

Community Midwives views of postnatal care in the UK; a descriptive qualitative study

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1 ABSTRACT

2 Objective

3 To explore views and experiences of community midwives delivering postnatal care.

4 Design

5 A descriptive qualitative study design undertaking focus groups with community midwives and
6 community midwifery team leaders.

7 Setting

8 All focus groups were carried out in community midwifery care settings, across four hospitals in two
9 NHS organisations, April to June 2018 in the West Midlands, UK.

10 Participants

11 47 midwives: 34 community midwives and 13 community midwifery team leaders took part in 7
12 focus groups.

13 Findings

14 Inductive framework analysis of data led to the development of themes and sub-themes relating to
15 factors influencing discharge from hospital, strategies to address increases in discharge and the
16 broader challenges to providing care. Conditions on the postnatal ward and women's experiences of
17 care in the hospital were factors influencing timing of discharge from hospital that resulted in
18 community midwives managing women and babies with more complex needs. In order to manage
19 increased workloads, there was growing but varied use of flexible approaches to providing care such
20 as telephone consultations, postnatal clinics, and maternity support workers.

21 Key conclusions and implications for Practice

22 In a context of short postnatal hospital stays, community midwives appear to be responding to
23 women's needs and service pressures in the postnatal period. Wider implementation of specific
24 strategies to organise and deliver support to women and babies may further improve care and
25 outcomes.

26 KEYWORDS:

27 Maternity, community midwives, early discharge, bed shortages, postnatal

28 LIST OF ABBREVIATIONS

29 Community Midwives (CMW)

30

31

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33

34

35 INTRODUCTION

36 Globally, providing practical, safe and cost-effective postnatal care services for women and babies is
37 challenging for policy makers and health professionals (Lynette and Roberta, 2017). The home and
38 community environments are important for early postnatal care in high income countries,
39 particularly as many women spend shorter duration in hospital (Harron et al, 2017). Good postnatal
40 care is crucial to prevent adverse maternal and neonatal outcomes and to provide support during
41 the adjustment into motherhood for first time mothers (Zardorznyj, 2006; Bick et al, 2011; Sacks and
42 Langlois, 2016).

43 In the UK most women receive care from the National Health Service. In the hospital, postnatal care
44 is provided by midwives and obstetricians. Once women and babies are discharged from hospital
45 care following the birth, care is transferred to Community Midwives (CMWs), who are usually
46 employed by and linked to the hospital where the woman gave birth. Postnatal CMWs'
47 responsibilities include supporting breastfeeding, monitoring and minimising the risk of maternal
48 and neonatal postnatal complications (e.g. infection, weight loss and jaundice in babies), recognising
49 the need for readmission to hospital (Metcalf et al, 2016). In many parts of the UK Maternity
50 Support Workers provide support to CMWs by undertaking a variety of responsibilities (such as
51 providing educational information and breastfeeding support) (Hussain et al, 2011), though this
52 varies between hospitals (Griffin et al, 2010; Hussain et al, 2011; Taylor et al, 2018).

53

54 Postnatal care in the community usually involves a minimum of three home visits by a CMW or
55 Maternity Support Worker, with additional visits where required. In some areas of the UK,
56 community postnatal clinics have been introduced to replace some home visits, to try and improve
57 organisation of care by increasing time efficiency, offering women more choice and thus improving
58 satisfaction for women and midwives (Lewis, 2013). Most women and babies are discharged from
59 community midwifery care to their Health Visitor (community nurses responsible for health and
60 development of babies and children) and General Practitioner (community doctor) around 10 days
61 after they give birth, but can remain under CMW care until six weeks after birth (Demott et al, 2006;
62 Public Health England, 2015).

63 The length of time that women stay in hospital for postnatal care has reduced considerably. Where
64 45% women stayed in hospital for 7 days in 1975, 2% of women did so in 2017-2018 in the UK (NHS
65 digital, 2018). The UK has been recognised as having the shortest postnatal stay for singleton vaginal
66 births amongst high-income countries (Campbell et al, 2016), where women are expected to be
67 discharged within 1-2 days (Malouf, Henderson, and Alderdice, 2019). This is in part due to the
68 growing pressure on resources and a decrease in the number of available hospital beds across the

69 NHS (Bowers and Cheyne, 2016; Kings Fund, 2020) but also led by women who report that they
70 prefer the conditions at home after giving birth (Malouf, Henderson, and Alderdice, 2019).

71

72 These trends in shorter duration of hospital stay are reflective of other high resource settings and
73 countries (Jones et al, 2016; Benahmed et al, 2017). For example, average length of maternal
74 postnatal stay in hospital decreased from 5.1 days in 1991 to 3.7 in 2000 in Australia, which is
75 comparatively longer than United States (2.6 days in 2008) and Canada (2.4 days for vaginal birth)
76 (Ford et al, 2012). The reduction in length of stay in hospital after giving birth comes despite the
77 increasing complex needs of women who become pregnant (Essex et al, 2013). Complex care needs
78 can be medical or social. The average age of mothers has increased from 26.4 years in 1975 to 30.4
79 in 2017, and women are more likely to be obese (Linton et el, 2020) and to have existing medical
80 conditions (Knight, 2019). Postnatal care in the context of shorter hospital stay, and increased
81 requirements for women with complex pregnancies, or recovering from birth can result in negative
82 experiences amongst women and create pressure amongst postnatal services (Bick, Duff and
83 Shakespeare, 2020; NICE, 2020).

