A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person Centred Care at Two Rural Community Maternity Units

Sara Helen Denham

A thesis submitted in partial fulfilment of the
requirements of the
Robert Gordon University
for the degree of Doctor of Philosophy

September 2015

ABSTRACT

Sara Helen Denham
Degree of Doctor of Philosophy

A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person Centred Care at Two Rural Community Maternity Units

Background: This research explores whether rural Community Maternity Units (CMUs) contribute to NHS Scotland's Quality Ambitions of safe, effective and person centred care. Currently there is no available recent evidence regarding the quality of this particular model of care in a rural setting. This research makes an important contribution given that most women are encouraged to access local maternity services.

Design: An exploratory case study was used with a hermeneutic phenomenological approach to the qualitative data collection and analysis. Quantitiative data were collected and analysed to provide descriptive statistics.

Methods: The study was conducted in three phases. In phase one a retrospective medical records review was undertaken to provide quantitative data on the care provided. Phase two was an observation of team meetings, interviews with staff and focus groups with stakeholders in roles aligned to the provision of care at the CMUs. In phase three observations of clinical encounters and interviews with women informed by aide memoire diaries were used.

Findings: Maternity services provided by the CMU teams achieved a consistently high standard of safety and effectiveness when measured against national guidelines, standards and other evidence. The stakeholders appreciated the ability within these small teams to provide local, accessible services to women with effective support when required from tertiary services. The women valued person centred and relationship based continuity of antenatal carer, provided by compassionate named midwives, but were disappointed by the discontinuity when complications occurred.

Conclusions: The CMUs' physical position within the community, smallness of scale and the midwifery team's ethos of normality within a socially based but medically inclusive service facilitated local access for most women to maternity care. This service provision addressed NHS Scotland's Healthcare Quality Strategy of improving health and reducing inequalities for the people of Scotland. The role of the named midwife was key to providing high quality care by maintaining connections across contextual boundaries for women experiencing normal and complicated pregnancies.

This research provides an original contribution to the study of rural maternity service provision in Scotland to help inform future sustainability and service development of rural CMUs.

Keywords: Quality maternity care, rural maternity services, midwife led care, community maternity unit, obstetrician led care, safety, effectiveness, person centred care, case study.

EXTERNAL OUTPUTS

Conference presentations and publications:

DENHAM, S., 2013. Do rural community maternity units contribute to NHS Scotland's Quality Ambitions? *NHS Grampian Quality Event* (Aberdeen, poster presentation, April)

DENHAM, S., 2013. Quality in the community? Do women receive quality maternity care at rural community maternity units? *Doctoral Midwifery Research Society Conference* (University of the West of Scotland, oral presentation May)

DENHAM, S., 2014. Knowing Me, Knowing You. Continuity of carer in Scottish community maternity units. *Royal College of Midwives Annual Conference,* (Telford, oral presentation, November)

DENHAM, S., TAYLOR, R. and HUMPHREY, T., 2015. Using Diaries as an 'Aide Memoire' to Inform Interviews Exploring Women's Experiences of Care at Rural Community Maternity Units: A Discussion Paper (under review)

ACKNOWLEDGEMENTS

I would like to express my thanks and gratitude to all the women and stakeholders who participated in this research and to those who gave permission for the research to be conducted in the chosen community maternity units. I particularly appreciated the enthusiasm and support of the teams at both maternity units who made me so welcome and the research a joy to conduct.

My supervisors, Professor Tracy Humphrey and Professor Ruth Taylor, have been a constant, sustaining source of patience, wisdom and enthusiasm for which I am deeply grateful. I feel very honoured to have had the opportunity to be guided throughout this journey by two such compassionate and inspirational women.

The research degree support team at Robert Gordon University have helped me in so many different ways through expert input, appropriate training and cheerfully answering my questions.

My friends and family, especially my sister Sue, have encouraged me every step of the way and I am so thankful for their calm, unfailing faith in me. They have gently smoothed the bumps along the way and made the entire journey possible.

Special thanks must go to Mike, Charlie, Annie and Catriona who have shown incredible fortitude and patience throughout this journey. They are my daily inspiration and I look forward to having fun with them again.

GLOSSARY OF TERMS.

(Adapted from the Overview Report of the Expert Group on Acute Maternity Services, 2002. pp 49-52 and NHS QIS 2009).

Amniocentesis - A test carried out during or after 15 weeks of pregnancy for fetal abnormality. The test involves the removal of a small amount of fluid from the amniotic sac by aspiration through the abdominal wall, for diagnostic purposes.

Antenatal Care - Care of women during pregnancy by professionals in order to detect, predict, prevent and manage problems with women or their unborn babies. Care also includes education, advice and support.

Audit - The measuring and evaluation of care against agreed standards with a view to improving practice and care delivery.

Caesarean Section - An operation where the baby is delivered through an incision through the abdominal and uterine walls.

Cardiotocograph - A test of fetal well being and uterine contractions. A combination of electro-cardiography and tocography. The fetal heart rate is obtained by a microphone placed on the woman's abdomen or by an electrode attached to the fetal scalp during labour. At the same time contractions of the uterus are measured by a tocograph placed on the woman's abdomen. Both are recorded on a monitoring device.

Community Maternity Unit - A maternity unit, midwife managed, occasionally with GP involvement, which may be a stand-alone unit or adjacent to a non-obstetric hospital or adjacent to a maternity unit.

Competency - Required level of skill and proficiency.

Congenital Abnormalities - An anomaly present at birth.

Continuity of Care - This term is used to describe a situation where all the professionals involved in delivery of care share common ways of working and a common philosophy. The aim being to reduce conflicting advice experienced by women, and the same philosophy of care is experienced by the woman throughout the period of her care.

Continuity of Carer - The same professional providing care throughout a woman's contact with the maternity services. It can also be used to describe the same caregiver throughout a specific episode of care, such as during labour and childbirth.

Demography - The study of statistics on births, deaths and diseases.

European Community Working Time Directive - The Working Time Directive provides for minimum daily and weekly rest periods, annual paid holidays, a limit on the working week of 48 hours and restrictions on night work. It excludes from its scope transport and work at sea.

Fetal - Of the fetus.

Fetus - The unborn baby, usually referring to development from the seventh week of pregnancy until birth.

Guidelines - Systematically developed statements which assist in decision-making about appropriate health care for specific clinical conditions.

Home Birth - This is usually a planned event where the woman decides to give birth at home, with care provided by the midwife. It is normal for 2 midwives to be present for the birth. Occasionally the GP is involved in the care and present at the birth.

Integrated Service - A multi-disciplinary, multi-professional approach to service provision.

Intrapartum - The period during labour and delivery.

In-utero - In the uterus/womb, unborn.

Labour, Latent Phase of Labour - A period of time, not necessarily continuous, when there are painful uterine contractions and there is some cervical change including cervical effacement and dilatation up to 4 cms.

Labour, First stage of labour - The first stage of labour is defined as established when there are regular painful uterine contractions and /or there is progressive cervical dilatation from 4cms.

Labour, Second Stage of Labour - The second stage of labour is divided into active and passive stages. The passive second stage of labour begins with the finding or signs full dilatation of the cervix in the absence of (or prior to) involuntary expulsive contractions. The active second stage of labour begins with expulsive contractions and full dilatation of the cervix, or when the head is visible, or active maternal effort once full dilatation of the cervix is confirmed in the absence of expulsive contractions.

Labour - Third Stage of Labour - The third stage of labour begins with the birth of the baby until the expulsion of the placenta and membranes. It is managed in two ways: physiological management or active management. Physiological management of the third stage of labour is the natural conclusion to a physiological (natural) first and second stage of labour. It involves a package of care that involves three components. The umbilical cord is not clamped until pulsation has ceased (unless separation from the placenta by clamping and cutting the cord is clinically indicated), no oxytocic drugs (to induce a strong and sustained uterine contraction) are used and the placenta is delivered (or birthed) by the mother's efforts. A physiological third stage is considered to be prolonged if the placenta is not delivered within 60 minutes after the time of birth of the baby

Active management of the third stage involves a package of care which involves three components. Oxytocic drugs are routinely given to the mother at the birth, the cord is clamped and cut after a delay (unless this is clinically inappropriate) and the placenta is delivered by the birth attendant using

controlled cord traction. An active third stage is considered to be prolonged if the placenta is not delivered within 30 minutes after the time of birth of the baby.

Lead Professional - The professional who will give a substantial part of the care personally and who is responsible for ensuring that the woman has access to care from other professionals as appropriate.

Maternity Care Team – Women with significant medical, obstetric or social issues have a Consultant Obstetrician as their lead carer, who share the care with midwives, GPs, anaesthetists, diabetologists or endocrinologists, haematologists, cardiologists, neonatologists, neurologists, psychiatrists and allied health professionals (physiotherapists, dieticians, pharmacists etc) as appropriate.

Maternity Services Liaison Committee - A committee set up within a NHS Board area which provides a forum for all the professions involved in the provision of maternity care with representatives of the women who use the services to discuss issues relevant to the provision and development of maternity services in the area.

Maternity Unit - A building or group of buildings in which maternity care is provided. It can be located within, or adjacent to, a general hospital, or away from the general hospital.

Midwife Led Care - Healthy women with uncomplicated pregnancies are offered a midwife as their named lead professional to book, assess and plan and provide their care. The midwife has agreed referral pathways to the wider maternity care team should any complications arise and a dynamic assessment of the woman's progress throughout the maternity journey is carried out in partnership with her midwife.

Multi-disciplinary - An approach combining the knowledge, skills and expertise of a range of organisations and professionals.

Multi-professional - Care delivered by a team of health professionals.

Named Midwife - A named, qualified midwife who will be responsible for planning and co-ordinating women's maternity care.

Neonatal Period - The first 28 days of a baby's life.

Obstetric - The branch of medicine and surgery that deals with pregnancy and childbirth.

Obstetric Unit - A maternity unit situated within a general hospital where doctors and midwives are available.

Postnatal - After the birth.

Postnatal Period - A period not less than 10 days or more than 28 days after the end of labour.

Preterm Baby - Born before the due date (less than 37 weeks gestation).

Primary Health Care - Primary Health Care is health care at the first point of contact with the Health Service, addressing physical, social and psychological problems, but also providing continuity of care. The traditional Primary Health Care Team of General Practitioners working with nursing, pharmacy, administrative and other support colleagues has largely been expanded to include colleagues from other agencies and disciplines relevant to the delivery of care appropriate to the person's needs.

Principles - A code of direction.

Professional - In this thesis, Professional usually refers to those who have been specially trained in health care such as the midwife, the GP, the obstetrician, the anaesthetist, the paediatrician/neonatologist and the health visitor.

Protocol - An adaptation of a clinical guideline or a written statement to meet local conditions and constraints, which has legal connotations.

Resuscitation - The revival of someone who is in cardiac or respiratory failure or shock.

Screening - Mass examination of the population to detect specific illnesses.

Strategy - A plan or a policy to achieve a specified outcome.

Supervisor of Midwives - A statutory function whereby a midwife who has completed the appropriate training is appointed to the role of supervisor of midwives. The role encompasses the provision of support and guidance for midwives, protection of the public, contribution to the regulation of the practice of midwives and promotion of high quality care. Each midwife has a named supervisor.

Telemedicine - Refers to any application of information and communications technology which removes or mitigates the effect of distance in health care - sometimes now referred to as "Telehealth".

Ultrasound Scan - An image created by the use of sound waves above the audible range of the human ear. It is useful in the confirmation of pregnancy, the determination of fetal size and wellbeing.

TABLE OF CONTENTS

TABLES

Figures

Boxes

CHAPTER 1

1.1 Introduction

Chapter 1 begins by exploring how I became interested in the provision of maternity services at rural Community Maternity Units in Scotland, and provides an overall context for this thesis of rural maternity care provision in Scotland. This contextual background provides the reader with an initial concept of whether they can draw conclusions as to the usefulness of the findings in their own contexts. The chapter discusses how current maternity policy directs the quality of care, and how services are now assessed and evaluated against the safety, effectiveness and person centredness of the care provided.

My own questions about the care provided at rural Community Maternity Units (CMUs) began during my research into women's information needs regarding induction of labour (Denham 2011). During that study, I interviewed women who had planned to give birth at their local rural midwife led CMU and were deeply disappointed to have not been able to fulfil these wishes. These concerns were not addressed by the staff at the Obstetric Unit (OU) where the induction of labour procedure took place, and the women were left with an unacknowledged sense of loss which one described as having her birth plan "ripped to shreds in my face" as soon as she entered the OU (Denham 2011).

I was also aware through my work as a midwife in community and tertiary OU settings that the women who are transferred from a CMU to the OU at any stage of pregnancy and during labour, are frequently very keen to have their care transferred back to their local CMU teams as quickly as possible. This intention to return to local community care often contradicted the commonly expressed opinion of the OU staff that the OU is the optimal place for women to receive maternity services. This conflict was explored in Pilley-Edwards' (2005) work on women's experiences of safety regarding home births in Scotland. She found that women viewed safety against a background of accessible medical services in an affluent country where women have

expectations of both their babies and their own survival, in holistic terms of becoming confident mothers by minimising emotional harm. She states that:

"*Women cannot be safe if their concerns are of no concern to those attending them, and if these concerns are likely to be overridden"* (Pilley-Edwards 2005, p.153)

My clinical experience as a midwife led me to hold assumptions about the influences on womens' opinions of rural maternity care. I believed that women who received care at local CMUs valued the provision of locally based, midwife led maternity care. I was also aware that healthcare professionals based at an OU often expressed the opinion despite the growing body of evidence (e.g. Birthplace in England Collaborative Group 2011) that being in a unit where obstetric services were 'on-site' should they be required was the safest way to ensure that women and their babies the safest care. My experiential knowledge differed from the concept that an OU was a place of safety and that rural maternity care was in contrast inherently 'risky'. Local rural maternity services provision at CMUs, also have been constantly under threat of closure for the last few decades. The historical strategic aims for the centralisation of services in large obstetrician led units (Mander and Murphy-Lawless 2013) were powerful inward drivers to draw the women to the providers of maternity services, using powerful arguments of financial viability and safety. The increasing compliance with the centralisation of services was due to several interlinking factors:

- The social and clinical characteristics of childbearing women were becoming more complex
- The General Practitioner was the first point of contact in pregnancy at the time, and would frequently direct women in their first pregnancy to an obstetrician led unit as a 'safe' option for maternity care
- Societal views of risk.

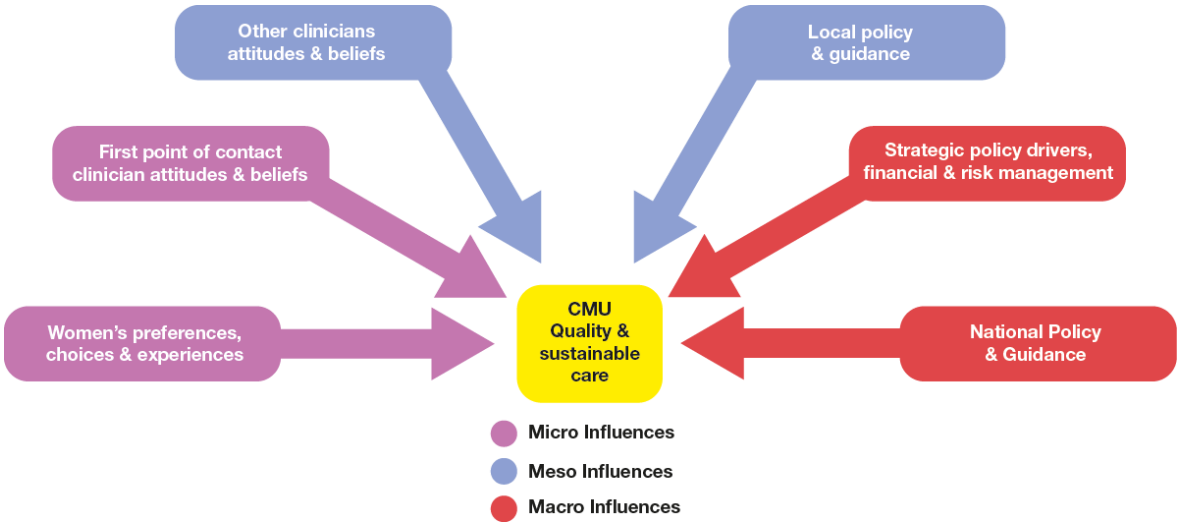
There seemed to be some anecdotal evidence that where strong representation of women's opinions and experiences had been made, local communities could influence women's use and the sustainability of their CMUs.

The use and sustainability of CMUs appeared to be complex and multifaceted and a better understanding of the quality of care provided at CMUs seemed to be necessary to inform the decisions of women and maternity care providers about the quality and ultimately the sustainability of the maternity services provided at local, rural CMUs. This could ultimately inform policy makers and service planners about the design and sustainability of maternity services in rural areas.

1.2 Initial Development of the Conceptual Framework

An initial conceptual framework was based on my existing knowledge and experiences, and an awareness of the available evidence that maternity service provision at rural CMUs was likely to be influenced by the women's preference for care nearer home with midwives they knew. I was also aware of the financial imperatives to streamline services so that the women travelled to the care providers in what was deemed to be a place of safety, just in case complications arose, and the increasing rates of complications in pregnancy (Maternity Services Action Group 2011) making the numbers of women clinically eligible to access rural midwife led maternity care potentially unsustainable (Figure 1).

Figure 1. Initial Conceptual Framework of Influences on the Use and Sustainability of CMUs



Scotland has a range of communities from the very remote to urban, each with a wide range of maternity care requirements which present complex issues in the provision of maternity services. Each provision of local maternity care has to facilitate access for all women, including those in areas of concentrated poverty and disadvantage, and those within a very dispersed population in some rural areas (Expert Group on Acute Maternity Services 2002). Women throughout Scotland have a wide range of needs in pregnancy and childbirth which different models of maternity care are striving to meet. This thesis explores the contribution that rural Community Maternity Units in Scotland make to NHS Scotland's Quality Ambitions (Scottish Government 2010) of safe, effective and person centred care.

Current expert guidance from the Royal College of Obstetricians and Gynaecologists (2011a) and the Royal College of Midwives (2014a) and the National Institute for Health and Care Excellence (2014), all encourage women with normal, uncomplicated pregnancies to access community based models of midwife led care for their labour and birth. The evidence base for these guidelines relates to comparisons of predominantly urban birth settings in England and there appears to be little evidence available about the quality of the care during the antenatal, birth and post birth periods available within the Scottish Community Maternity Unit (CMU) model for most women following obstetrician and midwife led care pathways.

1.3 Community Maternity Unit Model of Care

In Scotland, Community Maternity Units (CMUs) contribute mainly to pregnancy and post birth care, as well as providing care during labour and birth for some women with uncomplicated pregnancies (Tucker et al. 2010, 2006). The vast majority of care offered at CMUs aims to provide community based ante natal and post birth care from an initial early pregnancy assessment visit to post birth care for most women who access maternity care (EGAMS 2002). The choice of care venue and lead professional remains with the women, although clinically appropriate care pathways (NHS Quality Improvement Scotland 2009) are recommended to each woman depending on her individual needs. EGAMS (2002) published a tiered framework of the

options for care during labour and birth available in Scotland to meet the needs of Scotland's range of different communities, which is shown in Table 1.1

Table 1.1 Levels of Intrapartum Care in Scotland

	Location of Birth	Lead carer	Clinical Situation	Care need and delivery
1a	Home (planned)	Midwife	Normal pregnancy and labour	Suitable home facility with back-up from Scottish Ambulance Service (paramedics) and supporting advice from linked maternity unit.
1b	Stand alone Community Maternity Unit	Midwife	Normal pregnancy and labour	Appropriately equipped midwifery unit for normal care with agreed transfer guidelines to a linked maternity unit.
1c	Community maternity unit adjacent to non-obstetric hospital	Midwife	Normal pregnancy and labour	As 1b above. Medical staff (surgeon/GP) appropriately trained to perform emergency caesarean section
1d	Community Maternity Unit adjacent to maternity unit	Midwife	Normal pregnancy and labour	As 1b above
11a	Consultant led maternity unit with no neonatal facility	Consultant Obstetrician (plus midwife)	Low-risk pregnancy and labour	Maternity care with monitoring facilities and anaesthetic cover with no access to paediatric facilities on site.
11b	Consultant led maternity unit with on site neonatal facility	Consultant Obstetrician (plus midwife)	Low to medium risk pregnancy and labour	Maternity care unit with monitoring facilities, access to anaesthetic and paediatric cover, but transferring out as required to special care baby unit or neonatal intensive care in larger maternity unit.
11c	Consultant led unit maternity unit	Consultant Obstetrician (plus midwife)	Low and most high risk pregnancies and labour	Full maternity unit and support services with easy access to special care/neonatal intensive care and access to adult high dependency and adult intensive care.
111	Consultant led specialist maternity unit	Consultant Specialist in Fetal Maternal Medicine	Complex and high risk pregnancies	As for level 11c but with on site neonatal intensive care and access to neonatal surgery and adult intensive care.

(Adapted from EGAMS 2002 p.15)

Quality in maternity care was highlighted in the Changing Childbirth report (Department of Health 1993). This emphasised that the requirements of continuity of care (notably not carer) and women's choice over the place and type of birth and control over interventions in labour, were essential in achieving high quality care maternity services. The concept of woman centred care by establishing continuity, choice and control over their own care was seen as essential in the aim of reducing inequalities and improving safety in maternity care for all women. Subsequent maternity and early years policies, for example in Scotland the Framework for Maternity Services in Scotland (Scottish Executive Health Directorate (SEHD) 2001) and the Refreshed Framework for Maternity Care (Scottish Government 2011), and Getting it Right for Every Child (Scottish Government 2012) build on the premise that high quality maternity care is an essential precursor to maximising every child's chance to reach their full potential based on their emotional security, physical health and relationships as they grow.

The need for quality care clearly underpins maternity and early years strategies and policy direction. Current service provision is assessed and evaluated against quality indicators, which in Scotland were defined by the NHS Scotland Quality Strategy (Scottish Government 2010) as safe, effective and person centred care. Maternity care delivered by midwives in collaboration with obstetricians is based on the principle that

"*Every woman needs a midwife, and some need a doctor too*"
(Sandall 2012, p.323)

The quality of midwifery care delivered to women would appear to be integral to the quality of the maternity services received by women (Royal College of Midwives 2014b), whether they require the input of an obstetrician during their maternity journey or not. Midwifery care for women on midwife and obstetrician led care pathways is provided at rural CMUs, but little is known from the existing literature about the quality of that care provision, in terms of the safety, effectiveness and person centredness. Evidence regarding the rural CMU model of maternity care provision is not only important in order to assess

and evaluate the quality of care provided, but to inform the sustainability of accessible local maternity services against a background of less than 3% of Scotland's annual births occurring at CMUs (Information Services Division 2014), and the financial constraints and demands for greater efficiency across the UK. The study described in this thesis was an opportunity to generate evidence about the quality and sustainability of maternity service provision at rural CMUs.

CHAPTER 2: LITERATURE REVIEW

This chapter presents a review of the literature relating to rural maternity services focussing on the historical perspective of rural maternity units and the geographical context of rural maternity service provision. The concept of social capital is then briefly introduced within the context of the relationships required to provide rural maternity care, and NHS Scotland's Healthcare Quality Strategy (Scottish Government 2010) Quality Ambitions are explored.

The literature review focussed on midwife led models of care. The literature was searched systematically for studies published in English between 2004 and 2014 in peer-reviewed journals (including seminal works) using the key words and search engines and databases shown in Table 2.1.

Table 2.1 Literature Review Strategy

Database	Search Terms (used individually and in combination)
The Cumulative Index of Nursing and Allied Health Literature (CINAHL)	Midw*
Sage Journals Online	Midwife led care
Maternity and Infant Care	Continuity
Intermid	Person Cent* Care, Patient Cent* Care
Internurse	Woman Cent* Care
Science Direct	Relationship based care
Maternity and Infant Care	Safe*
Web of Science	Effective*
Cochrane Library	Quality
PsychArticles	Rural Maternity Care
SocIndex	Birth Centres
Internet sources:	Freestanding Midwife led Maternity Units
Google,	Models of Maternity Care
Google Scholar,	Interprofessional Collaboration
Metalib,	Multidisciplinary
UK and Scottish Government	Maternity*
Websites	
Book Review	
Expert Documents and Websites: Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, National Institute of Health and Care Excellence, Scottish Intercollegiate Guidance Network.	
Grey Literature: Open Air PhD Thesis repository, unpublished material (verbal communications, e-mail advice)	

2.1. Historical Perspective

In the 1900's, most women gave birth at home. By the 1920's concerns around insanitary conditions and the high rates of maternal mortality led to a drive by the medical profession to encourage women to give birth in hospital (Campbell and MacFarlane 1994).

The advent of the National Health Service in 1948, allowed every woman access to care that had previously only been available to a privileged few. The Peel Report of 1970 of the Standing Maternity and Midwifery Advisory Committee (Department of Health and Social Security (DHSS) 1970), further reinforced the trend towards hospital birth by recommending that:

> *"The resources of modern medicine should be available to all mothers, sufficient facilities should be provided to allow for 100% hospital deliveries"*

(DHSS 1970, para. 248)

This report was followed in Scotland by the 1973 Tennant Report (Scottish Home and Health Department (SHHD) 1973) making the same recommendations for 100% hospital births. Both reports suggested that birth should be regarded as normal only in retrospect and that the ultimate clinical responsibility for all women should be in the hands of a consultant obstetrician. This eroded the role of the midwife as the expert in the care of normality. Hospital facilities, which were essential for some women due to antenatal, intrapartum (during labour and birth) or postnatal complications, were then seen as essential for all women. Therefore when women did give birth without intervention in the process, and made an uneventful post birth recovery, normality was perceived as a retrospectively allocated surprise (Kightley 2010).

Twenty-two years after the Peel Report (DHSS 1973), 99% of all births took place in an obstetric unit within a general hospital. A statistical increase in the number of inductions of labour, episiotomy, operative delivery and caesarean section (Edozien and Mellows 2010), led to a House of Commons Select

Committee investigation which concluded that the previously endorsed policy of encouraging every woman to give birth in hospital could not be justified on the grounds of safety (House of Commons Health Committee 1992).

The Provision of Maternity Services in Scotland: a Policy Review in 1993 (SHHD 1993) also signposted a move towards woman centred care, and midwifery training entered a new era by moving away from nurse conversion courses to a three year direct entry programme diploma in midwifery with the training emphasis moving from pathology to normality. In 2008 the diploma programme moved on to a full graduate degree programme equipping midwives to fully meet the challenge of the role of lead maternity professional in normality. The Scottish Executive Health Directorate (SEHD) subsequently published A Framework for Maternity Services in Scotland in 2001, setting out a vision for maternity services in Scotland, which provided a template for best practice in maternity care (SEHD 2001). It aimed to ensure that pregnant women received care that was not only comprehensive and clinically effective, but also family centred, locally accessible, midwife managed and based on joint working between primary, secondary and tertiary services. The following year (2002), in response to representation from the Royal Colleges of Midwives and of Obstetrics and Gynaecology, the Minister for Health and Community Care set up an Expert Working Group on Acute Maternity Services (EGAMS). This expert group was established as a short term working group of stakeholders in maternity services and healthcare professionals to consider how the Framework for Maternity Services (SEHD 2001) should be applied in practice in response to pressure from women to facilitate the provision of birthplace choices (National Childbirth Trust 2011) and the slow implementation of the Framework for Maternity Services. One of the EGAM's key findings was that the role of midwife led care and local service provision were instrumental in implementing the vision of the Framework for Maternity Services (EGAMS 2002).

After a century of maternity services in Scotland being based on less than compelling expert evidence and government initiatives, women are now encouraged to make their own decisions regarding where to access care throughout their maternity journey. In order to inform these decisions, women

need evidence of the quality of the options they are presented with, as turning the tide of the "just in case" and "place of safety" opinion may prove to be an extremely difficult proposition (Warwick 2012). The large body of quality evidence that women with a normal pregnancy giving birth on an obstetric unit do not appear to have statistically better outcomes for themselves or their babies but increases their exposure to obstetric intervention (Walton 2012; Hodnett et al. 2012; Birthplace in England Collaborative Group 2011; Hatem et al. 2009) has now been accepted in England by the National Institute for Health and Care Excellence (NICE 2014). The revised intrapartum guidelines released in December 2014 encouraged women anticipating a normal labour after an uncomplicated (low risk) pregnancy, to access midwife led care during labour in an attempt to encourage the estimated 45% of women clinically eligible to access midwife led care at a local maternity unit or at home (NICE 2014).

2.2 Geographical Context

In the North of Scotland where 23% of the population live on 50% of the total landmass of Scotland (Tucker et al. 2005), women and stakeholders face distinct challenges in the choices and provision of maternity services. In 2007, the Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH) (SPCERH 2007) funded a study that aimed to implement and evaluate service redesign to enhance the sustainability of remote and rural maternity care models in Scotland.

Tucker et al. (2010) used data gathered during the SPCERH (SPERH 2007) study to address the gap in the evidence regarding the performance of these units, by assessing clinical appropriateness and outcome indicators for three rural models of care available at the time, one model being midwife led care. The findings were that the care provided was generally appropriate. However only 36% of women living in the catchment area of CMUs actually gave birth there, and this still resonates with recent evidence that less than 4% of all births in Scotland in 2013 were in rural stand alone, (level 1b in Table 1.1) CMUs or at home (Scottish Confidential Audit of Severe Maternal Morbidity 2014).

Pitchforth et al. (2008, 2009) also used part of the SPCERH (2007) study data to explore the perception of choice for women who live in rural areas over their place of giving birth. Their conclusions were that women frequently chose to travel to an Obstetric Unit (OU), because they saw the OU as a place of safety, based on both quantitative results from validated questionnaires and qualitative focus groups with women. These studies appear to emphasise the contextual influences on rural women's decision making on where to give birth in order to achieve a safe birthing experience. In England, Rogers et al. (2011) found that the majority (62.8%) of women in urban locations preferred the option of giving birth at midwife led stand alone birth centres. The reasons given for this choice were accessibility within the urban environment, along with the homely environment, the higher likelihood of a natural birth and the availability of birthing pools.

Studies of rural midwife led maternity care provision outside the UK, mainly in Denmark (Overgaard et al. 2011), Finland (Mander and Melender 2007), Sweden (Gottvaal et al. 2011) and New Zealand (Skinner and Foureur 2010) all conclude that maternity care in this context is at least as safe as care in an OU. In addition, significant advantages in the provision of person centred and effective care can also be demonstrated in these settings. A British Columbian exploratory study (Kornelson and Grzybowski 2012) took the concept of safety a step further and stated that the removal of maternity care provision from the community, however rural, and the restriction of options for women deciding where to give birth, created significant economic and social consequences for the women, their babies and their families.

The recent Birthplace in England Collaborative Group (BECG) study, published in 2011, explored the safety and cost effectiveness of maternity services in four settings and collected data on the labour and birth outcomes of a highly defined sample of women in predominantly urban locations who were experiencing normal, uncomplicated pregnancies (BECG 2011, Schroeder et al. 2011). One of the criticisms of the Birthplace study was its lack of evidence on safety in relation to the distance in travel time should transfer to a referral unit be required. A study from the Netherlands (Ravelli et al. 2010) found that transfers taking over 20 minutes were associated with poorer neonatal

outcomes. However, the study by Ravelli et al. (2010) has been criticised regarding the mode of transport and actual time taken for transfer, as only 3% of women requiring emergency referral to Consultant (OU) units were transferred by appropriate emergency transport (Nair and Hawkins 2011).

The rural CMU model of care as part of the maternity service provision for women has been overlooked in UK studies of rural care to date and reveals a gap in the evidence. The collaborative relationships required within this rural maternity service provision between the midwives and the women, and the wider maternity care team, according to Kirkham (2010) need to be based on reciprocity and trust which are strongly associated with social capital (Putnam 2000). Kirkham (2010) recognised the potential of midwives to enhance social capital by facilitating the development of social networks, support and resources within a community. Farmer et al. (2003) suggest that health professionals in rural communities have a high level of interaction with their local communities, and with external resources that are useful to the community and so are likely to be important contributors to building social capital. This is discussed more fully in Chapter seven.

The geographical context of the North of Scotland has changed considerably since the 2007 SPCERH study, particularly regarding the improvement of the supporting infrastructure leading to reduced transfer times (Transport Scotland 2013). The economic climate has also changed, and Scottish Health Boards have been challenged to make considerable financial savings which have led to the reconfiguration of many services, including maternity, against a backdrop of falling birth rates (Information Services Division 2014) requiring rural services in particular to justify their sustainability in the current climate (NHS Grampian 2012). Whilst there is a growing body of evidence around midwife led care specifically during labour and birth in predominantly urban contexts, there is no recent evidence in the literature of any exploration of the broader context of services provided to most women at CMUs in relation to the Quality Ambitions (Scottish Government 2010) of safe, effective and person centred maternity care.

This thesis aims to fill by exploring the contribution rural CMUs make to the provision of safe, effective and person centred maternity care, paying particular attention to women's perceptions of their options and subsequent decision making regarding their chosen place for giving birth.

2.3 Current Policy Context

The National Framework for Maternity Services in Scotland (SEDH 2001) and the Expert Working Group on Acute Maternity Services in Scotland (EGAMS 2002) both recommended the development of supported local access to midwife led maternity care, but there was little evidence available at the time about the performance of rural maternity units. This concurs with recent evidence that only 2.9% of births in Scotland in the year ending March 2013 were in rural (freestanding) CMUs (Information Services Division 2014). Although it is difficult to determine exactly how many women in an obstetric unit would have been clinically eligible to give birth at a midwife led CMU, as this data is not currently recorded by Health Boards, only very small numbers of the women who are eligible to give birth in a CMU choose to have their babies there.

The Refreshed Framework for Maternity Care (Scottish Government 2011) demonstrates how the Healthcare Quality Strategy (explored in section 2.2.5, p.18) applies to maternity services, in response to a then steadily rising birth rate (4.3% in 8 years) for women accessing maternity care with increasing social and medical complexities. Pressures from workforce changes have also occurred. Firstly with the reduction in doctors working hours since the adoption of the European Working Time regulations in 2004, and secondly the increase in part time working patterns, with a concurrent increase in the age profile of the workforce.

One of the key driving forces for The Refreshed Framework for Maternity Care is to reduce inequalities in maternal and infant outcomes at birth. This builds on the Scottish Government initiatives of Better Health, Better Care: action plan (NHS Scotland 2007) and The Early Years Framework (Scottish Government 2009) in recognising the first years of life as fundamental in

influencing the lifetime health outcomes of the most vulnerable in the population of Scotland. The Refreshed Framework acknowledges that early and sustained access to local maternity services during pregnancy allows a window of opportunity, when pregnant women are highly motivated to ensure the best outcomes for their babies. They are then more likely to engage with and respond to behavioural change or modification support and information, including intentions in relation to breast feeding (Scottish Government 2011). A clear way is seen of reducing health inequalities by tailoring services to reach women known to be at risk of poorer outcomes by actively engaging and co-ordinating collaboration with wider early years services.

Early access by all women in pregnancy for ongoing dynamic assessment of their health and social needs is seen as a pre-requisite for quality care. Early access to antenatal care has also been a key Scottish Government (2014) Health improvement, Efficiency and governance, Access to services and Treatment appropriate (HEAT) target which requires that:

> *"At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours."*

(Scottish Government 2014, Antenatal Access p.1)

This target is currently part of the strategic priority areas for NHS Boards performance standards for local delivery plans for 2015 – 2016. By March 2013, in the poorest performing Scottish Index of Multiple Deprivation (SIMD), the 80% target had not been reached at national level and only 74.6% of women had booked for antenatal care by 12 weeks (Scottish Government 2014). The SIMD was developed by the Scottish Government (2012) to identify small areas of deprivation throughout Scotland in a consistent way. Its aim is to allow the effective targeting of policies and funding by ranking small areas known as datazones of approximately 350 households. The datazones are ranked based on a weighted combination of data in the domains of current income, skills and training, employment, health, education, housing, geographical access and crime.

The determinants of health are complex and as stated in the Scottish Government HEAT target performance update for 2014,

> *"The first two trimesters following conception are vitally important. They are periods of significant fetal development, and are when fetal development is most vulnerable to the impact of adverse maternal biopsychosocial circumstances. For example maternal stress, use of tobacco, drugs and alcohol and poor nutrition."*

(Scottish Government 2014, Antenatal Access p.1)

The drivers of the Maternity Services Action Group's Refreshed Framework for Maternity Care (Scottish Government 2011) were emphasising the need to measure improved access, care and experiences for all women throughout their maternity journey, using women's experiences to drive service improvement, and to strengthen networks to improve collaboration between maternity services to tailor the right care for each woman every time. These drivers identified in the Refreshed Framework for Maternity Care (Scottish Government 2011) aim to build on the work of the Keeping Childbirth Natural and Dynamic programme and the Quality Improvement Scotland (QIS) maternity care pathways (NHS QIS 2009).

In its ten principles for maternity care, the Refreshed Framework aims to provide an overarching structure to facilitate the planning and provision of high quality and outcome focussed maternity services. This applies whatever the geographic and demographic challenges of the communities they serve may be.

2.4 NHS Scotland Healthcare Quality Strategy

The NHS Scotland Healthcare Quality Strategy (2010) (HQS) aims to maximise the contribution of NHS Scotland to the creation of sustainable economic growth by improving health and reducing inequalities across the Scottish population. It was built around the priorities of: caring; compassion; communication; collaboration; clean and safe environments; continuity and

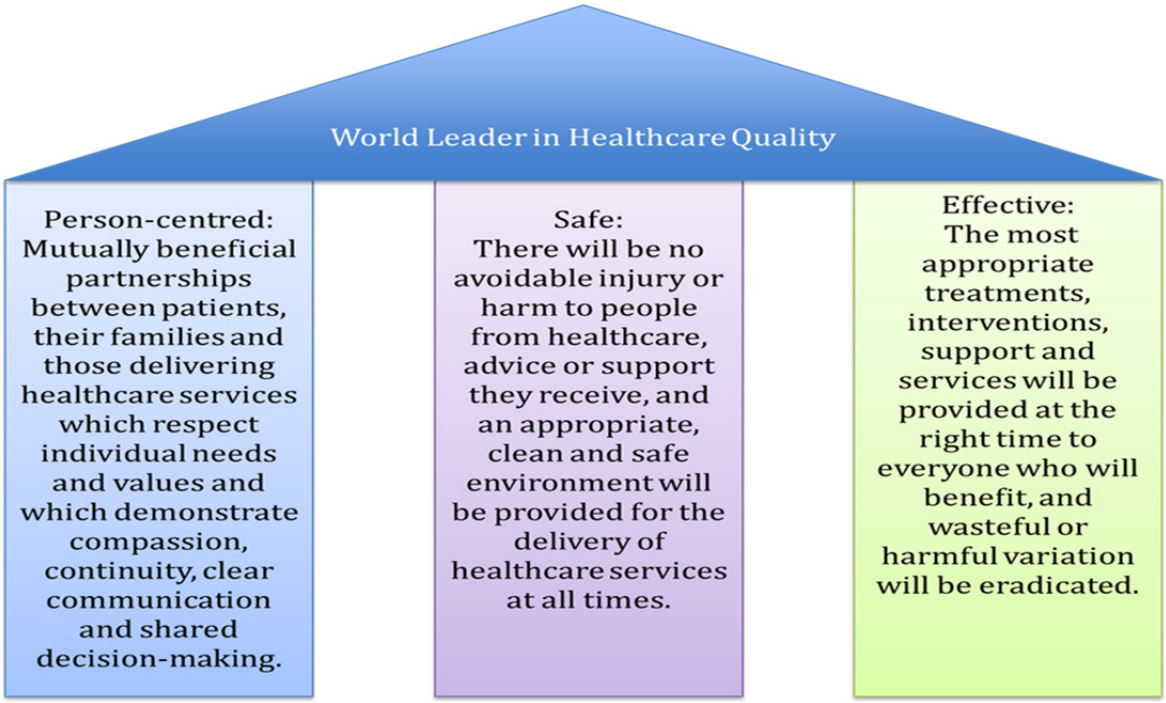
clinical excellence, to be delivered consistently in each one of the vast number of everyday care encounters.

The Quality Ambitions (Figure 2.1 p.20), were developed as a focus for all the activity planned to support its ultimate aim 'to deliver the highest quality healthcare services to people in Scotland ' (Scottish Government 2010 HQS p.21). The Quality Ambitions were developed during consultations with NHS Scotland staff, patients and carers, using the six key internationally recognized dimensions of healthcare quality by the Institute of Medicine (2001): person-centred; safe; effective; efficient; equitable and timely. The six dimensions of quality were developed in response to the growing requirement to provide collaborative care for the increasing number of people living with a number of co-existing long term conditions in a health service developed primarily to respond to acute episodes of ill health. The Institute of Medicine committee aimed to develop healthcare organised to bridge the gaps in the current provision of healthcare, and to cross the chasms in the predicted healthcare needs in the future.

The HQS (Scottish Government 2010) offers the three domains of safe, effective and person centred care into which the aspects of efficient, equitable and timely care, which were considered discrete domains in the Institute of Medicine's (2001) model, have been incorporated. As sustainability of the NHS in Scotland was a particular driver for the HQS, criticism of the omission of the dimension of cost-effectiveness could also be made. The HQS (Scottish Government 2010) was based on consultation with the people of Scotland, rather than established theoretical underpinnings and a further critique could be made that the HQS was launched without the provision of valid measurement tools. This lack of an appropriate framework to assess the quality of care provision was recognised and consultation has recently begun by Healthcare Improvement Scotland (2015) towards a comprehensive approach to reviewing the quality of care provided. This consultation acknowledges the importance of the roles that leadership, governance and the workforce play in improving the infrastructure supporting the delivery of safe, effective and person centred care with particular emphasis on independent, objective scrutiny of local systems of healthcare delivery.

The three Quality Ambitions described in the HQS are shown in Figure 2.1 and then individually explored in detail.

Figure 2.1 NHS Scotland's Quality Ambitions (Adapted from: The Scottish Government 2010)



2.4.1 Quality Ambition 1 – Person Centred

Interest in the concept of person centred care began in the context of caring for people living with dementia. Kitwood (1997) published the theory that viewing people with dementia purely in medical terms of disease symptoms and process made those people become objects rather than people with subjectivity and personhood. Personhood is described by Kitwood as:

> *"The standing or status that is bestowed on one human being by another in the context of a relationship and social being"*

(Kitwood, 1997 p.8)

Person centred care is seen, therefore, as more than simply individualized care, a person's and social identity is respected by what is said and done with them. For Kitwood, communication is the key to the person centredness of the

care given, but communication can be used in malign (or through 'malignant social psychological') ways, notably by treachery or objectification. Treachery means using deception to manipulate or gain control over a person's decisions or actions. Objectification refers to treating a person as though they have no opinions or feelings, merely a vessel for another purpose. These terms are familiar in studies of women's experiences in maternity services (Walsh and Devane, 2012; El Nemer et al. 2006). In Marshall et al.'s (2012) exploration of patient's views of person centred care, attentiveness of the staff and feeling involved in their own care as 'part of the team' were important in the provision of person centred care, but the overarching view was that connections between the staff and the participants was essential. This connectedness was important on a human level, regardless of roles and assumed power imbalances, based on mutual respect for one another.

Person centred care is described by McCormack and McCance (2010) as:

> *"Care which is concerned with: treating people as individuals; respecting their rights as a person; building mutual trust and understanding and developing therapeutic relationships."*

(McCormack and McCance 2010 p.1.)

It has however been recognised that translating these core concepts of person centred care into practice can be challenging (McCormack and McCance 2010). Healthcare Improvement Scotland set up a Person Centred Health and Care Collaborative in 2011, as a key part of a national programme of Health and Social Care service improvements. This brought stakeholders together to develop evidence-based interventions to provide practical improvements to person centred care and the five key 'Must do with Me' areas, shown in Table 2.1

Table 2. 1 Person Centred Collaborative Key 'Must Do With Me' Areas

'Must do with me'	Person Centred Practice
What matters to you?	Personal preferences, priorities and goals are discussed and form the basis of care and treatment.
Who matters to you?	Identify the people who matter most and give them the opportunity to be involved according to the person's wishes.
What information do you need?	Information to support informed decision making to achieve personal goals taking into account each person's wishes, priorities and preferences.
Nothing about me without me	The opportunity to be involved in communication about them between professionals and have their contributions acknowledged and valued.
Personalised Contact	Flexible timing and methods used to access services and resources adapted to individual needs.

(Healthcare Improvement Scotland, People at the Centre of Healthcare 2011 p.2)

These five areas aim to ensure that all interactions between staff and service users are based on compassion, respect, listening and dignity. The Healthcare Quality Strategy (Scottish Government 2010) definition of person centred care includes relationship based care as a pre-requisite in the provision for this by describing 'mutually beneficial partnerships' and the concept of choice, control and continuity of carer. Leap's (2009) description of woman centred midwifery implies that the maternity care provided incorporates six key aspects.

- Focus on the woman's individual needs, aspirations and expectations.
- Recognition of the woman's need for choice, control and continuity from a known caregiver.
- Inclusion of the needs of the woman's family, the baby and other people who are important to her as defined by the woman herself.
- Address and respect the woman's own social, emotional, physical, psychological, spiritual and cultural needs and expectations.
- Respect the woman's expertise in decision making about herself.

- Ensure these aspects of care follow the woman across the interface of community and tertiary (acute OU) settings.

The last aspect of woman centred care particularly encapsulates where these aspects align with person centred care, where the importance of each and every encounter is based in these principles, wherever they may occur. The 'must do with me' considerations and Kitwood's work were developed for use in service provision for older people, whilst Leap's (2009) woman centred concepts were developed to assist maternity service provision. The commonalities of these provide the key concepts of person centred care which are respect for individual needs and values within a mutually beneficial relationship which holds relational, informational (timely availability of relevant information) and management (communication across teams) continuity at its' core. Healthcare Improvement Scotland (HIS) (2014) has the responsibility for monitoring the provision of person centred care, and plan to do this by monitoring three areas of service provision: firstly the provision of care in partnership with people using services, secondly the treatment of people using services with dignity and respect and thirdly the provision of care in partnership with other core services. These areas are explored through specific objectives in this study of maternity service provision at rural CMUs.

2.4.2 Quality Ambition 2 – Safe

Research exploring the factors influencing women's choices about where to give birth (for example Coxon et al 2014; Hoang et al 2014; Grigg et al 2014; Rogers et al 2011; Pitchforth et al. 2008, 2007; Mander and Melender 2007), has predominantly found that the strongest influence is that of women's concepts of safety. Choosing an OU birth was seen by some women, who saw birth in terms of a risk laden process, as a method of mitigating their own risk and increasing the safety for their baby by accessing a tertiary unit birth. Those who chose to give birth in a midwife led unit saw safety in terms of proximity to home and the ability to maintain control over their environment with the option to transfer to an OU should complications arise. Houghton et al. (2008) found that the influence of the women's partners and the attitudes of the obstetricians and midwives were found to be crucial to women's final decisions on where to give birth. Tucker et al. (2006) also found in Scotland

that barriers to women choosing rural, freestanding midwife led units for labour and birth were on the grounds of safety, relating to concerns about the possibility of transfer in labour and the availability of specialist medical services and choice regarding restricted pain management options. CMUs are associated with safe clinical outcomes as endorsed by the Birthplace study (BECG 2011), but they also have strong associations with maternal satisfaction (Walsh 2007; Kirkham 2003), particularly by socially marginalised women and those from different cultures (Briscoe and Lavender 2009).

Safety in maternity care is often evaluated in terms of the risk of adverse outcomes for mothers and babies, in an attempt to quantify the risk of one care setting over others in matched cohorts of women to assist decision making about where to access care in labour as used by BECG (2011). Safe outcomes have a significant impact in the organisation and provision of maternity care, but the relevance of reported outcomes differs for each woman. This depends on whether her particular concept of childbirth is aligned with a medical or social model of maternity care (Grigg et al. 2014; Coxon et al. 2013). The two models of care are described by Bradshaw (1994) who contrasted the social model of care offered at CMUs with the more traditional medical approach to care, summarised in Table 2.2.

Table 2.2 Medical and Social Models of Care

Models of Health	Category
Medical	Absence of Disease Cure rather than prevention Disease rather than promotion of health and welfare Treatment of individual rather than social conditions Priority to acute, specialist medicine Hegemony of medical profession Emphasis on throughput numbers Paternalistic/Patriarchal
Social	State of complete physical, mental and social wellbeing and not merely absence of disease Holistic, life enhancing Emphasis on prevention, recovery and rehabilitation Acknowledges links between health and social structures Quality of life Primary care focus Interprofessional co-operation Personal experience of health valued

(Bradshaw 1994 p.21)

Women in all settings require care and services that are safe in the sense that mothers and babies have the same small risk of an adverse outcome, for example death or serious morbidity (ongoing health implications) of mother or baby. Pitchforth et al. (2008) found that women in remote and rural locations in Scotland were willing to make "trade offs", (of difficult access and parking, 'conveyor belt care' and time away from home) to access care that balanced their need to achieve safe outcomes within the 'ultimate safety net' of the OU, over their own personal preferences depending on their particular values regarding their birth experiences. One woman quoted in Pitchforth et al.'s (2008) study, expressed the opinion that obstetricians thought more about outcomes than experiences which appears to summarise the different worldviews held regarding safety in maternity care. Grigg et al. (2014) found that some women in rural New Zealand referred to giving birth at a freestanding, midwife led maternity unit in terms of 'gambling' the risks of a safe birth against having a relaxed birth. Safety for women who chose to give birth at an OU in both these studies was seen in dichotomous terms of specialist staff and facilities, as well as the avoidance of transfer in labour.

Those who chose to give birth in freestanding maternity units in Grigg et al.'s (2014) study were found to view safety in terms of location as the units were close to home and facilitated easy access for labour and for social support networks, the relaxed and calm atmosphere, availability of birthing pools and staff experienced in facilitating waterbirths, and previous experience of the person centred rather than institution led care provision available.

The literature on maternity care provision regarding safe care, suggests that the safety of women and babies in terms of no avoidable injury occurring, depends not only on the outcomes of that care, but also the appropriateness (to each person) of the environment provided for the delivery of healthcare services. As with person centred care, the ambition of safe care described by the HQS facilitates individual worldviews and values to be applied to the core principle of the quality ambition. Healthcare Improvement Scotland (HIS) have introduced the Maternity and Children Quality Improvement Collaborative (MCQIC) encompassing the activity of the Scottish Patient Safety Programme through its maternity care strand, an overall aim to:

> *"Improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families across maternity care settings in Scotland."*

(HIS MCQIC 2015 Maternity Care webpage)

The outcomes of these improvements are to reduce avoidable harm in women and babies by 30% by 2015 and to increase the percentage of women satisfied with their experience of maternity care to greater than 95% by 2015. This aim encompasses both the outcomes and experience aspects of safety in maternity care which will also be explored through specific objectives in this study of maternity services in rural CMUs.

2.4.3 Quality Ambition 3 – Effective

Effective provision of care is described as the use of the most appropriate interventions treatments, support and services, or care processes, provided at the right time to people who would benefit (Scottish Government 2010). This ambition requires a robust, dynamic and holistic approach to risk assessment and appropriate care pathways throughout a woman's maternity journey (NHS QIS 2009). The Scottish Government Health Directorates established in 2007 the Keeping Childbirth Natural and Dynamic (KCND) programme. This was in response to the need to ensure that the principle outlined in maternity policy, the Framework for Maternity Services in Scotland (SEHD 2001) was implemented in practice. The programme aimed to: ensure that all women had a robust assessment of their needs in early pregnancy; were offered the most appropriate care pathway for their needs and had their care provided by the most appropriately skilled maternity professional. The overall aim of the programme was to increase the rates of normal birth through the provision of evidence based care, the reduction of unnecessary intervention and to establish midwife led care for healthy pregnant women (Cheyne et al. 2013).

One of the strands of the KCND programme was to develop pathways for maternity care that facilitate continuous risk assessment to ensure that all women accessing maternity care in Scotland are offered evidence based care by the most appropriate professional. The pathways produced were based on the premise that "Pregnancy and childbirth are normal physiological processes and unnecessary intervention should be avoided" (NHS QIS 2009 p.2). The principles to be adopted and practiced by clinicians to ensure that the KCND pathway for normal maternity care is used effectively are shown in Box 1.

Box 1 Principles for Effective Maternity Care

Principles for Effective Maternity Care

There is a shared explicit practice philosophy that supports, protects and maintains normality.

The midwife is the lead professional for healthy women with uncomplicated pregnancies.

There is consistent high quality communication with women, with relevant information provided at appropriate times.

Discussion with all women is facilitated to enable them to make decisions regarding care and birth preferences, including place of birth and to encourage women to document these preferences in their handheld record.

Women are supported to take a central, active role in their own care during pregnancy, labour and the postnatal period.

There is recognition of the impact of inequality and social exclusion on health and it is ensured that appropriate information, support and referral are provided to all women based on need.

(NHS QIS 2009 p.2)

The care pathways introduced a clear traffic light system so that at the initial assessment women were streamed to either a green, amber or red care pathway. Healthy women with uncomplicated pregnancies were streamed to the green, midwife led pathway where the midwife is the lead professional. Women with any potential medical, obstetric or social risk factors were streamed to the amber pathway where referral for assessment with the appropriate professional was required and may return to the midwife led pathway following assessment, or the red maternity care team pathway with an obstetrician as the lead professional. Women with significant risk factors in their medical or obstetric history were streamed to the red care pathway where an obstetrician is their lead carer within the wider maternity care team of midwives, GPs, and other medical specialists, as appropriate to their needs.

The KCND care pathways (NHS QIS 2009) were intended to be used by all members of the multi-professional maternity care team and had multi-professional endorsement at national level. The pathways had been developed through a consensus based process, with the aim of leading to a sense of ownership and were firmly based on evidence to inform and standardise practice for all women (Cheyne et al., 2013). The implementation of the All Wales Clinical Pathway for Normal Birth had been found to be problematic as

the medical staff were less involved in the development of the pathways and felt excluded, creating interprofessional tensions which made using the pathways in practice difficult. The obstetricians were unsupportive and transfers of care became problematic (Hunter 2010). Cheyne et al.'s (2013) evaluation of the implementation of the KCND programme found that whilst programmes of change needed to be firmly based on established theories, sensitivity to the context in which programmes were implemented are indicative of how effectively they were applied in practice. The use of the KCND pathways in practice at CMUs specifically were not evaluated, but the programme based on supporting normal birth by implementing multiprofessional care pathways and normalizing midwife led care pathways at a national level would seem likely to be particularly well suited to the provision of effective care when supplemented with specific local contextually appropriate guidelines. Healthcare Improvement Scotland (2011) has published principles for monitoring the delivery of effective care which involve planning and delivering continuous improvement, and identifying, sharing, learning from and delivering best practice. These principles will be explored through specific objectives in this study of the provision of maternity care in rural CMUs in Scotland.

2.5 Summary

The need for a better understanding of how midwifery care may contribute to improvements in safety and quality was recognised by Sandall et al. (2010). Rural CMUs provide local antenatal and post birth maternity services to most women. The care at rural CMUs is not only provided to women in the local community experiencing normal, uncomplicated pregnancies through midwife led care, but it is also (in collaboration with obstetricians) provided to women with complications who require obstetrician led care with only a few exceptions (usually when several members of the wider maternity care team conduct collaborative antenatal consultations).

Much of the literature regarding the quality of care provided to women is based on midwife led care provided during labour and birth. The gap in the literature is of research exploring the quality of care provided locally for most

women by the teams at rural CMUs during the antenatal and post birth period. It is this locally accessible care that may be the key to the provision of sustainable rural maternity care for the majority of women, but the quality of this care provision is currently an under explored area.

The CMUs also offer midwife led care during labour and birth to those women who have experienced an uncomplicated pregnancy. The quality of this care provision has been explored in studies with data gathered almost ten years ago, but maternity policy, services and the transport infrastructure have changed in the intervening years. No recent studies have explored whether CMUs contribute to NHS Scotland's Quality Ambitions of person centred, safe and effective care. The gaps in the literature are:

- A detailed description of the socio-demographic and clinical characteristics of all women who access care at rural CMUs.
- The processes of care for women who access maternity services at CMUs.
- The process and outcomes of the women who access care in labour at rural CMUs.
- A detailed understanding of the views, preferences and experiences of the women who access care at rural CMUs.
- Exploration of the specific information needs and factors which influence the decision making of women who receive maternity care at rural CMUs about where to give birth.
- Exploration of key stakeholders' views and experiences of providing maternity care at rural CMUs and their views on the future development of the service.
- The potential non-clinical (social, psychological) risks or benefits of local access to CMU care, during parts or all of their maternity journey, for all women in the community.

A fuller understanding of the quality of the maternity services provided by rural CMUs would better inform women and stakeholders about the current

provision of care and inform future service development of the CMU model. The study reported in this thesis explores the approaches to the delivery of safe, effective and person centred care in rural CMUs. In the context of this thesis, stakeholders are defined as those who have roles aligned to the provision of maternity services provided at rural CMUs as heathcare professionals and lay representatives.

CHAPTER 3: METHODOLOGY

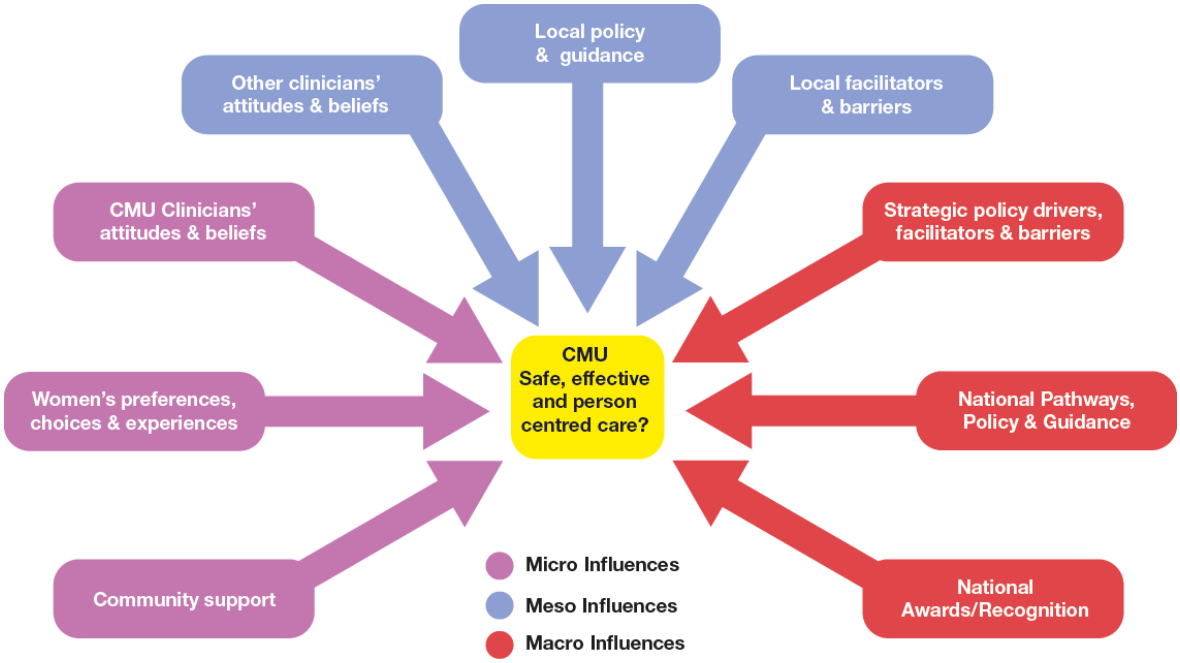
3.1 Introduction

This chapter begins with a presentation of the conceptual framework (Figure 3.1 p.31) or 'thinking tool' (Thomas 2011) from the sources of information described in the literature review (Chapter two), which were used to develop the research design. It then explores the philosophical foundations and approaches to different research paradigms before moving on to a justification of the particular choices of research design used in this study. The application of a case study approach as the overarching study design within the context of the research aim is the main focus of this chapter.

The influences on the quality of the maternity services provided at rural CMUs, based on this exploration of the literature originate from three main sources. Firstly, the national strategic direction from the Scottish Government for maternity services, and national pathways, policies and guidance give the wider context within which rural maternity services are provided and delivered. Secondly, at regional level, local evidence based policies and guidance developed by each NHS Health Board translate the national drivers to local service provision by a wide range of clinicians. This is where the interface of care between the rural CMUs and the OUs occurs. The maternity services provided at each rural CMU are influenced in turn by the national strategies, local policies and guidance and the women and clinicians' attitudes and beliefs. Thirdly, the support of the local community by engaging with and using the services of their local maternity units may also have an influence on the quality and sustainability of the rural CMU model of care.

Figure 3.1 Conceptual Framework

Conceptual framework of the influences on how CMUs contribute to safe, effective and person centred care



(Denham 2015)

The conceptual framework provides an overview of the micro, meso and macro influences derived from the literature associated with the maternity care provided at rural CMUs. Micro influences (shown in purple in the figure) are those which were identifiable at the point of care within the CMUs. The meso influences are those which were at the interfaces of care between the CMUs and the wider maternity care teams at local Health Board level represented by the influences in the blue boxes. The macro influences are those at national level, shown in red in the figure, which set the overarching benchmarks, guidance and strategy for the Quality Ambitions (Scottish Government 2010) to be delivered in a wide variety of care settings (for example CMUs). This conceptual framework was used to develop the research aim and objectives so that the areas identified at each level could be explored. Consideration of

appropriate methodology and methods are explained in the following two chapters.

3.2 Research Aim

The aim of this research was to explore whether rural Community Maternity Units contribute to NHS Scotland's Quality Ambitions of safe, effective and person centred care. To achieve this aim, the complex and multifaceted nature of two rural CMUs was studied in three phases, using a phenomenological perspective within case study methodology. The wide ranging objectives for this study are presented in three phases.

3.3 Research Objectives

Phase one objectives relate to the Quality Ambitions regarding the safety and effectiveness of the care provided within the rural CMUs. These are

- To quantify and describe the socio-demographic and clinical characteristics of women accessing care at CMUs during pregnancy, labour and the post birth period.
- To compare the clinical appropriateness of care provided to women during pregnancy, labour and birth and the post birth period with national pathways and guidelines (NHS QIS 2009).
- To describe the processes of care and clinical outcomes for the women who labour and/or give birth at the CMUs.

Phase two objectives relate to all three of the Quality Ambitions of safety, effectiveness and person-centredness of the care provided within the rural CMUs. These are:

- To contextualise and explore key stakeholders' views, beliefs and experiences of the safety, effectiveness and person-centredness of the care provided by the CMUs.

- To explore key stakeholders' guidance and recommendations about the services and the care that should be provided by rural CMUs.

Phase three objectives relate particularly to the Quality Ambition regarding the person-centredness of the care provided at the CMUs. These are:

- To contextualise and explore women's views and experiences of care they received at the CMUs, including their decision-making processes about where to give birth.
- To describe and explore what influences women's preferences for their planned place of birth by the completion of their booking process and at the end of their pregnancies.
- To describe and explore women's needs for information and their experiences of decision-making during their pregnancies about their planned place of birth.

