PC - AIMS

Primary Care
And Integrated Maternity Services

Report of the Bellevue Project

Contents

1 PC-AIMS

Primary Care and Integrated Maternity Services

This is the report of a pilot project at the Bellevue Medical Centre, Birmingham, involving the development of the maternity service from one based on conventional team midwifery, to a model of community midwifery fully integrated into the primary care setting.

The project was run by the West Midlands Perinatal Institute, in association with the Bellevue Medical Centre and Birmingham Women's Hospital.

Authors

Dr Andrew Carson	Lead GP, Bellevue Medical Centre
Angela McBennett	Community Midwife, Bellevue Medical Centre
Vivienne Bennett	Midwife, Birmingham Women's Hospital
Professor Jason Gardosi	Director, West Midlands Perinatal Institute

Special thanks to

Dr Jacky Chambers	Director of Public Health, Heart of Birmingham PCT (formerly DPH, Birmingham Health Authority)
Cynthia Folarin	Public Health Midwife Specialist, WM Perinatal Institute
Andre Francis	Statistician, WM Perinatal Institute
Dr Harry Gee	Consultant Obstetrician and Gynaecologist and Medical Director, Birmingham Women's Hospital
Vanessa Johnson	Matron. Community and Outpatients, Birmingham Women's Hospital
Jane Owen	Head of Midwifery, Birmingham Women's Hospital
Kate Sallah	Director of Nursing, Birmingham Women's Hospital
Audrey Toms	Maternity Services Manager, Birmingham Women's Hospital
Linda Hayes	Senior Lecturer in Women's Health Studies, University of Central England
Primary Care Team	Bellevue Medical Centre

Published by the Perinatal Institute, October 2003

Copies are available on www.perinate.org/pc-aims, or from:

Perinatal Institute,
St Chad's Court, 213 Hagley Road,
Birmingham B16 9RG
Tel 0121 695 2447; office@perinate.org

Further details, including a business plan for this model of care and a template contract for implementation are available on www.perinate.org/pc-aims

2 Executive summary

A pilot project examined the feasibility of an enhanced model of care to address issues relevant to the maternity service in an area of high socio-economic need. The project was run by the West Midlands Perinatal Institute in association with the Bellevue Medical Centre and Birmingham Women's Hospital. It was funded by Birmingham Health Authority (May 2001-May 2003) and South Birmingham Primary Care Trust (May to September 2003).

The model

The conventional maternity service was previously provided through a hospital based midwifery team, with a 0.7 WTE allocation which resulted in one midwifery clinic per week at the Bellevue Medical Centre. The enhanced service was implemented with the following main components:

- Stronger midwifery presence in the Practice, increased from one to four sessions per week, with full integration into the primary care team;
- Increased accessibility, including a drop-in facility for informal visits, and contact via mobile phone
- Emphasis on continuity, promotion of public health issues and parent education.

Evaluation

1. Comparative audit of all maternities over 12 months during the project, compared with the same number before commencement
2. Maternal satisfaction survey by semi-structured interviews
3. Staff survey of members of the primary care team
4. Practice midwife's experience, and assessment of the parent education classes

Findings

- The system was easily implemented over a relatively short time period
- Improved continuity of care, with an almost seven-fold increase in the likelihood of a mother being seen by the same midwife
- Antenatal booking occurred on average 18 days earlier in the enhanced care group
- Increased referrals to allied health professions, improving their engagement with maternity care.
- Two-thirds increase in the number of expectant mothers attending parent education sessions
- A significant reduction (> 50%) in caesarean sections
- A significant increase in breastfeeding rates, with a halving of the number of mothers who used only bottle for feeding
- High maternal satisfaction with the service, including continuity, ease of access, and decreased waiting times
- Mothers felt supported and reassured, informed and better prepared for childbirth
- There was strong support for the model by members of the primary care team, who felt that they were able to give mothers a higher quality of service.

Conclusion

This pilot of integrating maternity services into primary care found many advantages and no disadvantages. It was highly appreciated by mothers and care providers alike, and resulted in improved outcomes. The model is consistent with strategies for delivering a preventative, public health oriented maternity service. The authors recommend that PCTs should adopt this model for service development for mothers and children.

3 Introduction and background

Jason Gardosi

In 1999, Birmingham Health Authority commissioned a report on how delivery of maternity service within primary care can be improved, in general terms as well as with specific reference to Bellevue, an area of high socio-economic need in south central Birmingham. The HA had an active public health agenda which sought to address high rates of perinatal mortality and poor progress on pregnancy related targets including smoking cessation and breastfeeding. General Practitioners at the Bellevue Medical Centre, a PMS Pilot site, were keen to improve the service and define better care pathways for maternity care. Staff at Birmingham Women's Hospital, the main referral unit, had long been interested in strengthening community midwifery care.

To get a user view, I held informal but in-depth interviews with mothers coming for a postnatal visit at Bellevue. They revealed many concerns about lack of continuity, reassurance, education and preparation for childbirth and motherhood. Mothers wanted to be seen more often, but did not understand the need for routine hospital visits, nor the reason for being seen by many different midwives and doctors when there were no complications.

The Report

The full report is archived on the web [1]. In brief, it argued for the need to develop a service which considers the needs of the mother and her baby. It should also enable care providers to address the various agendas on smoking, breastfeeding and teenage pregnancy [2,3,4]. It should also allow care to be proactive, addressing issues raised by the Confidential Enquiries into Maternal Deaths, and into Stillbirths and Deaths in Infancy; in fact, reports published since only re-inforce these messages even further [5,6,7,8]. These are supported by an ever increasing awareness of the need for the health and social care system to work better together [7,8], and to augment access to maternity services and reduce inequalities [9]. Many current deliberations of the NSF for maternity and children move along the same lines, and the recently published 4th report of the Parliamentary Select Committee on Health also emphasises the key contribution which midwives should be able to make in maternity care [10].

The report also suggested that there was little evidence that the conventional model of risk assessment, on which the current 'shared care' system is based, is predictive. Most instances of adverse outcome occur unexpectedly and in 'low risk' pregnancies. There was also a question about applicability to mothers who are 'high risk' because they are smokers, late bookers, poor attenders etc, and who would in fact be better cared for within their own community. Furthermore, there was a need to look at the effects of risk assessment from the perspective of the baby as well as the mother. For example, monitoring for fetal growth is an accepted component of antenatal care, and is becoming ever more important with increasing awareness of the association between fetal growth restriction and avoidable perinatal deaths [11]. However, there is good evidence that the current NHS service fails to detect growth restriction antenatally in three-quarters of cases in the general maternity population [12]. This failure rate is even higher in 'low risk' pregnancies [13] suggesting that the designation of a pregnancy as 'low risk' may subsequently put the fetus at higher risk.

In the absence of viable methods to predict adverse outcome, surveillance and support for the mother and baby is needed throughout pregnancy.

The Proposal

There is a need to develop a system which allows a **Mother And Baby Oriented Antenatal Care**. This was defined as one which

> *aims to ensure the supervision of maternal and fetal well-being during pregnancy, making available all appropriate choices to fulfil optimal potential, and providing all necessary support and preparation for a high quality life after birth, with due respect for privacy and the least necessary interference.*

It was suggested that this aim would be best served through an enhanced midwifery service which is integrated into primary care. In practical terms, this required more midwifery sessions in the community setting. The service provided at Bellevue was part of the usual Team Midwifery scheme run by the Trust. The

midwifery allocation to Bellevue, which had a caseload of 70-80 maternities per annum, was 0.7 whole time equivalent. Being a member of the midwifery team, the midwife assigned to the practice had her various other commitments including caring for mothers at other practices, cover for other team members, and delivery suite work as required. All in all, the 0.7 WTE translated to only one session per week actually at the practice.

It was estimated that three additional sessions per week would be required for an enhanced service, allowing increased access for mothers through drop in clinics and parent education classes. The midwife would be working closely with GPs and health visitors, as well hospital midwives and obstetricians, and involve other professionals within primary and acute care, as required.

The Project

A series of meetings were held during 2000, with representatives of the Bellevue Medical Centre, Birmingham Women' Hospital, Birmingham Health Authority and the Perinatal Institute, to plan out details. The proposal had general support, but under the existing system of team midwifery, there was no 'give' to allocate additional midwifery sessions to the practice. Hence additional funding was required and provided by BHA for a 2 year pilot project. The project was run by the Perinatal Institute in association with the Bellevue Medical Centre and Birmingham Women's Hospital. Following interviews, Angela McBennett was appointed Primary Care Midwife by secondment from BWH and commenced work in May 2001.

The planned evaluation consisted of a quantitative assessment of pregnancy outcome over a one year period, compared with a matching number of pregnancies prior to the commencement of the study. A longitudinal assessment, despite the potential pitfalls of changing circumstances over time, was the only one considered feasible within the scope and timescale of the project. Evaluation was also to include qualitative surveys of the views of mothers and care providers involved in the project.

Although this was a short project in terms of pregnancy care, it was felt that some important questions could be asked:

1. Is this model feasible and easy to introduce into practice.
2. What are its effects in terms of antenatal visits - where and with which professionals;
3. What are its effects on pregnancy outcome, as far as it can be assessed during the available time frame?
4. How are the effects of this care model perceived by mothers?
5. How is the model received by the providers of maternity care?

The ensuing chapters will aim to address these issues, and include

- a quantitative assessment of the impact of the enhanced service, compared to the conventional service before the project (Chapter 5);
- evaluation of mothers' experiences (Chapter 6)
- feedback from staff working at Bellevue (Chapter 7)
- reflections by the project midwife about the enhanced service (Chapter 8) and parent education (Chapter 9).

References

1. Gardosi J. 1999 *The place and purpose of antenatal care: Proposals for the Bellevue Primary Care Midwifery Pilot Project* www.perinate.org/pc-aims/
2. *'Smoking Kills'* Executive Summary DoH 1998 www.doh.gov.uk/tobacco/smokexec.htm
3. Unicef UK Baby Friendly Initiative www.babyfriendly.org.uk/commun.htm
4. DoH Strategy on Teenage Pregnancy www.doh.gov.uk/teenagepregnancy/index.htm
5. Why Mothers Die 1997-1999; Confidential Enquiry into Maternal Deaths, 2002. www.cemd.org.uk
6. Confidential Enquiries into Stillbirths and deaths in Infancy (CESDI) - 8th Annual Report, 2002 www.cemach.org.uk/publications.htm

7. Building a safer NHS for patients. www.doh.gov.uk/builsafenhs
8. The NHS Plan www.nhs.uk/nhsplan
9. Tackling Health Inequalities www.doh.gov.uk/healthinequalities
10. Parliamentary Health Committee – Fourth Report
www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/464/46402.htm
11. Key Health Data for the West Midlands 2001 DPHE, University of Birmingham, May 2002.
www.publichealth.bham.ac.uk/publications
12. Hepburn M, Rosenberg K. *An audit of the detection and management of small-for gestational age babies*. Br J Obstet Gynaecol 1986;**93**:212-216.
13. Kean LH, Liu DT. *Antenatal care as a screening tool for the detection of small for gestational age babies in the low risk population*. J Obstet Gynaecol 1996;**16**:77-82

4 Description of post and midwife practice

Andrew Carson

The team

Bellevue Medical Centre is an inner city practice in Birmingham with a well established history of innovation and change. The multi-professional team serves a diverse community of about six thousand patients with a broad range of ethnic and socio-economic groups. One of the characteristics of this community, in common with many other inner city populations, is the mobile nature of the most deprived groups. It is frequently the case that the individuals who are most at risk of health problems are the same people who are hardest to reach from the point of view of the service deliverers. For this reason Bellevue Medical Centre has traditionally adopted a team-based, practice centred approach to all aspects of health care, with staff from local community units and other employers working alongside practice staff but using the practice database as the record system that is likely to be the most accurate reflection of the local population. The team is comprised of a broad range of employed and attached staff, including doctors, practice and district nurses, health visitors, a community psychiatric team and a dietician, as well as administrative and clerical staff and other allied staff such as a Citizen's Advice Bureau worker.