84 The postnatal period is a crucial time in women’s maternity journey that impacts both physical and
85 mental maternal health (Bick, Duff and Shakespeare, 2020).

86

87 The increased needs of women in the postnatal period in the context of earlier discharge from
88 hospital has contributed to rises in CMWs workloads (Suleiman-Martos et al, 2020). A quantitative
89 survey of CMWs conducted by the Royal College of Midwives suggested that postnatal care is
90 delivered on a resource-led rather than needs-led basis with nearly two thirds (65%) of CMWs
91 planning the number of postnatal visits they made to women based on organisation pressure in
92 comparison to 23% who based the number of these visits on women’s needs (RCM. 2014). Research
93 has also shown that midwives in the UK report high incidences of burnout, where levels of support
94 and greater ability to manage work-life balance around workloads could be protective factors for
95 CMWs providing care (Yoshida and Sandall, 2013; Suleiman-Martos et al, 2020).

96

97 In the UK context, where services face increasing clinical complexity, shorter hospital stays, ongoing
98 challenges in women’s experiences and midwifery workloads, identifying approaches to improve
99 community postnatal care are long overdue (Bick et al, 2011). These challenges are likely to be
100 relevant outside the UK setting. While there is a range of literature surrounding UK women’s
101 experiences of postnatal care, we have not identified evidence exploring this period from the
102 perspective of professionals (Malouf, Henderson and Alderdice, 2019; Goodwin et al, 2018). The aim

103 of this study is to address this gap, exploring CMWs' experiences and perspectives of their role in
104 delivering quality postnatal care in the context of increasingly short hospitals stays, and findings are
105 likely to resonate with postnatal care in other countries.

106 METHOD

107 Design

108

109 A descriptive qualitative study using focus groups was undertaken to provide a rich description of
110 CMWs views and experiences of delivering community postnatal care (Bradshaw 2017). Focus
111 groups were deemed appropriate method for encouraging discussions within teams, exploring
112 topics, enabling participants to debate different perspectives, and to compare and contrast views
113 between different teams and settings (Krueger and Casey, 2014).

114

115

116 Participants and setting

117

118 The study took place in two adjacent, NHS 'trusts' (a local area organisational unit), in a diverse,
119 urban area of the West Midlands, UK. The organisations care for approximately 20,000 births per
120 year, across four hospitals and 17 community-based midwifery teams. Midwifery support workers
121 were also part of the community postnatal team. All participants were CMWs employed by the
122 included organisations. Participants included 'Band 6' CMWs (with at least one-year post-
123 qualification experience), and 'Band 7' CMWs team managers and all participants were providing
124 postnatal care to women and babies. NHS staff are paid according to a banding system, starting from
125 2 ranging to 9, with roles and pay increments defined for each band. Each of the 17 teams had an
126 office 'base' in the community, often a primary care surgery/centre, and provided care to women
127 registered with local general practitioners.

128

129 Sampling and recruitment

130

131 Research has illustrated how using purposeful and convenience sampling alongside each other can
132 be useful to promote participation amongst midwives (Baker, Gillman, and Coxman, 2020). We
133 recruited a convenience sample of community midwives from across the organisations, arranging
134 five focus groups at convenient times in community midwifery team offices purposively selected for
135 maximum spread across the catchment area (three at one trust, two at the other). CMWs who were

136 on duty on the day, available and willing to take part, participated in focus groups. We purposively
137 sampled Band 7 team managers to participate in a further two separate focus groups, one at each
138 NHS trust. All 17 managers were eligible to take part and were contacted directly by email, with
139 focus groups arranged at a convenient time. Community matrons and community midwifery team
140 leaders were informed about the study and asked to distribute participant information leaflets at
141 least one week before the focus groups took place. Focus groups sites included Children’s centres,
142 General Practices, and hospital meeting rooms.

143

144 *Inclusion and exclusion*

145 Participants were eligible for taking part in the research if they were CMWs or team managers.
146 Participants were excluded if they were midwifery students, and midwives who did not work in the
147 community, as the study’s focus was on experienced midwives currently delivering postnatal care.
148 More junior midwives (Band 5 midwives) were not excluded but were not present at any of the focus
149 groups.

150

151 Data collection

152

153 All participants provided written consent. Demographic information was collected to contextualise
154 the findings and ascertain the representativeness of the sample. Focus groups were conducted
155 between April and June 2018 by two researchers with previous experience in qualitative research
156 with one acting as moderator and the other a facilitator (roles shared between FK, LG and a member
157 of the wider research team). Focus groups were audio recorded, and researchers took fieldnotes.
158 Discussions were structured using a topic guide (Appendix 1) based on the relevant literature and
159 covered questions on; transfer from hospital, care provided at home, referrals, workload, and areas
160 for improvement. Effort was made to maintain a balance between more dominant and quieter
161 participants.

