view corroborated by some midwives. In the past there was a view that women accessing SWBHT maternity services are all high-risk, because of the make up of the population served in Sandwell and West Birmingham, but the Trust is working to change this view and to encourage all staff to see each woman as an individual.

"They may have social risks, medical risks, foetal risks and they might have gynae risks and what they aren't is all the same. What we say is each time you have to individualise it, not think of them collectively"

SWBHT was winner of the Vitabiotics Award for promoting normal birth at the RCM Annual Midwifery Awards 2013 and has been cited by Birth Choice UK as having the most favourable birth outcomes in the UK[31].

Some midwives felt that there has been so much change at SWBHT, with a new management team and the opening of the MLU, that there is a need for a period of consolidation to embed the culture of promoting normality and independent thinking.

A strong theme that emerged from the interviews was the difference in culture between the MLUs and high-risk acute units.

"It's just amazing the difference in culture between a birth centre and a labour ward. It's really different. It seems to attract different kinds of midwives. There's this holistic approach with midwives working in birth centres whereas it's more like a factory in a labour ward."

One stakeholder pointed out that the MLU is exclusive to midwives and is to a great extent a women-only environment. Doctors cannot just '*come in and wander round*', they request access the MLU in the usual way. Midwives interviewed who work in a MLU were clear that they help women to achieve normality, and this was endorsed by a community midwife who said that she gets positive feedback from women who have attended the birth centre with its focus on normality. Another point made by a community midwife was that it is important that student midwives work in the community, whether or not they end up working in a hospital, because it gives them a grounding in normal routes to birth.

The consensus from both interviews and the survey was that MLUs are successful in promoting normality. Some respondents, however, made the point that the high-risk units could do more in this respect. One survey respondent cited New Cross Hospital in Wolverhampton as an example of a unit that is promoting normality for high-risk women in labour. A midwife working on a delivery suite felt that there is a real drive for normality for low-risk women, with more attention being paid to the environment, referring to having '*lovely rooms on the delivery suite*.'

[31] www.**birthchoiceuk**.com/

"[We should] *try to promote normality for all women, including high risk women*"

One midwife working in an acute unit with high-risk women stated that, in relation to normalisation, her aim is to support high-risk women, where possible, to have a safe vaginal delivery with as little medical intervention as possible to '*make it as normal for her as it can be*'.

One suggestion was to have a dedicated Consultant Midwife for the promotion of normality in high-risk units, and one interviewee said that she had an ambition to be a Consultant Midwife promoting normality on the labour ward, however several midwives noted that there are few roles like this available. It was also felt that more understanding of normal birth practice was needed among staff working on the delivery suites.

A particular challenge identified by several interviewees is how to increase the numbers of home births. One community midwife described how she discusses the option of home births with all her low-risk women and tries to find out what their concerns are around it. It was suggested that one model for increasing the numbers of home births could be to set up a dedicated home birth team with this remit. BWH does have a home birth service but, it was reported, the home birth staff are on rota at the hospital and cannot always be released to support home births if the hospital units are busy.

"Perhaps maybe looking more at women being able to have, or being offered home birth, having that facility there, I think that's a really important area that could be extended in maternity services."

3.2 Continuity of care

One of the key messages about quality of care from recent DoH policy work[32] was that '*Each woman and her partner need a midwife they know and trust to coordinate their physical and emotional care through pregnancy and until the end of the postnatal period*' (p 23). The same document cites the principles for all models of midwifery care from the Core Role of the Midwife report[33], which include:

- Women should have a seamless maternity service supported by an integrated model of midwifery care
- Women should receive the majority of their midwifery care by the same midwife
- Women should have 1:1 midwifery care when in established labour

[32] Department of Health (2010) *Midwifery 2020: Delivering expectations: joint publication: DoH/Scottish Government/Welsh Assembly/Health, Social Services and Public Safety (NI),* London DoH
[33] Core role of the midwife report: http://www.midwifery2020.org/documents/2020/Core_Role.pdf

- Women should have 24-hour access to advice and support from a midwife when they think they are in labour
- The role of the midwife extends to the postnatal period, the duration of which is determined by the professional judgement of the midwife together with the woman

These principles are all aspects of continuity of care. An independent inquiry into the safety of maternity services[34] also found that the development of continuity of care links to the promotion of normality, in that the '*Factors that are believed to reduce intervention rates in uncomplicated pregnancies include continuity of care and one-to-one support in labour'* (p20). Continuity of care is also welcomed by women accessing maternity services. Locally, recent research commissioned by Solihull and Birmingham LINks[35] into women's experiences of maternity care found that the women that took part preferred continuity of care and '*valued the close relationship that developed due to the regular contact they had with their midwives'* (p14).

A key finding that emerged strongly both from interviews with midwives and the responses to the survey was that many midwives find job satisfaction where they are able to provide continuity of care. They talked positively about building a relationship with the woman and her family, giving 1-to-1 care in labour, postnatal care and supporting breastfeeding.

> *"What frustrates me is that as midwives that's what we want and as women that's what they want. So why can't we get it right?"*

Survey respondents identified a range of aspects of continuity of care as good practice, for example:

- Getting to know the women and their individual needs
- Allocating the women to midwives they know, where possible
- 1-to-1 support in labour
- Examination of the newborn baby by a midwife
- 1-to-1 care in the postnatal period
- In the standalone MLU women regularly receive one to one care in both the intra partum and postnatal period.
- Effective breastfeeding support

[34] Kings Fund (2008) *Safe Births: Everybody's Business - An independent inquiry into the safety of Maternity services in England*: London, Kings Fund
[35] Lynch, Natalie, 2011, *Women's Experiences of Maternity Services in Birmingham East and North and Solihull,* Birmingham and Solihull LINks and Involvement Innovations.

Interviews with midwives generated a similar list of their positive experiences of providing continuity of care:

- Most community midwives mentioned that they enjoy getting to know women and seeing them throughout the pregnancy and afterwards
- Equally midwives based in delivery units reported enjoying being with women in labour, carrying out postnatal checks and delivering care until they go home
- They get job satisfaction from spending time with women and building a relationship with them and their family

> *"It's the spending time with women and advocating for those that need it the most. It's about the time to listen and building relationships with women and their families"*

A midwife from a delivery unit in Solihull praised the antenatal and postnatal work done in the community and felt it was very positive that women discharged from the unit were handed over to a midwife they already knew from their antenatal care. One stakeholder raised a concern about the transfer into hospital, where women were far less likely to know the midwives supporting them in active labour. Although community midwives in parts of the area covered by the study regularly rotate into delivery units, this is done on an area basis, so it is unlikely that a woman giving birth in a hospital or in a MLU will be cared for by the midwife who delivered her antenatal care.

> *"The most difficult point is transfer to hospital. The midwife there may be a complete stranger and the woman is plunged into an intense situation which requires them to trust a new professional. This can be very worrying for women and hospitals need to be aware of this and sensitive to this level of anxiety….And for the midwives, they have to win a woman's trust quickly..."*

There was general agreement that 1-to-1 care is the ideal in the labour ward, but staffing issues mean that this is not always possible.

> *"You never know what is going to come through the door – especially complex cases. They are lively places maternity wards, so sustaining a good standard of continuous care can be difficult to achieve."*

Similarly, in community settings, while continuity of care is more possible, except in some high-risks cases where women have all their appointments at hospital until after the baby is born, midwives do experience frustration in the short time allocated for antenatal appointments (15 minutes) as it is not long enough to complete all necessary checks, ensure accurate record keeping and build a meaningful relationship with women.

At present there is a shortage of midwives in the community and my time is often spent supporting other teams when staff are off sick or unavailable. This has an effect on the time I have available to provide the care and information to my own caseload.

Provision of antenatal care is mainly dependent on GPs' providing a room in a surgery for antenatal clinics to take place. This is often not available for more than 3-4 hours and this then has an effect on the time allowable for each woman attending, irrespective of her needs.

(…) Community work can be unpredictable and one woman needing additional support during a routine visit can result in other visits being rushed or cancelled to ensure I am able to attend in a timely manner to an antenatal clinic or prearranged timed visits. Women are increasingly being cared for in the community with more complex problems but no additional support or time is given for this.

Some community midwives report dissatisfaction with the amount of care they are able to provide, particularly in areas with very high caseloads and areas with complex needs. Others felt that in some areas the focus of resources was on providing a safe, efficient birth but that community services were pared down, with women offered a bare minimum of visits postnatally, especially if they had no medical complications, and midwives being encouraged to phone instead of visit. Some were concerned that with the drive to enable more early discharges after giving birth, postnatal community services are under-resourced and the quality of postnatal care to women is reduced.

Other community midwives feel they have worked hard to be able to provide a 'gold standard' of antenatal and postnatal care and they are concerned that pressure on resources will mean a reduction in the levels of care they currently provide.

"management want us to change things to make cost savings (…) want to downgrade our service to a lower level"

3.3 Breastfeeding support

The role of the midwife in providing breastfeeding support was an area of difference of view from the midwives who took part in the research. On one hand, many midwives see being able to provide support for breastfeeding as an essential and rewarding part of a midwife's role, both in acute units, MLUs and in the community. Many expressed frustration that they were not able to provide the support they would like to because of time constraints and the high numbers of women they are supporting.

On the other hand, many midwives felt the role of the midwife is evolving, particularly in the need to know more about the complexity factors affecting pregnancy and childbirth and the need to develop new skills to more effectively support women with a range of health, cultural and social needs. Several in this group had experience of breastfeeding support being provided by Maternity Support Workers, healthcare assistants and volunteers, including peer supporters, and feel others are better able to provide the consistent support that women need when establishing and maintaining breastfeeding.

Some midwives shared the good practice that has been established in Trusts to support breastfeeding, highlighting that in some units, such as MLUs, breastfeeding support is a priority. In the community, in Solihull for instance, a system for supporting breastfeeding with 'breastfeeding cafes' has been very successful and community-based infant feeding co-ordinators, funded by Public Health, have worked in partnership with other agencies to make breastfeeding support a priority. These roles are currently under review.

> *"we have a gone a long way to try and overcome (obstacles to breastfeeding support) we have an excellent feeding co-ordinator and a core team of midwives who have extra training from the co-ordinator, as well as key Maternity Support Workers and they enhance the work we do on the wards"*

Lack of time is the key obstacle to providing breastfeeding support cited by midwives in obstetric units. Some report that postnatal wards can be understaffed when the delivery suites are busy.

> *"Postnatal wards (are) very busy, staff often being taken by the delivery suite leaving 1 midwife on postnatal ward with 24 mums and babies, it is near on impossible to sit and spend time to help with breastfeeding and almost impossible to observe a full feed."*

Other views expressed by midwives were:

- Some relatives can be a hindrance to supporting breastfeeding and *"what they say undoes the good work the health professionals are saying and the women have to "obey""*
- It is unreasonable to expect women to go home 'established in breastfeeding' when they are only in for 12- 24 hours on average *"we can only teach the basics, establishing feeding takes days and weeks"*
- Women are being discharged into the community breastfeeding, but *"when we do a primary visit, the majority of the time we have to revisit the basics as ladies state there was not alot of input or support given on postnatal wards prior to discharge"*
- *"Breastfeeding can take up a lot of time which unfortunately is often needed for high-risk and intrapartum care"*

Overall, midwives who responded to the online survey were asked the extent to which they felt able to carry out breastfeeding support (see Chart 1 in section 4). It is revealing that only 53 out of 155 said that they felt fully able to do this, and 34 reported facing obstacles.

Midwives suggested the following as possible solutions to support breastfeeding:

- Make sure all midwives complete the postnatal notes section on observing feeding position and attachment prior to discharge
- Recruit more breastfeeding support volunteers
- Allocate breastfeeding support workers to labour ward, not just postnatal ward
- Enable trained Maternity Support Workers in community settings to support breastfeeding women and visit them at home between midwife visits

3.4 Good practice in quality of care

There was a lot of agreement among stakeholders and midwives that the MLUs are being successful in promoting normality, but that the high-risk maternity units had more work to do in this respect. One opportunity for professional development might be for MLU midwives to be involved in providing training and support for acute unit colleagues in the different ways of working and approaches currently being adopted in the MLUs. In some cases funding has been found or is being sought to upgrade the environment on the delivery suites in terms of making the atmosphere more relaxing and homelike, following the good practice in the MLUs.

It sometimes happens that women are booked into the MLU but cannot give birth there because there are not enough midwives available to staff the MLU at that time. It was suggested that it might be better, if the alongside MLU is closed, that a

woman who is booked in could go to the stand-alone unit instead, within the Trust, or even to another MLU in the region.

Research, stakeholders, midwives and women accessing maternity services all seem to be in agreement that continuity of care is desirable. In the survey, when midwives were asked to indicate five things that would improve maternity services, continuity of care was identified as one of the top five things that would help. However they also identified logistical obstacles to providing continuity of care including poor communication, staff shortages and deployment of staff. Various suggestions were made – some of them conflicting – about how to achieve better continuity of care.

For example:

- Community midwives should not have to cover hospital shifts as it affects their caseloads and ability to provide continuity of care. An alternative model would be an on-call system.
- A suggestion that arose in the focus group was that community midwives should be following the women more – i.e. the community midwife could come into hospital with the woman and deliver care during labour
- Because of leave arrangements and part-time staffing it is very difficult to achieve having a single carer. So community midwife teams have to take this into account and be sensitive about handover arrangements made for women. For example care could be shared between two midwives.

One area where continuity of care can break down is when women are sent to a ward or discharged very quickly. This has a negative impact on the support midwives are able to give new parents, including breastfeeding support. Also, it was reported, pressure on beds and staff shortages on the postnatal wards result in women being discharged very quickly, meaning that there is not time to give high quality support for breastfeeding. Suggested solutions to this would be an increase in the number of postnatal beds, or to deploy more midwifery support workers to provide care in first 24 hours of discharge home.

"Though we offer 1-to-1 care on delivery suite, following delivery you feel you have to ward the patient as quickly as possible due to staffing issues. Therefore you do not give the new parents as much support postnatally as you can."

4. Providing care for vulnerable and disadvantaged women

4.1 Diversity of population across the three areas

Birmingham, Solihull and Sandwell are areas with diverse, or super-diverse, populations. For example in Birmingham an analysis of the people registering with GPs between 2007 and 2010, whose previous address was outside the UK[36], recorded 42,149 people from a total of 205 countries. These ranged from countries from which a significant number of people arrived such as Pakistan (5585), India (4559) and Poland (4172), to more than 70 countries where fewer than 10 people originated.