The practice was a third-wave fundholding site and subsequently went on to become Birmingham's first Personal Medical Services (PMS) pilot in 1998. One of the cornerstones of the PMS bid was the team-based approach to multi-professional learning and working. This approach covered almost all aspects of service delivery but it was not possible to include maternity services into the bid at the time of changing to the PMS contract. For this reason, the mothers at Bellevue continued to receive a traditional approach to maternity care whilst most other aspects of the service were subject to modernization and an integrated approach to care, involving secondary care colleagues in the structure of the service where appropriate. The team-based approach to learning, with monthly in-house, half-day learning sessions for the entire team, underpinned the integrated approach to care. Thus the one area that still required proper integration with the rest of the team was the maternity service.

Maternity service development

As has already been referred to in the introduction and background to this report, in the lead-in period to the development of the enhanced, integrated pattern of maternity care, a survey of mothers at Bellevue Medical Centre was carried out. This showed that mothers were keen to have more contact, albeit informal, with a midwife during their pregnancy. Furthermore, attendance at parent education sessions had traditionally been almost non-existent due to the inaccessibility of the sessions, both at the local maternity unit, which was two bus rides from the practice area, and at the local community base for the midwives, which could only be accessed by walking a considerable distance through a park renowned for muggings and assaults.

In common with other deprived communities, increasing breastfeeding rates and reducing smoking were important public health issues for this group of families.

Adopting the same integrated, team-based approach to care that had been implemented across other aspects of health care within the team, the following criteria were applied to the new midwifery post associated with this service development:

- The midwife to be based at the practice, with her own office and clinical space;
- The midwife to be invited to attend all practice meetings, including the team-based learning half-days;
- Access to be improved through the midwife offering a mixture of formal antenatal sessions and informal drop-in sessions with a more pro-active risk assessment being performed at each antenatal contact;
- The midwife to have a mobile telephone to enable mothers to have direct access to advice from the midwife;
- Appointments with the midwife to be booked through the practice receptionists;
- Parent education sessions to be run on site, with the practice attached health visitors running some joint sessions with the midwife to establish an early relationship with new mothers;

- The midwife to act as the lead professional in the care of mothers during their pregnancies, making all necessary referrals to other members of the primary or secondary care teams;
- The midwife to continue to provide support to the team of midwives to whom she was attached.

These criteria formed the basis of the ensuing service developments.

Although the practice was nominally funded for 0.7 WTE midwife, the original midwife attended the practice for only one antenatal session per week and carried out postnatal visits in the home. The new service was increased to two formal antenatal sessions and two drop-in sessions at the practice, with the midwife also being accessible via mobile teephone. The overall increase in time in the practice was, therefore, three extra sessions. Although this was still well within the 0.7 WTE for which the practice was funded, an additional charge was made to cover the additional practice-based time.

5 Audit of enhanced and conventional care

Andrew Carson, Vivienne Bennett and Jason Gardosi

This audit was undertaken to assess the effects of the service development and integration of the midwife into the wider primary health care team at Bellevue Medical Centre, and compared the pregnancies of women booked at Bellevue and delivered at Birmingham Women's Hospital over two 12 month periods, before and after the commencement of the project.

Methodology

An electronic audit tool was developed to collect data about pregnancy characteristics and outcome (see Appendix1). This was used to collect the same data from both groups, i.e. from pregnancies cared for conventionally before the commencement of the project ('Conventional Care' group) and after the service enhancement ('Enhanced Care' group). All data were collected and entered by Cynthia Folarin and Vivienne Bennett.

The midwife appointed to the new, integrated post started work at the end of May 2001. After a period of time for training, establishing sessions and become integrated into the practice, the collection of cases for the audit commenced 1 August 2001. A total of 72 pregnancies were booked at Bellevue for delivery at Birmingham Women's Hospital over the ensuing 12 months up to 31 July 2002 ('Enhanced Care'). This time interval ensured that data on all pregnancies was available for analysis from April 2003.

The 'Conventional Care' group consisted of 72 consecutive pregnancies delivered at Birmingham Women's Hospital up to 31 December 2000 which had also booked at Bellevue Health Centre ('Conventional Care' group). Data files for these pregnancies were retrieved from the archives with the assistance of the Audit Committee of Birmingham Women's Hospital.

Not all information required in the audit tool was recorded in the notes of the Conventional Care group. For example, data about smoking cessation was often missing, and only half of the notes contained a record of the obstetric risk as assessed at the beginning of pregnancy, hampering comparisons of these variables.

Results

There were no significant differences between expectant mothers as concerns height, weight and body mass index, ethnic origin, employment status and smoking in early pregnancy. However, mothers in the enhanced care group had a lower parity, and significantly more were in their first pregnancy. This is likely to be due to new housing during the period of comparisons, encouraging an influx of first time mothers. There was also a (non-significant) trend towards more non Anglo-European mothers in the Enhanced Care group, which was probably due to an observed influx of Asylum seekers.

The mean number of visits was similar in the Enhanced and Conventional Care groups (11.1 vs 10.8). However, expectant mothers in the enhanced group were booked 18 days earlier (median 68 vs 86 days, Table 5.1). They were also much more likely to be seen by their named midwife (OR 6.8), with 72% of contact being with her in the Enhanced group, vs only 28% in the Conventional group (Figure 5.1).

As shown in Table 5.2, mothers in the Enhanced Care group had nearly twice as many referrals to other care providers (18.0 vs 9.7%, OR 2.05). They were also seen by a greater variety of team members - for physiotherapy, dietary advice, the mental health team, Citizen's Advice Bureau and counselling for stress management (Figure 5.2).

Only 11% of mothers in the conventional care group attended local parent education sessions, compared with 69% in the enhanced care group (Figure 5.3). A more detailed analysis of attendance at parent education sessions is presented later in this report.

	Enhanced				Conventional						
Number in study			72				72				
	No	%	Mean (sd)	Median	No	%	Mean (sd)	Median	OR	95% CI	p**
Maternal weight (kg)			66.0 (13.0)	65			64.8 (15.4)	61			NS
Maternal height (cm)			161.1 (7.6)	160			161.5 (6.3)	162			NS
BMI			25.2 (4.9)	24.1			25.0 (6.1)	23.1			NS
Maternal age (yrs)			27.5 (6.0)	28			26.6 (6.8)	27			NS
<20	7	9.7			15	21.1			NS		
20 to 35*	56	77.8			46	64.8					
35 +	9	12.5			10	14.1					
Parity			0.67 (1.03)				1.03 (1.13)				**0.02**
Primip	42	58.3			28	38.9			**2.20**	(1.13 - 4.28)	
Multip*	30	41.7			44	61.1					
1	20	27.8			25	34.7					
2	6	8.3			12	16.7					
3	0	0.0			4	5.6					
4+	4	5.6			3	4.2					
Ethnic origin											
European	24	33.3			31	43.1			NS	(0.34 - 1.30)	
Non-European*	48	66.7			41	56.9					
Afro-Caribbean	12	16.7			18	25.0					
Indian/Pakistani	15	20.8			11	15.3					
African	2	2.8			5	6.9					
Other	19	26.4			7	9.7					
Employment											
Employed	32	44.4			28	39.4			NS	(0.63 - 2.39)	
Not employed*	40	55.6			43	60.6					
Smoking											
None	55	76.4			55	76.4					
Any	17	23.6			17	23.6					

* Reference for odds ratio; ** p value using Mann-Whitney U test

Table 5.1 Characteristics of expectant mothers at booking

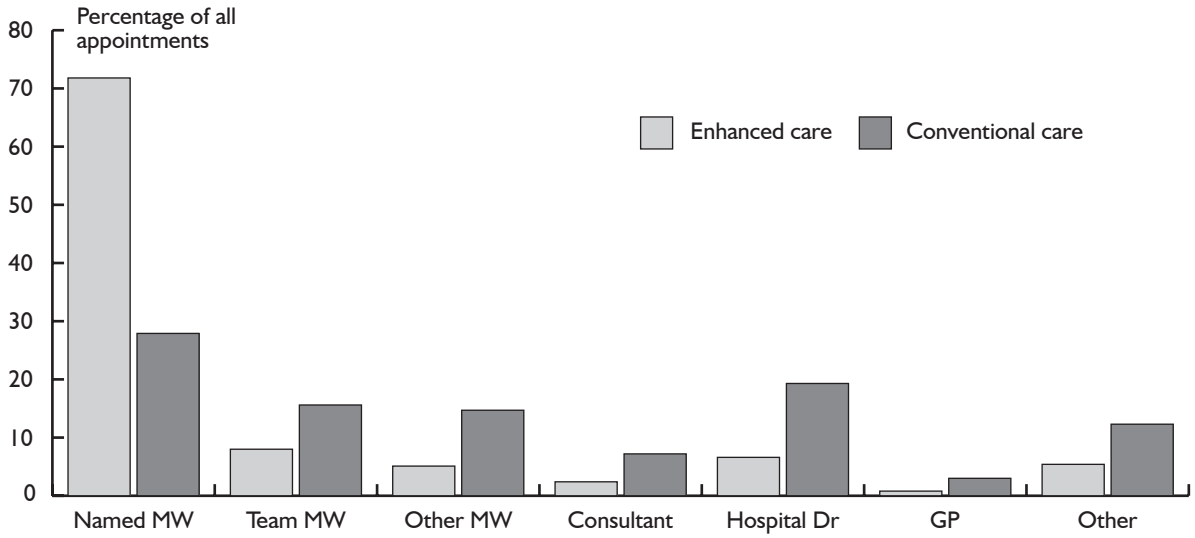

Figure 5.1 Appointments with different care providers, as proportion of total in Enhanced Care group (n=800) vs Conventional Care group (n=774).

	Enhanced			Conventional					
Number of cases	72			72					
Number of visits	800			774					
Mean number of visits	11.1			10.8					
	No	%	Value	No	%	Value	OR	95% CI	p**
Gestational age at booking (days)									
Mean (sd)			76.5 (24.7)			87.7 (30.4)			
Median			68			86			**0.01**
Number of antenatal visits									
Named MW	574	71.8		216	27.9		**6.72**	(5.33–8.48)	
Other*	183	22.9		463	59.8				
Other visits to:									
Team MW	64			121					
Other MW	41			114					
Consultant	19			56					
Hosp Dr	53			149					
GP	6			23					
Not known	43			95					
Outcome of visit									
Referred	144	18.0		75	9.7		**2.05**	(1.52–2.76)	
Not referred*	656	82.0		699	90.3				
Referred to:									
Consultant	52			13					
Day Assessment Unit	26			25					
Ultrasound	22			8					
Delivery suite	11			10					
GP	6			8					
Social Services				4					
Fetal medicine unit				6					
Early Preg Assess Unit	2			1					
Stress Mx	11								
Physiotherapy	9								
QE Psychiatric Hospital	2								
Dietician	1								
Sure Start	1								
Citizen's Advice Bureau	1								
Attendance at parent education classes									
No / Not known	20			62			**0.05**	(0.02–0.13)	
*Local	50			8					
Yes, other	2			2					