162

163 Ethical approval was gained from University XXX Ethics committee reference (ERN_17-0858).

164

165 Data analysis

166

167 Consistent with a qualitative descriptive approach, data was analysed thematically (Bradshaw 2017).
168 The framework method of thematic analysis was selected because it is a widely applied and
169 recognised method of qualitative data analysis used in health services research which enables the

170 systematic management and interrogation of the data. All stages of analysis were undertaken by FK
171 (psychology/social researcher) and EJ (midwife/researcher) and with input from BT (public health
172 doctor/researcher) and SK (midwife/researcher) in refining the framework and interpreting data.

173

174 The seven stages of the framework method were used (Ritchie and Spencer, 1994). Recordings were
175 transcribed (verbatim) and anonymised. Transcripts were read and re-read, followed by
176 independent inductive, line-by-line, open coding of two transcripts. Initial codes were reviewed and
177 discussed, and subsequently with members of the research team to develop a working analytical
178 framework of codes and categories. FK and EJ then applied the framework to the rest of the data
179 and quotes and summaries were charted into a framework matrix. Descriptive and interpretive
180 summaries were written and used to interpret and contextualise the data that linked the final
181 presentation of themes (Gale, 2013). Major themes and their sub-themes were presented
182 chronologically (in order of events in the 'postnatal period'), to showcase the order in which they
183 were discussed. Frequent meetings enabled reflection on the developing analysis and role of the
184 researchers. There was consensus and agreement for most of the focus groups, and nuanced
185 experiences of specific CMW teams were highlighted to develop the themes. Data saturation was
186 achieved. NVivo 10 software was used to organise the data and support development of the
187 framework matrices.

188

189

190

191 FINDINGS

192

193 Participants

194

195 Seven focus groups were carried out with 47 participants including 34 CMWs and 13 Band 7 team
196 leaders. Five groups included Band 6 midwives, and two groups included Band 7 midwives only. A
197 Band 7 was present in one Band 6 focus group with the consent of other members. There were 4 to
198 10 participants per group and discussions lasted between 35 to 70 minutes.

199

200 Further information on characteristics is provided in table 1.

201

202 Table 1. Demographics and characteristics of participants

Age (years)	20-29	30-39	40-49	>50
	3	12	15	17
Ethnicity	White	Mixed	Black	Other
	37	3	5	2
Years employed as CMW	1-5	6-10	11-15	>15
	9	9	5	24
NHS Employment Band	6	7		
	34	13		

203

204 CMWs views on postnatal processes

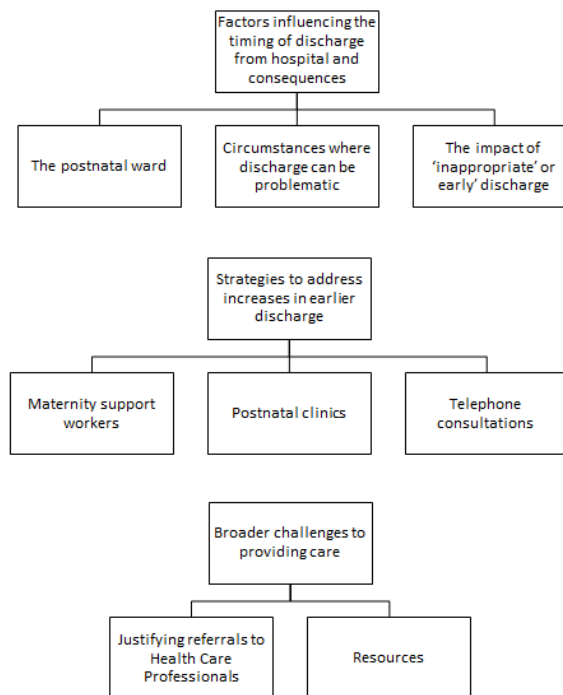
205

206 We present three main themes (and sub-themes) relating to CMWs experiences of providing
207 postnatal care, and chronologically reflecting women’s journeys through the care pathway. The first
208 theme concerns factors influencing the timing of postnatal discharge including CMWs’ beliefs about
209 pressure on the postnatal ward, and women’s experiences of care received on the ward,
210 contributing to shorter hospital stays. The second theme ‘strategies to address these increases in

211 earlier discharge' focuses on approaches to managing workload including maternity support
 212 workers, postnatal clinics and telephone consultations. The final theme, 'broader challenges to
 213 providing care' describes communication issues between healthcare professionals and reliance on
 214 technology. Descriptions are included to highlight whether the focus group consisted of CMWs or
 215 CMW team leads. Each theme and its sub-themes are illustrated in table 2.

216

217 Table 2. Themes and sub-themes



218

219 *Factors influencing the timing of discharge from hospital and consequences*

220

221 CMWs discussed their experiences of providing postnatal care in the community, but also their
 222 beliefs about the conditions on the postnatal ward (based on prior experience of working in the
 223 hospital) whilst managing safety and care quality concerns. Whilst discussing earlier discharge
 224 (shorter stay in hospital), CMWs in all focus groups noted bed shortages on the postnatal ward as a
 225 factor influencing 'inappropriate' discharges. Discharge was deemed 'inappropriate' if women or
 226 babies had significant care needs that would require constant monitoring, a complex or traumatic
 227 birth, issues establishing feeding or required referral back to the hospital (such as for jaundice,
 228 weight loss or infection).