There are, however, many different communities across and within the three areas. For example all three have communities that are almost entirely White British; there are areas with established South Asian and African Caribbean communities and other areas with migrant communities where the population is more transient. Demographics can change over a two to three year period and this presents a challenge to maternity service providers to stay flexible in order to meet the changing needs of their populations.

In addition to ethnic diversity there are other demographic changes that add to this super-diversity and impact on maternity services, for example:

- Rising birth rate
- Increasing number of older women giving birth for the first time
- Increasing numbers of women with diabetes and women who are obese
- Women with learning difficulties
- Higher than average levels of teen and pre-teen pregnancy
- More women giving birth with medical conditions that might previously have meant that they were unable to e.g. with heart conditions

Midwives described how this context of super-diversity impacts on maternity services in many ways, and in different ways according to the community served. For example in a particular area with a large Muslim community, there are issues, both medical and social, that impact on maternity services, for example diabetes and cultural norms. However there is not such a need in that area for work on smoking cessation and alcohol abuse as there is in a neighbouring area with a mainly white population. In recognition of this, community midwives tailor their services to meet the needs of the local population. This is an approach advocated by a maternity commissioner who thinks that midwives cannot continue to give all the social support they have always done with the rising birth rate and complexity of cases. The commissioner considers that midwives should target the brief interventions they

[36] Phillimore, J. and Goodson, L. (2011): Analysis of GP Registrations 2007-2010 by country of origin

offer, for instance on smoking, to women with high-risk indicators "*the right woman*" rather than all women. There has been a Consultant Midwife in Public Health who has used their data to help target interventions where they are most needed. This role is being lost in the transfer of Public Health into the local authority in Birmingham.

Many of the community midwives interviewed described how they had developed strong links with the local community, the families that live in the area, and the local organisations and community groups. One of the key messages in Midwifery 2020 is that midwifery 'needs to be firmly rooted in the community' (p26), that community midwives should have good local knowledge of the needs of the community in terms of health and social care, and also engage with local networks and services.

> *"Part of what I like is knowing the area, knowing the families. I've looked after women with numbers of consecutive pregnancies, and knowing the support networks, appreciating the children's centres and what they can provide, and working alongside people."*

This useful local knowledge is in some cases quite specific to particular communities. For example a community midwife reported that her area the women from a particular community will not consider a home birth, partly because many of them are living with extended families in small houses, and partly because it is seen as lower status - what people do if they do not have the option of giving birth in hospital.

One concern raised in the interviews with midwives was a need for more specific training on cultural differences that impact on midwifery services. One possible professional development opportunity would be if community midwives could share their learning of cultural differences with acute unit colleagues to improve the quality of care and to raise awareness of the different expectations women from different communities might have when coming into hospital to give birth. Midwifery 2020 also recommends that 'seamless maternity services which work effectively between community and hospital settings should continue to be developed' (p26).

Recent research suggests that maternity services need to take into account that migrant women may be particularly vulnerable. Sharp (2010)[37] noted that maternity services need not only to identify the health and social care needs of migrant women, 'many of which will be hidden and complex', but also 'address the barriers of language, culture, fear, confusion and a lack of empowerment experienced by many migrant women' (p4).

[37] Hilary Sharp, 2010, *Migrant Friendly Maternity Services: Toolkit for Improving Local Service Provision,* West Midlands Strategic Migration Unit / Department of Health.

"What we know about our catchment is that most women have anaemia – they are basically undernourished and myself and the clinical director looked at the risks involved in that if we've identified it early in the pregnancy and maintained steady levels of it – we will accept women with a haemoglobin of 9 into our MLU and our post partum occurrence of haemorrhage is no greater than or less than other units."

The maternity units in hospitals and the MLUs all serve larger communities than the community clinics but they still look at the needs of their own population. It is not always appropriate to apply one rule across every population group and another feature of the diversity of the population is that there is a higher incidence in particular groups of certain factors that lead to women being designated as high-risk, e.g.:

- Women who have had a lot of children
- Vitamin D deficiency / anaemia / malnutrition
- Women who have presented to maternity services late
- Women with HIV
- Women with diabetes

The effect of this is that Black Asian and Minority Ethnic (BAME) women are under-represented in the MLUs and over-represented in the high-risk acute units.

However, there is evidence that work is being done to offer some women with high-risk factors a low-risk birth pathway. For example one MLU, in an area where there is a high incidence of anaemia, will accept women whose haemoglobin is 9 or above, rather than 10.5 or above which is more usual.

4.2 Women's expectations

In the context of super-diversity outlined in the previous section there are huge differences in women's expectations of giving birth and maternity care. For example migrant women may come from a country where the cultural and societal norms are very different and birth in hospital under medical supervision is seen as the ideal. Many will come from countries where there is no GP system and will not be familiar with this concept. One survey response from HEFT mentioned that 'unbooked non-English speaking women turn up frequently'. Recent research into migrant women's experiences of maternity services[38] found that 'many migrant women did not understand the NHS system and were not familiar with how antenatal care is provided in the UK (p7)'.

[38] Phillimore, J., Thornhill, J. et al., 2010, *Delivering in an age of super-diversity: West Midlands Review of Maternity Services for Migrant Women:* University of Birmingham

Women born in the UK may also have widely different expectations, based on the experiences of their families and friends, their own previous experiences of giving birth and also on representations of childbirth in the media. One midwife interviewed expressed concern that women get information from the internet, some of it very helpful, but some quite negative about maternity services being over-medicalised and it being necessary to be very assertive if they want a normal delivery.

"It's just a concern that why do women feel they have to come in and fight for what they want? I think that's a real shame if that's what women feel."

One midwife based in a MLU made the point that women who have previously had a traumatic delivery may find a normal delivery a healing process. She also mentioned that many doctors give birth in the alongside MLU, and that pregnant doctors are often scared of having a normal birth '*because they never see them*' in their practice.

In some of the interviews midwives talked about some women having unrealistic or unreasonable expectations of childbirth and of maternity services, which they felt impacted on their work, e.g.

- Their idea of labour being based on TV dramas
- Expecting to be provided with basic equipment like formula milk and nappies
- Expecting the baby to fit in with their life
- Taking midwives for granted
- Being violent, disrespectful or abusive to staff

One key stakeholder who was interviewed felt that women in the area she deals with have lower expectations than nationally, in terms of not being so aware of their options.

"Across the UK generally women have higher expectations - and rightly so - but in this area less than other areas. I feel our women have lower expectations – poorer education attainment and they read less well, so for local women here the opportunities to identify what they can and can't have access to for themselves (are) much less."

There was a general agreement that some women need more support from midwives than others, and that often these women were the most rewarding to work with because they really value the help midwives provide.

"When they do need you and you can provide the care they want they're so grateful to you."

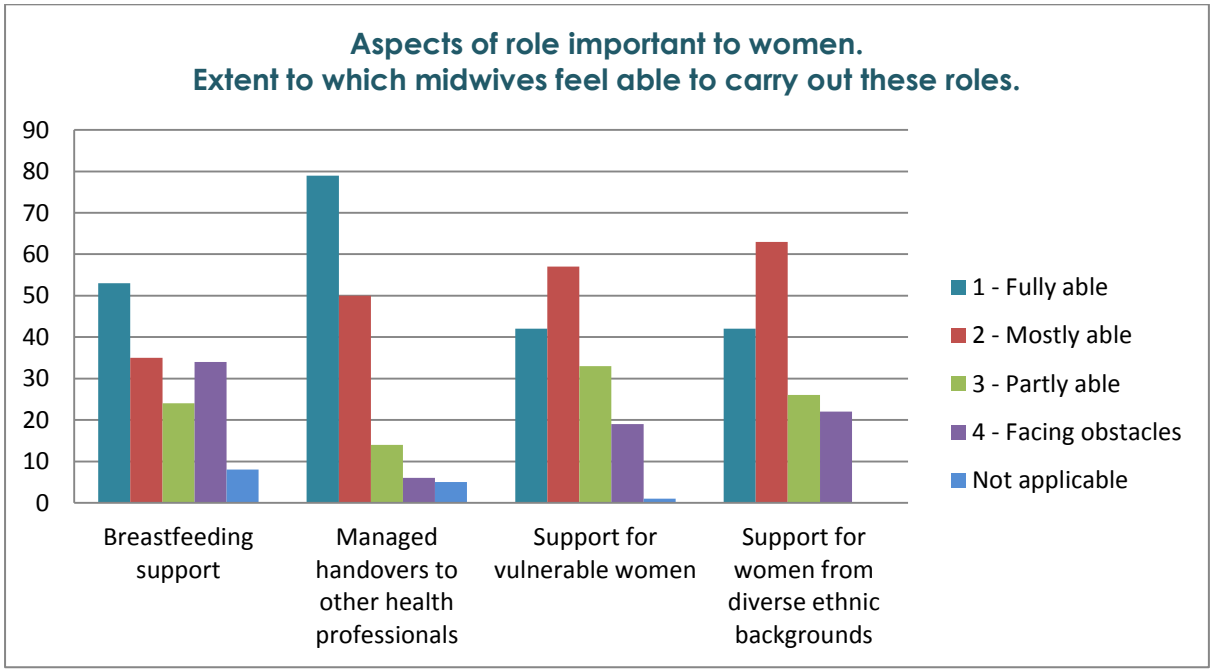
An important part of the midwife's role was also to act as an advocate for women to ensure that they end up with the birth experience they want, especially for more vulnerable women.

"At the end of the day, it's about them. Receiving the care and the birth experience that they want – within reason. They will then be better postnatally. We know all the research for that. If they're in control it's going to help them in the long term and they're not going to have any issues."

Midwives responding to the survey were asked the extent to which they felt able to provide support for vulnerable women and to women from diverse ethnic backgrounds (see Chart 1below). In spite of the context of super-diversity in which they work (and only one responded that support for vulnerable women was not applicable to their role), just over a quarter of midwives who responded felt fully able to carry out these aspects of the work.

The data suggests that more needs to be done to equip midwives with the skills and resources they need to effectively support vulnerable and BAME women. Most are reasonably confident they are doing the best they can in difficult circumstances, but are aware that support to these groups could be better.

Chart 1



No. responses 155

There are many cultural differences in the expectations of women and families accessing maternity services. Some of the main ones identified by midwives in this research were:

- Religious practices – some families want to pray with the baby immediately after the birth or give the baby something to taste etc.
- Screening - some women have religious objections to termination and do not necessarily understand the implications of the screening programme
- Vaginal examinations - a lot of women, especially Muslim women, find them upsetting and do not know they can say 'no' or ask if there is an alternative to a suggested approach or intervention
- Asking to be attended by women health care professionals – this is not normally problematic
- Role of the extended family – in some cultures many extended family members are considered close relatives and expect to be able to visit the mother and baby

One community midwife described her experience of Pakistani heritage women in the area where she works who live in extended families and have never been on their own, or slept in a bed on their own until they come in to the acute unit. She felt that many of these women are terrified and unprepared. They have been looked after by family members, had all their needs met, been '*spoiled in a way*', and they are not expecting to do anything for themselves post-delivery. They ring the bell for everything and if the acute unit midwives have a lack of cultural awareness there is a lack of knowledge of expectations on both sides. She also felt that some acute unit midwives '*get very uptight*' about large numbers of visitors around beds because they lack understanding of the very close relationships within extended families, where cousins are regarded as being like brothers and sisters.

> *"They say I'm soft on delivery suite because I respond to the bell – I've seen a midwife respond to a bell, stand at the bottom of the bed and say 'get it yourself'"*

An anonymised report[39] by a support worker who works with the Gypsy Traveller and Roma (GRT) communities in Birmingham raised particular concerns about the experiences of Roma women accessing maternity services. This report suggests that 'many are afraid to go to hospitals in Birmingham.' The particular areas of concern raised are:

- Not being treated with respect
- Nothing being explained

[39] Report on Roma Community accessing Health 01/04/2011 anonymised version

- No interpreters present
- Non-existent postnatal support, including support for breastfeeding

Based on this evidence the Roma community is clearly one where there is a need to listen to the concerns and expectations of the women. One model might be what SWBHT has done in terms of holding focus groups run by a Consultant Midwife to find out what specific groups of women, e.g. Somali women, want in terms of different cultural needs and beliefs.

A theme that emerged strongly from both the interviews and the survey was the number of women presenting with complex social needs in addition to their pregnancy. This is confirmed by recent research, for example Sharpe (2010) notes that '*In the West Midlands the need for greater focus on the social needs of pregnant women, particularly in the most vulnerable women, has been highlighted*.' Community midwives reported spending a lot of time helping women sort out their problems, giving information and signposting them to appropriate agencies.

Community midwives gave the following examples of issues that women present with:

- Domestic abuse
- Housing issues
- Poverty
- Financial problems and debt
- Substance misuse
- Child protection
- Teen and pre-teen pregnancies

A common complaint from community midwives was that 15 minute antenatal appointments were not nearly long enough to deal with women with complex social needs, sometimes in addition to medical needs. This is an issue that was also picked up by Phillmore and Thornhill (2010).

Various suggestions were made by midwives to tackle some of these issues:

- Having clinics at a 'one stop shop' or community hub to enable better multi-agency working
- Volunteer doulas that support vulnerable women and asylum seekers - a project in Sandwell was identified as a successful initiative by Phillmore and Thornhill (2010)
- Pregnancy outreach workers who work with women with high social needs – this is currently happening in some parts of Birmingham but not available in all areas

4.3 Language and interpreters

When asked about diversity one of the key themes that midwives and stakeholders talked about was language and the challenge of communicating with women and families who speak little or no English. It was agreed that communication is essential at all stages of maternity care and it is crucial that all information is translated accurately in both directions, i.e. from the women to the health professional and vice versa. However there are a number of barriers to this. For example:

- Populations in the region are transient, so translation requirements are not stable. It is relatively easy to find an interpreter at short notice to speak Punjabi for example, but there are many languages spoken in the region by very small communities
- Technical medical language can be a barrier, there may not always be a direct translation
- In some areas a lot of women need interpreters, for example it was mentioned that at one clinic about half of the women attending have an interpreter
- Commercial interpreters are expensive
- It is not always possible to get hold of a professional interpreter, for example at night or in an emergency, and women often go into spontaneous labour at night
- Sometimes an interpreter is booked for an appointment and then the woman does not attend. Phillmore and Thornhill (2010) found that migrant women often had difficulty attending appointments because of a range of factors, including lack of money for public transport, frequent moving and needing to prioritise sorting out legal or other problems

Even when an interpreter is available a number of challenges were identified associated with working with them, for example:

- Concerns about whether the information is being translated accurately
- Issues of confidentiality – sometimes the interpreter is known to the woman and they both belong to a small community. The interpreter may be very professional but the woman may not feel confident to disclose personal information.
- The personal beliefs of the interpreter may be an issue, particularly when it comes to antenatal screening
- Concerns about whether a woman is giving informed consent
- Time – an antenatal appointment with an interpreter takes much longer than the allotted 15 minutes
- Sometimes it is only possible to find a male interpreter and this may not be culturally appropriate e.g. for breastfeeding support

However, midwives were generally positive about their experiences of working with interpreters, including Link Workers, and it was mentioned that more Link Workers would be a help.

