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**Using a quality care framework to evaluate user and provider experiences
of maternity care: a comparative study**

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Abstract

Objective. The Quality Maternal and Newborn Care Framework describes the components and characteristics of quality care and emphasises relational and continuity elements. Continuity of care is increasingly a focus of maternity care policy in the United Kingdom. While some outcomes have been shown to be improved, there is uncertainty about why certain models of care are more effective. Our overall objective is to develop a maternity care evaluation toolkit which incorporates this Framework along with other outcome evaluations. An initial step in developing this toolkit was to use the adapted Framework to evaluate perceptions and experiences of maternity care. Our specific objective in this study was to test this adapted Framework in a series of focus groups with key stakeholders, and to compare findings between different groups. Findings related to service users (pregnant women and new mothers) are reported in our accompanying paper; this paper presents findings from focus groups with service providers (midwives and obstetricians), and then compares user and provider perspectives.

Design. A qualitative comparative enquiry involving three focus groups with 26 midwives (eight newly qualified; eight working in a community midwifery unit; and ten senior tertiary-based) and two focus groups with twelve obstetricians of all grades. We used a six-phase thematic analysis to derive then compare the focus groups' principal sub-themes; we then mapped these to the original Quality Maternal and Newborn Care Framework and compared these service providers' responses with those from the pregnant women and new mothers.

Setting. Two health boards in Scotland.

Participants. Midwives and obstetricians who had experience of various models of maternity care.

Findings. There were significant areas of overlap in their perceptions of providing maternity care. All groups reported ‘limited resources and time’; the community midwifery unit and senior midwives and one group of obstetricians provided a critique of the system. Achieving tailored care was acknowledged as a problem by the senior midwives and one group of obstetricians. Only obstetricians discussed strategies for improvement. The newly qualified midwives were most positive in their responses. There was both overlap and contrast when comparing the views of service users and providers. We found most agreement when participants discussed some of the Framework’s characteristics of care in negative terms, such as (in) accessible care, (lack of) adequate resources, and (absence of) tailored care.

Key conclusions. Being able firstly to map the participants’ responses to the Quality Maternal and Newborn Care Framework, and then to identify strengths and gaps in the provision of quality maternity care, suggests to us that the Framework, derived as it is from a comprehensive analysis of the global evidence on quality care, can indeed be used to inform an evaluation toolkit. While aware that we cannot generalise from this limited qualitative study, we are currently undertaking similar work in other countries by which we hope to confirm our findings and further develop the toolkit.

Keywords

Models of care Pregnancy Caseload midwifery Quality of health care
Childbirth Quality Maternal and Newborn Care Framework

Funding

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Introduction

The Quality Maternal and Newborn Care (QMNC) Framework was published in the Lancet Series on Midwifery following an extensive analysis and synthesis of the global literature on quality care by an international group of researchers (Renfrew et al 2014). In the first of these two linked papers (Symon et al 2019, tbc) we set out the context of recent changes in maternity care arising from midwife-led continuity of care, and the need to identify how such models work in order to be able to extend or replicate them. Following Bharj et al's (2016) proposal that the QMNCF can be used as a structure around which improvements in midwifery can be made globally, in 2018 we reported the adaptation of the QMNC Framework for use as a topic guide in evaluating different models of maternity care (Symon et al 2018). This was done in an area of Scotland which provides three of the four models described in a recent global taxonomy of maternity care (Symon et al 2017).

In any evaluation of models of care, obtaining the views of key stakeholders is essential. We therefore assessed the potential for adapting the QMNC Framework for use as a topic guide in focus groups involving pregnant women, new mothers, midwives and obstetricians in a study in eastern Scotland in 2017. The Symon et al (2018) paper described the process of that study. The current paper is the second of two linked reports of the study's findings. It provides contextual detail supporting our claim that the QMNC Framework is a valuable and useful means of assessing perceptions of care and of different models of care. To avoid repetition, the background to and rationale for the study are provided in full in the first of these two linked papers; only brief details are given here.

Since we conducted this study, leading international midwifery researchers published a further call for research using the QMNC Framework (Kennedy et al 2018). These authors claim the Framework should be used to discover the characteristics of midwifery-led continuity of care that provides optimal clinical outcomes in an effort to increase access to high quality care. This proposal strengthens the decision to use the QMNC Framework as an intrinsic part of an evaluation toolkit.