* Reference for odds ratio; ** p value using Mann-Whitney U test

Table 5.2 Antenatal visits and referrals during pregnancy

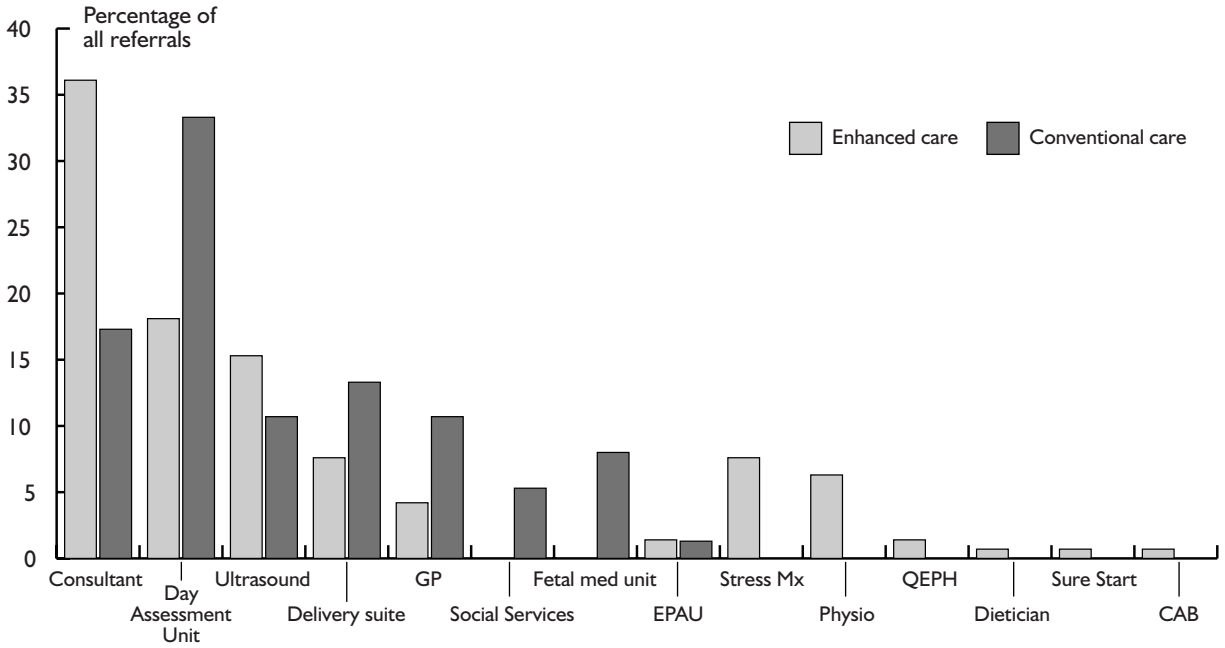

Figure 5.2 Percentage of referral visits

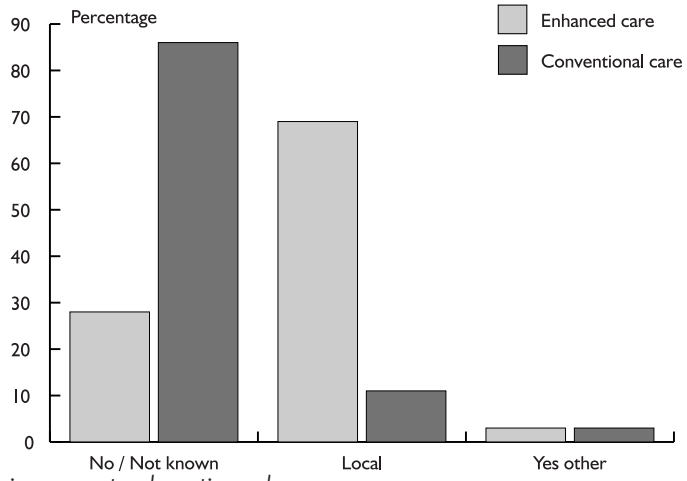

Figure 5.3 Attendance in parent education classes

There was a non-significant trend for pregnancies in the Enhanced Care group to be longer (by an average of 4 days) and for babies to be heavier (106 g) (Table 5.3).

The caesarean section rate in the conventional care group was 26.4%, which is similar to the overall annual rate for deliveries at Birmingham Women's Hospital (1999/2000: 26.3%; 2000/2001: 27.1%). By comparison, women in the Enhanced Care group had a significantly lower rate of caesarean sections, 12.5% (Figure 5.4) even though this group had a higher proportion of primipara, as shown in Table 5.1. This was accompanied by a slightly increased rate of instrumental deliveries. The lower rate of caesarean sections in the primip subgroup was also statistically significant (Table 5.3).

Number in study	**Enhanced** 72				**Conventional** 72						
	No	%	Mean (sd)	Median	No	%	Mean (sd)	Median	OR	95% CI	p**
Gestation (days)			278.4 (11.7)	281			274.2 (14.3)	276			NS
Prem (<37 wks)	4	6.1			6	8.3			NS	(0.19 - 2.63)	
*Term	62	93.9			66	91.7					
Birthweight (g)			3252.1 (467.8)	3275			3146.5 (562.7)	3150			NS
Customised centile			43.7 (27.8)	40			44.9 (30.5)	39			NS
IUGR (<10)	7	12.1			8	11.9			NS	(0.34 - 2.98)	
*Non-IUGR	51	87.9			59	88.1					
Mode of delivery											
Caesarean	9	12.5			19	26.4			**0.40**	(0.17 - 0.95)	
*Instrumental	8	11.1			5	6.9					
*Spont vaginal	55	76.4			48	66.7					
Primip only:											
Caesarean	6	8.3			10	13.9			**0.31**	(0.10 - 0.99)	
*Instrumental	7	9.7			3	4.2					
*Spont vaginal	28	38.9			15	20.8					
Breastfeeding											
Breast alone	54	81.8			41	62.1			**2.74**	(1.23 - 6.10)	
Breast (inc mixed)	58	82.9			45	64.3			**2.69**	(1.22 - 5.92)	
*Bottle alone	12	17.1			25	35.7					

* Reference for odds ratio; ** p value using Mann-Whitney U test

Table 5.3 Delivery details

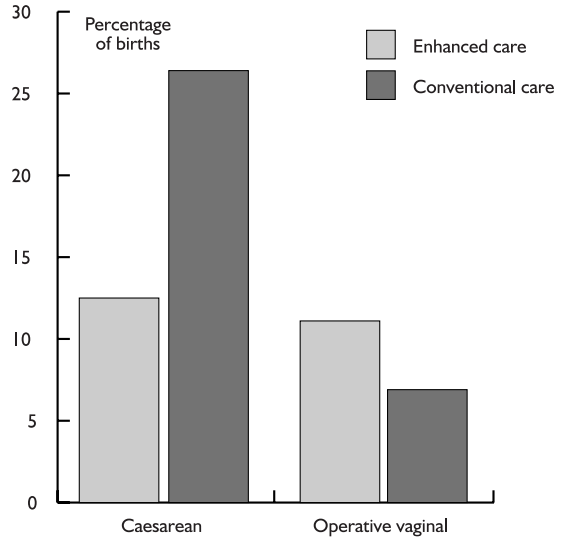

Figure 5.4 Mode of delivery - all cases

Breast feeding

The method of feeding at the time of discharge from the hospital was assessed from the information recorded in the notes. The proportion of mothers breastfeeding their babies increased significantly from 62% in the conventional care group to 82% in the enhanced care group (OR = 2.74). Four mothers chose mixed feeding in both the enhanced and the conventional care groups. This meant that the proportion of mothers who bottle fed exclusively dropped by over half, from 35.7 %o 17.1 %. (Figure 5.5)

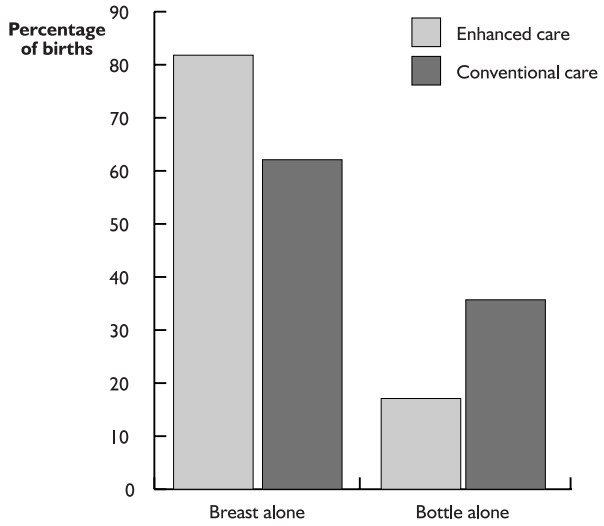

Figure 5.5 Breast and bottle feeding rates at the time of discharge

Smoking during pregnancy

Whilst the overall proportion of mothers who declared at booking that they smoked tobacco regularly was very similar between the conventional and enhanced care groups (Table 5.1), there were no data relating to smoking cessation for the conventional care group of mothers. The Enhanced Care group records showed that 4 out of the 14 women stopped smoking and three others made attempts and managed to stop for varying periods during their pregnancy.

Domestic violence

Three mothers disclosed exposure to domestic violence in the enhanced care group. There was no record of disclosures of domestic violence in the conventional care group.

Discussion

This comparative audit showed several clear differences in process and outcome between the two models of maternity care. The enhanced service achieved its goal of making the majority of visits – 72% - take place with the nominated midwife. By contrast, the conventional model appeared to fragment care, with more routine visits being with other team midwives, hospital midwives and hospital doctors, so that only 28 % of visits were with the nominated midwife in the community.

At the same time, there were substantially more referrals in the enhanced care group. While this project was much too small to evaluate the effect of these referrals, it would seem advantageous that more of the available professional team were involved. This was also apparent from comments by other members of the primary care team (see chapter 7).

This analysis has shown that, by integrating a midwife into the primary health care team to deliver maternity care to mothers it is possible to achieve a number of potential benefits:

1. Antenatal booking was on average 18 days earlier: this was likely to be a direct result of the increased 'presence' of the midwife in the Medical Centre. A copy of all antenatal referral letters was sent directly to her through the internal post system at the practice. Booking early is clearly advantageous, as it allows early assessment and action on obstetric risk, if required. Also, it allows expectant mothers to receive all necessary information to make unhurried choices about antenatal screening and general pregnancy care.
2. Better continuity of care, with the majority of visits with the nominated community midwife as primary care provider. In general, the practice-based midwife was more accessible to mothers locally, both through formal antenatal sessions, drop-in sessions and via mobile telephone. As a result, the workload of other, ad-hoc providers of antenatal care, including hospital midwives and doctors, was likely to be considerably lightened.
3. Referrals to a broader range of professional results in better utilisation of available services; this suggests that the midwife was working in a way that enabled a better assessment of the needs of mothers. It also suggests that the midwife was well integrated into the primary care team.
4. Increased uptake of parent education because of local availability ensuring easier access, as well as a culture which encourages participation. It is interesting to note that a number of multiparous mothers attended the sessions run within the practice by the team-based midwife, with health visitor involvement. This is relatively unusual and may reflect the paucity of parent education available to Bellevue mothers prior to the new service.
5. Reduced caesarean section rates are likely to be due to better preparation for childbirth, reduced anxiety and more confidence, which in turn is likely to be linked to a better relationship with the midwife. Enhanced antenatal care appears to represent an important strategy for reducing caesarean section rates. It is interesting to reflect that the reduction in caesarean section rates with its associated costs alone could release sufficient funds to enable the institution of this model of care.
6. There was an 18.6% increase in breastfeeding rates, which is in excess of current targets at PCT level. This increase could be further evidence for the effects of a more personal contact with the midwife. In addition, breastfeeding support sessions run jointly by midwife and health visitors were likely to be helpful and brought together existing breastfeeding mothers to act as a resource for expectant mothers, as well as helping postnatally if needed.

The three instances of disclosure of domestic violence in the enhanced care group could simply be a reflection of increased awareness, but it is interesting that no mothers were recorded as being subject to violence at home in the conventional care group. The importance of this area was highlighted in the most recent report of the Confidential Enquiry into Maternal Deaths. The observed increase in numbers could be due to mothers feeling safer disclosing to someone with whom they had a closer and more consistent relationship. This supports the recommendations that the midwife should act as lead professional in the care of mothers during their pregnancy, enabling her to perform an important advocacy role.