Ideally we don't use family members if we can possibly help it because you don't know if they're giving all the information objectively. But sometimes, in an emergency, there's no choice

It was widely recognised that it is important to use professional interpreters if at all possible and that using family members is inappropriate. One stakeholder expressed the view that it was particularly difficult when a woman's needs being expressed by a man in the family rather than another woman advocate. An extreme example of this is depicted in one of the case studies in Phillimore and Thornhill (2010 p90), which centred on a woman who had been raped by her husband and wanted an abortion but was unable to access help because either her husband or her sister-in-law was interpreting for her at all her antenatal appointments.

Concerns were also raised about written information given to women. It was felt that some of this was not very accessible and should be more visual, both for women with little or no English literacy and those with learning difficulties. The green forms used in the community were a particular source of concern. These are given to the women to read but are not very accessible. One midwife with a lot of Roma patients was aware that most of them could not read English and there was no point in giving them the information in this format.

I'm not saying my Roma patients don't need information; they just don't need it in English!

I think they're designed specifically for white middle class women

Some midwives described how they use other means of communication, visual material and mime. Telephone interpretation can also be used in an emergency.

I like the challenge of 'how can we get this information across?'

You find like your whole shift becomes a whole game of charades – I don't want to do something to somebody if they don't know what I mean. It can be quite difficult.

Communication is not just a problem with women who speak other languages. One community midwife, for example, has used different sized marbles with a blind parent to communicate the size of babies' tummies when discussing infant feeding, indicating that midwives need to be creative in their communication with women with disabilities.

4.4 Good practice in supporting vulnerable women

The super-diversity described in the previous sections comprises a range of factors – social, cultural, religious and linguistic. The Public Sector Equality Duty (PSED), under The Equality Act 2010, requires Primary Care Trusts (soon to be Clinical Commissioning Groups [CCGs]) to advance equality by:

- removing or minimising disadvantages suffered by people due to their protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation)
- meeting the needs of people from protected groups where these are different from the needs of other people

In order to cater for this complex and changing picture and comply with the PSED, maternity services across the three areas need to be flexible, and take into account the needs of women from all communities. One way of achieving this is to build on the specialist local knowledge of midwives working in the community. Another is a proactive approach engaging women from specific communities to inform the design of services, such as the focus groups with Somali women run by a Consultant Midwife, as mentioned earlier. These focus groups could provide valuable information that could be fed back to colleagues working in MLUs and acute units.

A key theme that came from interviews with midwives was a need for more specific training on understanding different cultural practices around pregnancy and childbirth and adapting to them. A concern was raised that midwives had attended study days on safeguarding issues, like domestic abuse and female genital mutilation (FGM), but that other training on cultural diversity was too generic. Current professional development around FGM, and provision for women who have experienced it, was generally regarded as good practice by both stakeholders and midwives. HEFT has a significant number of women who have suffered FGM and a Specialist Midwife in the Trust who is 'seen as a national expert' on the issue.

Survey respondents also felt there was a need for further professional development to increase knowledge and understanding of immigration status issues and the impact on women and their families.

Another instance of good practice highlighted by the midwives survey was partnership working within HEFT with local Children's Centres. This has enabled community midwives to work with other local services in a 'one stop shop' to provide

antenatal classes, postnatal groups, breastfeeding support, CAF and child protection.

There was a lot of agreement that vulnerable patients, child protection cases and women with little or no English require more time and attention. Community midwives interviewed and survey respondents agreed that there is currently no leeway within their caseloads to give the extra time and support required and a more flexible approach to this is needed.

"How can we provide extra support for vulnerable women when just to achieve basic care proves difficult?"

One suggestion made by a survey respondent from HEFT was for a better support structure in the community for vulnerable women so that they did not have to spend so long in the unit postnatally while staff try to 'organise court dates and placements'. This approach would most likely require closer multi-disciplinary working with other agencies to come together around the needs of the women.

5 Maternity workforce

Across Birmingham, Solihull and Sandwell there are three main Trusts that provide maternity services:

Birmingham Women's Hospital Community Trust offers births in
- An acute obstetric unit
- An alongside Midwife-Led Unit
- Home Birth service

Heart of England Foundation Trust offers births in
- 2 obstetric acute units at Heartlands and Good Hope Hospitals
- An alongside Midwife-Led Unit at Heartlands Hospital
- A stand alone Midwife-Led Unit at Solihull Hospital
- Home Birth service

Sandwell and West Birmingham Hospital Trust offers births in
- An acute obstetric unit at City Hospital
- An alongside Midwife-Led Unit at City Hospital
- A stand alone Midwife-Led Unit at Leasowes Health Clinic in Sandwell
- Home Birth service

BWH offers all of its hospital-based services from one site and it is a specialist provider of healthcare for women and their families. In this respect, maternity services are a core service strand within the Trust and face less competition for resources than in Trusts offering a wider range of acute hospital services.

HEFT operates hospital-based maternity services across 3 sites, in Birmingham, Solihull and Sutton Coldfield and SWBHT operates hospital-based maternity services across 2 sites, in Birmingham and Sandwell. Both Trusts offer a wider range of acute services and therefore maternity services compete with other specialist areas for resources, in both Trusts.

5.1 Workforce Profile Data

The data tables in this section of the report have been prepared using figures supplied by each of the three Trusts.

The presentational format and content for each of the datasets is not directly comparable across each of the 3 Trusts and as such it is not possible to provide useful analytical commentary. It should be further noted that the data provided offers a snapshot in time due to its live status.

The information from SBWHT and BWH related to midwives only, whereas HEFT data included information about support, administration and management staff. All data sources have been identified in the footnotes.

As far as possible this data has been re-categorised to allow for reasonably comparable data to be produced, however it would be unfair to draw any conclusions from the data. The data does however provide a useful 'feel' for the patterns of staffing within each Trust and has been included on that basis.

Table 4 Numbers of midwives employed by Trusts

Location	**BWH[40]**	**HEFT[41]**	**SWBHT[42]**
Acute	Included in MLU[43]	288	137.74
Community	64	93	89.8
Neonatal	13		5.21
Specialist	10	23 [44]	7.07
MLU	250	27	24.43
Totals	**337 (ACTUAL)**	**431 (ACTUAL)**	**264.25[45] (Whole Time Equivalent)**

Table 5 Number of midwives by Pay Band and Trust

Pay Band	**BWH[46]**	**HEFT[47]**	**SWB HT**
Band 5	54	27.36	34.92
Band 6	228	236.20	130.51
Band 7	50	69.34	44.89
Band 8a	1	6	
Band 8b	3	3	
Band 8c	1		
Band 9			
Total	**337 (ACTUAL)**	**341.90 (Whole Time Equivalent)**	**210.32[48] (Whole Time Equivalent)**

[40] Data Source BHW – Undated Word Document received 30/01/13 and are numbers of midwives in post as of January 2013
[41] Data Source – Document from HEFT Midwifery Workforce Profile Data as of 30th October 2012, data manually counted from a list of roles, grades and location and subsequently adjusted to include specialist midwife figures from additional Spread Sheet as supplied by HEFT.
[42] Data Source Spread sheet from SWBHT dated 31/01/2013 which uses whole time equivalents.
[43] Data source presents data as one single Acute/MLU figure.
[44] Specialist midwife numbers based on spread sheet showing specialist posts which includes vacant posts which have not been included in these figures.
[45] Data Source Spread sheet from SWBHT dated 31/01/2013 which uses whole time equivalents and which includes staff on Agenda for Change Bands 2 and 3 as part of the totals given against each area. It was not possible to disaggregate these figures.
[46] Data Source BWH Undated Word Document received 30/01/13 and are numbers of midwives in post as of January 2013
[47] Data Source – Document from HEFT Midwifery Workforce Profile Data as of 30th October 2012 and adjusted to include specialist midwife figures from additional Spread Sheet as supplied by HEFT.
[48] Data Source Spread sheet from SWBHT dated 31/01/2013 which uses whole time equivalents, but does not include one Agenda for Change Band 2 post based in the community that appears on the spread sheet.

Table 6 Profile of Midwives by Ethnicity[49]

Ethnicity/Trust	BWH	HEFT	SWB HT
White	258	273.63	159.56
Asian	20	8.23	19.27
Black	32	28.93	43.63
Mixed Heritage	2	2.51	9.52
Other Ethnic Group	2	6.11	1.61
Not Stated	23	22.51	30.67
Totals	**337 (Actual)**	**341.90 (Whole Time Equivalent)**	**264.26 (Whole Time Equivalent)**

The information presented in Table 6 on ethnicity is based on the ethnicity classifications used by SWBHT. The data sets on ethnicity from HEFT and BWH used a broader range of categories and these categories have been amalgamated in order to align with the categories used by SWBHT to facilitate the production of comparable data.

It is worth noting that In Birmingham, the percentage of the population describing itself as White British declined from 65% to 53% between 2001 and 2011 – with the largest single Black, Asian and Minority Ethnic group being of Pakistani origin.

Similarly, within Sandwell the ethnic makeup has seen extensive changes since 2001. Just under two-thirds of Sandwell residents now class themselves as being of White British origin, and a further 4.1% are of Other White origin with 30.1% of Sandwell's population from other ethnic backgrounds. Since 2001, the only group to see a decline in numbers is those of White British background.

The largest increases have been amongst those of Arab and Other Ethnic origin (+781.5%), Black African (660.6%) and Other Asian groups (+230.1%). However, these groups still account for a low proportion of Sandwell residents[50] overall (1.6%, 1.4% and 2.1% respectively).

With the exception of White British, the largest single ethnic group in Sandwell is Asian Indian, with just over 10% of residents considering this to be their ethnic background.

However, these 'headline' statistics of a rapidly changing population profile for the communities served by the Trusts, partially conceals a more complex – and challenging – picture for each Trust, in particular:

[49] BWH Data Source Spread Sheet from BWH and based on actual staff figures, SWBHT Data Source Spread sheet from SWBHT dated 31/01/2013 and based on full time equivalent figures, HEFT based on Spread sheet supplied by HEFT and used whole time equivalent figures

[50] Sources of population data: Office for National Statistic (Census 2011); Birmingham City Council (ethnicity and poverty projections 2010: Sandwell MBC: Summary Census Findings and BRAP: Summary of Birmingham Census Data (2011

- A youthful population: the Census recorded 404,200 young people under the age of 25 in Birmingham. This is 37.7% of Birmingham's overall population.
- A super-diverse population: whilst newly arrived communities/new migration statistics suggest that such communities (Chinese, Afghan, etc) make up a small percentage of the overall population, analysis of GP registrations[51] indicated that approximately 42, 000 GP registrations in Birmingham between 2007 and 2010 consisted of 205 different cultural and language groups.

Table 7 Sickness Rates expressed as a percentage of total midwifery workforce for 2011-2012

BWH[52]	HEFT[53]	SWBHT
5.69%	3.7%*	No Data

* NB this value approximated from given graph of sickness rates

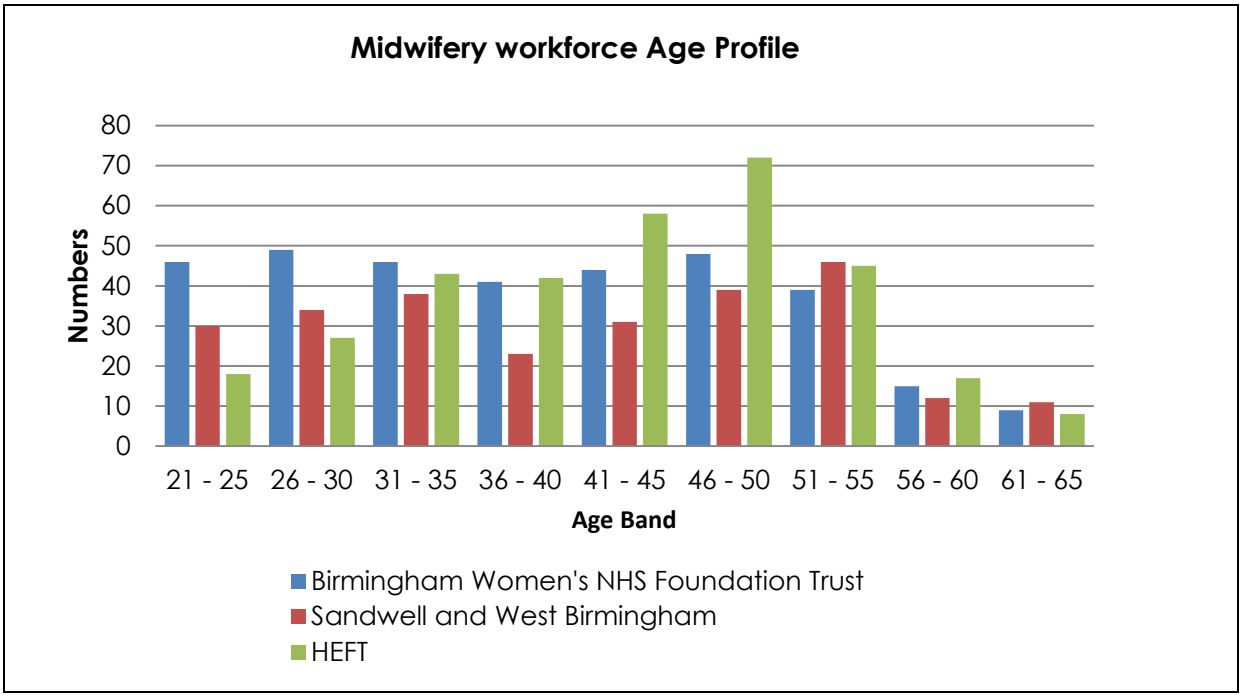
To set these figures in context, between July and September 2012 the average sickness absence rate for the NHS in England was 4.06% [54](NHS Information Centre 2013). The HSCIC[55] figures show that NHS staff had a sickness absence rate of 4.12 % in 2011/12. In 2010-2011 NHS Data showed a sickness absence rate of 5.21% for Nursing, Midwifery and Health Visiting Staff.