These objectives guided the exploration and interpretation of how and to whom the CMUs delivered care, who provided the care, how that care was given and how it was received using both quantitative (in phase one) and qualitative (in phases two and three) methods.

3.4 Research Paradigms

The word paradigm was used by Kuhn (1970) to mean a broad set of assumptions or schools of thoughts, beliefs and values. Parahoo (2006) suggests that research paradigms can be described as interpretive frameworks which influence the nature of phenomena studied, the way they can be studied and the designs and methods chosen as appropriate to answer research questions. The two paradigms most frequently described in social science and health research are positivist and interpretivist (for example, Polit and Beck 2012; Thomas 2009; Parahoo, 2006).

Within the positivist paradigm, the belief is held that knowledge about the social and psychological world can be objectively observed, measured and scientifically studied (Creswell 2014). Universal laws to explain human and

social phenomena are actively sought to predict with precision the probability of an event or phenomenon happening (Parahoo 2006). The worldview underpinning positivism is described as realism, meaning that the world that is perceived is straightforwardly as the one that is 'out there' (Thomas 2009). The researcher attempts to remove any elements of bias and conducts their research in circumstances that require their role to be as a detached observer and their impartiality is demonstrated as an essential part of the rigour of the process. The focus of rigour in the quantitative element of the research in this thesis is on the ability to represent results that could reliably be reproduced under the same conditions. Research within the positivist paradigm is methodologically aligned with quantitative epistemological beliefs about how reality is known and ontological beliefs about the nature of reality (Bryman 2012).

Interpretivism offers an alternative view on the world by upholding the belief that the social world is constructed by each person and their experiences can only be understood when the context in which they occurred and the way in which the experiences were interpreted or perceived by both the participant (researched) and the researcher is taken into consideration. Interpretivists focus on perception, language and subjective experiences to co-construct and ultimately attempt to understand the nature of the reality of a phenomenon using the lens of the researcher's background and influences, and the participant's descriptions and interpretations of their lived experiences. The rigour of qualitative research is seen in terms of trustworthiness and credibility, based in terms of whether the findings accurately represent the researcher and participants' interpretations (Creswell 2014). Research conducted within this paradigm is methodologically aligned with qualitative epistemological (how we know what we know) and ontological (what it is to be a human being) beliefs (Bryman 2012).

Case study research (CSR) is a methodological approach to research, regarded by many (Bryman 2012; Thomas 2011; Yin 2009; Stake 1995), as more than simply a collection of methods, and by some (Simons 2009) as a distinct research paradigm. The study of the particular, singular and unique (Simons 2009) may suggest to some (for example, Barbour 2008) that CSR belongs in

the qualitative, interpretive paradigm. The position adopted by CSR between the contrasting positivist paradigm where scientific laws, certainty and generalisable predictions are valued and the interpretive paradigm where holistic understanding and experiential learning are achieved, is seen by others (Creswell 2014; Yin 2009) as a continuum. A particular case study's place in that continuum depends entirely on the specific aims of the research (Crowe et al. 2011). The research described in this thesis was oriented towards the qualitative, interpretive end of the paradigm continuum, as the objectives for two of the three phases required a qualitative exploration of the views and experiences of the stakeholders and the women. The phase one objectives of the study, however, required statistical, positivist analysis of quantitative data about the women who attended for care and the care processes and outcomes. Each of these phases informed the other to provide a comprehensive and detailed exploration, from many different angles within both worldviews, of the case of maternity service provision in the specific context of rural CMUs.

3.5 Case Study Research

3.5.1 Case Study Research Definition

The terms case study and case study research have been used for differing purposes and to describe different research methods. Historically, the term 'case studies' has been used to describe a teaching tool (as in case histories) and a form of record keeping (as in case notes) (Yin, 2009). Researchers also use the term CSR differently, and there may not be an overall consensus about CSR. Clarke and Read (2010) suggest that CSR holds a unique place in research methodology by virtue of the emphasis it places on the importance of the impact of context on the phenomenon under investigation. The emphasis in this research was on exploring the approaches to the delivery of NHS Scotland's Quality Ambitions in the context of the day-to-day care provision at rural CMUs. The importance of exploring care provision within contextual complexities and everyday challenges was key to identifying the facilitators and barriers to policy implementation, and achieving an understanding of the CMUs' multifaceted care provision.

The various definitions by authors in the literature of CSR (Thomas 2011; Clarke and Read 2010; Yin 2009; Simons 2009; Robson 2002; Stake 1995) all have similar themes of an empirical investigation of a contemporary phenomenon in an everyday 'real life' context, using multiple sources of evidence. The emphasis on different aspects of CSR, boundedness or boundaries of the case by Yin (2009), complexity and particularity by Stake (1995) and Robson (2002), give an insight into the difficulty of defining a flexible approach which is shaped by each case being studied (Clarke and Read 2010). Though lengthy, Simons' (2009) definition appears to encapsulate the comprehensive overview that assists in understanding the relevance of CSR to the study described in this thesis. She states that:

> *"Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a real life context. It is research based, inclusive of different methods and is evidence led. The primary purpose is to generate in-depth understanding of a specific topic, programme, policy, institution or system to generate knowledge and/or inform policy development, professional practice and civil or community action."*

(Simons 2009 p.21)

The 'case' in this CSR was the maternity services provided at rural Community Maternity Units and two CMUs were selected (as described in Chapter three) as representative or typical examples of the case (Yin 2009). An in-depth exploration from multiple perspectives was achieved by the use of objectives that required many differing viewpoints to be addressed in detail, and through the use of a number of methods to address those research objectives.

3.5.2 Approaches to Case Study Research

There are a number of approaches to CSR described in the literature and the terms used to describe different purposes vary. Stake (1995) uses examples from his background in education for his predominantly qualitative text on the art of case study research, where he labels types of case studies as intrinsic, instrumental and collective. He describes intrinsic case studies as those where

the subject of interest is the case itself, and instrumental case studies where the study of a particular case is used to gain a more general understanding or insight into systems, processes or something other than the particular case. By contrast Yin (2009), who has a background as a psychologist and social scientist describes common case types as explanatory, descriptive and exploratory. Yin aligns his case types to existing theory, where exploratory case studies are used to develop theory in the early stages of question development and evidence building. Yin's descriptive studies aim to produce a comprehensive description of a phenomenon within its bounded (in time and activity) context, using existing theory or pre-understanding to fine tune the focus of a study and his explanatory case studies have an evaluative purpose and are used to test theories. Simons' (2009) experience in evaluative research, in which she found that quantitative evaluations failed to capture the complexity of educational programmes, led to yet more labels for types of cases based on the type of theory that the case was designed around. A numerical (quantitative) description of the characteristics, processes and outcomes of the women who accessed care at the CMUs was combined with in-depth interviews, focus groups, observation, policy documents and information presented at the units by key stakeholders and observation, diaries and in-depth interviews with the women who accessed the CMU service. This combination of information sources served to provide an in-depth or tightly focussed and deeply drilled (Thomas 2011) view of the real life, everyday services provided at the CMUs from different perspectives.

The purpose of this research was to use the two rural CMUs to explore what was happening and why regarding the provision of safe, effective and person-centred care at the CMUs, and so the purpose was identified as exploratory. An exploratory case study was used, where there is little pre-existing information, or theory, on a subject that requires investigation to gather facts and interpret these facts to pose potential explanations (Yin 2009). Case studies, according to Yin (2009), can also be used to describe an intervention in the context in which it occurred, and to explain presumed causal links to phenomena or events in the everyday context in which they occur.

This section has explored the reasons for the choices made in selecting CSR, essentially as a 'wrapper' (Thomas 2011) to provide the bounded frame for a focussed approach to a detailed, vivid description, and through the description, exploration of the provision of maternity care at two rural CMUs. The study uses multiple data sources to facilitate an in-depth, holistic understanding and interpretation of the contemporary phenomenon of care provision, from differing viewpoints to help the reader to begin to understand how (or if) rural CMUs fulfil NHS Scotland's Quality Ambitions. The 'thick', complete description of the context of the CMUs allows the reader to make judgements about the conclusions drawn from the research and aims to help readers to interpret whether the findings would be of use in their own context. The use of an exploratory case study brings together some fundamental characteristics of hermeneutic, interpretive phenomenology, the philosophical perspective of the research discussed in section 2.9 (p.38) and CSR in that they both assume that the researcher is integrally involved in the research, the actions and experiences are indivisible from their contexts, and that contexts are complex and should be studied from different viewpoints to see their completeness (Smythe 2011; Simons 2009).

3.5.3 Advantages of Case Study Research

Case Study Research has increasingly been chosen as a flexible and appropriate approach to midwifery research (McCourt et al. 2011; Pairman 2010; Bick et al. 2009), where the cases require investigation from various angles and viewpoints (Thomas 2011), to accurately illuminate the parts, enabling an in depth and 'thick' description leading to interpretation of the whole – in this instance the CMUs.

CSR offers particular advantages in providing a focussed in-depth approach to exploring if and how rural CMUs contribute to a national policy (i.e. NHS Scotland's Quality Ambitions). The advantages of CSR, when done well, are summarised by Taylor (2013) as it:

- Allows for the exploration of complexity through the use of multiple data sources.

- Is situated in real life settings.
- Is suited to research where phenomena are complex and based in realities.
- Is contextual with thick description enabling others to make judgements about the relevance of the findings to their own situation.

These four core characteristics of CSR were key to answering the research question and the way in which this study was designed. The comprehensive provision of maternity care to most women in rural, midwife led settings was recognised as a complex phenomenon (Cheyne et al. 2013). The everyday care encounters at the CMUs in this study were explored through a variety of data sources to ensure that as many viewpoints on these complex interactions could be accessed in the precise setting in which they occurred. The realities of these encounters revealed how the interpretation of complex situations in real life were made. The opportunity for vicarious learning by others when communicating information in clinical encounters in a wide variety of situations has been made available to the reader through the detailed contextual description of the incidents in this thesis.

3.5.4 Limitations of Case Study Research

CSR is not without its limitations and critics which Yin (2009) described as the four traditional prejudices against the case study method. These criticisms concerned lack of rigour due to their non-experimental design, poor basis for scientific generalisation, the length of time taken to complete and the length of the report produced. These criticisms appear to relate to the comparison of case study research, where the exploration of events occurs in their natural, real life contexts, with randomised controlled trials, where specific hypothesis are tested through deliberate manipulation of the environment in which the events occur (Yin 2009; Flyvberg 2006). Case study research is based in real life contexts, where variables cannot be controlled, but where 'how' and 'why' questions can be answered (Stake 1995). These concerns were addressed in this study by paying careful attention to the design and methods chosen to address the specific aim of the study, with no attempt being made to claim generalisability. The rigorous processes used during the study to ensure that

the resulting reported findings were not biased towards my preconceptions are described in Chapter 4, Section 4. The research schedule was planned within a timescale that gave a realistic allowance for each of the differing data collection methods. Preparations were also made for the differing attributes required of me as the researcher before, during and after data collection. These attributes according to Yin (2009) were the ability to: ask good questions; listen to the information given rather than ignoring that which did not conform to my preconceptions; remain alert and adaptive to evolving situations; maintain a firm grasp of the relevance of the issues being investigated; and remain aware of and not discounting of contradictory evidence. All of these attributes contributed to the aim of avoiding bias and collecting quality information which could answer the research question with enough contextual detail to allow 'thick' description, avoid irrelevancies but present findings that allow the reader to interpret them for use within their own settings or contexts.

Stake (2000) counters the criticisms of the ability to generalise from CSR by differentiating between the terms 'natural sciences' where predictable generalisation to the population is a central tenet and 'naturalistic generalisation' attempted by CSR. This naturalistic form of generalisation develops from both tacit knowledge (a form of understanding by experience) and propositional knowledge, which guides action as a product of experience. According to Stake, this 'naturalistic generalisation' never passes on to empirical knowledge characterised by scientific, predictive generalisations, but he claims that '*better generalisations are often those more parochial, those more personal'* (Stake 2000, p.23). His main premise is that research needs to be presented in full vivid and contextual detail to make the experience 'come alive' and be available to readers to compare with their own experiential knowledge, so that they can understand whether CSR can provide them with vicarious experience, building up the body of knowledge through 'naturalistic generalisation', on which the readers may act.

Lincoln and Guba (2000) take a more measured approach to the question of generalisation in CSR by arguing that it lies on a continuum between searching for general laws and studying the unique, where conclusions from one context

might hold as working hypotheses in another context. They use the term fittingness, which relies on 'thick description' (Geertz 1973) of the cases for the reader to judge whether the conclusions of one study will transfer or fit in another context. Donmoyer (2000) takes the approach that any type of generalisability is less useful for practitioners dealing with individuals where meanings and perspectives are central tenets to knowledge assimilation, accommodation, integration and differentiation. This approach builds on Stake's translation of tacit to propositional knowledge using language to generalise at the level of experience, recognising the way in which clinicians often encode experiential knowledge in stories and anecdotes transferring these to working hypotheses, which guide their actions. Donmoyer suggests that skilled clinicians have an interactive role, jointly constructing meanings with clients, which is not always captured in experiential learning. He utilises the language of Piaget's (1971) description of cognitive processing to help describe how clinicians make judgements about fittingness or generalisation of vicarious experiential learning recognising and including the diversity of the clinicians' role.

> *'When diversity is dramatic, the knower is confronted by all sorts of novelty [assimilation], which stimulates accommodation; consequently the knower's cognitive structures become more integrated and differentiated; after novelty is confronted and accommodated, he or she can perceive more richly and, one hopes, act more intelligently'*

(Donmoyer 2000 p.60)

The generalisabiity of this study will be determined by the way in which the reader can judge the fit of the contexts of the CMUs with their tacit propositional and experiential knowledge of their own practice and working environment. This judgement will be made on the basis of the depth and accuracy of the contextual descriptions presented in this thesis.

The primary importance of selecting appropriate cases to answer the research question is emphasised by Thomas (2011) as an essential basis for the quality of the resulting research.

3.6 Phenomenology

3.6.1 Hermeneutic Phenomenology

Hermeneutic interpretive phenomenology was chosen as the philosophical perspective as it encapsulates a means of accessing and interpreting individual views and experiences of a phenomenon. The emphasis of all phenomenological research is on understanding human experiences using a systematic, rigorous and critical means (Bondas 2011). Hermeneutic phenomenology places emphasis on the use of language (Crotty 1998) to express feelings and emotions, and interpretation by the use of written narratives (the transcripts of language used during focus groups and interviews) and listening to the way in which a narrative is told. The intention was to achieve a blending of the narratives of the participants' stories told in their own words and my own perception of their stories to achieve a new understanding (Smythe 2011) of the participants' views and experiences of the maternity service provision at rural CMUs.

The way in which this understanding is achieved differs between two main branches of phenomenology. Within one branch, Edmund Husserl (1859 – 1938) developed a philosophy of phenomenology that required 'epoche' or bracketing of previous knowledge so that new knowledge could be accessed. This new knowledge is achieved by understanding the essence of a phenomenon, by seeing that which makes something what it is and without which it could not be what it is (Dahlberg et al. 2008). The other branch of phenomenology was led by Martin Heidegger (1889 – 1976), who rejected the notion of bracketing and asserted that interpretation of phenomena could only take place through 'Being-in-the-world'. This existence, or being, in the world allows the ontological (what it is to be a human being) way of interpreting the meaning of being to be used to uncover existing phenomena by revealing their meaning or their significance which had previously been left hidden or ignored (Healy 2011). The Husserlian bracketing approach of stripping away the researcher's preconceptions or presuppositions (Converse 2012) was rejected for this study as removing me as the researcher from my world was less likely

to be achieved successfully than placing myself as a being in the world which is required by Heidegger's approach.

3.6.2 Hermeneutic Phenomenology Assumptions

By adopting an interpretive philosophical approach to this research, a number of assumptions, summarised by Smythe (2011), needed to be made explicit. This approach involved achieving understanding through interpretation and recognising that my background and worldview as a midwife and a mother would inevitably affect the interpretations of the meanings that I made from the qualitative data. My experience as a midwife meant that I had an understanding of the pleasures and challenges of providing maternity care within many different contexts. My experiences of maternity care as a mother were much less recent, but moments of great clarity remain an important influence on how I remember those experiences. These presuppositions, referred to as 'fore-havings, fore-sights and fore-conceptions' (Heidegger 1962), were required to be recognised and understood before entering the hermeneutic circle (shown in Figure 3.2, p.48), a never completed circle of understanding, where there is always room for re-interpretation (Converse 2012), with the intention of interpreting data collected during phases two and three of the study.

To reduce the potential of assumptions or taken for granted meanings between the participants and myself, clarity was sought by asking for an explanation or examples of commonly encountered professional phrases. This allowed an opening to move beyond 'already there' understandings and to avoid any misinterpretation of the meaning of the participant's words. Heidegger (1962, p.220) expresses the potential problem of assumptions about others' meanings as being 'fallen into the world', where one acts in a programmed way by simply conforming with others assumptions, without making the effort to discover whether a unique perspective can be brought to the interpretation of a phenomenon. Without careful assessment of assumptions on both my part as the researcher, and those of the participants, some data may have been lost or concealed within taken for granted assumptions.

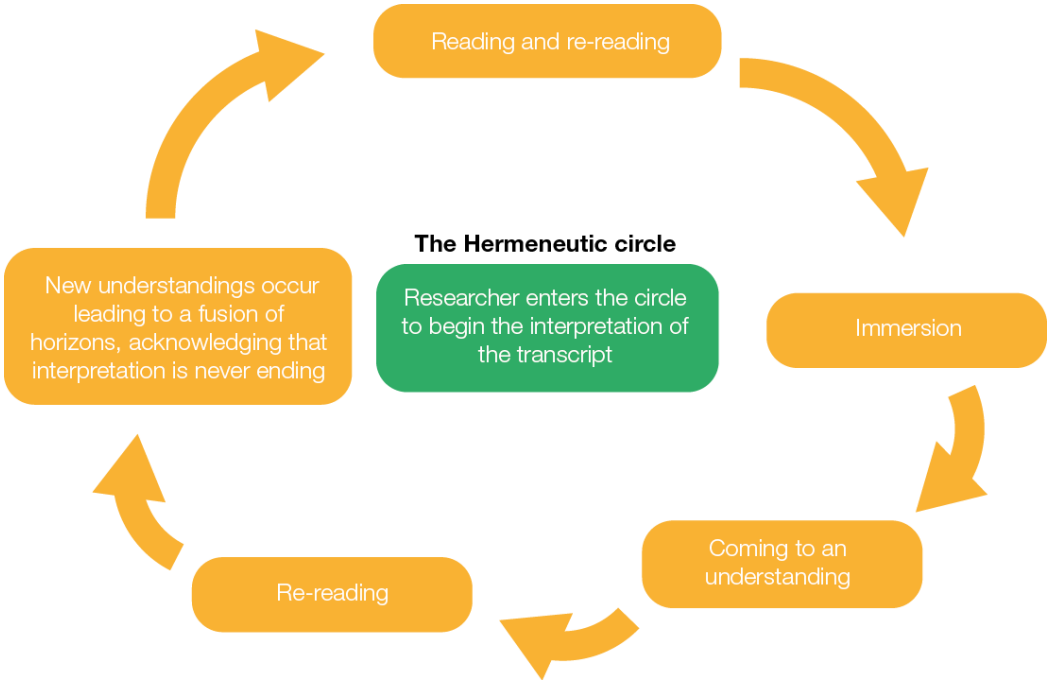
A further hermeneutic phenomenological assumption is that interpretation begins when the participants recount their experiences, which were focused on particular aspects of providing or receiving maternity care from their own, unique perspective. I could only offer my interpretations of their accounts of their views, beliefs and experiences and cannot claim to fully understand all of what was meant, as phenomenological interpretation of others' experiences is never complete (Smythe 2011). Within the uniqueness of human experience, however, there is understanding that resonates with others, and when my interpretation of the participants' views, beliefs and experiences was recognised and acknowledged, the phenomenological nod of agreement with the interpretation was given through the member checking process (Oliver 1982).

3.6.3 The Hermeneutic Circle

As shown in Figure 3.2 p.48, each new encounter and each interpretation led to a change in my perspective within the never completed circle of interpretation (Mackey 2005). Once my preconceptions were recognised and understood, the interpretation or exploration began on the understanding that it was through my particular lens, acknowledging Heidegger's basic stance that nothing can be interpreted without the interpreter being in the world. The participants' descriptions of their experiences were interpreted within the ongoing hermeneutic circle of the worlds of the participants and my own understanding. This occurred through back and forth movements between parts of the text (transcriptions of the data collected), and began my partial interpretations, and the complete whole of the full transcripts, to slowly reveal my interpretation of the meaning of the phenomenon. Gadamer (1976) took the hermeneutic circle a step further by using the metaphor 'fusion of horizons' (Dowling 2005) between the researcher and participants, so that neither the researcher's nor the participants' voices dominate, but a blending of the narratives facilitated the revelation of the phenomenon in a new light. Gadamer described an individual's horizon as a way to conceptualise understanding, their horizon being as far as they can see and understand. Each encounter changes the horizon of the participant and the researcher by developing through language a new understanding of each other's point of

view. This new understanding for both, leads to a shift in each persons horizon and when I was interpreting a written text (transcript), each new understanding brought a shift in my horizon of understanding closer to that of the participant. The fusion of horizons within the hermeneutic circle is never fully complete, as the reader will always bring a new worldview, or horizon of understanding to the interpretation. CSR and hermeneutic phenomenology have a similar emphasis on the contextual detail within multiple realities allowing the opportunity for vicarious learning by the reader.

Figure 3.2 The Hermeneutic Circle



(Denham 2015)

3.7 Summary

This chapter has stated the conceptual framework on which the research aim and objectives were based, and explored the methodological choices made for the overarching research design frame. The research objectives required exploration of the complex phenomenon of rural CMUs from many sources and viewpoints within the bounded framework of their maternity service provision. The boundedness of the case study allowed a tightly focussed spotlight to be shone on the day-to-day, real life complexities, over which the researcher had

no control, in the precise contexts within which they appeared. The use of hermeneutic phenomenology within the CSR framework enabled multiple realities to be interpreted and embraced whilst acknowledging that further interpretation is always possible. These multiple realities were essential in achieving a holistic view of the CMUs through the weaving together in this thesis of a statistical overview of the service provision and the experiences and views of those providing and receiving that care.

CHAPTER 4: RESEARCH METHODS

This chapter describes the methods used within the case study research to explore how rural CMUs contribute to NHS Scotland's Quality Ambitions of safe, effective and person-centred care. The different methods used in each of the three phases of the study were chosen to address the different objectives within each phase which combined to present a multifaceted exploration of the contextual complexities (Symons 2009) encountered at the CMUs. The rationale for the choice of methods, and the ways in which the data were collected, stored and analysed is then explored. The discussion of each phase begins with re-stating the phase objectives. Finally, the ethical issues associated with the study and ways in which they were addressed are considered.

4.1 Selection of Cases

The case was identified as the services provided at rural community maternity units. Classic examples of the case, rural CMUs, were sought throughout Scotland. The cases were selected by considering their potential to explore maternity service provision through multiple data sources, through the statistical description of the maternity services provided to women and through qualitative exploration of stakeholders' and women's experiences of the service provision. Stakeholders were defined (as described in section 4.4.3, p. 60) as clinicians who had roles and responsibilities aligned to the provision of maternity services at the CMUs. The service provision was required to take place in the reality, where multiple aspects, or the complexity, of the care provision could be explored in the exact, everyday context in which it occurred.

The data collection for the research was conducted from August 2012 to August 2013, during a period of wide-ranging review and reorganisation within maternity services. The sustainability of the CMUs for the duration of the research had to be taken into consideration, along with the number of births at the CMUs over the preceding years. Two rural CMUs were identified as potentially having an adequate annual number of women accessing maternity services there to describe and from which to draw conclusions. Whilst one

CMU may have provided the information required for an in-depth case study, a second case with similar number of births each year in a different local Health Board area, was used as a further classic example of rural maternity service provision. Exploration of the care provision at both CMUs was performed to enhance the fittingness or transferability of the study to other contexts and maximised what was learnt from both settings by understanding the differences as well as the similarities between the CMUs.

4.2 Pilot Study

A pilot study was carried out to test and refine the recruitment, data collection and data analysis methods and techniques (Yin 2009) for all three phases of the study (summarised in Figure 4.1 p.54) before the full study was launched, once all the appropriate permissions were in place. Four women were recruited, their second booking consultation with their midwife was observed, they were given their 'aide-memoire' pregnancy diaries and were then interviewed. A focus group was held with four stakeholders, the observation of a team meeting and two interviews with stakeholders were carried out, and twenty sets of maternity records were reviewed using the data collection tool developed for the study.

The pilot study demonstrated that the data collection tool, recruitment strategies and interview topic guides required adjusting in order to effectively address the aims of the study in each phase. Learning points taken from the pilot study were:

- The interview topic guides for both the stakeholders and the women were refocused on open questions inviting the participants to give detailed accounts of their individual experiences and views of the CMUs.
- The position of the variables within the data collection tool were adjusted to align with the order in which the data appeared in the maternity records to streamline the data collection and help avoid the risk of data entry errors.

Yin (2009) warns about the vast range of skills that a researcher has to bring to CSR. Although I had developed some skills in conducting interviews and

focus groups with stakeholders and women through a previous study (Denham 2011), further development needs in my data collection skills were identified and addressed. The supervisory team facilitated training in using open questions and allowing time for the participants to formulate and articulate their answers. My quantitative data collecting skills were assessed and improvements to the way that the data were recorded were made in the layout of the tool and the categorising of continuous data to assist in the analysis. The preparation of a quantitative data collection tool, quantitative data collection and non-participant observation techniques were some of the newer techniques that I had to grasp and, with training accessed from experts within the university and external courses, perform effectively.

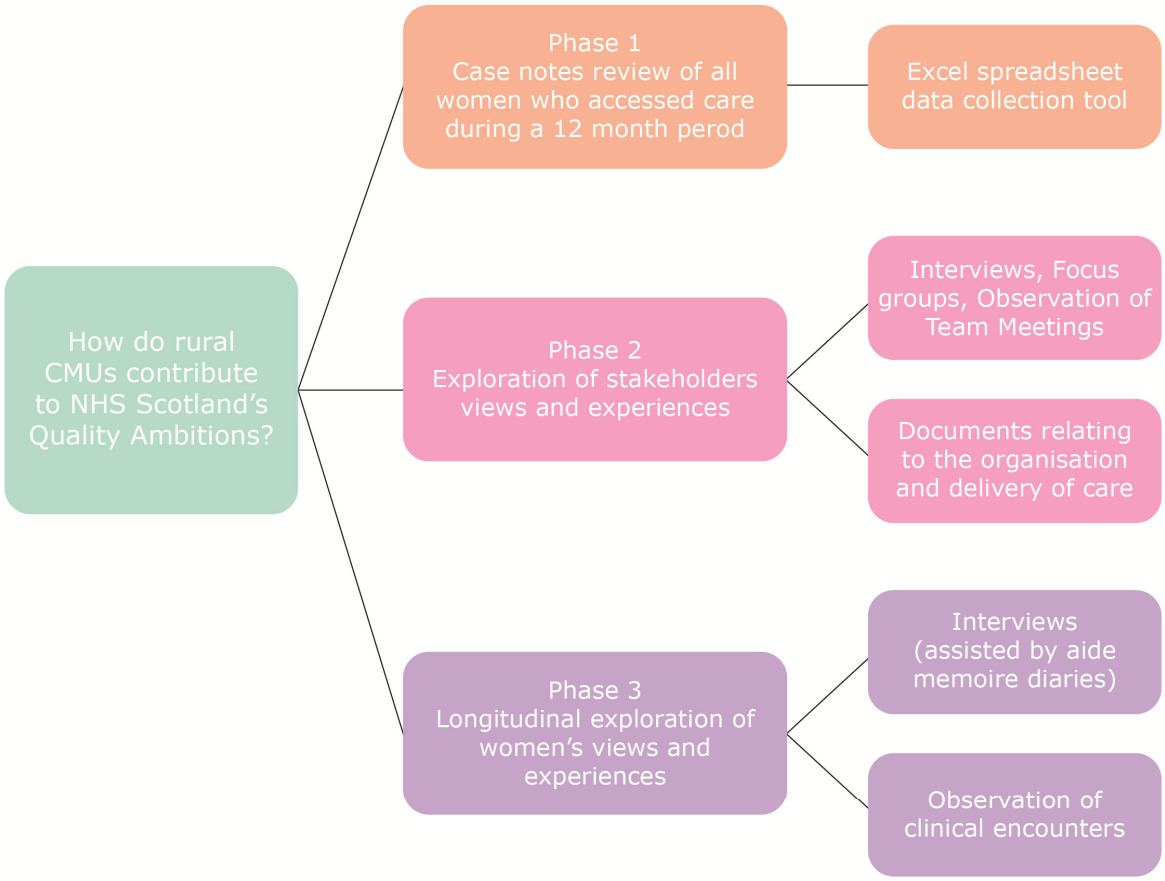
Conducting the pilot study taught me that:

- The recruitment strategy for both stakeholders and women, which I had anticipated to be complex, was enhanced by the positive support for the study shown by the midwives working at the CMUs.
- The data collection sheet required amending so that the data could be located in the maternity records and entered in a more logical sequence.
- The participants required open questions to relate their experiences, views and opinions, on general topics at the start of the interviews.

The data collected during the pilot study was considered of sufficient quality by the researcher and the supervisory team to be included in the main study.

On completion of the pilot study, the study design was confirmed and is summarised in Figure 4.1

Figure 4.1 Summary of Data Collection Techniques



4.3 Phase One

4.3.1 Research Objectives

The research objectives of phase one were to:

- Quantify and describe the socio-demographic and clinical characteristics of women accessing care at the CMUs during pregnancy, labour and the post birth period.
- Describe the processes of care and clinical outcomes for the women who laboured and/or give birth at the CMUs.
- Compare the clinical appropriateness of care provided to women during pregnancy, labour and birth and the post birth period with national pathways and guidelines (NHS QIS 2009).

Phase one of the research required a quantitative approach to achieve the phase one objectives, which set the contextually bounded backdrop to the CMU cases and allowed others to begin to interpret the transferability of the study described to their own situation. The statistical analysis of data gathered from the records of all women who accessed care at the CMUs over a 12 month period allowed the descriptive overview of who attended the CMU for maternity care, their care process and outcomes and how these compared to national guidelines and pathways. Interpretation of this descriptive information informed a number of contextual issues that may have influenced the individual views and experiences collected qualitatively in phase two and three. Approaching the issue of the provision of safe, effective and person centred care from different angles, helped to produce a holistic, more detailed overall picture.

4.3.2 Data Sources/Sample

Retrospective data were extracted from a consecutive series of maternity records of women identified as having accessed care at the CMUs during a 12 month period (1st June 2011 to 31st May 2012). A list of NHS identification numbers was provided to me for births in this time frame by the CMU staff. As

significant complications of pregnancy, labour and the post-birth period are uncommon (BECG 2011), a review of all cases during a 12 month period was considered necessary to assess the management of risk and adverse events.

4.3.3 Selection of Variables

The variables collected were selected from those used in Delivered with Care, a national survey of women's experience of maternity care (Redshaw and Heikila 2010). Information from Redshaw and Heikila's 2010 study aimed to enable comparison with similar work about women's experiences of maternity care provision carried out by Redshaw et al. (2007), which provided a benchmark of current practice of care provision and a baseline for measuring change in the future. It also enabled comparison between women's experience and care in different settings and units and covered outcomes of maternity care throughout the pregnancy episode. Some of the outcomes of Redshaw and Heikila's 2010 study were similar to the objectives of phase one of this study, which were: to quantify and describe the socio-demographic and clinical characteristics of a cohort of women accessing maternity care; and to describe the processes of care and clinical outcomes of these women. Variables used and validated in the Delivered with Care study (2010) and relevant to this study's objectives were selected which were theoretically and evidence based to enhance the validity of the study and avoid 'data dredging' where variables not supported by evidence are extracted which could lead to errors during data analysis (Petrie and Sabin 2009).

The spreadsheet used as the data collection tool for this research is shown in Appendix 1.

Socio-demographic and Clinical Characteristics

The variables selected to quantify and describe the socio-demographic characteristics of the women who accessed care over the 12 months were: nationality; postcode (to assess the Scottish Index of Multiple Deprivation (SIMD) quintile of deprivation for residence); relationship status and occupation. Age, parity (number of previous births), gestation at booking and

pregnancy model of care were the variables selected to describe their clinical characteristics.

Processes of Care and Clinical Outcomes

Variables chosen to describe the processes of care for the women who laboured and/or gave birth at the CMUs were: access to maternity care (gestation and clinician at first point of contact), the number of antenatal visits (both planned and unplanned and the reasons for unplanned visits); number of different midwives seen (to assess continuity of carer); planned place of birth at booking, at the end of pregnancy (36 weeks) and the onset of labour; number of visits to the CMUs in early labour; pain management strategies; length of labour; management of third stage and interventions (for example artificial rupture of membranes and episiotomy). Clinical outcomes for the women were described by the variables of: type of birth, perineal trauma, estimated blood loss at the birth and length of post birth stay on CMU. Variables collected to describe the outcomes for their babies were: birth weight, level of resuscitation, admission to the neonatal unit, type of first feed, type of feed on transfer home and on transfer from midwifery care.

Clinical Appropriateness of Care

Data variables selected to assess this required a yes/no answer to the question of, as an example, 'appropriate allocation of lead professional?' The allocation of the appropriate lead professional is clearly stated in the NHS QIS Pathways for Maternity Care (2009). Further variables relevant to this objective were: antenatal transfers to obstetrician-led care and referrals for obstetrician's opinions and reasons for these; transfers of women during labour and the reasons for these and post birth transfers and reasons for these.

4.3.4 Data Extraction

Data were anonymised by removing or categorising any identifiable data (e.g. postcode into Scottish Index of Multiple Deprivation category) and input into an Excel spreadsheet (Appendix 1) with the names of the variables collected along the top and the case number allocated to the set of records down the

side. Whilst it as acknowledged that it is best practice for data to be extracted by two separate individuals to enhance the internal validity of the study (Parahoo 2006), this was not possible as the named researcher, I was the only person given research and development and records department management permission to access the records in the two different locations and so all the data for this study were extracted by myself.

Data validation, or cleaning the data by checking for errors, was achieved by means of filters on the spreadsheet to identify internal consistency and reveal data entry errors showing data clusters/unusual or implausible entries/missing data allowing frequency checks. Cross tabs (Pivot tables) were also used at the end of every data collection episode. If inaccuracies were found, the records were re-checked and data entries corrected.

4.3.5 Data Storage

The anonymised data will be securely stored, in accordance with the university policy and practise, and the Data Protection Act 1998 at the university for ten years after collection in accordance with the instructions of the research ethics committee.

4.3.6 Coding Strategy

A codebook was created and initial codes allocated to categorical data (data which can only belong to one of a number of distinct categories of a variable) (Petrie and Sabin 2009) were guided by expert opinion from an experienced university statistician. Numerical variables which contained very small numbers (e.g. maternal age under 16 or over 45) were recognised and re-categorised with categorical variables, (e.g. all women under 20 years and all women over 40 years) to make the resulting analysis more meaningful when describing the variable.

4.3.7 Data Analysis

Anonymised data were stored on a password protected spreadsheet, on the university servers, and then uploaded into Statistical Package for the Social

Sciences (SPSS), version 21, a statistical analysis software package, for analysis.

Univariate analysis (of one variable across the dataset) was used to describe the trends in women accessing care at the CMUs, their social and clinical characteristics using frequency tables and percentage rates. Frequencies were calculated for all the variables. Frequency tables demonstrated the trends in the data.

4.4 Phase Two

4.4.1 Research Objectives

- Contextualise and explore key stakeholders' views, beliefs and experiences of the safety, effectiveness and person centredness of the care provided by the CMUs.
- Explore key stakeholders' guidance and recommendations about the services and the care that should be provided by rural CMUs.

Phases two and three of the research required a qualitative approach to achieve contextual detail within multiple realities, allowing the opportunity for vicarious learning by the reader. The use of a hermeneutic phenomenological approach in phases two and three of the case study, maximised the study's potential to collect 'thick' contextually detailed (Geertz 1973) and rich data. This helped to achieve its aim of exploring how rural community maternity units contribute to NHS Scotland's Quality Ambitions of safe, effective and person-centred care.

4.4.2 Recruitment

The Heads of Midwifery for each CMU were willing to support the research and agreed to act as impartial gatekeepers. Stakeholders were identified according to the inclusion criteria, stated in the next section, and were initially approached by the Heads of Midwifery by means of an introductory letter and information sheet about the study (Appendix 11 and 13). The letter also contained contact details and a reply slip to return to myself (as the study

researcher) to allow discussion with a view to informed consent for those who were interested in taking part.

Stakeholders were aware that participation was at all stages entirely voluntary. The Head of Midwifery took no further part in recruitment and had no knowledge of who had shown an interest so that no particular professional pressure or gain to take part could be shown.

Those who returned the slip to me and expressed an interest in taking part in the research were contacted by their preferred method and we met at a time and place of their convenience so that I could give them further information about the study and answer their questions.

4.4.3 Sample of Key Stakeholders

The sampling strategy for the face-to-face interviews in this phase of the research was purposive. This form of sampling was used to identify and recruit stakeholders who were likely, by virtue of their roles, to provide the data required to address the research objectives (Bryman 2012). The purposive sample aimed to achieve diversity in the roles and experiences of those who participated.

The inclusion criteria were stakeholders who had key roles and responsibilities aligned to the CMUs, within the host organisation (NHS Board). The relevant Heads of Midwifery identified potential participants by number of years and role working at or with the CMU, which aimed to give rise to differing perspectives and experiences. The sample was based on the following attributes:

- Discipline (midwife, maternity care assistant or obstetrician)
- Experience (years of clinical experience)
- Level of seniority (midwifery band 4 to 8, obstetric consultant)
- Area of work (within or aligned with the CMU).

The size of the sample took into consideration the scope and focus of the study, the depth and richeness of the data achieved and its' resources. Morse (2000) suggests that when each participant interviewed yields in-depth information, then a sample size of 6-10 may be sufficient. Carlson and Glenton (2011) also argued that the quality focus group data was revealed by the depth that goes beyond the superficial social meanings of the interactions, and the richness in detail of the description of a context of the data, rather than specific sample sizes.

4.4.4 Data Collection

The data were collected using the same methods for each CMU, through focus groups, semi-structured interviews, and non-participant observation (observation without taking part) of one unit meeting with stakeholders at each CMU. Various documents relating to clinical protocols and pathways, minutes of team meetings, statistics collected within the units, information sources for women and their families and information displayed on notice boards were collected. This documentary information was used in addition to the topics raised by the literature review, to inform the topic guides for the focus groups and interviews. For example, the literature raised questions of how information was given to women to assist in decision making and the different ways in which women could access information at each CMU was noted from the documents supplied, and explored with the stakeholders.

All the interviews and focus groups were digitally recorded and transcribed verbatim by myself. Notes taken during the examination of the documentary evidence and following the observation of the team meetings, which were written in the research diary and later were transcribed.

4.4.5 Data Storage

To protect the anonymity of the participants, the CMUs were allocated pseudonyms and the stakeholders were referred to by numbers. The list of numbers and names allocated to each participant and CMU were kept separately from the data collected in an electronic folder and file. Paper copies of consent forms were stored in a locked unit only accessible by myself, in a

locked office within the university buildings. Word processed transcriptions and documents were kept in password protected electronic files on the university H-drive. The transcripts were sent to the participants, with their consent, as soon after the data collection episode as possible to verify their accuracy, over a secure NHS e-mail server. The anonymised data will be securely stored at the university in accordance with university policy, the Data Protection Act 1998 and the NHS Research Ethics Committee instructions for ten years after the study has been completed.

4.4.6 Observation of Team Meetings

I observed one team meeting at each of the CMUs during July and August 2012. The aim of the observation was to witness how the everyday issues at the CMUs were identified for discussion at these monthly meetings, and by whom to give an insight into the ways in which the teams worked in practice. Observation of the way in which the meetings were led, and the development or restriction of discussion within the team, helped me to determine the key 'players' and unspoken rules (Simons 2009) in the informal team structure. This informal structure may not have been referred to or even noticed by the stakeholders, but could be observed by the researcher as subtle but obvious to an 'outsider' of the team.

Notes were made in the research diary following each meeting and areas to be followed up at interview and focus group discussions were identified particularly regarding the team leader's role and the way in which the team translated individual issue resolutions into a team ethos (Simons 2009).

4.4.7 Focus Groups

The focus groups were held at the early stages of the data collection, to allow an overview or scope of the issues concerning care provision. This provided data that, along with issues raised in the team meetings, helped to iteratively inform, or progressively focus (Stake 1995), the subsequent individual interviews with stakeholders in strategic and clinical roles.

Focus groups have been described as open-ended, in-depth group discussions that are focussed on a pre-defined topic (Goodman and Evans 2010). Focus groups with midwives and maternity care assistants working at each CMU were used as a means of collecting the views, opinions and recommendations of the midwives through the medium of group discussion. The discussions also allowed the researcher an insight into the views and experiences held and shared within the team through the language used, the space and respect offered to each participant by the group and the willingness to engage or reticence shown by individuals within the group (Barbour 2008).

The groups were both facilitated by myself as the researcher and one was observed by a member of the supervisory team. A topic guide was used (Appendix 3) prepared firstly from issues identified in the literature review, secondly supplemented by issues noted in the documents supplied to the researcher by the stakeholders and thirdly by notes taken during the observation of the CMU team meetings. The topic guide consisted of open ended questions and prompts, (Barbour 2008), aimed to stimulate discussion between the group members relating to the phase two objectives. The purpose of these group discussions on the participants' views, experiences and opinions about the care provision at the CMUs was to capture of in-depth data, exposing different points of view and agreement within the group. The full potential of focus groups lies in capturing the interactions within the group and not attempting to elicit an in-depth personal narrative from each participant.

One focus group was held at each CMU. The differing experiences of the group members in terms of length of time working at the CMU, their ages and background experiences (Kreuger and Casey 2009; Thomas 2009; Barbour 2008), aimed to give rise to different opinions on the issues raised and appeared to encourage lively discussions at both CMUs. The benefits of using focus groups in hermeneutic phenomenological studies are summarised by Benner (1994) as:

- Creating a natural communicative context for telling stories from practice.
- Providing a rich basis for active listening.

- The meanings of the participants' stories can be enriched by stories triggered to counter, contrast or bring up similarities.

- Simulating a work environment that creates a forum for thinking and talking about work situations.

4.4.8 Semi-structured Interviews

Semi-structured interviews lie on a continuum between structured interviews where the researcher dictates the direction of the interview and unstructured interviews where beyond a general interest the topic, interviewees lead the direction of the conversation determining the issues they feel should be covered (Thomas 2009). The semi-structured interview, or guided conversation (Yin 2009) allows the researcher to guide the topics for discussion whilst allowing the interviewee a great deal of freedom to express their views and explore their experiences of care provision at rural CMUs. Smythe et al. (2008) describe this as 'Our interviewing style is not structured in that we follow a pre-organised plan, nor unstructured where we go with no clear sense of why we are there, but always an interview is about something' (Smythe et al. 2008 p.1392).

A topic guide for the interviews (Appendix 2) was prepared using issues raised from the literature review, the observed team meeting, the focus group and the gathered documents and written information. The topic guide was used both as a prompt and checklist to ensure that broadly similar areas relating to the phase two objectives were covered at each interview. Considerable flexibility was also afforded for the use of questions to follow up unique or individual views and opinions expressed by different interviewees to explore how they individually framed and understood issues and events relating to the CMUs, and to distinguish what in particular was important to them (Bryman 2012).

The purpose of the interviews was to encourage the stakeholders to recount their 'lived experiences', coloured and textured with the detail and context that shaped their experiences (Healy 2011), whether at a strategic or operational level, of the provision of maternity care at the CMUs. Initial

questions about their background and how they came to their current role allowed a relatively gentle start to the interview whilst bringing the focus on maternity service or care provision at the CMUs. It is recognised that when asking participants about experiences that are common to them, asking about recent events allows a descriptive clarity and the adoption of a storytelling mode. This is particularly useful in phenomenological interviewing (Smythe 2011). Open ended questions about how examples of maternity care given by the stakeholders came about, what happened, what went well and how they felt about these together with an awareness of the effect of the listening attitude of the researcher, led to the collection of rich data from the stakeholder participants.

4.4.9 Data Analysis

The data analysis approach taken for this phase of the study is based on the work of Koch (1999), Burnard (1991) and van Manen (1990), as used by Taylor (2009, 2005). The approach is based on a cyclical process where the researcher moves between the whole text and parts of the text as described in the hermeneutic circle of understanding, in an attempt to identify common themes across the participants that form a pattern of understandings.

Analysis began at the time of the interviews, when an initial stage of interpretation as an understanding of the participants' lived experiences was attempted. As this was an iterative process, I was able to use my worldview as a midwife and a mother to help me understand some of the participants' experiences of providing care in various contexts (Lowes and Prowse 2001). I was aware of the need to remain open minded and willing to be surprised. I also had to accept that in the process of telling their stories, the participants' own interpretation and pre-understandings were brought to the interviews and focus groups (Koch and Harrington 1998).

The interviews and focus groups were audio recorded and transcribed verbatim. The transcripts were returned to the participants to give them the opportunity to assess whether they felt the interviews had been transcribed accurately, to aid transparency. The opportunity was given for participants to

change the opinions and stories expressed in the transcripts, add any further thoughts since data collection or to withdraw from the study if they wished at that stage.

The transcripts were read and re-read, and codes or issues were identified on each transcript, with page numbers and lines noted so that the occurrence of each issue could be noted.

The supervisory team (n=2) independently coded a random (n=4) selection of transcripts. Notes were made tracking the process of early interpretations of emerging categories and the three main themes. Independent coding was used to identify different opinions regarding the classification of data, reduce the possibility of members of the team acquiescing to the perceived seniority of one coder over another and reduce the opportunity for individual subjectivity (Bowling 2009). The team then met and discussed their interpretations of the codes or issues, and intercoder agreement of a coding framework was reached. This process was repeated for each transcript, a qualitative codebook was developed with definitions of codes and emerging themes, and consensus was agreed before proceeding. Creswell (2014) cautions against researchers 'going native', meaning that they become so immersed in the perspectives of the participants that they begin to 'take sides' and discuss only the results that place the participants in a positive light, ignoring findings that may be contrary to the themes developed. By working within the supervisory team, I was able to recognise, or be shown, whether my influences during data collection were affecting the way in which my transcripts were coded in comparison with those of the independent supervisors.

Moving back to the transcripts again, to reach an overall understanding of the phenomena, categories of similar issues were formed. Once the categories had been identified, the transcripts were again re-read and listened to, to identify any missing issues or categories in relation to the whole of the participants' accounts. Revisiting the participants' accounts helped to develop my understanding of the essences of the participants' views, beliefs, experiences and recommendations, which allowed the identification of the themes. The

categories were grouped along similar areas as the identified themes, for example all the participants described the importance of the CMU location within the communities, the small size of the units and the teams of staff who work there, and their commitment to maintaining their strong relationship with the people within that community. These categories were important to each participant in differing ways, but the overarching theme was that this made the participants believe that the CMU teams offered an alternative service to other maternity care providers, and so the theme 'being different' was identified.

The cyclical movement within the hermeneutic circle, shown in Figure 2, Chapter 2, between the texts and the dynamic interpretative process (Converse 2012) allowed a continuously deepening partial understanding, until no new interpretations were revealed. This was the point at which a fusion of horizons occurred, where the worlds and experiences of the participants are incorporated into worldview brought into the research process by myself to bring from two differing understandings, one new understanding (Dowling 2007).

At this point the relevant literature was used to enhance the researcher's understanding of the issues raised through the new understanding of the participants' views, experiences and recommendations. The literature revealed not only tacit knowledge, the taken-for-granted meanings that may not have been seen by the researcher, but also different insights into similar areas identified as important to and by the participants. For example, the paper that explored midwifery leadership by Byrom and Downe (2010), helped me to understand what qualities, beyond safe, competent and knowledgeable practice, made the midwives see their manager as a "good" leader. This was something that the participants and the researcher at different levels had taken for granted, but not understood, which led to an exploration of the literature about emotional intelligence and resilience.

The themes and categories by this stage were established (Appendix 4) and the participants who had contributed to these were identified. In an attempt to address an aspect of the rigour of the study, all the participants were

contacted by their preferred method (permission to contact and method was confirmed at the time of interview), with a brief explanation and overview of the themes and categories identified, along with the request for any comments to be made to the researcher (Appendix 6).

The 'member checking' stage allowed the participants to assess whether they were able to recognise the themes and categories as an honest and fair interpretation of their views (McBrien 2008). Richards and Morse (2007) caution against an over-reliance on member checking, and so further attempts to enhance rigour were made through the engagement with experienced and expert supervisors throughout the process. This maintained a transparent written audit trail following the interpretive journey with the values and pre-judgements (prejudices) of the researcher being made explicit in the research diary, as required when entering the hermeneutic circle of understanding.

4.5 Phase Three

4.5.1 Research Objectives

The research objectives for phase three were to:

- Contextualise and explore women's views and experiences of the care they receive at the CMUs, including their decision-making processes about where to give birth.
- Describe and explore what influences women's preferences for their planned place of birth by the completion of their booking process and at the end of their pregnancies.
- Describe and explore women's information needs and their experiences of decision-making during their pregnancies about their planned place of birth.

A longitudinal design was chosen for this phase of the study, requiring at least two data collection points over a specified time period (Bryman 2012). The particular strengths of longitudinal designs lie in exploring changes in people's lives, and as such, this long view facilitates the capture of an evolving experience, allowing the exploration of difference in expectations, experiences

and decision-making over time (Gerrish and Lacey 2010). Longitudinal studies can be particularly relevant in midwifery research, where women's engagement with maternity services during the maternity journey of up to one year during each pregnancy, can reveal insights that change and evolve during their experience, which may not be captured during a single data collection episode. Schmied et al. (2013) used the evolving experiences of women's prolonged engagement with the wider maternity care team to identify and describe the factors which had an impact on maternal mental health in the perinatal period and their effect on women's subsequent health five years later.

There are a number of challenges associated with conducting longitudinal research. The key challenges (Parahoo 2006) are the commitment required by the participants to repeated data collection episodes, the need to capture contemporaneous data during the length of the study, and the attrition rates associated with that commitment. Hayman et al. (2012) suggest four strategies to help maintain commitment from the participants in longitudinal studies, and these strategies were used in this study by the provision of:

- A careful explanation of the commitment required was given to each participant before they consented to take part in the study.
- Regular contact with the participants was made using Christmas cards, baby congratulations cards and my regular presence at the unit throughout their pregnancies were used in this study to encourage and validate the importance of their contributions.
- Ongoing trust and confidentiality were maintained by continuing measures to protect the privacy of information collected.
- Clarity was also given to the participants regarding the information sought at interviews by reminding them about the research aims and suggesting they refer to their pregnancy diaries (discussed later) a few days before their planned interviews.

4.5.2 Recruitment

Before the research began, I gave a presentation to the heads of midwifery and the staff at each CMU about the aims and objectives of the research, how the recruitment of the women and ongoing data collection would proceed and the ways in which the staff could help if they wished. An opt-in approach was required to ensure that only those who were interested in participating were introduced to me. Fletcher et al. (2012) reviewed the recruiting activity of clinicians and they noted the attitude of the staff regarding their knowledge and enthusiasm for the research was important in ensuring that all eligible participants were given the opportunity to be involved. My presence at the CMUs during the period of recruitment for the study allowed the staff to remain aware of the study and to ask questions about any aspect of the research and my role.

Recruitment of women to the study proceeded as described for the stakeholders. A letter of invitation to participate from the head of midwifery, an information sheet about the study and a reply slip to be returned to me if interested was sent to all women who met the inclusion criteria for the study. Arrangements were made with the women who did consent to participate to confirm their consent before their next antenatal appointment at the CMU.

4.5.3 Sampling

The sampling strategy for the women in this phase of the study was purposive. This form of sampling was used to identify and recruit women who were accessing maternity care at the CMUs and were likely to be able, by virtue of their socio-demographic and clinical characteristics, to provide the data required to address the research objectives (Bryman 2012).

Inclusion criteria were pregnant women who accessed maternity care at the CMUs for their first visit between August 2012 and October 2012 were eligible to participate in the research. Exclusion criteria were women under 16 as there were issues with their competency to consent, and those who could not read or speak English fluently as the resource constraints of the study excluded the services of a translator.

The purposive sample of women for this phase was based on the following attributes:

- Age
- Parity (number of previous births)
- Anticipated care pathway (based on previous medical history if known by team leader from last episode of care)

The exploration of women's views and experiences of care and decision-making, required women with different care requirements and expectations to maximise what can be learnt about the care provision at the CMUs.

4.5.4 Sample Size

The sample size was selected in view of the scope and focus of the study, the anticipated quality of the data obtained and the resources available (Morse 2000). Consideration was also given to the attrition rates for long-term studies, in that participants could withdraw as the study progresses, or complications of the pregnancy, birth or postnatal period made their continued participation inappropriate (Barbour 2008). Midwifery studies appear to have low attrition rates (Zielinski 2010) and whilst twenty four women were recruited in early pregnancy, it was hoped that sixteen would continue to participate throughout the study. Consideration was given to the possibility of pregnancy loss, potentially approximately 20% (NICE 2012) and around sixteen remaining participants would seem likely to maintain the diversity of social and clinical characteristics to allow the collection of the rich data required for this case study.

4.5.5 Data Collection

The data collection method of interviews informed by non-participant observation of the women's clinical encounters, and 'aide memoire' diaries, was selected to answer the research questions for this phase of the study. The research questions focussed on exploring the women's views and experiences of maternity care at the CMUs, particularly their information needs and the

influences on their decision making on where to give birth. The early pregnancy observations and interviews took place when the women were approximately eight weeks pregnant (August to November 2012). The late pregnancy observations and interviews took place when the women were thirty four to thirty six weeks pregnant (between February and May 2013). The final post- birth interviews took place between six and twelve weeks after the birth of their babies (May to July 2013). All interviews were conducted by myself using a topic guide, were digitally recorded and also transcribed verbatim by myself which helped facilitate my early immersion in the data and the recognition of emerging categories whilst the data collection was still ongoing.

4.5.6 Data Storage

To protect the anonymity of the participants, pseudonyms were allocated to the CMUs and the participants. Data were stored, verified by the participants and destroyed as described in section 4.4.5.

4.5.7 Non-Participant Observation

Non-participant observations of the women participants' booking and thirty four to thirty six week antenatal clinical consultations were carried out so that I could identify any issues that required further exploration at interview. I was able to observe how the participant interacted with their clinician, particularly how information was presented and received between them. Whilst it is recognised that my presence may have affected the way that these discussions proceeded (Bryman 2014), the observation of the way that information and attitudes are expressed and received between clinicians and women in the natural setting (Yin 2009) of the CMUs allowed useful insights into this process.

4.5.8 Aide Memoire Diaries

The challenges associated with conducting longitudinal research were discussed in Section 3.5.1, and pregnancy diaries (Appendix 15) were given to

the participants during the data collection period to help address these challenges.

Some of the advantages of collecting written data in a diary format are that diaries enable the participant to record data in privacy at a time and place of their own choosing, avoiding the inconvenience associated with multiple scheduled contacts with the researcher for repeated data collection over time (Powell 2012). Accounts written in diaries by participants to record their views and experiences in their own words, aims to capture data with the clarity afforded by its proximity to the present. Diaries are used in an attempt to record otherwise elusive influences on decision-making, allowing access to fleeting, important at the time but ever changing experiences and thoughts that may be lost or forgotten at later data collection points (Barbour 2008). Diary accounts are also useful for allowing comparisons of the participants' expectations and subsequent experiences of events or care over a period of time, for example pregnancy and birth. The use of the diary to collect longitudinal data can add a useful dimension or value to interview-based methods, particularly for generating questions at interview (Way 2011; Kenton 2010; Alasewski 2006; Elliot 1997).

The complementary diary and interview approach has been effectively used in longitudinal midwifery studies. Examples of these include studies contributing to a deeper understanding of the factors that influenced women's decisions to access care and the impact of sending them home in early labour (Barnett 2008); women's views, perceived choices and preferences regarding induction of labour (Humphrey 2008); and midwives' experiences and confidence when providing care to women in labour (Bedwell 2010). The use of the diary and interview method appears to combine the advantages of diary use and provide the researcher with the opportunity to develop a deeper understanding of the participants' recorded views and experiences through their exploration at subsequent interviews.

The women were given a diary to record their views and experiences of care throughout their pregnancies so as to capture information that may not readily be recalled at the time of the interviews. The diaries were not collected by the

researcher for analysis, allowing the women to use them as an 'aide-memoire' without the fear of judgement by another during analysis. The use of a diary in this way allowed a finely tuned insight into the women participants' particular and unique view of their world, allowing a new depth of data to be accessed.

4.5.9 Semi-Structured Interviews

Interviews were the method of choice for this longitudinal part of the study as it was felt that when exploring women's individual experiences, feelings and thoughts on a particularly intense and intimate life event, that of pregnancy, the birth of their baby and their post birth experiences, they would have the capacity to describe, explore and explain issues from the women's perspective (Tod 2010). The semi-structured style of interview, informed by the observation of the clinical encounter, the 'aide-memoire' diaries and the topic guides allowed the capture of the women's 'lived experiences' which focused on topic areas rather than specific questions. This, as for the stakeholders, allowed a balance of some structure to guide the interview but incorporated flexibility to explore areas of interest, which may have been raised by the women but may not have been anticipated.

All the early antenatal interviews were initiated with a broad open-ended question, asking the participants about their maternity journey, centred on the phrase "tell me about what's been happening to you". A conversational approach to interviewing helped me to approach the questions in a natural progression around the topic guide (Appendix 7) (Walsh and Baker 2004). This approach also attempted to reduce the traditional researcher-participant roles described by Finch (1984) who found that less structured techniques on a continuum between structured and unstructured, avoided creating a hierarchical relationship between the researcher and the participant.

The early interviews were relatively brief but served as an introduction to the experience of being interviewed for the study, the type of broad experiential questions that would be asked and laid the foundations of my relationship with the participants which would be maintained throughout the study. Important early impressions of their expectations of care, experiences of access to the

CMU for care, preferences for information and early influences on decision making for care throughout pregnancy and the birth were accessed during these encounters.

The late pregnancy observation and interviews were held when the women participants were making their decisions about where and how they planned to give birth using the same initial opening question and moulding the subsequent prompts from the topic guide (Appendix 8) as the conversation naturally progressed. The topic guide was developed from that used at the early interviews from the initial issues noted at these interviews and issues raised at the observed antenatal consultation. The late pregnancy interviews lasted from 45 to 90 minutes. The women by this time felt they had more experience of care at the CMUs to draw upon and many had used their diaries contemporaneously to record events and experiences which they felt important to discuss at the interviews, which may have faded over time, relating particularly to their information needs and decision making influences.

The majority of women chose to hold their post birth interviews in their homes at approximately six weeks after the birth. For my personal safety, the address of where the interviews were to be held was left with a member of staff at the CMU and I made them aware of when I entered and left the women's homes. Two women preferred to be interviewed at the CMU, as they wanted to return to show their baby to the staff. Although no particular time after the birth is considered optimal to capture the depth and complexities of each woman's birth experience, Lundgren (2011) suggested that whilst an immediate perspective may initially be coloured by a plethora of conflicting emotions, the passage of time allows women a longer term perspective on the physical and emotional effects of her birthing experience. The topic guide for these interviews (Appendix 9) was again adapted by emerging issues from the initial analysis of the antenatal interviews, allowing the iterative process to continue throughout data collection period. Fewer (n=8) women continued to use their diaries at this stage, but the interviews continued to yield rich, detailed contextual descriptions of the women's lived experiences of giving birth and their post birth care.

4.5.10 Field Notes

A research diary was kept in which the researcher recorded observations after each contact with the participants. These observations were made to provide a back up in case the recordings of the interviews failed or were hard to transcribe due to background noise, and to capture non-verbal communication of the participants. Observations about the preceding clinical encounter were also recorded along with a description of the interview setting and early thoughts on areas of interest that were emerging from the participants that guided the topics covered in subsequent interviews. The field dairy served to enhance the rigor of the study as a record of the research process and a reflexive account (Doucet and Mauthner 2012; Kingdon 2005) of the decisions made during the data collection and analysis process.

4.5.11 Data Analysis

The data used for analysis in phase three were the transcriptions of the interviews with the women at the three key stages in their pregnancy journeys. The interviews were informed by the observation of their antenatal consultations and their diary entries. The hermeneutic phenomenological approach as described in phase two was used in this phase as it again seeks to explore the lived experience, in this case of the women participants, valuing each of their stories in their 'everydayness' as they engaged with their chosen CMU for care during their maternity journey (Miles et al. 2013).

Each interview was audio recorded and transcribed verbatim by myself. Four postnatal transcripts were typed by an audio-typist and checked for accuracy by myself. The transcripts were returned to the participants to allow the opportunity to assess whether they felt the interviews had been transcribed accurately. Returning the transcripts to the women also enabled opportunities for continued communication with the women throughout the data collection period, encouraging continued participation and reminding the women about the use of their 'aide-memoire' diary. The opportunity was given for participants to change the opinions and stories expressed in the transcript, add any further thoughts since data collection or to withdraw from the study if they wished at that stage.

The same qualitative data analysis techniques used in phase two of the study, were used as described in section 4.3.9. The steps used in the analysis process are summarised by Taylor (2009 p.77).

1. Transcription of the interviews
2. Checking at each stage for accuracy with the participants
3. Immersion in the data by reading and re-reading the transcripts for each stage to get a sense of the whole
4. Note taking and continued systematic reading, stage by stage
5. Generation of issues by content analysis
6. Noting similarities and differences
7. Generation of broader categories
8. Establishing that categories cover all aspects of the interviews
9. Finalising categories
10. Generating themes and deciding under which themes categories belonged
11. Guarding against bias
12. Checking trustworthiness (going back to the participants with the themes).

4.6 Rigour

Reliability and validity are concepts used to measure the quality of research and the conclusions drawn in methodologies where instruments are used to test or measure responses from participants. Whilst it is important that they reliably provide accurate data to allow consistency of findings across differing situations and data, their applicability to CSR is limited. CSR, according to Yin (2009) can be used to explore phenomena or events in the precise, everyday context in which they occur, and help to understand links and pathways in how the maternity services provided at rural CMUs contribute to NHS Scotland's Quality Ambitions. Whilst a reliable instrument can be a valuable part of the information required, other sources of evidence are required to achieve the more detailed, holistic picture that can inform the required understanding.

The quantitative data were collected for this research from an adapted version of a validated instrument, a questionnaire used in national surveys (Redshaw

and Heikila 2010). The validity of that instrument applies in those particular circumstances and this lends confidence for its use in this research, as the results will be comparable to the original survey. The same instrument (an Excel spreadsheet) was also used across both CMUs allowing consistency in the variables collected and the opportunity to provide comparisons, if required, between these (Appendix 1). Should this research be repeated using the same instrument to find out the same information, then it would be a valid and reliable instrument, but should the full CSR be repeated it would be unlikely that the same findings would be replicated throughout the study. The boundedness of the case by time, as a snapshot of a particular period in the life of the CMUs, and the interpretive lens or background that the researcher brought to the interpretation would make similar findings possible but not necessarily the desired outcome of CSR (Thomas 2011).