229

230 The postnatal ward

231

232 There was an emphasis on the limited capacity on the postnatal wards affecting the duration of
233 hospital stay. As a consequence of the limited availability of beds, CMWs recounted that staff were
234 prioritising women with the most urgent medical needs and discharging other women which in the
235 CMWs view, should remain in hospital for example for repeat blood tests and blood pressure
236 monitoring.

237

238 "When the department gets busy or the hospital gets busy and you know, there's more women on
239 delivery suite that need a post-natal bed, they go round and look at which ladies can go home. And if
240 you're well and you can go home, and the community midwife can do the next blood test and they
241 send you home."

242 (CMW: focus group 5)

243

244 CMWs referred to incidences where women chose to be discharged from hospital due to their
245 family's and personal expectations around time spent in hospital, or a lack of satisfaction with care
246 (in four focus groups). CMWs recognised that women who were motivated to be discharged were, at
247 times, risking their health in order to recover in more comfort at home adding to the care burden of
248 the CMWs who would need to monitor them closely.

249

250 "I'll take the self-discharge and the doctor said, if you go you might die and all this, sign your life
251 here woman. And then you get home and then the woman is happy...as soon as they get in the front
252 door they go upstairs and it all happens because she's got her creature comfort, she feels better, she
253 can sleep in her own pit. And the baby is then more relaxed, she is more relaxed "

254 (CMW: FG 2)

255

256 Circumstances where discharge can be problematic

257

258 CMWs across all focus groups acknowledged the greater risk of early discharge for first time mothers
259 (nulliparous women, particularly those breastfeeding), women having difficulty establishing feeding
260 or infants likely to develop jaundice.

261

262 "I think first time breast feeders do tend to come home too early and I do try to
263 say to women, 'If you are planning on breast feeding, don't come home until you
264 are happy you can latch that baby on'...we go in the next day, by which time their
265 nipples are shredded... it's because they've come home too early."

(CMW: focus group 3)

267

268 CMWs frequently highlighted circumstances (such as after a caesarean section or difficulty
269 establishing breastfeeding) when a short hospital stay could be particularly inappropriate (in six
270 focus groups). CMWs reported that social support from family and friends could act as a vital 'buffer'
271 for protecting women's emotional and mental well-being during this adjustment period if women
272 were sent home earlier or with on-going issues (in five focus groups).

273

274 "If a lady's had a really traumatic time and then she's sent home quite early, I
275 really worry about those women, about what's going to happen, what support
276 have they got at home? Have they got adequate support from mum, partner,
277 you know, is the partner on paternity leave, is he going to be there for her? Or is
278 she going to go home on her own and be left with this baby to cope and then end
279 up really depressed?"

(CMW: focus group 2)

281

282 The impact of 'inappropriate' or early discharge

283

284 CMWs considered the additional care needs, particularly for first-time mothers, as a crucial part of
285 their responsibility, while acknowledging that it could contribute significantly to their workload (in
286 five focus groups).

287

288 "We're only staffed to do the primary visit, the day five visit and the day ten visit. All
289 the others which these early discharges need because of feeding, jaundice, wound
290 breakdown, perineum breakdowns, they need a lot more visits so we're stretched so
291 thin now because we're doing all these extra visits when in actual fact if they stayed in
292 hospital for, say, an extra day, they wouldn't need half as many "

(CMW: focus group 5)

294

295 In some instances, CMWs reported making modifications to their visiting patterns in order to
296 accommodate women’s needs, and contrasted this to other organisations where CMWs have
297 restrictions or limited capacity to operate outside of postnatal clinics or routine visit allowance (in
298 three focus groups).

299

300 “We don’t do a first day, a day five and discharge at day ten and I think some trusts are quite rigid
301 they have clinics and they see them on those dates. I think we’re lucky in we can use our own
302 professional judgment and if somebody needs that extra support or extra visits, at the moment, the
303 trust allows us to give individualised care cause we are responsible up to twenty-eight days, not day
304 ten”

305 (CMW: focus group 3)

306

307 Discharge care plans from the hospital requiring repeat tests (e.g. daily blood pressure checks), were
308 described by CMWs in four focus groups as being particularly labour intensive;

309

310 “Daily blood pressures for two weeks... It just increases your workload, the
311 woman’s fed-up of seeing you but also if she needs daily (checks), they’re that
312 worried about her blood pressure, should she be home?”

313 (Community midwifery team leaders focus group 1)

314

315

316 *Strategies to address increases in earlier discharge*

317

318 CMWs discussed the use of Maternity Support Workers and Maternity Assistants, postnatal clinics,
319 and telephone consultations to manage their workload.

320

321 Maternity Support Workers

322

323 Maternity Support Workers and maternity assistants provided support under the supervision of
324 CMWs, such as undertaking routine observations (e.g. providing feeding support)..

325

326 CMWs described benefits and challenges of working with Maternity Support Workers (in six focus
327 groups). There was variation in access to this support across the teams and; Maternity Support
328 Workers conducted home visits (usually day 5) in three teams, Maternity Assistants provided
329 support in clinic in three teams, and provided additional breastfeeding support to two teams.

330

331 CMWs in two focus groups (one team leaders and one from CMWs in a different trust) reflected
332 positively on the role of Maternity Support Workers and Maternity Assistants.