Table 8 Annualised Percentage Turnover 2011-2012

BWH[56]	HEFT[57]	SWB HT[58]
7.76%	8.8%	10.69%

[51] Phillimore, J. and Goodson, L. (2011): Analysis of GP Registrations 2007-2010 by country of origin
[52] Data Source BWH Undated Word Document received 30/01/13 and are numbers of midwives in post as of January 2013 and based on the calendar year for 2012.
[53] Data Source – Document from HEFT Midwifery Workforce Profile Data as of 30th October 2012 and taken from a graph showing sickness absence trends as %
[54] Bullard I (Jan 2013) *Sickness Absence rates in the NHS July Sept 2012* The NHS Information Centre
[55] The Health and Social Care Information Centre Web Site accessed 14th February 2013
[56] Data Source BWH Undated Word Document received 30/01/13 and based on the calendar year for 2012.
[57] Data Source – Document from HEFT Midwifery Workforce Profile Data as of 30th October 2012 and the note comments that this is the annualised turnover specifically for midwives but does not state which period this covers.
[58] Data Source Spread sheet from SWBHT dated 31/01/2013 which uses whole time equivalents

Chart 2 Age profile of Maternity Workforce[59]



The data contained in this table consists of a mix of actual and whole time equivalent staff which makes like to like comparisons difficult. It does however give a feel for the age profile of the midwifery workforce across the three Trusts. (See footnote 17 for more information).

It is clear from Chart 2 above that there is an aging workforce across the Trusts, a view supported by midwives and stakeholder interviews and through the Royal College of Midwives State of Maternity Services Report 2012 which notes:

> *"The midwifery workforce is getting older too. In England, between 2002 and 2011, the proportion of midwives aged 45 or over jumped from a third to a half. The small number of midwives still working at the age of 65 or above jumped from 13 to 122. Thankfully a rise in the number of younger midwives may start to reverse this trend, but that influx will need to be maintained."*

One midwife interviewee pointed out that many of the young midwives being recruited now are likely be having their own babies over the next 5-10 years, just as the older midwives retire, so they may not fill the gap after all.

[59] BWH Data Source Spread Sheet from BWH and based on actual staff figures, SWBHT Data Source Spread sheet from SWBHT dated 31/01/2013 and based on full time equivalent figures, HEFT based on Spread Sheet received from HEFT 14/11/12 and based on WTE.

The age profile of staff was raised by stakeholders, some of who described an 'hourglass' workforce which was top and bottom heavy '*with very little in the middle'*. One senior manager commented:

> *"We have a bi-polar midwifery workforce. Older nurses who are highly skilled but have a certain way of doing things – and then a younger, recently trained, group of midwives who have a very different approach"*

5.2 Team working

Midwifery 2020[60] identifies the importance of team and partnership working; our interviews with midwives reflect this. Midwives would like more opportunities to come together as a team and discuss their work.

Some concerns were expressed that midwives tended to "*work in silos*" and several interviewees and survey respondents suggested that there needed to be better communication across wards, clinics and community. Interviewees noted that poor communication can create delays for women when staff take attitudes that are job focused rather than patient focused – "*this is my job, not your job*" or "*that's not my job.*"

Community midwives found that team meetings were invaluable to avoid isolation, and several noted that they would welcome the opportunity to come together with hospital based colleagues to share good practice and break down barriers.

Midwifery 2020 notes that:

> *"We would like midwives to build on effective communication and teamwork with colleagues in the maternity services team to continuously improve the delivery of quality services for women, babies and their families."*

> *"Strengthen teamwork to improve quality maternity services."*

5.3 Role of midwifery support staff

Midwifery support staff have a key role of play in supporting midwives and there was general agreement from midwives (across interviews and survey data) and

[60] Rogers J (2010) *Midwifery 2020: Delivering Expectations* Cambridge

stakeholders that midwifery support staff are a valuable addition to the midwifery workforce. Amongst midwives (in all settings) there was a consensus that support staff can relieve pressure on midwives, when both worked in partnership with each other.

Stakeholders expressed their support for such roles in terms of workforce capacity and the ability of such staff to "*free up*" midwives so that they can carry out "*high level functions.*" Nationally and locally there has been a growth in the employment of support staff[61].

There was general agreement from across midwife interviews, stakeholder interviews and survey data that maternity support staff add value to the midwife's role, a view supported by the work done by Sandall for the report Staffing in Maternity Units:

> *"There is fairly widespread use, in the UK, of Maternity Support Workers who have been deployed with a view to freeing up midwives and doctors to enable them to focus on more complex tasks. There is positive anecdotal evidence for the effectiveness of such roles but little data is available as to their numbers and deployment and formal evaluation is required to fully assess their impact."*

Midwives valued the role played by support staff who were able to take over the day to day administrative tasks such as computerising E3 discharge forms. Midwives would like to see more support staff taking over such tasks in order to free them up.

Across the three Trusts there are differences in approach to the support staff role, this is not particular to the three areas covered in this research and one of the challenges for the research team has been clarifying the terminology used to describe maternity support staff as midwives tended to use a number of interchangeable role titles – an issue identified in Staffing in Maternity Units[62] which notes:

> *"Evidence as to the effectiveness of support workers in maternity services is limited largely because of the plethora of titles used to describe them and the variability of tasks they perform."*

[61] Sandall et al (2011) *STAFFING IN MATERNITY UNITS Getting the right people in the right place at the right time.* London Kings Fund.
[62] Ibid.

Midwives found maternity support staff extremely helpful for tasks such as chasing blood results, as one midwife interviewee commented "*I saw three ladies today, 45 minutes worth of taking blood … I think it's an area where support staff can be utilised.*"

Other aspects of the maternity support worker role were seen as more controversial. One midwife interviewee noted that this role could be perceived as taking away 'soft skills' from midwives such as blood tests, breastfeeding support and parent education, other midwife interviewees felt it was important that midwives had the opportunity to regularly practise a range of basic skills and one person commented that "…*there are concerns about midwives roles being eroded.*" Others felt that if support staff take on too many of the core midwifery roles that midwives were in danger of becoming '*obstetric nurses*'.

Likewise there were mixed views about what Maternity Support Workers should be doing to support midwives, and these views tended to reflect individuals' experiences of working with maternity support staff. However there was broad support for:

- Arranging and chasing appointments
- Data entry and paperwork
- Blood taking and phlebotomy
- Urine testing
- Taking women's blood pressure on arrival
- Doing observations on babies as well as mothers
- Supporting clinical staff in the birth centres
- Washing of post-partum women
- Education on smoking cessation, dietary advice, healthy eating
- Providing practical support such as stocking up birthing rooms

Several stakeholders and a small number of midwives suggested that support workers could help women with breastfeeding, however the midwife interview and survey data suggests that supporting women to breastfeed is a part of their job that many midwives would like to retain.

Several midwives and stakeholders commented that support workers needed better training and recognised qualifications, an issue identified in both Staffing in Maternity Units[63] and Midwifery 2020[64].

[63] Sandall J, et al (2011) *STAFFING IN MATERNITY UNITS Getting the right people in the right place at the right time.* London Kings Fund.
[64] Rogers J (2010) *Midwifery 2020: Delivering Expectations* Cambridge

The Royal College of Midwives[65] notes that

> *"…Maternity Support Workers (MSWs) have an important role to play in delivering quality maternity care. To do so safely however they must be adequately trained, suitably deployed and appropriately overseen, and their numbers should not typically exceed around 10 per cent of the clinical workforce. To ensure in particular that they are suitably overseen, it is important that midwife numbers continue to rise; recruiting MSWs faster than midwives could leave MSWs without the supervision and oversight needed to ensure they only carry out those duties they are able and safe to perform. MSW and midwife numbers must rise together."*

5.4 Changing expectations of midwives

The NHS is changing and maternity services are not immune from the processes around them. The government has, for instance, introduced a Choice Framework[66] which sets out the choices women are able to make about the care they receive during pregnancy and birth. It has also introduced the concept 'No Decision about Me without Me' and placed it at the heart of the Health reforms.

The introduction of Clinical Commissioning Groups (CCGs) will shift commissioning decisions about maternity services from Primary Care Trusts with dedicated maternity commissioners, to a GP-led commissioning approach. 2 CCGs in Birmingham and the Solihull CCG will retain 1 shared commissioner for maternity services, initially, and in Sandwell the CCG has appointed its own commissioner who will commission maternity services for Sandwell and West Birmingham as part of a portfolio of other services. Community midwifery will be commissioned against a Payment by Results block contract so Trusts will need to evidence the care they provide.

Several stakeholder interviewees noted that this change in the commissioning environment would almost certainly present challenges, particularly in the current financial climate.

> *" Any developments in the future will be predicated by finance – developments need cash injections first and given the current financial constraints we've cut to the bone there's nothing else to cut and we're going to be hard pressed to find those financial savings that are likely to come"*

[65] RCM (2012) State of Maternity Services report 2012
[66] Department of Health (2012) *2013/13 Choice Framework*. London

In addition, the RCM in the State of Maternity Services 2012 identifies the following factors that impact on what is expected of midwives:

- Birth rates in England are continuing to rise
- Mothers are getting older
- Ageing midwifery workforce

Increasingly, also, the views of women who use maternity services are being sought and, although elsewhere in this report it was identified that many women in Birmingham, Solihull and Sandwell have low expectations of services, other research has identified dissatisfaction with some elements of care. For instance the Birmingham and Solihull LINks report in 2011[67] found that some women from vulnerable groups felt that they were not receiving adequate levels of support or good quality information. This was due to language barriers, poor treatment from NHS staff and insensitivity to their cultural needs. The RCM report cited the findings of a survey from the *Bounty Word of Mum Panel (2012) which*

> *"found that 40 per cent of women had always seen a different midwife during their most recent pregnancy. The survey also found that a fifth of women did not feel supported by the NHS during their pregnancy and birth, rising to a third who did not feel supported following the birth."*

The following factors affecting the expectations of midwives were also identified by interviewees (both stakeholders and midwives):

- The transfer of midwifery education to Universities – which some midwives think encourages new midwives towards reliance on technology rather than good communication, working with women and building relationships with them
- The impact of super diversity on communication and relationships
- Increasing numbers of women who are classed as 'high-risk' or complex cases, particularly relating to obesity (BMI of 30 or more) and related illnesses
- Time pressures due to staffing levels and paperwork
- Appointment times in antenatal clinics where midwives are expected to take urine and blood samples (or find out the result of previous blood tests), check the woman, check that the baby is growing properly, ask the women if she has any problems, check for domestic violence and carry out a risk assessment within a 15 minute appointment time
- Having to work with 3 or 4 women at a time as one midwife commented – *"It's awful having to look after 3 or 4 women in labour – not being able to stay with a woman who's in pain and give her the care you would like."*

[67] Lynch N. Dr. (2011) *Women's Experiences of Maternity Services in Birmingham East and North and Solihull* Solihull and Birmingham LINk

- Increasing caseloads
- Safeguarding responsibilities increasing and an increased likelihood of midwives taking on the role as lead professional in a CAF (Common Assessment Framework)process

Midwives, stakeholders and commissioners will need to manage changing patterns in delivery as one stakeholder commented:

> *"A real challenge is adjusting the workforce to levels of changing admissions (in delivery). Providers need sophisticated escalation plans to deal with any sudden increase in admissions so workforce matching is challenging: using a pool to staff 'on tap' but not pulling them away from other duties."*

All of these expectations have an impact on the quality of care midwives can provide and many mentioned their levels of frustration at not being able to spend enough time with women to build a relationship. This frustration is shared by women themselves who reported in the previous LINks research[68] that they found it distressing, for instance, to have multiple midwives during pregnancy and birth and that they felt understaffing led to midwives being unable to spend sufficient time with each woman.

Midwives identified the following as things that would help:

- The specialist Safeguarding Midwife taking lead responsibility for CAF
- Postnatal ward-based midwives having 4 patients each and being able to work with them on breastfeeding, infant bathing, top and tailing and general baby care
- Community-based midwives would like better and easier access to IT systems and better IT equipment
- Being able to spend more time with the women they are working with, midwives feel that if they were able to spend more time with women that this may help reduce complaints
- Giving care to the mother and baby as one unit rather than the nursery nurse checking the baby and midwife checking mum

5.5 Recruitment & retention

Concerns about recruiting and retaining midwives were mentioned throughout the research.

[68] Lynch N. Dr. (2011) *Women's Experiences of Maternity Services in Birmingham East and North and Solihull* Solihull and Birmingham LINk

New midwives become autonomous and accountable practitioners from the moment of registration (Preceptorship Framework[69]) and their transition into employment is then supported through a Preceptorship programme. We haven't any significant evidence about how this framework is being implemented in the three areas involved in this research, other than preceptoship processes are being put in place to support newly qualified midwives up to becoming Band 6. Some new midwives commented that mentorship was an important support mechanism for them and there are indications of a variety of experience of mentor support, with some having very good relationships with their mentors and others feeling that their mentors would benefit from more training.

> *"The Birth Centre and Postnatal are very good at supporting each other emotionally and this reflects in how the women and I feel about even being there. This is purely from a student's perspective as I have on occasion been made to feel very unwanted whilst on placement except on the 2 departments I have mentioned"*

> *"Mentors that are more supportive and ready to teach students and not put them down but encourage them."*

Midwifery staff highlighted concerns about:

- The pressure on their time and allied concerns leading to high levels of stress
- Long shifts – although several interviewees suggested that some midwives were actively choosing to work longer shifts
- Being worried about making mistakes due to tiredness
- Not being able to take breaks
- Large caseloads
- High levels of sickness absence
- The replacement of Band 6, or even Band 7 staff on long term sick or on maternity leave with band 5s
- The amount of unpaid overtime and the fact that *"a lot of us are working on good will and that's very frustrating because we love our jobs and want to make a difference."*

[69] Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals. (2010) Department of Health

One stakeholder interviewee commented:

"I think the staff commitment is impressive. They don't make a fuss despite the complexity of much of their work. They quietly get on with their work without a big media splash."

Midwives also talked about the importance of good managers and strong strategic leadership in retaining midwives, which was a key factor identified by Tolofari in her 2012[70] dissertation that explored the reasons for midwives leaving the profession.

Midwives welcomed the fact that Trusts were trying to recruit more midwives, however stakeholder interviewees talked about the challenges they faced in recruiting midwifes. One stakeholder commented that there was competition between Trusts to recruit, attract and retain skilled midwives.

"We're all out here fighting to have more midwives. There are not enough midwives out there to get them into the service – these are huge factors for the future because you've got to make sure in the future that you've got a maternity service fit for purpose."