It appears that many of these aims are met through the simple act of integrating a community midwife into the rest of the primary health care team at a practice level.

Working within a team can be a very enlivening experience especially when, as was the case here, mothers are highly appreciative of the service that they receive. This type of post could also help to address the current problems of recruitment and retention, and attract midwives back who have left due to disillusionment with the traditional approach to maternity service delivery.

6 Maternal survey

Vivienne Bennett

Aim

The aim of this audit was to assess the response and reaction of women to the care they received during the Bellevue integrated maternity project. It was not possible to make comparisons with the conventional care group which consisted of pregnancies in 2000. However, it was hoped that issues which mothers thought to be relevant to their care would emerge, which could then give a picture of their responses to this pilot.

Method

Semi structured interviews were deemed appropriate for this audit, as they have the flexibility to explore attitudes or experiences described by the respondent (Rees 1997), in this case relating to AN care. They are useful when the response to identified questions cannot be predicted (Morse & Field 1995). Large numbers of interviews are not required in this type of data collection as representativeness refers to the data rather than the subjects or settings (Sandelowski 1986). The interviewer therefore followed a loose format in order that points were included to reveal mothers' experience and opinions of antenatal care. Appendix 2 shows the interview schedule.

Letters were sent to mothers inviting them to share their experience of antenatal care during a short and informal interview (see Appendix 3). Interviews were conducted over a 4 week period, usually in the health centre when the mother would be coming for a routine check-up in the mother and baby clinic.

Interviews were carried out and recorded by one interviewer. All recordings were anonymised when the narrative data was transcribed onto a secure computer system at the Perinatal Institute. Appendix 4 describes the anonymised respondents.

Content analysis was achieved by identifying emerging themes at the time of interview and also during the process of transcription. The point of data saturation was identified when no new themes emerged from the interviews; this occurred when 12 mothers had been included. 3 women were accompanied by their partners, who were able to contribute to the interviews. Transcripts were also read by an independent reviewer (J.W.), to confirm the themes identified.

Headings and categories were identified inductively through a process of 'open-coding' using the constant comparison method (Pope et al 2000). Common themes were grouped and the number of interviewees that identified a theme was recorded as a way of establishing it's importance. For example, eleven of the twelve interviewees identified 'continuity of carer' as an issue. Categories were broken down into smaller thematic groupings, where necessary, by a process of 'funnelling' (Burnard 1991) using grid analysis and are presented as Table 6.1. They were further amalgamated into three main topics for presentation: System of care, relationships and education.

Results

The sample consisted of a mix of primiparous and multiparous women, and included 'high' and 'low' risk pregnancies, as identified at the first AN appointment, and a mother with twins.

1 System of care

The provision of a flexible system of care that was available locally was much appreciated. Women commented on better access, and the ability of their midwife to facilitate quick referrals. Women felt they were able to 'drop-in' or phone if they had any queries and they valued having time to talk without being rushed.

> *…if I had any worries I'd be able to just go whenever I wanted to and see her, or phone her up and she'd come and see me.*

It was also recognised that not having a local service could affect uptake of care.

….like here [surgery] it's close by to us, so we can come and if it's far off, we'll also think…during the pregnancy you know…there are lots of problems women have…they would just avoid it.

Theme and subtheme	*No.*	*No./Total*
Continuity		*11/12*
Relationship	*7*	
Phone contact	*10*	
Not repeating	*5*	
Feeling safe	*4*	
System of care		*11/12*
Waiting	*8*	
Accessibility	*8*	
Flexibility	*8*	
Support network		
Own support networks	*3*	
Additional support network	*7*	
Professional friend		*10/12*
Fears	*4*	
Relationship	*8*	
Knowing and being known	*6*	
Parent education		*9/12*
Learning	*3*	
Preparation for labour	*5*	
Information	*4*	
Peer support	*3*	
Skilled professional		*9/12*
Source of knowledge	*7*	
Facilitator	*6*	
Advocate	*5*	
Post dates / IOL		*4/12*
Comparing care		*4/12*
Benefit to local community		*4/12*

Table 6.1 Responses from 12 interviews

Women waited more frequently, and for longer, at the hospital than at the surgery and comparisons were inevitable. However women recognised the expertise and facilities that were available to them at the hospital.

And it's like…you're in a queue…it's almost like – taking a ticket and waiting your turn……you have the more friendly, intimate, personal, one-to-one care we got down here

When women had to wait they appeared to be more understanding of delays at the health centre, which were perceived as justifiable. They recognised that if they required more time, the midwife would be able to give them that time and they wouldn't be rushed through their appointment

2 Relationship

Women valued greatly the continuity of carer during the antenatal period, which resulted in the development of a supportive relationship with 'their' midwife. This helped them to feel 'safe' and reassured. Interestingly, this was a particular feature for those with more complex pregnancies who may have had the majority of their antenatal care at the hospital.

> *I always end up under a consultant, and I'm at the hospital every single week, so you sort of feel very left out. I mean you never get the closeness with the MW and for the first time I had it.*

> *I wanted to tell everybody, because it was like bragging because if people said…people were shocked …you know to hear that I'd had the same MW.*

Much of the relationship was supported and augmented through phone contact. One woman who had a complex pregnancy, would phone after each hospital appointment as a means of reassurance. This suggests that although her clinical needs were being met, her psychosocial needs were not.

> *… my placenta was quite low and immediately after coming from the hospital I used to ring her and ask what to do. She really helped me.*

In this particular case, the woman had only lived in the UK for a year and was unfamiliar with the health care system. The open and non-judgemental attitude of the professional friend can promote a relationship of trust and mutual responsibility at a time when women can feel very vulnerable.

More flexible and frequent opportunities for communication increased the feeling of being known as an individual.

> *…you didn't have to repeat yourself then…because you see the same person, …it's the other things that (MW) knew … because of conversation.*

Several women described the relationship with their midwife as one of a friend or of a family member. This reflects work by Pairman (1998) which described the midwife as being a 'professional friend'. If a trusting relationship develops then sensitive issues are more likely to be disclosed.

> *you don't feel stupid crying in front of them, you can tell them like really personal things*

Some women commented on the qualities required of their midwife and recognised that midwifery is a demanding profession

> *you can't not like what you're doing if you're a MW - you just wouldn't last.*

> *…no way is she any sort of like … pushover for anybody either, she's a good … you know, she's a strong person which is really, really nice. She makes you feel safe.*

and that the relationship that develops can have far reaching effects upon individuals

> *… There's a lot of young girls here as well, who have got attitude…And I mean you see them with the midwife and they're different people…and it's because they've got to know somebody. …. because you are made to feel special. … there's this person who, when you walk in, looks happy to see you. You know…. And I think that's really, really important. I think it can add a lot to how…especially for the young mums*

3 Education and support

The local provision of parent education was appreciated and tailored to women's needs, with some women receiving it at home. Women felt they were well informed on general issues, as well as health issues and preparation for birth. A strong feature of parent education related to peer support. This encouraged the opportunity for questions and discussion and was promoted by the supportive and non-judgemental environment.

> *…if somebody else had the same questions as you, you would know that somebody else is going through the same thing. So it's quite comforting that was.*

The friendships that developed between women were fostered and supported by the provision of postnatal reunions. Several women described the support networks that were available to them whether from family and friends but often the midwife would be the source of not only information but also of support that might usually be given from family members.

…because in this country we don't have anybody like …we don't have any elder person……. my husband is here…he doesn't know much …so there was nobody to guide me…..I came to know a lot of things which I never knew.

This illustrates how the midwife is ideally placed to support those women at risk of social exclusion by coordinating their care and supporting them through their pregnancy. Women commented on the overall care they received, by comparing their experience to that of friends and family, or with antenatal care during a previous pregnancy. They concluded that their experience of care was clearly better than the conventional pattern of care.

…it was a lot better than previously because I never really saw (community MW) much through my last pregnancies…

A feeling of responsibility to the local community was also apparent

I think it's valuable to making sure that other people get the care that we have…I think that it's important for other people

Summary

Pregnancy is a time when women may access the health services for the first time. Promoting a positive experience at this point in a woman's life can be pivotal in boosting a woman's confidence and establish a firm foundation, not only for future health care messages, but also positive life style choices. Midwives are ideally placed to promote public health messages and present a role model. The one teenage mother who was interviewed in this sample stated that she was not really interested in a profession before, but would now like to become a midwife.

It was apparent that this model of maternity care based within the primary care team readily recognised women's priorities for care. It was regarded highly because:

- the system of care which represented continuity, ease of access, decreased waiting times and appeared to facilitate quick referrals
- the relationship with the midwife as primary carer made mothers feel safer and more re-assured because of being known as an individual.
- ability to be better informed through accessible parent education sessions and recognised channels of communication, which resulted in feeling better prepared for birth.

I would like to thank Jill Wright for her conscientious reading of the transcripts and encouraging support, and Linda Hayes for her valuable advice in writing up this audit.

References

Bowling, A. (1997). *Research Methods in Health. Buckingham, Open University Press.*

Burnard, P. (1991). *A method of analysing interview transcripts in qualitative research. Nurse Education Today. Vol 11, p 461-466.*

Morse, JM. Field, PA. (1995). *Qualitative Research Methods for Health Professionals (2nd Edn). London, Sage Publications Ltd.*

Pairman, S. (1998). *Woman-centred midwifery: partnerships or professional friendships? New Zealand College of Midwives Journal. Nov 1998. No 19, p 5-10.*

Pope, C. Ziebland, S. Mays, N. *Analysing qualitative data. IN: POPE, C, MAYS, N.(Eds)(1999). Qualitative Research in Health Care (2nd Edn)(Ch 8). London, BMJ Books.*

Rees, C. (1997). *An Introduction to Research for Midwives. Cheshire, Books for Midwives Press.*

Sandelowski, M. (1986). *The problem of rigor in qualitative research. Advances in Nursing Research. Vol 8, No 3, p27-37.*

7 Staff survey

Andrew Carson

Introduction

An alteration to the structure and function of any team may have unforeseen consequences and it was felt important to assess the perception of the new maternity service from the point of view of staff within the team. There could be a number of approaches to obtaining this type of information, including structured or semi-structured interviews or questionnaires. At the time of carrying out this particular aspect of the audit of the new service in January 2003, there were some thirty team members apart from the midwife who needed to be invited to take part in sharing their views. For logistical reasons it was not possible to offer one-to-one interviews with so many staff members. Feedback within a focus group was not used as it was felt that staff might prefer to give anonymous feedback. For this latter reason the decision was made to use a questionnaire.

Methodology

A questionnaire was developed through discussion with members of staff at WMPI and Bellevue Medical Centre. The final form allowed staff to record comments as free text as well, as recording closed question responses. At the beginning of January 2003 the questionnaire was circulated to thirty employed and attached staff, a breakdown of which is shown in Table 7.1, along with the response rate from each group. Respondents were asked to return the questionnaire to a particular member of staff who had not been involved in the earlier development of the maternity service. The results of the staff survey are summarised in Tables 7.2-7.6 below. Representative comments made by staff are shown below the tables.

Results

Staff group	Number of questionnaires sent	Response rate
General Practitioner	*12*	*8*
Practice Nurse	*3*	*3*
Health Visitor	*2*	*1*
District Nurse	*2*	*0*
Primary Care Manager	*1*	*1*
Administrator	*2*	*1*
Secretarial/Clerk	*4*	*4*
Receptionist	*4*	*4*
Total	*30*	*22 (73.3%)*

Table 7.1 Staff questionnaire response rate

	Yes	No	N/A	No response
Interaction with midwife before May 2001	10 (45.5%)	3 (13.6%)	7 (31.8%)	2 (9.1%)
Interaction with midwife after May 2001	19 (86.4%)	2 (9.1%)	0	1 (4.5%)

Table 7.2 Interaction with midwife before and after service development

	Increased	Decreased	N/A	No response
Change in contact since May 2001	11 (50%)	1 (4.5%)	2 (9.1%0	8 (36.4%)

Table 7.3 Change in contact with midwife

"I will frequently have discussions about mothers with the midwife, both informally and formally."