Materials and methods

We refer the reader to our accompanying paper's Methods section. Briefly, and as reported in Symon et al (2018), two Research Assistant (RA) midwives from two Scottish Health Board areas (HB1, HB2) were seconded firstly to help recruit participants and then to facilitate, document and analyse the focus group discussions. The two health boards were chosen because between them they offered a range of models of care: Modified Universal provision including alongside midwife-led unit; 'High risk' model; Caseload model, including stand-alone units. The three other team members are all midwives with extensive experience in qualitative research who between them attended all the focus groups and were involved in the analysis of the data through constant comparison to arrive at the final findings.

Data were collected via focus groups involving service users and service providers (details provided in Participants section below), the topic guides for which were produced by distilling the characteristics of care described in each of the QMNC Framework's five components. The topic guides are available in our open access paper (Symon et al 2018). In this paper we compare midwives' and obstetricians' perceptions, and then compare the perceptions of service users and service providers.

Participants and recruitment

The focus groups included service users (pregnant women and new mothers; recruitment details and main findings reported in the first of these two linked papers) with experience of caseload midwifery, 'high risk' care, and modified universal provision care, and service providers (midwives and obstetricians; findings reported here). In HB1 these included a group of newly qualified midwives (NQMs) who were within one year of registration and who worked in a range of clinical areas including community-based caseload midwifery, and all the midwives in a community midwifery unit (CMU). In HB2 they comprised a group of senior midwives, ranging from those managing the overall service to those providing advanced specialist care. The two RAs liaised with midwifery managers to identify and recruit midwives working in a range of areas. Invitation letters and Participant Information Sheets were sent to all potential participants. The RAs also invited all the obstetricians in both health boards to attend. In addition, posters advertising the study were placed on staff notice boards so interested practitioners could ask to be

included. All focus groups were conducted in maternity unit premises during working hours and were audio-recorded and transcribed verbatim.

Data analysis

We analysed the transcripts using Braun and Clark's (2006) six-phase thematic analysis, then performed a between-group comparison of principal themes. Finally, we 'mapped' the sub-themes to the original QMNC Framework to identify the areas of overlap and contrast in terms of the Framework's relevant characteristics of care.

Ethics

We received ethics approval for the study from the South Central – Berkshire B Research Ethics Committee (Ref.: 16/SC/0496).

Findings

Findings 1 Comparison of midwives' and obstetricians' views

Five focus groups were included in this part of the research. The three with midwives comprised newly qualified midwives ('NQMs'; n=8), midwives based in a community midwifery unit ('CMU midwives') that was located within hospital premises (n=8), and senior midwives ('SMs') based mainly in a tertiary unit who were either managers or who had responsibility for specialist services (n=10). Both groups with obstetricians comprised six practitioners of varying degrees of seniority. As we did for the mothers' responses, we assessed the four most prominent discussions in each focus group; we refer to these as the four principal sub-themes from each group. Some of the striking similarities between the groups are highlighted in Table 1.

Table 1 Four principal sub-themes from the midwives' and obstetricians' focus groups: areas of overlap highlighted

FG1 Newly-Qualified Midwives (HB1) ^o	FG2 CMU* Midwives (HB1)	FG9 Senior Midwives (HB2)	FG12 Obstetricians (HB1)	FG4 Obstetricians (HB2)
Limited resources / time	Limited resources / time	Limited resources / time	Limited resources / time	Limited resources / time
<i>Positive ways of working</i>	Criticising the system	Criticising the system	Criticising the system	<i>Lack of / barriers to information</i>
<i>Tailored care</i>	<i>System-driven care</i>	Difficulties with achieving tailored care	Difficulties with achieving tailored care	<i>Empowering women</i>
<i>Positive relationships</i>	<i>Continuity of care</i>	<i>Flexible maternity care</i>	Strategies for improvement	Strategies for improvement

1.1 Areas of overlap

1.1.1 Limited resources / time

This was one of the four principal sub-themes in all five groups. The newly-qualified midwives, asked if they were able to provide care as specified in the ‘Practice Categories’ component of the QMNC Framework (*e.g.* education, health promotion, assessment, screening, care planning), focused their initial discussion on the booking-in appointment:

“The very first appointment that we see women we’re asking them for consent to take their bloods and everything... we are expecting them to give consent on the same day and not giving them time to process information.” (Alice, NQM; FG1: 2)