The RCM's State of Maternity Services Report 2012[71] notes that the number of midwives has increased. In 2012 there was the equivalent of 20,935 full-time midwives working in the NHS in England. This was up over 3,000 since the start of the baby boom in 2001, although the RCM calculates there is still a national shortage of 5,000 full-time equivalent midwives. In the West Midlands, the number of live births per year has increased by 20% between 2001 and 2011, an extra 12,200 live births per year, while the number of midwives has increased by 14% between 2001 and 2012, an additional 297 midwives.

There is limited anecdotal evidence from interviews to suggest that midwives come into the region to train because of the intensive learning environment that is created by the super-diversity of the population and the range of complexities around birth in this area. These midwives are then alleged to take up employment opportunities elsewhere, but we have no evidence to support this view.

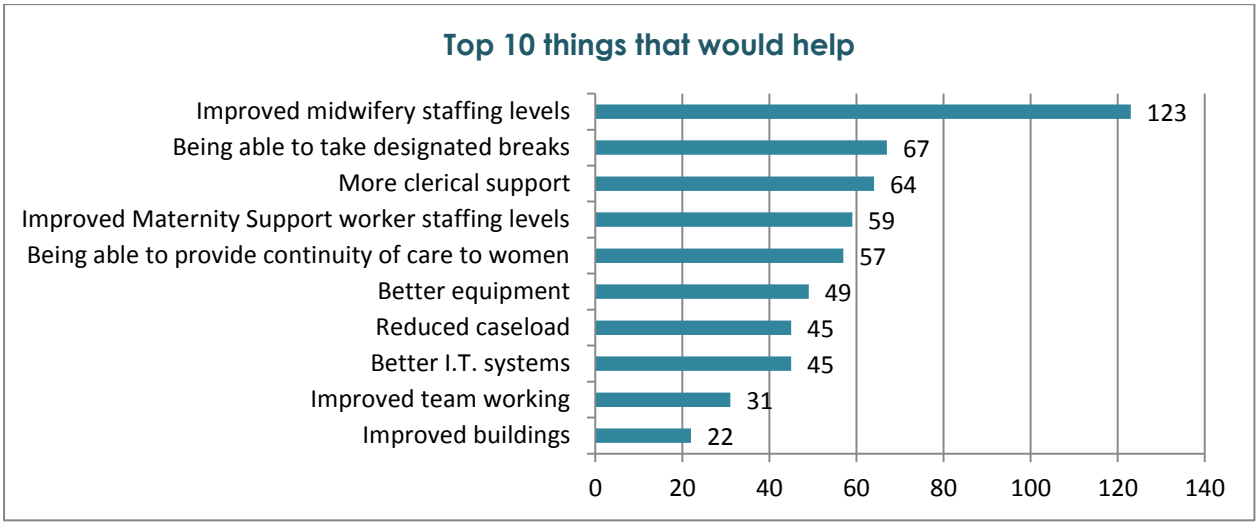
[70] Tolofari M. (2012) Why do midwives leave their posts? The Advanced Practitioners role in reducing staff turnover and determining job satisfaction
[71] RCM (2012) State of Maternity Services report 2012

Stakeholders want to ensure that within their Trusts they have a maternity workforce that is both fit for purpose and compassionate and caring[72] towards the women they support.

> *"It is about making the best decisions that you can to ensure the best service for the women and that you've got the best places for the midwives, that they're developed to meet the needs and that we train them in practice. That's what we're aiming for isn't it, that we've got very competent midwives who are caring towards our women, because we do have issues with attitude, and that we're continually improving.*
> *And that's the sort of aims that we all want."*

> *"At interview I ask everyone one – if I was to walk into a room when you were working with a women how would I know that that woman was being treated with kindness – you would not believe how hard people find this to answer – you should be able to see from what she's doing with the woman some element of passion and care for the woman she's working with."*

Midwives identified the following as things that would help support them in the workplace:
Chart 3



No. responses 162 – each midwife could pick 5 things. The full list of responses can be seen at Appendix 3.

[72] NHS Commissioning Board (Dec 2012) *Compassion in Practice* NHS Commissioning Board. London

Midwives who attended the research feedback session were not surprised that staffing levels overwhelmingly came out top of the list. They agreed that staffing levels are a complex issue, for instance several midwife interviewees identified covering long-term illness and maternity leave as key issues in terms of being short-staffed. Some midwives felt that cultural change might be necessary, as numbers of midwives have increased over the last few years (although not quite in step with the rising birth rate) but some midwives might never feel there was enough.

The midwives at the feedback session also discussed the concerning issue of midwives not being able to take designated breaks during shifts. Most agreed that there is a culture in some units that frowns on people taking the breaks they are entitled to when units are busy, others mentioned that some breaks did not allow time to go out, or even to the canteen. It was mentioned that BWH has a nicely appointed coffee room in the obstetric unit where midwives can take a short break. Other midwives felt that it was the responsibility of midwives, as autonomous and responsible individuals, to manage their own breaks and take them when they can, rather than at specific times and to accept they might not always get a break at the same time as their friends.

There were a number of practical elements in the top 10 list, like better IT, buildings and equipment but, other than a number of staffing-related points, the other key factor that would support midwives in the workforce would be being able to provide continuity of care, which has long been seen a significant indicator of job satisfaction for midwives[73].

5.6 Professional development and support

Several midwives noted that they shared up-to-date information with colleagues and felt that they received a lot of support and advice from colleagues. There were mixed views about the amount of training on offer, with some midwives wanting more Continuing Professional Development (CPD) and on-the-job training opportunities and others who felt that the "*training is quite excessive at the moment, the amount of things we're supposed to be going on.*" Others would like mandatory annual training, such as infection control, to take a different focus each time to avoid repetition.

Others talked about the challenge of keeping up-to-date; some community midwives experience difficulties in accessing online training from their laptops and find themselves having to go into the hospital to do it. Others noted the difficulties midwives can experience in taking time off to attend training, particularly if their work area is experiencing staff shortages, sickness or other staff absence. This is a

[73] e.g. Christopher J. Todd Team midwifery: The views and job satisfaction of midwives in Midwifery Volume 14, Issue 4, December 1998, Pages 214–224

perennial issue one that was identified in Safe Births[74] which identified that training requirements were not always met because of difficulties in securing time off to attend.

There was a clear view from some midwives that, although busy, many, but not all, midwives do help themselves by being engaged in new developments in their field. There was a strong view that midwives should take responsibility for keeping up-to-date by making use, for instance, of the resources accessible through their professional bodies. Often, it was suggested, changes in service are experienced by some midwives as coming 'out of the blue' because they have not found time to actively engage in the debate around the future of maternity services. One stakeholder felt that midwives did not actively engage in staff consultations on proposed changes.

> *"….They don't keep up to date with the changes in the NHS and they don't get involved till it hits home when they get angry and it's too late in the day then…"*

If midwives are willing and able, it was suggested, to find out more about good practice that is happening in other Trusts and how they might apply it in theirs, they may reignite their passion for midwifery and their role in it. Midwives who attended the feedback session felt that the need to keep themselves up-to-date must be understood in the context of midwives working split shifts and nights as well as often providing family care at home.

One newly qualified midwife when reflecting on what would help her development commented:

> *"Longer training, if I had heard myself say that when I was a student; but having gone to work in a high risk unit you are briefly told about what is epilepsy, what is diabetes etc but really it doesn't cover everything."*

Other more recently qualified midwives felt that colleagues who had entered the profession having first been a nurse understood more about the underlying illnesses that can lead to high-risk or complex births.

> *"…. Some of the people who had trained as nurses before they were midwives are better equipped to start with…."*

[74] O'Neill O Professor; Cornwall J Dr., Thompson A Professor, Vincent C. Professor, (2008) *Safe Births Everybody's Business* Independent Inquiry into the Safety of Maternity Services in England. Kings fund London

Midwives identified the following as things that would help:

- Live skills drills
- Bi-monthly practice development meetings
- In depth training on a range of medical conditions
- Skills testing for midwives on rotations such as checking IV competency

Stakeholders suggested that midwifery training needed to focus on preparing midwives for leadership in the same way that nursing prepares nurses for leadership.

One route for professional development in midwifery is to specialise. All Trusts in the area covered by the research have Specialist Midwife roles. One Specialist Midwife who supports women with diabetes described how her role enables her to educate women about their diabetes, for many women she works with it is the first time they have received effective education about their condition. She is also able to provide training on supporting pregnant women with diabetes to other midwives and other professionals. Discussion of specialist roles with midwives at the feedback session highlighted that some midwives see specialists as taking some of their caseload off them and are keen to 'hand over' any diabetic women, for instance, to a Specialist Midwife at once, rather than supporting them themselves with advice and guidance from the Specialist Midwife. Midwives recognise this behaviour as a symptom of high caseloads but it does not necessarily provide the best support for women.

6. Accountability and autonomy

6.1 Impact of record keeping on midwifery practice

Insurers across both the commercial and specialist medical defence bodies have recognised the high risk that midwifery presents in terms of the potential for claims alleging negligence by a midwife (RCM 2011) [75]. All NHS providers need to have in place suitable clinical negligence and other insurance.

The aim of the Clinical Negligence Schemes for Trusts (CNST) Maternity Standards and associated assessment framework is to improve the safety of women and their babies. The Standards are measured on a 0-3 scale against compliance with the standards. Maternity services complying with the standards 1-3 receive a discount from the maternity element of their CNST contributions. (NHS Litigation Authority 2012-13) [76].

The discounts against premiums are:

Level 1	10%
Level 2	20%
Level 3	30%

Stakeholders identified that the Royal College of Obstetricians and Gynaecologists have provided standards on levels of maternity staffing and noted that these guidelines on cover have been incorporated in clinical negligence schemes.

Stakeholders commented that the recommended staffing levels can "*challenge the financial envelope*" for maternity units as increases in recommended staffing levels affect financial viability. Should Trusts not achieve recommended staffing levels, the number of babies able to be born there will have to reduce accordingly and any reduction in the number of births leads to less income and this in turn makes them less financially viable.

Some stakeholders did comment that CNST was a driver for safety; other interviewees felt that the CNST authorisation processes had shifted the focus away from quality of care to evidencing what had been done and saw it as a driving factor for increased paperwork. This was discussed at the research feedback session with midwives and the view was expressed that CNST does not improve 'safety' for midwives but, if engaged with in a positive way, it does drive up standards and make people accountable –" *it is about money but more than that, it can be used for service improvement*".

[75] Flaxman Partners Ltd;, (2011) *The feasibility and insurability of independent midwives* Royal College of Midwives
[76] DMV Healthcare (January 2012) *Clinical Negligence Schemes for Trusts; Maternity; Clinical Risk Management Standards, Version 1 2012/12* NHS Litigation Authority

Some midwives described how CNST was being used in their Trust to challenge poor practice, that active monitoring of CNST paperwork has highlighted that some midwives are not recording, and therefore not providing basic midwifery care because there is no evidence that they have done so. SWBHT has a CNST team to support midwives in how to implement the standards, including an Education Midwife. There was a difference in opinion at the meeting and some midwives were not convinced that CNST is more than a box-ticking exercise.

Stakeholders and midwives expressed frustrations at the level of paperwork attached to the CNST standards.

> *"I think that's the way the maternity service has changed in as much as we are very occupied with finance and targets and fundamentally safety and quality are our job."*

Midwives reported feeling worried about making mistakes and about failing to complete paperwork, some felt that much of their day-to-day practice was focused on evidencing what they had done rather than doing it, in order to avoid the risk of litigation. Midwives talked extensively about how much form-filling relating to professional indemnity insurance that they did and many felt that this got in the way of delivering a service that was focused on women's needs. Both stakeholders and midwives reported that Maternity Insurance was the most costly element of insurance for the Trusts.

Most midwives were unhappy about the level of record keeping that they have to complete. Many talked about the completion of 'Green Notes'[77] which contain 25 pages, 12 of which require the woman's name, postcode and NHS number to be written on them by hand. One midwife interviewee commented *"I could spend my whole time form-filling",* others reported frustration with *"things that don't directly benefit the patient but take up a lot of our time."*

A maternity commissioner interviewed for the research is also frustrated by the paper hand-held notes and how difficult it is to get any data from them, for instance on demographics or assessments for high-risk pathways. It was reported that all Trusts are working towards a community I.T. system, driven by Payment by Results, which would make a positive difference, but that they are all doing it differently which is likely to create confusion, particularly in cross-boundary areas.

The issue of paperwork coming between the midwife and the women she supports was picked up in the previous LINks research report into women's experiences of

[77] 'Green Notes' are part of patient held maternity records

maternity services[78]. The report includes quotes from mothers who raise issues about how the impact of paperwork affects the quality of the relationship between the midwife and the woman.

Some midwives felt that midwifery practice was becoming increasingly defensive and one interviewee commented *"You've always got litigation at the back of your mind"* A view supported by the fact that in 2010 the number of negligence claims rose by 20%[79].

6.2 Compliments, complaints and staff morale

Foundation Trust status requires the Board of such Trusts to actively engage with patients, staff and other key stakeholders on quality. This requirement includes actively engaging patient feedback as part of the process for objective coverage of both good and bad performance.

Boards need to receive feedback from patients on the quality of the service they have received with *"summary reports reviewed regularly and intelligently by the Board."* Moreover Boards are expected to regularly *"review and interrogate complaints and serious untoward incident data."* (Monitor 2012) [80].

The Francis Report[81] makes a number of strong recommendations around effective complaints handling that include, for example, the handling of patient concerns, the co-ordinated collection of accurate information (including complaints) made available to providers, commissioners and the public and the introduction of mandated returns to the Care Quality Commission on the pattern, handling and outcome of complaints.

Several midwives did express concerns that they were working in an environment where women are actively encouraged to complain, and one in which compliments and letters thanking midwives are not always recognised or celebrated. Midwives are concerned about making a mistake, the likelihood of which increases under the pressures described in the section below on autonomy.

One interviewee did report that, more recently, letters that had come in complimenting staff were being copied and displayed and she felt this simple action had really helped to boost morale.

While midwives understand the need to speak out to protect patients they are concerned about risking their jobs or, more importantly, their registration. There are a

[78] Lynch N. Dr. (2011) *Women's Experiences of Maternity Services in Birmingham East and North and Solihull* Solihull and Birmingham LINk
[79] Tolifari M. (2012) *Why do midwives leave their posts? The Advanced Practitioners role in reducing staff turnover and determining job satisfaction.* MSc Dissertation
[80] Monitor (March 2012) *Compliance Data 2012/13* Monitor Independent Regular of NHS Trusts
[81] Francis R QC (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Enquiry*. The Mid Staffordshire NHS Foundation Trust

small number of comments (less than 5) about the impact on midwives of working in a 'blame culture.' However no-one gave specific information about how this culture manifests itself.

