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

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ABSTRACT

Objective

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

Design

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

Setting

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

Participants

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

Findings

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

Key conclusions and implications for Practice

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

KEYWORDS:

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

LIST OF ABBREVIATIONS

Community Midwives (CMW)

INTRODUCTION

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

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

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

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

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

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

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

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

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

METHOD

Design

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

Participants and setting

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

Sampling and recruitment

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

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

Inclusion and exclusion

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

Data collection

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

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

Data analysis

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

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

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

FINDINGS

Participants

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

Further information on characteristics is provided in table 1.

Table 1. Demographics and characteristics of participants

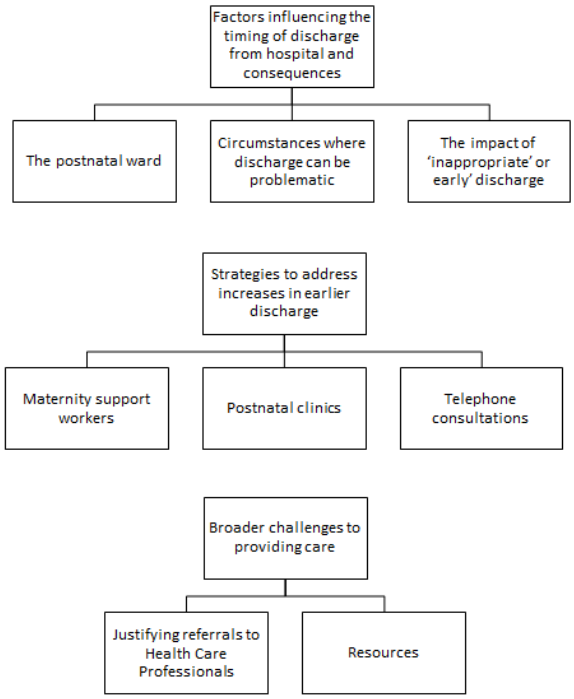
Age (years)	**20-29**	**30-39**	**40-49**	**>50**
	3	12	15	17
Ethnicity	**White**	**Mixed**	**Black**	**Other**
	37	3	5	2
Years employed as CMW	**1-5**	**6-10**	**11-15**	**>15**
	9	9	5	24
NHS Employment Band	**6**	**7**		
	34	13		

CMWs views on postnatal processes

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

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

Table 2. Themes and sub-themes



Factors influencing the timing of discharge from hospital and consequences

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

The postnatal ward

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

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

(CMW: focus group 5)

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

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

(CMW: FG 2)

Circumstances where discharge can be problematic

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

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

(CMW: focus group 3)

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

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

(CMW: focus group 2)

The impact of 'inappropriate' or early discharge

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

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

(CMW: focus group 5)

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

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

(CMW: focus group 3)

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

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

(Community midwifery team leaders focus group 1)

Strategies to address increases in earlier discharge

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

Maternity Support Workers

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

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

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

"…We've got that at the breastfeeding support I suppose going back now to people that haven't had that support in the hospital setting, but we've got our MA's who are good with that, you know, if we do need that extra support say for feeding issues or even sterilisation, breastfeeding. I suppose that's where we fill in the gap"
(CMW: focus group 4)

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

"Even though she's [Maternity Support Worker] ours, she's still helping other teams which is a bit frustrating cause we've got one, other team got two.
(CMW: focus group 1)

Postnatal clinics

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

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

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

> "Ours (postnatal clinics) is used really well …they can go to the children's centre, and get the timetable for like baby massage, and mums and baby groups, and stuff like that".
> (Community midwifery team leaders focus group 1)

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

> "Usually by about day ten they're ready to be up and about...and by day 15, definitely. So, I think if you haven't discharged them on day 10...the next time they can be discharged in the clinic"
> (CMW: focus group 5)

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

> "There's no doors on her flat, he's taken the doors off, so she can't hide. You wouldn't see that in a post-natal clinic".
> (CMW: focus group 3)