“(At) the booking appointment that’s when they make the consent for screening and things, and if they have never heard about it before they are kind of forced into a decision.” (Rebecca, NQM; FG1: 6)

A participant in the senior midwives’ group agreed that informed decision-making was difficult:

“If you’re looking at informed choice and the definition of informed choice is that a woman understands what’s being offered before they consent to it, I would doubt that 50% of them do. And I doubt that there is the time within a high risk clinic to sit with these ladies and do that.” (Bronagh, SM; FG9: 133)

In one of the other groups a midwife noted that when women are found to have a significant risk factor, the drive to deal with that aspect of her pregnancy meant other things were omitted: “the health promotion thing gets missed, whooping cough, breastfeeding information. These things tend to get missed” (Jess, CMU; FG2: 12).

The increased numbers of pregnancies that are complex or complicated made demands on obstetricians’ resources:

“We see more complicated women, more high-risk women who have different complications... we’re getting pressure from national guidelines that tell us how we should be providing care but, we don’t have the resources or the staff or the time to implement what we know is the best evidence based care.” (James, obstetrician; FG12: 83, 84)

Participants described a higher obstetric workload caused by increasing numbers of women with complex pregnancies. Some referrals were felt to be inappropriate:

“We see a proportion of women ... when actually their issue doesn’t necessarily need to be seen by a consultant... I’ve had women coming just being afraid of certain things about labour and you know, I have actually said to them ‘Have you spoken to your midwife about this?’ and you know, they’ve said ‘No not really. The midwife just told me to come and see you’.” (Imogen, obstetrician; FG4: 12)

‘James’ went on to note that otherwise low risk women still became anxious and sought reassurance:

“They just want to come and speak to someone. I think we have to provide that service and we do provide that. But, if they want an hour of your time in the antenatal clinic where there are twenty-nine or thirty odd women ... how do you provide the time for that woman to give her what she needs?” (James, obstetrician; FG12: 87)

Facilitator: “Do you feel that’s inappropriate, that she could maybe get that reassurance and information elsewhere? Does she need to come and see an obstetrician?”

“I suppose she would see the midwife regularly but, if she doesn’t get that reassurance, it is the midwife who actually says, ‘Look, I will refer you to the obstetrician’.” (Johanna, obstetrician; FG12: 91)

The sometimes-blurred boundary between midwifery and obstetric practice was commented upon by several obstetricians, the argument being that specialist nurses have reduced medical workload in other areas of health care:

“We need more specialist midwives who can take a fair bit of (the workload of)... high risk (women), like previous sections, third degree tear or diabetic.” (Tina, obstetrician; FG4: 19)

Ultimately this comes down to a question of resources: extra specialist staff cost more money.

“Equality [of care] ... is at risk of slipping now because of the huge budget constraints and the demand, particularly in England.” (Denise, obstetrician; FG4: 297)

While it was felt that by and large the system copes well with workload demands, expectations have to be managed:

“We aren’t resourced. You know, that’s where you have to manage expectations more intelligently.” (Kate, obstetrician; FG4: 198)

1.1.2 Criticising the system

Three groups (two of midwives [FG2, FG9] and one of obstetricians [FG12]) discussed this feature, which often began as a discussion of perceived lack of resources or time, and then developed into criticism of the system. Pressure on the antenatal clinic system is increased because sensitive pregnancy tests that are widely available meant women often self-referred very early in their pregnancies. While this used up a clinic slot, the women were then told, “Do another test in a couple of weeks and come back” (Kylie, SM; FG9: 95). There was general agreement that this caused pressure on clinic capacity. Asked what the answer was, Katie (SM; FG9: 107) responded:

“The answer is a central booking line for women to be told to phone up and see their midwife here or at an outlying clinic or wherever it is and not the GP surgery clinic, because these should really be used for antenatal follow-ups...”

While the midwives felt this should be a clerical task, it was claimed that midwives were simply expected to cope with the extra workload, receiving no extra resource to accommodate this. Staying late to deal with the paperwork ‘after hours’ brought no reward either: “We’ve given up writing down our overtime, because what’s the point?” (Kylie, SM; FG9: 247).