The terms offered by some qualitative researchers as ways of establishing the rigour of a study appear to employ external measures applied once the study is completed (Ritchie and Lewis 2009) Credibility refers to the truth, value or believability of findings, dependability relates to the trustworthiness of the data presented and transferability is the extent to which the findings could be replicated in a similar setting (Creswell 2014). The dependability of this research was addressed by ensuring that there was a transparent audit trail. This trail began with the original protocol, ethical and management permissions, consent forms and associated documents and led to the anonymised raw data transcripts, research diaries, spreadsheets and analysis summaries. These are clearly documented and available for verification at all times (Parahoo 2006), but the echoes of the terms, validity and reliability can be hard to reject as underpinning concepts. Morse et al. (2002) suggest that rigor is achieved by building validity and reliability measures into a study, as an intrinsic part of the research process, rather than relying on external measures on completion of the study. The verification strategies that they suggested to ensure quality and rigor include methodological coherence, appropriate sampling and concurrent data collection and analysis.

In this study, methodological coherence involved a constant awareness of the research question, the appropriateness of the sampling frame, the data

collection methods and the concurrent analysis in order to make appropriate changes and modifications, to maintain the focus on the aims of the case study research. Thomas (2011 p.66 - 68) summarises the criteria for indicating the quality of CSR as:

- Clarity of writing, terms consistently used, defined where necessary and well constructed.
- The problem or question being addressed being clearly outlined and sufficient rationale is used for its significance.
- Research methods adequately justified and chosen appropriately
- Sufficient information given about the research process and the researcher.
- Clarity of the evidence for the main findings
- Appropriateness of the selection of cases, data collection processes and analytical techniques.
- Contextual description for the study explained and justified.
- Rival explanations addressed and justifiable conclusions drawn.

As discussed within the philosophical framework and the qualitative data analysis sections in later chapters, I made transparent my presuppositions about the care provided by CMUs as an absolute prerequisite for the credibility, transferability and dependability of this research.

The participants were asked to check initially the accuracy of their individual transcripts, and later the interpretation of early themes emerging from the study. As discussed in Section 4.7 regarding ethical and analytical issues, the views of one participant on the summary of my interpretation of the early themes arising from this research meant that a new understanding was reached (Dowling 2011). The dependability of the interpretation and presentation of the findings were then addressed by the "phenomenological nod", when the final description resonated with those who lived the experience (Oiler 1982 p.179).

4.7 Ethical Considerations

Ethical considerations regarding the conduct of this study were focussed on encompassing protection of the dignity, rights, safety and well being of all the research participants. Beauchamp and Childress (2013) identify four principles that can be used to guide ethical responsibility and accountability in research practice.

4.7.1 Beneficence

Beneficence is defined by as:

> *"A statement of moral obligation to act for the benefit of others"'.*
>
> Beauchamp and Childress (2013, p.203)

The principles of beneficence are identified as minimising harm and maximising benefits (Polit and Back 2012). Beneficence concerns providing benefits to others whilst balancing the risks, benefits and costs to achieve the best overall results for all (Beauchamp and Childress 2013). The participants in this research were made aware that whilst there were no immediate benefits to themselves in taking part, they would be helping midwives and women in the future by contributing to research that aimed to inform service development and improvement. It was recognised that when the study was completed, the termination of involvement with the research may have caused or exacerbated any feelings of isolation, which could have been potentially harmful. Contact was maintained through asking the participants to check the transcriptions of their interviews and by requesting comments on the analysis summary as the study drew to a close. This allowed a gradual closure of their contributions whilst leaving communication for any further comments open for the participants for a final month after they received the summary.

4.7.2 Non-Malificence

Beauchamp and Childress (2013 p.150) state that 'the principle of non-malificence obligates us to abstain from causing harm to others.'

Harm in this research could have caused to the participants in four ways described by Richards and Schwartz (2002) which are: anxiety and distress, exploitation, misrepresentation and identification of the participants in presentations and published papers. Each of these was addressed in this research by measures described in the following sections.

Anxiety and distress can be caused by all types of research, but qualitative research has the potential to cause harm particularly when participants are asked to recall intimate and potentially traumatic experiences (Creswell 2014; Bryman 2012; Bahn and Weatherill 2012; Parahoo 2006). During the consent process, all participants in this research were made aware of their right to stop during any data collection and withdraw any information given. Several women became tearful when recounting previous traumatic birth experiences at which point the data collection was stopped and only continued at the participant's expressed request. The long intervals between data collection points during the women's (phase three) part of the research also held the potential for me to cause them anxiety or distress by contacting them without being aware of any complications or poor outcome in the intervening weeks. This scenario was addressed by ensuring that consent was given by each woman for me to access her medical records via a clinical stakeholder (their midwife at the CMU) before any contact was made.

Exploitation was guarded against in this research by ensuring that the opportunity to recruit stakeholders and women, and to obtain data did not take precedence over the participants' needs, wishes and rights. Participants were not introduced to me until their first booking clinical consultation had been completed and they were comfortable to discuss their opportunity to participate. My observation of clinical encounters at the second booking appointment took place only after consent was reconfirmed with the participant and the clinician, and on one occasion this was given but I discontinued the observation when the participant was feeling unwell and it became inappropriate to observe her examination and distress. The interviews and focus groups were all held at the time and place requested by the participants and the comfort and appropriateness (for example clinical activity and privacy) and remained a primary concern throughout.

Participants may disclose information as part of a relationship of trust between the participant and researcher (Bowling 2009). For example in this study a disclosure of domestic abuse was made, which had not been revealed to the participants' midwife. In this circumstance the wellbeing of the woman required me to encourage the woman to inform her midwife of this abuse, which she did. The woman was made aware that if she had not informed her midwife, action would have been taken on my part to safeguard the participant by revealing this disclosure to her midwife (ICM 2014). The safety of the woman took precedence over the research objectives even if this subsequently caused a breakdown in the trusting research relationship. All participants were made aware of my priorities should circumstances arise where women or stakeholders disclosed information, or I observed behaviour, that required action from me in order to protect a participant and this was stated in the participant information sheet (Appendix 10), before each participant gave consent to take part.

Misrepresentation may have occurred in this research if the participants felt that I had misinterpreted them, leading to an apparent incorrect representation of their views, beliefs or experiences (Miller and Bell 2012). When participants were asked to validate abbreviated findings of the research, or transcripts of their interviews or focus groups, apparent misrepresentation of their views may be revealed. Participants may also feel that their views have been ignored or subjected to an alternative agenda for which they had been unwillingly used (Parahoo 2006). A short summary of the findings of the research was sent, with an accompanying letter explaining the summary related to general themes from the overall research, to all the participants in this study. Whilst all the vast majority of the responses were positive in that the participants could recognise their views within the analysis, one participant found that the summary of the findings did not place enough emphasis on her strongly held views on the value of one aspect of care at the CMUs. Further communication and clarification allowed the participant to appreciate that I had understood her contribution, which resolved her initial anger at the apparent misinterpretation within the necessarily abbreviated findings.

Harm caused by the identification of participants (Hardicre 2014) was a particular concern for this study and whilst I took measures to protect their confidentiality (as described in the justice section), the anonymity of research sites and thus the participants could not be completely guaranteed within a contextually detailed case study. The research sites were anonymised in this research by the allocation of pseudonyms (Cherrytrees and Seaview), and these have been consistently used in any presentations or publications resulting from this research. It was also recognised, and potential participants informed, that the small sample size in the qualitative phases of the study, even with the use of anonymised quotes to illustrate the participants' views, could potentially lead to identification of the participants.

4.7.3 Respect for Autonomy

Beauchamp and Childress (2013, p.101) define personal autonomy as something that 'encompasses self-rule that is free from both controlling interference from others and limitations that prevent meaningful choice, such as inadequate understanding.' The right to self-determination and autonomy includes the right to full disclosure enabling participants to make voluntary, informed decisions about whether to take part in research. Full disclosure of the expectations and commitment required for participants in this research was achieved by basing discussions, which included answers to any questions asked about taking part, and on a detailed information sheet (Appendix 11 and 12). There must be an absence of coercion to take part for a voluntary decision to be made, ensuring the ability to decide freely without the risk of prejudicial treatment by others based on that decision (Polit and Beck 2012). The right to withdraw at any time without giving a reason and to refuse to answer a question put to the participants as a part of the research was made explicit when consent was obtained and re-established before every data collection episode in this research. Informed consent for the observation of clinical encounters was also established with the clinicians before the observation took place. Impartial gatekeepers, who had no further involvement in the recruitment process for the research, were used to make initial contact with potential participants in an attempt to avoid any potential coercion. By making the initial contact with potential participants, the

gatekeepers ensured that I could not use any professional or personal contacts to persuade an expression of interest. It was made clear to all potential stakeholder participants that the Heads of Midwifery would not know who had expressed an interest. Participation in order to impress these senior midwives professionally could not be used. In the women's part of the study (phase three) any desire to gain preferential treatment or care was also avoided and anonymity preserved for all those who expressed an interest and those who decided to take part in the research.

Full disclosure involves providing a great deal of information to a potential participant, which can be overwhelming (Foster and Lasser 2011). The information needs to be understood and considered before any decisions regarding consent to take part in a study can be made. Informed consent was seen as a process in which a decision was made over time (Miller and Bell 2012). I encouraged the potential participants who requested further information about the research to ask questions and discuss with others about the commitment required to take part before any decision was made. Participants were given at least a week's 'cooling off' period to consider whether to consent to participate in this study. Informed consent with full disclosure was then revisited before each data collection episode, as continuing consent to be involved in this research by any participant could never be assumed.

4.7.4 Justice

The principle of justice, which includes the right to fair treatment and the right to privacy, is defined by Beauchamp and Childress (2013 p.13), as 'issues of diversity, equity and egalitarian distribution of resources'.

One aspect of fair treatment concerns the inclusion criteria of who is to be invited to take part in a study, in that participant selection should be based on the study objectives rather than on the power that the researcher holds over a particular group (Polit and Beck 2012). The inclusion criteria for all three phases of the research were based solely on the specific research objectives. I was known to the stakeholders to be a midwife, which raised the potential

issue of differing power balances between the practitioners and my changing role from clinical practice to researcher. In an attempt to address these imbalances, I made sure that the stakeholders were aware that my interest was in their own views and experiences concerning the delivery of maternity care at the CMUs and that there were no right or wrong answers to my open questions at the interviews. Whilst conducting the research at the CMUs, I treated all the staff in the same way with respect and integrity, whether they chose to take part or declined the opportunity.

I introduced myself to the women who had expressed an interest in taking part in phase three as a researcher. Respect for the different habits, lifestyles and beliefs was also an important issue regarding the principle of justice and this was addressed by showing tact and courtesy to all people that I came into contact with.

The need to effectively safeguard all the research participants' right to privacy regarding the confidentiality of any information held as part of this research remained a continuous priority. Anonymity was addressed in phase one of this study by removing any identifiable information from the data collected from the maternity records to protect the privacy of the women whose records had been accessed. The stakeholders who participated in phase two were assigned pseudonyms and any identifying information removed from the interview transcripts. Their roles were categorised into non-midwife, midwife, manager and strategic when quotes were used within the findings chapters of this thesis to allow the reader to understand the context of their words. The women in phase three were also assigned pseudonyms and any identifying information removed from their interview transcripts. When using quotes from the women in this thesis, their pseudonym, parity and stage of pregnancy were noted to allow the reader to understand the context of their comments.

Confidentiality was addressed by keeping the electronic data collected in all phases of the study in password protected files on a secure university H-drive. The identity of the participants and the data collected during observation and interviews was known only to me and discussed when necessary within the supervisory team. Participants at the focus groups were each made aware

during the re-establishment of informed consent of the need to show respect for each other's confidentiality before each discussion. Whilst I did not discuss any information given by the women, the midwives or obstetricians caring for them knew that they were participating in the research as two of their clinical consultations were observed. Pseudonyms for the women and numbers for the stakeholders were used to maintain each of the participants' privacy throughout the research and this has included, and will continue to include, their use during presentations and papers written to disseminate the findings.

4.7.5 Ethical Governance

The ethical governance framework for this study began with an application to the University School of Nursing and Midwifery ethics review panel. Their feedback centred around the plans in place to ensure that the women who suffered pregnancy losses were not harmed by inappropriate contact by the researcher as part of the longitudinal women's study. This was addressed by clarity around my intention to request the women's written permission, included on their consent form to participate in this research, to access their maternity records to ensure that inappropriate contact after complications or poor outcomes was not made. The review panel gave their permission for me to conduct the study, once a favourable opinion had been sought and given by NHS Research Ethics Services, the individual Health Boards Research and Development departments, the heads of midwifery and records department managers.

Any research involving NHS healthcare settings in the United Kingdom is subject to the NHS Research Governance Framework (SEHD 2006) and requires approval, governance and monitoring. This framework is in place to ensure that the patients and staff are protected from harm and that any proposed research is of sufficient ethical and scientific quality to achieve benefit to individuals, the services provided or in the policies informed by the research (Hardicre 2014).

Ethical approval was duly sought from the North of Scotland and multi-centre NHS Research Ethics Services and individual Health Board Research and

Development level. Full ethical approval was given for the study to proceed (study number 12/NS/0055) in August 2012. As anticipated and discussed in Section 4.5, the areas of particular concern for ethical governance bodies regarded the anonymity and confidentiality in the necessarily contextually detailed reports resulting from the research.

4.8 Summary

This chapter has explored the design of the study, the rationale for the data sources and sampling approaches selected. The way in which the varied data collection methods were chosen to inform this case study research were explored and their ability to provide different perspectives and viewpoints to the in-depth, real life, contextual exploration of the maternity service provision at rural CMUs. The different methods chosen to analyse the quantitative and qualitative data were explored in relation to addressing the study objectives and the requirements of the CSR methodological and phenomenological perspectives described in Chapter three. The ways in which the rigour of this study was demonstrated by the validity and reliability of the evidence from phase one, and the credibility, dependability and transferability of the evidence from phases two and three were explored. Finally, the ethical considerations for research involving data collected from the participants in this study were discussed and the ways in which particular concerns around the extent to which anonymity of the CMUs and the participants could be absolutely guaranteed in necessarily contextual outputs from the study were considered and addressed. Chapters five and six present the findings from each CMU and a synthesis of these findings is made in Chapter seven.

CHAPTER 5: SEAVIEW FINDINGS

5.1 Introduction

This chapter presents the findings of one of the CMUs, which has been given the pseudonym of Seaview. The methodological foundations, data samples, collection methods and analysis informing this chapter have been described in Chapters two and three. The findings related to each of the phase objectives are presented separately to show the similarities and differences in the views, beliefs and experiences of the stakeholders, the women and the story that the archived records in the retrospective maternity records review told. These sources of evidence were used to investigate the contemporary phenomenon of maternity service provision at the CMUs, in their complex everyday context, within the bounded framework of their care provision with the aim of answering the question: How do rural Community Maternity Units contribute to NHS Scotland's Quality Ambitions of safe, effective and person centred care?

Seaview was a rural CMU situated within a community hospital built 30 years ago, with main road access to the nearest tertiary referral obstetric unit 40 miles away. It had two single ensuite rooms, a three bedded ward area and two single rooms used for labour and birth care. Two rooms adjacent to the reception and waiting area were used as consulting rooms and a large communal area was used as a 'day room'. One further small room was used as a staff break area and for occasional overnight accommodation for midwives on call. Located within the CMU but set apart from the clinical areas was a large multipurpose room which was used for antenatal education classes, post natal groups and occasionally for staff meetings of local primary care services. Seaview had a staffing establishment of ten midwives (eight of whom worked part time), one team leader, three maternity care assistants and four healthcare support workers and one part time receptionist. A community midwifery manager held line management responsibility for the CMU teams and a strategic and service planning role for all community services in the Health Board area. The head of midwifery had a strategic responsibility for midwifery care and the quality of the care provided.

Areas within the unit were clearly designated (by physical barriers of a long desk, glass screens and closed doors) as staff space and there were no areas in the unit that appeared to be used as shared physical space for the women and the CMU team. No pictures were on the corridor walls, when the staff were asked about this they cited hospital acquired infection regulations as prohibitive for such decoration. The staff wore standard NHS Scotland uniforms according to their role. The midwives held monthly team meetings facilitated by the team leader and some individually discussed reflective practice sessions, but this was not a regular event. The team leader's office was set apart from the main reception area, the door was kept closed and she did not carry a clinical caseload. There did not appear to be an organised user support group for the CMU.

5.2 Phase One

Retrospective Maternity Records Review.

The data gathered from the retrospective maternity records review described in chapter three are presented in tables. The results are grouped according to the objectives they address. Each objective relates to an area identified in the conceptual framework of influences (Figure 3.1, p. 34) on the quality of maternity service provision at CMUs.

5.2.1 Objective One Findings

Objective One: Quantify and describe the socio-demographic and clinical characteristics of the women accessing care at the CMUs during pregnancy, birth and the post birth period**.**

The majority of the 381 women who accessed maternity care in the 12 month review period at Seaview were British (88.7%, n=338), other nationalities are presented in table 5.1. Almost two thirds of the women were employed, with 36.1% (n=138) of the women stating that they were unemployed. Table 5.1 shows the number (and percentage) of women who accessed maternity care before and after 12 weeks of pregnancy. The vast majority of women (n=366, 96.6%) at Seaview accessed maternity care within the first 12 weeks of

pregnancy, with 18 (4.7%) booking later. This early access to healthcare is associated with improved outcomes and offers the opportunity for sustained health benefits for the women and their babies (Scottish Government 2014). It appears that women less likely to access early antenatal care were expecting a second or subsequent baby, following a midwife led care pathway and were living in Scottish Index of Multiple Deprivation quintiles three and four, where quintile 5 represented the least deprived areas.

The Scottish Index of Multiple Deprivation (SIMD) was used to assess the quintile of deprivation allocated by means of the women's postcodes. The postcodes were assessed and ranked from least deprived (ranked 5) to the most deprived (ranked 1). This information is available on an open access website which was used to allocate a quintile of deprivation score to each woman's postcode. The SIMD was developed by the Scottish Government (2012) to identify small areas of deprivation throughout Scotland in a consistent ways. Its aim is to allow effective targeting of policies and funding by ranking small areas known as datazones of approximately 350 households. The datazones are ranked based on a weighted combination of data in the domains of current income, skills and training, employment, health, education, housing, geographical access and crime.

Most women (n=221, 58.0%) at booking were initially allocated to a midwife led model of care, as they had no significant morbidity or obstetric risk factors. Almost one third of the women (n= 95, 29.9%) were allocated an obstetrician led model of care due to existing ill health, or previous pregnancy or birth complications. A smaller number of women (n=65, 17.1%) required an additional specialist assessment before their lead professional and model of care was allocated as shown in Table 5.1. Two women experienced a miscarriage before assessment was made.

Table 5.1 Socio-demographic and Clinical Characteristics of the Women who Accessed Maternity Care at Seaview

Accessed maternity care	Before 12 weeks		After 12 weeks	
Characteristic	Frequency	Percentage (%)	Frequency	Percentage (%)
Maternal age (years)				
15-20	38	10.0	3	0.8
21-25	109	28.6	2	0.5
26-30	117	30.7	7	1.8
31-35	66	17.3	5	1.3
36 and over	33	8.7	1	0.3
Nationality				
White British	324	85.0	13	3.4
Eastern European	32	8.4	5	1.3
Asian & African	4	1.0	0	0.0
Other European	3	0.8	0	0.0
Relationship Status				
Married/Co-habiting	309	81.1	14	3.7
Single	54	14.2	4	1.0
Employment Status				
Employed	222	58.2	10	2.6
Unemployed	131	34.4	7	1.8
Studying	10	2.6	1	0.3
Previous Births				
None	173	45.4	4	1.0
One	126	33.1	5	1.3
Two	42	11.0	7	1.8
Three	15	3.9	2	0.5
Four or more	7	1.8	0	0.0
Scottish Index of Multiple Deprivation				
Quintile 1	34	8.9	0	0.0
Quintile 2	72	18.9	5	1.3
Quintile 3	106	27.8	5	1.3
Quintile 4	107	28.0	6	1.6
Quintile 5	45	11.8	1	0.3
Allocated Care Pathway				
Midwife Led	244	64.0	13	3.4
Obstetrician Led	118	31	4	1.0

5.2.2 Objective Two Findings

Objective Two: Describe the processes of care and clinical outcomes for the women who laboured and/or gave birth at the CMUs.

The midwife was the first point of contact with a healthcare professional for 97.6% (n=372) of women. The number of planned antenatal visits recommended by the KCND national pathways (NHS QIS 2009) are nine in a first pregnancy and seven in a second and subsequent pregnancies that last for 40 weeks. At Seaview, the median number of antenatal clinic visits for all women was nine (mean 8.94 Standard Deviation 2.13).

Just over half of all women who accessed antenatal care (n=192, 50.4%) did not make unplanned antenatal visits to the unit. Those who did make unplanned visits sought advice for a number of reasons, shown in Table 5.2

Table 5.2 Reasons for Unscheduled Antenatal Visits to Seaview

Reason for Unscheduled Antenatal Visit	Number	Percentage
No unplanned visits	191	50.3
Abdominal pain	50	13.1
Decreased fetal movements	36	9.4
Ruptured membranes	36	9.4
Headache	21	5.5
Vaginal bleeding	21	5.5
Trauma (slips and falls)	13	3.4
Feeling generally unwell	11	2.9
Gastro-intestinal upset	2	0.5
Total	**381**	**100**

Continuity of carer, defined during a recent survey (Scottish Government 2014), as seeing the same midwife all or most of the time during pregnancy, was achieved for most women. The number of midwives seen varied between one and six, and the majority of women (n=361, 94.8%) saw three or fewer midwives throughout pregnancy, which is the quality indicator set by the Scottish Government (2014) for continuity of carer.

The women's planned places of birth varied during pregnancy, with a notable rise in the number of women intending to give birth at Seaview when their birth plans were discussed and reviewed with their maternity care provider at 36 weeks of pregnancy, as shown in Table 5.3. By late pregnancy, just over half of the women (n=221, 58%) had chosen to give birth at Seaview. At the onset of labour, that number had fallen to 194 women (50.9%) which may partly be explained by 28 (7.2%) women encountering complications of pregnancy and transfer to obstetrician led care, which is discussed further in section 5.2.3.

Table 5.3 Changes in Place for Birth Decisions From Early to Late Pregnancy

Intended birthplace	Number	Percentage (%)
At booking		
Seaview	197	51.6
Obstetric Unit	130	34.0
Undecided	42	11.0
Alongside MLU at OU	9	2.4
Home	3	0.8
At 36 weeks		
Seaview	221	58.0
Obstetric Unit	127	33.3
Undecided	8	2.1
Alongside MLU at OU	16	4.2
Home	1	0.3
Delivered	8	2.1
Onset of Labour		
Seaview	194	50.9
Obstetric Unit	154	40.4
Alongside MLU at OU	26	6.8
Home	0	0
Delivered	7	1.9

The mean gestation for the onset of labour at Seaview was 282 days (40 weeks and 2 days) with a minimum of 246 days (35 weeks and 1 day) and a maximum of 293 days (41 weeks and 6 days). The birth at 35 weeks and 1 day was pre –term. Term, or mature babies, have a completed gestation

period of 259 days, and as such a pre –term birth was an unusual case, which in the rural location occasionally occurs when birth is imminent and the appropriate care at a distant referral centre is inaccessible to the woman in advanced labour.

Of the 194 women who planned to give birth at Seaview, over half (n=107, 55.2%) did not visit in early labour. Of the 87 women who did attend Seaview for advice in early labour, most visited once, (n=65, 74.7%) and some women visited twice (n=17, 19.5%). A small number (n=5, 5.7%) of women visited Seaview for assessment and advice three times before labour was established.

The most frequent form of pain management used at Seaview for the 164 women who gave birth there, was by the use of inhaled Extonox, (n=112 63.8%). Entonox is an inhaled compressed gas mixture of 50% oxygen and 50% nitrous oxide that provides self administered, short acting analgesia for the woman in labour when used during contractions. Some women (n=29, 17.7%) chose to have an intramuscular injection of morphine. For some women (n=10, 6.1%) the method of pain management data was missing and a small number of women (n=13, 7.9%) did not require any. Immersion in water was not recorded as a method of pain management, as a birthing pool was not available in Seaview.

All of the 164 women who gave birth at Seaview experienced a spontaneous vaginal birth, after a first stage of labour lasting for women having their first baby (primiparous) a mean of 7.5 hours, ranging between 2 and 20 hours and for those having a second or subsequent baby (multiparous) a mean of 5 hours ranging between less than 1 hour to 16 hours. The second stage of labour for primiparous women lasted a mean of 1 hour, with the longest lasting 2 hours 10 minutes, and the third stage mean of 17 minutes with the longest being I hour. For multiparous women, the second stage was shorter, lasting a mean of 30 minutes with the longest being 1 hour 39 minutes, and the third stage also slightly shorter mean of 10 minutes, with the longest being 40 minutes.

The third stage of labour management was primarily actively managed (n=144, 87.8%), with the use of oxytocic drugs and controlled cord traction to expel the placenta. A physiological third stage (without the use of oxytocic drugs and controlled cord traction) was achieved by five women (3%), and the records were not complete for the remaining fifteen (9.2%) of women. All women experienced a normal blood loss of less than 500 mls.

The degree of perineal trauma experienced by the women is shown in Table 5.4.

Table 5.4 Perineal Trauma Sustained During Births at Seaview

Degree of Perineal Trauma	Number	Percentage (%)
At booking		
None	70	42.7
First Degree	53	32.3
Second Degree	37	22.6
Third Degree	1	0.6
Episiotomy	3	1.8

All the women who were in labour and those who gave birth at Seaview received one to one care from a midwife.

The babies born at Seaview had a mean birthweight of 3.434 kgs, the smallest being 2.000 kgs and the largest 4.600 kgs. Two thirds of the babies (n=109, 66.5%) were breast fed at birth, and a similar number (n=97, 59.1%) were breast fed on transfer home. On transfer from the care at home of the Seaview midwives to the care of their health visitor, less than half (n=72, 43.9%) of the babies continued to be breastfed.

The resuscitation requirements of the babies born at Seaview are shown in Table 5.5. Three babies (1.8%) born at Seaview were admitted to the neonatal unit at the referral centre, all were over 12 hours old at transfer and were discharged within 48 hours. Discharge from an NNU within 48 hours is a proxy measure for where there was no significant morbidity for the baby, as

the short stay is most likely to be for assessment of the initial reason for admission (Tucker 2008).

Table 5.5 Neonatal Resuscitation Requirements At Birth, Seaview[1]

Baby Resuscitation Requirements	Number	Percentage (%)
None	149	90.8
Simple	9	5.5
Basic	6	3.7
Advanced	0	0.0

For their post birth care, just under half of the women (n= 80, 48.8%) transferred home within 6 hours of the birth, and just over half (n=81, 49.9%) stayed on at Seaview for post natal care. The mean length of stay was 2 days and a maximum stay of 4 days. Reasons for lengths of stay over 6 hours were given as assistance with breastfeeding for some (n=16, 14.8%) women, but no reason was given for most women's stay.

5.2.3 Objective Three Findings

Objective Three: Compare the clinical appropriateness of care provided to women during pregnancy, labour and birth and the post birth period with national pathways and guidelines (NHS NIS 2009).

At their booking appointment, 369 (96.8%) of the 381 women who accessed care at Seaview were allocated the clinically recommended national care pathways (NHS QIS 2009). Variations from the recommended antenatal care pathways, shown in Table 5.6 were recorded for twelve women. For one woman, referral for a previous pregnancy terminated due to fetal abnormalities was not arranged appropriately. Four other women had significant medical histories that warranted referral to the obstetrician led maternity care team, only one of whom had refused to accept the referral. For the remaining seven women, errors in documentation had been made, where the maternity care pathway recorded did not reflect the appropriate referrals

[1] Simple = Stimulation, Basic = bag and mask ventilation Advanced = Intubation and admission to NNU (Lee et al. 2011)

made and documented throughout the pregnancy record as evidence that the correct lead professional had been allocated and a clinically appropriate care pathway followed. This documentation error had not been noted or reviewed by the Seaview staff.

Table 5.6 Clinical appropriateness of allocated model of care at booking, Seaview

Appropriateness of allocated care pathway	Number	Percentage (%)
Appropriate	369	96.9
Documentation Error	7	1.8
Significant Medical History	4	1.0
Previous Fetal Congenital Abnormality	1	0.3

Twenty eight women were appropriately transferred during pregnancy from a midwife led care pathway to obstetrician led care. The reasons for transfer are shown in Table 5.7.

Table 5.7 Reasons for Antenatal Transfer from Midwife to Obstetrician led Care Pathway, Seaview

Reasons for Antenatal Transfer	Number	Percentage (%)
Post maturity	9	3.5
Raised blood pressure	6	2.3
Prolonged rupture of membranes	5	1.9
Small for gestational age	3	1.2
Ante-partum haemorrhage	2	0.8
Obstetric cholestasis	1	0.4
Breech presentation	1	0.4
Other	1	0.4

For women who planned to give birth at Seaview, 30 (15.5%) were transferred appropriately during labour to the referral unit for obstetrician led care, the reasons for transfer are shown in Table 5.8. Twenty four (12.4%) women transferred were primiparous women and five (3.1%) multiparous.

Table 5.8 Reasons for Transfer in Labour from Seaview

Reasons for Transfer in Labour	Number	Percentage (%)
Delayed progress in 1st Stage	7	3.6
Meconium stained liquor	7	3.6
Maternal medical complications	3	1.5
Delayed progress in 2nd Stage	3	1.5
Pregnancy induced hypertension	3	1.5
Epidural request	2	1.5
Maternal pyrexia	2	1.0
Suspected fetal compromise	2	1.0
3rd Stage complications	1	0.5

Interventions in labour can be defined as any interference in the physiological (normal) process of labour and birth including the use of pharmacological pain relief (including entonox and morphine) as described in the RCM, NCT and the RCOG joint statement on normal birth (Maternity Care Working Party 2007). The RCM normal birth definition has since included pharmaceutical pain management but excluded regional (epidural) and general anaesthesia (RCM 2015). Using the latter RCM definition, interventions in labour were uncommon and 156 (95.1%) of women experienced none. Interventions that women did experience at Seaview were the artificial rupture of membranes and episiotomy. An artificial rupture of membranes (ARM) was performed on five occasions, and three women had an episiotomy (a surgical incision in the perineum) at Seaview. An ARM is occasionally appropriately used (following careful consideration of the consequences including fetal compromise) to accelerate delayed progress in labour when transfer to the obstetric unit is under consideration at a CMU, or at a women's informed request (Seaview local guidelines 2011*). Episiotomies should only be used for instrumental deliveries and when fetal compromise is suspected (Seaview local guidelines 2011*, NHS QIS 2009). The reason for the episiotomies was not recorded for any of the three women, which would question the appropriateness of this intervention. *

Post birth nine (4.9%) women were appropriately transferred to the OU. Three women transferred were mothers involved with the substance misuse services

* The CMU local guidelines are not referenced and attributed to their source as this would compromise their anonymity.

on an obstetrician led model of care but had accessed care in advanced labour at Seaview and were transferred to the OU immediately after the birth. One woman was transferred for suturing of a third degree perineal tear by an obstetrician, one had developed pregnancy induced hypertension and 3 transfers were for further opinions concerning the babies. The outcomes of those mothers transferred in labour are shown in Table 5.9.

All of the five women who underwent an emergency caesarean section were transferred in the first stage of labour. Four were transferred for delayed progress and were primiparous. One of the five was multiparous and transferred due to significant meconium stained liquor. The mean of their ages was 24.

Over two thirds (n=21, 70%) of the women transferred in labour had a normal blood loss at the birth of less than 500 mls. Just below one fifth (n=5, 16.6%) of the women experienced a post partum haemorrhage with a blood loss of over 500 mls and four women (14.7%) sustained a blood loss of over one litre.

Nine of the babies whose mothers were transferred in labour from Seaview required resuscitation at birth, one required intubation and ventilation and was admitted to the neonatal intensive care unit (NNU) for more than 48 hours. Three babies were given intermittent positive pressure ventilation by bag and mask before they established regular respirations and one of these babies was also given naloxone to stimulate a respiratory response frequently used when the mother has undergone a general anaesthetic.

Table 5.9 Outcomes for Women and Babies Transferred from Seaview in Labour [2]

Type of Birth	Number	Percentage (%)
Spontaneous Vaginal	17	56.7
Emergency Caesarean Section	5	16.7
Assisted Vaginal Birth	8	26.6
Estimated Blood Loss		
Less than 500mls	21	70.0
501 – 1,000mls	5	16.7
Over 1,000 mls	4	13.3
Baby resuscitation Requirements		
None	21	70.0
Simple	5	16.7
Basic	3	10.0
Advanced	1	3.3

The breastfeeding rates of these babies were similar to those born at Seaview with almost two thirds 63.3 % (n=19) breastfeeding at birth, but fewer than one third (n=9, 30%) were still breastfeeding on transfer to the care of the health visitor. The mean of their birthweights was 3.532 kgs, with the lightest being 2.700kgs and the heaviest 4.270 kgs.

Summary

The safety and effectiveness of the care provided at Seaview can, in part, be measured by the descriptive quantitative data collected on the processes of care and the clinical outcomes recorded in the maternity records reviewed. The clinical and socio-demographic characteristics of the women revealed that a wide range of women accessed care at Seaview, one third of whom at booking were allocated to obstetrician led care and continued to receive maternity services based at Seaview. The care delivered to most women was safe. Timely referrals were made appropriately to the right healthcare professionals and safe outcomes were achieved by all the women who accessed care. Effective, early, local access to maternity services was achieved

[2] Simple = Stimulation, Basic = bag and mask ventilation Advanced = Intubation and admission to NNU (Lee et al. 2011)

by most women from the same carer throughout pregnancy and most clinically eligible women planned to give birth at Seaview.

Key findings in the domain of safety were:

- 96.9% of women were allocated to the clinically recommended care pathway at booking.
- 12.6% of women were appropriately transferred from midwife led to obstetrician led care during pregnancy.
- 15.5% of women were transferred appropriately to obstetrician led care at the OU in labour.
- 95.1% of women received no interventions in labour.

Key findings in the domain of effectiveness were:

- Early access to antenatal care, 96.6% of women attended their first antenatal visit by 12 weeks of pregnancy
- Most women planned, and were clinically eligible, to give birth at Seaview at 36 weeks of pregnancy.
- 94.8% of women received antenatal care from three or fewer midwives.
- 50.9% of all women who accessed maternity care at Seaview chose to access care there in labour
- All women in labour at Seaview received one to one care from a midwife.
- 43.9% of babies born at Seaview and 30% of those transferred in labour to the OU were fully breastfed on transfer to the care of the health visitor at 10 days old.

5.3 Phase Two

Seaview Stakeholders' Study Results

This section describes my interpretation of the data collected in phase two of the study. The section begins with the presentation of an overview of the themes and categories identified. The themes are then explored in relation to the objectives and a summary of the key points in relation to each part of the objectives will be given.

Quotes from the participants who took part in the focus group and individual interviews have been used, using numbers to maintain anonymity, to provide a link between the interpretation and the raw data. The quotes were chosen on the basis of their representativeness in their way of expressing a number of others' opinions, their demonstration of different or opposing opinions and those which succinctly summarised an experience.

5.3.1 Phase Two Objectives

The objectives for this qualitative phase of the study were to:

- Contextualise and explore key stakeholders views, beliefs and experiences of the safety, effectiveness and person-centredness of the care provided by CMUs
- Explore key stakeholders guidance and recommendations about the services and the care that should be provided at CMUs.

5.3.2 Purpose of the focus group and interviews with stakeholders

The purpose of the focus group and interviews was to investigate the stakeholders' views, beliefs and experiences of the provision of care at Seaview. Both methods had been informed by the observation of a team meeting and the collection and reading of documents relating to and including the unit guidelines for clinical care and audit, and documents displayed on noticeboards. The aim was to gather in depth information about the

stakeholder's lived experience at strategic and clinical levels of the services and care provision at Seaview.

Tables 5.10 and 5.11 show a summary of the recruitment and the participants' roles in relation to Seaview.

Table 5.10 Summary of Recruitment to Seaview Focus Group

Post	Invited to participate	Participated in Focus Group
Maternity Care Assistant	3	0
Midwife		
CMU Experience <5 years	2	2
5-10 years	3	3
Over 10 years	4	1

In total, twelve stakeholders were invited to participate and six declined.

Table 5.11 Summary of Recruitment to Seaview Individual Interviews

Post	Invited to participate	Interviewed
Maternity Care Assistant (non-midwife)	3	1
Midwife		
CMU Experience <5 years	2	1
5-10 years	4	1
Over 10 years	5	3
Manager/Local policy maker	2	2
Obstetrician	1	1

In total, 18 key stakeholders were invited to take part, nine declined.

5.3.3 Data Collection and Locations

The focus group took place at Seaview in a meeting room, and lasted 55 minutes. Individual interviews were offered at a time and place of the participant's choosing. All the participants chose to give their interviews at Seaview, except the head of midwifery and the obstetrician who gave their

interviews in their offices at the obstetric unit. These interviews lasted between 35 and 70 minutes.

5.3.4 Overview of Seaview Stakeholders' Phase Two Results

The rich and complex data obtained from this phase of the study was analysed as described in Chapter 4. Three main themes were identified from the categories, which arose across the spectrum of stakeholder experiences. The themes identified were: being different, aspiring to improve and reaching out. Within each of the themes, the following categories were identified:

1. Being different
    - Geographical isolation from the Obstetric Unit (OU)
    - Small, stable team
    - Community support
    - Continuity of carer
2. Aspiring to Improve
    - Focus on women and their choices
    - Recognition of success, constant monitoring
    - Developing and sharing knowledge and skills
3. Reaching Out
    - Recognising differences
    - Building networks
    - Working across boundaries
    - Communication with respect and integrity.

Each of these is discussed separately, although links between the themes and categories are made where relevant.

5.3.5 Being Different

In the context of this research, being different meant providing a different, alternative service to that offered by other maternity care providers in other parts of the service such as an OU or an alongside (located beside an OU) midwife led maternity unit. Seaview's ability to offer an alternative service for a wide range of maternity care for most women, was clearly linked to their geographical isolation from the OU where the stakeholders perceived that they were able to provide a calm, less hurried environment for maternity care, in contrast to the busy OU. The small, stable team working at Seaview allowed them to develop strong supportive ties between team members. The stable team were also able to provide continuity of carer for women in the community and establish the position of Seaview in the community for the provision of maternity care to most women in the area. The support of the community allowed the staff to have a confident outlook on Seaview's unique place within the range of maternity care options presented to women in the area.

Geographical Isolation

All the stakeholder participants in clinical roles saw the geographical isolation of Seaview as having a direct effect on the calm and relaxed atmosphere that they perceived had been created. One stakeholder noticed that when women who had been given care at Seaview were transferred to the OU, they were surprised at the difference. The use of language is also of interest in this quote, 'patients' from the OU and 'women' from Seaview, implying perhaps the ways in which this stakeholder perceived women in different settings.

> *"I have a lot of patients from (OU) who think that the women from (Seaview) get a five star service, so there can be a bit of…and also the (Seaview) women expect a bit more so if they come down to (OU), they are just used to a different standard of care, so they find (OU) a bit of a shock. So, in some ways we spoil them a little, you always hear from*

(OU), oh, your (Seaview) women are on another planet." (Obstetrician Interview)

Whilst geographical isolation can be regarded as a disadvantage for some women who needed to access specialist maternity team services at times during their antenatal, labour and birth and post birth care at the OU situated forty miles away, Seaview provided local access to the services required by most women. These locally accessible, decentralised services were seen by the stakeholders to be important in reducing health inequalities for all women, particularly those who were unable or unwilling to travel to the OU. One non-midwife stakeholder working at Seaview encapsulated the importance of locally accessible maternity services.

"The girls on our side have poor employment, there is a lot of social problems, it's the deprivation, it's these girls you need to target […] and they need their community maternities. They need the support, they need the education and they need the trust so that they feel comfortable. If they don't feel comfortable, if they're going in to (OU), they clam up and they won't tell you nothing. Here (Seaview) they tell you everything. There is a niche that you can nurture with some of them, and you can improve their quality of life." (Non Midwife, Interview)

The distance from the OU did pose challenges that were recognised and considered when making clinical decisions. The midwives at Seaview referred to times when they were affected by adverse winter weather which they perceived held issues for them which were more complex than planning for transfer of women from Seaview to the OU. These complexities extended to the OU staff not considering deteriorating road conditions when advising women in labour and planning to give birth at the OU, when they should attend for care.

"We were in control up to that point, but then the women decided to deliver and another lady that was in labour turned up and decided to go quickly as well. If we had phoned for help, it would have taken a good hour and a half for the help to arrive anyway […] and sometimes when we do call, there's no-one on the end of the phone." (Midwife 8, Interview).

The midwives related historical stories of women and ambulances arriving at the CMU with women who required the input of the full maternity care team at the OU, but were unable to continue their journey as they were in advanced labour and 'called in' at Seaview to access the care of the midwives for the imminent birth as a safer (and warmer) option than an icy roadside. These stories were told by the team leader and members of the team with typically over ten years of experience at Seaview, and despite improvements in the transport infrastructure, they contextualised a sense of vulnerability associated with their geographic isolation.

Small, Stable Team

The strengths and weaknesses of the team were perceived in different ways by the stakeholders in strategic and clinical roles. They all agreed that the stability of the team and their ability to work together was a great asset. One stakeholder felt that this had also been a weakness, in that the team had been left to its own devices until a new management structure had recently been implemented.

> *"It's quite a stable team, therefore haven't always had the opportunity to bring new ideas and new thinking into the team. I think the fact that they are such a closely knit team […] has actually at times made it quite difficult for them to be objective with each other. In day to day clinical practice for example, they all know each other so well that there can be a tendency for them to say, well, (name)'s such a good midwife, if she's made that decision, that must be right."* (Manager 1, Interview)

The stakeholders who had clinical roles, however, saw the team as supportive, and during the focus group the first comment made about working at Seaview, was about the team.

> *"It's a really good team, we are supportive of each other. We aren't scared to bring things up with each other as well, we give constructive criticism if need be."* (Midwife 3, Focus Group*).*

This difference in views may indicate that the drivers for change within the team, which were a number of critical incidents, and learning from these

adverse events had achieved a significant change in the team moving forwards in their professional relationships to enhance safe practice throughout the team.

> *"Good always comes out of bad situations here in (Seaview) because I do actually see that they've changed the way they behave […] that's what I think is really positive about this team."* (Manager 1, Interview).

The staff at the CMUs were consistently able to provide one to one care for women in labour. Team on call systems were in place to ensure that midwives were available as required to care for women in labour and working patterns were used flexibly during periods of high demand so that women's choices to access care in labour at the CMU were facilitated.

> *"One to one supportive care in labour which helps reduce the interventions, again that is a luxury that we can have that other bigger units can't provide. It is a luxury that we can afford but it shouldn't be a luxury, again it's down to staffing, but we do have that luxury here."* (Midwife 1, Focus Group).

Leadership attributes in the Seaview team appeared to be shown by all those who participated, although it is recognised that participation in itself revealed a self-selecting group. Each team member had developed their own strengths and recognised where service improvements could be made, for example in setting up young women's antenatal education groups and streamlining the communication of women who have accessed antenatal care to their General Practitioners (GPs). Recognising and developing the weaknesses of the team was a leadership attribute displayed by individual members of the team, particularly accessing training for obstetric emergencies relevant to the CMU context. These were all discussed and shared at the focus group and solutions to problems offered. The lack of a clinical leadership role was evident.

> *"I know (team leader) is meant to be on the floor always, she's got so much managerial things to do now, she's always in the office, so it would be nice to have a midwife you can touch on for querying things. You can*

disturb her, but then she'll say, where's the midwife?" (Non Midwife, Interview).

Seaview had undergone some considerable changes in the three years before the study began, and whilst the changes were seen by the staff to have been imposed in a 'top down' approach, the lack of a strong team vision for the future development of the CMU may have prevented the team developing their own 'bottom up' ideas for service improvement. One of the managers responsible for implementing the Health Board's strategic vision expressed her wish for the staff delivering the services to be more active in the development and ownership of changes.

"I think that it would be really good to be able to get them more involved and then able to feel that they have a greater input into how the service is going because they have the answers […] but I think sometimes it's the belief, even dare I say the value, they can feel that their ideas are not going to be good enough." (Manager 2, Interview).

Community Support

Seaview is situated in the centre of the community, close to the local shops and schools on the first floor of the local community hospital. The community held a perception that Seaview as a small maternity hospital that was able to provide for all maternity needs, most notably operative and assisted births as it had done historically in the memory of the community. This community historical memory and immediate proximity to the local hospital gave the staff some issues.

Despite these apparent historical shortcomings, Seaview was seen as an important part of the choices of care venues offered to women within the maternity services available in the Health Board area, supported at a strategic and midwifery team level. The midwives saw Seaview's central role in the life of the community as an important part of its' sustainability in the future, and as such were seizing opportunities to expand the services available within Seaview, subject to the development of the necessary knowledge and skills.

"We are a very social unit, and we have the potential that we could bring families together and be the heart of the community. I don't think we are quite achieving that just yet, we could bring families together if you've just moved to the area and don't know anyone yet, but we've got baby massage […] There are always things we can improve on but we will get there, things like the pool." (Midwife 1, Focus Group).

The perception that the community was very supportive of Seaview gave the midwives confidence when discussing their choices of where to give birth with women, although that perception was not universal.

"I think some of the older women, they're so supportive of this unit (Seaview). I always say keep your options open, then one woman came back and said I'm having my baby here, my Mum said so" (Midwife 7, Interview).

Another Seaview midwife was concerned that not enough of the local women were choosing to give birth there, as she felt that the town it was located in had a poor reputation, which could have made it less attractive to the women from a large new town a few miles away. To address these perceived misconceptions, she organised an open day to let the women see around the CMU and meet the staff, to which she was delighted to have attracted forty couples.

"My idea was, come and have a look then you can make a proper, informed choice" (Midwife 5, Interview).

"I think we will only have success with that (Open days) for 3 or 4 years because the new unit will open, and I think they will go that way because it is en route to the consultant unit in a way, so I think we will struggle again then." (Midwife 5, Interview).

This midwife was less optimistic about the support for Seaview in the future, as she was concerned about the impact of the predicted opening of a new rural CMU in a town 30 miles away and geographically closer to the OU.

Continuity of Carer

The ability to provide continuity of carer was a key source of satisfaction and pride for the Seaview team, and the linked visiting obstetrician recognised the value of this aspect of care that the CMU model was able to achieve. The midwives each carried a caseload of approximately 30 women allocated to them by virtue of assigning the women by their GP. This meant that when women contacted Seaview to access care in early pregnancy, they were given the name of the midwife who would be their named midwife co-ordinating their care throughout their pregnancy, whichever care pathway they followed. Occasionally through a change of GP between pregnancies, a midwife who had cared for them in previous pregnancies would be requested. The linked Consultant Obstetrician was also able to provide continuity to most women on the maternity team care pathway, which she valued as a rare experience in her role.

> *"I know my women from (Seaview) much more than I know my women from here (OU). It's a busy clinic, but I quite enjoy it because of the continuity with the women, which is sometimes very lost in a bigger unit, you know, you see them once then you don't see them for the next four months. I find that's not the case with Seaview at all, and it's a nice little unit I enjoy going there and working with the people there and again because it's so small and you know everybody, I quite like that."* (Obstetrician, Interview).

Contact with a named midwife during pregnancy is seen by the Scottish Government (2011) as an effective way of encouraging access to care, whether within the antenatal clinics held at the CMU and at some GP surgeries, or outside usual clinic hours and venues. Midwives frequently referred to their flexibility in arranging antenatal appointments for women in their caseload outside normal clinic hours to accommodate women's working hours and confidentiality issues in early pregnancy.

> *"There was a lady the other day who had her first appointment in the clinic, she was aware that there would be other people coming in that*

morning. It was her second or third baby but she really didn't want anyone to know so she started getting more and more anxious, because her midwife was able to recognise that because she had known her before she asked, will we reschedule and you can come back in the evening or at the weekend?" (Midwife 1, Focus Group).

Some midwives felt that as women's relationship and trust grew with a named carer, they were more likely to share confidences about their medical or social situations.

"'You wonder if that helps them disclose more, because they feel comfortable." (Midwife 1, Focus Group).

The midwives were also able to provide continuity of carer within families and got to know the family circumstances.

"We don't just know our women, you know their families and you know a lot about their backgrounds and you just know so much about so many people, not in a gossipy way, you just know them and you're much more sensitive to it" (Midwife 7, Interview)

Continuity of carer during pregnancy was also seen by the midwives as an advantage when women chose to give birth at Seaview, particularly when their named midwife was available to care for them in labour, as the antenatal period was seen as preparation for labour and the relationship developed over time helped the women to stay focused and relaxed.

"I think that when you've got that continuity, when you have that one to one care you are actually in a more privileged position where we can identify deviations from normal quicker." (Midwife 1, Focus Group).

The midwives were all aware that post birth the continuity of carer model was not maintained, but valued the continuity that maternity care assistants provided with post birth care.

"That's what I like about working within the community, you've got that follow through, because you go out to them and you see them, they are

used to seeing you about in the unit, so they are comfortable with you, you're not just a face in a sea of faces." (Non Midwife, Interview).

The problem of arranging a known carer for antenatal clinics when the named midwives were on holiday was also raised as a barrier to maintaining a commitment to continuity of carer. Arranging a suitable midwife for the clinics was termed as 'stressful', particularly when the team leader was away at the same time, perhaps raising the issue of a lack of co-ordinated forward planning of consistent care within the Seaview team.

5.3.6 Aspiring to Improve

This theme represented the stakeholders' aim to provide women with the best care for each person, centred on their choices and preferences throughout their maternity journey. The ways in which they achieved this aim was represented by their ability to recognise the successful areas of their work where their vision of the person centred care they provided aligned with safe and effective care. The Seaview team did however find the pressure of a perception of constant surveillance from their managers difficult to accept as a positive influence on the care that they provided. The Seaview team were undergoing a process of change and recognised the need to develop new skills to develop their competencies in areas that improved the women's experiences of maternity care within their own communities. This emphasis on care nearer to home had implications for the sustainability of Seaview within the wider provision of maternity care and refocused the Seaview team's aspirations to improve the service they provided to women.

Focus on Women and Their Choices

All the stakeholder participants discussed the choices women made around where to give birth. Some felt that opinions on the suitability of Seaview as a place to give birth were polarised and women were either very wary of the OU, or very keen to be at the OU in case of emergencies occurring. The options of home birth were rarely mentioned by the midwives during the observation of clinical encounters, but featured in the midwifery manager's considerations. The obstetrician presented the alongside midwife led unit at the OU as an

acceptable option for women who wanted to give birth in a midwife led unit but were at risk of experiencing complications during labour.

Awareness of the dynamic nature of risk assessment and the ability to change care pathways during pregnancy was indicated by the midwives, but the accommodation of requests by women to give birth at Seaview when they were not anticipating a normal care pathway seemed to be less well received. The process of referring women who made unusual requests described by the midwives appeared to bypass the team leader, despite her clinical leadership role, and move directly to the consultant midwife or obstetrician for an individual plan to be made for the birth.

The midwives felt that they used a flexible approach to accommodating women's particular requests for maternity care, but possibly due to an adverse event to which they all alluded, any requests for unusual care in labour were met with grave concerns.

> *"I had one woman who put her hand over my hand and said you're not calling (OU), I'm not going and you're not going to write that in my notes. I got into trouble with that and I learnt my lesson to hell with that and now if the women come in, then they sit here until I document in the notes, so if I see them for ten minutes and it takes me half an hour to write it, then they're waiting for half an hour. I've got more firm and strict about that because I have to protect myself, before I trust the women."* (Midwife 8, Interview).

The language used when describing women's choices proved to be revealing. The Team Leader referred to a particular group of women who accessed Seaview to give birth when an OU birth had been planned as "monkeys" as she felt that they were putting her staff "at risk". Another midwife described caring for women who were not clinically eligible but chose to access labour and birth care with the Seaview midwives.

> *"It can make you nervous if it goes to the stage where we actually have to provide the care."* (Midwife 4, Interview).

This nervousness perhaps indicated a lack of clinical leadership and support when women's choices required a collaborative approach with the OU team and supervisiors of midwives.

Recognition of Success and Constant Monitoring

The midwifery managers and the obstetrician all identified successful areas of the Seaview team's work. The team was described as very enthusiastic, embracing of new ideas and open to new ways of working. A recent maternity services review had reaffirmed Seaview's place within the NHS board provision for maternity services with future plans to expand the services offered to offer local care to more women experiencing some pregnancy complications, indicating confidence at a strategic level in the model of care delivered at Seaview.

Recognition of the success of the Seaview team was given by the OU staff through feedback from the care of women who been transferred from Seaview to the OU. Where feedback was given from the OU team to individual midwives, it was deeply appreciated. The Team Leader's role in feedback was seen to be passing it on from other sources, at team meetings or on an individual basis.

> *"Yes, that really is appreciated, it is nice to know sometimes that you've done it right as most of the time we are doing it right, but you do get incidents."* (Midwife 7, Interview).

The risk management team at the OU encouraged the midwives to recognise their successes, but also contributed to them feeling under a spotlight.

> *"When risk management audits our notes, there's not usually much to complain about, but we get picked up on very quickly when we do things wrong, trust me."* (Midwife 7, Interview).

The manager's views on the spotlight shone on Seaview differed in how representative they considered the incidents were of the general standard of the safety of the care provided.

"When incidents happen in a CMU, because they're midwife led and low risk, they can take on a level that is out of proportion to something that can happen in a tertiary unit that can be very similar." (Manager 2, Interview).

"When you look at that in comparison with the very small number of births that they (CMUs) have, you have to think that's significant." (Manager 1, Interview).

Records were kept by one of the midwives at Seaview of monthly figures about the births at the CMU, transfers and the reasons for these but not the outcomes, and the number of unplanned visits. They were available for the staff to consult, but the records are kept in raw data form, so descriptive conclusions were not drawn for the staff to see the trends in the data. The staff made varying guesses at Seaview's rate of the transfer of women in labour, and all referred back to the book where the information was gathered but were unable to draw on any analysis of that information.

The perception of increased scrutiny caused frustration amongst some of the midwives allowing it to define their practice as more defensive in their approach to transferring women to obstetrician led care.

"Hopefully we are transferring them in plenty of time so it doesn't become a problem" (Midwife 3, Focus Group).

Some of the midwives turned this spotlight into a positive.

"If anything we have to think faster because we haven't got a buzzer, we have to rely on our own intuition, and training and guidelines [….] you are the one who is in charge of her care so it is your decision, make your own decision." (Midwife 5, Interview).

This midwife used the perceived scrutiny as a way of enhancing the team's decision-making, confidence and use of the unit's guidelines.

Developing and Sharing Knowledge and Skills.

The need to develop the knowledge and skills of the staff at Seaview has been recognised by the team and their managers. Plans have been made to enhance Seaview's sustainability by developing and extending the local maternity services provided there. The linked obstetrician has clearly noticed improvements in the way that the skills of the midwives in antenatal risk assessment and appropriate referral have developed.

> *"I think they've got much better at intervening at the right time and picking up the risks […] I used to get a lot of referrals saying is she OK to deliver here, but they make that decision themselves now a lot of the time. They now know the protocols they work with and I think these have helped."* (Obstetrician, Interview).

The sustainability of Seaview was at the time of the research predicted to be improving, as the understanding from the service review was that whilst birth numbers were important, local access to most maternity services for most women was also of great importance.

> *"All that sort of stuff you can do out there that prevents women coming in to a tertiary unit makes a huge difference, that also makes a huge difference to the tertiary unit (OU) because it is bursting at the seams and we're fully well aware of that but until we can push some of that back out very appropriately, back into the community, then we're not going to be able to make the changes in the tertiary centre."* (Manager 2, Interview).

The staff at Seaview were aware that if they were to be more accessible to all women and provide the day assessment and services that they understood had been proposed, changes in their networks of governance and communication would have to be made. These changes primarily involved a closer relationship with the wider maternity care team. The team leader had reservations about how these changes would happen and the support she would be given.

"*I'm not sure how they are going to work that out. That is a plan that they have and I welcome that but we need…there isn't enough staff to deal with*

that at the moment although my manager thinks there is. I just don't think so…I don't know what they're going to do, how are they going to achieve that? It's a terrific unit, it works well, the patients like it and I am proud of it." (Midwife 6, Interview*).*

The midwives also noticed an issue around support for access to training, but attributed that to its limited availability in the local area.

> *"Even certain training things as well, there are a lot more dates and a lot more things that midwives will get regular access to being in the busy hospital, […] whereas being more isolated you would think that it would be more of a priority to make sure our skills are up to date."* (Midwife 1 Focus Group).

One midwife identified opportunities to share the contextually appropriate skills with OU staff when developing an emergency 'skills and drills' course, to share the transferable skills that the midwives used when there was no emergency buzzer to pull for help to arrive immediately.

5.3.7 Reaching Out

This theme represented the stakeholders' views, experiences and beliefs about the relationships that the team had developed with the obstetrician to enhance collaboration for all women who accessed maternity services at Seaview. The provision of maternity care to most women required effective, efficient and proportionate use of resources, initiated for those who required onward referral by the Seaview midwives. The mutual recognition of the roles each clinician provided for the differing needs of women as they progressed through their maternity care journey was noted as an area where the improvement of staff attitudes towards each other's roles would greatly enhance the transitions of care that may be required. Reaching out from Seaview to appropriately access care across contextual boundaries was seen as essential to maintain the provision of safe and effective care, but inter and intra professional relationships were seen as barriers to this. Ways of communicating with respect and integrity were offered as a solution to

reaching across these contextual professional boundaries, but reaching out to colleagues in the wider maternity care team remained a problematic area.

Recognising Differences

Recognising the CMU's place within the wider maternity service provision was important for the Seaview stakeholders to appreciate their value within the wider team, and appreciation of the differences in midwifery roles in different contexts. Whilst the Seaview team felt that they were considered by other midwives at the OU as less clinically competent than them, their team leader was keen for them to have confidence in their contextual knowledge and experience, and this did seem to translate into their practice.

> *"When they make you feel small on the phone and you're saying well, I've been a midwife for quite a while now, I think I know what I'm talking about."* (Midwife 8, Interview).

The Seaview team described a degree of frustration with the lack of knowledge about the context of the care that could be provided at Seaview. Several incidents were used as examples of OU midwives questioning Seaview midwives about their transfer decisions and giving their opinions on the suitability of the decision, and of medical staff requesting the Seaview staff to carry out procedures and investigations which were inappropriate in the CMU context. The Seaview midwives were aware of the parameters of the services they could provide and confidently used their guidelines to explain their actions. Historical issues with the ambulance service using Seaview as a place to collect midwife escorts en route to the OU appeared to have also been resolved. The midwives did express a wish that the differences in context could be resolved.

> *"Sometimes it can be a little more aggressive than supportive"* (Midwife 1, Focus Group).

One Seaview midwife's view that her role was "true midwifery", when referring to the spectrum of care that she was able to provide within her role in the CMU model.

> *"I mean that is true midwifery that we get to practice and I think that's one of the things with the rural area, you get to do a bit of everything. When I left the OU, that's when I learnt so much about normal midwifery."* (Midwife 3, Focus Group).

This could be seen as a contributing factor to barriers in understanding the differences between practise contexts. This term could be construed as a slight on the work of midwives who choose to work in other areas and specialities as not being "true midwifery".

Building Networks

Seaview relied on supportive networks with other healthcare professionals within the community that they served, and with the OU team. Local networks with the Health Visitors had recently improved by strengthening the daily face to face contact that came about by an office move to the same floor as Seaview. The social work department had also recently begun, by the invitation of the team leader, to use a meeting room adjacent to Seaview each week to hold their child protection meetings to improve interaction and collaboration between the social work and the Seaview teams.

> *"What's improved is before with the Health Visitors, we never used to have this good relationship, they would complain about us and we would complain about them, until we met up with them each morning. Now they see our job and we see their job and it's completely different."* (Midwife 6, Interview)

The networks between the Seaview team and the GPs in the area appeared to depend on the amount of contact that the midwives had with the surgery. Three midwives held their antenatal clinics at the surgeries and this caused some problems in effective communication when different IT networks were used by Seaview and the GP surgery.

> *"That's the downside of the satellite (GP) clinic is we don't have access to the computer system, I do in (local village 1) and I can access all the details there, but if I come back here and see a patient here, I don't have*

access to the system in (local village 1) from here." (Midwife 3, Focus Group)

The midwives did however report that their regular presence and contact had helped to make progress in the referral of women to the midwife as their first point of contact with maternity services and maintain the women's relationships with their GPs for medical care during her pregnancy.

"It's just having a chat and saying well, this woman is pregnant, going over the caseload and letting them know. The benefit of doing it in the surgery is that I can go and ask can you help me with this, can you do a prescription and you know…I really like it, and the GPs are feeling a bit cast aside." (Midwife 4, Focus Group)

For those women who chose to give birth at Seaview but did not fulfil the clinical criteria, plans for their care during labour and birth were agreed with the Consultant Midwife who would ensure that the care plan had been communicated throughout the multidisciplinary maternity care team where relevant. The midwifery managers both saw the accommodation of the women's decisions to give birth at Seaview as an important part of providing person centred care, however they emphasised that the impact on the staff meant that the team needed to be aware of the support necessary, including by Supervisors of Midwives, for the midwives to provide that care.

"Ultimately, we can't talk about choice on our terms only […] we have to be very aware of the staff and the support required for them in these difficult circumstances." (Manager 1, Interview)

Occasionally, that support system of the advice of the Supervisors of Midwives was difficult to access for the Seaview midwives as the contact was made via the OU receptionists.

"As she left for the OU, the Supervisor of Midwives on call phoned to inform me that reception had been calling the wrong number, but the Supervisors (of Midwives) on labour ward were excellent, they were all excellent and they advised all the things we could do." (Midwife 4, Interview)

Access to other support through the multidisciplinary team at the OU was achieved in these circumstances and the Seaview midwives found that effective relationships through the link obstetrician helped to achieve a satisfactory outcome for a women and baby in difficult circumstances.

Working Across Boundaries

The Seaview team worked across the boundaries of care provision when they referred women at any stage during their maternity journey to the obstetrician led team, and when they resumed the care of women as their care pathways changed during their maternity journeys. Most of the women who required the input of an obstetrician during their antenatal care were seen by the linked obstetrician at a fortnightly clinic held at Seaview. The obstetrician led antenatal care was provided locally for the women, but this did raise some issues regarding the services that could be provided within the limitations of the IT and equipment resources available at Seaview. Communication links from that clinic to the Seaview team had also historically been found to be less than optimal and a formal link at the clinics between the obstetrician and the team leader did not appear to have been made a priority. The obstetrician was not communicating information with the Seaview staff in a timely manner regarding women's diagnosis, treatment and plans following referral. Individual midwives had developed an informal method of contacting the women to find out what had been said and organised, but the team leader had not addressed this communication issue, which had the potential to affect the quality of the care provided by the Seaview team.