	Yes	No	N/A	No response
Adequate contact	22 (100%)	0	0	0
Adequate support	20 (91%)	0	1 (4.5%)	1 (4.5%)

Table 7.4 Perception of adequacy of contact with midwife and support since May 2001

"I feel I have total support from the midwife."

	Satisfactory	Unsatisfactory	N/A	No response
Access to midwife before May 2001	3 (13.6%)	8 (36.4%)	7 (31.8%)	4 (18.2%)
Access to midwife after May 2001	20 (91%)	0	1 (4.5%)	1 (4.5%)

Table 7.5 Staff access to midwife

"The midwife is easily contacted and always able to give help, support and advice."

"Prior to May '01 I had little or no contact with the midwife. Problem cases were rarely, if ever, discussed. Now I have frequent contact with the midwife over the course of a week and any problem cases are flagged up at an early stage. Uptake of parent education sessions has been a remarkable turn-around with most mothers now attending sessions."

"Before May '01 my contact with the midwife was mainly by telephone, usually initiated by myself as and when problems occurred. Now my contact with the midwife is daily and mainly in person and all the mothers who have problems are known either to me or my colleague before the baby is born."

	Yes	No	N/A	No response
Difficulty making client referrals before May 2001	5 (22.7%)	3 (13.6%)	13 (50.1%)	1 (4.5%)
Difficulty making client referrals after May 2001	0	15 (68.2%)	6 (27.3%)	1 (4.5%)

Table 7.6 Perceived difficulties in staff making client referrals to midwife.

"Before May '01 it was often difficult to find the midwife and for her to give time to your specific problem. If there were problems with known mothers, joint visits and social service referrals took a long time to set up and this often compounded the problem. As there is now daily personal contact these problems do not arise."

"…been able to refer pts quicker since May '01 due to increased access to midwife."

"Very good service from our midwife - a personal approach - she shows real understanding and is always supportive and helpful."

At the end of the questionnaire, staff were invited to make any further observations, whether negative or positive, about the maternity service at Bellevue. Some representative contributions are set out below:

"Currently we have an excellent midwifery service to mothers. We have a much better uptake of antenatal care from patients and the quality of antenatal and postnatal care delivered has saved us as GPs a lot of time and concern. The whole process is streamlined and patient focused. Antenatal care has been enhanced by parentcraft, relaxation for mothers and the postnatal care has improved with the breastfeeding programme and support from the midwife's and health visitors' team. Mothers who have had home births have been delighted with the experience under the skill and care of the midwife."

"Excellent service - good continuity of care and good communication between GPs and midwife."

"I feel that the antenatal mothers at Bellevue now have a service that is second to none. Everything that is discussed from a best practice viewpoint is now carried out. The midwife does not work in isolation from the primary health care team but works with us and utilises our particular skills to enhance the work that she does. As a health visitor I find I am more actively involved with my patients antenatally. I am aware of any medical or social problems prior to the birth of the baby and when problems occur, a decision about care is made as a team, which means that I am not practising in isolation."

Staff were finally asked for any further comments that they wished to make. There was general consensus that the service was working extremely well and that mothers were receiving a very high standard of care.

"There is a window of opportunity during the antenatal period mothers-to-be are very open to listen to advice. I have found that if we can utilise this time and make it a good experience for mothers, then they will ultimately use the service better and are more ready to listen to advice once the baby is born. I feel that this is OK and the reason that our breast feeding figures have increased. Also with a better understanding of what goes on, the mothers appear to be having better birth experiences. Only anectdotal but we are getting less post-natal problems. As we are working towards better standards in clinical governance, I feel that the way the midwifery service is now running at Bellevue constitutes a high standard of care that other practices should be working towards.

Discussion

There was a good response rate with 73% of questionnaires being returned, with all groups of staff within the team being represented, with the exception of the District Nurses. It is interesting to note that fewer than half of all respondents (45%) indicated that they had had any interaction with the incumbent midwife prior to the service modernization. This rose to over 86% of the team having some form of contact with the midwife who was integrated into the team. Whilst it is possible that some of this change could be ascribed to staff turnover during the period between May 2000 and January 2003, this is unlikely to account for the scale of the change observed. The fact that most respondents indicated that they had some form of interaction with the midwife

under the new arrangements appears to be a reflection of the level of integration achieved by the midwife and the rest of the team. This fact was further supported by the fact that all respondents reported that their contact with the midwife was adequate at the time of administration of the questionnaire, while 90% indicated that the support that they received from the midwife was also adequate.

Fifty percent of respondents reported that their contact with the midwife had increased following the integration of the midwife into the primary care team. The one respondent who indicated that their contact had decreased commented that this was simply due to the fact that they had dropped their commitment within the practice to a single session per week, with their having no involvement with any pregnancies since the midwife had taken up her post within the team.

The shift in the team's perception of satisfactory access to the midwife from 13% under conventional care to 90% with the new, integrated service should come as no surprise, with the midwife being based within the surgery premises and working closely with team members. The fact that no members of the team reported any difficulty in making client referrals following the implementation of the integrated service would also appear to support the ease of access to the midwife. The increase in numbers of staff members who made referrals to the midwife from 36.4% respondents to over 63% also suggests that a greater variety of members of staff felt able to refer clients to the midwife under the new arrangements, again indicating that the entire team was functioning in a more integrated way.

Conclusions

From the point of view of the staff involved within the team, integrating the midwife into the rest of the primary care team resulted in:

- More members of the team and a wider range of staff having contact with the midwife;
- Staff generally felt that the contact with, and support from the midwife was far more satisfactory than it had been previously;
- Ease of access to the midwife increased, as did the number and range of people making referrals to the midwife;
- No adverse comments were received from team members about the integration of the midwife into the team and the ensuing impact upon the team and the service delivery;
- Those with closest involvement with the maternity service felt proud of the quality of the new level of service to Bellevue mothers.

8 Midwife's report

Angela McBennett

Introduction

The purpose of this project was to develop and evaluate a needs led, community based maternity care for women and babies at Bellevue. It was to include working with other disciplines in key areas of public health. (Please refer to Dr A Carson and Professor J Gardosi's report for information prior to the project).

Demographics

This is an inner city area, with a great deal of poor housing that is mainly rented. Many of the women are lone parents and often isolated due to living in high-rise flats, language barriers, teenagers, depression, drug addiction, having no close family networks etc. Approximately two thirds of the women are from multi ethnic groups, and a growing number of families moving into the area are seeking asylum. Many of these women do not speak English and find it difficult to access health services due to language barriers, but also problems in understanding the system of care in this country.

This is an extremely mobile population with an annual turn over rate of approximately 30%. Timely, equitable and accessible care is essential for all women especially the most disadvantaged, as noted in the latest confidential enquiry into maternal deaths report [1]. This found that women from the most disadvantaged groups of society are 20 times more likely to die compared to those in the highest two social classes. Sadly this latest report also found that women who were from ethnic groups other than white are, on average, twice as likely to die than women who are in the white group. A high proportion of the women were non-English speaking. Perinatal and child hood mortality and morbidity also follows similar poor outcomes. There appears to be a huge need for accessible and equitable health care for families such as those living around the Bellevue Practice.

Women have been described as the 'gate keepers' of health for the family [2]. Pregnancy is a lifetime transition for women. Midwives are in a unique position to influence lifestyle changes in pregnancy when women are most receptive, therefore improving health outcomes for both mother and baby [3].

Midwife's experience prior to the project

Prior to commencing this exciting position, I have practiced as part of a core team working on delivery suite and also a community midwife. Since qualifying as a midwife almost 10 years ago, the majority of my care has been based within the community. This involved providing caseload care for women throughout their maternity experience, and also traditional antenatal and postnatal support shared within a midwife team of between 5 and 8 midwives. These two models of midwifery care worked closely with team members, however contact with the rest of the primary health care group e.g. health visitors, G.P.s was often fragmented.

Getting started

This two-year pilot study involved three extra half-day sessions a week dedicated to Bellevue Women and families. Prior to this there was only one midwife antenatal clinic a week, and no parent education provision from midwives at the Medical Centre. This protected time enabled me to be able to develop and provide maternity care that focused on public health and the individual needs of the women, their babies and families. The G.P.s at the practice were keen to include the midwife as part of the team at Bellevue and therefore a room was provided for the midwife.

This is a joint position, involving the other 6 half days working as part of a team of midwives from Birmingham Women's Hospital, providing care in the community, hospital clinics and delivery suite. Being a joint position I was faced with the challenge of implementing enhanced and conventional care patterns.

It was important to familiarise the rest of the midwifery team with this new way of working. This was a new area for me and the team at Bellevue were very welcoming from the Health Visitors, Practice Nurses, Receptionists, Practice Managers, and G.P.s etc. This integration enabled me to quickly learn about the local

support networks for women both professional and voluntary. Familiarity with the main maternity hospital where the majority of the women booked was of immense value in helping women access timely and appropriate care. It enabled a seamless service between the community and the acute unit. This follows the recommendations of the Royal College of Midwives Report Vision 2000 [4].

Developing a 'women led' service

Having a base at the Health Centre enabled me to quickly ascertain what the concerns were from both the Bellevue staff and also the women themselves. As the population are so mobile, my first goal was to ensure early contact with women who are pregnant or contemplating pregnancy. Working so closely with the team at Bellevue makes this possible as communication is excellent and everyone is aware of the process of referral.

It was quickly apparent that the women and other patients at Bellevue have a very high regard for their health centre. They advised that they find it comfortable, within easy reach and feel more relaxed than when receiving their antenatal care within the hospital. The two health visitors Jackie Charlton and Elaine Meredith are based at Bellevue and both have a wide experience in public health. The Health Visitors have a wonderful understanding of the women and their families.

After meeting many of the mums in the area and discussion with the primary care team and support networks, the main elements of care need to focus on accessibility, flexibility, continuity of care/carer, risk assessment, co-ordination of care, equitability, education and communication. I was in the ideal position based within the G.P. practice to be able to plan and help provide this enhanced service with the help of Bellevue colleagues' expertise in certain areas e.g. anxiety management, sexual health etc.

The timing of the midwife sessions at Bellevue were provided around the optimum time for women e.g. drop in clinic on a Wednesday morning when the Citizen Advice Bureau service is available also at Bellevue. Parent education is available on a drop in basis, on different days and times. Initially the timetable was developed between Cynthia Folarin, Public Health Specialist Midwife from the West Midlands Perinatal Institute and myself. The time was agreed with Dr Andrew Carson, G.P. and my Midwife Team Manager. It has changed slightly to meet the needs of the women and to be able to provide unplanned postnatal care at home and home confinements. Also as this is a lone project at present, the service provision needed to bear in mind any annual leave etc. The extra 3 midwifery half day sessions would not be covered during my absence, although the Midwife team would provide one of the antenatal clinic sessions. Initially I thought it would be difficult to plan regular extra antenatal sessions around this, however, it has worked well with careful forward planning. I quickly learnt that the midwife could not provide all the services, and it was in the best interest of women to utilise the vast array of support networks available.

The development of the maternity service provision for Bellevue has been continually evaluated and changing to meet the needs of the women.

Communication and Accessibility/Flexibility

All of the women are aware of my mobile telephone number and emergency telephone numbers. Women, their partners, older children and grandparents often contact me via the mobile number for a variety of reasons e.g. anxieties in early pregnancy, new pregnancies, miscarriages, emergency contraception, housing problems, abdominal pain, fetal movements, breastfeeding problems, domestic violence etc.