In the other midwifery group, there was agreement that increasing workload – such as adding a de-briefing service – should not have to be covered within existing resources:

“I think it’s a service that would need to be dedicated to that one task instead of it just being added on to the other millions (laughs) of tasks that we are expected to do...” (Joanna, CMU; FG2: 95)

The requirement to undertake mandatory update training outside working hours was commented upon. Joanna (CMU; FG2) noted that she did not have a problem with undertaking optional training in her own time, drawing the comment

“As a midwife you want to learn and you want to learn to be a better midwife [but] if you have to do that all in your own time the girls just won’t do it.” (Martha, CMU; FG2: 195)

The obstetricians, while discussing pressures on workload, also discussed strategic issues. This included a lengthy discussion about how to manage post-discharge care, particularly in complex cases:

“I think we’re still trying to work out. For example, the very super, morbidly obese, we’re trying to work out who to contact. I don’t think we’ve got the necessary

contacts around to actually refer them for obesity management..." (Johanna, obstetrician; FG12: 14)

Facilitator: "Is it a question about whose responsibility it is to manage this?"

"Yes, does our responsibility end at delivery? They come back again to us but is it the GP's responsibility, the patient's responsibility?" (Johanna, obstetrician; FG12: 16)

Facilitator: "This sounds like a blur of boundaries, responsibilities. Is that something that other people have encountered?"

"Yes, I think it can be difficult to link into, especially as a lot of diabetic women that particularly have other risk factors, for various health problems, not just during their pregnancy. How do you enable them to be healthier in pregnancy and when then, once they've delivered?" (Rose, obstetrician; FG12: 18)

There was also a discussion and critique of the cost of having women coming into hospital to be induced but having to wait several days because of a shortage of midwives. The discussion also turned on the need for a cultural change on the labour ward, moving away from continuous fetal heart rate monitoring for low risk women.

"Some women ... don't necessarily require the sort of routine IV access, continuous monitoring but, I think people do it automatically without thinking. There are some women who really shouldn't be having continuous monitoring." (Johanna, obstetrician; FG12: 102)

1.1.3 Difficulties in achieving tailored care

The newly qualified midwives discussed how tailored care – that is, care negotiated with the woman to suit her own particular needs – could be given:

"The caseloading model is, from what I have seen so far, women seem to like it as they can build up a rapport with their midwife and makes it easier for things like screening and you know health promotion..." (Claire, NQM; FG1: 16)

An inherent part of tailored care was the relational element that developed when continuity of carer was present.

"I think they always know how to reassure you. I feel I walk in the door and she already knows how I'm feeling ..." (Mo, FG11: 55)

However, two groups (FG2 – CMU midwives; FG12 - obstetricians) discussed difficulties in achieving continuity of care:

“You are attached to a GP surgery so you see all your girls on the same day, but if they were to come in on another day, other than that day...you’re not going to see them.” (Martha, CMU; FG2: 122)

This difficulty continued postnatally. One midwife claimed it should be possible for the midwife to see the same woman, drawing the response

“But the thing about that is, would you be on that day? Well, ‘cos that would mean...” (Martha, CMU; FG2: 133)

“Well that’s it; you would do that so you were on.” (Nancy, CMU; FG2: 134)

“Well you see just now postnatally they would need a visit on certain days and unless you were on that’s where it kind of falls down... ‘cos I can’t follow 73 women.” (Martha, CMU; FG2: 135)

Martha returned to this later in the discussion:

“I get where we are not getting (continuity) right but I am unsure as working females, we all have lives elsewhere, how we get the postnatal care right ... I am speaking for myself now, I have children, a family and a life so I can’t go on call seven nights a week, that’s just not going to happen, but I would like to be there for all of my postnatal girls’ visits.” (Martha, CMU; FG2: 175)

For the obstetricians, tailored care that meets all the woman’s needs becomes difficult because of time pressures:

“We don’t have time. We see more complicated women, more high-risk women who have different complications... These women are now becoming pregnant and you can’t manage them in a short appointment... My anxiety is that I miss things, that I focus on the problem and forget about the two plus protein units she’s got and I’ve just not picked up, because you’re thinking about the medical problem...” (James, obstetrician; FG12: 83, 84)

These are concerning comments – both from the perspective of clinical safety and the health and wellbeing of mother and baby, and from the strain this situation is likely to cause for practitioners who feel or know they are practising below a safe level. Another difficulty arose from trying but not being able to accommodate cultural sensitivities. If tailored care is that which is designed to meet an individual’s woman’s needs, in theory the NHS should be striving to meet this. Johanna noted that

“The big one in obstetrics [is] the preference for a female doctor. I don’t feel that the NHS can provide that. It is a culturally sensitive issue but it becomes unsafe when you try and honour that. Because, the way the NHS runs, it’s not based on gender, we employ people according to their competence, we don’t discriminate against gender ...” (Johanna, obstetrician; FG12: 98)

This issue relates partly to expectations of the service, which was also discussed in the ‘Limited resources / time’ section above.