> *"So now I follow them up with an appointment or a phone call, I try to follow them up […] it's quite difficult because she (the obstetrician) will plan certain things and sometimes, until you get the letter through, you don't know what's happening, so personally, I don't know about the other midwives, but me personally, I'm trying to follow them up. I don't know if that's successful, but I'm hoping that it is, because there's that potential to get missed."* (Midwife 7, Interview)

Future plans made during the health board maternity services review for Seaview, included closer collaboration with the obstetrician led team by extending the provision of some maternity services, for example day care

assessment, to Seaview. Whilst the implications for Seaview staff development were recognised by all, working across the boundaries of physical distance and service provision was recognised by one manager as having implications for building bridges from both sides (OU and Seaview) to improve the service provided to the women.

> *"There's some aspects of development that need to happen not just for the staff here, but for the staff they will be linking with, in terms of how they engage with local services and react as well with local services, like our consultant colleagues who really need to fully buy into the concept and I'm not sure they do, despite the fact that we've got a strategy."* (Manager 1, Interview)

Communication with Respect and Integrity

A vital part of reaching out across contextual boundaries and developing the professional networks that support women when these boundaries were pushed or challenged, was the ability to communicate effectively, with honesty and respect both for the different professionals at either end of the communication, and the woman about whom the communication was being made.

The SBAR (Situation, Background, Assessment and Recommendations) tool had been introduced into the practice of the Seaview staff as a structure to encourage safe and effective communication at any interface of women's care between professionals. Whilst one manager stated that it had been embedded into practice at Seaview, some midwives appeared to have experienced difficulty in using the SBAR as a communication tool. After explaining her difficulty in establishing with the OU staff that the difference in guidelines for labour management were because they were contextually appropriate when attempting to transfer women in labour, one midwife was asked how she found the SBAR tool. Her reply was that she had "never" found it to be useful.

This lack of enthusiasm for the SBAR tool expressed by some Seaview midwives may be explained by two barriers to its use, which were revealed by the stakeholders. The first barrier may have been that tool was introduced at

the same time as changes were made in the referral mechanisms, from a midwife to midwife exchange to informing the appropriate level obstetrician, usually the speciality trainee registrar. The Seaview midwives took time to adjust to informing a doctor of a decision to transfer that they had made in advance, rather than a historically collaborative joint decision on the merits of transfer with the OU midwives.

> *"It's nice to know that there's a somebody in the OU on the end of the phone that we can rely on. It's one situation speaking to the midwives, but if there's no registrars available you have to go to the consultant and you shouldn't be speaking to the labour ward sister. I think that sometimes, because they work in the labour ward, they come across these situations, so whether it be guidelines or their own experience, they would be able to advise us what to do."* (Midwife 8, Interview)

The second barrier to SBAR use by the Seaview midwives was that the tool had not been introduced throughout the maternity services at the same time, and the OU staff had not been trained in its use.

> *"They're getting interrupted all the time when they're speaking about what, you know, going through their SBAR and the person at the other end isn't listening to them and jumping in […] It's that meeting in the middle we have to work on and get better."* (Manager 2, Interview)

Respectful language was also an issue that required attention when communicating information about the care of women. Attention has already been drawn to the use of the word "monkeys" by the team leader, and her frequent use of "patient" and "deliveries" referring to women and births was noted as part of her more traditional approach, historically based on a medical model, style of leadership. The term "patient" was used to a lesser extent throughout the Seaview team, with some staff referring to the women in their caseload in a paternalistic way as "my girls".

The Seaview midwives used different methods of communication with the GPs, ranging from using opportunities for informal conversations during GP practice based antenatal clinics, to e-mailing the practice managers generally and GP's

individually to disseminate information about which current antenatal guidelines and information related to those for pregnant women. They found that by opening the lines of communication, they were able to prevent results copied to GPs and, for example in the case of glucose tolerance tests, unnecessary extra investigations being initiated by the GP.

> *"Maybe you should email them the protocol for diabetes in pregnancy, we got (name) to do that and it's really cut down the number of fasting blood sugars that they were doing. There are little niggly things like that which do come about."* (Midwife 2, Focus Group)

The standard of communication between the midwives and GPs appeared to impact on the effectiveness of the care provided to the women. No standardised method had however been initiated or agreed between Seaview and the GPs.

5.3.8 Summary of Key Points

The stakeholders were confident that women experiencing an uncomplicated pregnancy who chose to labour and give birth at Seaview received safe care. The stakeholders appeared slightly less confident in the provision of safe care to the women who experienced pregnancy complications and continued to access care with the linked Obstetrician at Seaview, which had implications for the ongoing service redesign plans. This lack of confidence appeared to be due to unresolved issues with inter and intra professional communication and management and informational continuity of women's care. Women who chose to access care at Seaview during labour and birth but were clinically unsuitable for midwife led care also raised concerns for the midwifery team about the safety of the care that could be provided for women and their babies in the rural context. The team had developed networks of support and looked beyond their immediate team leader and colleagues to pro-actively and safely prepare for unusual labours and births.

The stakeholders were also confident that they provided effective care to women who accessed maternity care at Seaview in that they referred women appropriately to other members of the maternity care team, effectively

directing the right women to the right clinician at the right time. The team at Seaview, managers, and the stakeholders with strategic roles described issues with referrals particularly during labour and birth relating to their ability to effectively reach out to the wider maternity care team using respectful communication with appropriate obstetricians. These issues seemed to be rooted in a lack of understanding and agreement about contextual issues between members of staff that appeared on occasion to create barriers to the effective transfer of the women in Seaview's care.

The stakeholders held differing views about the person centredness of the care provided at Seaview. The team providing clinical care were keen to highlight areas where the needs, wishes and preferences of the women were sought and respected through developing relational continuity of carer throughout the antenatal period. Non-clinical stakeholders in management roles were concerned that women were not offered all their place of birth options such as homebirth.

The stakeholders' guidance and recommendations about the services and care that should be provided at Seaview focussed on the future progression of the CMU within strategic plans to develop the maternity services available to most women in their local area. The mixed reception to these plans centred mainly on an enthusiasm for expanding local services tempered with anxiety about the commitments to staff development required and improving communication with the wider maternity care team to safely bridge the cultural divide between the OU teams and the rural Seaview team.

5.4 Phase Three. Women's Longitudinal Study Results

This section describes the researcher's interpretation of the data collected in phase 3 of the study. The observation of clinical encounters and interviews informed by the aide memoire diaries provided rich and complex data from the women's perspective on their views, preferences and experiences of the maternity care they received at Seaview. An overview of the themes and associated categories is presented and themes are then explored in relation to the objectives and a summary of the key points will be given at the end of the

section. As this was a longitudinal study, where appropriate, findings will be presented chronologically. Quotes have been selected and used as described in section 5.3 to illustrate some of the findings and pseudonyms are used to protect the participants' anonymity.

5.4.1 Phase Three Objectives

The objectives for this qualitative longitudinal phase of the study were to:

- Contextualise and explore women's views and experiences of the care they received at Seaview, including their decision making processes about where to give birth.
- Describe and explore what influenced women's preferences for their planned place of birth by the completion of their booking process and at the end of their pregnancies.
- Describe and explore women's needs for information and their experiences of decision-making about their planned place of birth.

5.4.2 The purpose of the observation and interview

The purpose of the observation of the women's clinical encounters at the beginning and the end of pregnancy was to observe how information was exchanged at these encounters, though it was acknowledged that my presence was likely to cast doubt on the 'typicalness' of these encounters. I placed myself out of the sightline between the participant and her midwife and remained quiet and still throughout the consultation in an attempt to minimise the impact of my presence. The purpose of the interviews was to investigate the women's lived experiences of their care by exploring their views and experiences of their information needs, preferences for place of birth and what influenced these preferences and ultimately their decisions on where to give birth.

The demographic and clinical characteristics of the women recruited to the women's longitudinal study are shown in Table 5.12. Twelve of twenty five women who were invited, consented to take part. One experienced a

miscarriage shortly after the first data collection episode. Eight women continued to participate in the late pregnancy observation and interview and seven women participated in the post birth interview. Reasons for attrition did not need to be given, but attrition was noted to be more common amongst women who had developed complications during pregnancy and those who gave birth at the OU.

Table 5.12 Demographic and Clinical Characteristics of Women Participants, Seaview

Characteristic	Number of Women
Maternal age (years)	
15-20	4
21-25	2
26-30	3
31-35	2
36-40	1
Nationality	
White British	12
Relationship Status	
Married/Cohabiting	9
Single	3
Employment Status	
Employed	7
Unemployed	5
Previous Births	
None	5
One or More	7

5.4.3 Data Collection and Locations

The observation of clinical encounters took place at Seaview for all twelve participants except one whose care was being given by a Seaview midwife at her GP's surgery, where she also chose to hold her antenatal interviews. All the other antenatal interviews were held in a private, quiet area adjacent to Seaview. Though participants were encouraged to choose the time and place of their interview, most preferred to combine them with their clinical observation visit to Seaview. One post-natal interview was also held in the quiet room adjacent to Seaview. The other six were held at the women's

homes. Whilst the early pregnancy interviews were short, varying between 15 and 35 minutes, the later interviews lasted between 45 to 70 minutes.

5.4.4 Overview of Women's Study Results

The data obtained from this phase of the study was analysed as described in Chapter 4. Three main themes were identified from the categories in the same way described for the stakeholders, which arose across the varied women's experiences. These were: being known; being available; and decision-making influences. Within each of the themes, the following categories were identified:

1. Being Known
    - Welcomed, remembered, centre of care
    - Continuity of carer
    - Wishes, decisions and preferences respected.
2. Being Available
    - Information giving and information seeking
    - Accessible community service
    - Inclusivity.
3. Decision-Making Influences
    - Environment
    - Experiences of care
    - Confidence

5.4.5 Being Known

The theme of being known encompassed the women's desire to feel valued by the staff providing their care through their initial welcome to Seaview both in person and over the phone, and through the conduct of their caregivers after

their initial contact. Remembering the women's wishes and preferences from visit to visit and from previous pregnancies was an important aspect of how the women perceived the person centredness of their care and this was closely linked to continuity of carer. The importance of maintaining continuity of carer particularly when complications arose before or after the birth was emphasised by the women as crucial to their perception of the safety of their care. Continuity of carer was also closely linked to how the women's wishes and preferences were taken into account and respected by their clinicians when information was being discussed in partnership with the women. Being known by the caregiver seemed to encapsulate these issues for women throughout their varied experiences of maternity care.

Welcomed, Remembered, Centre of Care

From their first contact with Seaview, most women were very pleased with the friendly reception they had and were either given an appointment at the time, or were told the name of the midwife who would be caring for them and when it would be convenient for their named midwife to call them back to arrange a booking visit. Most women were also impressed that they were encouraged to call Seaview if they had any questions in the meantime and were given information about recommended vitamin supplementation in early pregnancy.

> *"I phoned the unit to say that I needed to make an appointment and they said yes, perfect we'll get (name of midwife) to phone you back. She phoned back when they said she would and gave me the appointment and a number to phone anytime with any questions beforehand, or come up anytime. So I found them really friendly, really helpful and friendly."*
> (Kate, second baby, 8 weeks pregnant)

Fiona found her reception a little less helpful when she required a scan at 8 weeks, suggested by her obstetric consultant following a late miscarriage the previous year. When she called Seaview to access this care she was told to make the scan appointment independently and had problems arranging this until her GP was able to access a scan appointment for her.

> *"I didn't really know how to do that because I thought it would maybe be the midwife's job but then one of the other midwives let me know that it*

was, well, I was told that it was my job. It did take quite a few phone calls to actually get that done because it ended up that the GP did it for me. Just different to how it's been in the past." (Fiona, third baby, 8 weeks pregnant)

Another woman, Kate, had been offered pre-natal counselling by her Seaview midwife following a traumatic birth at the OU in her previous pregnancy. When her named midwife saw that she had made an appointment to see her, she pro-actively called the woman to see how she was before the appointment and tailored her antenatal care around the woman's needs. These experiences appear to illustrate quite contrasting approaches to care from different Seaview midwives for two women with non-standard care needs.

As their pregnancy progressed, most women appreciated feeling known and remembered. Niamh described this after she recounted a visit to the OU.

"I felt just like a number, but here (Seaview) you've got a name, you've got a face, so it's totally different care." (Niamh, first baby, 12 weeks pregnant)

Most women continued to receive care tailored to their individual needs. One woman had experienced antenatal depression for which she required extra support in the form of increased antenatal visits with her midwife.

"But they've been really supportive, (Midwife) made my appointments every two weeks for a while, then every four weeks, just to see how I was getting on because I would rather that than go in to the doctor for some reason, and she was fine with that and she said anytime I can phone, which was, it was lovely just having them on the end of the phone, so I've been looked after, definitely, yes definitely, it's been really personal." (Kate, second baby, 36 weeks pregnant)

Fiona received most of her antenatal care at the OU, but was very clear on what she felt she had missed out on at Seaview.

"I'm quite a people person so you like to feel wanted, and there (at Seaview) they are there for you, they've got time for you, just the nice

things, friendliness really, and that you're not being a pest in any way […] it's just having time, giving people the time they need and eye contact or sitting down with you for a few minutes." (Fiona, third baby 38 weeks pregnant)

At the post birth interview all the women who gave birth at the OU were disappointed with the lack of personalised care they received after their babies were born. Jane had experienced a pre term birth by emergency caesarean section, following a severe ante-partum haemorrhage, which occurred when she was alone at home. She had hoped for more understanding of her traumatic experience and recognition of her need for extra support from the Seaview team when she and her baby were discharged from the OU.

"I thought the midwife was to come back the following day, and she says no, you only see us for your first ten days, and that's her ten days old now, so we're just coming in and then we'll hand you over to the health visitor and I thought, that's not really, I didn't really like that. I wasn't happy with that. Fair enough she was ten days old, but she was still quite vulnerable. I'll never forget, I saw, I think it was (midwife's name) came to my house the day after I came home, I came home on the Sunday, and she came here on the Monday morning, and after that, that was it." (Jane, fourth baby, 10 weeks post birth)

Several women referred to their post birth care as a "tick box" exercise that appeared to be focussed on getting the paperwork completed rather than the needs of the women and their babies.

Rachel gave birth at Seaview and had a very different experience. She remained at Seaview for several days as her baby had lost weight, but she declined the paediatrician's advice to transfer to the OU. Her two year old daughter found the separation from her mother very difficult, but the staff helped to minimise this.

"They let, normally it's just visiting, but because I was there for a week, they let her come in anytime, so whenever she needed me." (Rachel, second baby, 8 weeks post birth)

Niamh gave birth at the OU due to late pregnancy complications.

> *"I think that at (Seaview) it's personal, you just feel like it's about you."* (Niamh, first baby, 12 weeks post birth)
>
> She felt that her experience of care at Seaview before and after the birth, in comparison with OU care, was centred on her own personal needs and not on the requirements of the staff or institution.

Continuity of Carer

Women who had accessed maternity care at Seaview in the past, often asked for the same midwife to be their named carer in subsequent pregnancies.

> *"I phoned up and asked to speak to (midwife) because I remember she said that if I was trying again or I found myself pregnant to get in touch with her. […] I think, knowing that I will be in contact with her for the next nine months, and she is responsible for my care, I think you have to build up a relationship with her, but she makes it easy for that, and approachable as well"* (Caroline, third baby, 8 weeks pregnant)

Those who were expecting their first babies were told the name of their midwife at their first contact with Seaview and for those who did not have any other contact with Seaview for advice, their relationship with that midwife began at their first booking ante-natal visit. Most women reported feeling excited about their first visit, and those meeting their midwife for the first time also felt nervous, but their nerves were settled quickly.

> *"I felt sort of calm with the midwife I was given."* (Catriona, first baby, 9 weeks pregnant)

For some women, the relationship with their named midwife developed into a confidence and trust in the midwife's abilities to provide effective care and balanced information tailored to each woman's circumstances. This relationship with their midwife occurred particularly for those who were on a midwife led care pathway and received continuity of carer throughout their pregnancy.

"They've got the time to be friendlier and build up a relationship with you [..] I do feel that especially (midwife), I've seen a couple of other midwives, but it feels like she will go beyond, yes, to help and to make sure that everything went as normal as possible. I feel totally relaxed with her and I can ask her anything, talk about anything and I know that if anything changed tomorrow she would put me to OU for my safety." (Kate, second baby, 36 weeks pregnant)

Other women experienced a lack of continuity for various reasons. Some developed complications at an early stage, which meant that their care was transferred to the obstetric consultant who saw them regularly at a clinic located within Seaview, but they lost contact with their Seaview midwife.

"It was a pain, I had someone different between (midwife) and (midwife). It was alright, but I had to come and see different folk at different times." (Sally, first baby, 36 weeks pregnant)

Several women missed out on continuity of carer as two midwives went on maternity leave and the women on their caseload were not re-assigned to another midwife on a permanent basis. This omission led to four women, including those with complex needs, not having a named midwife to co-ordinate their care and provide a named continuous midwifery contact for the women throughout their potentially disjointed maternity journey.

"Because my midwife went on maternity leave I didn't really see much folk at all, I saw a couple of different midwives, but as for going through my book (maternity record) and stuff like that, it's been (obstetric consultant). I went to a couple of antenatal classes but they weren't much help either because they don't really help with twins." (Anne, first babies, 34 weeks pregnant)

The women who had experienced continuity of carer with their named midwife throughout their pregnancy, were disappointed at the discontinuity they experienced after the birth.

"I had different ones come in every day. Then he (the baby) developed a touch of jaundice and they said they'd keep an eye on it, but it was a

different midwife every time. They were asking me, has it got any better? I thought well, a bit of consistency would have been better. I was a bit kind of, I don't see the point, there's no consistency." (Caroline, second baby, 11 weeks post birth)

Fiona had been advised by her obstetrician, due to her complex obstetric history, to access most of her antenatal care at the OU.

"I do think that if they could have had the same person it would be better, because you sort of feel under pressure as well, because you sort of think don't cry when somebody comes and especially if it's someone new as well, you think oh no, so I do think it would be better if it was the same person, especially for vulnerable families, I think that would be much better." (Fiona, third baby, 6 weeks post birth)

She experienced issues in pregnancy with conflicting advice from the many different obstetric doctors that she saw. Whilst she tailored the post birth care around her family's needs by visiting Seaview to access some of this care, she was aware that other women may feel the pressure of having a new midwife visiting most days to deal with.

Wishes, Preferences and Decisions Respected

During early pregnancy, some women preferred to be seen at Seaview outside normal antenatal clinic times so that they could maintain their privacy over the pregnancy, and fit these visits in around their work and family commitments.

"It was an evening appointment because obviously before twelve weeks I didn't want to tell anyone else, so it was fine for me, it fitted in fine for me." (Angela, first baby, 9 weeks pregnant)

At their first appointments, I observed women being asked about their preferences and any decisions they had made about early screening tests were explored. Whilst all the women consented to blood tests to monitor maternal wellbeing and most consented to screening tests quantifying risk categories for specific fetal conditions, not all did. One woman held firm beliefs about the relevance of the tests to her decision-making, and these were listened to and respected by her midwife.

"For the blood tests and stuff, yes, they're not forcing you into anything." (Kate, second baby, 8 weeks pregnant)

Most women reported that they brought a relative, partner or friend to support them during at least one antenatal consultation. These people were recognised as important aspects of the women's social support network, were welcomed to the consultations and included in the care whenever it was appropriate.

"It was her (midwife) that suggested going to the classes for him, because she knew I was more worried about him and the labour than myself." (Caroline, third baby, 36 weeks pregnant)

Nine of the twelve women expressed a wish to give birth at Seaview, and their midwives supported these wishes. Where there was doubt as to the clinical appropriateness of these wishes, the midwives were seen to respect their decision and make efforts to ensure that these preferences were based on an understanding of their particular circumstances. Angela was planning to give birth at Seaview and was referred to the obstetric consultant because her baby clinically seemed to be large for its gestational age.

"Since I spoke to the midwife today, and the bump is not as big as it was, I'm quite happy just to stick with (Seaview). As (midwife) said, it depends on the next scan, and then we'll just see what happens then, but (midwife) seems quite happy that I can, that I'll be fine here, so I can stay here." (Angela, first baby, 36 weeks pregnant)

After the birth of her baby, Rachel felt that she had been clearly listened to and that respect was shown for her preferences.

"(Seaview) tried to get me to go to OU, so I just said I wasn't going unless he started losing weight. So, for the first few days they weighed him every morning at the same time, phoned OU and they spoke to me at the same time but he was fine, he was doing fine" (Rachel, second baby, 8 weeks post birth)

Other women, however did not feel listened to, and their preferences were not supported. Caroline had tried to breastfeed her baby in the OU where he was born, without success.

> *"She was kind of like no…no. I can appreciate that they are busy, but I still don't feel really like I was treated well, but she was having none of it. Don't ask the question if you don't want to hear the answer. So, I never got to have him in (Seaview), I never got to breastfeed him and I never got to do anything I was wanting."* (Caroline, third baby, 11 weeks post birth)

When she returned home, she was disappointed and wanted to try breastfeeding again. This course of action was encouraged by the first midwife she saw, but dismissed by the second. When she tried to discuss this, and her traumatic labour with the midwife, she felt the midwife was not prepared to listen and summarised her care during labour, birth and the post birth period as not achieving any of her wishes.

5.4.6 Being Available

The theme 'being available' arose from categories that explored Seaview's ability to be accessible to all women, at all times, for information and consultation by whatever method the women found convenient. The ways in which women sought information about issues that were important to them and the ways that these needs were met were often related to the readiness of the Seaview midwives in the sharing of information. The ability to present relevant individualised information to women in an accessible form, whether by using verbal explanations, printed literature or offering advice over the phone, was important in helping the women to understand and deal appropriately with issues relating to themselves and their pregnancies. The information sought by women in different circumstances was required to be accessible to them at the times that it was needed, and had to be inclusive of their specific needs in order to fulfil all their requirements. The Seaview team needed to provide information tailored to women's individual circumstances in an effective and inclusive form, for them to access care that conformed to their preferences and wishes in a safe manner.

Information Giving and Information Seeking

Most women said that they appreciated the verbal and written information they were given at their booking visits. The written leaflets and books offered by the midwives were opened and relevant sections explained to the women in every early pregnancy encounter that I observed. Niamh described the huge amount of information she had to take in, and how the midwife helped with that.

> *"I think the whole being pregnant thing was kind of overwhelming, so it's hard to take everything in, but the way the (midwife) has been explaining everything to me, she's not used big fancy words or anything I don't understand. She's put it in a way that I understand so I know what's going on and what's happening and I don't sound stupid when I'm trying to ask her what she's talking about. So she says it in a way that I can just, I can refer to."* (Niamh, first baby, 11 weeks pregnant)

In later pregnancy, access to information and advice were made by phone and by visiting Seaview for specific problems, and most women were satisfied by the responses given to these information needs.

> *"I was really out of breath a few months ago and didn't feel well. I phoned up and they said OK, come straight up. So I came up and they tested my iron. It was quite low and I got tablets within two days. There was no waiting or making an appointment or anything… I couldn't ask for anything more from them here"* (Kate, second baby, 36 weeks pregnant)

Kate also had specific information needs following her feelings of a lack of involvement in her care during a traumatic birth in her last pregnancy.

> *"So this next time, even if it's shouting at me, shout and tell me what's going on, just tell me at the top of your lungs, just shout and tell me what's going on and that's because I had to be cut before the forceps went in and they never told me about that and that was the worst pain, that was the worst, more than the contractions and the delivery."* (Kate, second baby, 36 weeks pregnant)

Caroline was, however, disappointed with the Seaview midwife's response for information about the wellbeing of her baby after a fall on ice whilst out shopping. She was told to contact the OU, where the appropriate care and information could be given. Without transport or childcare, she found the advice extremely difficult to follow.

> "*I'd just got such a shock, and then I phoned (Seaview) and they couldn't, nobody here would because entertain me, see me or nothing because I was only thirty one weeks."* (Caroline, third baby, 36 weeks pregnant)

When her continuity of care began to fragment, Sally chose to use the information given on a television programme, to help her glean information to discuss with her mother about what to expect in labour.

> *"I watch that 'One Born Every Minute' , I watch it with my Mum. If I watch it with him (partner), he just laughs and thinks it's funny. My Mum says that some of that's just for the camera, they make it look bad when it's not bad."* (Sally, first baby, 36 weeks pregnant)

After the birth, the women had time to reflect on the information they had been given about labour and birth and evaluate whether it had been useful to them. Kate and Caroline had varying responses to information about induction of labour give to them by their midwives. One had sought and received the information she required from her midwife during an antenatal consultation, in case she was faced with the prospect of having her labour induced, but another had a different experience.

> *"Another bit of detail on it, it's nice to know what happens as I wasn't too sure how long after your due date you're allowed to go." (Kate, second baby, 36 weeks pregnant)*
>
> *"It was afterwards when I read online about you actually don't have to agree with the date they give you. I thought it was compulsory, you couldn't go past a certain number of days or it would be extremely, that was the impression I was told, it would be very dangerous. I could have*

been at home for two days maybe and out walking a bit more, then he might have come on his own." (Caroline, third baby, 11 weeks post birth)

Caroline was not satisfied with the information she received from her midwife and described her frustration at not feeling fully or appropriately informed about her options when an appointment for the induction of labour was arranged for her.

Accessible Community Service.

Most of the women participants accessed the majority of their antenatal care at Seaview. Sally, Anne and Niamh developed complications, which could have meant that they required antenatal care at the OU, but were able to continue their care locally due to the range of services provided at Seaview.

All the women expressed their appreciation of the ease of accessing care at Seaview or their local GP surgery, for the convenience of its locality and the simple ways that they could make contact by referring themselves in early pregnancy rather than going through a third party. All of the women expecting their first baby contacted their GP initially and then were directed to Seaview to organise their care. Most of those who had previously accessed maternity care contacted Seaview in the first instance, though Rachel did contacted her GP initially as she was considering whether to continue with the pregnancy, then accessed care at Seaview once she had made her decision to continue.

The women were aware that once care had been accessed at Seaview, they would then be referred on to the wider maternity care team if necessary.

"I know I'll have to go to (OU) this time, but I'll still be here right up til it's time to, but you never know, it could change and I could end up coming here." (Mary, second baby, 8 weeks pregnant)

Mary described her hopes that Seaview would develop facilities that could make it appropriate for more women experiencing complications to give birth locally, in the care of staff that they knew and trusted and close to their local support networks of family and friends.

"It's a shame that it's just if you have a straightforward birth, that you can only come here if you've been here all the time. You go to (OU) and you don't know anybody. You've never met any of them before, and there's lots of people there and it's just kind of, you're next." (Mary, second baby, 8 weeks pregnant)

Access to some services provided at Seaview were at times overstretched, and some women were asked to go to an neighbouring maternity unit to have their ultrasound scans during particularly busy times. The linked obstetric consultant's antenatal clinics were also run to capacity and several women felt the effects of that.

"The number of appointments I've had cancelled, changed appointments, like today I was due to be seen at ten past one, and that's ten past two when I got to see her. Sitting there on those uncomfortable seats for an hour, when I'm in the discomfort that already I'm in, it doesn't help and that's just about every time I come. If I was still at work, it wouldn't be good trying to explain that every time I come here, oh how come it took you so long?" (Anne, first babies, 34 weeks pregnant)

Accessible local services were important after the birth for Anne who gave birth to twins at the OU but required extra support with breast feeding before she went home. She described great relief at coming to Seaview, where she felt the staff had the time and patience to help her. Unfortunately, Anne was overwhelmed by the number of local visitors she received immediately after arriving at Seaview, and was disappointed that the staff did not help her to create the quiet, nurturing environment that she had anticipated.

"I think it took a lot out of me because I was really emotional, I had so many visitors, I think it just took everything out of me, I broke down and said no more visitors, I'd just had enough." (Anne, first babies, 6 weeks post birth)

The importance of local access to post birth care at Seaview following discharge from the OU, was demonstrated by Fiona and Angela in particular. Fiona had arranged to visit Seaview to access post birth care at times that suited her family commitments rather than waiting at home to be visited, the

timing of which proved to be too unpredictable for her. Angela developed an infection in her caesarean section wound and was able to access effective information and treatment at Seaview.

> *"The stitches were sort of leaking and it had changed colour. I just went into the maternity and just said to them look, can you just check, so the midwife said oh come right through, and she took a swab."* (Angela, first baby, 8 weeks post birth)

Angela's experience of the willingness of the Seaview staff to provide post birth care at Seaview revealed that the venue of the care, within Seaview's buildings or at the women's homes, appeared to make a difference in how effectively the services were delivered in terms of the use of the women's and the midwives' time.

Inclusivity

Although all the women participants were white and British, Rachel, Sally, Claire, Kate, Anne and Caroline had potential issues of exclusion due to reasons related to their social and economic situations, sexuality or the ethnicity of their partner. Self referral by the women to the Seaview team allowed timely, early access to an assessment of each woman's maternity care needs with their midwife. Sally was young (sixteen) and in a relationship with a man who had a criminal conviction for sexual offences. The man accompanied the woman on all antenatal encounters and answered for her frequently during the observed consultation. The midwife explained the importance of hearing exactly what the woman's thoughts and answers were, using humour but clearly asserting her point.

> *"The midwife asked the woman to provide a freshly voided sample of urine and accompanied her to show her to the toilet, where as the partner could not ostensibly follow, she made enquiries about the couple's domestic situation and specifically about domestic violence. She told me about this after the couple had left, but started a family record when they returned from the toilet, which she clearly explained to the couple meant social work involvement."* (Research diary extract)

Kate developed mental health issues during her pregnancy, which she felt were quickly recognised and treated with sensitivity by her midwife.

> *"I came to one of my appointments with (midwife) a few months ago and told her I had been feeling really low […] I did a lot of crying and staying up till 2 or 3 o'clock in the morning just worrying about money and things I wouldn't normally worry about. So I had been talking to her and she said it was maybe antenatal depression. That explained everything to me, it's not me, it's this pregnancy."* (Kate, second baby, 36 weeks pregnant)

Kate was concerned about the stigma of admitting to having mental health issues, particularly regarding whether her care of her son may have been called into question. Her support from her midwife and specialist local GP services allowed her to begin to make a recovery before the birth.

> *"Yes, it's been really hard but that's passed and I'm more excited now."* (Kate, second baby, 36 weeks pregnant)

Caroline's husband was becoming a father for the first time and in his culture women helped other women to give birth and men were not included. She had become concerned about his reluctance to be with her during labour. This was compounded by the fact that Caroline was expecting her third baby, and other parents made assumptions that they were both experienced in maternity and childbirth matters. Caroline's Seaview midwife recognised her anxieties about her husband's apparent lack of involvement and made suggestions to her help overcome these concerns. During her labour in the OU, however, she felt that he was traumatised.

> *"He did say it's put him off having another one. My Mum did say, she did see him the next day just being totally shocked, I think he got a big shock because he's never been involved and so he panicked."* (Caroline, third baby, 11 weeks post birth)

The OU staff had made assumptions that he had experience of being with his wife in advanced labour and was comfortable with that scenario when the midwife was not present in the room, which left him traumatised and unwilling to contemplate ever supporting her in labour again.

5.4.7 Decision-making Influences

This theme emerged form the data relating to how women felt about Seaview as an appropriate place, or not, to access care throughout their maternity journey. This theme follows on from those relating to the differences that Seaview offered in comparison with other locations for maternity care and the availability of information and appropriate referral at anytime for each woman from the small team of staff. The calm environment created within Seaview, and the way in which the staff appeared to have time to spend with each individual woman was appreciated by the women although to Fiona it emphasised the remoteness of Seaview should an emergency occur. The women's previous experiences of care at Seaview and the OU were particularly influential on their decisions about where to give birth particularly regarding how they felt about the safety and person centredness of the care they had received in the current and previous pregnancies. Confidence in the care that the women received was closely related to continuity of carer, which remained a strong influence on the confidence and trust exhibited by the women through their decision making in partnership with, or in the absence of their named midwives.

Environment

All the women commented on the quiet, relaxed environment provided at Seaview. Most attributed this to the amount of time that was spent with them by the staff and the absence of a feeling of time pressure or rushing.

> *"It's so easy because I sometimes think I may be holding her up, but it's so comfortable and we yap, it's nice that you can come in and have a bit of a laugh."* (Fiona, third baby, 9 weeks pregnant)

The environment was influential on many women's decisions about where to give birth. The time that some women had spent at Seaview for their antenatal care allowed them to appreciate the atmosphere and support available.

> *"I'm happy to stay here to have the baby. It's easier for family and it's a lot better and more supportive than what (OU) is, and it's quiet and everything."* (Sally, first baby, 36 weeks pregnant)

Fiona did, however, find the quiet atmosphere a little disconcerting.

> *"The lights were off, there were no women in and there were just the two midwives there and it made me think if something was to go wrong, I know there must be doctors in the other part of the hospital, but if they needed somebody it's, at certain times there's not the same volume of staff there, say if something went wrong, that (OU) would have."* (Fiona, third baby, 36 weeks pregnant)

The local setting of Seaview was noted by the majority of women as an important aspect of their decisions about accessing care, particularly during labour and birth, to stay close to their families and support networks.

> *"It's more about being close to home. You sort of feel so alone when you're through in (OU). It's only certain times people can come through and it's so far. Sometimes it's awkward for the kids finishing school, by the time they're finished, have their tea and come through they're tired. It just feels more relaxed, because you know that like my mum could be in just after I have the baby and you've got the company there that you know you need."* (Catriona, fourth baby, 8 weeks pregnant)

For Rachel, who gave birth at Seaview, the support of her grandmother was recognised as very important to her.

> *"In (Seaview) my grandma got her breakfast and stuff, and her dinner along with me, she was there with me first thing in the morning until five at night".* (Rachel, second baby, 8 weeks post birth)

This closeness to Rachel, both emotionally and physically as her grandmother was within walking distance of Seaview, meant that the Seaview staff ensured that Rachel's post birth support network remained intact.

Experiences of Care

The decision in early pregnancy about where to give birth was based on what happened in labour the last time for women who had been cared for in a previous pregnancy at Seaview. Those who had been transferred to the OU in labour still planned to give birth at Seaview again. They appreciated that transfer was a risk but balanced that risk with the benefits of accessing local care with known midwives.

The women expecting their first baby used the opinions of their friends and relatives about Seaview's local reputation to form part of their decision making influences. Some, however, trusted the midwives to guide them.

> *"It's local and I'd had no dealings with this place before. I'd never been or anything like that, but there was no reason not to come here. If there was something that went wrong here, they would just put you through to (OU), but hopefully they won't need."* (Angela, first baby, 8 weeks pregnant)

By late pregnancy, as their various experiences of care at Seaview, and for some the OU developed, their perceived options for care during labour changed. Some developed complications including of multiple (twin) pregnancy, the placenta covering the exit to the birth canal and severe obstetric cholestasis (liver complication of pregnancy), and they planned to give birth as recommended by their obstetrician, at the OU. Angela was frightened and disheartened by the language used by the linked obstetrician when she saw her at Seaview and questioned her own ability to give birth.

> *"I just, after the obstetrician, when she said you can try for (Seaview) but, it was just those words, you can try. It was like, how long will you leave me struggling before you decide to put me to the OU, where I might need a section anyway. Surely if that's the case then I should just be booked in for a section and that's it."* (Angela, first baby, 36 weeks pregnant)

The change in her outlook and expectations were obvious between early and late pregnancy. Angela's labour was eventually induced six days after her estimated date of delivery, and her normal sized baby was born by caesarean section because her labour did not progress following induction. When

revisiting her decisions after the birth, she regretted her decision to have her labour induced as she felt she had not been given enough information on the process and expected outcome.

> *"If I'd known that then I maybe wouldn't have been so keen to go in… should (Obstetrician) not have explained that before we went in?"* (Angela, first baby, 8 weeks post birth)

Some experiences of care helped women to decide to give birth at Seaview as they had built a relationship with the team and to be part of a larger, and perceived as less individualised form of care was not what they had hoped for during labour and birth.

> *"There's no point in me traipsing in to (OU) to get treated as just some number, but here (Seaview) you can just tell by the whole maternity unit that they're so nice when they speak to you normally and stuff. When I was in (OU) you're in there for two seconds and then they'd pass you on to someone else or they'd do this and then they'd go away and leave you because they had other stuff to do."* (Niamh, first baby, 11 weeks pregnant)

Conversely, Fiona's experiences at Seaview confirmed her decision to give birth at the OU.

> *"When I've been in (OU) everything seems more efficient and in its place, you know that everything has been topped up, but when you're in (Seaview) they usually have to go looking for things and one time it was four or five times she had to go out of the room, and you think if I came here would everything be in the room or would you have to keep..it's maybe my sort of job as well, if you don't have everything ready you lose the class, so I like to have everything ready."* (Fiona, third pregnancy, 36 week interview)

Fiona felt that whilst the care she was given at Seaview was good, the organisation of equipment in the consulting room was less satisfactory. The frequent absences of her midwife to collect items that were required but not

immediately available, gave Fiona concerns about how these apparent inefficiencies could translate to her care in labour.

Confidence

Confidence in the advice given by their midwife appeared to be closely linked to the trust developed through the relationship between the women and their midwives when continuity of carer had been experienced during pregnancy. Advice given in early pregnancy regarding the women's decisions about antenatal testing helped some women develop confidence in their midwives. Events through pregnancy helped the women gain confidence in their midwife's advice, particularly when it was seen to be related to their individual birthplace choices. Kate's midwife accessed her records from her last birth and helped her to understand the events leading up to the birth. Kate had been sure that the birth following her transfer from Seaview to the OU was a bigger emergency than it appeared to be. Once she understood what had actually happened from her records, she was able to make the decision to give birth at Seaview.

> *"To start with, before I got my notes, I wanted to go to (OU) because I thought it was the safest place to be if there was anything that was going to go wrong. Then, as we went through my notes, there wasn't actually anything major that went wrong, it just felt so much bigger than it actually was. After, when I got explained all that, I was like well, there's no reason why I couldn't come here."* (Kate, second baby, 36 weeks pregnant)

Kate also expressed her confidence in her midwife because she had not tried to persuade her to give birth at Seaview just to keep the birth numbers up, but because it seemed the right decision for her. Kate was also confident that she would be referred thoughtfully and appropriately should the need arise. Some women had a fatalistic view about any decision they made as they viewed labour and birth as unpredictable events that quickly change.

> *"I just really go along with whatever information they kind of tell me, to be honest."* (Mary, second baby, 8 weeks pregnant)

Most women were confident that they would be given one to one midwifery care during labour and birth.

> *"I really felt like I had her full attention and it was nice because we chatted and you know passed the time in between contractions, so you know, it's nice to feel like you'll have a midwife like that, that you feel you can lean on."* (Catriona, fourth baby, 8 weeks pregnant)

Many stories were recounted about the women's relatives and friends being left alone in labour at the OU, which contrasted with confidence they had in the staff at Seaview to provide the care they required.

> *"Here they're fine people, they always come and check on you and I know in (OU) you're in a room and waiting forever for someone to come and see you but here they check you all the time."* (Tina, third baby, 8 weeks pregnant)

In early pregnancy, eleven of the twelve women participants expressed confidence in themselves and the care they anticipated receiving at Seaview by planning to give birth there, only Fiona planned to give birth at the OU. By late pregnancy, Kate, Sally, Caroline, Rachel and Tina clinically and by their own choice, were still confident that they would be able to give birth at Seaview, one was unsure. Kate, Tina, Rachel, Catriona and Sally actually gave birth at Seaview. Three women had normal births, Niamh gave birth at the OU labour ward, and Fiona and Caroline gave birth in the midwives unit alongside the OU. Jane and Angela underwent caesarean sections in labour and Anne had an elective caesarean section.

5.5 Summary of Key Points

This section has presented the findings from phase three, where insights into a cohort of women's views, experiences and opinions of the care they received at Seaview, the information they required and the influences on their decision making about where to give birth were presented. Whilst the women had widely varying experiences, they were united in expressing their preference to be cared for consistently by a known carer at all stages in their maternity journey. Most women, particularly those who had given birth before,

expressed their opinions on feeling safe by accessing care where they were known, close to local their networks of support and where they knew and trusted their carers. Some women saw the OU being a place of safety where medical staff and equipment were available in case of complications or emergencies occurring.

The effectiveness of the care that the women felt they received also seemed to vary quite widely between women depending on how care was made available by the Seaview staff. The availability of staff and resources at Seaview to deal contemporaneously with the women's information needs was valued by most women, but on occasion the advice given to access care elsewhere was felt to be ineffective when it could not be followed but no alternative was offered. When complications arose and women's care was referred on to the linked Obstetrician, the collaborative relationship between the women, the obstetrician and their Seaview midwives appeared to break down and effective communication of information, or informational continuity, was lost. The effectiveness of the care also depended on its accessibility, not only in geographical terms within the local area, but also the women's ability to access the care they required at a time that suited them. Whilst antenatal care appeared to be available when required, post birth care was less effectively organised around the women's needs and was perceived by the women as more for the completion of paperwork than an effective needs based clinical consultation when it was provided in the women's homes.

The women appreciated the efforts made by the Seaview staff to tailor their access to antenatal care and information to their individual needs. Some women found that attending the antenatal classes offered was less useful in their individual circumstances and the midwives varied in their response to the information needs of women whose named midwives no longer worked at Seaview and were not in their caseload. Several women described their experiences of midwives providing antenatal care that was sensitive and responsive to the women's needs but this was a rare occurrence in the post birth period. Post birth care, with its apparent lack of continuity of carer, was found by most of the women to be much less person centred, unless the

women themselves proactively organised the care around their own and their families needs.

5.6 Seaview Findings Conclusion

The findings from Seaview have provided information from different sources and viewpoints about the provision and experiences of maternity care by the Seaview team. A clinically appropriate pathway of care was allocated to 96.8% (n=369) of women at booking and clinically appropriate transfers of care were made throughout the antenatal, birth and post birth periods. No women or babies suffered significant morbidity in their maternity care episode during the 12 month maternity records review. The outcomes indicate that the care provided at Seaview was safe. Most stakeholders, with the exception of one manager, were confident that they provided safe care for women experiencing continuity of carer during uncomplicated pregnancies, and one to one care during labour and births. Seaview's isolation gave the stakeholders some concerns about their care provision to women who had complicated pregnancies but chose to access care during labour and birth. One woman also expressed concerns about the isolation of Seaview in terms of her safety in labour, but all the other women saw their safety, as did the stakeholders in terms of the degree of continuity of carer they received. Antenatal continuity of carer and feeling safe were closely related but all the women expressed feeling a loss of safety when continuity was lost in the post birth period.

Early access to antenatal care was made by 96.6% of women before their twelfth week of pregnancy and this access was made by women in all SIMD quintiles, suggesting equality of access to care for all women including those at risk of a poorer pregnancy outcome. The stakeholders were confident that the community location, small team and continuity of carer available at Seaview encouraged women to access care appropriately, and over 50% of the women chose to give birth there. The stakeholders were confident in their ability to provide one to one care during labour and birth, which they believed increased the effectiveness of the care they provided. Effective, appropriate and timely transfers of care during labour to the obstetrician led team occurred for 15.5% of women. Barriers to effective care provision were

recognised as poor communication with the obstetrician led teams by the stakeholders, and the loss of relational continuity of carer by the women.

The statistical description that the majority of women received continuity of carer was not upheld by the women's experiences when pregnancy complications and staff changes occurred. Whilst evidence of the provision of care centred around the women and their unique needs during the antenatal period was given, care in the post birth period was recognised by the women and the stakeholders as an area that required improvement. The women were clear that continuity of their carer would enhance the planning and delivery of post birth maternity services that addressed their individual needs.

CHAPTER 6: CHERRYTREES FINDINGS

6.1 Introduction

This chapter presents the findings of the second CMU studied, which was given the pseudonym of Cherrytrees. The methodological foundations, samples, data collection methods and analysis that informed the findings in this chapter have been described in Chapters two and three. As in Chapter four, the objectives for each phase have guided the presentation of the findings, so that comparisons can be easily related between and within the two CMUs whilst keeping a link between the multiple sources of data presented. The findings from Cherrytrees will complete the presentation of the evidence from both CMUs of their maternity care provision. Chapter six provides a synthesis of this evidence from both CMUs and provides a discussion of the implications of the findings in relation to how rural CMUs contribute to NHS Scotland's Quality Ambitions (Scottish Government 2010).

Cherrytrees is located on the first (top) floor of a community hospital built one hundred years ago. The unit comprised of two areas that accommodated four beds and two single rooms which were used as consulting rooms. Two further rooms were used as birthing rooms, one single room contained a birthing pool and a double Bradbury birthing mattress made up into a double bed, and one room that accommodated a single bed and an inflatable birthing pool. A small reception area, a small office and the kitchen were areas only used by the staff, but a large day room was used as a communal area for staff and the women. A former nursery area was used as a further flexible consulting space. On the same floor, but not within the Cherrytrees unit was also a large room, which was used for antenatal classes and post birth support groups run by the staff and a meeting room for community groups. The staff team comprised one maternity care assistant, twelve midwives (two full time) and one team leader. One consultant midwife and one head of midwifery provided strategic support to the Cherrytrees team.

Access to the unit was via a door that was locked during the day and the CMU team escorted women and visitors to the door as they left. Though glass

windows allowed light into the small reception area, the physical spaces appeared to be used flexibly and communal areas shared by the CMU team and the women. The team leader's office was situated outside the main door of the CMU, and was rarely used but allowed private discussions, when required, to take place away from the main part of the CMU. The staff at the time did not wear uniforms, a change which had occurred after the team leader and the women were consulted during a hot spell and approval was given. The head of midwifery was also aware of this change and appeared supportive. The walls had quotes about birth painted on them, pictures of women and their babies and laminated posters of the most recent monthly birth and transfer figures. The team leader facilitated monthly team meetings, and one midwife each month was designated to review all the records for the previous four weeks and feedback on the care provided to the team leader and the team to encourage reflective practice sessions. Statistics were collected about the care provided by the CMU including births, transfers and the outcomes of those women transferred on a password protected spreadsheet accessed by all the midwives which allowed calculations of the data as required. An organised user group had strong links with the team and particularly the team leader and evidence of the unit's strong roots in the community is presented in this chapter.

6.2 Phase One

Retrospective Maternity Records Review

The maternity records review, described in Chapter four, was used to collect the quantitative data for this phase of the research. The results of that analysis are presented as tables and grouped, as in Chapter five, by the objectives they address. The objectives address areas identified in the conceptual framework (Figure 3.1, p.34) that appeared to influence the quality of care provided at rural CMUs.

6.2.1 Objective One Findings

Objective one: Quantify and describe the socio-demographic and clinical characteristics of the women accessing care at the CMUs during pregnancy, birth and the post birth period.

The majority of the 302 women who accessed maternity care in the 12 month maternity record review period at Cherrytrees were British (n=274 90.7%), other nationalities are presented in Table 5.1. As described in Chapter four, the Scottish Index of Multiple Deprivation was again used to assess by the women's postcode the quintile of deprivation allocated to the datazone in which they lived, ranked as 1 for areas considered to be the most deprived and 5 for the least deprived.

The clinical characteristics of the women were used to assess the pregnancy model of care allocated at booking, which determined the clinical care pathway recommended for women. Just over half of the women (n=178, 58.9%) at booking were allocated a midwife led model of care as they had no significant morbidity or obstetric risk factors, and following assessment almost three quarters of the women (n= 227, 74.5%) were allocated a midwife led care pathway. Table 6.2 provides a summary of the allocated care pathways. Nine women experienced a pregnancy loss between booking and the allocation of their care pathway. All the women's records reviewed had an allocated model of care recorded at booking.

The majority of women (n=293, 97%) accessed maternity care (usually referred to as booked) within the first twelve weeks of pregnancy, but eleven (3.6%) women accessed maternity care later.

It appears that women less likely to access early antenatal care were expecting a second or subsequent baby, following a midwife led care pathway and were living in SIMD quintiles three and four.

Table 6.1 Demographic and clinical characteristics at booking of women who accessed care at Cherrytrees

Accessed maternity care	Before 12 weeks		After 12 weeks	
Characteristic	**Frequency**	**Percentage (%)**	**Frequency**	**Percentage (%)**
Maternal age (years)				
15-20	29	9.6	2	0.7
21-25	79	26.2	3	1.0
26-30	97	32.1	4	1.3
31-35	77	25.5	3	1.0
36 and over	20	6.6	1	0.3
Nationality				
White British	265	87.7	9	3.0
Eastern European	8	2.6	2	0.7
Asian & African	9	3.0	0	0.0
Other European	9	3.0	0	0.0
Relationship Status				
Married/Co-habiting	261	86.4	6	2.0
Single	30	9.9	5	1.7
Employment Status				
Employed	185	61.2	6	2.0
Unemployed	88	29.5	5	1.6
Studying	9	3.0	0	0.0
Previous Births				
None	142	47.0	3	1.0
One	93	30.8	5	1.7
Two	39	12.9	2	0.7
Three	12	4.0	1	0.4
Four or more	10	3.3	0	0.0
Scottish Index of Multiple Deprivation				
Quintile 1	16	5.3	0	0.0
Quintile 2	86	28.5	3	1.0
Quintile 3	78	25.9	4	1.3
Quintile 4	87	28.8	4	1.3
Quintile 5	24	7.9	0	0.0
Allocated Care Pathway				
Midwife Led	218	72.1	9	3.0
Obstetrician Led	63	20.9	3	1.0

6.2.2 Objective Two Findings

Describe the processes of care and clinical outcomes for the women who laboured and or gave birth at the CMUs.

The midwife was the first point of contact with a healthcare professional for 88.7% (n=268) of women. The mean number of planned antenatal visits was 8.75. The minimum number of visits was five and the maximum 13. The recommended (NHS QIS 2009) number of antenatal visits are eight for multiparous and ten for primiparous women for pregnancies lasting 40 weeks.

Over half of the women (n=99, 52.7%) planning to give birth at Cherrytrees made unplanned visits to the unit for a wide variety of reasons. Table 6.2 presents the frequency and reasons for unplanned antenatal visits.

Table 6.2 Reasons for Unscheduled Antenatal Visits to Cherrytrees

Reason for Unscheduled Antenatal Visit	Number	Percentage (%)
No unplanned visits	131	43.4
Abdominal pain	57	18.8
Decreased fetal movements	22	7.3
Ruptured membranes	21	7.0
Vaginal bleeding	20	6.6
Headache	19	6.3
Trauma (slips and falls)	13	4.3
Feeling generally unwell	12	4.0
Gastro-intestinal upset	7	2.3

The number of different midwives seen during each woman's antenatal care varied between one and eight. Most women (n=122, 64.9%) saw five midwives or fewer throughout their pregnancies. The Scottish Government target for continuity of carer is for women to see three or fewer midwives throughout pregnancy (Scottish Government 2014).

The women's planned places of birth changed during pregnancy, with a rise in the number of women planning to give birth at Cherrytrees when their birth plans were made with their maternity care provider, presented in Table 6.3.

By late pregnancy, almost three quarters (n=225, 74.5%) of women had chosen to give birth at Cherrytrees and the number of women planning to give birth at the Obstetric led Unit (OU) had risen to 66 (21.9%). At the onset of labour, the number of women choosing to access care at Cherrytrees had dropped to 188 (62.3%), and just over one third (n=105, 34.8%) began their labour at the OU. Some, (n=40, 13.2%) but not all of these changes can be attributed to women following clinicians advice to give birth at the OU when complications of pregnancy developed. Four women were planning a home birth. Fifteen (5%) of the women had been transferred from midwife led to obstetrician led care for induction of labour due to post maturity (the pregnancy continuing beyond 42 weeks). Twenty five women were transferred to Obstetrician led care at the OU, where their babies were subsequently born, due to pregnancy complications which are shown in Table 6.6 in section 6.2.3 p.164.

Table 6.3 Changes in place for birth decisions from early to late pregnancy

Intended birthplace	Number	Percentage (%)
At booking		
Cherrytrees	199	65.9
Obstetric Unit	56	18.5
Undecided	42	13.9
Alternative MLU	2	0.7
Home	3	1.0
At 36 weeks		
Cherrytrees	225	74.5
Obstetric Unit	66	21.9
Undecided	1	0.3
Alongside MLU at OU	5	1.6
Home	2	0.7
Given birth	3	1.0
Onset of Labour		
Cherrytrees	188	62.2
Obstetric Unit	105	34.8
Alongside MLU at OU	2	0.7
Home	4	1.3
Given birth	3	1.0

The mean gestation at the start of labour was 281 days (40 weeks and 1 day), varying between 259 days (37 weeks) and 294 days (42 weeks).

When the women who planned to give birth at Cherrytrees went into labour, under half (n=79, 41.1%) visited in early labour once, and a small number (n=17, 8.9%) returned once more before labour was established. All women in established labour received one to one care.

For the primiparous women, the mean for the length of the first stage of labour was 8 hours 20 minutes, ranging between 2 and 26 hours, 45 minutes for the second stage varying from 2 minutes to 4 hours and 25 minutes for the third stage, varying between 3 minutes and 2 hours 15 minutes.

For multiparous women, the mean for the length of the first stage of labour was 4 hours, ranging from 10 minutes to 10 hours, 50 minutes for the second stage varying between 2 minutes to 1 hour 13 minutes and 20 minutes for the third stage varying from 2 minutes to 1 hour 5 minutes.

The most frequent form of pain management for the 161 women who gave birth at Cherrytrees (n=157) and at home (n=4) was water. In this unit women had access to a pool during labour and the birth, and for 142 (90.4%) of the women, water had been recorded as part of their pain management strategy. The most frequently used pharmaceutical method of was inhaled entonox (gas and air), n=114 (70.8%). Twelve women (7.5%) chose to use an intramuscular injection of morphine sulphate, a pharmaceutical form of pain management.

For the four women cared for at home by the Cherrytrees midwives, two were planned home births and two occurred following unexpectedly fast (precipitate) labours. One woman used water in a pool, and was recorded to have had a waterbirth, the others used no form of pain management and gave birth without the use of water.

All women cared for by the Cherrytrees team in labour received one to one care from a midwife.

All the women at Cherrytrees and at home experienced a spontaneous vaginal birth, and 116 (72.0%%) were recorded as waterbirths. Just under half of the

women (n= 77, 48.0%) chose to have a physiological third stage of labour, without the use of intramuscular oxytocic drugs and controlled cord traction to deliver the placenta, and 54% (n=87) opted for active management using oxytocic drugs and controlled cord traction to expel the placenta. The blood loss at the birth for the majority of women (n=156, 96.9%) was estimated to be 500 mls or less.

The degree of perineal trauma sustained by the women is shown in Table 6.4. No third degree tears were sustained.

Table 6.4 Perineal Trauma sustained, Cherrytrees

Degree of Perineal Trauma	Number	Percentage (%)
None	93	57.8
First Degree	50	31.1
Second Degree	18	11.1
Third Degree	0	0.0
Episiotomy	0	0.0

Few babies (n=5, 3.1%) required any form of resuscitation at birth. The resuscitation requirements of these babies are shown in Table 6.5.

Table 6.5 Neonatal Resuscitation Requirements at birth, Cherrytrees

Baby Resuscitation Requirements[1]	Number	Percentage (%)
None	156	96.9
Simple	3	1.9
Basic	2	1.2
Advanced	0	0.0

[1] Simple = Stimulation, Basic = bag and mask ventilation Advanced = Intubation and admission to NNU (Lee et al. 2011)

The mean of the birth weights of the babies born at Cherrytrees and at home was 3.529 kilograms (kgs), the lightest was 2.240 kgs and the heaviest 4.740kgs. Over two thirds (n=109, 68.5%) of the babies born at Cherrytrees and at home were breast fed at birth, the figure falling to just below two thirds (n=95, 59.7%) by the time they were transferred home in the care of the

Cherrytrees team or community midwife, and just under half (n=80, 50.3%) of the babies were fully breast fed on transfer to the care of the Health Visitor at about 10 days old.

Just under half of the women (n=69 44.5%) were not transferred home within six hours of the birth, and just over half (n=86, 55.5%) stayed at Cherrytrees for just over 24 hours (mean 28.5 hrs). Reasons for stays of over six hours when given, were recorded as the women's preference.

6.2.3 Objective Three Findings

Compare the clinical appropriateness of care provided to women during pregnancy, labour and birth and the post natal period with national pathways and guidelines (NHS NIS 2009).

At the booking appointment, 298 (98.7%) of the 302 women who accessed care at Cherrytrees were allocated the clinically recommended national pathway of care. Variations from the recommended antenatal care pathway existed for four women, shown in Table 6.6.

Table 6.6 Clinical Appropriateness of Allocated Model of Care at Birth, Cherrytrees

Appropriateness of allocated care pathway	Number	Percentage (%)
Appropriate	298	98.7
Significant Medical/ Mental Health Issues	2	0.7
Age 15 years	1	0.3
Booked After 20 weeks	1	0.3

Fifteen (5%) of the women had been transferred from midwife led to obstetrician led care for induction of labour due to post maturity, and twenty five (8.3%) women had their care appropriately transferred during the antenatal period to the obstetrician led team. The reasons for these transfers are shown in Table 6.7.

Table 6.7 Reasons for Antenatal Transfer From Midwife to Obstetrician led Care, Cherrytrees

Reasons for Antenatal Transfer	Number	Percentage (%) (of 225 women)
Post Maturity	15	6.7
Raised Blood Pressure	6	2.6
Prolonged Rupture of Membranes	5	2.2
Small for Gestational Age	5	2.2
Ante-partum Haemorrhage	4	1.7
Pre-term Uterine Contractions	2	0.8
Breech Presentation	2	0.8
Other	1	0.4

Interventions in labour for those who gave birth at Cherrytrees occurred for only two women, (excluding as discussed in Chapter 5, pharmaceutical methods of pain relief) for whom a clinically appropriate, according to local and national guidance (NHS QIS 2009), artificial rupture of membranes was performed. No episiotomies were performed.

Of the 196 women who accessed care in labour and planned to give birth at Cherrytrees or at home, 36 (18.4%) were transferred to obstetrician led care during labour, most commonly for failure to progress in the first stage of labour. Two women experienced a post birth haemorrhage of an estimated blood loss of over 1000 mls. Table 6.8 shows the reasons for transfer and the number of women affected. Thirty of the women transferred, (15.3% of all women who accessed care in labour) were primiparous, and six (3.6% of all women who accessed care in labour) were multiparous.

Table 6.8 Reasons for Transfer in Labour from Cherrytrees

Reasons for Transfer in Labour	Number	Percentage (%) (of 196 women)
Delayed Progress in 1st stage	11	5.6
Third Stage Complications	6	3.0
Meconium Stained Liquor	5	2.5
Fetal Distress in First Stage	4	2.0
Epidural Request	4	2.0
Delayed Progress in Second Stage	4	2.0
Pregnancy Induced Hypertension	1	0.5
Maternal Pyrexia	1	0.5

The outcomes for the mothers who were transferred in labour are presented in Table 6.9.

Post birth six (3.7%) of the women who gave birth at Cherrytrees had their care appropriately transferred to the obstetrician led team at the OU. One woman developed a raised blood pressure 24 hours after the birth, and one experienced a post partum haemorrhage 12 days after the birth. Four babies were referred, two for assessment of a weight loss from birth of over 12%, one was noted to have a persistently low temperature and one for investigations of abnormal movements. All the babies referred were discharged home within 48 hours.

All of the twelve women who underwent an emergency caesarean section were transferred during the first stage of labour. Five were transferred in due to delayed progress, six women were transferred due to fetal distress and significant meconium stained liquor. One woman was transferred following her request for an epidural and the caesarean section was performed following a failed forceps delivery. Ten were primiparous and all the women were following a midwife led pathway. The mean of their ages was 26.6 years.

Twenty two (59.4%) of the women who were transferred had an estimated blood loss of less than 500 mls, seven (19.4%) experienced a post partum haemorrhage of between 500 and 1000mls and a further seven (19.4%%) of

the women transferred from Cherrytrees sustained a blood loss of over 1000mls.

Five of the babies required resuscitation, two required suction under direct vision to prevent meconuim aspiration syndrome, and three were resuscitated using intermittent positive pressure ventilation. None were admitted to the Neonatal unit. The breast feeding rates were similar to those of the babies born at Cherrytrees and home in that three quarters (n=28, 75.7%) were breast fed at birth, and just over half (n=21, 56.8%) were fully breast feeding on transfer to the care of the health visitor at around 10 days old. The mean of their birth weights was 3.456 kgs, with the lightest being 2.420 kgs and the heaviest 4.620kgs.

Table 6.9 Outcomes for Women and Babies Transferred from Cherrytrees in Labour

Type of Birth	Number	Percentage (%)
Spontaneous Vaginal	16	44.4
Emergency Caesarean Section	12	33.3
Instrumental Vaginal	8	22.3
Estimated Blood Loss		
Less than 500mls	22	61.2
501 – 1,000mls	7	19.4
Over 1,000 mls	7	19.4
Baby Resuscitation Requirements[1]		
None	31	86.1
Simple	2	5.6
Basic	3	8.3
Advanced	0	0.0

[1] Simple = Stimulation, Basic = bag and mask ventilation Advanced = Intubation and admission to NNU (Lee et al. 2011)

Summary

The socio-demographic characteristics of the women who accessed care revealed that a wide range of women accessed care in pregnancy, almost one third of whom were following an obstetrician led care pathway. Safe outcomes were achieved for all the women, but a higher than expected rate of caesarean section births for women who were transferred in labour to obstetrician led care was noted. Early access to antenatal care was achieved for the vast majority of women, but only one third of the women experienced continuity of carer.

Key findings in the domain of safety were:

- 98.7% of women were allocated the clinically recommended maternity care pathway at booking.
- 18.4% of women were transferred appropriately to obstetrician led care at the OU in labour.
- Two women experienced a post partum haemorrhage of over 1,000 mls.
- 98.8% of women experienced no interventions in labour.

Key findings in the domain of effectiveness were:

- Early access to antenatal care, 96.4% of women attended their first antenatal visit by 12 weeks of pregnancy.
- 31.3% of women received antenatal care from three or fewer midwives.
- Most women planned, and were clinically eligible, to give birth at Cherrytrees at 36 weeks of pregnancy.
- 62.3% of all women who accessed maternity care at Cherrytrees chose to access care there in labour.
- All women in labour at Cherrytrees received one to one care from a midwife.

- 50.3% of the babies born with the Cherrytrees team and 56.8% of those transferred in labour to the OU were fully breastfed on transfer to the care of the health visitor at 10 days old.

6.3 Phase Two

Cherrytrees Stakeholders' Study Results

This section describes my interpretation of the data collected in this phase of the study and is structured in the same way as in Chapter 5.

6.3.1 Phase Two Objectives

The objectives for this qualitative phase of the study were to:

- Contextualise and explore key stakeholders views, beliefs and experiences of the safety, effectiveness and person-centredness of the care provided by CMUs
- Explore key stakeholders guidance and recommendations about the services and the care that should be provided at CMUs.