Meeting the women in the community at the earliest possible time in their pregnancies helped me to develop a closer relationship with the women as early as possible. This enabled me to assess their individual needs as timely as possible. For example a young mum who had recently been addicted to cocaine and had a very traumatic childhood was able to confide in me that she was experiencing domestic violence. This enabled me to assure she had the relevant support (substance addiction team, Women's' Aid etc) and telephone contacts. She went on to experience physical abuse during the middle of the night, was able to seek refuge and leave Birmingham for the safety of herself and unborn child. Pregnancy had a very positive effect on Mandy (pseudo name). She left her violent partner and went to live in another part of England with her mother and felt that she no longer had to endure the ongoing violence she had previously tolerated. Mandy was now protecting her unborn baby, she frequently telephoned me to seek advice and I encouraged her to register with a local G.P. and meet her new community midwife, which she did. The local midwife was aware of Mandy's past and needs. Mandy had previously had a fragmented experience of health care, had a history of persistent

defaulting G.P./Practice Nurse appointments and very low esteem; by having early and accessible care she was able to feel in control of her future and empowered by needs of her unborn baby. This flexible model care enabled Mandy to "drop in" to the practice to see the midwife and the primary health care team to work together towards her needs.

This model of care has encouraged more women to self-disclose domestic violence. This is possibly due to the midwife being more accessible, increased continuity, more time to spend with women, having a higher community profile and an increased network of information from other primary care members. Studies have found that domestic violence often escalates during pregnancy [5][6]. This is likely to have negative effects on both maternal and perinatal well being, it is imperative women have access to rapid and empathetic care.

The Bellevue model of care is an integrated provision of care with the primary health care team and outreach workers. This provides the highest quality of care for women targeting holistic and long term health care for the woman, her baby and family. Communication levels are outstanding and having a base within the health centre enables early and frequent contact with the other carers to establish the best plan of health care. This is imperative in such a mobile population and it enables an individual plan of care to be established for each woman. Often when child protection issues are involved early contact and communication with the parents, health visitors, counsellor, G.P., Social Services and myself (midwife) enable the best interests of the baby and parents to be achieved. This is by empowering the parents to make choices regarding antenatal care, education and close partnership working with the agencies involved in the best interests of the baby.

G.P.s often contact me via email, mobile phone or just personal contact within the health centre with concerns, requesting advice or information regarding mothers and babies. We work as a team and I believe the Health Centre staff has an appreciation of the role of the midwife. This not only enhances my job satisfaction, but also provides higher quality of care through increased continuity and reduced contradictory advice. It is very satisfying to have a view of the long-term health care for the woman, her baby and family, with clearer public health targets. As midwives we often only see a caption of the family health needs. We are in a prime position to influence the health of the family at this vulnerable time. This model of care enables the midwife to achieve long-term public health objectives for the woman and her baby, through interagency collaboration and empowering women with this information.

Continuity

There is much debate as to the benefits of continuity of care/carer. A survey of women's views of maternity care found that many women commented on their lack of continuity of carer during the antenatal and postnatal period [7]. Women advised that it was frustrating having to explain everything at each consultation with a number of professionals. They commented that they were concerned that mistakes could be made, as one mother commented "Everybody I met was very helpful and friendly but it was very frustrating having to explain each time I went for a check up who I was, etc, because it was always a different person and they would often make mistakes or misread my notes – which was very worrying, especially near my delivery" [7 p58]. Concerns were also raised regarding contradictory advice. Continuous care with the same person throughout labour was rated as more important with twice as many women saying it was 'very important', as those who said it was important to have met the staff before [7]. It has also been suggested that this information may be subjective; as women may only be able to comment on the care they have already received. However, anecdotal information from women and experience suggests that continuity of care increases the quality of the care provided during the antenatal and postnatal period.

The Bellevue Model of care has vastly increased the continuity of care and carer. Continuity of care is essential in such a mobile inner city area. The increased communication with the Bellevue Team has enhanced the holistic and long-term health care plans for families.

The continuity helps to reduce contradictory advice and enables time to build up trusting relationships and change attitudes. Women, who have had traumatic experiences, need not repeat this memory on a regular basis by seeing many different midwives.

As a midwife, I have found the increased continuity of care very satisfying and it enables me to notice subtle differences in a woman that may indicate a problem. Also having the advantage of background information that is not usually available within the pregnancy notes, provides a greater holistic assessment.

Tackling inequalities in health

As already defined in several studies dating back for many years for e.g. the 'Black Report' [8] infant and adult mortality and morbidity continues to have the unequal balance of higher deprivation. It correlates with increased morbidity, accidents and mortality and decreased uptake of preventative health care. The population served by Bellevue live two or three bus rides away from the three maternity hospitals.

Many of the women are lone parents and have to rely on public transport. As already mentioned the majority of the parents identify with their local health centre, which is easily reachable and welcoming. This model of care offers the majority of antenatal provision/education within the Bellevue Medical Centres. The parents find this non-threatening, their children are welcomed and it should have no financial and less time constraints.

As already mentioned two thirds of the women are from multi-ethnic groups with many of the mums understanding limited English. Continuity of carer helps to establish an understanding of the woman's needs and enables more time for a trusting relationship to be formed. This is vital for these women whom may find the culture of the British health services difficult to understand and they may feel vulnerable. Important health issues may be less likely to be missed if communication and trust is established. It is important that the midwife is up-to-date with evidenced based care.

Teenage parents have been known to be less likely to book for antenatal care at an early stage and uptake parent education. Many teenage mothers have experienced poor social histories. However, pregnancy can sometimes have a positive affect for women who have had oppressive pasts. A study found that mothering could have a corrective experience that promotes the development of maturity and responsible behaviour for some young mothers with disruptive childhood experiences [9]. Therefore support and the promotion of positive parenting skills are vital components of maternity care. During this project I have found teenage parents extremely unlikely to default from community clinics, have an excellent take up rate of parenting groups and often take a lead during the education sessions. I feel this is due to the local environment and that as the majority of the parents have some difference through, social class, age, ethnicity, language etc., teenage parents do not feel alienated. All the parents know me before the sessions and this makes a huge difference to the women's self-confidence and also to my own ability to meet their individual needs. Antenatal care is sometimes provided at home on occasions and this enables me to communicate with grandparents and work with the family. The educational future and prevention of an unplanned further pregnancy is part of the care provided by the midwife.

During the project many teenage parents have been helped. At the beginning of the placement an 18-year-old pregnant young single woman who had no permanent address: came to see one of the G.P.s. She was late booking at approximately 25 weeks pregnant. The G.P. telephoned me and conveyed her concern regarding this young woman. I contacted her immediately and arranged to see her at home. Megan (pseudo name) was extremely withdrawn. After a few contacts she began to attend the parent education groups and excelled as a member. She went on to give birth to a beautiful, term baby of a good weight by a normal delivery and breastfed him for at least six months. Megan found accommodation and has started a college course that has a crèche for her baby. Pregnancy had a positive effect for this young mum, she was able to feel empowered as a new mother and that there was future for her and her baby. It was such an inspiration to be able to be the midwife who helped to support this young mother through continuity and local care.

Many women and families seeking Asylum have recently moved into the area. Often the women have had traumatic experiences before entering England and have intense problems with cultural differences, language, financial hardship, poor health, emotional trauma of leaving their families, lack of understanding of the health care system, isolation and so on. Maternity care within the community enables them to establish a base and the integration of their health care is vital. As a midwife the more information and services available to help these parents at a local level the better. One of the mothers I recently cared for has many needs, she needed emotional support as she had problems with her asylum application, her English was limited at first, and she had underlying health problems, felt isolated, was pregnant with her first child and had severe antenatal depression. She was able to gain support from other mothers in the parent education groups, myself, Health Visitor, G.P.s, In-house Citizen Advice Bureau, Consultant Psychiatrist and Mother and Baby Team. Saraswati (pseudo name) went on to have a term normal delivery of a bonny girl and breastfed. She has bonded well with her daughter and has returned to college to learn English.

Women experiencing substance abuse are often found to be living on the fringe of society and are less likely to access health promotion. At this G.P. practice many of these women attend for other family members,

e.g. children, partners, parents etc. By having an increased presence at the surgery the woman may be more likely to receive antenatal care and follow-up. As the woman is already familiar with the centre she will be known to some of the primary health care team and may feel more relaxed in this environment, rather than a hospital. As an example one mum who was expecting her first baby attended Bellevue regularly for antenatal care, she felt unable to attend a group for parent education and therefore benefited from one to one sessions to meet her and her partner's needs. We worked closely with her local support with the addiction support group to continue her alternative therapy. Maggie (Pseudo name) felt uncomfortable during her consultant visits at the hospital and was concerned that her carers may be judgemental. I arranged to meet her after her scan appointment and accompanied Maggie and her partner around the labour ward, neonatal department and transitional care ward. They were able to meet the staff and felt more relaxed and had a greater understanding of their plan of care. She continued to attend all her antenatal appointments and had a term normal delivery of a bonny healthy baby son.

Poor or lack of housing is often a problem for pregnant women in the area and obviously has an adverse affect on their own health and the health of the baby. As the midwife who regularly sees the mums in community, being aware of the local networks enables the facilitation of extra support and information.

Mental health and sexual abuse

Many of the families living in the area suffer from depression and anxiety. Poor mental health in pregnancy and after childbirth is likely to have serious affects on the woman's health and therefore affecting the baby and other family members. Often this leads to long term health problems, poor education, deprivation and sometimes-even death. A summary of the Confidential Enquires into maternal deaths, found that the leading cause of maternal death within the first year of birth was suicide [1]. The increased integrated care within the community has enabled earlier identification of mental health problems and network of appropriate facilities.

The increased communication between the woman, her family and the midwife due to continuity and accessibility has helped women to divulge sensitive concealed problems. For example, a mum Carrie (pseudo name) who was expecting her second baby who had always 'put on a brave face' at each of her visits, suddenly broke down and revealed intense negative feelings towards her baby. She went on to receive home visits for antenatal care/support in combination with Obstetric Consultant review, Psychiatric Assessment and Health Visitor support. Carrie later gave birth to a term, good weight, healthy baby whom she breastfed and continued with ongoing mental health care.

Many of the women are lone parents and isolated. The provision of local parent education groups, 'drop in' antenatal time, anxiety management groups and information regarding outreach services e.g. Citizen Advice Bureau within the centre helps to reduce women's anxiety at an early stage. It is possible that acknowledging worries and listening to women are strategies that may help to reduce women's worry during pregnancy [10].

Contrasting enhanced and conventional community care provision

Whilst providing this newly developed model of care for the Bellevue families, I became the named midwife for another practice on a temporary basis of eight months due to short staffing in the midwife team. This was a small and friendly G.P. practice. The area covered was not as generally deprived as the Bellevue remit, however, it also included students who were often isolated from their country and families. Many of the women also experienced medical and obstetric problems. During this period of time it became even more evident that the overwhelming quality of the care I was able to provide for women in each practice was extremely different. This was due to having the autonomy and time to provide the care needed for the Bellevue women, whilst having to offer the traditional midwifery care to the other practice.

As a midwife I always endeavour to provide the best possible care that is tailored to individual women's needs and like many other colleagues feel frustrated with limited time and resources. By visiting the other surgery only one half day a week and sometimes only providing fortnightly clinics, communication with the primary care team is often difficult. During the eight months I had very little contact with the named Health Visitor as she was based elsewhere. In contrast having a base at Bellevue along with the Health Visitors, G.P.s, and Outreach workers enabled a more holistic awareness and long-term health outcomes. Midwives from other areas who were keen to share ways of enhancing practice, came to visit Bellevue and student midwives have been extremely eager to experience a different model of community care. They have expressed that their placement during the project was a very positive learning experience (see appendices).