1.1.4 Strategies for improvement

The obstetrician groups were the only two to consider this issue. In the first group, the discussions ranged from having more antenatal visits (some of them group-based) to providing more technology-driven solutions.

“What about like group sessions with their community midwife? ... where women can talk to each other plus to a midwife ...” (Imogen, obstetrician; FG4: 86)

“I don’t know, because I think a lot of it is very, very private and difficult, but ... I think the old fashioned way of having lots of antenatal classes actually worked. Because it gave women a group and a support system and access to the service...” (Kate, obstetrician; FG4: 97)

The technology-related discussions concerned online platforms:

“One of the things that might help is having a website with a bit more information on it for women... I also think we need to empower them more. Because they are pretty passive participants in the process you know... all our systems encourage them to just passively show up and be told what’s happening to them.” (Kate, obstetrician; FG4: 169, 177)

Facilitator: “Of course empowerment comes from...” (FG4: 185)

“People.” (Denise, obstetrician; FG4: 185)

“Understanding.” (Kate, obstetrician; FG4: 185)

“And information as well.” (Imogen, obstetrician; FG4: 185)

“Information that works for them not just our bossy-boots information and not just NICE and Royal College but actual information that’s pertinent to them that they can understand and work on...” (Kate, obstetrician; FG4: 191)

This group discussed various technological options including apps and clinical portals.

The second obstetrician group focussed more on strategic development of the service, including the proposal that women are seen proactively by an obstetrician early in pregnancy, rather than having to step in much later in a reactive capacity.

“We are reacting to things rather than proactive in management. It would be nicer to have a pre-pregnancy clinic, where GPs refer women with complications from their area to the pre-pregnancy clinic for the consultant to plan.” (Riya, obstetrician; FG12: 70)

“I think our focus should be more on post-delivery clinics. Because, when you have a problem developing then you see them postnatally, then you plan for the next pregnancy. I think pre-pregnancy, a lot of times that women are pregnant before you know so, a lot of pregnancies aren’t planned.” (Johanna, obstetrician; FG12: 72)

1.2 Areas of contrast

The areas of contrast were also interesting, not least because the newly-qualified midwives had more distinct areas than any of the other groups, and these were all positive in tone: ‘Positive ways of working’, ‘Tailored care’ and ‘Positive relationships’ all reflected a generally optimistic approach. In all the groups, at least one of the four principal sub-themes was positive. However, it was striking that the more senior midwives seemed to focus on the more negative aspects of care provision. It was also intriguing that the only focus group to raise ‘empowering women’ as a significant issue was one of the obstetrician groups. Nine of the obstetricians were female, and most (although not quite all) of the discussion on empowering women did come from them.

Findings 2 Comparison of women’s and practitioners’ views

The results presented here combine findings from the women’s focus groups (which were reported in the first of these two linked papers) and the midwives’ and obstetricians’ focus groups. The four principal sub-themes from these various groups had some areas in common, but also showed significant differences (Table 2). These are further divided into positive, ambivalent and negative sub-themes:

Table 2 Four principal sub-themes from each focus group: areas of overlap and contrast between women’s and practitioners’ groups

Women’s sub-themes only	Shared sub-themes	Practitioners’ sub-themes only
<i>Positive sub-themes</i>		
Accessible care Effective communication Seeking information and support Social & community support	Positive relationships Tailored care	Continuity of care Empowering women Flexible maternity care Positive ways of working Strategies for improvement
<i>Ambivalent sub-themes</i>		
Accepting uncertainty	-	-
<i>Negative sub-themes</i>		
Anxiety / confusion Poor communication	Criticising the system Difficulties in achieving tailored care Lack of / barriers to information Limited resources / Time System-driven care	-