6.3.2 Purpose of the focus group and interviews with stakeholders

The purpose of the interviews and focus group were as described in Chapters four and five, to investigate the stakeholders' views, beliefs and experiences of the provision of care at Cherrytrees. Both methods had been informed by the observation of a team meeting and the collection and reading of documents, including the unit guidelines for clinical care and audit and documents displayed on notice boards. The aim was to gather in depth information about the stakeholders' lived experiences at strategic and clinical levels of the services and care provision at Cherrytrees. Table 6.10 and 6.11 present summaries of the recruitment of stakeholders to the focus group and interviews.

Table 6.10 Summary of Recruitment to Focus Group, Cherrytrees

Post	Invited to participate	Participated in Focus Group
Maternity Care Assistant	1	0
Midwife		
CMU Experience <5 years	3	3
5-10 years	3	0
Over 10 years	2	2

Nine stakeholders were invited to take part and four declined during a particularly busy spell at Cherrytrees when two midwives who planned to attend had been called in overnight to help with four births.

Table 6.11 Summary of Recruitment to Individual Interviews Cherrytrees

Post	Invited to participate	Interviewed
Maternity Care Assistant	1	1
Midwife		
CMU Experience <5 years	3	1
5-10 years	3	1
Over 10 years	4	2
Manager/Local policy maker	2	2
Obstetrician	1	1
User Representative	1	1

The linked Consultant Obstetrician was invited to participate in the interviews but declined. Fifteen stakeholders were invited to take part and six declined.

6.3.3 Data Collection and Locations

The focus group took place at Cherrytrees in a room used for staff meetings. Individual interviews were offered at a time and place of the participant's choosing, and all the Cherrytrees midwifery participants including the team leader chose to use a private room within the unit. The Head of Midwifery and Consultant Midwife held their interviews in their offices at the OU, and the user representative chose to be interviewed at her home. The interviews lasted between 45 and 120 minutes, and the focus group discussion lasted 75 minutes.

6.3.4 Overview of Cherrytrees Phase Two Results.

Rich and complex data were obtained from this phase of the study, which were analysed as described in Chapter three. Three main themes, very similar to those of Seaview, were identified from the categories arising from the stakeholder's beliefs, views and experiences. The differences in the categories were that the team at Cherrytrees displayed attributes of transformational leadership with their progressive outlook, shared vision and ability to enable others to lead changes. One extra category identified for this CMU which was sustainability, as the future of the unit was uncertain after a recent maternity services review and this raised particular concerns and pressures to 'be the best' for the stakeholders. Accordingly, the second theme was identified as aspiring to be the best.

1. Being Different
    - Geography
    - Small, transformational team
    - Community support
    - Continuity of carer
2. Aspiring to be the Best
    - Focus on women and their choices
    - Celebrating success, constant monitoring
    - Developing and sharing knowledge and skills
    - Sustainability
3. Reaching Out
    - Recognizing differences
    - Building networks

- Working across boundaries
- Communication with respect and integrity

As with Chapter five, each of these are discussed separately, with links made between the themes and categories where relevant.

6.3.5 Being Different

In the context of Cherrytrees, being different meant providing a different, alternative service to that offered by other maternity care venues at obstetric units (OUs) or alongside (beside OU) midwife led maternity units. The geographical isolation of the unit within the community was seen by the stakeholders as a local, easy to access hub for maternity care for the majority of the women in the local area. The small team of staff providing maternity care to women and their families made efforts, with the support of the local community, to continually develop and improve the services they provided to women. The team were also able to provide continuity of carer and retain contact with women who had been referred to the wider maternity care team during pregnancy which they felt not only enhanced the safety of the care and effectiveness of the timely referrals they provided but also enabled women to retain continuity in the information they were given.

Geographical Location

All the stakeholders were unanimous in their conviction that locally accessible care was vital for women to initiate early engagement with maternity services, which they saw as vital in reducing health inequalities.

> *"In order to continue ensuring safety for women it is absolutely vital that we continue to provide the option of local CMUs for all women.[…] What we would hope and what we are striving for is that every woman who chooses to access our services, wherever, is happy and has a great experience whatever that means to the women.[…] to develop services for women that are locally accessible and provide an option where women can receive care and how they receive that care."* (Manager 2, Interview)

The stakeholders were also clear that Cherrytrees offered a calm, relaxed atmosphere, which they perceived that women appreciated when they attended for antenatal care, in contrast to the clinical appearance of the OU.

> *"When they come in, even if it's for their initial appointment, and see round and things, they are always like this is amazing, it's homely, it's lovely.[..] I think that's what a lot of people want when they're having a nice normal pregnancy, aiming for a normal birth. It's not medicalised, it shouldn't be clinical, it should be homely and relaxing and that's what a lot of people get when they come here."* (Midwife 3, Interview)

The geographical isolation of Cherrytrees brought challenges. One midwife described feeling vulnerable at night when working alone, and another discussed the awareness of the amount of time needed for the on-call midwife to arrive, as well as the predicted road time by ambulance, in mind when considering transferring women in labour at night.

> *"You do start thinking, right, there are certain things I have to do because of this journey that might be coming up, I don't think you ever lose sight of that."* (Midwife 2, Interview)

The remoteness of Cherrytrees, which was situated 40 miles from their closest referral OU, was seen positively by one stakeholder because the flat management structure for CMUs in the Health Board meant that she worked closely with the team at Cherrytrees, which in turn meant that she had confidence in their care provision, despite the distances involved.

> *"We have a very flat senior structure in midwifery here so the team leaders in each of the midwife led units report directly to me. […] They're confident practitioners, they deliver the greatest percentage of the local population of all our teams, but they do so safely, they do it in a considered way. They've got all the qualities that allow them to provide this very remote service with minimal support from medical staff or whatever. We don't have that replicated in other teams."* (Manager 1, Interview)

The isolation of the unit was seen as an advantage by the team as it attracted midwives who wanted to practise in a CMU model and fulfilled the local community's requirements of their local maternity unit.

> *"That makes this place different because now a lot of the people who have chosen to come here and join the team, have come here because of what the unit is, but it was actually driven by the community, by women and particularly by our user rep who was hugely educated on birth centres, normal births and changing the ways that midwives were practising"* (Midwife 1, Focus Group)

Small, Transformational Team

An area of concordance between all the participants was the confidence and maturity of the Cherrytrees team, who had enough ownership of their working environment that they consistently drove to develop and improve the services they provided. Frequent examples were given of members of the team suggesting ideas for service improvements that were facilitated and encouraged by the Team Leader.

> *"So, (midwife) and I made up a new class about early pregnancy, healthy eating, exercise, what the notes are and plans of care, just questions they have, we do that fortnightly as an optional class."* (Midwife 3, Interview)

The team leader was described as having a transformational style of leadership, both by midwifery managers and the team members. This style was perceived to demonstrated by the way in which she encouraged members of the team to use their particular talents to collectively bring improvements to the service offered, whilst maintaining an overall leadership role.

> *"She is the boss, there's no question, she gets her way […] that's the great thing, she hasn't necessarily passed it on to people, but she's released it in people."* (Strategic role 1, Interview)

The Cherrytrees team displayed confidence in their collective ability to provide care to all women who accessed their service, by recognising and working with each other's strengths and weaknesses. The midwifery team all took turns in

contributing to a monthly review of all the records of the women who were cared for at Cherrytrees, which they felt contributed to their ability to have a reflective, open dialogue with each other.

> *"We are all part of that system, we all have different… like the audit of documentation, someone does it each month and it is all fed back."* (Midwife 2, Focus Group)

The Cherrytrees team were all confident in their ability to provide one to one care to women in labour. On call systems were in place to ensure that a midwife was available for women in labour at all times and flexibility in the working patterns of the staff allowed them to be responsive to peaks in demand.

> *"One member of staff off sick, two women in labour and clinic planned. Midwife contacted the women and rescheduled the appointments. (midwife) came in 2 – 8 pm, (midwife) with woman in labour, welcomed another in labour as (midwife)'s clinic finished. Inflatable pools filling."* (Research Diary Extract)

The trust and respect within the team, however, was not transferred to the wider maternity team where assumptions about the attitudes and behaviours of OU staff were widely held. These assumptions are discussed further in the 'reaching out' theme where their effect on inter and intra professional relationships is explored.

> *"I honestly believe that we give a huge amount more than a shop floor band 6 midwife in a consultant unit would give."* (Midwife 1, Focus Group).

The Cherrytrees team was seen as a unique combination of individuals and relationships that worked well together.

> *"I wonder if people can pick things up and replicate them, I'm not always confident that you can, or whether you should. It's horses for courses and what we've got in (Cherrytrees) fits our course absolutely and the horse is running really well. I'm not sure that would translate to another area."* (Manager 1, Interview)

The transferability of the combination of the team and the specific demographics of the community they served was, however, considered to be difficult to replicate.

Community Support

Cherrytrees had been established in the community as a GP unit, where historically GPs were available to oversee the care provided by the midwives, perform some assisted births and undertake the examination of the newborn. A small number of women gave birth there, but women from the local area, who had given birth at the OU, traditionally used it for post birth care.

Fifteen years ago, Cherrytrees was under threat of closure, and one woman who had given birth there started a community campaign. She went on to become the user representative for Cherrytrees and led a campaign to oppose the closure plans.

> *"You know, when you do a campaign, if it's going to be successful, it has to work on a number of different levels. The most difficult level for people I think, looking back on it, is the strategic level. So people's passion was for the town, their local place, their midwives, their unit and things not being taken away by the big nasty (OU). "* (Non- midwife 1, Interview)

The long running campaign to keep Cherrytrees open led to a sustained community commitment to having a CMU in the town and to ongoing community fundraising.

> *"I had a women this morning who was having her 40th birthday party and she said, I don't want presents, can I get everyone to donate to the unit? I know it's because it's a knock on effect for their family and friends because it's a local unit."* (Midwife 2, Focus Group)

The wide support across generations of families in the community was demonstrated by the regular donation of knitted toys from a local group of pensioners, and recurring community events that were organised and supported by a wide range of local groups, including best dressed Christmas tree competitions run by a local business, sponsored swimming events and

head shaving at a local bar. All these activities were seen to strengthen the mutually supportive ties between Cherrytrees and the community it served.

> *"There was a local bar recently, where they were getting waxed to give money to us, and that is definitely because we are part of the local community. The people of (Town) seem to value (Cherrytrees) […] because people rally round, they always do, people stop you in the street and say is everything ok, do you need me to man the barricades?"* (Midwife 7, Interview)

The midwives were very aware of their perceived dependence on community support for their continued ability to provide maternity care at Cherrytrees.

> *"We can't exist without them, more than they can't exist without us, so if they choose not to come here, we don't have jobs but they will still have midwives. So we need them more than they need us really."* (Midwife 3, Focus Group)

This focus on the community for sustaining the continued existence of Cherrytrees facilitated a recognition of the delicate power balance between the women's choices about where to give birth and the influence of the midwives on those choices.

Continuity of Carer

The midwives had, over the preceding year, introduced the policy of having named midwives for each woman, in accordance with national standards (Scottish Government 2012). The women in the past were allocated to a team of four midwives who provided their antenatal care. The midwives all expressed their enthusiasm for this change and noticed the difference on a number of levels including access and person centred care, as well as continuity.

> *"We recognise our women and they can come and chat to us and they feel a big difference with the named midwife as well because they can phone up and ask for you by name, they know who you are and they are quite comfortable to phone up and chat to you. Before they wouldn't have*

phoned because they wouldn't know who they were going to speak to. I love the named midwife, I think it's much nicer and relaxed for the women." (Midwife 8, Interview)

The ability to provide continuity of carer was seen as part of providing safe and effective care. The midwives had confidence in their ability to notice small changes in the women's progress through their pregnancies, which may have been missed had the women been seen by a different midwife, or even a member of a team of midwives.

"Even just measuring the fundal height, you just feel, is that a bit bigger than last time I saw her, have we kind of slowed down a wee bit here?" (Manager 3 , Interview)

Providing continuity of carer as the named midwife for women who had more complicated pregnancies was also a source of satisfaction to a midwife.

"Some women with really complicated backgrounds, it's actually quite nice when we book women like that now because they now have the named midwife so we see them right through. That lady will be going away for a c/section but she'll come back here and we'll see her here and we'll see her postnatally, so all the big pathway, we do all that." (Midwife 7, Interview)

The team leader also provided continuity of information between the women with complicated pregnancies who were referred to the linked obstetrician and their named midwife. The team leader discussed the care plan made between the woman and her obstetrician either with the obstetrician at the clinics held at Cherrytrees, or by accessing the women's records to review the plan made so that she had an overview of what was happening to the women. The team leader would then pass that information on to the named midwife and where relevant the full team.

"There's very few case notes that come through here that she says, oh I don't know that name at all and I can understand that, (Cherrytrees) probably have about 200 – 250 bookings a year […] they've had 7,8,9 or 10 visits with you, they've come to parent education, so it's not a difficult

thing to do, but it does show a level of commitment to pro-actively review all those notes." (Manager 1, Interview)

All the stakeholders recognised the lack of continuity of carer provided to women within the post birth service provision. The women were provided with daily contact from the CMU by telephone from a midwife, but not necessarily the women's named midwife, and visits were based on the needs assessed with the women once the morning phone call had been made. For those women who were breastfeeding, a breastfeeding support worker was contacted on the women's discharge from the CMU, with their consent, who offered support, advice and visits from the same person to augment the midwife or maternity care assistant's visits.

"All the same advice, just someone else that they can speak to and will have some extra time to go out and spend time with them, they're great." (Midwife 8, Interview)

These two initiatives of daily midwifery contact and the provision of a support worker to women who chose to breast feed went some way to assist some women in the post birth period, but the ability to maintain continuity of carer was not provided for most women.

6.3.6 Aspiring to be the Best

Categories within this theme were identified concerning the stakeholders' aims to provide women with the best care for each woman, centred on their choices and preferences throughout their maternity journey. The focus on women and their choices was seen as an attempt to facilitate person centred choices by developing individual strategies for each woman's particular wishes and preferences to achieve the best possible outcomes. In developing skills to facilitate each woman's choice of care particularly during labour and birth, the team had developed knowledge and skills that they were keen to share. The team constantly strove to recognise and celebrate their success by publicising their service and outcomes both locally and nationally but were aware, particularly around transferring women to the OU for care during labour, that their actions and outcomes were externally scrutinised. The unit had established methods of internal scrutiny to which they all contributed and used

to monitor and improve their care provision. The stakeholders were all aware that Cherrytrees had an uncertain future and the staff saw their role in securing its future in different ways, all of which were linked to striving to provide the best possible service to the women and their families, wherever that service was based.

Focus on Women and Their Choices

The stakeholders were all very clear about their role in understanding each woman's individual experiences and influences on their decision making process, particularly when unusual requests for care were made. Efforts were made to ensure that the responses to those requests were based on the women's wishes and not the midwives' preferences. One midwife described her reaction to and subsequent acceptance of an unusual request for support in labour.

> *"I remember a woman who wanted four people in the birthroom and I thought, you must be joking, but then I thought that's about how I feel about it, not what she wants."* (Midwife 4, Focus Group)

Some women's choices were less easy to accommodate and the stakeholders aimed to achieve balanced decision-making by exploring the reasons for the preferences and giving information to help ensure that women's decisions were fully informed.

> *"I can't tell somebody what I think the risks are, what I think is safe and unsafe, but what I can tell them is about the facts, and they can make an informed choice about that."* (Manager 3, Interview)

The stakeholders were also unanimous in their commitment to providing a flexible service to women, which facilitated their individual choices including appointment times and preferences for care in the antenatal period. The midwives also attempted to understand and support the women's choices for place of birth and to provide post birth care based on the women's understanding of their own needs.

> *"They're very with women, they're very women focussed […] they've just taken that approach and just absolutely run with it, you know everything they do is geared around making things better for the women."* (Manager 1, Interview)

The language used when describing their approach to the discussion of women's choices occasionally appeared to reveal a more coercive stance by several stakeholders in clinical and strategic roles, when words including "tackle", "persuade", "convince" and "turn around" were used. One midwife expressed her confidence during her interview that the Cherrytrees team would "try" to facilitate women's choices, "as long as the women's choice is within reason." This comment would appear to indicate some tension between women's choices and midwives' preferences for safe and effective birthplace choices based on the women's personal preferences. A comment made by another stakeholder perhaps encapsulates the overall aim of the service that the Cherrytrees team attempted to support, despite being occasionally baffled by decisions made by the women.

> *"The safest place for a woman to be is where they choose to be."* (Manager 2, Interview)

A perception of vulnerability could perhaps be seen as placing pressure on the midwives when assisting women to make informed choices about place of birth. Whilst the midwives were very sure that there was no coercion, if a woman expressed an intention to give birth at the OU, the midwives tended to consider that decision as left open rather than final.

> *"When the GPs get in first […] we do get the odd one who wants to go to the (OU) if it's their first time, but I usually say wait, as time goes on to make the decision, come to the classes and hear what happens and you usually find that the majority, just the way of getting used to coming here, don't want to go to a different hospital."* (Midwife 6, Interview)

The language used by the midwives can also give an insight into how they interpreted the balance of women's choices and maintaining or improving the Cherrytrees unit's birth numbers. The midwives in the focus group described feeling "protective" over "your girls" denoting paternalism, and on occasion

being excited about "birth", rather than expressing excitement about and for the women who were giving birth.

Celebrating Success, Constant Monitoring

The Cherrytrees team had been nominated for, and had won, national awards that were seen to have helped to establish their reputation both locally and nationally and encouraged more women to access care there.

> *"We have had ladies from all over the UK that have heard of us. My friend put a request on Classic FM for the award winning (Cherrytrees) maternity unit. A couple of weeks later we got a phone call from a woman in London who had heard the request and wanted to come and have a look around."* (Midwife 7, Interview)

The CMU team were very aware of the perceived focus on birth and transfer numbers as a measure of their success, rather than the wide range of services and care they provided to most women. This constant monitoring was seen as pressure to keep the birth rate up and the number of transfers low, largely ignoring the rest of the work carried out.

> *"We can lose sight of the job that we do, all the antenatal care, the booking, education, aquanatal, relaxation, breastfeeding groups, all these things we do. […] All that's zoned in on is the fact that we transferred a woman, even though it was the correct decision, we really beat ourselves up and super analyse."* (Midwife 2, Focus Group)

This negative association with constant monitoring expressed by one midwife, was seen by other midwives and managers in a positive light as a way of encouraging reflective practice both personally, with the team leader and with the wider Cherrytrees team to constantly learn from and improve the care that had been provided for the women. As one of the managers explained,

> *"We are going to constantly question ourselves, but we are going to celebrate like crazy when we do good stuff."* (Manager 1, Interview)

Developing and sharing Knowledge and Skills

The Cherrytrees team were actively encouraged by their team leader and those in strategic roles to develop skills that extended the midwife led services available to women. Some midwives within the team were able to provide most scanning and post birth contraceptive services. The full team of midwives were involved in developing particular skills and competencies to assist women in response to their choices where these choices pushed the boundaries of the skills in normality, in an attempt to enhance the safety of care for unusual situations.

> *"If it was somebody who decided to have a breech birth at (Cherrytrees), then what they would do is say that we will update ourselves, we will try to get some breech births, and we will certainly practice with the mannequin and we'll watch some videos and on the day, this is what we'll do, we would make plans."* (Manager 1, Interview)

The midwives had a substantial collective experience of providing care during labour and birth to women who chose to experience a waterbirth. This experience was widely shared with visiting students and midwives from throughout the UK. A student midwife from England had chosen to spend part of her elective placement at Cherrytrees, and a recently set up UK research centre had called to speak to the team leader about her experiences of optimal water temperature and depth in the birth pools during the data collection period.

> *"It's a generosity of spirit that they're willing to give their time and energy to that, whereas other people I ask to do things are well we're really busy, we don't have time for that, she would just have to stand and watch. They have this, well it is a generosity of spirit I think."* (Manager 1, Interview)

The team and their user representative also ran an annual study day for students, midwives, doulas (lay birth supporters) and interested parties to attend during which most members of the team and some of the women who had received care at the unit presented and shared their particular interests and stories of their experiences, along with invited speakers with an interest and relevance to CMU care.

"But it is having it at (Cherrytrees), I think. That's really important. It's a really good day. They have videos, and they have some quite amazing stills from water births. You could hear a pin drop, it's quite emotional. They are very practical and that is so important. These are real midwives doing real jobs with real women in (Cherrytrees) and similar units. It is absolutely vital that that comes across." (Non-midwife,1, Interview)

The venue of the study day allowed the Cherrytrees team to share their ethos and pride in their work within the environment that they had adapted with the help of the women and the local community.

Sustainability

Whilst the number of women choosing to access care throughout their maternity journey had risen and the team facilitated births for the highest proportion of their community than any other CMU in the NHS Board area, the team were not hopeful about the future of Cherrytrees. Assumptions were made about how others viewed their service.

"That's the downside, you're always one step ahead of closure or under that cosh because you know that people regard you as an expensive service, or an unnecessary service or an elitist service." (Manager 3, Interview)

The Cherrytrees building required substantial investment to maintain its safety which was felt to impact on the sustainability of the unit within its physical position in the community. Plans to move to a new purpose built unit had been withdrawn and the Cherrytrees team were guarded about their future. One midwife summed up how she saw the imperative of maintaining and improving their birth rate and how that fundamentally affected their future sustainability.

"We have to keep this place, this has to be the best and we are very competitive. We have to win a lot, we have to have women on board with us, we have to have a low transfer rate and we have to say to people it's a reasonable choice to come here because it's unlikely that you'll transfer and you're much more likely to have a good experience. We have to make that happen, otherwise we won't exist." (Midwife 1, Focus Group)

One midwife did not agree that sustainability of the team and the reputation that they had developed within the community could be seen simply in terms of the four walls of the building.

> *"The building is rubbish, it leaks and it rattles, it's old and it's shabby but we do love it. I don't think being in this building is going to last much longer, but we've all decided that we can do this anywhere, it doesn't matter. One of our mums said I'd have my baby in a tent in a field if it was the (Cherrytrees) midwives looking after me."* (Midwife 7, Interview)

One stakeholder had concerns about the sustainability of the current provision of midwife led care, ignoring the contribution made by the CMU model to the care of most women and not just those following a midwife led care pathway.

> *"I've changed my perspective because the complexity of women's histories, even the rising BMI, they're almost taking themselves out of the category of being safe for midwife led care. […] We're doing lots of work to try to reduce inequality so that they engage with services early, so that we hopefully keep them so that they can still fit within the criteria for midwife led care […] if I'm honest I suspect it may become a harder fight to keep midwife led care going."* (Manager 1, Interview)

This manager's concerns were centred on the rising incidences of maternal complexities, where she predicted that the priorities for providing proportionate, clinically appropriate care were changing.

6.3.7 Reaching Out

This theme explores the development of effective collaborative relationships to enhance the safety of women's care when the assistance of the wider maternity care team was required. These collaborative relationships were seen to be based on the understanding of each team member's role in the provision of maternity care to the women. The relationships between the members of the team allowed networks to be built and to work effectively for the women when transfer of care at any stage between members of the wider maternity care team was required. Working across inter and intra professional boundaries affected how these relationships and networks worked effectively

on a day to day basis. Communication with respect and integrity was seen as essential to each woman's maternity care journey. However this was particularly difficult to achieve and maintain when the Cherrytrees midwives attempted to reach out to access other healthcare practitioners' expertise when required in practice.

Recognising Differences

The stakeholders all, in individual ways, had experience of working within the wider context of NHS services: in mental health, speech therapy and maternity services. The CMU's place within the wider, multidisciplinary maternity care team which was available when required for each woman, was recognised by one midwife during the focus group, but this was seen in a rather negative context which pervaded the discussion of the relationship between CMU and the OU teams.

> *"The kind of derogatory way that people sometimes talk about birth units, they talk about how they're going to fix your mistakes, they're going to fix your lady, I think that is very, very difficult because you're quite defensive about it and you don't want to be like, actually we are all supposed to be a team."* (Midwife 4, Focus Group)

The role of the midwife in different contexts was seen in terms of "real midwifery", practised by the midwives at Cherrytrees, and the midwives who simply worked in an obstetric unit. The following quote was given by the same midwife who made the assumption that their team 'gave' more than a 'band 6 midwife working in an OU'.

> *"I honestly believe that there are midwives who will look after a woman their whole shift and then go for a drink after work and not give a second thought that she went through to theatre, she had a section. I'm not saying that they wouldn't care if something drastic happened, but in general they're completely hardened to women having babies, so a normal birth is no more exciting than a forceps, and a forceps in no more upsetting than a normal birth, that's just what happened."* (Midwife 1, Focus Group)

There appeared to be little appreciation of the differing complexities of the midwives' roles in different contexts, and the Cherrytrees midwives believed that their role in women's maternity care was undervalued by their colleagues working in OUs.

> *"What I find really difficult is they really have no insight into what we do […] they are very self centred."* (Midwife 3, Focus Group)

This view was also echoed by a stakeholder who had been involved in developing an escalation plan, which involved the use of midwives working at CMUs to be made available to provide staff for the OU at times of high clinical demand.

> *"The staff here (OU) feel that the staff in (Cherrytrees) have it easy. I say they don't have it easy. They may not be in a room providing 1 to 1 labour care but there's never a moment when they don't have something to do […] because they don't just do labour care. There is this perception that they're not doing much."* (Midwife 9, Interview)

One manager took an active role in attempting to ensure that her team understood their role in communicating effectively with the wider team at the point of transfer of care to enhance the woman's safety during that transition.

> *"It's important that you address that, not necessarily at that point, but later on and as team leader that is something that I would do, to address things afterwards."* (Manager 3, Interview)

The importance of addressing any issues where barriers to communication due to assumptions about one another's roles was very clear and she ensured that these barriers were always addressed to ensure the safe, effective and person centred transition of care between Cherrytrees and the OU teams.

Building Networks

Within the background of tensions between the differing contexts of provision of maternity care, one stakeholder described her role in challenging unprofessional behaviour shown by those who did not appreciate the contextual differences when multiprofessional individualised care plans for

women requesting unusual care needed to be negotiated with the women and communicated throughout the service. This was done to provide a support network to assist the Cherrytrees midwives in providing clinically appropriate care for women whose preferences, for example to give birth at Cherrytrees, may be outside the usual clinical guidelines for safe and effective care.

> *"What matters for me is that if midwives in that context put their hands up and say we need help here now, something is happening here, and I need to do X, Y and Z so that everything will be in place for that to happen and that there will be no obstacles that get in the way."* (Manager 2, Interview)

Networks within the community particularly with local GPs were perceived to be improving as the introduction of midwife-led care meant the GPs no longer had a clinical role in providing antenatal care to women during pregnancy. The GPs did however remain the professional who was able to prescribe necessary medication and supplements according to the maternity protocols, and the person to whom the midwives referred women with any appropriate medical issues during their pregnancy. The introduction of the KCND (NHS QIS 2009) pathways also made the midwife the first point of contact for pregnant women who intended to continue with the pregnancy, which removed the women's initial visit for the GP's advice and referral in early pregnancy. This had made the relationship between the GPs and the CMU midwives a little distant.

> *"I think we're moving on to a new generation of GPs as well, who, the dynamic of that relationship is changing and they are phoning us for advice and support, not seeing it as demeaning. […] They weren't skilled, they weren't up to date and you can't expect them to be with every policy, protocol and guideline that's brought out regarding pregnancy. You can expect the midwives to be, that's our remit, that's what we should know."* (Manager 3, Interview)

One midwife expressed her confidence in the ability of the team to provide safe and effective maternity care within the currently established networks, and was frustrated when a proposal was made to move the CMU to an extension of a new GP surgery. Her assumption was that the proposal was an attempt to foster closer relations with the local GPs.

> *"We are sufficient on our own, if we need advice, we will reach out for it. The last thing that we would want is GPs nipping in to check if we are okay, that's not really – we don't want that."* (Midwife 2, Focus Group)

One of the most effective support networks for Cherrytrees was built by their lay representative, between the health board, the women and the team leader when the unit was under the initial threat of closure. The success of that collaboration had sustained the growth and continuous development of Cherrytrees in the intervening years. The user representative encapsulates in the following quote a way of building networks by acknowledging that each person had a part to play.

> *"To me, it's being able to look at things and acknowledge who has helped you and who has made a difference. I find it quite difficult when people think it's all down to them (the Cherrytrees team) when you know it isn't, because if they genuinely think that way, then it's a barrier to passing that on."* (Non-midwife, Interview)

Building networks with the women who used the maternity services in the local area was important in the continued development of the services available at the unit.

> *"We asked the women's opinion and as soon as we started we got reams and reams of women giving their opinion on the unit. They just share, we share with them, we don't have an ethos of us and them at all, we have women that come in and we genuinely get on with them, we form really good relationships with them and I think that comes across, it makes it a really nice place to work and I think that's why the women give us such nice feedback."* (Midwife 1, Focus Group)

The midwives collected information about the women's opinions of the care they received at Cherrytrees by encouraging feedback through their Facebook page and by written feedback. The information given by the women was then collated on a monthly basis and regularly shared with the team.

Working Across Boundaries

The effectiveness of shared roles across boundaries was recognised by most of the stakeholders, particularly by one midwife who held a shared role between Cherrytrees and the OU. Her perception of the differences in her role and the care she gave was less polarised than that of the midwives who worked solely at the CMU. The midwife's shared role allowed her to understand the challenges of both contexts which made the concept of barriers to safe and effective care when transferring from one context to another, where she was known in both, superfluous. When she made transfers to an alternative OU where she did not work, she found the process less seamless and perceived it as "different" although she had a working understanding of the same challenges, the barriers were more visible to her.

> *"Well, that's different because obviously I don't know anybody there […] just the same protocols, speaking to the registrar and saying why they need to go up there, but it's different there in triage."* (Midwife 7, interview)

A gradual breaking down of the boundaries between the OU and Cherrytrees had been noticed throughout the Health Board area, where staff were undertaking occasional extra shifts in areas outside their usual work areas. A gradual open sharing of cultures within differing models of care was seen to be developing, which the stakeholders saw as positive in enhancing the reliability and consistency of care provision across the interfaces of care, providing a basis for seamless care for the women.

> *"Now what we're getting is the team boundaries breaking down, they are realising that they're not losing anything by having a member of staff doing an extra shift anywhere. These are good things because if you don't have that kind of open sharing there's a sense that oh what are they doing out on community or these folk in hospital wouldn't do this. We haven't pro-actively gone out there to break down these boundaries, but where things have been happening we've been happy to let them happen, to encourage people to do a bit of that so that we do break the boundaries."* (Manager 1, Interview)

For one midwife, who had recently moved to the area, working across boundaries proved more difficult than she had expected when transferring women in labour for clearly defined complications, which for the baby's safety, required the input of the obstetrician led team.

> *"There's nothing anyone can do (about meconium stained liquor) but your reception is sometimes a bit stony, which I find quite difficult because you go in and you feel so passionately about your woman, and then you get told off for doing something before something happened."* (Midwife 5, Focus Group)

The team were very proud of their close relationship with their linked obstetric consultant, to whom they referred women for an obstetric opinion if required during pregnancy.

> *"We have a really supportive Consultant (Obstetrician) too, she's very positive about us and trusts us and a lot of the time it's about the woman's choice of where she wants to come, but she will push boundaries."* (Midwife 4, Focus Group)

The Obstetrician worked closely with the team leader and with the women, particularly when planning the care for women who chose to give birth at Cherrytrees in circumstances where the OU would have been a more clinically appropriate venue.

Communication with Respect and Integrity

Respectful relationships encouraging communication with honesty were recognised by all the stakeholders as essential for effective collaboration within the wider maternity care team for the women who accessed care with them. The team statement displayed on the notice board at Cherrytrees included the following two points:

> *"All members of the team should be treated equally and with respect."*
>
> *"We believe that communication should be positive and professional."* (Research diary extract)

The quality of the relationships between Cherrytrees and the obstetrician led team at the OU were variable, as described in the previous sections about recognising differences in each others' roles, building effective support networks to work safely in geographical isolation and breaking down barriers between professionals by building bridges across contextual boundaries.

The use of the SBAR communication tool had been introduced into practice at Cherrytrees, and it was seen a solution to a problem encountered in the past.

> *"We did focus on it and we did have meetings about it because there used to be a problem that when certain people were on, they saw (the OU) as the mothership. They were asking unreasonable things, phoning from a unit 40 miles away (Cherrytrees) and asking the sister in the old hierarchical way to make a decision for them. There was a lot of talk about that 6 or 7 years ago, that wasn't acceptable."* (Midwife 1, Focus Group)

The communication with the OU fell short of respectful when the transfer of care coincided with a clash of cultures.

> *"I had a registrar on the phone when I was going to transfer someone who was bleeding from a tear, her uterus was firm, she was bleeding from a tear and he actually said to me well, you'd better hope she gets here in time, and you think, how is that helpful?"* (Midwife 7, Interview)

When the transfer of care within the collaborative relationship between Cherrytrees and the OU went well, the communication with respect and integrity was attributed to their reputation of only transferring care if there were good clinical reasons for the decision, and the decision was clearly communicated.

> *"If you have to transfer somebody down there, if they come from here (Cherrytrees) then everybody says well, they need to be here. They don't ever think it's an unnecessary transfer or an unnecessary reason to see them down there. That's obviously from our track record, looking at every women we have sent down, they have needed to be there."* (Midwife 7, Interview)

This view was contradicted by an experience of another midwife discussed during the focus group, when she tried to transfer a women for further investigations and was met with what she perceived as a bullying attitude from the OU midwives. The behaviour between midwives from different contexts appeared to be less respectful than that between the Cherrytrees midwives and the medical staff.

> *"In terms of collaborative relationships, I would say that I found it a lot easier to deal with medical staff than other midwifery staff, I feel they're a lot more forthcoming and a lot more pleasant a lot of the time than the midwifery staff."* (Midwife 4, Focus Group)

The team leader's impression was that relationships had improved considerably, the OU staff trusted the Cherrytrees midwives' judgements and decision-making skills, which was an important aspect of the improvement.

> *"I think our relationship has improved because the trust has improved, they recognise that we are actually qualified […] The relationship is both our responsibilities, you couldn't criticise (OU) and not do some work ourselves."* (Manager 3, Interview)

Women who had been transferred in labour from Cherrytrees to an OU, were invited by the midwife who made the decision to transfer, to meet her to discuss their experiences and the circumstances of the transfer. The midwives valued this opportunity to reflect with the women on the transfer experience and their views of the care she received before and after transfer. One midwife who had a role at Cherrytrees and the OU expressed surprise that the women rarely remembered the physical transfer of care to the OU, and recognised the importance to the women of the seamless transfer of care.

> *"A lot of them say that actually they don't remember the ambulance part, so they were sad to transfer, but if it's done efficiently then there's no problem."* (Midwife 8, Interview)

During the data collection period, the unit vision was updated. The process was described as the midwives developing a unit vision, "our unit vision" then the women were asked to give their opinion. This apparently collaborative

process perhaps could be seen as the midwives claiming initial ownership of the vision, rather than allowing the women to start the process. If the women had stared the process this may have led to a vision created and owned by the women for the midwives to consider and base service development on. Perhaps this is best summarised by one participant when discussing post natal care,

> *"We almost, we diminish them, because there's so many different opinions, even if they're all on the same themes, the women don't fly on their own, they're waiting for you to tell them what to do."* (Manager 3, Interview)

6.3.8 Summary of Key Points

The findings from phase two at Cherrytrees, have shown the stakeholders' views, experiences and beliefs about the safety, effectiveness and person centredness of the care provided. The stakeholders were confident that women who accessed care at Cherrytrees at all stages in their maternity journey received safe care.

The Cherrytrees team were also confident that they provided effective maternity care through continuity of care within a small team which had developed expertise in maintaining normality, adapting to facilitate women's care preferences, and referring appropriately when deviations were recognised. Constant monitoring of their performance was accepted as necessary to providing an ever improving service where outcomes were regularly monitored by the team, the team leader and the head of midwifery. Reflective practice was actively encouraged as a mechanism to help the team learn from and support each other's practice under the supervision of the team leader, who provided strong, clinically credible leadership, and encouraged the team to develop their own leadership attributes leading to a very confident approach to providing rural midwife led care.

When women chose to plan their birth at Cherrytrees but whose circumstances indicated that birth at the OU with the obstetrician led team would be the clinically recommended option, the stakeholders took great pride in their

ability to facilitate women's wishes as safely as their rural circumstances would allow. However, when women who were clinically eligible to give birth at Cherrytrees planned to give birth elsewhere, a tension was recognised between the midwives' need for women to choose to use their services for labour and birth, and accepting the choices that women actually made.

The stakeholders' guidance and recommendations about the services and care that should be provided at Cherrytrees focussed on the recent Health Board maternity service review that had identified that one CMU in the area was likely to close. Most of the stakeholders were aware that Cherrytrees, though successful in terms of numbers of women accessing care, was unlikely to be sustainable in the long term in its current building. The unique characteristics that made up the unit, the demographics of the local population, the attributes of the team and Team Leader, the active support of the community led by the user representative and the support of the Health Board were universally felt unlikely to be transferable into another context, but some of the midwives were confident that their ethos and skills were eminently transferrable.

6.4 Phase Three. Women's Longitudinal Study Results

This section will describe the researcher's interpretation of the data collected in this phase of the study. Observation of clinical encounters and the interviews, informed by the aide memoire diaries, were the sources of data used to explore the women's perspectives of the maternity care they received at Cherrytrees. As in Chapter four, the phase three objectives of the study and the purpose of the observations and interviews are stated. An overview of the themes and associated categories is then presented. The themes were explored in relation to the objectives and a summary of the key points is given at the end of the section. As this was a longitudinal study, where appropriate findings are presented chronologically. Quotes were selected and used to illustrate some of the findings and pseudonyms are used to protect the participants' anonymity.

6.4.1 Phase Three Objectives

The objectives for this qualitative longitudinal phase of the study were to:

- Contextualise and explore women's views and experiences of the care they received at Cherrytrees, including their decision making processes about where to give birth.
- Describe and explore what influences women's preferences for their planned place of birth by the completion of their booking process and at the end of their pregnancies.
- Describe and explore women's needs for information and their experiences of decision-making about their planned place of birth.

The purpose of the observation of the women's clinical encounter at the beginning and the end of pregnancy, the use of aide memoire diaries and the three interviews during pregnancy and post birth were described in Chapter five, Sections 5.4.2. The recruitment process for the women at Cherrytrees was the same as that used for Seaview, and the demographic characteristics of the participants is summarised in Table 6.12.

Table 6.12 Demographic and Clinical Characteristics of Women Participants, Cherrytrees

Characteristic	Number of Women
Maternal age (years)	
15-20	2
21-25	3
26-30	2
31-35	3
36-40	1
Nationality	
White British	12
Relationship Status	
Married/Cohabiting	10
Single	2
Employment Status	
Employed	10
Unemployed	2
Student	0
Previous Births	
None	7
One or More	5

6.4.2 Data Collection and Locations

The observation of clinical encounters took place at Cherrytrees with all participants. All the antenatal interviews were held in a private, quiet area. Though participants were encouraged to choose the time and place of their interview, most preferred to combine them with their clinical observation visit. One post birth interview was also held in the quiet room adjacent to the Cherrytrees. The other six were held at the women's homes. Whilst the early pregnancy interviews were short, varying between 15 and 35 minutes, the later interviews lasted between 45 to 120 minutes.

6.4.3 Overview of Women's Study Results

The rich and complex data obtained from this phase of the study was analysed as described in Chapter three. Three main themes were identified from the categories that arose across the women's experiences, which were; being

known, being available and decision-making influences. Within each of the themes, the following categories were identified:

1. Being Known

    - Welcomed, remembered, centre of care
    - Continuity of carer
    - Wishes, decisions and preferences respected

2. Being Available

    - Information giving and information seeking
    - Accessible community service
    - Inclusivity

3. Decision Making Influences

    - Environment
    - Experiences of care
    - Confidence

These categories and themes were the same as those identified for the Seaview participants, and reflected the similarities and subtle differences between the two CMUs, which are explored further in the synthesis of findings in Chapter seven.

6.4.4 Being Known

The categories encompassed by this theme were women's appreciation of being welcomed from their first telephone contact with the staff, remembered from their previous pregnancies and being consistently addressed by name by all the members of the Cherrytrees team. The warmth of their welcome and provision of care centred on the women's needs and priorities, throughout

their maternity care, was also important to the women, both before and after the birth of their babies. Continuity of carer from previous pregnancies and throughout the current pregnancy through having a named midwife was also important to the women knowing their midwife and feeling known. Being known by their midwife and the team at Cherrytrees also included the ways in which women's personal wishes, views and preferences were addressed by the all the staff when continuity of carer could not be provided.

Welcomed, Remembered and Centre of Care

Most of the women were very positive about their first contact with the Cherrytrees staff to access maternity care, particularly those women who were already known to the team.

> *"Everyone's really welcoming and this time around when I phoned and said who I was, it was (name) who I spoke to on the phone and she was how are you, how are you getting on, remembering me.[…] I've always felt really welcomed even if it's a new member of staff or anything, people introduce themselves and that's reassuring, definitely."* (Judy, third baby, 8 weeks pregnant)

Women were also pleased with the availability of appointments to see their midwife very shortly after their initial request for care, and the range of services that the midwife could access for them in specific circumstances to meet their personal wishes and preferences.

> *"It's been brilliant, I never thought to come in a week later after I phoned. My first appointment was the day after I phoned and they've took great care of me, because of my previous miscarriage they decided to offer me a scan today to see that everything's OK and that's been great."* (Linda, third baby, 8 weeks pregnant)

This initial impression of being welcomed and remembered continued to be important to all the women as their pregnancies progressed, and being known by all the midwives led to women feeling confident that they were welcome to access care even when their named midwife was not available.

> *"They don't give you less time or the treatment doesn't alter in any way because they've got, they're full or they've got people off sick or whatever, which you totally appreciate."* (Judy, third baby, 36 weeks pregnant)

Amy was less sure of her welcome and was not anticipating a particularly positive experience of maternity care.

> *"It's not what I'd hoped for, they were dozy in some ways. The first lady that I got when I got here, she was writing on tissue when she was jotting down my information and that wasn't what I was hoping for. […] I didn't really have high expectations of getting a lot of things here when I came in the first place."* (Amy, first baby, 9 weeks pregnant)

Her opinion changed as her pregnancy progressed, and she grew to appreciate the way that the care provided by her midwife made her feel.

> *"That was just because it was a quick meeting but other than that they seem to be doing everything right and doing their jobs and I don't really have much to worry about. Yes, it feels as though they are going to get the job done so I have no reason to panic."* (Amy, first baby, 37 weeks pregnant)

After the birth of their babies, the women's perception of being the centre of care changed a little, particularly for Jenny, whose care was transferred in late pregnancy for suspected intra uterine growth retardation. Jenny had her labour induced at the OU, her baby was born by forceps delivery in theatre and she was transferred to Cherrytrees twenty four hours after the birth, with a urinary catheter still in situ, for post birth care.

> *"It was okay. I like to be left to do my own thing, which they done, but they didn't check on me as much as I think, well I would have rather that they did. […] There was another woman in labour so they were saying they were seeing to her, but once she had it, it was still like I was just left."* (Jenny, first baby, 10 weeks post birth)

The competing priorities of a woman in labour and another requiring post birth care appeared to impact on Jenny's perception of the effectiveness of her care, when she had to find the staff and ask for analgesia at regular intervals.

> *"I had phone contact every day, but I didn't see the midwives every day. I didn't feel I needed to. I was confident that what they had said was if you want us to come and visit, then you just need to ask and we'll come out. But they phoned every day just to check how I was doing and asked if I wanted a visit.* (Judy, third baby, 9 weeks post birth)

Judy found that the regular contact made when she was transferred home after the birth allowed her to tailor her care to her own needs.

Continuity of Carer

The women valued being able to choose the midwife who was going to provide their care, particularly those who had accessed care at Cherrytrees before and wished to retain the same midwife.

> *"I got to choose, when I mentioned that I had (name) as my midwife with these two, I got the option of having her again which was great."* (Lisa, fourth baby, 8 weeks pregnant)

Later in the pregnancy, the relationship each woman had with their midwife had developed in different ways. Some women had been referred during the current or previous pregnancies to the OU for maternity care not available at Cherrytrees, and their experiences contrasted with the care they had received from their named midwife at Cherrytrees, who knew them and their histories well.

> *"It's not like having to traipse to the big hospital (OU) because that's horrendous, and it's not just the inconvenience of getting there and getting parked, but also not knowing who you're going to be seen by, so it's nice this time to be getting a named midwife. I like the continuity we get, I think that's really supportive and you're not having to tell how you've been and the same story to different people, that makes a huge difference, definitely. So much of your pregnancy is trust based, you've*

got to have that bond with someone." (Judy, third baby, 36 weeks pregnant)

The trust built during the antenatal period was an important aspect of many women's experiences of continuity of carer at Cherrytrees. When apparently conflicting advice was being given to Lisa, who wished to give birth at Cherrytrees, she was able to make an appointment to discuss her situation with her named midwife, whom she trusted to know and understand her needs.

"When she started, the doctor (at OU) hadn't even read my notes, and then she went and got them which annoyed me even further. She didn't know me, so I made an appointment with (midwife) to talk to her about it. You can't beat (Midwife), she knows all my children's names, so she remembers every single one of them. She remembers every single birth, which I think is wonderful. I think just everything, she listens to you, she caters to your needs rather than lets get you in, sorted, then out, done. It's more personal, much more personal." (Lisa, fourth baby, 8 weeks post birth)

For Judy, the reliance on one midwife to understand her needs within the context of continuity of carer, caused some anxiety when that midwife was unexpectedly unavailable just before she gave birth. Her concerns centred on her perception that only her named midwife knew the thinking behind her individual birth plan, and that she may have been challenged about it during her labour when she anticipated feeling vulnerable and may have had difficulty explaining her plan.

"I did feel that although I had written by birth plan and I'd been quite detailed about what I wanted and things like that, I didn't feel I got the option to discuss my birth plan this time, because my named midwife was off. […] I suppose it's just not making assumptions about that and particularly because I had said in my birth plan that if I had gone to (OU) I didn't want treatment from one member of staff who I know is still there." (Judy, third baby, 9 weeks post birth)

Some women visited the OU to access ante natal services that were not available at Cherrytrees. One woman was referred to the wider maternity care team when gestational diabetes was suspected from a routine antenatal blood test, and another required specialist fetal cardiac scans as her first baby had a heart defect. Both women maintained continuity of carer with their named midwife and found that their experiences at the OU allowed them to reflect on their relationship with their named carer.

> *"You don't know anybody there, you're just a number. You don't know anybody and they don't know who you are and that's really daunting. I do think it's better one to one because they know you better."* (Carly, fourth baby 36 weeks pregnant)

After the birth, most women appreciated their daily telephone contact from the midwife on duty, appearing to accept that continuity of carer with their named midwife was not maintained after the birth. Emma, who chose to access care at Cherrytrees but lived out of the area, felt that she had suddenly lost out on continuity in her post birth carer. Her post birth care was provided by her local midwives, but she felt she missed her connection with her midwife at Cherrytrees.

> *"As soon as I was out of (Cherrytrees) that was it, (name) and the midwives from there can't come out to here, which I understand, but that was the only thing, I think that was a bit of a shame. I think I lost out a wee bit."* (Emma, second baby, 8 weeks post birth)

Judy's midwife ensured that she maintained her continuity of carer role after the birth.

> *"She was very clear that she wanted to hang on to us for post natal visits, so she got to come and visit us at home a couple of times, so that was really nice. You do feel that you've got a special relationship with them and they're sharing a really important experience in your life. I find it quite difficult to detach myself from everyone here now."* (Judy, third baby, 9 weeks post birth)

The maintenance of her continuity of carer and named midwife role was appreciated by the woman but also made it difficult for her to "detach" herself from Cherrytrees.

Wishes, Decisions and Preferences Respected

In early pregnancy, some women had specific needs, which were met with the provision of personalised early pregnancy care from the midwives. Those women who had experienced miscarriages occasionally requested an early scan, before the routine twelve week dating scan offered to all women. This request was met positively by the midwives and scans were arranged when the midwife with sonography skills was on duty.

> *"I was worried that I was going away on holiday, they were really nice and said we will get you in […] before you go away. It was good to see the scan and it was very clear and reassuring."* (Pauline, first baby, 9 weeks pregnant)

The women's families, friends and siblings were welcomed and included in the women's care and appointments were made flexibly to ensure that the women's preferences were met.

> *"When you only work two days a week, you really need to be there for the days you are working, so there was much more flexibility here and that worked out fine for me and the wee one (sibling toddler) here."* (Emma, second baby, 9 weeks pregnant)

Work and family commitments meant that several women had to change or rearrange appointments but the women remained confident throughout their pregnancies that appointments were always made to suit them around their named midwife's shifts.

> *"They make the appointment to suit that they're going to be there for you as well, instead of you've got to come in that day, that's it. It was always to suit me, never, well that's the time and that's it. It was what time do you want, which was good."* (Carly, fourth baby, 8 weeks post birth)

At their early pregnancy interview, every participant expressed a preference to give birth at Cherrytrees. Some became more sure of that decision as they experienced care from their named midwife in particular and became familiar with the team in general.

> *"Because I've been here all the time for appointments and things, so I know like the midwife and I just, for a while I did think about going to the OU, but I thought my pregnancy's been fine, so I don't know why anything else wouldn't be."* (Susie, first baby, 36 weeks pregnant)

Marie found herself in a difficult dilemma over her birthplace decision, in which she was torn between planning to give birth at Cherrytrees with midwives she knew, and attempting to mitigate the risks involved in childbirth by opting to give birth at the OU. This dilemma perhaps indicated that although she trusted the midwives to provide antenatal care that lay within predicted pathways and was guided by straightforward referral mechanisms, she did not feel able to continue that preference during the unpredictability of labour and birth. Her perception of the midwives reactions to her ultimate decision to choose the OU was less positive than she had hoped.

> *"I think they are very keen for you to have your baby here (Cherrytrees). Sometimes I think because you're feeling a bit emotional, some days you think you're being pressurised, you take things by heart but no, they were just wanting to make sure that you made the right decision. It's very much about you and your baby, yes, so it's good."* (Marie, first baby, 36 weeks pregnant)

Marie appears to have felt pressurised by the Cherrytrees midwives to make the 'right' decision, to give birth there. She appeared to have reconciled her perception of the midwives' less supportive reaction as being part of her emotional vulnerability. Judy described her experience of the midwives removing pressure on her by listening to, respecting and facilitating her preference to decline the offer of a date for the induction of her labour at the OU at forty-two weeks of pregnancy so that she could continue with her plan to give birth at Cherrytrees.

> *"I'm really glad they didn't do that, because I think that would have pushed me over the edge. […] The pressure that would have put on me, with the added pressure of his side of the family, they were saying why have you not got a date for induction, I hope you're not putting yourself first before the baby, I was like, no the baby's happy. The midwives are happy for me to go overdue."* (Judy, third baby, 9 weeks post birth)

Carly and Lisa brought their children with them to Cherrytrees when they were in labour. They felt their entire families were welcomed and included, which allowed the women's partners and the babies' siblings to be present and should they wish, witness the birth.

> *"They had to come with us, it was a mad dash (daughter) was in the room with us the whole time and (son) sat outside, he was at a funny age, he was fine sitting in the corner playing on the phone, they were both fine, they got juice and everything. (Daughter) was right there and she helped get her cleaned up, she was part of that as well, they (the midwives) actually explained everything they were doing to her as well."* (Carly, fourth baby, 8 weeks post birth)

Emma described her pleasure at feeling listened to and her responses respected during her labour at Cherrytrees.

> *"It was all about how I felt and where I thought I was in labour, they weren't really trying to tell me. It was to do with how I felt, and how I felt things were progressing."* (Emma, second baby, 8 weeks post birth)

After giving birth, one woman felt a distinct change in atmosphere when the midwife who had helped her give birth left and another took over her care in the post natal area. This woman's experience centred around the midwife's reaction to her question about a large birth mark on her baby's leg which was causing considerable concern to the woman due to its size and appearance.

> *"She was like, it's nothing, she'll just be very conscious of it when she's a teenager. That's not a very nice thing to say. […] She went over to (another woman) and she was like, you need to get out of your bed, kind of hollered her out of bed. I was like, God, this isn't right. […] Her (the*

other woman's) husband said I just don't think she feels very comfortable in here" (Susie, first baby, 7 weeks post birth)

Susie returned to Cherrytrees the next day and the midwife examining the baby listened to, acknowledged and showed respect for her concerns about the marks on her baby's leg. She referred the baby to a dermatologist who examined her leg and explained the way in which he predicted the marks would fade as she grew and her skin stretched.

"Even if she'd just said that to me, I would not have been so scared." (Susie, first baby, 7 weeks post birth)

6.4.5 Being Available

This theme aims to encompass the experiences of the women in their ability to access information and consultations by whatever method was convenient to them at the time. The way in which information was offered to the women, during planned antenatal consultations, through telephone and e-mail contact with their midwives, and during the many and varied antenatal classes and groups available, allowed women to address specific information needs in the way that they felt most appropriate. The availability of the staff and facilities at Cherrytrees at all times when the need for immediate advice or care arose, was also important to the women, particularly the local setting and ease of access for local women. Inclusivity of self referral in early pregnancy for all women in the community was also identified as an important issue for women with social, financial and clinical needs where the local availability of advice and support at an early stage was appreciated.

Information Giving and Information Seeking

All the women were given a large amount of verbal information at their booking appointment, which was supplemented by written information. I observed all the women being referred to parts of the written information relevant to the stage of their pregnancy and the decisions they would be asked to make over the coming weeks. In doing this, the midwives opened the relevant books and leaflets to discuss the written information and supplemented it with information relevant to each woman's particular context.

Most women found this way of being given information acceptable and valued the opportunity to ask questions at the time. Some found the amount of information and their role in reading and considering their options a little daunting.

> *"Some of it's too much, but I've got all this time to read it, I haven't read it yet but she explained to me the bits I needed."* (Amanda, first baby, 10 weeks pregnant)

The women all mentioned that they were welcome to ask questions, and to contact their midwife to discuss any issues that occurred to them after their visits. The majority of the women were confident that their questions would be answered at their consultations and by late pregnancy described various methods used to seek information during and between consultations as their needs arose.

> *"There were a few things at the beginning, I just e-mailed (midwife) and she got straight back to me, and it was absolutely fine, any worries and she was there."* (Carly, fourth baby, 36 weeks pregnant)

Information was also sought by the women through attending antenatal classes offered at Cherrytrees. The wide variety of classes and groups attempted to fulfil the women's physical, social and emotional needs by providing classes ranging from yoga, aquanatal, relaxation and self hypnosis and positive birthing, to infant feeding and 'knit and natter' groups. Marie embraced all these opportunities to be physically active in pregnancy, to understand more about the positive aspects of birth and to fulfil her need to meet people who were at a similar stage of pregnancy as herself to establish a new network of social support.

> *"I was so active physically before I was pregnant, it feels like you're doing something to keep that activity going. I have to say that the antenatal classes were amazing, because I did come into this with a negative mindset on the birth itself, just because you always hear bad stories […] I did come out of them feeling very emotional, but I did come out on the other side much more positive. […] Having the antenatal classes made a*

big difference as someone who's worked, who's not from the area, all your friends are at work […] then I think for me it was important to try to do these things as well." (Marie, first baby, 36 weeks pregnant)

Jenny reflected on the information given to her when she was referred in late pregnancy to the OU as her baby did not appear to be growing at the expected rate. She was disappointed at the information given to her about why she had been referred by her midwife at Cherrytrees.

"It was a bit like we didn't know what was going on, but when we got the appointment through to (OU) and when we were there, they explained it. […] That was a couple of weeks before we actually fully knew what was going on. You do your website searches but you don't want to believe anything. […] We were a bit miffed about it, we didn't really know what to think about it." (Jenny, 10 weeks post birth)

All the other participants were pleased with the information they received in preparation for the birth from their named midwife and the wider Cherrytrees team. An experience at the OU where an obstetrician made assumptions about one women without referring to her notes before giving her information about the results of a scan, led that woman to reaffirm her clear preference to receive her care and information from her Cherrytrees midwife.

"She came in and didn't even open my notes, I had my youngest with me at the time and she went, is this our first baby? I thought no, fourth, and she went, oh we get a lot of bored housewives in here. At that point I just went, oh, just say what you want to say and let me out of here. She kept saying oh, you're midwife led unit at (Cherrytrees), like it was a second class place to go.
Interviewer: How did that make you feel about (Cherrytrees)?
Even better, even better, I've always felt there's nothing that worries me about coming here." (Carly, fourth baby, 36 weeks pregnant)

During labour and birth the information given to women appeared to reflect a confidence in the women's assessment of when they felt the need to come in to the unit, as had been anticipated by the women who had given birth there before. Susie, however, was expecting her first baby, and had been told by

her midwife that she was unlikely to go into labour for a few weeks, so was confused and surprised when she went into labour that night.

> *"We phoned (Cherrytrees) and told them because I was like, but it can't be because they said they probably wouldn't see me for another few weeks. You take that in. They just asked how I was feeling and because it was coming every five minutes, to come down. They said I could stay there if I wanted or go home for a bit."* (Susie, first baby, 7 weeks post birth).

During the birth, information was given to the women dynamically as their situation changed and their labour progressed. All the women reported feeling well informed about their progress by their midwives.

> *"She didn't bother examining me because I said, I know it's happening. It was happening. Basically just got in the pool and then it was very, very quick. Then I had to start pushing, I just kind of went in my bubble and got on with it. I was zoned out, very calm, but that was just the whole - she was in the water and I was sort of going, ahh. She just came out really quick."* (Carly, fourth baby, seven weeks post birth)

Most women expressed a feeling of being "in the zone" where they were able to concentrate intensely on what was happening to them and used that information along with the midwives' assessment to assess their progress throughout their labour.

Accessible Community Service

Most of the women accessed care at Cherrytrees in early pregnancy as it was their local CMU where they or their friends had received maternity care in the past.

> *"I only live around the corner. I was born here my mum was trying to make it to (OU) but she came here, so I wanted to stick to here."* (Amy, first baby, 9 weeks pregnant).

Emma had given birth at Cherrytrees in her last pregnancy and Linda and Amanda lived out of the immediate area but knew of Cherrytrees by its reputation, and for Marie it was close to her place of work. Jenny, Amy and

Sophie, all expecting their first baby, contacted their GPs in the first instance, and were directed to Cherrytrees to access maternity care. All of the women were planning to experience a waterbirth and gave that as well as the local setting as the reason for choosing to access care there.

The services available at Cherrytrees meant that one women could access treatment for her severe nausea at her booking visit as the collaborative relationships within the local community allowed the midwives to co-ordinate the prescription and delivery of the treatment for collection at the local chemist. Early pregnancy scanning services allowed women to access routine scans locally, and referral to the OU for assessment or transfer of care to the obstetrician led team could then be made should this be necessary.

Later in their pregnancies, the women commented on the convenience of local provision of care, and this was particularly important to Amy, who found her pregnancy very tiring and access to local care meant that she attended for care when perhaps travelling may have been a problem for her.

> *"It's just that some days it's tiring even to get out of bed, so it gives me that push to get out of the house. I mostly look forward to them (antenatal appointments), but little ones like this (blood pressure check), I just can't be arsed so I would rather just miss it, but it needs to be done, you need to have a check every so often."* (Amy, first baby, 37 weeks pregnant)

Local access to care during labour was recognised as very important for Lisa who had to make provision for her family to get home at night after the birth when taxis were prohibitively expensive and the buses had stopped running.

> *"Because (partner) was bringing the buggy, he got on the bus and I got a taxi and we met there, it was mainly for getting the girls home that night. […] They went home at about ten, but because there were no night buses as usual, they had to walk."* (Lisa, fourth pregnancy, 8 weeks post birth)

The provision of local maternity services during the unpredictable timings of labour and birth were essential to this family's ability to fulfil their wishes of the birth being a family occasion not a medical occurrence.

Inclusivity

All the participants were white and British, but exclusion due to their social and economic circumstances were potential issues for some. The women all appreciated the simplicity of being able to self refer via a telephone call to make an appointment for antenatal care at their convenience. During all of the early pregnancy consultations observed, the midwives approached these issues with sensitivity and a thoughtful assessment of each of the women's needs was made. The outcome of these needs assessments were demonstrated by the midwives giving targeted information to individual women.

Amy, who had particularly requested information about the financial assistance available for pregnant women, was concerned that her midwife had introduced the subject and offered her information to help, but she had not at the time of her interview received that information. The research dairy entry about that interview revealed why that information had been delayed.

> *"After our interview, (midwife) was waiting for (name) to tell her to contact the Citizen's Advice Bureau, who could provide advice on her particular issue free of charge. Whilst (name) was being interviewed, she had contacted local resources to explore how, without revealing any confidential information, someone might access help in addressing some complex financial and legal employment issues which had been disclosed during the observed antenatal consultation."* (Research Diary Extract)

Marie was noted to have some complex social issues in that she lived some distance from her immediate family and close friends and had a very demanding job which left her little time to develop a supportive social network in preparation for when she began her maternity leave. Her named midwife recognised the potential for her to become socially isolated particularly after the birth, and encouraged her to take the opportunities afforded by the activities run by Cherrytrees staff and within the community to meet with

other pregnant women. This caused her some anxiety over whether the friendships she had made would continue after the initial meetings.

> *"A lot of my friends, you know, good friends are further away. It's still a worry that you are going to get out there, but I think it will help […] A worry that you won't meet people or keep up with people, yes, that's it."* (Marie, first baby, 36 weeks pregnant)

Judy had experienced postnatal depression after her first baby had been born at the OU, where she had been traumatised by the birth. The birth experience for her husband had also been deeply traumatic. Judy's husband described his memories of her first birth during my observation of her early pregnancy visit as feeling like they were on a sinking ship, out of control and with no way out.
.

> *"As soon I found out I was pregnant, my night terrors started. I had quite lot of counselling the last time because I had postnatal depression. Actually coming in and seeing the consultant here (Cherrytrees), that was, that was a very, I think they describe it as a cathartic experience. My husband felt it the same, because there were questions that he had, because yes, okay, I experienced the birth, but he found the whole thing really distressing as well and we both got really upset about it, so that helped, definitely."* (Judy, third baby, 8 weeks pregnant)

The residual trauma and its potential effect on the current pregnancy was noted by her midwife, and further counselling was offered to them both with the linked obstetric consultant whom they had consulted following the first birth.

6.4.6 Decision Making Influences

This theme was developed from the categories and codes that arose when considering how the women felt about whether Cherrytrees was an appropriate place to access care for the different stages and needs during their maternity journey. The environment at Cherrytrees was identified as an important influence on how women felt about its' suitability for access during labour and birth. The buildings were old, but the women found the calm,

compassionate (although women did not use this word) and warm environment inside to be an important influence. The women's own experiences of care at Cherrytrees or the OU were also identified as important when decisions about where to give birth were being made. The women's relationship with their midwife and confidence in the team providing care was an important factor in the women's decision making particularly when their trusting relationship was being challenged by their differing opinions around the safest place to give birth.