333

334 "...We've got that at the breastfeeding support I suppose going back now to
335 people that haven't had that support in the hospital setting, but we've got our
336 MA's who are good with that, you know, if we do need that extra support say for
337 feeding issues or even sterilisation, breastfeeding. I suppose that's where we fill
338 in the gap"

339 (CMW: focus group 4)

340

341 However, there were differing views on the use of Maternity Support Workers in three
342 focus groups as Maternity Support Workers were not always readily available.

343

344 "Even though she's [Maternity Support Worker] ours, she's still helping other
345 teams which is a bit frustrating cause we've got one, other team got two.

346 (CMW: focus group 1)

347 Postnatal clinics

348

349 CMWs described that postnatal clinics are usually run in a General Practitioner surgery or
350 community centre, where CMWs (or Maternity Support Workers) can review women and babies'
351 condition. CMWs in all seven focus groups described postnatal clinics as a practical solution for
352 managing increased workloads as they minimised home visits. CMWs also accentuated that some
353 women would prefer a choice of being seen by a midwife at home or at a clinic.

354

355 "A lot of the women that we see in the area we work in, they're two, three, four children so you
356 then have to tailor your visit around trips to school, nursery, etc. so they don't want to be tied down.
357 Often, we'll go in on day two and they're not there, they're out shopping, doing whatever, so trying
358 to get those women pinned to a visit at home, a postnatal clinic would be the best idea. So, even
359 their first visit could be at the postnatal clinic". (CMW: focus group 5)

360

361 In particular, CMWs focus group (three from the same trust) described the importance of postnatal
362 clinics at GP surgeries and children's centres for highlighting access to support groups and activities
363 (four focus groups);

364

365 "Ours (postnatal clinics) is used really well ...they can go to the children's centre, and get the
366 timetable for like baby massage, and mums and baby groups, and stuff like that".

367

(Community midwifery team leaders focus group 1)

368

369 CMWs identified the postnatal clinics as an ideal location for providing discharge appointments (in
370 five focus groups).

371

372 "Usually by about day ten they're ready to be up and about...and by day 15, definitely. So, I think
373 if you haven't discharged them on day 10...the next time they can be discharged in the clinic"

374

(CMW: focus group 5)

375

376 CMWs reflected on their past or present experiences with postnatal clinic in all focus groups. While
377 understanding the need for postnatal clinics they reported several concerns (especially for earlier
378 visits on day 1 or 5); fixed appointments meant women cancelled at short notice or did not attend,
379 women recovering from Caesarean-sections or procedures may take longer to recover; and limited
380 social support, transport and understanding of the appointment could be a barrier to attendance.
381 CMWs also highlighted a risk of de-personalisation in clinic instead of in the home where it was
382 easier to provide more holistic assessment, including identification of safeguarding concerns;

383

384 "There's no doors on her flat, he's taken the doors off, so she can't hide. You wouldn't see that
385 in a post-natal clinic".

386

(CMW: focus group 3)

387

388 Telephone consultations

389 CMWs in one focus group described that a telephone consultation is where a CMWs or Maternity
390 Support Worker will contact the mother via telephone to discuss their condition and assess whether
391 a face-to-face meeting is required. 'Phone-call consultations' were mentioned in one of the team
392 managers' focus groups as a useful alternative to a home visit, providing another example of how

393 CMW can find ways to assess needs and offer individualised care without increasing their workload
394 through visits.

395

396 "Day 5 is sometimes done by maternity assistants. We'll do a phone call
397 consultation, if there's a concern with mum or the baby and the concern needs
398 acting on, or we'll do a phone call consultation the next day."

399 (Community midwifery team leaders focus group 2)

400

401 Verbal information alongside observations made in earlier visits could be used to conclude if a visit
402 was necessary, or if workload could be managed more efficiently.

403

404 *Broader challenges to providing care*

405

406 CMWs identified other areas of community work that affected postnatal care delivery. Managing
407 communication and relationships with healthcare professionals and limited resources were amongst
408 the most apparent issues.

409

410 Justifying referrals to Health Care Professionals

411 CMWs drew attention to their interactions with other healthcare professionals, and how questions
412 about their clinical decisions affected interprofessional relationships. CMWs stressed the need to
413 justify and defend their decisions (in six focus groups).

414

415 "We're all very experienced Midwives here, we all know what we're doing, we've
416 all been out to the community, I've been out for nineteen years, if I've got a baby
417 I'm really worried about, then I don't need to fight my corner about it...it needs
418 to be reviewed now, I do know what I'm talking about. And to have to fight to get
419 this done is unacceptable. We don't send them in willy-nilly [colloquialism for
420 haphazardly], you know, most things we can address at home ourselves, but
421 serious issues such as excessive weight loss and jaundice and what have you, it
422 needs to be seen in the hospital."

423 (CMW: focus group 3)

424

425 CMWs in two focus groups gave accounts of the impact of such interactions, resulting in them
426 feeling embarrassed and frustrated in front of women and their families.

427

428 " It's hard as well sometimes.... when you're trying to get a postnatal woman back up to triage for
429 something and they will fight with you on the phone and it's in front of the, in the house, with her
430 partner and it's so difficult, so difficult"

431 (CMW: focus group 2)

432

433 In addition to the increasing postnatal care workload, CMWs highlighted the challenges of dealing
434 with the resistance from other health care professionals in re-admitting women or babies to the
435 hospital.