This comparison demonstrates that the experience of care of service users and providers, while sharing many features in common, is often experienced (or at least expressed) in different ways. To identify the salient characteristics of care, as determined by the QMNC Framework, we then mapped these sub-themes to the characteristics of care described within the Framework. In some cases, this was straightforward: for example, the sub-theme ‘accessible care’ clearly matched the QMNC Framework’s ‘accessible care’ characteristic of care. In other cases we identified the nearest relevant or equivalent characteristic of care: ‘limited resources / time’ mapped to the Framework’s ‘Adequate resources’, and ‘empowering women’ mapped to ‘strengthening women’s capabilities’. We further divided these into discussions that were positively expressed (Table 3) and those that were negatively expressed (Table 4). In the latter case what the participants had expressed had often been an absence of the relevant characteristic of care – in other words, the characteristic of care as expressed in the QMNC Framework had been felt to be deficient.

Table 3 QMNC Framework characteristics of care that were expressed in positive terms: comparison of women’s and practitioners’ focus group discussions

Women	Shared	Practitioners
Assessment Care planning Community knowledge Expectant management Practitioners with knowledge and skills Promotion of normal processes	Accessible care Care tailored to women’s needs Communication Continuity Division of roles and responsibilities Education / Information / Health promotion Information Integrated services Optimising psychological and social processes Practitioners with interpersonal and cultural competence Respect Strengthening women’s capabilities	Adequate resources Good quality services

Table 4 QMNC Framework characteristics of care that were expressed in negative terms: comparison of women’s and practitioners’ focus group discussions

Women	Shared	Practitioners
Acceptable, good quality services [∞] Respect [¥] Screening [§]	Accessible care Adequate resources Care planning Care tailored to women’s needs Communication Continuity Division of roles and responsibilities Education / Information / Health promotion Expectant management Good quality services Information Integrated services Optimising processes Practitioners with clinical knowledge and skills Practitioners with interpersonal and cultural competence Strengthening women’s capabilities	Competent workforce

[∞] - i.e. the women indicated that services were not acceptable or of good quality

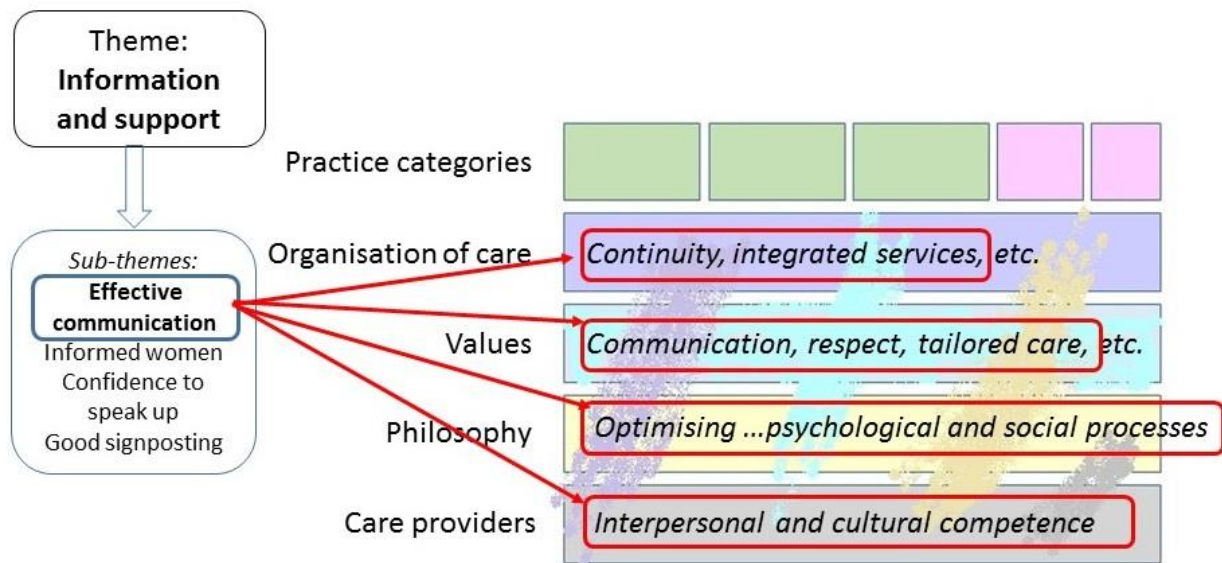
¥ - i.e. women indicated that they had experienced disrespect

§ - i.e. screening had not been offered appropriately; *etc.*

As can be seen, when the sub-themes are mapped back to the QMNC Framework’s characteristics of care there is much greater evidence of overlap, particularly in relation to perceived deficiencies in care, where only four out of 19 characteristics of care were not shared in common.