Environment

Whilst the majority of the women commented on the calm, relaxed and quiet atmosphere that they noticed on their early visits, Amy found the external appearance of the old buildings quite offputting but came to the conclusion that as long as it was clean, she would be happy. Most women knew of Cherrytrees from its reputation within the community and were willing to overlook the outside façade when making their decisions on where to give birth, once they had experienced the warmth of their welcome and the homely feel described by the women, where elements of the theme of being known were also important.

> *"I prefer to come here than the hospital, I don't like hospitals, it's not like a busy hospital, it's a lot more calm. It's a nice atmosphere for different things, not just one thing. At (OU) it's havoc and of course that stresses you out because you're panicking about giving birth and then you come here and it's quiet and you've got your midwife."* (Amanda, first baby, 9 weeks pregnant)

By late pregnancy, all the women focussed on the environment as being relaxed and homely, emphasising the difference between Cherrytrees and a hospital, or OU, environment. Marie found that the relaxing environment had an influence on her decision-making, but on balance preferred the on site availability of the obstetric, anaesthetic and paediatric team as her main influence on where to give birth.

> *"No, I still intend to go down to (OU), just to have everything there if I need it, but I fully appreciate that you'd then be more likely to need it if*

you're not relaxed, but if you're up here (Cherrytrees) you may be more relaxed, so maybe you don't need it" (Marie, first baby, 36 weeks pregnant)

Amy described several influences that helped her to decide where to access care, but sums them up with what seem to be her strongest influences, namely a calm, quiet and clean environment.

"Just mainly because its local and the whole family's local so it makes it easier. […] There's no reason for me to go round to another place, it just seems calm and quiet and clean." (Amy, first baby, 37 weeks pregnant)

For Lisa, Carly, Emma, Susie and Judy, who all gave birth at Cherrytrees, the availability of the birthing pool was important to each of them to create the environment they required to labour and give birth effectively.

"It was good because we had the run of the place, it was quiet. I just said I need to get in the pool […] Then it was like well this is amazing, it felt great." (Emma, second baby, 7 weeks post birth)

Emma also noticed that she had privacy in that she was the only woman there and the individual attention of her midwife.

Experiences of Care

Experiences of care were closely bounded with the information the women were given during those experiences. Most women who had given birth before drew on their experiences of birth at Cherrytrees and at the OU to inform their decision about where to give birth in their current pregnancy. Judy had experienced being transferred to the OU during the early stages of labour in her first pregnancy. Judy's subsequent experience of care at the OU (referred to in the inclusivity section) made her very determined to give birth at Cherrytrees in the future.

"Being here (Cherrytrees), it's not just about me personally feeling comfortable, but (husband's name) feels comfortable about being here too, and if he feels comfortable and happy being here, then that in turn passes on to me and I feel that I'm then being supported whereas when

we were in (OU) and we both didn't know what was happening and we both felt absolutely out of control."(Judy, third baby, 36 weeks pregnant)

Carly also had poor experiences of care at the OU, both during previous pregnancies and her first birth, which clearly affected her choice to access care and give birth at Cherrytrees.

"My time at (OU) was just horrendous, I was young, I didn't know what to expect. I'd gone for an epidural […] then when I got there I didn't get my epidural, then they told me he was in distress, they had to put a monitor on his head there was a voice from the bottom of the bed with forceps going if you don't hurry up, this is what's going to happen. Legs in stirrups you know, it was horrific. Then afterwards you're shoved in a shower and told to get on with it. You're standing there and you don't expect to be just left, but nobody told you about it, you're completely lost, it was horrific." (Carly, fourth baby, 36 weeks pregnant)

She described her experiences of care at Cherrytrees, for her two subsequent births, which were in complete contrast.

"Having the waterbirths as well, makes a big difference, the care here as well, the dimmed lights, there's no-one else around screaming and shouting, just completely different." (Carly, fourth baby, 36 weeks pregnant)

Most of the women who were expecting their first baby relied on the stories of others' experience of maternity care and the differing birth settings, which appeared to continue the theme of satisfaction with the care at Cherrytrees, and less positive stories from births at the OU. Amy felt that she had no interest in others' experiences, as she was the only person who could decide where it was appropriate for her to give birth.

"I don't really care about anyone else to be honest, if they say it's bad, then it's bad for them, if others say it's good, then it's good for them. I have no experience of this place." (Amy, first baby, 9 weeks pregnant)

Her experience of care as her pregnancy progressed, allowed her to make a decision that she had based on the evidence of her own care.

> *"We came last week and (midwife) talked us through a few things and then we just came to the decision of doing a waterbirth. She showed us both of the rooms and what they have and what can be suited to my needs and stuff. (Midwife's) been there and been able to give me the information that I need, so there's no reason to go to another place"* (Amy, first baby, 37 weeks pregnant)

After her baby was born, Susie found that her experiences of care at Cherrytrees in the post birth period made her question whether she would access care there during future births, if one particular midwife was on duty.

> *"If I was having another baby and she, if I got told that she was the midwife I wouldn't want her to be my midwife. I know that sounds nasty, but I wouldn't feel comfortable having her there."*(Susie, first baby, 7 weeks post birth)

Jenny was referred to the OU in pregnancy and was relieved as she was about to tell her midwife that she wanted to give birth at the OU. She was very pleased with her care at the OU, which compared favourably to that received post birth at Cherrytrees.

> *"The more I thought about it nearer the end, I wanted (OU) actually, just because there's more back-up. […] I loved it there, I preferred it there than when I came to (Cherrytrees) actually, just because they were always there and they came, not enough to annoy you but they came often enough to see how you were doing."* (Jenny, first baby, 10 weeks post birth)

Lisa, Carly, Emma, Susie and Judy were delighted with their labour and birth experiences at Cherrytrees, and were very keen to ensure that their good experiences would be acknowledged and the team recognised for the excellent care they provided.

> *"I felt very safe at (Cherrytrees), it's very person centred because everything's about being easy for me, to take him (sibling) to my appointments, to just stay there on the day and tend to (baby) and tell them how I'm feeling and for effectiveness, a safely delivered baby."* (Emma, second baby, 7 weeks post birth)

Emma was keen to summarise her experience in terms of how her care was delivered by her midwife from her first visit to going home (out of the Cherrytrees area) with her baby.

Confidence

Most women in early pregnancy expressed confidence in the maternity care they were expecting to receive, by their intention to remain at Cherrytrees to give birth. Some women who had experienced complications in previous pregnancies were a little more guarded about planning an event in the future, but were still keen to aim to receive the majority of their care with the team.

> *"I'd like to be here (Cherrytrees), but I'll just have to see what happens as things go on, with me being so little and things, but I would prefer to be here."* (Pauline, 9 weeks pregnant)

As the women were preparing to make their birth plans in late pregnancy, most demonstrated a growing confidence in the team to continue to provide appropriate care for them during labour and birth and the post birth period.

Jenny had been referred to the OU at a time that coincided with her losing confidence in giving birth at Cherrytrees as she

> *"Both of my sisters planned to go (Cherrytrees), but they ended up in (OU) as well so I was like, I may as well just go (OU) as I'll probably be the same as them. I would have told (Cherrytrees midwife) when I was at that appointment but I knew I was going to go to (OU) anyway."* (Jenny, first baby 10 weeks post birth)

Marie had chosen to access care during labour and birth at the midwifery led unit situated within the OU buildings. She had great difficulty in balancing her desire to have a normal birth with her fear of complications during labour,

about which she had heard overwhelmingly negative stories from other women and saw as an event over which she had no control. In her assessment of the risks associated with her labour and birth, she appeared not to acknowledge, nor perhaps have confidence in the role of the midwifery team in providing dynamic risk assessment and appropriate, timely transfer of care should this be necessary.

> *"It's difficult, because (midwife) keeps saying, you're still in control, and yes you are, to a certain extent, but you can't control when you go into labour, you can't control how long it's going to be, you can't control, necessarily, what the pain level's going to be. So there's a lot of things you can help control, but there's still a lot of things you can't, and the type of person I am, that is difficult."* (Marie, first baby, 36 weeks pregnant)

In contrast Judy had absolute confidence in the midwives' ability to provide appropriate safe and effective one to one midwifery care during labour and birth, and transfer to the OU would be an integral part of that care should the need arise. She also displayed a confidence in her own ability to give birth, which she attributed to the support and confidence shown by the midwives towards women and their ability to give birth.

> *"I'm very clear that I want to be here, I really want to be in (Cherrytrees) and I'm confident that the girls will make sure they do everything they can to make sure I can be here, but at the same time, they wouldn't take any chances if they need to transfer me for any reason. Because you feel safe and supported, then your body knows what it's doing and it goes for it. […] Outside it says if you can believe in yourself, then you can do anything and the girls here make you feel that they absolutely believe that you can do anything."* (Judy, third baby, 36 weeks pregnant)

After the birth of their babies, the women who gave birth at Cherrytrees looked back on the choices that they made leading up to and during labour and birth with pride and described their experiences as very positive, affirming their confidence in the staff who helped them and in their own ability to give birth to their babies.

> *"The midwives here always say don't let anyone push you into something you don't want to do, pregnancy and birth wise. At the end of the day it's your body, it's your decision and it's your baby, you decide. It gave me the confidence to tackle anything. It was the most wonderful experience, this place (Cherrytrees) is wonderful, I just love it."* (Lisa, fourth baby, 9 weeks post birth)

The confidence that the women had in the midwives and their care did not always transfer to their post birth care, Susie and Jenny had specific issues with their post birth care whilst staying at the Cherrytrees. Those who went home within a few hours of the birth were confident that they could tailor their care around their families' needs.

> *"I got a slight infection on day four so I was going in on day five anyway. It was sorted out there and then. They phoned a prescription through to my GP so I could pick it up when I got home. So yes, it was just dealt with quickly. They just made sure that I was feeling better and that I had done the antibiotics and that was it."* (Carly, fourth baby, 8 weeks post birth)

Carly was visiting Cherrytrees for her post birth care when she suspected that she had a urine infection and received advice and effective treatment that she was confident would be provided by the team.

6.5 Summary of Key Points

The women's experiences of care, their information needs and the influences on their decision making about where to give birth presented in this section have demonstrated that their experiences were closely related to the connections that they had made with their named midwife and how these connections helped the women to trust and have confidence in their carer. This trust led to a mostly confident approach to their expectations and experiences of maternity care, accessing information and advice as required in the antenatal period. Their decision making processes about where to give birth appeared to be made on the basis of their own and others' experiences of labour and birth, the relationship with their midwife the welcome they received at each visit, and the facilities available to achieve the birth they wanted. Safety in terms of the availability of medical staff and equipment was

occasionally brought into the decision making process, notably by women expecting their first baby.

The effectiveness of their care during the antenatal period was seen in different ways by the women, depending on their individual experiences. Antenatal referrals to an Obstetrician were welcomed by some women but found to be less useful for others who felt that effective care was not offered in their particular circumstances that had not been established by the OU staff. Referrals made by the midwives were seen by the women to have been appropriate. The appropriateness of referrals is also supported by the phase one findings on the processes and outcomes of the care provided, both antenatally and in labour, and the stakeholder's views of the way in which referrals are discussed and made with the women. The women accepted that referral and transfer in labour was always a possibility and were confident that the midwives would maintain the mother and her baby's safety by appropriate referral should this become necessary.

The antenatal care received at Cherrytrees was found by most women to be centred on their needs and preferences, which influenced their decisions to give birth at the CMU. Those who made decisions to give birth elsewhere were less convinced that their individual decisions were supported rather than the team's preferences were supported and this tension was recognised in the stakeholder findings. Those who gave birth at Cherrytrees found their care during labour and birth to be exactly as they had wished, despite all receiving care from another member of the team, not their named midwife. All their birth plans were facilitated by the midwives caring for them despite one women's concerns that the rationale for her wishes may not have been fully explained. Most women's familiarity with all the members of the team through antenatal classes and visits helped them to feel confident that the team would provide the expertise necessary to guide them through their births.

The two women who received post birth care within Cherrytrees experienced care that did not meet with their individual preferences concerning their needs for information and for a therapeutic connection with the midwives caring for them. The women who went home within a few hours of birth found their care

to be flexible and effective with a particular emphasis on arranging the care to suit the women and their family commitments, there appeared to be no expectation of retaining continuity of carer after the birth, although this was achieved for one woman.

6.6 Cherrytrees Findings Conclusion

The findings presented in this Chapter have presented different viewpoints on the provision of maternity care at Cherrytrees. The provision of safe care was viewed in similar terms by the stakeholders and the women, but occasional differences in the women's views on the safest place for them to give birth arose. The statistical analysis of the outcomes of the care provided revealed that all women who accessed care at Cherrytrees received safe care from the team and early access to antenatal care (n=268, 88.7%) with a midwife as the first point of contact was achieved for n=293, 97% of women.

The stakeholders' and the women's views on the effectiveness of the care provided also concur that appropriate referrals were made using the KCND (NHS QIS 2009) pathways at the right time to the right professionals and services. The descriptive statistical analysis however revealed that when women were referred in labour to obstetrician led (OU) care, the incidence of caesarean section was higher than those referred to a different OU from Seaview, but the resuscitation levels required by the babies were lower. Barriers to the provision of effective transfer of women's care were being addressed by integration of the CMU midwives with the OU team to improve collaboration and communication.

The statistical description of the historical lack of antenatal continuity of carer was not upheld by the views and experiences of the stakeholders or the women. All women, with one initial exception who changed her view as her pregnancy progressed, described incidences of care provision tailored to their individual needs and preferences during pregnancy by their named midwife, and during labour and birth from the team. Barriers to person centred care at this CMU seemed to stem from issues with the midwives supporting the team philosophy of the best place to give birth rather than their own preferences.

Post natal care was recognised by the women and the stakeholders as an area where improvements in the provision of all three quality ambitions of safe, effective and person centred care for all women were required. The Cherrrytrees team had introduced an improvement of daily telephone contact with the women but this did not appear to address the full range of women's post birth needs and preferences for the continuation of continuity of carer.

CHAPTER 7: SYNTHESIS OF FINDINGS

7.1 Introduction

This Chapter brings together and interprets the findings from Seaview and Cherrytrees in relation to the aims and objectives of this study and the research question. Some aspects of the findings, for example continuity of carer, resonate throughout all three of the quality ambitions. Relationships between the women, the CMU teams and the wider maternity care teams, are explored using the framework of social capital theory which was briefly introduced in the literature review, Chapter two, p.15. The wider literature is then used to inform the development of the key points which are explored in the discussion presented in Chapter eight.

This thesis has explored how CMUs contribute to the delivery of safe, effective and person centred care in two rural CMUs. It has quantified and described the socio-demographic and clinical characteristics of the women who accessed maternity care at the CMUs. The processes of care and clinical outcomes for the women who laboured and gave birth at the CMUs have been described and the clinical appropriateness of the care has been compared to national pathways and guidelines (NHS NIS 2009). These findings have suggested that the socio-demographic and clinical characteristics of the women who accessed care across both CMUs were similar, but some outcomes for women varied according to which CMU team provided their maternity care. The exploration of stakeholders' views and experiences suggest that the variation in care processes and outcomes may partly be explained by the healthcare providers variations in practice, the services available at each CMU and women's individual preferences. The women's accounts of their care were also explored and factors were identified which influenced their decision-making about place of birth and how their information needs were fulfilled, or not, in partnership with those caring for them.

7.2 Safety

The Scottish Government (2010) described safe healthcare as care from which no avoidable injury or harm occurs to those who receive care, and that it is

consistently provided in a safe, clean and appropriate environment. The rural CMU teams provided antenatal, (including pre-pregnancy counselling, ultrasound scanning, parent education and obstetrician led clinics) and post birth care to 683 women. Of the 482 women who received midwife led care at booking, 92.5% (n=446) expressed a preference to give birth at the CMUs in their birth plans made in late pregnancy. Some (n=325, 47.6%) women who accessed care across both CMUs followed a midwife led pathway and gave birth at the CMUs. These women received maternity care throughout pregnancy, labour and birth and the post birth period from the CMU teams. Just over half (n=358, 52.4%) of the women who followed an obstetrician led care pathway also received care in pregnancy and after the birth from the CMU teams. Aspects of the safety of the care relating to the outcomes achieved for the women and their babies provided by the teams in Seaview and Cherrytrees are presented for the different stages of the women's maternity journeys.

7.2.1 Antenatal

Appropriate assessment and referred at the initial risk assessment at booking occurred for 97.5% (n= 666) of all women who accessed care at the CMUs. Seven women's records were not completed accurately to reflect the appropriate referrals actually made in practice in Seaview, the documentation of the lead carer in pregnancy had not been updated after appropriate early referral for assessment had been made. This documentation error was not found at Cherrytrees and may reflect the different ways that records of practice were audited and monitored in the two CMUs.

7.2.2 Labour and Birth

Women who accessed care in labour (50.8%, n= 194 for Seaview and 64.9%, n= 196 for Cherrytrees) were found to have used different methods of managing their pain. The women at Seaview did not have access to a birthing pool, and 17.7% (n= 29) chose to use intramuscular morphine during labour. Women at Cherrytrees did have access to a birthing pool and only 8.1% (n=12) used morphine as a pain management strategy. This finding echoes that of the Cochrane systematic review on immersion in water in labour and

birth (Cluett and Burns 2012), which found a decreased use of opiates by women who chose to labour in water. Morphine is an opiate with the ability to cross the placenta and depress the respiratory drive of the baby at birth (American Association of Paediatricians, 2011) and the use of morphine during labour has an impact on the condition of neonates at birth. Six (3.6%) babies required basic resuscitation assistance at birth to establish spontaneous regular respiration at Seaview, compared to two (1.2%) at Cherrytrees. No babies required admission to the neonatal unit at the OU.

Access to a birthing pool may also have some relevance when the degree of perineal trauma sustained by the women was compared. Fewer women at Cherrytrees, where a birthing pool was available and used by 88.7% (n=141) of the women, sustained any trauma. The women who gave birth at Cherrytrees experienced a lesser extent of perineal trauma than the women at Seaview where no birthing pool was available. 42% (n=69) of women at Seaview and 56.8% (n= 89) at Cherrytrees had no trauma, and 24.4% (n=40) at Seaview versus 11.5% (n= 17) at Cherrytrees sustained a second degree tear. 62% of women at Cherrytrees who gave birth in water sustained no perineal tears, which may be related to the lower overall incidence of perineal trauma during waterbirths found by Burns et al. (2012).

Safety for all women who accessed care during labour and birth appeared to have been approached differently by the two CMU teams, depending on the amount of advanced planning that could be made in each women's circumstances. Training in the necessary knowledge, skills, and obstetrician led team support were accessed by the Cherrytrees team when unusual births were planned in an attempt to enhance the safety of women and their babies. Similar plans were made when choices for birth outside the clinical recommendations for midwife led CMU care were planned by women at Seaview, but the team expressed concerns about their own professional and contextual vulnerability in circumstances when women with clinical complexities accessed unplanned care in advanced labour at the CMU. Tucker et al. (2008) found that 5% of women who accessed care at rural CMUs in advanced labour, and gave birth before onward transfer could be facilitated. Seaview was located 'en route' to the OU and this position beside a main road

brought complexities to the provision of safe maternity care to women who accessed care at rural CMUs in unplanned and clinically inappropriate circumstances.

Episiotomies were performed on 1.8% (n=3) women at Seaview, and the Cherrytrees team performed none. The guidelines for Seaview, informed by the national guidelines (NICE 2007) and evidence of Hartmaan et al. (2005) and Danneker et al. (2004), stated that the use of episiotomies should be restricted to instrumental deliveries and suspected fetal compromise. No documentation of fetal compromise had been made in the records and these babies required no resuscitation. The resuscitation requirements may have been greater had fetal compromise been suspected, but there is no evidence that was the case, leading to the question of whether the episiotomies were clinically justified. One woman (Carly) in Cherrytrees described one of her reasons for using the birthing pool was to maintain a barrier between herself and any potentially harmful intervention during her labour. That perceived barrier of water to protect the women from intervention was not available to the women in Seaview. Garland (2011) argued that the use of water as a barrier, or as described by Carly in this research as a 'bubble', between the women and the outside world, allowed women to retreat safely into focussing on their labour.

Perception of risk appeared to affect practice between the cases where differences were noted in the management of the third stage of labour between the two CMUs. Physiological third stages were experienced by 3% (n=5) of women at Seaview and 48% (n=71) of women at Cherrytrees. This difference cannot be explained by the socio-demographic or clinical characteristics of the women as these were found to be very similar. The qualitative data revealed that each CMU team's perception of the evidence regarding the risks and benefits of active and physiological management differed, and this was observed to affect the advice they gave to women and ultimately their practice. No women who gave birth at Seaview and two women who gave birth at Cherrytrees experienced a recorded blood loss of over 1,000 mls, one of whom opted for a physiological third stage and one had active management. These findings are similar to the evidence from Begley et

al.'s (2011) systematic review of active versus expectant (or physiological) management of the third stage where active management reduced the incidence of post partum haemorrhage of over 1,000 mls. The experiences of women who gave birth in water in this study suggested that getting out of the water to facilitate the active management of the third stage had an influence on their decision-making as their preference was to remain undisturbed in the pool. The guidelines for each CMU differed slightly in their approach to a physiological third stage in that the Cherrytrees guidance begins with the premise that a physiological third stage is the natural conclusion of a normal, physiological labour whilst the Seaview guidance suggests that women should be supported in their choice, using perhaps a more neutral tone.

7.2.3 Post Birth

In the post birth period, a loss of continuity with their midwife was found in the qualitative data of both CMUs, which gave the women concerns about the inconsistent advice and care that they, or their baby, received from the teams. The organisation of post birth service provision did not facilitate the maintenance of a continuous carer, which subsequently affected the women's perception of safe post birth care. The team at Cherrytrees were able to provide this for one woman, but the continuation of care by a named carer for all women would have required changes in the organisation of post birth care that were considered by the stakeholders to be unfeasible in practice. The advantages of the relationship between the woman and her midwife, of feeling safe, respected, treated with dignity and listened to were clear to both in the antenatal period, but the system used to allocate post birth care did not capitalise on this relationship. Relationship based care is discussed further in Chapter 8, section 8.3.1, p.255 where continuity of carer is discussed. The unpredictability of the timing of the women's needs for post birth care were seen as barriers to maintaining continuity of carer. Changes, in consultation with the women, to adapt the ways that post birth care was prioritised and delivered may have helped the stakeholders to improve the women's perception of safe care provision. One woman (Judy) did experience post birth continuity of carer from her midwife at Cherrytrees, which she felt enhanced her confidence in the safety of the care provided for herself and her baby.

7.3 Effectiveness

Effective healthcare is described by the Scottish Government (2010) as providing the most appropriate support, services, interventions and treatment to the people who will benefit at the right time and to eradicate harmful and wasteful variation. In the context of this thesis, effective healthcare would encompass provision of maternity services according to the needs of the population who accessed care at the CMUs. The appropriateness of the maternity care provided at both cases was assessed by comparison with national pathways and guidelines (NHS QIS 2009).

7.3.1 Antenatal

Early antenatal access to care, before 12 weeks gestation, was achieved by 97.8% (n= 668) women and 640 (93.7%) made a midwife their first point of contact. The mean number of visits at both CMUs was greater than the clinically recommended 9 for primiparous women and 7 for multiparous women at less than 41 weeks gestation. The variance in the number of visits is of similar proportions in both cases, suggesting that efficiencies could be made that are evidence based (Dowswell 2010, NHS QIS 2009) and following national guidance.

The reasons for unplanned antenatal visits by 44.3% (n= 108) of women at Seaview and 52.7% (n=99) at Cherrytrees were similar across both CMUs. These reasons (e.g. decreased fetal movements, abdominal pain and vaginal bleeding) required immediate referral for an obstetrician's review to assess potentially serious complications for the women and their babies. When women presented with potential complications at the CMUs, the midwives assessed each woman, and appropriate onward referrals were demonstrated in the quantitative and qualitative data analysis. The use of the CMUs as the first assessment area when potentially serious pregnancy complications were reported, was not the most effective and timely way for women to access appropriate services, support and treatment when immediate obstetric assessment at the OU would have been more appropriate. The findings from

the stakeholders and the women's phases of this research indicated that women occasionally attended the CMUs without phoning to seek advice first, or chose to access the CMUs despite advice to go to the OU, and this may account for the some of the apparently less clinically appropriate visits, but also caused unnecessary delays in accessing care by the right person at the right time.

The provision of continuity of carer, varied widely between the two CMUs, 94.8% (n=184) at Seaview and 31.3% (n= 57) at Cherrytrees. This variation reflected the different models of care provided during the retrospective record review. The Seaview team used a caseloading model where women were allocated to one midwife who was responsible for their care provision throughout the antenatal period. The Cherrytrees team followed a team approach where the women's care was allocated to a team of four midwives who shared responsibility for their antenatal care provision for the majority of the 12-month period during which the records were reviewed. Continuity of carer was introduced by changing from a team model to individually named midwives responsible for the antenatal care of a caseload of women, in the last 3 months of the review and this change was reflected in the small proportion of women who received continuity of carer.

Variations in the meaning of the term continuity of care exist. Freeman et al (2007) define three main types of continuity: management, informational and relational. Management continuity refers to the communication of facts and judgements across team, institutional and professional boundaries, for example the guidelines for care used in the cases. Informational continuity refers to ensuring that relevant information is available at the right time, for example between professionals during the transfer of a women's care. Relational continuity, referred to in this research as continuity of carer, is described as a therapeutic relationship of a service user with one or more health professionals over time.

The team leaders at the CMUs had different approaches to maintaining management and informational continuity. Where continuity of carer was missing at Cherrytrees, the team leader ensured that management and

informational continuity for each woman was maintained across the CMU team, using a team philosophy that the provision of management and informational continuity of care during the antenatal, labour and birth and the post birth periods held importance alongside relational continuity of carer. Their emphasis was on the maintenance of clear communication and effective collaboration as essential parts of continuity of care to achieve clinical excellence. Where continuity of carer was provided at Seaview, the team leader appeared to play a less effective role in linking management and informational continuity between the women and the CMU team.

During the longitudinal study, some women at Seaview reported a deterioration in the provision of continuity of antenatal carer that was attributed by them to a period of staff absence. Conversely, the stakeholders and the women at Cherrytrees referred to improvements in the provision of continuity of carer with the implementation of a caseload model in practice. The provision of continuity of carer depended on the commitment of the team to adapt the service provision according to the women's needs when planned disruption was anticipated. The Cherrytrees team demonstrated maintenance of continuity of carer during a period of sudden long-term sick leave by pro-actively adapting the allocation of the women appropriately and proportionately to alternative named carers to minimise the effect of the absence on the women.

A wide range of antenatal classes was offered at Cherrytrees, which aimed to help women maintain and improve their physical and psychosocial wellbeing in pregnancy as well as providing information about pregnancy, birth and parenthood organised in small groups within and outside the CMU. Both CMUs based their antenatal education on the Scottish parent antenatal core syllabus (NHS HIS 2011), which was launched nationally to reinforce parent education as an integral part of maternity care by Healthcare improvement Scotland. The aim of the core syllabus was to provide midwives with universal evidence based and effective parent education, targeting particularly the needs of vulnerable and socially excluded women. The antenatal classes at Seaview were held within the CMU and described by the women as very busy, crowded and less conducive for the women to effectively enhance their understanding

of the information offered, or to develop social networks. The team at Cherrytrees valued their strong connections with the community and were able to both offer and connect women with a wide variety of maternity and post birth groups. The team at Seaview appeared less connected with local community groups and this may have led to the comparatively limited opportunities for social and educational groups to be offered to the women. The large numbers reported to attend the available groups would suggest that the development of wider connections with relevant groups would have multifaceted benefits to the local women and the Seaview team.

7.3.2 Labour and Birth

All the women who accessed care in labour at both CMUs received continuous one to one care in established labour from a midwife which the evidence from the Cochrane systematic review (Hodnett et al 2013) suggested reduced women's risk of caesarean section, instrumental birth and increased their satisfaction with the experience of childbirth. The guidelines at both CMUs emphasised the importance of providing continuous support to women in labour and that women should not be left alone once in labour unless it was their choice and these choices appeared to have been followed, recorded and noted during the records review.

Transfers in labour to obstetrician led care at the OU were appropriately made for similar reasons in both cases, most commonly across both cases for delayed progress in the first stage, but the overall transfer rate for women accessing care in labour with the Cherrytrees team (18.4% n=36) was slightly higher than that of women accessing care in labour with the Seaview team (15.5% n=30). The mode of birth of the women transferred differed widely between the CMUs, despite similar reasons for the transfer and the provision of one to one care. Emergency caesarean sections were performed on twelve (33.3%) women transferred in labour from Cherrytrees, compared with five (16.6%) women transferred from Seaview. The overall caesarean section rate (elective and emergency) for all women who accessed antenatal care at booking at Seaview was 17.8% (n=68), and 18.9% (n=59) at Cherrytrees. The emergency caesarean section rate for all women who accessed antenatal

care at booking at Seaview was 9.1% (n=35) and 11.8% (n=37) at Cherrytrees which is consistent with the 2.4% increase in the overall national emergency caesarean section rate for 2013 (Source: ISD 2014) at the referral OU for Cherrytrees than that of Seaview. Differences in the mode of birth for those women transferred in labour noted in this research could be explained by variations in practice of the obstetric teams at the different OUs, but the reasons for the births by emergency caesarean given in all the records reviewed were in keeping with national (NICE 2007 and 2014) intrapartum guidance for diagnostic parameters of delayed progress, and those of diagnosing fetal distress requiring expedited (emergency) delivery in labour.

The transfers in labour made by both cases appeared from the records to have been appropriate, timely and carried out according to the recommended pathways for care during all three stages in labour (NHS QIS 2009). The stakeholders in both cases described communication between the teams during the transfer of care as an area where further development was required, and both were using a standardised communication tool (SBAR) to facilitate effective collaboration. The Cherrytrees stakeholders had also introduced integrated team roles where midwives worked across the contextual boundaries of Cherrytrees and the OU. The roles were perceived to be effective in smoothing the communication and transition between areas of care for the women.

7.3.3 Post Birth

The breastfeeding rates of all 683 women who accessed care was 51.5% (n= 352) which is above the Scottish national average rate of 48.4% (Source: ISD 2014) on transfer to the health visitor's care at around 10 days of age. Women in SIMD quintile 2 in this research had the lowest rate of just 37.7%, but women in SIMD quintile 1 achieved a breastfeeding rate of 53.5%, a higher rate than those in quintile 5 who had the greatest drop in rate from birth of 75.8% to 53.2% on transfer to the health visitor. Community volunteer peer supporters supplemented Breastfeeding support from the CMU teams, and this combined approach appeared successful in supporting the early establishment of breastfeeding. The initiation rates for breastfeeding at

the CMUs of 69% (n=471) are also above those found in the Growing up in Scotland (GUS) study results for 2010/11 (Bradshaw 2013) where 63% of babies were breastfed at birth, and the reason for initiating breastfeeding was attributed to antenatal discussions, particularly with a midwife.

The effectiveness of post birth care was seen by the women to vary between that provided within the CMU buildings and that provided in their homes. Women questioned the effectiveness of the lack of continuity in their care during home visits from different CMU team members, in particular when assessing the day-to-day deterioration or improvement of a baby's jaundiced colour. The women who accessed post birth care at times and places of mutual convenience with their named midwives found the service to be more effective both in accessing timely, appropriate treatment and in the use of their own time. Evidence of appropriate transfer for obstetric or paediatric team assessment was obtained from the record review and the women's experiences, but support and services at the right time by the right person in the right place was perceived by the women after the birth to have a lower priority in service delivery than their antenatal and labour and birth care.

7.4 Person Centredness

The Scottish Government's (2010) description of person centred care involves reciprocal or mutually beneficial partnerships between women (or patients depending on the context) and their families and those who deliver healthcare services, the case teams. These partnerships or relationships were described by the Scottish Government (2010) as respectful of individual values and needs and included continuity, compassion, clear communication and shared decision-making. Person centredness in the context of this case study would appear to encompass continuity of carer and the women's decision making influences.

7.4.1 Antenatal

Several women confirmed their appreciation of their midwives' efforts to tailor the information discussed with them to their own wishes, preferences and needs in their accounts of their care, but this was not universal and depended

on the degree of continuity of carer that the women received. Women cared for by the Seaview team appeared to 'lose' contact with a named midwife to co-ordinate their care and maintain a source of support when complications arose, even when that care was provided at the CMU. Women cared for by the Cherrytrees team described retaining contact with their named midwives when referrals were made. Contact was maintained with the women through NHS e-mail and by phone at Cherrytrees, and this was discussed but not routinely used at Seaview, which perhaps was the reason for the differences found. Exploration of mutually acceptable measures to maintain communication between women experiencing potentially more psychosocially and physically difficult pregnancies and their midwives could usefully be pro-actively discussed before onward referrals were made to avoid this loss of contact. Those who did receive continuity of carer at both CMUs described felling cared for by staff who demonstrated empathy and consideration for their individual circumstances and concerns. Though the word compassionate was not used, it appears to encapsulate the care they described experiencing.

Decision-making regarding place of birth and birth plans with the Seaview team was based on information tailored to the women's circumstances and whilst births at the CMU were encouraged for women experiencing uncomplicated pregnancies, births at home were offered but with less enthusiasm. The team at Cherrytrees, however, held the belief that their sustainability depended in the number of women who chose to give birth with the team, in the CMU or at home. The Cherrytrees team also made the assumption that women with uncomplicated pregnancies would choose to access care in labour and birth from their team. The assumptions made by both CMU teams were reflected in the birth choices of most women, rather than individual choices made within a context of balanced information.

Women who were clinically eligible for care provision by the CMU teams but chose to give birth at the OU all gave similar reasons of feeling safer with the immediate availability of specialist anaesthetic, obstetric and paediatric teams, 'just in case' and to eliminate the need to transfer in labour to the OU should complications occur. Fewer women at Cherrytrees (where birthing pools were available) were planning to give birth at the OU to access epidural anaesthesia

for pain management in labour. At the time of the qualitative data collection, much had been made in the media about the risk of transfer and births at home attended by midwives which had been raised by the recently published Birthplace study (Hollowell et al. 2011). This media interest, which, it could be argued sensationalised the debate on place of birth (Warwick 2012), and may have influenced some women's decisions. The lack of a birthing pool was also identified by the stakeholders and the women as a barrier to women choosing to give birth at Seaview, when pools were available at an alternative local CMU and at the midwife led unit attached to the referral OU.

7.4.2 Labour and Birth

The team at Cherrytrees did express a willingness to facilitate women's wishes of giving birth with them, when clinical recommendations would have been to give birth at the OU with the support of the wider maternity care team. The women also described their wish to access labour and birth care at Cherrytrees despite advice to the contrary from Obstetricians. The team at Seaview were more likely to facilitate unplanned births at the CMU when care was accessed 'en route' to the OU in an advanced stage of labour and the birth imminent. This may help to explain the slightly higher transfer rate during labour (18.9% n= 37) observed at Cherrytrees and the higher post birth transfer rate (n=9, 4.9%) at Seaview when women had accessed midwife led care for birth when clinically this was inappropriate.

Information provided by the midwives to assist women's decision-making regarding their preferences during labour differed in emphasis between the cases. The midwives at Cherrytrees described a physiological third stage of labour as a natural conclusion to a physiological first and second stage, which was accepted by just under half (n= 75, 48%) of the women. At Seaview women were given information about the benefits (decreased risk of early post partum haemorrhage and shorter duration of the third stage) and risks (abdominal pain and vomiting) of active management of the third stage, and information about physiological management was given if requested. The information given by the midwives at both cases was based on the clinical

guidelines in use at each CMU, and reflected the midwives' own preferences which may in turn have influenced the women's preferences and decisions.

7.4.3 Post Birth

The post birth care given to the women once they had been transferred home from the OU or CMU was particularly criticised by most (n= 6) of the women from Seaview for the lack of continuity of carer which led to feelings of frustration and vulnerability which they attributed to their difficulty in expressing their individual needs and preferences. At Cherrytrees daily contact was made with the women by the midwife on duty and their needs discussed before a plan was made to address these needs. Although continuity was still missed by the women, the decisions for the frequency, times and venues of the contact were shared with them. In both CMUs several women took control of their care by maintaining contact with their known midwife and visiting the CMU to access care with whom and at times that suited the women and their families. These women did not express the feelings of frustration and vulnerability that were evident in the Seaview women's accounts. As noted in the section on effectiveness of care, it may be that the women have offered a person centred solution for some to the perceived issues of safety and effectiveness post birth service provision.

7.5 Social Capital

The similarities and the differences in the findings of this case study reveal two key elements, which appear to be important in the provision of safe, effective and person centred care at rural CMUs. These elements appear to be reciprocity and trust in relationships between the midwives and the women, and the wider maternity care team. How, and if, this reciprocity and trust manifested itself within these relationships seems to encapsulate the themes analysed from the qualitative phases two and three of this study. Reciprocity and trust also help to add some explanation to the phase one qualitative descriptions of the maternity care processes and outcomes of women receiving care at the CMUs.

7.5.1 Introduction to Social Capital

Trust and reciprocity also have resonance with social capital theory and Kirkham (2010) recognised the potential of midwives to enhance social capital by facilitating the development of social networks, support and resources within a community. Social capital would seem to be a useful framework to further explore the multifaceted nature of maternity care provision at the CMUs which were placed within their respective communities to provide local, community based care with established links to wider resources.

7.5.2 Definition of Social Capital

Social capital was defined by Putnam as 'the connections amongst individuals – social networks, and the norms of reciprocity and trustworthiness that arise from them' (Putnam 2000 p 42). Walsh (2007) used the concept of social capital to explain the way in which the staff at a birth centre worked together, trusted and supported each other 'like a family'. In 2010, Kirkham asserted that building on the trust between mothers and midwives had the potential to enhance the social capital of both and led to the development of further support resources for women and midwives, but at the time was an area in which further research was required. Taylor (2011) suggested that accepting and valuing the social capital of networks and relationships that people bring with them into an environment, also enhances the opportunity to build social capital for the benefit of the individuals and the community. In the case of the CMUs, the networks and relationships that the women brought to the CMU team and connections between the CMU teams and wider healthcare resources, could be used to enhance the social capital of the community that the CMUs serve.

Whilst social capital is not a new concept, Halpern (2005) asserted that the roots of social capital could be traced to the writings of Aristotle regarding the role that community had in the wellbeing of individuals, but specific use of the term was first described by Hafinan in 1916. Social capital was then used to explain the importance of 'soft' social assets of goodwill, sympathy and fellowship, emphasising the concepts of trust and reciprocity, to economists primarily concerned with tangible financial capital (Halpern 2005). In 1933

Durkheim, a prominent figure in sociological thought at the time, wrote of his particular interest in the way in which social ties served as a thread that held wider society together in a more mobile modern society (Field 2008). Bordieu and Coleman further contributed to this work by studying social capital in terms of educational achievement, but Putnam, a political scientist, published a paper in 1995 which caught public attention by addressing the decline in American associational life, the networks of trust and reciprocity in social capital, and linked this to a decline of the governability of urban America (Putnam 1995). Putnam's work extended to positive associations between social capital and well being, but was criticised as being presented as a benevolent panacea in a communitarian and naïve way (Edwards and Foley 1998)). Halpern (2005) refuted this allegation, noting that Putnam pointed out that social capital facilitates co-operative action but the outcomes of that action cannot be predicted, examples of the 'dark side' may be of terrorist organisations, or the ability of networks to discourage social inclusion within the norms, and use of sanctions when the expected norms are not met, of their exclusive club.

The nature and configuration of networks, or the threads that connect people, and how they are weaved together appears to be key in their ability to enhance the way social capital is used to build bridges from members of a specific community to other networks, skills and resources they may require (Burt 2000). The strength of these threads (or ties) was explored by Woolcock (2001) who built on Putnam's model of trust, reciprocity and interconnectivity within social networks, and identified three specific types of social capital:

1. Bonding, described as the enduring, multifaceted ties between people in close knit groups with strong mutual commitments, for example in the context of this study between family members, close friends and CMU team members.

2. Bridging, formed from the connections between people who have less in common but mutual interests, in the context of this study between women and their named midwives, connections or ties made between the women accessing facilities at the CMU and between the CMU team and the community through co production.

3. Linking, links which cut across people and organisations, beyond the bonding and bridging peer group boundaries, for example in this study to access resources from the wider maternity care team and to influence local and national policies.

Whilst the distinctions between the types of social capital are not always clear-cut, Woolcock provides a useful theoretical model for considering the nature and purpose of the networks and different interactions observed in the findings of this study.

Bonding, bridging and linking social capital were seen by Putnam as influential on the health of a community for a number of reasons including reinforcing healthy norms in behaviour and attitudes, enhancing the immune system by regular social contact, access to help to reduce stress and the ability to access specialist care when required. Much is also made of the necessity of shared norms and values, trust and reciprocity being reaffirmed over time through sustained interaction and co-operation to allow people to work together for a common purpose (Field 2008; Halpern 2005; Fukuyama 1996). Trust is further defined as:

> "*an expectation of mutual commitment and a degree of predictability about others behaviour, delivering what is promised and an expectation of others to be reliable, capable and accountable"*

(Gilchrist 2009, p.10)

Environments characterised by trust, reciprocity and community participation were also considered by Campbell and Jovchelovitch (2000) to be health enabling, in that they were most likely to support health enhancing behavioural norms throughout their respective communities.

7.5.3 Bonding Social Capital

Bonding social capital was evidenced in the findings of this study by the way that the teams referred to the close relationships with each other as being like a family, which was encouraged as supportive at Cherrytrees but seen as less desirable by managers at Seaview. Team members from both CMUs referred

to the trust and reciprocity that they experienced within their teams as one of their favourite aspects of working at the CMUs. Their strong bonds appear to help mitigate the burdens described in the growing body of literature (e.g. Deery and Hunter 2010; Deery 2009; Pilley-Edwards 2009; Deery and Kirkham 2006) of containing and managing emotions in themselves and the women they cared for in a service which was seen as less able to provide quality health services. It could be argued that the increased bonding social capital enjoyed by the small, stable teams at the CMUs allowed them to maintain a degree of resilience to the 'burnout' often referred to when caseloading within prescriptive task and time oriented working practices and environments (Choucri 2012; Bryson and Deery 2009; Walsh 2006; Kirkham 2003; Stevens and McCourt 2002c; Ball et al. 2002). Examples in this study of supporting each other to maintain staffing levels at the CMUs by working flexibly with their colleagues were given. The strong bonds of the teams gave one external manager concerns that objectivity could not be demonstrated regarding each others practice, resulting in a less desirable outcome of social capital, but concerns that the team were too close to maintain the ability to challenge one another's professional judgement did not appear to be the case.

Bonding social capital amongst the teams at the CMUs appeared to have the useful effect of maintaining stable (or enduring) teams. These teams had developed informal systems to maintain norms of continuity of staff at the units and maintain the quality of the care provided within their network of trust and reciprocity for people with strong mutual commitments.
Bonding social capital was also evident in the relationships within the social support networks that the women brought to the CMUs. Most women attended appointments and classes with their partners, mothers or close friends, and frequently brought more than one person with them to provide support during labour and birth. The maintenance of these close social bonds during their maternity journey, appeared to help many women to make a smooth psycho-social as well as physical adjustment to parenthood within the context of a socially inclusive model of care offered at the CMUs. Those women who were unable to maintain their social networks of support described their experiences in terms of being a number and with anger at their needs apparently being

ignored or dismissed by busy staff, perceiving a lack of person centred care, summed up by one participant as 'having a face'.

7.5.4 Bridging Social Capital

Bridging social capital was evidenced within the findings of this study in the relationships between the women and their midwives, formed between people who had a mutual interest of achieving safe, effective and person centred care for each woman who accessed care at the CMUs. The ties or bonds in these relationships are seen as less strong than those found in bonding social capital (Halpern 2005; Woolcock 2001), but are firmly based on trust and reciprocity, which as discussed in Chapters five and six, is an important aspect of the continuity of carer model offered at the CMUs.

For the midwives, bridging social capital added to the advantages accrued with the bonding social capital from working in the CMU teams. Relationships with individual women, built up over time have been described as crucial to midwives job satisfaction (Deery and Hunter 2010; Deery 2009; Dykes 2009). Providing continuity of carer has also been found to contribute positively to the midwives sense of self, being known and valued in that they were an individual as well as a midwife who could provide technical knowledge and skills, but could not be seen to be performing a task or role that was immediately replaceable by another (McCourt and Stevens 2009; Hunter 2006). The ability to 'own' a caseload allowed the midwives to use a set of skills which were responsive to the women in their care, examples in this study were providing pre-pregnancy counselling and co-ordinating the care of a women with antenatal depression within a network of local contacts.

The mutual trust required in the bridging relationship between the women and their midwives is multifaceted and closely related to their common values of building a relationship where the women trusted their midwives to ensure that their antenatal progress was being intelligently monitored and appropriate referrals, in consultation with the woman's wishes, would be made. This relates to information flow within the relationship, which is found to flow within all types of social capital, but particularly effectively within bridging relationships where contact with others through the network may be

advantageous (Field 2008). The close relationship developed required the midwife to trust the women to keep her own networks of social support and respect the professional boundaries of their relationship (Deery and Hunter 2010).

For the women, continuity of carer through the bridging relationship between themselves and their midwife was greatly valued. They trusted the advice they received throughout their pregnancy particularly as they were aware that the midwife knew them well and the information given was tailored to their specific situation. Their pleasure in getting to know each other and be known was reciprocal and the women's confidence grew in their ability to give birth and become a mother (McCourt and Stevens 2009). Women who had begun their antenatal care with the expectation of contact with a named midwife, through continuity of carer, were left deeply disappointed when they began to experience discontinuity for various reasons during pregnancy. At Seaview, investment in the social capital of that continuous relationship was not made and the women were left without the safety net or 'mind the gap' approach that may have enhanced their experience of person centred care and in turn, their perception of safe antenatal care. Those women who potentially could have lost contact with their named midwife at Cherrytrees, made efforts to remain in contact so that their investment in the social capital of the bridging networks was maintained.

7.5.5 Linking Social Capital

Linking social capital at the CMUs was evident in the form of collaborative links (across organisations and peers) to the wider maternity care team and policy makers, enabling access to resources occasionally required by those in the bonding and bridging communities of the CMUs. These are considered to be the weakest ties within networks (Woolcock 2001), and this is borne out by the difficulties encountered between the CMU teams and the OU team when informal networks of colleagues and acquaintances had not been established. Communication and collaboration across boundaries appeared in this study to work smoothly when the midwives could rely on personal contacts when a transfer of care at any stage, but particularly in labour was required. The

importance of relationships and not merely connections, which could be interpreted as guidelines, are emphasised by Gilchrist (2009) for effective ways of organising complex situations. These relationships require sustained reciprocal interactions between individuals, the personal interweaving of knowledge, skills and values to ensure that they work effectively and so, as with other types of social capital need considerable investment to see a return in the form of strengthening the web of these weaker ties.

The lay representative at Cherrytrees described the need to make sustained attempts to develop and maintain links between members of the community, the CMU teams and strategic policy makers when the future of the CMU was threatened. Her ability to make and maintain these connections enhanced the community's involvement in the campaign to keep Cherrytrees open, and encouraged the continued involvement of the people in the local area in fundraising, and using and improving the CMU maternity services to help maintain its future sustainability. Links with the community were maintained by the Cherrytrees team's involvement in community activities and through social media. Kawachi et al. (1998) recognised that communities rich in social capital, as the Cherrytrees community appeared to be, can be more successful in influencing political decision makers and fighting cuts to local services.

In terms of constant improvement and social capital, the Cherrytrees team's aspirations to be the best may be seen as achieving an exclusive rather than inclusive form of social capital. Exclusive social capital appears to occur when bonding social capital allows strong ties to develop in a network where the norms and sanctions of the group exclude those who do not subscribe to the strong mutual commitment, for example that the Cherrytrees provided a gold standard of care, which others could not achieve. It could be argued that the outcome of this is to alienate other providers of maternity care who are able to give women access to the care that is appropriate for their particular needs, and to create concern for the women for whom CMU care may not be the most safe and effective option, that they will be receiving a lower standard of care. This could be described as a negative outcome of social capital.

The Seaview staff and community had never needed to contemplate the imminent closure of their CMU, and had not invested in their linking social capital with their immediate community in any sustained way. The potential future development of services available at Seaview will perhaps mean that

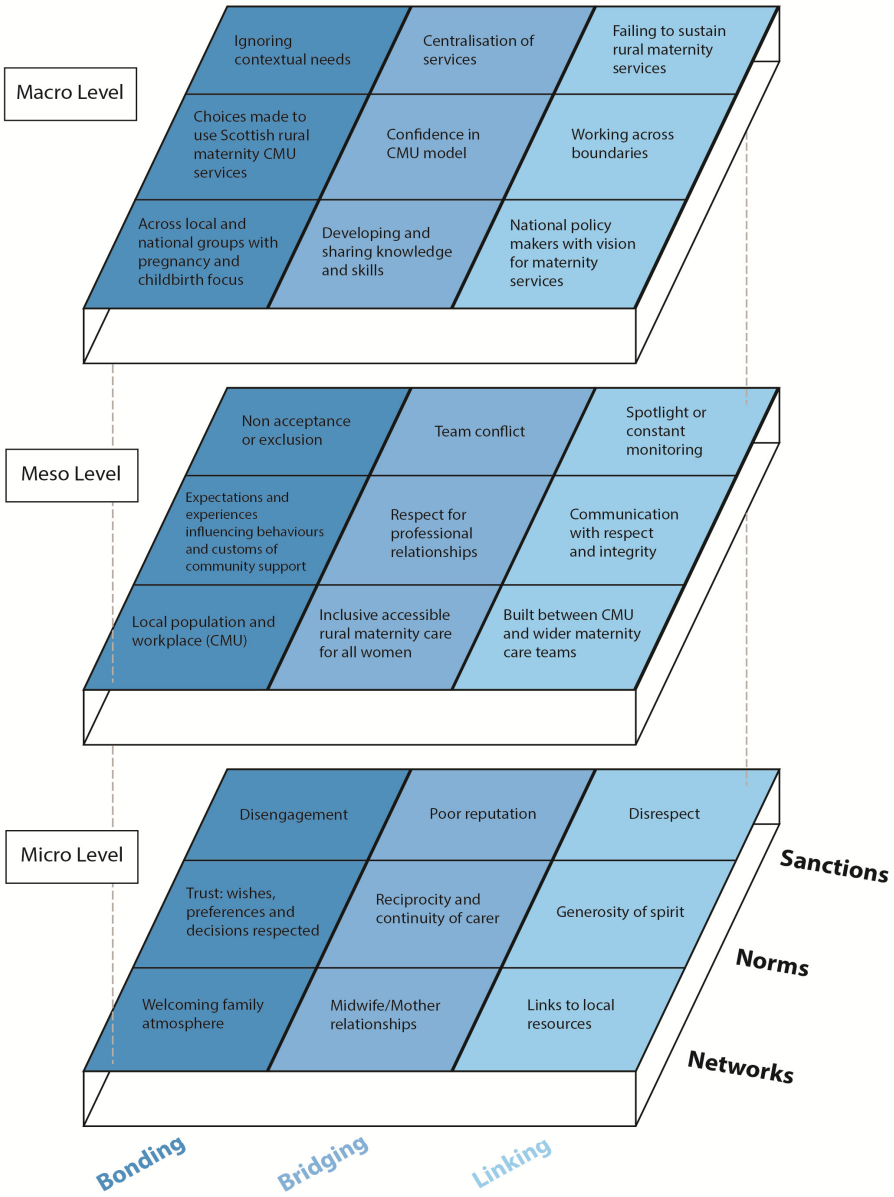
development of their linking social capital will make communication and collaborative working with the wider maternity care team more effective. Relationships based on trust and reciprocity to enhance the delivery of community based care of increasing complexity will have the capacity within social capital to improve fast access to the right person, within a wide network of contacts, and help to break down the contextual barriers of care for the women. As Putnum (2000) stated, when reflecting in the levels of reciprocity and trust within a community,

> "*a well connected individual in a poorly connected society is not as productive as a well connected individual in a well connected society*"

(Putnam 2000, p20)

Although it is recognised that the CMUs were at different stages in developing and maintaining social capital, there still remained much potential for developing, maintaining and expanding the networking roles of the CMU teams to increase their social capital, particularly in the bridging and linking relationships that would potentially provide a wide reaching web of reciprocal relationships with the wider maternity care teams and beyond. Social capital has provided a useful theoretical framework to explore the health supporting environments that the CMUs aimed to provide. The mapping of the different bonding, bridging and linking social capital observed at the CMUs has provided information on the balance of the network links which work to allow the sustained provision of safe, effective and person centred maternity services at rural CMUs within and between local, (micro), tertiary (meso) and policy maker (macro) networks. Halpern (2005 p.27) provides a conceptual map of the complexity of social capital, which I have adapted in Figure 7.1 to show examples of how this works within the different levels of the CMU model of care.

Figure 7.1 Conceptual map of Social Capital and CMUs using examples from Seaview and Cherrytrees



Adapted from Halpern (2005) p.25.

7.6 Key Findings

The key findings about the safety, effectiveness and person centredness of the care provided at the two cases are summarised in the points below.

1. Continuity of carer with a known midwife was associated with each aspect of the women's perception of the safety, effectiveness and person centredness of the care they received. Where continuity was lost, particularly in the post birth period, care was perceived as less safe, less effective and individual needs and preferences less well addressed.

2. Caring and compassionate staff were providing maternity services close to their home and families for not only women eligible for midwife led care, but also inclusive of women who required the input of obstetrician led care.

3. Clinical excellence by achieving early access to antenatal care for 97.8% of women, exceeding national targets, 97.5% of women were allocated an appropriate lead professional at booking to facilitate effective care, and breastfeeding initiation and continuation rates exceeding the national average.

4. Effective collaboration between the CMUs teams and the OU teams allowed timely and appropriate transfer of care, with local professionals and groups to enhance the use and support the sustainability of the CMUs, and with the women when solutions to problems need to be found.

5. A clean and safe environment, where: almost all the women who were clinically eligible expressed a preference in late pregnancy to give birth at the CMUs; the staff were competent to provide the care required; one to one care was provided in labour to every woman; interventions in labour were rare and safe outcomes for women and their babies were achieved.

6. Clear communication and explanation of the women's options and choices throughout their care, though occasionally provided with assumptions as to the preferred options from the midwives.

CHAPTER 8: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The findings from both CMUs were brought together in Chapter seven, revealing where the service provision achieved safe, effective and person centred care, and areas where this could be improved. This Chapter discusses the strengths and limitations of this study and compares the findings to the existing literature in relation to the conceptual framework of the research, and states the original contribution to knowledge that this study makes about rural CMU maternity services. The Chapter then concludes this thesis with a number of recommendations for maternity service provision addressing areas for improvement identified in this study of the CMU model and recommendations are made for the focus of future research in this area.

Phase one of this research has described the socio demographic and clinical characteristics of women who accessed care at these CMUs over a 12-month period, revealing that local maternity services were accessed early in their pregnancies by women in the community with a wide range maternity care needs, not only those women who were eligible for midwife led care. The processes of care, and the outcomes of women who accessed care during labour and birth at these rural CMUs were compared, along with the clinical appropriateness of the care provided, with national policies and guidelines. The outcomes of the care provided demonstrated that safe care was given to most women, with allocation at booking of 97.5% (n=666) women to clinically appropriate lead professionals. Effective care was demonstrated in phase one by the statistical description of appropriate transfer of care to the right clinician at the right time when complications of pregnancy and labour were recognised in a timely manner.

The women's and the stakeholder's accounts of the care provided were explored in phases two and three of the research which helped to explain and explore different individual viewpoints of the maternity services provided at the rural CMUs. The stakeholders and the women were able to add the

dimension of individual viewpoints to the descriptive statistical overview provided by phase one. These personal views and experiences of maternity service provision allowed the exploration of person centredness as well as corroborating (triangulating) or refuting the evidence gathered from the other phases. The findings from the stakeholders and the women emphasized the importance of the provision of continuity of carer in enhancing the safety, effectiveness and person centredness of the care that women received, and the way in which women's perception of these aspects of care changed when a lack of continuity of carer was experienced. The ways in which one to one midwifery care in labour was achieved by both teams for all women in labour at the CMUs were also revealed.

8.2 Strengths and Limitations

This study has a number of limitations that need to be taken into account when determining its value in informing future practice and service development and in making a contribution to the evidence base. These limitations can be related to my role as the researcher, the methods used and the scope of the enquiry. As discussed in relation to the phenomenological stance of this research, the influence of my role as a midwife and a mother was acknowledged as an integral part of the qualitative data collection and analysis. Some stakeholders at one of the CMUs were known by me and as discussed in the ethics section of Chapter four, care was taken not to coerce their participation in the study and the use of impartial gatekeepers assisted in this respect. The motivation of those who took part and were known could be questioned regarding their wish to make a positive impression and demonstrate their knowledge and good practice. The participants who knew me talked in the interviews and focus group about their experiences in the same way as the other participants and the same re-validation of consent, explanation of the aims and objectives of the research, reassurance that there were no right answers and their ability to stop at any time was given. No notable differences were found in the data between those who were known to me and those who were not. I was occasionally introduced as a midwife to the women participants but made clear that my role with them was that of a

researcher and no notable differences were again found in the data between women who knew my midwifery background and those who did not.

The statistical data that were collected in phase one allowed a description of the frequency and percentage of the characteristics of the sample, the process, outcomes and appropriateness of the care provided. More sophisticated statistical analysis was not required to achieve the research objectives, nor was it possible due to the low frequencies within certain variables, so inferences and associations between processes and outcomes cannot be made. Issues relating to missing sets of maternity records and recruitment of the women and the stakeholders were discussed in Chapter four. A proportion (n= 45, 11.9% for Seaview and n=26, 8.6% for Cherrytrees) of full records were missing from the two cases, and it cannot be assumed that these records would not have influenced the descriptive results achieved. The maternity records were not all fully completed and missing data occurred in 3.4% (n =12) of Seaview records and 2% (n=6) of Cherrytrees records. The difference in the way that the CMUs recorded information about women who accessed care may explain the difference in the number of records missing. The Seaview team handwrote the names, addresses, the women's dates of birth and estimated date of delivery for women who booked for antenatal care with the team, but no further information was recorded about the pregnancy outcome. No information was therefore available about, for example, those who had moved away or experienced a miscarriage and sets of records may have been noted as missing in these circumstances. The women's NHS identification number was also not recorded and this led to an inability to identify some sets of records (as they are filed by the women's NHS numbers), which were also described as missing. The Cherrytrees team kept records of all these details and each pregnancy outcome as part of their service provision monitoring system, and so there were less missing data in the Cherrytrees dataset. Missing data was displayed in the quantitative findings sections of both CMUs and did not appear to have a significant impact on the overall results.

The numbers of participants in the qualitative phases of the study were small, but appropriate for this type of study, (Carlson and Glenton 2011; Richards

and Morse 2007) and by using the specified sampling techniques, stakeholders and women were recruited with a wide range of clinical characteristics and across a wide range of roles and responsibilities relating to the cases. Attrition rates were higher than expected over the longitudinal women's phase of the study. Of the 24 women originally recruited, 16 continued to participate at 34 – 36 weeks of pregnancy and 13 participated in the post birth interviews. I kept in regular contact with the women by way of Christmas cards and congratulations notes when their babies were born and the women used the text number given to them to maintain contact when their antenatal observation appointments were due and their babies were born. I also remained aware of the women's right to withdraw from the study at any time without giving a reason and so contact with those who did not respond to interview requests was kept to one further reminder text.

The number of women who continued to use their 'aide memoire' diaries throughout pregnancy to inform their interviews was also fewer than expected. Some women used applications of their smartphones as a diary to record events for reference at interview, and the development of these applications or a secure online comments area accessed only by each study participant may have proved to be more acceptable, and perhaps private, than a paper diary as found by Hayman et al. (2012). Attrition from the study meant that some data on the women's experiences of post birth care provision by the CMU teams and reflections on their maternity experiences were lost to the study, but the women who continued to participate were able to provide data on a wide range of experiences relating to their maternity care provision at rural CMUs. The venue chosen by the women for their interviews may have had an effect on the data obtained and the post birth attrition rates. All the women participants chose have their antenatal interviews in a private room at the CMUs and this may have introduced a bias towards positive comments about their experiences of their care, and potentially discouraged those women who had poor experiences during birth, or did not give birth at the CMUs, from continuing to participate. Only two women who gave post birth interviews at the CMUs and those who recounted their experiences at home appeared more willing to describe both positive and negative aspects of their experiences. The offer of a more neutral interview venue away from the CMUs

was made, but declined, and may have both reduced the attrition rates and potentially allow women more freedom to express their views.

The focus of this enquiry was on rural maternity services that were provided by CMU teams. The research has provided findings which may be relevant to other CMUs, midwife led and wider maternity care team approaches to the provision of maternity services. The nature of case study research means that it is specific to the context studied and bound by the time and place during which the research took place. Though generalisability of the findings was not the aim of the study, the detail and depth of the description of the cases within this case study attempts to allow others to ascertain the fit of this research to their own context and understand how these findings can effectively be used to inform practice and service provision in wider care applications.

One of the strengths of this research could be seen as the involvement of all women in phase one, and all those over 16 years and English speaking (as described in the inclusion criteria) who accessed care at the CMUs in phase three. Some of the women experienced pregnancy complications but continued to receive part of their care appropriately from the CMU teams. Many studies of women's experiences of maternity services excluded women with pregnancy complications (e.g. MacFarlane et al. 2013; McCutcheon and Brown 2012; Rogers 2011; Walsh 2007), and so this group of women are underrepresented against the rising trend of women with more complex needs accessing maternity care (McCourt et al. 2011; RCOG 2011a). The women recruited for this research were purposively selected to represent a wide spectrum of clinical and socio-demographic characteristics to enable a broad exploration of the care and services provided within the cases. None of the participants were from ethnic minority groups, which was reflected in the small number of these groups accessing care at the CMUs, but future research should include these women so that their views, preferences and experiences could be taken into account and possible variations in these identified.

The longitudinal design of phase three appeared to be a strength of this study as the collection of contemporary primary data prospectively on three

occasions allowed the dimension of the changing experiences, views and preferences of the women to be explored throughout pregnancy, birth and the post birth period. The 'aide memoire' diaries helped those who completed them to remember specific incidents in their lives or their care that contributed to the affirmation or changes in their opinions of the care they were receiving for recall at interviews held with long intervals between them.

Observation of clinical consultations during early and late pregnancy could also be seen as a strength of the study as they allowed an insight into both how information regarding women's decisions about their choices about antenatal care and investigations and birth was framed by the stakeholders to the women and how the women voiced their own preferences and interpretations of the information offered. Observation allowed the collection of data of clinical practice and information exchange between two discrete groups of participants in the research. Interviews with both stakeholders and women had taken place before these clinical encounters and the benefits of this were twofold. The accounts given by the stakeholders of how information regarding decision-making was given to women were verified, or refuted by the observation of these exchanges in practice. The women's involvement in this exchange could also be observed in the light of the preferences and views they expressed at their early interviews, which could then be explored at their interview a short time after the clinical encounter. My presence at the clinical encounter may have introduced some bias by influencing the behaviour of the stakeholders and the women but attempts were made to remain unobtrusive during the consultation to reduce this (Richards and Morse 2007). Whilst the use of short periods of non-participant observation in the research proved to be particularly useful for informing interviews, extended periods of observation may have facilitated further exploration of aspects of the collective shared patterns of behaviour, language and culture of the stakeholders in each CMU (Creswell 2014).