436

437 Resources

438 CMWs also stated that limited availability of resources in the community affected their ability to
439 plan their visits or undertake their work (in six focus groups). One team expressed their
440 discontentment with resources given the context of earlier discharge;

441

442 "I just think you need more resources out here."

443 "To impact on that."

444 "Yeah, to go with the early discharge."

445 "If you're going to have an earlier discharge."

446 (CMW: focus group 1)

447

448 CMWs in two focus groups and one community midwifery team leaders' focus groups from the same
449 trust reported frequently sharing equipment within their team and dedicating time to dropping off
450 medical devices to assist other midwives unexpectedly. Transcutaneous bilirubin tests (to measure
451 bilirubin through the skin using a device) for jaundiced babies often necessitated searching for
452 available and functioning bilirubin meters, making visits less efficient.

453

454 CMWs in two focus groups from differing trusts pointed out that some equipment shortages would
455 not be an issue if women who required further medical testing remained in hospital. CMWs also
456 mentioned issues with IT equipment resulting in compromised communication with other teams, the
457 trusts and hospital, and limited access to medical records (in four focus groups).

458

459 "...there's me sitting having a meltdown. Our technology is horrendous, our
460 phones, our iPads."

461 (CMW: focus group 3)

462

463 For CMWs in two focus groups from the same trust, simple office equipment was an additional
464 obstacle, where outdated and faulty equipment complicated their ability to work. Not being able to
465 receive faxes with information on discharged women and babies from the hospital would mean that
466 visits were missed and important information is not relayed quickly enough to the CMWs. This was
467 important where hospitals or trusts relied on a particular method (e.g. fax machines) for
468 communication;

469

470 "I can't send her scan referral because I haven't got a fax machine."

471 "And they won't accept a referral over the phone, will they?"

472 "So, you have to drive to the hospital."

473 (CMW: focus group 1)

474

475 Some CMWs reported feeling powerless to change the situation.

476

477 "We've brought up complaints about the iPads and that, we've been told '(work) with what you've
478 got, get used to it. Accept it.' There's no discussion, no, until something goes wrong and then we're
479 in trouble"

480 (CMW: focus group 3)

481

482 DISCUSSION

483

484 This is a recent and in-depth exploration of CMWs' views of postnatal care in community settings in
485 the UK. The findings show how some CMWs identify and provide individualised care for women and
486 babies, and identifies potential approaches to safely manage their increasing workloads.

487

488 One of the key findings of this research is CMWs' perceived that the primary factors influencing the
489 decision for discharge from hospital are about resources and capacity in the hospital, rather than
490 mothers' needs. CMWs did suggest, however, that once discharged into the community, some were
491 responding to individual need and providing care by tapering more or less support to women as they
492 required. Measures to reduce cost and alleviate the burden on postnatal ward staff will continue to
493 have repercussions for community practice. Our study supports the notion that care provided in the

494 postnatal period is the ‘Cinderella’ service in comparison to antenatal or intrapartum care, and post-
495 birth care needs to be strengthened and further developed through CMWs ability to provide care in
496 countries such as the UK and Australia in order to improve women’s satisfaction (Crowther, MacIver
497 and Lau, 2019; Bick, Duff and Shakespeare, 2020).

498

499 There may be benefits to providing personalised care in the community, and within healthcare the
500 boundaries of what can and should be provided in a more comfortable community setting are
501 increasingly stretched (Winpenny et al, 2016). However, it is only possible if CMWs have the
502 resources and support to put the care in place. CMWs in this research recognised Maternity Support
503 Workers as a valuable resource whose skills could be more efficiently integrated, though midwives
504 remain accountable and there are limits to task-shifting. The use of Maternity Support Workers was
505 discussed positively by most CMWs, but with varied use across the teams. Research suggests that
506 the midwife-maternity support worker relationship can be challenging, due to the limited definitions
507 of their role (boundaries and responsibilities), training, and retention issues (Cantab, Cantab, and
508 Page, 2009; NHS, 2011; Naiman-Sessions, Henley and Roth, 2017).

509

510 As a mechanism for managing postnatal care, postnatal clinics have been introduced to try and
511 improve organisation and efficiency with implications for improved choice and satisfaction for both
512 women and midwives, but this remains to be fully explored (Lewis, 2013; Marsh et al, 2015).

513 Postnatal clinics could be a practical solution to help manage the increasing burden for CMWs,
514 however, as noted in our findings, they should be used with caution as they may not be suitable for
515 all women or replace earlier visits, where crucial observations (for women’s and babies’ clinical
516 condition and social needs) could be made. As an alternative to managing workloads the CMWs in
517 the present study noted use of postnatal clinics for discharge appointments (where women and
518 babies are discharged from maternity services to the care of their general practitioners and health
519 visitors), but greater considerations would be required in terms of when and for whom
520 appointments are appropriate in order to individualise care. In the current UK climate, postnatal
521 care delivery maybe slowly shifting from home visits to postnatal clinics to increase cost-efficiency,
522 but women still rate home visits as more satisfactory (Marsh et al, 2015). A similar model has been
523 applied in Canada (where women in some regions received postnatal visits by midwives on days 1, 5
524 and 10) and was successful in reducing postnatal ward length of stay by supplementing post-
525 discharge care with postnatal clinic appointments accompanied with follow-up visits for those that
526 did not attend. It was considered a suitable model due to its potential to be developed in the context
527 of decreasing hospital stay (Hardy et al, 2018).