To illustrate the overlap that we found between the QMNC Framework’s components of care, we show how one particular sub-theme, ‘Effective communication’, relates to several Framework components (Figure 1):

Figure 1 The sub-theme ‘Effective communication’ mapped to four of the QMNC Framework components



While the Framework necessarily categorises aspects of care, the experience of care can encompass several of those categories. The original QMNC Framework can be seen in the first of these two linked papers (Symon et al 2019, tbc).

Discussion

This study set out to adapt the QMNC Framework for use as a topic guide to evaluate experiences concerning maternity care, this being our first step in developing a maternity care evaluation toolkit. In our initial paper, we reported what we did and how we did this (Symon et al 2018). In this current paper and the accompanying one, we have reported and compared the findings from the focus groups which explored service user and service provider experiences of a range of different models of care. While we have focussed on the principal sub-themes to emerge from each group, we note that these did not represent the totality of the conversations. This discussion firstly considers the service providers' responses, and then goes on to compare responses from service users and providers. Lastly, it reflects on the approach taken in this study and the prospects for incorporating this in future service evaluations.

Service providers' responses

We found that there was considerable overlap in the principal sub-themes raised by midwives and obstetricians. All five groups identified 'limited resources and time' as a major issue. This reflects the most recent National Health Service (NHS) staff survey, which found that 71% of staff in England reported working extra hours just to get the job done (NHS SCC 2018). Given the near-constant media coverage of a 'funding crisis' within the NHS (*e.g.* Mann 2017; Matthews-King 2018) it would perhaps be surprising if this issue of limited resources did not feature prominently. Likewise, midwives and obstetricians provided a 'critique of the system' that was decidedly negative in tone, but this was somewhat offset by more positively framed discussions concerning positive ways of working, flexible care, and continuity of care. Again, this reflects the recent NHS staff survey, which provided a mixed picture: for example, 68% of NHS staff in England felt their manager took an interest in their health and well-being, but 38% reported feeling unwell due to work-related stress (NHS SCC 2018).

In terms of the most prominent issues raised by both midwives and obstetricians, difficulties with achieving tailored care (Renfrew et al 2014) featured strongly. This factor has also been identified in the Netherlands (Posthumus et al 2013) and elsewhere in the UK (Aquino et al 2015). It seems intuitive that tailored care is much more likely within the relational context of continuity of carer (Fontein-Kuipers et al 2018). It was notable that it was the senior midwives who raised this issue.

The newly qualified midwives, some of whom were working within a caseload model, found that tailored care and continuity of carer were very positive features of their working lives. It was also interesting that the overall tone of the newly qualified midwives' discussions was markedly more positive than that found in the other midwives' groups. Since many of the junior midwives were working within midwife-led models of care where continuity of care and carer was the norm, this was perhaps not surprising. There is evidence from Australian studies that providing this kind of care improves job satisfaction (Cummins et al 2015) and reduces burnout (Jordan et al 2013; Newton et al 2014; Martin et al 2015; Homer 2016). While the CMU midwives also discussed the benefits of continuity of care, most of their conversation concerned problems with care provision, such as limited resources, or the technocratic / managerialist nature of much health care (*cf.* Walsh 2006; Frith et al 2014). Given the widespread discussion between the various groups about problems within the health service, it was striking that the sub-theme 'Strategies for improvement' only occurred within the obstetrician groups. These included suggestions for both organisational change and better use of technological opportunities.

Comparison of responses from service users and providers

We compared the findings from service users and service providers, both in terms of the principal sub-themes within each focus group, and also having mapped the discussions back to the QMNC Framework's identified characteristics of care. There were interesting similarities and differences in the principal sub-themes emerging from service users and providers. The women's discussions focussed heavily on communication (both effective and poor) and relational issues (seeking information and support; social and community support); these factors have for some time been acknowledged as vital components of quality care (Berg et al 1996; Butler et al 2014). The practitioners focussed more on organisational matters, such as improvement strategies, positive ways of working, and how to provide flexible care and empower women. The different groups were more in agreement over lack of information (globally acknowledged as a problem – *cf.* Hatamleh et al 2013; Makowharemahihhi et al 2014; Murray-Davis et al 2014), limited resources (*cf.* Ryan et al 2013; Molina et al 2016), tailored care not being achieved and care generally being system-driven. Indeed, we found huge overlap between users and providers when we analysed the sub-themes in terms of how they mapped to the QMNC Framework's characteristics of care; this

was particularly so with negatively-expressed comments. What this suggests to us is that the QMNC Framework, suitably adapted, can be used as an effective data collection tool as it does cover the salient aspects of care.