8.3 Comparison with existing literature

This case study has focussed on an exploration of the provision of safe, effective and person centred maternity services at rural CMUs in Scotland. As

discussed in the literature review, research over the last decade into midwife led maternity services has tended to only include women clinically suitable for midwife led care, experiencing normal pregnancies in largely urban locations. Addressing the gap in the literature by exploring the care provided to women who were following obstetrician led and midwife led care pathways, has facilitated evidence to be provided on the quality of the care provided to all women in these rural CMUs. Much of the comparison with the existing literature for this research has been with data analysed for birthing units where the emphasis is on care during labour, birth and the immediate post birth period. The sustainability of rural CMUs would appear to require evidence and understanding of the comprehensive maternity services provided by the CMU teams for most women throughout their maternity journey.

The key findings of this research are explored using the framework of NHS Scotland's Quality Strategy (2010) seven C's:

"We have a clear and shared vision for high quality healthcare services in Scotland which is derived from what people have told us they want and need:

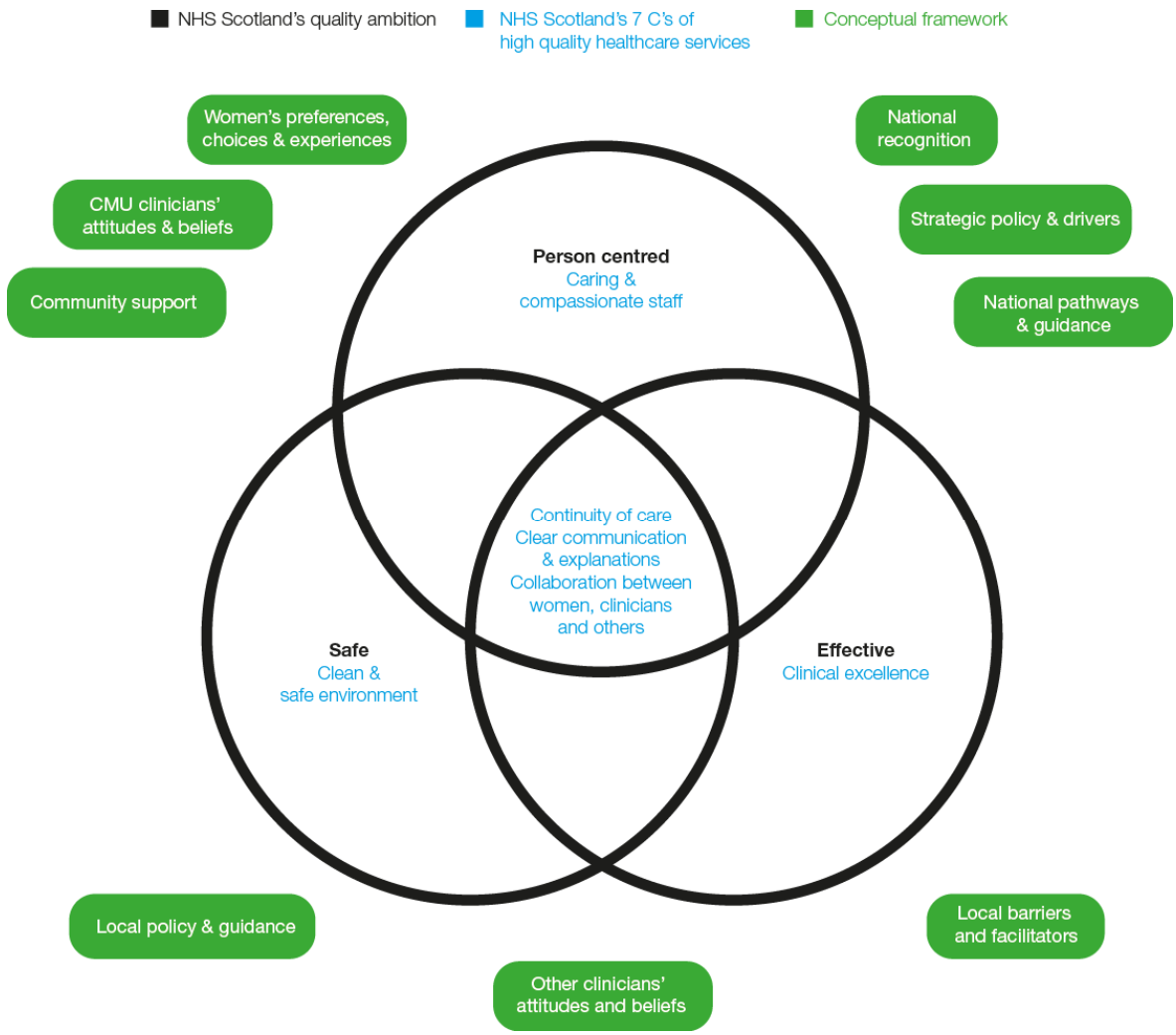
- **Caring** and **compassionate** staff and services;
- Clear **communication** and explanation about conditions and treatment;
- Effective **collaboration** between clinicians, patients and others;
- A **clean** and safe care environment;
- **Continuity** of care; and **Clinical** excellence."

(Scottish Government Quality Strategy 2010, p.2)

Figure 8.1 brings together the treads of this thesis using a diagrammatic representation of the ways in which the conceptual framework (on which the objectives for this research were based), the Quality Ambitions (on which the research question was based) and the 7 C's (which guide the discussion and conclusions of this thesis) are interrelated. The relationships between each aspect of the maternity services provided, and the degree to which no aspect

relating to the quality of care stands alone, reveal the complex interactions between each of NHS Scotland's Quality Ambitions. The themes analysed from the stakeholders' and the women's' phases of the research relate to these interrelated aspects of quality care and are aligned to the 7 C's to allow clarity of discussion where the overlapping areas of safe, effective and person centred care can be explored.

Figure 8.1 Relationships between the conceptual framework for this study, the 7 C's of high quality care provision and NHS Scotland's Quality Ambitions



(Denham 2015)

8.3.1 Continuity of Care

In this study the stakeholders and women associated the safety of those women who accessed care at the CMUs with continuity of carer. This association was also described in Sandall's (2014) RCM report on the contribution of continuity of midwifery care to high quality maternity care which concluded that a substantial amount of evidence existed to suggest that midwife led continuity of care models did contribute to cost effective high quality and safe care in high income countries. Comparisons of midwife led continuity of care models (with continuity of carer achieved throughout the antenatal, labour and birth and post birth period) with shared or medically (obstetric) led care have continued to reveal benefits focussing on labour and birth, of fewer epidural requests, fewer interventions in labour and a higher incidence of spontaneous vaginal birth with no adverse effects on the baby (Sandall et al. 2013; McLachlan et al., 2012; Beake et al. 2012 and Huber et al. 2009). In this research these findings were echoed in the low attrition rate in early pregnancy, the low rate (1.3%) of transfer in labour for regional pain management, a low incidence (2.6%) of intervention in labour and high rate of vaginal birth (91.8%) including those women transferred to the OU during labour.

A UK wide survey by the RCM (RCM 2013) found that continuity of carer through the antenatal and post birth period was achieved for 27% of women. Two recent national surveys of women's experiences of maternity care revealed that 34% of women in England (Care Quality Commission 2013) saw the same midwife every time antenatally, and 62% of women in Scotland (Cheyne et al. 2014) saw the same midwife for all or most of their antenatal care. The questions are framed slightly differently. This may have elicited different responses. However, they do provide a comparison for the results of this study, which revealed a wide variation in the continuity of carer experienced by the women when differing models of care, team and caseloading, were used.

The women received different degrees (94.8% and 31.3%) of relational continuity of carer from the CMU teams in this study, but all received one to one care during labour from a small team of midwives. The outcomes for the women and babies in this research appeared to support the advantages of continuity of carer across both CMUs, despite the differences in provision of continuity of carer. Continuous support for women during labour and birth (Hodnett et al. 2013) is also associated with a higher incidence of spontaneous vaginal birth and less use of analgesia and epidural regional anaesthesia with no adverse effects on the baby. The provision of one to one support during labour may, in this research, have had as much influence on the safe outcomes of the women during labour and birth at both CMUs. The provision of one to one support during labour may, in this research, have had as much influence on the safe outcomes of the women during labour and birth at both CMUs. Post birth continuity of carer provision was found in an RCM (2014b) survey of post birth care planning across the UK, to occur for only 4% of women, and this paucity of provision was apparent in this research from the women's expressions of dissatisfaction with this aspect of their care.

As discussed in section 7.5 on social capital theory, the importance of a one to one relationship as a named midwife within a small team of staff at the CMUs was also recognised for its reciprocal benefits to midwives and women of trust and partnership (Deery and Hunter 2010; Kirkham 2009; Walsh 2007; Deery and Kirkham 2006). Relationships with individual women, built up over time have been described as crucial to midwives' job satisfaction (Deery and Hunter 2010). Providing continuity of carer has also been found to contribute positively to the midwives sense of self, being known and valued as an individual as well as a midwife (McCourt and Stevens 2009;Hunter 2006). The ability to 'own' a caseload allowed the midwives to use a set of skills which were responsive to the women in their care, examples in this study were providing pre-pregnancy counselling and co-ordinating the care of a women with antenatal depression within a network of local contacts.

The provision of continuity of care requires prolonged engagement with women. Whilst some midwives were found by Deery (2009) to be energised by the engagement, others found the longer contact to be more arduous with an

increasingly heavy burden of women's revelations and expectations (Deery and Kirkham 2007). These differing views on the reciprocal relationships developed with women over time are attributed by Deery (2009) to the midwives' differing abilities to cope with longer periods of emotional composure or "putting on a front" (Deery 2009, p.77) required to balance the emotional demands of the women, their organisation's demands and the need to retain good relationships with their immediate team colleagues. Those who were able to balance these demands well demonstrated the ability to chose the right level of engagement with each of the demands to maintain a positive, personally enhancing way of working which embraces care and compassion for the women and their team colleagues.

The midwives in this research appeared to have had different levels of commitment to providing continuity for women whose care had become fragmented and this may be related to the leadership style of their team leader. Those who remained committed to maintaining continuity with women were in a team that demonstrated flexibility in their response to organisational issues (for example daily contact by phone for women at home post birth), and a mutual trust and respect for one another (demonstrated in the comments made during the focus group discussion). The team leader robustly facilitated small, flexible and "emotionally safe" (Deery and Kirkham 2007 p.81) reflective sessions, where learning and not blame was the focus, with her team on a regular basis, and modelled the balancing skills required when managing her own caseload. The team appeared to embrace continuity of carer and valued the long term relationships developed with the women, described as a generosity of spirit by the head of midwifery, and the women used the relationships developed with their midwives to develop confidence in their own abilities to cope with birth and parenthood (evidenced by Judy in her post birth interview, in the confidence category). In the absence of these reflective sessions, continuity of carer appeared to be a more fragile aspect of care provision when care deviated from a normal pathway.

8.3.2 Caring and Compassionate Staff and Services

The provision of local maternity services to most women within a small unit, afforded an opportunity for welcoming and considerate care to be demonstrated. This was where the women were known individually by the staff when they attended for care whether at the obstetrician led clinics or with their named midwife. Walsh (2007) explored this in his analysis of a birth centre where he found that friendship, home and family were recurring words used by the women and the staff, and a process of 'matrescence' or becoming a mother was a dominant theme. The small scale and lack of a busy atmosphere allowed the staff and the women in Walsh's (2007) study to have time and space to understand each other's, rather than pressing organisational, needs. The less time pressured priorities of the staff allowed a nurturing ethos to develop, where emotional intelligence was used to understand when to observe and listen to the women and when to talk. These attributes were used in Walsh's (2007) study to maintain a balance in providing women and the team members with reciprocal, inclusive and trusting atmosphere, whether women were visiting the unit as were most women at the CMUs, or accessing care during labour.

Over half of the women who experienced the maternity care and services available planned to give birth at the CMUs and just under half (n=325, 47.6%) gave birth at their rural CMU. Tucker et al. (2008) found that only 36% of women remained eligible for midwife led care and just over one third (31%) gave birth at a rural CMU. MacFarlane et al.'s (2014) more recent study revealed the impact of staff attitudes on women's positive experiences of maternity care. When women felt listened to, involved and cared for in contrast to when the midwives were rushing. This may indicate that the empathetic care provided at CMUs may not only assist women to make decisions to give birth there, but also enhance women's experiences of antenatal care in a local, smaller scale environment.

One of the important factors in this research was the leadership of the CMUs and support from senior management. This impacted on the ability of the CMU teams to provide the flexible and inclusive care that can be offered in a local setting. McKee et al.'s (2010) work on the effect of staff wellbeing on patient safety, made a comparison between the characteristics of resilient NHS Trusts

in England, and those in recovery. Trusts with longstanding tenure and affinity with the local population; a) open, cohesive and trusting relationships with wider service providers; b)who pro-actively used relationships with local media to educate and not sensationalise and encourage collaboration within stable teams were found to have the greatest resilience to the pressures of constant change. These traits seem to replicate those found within Cherrytrees, and may help to explain some of the differences in the leadership styles of the strategic and team leaders, and the way in which change was championed and managed in the CMUs. McKee et al. (2010) described trusts where there was distrust between management and clinicians, as found at Seaview. These were overwhelmed by externally imposed change and developed a risk averse culture that limited their ability to respond to problems and initiate change.

The degree of ownership that the teams expressed about their ability to initiate and make changes in practice leading to service improvement and development may reveal potential tensions in aspects of the provision of person centred care at the cases. Tension from the Seaview team concerning women's individual choices and the midwives preferences for providing care, appeared to emanate from a sense of working in a less supportive and more hierarchical management structure from which a degree of individual self preservation needed to be maintained (Noseworthy et al. 2012; Byrom and Kay 2011). The Cherrytrees team appeared to have a more developed sense of team and in particular team leader support in circumstances when the women's choices pushed the boundaries of their abilities. Tensions for this team appeared to be with their aim to set themselves apart from the other choices the women may have, to be seen to be the best option, on which their perceived fragile existence depended.

Role models who provided positive leadership within the CMU teams were also less obvious in Seaview. Service development had led to changes in practices which were seen by the team as changes imposed in rapid succession in which they were not fully engaged, and had some difficulty in implementing on a day to day basis. Lack of ownership of the person centred improvements being implemented, led to difficulty in engaging with the changes was also described

in McKellar's (2009) study of improvements in post natal care that were seen to be imposed on rather than developed by the staff.

Concerns were also expressed by the team at Seaview about their manager's understanding of the challenges of providing care within their rural context and a lack of confidence in the future development plans for the CMU. Future development of the services provided at Seaview appeared to the team to be underway before they felt prepared. This resonated with the findings of Tucker et al.'s (2005) study of staff concerns about their ability to sustain the required skills competencies and training for the continued provision of maternity services in remote and rural Scotland.

8.3.3 Clinical Excellence

The findings of this research regarding the use that women made of their local rural CMUs have shown that more women (97.8%) accessed care earlier in pregnancy than the Scottish average, and that when they did, their care was allocated appropriately (97.5%) to the clinically recommended lead clinician. Cheyne et al.'s (2014) evaluation of the NHS QIS (2009) maternity care pathway implementation found the appropriate allocation of midwives as lead carer for 'low risk' women occurred in 84- 98% of cases reviewed, and so accurate referrals were still not consistently made across Scotland, but were consistently made in the CMUs. Tucker et al (2008) also supported the finding that accurate lead professionals were allocated for 97% of women at rural CMUs. Self referral to the CMU for all women made the midwife a consistent first point of contact for local women and allowed for timely referrals without the need to involve an third party.

Early access to antenatal care at the CMUs was achieved by over 90% of women in all SIMD quintiles. The Scottish Government HEAT target for March 2015 is that over 80% of women in each SIMD quintile accessed antenatal care by the 12th week of pregnancy. Local access to maternity care appeared to be successful in encouraging contact with a midwife during early pregnancy, and later access in this research by women in SIMD quintiles 2 and 3 appeared to contradict the national trend of only 65.2% (ISD 2013) of women living in

quintile 1 areas booking for maternity care by the 12th week. The safe clinical outcomes for women who accessed care in labour also compare favourably with the literature on midwife led birth settings (e.g. McFarlane et al. 2014; Dahlen et al. 2012 and Burns et al. 2012; Overgaard et al. 2011; BECG 2011) across the UK, Europe and Australia.

Clinical guidelines and care pathways (NHS QIS) have been developed to support equity of quality care provision for all, but variations in the implementation of these into practice has been recognised as slow and inconsistent (Cheyne et al 2013). Champions for initiatives working as day to day role models at practise level, as demonstrated by the team leader at Cherrytrees, are suggested by Cheyne et al (2013) as a way of delivering a complex intervention for service improvement aimed at reducing unnecessary interventions and variation in clinical practice. Whilst it is recognised that interprofessional role models may prove to be effective in changing clinical practise, implementation across the wider maternity care team may prove complex (Dixon-Woods et al. 2012). Exploration of the pivotal role of the named midwife as a role model in improving the practices of all members of that team through individual encounters with each woman may prove to be the key to the quality of care women access through their CMUs.

A post partum haemorrhage was experienced by two (0.3%) women who gave birth at the CMUs and one woman (0.1%) sustained a third degree tear, which involved damage to the anal sphyncter. These outcomes for the women carry ongoing issues of morbidity. The occurrence of a post partum haemorrhage for women was found to be 3.5% and third and fourth degree tears were noted to occur in 2.3% of births at FMUs in Overgaard et al.'s (2011) study, and 3.3% of births at freestanding maternity units in the BECG study (2011). Burns et al. (2014) found that 1.9% of primiparous women giving birth in water in a UK wide study sustained a third or fourth degree tear and 10.2% of women experienced a post partum haemorrhage. The consistently lower rate of perineal trauma found at the CMUs in this study compare favourably with national and international data and demonstrates a level of safety and effectiveness in the outcomes of women who gave birth at the cases during the 12 month records review.

The ability of the CMU teams to provide one to one care to every woman in labour also contributed to the clinical excellence delivered at the CMUs, and this standard of care is recommended, though not always provided (Allen and Thornton, 2013), in the NICE (2014) guidance on intrapartum care. The teams at the CMUs were able to organise their time and rebalance their commitments, so that care for women in labour was prioritised over scheduled appointments and visits, which was found to have an impact on post birth care. The ability of some women to labour and give birth in water with staff skilled and experienced in this provision was also found to have outcomes that contributed to the provision of clinical excellence. Burns et al. (2012) reported the association with the use of water during labour, and a lower number of women choosing to use opiates for pain management, fewer interventions, less perineal trauma and fewer babies requiring resuscitation at birth.

The modes of birth following transfer to the each unit's different referral OU teams in this study varied widely between the CMUs. A marked difference in 16.6% of women transferred from Seaview (2.6% of all women who accessed care in labour) and 33.3% transferred from Cherrytrees (6.4% of all women who accessed care in labour) gave birth by caesarean section. Overgaard's (2011) matched cohort study in Denmark revealed caesarean birth rates of 2.5% for women who began labour at a freestanding maternity unit (FMU). The English Birthplace study (2011) revealed a caesarean section in labour rate of 3.5% of women who planned to give birth at an FMU. There appears to be little explanation for the caesarean section rate for women transferred in labour from Cherrytrees and this finding would benefit from further research. A similar scenario was found by Knight et al. (2014) when exploring widely differing emergency caesarean section rates at hospitals throughout the UK for women with similar clinical characteristics and they too were unable to provide an explanation for these variations.

8.3.4 Collaboration

As discussed in section 7.5 on bridging and linking social capital, effective collaboration between the CMU staff and the staff at the OU, other healthcare providers in the community and local groups and agencies, particularly service

user groups was important to the provision of high quality rural maternity care. Walsh and Devane's (2012) metasynthesis of midwife led care warned that the advantages of this model of care were directly dependent on the quality of the collaborative relationship with the OU teams. This is often where a clash of culture is experienced at the interface or boundary between the social and medical models of care. In this research, collaborative relationships were enhanced by CMU staff working in both settings and developing respectful relationships with the OU staff, described by Downe et al. (2011 p.224) as "a willingness to cross sticky boundaries" to achieve "authentic collaboration".

The transfer rate for women in labour in the CMUs (16.9%) was lower than that found in BECG study (2011) which found that the transfer rate for all women who planned to give birth at a freestanding maternity unit was 21.9%, with broadly similar reasons for transfer and safe outcomes for the women and their babies. Overgaard's (2011) Danish matched cohort study of 839 low risk women and planning to give birth at a freestanding maternity unit (FMU) and an OU found a total intrapartum transfer rate for all women at the FMUs of 14.8%, which again gives a similar rate as the CMUs in this study. The similarities in these transfer rates, reasons for transfer (most frequently for delay in the first or second stage of labour) and safe outcomes reported would suggest that transfers were made appropriately at the CMUs, ensuring that the women were transferred to the obstetric team in a timely manner.

The breastfeeding rates found at the CMUs were above the Scottish average figures and collaboration with local volunteer breastfeeding peer group supporters were used as part of the post birth support offered to women. Deery et al. (2010) recommend relationships with local groups to enhance the sustainability of CMUs. The recommendation stems from the conclusion of their detailed work on the demise of a birth centre, where one of the contributing factors was a lack of a strong and organised user group whose campaigning with local agencies and political voice may have been heard when the professional leaders at the birth centre could not. Strong user group representation at health board level had successfully sustained one of the CMUs during several closure threats, but the leader had moved on and the

sustainability of the CMU had been called into question at the time of the research.

8.3.5 Communication

The communication of the views, beliefs and preferences of the midwives at the CMUs in this study appeared to have an effect on women's decision making, for example the way in which information about the management of the third stage of labour was given. Noseworthy et al. (2013) described the complexities of decision making within relationships and connections that women make with their midwives where trust has been established over time, and rejected the shared decision making model of providing complete, unbiased information. Kirkham and Stapleton (2004) also suggested that when midwives and women had developed a trusting relationship, the women followed the midwives' philosophy of care so that decision-making became irrelevant and intrusive. It could, however, be argued that the midwives at the cases were following a more patriarchal form of decision making. This is where the midwives' perception of the best option for the women was presented in a way that limited the information volunteered about other options available. Therefore the women may have acquiesced to the views and preferences of their midwife, rather than coming to their individual decisions.

As discussed in the collaboration section, effective care at the transfer between the CMU teams and the obstetrician led teams, at any stage of a women's maternity journey, depended on good communication at the interface of a woman's care (Dixon-Woods et al. 2012; McCourt et al. 2012; Downe and Finlayson 2011). Midwives from both CMUs described incidents where they had been made to feel 'small' or 'like country bumpkins', and received a stony reception on arriving at the OU. This finding is echoed in Harris et al.'s (2010) study where undermining relationships existed between rural midwives and their colleagues in large urban units, when attempting to communicate information about the women in their care. This apparent clash of perspectives (Harris et al. 2010; Mackenzie-Bryers and van Teijlingen 2010) occurred in the midwives' descriptions of occasions when women were experiencing

complications and required continuity of information, support and a consistent approach from their caregivers. Rowe et al. (2012) and de Jonge (2014) both emphasised the importance to the women's perception of her experience that both a written and a thorough verbal handover of the women's care was given in their presence.

8.3.6 Clean and Safe Environment

When considering their birth plans, over half of all the women who had received care at the CMUs, and almost all (92.5%, n= 446) of those clinically eligible to give birth at the CMUs, planned to access care there for labour and birth. Whilst this finding is likely to be related to the issues discussed in the communication section, where some women may have been following their midwives' preferences during their birth plan discussions, it remains a surprising finding in view of the literature on women's preferences for birth environments. Whilst Tucker et al. (2008) found that only 31% of women who lived in the catchment area actually gave birth at their local CMU, the preferences of women living in rural areas were explored by Pitchforth et al. (2008). Pitchforth et al. (2008) found that midwife led care held the quality in terms of emotional safety that women desired, but obstetrician led care including birth at an OU fulfilled their desire for safety in terms of having help available if complications arose and so trade offs were made. When women perceived that they had a choice to make, between the quality of their experience at CMUs and the safe but less fulfilling option of OU care. The women in this research seemed at the end of pregnancy to be less torn by the safety versus quality debate, and more prepared to use their own experiences to inform their concept of safe care. The Birthplace study (BECG 2011) has given stakeholders and women evidence about safe outcomes of care at freestanding maternity units (FMUs), and Rogers et al.'s (2011) findings that 62.8% of women would choose to give birth in an urban FMU. This may be indicative of a change in women's perception of the safety of birth. As more women experience the CMU model of care, the findings of this research may indicate that more women will choose to use the full range of maternity services, including one to one labour and birth care, that they offer and in turn enhance the sustainability of rural CMU care.

8.4 Conclusions and Recommendations

The three phases of this research have explored how two rural community maternity units have contributed to NHS Scotland's (2010) Quality Ambitions of safe, effective and person centred care. Where the team's allegiances were more outwardly looking to the women than inwardly focussed towards institutional demands, described by Deery (2010), the care of the women, with the exception of post birth care, was adapted to their individual needs, desires and values. The findings have suggested that the maternity service provision at rural CMUs achieved a consistently high standard of safety and effectiveness when measured against national standards and international evidence. The provision of health and social care in the community for most women through the CMUs of a socially based but medically available inclusive, accessible service, would seem to be in alignment with current government policy of integration of health and social care (Scottish Government 2015). The exploration of the way in which this quality of care is provided found that it is linked to several issues.

- The CMUs physical position within their communities facilitated ease of access to maternity care and associated mutually supportive community resources for most women.
- The smallness of scale allowed all women, not just those accessing midwife led care, to be known as individuals by their named midwife and the small team of staff.
- The CMU team skills and ethos were intelligently centred on normality, with a keen contextual understanding for timely and appropriate referral to the obstetrician led team with whom integrated roles and professional communication tools aimed to provide seamless care for the women and their babies.

There were, however, some areas of each Quality Ambition that required further development to improve the delivery of these ambitions to the women who receive maternity services via their local CMUs. The area where women perceived their safety to be at risk was found in this research to be when their expectations for relational continuity of carer were not fulfilled.

Effective care was found in this research to have been provided for the majority of women by accurate assessment of the needs of each woman and appropriate, timely referral to the right professional group at the right venue. Communication between professionals when transfer of care was required across different care contexts was an issue for most of the stakeholders and means to break down these boundaries were being explored.

Whilst the stakeholders' intentions to tailor women's care around their views, beliefs and preferences were clearly stated, this research found that their assumptions around the right choices were apparent in the way that information was communicated and women's decisions were listened to and supported (or not) when they were articulated. Post birth care in particular raised issues for women, during a period when the need for compassionate caregivers during the physical and emotional demands of becoming a mother were clear, but frequently remained unmet.

8.4.1 Original Contribution to Knowledge

This study provides an original, contemporary and comprehensive exploration of the care provided at rural CMUs in different Health Board areas in Scotland. The quality of the actual day to day care provided to all women (not just those receiving midwife led care) by the CMU teams and was evidenced by record reviews, observation of the provision of care and exploring stakeholders' and women's experiences of providing and receiving rural maternity care. The data obtained in this case study has not previously been collected or analysed to provide evidence of the comprehensive provision of care to most women, including those experiencing obstetrician led care, through maternity services provided by rural CMUs.

Original methods were used to collect the data. The original use of 'aide-memoire' diaries allowed women control and privacy over the data they chose record and to share. This control enabled women to record aspects of their care they felt were important at the time it happened, and to later share as much of that information as they wished during their interviews. The quantitative data collection tool was adapted from a questionnaire used to assess women's recalled experiences of maternity care (Redshaw and Heikila 2010). Through adaptation it became a tool for collecting data recorded in the women's records of the maternity services delivered throughout their maternity journey (whether midwife led or referred to an obstetrician at any time during their care) to each woman who accessed care. This comprehensive data of all women who accessed care at the CMUs has not been collected systematically across different CMUs before. This tool became an original method of collecting quantitative data routinely recorded in all Scottish women's maternity records in a standardised way, specifically aligned to assessment of national guidance and standards to measure the quality of care provided to women.

This original, detailed case study provides new, contemporary evidence on the full range of service provision at CMUs for most women. This evidence supports the case for both the current sustainability of the rural CMUs model in Scotland and UK Government policy (House of Commons 2014) to develop more community based, midwife led maternity services as part of the multidisciplinary team for all women. The original evidence presented reveals how CMUs addressed the lack of continuity of carer and choice regarding the availability of local birth settings revealed by a joint survey of the NCT and the National Federation of Women's Institutes (NFWI) (NFWI 2013).

The House of Commons report on Maternity Services in England (Session 2013-2014) (House of Commons 2014) recommended that NHS England should build on recent research on women's birthplace choices, inequalities in maternity care. This study adds original, contemporary evidence to the data required to oversee and inform policy decisions on maternity services. The original evidence presented in this study revealed that the CMU model helped

address health inequalities in pregnancy (Scottish Government 2012) by providing a socially based, but medically inclusive continuity of carer for most women. This study also provides original, contemporary evidence on the birthplace choices made and influences on those decisions made by women, notably after the high profile public information about the safety of midwife led birth settings became widely available from the Birthplace study (BECG 2011; Warwick 2011).

8.4.2 Recommendations for Stakeholders

This research has explored the provision of maternity care at rural CMUs to most local women, including those experiencing local provision of obstetrician and midwife led care. This research has suggested that the Quality Ambitions of safe, effective and person centred care were achieved for most women who accessed care at the CMUs, but there were areas where opportunities to improve this provision had been missed. The named midwife role may be the key to achieving a consistently high quality of care for all women through maintaining connections with women when pregnancy complications are identified, and their care crosses contextual boundaries. Opportunities to develop, maintain and build on relationships with the wider community have also been recognised as a way of ensuring that the women and the community's voices were heard, particularly in relation to the sustainability of rural CMUs. Information about care provision could be disseminated and received in an informative rather than sensationalist way through closer contacts with the CMU teams and local media and voluntary groups. The recommendations below are made to bridge the gaps noted in the provision of care in practice at the CMUs, so that safe, effective and person centred care can be delivered to women who access maternity services through their local CMU.

Recommendations for maternity service provision at rural CMUs:

1. **Continuity of carer**

This research has demonstrated that most women who receive midwife led care have continuity of care during pregnancy from a named midwife. Discontinuity of carer was evident when women received obstetric led care or where referrals were made, and during the post birth period. Ways of achieving better continuity of carer for all women during the entire childbirth continuum are needed. This needs to be improved through effective communication and team work within multidisciplinary teams. Antenatal and specialist scheduled care, such as antenatal clinics need to be moved out of hospitals and into communities wherever possible, taking the care to the women as close to home as possible. This will also enable midwives working in CMUs to build respectful relationships with the wider maternity care team, whilst continuing to co-ordinate and contribute to the care of women within their caseload. Prioritising post birth care and facilitating midwives to continue to caseload manage women after childbirth is also required.

2. Collaboration

Collaborative relationships between the women and their midwives, the local community and their CMU and the CMU staff and the OU teams were all shown to have significant influences on the quality of the care provided at the CMUs. The midwives in this study recognised the importance of maintaining links with the OU teams, but the benefits of collaborative links with the local community were not universally recognised. There is a need to enhance these collaborative relationships by developing trust and reciprocity through the networks forged between the CMU teams. Initiatives, including input from service user and relevant local groups, need to be explored to improve the quality of post birth delivered to women.

3. Leadership

The midwifery leaders and lay representatives of the CMUs demonstrated their sustained commitment to the CMU model of care in rural communities by continually striving to maintain the maternity service provision at each unit over many decades. They revealed the need to constantly champion future service development at local and strategic levels to ensure the

sustainability of rural maternity services for women. When individual leadership initiatives were harnessed and developed by the team leader, the team were collectively able to focus positively on service provision and improvement. The findings from this study demonstrated the need for leaders at all levels including midwives, obstetricians and service user representatives, to collaboratively support and develop local maternity service delivery at rural CMUs.

Recommendation for education:

4. Education

The CMU teams in this study demonstrated enthusiasm to share the skills required to provide maternity services within small teams using an intelligent, reflective philosophy of practice through a social model of care. This study has shown that the CMU teams modelled the provision of holistic care, recognising the women's wider social and economic needs and how these impacted on their own and their children's health. These individual needs were met in close collaboration with voluntary and professional agencies in the community. There is a need to share these skills with all student midwives by including rural CMU placements wherever possible. If more service provision is relocated to the CMUs, these could be used as hub placements for student midwives who could then use OU placements as the spokes. In this case, the students would follow women within their caseload across the 'sticky boundaries' of care and model the provision of consistency in continuity of carer. This would provide multiple benefits by enhancing the student's curriculum in preparation for future autonomous but collaborative practice. Experience during training of CMU placements would also enhance midwifery workforce planning for the future sustainability of the CMU model.

8.4.3 Recommendations for further research

By exploring the care provided in rural CMUs, stakeholders' views and experiences as well as the women's preferences and experiences of care received, this study has identified some of the key attributes that contributed to the quality of care received by the women in these settings. Based on the findings of this research and the existing evidence, women need better

provision of information on what to expect from their named midwife and their options throughout their maternity care. Stakeholders across the maternity care team would benefit from support to challenge and acknowledge their own assumptions and judgements so that they can engage with women's preferences and decisions for their care, to provide care centred on the women's multifaceted needs.

In summary, recommendations for the focus of future research are:

1. Development, implementation and evaluation of role models championing continuity of carer and named midwife throughout the childbirth continuum.

2. A multi-centre exploration of the maternity services provided at all CMUs throughout Scotland to build on the evidence provided by this research about the quality of the care provided through the CMU model to most women in Scotland.

3. Exploration of the influence of links between policy makers, the community and service user groups on the sustainability of CMUs using social capital theory.

4. Investigation of the cost-effectiveness of the CMU model of maternity service provision.

REFERENCES

ALASZEWSKI A., 2006. *Using Diaries for Social Research*. London: Sage Publications.

ALLEN, M. and THORNTON. S., 2013. Providing one to one care in labour. Analysis of 'Birthrate Plus' labour ward staffing in real and simulated labour ward environments. *British Journal of Obstetrics and Gynaecology.* [online]. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23078233 [Accessed 25 September 2013].

AMERICAN ACADEMY OF PAEDIATRICS, 2011. *Textbook of Neonatal Resuscitation.* 6th Edition*.* New York: American Academy of Paediatrics and American Heart Association.

BAHN, S. and WEATHERILL, P., 2012. Qualitative social research: a risky business when it comes to collecting 'sensitive' data. *Qualitative Research*. [online]. Available from: http://qrj.sagepub.com/content/13/1/19 [Accessed 14 January 2014].

BALL, L., CURTIS, P. and KIRKHAM, M., 2002. *Why do Midwives Leave?* London: Royal College of Midwives.

BARBOUR, R., 2008. *Introducing Qualitative Research: A student guide to the craft of doing qualitative research.* London: Sage Publications.

BARNETT, C. et al., 2008. Not in Labour: The impact of sending women home in the latent phase. *British Journal of Midwifery*, 16(3), pp. 144–153.

BEAKE, S. et al., 2013. Caseload midwifery in a multi-ethnic community: The women's experiences. *Midwifery*, [online]. Available at: http://dx.doi.org/10.1016/j.midw.2013.01.003 [Accessed 25 September 2013].

BEAUCHAMP, T and CHILDRESS, J., 2013. *Principles of Biomedical Ethics*. 7th Edition. Oxford University Press.

BEDWELL, C., McGOWAN, L. and LAVENDER, T., 2010. Using Diaries to explore midwives' experiences in intrapartum care: An evaluation of the method in phenomenological study. *Midwifery.* [online]. Available from:

http://www.elsevier.com/midw.doi:10.1016/j.midw.2010.12.007 [Accessed 21st January 2014]

BEDWELL, C., McGOWAN, L. and LAVENDER, T., 2014. Factors affecting midwives' confidence in intrapatum care: A Phenomenological Study. *Midwifery*. [online]. Available from: http://dx.doi.org/10.1016/jmidw.2014.08.004 [Accessed 16 September 2014].

BEGLEY, C. et al., 2011. Active versus expectant management for women in the third stage of labour. *The Cochrane Collaboration.* [online]. Available from: http://onlinelibrary.wiley.com/store/10.1002/14651858.CD007412.pub3/asset/CD007412.pdf?v=1&t=i67y8w30&s=4ef301bf13568cdb6cbb615f4fb41d13845586d8 [Accessed 12 January 2014].

BENNER, P., 1994. *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness.* London: Sage Publications.

BICK, D., RYCROFT-MALONE, J. and FONTELNA, M., 2009. A Case Study Evaluation of Implementation of a Care Pathway to Support Normal Birth In One English Birth Centre: Anticipated Benefits and Unintended Consequences. *Biomed Central Pregnancy and Childbirth*. [online]. Available from: http://www.biomedcentral.com//1471-2393/9/47 [Accessed 12 December 2011].

BIRTHPLACE in ENGLAND COLLABORATIVE GROUP(BECG), 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. *British Medical Journal*. [online]. Available from: http://www.bmj.com/content/343/bmj.d7400 [Accessed 25th January 2013].

BONDAS, T., 2011. Husserlian phenomenology reflected in caring science childbearing research. In: G. TOMSON, F. DYKES and S. DOWNE, eds. *Qualitative Research in Midwifery*. London: Routledge. pp.1-18.

BOWLING, A., 2009. *Research Methods in Health: Investigating health and health services.* 4th edn. Maidenhead: Open University Press.

BRADSHAW, A., 2013. Listening to the patient's self reported testimony: the authentic hermeneutical witness to the compassionate nurse? *Journal of*

Advanced Nursing. [online]. Available from: http://onlinelibrary.wiley.com/doi/10.1111/jan.12170/abstract [Accessed 24th February 2014]

BRADSHAW, J. et al., (2013) Growing Up in Scotland: Birth Cohort 2- Results from the first year *Scottish Government* [online]. Available from: http://www.scotland.gov.uk/Publications/2013/02/3280 [Accessed 14 December 2014].

BRADSHAW, J., 1994. The conceptualization and measurement of need; A social perspective. In: J. POPAY and G. WILLIAMS, eds. *Researching People's Health*. London: Routledge.

BRISCOE, L and LAVENDER, T., 2009. Exploring Maternity care for Asylum Seekers and Refugees. *British Journal of Midwifery*, 17(1), pp. 17-23.

BRITTEN, J., HODINETT, P. and McINNES, R., 2006. Breastfeeding Peer Support: Health Service Programmes in Scotland. *British Journal of Midwifery*, 14(1), pp.12-19.

BRYMAN, A., 2012. *Social Research Methods*. 4th edition. Oxford

University Press.

BRYSON, V., and DEERY, R., 2009. Public policy 'men's time' and power: The work of community midwives in the British National Health Service. *Women's studies International Forum.* [online]. Available at: http://dx.doi.org/10.1016/j.wsif.2009.11.004 [Accessed 30 March 2013].

BURNARD, P., 1991. A method of analysing interview transcripts in qualitative data research. *Nurse Education Today*, 11, pp. 461-466.

BURNS, E. et al., 2012. Characteristics, interventions and outcomes of women who used a birthing pool: A prospective observational study. *Birth*, 39(3), pp 192- 202.

BURT, R., 2000. The network structure of social capital. In: B. STAW and R.SUTTON, eds. *Research in Organisational Behaviour.* New York: Elsevier.

BYROM, S. and DOWNE, S., 2008. 'She sort of shines": Midwives accounts of 'good' midwifery and 'good' leadership. Midwifery, [online]. Available from: http://dx.doi.org/10.1016/j.midw.2008.01.011 [Accessed 30 March 2013].

BYROM, S. and KAY, L., 2011. Midwifery Leadership, Theory, Practice ans Potential. In: S. DOWNE, S BYROM and L SIMPSON, eds. *Essential midwifery practice: Leadership, expertise and collaborative working.* Sussex: Blackwell Publishing. pp.7-22.

CAMPBELL, C. and JOVCHELOVITCH, S. 2000. Health, Commuity and Development:towards a social psychology of participation. *Journal of Community Applied Social Psychology.* 10 pp. 255-70.

CAMPBELL, R., and MacFARLANE, A., 1994. *Where to be born? The debate and the evidence* National Perinatal Epidemiology Unit 2nd edn.

CARE QUALITY COMMISSION (CQC), 2014. *National findings from the 2013 survey of women's experiences of maternity care. CQC.* [online]. Available from: http://www.cqc.org.uk/sites/default/files/documents/maternity_report_for_publication.pdf [Accessed 28 June 2014].

CARLSON, B. and GLENTON, C., 2011. What About N? A methodological study of sample sizes used in focus group studies. *Biomed Central Medical Research Methodology* [online]. Available from: 10.1111/j.1365-2648.2006.04042.x [Accessed 30th October 2013].

CHEYNE, H., ABHYANKAR, P. and McCOURT, C., 2013. Empowering Change: Realist Evaluation of a Scottish Government programme to support normal birth. *Midwifery* (online). Available at: http://dx.doi.org/10.1016/j.midw.2013.07.018 [Accessed 13 September 2014].

CHOUCRI, L., 2012. Midwives and the time: a theoretical discourse and analysis. *Evidence Based Midwifery*, 10(1), pp.1-15.

CLARKE, C. and READ, J., 2010. Case Study Research. In: K. GERRISH and A. LACEY, eds) *The Research Process in Nursing*. Chichester: Wiley Blackwell. pp. 237-247.

CLUETT, R. and BURNS, E., 2009. Immersion in water in labour and birth. *Cochrane Database Systematic Review* [online] Avaliable from: http://onlinelibrary.wiley.com/store/10.1002/14651858.CD000111.pub3/asset/CD000111.pdf?v=1&t=i66uohsv&s=113f4cfa19b865488bef26925ed45ca5427daeee [Accessed 13 September 2014].

CONVERSE, M. 2012. Philosophy of phenomenology: how understanding aids research. *Nurse Researcher*, 20(1), pp. 28-32.

CORTES, E., BASRA, R. and KELLEHER, C., 2010. Waterbirth and Pelvic Floor Injury: a retrospective study and postal survey using ICIQ modular long form questionnaires. *European journal of Obstetrics and Gynaecology and Reproductive Biology*, 155 pp. 27-30.

COXON, K., SANDALL, J. and FULOP, N., 2014. To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions. *Health Risk and Society*. [online]. Available at: http://dx.doi.org/10.1080/13698575.2013.859231. [Accessed 28 June 2014].

CRESWELL, J., 2014. Research Design 4th edn. London: Sage Publications.

CROTTY, M., 1998. *The Foundations of Social Research. Meaning and perspective in the research process*. London: Sage Publications.

CROWE, S. et al., 2011. The Case Study Approach. *Medical Research Methodology.* [online]. Available at: www.biomedcentral.com/1471-2288/11/100 [Accessed 30th October 2013].

DAHLBERG, K., DAHLBERG, H. and NYSTROM, M., 2008. *Reflective Lifeworld Research.* Lund: Studentlitteratur.

DAHLEN, H et al., 2012. Maternal and perinatal outcomes amongst low risk women giving birth in water compared to six birth positions on land. A descriptive cross sectional study in a birth centre over 12 years. *Midwifery*, 29, pp. 759-764.

DANNEKER, C. et al., 2004 Episiotomy and perineal tears presumed to be imminent: randomized controlled trial. *Acta Obstet Gynecol Scand*. 83(4), pp. 364-368.

DEERY, R. and KIRKHAM, M., 2006. Supporting Midwives to support women. In: L. PAGE and R.McCAVENDISH, eds. *The New Midwifery Science and Sensitivity in Practice.* Philadelphia: Churchill Livingstone Elsevier. pp 125-140.

DEERY, R. and KIRKHAM, M., 2007. Drained and Dumped on: the generation and accumulation of toxic waste in community midwifery. In: M.KIRKHAM, ed. *Exploring The Dirty Side of Women's Health.* Abingdon: Routledge. pp. 72-83.

DEERY, R., 2009. Community Midwifery 'Performances' and the Presentation of Self. In: B.HUNTER and R.DEERY, eds. *Emotions in midwifery and reproduction.* Basingstoke: Palgrave MacMillan. pp.73-89.

DEERY, R. and HUNTER, B., 2010. Emotion Work and Relationships in Midwifery. 2nd Edition. In: M. KIRKHAM, ed*. The Midwife-Mother Relationship*. Basingstoke: Palgrave Macmillan. pp. 37-54.

DEERY, R., HUGHES, D. and KIRKHAM, M., 2010. *Tensions and Barriers in Improving Maternity Cre: The story of a birth centre.* Oxford: Radcliffe Publishing.

DENHAM, S., 2011. *An exploration of women's information needs regarding induction of labour.* Unpublished MSc thesis, University of Aberdeen.

DEPARTMENT of HEALTH and SOCIAL SECURITY (DHSS), 1970. Welsh Office. *Domiciliary midwifery and maternity bed needs. Report of the subcommittee. [Chair: Sir J. Peel]*. London: Her Majesty's Stationary Office.

DEPARTMENT OF HEALTH, 2007. *Maternity Matters*: *Choice, access and continuity of care in a safe service.* London: Her Majesty's Stationary Office.

DeYONGE, A. et al., 2014. Continuity of care: what matters to women when they are referred form primary to secondary care during labour? A qualitative interview study in the Netherlands. *BMC Pregnancy and Childbirth*. [online]. Available from: http://www.biomedicalcentral.com/1471-2393/14/103 [Accessed 24 September 2014].

DIXON-WOODS, M., McNICOL, S. and MARTIN, G., 2012. Ten Challenges in Improving quality in healthcare: lessons from the Health Foundation's programme evaluation and relevant literature. *British Medical Journal Quality and Safety*. [online]. Avalialbe from: http:// dx.doi.org/10.1136/bmjqs-2011-000760 [Accessed 9 September 2014].

DONMEYER, R., 2000. Generalisability and single-case study research. In: R. GOMM, M. HAMMERSLEY and P. FOSTER, eds. *Case Study Method*. London: Sage Publications. pp. 45-68.

DOUCET and MAUTHER, N., 2012. Knowing Responsibly: Ethics, feminist epistemologies and methodologies. In: M. BIRCH, T. MILLER and N. MAUTHER, eds. *Ethics in Qualitative Research*. London: Sage Publications.

DOWLING, M., 2005. From Husserl to Van Manen. A review of different phenomenological approaches*. International Journal of Nursing Studies*, 4, pp. 131-142.

DOWNE, S. and FINLAYSON, K., 2011. Collaboration: Theories, Models and Maternity Care. In: S. DOWNE, S BYROM and L SIMPSON, eds. *Essential midwifery practice: Leadership, expertise and collaborative working*. Sussex: Blackwell Publishing. pp. 155-179.

DOWNE, S., SIMPSON, L. and BYROM, S., 2011. Bringing it all Together. In: S. DOWNE, S. BYROM and L. SIMPSON, eds. *Essential midwifery practice: Leadership, expertise and collaborative working*. Sussex: Blackwell Publishing. pp. 221-225.

DOWSWELL, T. et al., 2010. Alternative versus standard packages of antenatal care for low-risk pregnancy. *Cochrane Database of Systematic Reviews*. [online]. Available from: http://apps.who.int/rhl/reviews/CD000934.pdf [Accessed 24 January 2012].

DYKES, F., 2009. 'No time to care': Midwifery work on Postnatal Wards in England. In: B.HUNTER and R.DEERY, eds. *Emotions in midwifery and reproduction.* Basingstoke: Palgrave MacMillan. pp. 90-104.

EDOZEIN, L. and MELLOWS, H., 2010. Place of Birth. In: *Models of Care in Maternity Services*. C. MAHMOOD, P. OWEN, S. ARULKAMARAN, and C. DHILLON, eds. London: Royal College of Obstetricians and Gynaecologists Press.

EDWARDS, B. and FOLEY, M., 1998. Civil Society and Social Capital Beyond Putnam. *American Behavioral Scientist.* 42(1) 142-139.

El NEMER, A., DOWNE, S. and SMALL, N., 2006. 'She would help me from the heart': an ethnography of Egyptian women in labour Social Science and Medicine. [online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16005133 [Accessed 12th June 2014].

ELLIOT, H. 1997. The use of diaries in sociological research on health experience. *Sociological Research Online.* [online]. Available from: http://www.socresonline.org.uk/2/2/7.html. [Accessed 21st January 2014]

EXPERT ADVISORY GROUP on ACUTE MATERNITY SERVICES, 2002. *Implementing a Framework For Maternity Services In Scotland*. Edinburgh: Scottish Executive Department of Health.

FARMER, J. et al., 2003. Dr John has gone: assessing health professionals' contribution to remote and rural community sustainability in the UK. *Social Science and Medicine.* 57 (2003), pp.673-686.

FIELD, J., 2008. *Social Capital.* Second Edition. Abingdon: Routledge.

FINCH, J., 1984. 'It's great to have someone to talk to': ethics and politics of interviewing women. In: C. BELL and H. ROBERTS, eds. *Social Researching. Politics, Problems, Practice.* Abingdon: Routledge.

FLETCHER, B. et al., 2012. Improving the recruitment activity of clinicians in randomised controlled trials: a systematic review. *British Medical Journal.* [online]. Available from: http://bmjopen.bmj.com/content/2/1/e000496.full [Accessed 23 October 2013].

FLYVBJERG, B., 2006. Five misunderstandings about case-study research. *Qualitative Enquiry* 12(2), pp 219-245.

FOSTER, I. and LASSER, J., 2011. *Professional Ethics in Midwifery Practice*. Massachusetts: Jones and Bartlett Publishers.

FREEMAN, G. et al., 2007. *Continuity of Care 2006: What have we learned since 2000 and what are policy imperatives now?* [online]. Available from: www.sdo.nihr.ac.uk/files/project/138-final-report.pdf [Accessed on 4 January 2014].

FUKUYAMA, F., 1996. *Trust: The social virtues and creation of prosperity.* London: Hamilton Press.

GADAMER, H-G., 1976. *Philosophical Hermeneutics,* (translated by D.E.Linge). Berkley: University of California.

GARLAND, D., 2011. Revisiting Waterbirth, *An Attitude to Care*. Basingstoke: Palgrave Macmillan.

GEERTZ, C., 1973. Thick description: toward an interpretive theory of culture. In: GEERTZ, C. *The interpretation of culture*. New York: Basic books.

GERRISH, K. and LACEY, A., 2009. *The Research Process In Nursing*. Oxford: Blackwell Publishing.

GILCHREST, A., 2009. *The Well Connected Community: A networking approach to community development.* Bristol: The Ploicy Press.

GOODMAN, C and EVANS, C., 2010. Focus Groups. In: K GERRISH and A. LACEY, eds. *The Research Process in Nursing.* Sussex: Blackwell Publishing.

GOTTVALL, K. et al., 2011. In-hospital birth centre with the same medical guidelines as standard care: A comparative study of obstetric interventions and outcomes. *Birth*. 38(2), pp. 120-127.

GREEN, J. and THOROGOOD, N., 2004. *Qualitative methods for Health Research*, London: Sage.

GRIGG, C. et al., 2014. An exploration of influences on women's birthplace decision-making in New Zealand: a mixed methods prospective cohort within the Evaluating Maternity Units study. *BMC Pregnancy and Childbirth.* [online]. Available at: http://www.biomedicalcentral.com/1471-2393/14/210 [Accessed 25 September 2014].

HALPERN, D., 2005. *Social Capital.* Cambridge: Poilty Press.

HARDICRE, J., 2014. An overview of research ethics and learning from the past. *British Journal of Nursing.* 29(9), pp. 483-486.

HARRIS, F., et al., 2010. The buck stops here: Midwives and maternity care in rural Scotland. *Midwifery*, [online]. Available at: http://dx.doi.org/10.1016/j.midw.2010.10.007 [Accessed on 25 January 2013].

HARTMAAN, K. et al., 2005. Outcomes of routine episiotomy: a systematic review. *Journal of the American Medical Association.* 293(17), pp. 2141-2148.

HATEM, M. et al., 2009. Midwife-led versus other models of care for childbearing women. (online). Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub2/full [Accessed 25th January 2013].

HAYMAN, B., WILKES L. and JACKSON, D., 2012. Journaling: Identification of challenges and reflections on strategies. *Nurse Researcher* 19 (3), pp 27-31.

HEALTHCARE IMPROVEMENT SCOTLAND, 2011. Core syllabus for professional practice to support education for pregnancy, birth and early parenthood. [online]. Available from: http://www.healthcareimprovementscotland.org/programmes/reproductive,_maternal__child/parent_education/parent_education_syllabus.aspx

HEALTHCARE IMPROVEMENT SCOTLAND, 2011. Healthcare Quality Standard. Assuring Person Centred, Safe and Effective Care: Clinical Governance and risk management. [online]. Available from: http://www.healthcareimprovementscotland.org/previous_resources/standards/healthcare_quality_standard.aspx [Accessed 14 December 2014].

HEALTHCARE IMPROVEMENT SCOTLAND, 2014 Person Centred Health and Care Collaborative. [online]. Available from: http://www.healthcareimprovementscotland.org/our_work/person-centred_care/person-centred_collaborative.aspx [Accessed December 14 2014].

HEALY, M., 2011. Heidegger's contribution to hermeneutic phenomenological research. In: G. THOMSON, F. DYKES and S. DOWNE, eds. *Qualitative Research in Midwifery and Childbirth*. London: Routledge.

HEDEIGGER, M., 1962. *Being and Time*. Albany: State University of Albany Press.

HOANG,H., Le,Q. and OGDEN, K., 2014. Women's maternity care needs and related service models in rural areas: A comprehensive systematic review of qualitative evidence. *Women and Birth*. [online]. Available at: http://dx.doi.org/10.1016/j.wombi.2014.06.005 [Accessed on 24 September 2014].

HODNETT, E ., DOWNE, S. and WALSH, D., 2012. Alternative versus conventional institutional settings for birth. *Cochrane Database of Systematic Reviews* Issue 8. [online]. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000012.pub4/pdf [Accessed 25th Jan 2013].

HODNETT, E. et al., 2013. Continuous support for women during childbirth (Review). *The Cochrane Collaboration*. [online]. Available from: http://onlinelibrary.wiley.com/store/10.1002/14651858.CD003766.pub5/asset/CD003766.pdf?v=1&t=i685yefu&s=514dcdabc053d3cfd40bb635a2a8426694c863bb [Accessed 14 December 2014].

HOGG, M., PENNEY, G. and CARMICHAEL, J., 2007. *Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005.* [online]. Available from: www.healthcareimprovementscotland.org/idoc.ashx?docid...1 [Accessed 26th January 2013].

HOLLOWELL, J. et al., 2011. The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth Birthplace in England research programme. Final report part 4. NIHR Service Delivery and Organisation programme. [online]. Available from: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR4_08-1604-140_V03.pdf [Accessed 14th December 2011].

HOUGHTON, C. et al., 2013. Rigour in qualitative case-study research. *Nurse Researcher*, 20(3), pp 12-17.

HOUGHTON, G. et al., 2008. Factors influencing choice in birth place – an exploration of the views of women, their partners and professionals. *Evidence Based Midwifery*. [online]. Available at: https://www.rcm.org.uk/learning-and-career/learning-and-research/ebm-articles/factors-influencing-choice-in-birth-place— [Accessed 26th January 2013].

HOUSE of COMMONS, 2014. *Committee of Public Accounts. Maternity Services in England. Fortieth Report of Session 2013-14.* London: HMSO.

HOUSE of COMMONS HEALTH COMMITTEE, 1992. *Second Report, Maternity Services, Volume 1.*London; HMSO.

HUBER, U. and SANDALL, J., 2007. A qualitative exploration of the creation of calm in a continuity of carer model of maternity care in London. *Midwifery*. [online]. Available at: http://dx.doi.org/j.midw.2007.10.011 [Accessed 13 September 2014].

HUMPHREY, T., 2008. *Rates of Induction of labour: Exploring the Determinants.* University of Aberdeen: Unpublished PhD thesis.

HUNTER, B., 2006. The importance of reciprocity in relationships between community based midwives and mothers. *Midwifery* 22 (4), pp. 308–322.

INFORMATION SERVICE DIVISION, NHS SCOTLAND, 2010. *Live births by hospital.* [online]. Available from: http://www.isdscotland.org/Health-Topics//Maternity-and-Births/Publications/data-tables.asp?id=897#897 [Accessed 31 December 2012].

INFORMATION SERVICES DIVISION, NHS SCOTLAND, 2014. *Births In Scottish Hospitals Year Ending 31st march 2013 Publication Report*. [online]. Available at: http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2014-08-26/2014-08-26-Births-Report.pdf

INFORMATION SERVICES DIVISION, NHS SCOTLAND, 2014. *Breastfeeding Statistics, Financial year 2013/2014.* [online]. Available from: https://isdscotland.scot.nhs.uk/Health-Topics/Child-Health/Publications/2014-10-28/2014-10-28-Breastfeeding-Report.pdf?67278689147 [Accessed 14 December 2014]

INSTITUTE of MEDICINE, 2001. Crossing The Quality Chasm: A New Health System for the 21st Century. [online]. Available From: http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx [Accessed 1 May 2010].

INTERNATIONAL CONFEDERATION of MIDWIVES, 2014. Position Statement: The Role of the Midwife in Research. [online]. Available from: http://www.internationalmidwives.org/assets/uploads/documents/Position%20Statements%20-%20English/Reviewed%20PS%20in%202014/PS2008_017%20V2014%20Role%20of%20the%20Midwife%20in%20Research%20ENG.pdf [Accessed 14th October 2014].

KAWATCHI, I., KENNEDY, B. and GLASS, R. 1999. Social Capital and self-rated health: a contextual analysis. *American Journal of Public Health.* 99(11) pp. 1187-93.

KEMP, J and SANDALL, J., 2010. Normal Birth, Magical Birth: The role of the 36-week birth talking caseload midwifery practice. *Midwifery*, 26 pp. 211- 221.

KIGHTLEY, R., 2010. Power of Birth: Uncontrollable Urges and the transition to motherhood. *British Journal of Midwifery* 18(3), pp. 151-158.

KINGDON, C., 2005. Reflexivity: Not just a qualitative methodological research tool. British *Journal of Midwifery*.13(10) pp. 623–627.

KIRKHAM, M., 2003. Birth Centres: a social model for maternity care. Oxford: Books for Midiwives.

KIRKHAM, M., 2009. Weaving it all together. Emotion work around Reproduction: Supportive or Constraining? In B. HUNTER and R. DEERY, eds. *Emotions in midwifery and reproduction*. London: Palgrave MacMillan.

KIRKHAM, M., 2010. We Need to Relate. In M. KIRKHAM, ed. *The Midwife-Mother Relationship.* London: Palgrave MacMillan.

KITWOOD, T., 1997. *Dementing reconsidered: The person comes first.* Oxford:Open University Press.

KOCH, T. and HARRINGTON, A., 1998. Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing* 28(4), pp. 882 – 890.

KOCH, T., 1999. An interpretive research process: revisiting phenomenological and hermeneutic approaches. *Journal of Advanced Nursing*, 24(1), pp. 174-184.

KORNELSON, J. and GRZYBOWSKI, S., 2005. Safety and Community: The Maternity Care Needs of Rural Parturient Women. *Journal of Obstetricians and Gynaecologists of Canada*. 27(6), pp. 247-254.

KORNELSON, J. and GRZYBOWSKI, S., 2012. Cultures of risk and their influence on birth in rural British Columbia. *BMC Family Practice*. [online]. Available at: http://www.biomedcentral.com/1471-2296/13/108 [Accessed on 26th January 2013].

KREUGER, R. and CASEY, M., 2009. *Focus Groups: A practical Guide for Applied Research* 3rd edn. London: Sage Publications.

KUHN, T.S., 1970. *The Structure of Scientific Revolutions*. 2nd edn. Chicago, IL: University of Chicago Press.

LEAP, N., 2009. Woman-centred or women centred: does it matter? *British Journal of Midwifery* 17(1), pp. 12–16.

LEAP, N. et al., 2010 Journey into confidence: women's experiences of pain in labour and relational continuity of care. *Journal of Midwifery and Women's Health*, 55(3), pp. 234-42.

LEE, C et al., 2011. Noeonatal resuscitation and immediate newborn assessment and stimulation for the prevention of neonatal deaths: a systematic review, meta-analysis and Delphi estimation of mortality effect. *Public Health*. [online]. Available from: http://www.biomedcentral.com/content/pdf/1471-2458-11-S3-S12.pdf

LINCOLN, Y and GUBNA, E., 2000. The Only Generalization Is: There Is No Generalization. In: R. GOMM, M. HAMMERSLEY and P. FOSTER, *Case study Method.* London: SAGE.

LOWES, L. and PROWSE, M., 2001. Standing outside the interview process? The illusion of objectivity in phenomenological data collection. *International Journal of Nursing Studies* 38(4), pp. 471 – 480.

LUNDGREN, I., 2011. The meaning of giving birth from a long-term perspective for childbearing women. In: THOMSON, G., DYKES, F. and DOWNE, S., *Qualitative Research in Midwifery and Childbirth Phenomenological approaches.* Routledge, London.

MacFARLANE, A., ROCCA_IHENACHO, L. and TURNER, L., 2014. Survey of women's experiences of care in a new freestanding midwifery unit in an inner city area of London, England: 2. Specific aspects of care. *Midwifery*, (online). Available at:http://dx.doi.org/10.1016/j.midw.2014.05.008 [Accessed 19 September 2014].

MacKENZIE-BRYERS, H. and van TEIJLINGEN, E., 2010. Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care. *Midwifery*. [online]. Available at: http:// dx.doi.org/ 10.1016/j.midw.2010.07.003 [Accessed 14 January 2013].

MacKEY, S., 2005. Phenomenological nursing research: methodological insights derived from Heideggers interpretive phenomenology*. International Journal of Nursing Studies*, 42, pp. 179 – 186.

MANDER, R. and MELENDER, H., 2007. Choice in Maternity: Rhetoric, reality and resistance. *Midwifery*, 25, pp. 637-648.

MANDER, R. and MURPHY-LAWLESS, J., 2013. *The Politics of Maternity*, London: Routledge Publishing.

MARSHALL, A., KITSON, A. and ZEIT, K., 2012. Patient's views of patient centred care, *Journal of Advanced Nusring*. [online]. Available at: *http://dx.doi.org/10.1111/j.1365-2648.2012.05965* [Accessed 30th October 2014].

MATERNITY CARE WORKING PARTY, 2007. *Making Normal Birth a Reality. Concensus statement from the Maternity care Working Party*. [online]. Available from: https://www.rcm.org.uk/sites/default/files/NormalBirthConsensusStatement.pdf [Accessed 14 December 2014].

MATERNITY SERVICES ACTION GROUP, 2011. *A Refreshed Framework for Maternity Care In Scotland*. [online]. Available from: http://www.scotland.gov.uk/Publications/2011/02/11122123/0 [Accessed 14 January 2013].

McBRIEN, B., 2009. Translating change: The development of a person-centred triage training programme for emergency nurses*. International Journal of Emergency Nursing*. 17, pp. 31-37.