528

529 During the discussions CMWs described some approaches they used to manage their workload. The
530 benefits of using telephone consultations were highlighted by some CMWs in this study to ascertain
531 if face-to-face visits are required. This could provide a way plausible way to mitigate risks while
532 providing safe and suitable care. The COVID-19 pandemic has resulted in the application of these
533 strategies being tested in practice due to the external forces driving this change (Jardine et al, 2020;
534 Homer et al, 2020), but further evaluation is required. Use of audio-visual devices holds prospects
535 for maternity services where videoconferencing equipment has shown positive qualities in helping
536 parents discharged from hospital early (Lindberg, Christenson, and Ohrling, 2009; Taylor et al,
537 2019b).

538

539 Better communication between healthcare workers in hospital and community would result in
540 enhanced mutual respect and understanding of work demands, and functioning IT equipment would
541 further support improvements. There is a rapid move towards digital maternity records in the UK
542 which may mitigate some of the communication issues mentioned in this research (NHS Digital,
543 2020b).

544

545 Relieving the pressures on the postnatal ward together with preparing women for postnatal life at
546 home would support CMWs in managing earlier discharge, together with the need to have flexibility
547 around home visits, and appropriate alternative strategies (such as visits from Maternity Support
548 Workers, postnatal clinics or telephone consultations).

549

550 Implications for practice

551 Maternity services need to be responsive to individual women's needs and preferences. (National
552 Maternity Review, 2016; NHS England, 2019; Commonwealth of Australia, 2018) and this research
553 suggests that this is happening in the postnatal period. The findings shed light on the pressures on
554 the postnatal ward resulting in women being sent home sooner, and the perspectives and
555 experiences of CMWs have highlighted a number of flexible approaches to manage workload.

556

557 Some of the approaches suggested by the participants could be implemented pragmatically:
558 improving support on postnatal ward to minimise the effects of 'inappropriate' early discharge,
559 identifying women's needs better pre-discharge, improving communication between midwives,
560 hospitals, community and GP would all mitigate some of the challenges identified. While we have
561 found midwives do personalise care, a more standardised risk assessment may enable more

562 accurate identification of all women and babies who would benefit from additional support, and
563 those who do not need any. While there are benefits associated with risk assessment tools (Wouk,
564 Stuebe and Meltzer-Brody, 2017), caution should be observed if standardising care to ensure
565 women's individual needs and choice are not lost.

566

567 There is a greater emphasis on the ways CMWs might provide postnatal care through approaches
568 that minimise face-to-face contact due to the recent COVID-19 pandemic. Our finding suggest that
569 pre-COVID CMWs were using postnatal clinics and telephone consultations to improve management
570 of workload, so these alternatives do offer potential to increase individualisation, quality and
571 efficiency of postnatal care through remote home monitoring for women and babies, where
572 appropriate.

573

574 Strengths and limitations

575

576 This study is the first in-depth qualitative research exploring CMWs' views of delivering postnatal
577 care in the UK to our knowledge. Findings of this research are from a large and diverse sample of
578 participants, analysed using a transparent and robust method. The diverse multi-disciplinary nature
579 of the team who undertook this work positively impacted the data collection and analytical process
580 which was supplemented by the views of members of the team outside of the midwifery profession
581 This supported challenge and discussion of the data from a blend of perspectives. We did not
582 explore the views of the postnatal midwives or the women, as the focus was CMWs views.
583 Working practices may differ across the UK, however findings from the sample of CMWs from
584 diverse teams in this research may not be generalisable but are likely to be transferable to other
585 maternity services and health systems. Transferability of findings may be limited in terms of
586 international context due to different organisational structures, but they may be useful in countries
587 trying to implement a community care model (such as in Australia) who can learn from examples in
588 the UK.

589

590 CONCLUSION

591

592 Despite increases in both maternal morbidity and workload, CMWs are mostly able to tailor care in
593 response to women's individual needs. Our study suggested that drivers of timing of discharge are
594 resource led and alongside the conditions under which CMWs provide postnatal care this can be

595 burdensome. This is exacerbated by the inconsistent availability of resources such as maternity
596 support workers, and issues with communication and IT. Strategies to manage CMWs increasing
597 workload and the increasing clinical risk of women are promising. These includes potentially
598 deploying maternity support workers more in the community, using postnatal clinics and remote
599 home monitoring through telephone consultations. Postnatal care remains an under resourced
600 aspect of the maternity system and it is crucial to long-term health and wellbeing of the population:
601 this study highlights a need for reform.

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889 Appendix 1: Topic guide

890 **Community midwives' experiences of discharge after birth of mothers and babies: topic**
891 **guide**

892 We would like to take this opportunity to thank you and welcome you to the focus group
893 today. We appreciate the time you have taken to participate and value your views in
894 developing our understanding of community midwives' experiences of the discharge of
895 women and babies.