Having the privilege of a nominated room, time to spend with women and being included within the primary health care team increases the feeling of being a valued member of the team. Often midwives express their despair at being given inappropriate rooms, with little regard for privacy at G.P. practices. This is likely to affect their ability to provide unrushed consultations and integration into the primary health care team. Midwives may feel unvalued and frustrated in not being able to provide the quality of care needed and leave the profession [11]. It may also not help women's' self-esteem and convey the importance of their antenatal care. A study by Mavis Kirkham found that even if women were extremely worried or upset, they rarely contacted a midwife, because they 'did not want to trouble her' [12].

It was ethically difficult providing two models of care for women at the same time. The communication and relationship with the women at Bellevue was enhanced due to the continuity, community integration, having more time, personally providing the local parent education classes and greater flexibility. This enabled improved public health messages to be conveyed and closer work within the family.

Summary

This integrated model of care facilitates the role of the midwife as an Advocate. The majority of the services provided are local and accessible. Therefore offering more of an equitable provision of care. Domestic violence and mental health problems are more likely to be self-reported. This is due to continuity of carer and improved accessibility, as the midwife can develop a closer relationship with the woman and increase her awareness of subtle changes. The increased midwife presence in the practice has facilitated informal contact with women and reduced defaulting appointment rates. The midwife feels a valuable member of the Primary Health Care Team and enjoys greater job satisfaction as an autonomous practitioner. This enables more flexibility to develop community maternity services to meet the needs of the local population. Also an understanding of the care provision within the maternity hospital and points of contact, enhance the provision of a seamless service for women. Student midwives value their experience at Bellevue as a wonderful learning environment and feel inspired to deliver women's' led care in the future. Improved partnership working, greater autonomy and working conditions may improve the retention and recruitment of midwives.

I would like to express my appreciation to colleagues and friends from Bellevue, the Edgbaston Team of community midwives, Birmingham Womens' Hospital and West Midlands Perinatal Institute for their suppport during the project. A special thank you to all the parents for their participation, openness and willingness to share their experience with others.

References

1. Department of Health. Why Mothers Die 1997-1999. *The Confidential Enquiries into Maternal Deaths in the United Kingdom*. RCOG Press. London, 2001.
2. Oakley A. *Sex, Gender and Society*. Maurice Temple Smith, London, 1972
3. Byrom S. *Supporting Teenage Mothers*. ENB for Nursing, Midwifery and Health Visitors. Midwives in Action: a resource. ENB. London. 2001
4. Royal College of Midwives. *Vision 2000 - Executive Summary*. RCM, London. 2000.
5. Royal College of Midwives. *Domestic Abuse in Pregnancy*. Position Paper 19, RCM: London. 1997
6. Mezey G C. IN: *Domestic Violence in pregnancy*. Chapter 21. Bewley S, Friend J, Mezzey G (eds) 1997.
7. Audit Commission. *First Class Delivery*. National Survey of Women's Views of Maternity Care.1997.
8. Townsend P, Davidson N (eds) *Inequalities in Health*. Hammondsworth. Penguin. 1982.
9. Smith Battle L. *Developing a caregiving tradition in opposition to one's past : lessons from a longitudinal study of teenage mothers*. Public Health Nurse, 17: 85-93, 2000.
10. Homer C, Farrell T, Davis G, Brown M. *Women's worry in the antenatal period*. British Journal of Midwifery 10 (6) : 356-360 June 2002
11. Kacary R. *Pushed to the limit* The Practising Midwife 6;6, p42. 2003
12. Stapleton H, Kirkham M, Curtis P, Gwenan T. *Silence and time in antenatal care* British Journal of Midwifery 10; 6:p 393. 2002

9 Parent education survey

Angela McBennett

Purpose of parent education

Until fairly recently classes to help women to relax during labour and prepare themselves psychologically for childbirth were focused on middleclass and articulate women [1]. In addition to these aims important public health issues need to be incorporated during pregnancy. Therefore antenatal education should also include these health messages to work towards changing attitudes and beliefs. 'Saving Lives' [2] a Government document advised: "Midwives are uniquely placed to improve health and tackle inequality through services to women and their families" [2 : 135-136]. Education has the possibility of empowerment, improving health spiritually, physically, socially and mentally, and providing hope for the future.

Provision at Bellevue prior to the enhanced community service

The majority of parent education provision was provided within the Maternity hospitals. This involved travelling on at least two bus rides away. There was no midwife led parent education group provision for women within the Bellevue Centre. The Health Visitors were concerned, as the majority of women did not attend any form of parent education group. Therefore they set up some sessions for women on a short-term basis at the Practice. It evaluated well, however, they felt it lacked midwifery input and small numbers were involved. Unfortunately the Bellevue location is not part of a Sure Start area (Government Initiative for deprived areas). Although there are services outside the area, women are reluctant to attend due to concerns of safety walking through certain areas, and are not familiar with the staff there.

Programme development

During the two-year project the provision of parent education groups has continually developed. It has changed to try and meet the needs and suggestions that women and their partners have shared through anonymous evaluation sheets after each session. Different days, times and venues have been included.

The Bellevue Practice has a great deal of resources in skill mix and I have co-ordinated the sessions to include colleagues. These include Health Visitors, Sexual Health Outreach Workers, Counsellor, student midwives and myself. Yoga sessions and baby massage was also provided for a set period of time. The integration of health workers enables a relationship to be developed before childbirth and also for the families to receive a wider public health education.

Attendance at Bellevue

92 (61%) women attended parent education groups at Bellevue out of a total of 150 births during the two-year period.

- 63 primipara
- 29 multiparas

The groups also included partners, siblings, friends (inc. other pregnant women from different areas), parents, grandmothers and students. There was a large diversity of cultural and ethnic backgrounds. Approximately 64% of the pregnant women were from minority ethnic groups. This was sometimes a challenge due to language barriers, interpreters were provided when possible. Many of the mothers brought friends to interpret and the method of teaching was developed to include a large proportion of visual aids. This rich diversity of people helped to create a very interesting learning environment for all of us as they often shared their experiences.

There were a variety of age groups, social classes and parity. A young mums to be group was set up initially with a poor response. However, the younger women were happy to attend a mixed age group and the attendance was 70% of all the teenage mums (aged 19 years or under). Teenage fathers also came along for some of the sessions and supported their partners. The younger women often took the lead role in the group discussions and had much to offer. All three of the mums whose unborn babies were on the Child Protection

'At Risk' register attended parent education groups. None of these three mums had received any parent education in their previous pregnancies. Attending these sessions helped raise their self-esteem, and two of the mums were able to share their birthing experience with first time mums.

One to one parent education was provided for the majority of women who did not attend group sessions; therefore almost all the women at Bellevue received parent education either at home or Bellevue.

Benefits of provision held within a medical centre

- Easily accessible
- Familiar environment
- Women already know the midwife
- Parent education is actively encouraged by the midwife who provides antenatal care – enhances continuity of care
- Opportunity to meet other local Health Care Professionals who may be involved in their care later
- Meet new local friends
- Parent led emphasis on learning from each other
- Young siblings are welcome to come along
- Experienced mothers attend to offer peer support
- Breastfeeding buddy mother support
- Flexible – drop in (not prebooked)
- Utilisation of local network of skills and resources
- Rich diversity of age groups, social, ethnic and cultural backgrounds and many mothers are lone parents.
- Greater public health emphasis e.g. diet, sexual health, stress management etc.
- Early pregnancy group, inc. preterm delivery information

Evaluation of parent education by parents

Methodology

A total of 130 separate evaluation sheets were completed. It was emphasised these would be anonymous and to feel free to use constructive criticism to enable regular review of whether the sessions are meeting the needs of those attending. The majority of the responses included comments. A short evaluation sheet was used (Appendix 5), using an adapted version of Mary Nolan's questionnaire [1].

The responses to the question, "What I found most helpful about the class was…" correlated into themes. Twelve themes were highlighted (Appendix 6). The information was also reviewed with a credible midwife experienced in Parent Education (BE).

Findings

The main themes involved:

- Preparation and Information on Labour and Birth (24 comments)

  For example: "Finding out about how the pelvis affects delivery" and "What to expect during the different stages of labour and different options i.e. water births"
- General Information/help advice (23 comments)

  For example: "Overall information and diet" and "All the information was helpful"
- Meeting other people and peer support/mum & baby (21 comments)

  For example: "People sharing their experience. Able to ask questions, you don't get this opportunity during an antenatal appointment at the hospital." and "Getting to meet moms who are breast feeding and getting to talk to people who are in the same situation as me."

Other themes were:

- Relaxing/enjoyable and reassuring (13 comments)
- Information on Preterm Births and Baby Development (10 comments)
- Breastfeeding (8 comments)
- Visiting the Delivery Suite with named midwife (7 comments)
- Pain Relief Information (5 comments)
- Role of the Midwife (5 comments)
- How to help your partner (2 comments)
- Contraception (1 comment)

There was no particular theme to the comments regarding the three last sections and each comment was very individual:

"What I found least helpful about the class was ..."

"... the humidity of the weather"

"... being brought around the delivery suite"

"... no Turkish cassette"

"General discussion on medical aspect" (doctor)

"Since this is my second pregnancy a lot of the things discussed were things which I already knew of before"

"What I least liked about the course was ..."

"... building work"

"... fridge was making a lot of noise"

"... I sometimes couldn't get to them during the day – happy to have notes/booklets if can't make them"

"... it is only something little the subtitles on the video that's all"

"What else I would like included"

"A full on video to scare myself"

"Gentle exercises before and after pregnancy"

"More time and leaflets"

"Ball Birth Video"

Where possible all of these issues were addressed for next session.

Comments on Findings

It was surprising that women commented less on pain relief in labour (5 comments). Anecdotally midwives previously expected women's main interest in parent education to be regarding pain relief. This evaluation suggests that women wish to be prepared for labour and birth, receive general information on pregnancy, the opportunity to ask questions, share experience with other parents, peer support, and the opportunity to discuss worries and questions. The majority of parents 95% felt that they had learnt a great deal/quite a lot from the group sessions. 98% of the respondents felt that as a whole the classes had been Excellent/ very good. This helped the midwife to assess the teaching methodology and was one of the tools used to review learning targets (Figure 9.1).

The provision of Early Pregnancy groups is a fairly new innovation, this has evaluated well with 10 comments regarding preterm birth and fetal development. Obviously different group dynamics will produce different directions in classes. These evaluation comments were received from a wide variety of women and non-English speaking women completed the forms with the help of an interpreter. Therefore this was a good representation of the population for Bellevue. It was difficult to followup all postnatal women due the transient nature of the population in this area. However of the 79 women whose records were available

66 (83%) went on to breastfeed. Seven of these women mixed fed. Breastfeeding information was included in every parent education group to help gradually change attitudes via information, and meeting local breastfeeding mothers.

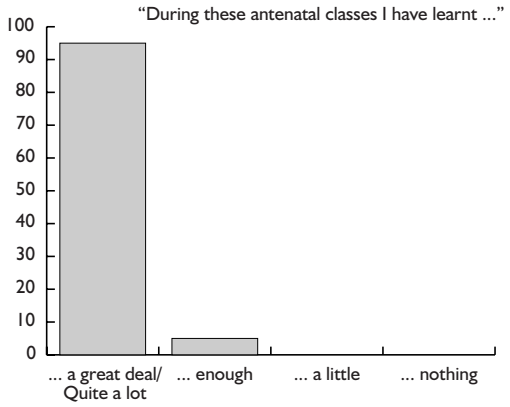

Figure 9.1 Responses from Question 1

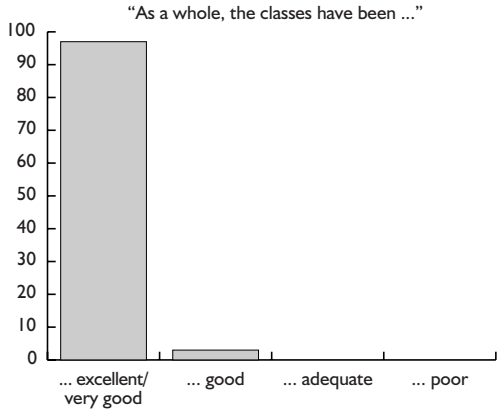

Figure 9.2 Responses from Question 2

Summary

Parent education was provided at the health centre and was also available on a one-to-one basis, for those women who were unable to attend local sessions. Sessions included a rich diversity of people and were well received. The majority of teenage parents attend the parent education groups. Sessions were enhanced and enriched by other members of the Health Centre's staff/out reach workers providing their expertise. Women and families have evaluated the education groups as an enjoyable learning experience. The main themes on what parents found useful were; information on labour/birth, general information, peer support and the opportunity to discuss worries and questions. Parents also positively evaluated the early pregnancy groups. Student midwives have had the opportunity to help develop and provide parent education sessions within the community. The midwife has appreciation of the benefits of continuity of care being provided throughout the pregnancy, integrating antenatal care and parent education. This enables the midwife to tailor the classes to meet the groups/individual needs, as she knows the women. The majority (83%) of the women breastfed. Community based groups for the local population help to facilitate peer group support, as well as provide parent education including public health messages. This helps to focus on both short term and long term health aims for the family.