It was suggested by several interviewees that midwives should be able to get access to counselling and emotional support.

> *"I also think we should have access to a counsellor, we do take part in safeguarding cases that are sometimes very difficult and emotional and to be able to offload would be a help."*

Others talked about the informal support they received from other midwives and how much they appreciated it.
Midwives in the feedback session agreed that support from other midwives is very valuable and great in some teams but that in some units midwives have stopped caring for each other. They felt that "*it will help with giving good care, if you feel cared for*".

6.3 Autonomy

As part of the research brief, the LINks Project Board asked the research team to investigate to what extent midwives who took part in the study felt able to exert autonomy in their practice. Questions on autonomy were included in both the online survey and the interview question guides. The research team were directed to refer to the International Confederation of Midwives' definition of a midwife[82] for this element of the research. Feedback on the research findings suggests that midwives may have found the NMC Code and Standards of Conduct against which they are assessed more appropriate and familiar for this element. This is useful learning for future research.

> *"Our team, although thin on the ground, are very supportive of each other and I think this is the only reason we have been managing to cope under such awful conditions. We will often call each other when we're not on duty to debrief or to discuss bad situations, we then fully support each other when taking action, this is something midwives need to do to get away from the terrible culture of blame."*

Midwifery 2020[83] notes that midwifery education "*will prepare and develop midwives to be skilled and safe, empathic and trustworthy with increased emphasis*

[82] See Appendix 4 for a copy of this definition
[83] Rogers J (2010) *Midwifery 2020: Delivering expectations* Cambridge

on the principles of autonomy and accountability within multidisciplinary and multi-agency teams."

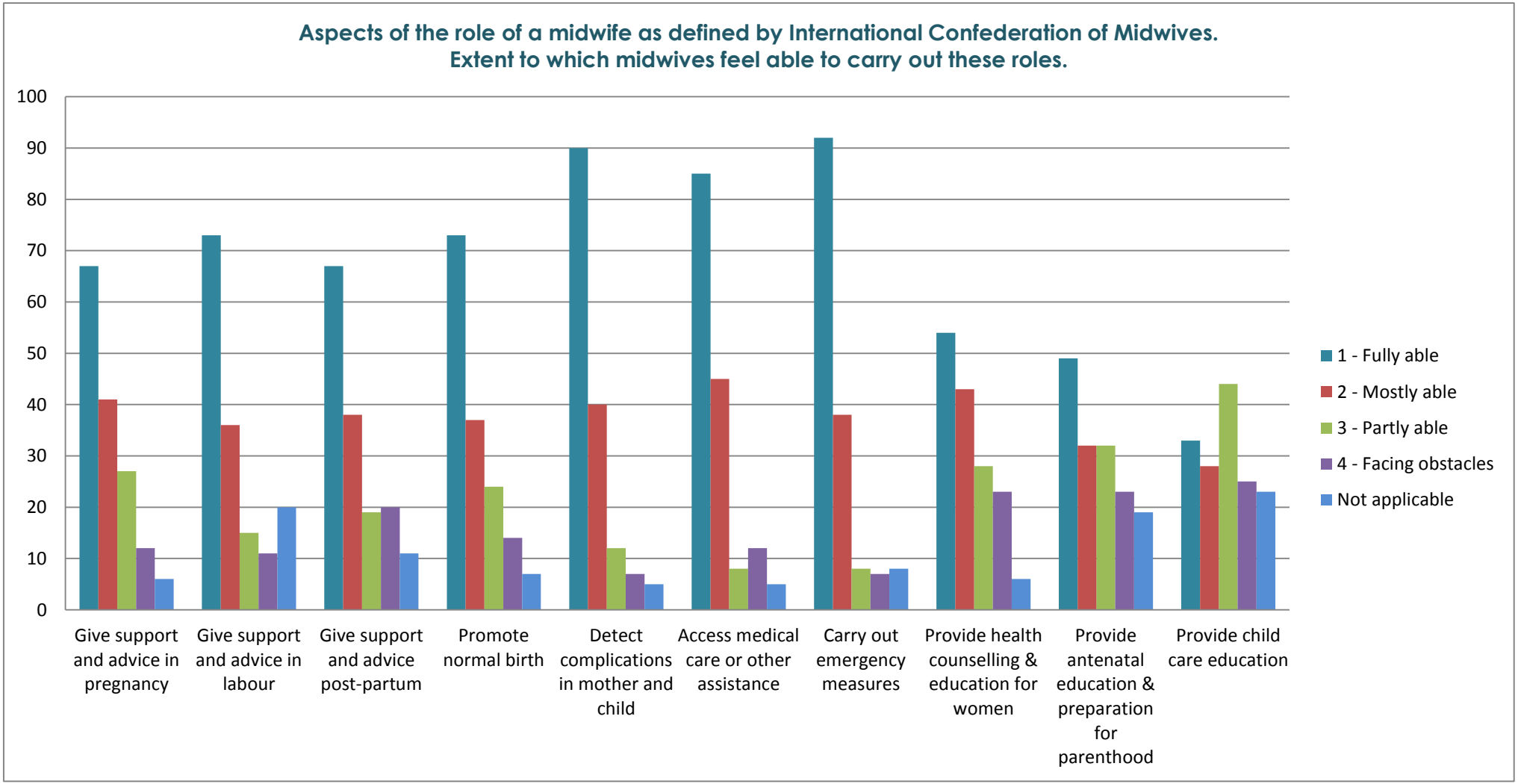
Midwives interviewed for the research expressed a number of clear views about autonomy in midwifery.

> *"I expect midwives to be able to advocate for a women using her professional autonomy and that's not about putting herself at risk or the mother at risk. It's about clearly understanding what your professional role is."*
>
> *"Midwifery is all about midwives acting as advocates for women."*

As part of the online survey the different aspects of the midwifery role as identified by the ICM were listed and midwives were asked to reflect on how able they are to fulfil these roles, see Chart 4 on page 57.

The chart shows that the majority of midwives feel fully or mostly able to fulfil all aspects of their role. The role of providing child care education appears on face value to be the most difficult to deliver but feedback from midwives suggests that many midwives may consider that as part of the role of 'giving support and advice postpartum' and would not see it as a separate role. The same could be said for all of the last three roles on the chart. We know, however, from elsewhere in the findings that midwives have expressed concern about the lack of time in the postpartum and postnatal period to give full advice and information to mothers, including on basic baby care and in the antenatal period one stakeholder identified that parentcraft classes and infant feeding co-ordinators are vulnerable parts of maternity services that are being cut to make savings.

Chart 4



No. responses 155

Midwives answering the survey question on ICM roles were asked to state the obstacles they faced in being able to deliver them. 97 midwives reported obstacles and almost half of these were concerned with the time pressures midwives experience.

The most frequently cited reason for time pressures was staffing shortages created by staff sickness, maternity leave or lack of staff. One interviewee captured the views of a number of midwives when she commented:

> *"Today was a classic – 2 or 3 midwives were on a mandatory study day, 2 on annual leave, 2 off sick, 1 at a safeguarding meeting which left 5 midwives for 4 clinics and 13 visits"*

Other reasons for time pressures included large caseloads, paperwork, appointment times not being long enough and access to resources, or having to work on days identified as study days. Whilst there is no evidence from the survey data that midwives feel that these time constraints affect patient safety, as mentioned in section 2, concerns about safety could be implied from the high numbers of respondents identifying staff shortages and time constraints as barriers to good care. Midwives who contributed to the report felt it is unlikely that midwives would overtly suggest the care they deliver is unsafe in a telephone interview or online survey, even an anonymous one. They are bound by the working guidelines of the Trusts that employ them but many expressed views that suggested that they were not satisfied with the levels of care they were able to give due to high caseloads and time constraints and that in a culture where taking designated breaks is difficult, mistakes could be made.

There were a range of views expressed about whether or not midwives saw themselves as being autonomous and able to act as an advocate for the women in their care. Some midwives felt that there were too many rules in place for them to exert autonomy, however overall community midwives generally felt able to exert autonomy – although they too experience time pressures due to staffing and the size of their caseloads.

There was a clear view that midwives in the community had more opportunities to both advocate on behalf of the women they work with and to exert appropriate levels of autonomy. Some Trusts are actively placing newly qualified midwives into the community setting to provide them with the opportunity to develop their own advocacy skills and to foster an autonomous approach to their work.

One community midwife from SWBHT commented that increased staffing levels in the past year had alleviated some of the time pressures she had previously experienced.

Midwives working in Midwife-Led Units also felt (and were seen by other midwives) as being satisfied with their ability to be autonomous, due in part to the fact that working in a Midwife-Led Unit offered more opportunities for exerting autonomy and for being accountable for their practice.

Of those midwives responding to the survey question, only 8 midwives (5.8%) wanted more autonomy in everyday practice.

Across the interviews there were mixed views from newly qualified midwives with some reporting feeling they were unable to exert autonomy and others who felt that they were able to exert autonomy but that they had no authority within their working environment.

Within a hospital setting particularly some concerns were expressed about whether or not the 'system' supported and enabled midwives to exert autonomy. With technological advances, it was suggested, some midwives may become dependent on the tools and lose confidence in their own judgement.

> *"We've taken away their confidence in their own decision making and midwives are very used to referring up – we're created a very hierarchical model where everything is referred up and that doesn't support midwives' autonomy."*

Some midwives reported feeling able to exert autonomy when there was a senior midwife on shift able to support with decision making and with the escalation of problems and issues. Midwives also report feeling more autonomous when they work in an environment where they can report concerns and be activity involved in action planning for improvements.

Accountability for personal practice was seen as being partly dependant on individual midwives and what they felt comfortable with. There was a strong sense that accountability and autonomy are linked to an individual's level of personal confidence and the support available.

7 Conclusions and recommendations

7.1 Conclusions

Midwives are very busy, they feel stretched and they feel they often do not have the time to do their jobs to the best of their ability and it is the quality of time spent with women, at all stages of pregnancy and birth, that is affected most. There are differences of experience across and within the three areas but this frustration is most often expressed as being caused by staffing shortages and increased caseloads.

With the advent of the Friends and Family Test, and in the wake of the Francis Inquiry report, feedback on the quality of care and the experiences of women and their families becomes even more important. Trusts must consider how they can best deploy their available resources so that quality of care and informed choice for women is improved, as well as efficiency.

Midwives feel they have professional knowledge and experience that could usefully inform the development of maternity services and many would like staff engagement processes to be more meaningful so that their contributions are seen to be listened to and taken on board.

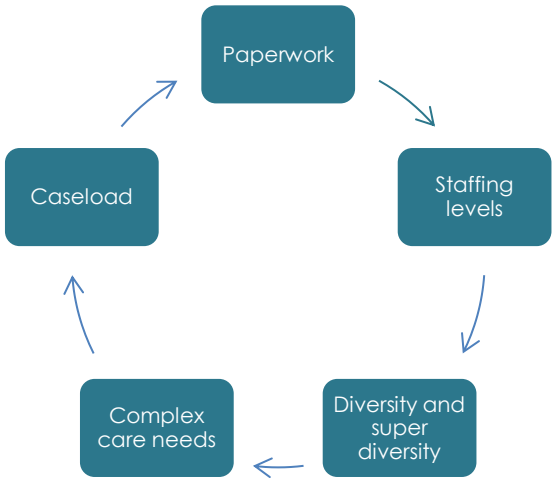
The following points highlight key learning from the research.

- **Time pressures**

Midwives report that time pressures present the key obstacles to providing the highest quality of care. From midwives' perspective, lack of time means they are unable to do their job as well as they would like and it is the softer, more 'human' elements of their role that are being affected most. This can then lead to poor morale and dissatisfaction with their work.

Time pressures experienced by midwives do impact on patients and the quality of patient care and can create an environment in which women are more likely to complain about their experiences of maternity services. The findings of this report mirror those of the previous LINks report into women's experiences which also identified pressure on midwives' time as a factor in patient dissatisfaction.

The diagram below illustrates some of the more commonly agreed factors that exert time pressures on midwives.



- **Supporting vulnerable women**

Changes in population demographics and increases in the number of complex cases mean that midwives across the three Trusts are working with more vulnerable women than ever before.

They understand that these women need additional support and that a 'one size fits all' approach has never worked in maternity services, which have at their core a commitment to working with women on an individualised basis. Many specialist roles have been developed to support vulnerable women across all three areas, but complexity is so common, and increasing, that all midwives really need to develop core knowledge and skills to meet the needs of the population mix in their areas.

Midwives are doing their very best to support vulnerable women and to offer a caring and compassionate service but they recognise that they need more support, information and skills to do so more effectively.

- **Impact of super-diversity**

Midwives across the three areas, particularly but not exclusively in community settings, are developing skills and knowledge about the communities they work in, often very different on a geographical basis. Midwives in acute units have more access to Specialist Midwives for support with women with complex needs but less access to the knowledge of customs, attitudes and beliefs of women from the wide range of communities served. This lack of knowledge, along with language barriers, can impair their ability to provide women with a good quality of care, sometimes compounded by negative attitudes and judging women by their own cultural norms. Midwives are encountering more and more women from super-diverse communities that it is imperative that the knowledge gained in the community is shared with colleagues in acute and MLU settings to improve standards of care for often very vulnerable women.

- **Postnatal care**

Evidence from the research suggests that the area of maternity services most in need of attention in terms of improving the quality of care is the postpartum and postnatal period in acute units. This appears to be the stress point which 'gives' in a busy unit, whereas women in labour and intrapartum cannot be left for long, women are quickly moved 'on to the ward' after delivering their babies to free up a delivery bed and may receive minimum attention from then on, especially if they have no complications, as ward midwives are often called to help with deliveries.

Anecdotal evidence from the research suggests that postnatal care in community settings varies between Trusts and also within Trusts. Following service re-configurations and amalgamations across hospitals there appears to be pockets of different practice across Birmingham, Solihull and Sandwell which almost indicates a postcode lottery in levels of care in community midwifery. The nature of being linked to specific GP surgeries is likely to be a factor in this, as is the degree to which some midwives have become embedded in the communities they serve. This is an area that would benefit from further research, although Trusts are probably already aware of it.

The transition of care between community and acute unit or MLU settings, particularly postnatally, appears to be an area where communication between professionals can be limited and women who may be experiencing non-medical postnatal difficulties may not be quickly identified.