The approach taken in this study

While ‘traditional’ approaches to evaluating clinical services and care effectiveness have relied heavily on counting clinical outcomes, it is now recognised that it is essential also to include service user perspectives, often through Patient-Reported Outcome Measures (PROMs) (Black 2015). Likewise, it is vital when evaluating a service to include both service user and provider perspectives, and to consider both what reflects good quality care and the ways in which quality care is not achieved.

This study has shown that it is entirely feasible to evaluate stakeholder perspectives using a framework which sets out the constituent parts of quality care. Having started with a quality care framework (Renfrew et al 2014) we were then able to map these experiences and perceptions against the current best evidence about what quality care should look like. Many of the sub-themes emerging from the focus groups did not fit neatly within the Framework’s classification of the components of care (Practice categories; Organisation of care; Values; Philosophy; Care providers). This is not a criticism of the Framework: synthesising and distilling the best available evidence of quality care required the development of descriptive categories. While the participants’ wide-ranging discussions often crossed the boundaries of these categories, they were readily linked to the Framework’s description of the characteristics of care. We illustrated this in Figure 1. The importance of ‘effective communication’ in achieving optimal maternity care outcomes is acknowledged by Chang et al (2018). Communication is threaded throughout the care experience and so this was an easy example to show. Nevertheless, we found Framework overlaps in many of the sub-themes. The fact that Framework captures these aspects effectively suggests to us that its’ components and characteristics of care can help to form the backbone of an evaluation tool which will capture the essentials of the care experience, perhaps by acting as a benchmark against which to assess care. In our on-going programme of work we will evaluate this against other standard measures of maternity care such as the maternity services survey and patient satisfaction questionnaires.

Limitations

There are inherent limitations in small-scale qualitative research, although with twelve focus groups in all, involving 69 participants, this was larger than many qualitative studies. To avoid repetition, we again refer the reader to our accompanying paper where these limitations are considered in more detail.

We acknowledge a certain circularity in our method: having based our focus group prompt questions on the Framework, we found that responses related back to the Framework. We respond that since the Framework is derived from the most comprehensive analysis to date of what quality care looks like it is not surprising to find these issues echoed in discussions of the maternity services. Where we diverge from the Framework is in reporting the tone of the discussions: the Framework is written from the perspective of what quality care looks like – or should look like. Our evaluation of what care is actually like reflects both positively and negatively on the reality of maternity care. In any evaluation of care models, particularly when looking to see which features appear to work well and should therefore be strengthened and replicated, it is essential also to identify what does not work well. Our study suggests that there are many areas where there is broad agreement that improvement is needed.

Conclusion

The main purpose of our study was to assess how feasible it was to adapt the QMNC Framework into a data collection tool for use within an evaluation toolkit. By using an instrument that represents the best available evidence of quality care, we were able to explore perceptions and experiences of care of both service users and providers within a range of different care models. We analysed data from twelve focus groups in total using a standard qualitative approach, and identified areas of commonality and contrast regarding the service users with regard to different models of care. For the service providers we were similarly able to identify areas of commonality and contrast regarding different clinical backgrounds. In all cases, we were able to map the emerging themes back to the original Framework. This suggests to us that the Framework, derived as it is from an analysis of the global evidence on quality maternal and newborn care, can be used

as the basis for evaluating aspects of care within specific localities. We acknowledge that this study was geographically-specific, and there is a need to develop this approach in different contexts. We have extended the McTempo research programme (McTempo: Models of Care: The Effects on Maternal and Perinatal Outcomes) to a twin-site study in Australia, and plans are underway to do the same in the Netherlands; further work is underway in Scotland. Initial discussions are also taking place about a study within a low-income country. Once these are complete, the next stage of our research programme will aim to identify which aspects of the care experience are most important to include in an evaluation toolkit. Policy makers and planners require a sound evidence base for what helps or hinders the delivery of care.

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