References

1 Nolan M. *Antenatal Education : a dynamic approach*. London: Balliere Tindall 1998

2 Department of Health. *Saving Lives – Our Healthier Nation*. Presented to Parliament by the Secretary for Health by Her Majesty. London. HMSO. : 135-136 July 1999

10 Student midwife's view

Anna Byrom

Having worked in Bellevue prior to the development of the current project I am able to make comparisons and observe the changes made first hand. Also having been involved in the project at its conception and then two years following, I have witnessed the huge impact it has made to women and families within the area.

Most of the qualitative improvements the project has instigated involve the huge amount of trust and respect women have for their midwife, facilitated by effective partnerships and continuity. This is evidenced in many women's openness and body language with women divulging deeply personal information pertaining to domestic violence and depression. One particular women, of ethnic minority, felt able to share with her midwife her husbands infidelity and as such could talk about her feelings and help to share her depression. As she was unable to discuss her concerns and emotions with any of 'her immediate family', the midwife's role became even more essential. Fortunately the Bellevue project enabled the midwife to have the time to build up a solid relationship with the woman antenatally making such discussions and openness much easier. Also

as the project strengthened multi-disciplinary bonds appropriate communication with the woman's G.P. and health visitor were made to ensure that effective monitoring and support continued. Depression often leads to other underlying issues and psychological problems. I feel certain that if the woman, having relative communication barriers, had been provided with traditional maternity care her depression would have continued with no help.

The project has enabled appropriate support for women of the predominantly deprived area. Care provision has been tailored specifically to meet the changing needs of the Bellevue community and the post has improved the accessibility of maternity care provision essential for the highly mobile community of the Bellevue area. This was achieved by offering extra 'drop in' clinics where women could have their blood tests taken or share their concerns reducing the need for hospital visits. The clinics were utilised effectively and it provided extra time and opportunities to detect problems develop relationships and connect appropriately with the childbearing women of the area. Many women attended the clinic to discuss their concerns and worries, which they otherwise would have been unable to do. One woman attended suggesting she was having abdominal pain and a small amount of vaginal blood loss, therefore the drop in clinic provided an opportunity for her to be seen early and for appropriate assessment to be arranged. This particular woman's partner was at war with the army and therefore increased attendance offered her important extra, emotional support.

As a student, working with the Bellevue project has been extremely beneficial to my development and training. It has shown me how important it is to strive for equity of access to services to help reduce many of the social and health inequalities currently prevailing. Also care is provided in such a way as to maximise all women's potential and self-esteem. This is achieved by encouraging mother's to share their experiences with each other. A woman from the Bellevue area has been involved in, becoming a breast-feeding buddy helping her to feel good about herself whilst providing valuable support for other mothers and families. Also many other breastfeeding mothers have returned to parent education 'drop in' sessions to demonstrate the benefits of feeding. This also helps to facilitate friendships between the often-isolated women of the area. The education sessions offer women the chance to feel included and active participants in their care provision.

Summary

Throughout my time working at Bellevue during the Project, my appreciation of community midwifery care provision has broadened significantly. The project has offered me valuable insight into the public health role of the midwife highlighting how increased continuity, support and highly developed multidisciplinary working can improve the health of women, infants and families within the community.

I feel that the Bellevue project has had a positive impact on the women and families of the Bellevue area, complying with many of the recent government suggestions and targets. The post represents how midwives can provide truly women-centered care and improve the health of our communities. I hope I can replicate many of these beliefs, practices and skills in my career as a midwife.

Appendix 1 List of database fields

Name	Previous obstetric history
Reference Number	No. of live births
Expected Date of Delivery	No of stillbirths
Date of Booking	No. of miscarriages
Date of Delivery	No of preterm births
Gestation at booking -weeks	No of terminations
Gestation at booking -days	Previous SID?
Gestation at birth - weeks	Previous IUGR?
Gestation at birth - days	Previous SGA
Maternal date of birth	Antenatal Feeding choice
Maernal age at booking	Postnatal feeding decision
Maternal height	Occupation of Mother
Maernal Weight	Occupation of partner
Maternal BMI	Support status
Ethnic origin	SSBenefits
Pregnancy Planned?	Student?
Contraception antenatally	Employed
Contraceptive Advice	Previous mental health problems
Cervical Screening status	6 week PN check location
Screening by AFP	Attended parent education
Screening by amniocentesis	Transfer in to area
Screening by CVS	Transfer out of area
Screening Privately	Place of birth booked at
Smoker / non-smoker / number smoked	FolicAcid
Alcohol	Related Family Medical History
Substance Misuse + text	Birthweight
Domestice Violence + text	Mode of Delivery
Previous anomaly + text	Risk Status at Booking

Appendix 2 Interview schedule

Interview Schedule – Women's Views

- Can you tell me about your experience of antenatal care?
- What was your experience of the clinics – either hospital or Bellevue?

  Did you see the same or different MWs?

  Did this matter to you?

  Were you able to access the clinics easily?

  What about waiting times?
- What did you expect from the midwife at the clinic?
  - Expand
  - What about your relationship with other staff?
- Can you tell me about your antenatal education?
- What useful information did you receive from the MW?
- What was the best thing about the AN Care?

  At the hospital

  At Bellevue?
- What was the worst thing?
- How could your experience of antenatal care have been improved?

Appendix 3 Consent form

Bellevue Consent and Information Form

Congratulations on the birth of your baby!

Having a baby is a very significant event in anyone's life. The care and information that you receive whilst pregnant is also important. We are currently evaluating the maternity care that has been available to you and are interested in hearing your views and experiences.

Would you be interested in talking to a midwife about your experience of antenatal care? If you agree, the midwife – Vivienne Bennett - will be available when you come to the baby clinic on any Tuesday in July. The discussion can then take place while you are waiting to see the GP, health visitor or practice nurse.

Alternatively, Vivienne could visit you at home – please contact the surgery if you would like us to arrange this.

In order that the discussion can be effectively analysed the conversation may be tape-recorded. You will not be identified from these discussions and the information that you give will not affect your care in any way. You are able to withdraw at any point.

Consent Form

I ……. consent to taking part in this interview.

I understand that I can withdraw at any point, that I will not be identifiable and that any care subsequently given to me will not be affected in any way.

Signed…….

Witnessed by …….

Date ……

Appendix 4 Coded interviewees

001 - Aged 43yrs P4 lost 1 twin early in pregnancy
Previous 20/40 IUD
Mixed race, full time mother. Son 3/12

002 - Aged 25yrs P3. Educational needs, 2 children in care.
White British, unemployed. Son 11 months

003 - Aged 26yrs P1.
White British. Voluntary worker. Daughter 4 months

004 - Aged 18yrs P2.
Black Caribbean, shop assistant. Twin son and daughter 4 months

005 - Aged 35yrs P1.
Cholecystitis during pregnancy
Indian, Housewife. Daughter 3 months

006 - Aged 27yrs P1
Placenta praevia until 36/40
White British, police officer. Son 7 months

007 - Age 24yrs P1
Indian– Full time mother. Son 7 months

008 - Aged 26yrs P2
Indian, Full time mother. Son 7 months

009 – Aged 31yrs P4
Delivered at 34/40
Mixed Race, Lunchtime Supervisor. Son 8 months

010 Aged 25yrs P1
Mixed race, waitress Daughter 6 weeks

011 - Aged 25yrs – P4 (1 SB)
Black Caribbean, full time mum Daughter 3 months

012 –27yrs P1
White British, barrister Son 5 months

Appendix 5 Parentcraft Evaluation Form

Please complete and return to……

1. During these antenatal classes I have learned: (please circle)

A great deal quite a lot enough a little nothing

2. As a whole the classes have been: (please circle)

Excellent very good good adequate poor

3. I would like: (please tick those that apply)

less lecture less practical less group discussion

more lecture more practical more group discussion

the balance is about right

4. What I found most helpful about the classes was:

5. What I found least helpful about the classes was:

6. What I least liked about the course was:

7. What else I would like included in the course:

Reference: Nolan, M (1998). Antenatal Education A Dynamic Approach. London: Balliere Tindall.
McBennett A (amendments)

Appendix 6 Themes from parent's evaluation of parent education

"What I found most helpful about the class was":

Preparation and Information on Labour and Birth (24 comments)

"Finding out about how the position of the pelvis affects delivery."

"What to expect during the different stages of labour and different options i.e. water births."

General Information/help and advice (23 comments)

"Overall information and diet"

Meeting other people and peer support/mum & baby (21 comments)

"People sharing their experience. Able to ask questions, you don't get this opportunity during an antenatal appointment at the hospital."

"Getting to meet moms who are breast feeding and getting to talk to people who are in the same situation as me".

Opportunity to discuss worries and questions (19 comments)

"Being able to discuss mother & father issues and being put at ease, also finding out there are others in the same boat as you, & you're not alone."

"Speaking with the midwife about concerns that in the course of events, you don't want to raise with your partner/G.P. and find out that the concerns are often raised by other mums"

Relaxing/enjoyable and reassuring (13 comments)

"Good relaxing (time away from children)".

"I found the class very helpful. I learnt a great deal. Angela was very helpful. I enjoyed it a lot."

Information on Preterm Births and Baby Development (10 comments)

"Growth of the baby, diet and understanding"

"Talk about causes of going into premature labour"

Breastfeeding (8 comments)

"How to feeding the baby. The benefit for both mum and baby."

"Hearing mothers' opinions who do breastfeed."

"How to give it the baby (positions)."

Visiting the Delivery Suite/Ward with named midwife (7 comments)

"Seeing the facilities we will use and some of the staff (delivery suite)".

Pain Relief Information (5 comments)

"Detailed information re pain relief – disadvantages and advantages - also meeting a new mum."

Role of the Midwife (5 comments)

"To be told about all the different things that the midwives can do for you."

How to Help Partner (2 comments)

"The discussions on pain relief was very good and also how to help your partner."

Contraception (1 comment)

"More information on the coil."

"What I found least helpful about the class was":

"The humidity of the weather"

"Being brought around the delivery suite"

"No Turkish cassette"

"General discussion on medical aspect" (doctor)

"Since this is my second pregnancy a lot of the things discussed were things which I already knew of before"

"What I least liked about the course was":

"building work"

"fridge was making a lot of noise"

"I sometimes couldn't get to them during the day – happy to have notes/booklets if can't make them"

"It is only something little the subtitles on the video that's all"

"What else I would like included":

"A full on video to scare myself"

"Gentle exercises before and after pregnancy"

"Exercises after the baby is born"

"More time and leaflets"

"Ball Birth Video"

When possible all of these issues were addressed for next session.

Published by
West Midlands Perinatal Institute
October 2003

perinatal
institute
for maternal and child health

www.perinate.org