- **Silo working and communication**

While many midwives cited good team working as an example of good practice in their setting, including good multi-disciplinary working, many also reported that in services that cover large and varied geographical areas, there are incidences of 'silo working', with poor communication between settings which could impact on the quality of care for women at key service transition points. Some community midwives in particular identified transition points as crucial for supporting women in terms of continuity of care. There appears in some circumstances to be a lack of understanding of what other teams do, and how elements of the service could dovetail together more effectively.

Midwives reported that there needs to be better communication across all elements of the maternity service – wards, clinics and the community. Many feel that where rotation to all areas takes place, this appears to be beneficial in increasing understanding and awareness of the range of roles involved in supporting women through a healthy pregnancy and safe birth. There are different views on this, however, some midwives feel that high-risk delivery suites in particular need core staff that do not do more than short rotation periods in other settings, to develop the

necessary expertise, and others dislike rotating all areas because they feel they never get to develop good team working or feel they belong.

Midwives felt that improved internal communication may lead to fewer delays for women and have a positive impact on women's experiences of maternity services.

- **Maternity Support Workers**

Although there is some uncertainty about the possible loss of elements of their role, it is widely acknowledged by the midwives involved in this research that working with Maternity Support Workers, and other support staff, in a team approach is beneficial for both women and staff. Midwives that do not have opportunities to work with Maternity Support Workers, often those in community settings or MLUs, really appreciate the difference they make when they experience it first-hand.

- **Consultant Midwives**

Throughout the research, midwives identified the importance of Consultant Midwives, in promoting normality in different settings, in researching the needs of diverse communities and in accessing and interpreting Public Health data to target midwifery services, for example. Research evidence suggests that there are few of these roles available with local Trusts and that some of them may be under threat during the re-alignment due to the implementation of the current Health reforms.

- **Autonomy and accountability**

There were a range of views expressed about whether or not midwives felt able to exert autonomy. Some midwives felt there were too many rules in place for them to be fully autonomous but only 8 midwives responding to the survey indicated that they would like to be able to be more autonomous in their everyday practice. In interviews, community midwives were generally more satisfied with their levels of autonomy.

Midwives feel they spend a lot of time recording their activities in order to demonstrate what they do and evidence their accountability. They have a clear understanding of the accountability of their professional role, as signified by their registered status, and many are concerned about the risks and consequences of making mistakes, for the patients and for themselves, particularly less experienced midwives. This can create a 'risk adverse' culture but the direction of travel requires midwives to be more confident in assessing risks to ensure women are offered the appropriate choices for their care pathway. Some Trusts recognise this potential conflict and are looking to support midwives to be more flexible in their assessments of women at each stage of their pregnancy and birth journeys. Some are also using CNST proactively to drive up standards of basic midwifery care.

- **Being involved**

Many midwives make time, often out of working hours and in addition to family commitments, to keep up-to-date with policy changes and service developments, to be aware and engaged with the changing environment around them. Many others are focused on supporting women while at work and find that, with working shifts, completing necessary paperwork, mandatory training and their own family care responsibilities, finding time to keep up-to-date is difficult. As a consequence they can feel disengaged from staff consultation processes and under-prepared when new policies and practices come into force.

If midwives are willing and able, it was suggested, to get involved, for instance to find out more about good practice that is happening in other Trusts, and how they might apply it in theirs, it could help to reignite their passion for midwifery and their role in it.

7.2 Recommendations

Midwives who participated in the research made many suggestions for improvements to support their practice and women's care experiences. Some of these are summarised in Appendix 5. Recommendations have been made for the attention of different stakeholders but it is suggested that a collective approach to some issues may be more effective.

Recommendations for provider Trusts

1. Improve communication and team working

There were a number of practice-based suggestions from midwives about how to improve team working and communication that should be implemented:

1.1 Enable more short-term rotation of staff to other settings, including acute unit staff, to foster a better understanding of other midwifery roles and as an aid to professional development, helping midwives retain and extend their skills. Make sure midwives are fully prepared before they work in a new setting; this was seen as particularly important when providing cover at short notice, so that they can operate effectively and with confidence

1.2 Introduce better ways of ensuring effective handovers – someone suggested using role play, theatre groups coming in and internal rotation to enable staff to see things from the point of view of other staff in other areas

1.3 Clarify the role of Maternity Support Workers, with clear training and development processes in place and ensure midwives are informed of MSWs roles and responsibilities

1.4 Recognise and celebrate good practice and compliments with staff, for instance BWH has a 'staff member of the month' award scheme

These measures could help to improve staff morale, enable smoother handovers for women and have the potential to improve women's experiences of maternity care and to reduce complaints.

2. Improving patient pathways

2.1 Trusts should explore an experience-led co-production[84] approach to designing maternity care pathways. One current initiative that may be appropriate for the development of maternity services is the Hospital

[84] *"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and carers. Where activities are co-produced in this way, both services and service users become far more effective agents of change" adapted from NESTA 2010 http://coproductionnetwork.com/forum/topics/what-is-the-definition-of*

Pathways Programme (or Patient and Family Centred Care). This is a model being trialled by a number of Trusts nationally, supported by the King's Fund[85]. It starts with seeing services through the eyes of patients and their families and then through the eyes of staff, to understand all perspectives on a pathway of care. Evidence such as this report and the previous LINks report into women's experiences of maternity services could form a baseline for the process, although it is very much a 'hands-on' experiential learning programme. This approach could be particularly useful in understanding women's experience of postnatal care

3. Skill retention and professional development

There is expertise within Trusts that could be more effectively shared to improve the quality of care to women.

3.1 Community midwives should share their learning of cultural differences with acute unit colleagues to improve the quality of care and to raise awareness of women's expectations in hospital

3.2 Training should be provided that is relevant to midwifery practice, for instance how should safeguarding principles be applied in a maternity context, rather than generic training

3.3 Study time for Continuing Professional Development should be protected and staff cover provided for people on study days

3.4 Open peer support forums could be set up, where for example Band 6's could come together to share good practice

3.5 Regular team meetings should be held with a focus for part of the meeting on cascading learning and professional development

4. Listen to the voices of midwives

4.1 To enable active engagement, Trusts need to listen to the voices of midwives, to really hear what they are saying and give this cohort of extremely experienced professionals the opportunity to be directly involved in shaping the future of services, feeling valued and able to make a genuine contribution

4.2 Relieve the pressures on midwives by investing in effective, accessible IT systems and better equipment

4.3 Enforce 'no tolerance' policies of violence towards midwives and provide lockers to keep their property secure (an issue raised at the feedback session)

[85] For more information about the Hospital Pathways Programme please follow this link
Kings Fund Hospital Pathways Programme

5. Learn from the best

The research identified a number of areas where the Trusts are developing models of best practice that could be shared, for example:

5.1 The expertise developed by HEFT's Specialist Midwife in female genital mutilation (FGM)

5.2 The computerised record-keeping system at BWH, where all observations are written up in real time and accessible anywhere in the hospital

5,3 The award-winning approach to normalisation taken by SWBHT, 'your birth in our home', creating care pathways based on understanding the profile of the population

5.4 The use of CNST in one Trust to drive up standards of quality of care, making a system that is a requirement work better for patients and for Trusts

Commissioners have a role in encouraging the sharing of good practice and promoting collaboration between Trusts for the benefit of the whole population across Birmingham, Solihull and Sandwell.

6. Improving recruitment and retention

6.1 Provider Trusts should consider working together to offer development opportunities for maternity staff, for instance short-term placements in other Trusts to learn from Specialist Midwives, rather than competing for the best midwives. Through the Services Capacity Review they could consider a 'federated' approach to staff development and progression to help keep skills and experience in Birmingham, Solihull and Sandwell

6.2 The population and workforce data analysed for this research shows that the population across Birmingham, Solihull and Sandwell is hyper-diverse but the midwifery workforce is not. The Services Capacity Review could explore and support a shared midwifery recruitment drive in BAME communities to encourage more people from those communities to apply to be midwives

7. Consistency across boundary lines

7.1 The Services Capacity Review provides an opportunity for providers to share their approaches to data collection across the boundaries of the three areas and to consider if it might be possible to either synchronise how they collect the data or agree to share their data, as women do not observe boundaries and patient choice is making the provision of consistent messages and levels of service difficult on the ground

7.2 Trusts should share information about their low-risk and high-risk pathways with each other, and particularly with their respective community teams, so that consistent messages can be given to women, informed choice can be offered and false expectations can be avoided

7.3 In a climate of reducing resources, the Services Capacity Review could consider how resources might be shared to provide support to women accessing services in more than one Trust, to avoid duplication and confusion of purpose

Recommendations for commissioners (CCGs) and Public Health

8. Changing the culture around normalisation of birth

8.1 Commissioners should ensure women have access to good antenatal education so that they are well informed about the benefits of low-risk birth for them and their babies, to help change the culture that sees hospital as the only safe place to give birth

a. CCGs should be ensuring that GPs in their groups are educated about the findings of the Birthplace study and the normalisation agenda, so that they can reinforce positive messages about the safety of low-risk births

b. Public Health should be raising the awareness of the general population of the safety of birth in low-risk settings for women without existing medical conditions or other risk factors, to reinforce the normalisation of birth message with families and through the media

Recommendations for midwives

9. Keep up-to-date

9.1 Midwives can help themselves by taking responsibility for keeping up-to-date on policy and practice developments. They can make good use of the resources accessible through their professional bodies and find out about good practice that is happening in other Trusts and how they might apply it in theirs.

10. Actively engage in service re-design and improvement

10.1 Staff consultation and engagement will not be meaningful if staff do not engage with it. The current climate will offer increasing opportunities for staff to contribute ideas for improving the quality of care for women and their families, and for improving effectiveness and efficiency. Midwives should find the time to get involved and help to make things better for women and for themselves.

Recommendation for new Healthwatch organisations

11. Ensure findings of this research are followed up

11.1 There is a risk in the transition from LINks to Healthwatch that the findings of this research could become lost or deferred as the new organisations bed in. It is important that the impetus behind the research is not lost and that these recommendations are followed up by each of the three new Healthwatch organisations.

Glossary

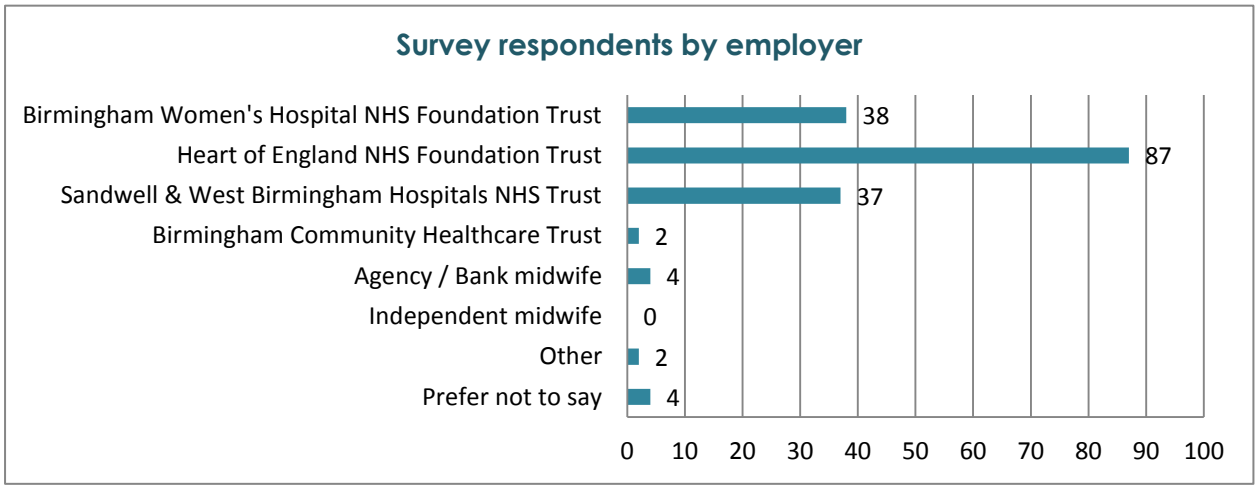
AMLU	Alongside Midwife Led Unit (in hospital next to obstetric unit)
BAME	Black, Asian and Minority Ethnic communities
BWH	Birmingham Women's Hospital Community Trust
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
CNST	Clinical Negligence Schemes for Trusts
CoGS	Community Growth Scanning scheme
CTG	Cardiotocograph is a record of the foetal heart rate
FGM	Female Genital Mutilation
GP	General Practitioner
HEFT	Heart of England Foundation Trust
HIV	Human Immunodeficiency Virus
HSCIC	Health and Social Care Information Centre
ICM	International Confederate of Midwives
Intrapartum	Occurring during labour or delivery
I.T.	Information technology
I.V	Intravenous
LINk	Local Involvement Network
MLU	Midwife Led Unit
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
PCT	Primary Care Trust
RCN	Royal College of Nursing
RCM	Royal College of Midwives
SAMLU	Stand Alone Midwife Led Unit (in the community)
SWBHT	Sandwell and West Birmingham Hospital Trust
UNICEF	The United National Children's Fund
WAITS	Women Acting In Today's Society (A voluntary organisation)

Appendix 1: Project Objectives

- To undertake an independent in-depth and qualitative, study to understand the work performed by the midwifery cadre.
- To explore, understand and describe the factors and issues in the day to day experiences of providing midwifery care in the described localities by the frontline staff.
- To gather qualitative data of the experiences of that workforce in maternity care provision.
- To identify areas of possible improvement based on suggestions by the participants.
- To make recommendations based on the findings, for the purpose of service improvement which will improve outcomes for all mothers and babies.
- To highlight ways in which staff can make a significant contribution to the improvement of Public Health in the local authorities
- To identify between 6 and 10 examples of good practice.
- To provide robust information for the LINks' to use their 'powers' in ensuring a sustainable quality service on behalf of service users.
- To provide qualitative evidence to the ongoing Maternity Workforce Capacity Review, as agreed at their inaugural meeting.
- The consultant will also produce a final report with recommendations for further action and any suggestions for resourcing
- The consultant will make 3 formal presentations of the completed report, the details of which are to be agreed with the LINks.