Telephone consultations

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

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

> "Day 5 is sometimes done by maternity assistants. We'll do a phone call consultation, if there's a concern with mum or the baby and the concern needs acting on, or we'll do a phone call consultation the next day."
> (Community midwifery team leaders focus group 2)

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

Broader challenges to providing care

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

Justifying referrals to Health Care Professionals

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

> "We're all very experienced Midwives here, we all know what we're doing, we've all been out to the community, I've been out for nineteen years, if I've got a baby I'm really worried about, then I don't need to fight my corner about it…it needs to be reviewed now, I do know what I'm talking about. And to have to fight to get this done is unacceptable. We don't send them in willy-nilly [colloquialism for haphazardly], you know, most things we can address at home ourselves, but serious issues such as excessive weight loss and jaundice and what have you, it needs to be seen in the hospital."
> (CMW: focus group 3)

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

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

(CMW: focus group 2)

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

Resources

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

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

"To impact on that."

"Yeah, to go with the early discharge."

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

(CMW: focus group 1)

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

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

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

(CMW: focus group 3)

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

"I can't send her scan referral because I haven't got a fax machine."
"And they won't accept a referral over the phone, will they?"
"So, you have to drive to the hospital."
(CMW: focus group 1)

Some CMWs reported feeling powerless to change the situation.

"We've brought up complaints about the iPads and that, we've been told '(work) with what you've got, get used to it. Accept it.' There's no discussion, no, until something goes wrong and then we're in trouble"
(CMW: focus group 3)

DISCUSSION

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

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

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

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

As a mechanism for managing postnatal care, postnatal clinics have been introduced to try and improve organisation and efficiency with implications for improved choice and satisfaction for both women and midwives, but this remains to be fully explored (Lewis, 2013; Marsh et al, 2015). Postnatal clinics could be a practical solution to help manage the increasing burden for CMWs, however, as noted in our findings, they should be used with caution as they may not be suitable for all women or replace earlier visits, where crucial observations (for women's and babies' clinical condition and social needs) could be made. As an alternative to managing workloads the CMWs in the present study noted use of postnatal clinics for discharge appointments (where women and babies are discharged from maternity services to the care of their general practitioners and health visitors), but greater considerations would be required in terms of when and for whom appointments are appropriate in order to individualise care. In the current UK climate, postnatal care delivery maybe slowly shifting from home visits to postnatal clinics to increase cost-efficiency, but women still rate home visits as more satisfactory (Marsh et al, 2015). A similar model has been applied in Canada (where women in some regions received postnatal visits by midwives on days 1, 5 and 10) and was successful in reducing postnatal ward length of stay by supplementing post-discharge care with postnatal clinic appointments accompanied with follow-up visits for those that did not attend. It was considered a suitable model due to its potential to be developed in the context of decreasing hospital stay (Hardy et al, 2018).

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

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

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

Implications for practice

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

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

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

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

Strengths and limitations

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

CONCLUSION

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

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

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Appendix 1: Topic guide

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

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

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

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

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

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

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

1) Please speak whilst being considerate of your fellow attendees so that we don't miss any important parts
2) There is no right or wrong answer as we are interested in your views

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

Does anyone have any questions before we start?

Opening question

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

Covering the process from the beginning

Questions, prompts and points to address

1) *Transfer from hospital*

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

- How does the transfer process take place? Who does what?
    - *Prompt*- What is good or bad about this?
    - *Prompt*- How can it be improved?
- What information do you receive from the hospital?
    - *Prompt*- How does the hospital tell the team? What access do you have to information? Is there information you would like that you currently don't get? What information would you like?
- What information are women given before they are discharged from hospital?
    - *Prompt*- What do women get to know? Are women given any written or verbal information specifically? For example, are they given any notes?
- What are the issues?
    - Prompt- Have you faced any issues with the information systems/ ward staff availability/ missing information?

2) *Care at home*

Postnatal visits by community midwives

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

3) *Referrals*

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

Summary

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

Is there anything else you would like to add?

Thank you for attending the session today. Please feel free to contact myself or any other member of the research team if you have any questions.