McCORMACK, B. and McCANCE, T., 2006. Developing a Framework for Person Centred Nursing*. Journal of Advanced Nursing*. [online]. Available at: http://dx.doi.org/10.1111/j.1365-2648.2006.04042.x [Accessed 30th October 2013].

McCORMACK, B. and McCANCE, T., 2010. *Person-Centred Nursing: Theory and Practice.* Sussex: Wliey Blackwell Publishing.

McCOURT, C and STEVENS, T., 2009. Relationship and Reciprocity in Caseload Midwifery. In: B. HUNTER and R. DEERY. *Emotions in midwifery and reproduction*. London: Palgrave MacMillan.

McCOURT, C. et al., 2011. Birthplace Qualitative Organisational Case Studies: How maternity care systems may affect the provision of care in different birth settings. *Birthplace in England research programme. Final report part 6. NIHR Service Delivery and Organisation Programme.* [online]. Available from:

http://www.sdo.nihr.ac.uk/files/project/SDO_FR6_08-1604-140_V01.pdf [Accessed on 25 January 2013].

McCOURT, C. et al., 2012. Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organizational case studies. *Midwifery*. [online]. Available at: http:// dx.doi.org/10.1016/j.midw.2012.07.004 [Accessed 24 September 2014].

McCUTCHEON, R. and BROWN, D., 2012. A Qualitative exploration of women's experiences and reflections upon giving birth at home. *Evidence Based Midwifery*, 10(1), pp. 23-28.

McKEE, L. et al., 2010. *Understanding the dynamics of organisational culture change: creating safe places for patients and staff.* London: NIHR Service Delivery and Organisation programme.

McKELLAR, L., PINCOMBE, J. and HENDERSON, A., 2009. Encountering the culture of midwifery practice on the post natal ward during Action Research: An impedimant to change. *Women and Birth*, 22, pp. 112-118.

McLACHLAN, H. et al., 2012. Effects of continuity of care by a primary midwife(caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randominsed controlled trial*. British Journal of Obstetricians and Gynaecologists*, 2012(119), pp. 1483-1492.

MILES, M. et al., 2013. Exploring Heideggerian hermeneutic phenomenology: a perfect fit for midwifery research. *Women and Birth*. [online]. Available at: http:// www.dx.doi.org/10.1016/ijnurstu.2004.06.011 [Accessed on 14th June 2013].

MILLER, T. and BELL, L., 2012. Consenting to what? Issues of access, gate keeping and 'informed' consent. In: Y. MILLER, M. BIRCH, M. MAUTHNER and J. JESSOP, eds. *Ethics in Qualitative Research*, 2nd edn*.* London: Sage.

MITCHELL, M., 2011. A Reflection on the Emotional Potential of Qualitative Interviewing. *British Journal of Midwifer*y, 19(10), pp. 653-657.

MORSE, J., 2000. Determining sample size. *Qualitative Health research*. 10(1) pp. 3–5.

NAIR, R. and HAWKINS, E, 2011. Corrsespondence: Birthplace Study. *British Journal of Obstetrics and Gynaecology*. [online]. Available from:

http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2011.02945.x/full [Accessed on 1 May 2013].

NATIONAL CHILDBIRTH TRUST, 2011. *NCT Policy Briefing: Midwife led units, community maternity units and birth centres.* [online]. Available at: http://www.nct.org.uk/sites/default/files/related_documents/Midwife-led%20units,%20community%20midwifery%20units%20and%20birth%20centres.pdf [[Accessed 12 January 2013].

NATIONAL FEDERATION of WOMEN'S INSTITUTES, 2013. *Support overdue: women's experiences of maternity services.* [online]. Avaialable from: http://www.thewi.org.uk/__data/assets/pdf_file/0006/49857/support-overdue-final-15-may-2013.pdf [accessed 14 December 2014].

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE, 2007. *Intrapartum Care: management and delivery of care to women in labour.* [online]. Accessed from: http://guidance.nice.org.uk/CG55 [Accessed 25 January 2013].

NATIONAL INSTITUTE for HEALTH and CARE EXCELLENCE, 2012. *Ectopic pregnancy and miscarriage: diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage.* [online]. Available from: https://guidance.nice.org.uk/CG154 [Accessed 9 December 2014].

NATIONAL INSTITUTE for HEALTH and CARE EXCELLENCE, 2014. *Intrapartum Care: care of healthy women and their babies during childbirth.* [online]. Available from: https://www.nice.org.uk/guidance/cg190 [Accessed 14th December 2014].

NATIONAL STATISTICS – RURAL SCOTLAND KEY FACTS, 2011. [online]. Available from: http://www.scotland.gov.uk/Publications/2011/09/29133747/2 [Accessed 26 January 2013].

NHS GRAMPIAN, 2012. *Maternity Services Review - Information for staff, public and other interested parties.* [online]. Available from: http://www.nhsgrampian.org/maternityreview [Accessed on 25 January 2013]

NHS QUALITY IMPROVEMENT SCOTLAND, 2009. *Pathways for maternity care.* [online].. Available from: http://www.healthcareimprovementscotland.org/our_work/reproductive,_maternal_child/programme_resources/keeping_childbirth_natural.aspx [Accessed 25 January 2014].

NHS QUALITY IMPROVEMENT SCOTLAND, 2007. *Safety and risks associated with free standing midwife led maternity units.* [online]. Available from: http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/earlier_evidence_notes/evidence_note_18.aspx [Accessed 1 May 2013].

NHS SCOTLAND SCOTTISH EXECUTIVE, 2007. *Better Heath, Better Care: A discussion document.* [online]. Available from: http://www.gov.scot/resource/doc/194854/0052337.pdf [Accessed 14 February 2012].

NOSEWORTHY, A., PHIBBS, S. and BENN, C., 2012. Towards a relational model of decision making in midwifery care. *Midwifery*. [online]. Available at: http://dx.doi.org/10.1016.j.midw.2012.2012.06.022 [Accessed 24 September 2014].

OILER, C., 1982. The phenomenological approach in nursing research. *Nursing Research* 31 (3) pp. 171– 81.

OVERGAARD, C. et al., 2011. Freestanding midwifery unit versus obstetric unit: a matched cohort study of outcomes in low-risk women. *British Medical Journal*. Available From: http//www.bmjopen.bmj.com/content/1/2/e000262.full.pdf [Accessed 27 January 2013].

OVERGAARD, C., FENGER-GRON, M. and SANDALL, J., 2012a. Freestanding midwifery units versus obstetric units: does the level of place of birth differ with level of social disadvantage? *BMC Public Health* [online]. Available from: http:// www.bimedcentral.com/1471-2458/12/478 [Accessed 26 January 2014].

OVERGAARD, C., FENGER-GRON, M. and SANDALL, J., 2012b. The impact of birthplace on women's experience of brth and perceptions of care. *Social Science and Medicine*. [online]. Available at:

http://dx.doi.org/10.1016/j.socsimed.2011.12.023 [Accessed on 24 September 2014].

PAIRMAN, S., 2010. Sustainable Midwifery Education: A Case Study From New Zealand. In: I. DAVIES, R. DAELLENBACH and M. KENSINGTON, eds. *Sustainability, Midwifery and Birth*, London: Routledge Publishing.

PALLANT, J., 2013. *SPSS Survival Manual*. 5th edn. Open University Press, Berkshire: McGraww-Hill.

PARAHOO, K., 2006. *Nursing Research Principles, Process and Issues*. Hampshire: Palgrave MacMillan.

PETRIE, A. and SABIN, C., 2009. *Medical Statistics at a Glance*. 3rd Edition. Sussex: Wiley-Blackwell.

PIAGET, J., 1971. *Biology and Knowledge*. Cicago: University of Chicago Press.

PILLEY EDWARDS, N., 2005. *Birthing Autonomy Women's Experiences of Planning Home Births.* Abingdon: Routledge Publishing.

PILLEY EDWARDS, N., 2009. Women's Emotion Work in the Context of Current Maternity Services. In: B. HUNTER and R. DEERY, eds. *Emotions in midwifery and reproduction*. London: Palgrave MacMillan.

PITCHFORTH, E. et al., 2008. Models of Intrapartum care and Women's Trade-offs in Remote and Rural Scotland: a mixed methods study. *British Journal of Obstetrics and Gynaecology*, 115(5), pp. 560-568.

PITCHFORTH, E. et al., 2009. "Choice" and place of delivery: a qualitative study of women in remote and rural Scotland. *BMJ Quality and Safety*. [online]. Available at: http://dx.doi.org/10.1136/qhsc.2007.023572 [accessed 24 September 2014].

POLIT, D. and BECK, C., 2012. Nursing Research: Generating and Assessing Evidence for Nursing Practice. 9th Edition. Philadelphia: Wolters Kluwer Health, Lipcott Williams and Wilkins.

POWELL, I., 2012. Can you see me? Experiences of nurses working night shift in Australian regional hospitals: a qualitative case study. *Journal of Advanced Nursing*. [online]. Available from: http://onlinelibrary.wiley.com/doi/10.1111/jan.12079/full [Accessed 24th February 2014].

PUTNAM, R., 1995. Bowling Alone: America's declining social capital. *Journal of Democracy,* 6, pp. 65-78.

PUTNAM, R., 2000. *Bowling Alone: The Collapse and Revival of American Community.* New York: Simon and Schuster.

RAVELLI, A. et al., 2010. Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands*. British Journal of Obstetrics and Gynaecology*. [online]. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02816.x/full [Accessed 1 May 2014].

REDSHAW ey al. 2007. Recorded delivery: a national survey of women's experience of maternity care 2006. *National Perinatal Epidemiology Unit.* [online]. Available from: https://www.npeu.ox.ac.uk/downloads/files/reports/Maternity-Survey-Report.pdf [Accessed 14 December 2011].

REDSHAW, M. and HEIKILA, K., 2010. Delivered with care: a national survey of women's experience of maternity care 2010. *National Perinatal Epidemiology Unit*. [online]. Available from: https://www.npeu.ox.ac.uk/downloads/files/reports/Maternity-Survey-Report-2010.pdf [Accessed 15 October 2011].

REDSHAW, M. et al., 2011 Mapping maternity care: the configuration of maternity care in England. Birthplace in England research programme: final report part 3. [online]. Available from: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR3_08-1604-140_V04.pdf [Accessed 27 January 2013].

RICHARDS, H and SCHWARTZ, L., 2002. Ethics of qualitative research: are there special issues for health services research? *Family Practice.* [online]. Available at: http://fampra.oxfordjournals.org/content/19/2/135.long [Accessed 15 June 2012].

RITCHIE, J. and LEWIS, J., 2009. *Qualitative Research Practice A Guide for Social Science Students and Researchers*. London: Sage Publications.

ROBSON, C., 2002. *Real world research: a resource for social scientists and practitioner researchers*. 2nd edn. Oxford: Blackwell publishing.

ROGERS, C., 2012. The Birthplace Study: Turning the tide of childbirth. *British Journal of Midwifery*, 20(1), pp. 28-27.

ROGERS, C., HARMAN, J. and SELO-OJEME, D., 2011. Perceptions of birth in a stand-alone centre compared to other options. *British Journal of Midwifery*, 19(4), pp. 237-244.

ROGERS, C., PICKERSGILL, J., PALMER, J. and BROADBENT, M., 2010. Informing choices: outcomes for women at a stand-alone birth centre. *British Journal of Midwifery*, 18(1), pp. 8-15.

ROWE, R. et al., 2012. Transfers of women planning birth in the midwifery units: data from the Birthplace prospective cohort study. *British Journal of Obstetricians and Gynaecologists*. 2012 (119), pp. 1081-1090.

ROWE, R. et al., 2012. Women's experience of transfer from midwifery unit to hospital obstetric unit during labour: a qualitative interview study. *BMC Pregnancy and Childbirth*. [online]. Available at: http://www.biomedcentral.com/1471-2393/12/129 [Accessed 24 September 2014]

ROYAL COLLEGE OF MIDWIVES, 2007. Position Statement: *Woman Centred Care.* [online]. Available at: http://www.rcm.org.uk/college/policy-practice/guidelines/rcm-position-statements/position-statements/ [Accessed 25th January 2013].

ROYAL COLLEGE OF MIDWIVES, 2014a. Freestanding Midwifery Units Local, high quality maternity care. *Busting the Myths.* [online]. Available at: https://www.rcm.org.uk/sites/default/files/FMU%20Mythbuster%20-%20Web%20Final.pdf [Accessed 14 June 2014].

ROYAL COLLEGE OF MIDWIVES, 2014b. Pressure Points. The case for better postnatal care. Pressure Point 4 Postnatal Care Planning. [online]. Available from: https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf [Accessed 15 December 2014].

ROYAL COLLEGE OF MIDWIVES, 2015. Normal Birth, maximising normality through pregnancy birth and the postnatal period. [online]. Available from: http://www.rcmnormalbirth.org.uk/about/ [Accessed 27 January 2015].

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, 2008. Safer Childbirth – *Minimum Standards for the Organisation and Delivery of Care in Labour.* [online]. Available from: www.rcog.org.uk/womens-health/clinical-guidance/safer-childbirth-minimum-standards-organisation-and-delivery-care-la [Accessed 27th January 2013].

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, 2011a. High Quality Women's Health Care: *A Proposal for change.* [online]. Available from: http:/ www.rcog.org.uk/high-quality-women's-health-care [Accessed 28 January 2013].

SANDALL, J., 2012. Every Woman Needs a Midwife, and Some Women Need a Doctor Too. *Birth.* 39(4), pp. 323-326.

SANDALL, J., 2013. The Contribution of Continuity of Midwifery Care to High Quality Maternity Care. *Royal College of Midwives* [online]. Available at: https://www.rcm.org.uk/sites/default/files/Continuity%20of%20Care%20A5%20Web.pdf [Accessed 14th June 2013].

SANDALL, J., et al, 2010*. Improving Quality and Safety in Maternity Care: The Contribution of Midwife Led Care.* Journal of Midwifery and Women's Health [online]. Available from: http://www.jmwh.2010.02.002 [Accessed 26 January 2014].

SCAMELL, M. and ALASEZEWSKI, A., 2012. Fateful moments in the categorisation of risk: Midwifery Practice and the ever-narrowing window of normality during childbirth. *Health, Risk and Safety*. [online]. Available at: http:// dx.doi.org/10.1080/13678575.2012.661041 [Accessed 14 June 2012].

SCHMIED, V. et al., 2013. Maternal Mental Health in Australia and New Zealand: A Review of Longitudinal Studies. *Women and Birth.* [online]. Available from: http://dx.doi.org/10.1016/j.wombi.2013.02.06. [Accessed 24th February 2014].

SCHROEDER, L. et al., 2011. Birthplace cost-effectiveness analysis of planned place of birth: individual level analysis. Birthplace in England research programme: final report part 5. [online]. Available from: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR5_08-1604-140_V02.pdf [Accessed 12 December 2011].

SCOTTISH CONFIDENTIAL AUDIT OF SEVERE MATERNAL MORBIDITY, 2014. Reducing avoidable harm, 10th Annual report. *Quality Improvement Scotland.* [online]. Available at: www.healthcareimprovementscotland.org [Accessed 14th December 2014].

SCOTTISH EXECUTIVE HEALTH DEPARTMENT, 2006. Research Governance Framework for Health and Community Care. [online]. Available from: http://www.cso.scot.nhs.uk/wp-content/uploads/Publications/ResGov/Framework/RGFEdTwo.pdf [Accessed 25 January 2013]

SCOTTISH EXECUTIVE HEALTH DIRECTORATE, 2001. A Framework for Maternity Services in Scotland. [online]. Available from: http://www.sehd.scot.nhs.uk/publications/ffmsshow/ffms-00.htm [Accessed 16 December 2011].

SCOTTISH GOVERNMENT, 2003. Implementing A Framework for Maternity Services in Scotland: *Overview of the Report of the Expert Group on Acute Maternity Services*. [online]. Available from: http://www.scotland.gov.uk/Publications/2003/01/16021/15813 [Accessed 14th January 2014].

SCOTTISH GOVERNMENT, 2009. The Early Years Framework. [online]. Available from: http://www.ascscotland.org.uk/upload/file/Reports/Framework.pdf [Accessed 14th February 2012].

SCOTTISH GOVERNMENT, 2010. *The Healthcare Quality Strategy for NHS Scotland.* [online]. Available from: http//www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf [Accessed 15 January 2013].

SCOTTISH GOVERNMENT, 2011. *A Refreshed Framework For Maternity Care in Scotland*. [online]. Available from: http//www.scotland.gov.uk/Publications/2011/02/11122123/2 [Accessed 20 January 2013].

SCOTTISH GOVERNMENT, 2012. Getting it Right for Every Child. [online]. Available from: http://www.gov.scot/Topics/People/Young-People/gettingitright/background [Accessed 14 June 2013].

SCOTTISH GOVERNMENT, 2014. *Updates for NHS HEAT targets, Antenatal Access*. [online]. Available from: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/AntenatalAccess [Accessed 14 June 2014].

SCOTTISH GOVERNMENT, 2014. *Having a baby in Scotland 2013: Women's Experiences of Maternity Care. Volume 1: National Results*. [online]. Available at:http://www.gov.scot/Resource/0044/00442822.pdf [Accessed 14 June 2014].

SCOTTISH GOVERNMENT, 2015 *Integration of health and social care.* [online]. Available from: http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration [Accessed 16 February 2015].

SCOTTISH GOVERNMENT, 2015 *NHS Scotland Local Delivery Plan Guidance.* [online] Available from: http://www.scotland.gov.uk/Publications/2015/01/7433 [Accessed 16 February 2015].

SCOTTISH HOME and HEALTH DEPARTMENT, 1973. Maternity Services: Integration of maternity work (Tennant Report). Edinburgh: HMSO.

SCOTTISH HOME and HEALTH DEPARTMENT, 1993. Provision of Maternity services in Scotland: A Policy Review (Health Policy and Public Health Policy Reviews). Edinburgh: HMSO.

SCOTTISH PATIENT SAFETY PROGRAMME, 2015. *Maternity and Children Quality Improvement Collaborative.* [online]. Available from: http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mcqic [Accessed 24 January 2015].

SCOTTISH PROGRAMME FOR CLINICAL EFFECTIVENESS IN REPRODUCTIVE HEALTH, 2007. Audit of care provided and outcomes achieved by community maternity units in Scotland 2005: final report. 2007; Available from: http://www.healthcareimprovementscotland.org/previous_resources/audit_report/scottish_programme_for_clinica.aspx [Accessed 26 January 2013].

SHAW, J. and CONNELLY, D., 2012. Phenomenology and physiotherapy: meaning in research and practice. *Physical Therapy Reviews* 17(6), pp 398-408.

SIMONS, H., 2009. *Case Study Research in Practice*. London: Sage Publications.

SKINNER, J. and FOUREUR, M., 2010. Consultation, referral, and collaboration between midwives and obstetricians: lessons from New Zealand. *Journal of Midwifery & Women's Health*, 55(1), pp. 28-37.

SMYTHE, E. et al., 2008. Doing Heideggarian hemeneutic research: a discussion paper*. International Journal of Nursing Studies* 45 (2008), pp. 1389– 1397.

SMYTHE, E., 2011. From beginning to end: how to do hermeneutic interpretive phenomenology. In: *Qualitative Research in Midwifery and Childbirth Phenomenological approaches.* F.THOMSON, F. DYKES and S DOWNE, eds. Oxford: Routledge.

STAKE, R., 1995. *The Art of Case Study Research*. California: Sage.

STEVENS, T. and McCOURT, C., 2002c. One to One Midwifery Practice part 4: sustaining the model. *British Journal of Midwifery.* 10(3), pp. 174-179.

STYLES, M. et al., 2009. The Scottish trial of refer or keep (the STORK study): Midwives' intrapartum decision-making. *Midwifery*, 27, pp. 104-111.

SYMON, A. et al., 2010. Care and Environment in midwife-led and obstetric-led units: A comparison of mothers' and birth partners' perceptions. [online]. Available from: http:// www.elsevier.com/midw.2010.10.002 [Accessed 14 January 2012].

TAYLOR, R., 2005. Creating a connection: tackling student attrition through curriculum development. *Journal of Further and Higher Education*, 29 (4), pp. 367-374.

TAYLOR, R., 2009. Creating Connections: An Investigation Into the First Year Experience of Undergraduate Nursing Students. Robert Gordon University PhD Thesis. [online]. Available from: https://openair.rgu.ac.uk/bitstream/10059/373/1/Ruth%20Taylor%20thesis.pdf [Accessed 1 May 2012].

TAYLOR, R., 2011. Social Capital and the Nursing Student Experience. *Nurse Education Today,* 32 (2012, pp. 250-254.

TAYLOR, R., 2013. *Case – study research in context*. Nurse Researcher 20(4), pp. 4–5.

THOMAS, G., 2011. *How to do your Case Study: A Guide for Students and Researchers*. London: Sage Publications.

THOMAS, G., 2009. *How to do your research project: A guide for students in Education and Applied Social Sciences*. London: Sage Publications.

THOMPSON, G., 2011. 'Abandonment of Being' In Childbirth. In: *Qualitative Research In Midwifery and Childbirth*. Phenomenological Approachs. F.THOMSON, F. DYKES and S DOWNE, eds. Oxford: Routledge.

TOD, A., 2010. Collecting data, Interviewing. In: K GERRISH and A LACEY, eds. The *Research Process in Nursing,* 6th edn. Sussex: Wiley Blackwell.

TRACY, S. et al., 2013. Caseload midwifery care versus standardised maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet,* 328 pp. 1723-1732.

TRANSPORT SCOTLAND, 2013. *Road Improvements*. [online]. Available from: http://www.transportscotland.gov.uk/road/projects [Accessed 20 April 2013].

TUCKER, J. et al., 2005. Sustainable maternity services in remote and rural Scotland? A qualitative survey of staff views on required skills, competencies and training. *Quality and Safety in Healthcare*, 14, pp. 34-40.

TUCKER, J. et al., 2006. *Sustainable Maternity Service Provision in Remote and Rural Scotland: implementing and evaluating maternity care models for remote and rural Scotland.* Dumfries: RARARI Project Board for Maternity Services.

TUCKER, J. et al., 2010. Maternity care models in a remote and rural network: assessing clinical appropriateness and outcome indicators. *Quality and Safety in Healthcare*, 19, pp. 83-89.

WALSH, D. and BAKER, L., 2004. How to collect qualitative data. In: T. LAVENDER, G. EDWARDS and Z. ALFIREVIC, eds. *Demysifying qualitative research in pregnancy and childbirth*. Salisbury: Quay Books pp. 63-86.

WALSH, D. and DEVANE, D., 2012. A Metasynthesis of Midwife –Led Care. *Qualitative Health Research*, 22(7), pp. 897-910.

WALSH, D., 2005. 'Nesting' and 'Matresence' as distinctive features of a free standing birth centre in the UK. *Midwifery*, 22, pp. 228-239.

WALSH, D., 2007*. Improving Maternity Services: small is beautiful- lessons from a birth centre*. Oxford: Radcliffe Publishing.

WALTON, C., 2012. The Birthplace in England Study: Methods, Findings and Evaluation. *British Journal of Midwifery*, 20(1), pp. 22-27.

WARWICK, C., 2012. Outcomes by planned place of birth: Implications of the Birthplace study. Home Birth Supplement. *British Journal of Midwifery.* 20(1), pp. 20-21.

WOOLCOCK, M., 2001. The Place of Social Capital in Understanding Social and Economic Outcomes*. ISUMA: Canadian Journal of Policy Research*. 2(1), pp. 11-17.

YIN, R., 2009. *Case Study Research Design and Methods*, 4th Edition. London: Sage Publications, London

ZIELINSKI, R., ACCERSON, K., MISUINAS, R. and MILLER, J., 2010. Feasibility of a Longitudinal Study of Women Anticipating First Pregnancy: Recruitment and Retention Challenges. *Contemporary Clinical Trials*, 31(6), pp. 544-548.

APPENDIX 1: EXCEL SPREADSHEET

Excel Spreadsheet

I/d no of patient
Age
Nationality
Postcode/ SIMD
Marital Status
Occupation
Parity
1st point of contact clinician
Gestation
Scheduled A/N Visits

Unscheduled A/N Visits
Reason for unscheduled visit
No of different midwives seen
Pregnancy model of care
Appropriate allocation of lead professional
Planned place of birth 12 weeks
Planned place of birth 36 weeks
Place of birth at onset of labour
Antenatal transfer
Visits in early labour
Gestation at onset of established labour
Transfer in labour
Reason for transfer
Pain management strategies water/ent/tens/morp/other
Duration of 1st stage
Duration of 2nd stage
Duration of 3rd stage
Management of 3rd stage
ARM/Epis/Induction
Type of Birth
Waterbirth?
Perineal Trauma
Post Natal Transfer to OU?
Reason

EBL 500mls or less
EBL 501-1000 mls
EBL 1000 + mls
Birthweight
Resus levels
Type of first feed
Feed Method on transfer home
Feeding Method on transfer to Health Visitor
Early transfer to community care
Duration of postnatal stay at CMU

APPENDIX 2: INVITATION LETTER, CLINICIANS INTERVIEW.

Invitation Letter, Clinicians Interview.

ROBERT GORDON UNIVERSITY•ABERDEEN

Study Number 12/NS/0055

24/04/12 Version 4

Letter of Invitation to Participate.

I am inviting you, on the behalf of Sara Denham, a PhD student with Robert Gordon University, to take part in a study entitled: **A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person-centred Care in Two Rural Community Maternity Units.**

This is a research project that aims to explore how rural Community Maternity Units contribute to the provision of safe, effective and person-centred maternity care.

You have been asked to consider taking part in this study because your role involves the provision of care to women who attend rural CMU's.

Enclosed you will find an information leaflet with more details about the study, a reply slip and an addressed paid envelope.

Your participation will involve being interviewed, which will take about 45 minutes.

Sara would be happy to answer any further questions you may have regarding the study.

Thank you.

Head of Midwifery

Contact for further information:

Mrs Sara Denham, PhD Student
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
Tel: 01224 262650 Email:s.h.denham@rgu.ac.uk Mobile/Text: 07964 890386

Professor Ruth Taylor, Associate Head of School
School of Nursing and Midwifery
Robert Gordon University
Tel: 01224 262908 Email: ruth.taylor@rgu.ac.uk

Tracy Humphrey, PhD
Clinical Professor of Midwifery
School of Nursing and Midwifery
Robert Gordon University/NHS Grampian
Tel: 01224 262615 Email: t.humphrey1@rgu.ac.uk

APPENDIX 3: STAKEHOLDERS FOCUS GROUP TOPIC GUIDE

Stakeholders Focus Group Topic Guide

1. Introduction

- Outline purpose of Focus Group
- Ensure all participants have read the information sheet
- Discuss confidentiality and audio recording particularly regarding what individuals say during the focus group should not be discussed by other participants' outwith the group.
- Explain about fair contribution and respectfulness to other participants
- Opportunity for questions
- Revisit consent form and ensure all participants have a copy.

2. In relation to views and attitudes to CMU

Tell me about your local CMU

- Can you tell me what it's like working in/with the CMU?
- What is the CMU trying to achieve? What are its goals?
- Describe the population you serve?
- Why do women choose to/ not to use the services you offer?
- What's good about working here? …ask for examples of positive experiences.
- Is there anything not so good about working here?.....ask for examples of any negative experiences.

- What are your perceptions of the service you are providing to women and their families?
- What would help to improve the services you offer?
- Professional and team working arrangements – do they work in practice? How could we improve on collaborative relationships?
- What is your relationship with the referral Consultant Unit? Examples
- How does the group see the future of rural midwife led maternity services?
- How do you feel that your unit contributes to safe and effective care? How is this monitored?
- What do you think are women's experiences of the service? Ask for examples ….
- How do you think your unit contributes to person-centred care? i.e. partnerships between themselves and the women and their families demonstrating respect for individual needs and values, shared decision making and effective communication?
- What do you think women would say if I asked them the same question?

3. Any other questions, comments and general discussion

Thank the participants for their time, giving further assurances about anonymity and confidentiality. Ask them if they would like a written summary of the findings.

APPENDIX 4: STAKEHOLDER ANALYSIS, SEAVIEW

Stakeholder Analysis, Seaview.

MAIN THEMES	Definition	Categories	Codes
Being Different	Different/alternative service to that offered by alternative care venues, alongside MU or OU	Geographical Isolation from OU	Positive: Calm and relaxed atmosphere, choice for women, temporality, reducing inequality by local access to most m/led services for most women Negative Transfer time and effect on decision-making, unique demographic characteristics, vulnerability adverse weather. Local accessibility/isolation leading to concerns about not knowing who could come through the doors, perception of proximity to prison, large migrant workforce, high index of social deprivation (link to quantitative findings?)
		Small, Stable Team	Positive: All contribute leadership attributes to unit, Knowing each other – building strengths, recognising weaknesses, ability to challenge and support each other in the absence of a vision and leadership Negative: Lack of ownership of their working environment, Others driving and developing CMU services Less willing to adapt to rapid change imposed from outside the team Team Leader "absent", no team vision or visible leadership. Manager's perception that team do not challenge each other Individual attempts to develop self and service in isolation, not encouraged or joined up for CMU as a whole's benefit

		Community Support Continuity of Carer (Knowing me, Knowing you)	Positive: History of the CMU in town as the place for normal birth Perceived reputation of being a local, safe option for maternity care Historically still referred to as "hospital", implying wider care provision eg operative deliveries Negative: Building= care provision, 4 walls Changes in services not communicated widely within local community, no local PR contact Positive: Named carer, asked for by name and perceive that women comfortable to access them that way. Building effective relationships, knowing family as well as personal history Negative: Doing what is necessary when named midwife absent Interruptions during clinic when TeamLeader available
Aspiring To Improve	Aiming to provide most women with the best care for each person, centred around their choices and preferences throughout their maternity journey	Focus on women and their choices	Positive: Attempting to understand each woman's choices Information giving – assumptions, risk perception and evidence base Dynamic risk assessment throughout maternity journey, changing pathways and informed consent/preferences Flexibility to facilitate choices eg appointment times, less regarding to place of birth. Initiatives from midwives to tailor care to specific needs eg young women specific antenatal groups Negative Language - women have to "persuade" midwives they are suitable for CMU birth, referred to by TL as 'patients and 'monkeys'. Managers perception that full range of choices (eg home birth) not routinely discussed Women's choices linked to midwives lack of confidence and

			support, defensive practice Women's choices v midwife's preferences, defensive decision making, tactics employed
		Recognition for Success, constant monitoring	Positive: Process and outcomes reviewed for some women, reflective learning from events fed back by OU Positive feedback on transfers, less on job well done within CMU Negative: Perceived pressure to transfer early, 'under the spotlight' TL's lack of attention to detail, role modelling, positive and negative feedback, confidence in clinical decision making
		Developing and Sharing Knowledge and Skills	Positive: Staff development, extending midwife led services available to women at CMU Developing skills in response to women's choices, aiming to enhance safety, pushing the boundaries of the care that can be given by midwives Team reputation for generosity of spirit, willingness to share knowledge and skills to visiting students, midwives and occasionally GP's from UK and abroad. Negative: Pushing the boundaries beyond the experience and competency of the midwifery team
		Sustainability	Positive: Success of the CMU relies on it being seen by women as an appropriate place for them to give birth More women are choosing to give birth/access care there Support for CMU future development by Board as part of ongoing service development Negative: TL not confident about the future plans for CMU, knowledge and skills and staffing implications

Reaching Out	Developing effective collaborative relationships to enhance women's care when the assistance of the wider maternity care team is required	Recognising Differences	Positive: Recognising the CMU's place in the larger multidisciplinary maternity care team Appreciating the difference in roles between midwives in different contexts Negative: Perception of being undervalued in the CMU context View that others don't understand the care that CMUs provide, the CMU model Undermining the OU midwifery role, perceiving CMU role as 'real' midwifery, creating barriers
		Building Networks	Positive: Unprofessional behaviour from those who do not understand the CMU's contextual issues recognised and challenged Multiprofessional individualised care plans usually in place to provide a support network for women for clinically appropriate care by developing effective relationships with the wider maternity team Plans to develop cross-organisational working Negative: Relationship between CMU and OU/GP's, but improving over time with recognition of barriers, IT issues and effective communication Us and them language (woman at CMU, someone at OU)
		Working Across Boundaries	Positive: Maintaining and refreshing skills by moving across contextual boundaries History of appropriate onward referrals to OU, using shared pathways and procedures CMU team maintains communication and good relationship with linked obstetrician Negative: Recent historically difficult relationship with GP's, interface within community care for clinically appropriate care

		Communication with Respect and Integrity	Positive: Recognised as important in improving all relationships, team, collaborative and with women Acknowledged that respect on both sides essential and responsibility for poor communication lies with both sides (OU/GP and CMU) Tools for effective communication embedded into practice, but not used consistently by recipients Negative: Language used referring to women as 'girls', 'monkeys' and patients denotes paternalism or ownership, No formal feedback sessions for staff or women Change management imposed on staff and unit

APPENDIX 5: ANALYSIS THEMES AND CATEGORIES, WOMEN PARTICIPANTS SEAVIEW

Analysis Themes and Categories, Women Participants

Women's Interviews (Early in black, 3rd trimester in blue, post birth in green)

MAIN THEMES	Definition	Categories	Codes
Being Known	Addressed by name, remembered and welcomed, having a named carer providing continuity of care and having personal wishes and preferences respected	Welcomed, Remembered, Centre of care	Positive: - Congratulated, welcomed and remembered from last pregnancy/ family member's care at CMU - Having a face, not being a number - Felt able to discuss sensitive mental health issue with midwife and care adapted to her needs despite anxieties about perceived consequences of seeking help - Women feeling that they were the focus of the care received - Cultural differences for woman, midwife suggested ways of minimising their impact on her experience - Warm welcome for everyone, knowing someone cares about them - Continued appreciation of being welcomed, remembered and addressed by name - Care perceived as personal, granny's supportive relationship remembered and encouraged at CMU Negative: - Felt anonymous at the OU - Frightened by childhood and previous maternity care experiences at OU - Comparison with OU, care at CMU more person-centred - Long uncomfortable waits to see OU linked consultant, women's time not valued
		Continuity of Carer	Positive: - Valued same midwife for subsequent pregnancies, offered pre-pregnancy counselling by her - How being known by named midwife made women feel - Calmed by midwife, made to feel comfortable and at ease - Special relationship with their named midwife who understood her as a person so adapted information giving style to her individual needs - Feeling safe in midwife's care – midwife demonstrated her priority to

		Wishes, Decisions and Preferences Listened to and Respected	be woman's safety above all else (CMU birth no's in particular) - Building a bond, not having to go over old ground or listen to a different opinion every time Negative: - Continuity not re-established when 2 staff left - Care pathway meant lack of continuity of care, not pro-actively dealt with - Lack of continuity leading to misunderstandings with OU staff about needs for information - P/N experience of many different staff visiting, with different opinions, not remembering/acknowledging woman's experience - Would have felt safer if continuity continued P/N Positive: - Family, friends and siblings welcomed and included in care - Previous good experiences of care at CMU - Wishes and expectations exceeded on first visit for some, responsive to needs - Appointment times arranged around women's commitments and need for privacy - Continue to receive flexibility in time/venue when accessing care - Experience of CMU midwives offering support and information so young woman didn't feel alone (pre term labour on her birthday) - Baby weighed and progress discussed with her each day, decision not to go to OU listened to and felt preference respected - Siblings welcomed at any time - Preferences confirmed and prepared (pool filled) - Flexibility over times and venues for care during the post birth period organised around family commitments Negative: - OU experience of feeling preferences not respected - First appointment not with named midwife as expected - Visited CMU after scan to have blood taken, not understood by CMU staff so waited for next appt with named midwife to explain what she needed - Repeated experiences of OU staff not respecting woman's history, did not feel listened to or understood, missed out on relational continuity - OU assumptions about partner made him feel fearful and reluctant to support woman during birth - Concern about assumptions that may be made over birth plan if woman unable to explain it fully in labour - 1 woman felt only doctors could prescribe decisions for care in labour, these had to be written down for midwives to follow

			- P/N experience of many different midwives visiting
Being Available	Accessible to all women "Open all hours" for information and consultation by whatever method is convenient to the women	Information Giving and Information Seeking	Positive: - Helpful from first phone call, encouraged to contact the CMU by phone at any time - Staff at CMU approachable for information and care, didn't feel stupid asking questions - Information needs met by midwife, preferred to be told all she needed to know - Positive experiences of access to information and advice, lovely to have support on the end of the phone - Midwives explaining what Ou linked cons didn't have time to explain - Experience of midwives having time to chat and answer questions, easing the stress of the unknown (induction of labour discussion) - Twins Mum accessed care at CMU, advice and tubigrip given - Positive OU experience of information regarding antenatal referral - Relevant, positive questioning about birth plan by CMU midwife - Information for labour, birth and infant feeding "good" Negative: - Financial information sought, but lack of confidence in what she will be told - Antenatal classes too crowded to be useful - Conflicting advice re IOL and pain management options from OU staff, no input from CMU named midwife - Long waits for linked Obstetrician at CMU then for some a very quick consultation not fully addressing women's information needs perceived due to time pressures - Discovered post birth via internet that IOL not mandatory and could have chosen to give birth at CMU - Conflicting information from CMU midwives on establishing breast feeding - Post birth visits tick box exercises, not fulfilling specific information needs
		Accessible Community Service	Positive: - Local, close to women's support networks for ease of access, transport barrier to travelling to OU - Services available for most women, not just "low risk" - Local flexible appointments facilitating early access to maternity care - Collaborative relationship with local services (keeping well clinic, local

Decision-making influences	How women feel about the CMU as an appropriate place or not to access care for their maternity journey	Inclusivity	pharmacies) - Post birth intention to rest in unit but stay close to local siblings - Local birth support organised, some cannot drive, peace of mind - Travel time in labour reduced - Childcare, family and CMU all within easy access for labour, birth and post birth care - Collaborative relationship with local services Negative: - Woman felt midwives distant and unwilling to help when fell on ice, simply told to call OU (transport and child care issues) Positive: - GP surgeries referred all women who requested maternity care to CMU - Non-judgemental attitude shown by midwife re mental health, age and partners involvement in criminal justice system Negative - Perception of missing out on CMU relationship when following an alternative care pathway (twins at CMU, complicated pregnancy and all OU care)/ information/continuity - Special antenatal education needs not fulfilled
		Environment	Positive: - Relaxed, not rushed, having a laugh, having time, not pressurised, quiet and safe - Close to home and those who she loves - Quiet, peaceful, relaxed, comfortable, safe and warm - Anticipating from environment and experience that CMU care during labour and birth will make it easier - Peaceful, quiet environment for birth, contesting with OU experience - Negative: - Waterbirth and some scans not available at CMU - Not controlled by CMU staff P/N, too many visitors allowed in, overwhelmed - Too quiet – remote – for 1 woman to feel safe
		Experiences of Care	Positive: - Past experience of care at CMU, felt nurtured and protected - Positive reputation in community, friends/family experiences, why go

		Confidence	anywhere else? - History sought, reviewed and information shared with woman to make informed decision, not forced either way by midwife - Experience of OU staff not reading records and making incorrect assumptions about women and partner - Normal pregnancy, anticipating normal labour and birth so why go elsewhere? - Dynamic decision making encouraged, wait and see approach Negative: - No-one knew who was responsible for arranging 8 week (non-standard) scan - Concerned by out of hours visit, seemed disorganised and perceived too few staff should an emergency occur - Anxieties about birth and previous transfer to OU - Linked consultant's language "try to deliver" sewing huge seed of doubt - Experience of being left alone in labour at OU, confident this wouldn't have occurred at CMU - Lack of timely, effective pain relief at OU - OU birth and unable to B/F didn't get anything she wanted Positive: Advice given by midwife re antenatal testing good, confident of good care - Confident in the midwives ability to provide the care that women wish for in labour, and to refer thoughtfully and appropriately if necessary - Confident that 1:1 supportive, focussed care will be given - Trust all midwives to optimise their options (pushing the boundaries) - Confident that help with feeding - Confidence to ask for what they want as already trust staff to provide this - Supported by CMU midwives to make own decisions - Proud and positive about choices made - Felt safe during previous transfer, KMKU midwife with her Negative: - Only confident in OU care "just in case" - Terrifying experience at OU as a child - Fear of lack of control over events - Language of linked OU cons – you can try, huge doubt sewn - Feeling safer to give birth at OU with doctors available "just in case"

			Felt unsupported by OU midwives when making difficult IOL decision at 36 weeks

APPENDIX 6: LETTERS TO PARTICIPANTS

Letters to Participants

19th March 2014

Dear ,

You may remember (though a lot has happened since then!) that some time ago that I interviewed you for my PhD research. I have now had a chance to look at all the information together, and have started to analyse the data from the interviews and the focus group. It has been a very interesting process!

The purpose of getting back in touch with you is to show you what my initial findings are. I have come up with three themes and a number of categories within the themes that seem to encompass the experiences of all the midwives, managers and user representatives. This letter provides you with those themes and categories. I am now in the process of describing these more fully by using the quotes you have given me in your interviews, and by referring to the literature.

As part of the research process, I would like to ask that you look at the themes and categories as a system of 'member checking'. This final part of the member checking process enables you to see whether you think that the themes and categories are familiar and link to what you told me. If you have any comments, please feel free to e-mail me at s.h.denham@rgu.ac.uk.

I can assure you that this is the last time I will be in touch with you to seek your views. I hope that it won't be too long before I complete my thesis and you will then have an opportunity to see what the findings are.

May I take this opportunity to thank you once again for taking part. Having sat down with all the focus group and interview transcripts and worked with them for the past few months, I have really appreciated your honesty and the interesting and thought provoking discussions we had.

A number of themes and categories were identified, and the themes are:

1. Being Different

Offering a different or alternative service to that available at other maternity care venues (alongside midwife led unit or obstetric unit).

Categories within the theme were:

- Geographical isolation from OU
- Small, transformational team
- Community support
- Continuity of carer

2. Aspiring To Be The Best

Aiming to provide most women with the best care for each person, centred on their choices and preferences throughout their maternity journey.

Categories within the theme were:

- Focus on women and their choices
- Celebrating success, constant monitoring
- Developing and sharing knowledge and skills
- Sustainability

3. Reaching Out

Developing effective collaborative relationships to enhance women's care when the assistance of the wider maternity care team is required.

Categories within the theme were:

- Recognising differences
- Building networks
- Working across boundaries
- Communication with respect and integrity

Each of these will be discussed separately although it will become clear that there are definite links between and across the themes and categories. For example, when discussing small, transformational teams, this has an impact across all the themes and many of the categories.

The literature has been used to inform the process of the development of the themes and categories, and to add clarity to the findings. In some cases, the literature clearly demonstrates that the issues are familiar to a number of researchers. In others, the lack of available literature suggests that further research should, and could, be undertaken in these areas.

Please feel free to comment on the themes and categories by e-mail to s.h.denham@rgu.ac.uk Thank you once again for your time, patience and honesty,

Best Wishes,

Sara Denham

PhD student, School of Nursing and Midwifery, Robert Gordon University.
E-mail: s.h.denham@rgu.ac.uk

APPENDIX 7: WOMEN'S INTERVIEW GUIDE

Women's Interview Guide

TOPIC GUIDE – STUDY NO: 12/NS/0055 INTERVIEWS WITH WOMEN (LONGITUDINAL STUDY)

Introduction

- Outline purpose of interview
- Ensure participant has read information sheet
- Discuss confidentiality and audio recording
- Opportunity for questions
- Revisit consent form and ensure participant has a copy.

In relation to experiences of antenatal care:

12 Weeks

Thinking about your first contact with your heathcare provider after you confirmed your pregnancy…

What happened at you first visit/telephone contact and what stands out in your mind about that?

And moving on to include your most recent visit…..

What were your expectations of these first couple of appointments?

Were these expectations met or not, if so why or why not?

How accessible have you found the care so far? Why?

What do you think of the CMU? What do you understand are the services and care the CMU provides?

Have you felt able to ask questions and discuss your care at your consultations?

How do you feel about the information you have been given so far?

Is it enough/too much/too little?

How do you feel that your views and preferences are/are not being responded to in your plan of care? Examples?

What are you hopes and aspirations for your care in this pregnancy and where you would like to give birth?

What choices do you see that you have about your care?

How involved in decision making do you want to be?

Explore reasons for choice/open mind.

APPENDIX 8: WOMEN'S LATE PREGNANCY INTERVIEW TOPIC GUIDE

Women's Late Pregnancy interview Topic Guide

36 weeks

Review information sheet and consent form – obtain verbal consent to continue.

Encourage woman to consult her diary as an "aide memoire".

Thinking back to when you last spoke to me…..

Broadly speaking, How do you feel about your antenatal care so far?

What have been the best bits? Why?

What aspects of your care could be better? How?

Do you feel as though the staff are supporting you? How or why not? (information seeking, emotional support, inclusivity).

Do you feel that your views and preferences have been responded to? Examples ….

Are there any things that you would like to have had more "say" about?

Has anything that you have seen or heard about affected where you have considered giving birth?

What do you understand are your choices about giving birth?

Have you decided where you would like to give birth?

How do you feel about your decision?

What do you feel were the crucial points in making that decision?

Do your partner/ family or friends have ideas about where they would prefer the baby to be born?

What information would you like from your midwife/obstetrician to help you?

APPENDIX 9: WOMEN'S POST BIRTH TOPIC GUIDE

Women's Post Birth Topic Guide

Post Natal

Review information sheet and consent form – obtain verbal consent to continue.

Encourage woman to consult her diary again to remind her of her thoughts and feelings.

In relation to labour, birth and post natal care:

Tell me about your labour, how did it start? How prepared did you feel?

Now tell me about the best bits of your labour and giving birth care?

What aspects of your care could have been better? Why and how?

What decisions did you make about pain management? Why?

Would you choose the same strategies again?

How did you feel the staff responded to your needs? Examples….

Were you content with your decision about where to give birth as your labour began? And looking back, do you still feel happy now? How does your birth partner feel?

What would you do next time?

How is the baby - feeding and growing well?

How are the rest of the family coping with the new arrival?

Looking back, how would you describe your whole experience to a friend who is pregnant?

What advice would you give her?

Opportunity for participant to ask questions, make comments and general discussion.

Thank the participant for her time, giving further reassurances about anonymity and confidentiality. Re-confirm her contact details, and ensure she still has contact details for researcher. Ask if she wants a summary of the study findings.

APPENDIX 10: OBSERVATION PARTICIPANT INFORMATION SHEET

Observation Participant Information Sheet

Clinician Observation

Study Number: 12/NS/0055
Version 4 24/04/12

Title: A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person-centred Care in Two Rural Community Maternity Units.

Invitation

You are invited to participate in a research study. We hope that the following information about the study and what is involved will assist you in reaching a decision on whether or not to take part. Please read the information given and ask us if anything is not clear.

Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to map the current provision of maternity services provided within two Community Maternity Units in Scotland and describe how they contribute to safe, effective and person centred care. This will inform the development of such services both locally and nationally.

Why have I been chosen?

You have been asked to consider taking part because you are a healthcare professional involved in the care of women who access care at CMU's.

Do I have to take part?

The decision to take part is entirely yours. We will describe the study and go through this information sheet. If you decide to take part we will then ask you to sign a consent form. You are free to withdraw your consent at any time without giving a reason.

What will happen to me if I do take part?

You will be asked to allow the researcher to observe an antenatal consultation with a woman participant in the study, which you will be providing. At any time during the consultation, the researcher will leave if you or the woman participant wishes. The consultation will not be recorded, but the researcher will take written notes during the consultation.

What are the possible risks and disadvantages to taking part?

There are no identified disadvantages to taking part in this study, other than taking up your time.

What are the possible benefits to taking part?

The results of this study will help to identify the contribution of rural CMUs to the provision of safe, effective and person centred care in Scotland.

Will my taking part in this study be kept confidential?

All information from the observation of clinical consultations will be anonymised. All information collected during the course of this research will be kept strictly confidential. No participants or CMU's will be named in any reports or publications resulting from this study and particular efforts will be made to retain this anonyminity within context specific reports.

What if there is a problem?

If you have any complaint about the way you have been approached or dealt with during the study, you should contact the study supervisor, Professor Ruth

Taylor: 01224 262908 or Email: ruth.taylor@rgu.ac.uk Existing NHS protocols will be followed if there are any concerns about the standard of clinical care observed.

What will happen to the results of the research study?

The results will form part of a PhD research thesis. The results will also be submitted for conference presentation and publication in peer reviewed journals. None of the CMU's, Consultant Units or participants taking part in this study will be indentified in any report or publication that may result from this study. The completed thesis will be published on the university's Open Air website.

Who is organising and funding the study?

The study is being organised and partly funded by the Robert Gordon University, Aberdeen.

Who has reviewed the study?

The study has been reviewed by the Robert Gordon University Research Ethics Committee, the North of Scotland Research Ethics Committee and the NHS Research and Development Committee.

Contact for further information:

Mrs Sara Denham, PhD Student
Institute of Health and Welfare
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
Tel: 01224 262650
Email: s.h.denham@rgu.ac.uk Mobile/Text: 07964 890386

Professor Ruth Taylor, Associate Head of School
School of Nursing and Midwifery
Robert Gordon University

Tel: 01224 262908
Email: ruth.taylor@rgu.ac.uk

Tracy Humphrey
Clinical Professor of Midwifery
School of Nursing and Midwifery
Robert Gordon University/NHS Grampian
Tel: 01224 262615
Email: t.humphrey1@rgu.ac.u

APPENDIX 11: STAKEHOLDER INTERVIEWS PARTICIPANT INFORMATION SHEET

Stakeholder Interviews Participant Information Sheet

Study Number: 12/NS/0055
Version 4 24/04/12

Title: A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person-centred Care in Two Rural Community Maternity Units.

Invitation

You are invited to participate in a research study. We hope that the following information about the study and what is involved will assist you in reaching a decision on whether or not to take part. Please read the information given and ask us if anything is not clear.

Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to map the current provision of maternity services provided within 2 CMU's in Scotland and describe how they contribute towards safe, effective and person centred care.

Why have I been chosen?

You have been asked to consider taking part because you are a healthcare professional involved in the care of women who access care at CMUs.

Do I have to take part?

The decision to take part is entirely yours. We will describe the study and go through this information sheet. If you decide to take part we will then ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I do take part?

You will be asked to take part in an interview exploring your views and attitudes about the contribution of rural CMU's to the provision of safe, effective and person centred care. The interviews will be audio recorded to help the researcher remember all that is said. After the interview, the information will be typed up by the researcher. I would suggest the interview should take about 45 minutes. At any time during the interview, we will stop if you wish.

What are the possible risks and disadvantages to taking part?

There are no identified disadvantages to taking part in this study, other than taking up your time.

What are the possible benefits to taking part?

The results of this study will help to identify and understand the contribution of rural CMU's to the provision of safe, effective and person centred care in Scotland. This will inform the development of services at CMUs both locally and nationally.

Will my taking part in this study be kept confidential?

All information from the interviews will be anonymised. All information collected during the course of this research will be kept strictly confidential. No participants or CMUs will be named in any reports or publications resulting from this study and particular efforts will be made to retain this anonyminity within context specific reports.

What if there is a problem?

If you have any complaint about the way you have been approached or dealt with during the study, you should contact the study supervisor, Professor Ruth Taylor: 01224 262908 or Email: ruth.taylor@rgu.ac.uk

Existing NHS protocols will be followed if there are any concerns about the standard of clinical care observed.

What will happen to the results of the research study?

The results will form part of a PhD research thesis. The results will also be submitted for conference presentation and publication in peer reviewed journals. None of the CMUs, Consultant Units or participants taking part in this study will be indentified in any report or publication that may result from this study. The completed thesis will be published on the university's Open Air website.

Who is organising and funding the study?

The study is being organised and partly funded by the Robert Gordon University, Aberdeen.

Who has reviewed the study?

The study has been reviewed by the Robert Gordon University Research Ethics Committee, the North of Scotland Research Ethics Committee and the NHS Research and Development Committee.

Contact for further information:
Mrs Sara Denham, PhD Student
Institute of Health and Welfare
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
Tel: 01224 262650
Email: s.h.denham@rgu.ac.uk Mobile/Text: 07964 890386

Professor Ruth Taylor, Associate Head of School
School of Nursing and Midwifery
Robert Gordon University
Tel: 01224 262908
Email: ruth.taylor@rgu.ac.uk

Tracy Humphrey,
Clinical Professor of Midwifery
School of Nursing and Midwifery
Robert Gordon University/NHS Grampian
Tel: 01224 262615
Email: t.humphrey1@rgu.ac.uk

APPENDIX 12: WOMENS' PARTICIPANT INFORMATION SHEET

Womens' Participant Information Sheet

Study number: 12/NS/0055

Version 4 24/04/12

Participant Information Sheet (Observation and Interviews)

A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person-centred Care in Two Rural Community Maternity Units.

You are invited to take part in a research study. Before you decide, we would like you to understand why the research is being done and what it will involve for you. The researcher will go through the information sheet with you at the antenatal clinic and answer any questions you have. We would suggest this should take about 10 – 15 minutes.

Talk to others about the study if you wish.

This information sheet tells you the purpose of this study and what will happen to you if you take part.

Ask us if there is anything that is not clear.

What is the purpose of this study?
The aim of the study is to explore and describe how rural community maternity units contribute towards the provision of safe, effective and person centred care for all women.

Why Have I been Chosen?
You have been asked, along with several other women, to take part in the study because you are pregnant and are accessing care from a rural community maternity unit.

Do I have to take part?
It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the care you receive.

What will happen to me if I take part?
If you agree to take part, I will observe your antenatal clinic visits at 10-12 and 34-36 weeks, and then interview you within a week of these consultations. This may be face-to-face or by telephone, whichever you would prefer.

I will also ask you to keep a pregnancy diary, which is yours to keep, to write down any thoughts or feelings about your pregnancy journey.

I will also ask if I can interview you about 6 weeks after your baby is born, at a time and place of your choice. I will ask you then about your experiences of labour and giving birth, wherever your baby is born.

The interviews will be audio recorded to help the researcher to remember all that is said. After the interview, all information about you will be anonymised and the recording typed up by the researcher. I would suggest the interview

should take about 45 minutes to 1 hour. At any time during the interview, we will stop if you wish.

Where will the interviews take place?
I will interview you at a time and place of your choice, either face to face or by telephone, whichever you prefer.

What will I have to do?
All that would be expected of you would be to keep the diary which I will give to you, allow me to observe your antenatal visits, and answer some questions regarding your thoughts about your visits.

If you wish, I will look at your diary and ask about some of the things that you have written there as well. When your baby is about 6 weeks old, I will ask if I may interview you then so that you can tell me about your labour, and the birth of your baby.

What are the possible disadvantages of taking part?
There are no identified disadvantages to taking part in this study, other than taking up your time.

What are the possible benefits to taking part?
We hope that the information from this study will help us to understand and improve in the future, the provision of safe, effective and person-centred care at rural Community Maternity Units.

Will my taking part in this study be kept confidential?
All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. This information will be destroyed at the end of the study.

What will happen to the results of the research study?
The study will be written up as the basis for my thesis, and be used to produce an article for publication in a health related journal. It will also be used as a

presentation at a local or national conference. It will not be possible for you to be identified in any of these reports or presentations. If you are interested in receiving a summary of the findings, please let me know and I will arrange for you to be sent a copy.

Who is organising and funding the research?
The study is being organised and partly funded by the Robert Gordon University, Aberdeen.

Who has reviewed the study?
The study has been reviewed by the Robert Gordon University Ethics Committee, the North of Scotland Research Ethics Committee and the NHS Grampian Research and Development department. I am also being supported by two academic supervisors from Robert Gordon University.

What if there is a problem?
If you have any complaint about the way you have been approached or dealt with during the study, you should contact the study supervisor, Professor Ruth Taylor: 01224 262908 or e-mail: ruth.taylor@rgu.ac.uk

Contact for further information:
Mrs Sara Denham, PhD Student
Institute of Health and Welfare
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
Tel: 01224 262650
Email: s.h.denham@rgu.ac.uk Mobile/Text: 07964 890386

Professor Ruth Taylor, Associate Head of School
School of Nursing and Midwifery
Robert Gordon University Tel: 01224 262908 Email: ruth.taylor@rgu.ac.uk

APPENDIX 13: PARTICIPANT LETTER OF INTRODUCTION

Participant Letter of Introduction

Study Number 12/NS/0055
24/04/12 Version 4

Letter of Invitation to Participate.

I am inviting you, on the behalf of Sara Denham, a PhD student with Robert Gordon University, to take part in a study entitled: **A Case Study Exploration of Approaches to the Delivery of Safe, Effective and Person-centred Care in Two Rural Community Maternity Units.**

This is a research project that aims to explore how rural Community Maternity Units contribute to the provision of safe, effective and person-centred maternity care.

You have been asked to consider taking part in this study because your role involves the provision of care to women who attend rural CMU's.

Enclosed you will find an information leaflet with more details about the study, a reply slip and an addressed paid envelope.

Your participation will involve being interviewed, which will take about 45 minutes.

Sara would be happy to answer any further questions you may have regarding the study.

Thank you.

Head of Midwifery
Contact for further information:
Mrs Sara Denham, PhD Student
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
Tel: 01224 262650 Email:s.h.denham@rgu.ac.uk Mobile/Text: 07964 890386

Professor Ruth Taylor, Associate Head of School
School of Nursing and Midwifery
Robert Gordon University
Tel: 01224 262908 Email: ruth.taylor@rgu.ac.uk

Tracy Humphrey, PhD
Clinical Professor of Midwifery
School of Nursing and Midwifery
Robert Gordon University/NHS Grampian
Tel: 01224 262615 Email: t.humphrey1@rgu.ac.uk

If you are willing to take part in this study, please complete this form and return it to Sara Denham in the envelope provided.

She is trying to include stakeholders with differing experiences of Community Maternity Units and asks for this information about you so that she can monitor the characteristics of the study sample.

I may be interested in taking part in this study. You may contact me as stated below to discuss it further.	
Name	
Professional Grade (e.g. Band 6)	
Main work location(s) (e.g. Obstetric unit/CMU)	
Contact information (please tell me how and when you would prefer to be contacted about the study)	

Thank You. You can return this form using the envelope provided, or contact me at: E-mail s.h.denham@rgu.ac.uk. Tel 01224 262650 Mobile/Text: 07964 890386

Study no: 12/NS 0055

Version 4 24/04/12

APPENDIX 14: STAKEHOLDERS INTERVIEW TOPIC GUIDE

1. Introduction

- Outline purpose of interview
- Ensure participant has read information sheet
- Discuss confidentiality and audio recording
- Opportunity for questions
- Revisit consent form and ensure participant has a copy.

2. In relation to views and attitudes to CMU

Lets start with your background and how you came into your role…

Tell me about your role and responsibilities?

Can you tell me what it's like working in/with the CMU?

What's good about working here at the CMU (or with the CMU)? …ask for an example of a positive experience.

Is there anything not so good about working here (or with the CMU)?.....ask for an example of a negative experience.

What are your perceptions of the service you or they are providing to women and their families?

What do you feel are the moments in the women's maternity journeys that shape their overall experience?

What would help to improve the services you offer?

Safety

Based on your experience, how do you feel about the **safety** of care provided at the CMU? (e.g. environment, collaboration)

Ask for examples

What do you feel makes a safe service?

How do you contribute to that?

What is the working relationship like with the referral Consultant Unit? Examples of transfers, communication etc

Effectiveness

And in your experience, do you have any views on the **effectiveness** of the care provided at the CMU? (e.g. right intervention and outcomes, care and services, right care at the right time?)

Ask for examples

How is this measured and monitored?

Person-centred

How do women make choices about accessing care at the CMU?

What information is given to them and what advice do they receive?

What do you think influences their decisions?

How do you manage cases where women want to access care or give birth in the CMU, but they are not clinically eligible to do so? (looking for policy, referrals, management, care etc) Examples……

What affect do women's choices have on staff?

How do you see the future of rural midwife led maternity services?

What services do you think they should or should not be providing?

Anything you would like to add?

3. Any other questions, comments and general discussion

Thank the participant for their time, giving further reassurances about anonymity and confidentiality. Ask them if they would like to receive a summary of the findings.

APPENDIX 15: AIDE MEMOIRE DIARY PAGE EXAMPLES

Your Pregnancy Diary

Study no 12/NS/0055
Version 6 6/5/12

ROBERT GORDON UNIVERSITY • ABERDEEN

Your Pregnancy Diary

Thank you for taking part in this study and agreeing to keep a pregnancy diary.

Your diary is for you to record your thoughts and experiences of care during your pregnancy, labour and giving birth. Try to remember to note down any information you are given and how this has influenced you, and the decisions you make.

For example, you may want to write about any appointments you have with your midwife or doctor or about discussions with your partner, family members and friends. It may even be something you read or see on television that makes you perhaps think about where you would like to give birth to your baby. Feel free to write about anything that is important to you.

The diary is yours to keep at all times, and will not be read by any midwives or doctors caring for you, or the researcher, unless you choose to show it to them.

There are pockets in the diary for you to store any pictures or cards that you may like to keep.

ROBERT GORDON UNIVERSITY • ABERDEEN

Your Pregnancy Diary

How to complete your pregnancy diary

Use each page of your diary to record any events that may have happened to you since your first interview.

You may have heard, seen or read about something, which makes you think about the decisions you make during pregnancy. If this happens, writing it down will help us to understand what influences your decisions.

There are two pages for each two weeks of your pregnancy.
Please use these sections to write down your experiences of care or any events that happen during your pregnancy that affect how you feel. Feel free to write more than one entry for the two weeks.

After the birth, there is a large section for you to write down your thoughts, feelings and experiences of labour, giving birth and your care after the birth.

At the back of the diary there is space for you to make comments about anything else you feel is important to you.

ROBERT GORDON UNIVERSITY • ABERDEEN

Your Pregnancy Diary

12th and 13th weeks of pregnancy

What has happened to you this week? Have you had an ante-natal appointment with your midwife or doctor at your Community Maternity Unit? If you have, what information were you given? Were any plans made with you for your ongoing care?

Your Pregnancy Diary

12th and 13th weeks of pregnancy

What are your thoughts and feelings about your pregnancy and the care you have been given so far? Have you made any plans about where you would like to give birth yet? What has influenced the plans you have made?

ROBERT GORDON UNIVERSITY • ABERDEEN

Your Pregnancy Diary

36th and 37th weeks of pregnancy

Have you been thinking about the birth of your baby? What have you most been looking forward to? Do you have any concerns? What about after your baby's birth? Are all your questions being answered?

ROBERT GORDON UNIVERSITY·ABERDEEN

Your Pregnancy Diary

After the birth...

How do you feel about your labour? Did you feel prepared for it? What do you feel about the care you received? Is there anything else you would like to tell us about? What have you named your baby? Where was your baby born? Tell us about your baby...

Your Pregnancy Diary

After the birth...

On reflection...
Do you feel that you made the right decision about where to give birth? Did you have the right amount of the information you needed to make your decisions? Was the birth of your baby as you expected it to be? What would you do differently next time if you have another baby?

ROBERT GORDON UNIVERSITY·ABERDEEN