896 Before we begin, please confirm that you have read through the participant information
897 leaflet and are aware that once the focus groups start we cannot remove your data from the
898 analysis if you wish to withdraw. The discussions will be audio recorded and once it is
899 written up all the names will be removed so that the quotes from these discussions can be
900 used in reports but no-one will know who was involved or who said what. We will follow
901 ethical and legal practice and all information about you will be handled in confidence.

902 In the unlikely event that poor practice is disclosed or if something is said during the focus
903 group that has the potential to cause harm to the women, we have a professional
904 accountability and duty of care to report these issues to the management team within the
905 relevant maternity trust.

906 The purpose of the focus group today is to try and find out about your thoughts and
907 opinions, as well as any problems or solutions for any issues around the provision of good
908 quality care in earlier discharge. Your views really matter in bringing about change and
909 improving services for providers and receivers of care.

910 I would like to focus largely on earlier discharge of mothers and babies but you are welcome
911 to discuss any topics associated with it for example, infant-feeding support that you have
912 had to provide.

913 Now we will go through some of the ground rules for the group:

914 1) Please speak whilst being considerate of your fellow attendees so that we don't miss
915 any important parts

916 2) There is no right or wrong answer as we are interested in your views

- 917 3) To respect each other's' confidentiality we advise limiting discussions to the focus
918 groups and not talking about the content covered today outside of the session
919 4) You can ask questions during or after the focus group

920

921 Does anyone have any questions before we start?

922

923 ***Opening question***

924

925 What usually happens when a woman is discharged from the hospital and into community
926 care?

927 Covering the process from the beginning

928

929 *Questions, prompts and points to address*

930

931 **1) *Transfer from hospital***

932 When women are discharged from the hospital (labour/postnatal ward) to community care

933 - How does the transfer process take place? Who does what?

934 ○ *Prompt*- What is good or bad about this?

935 ○ *Prompt*- How can it be improved?

936 - What information do you receive from the hospital?

937 ○ *Prompt*- How does the hospital tell the team? What access do you have to
938 information? Is there information you would like that you currently don't
939 get? What information would you like?

940 - What information are women given before they are discharged from hospital?

941 ○ *Prompt*- What do women get to know? Are women given any written or
942 verbal information specifically? For example, are they given any notes?

943 - What are the issues?

944 ○ *Prompt*- Have you faced any issues with the information systems/ ward staff
945 availability/ missing information?

946

947 **2) *Care at home***

948 Postnatal visits by community midwives

- 949 - How are postnatal visits usually carried out? Who does the postnatal visits?
- 950 ○ *Prompts*-What happens? How does it work? What is the frequency of visits?
- 951 Are most of them carried out by band 5's/MSWs? Who decides number of
- 952 visits? Which guidelines are used? How do you share the workload? What
- 953 impact do postnatal visits have on workload? Is there access to complete
- 954 kits?
- 955 - What do you think about early discharge?
- 956 ○ *Prompts*- Do you think women get sent home early? Can you think of any
- 957 particular women who are sent home too early?
- 958 - How informed are women about their postnatal care?
- 959 ○ What information do women request at the postnatal visit? What are
- 960 women's expectations? How does this differ for women with earlier
- 961 discharge?
- 962 - What affects your judgement about what postnatal care a woman requests?
- 963 ○ *Prompts*- Clinical: mode of delivery/ vaginal or C-section,
- 964 ○ *Prompts*- Social: home/ safeguarding/ partner/ mental health/ language,
- 965 ○ *Prompts*- Logistic: team availability
- 966 - What about continuity? What is continuity like in postnatal care? (Relational [having
- 967 a relationship with the same caregiver or small team of caregivers over a period of
- 968 time], management [communication of facts and judgements across and between
- 969 teams, professionals and service users], informational [the timely availability of
- 970 relevant information-consider conflicting advice or information])
- 971 ○ *Prompt*- Should it be different? If so, in what way?
- 972 - Do you use postnatal clinics?
- 973 ○ *Prompts*- What are your thoughts on postnatal clinics? How do they work?
- 974 How should they work? (e.g. 1st visit at home and the rest at the clinic).
- 975 - What are the barriers to care delivery?
- 976 ○ *Prompt*- what about staff availability/time? Availability of resources,
- 977 guidelines, mandated visits?
- 978 - How can this be improved?
- 979

980 **3) Referrals**

- 981 - What happens if women need to be referred to another service?
- 982 ○ *Prompts*- How are further tests organised? How are appointments made with
- 983 GPs/ Healthcare visitors/ A&E/ Ambulance/Triage? How are investigations
- 984 leading to referral carried out? E.g. Skin Bilirubin for jaundice.
- 985 - What are the things that you find most problematic?
- 986 ○ *Prompt*- Are there any challenges in making these appointments/referrals?

987

988 Summary

- 989 - What do you think you need in order to care for women?
- 990 ○ *Prompt*-Is there any additional help or support you need? What are your
- 991 thoughts on the information you receive? Would you need more time with
- 992 women in the community? What are your thoughts on the availability of
- 993 equipment?
- 994 - What do you think women need?
- 995 - Based on what you've said today at the focus group, what do you think are the main
- 996 issues?
- 997 ○ *Prompt*- what can we prioritise?

998

999 Is there anything else you would like to add?

1000

1001 Thank you for attending the session today. Please feel free to contact myself or any other

1002 member of the research team if you have any questions.

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1007