Appendix 2: Profile of participants

Online survey – valid sample size 181



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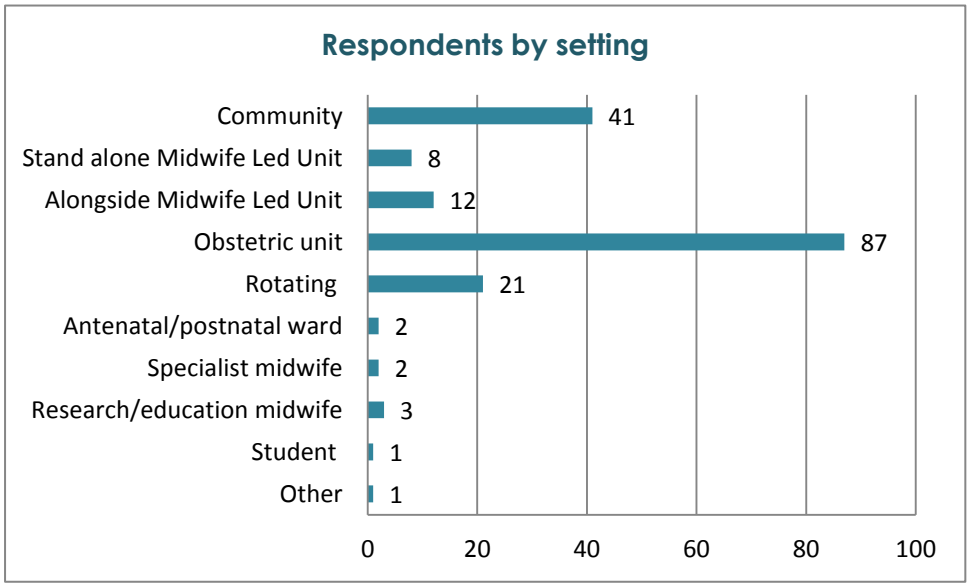

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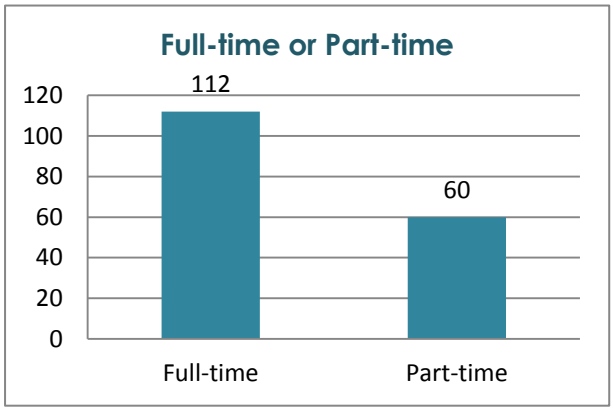

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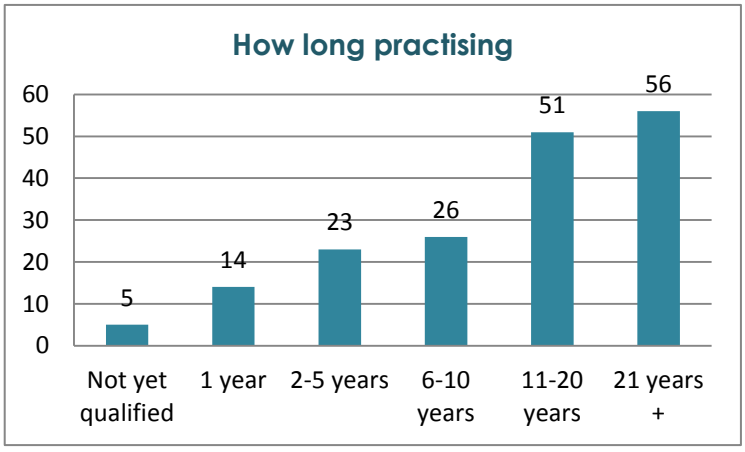

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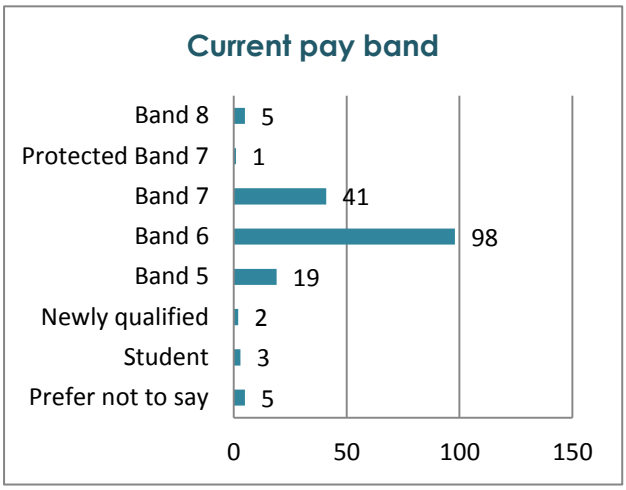

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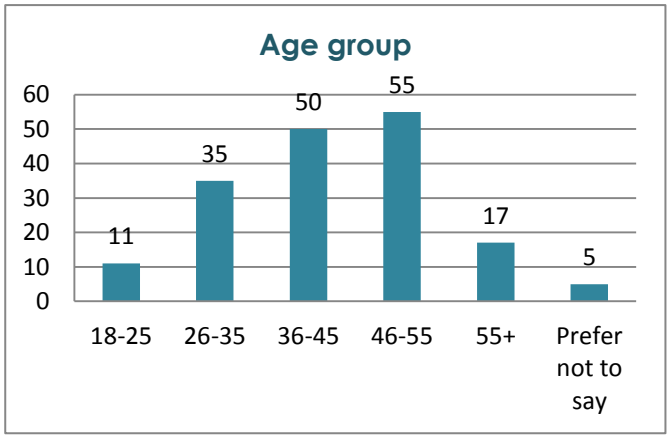
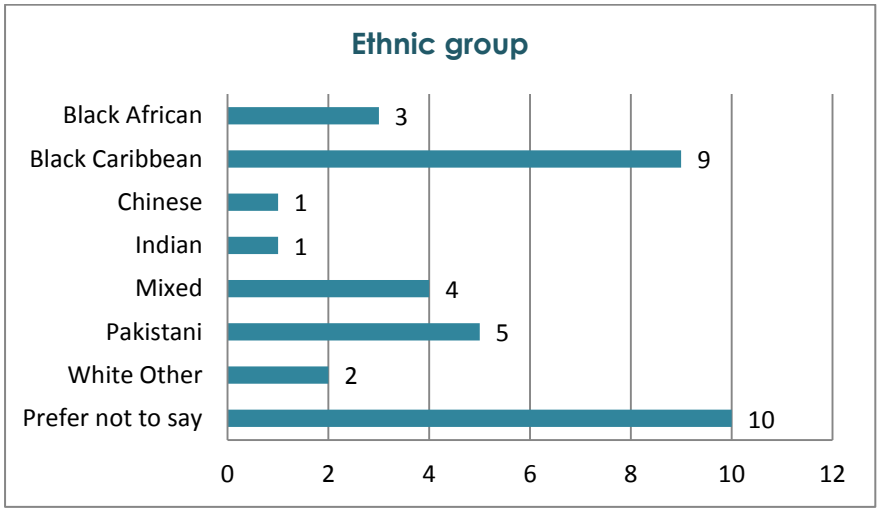


No. responses 173

A majority of respondents (136) identified themselves as White British so the chart below shows the responses of people from other groups.

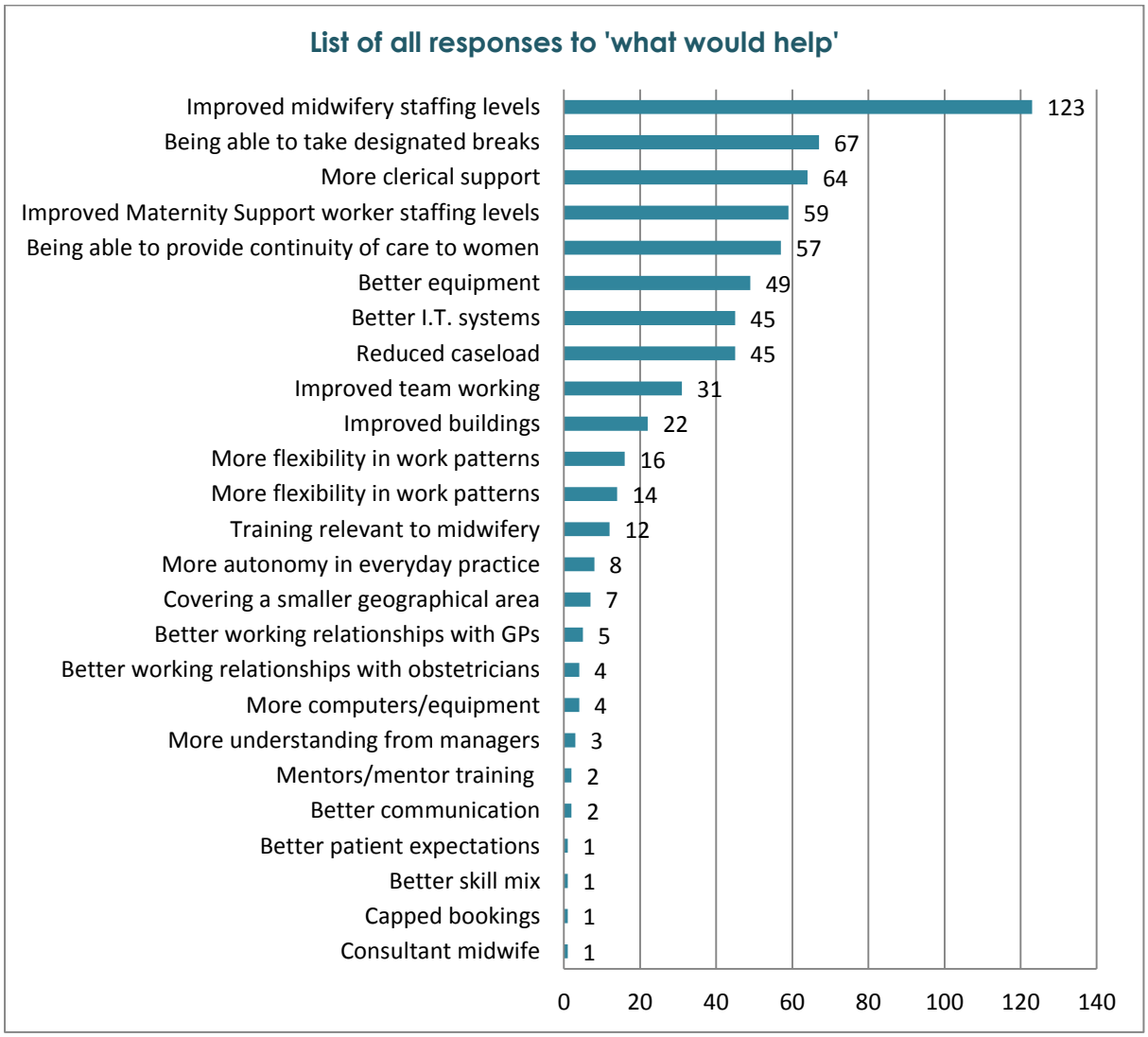


No. responses 171

Profile of midwife interviewees by Trust

Trust	No. Midwife interviewees
Birmingham Women's Hospital CT	7
Heart of England FT	9
Sandwell West Birmingham HT	4

Appendix 3: What would help midwives to carry out their role



No. responses 162 – each midwife could pick 5 things. The bottom 8 suggestions come from midwives completing the 'other' box on the online survey.

Appendix 4: The International Confederation of Midwives (ICM) Definition of a Midwife

"the midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ''midwife'; and who demonstrates competency in the practice of midwifery."

Scope of Practice

"The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.
The midwife may practise in any setting including the home, community, hospitals, clinics or health units."

Revised and adopted by ICM Council June 15, 2011

Appendix 5: Suggestions from midwives and stakeholders

This summary highlights some of the suggestions made during the research mostly by midwives and a few by stakeholders.

- Wider dissemination and discussion of the evidence from the Birthplace research, along with in-house assessment training for low-risk and high-risk pathways, would help to reassure midwives about the safety of low-risk pathways and normality in birth and enable them to develop a more flexible approach to individual women's needs

- NICE guidance is interpreted differently by different providers. This can create confusion for women who could be told one thing by their community midwife and something different by hospital staff. One midwife suggested it would help if providers across the region could use the same criteria, or at least share their care pathways

- Women arriving on labour wards could be re-assessed to see if they are suitable for a low-risk birth in a MLU, if spaces are available, or a labour triage system could assess them on arrival at the unit

- It sometimes happens that women are booked into the MLU but cannot give birth there because there are not enough midwives available to staff the MLU at that time. It was suggested that it might be better, if the alongside MLU is closed, that a woman who is booked in could go to the stand-alone unit instead, within the Trust, or even to another MLU in the region.

- Midwives think there should be more Consultant Midwife roles and they should form part of career pathways for ambitious midwives

- Community midwives in Solihull (part of HEFT) have been involved in achieving a UNICEF Stage 3 accreditation for baby friendly services which sets common standards of care across multi-disciplinary teams. They have also been trained in the Solihull Approach[86] which supports practitioners to work with children and families and supports parents and to understand their child. They would like to see this good practice rolled out across the Trust.

- Midwives want better IT systems, to reduce paperwork and improve access to test results and real time information on the women they support, like the computerised record-keeping system at BWH, where all observations are written up in real time and accessible anywhere in the hospital

[86] For Solihull Approach see http://communityservices.heartofengland.nhs.uk/default.asp?page=376

- Midwives suggested the following as possible solutions to support breastfeeding:
  - Increase in the number of postnatal beds
  - Make sure all midwives complete the postnatal notes section on observing feeding position and attachment prior to discharge
  - Recruit more breastfeeding support volunteers
  - Allocate breastfeeding support workers to labour ward, not just postnatal ward
  - Enable trained Maternity Support Workers in community settings to support breastfeeding women and visit them at home between midwife visits

- Various suggestions were made by midwives to tackle some of the issues faced by vulnerable women:
  - Having clinics at a 'one stop shop' or community hub to enable better multi-agency working
  - Volunteer doulas that support vulnerable women and asylum seekers - a project in Sandwell was identified as a successful initiative by Phillimore and Thornhill (2010)
  - Pregnancy outreach workers who work with women with high social needs – this is currently happening in some parts of Birmingham but not available in all areas

- Midwives identified the following as things that would help manage the increasing expectations on them:
  - A specialist safeguarding midwife to take lead responsibility for Common assessment Framework (CAF) cases
  - Postnatal ward-based midwives having 4 patients each and being able to work with them on breastfeeding, infant bathing, top and tailing and general baby care
  - Community based midwives would like better and easier access to IT systems and equipment
  - Being able to spend more time with the women they are working with, midwives feel that if they were able to spend more time with women that this may help reduce complaints
  - Giving care to the mother and baby as one unit rather than the nursery nurse checking the baby and midwife checking mum