How is quality of care conceptualised by the different constituencies involved in maternity care in the UK? An organisational ethnography

By

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Abstract

Background: A consensus exists between different constituencies involved at all levels of maternity care that high quality care is important. The implicit assumption is that everyone defines and understands the idea of quality in maternity care identically. However, contemporary debate about where the balance between safety and personalisation in maternity care lies, raises important questions about the different definitions that might be operating when people talk about 'Quality' in this context.

Methods: This PhD aimed to examine how quality of maternity care is defined by the different constituencies in maternity care over time, and how its dimensions are implemented. A meta-narrative review, analysis of the Babies Born Better survey, and an in-depth organisational ethnography in two diverse maternity units within one English NHS Trust were conducted, including interviews, focus-groups, documentary analysis, and observations. Framework analysis, based on previous study phases, was applied inductively to analyse the data obtained.

Findings: Sixty-three papers were included in the meta-narrative review, thirty-seven surveys were analysed**,** and forty-eight participants (managers, frontline staff, women, and their birthing partners) were recruited for the organisational ethnography. Twenty-seven interviews and two focus-groups were conducted. One hundred and eighty hours of observation took place, and twenty documents were collected. Results indicate that the understanding of 'quality' and implementation of the 'quality of maternity care dimensions' was not uniform. Closely interlinked factors such as safety and personalisation were seen as separate entities, where the organisation's definition of safety was largely prioritised over the woman's personal or individual preferences.

Conclusions: Even though people think they are communicating a shared concept when they talk about quality of maternity care, this study suggests that their underlying definitions for the term may differ substantially. High quality maternity care goes far beyond preventing morbidity and mortality. The implementation of a clear and shared vision about what goes well, for whom, under what circumstances is necessary for a maternity service to thrive.

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Glossary of terms and abbreviations

Abbreviations or acronyms used:

AMU: Alongside Midwifery Unit

BAME: Black, Asian and Minority Ethnic

BBB: Babies Born Better

BSc: Bachelor of Sciences

CQC: Care Quality Commission

DHSS: Department of Health and Social Security

EBM: Evidence Based Medicine

FG: Focus-group

FMU: Freestanding Midwifery Unit

FTE: Full time equivalent

HCP: Healthcare provider

HIC: High Income Country

HV: Health Visitor

IOM: Institute of Medicine

IRAS: Integrated Research Application System

LIC: Low Income Country

MRCS: Maternal Request Caesarean Section

MSc: Master of Sciences

NHS: National Health Service

NICE: National Institute for Health and Care Research

ODP: Operating Department Practitioner

PI: Principal Investigator

QoC: Quality of Care

QoMC: Quality of Maternity Care

RCM: Royal College of Midwives

RCOG: Royal College of Obstetricians and Gynaecologists

SDGs: Sustainable Development Goals

TQM: Total Quality Management

UCLan: University of Central Lancashire

WHO: World Health Organisation

Glossary of terms:

Band: The NHS pay scale for nurses and midwives, which usually ranges from Band 5 (newly qualified midwife) to Band 8 a-c (consultant midwife, head of midwifery, director of midwifery).

Caesarean section: A surgical procedure used to deliver a baby through incisions in the abdomen and uterus.

Data saturation: When sufficient data has been collected to draw the necessary conclusions, and where extra data collection would not produce any additional insights.

Maternity Unit: One maternity unit or selected case study can consist of different maternity care facilities such as an antenatal clinic, triage, postnatal ward, labour ward, a home birth team, an alongside midwifery unit and a freestanding midwifery unit (depending on which place(s) of birth the selected maternity unit offers).

Midwifery Unit: (MU): Designed for women with uncomplicated pregnancies, MUs provide a home-like environment where midwives lead the birthing experience. These units can be freestanding, separate from hospitals, or alongside existing obstetric units for easy access to additional medical care if needed.

Neonatal death: A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born.

NHS Trust: A healthcare organisation within the National Health Service (NHS) of England and Wales that delivers healthcare services to a specific geographical area and operates as a public sector organisation. It is governed by a board with both executive and non-executive directors.

Post-partum haemorrhage: A blood loss of 500 ml or more within 24 hours following birth.

Research tradition: A specific scientific community (e.g. public health, social sciences, obstetrics & gynaecology) publishing research about topics of interest to build their body of knowledge.

Salutogenesis: A term that was introduced by the medical sociologist Aaron Antonovsky in his book "Health, Stress and Coping" (1979), that refers to the study of the origins of health and wellbeing, focusing on factors that support human health rather than those that cause disease (pathogenesis).

Serious Incidents (Sis): Refer to incidents that have resulted in serious harm or loss.

Stillbirth: A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. It is important to note that this definition may differ internationally.

Woman: Throughout this thesis, I have used the terms woman and women, recognising that this reflects the identity and biological reality of the great majority of those who are childbearing. This thesis is inclusive of those whose gender identity may not correspond with their sex assigned at birth or who identify as non-binary. It is essential that all individuals using maternity care and services receive individualised and respectful care, including the use of their preferred gender pronouns and nouns.

Disseminations: Presentations resulting from this thesis

Peer reviewed published research abstracts:

- Thaels, E., Downe, S., Prescott, G., Kingdon, C., Balaam, M., McCourt, C., Beeckman, K. (2021) Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography. Research Registry, 1-8.
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CHAPTER 1: INTRODUCTION

1.1 Overview

This thesis presents the findings of a critical realist investigation into quality of maternity care in the UK.

A woman's birth experience is not something that just happens to her and then it is over. A woman's birth experience is about who she is, it is about who she becomes, it defines her, and it remakes her, it unravels her, and it puts her together again. – (Dahlen, 2019)

Childbirth is a complex holistic, psychological, physical, biological, neuro-hormonal, cultural, social and emotional process with all these facets intertwined (Downe & Byrom, 2019; Karlström et al., 2015a; Leinweber et al., 2023; Olza et al., 2018; Reed, 2021; Reed et al., 2017). It is one of the most important moments in every human being's life as we are all born, but especially in a childbearing woman's life. It transforms a woman's sense of self and articulates her role in society as it initiates her new role as a mother (Reed, 2021). How a woman experiences the birth of her baby will have a major impact on both her physical and her postnatal mental health and subsequently on her capacity to look after- and mother her baby (Hildingsson et al., 2013). Research has shown that women remember details from their experience such as care providers' actions and interactions but also the emotions they felt for decades afterwards (Reed et al., 2017).

In recent years, attention has been drawn to poor quality of care in maternity services in the UK. The Health and Social Care Committee examined evidence based on external enquiries in relation to ongoing safety concerns (HSCC, 2021). Despite several efforts that have been made to improve maternity care quality by making recommendations and setting out the 'NHS Patient Safety Strategy' in 2019 (NHS England, 2019a), accounts of poor-quality maternity care have come to light (APPG, 2024; Ockenden, 2022).

The recently published report *'Listen to Mums: Ending the Postcode Lottery on Perinatal Care'* published by the All-Party Parliamentary Group on Birth Trauma (May 2024), based their reports on 1300 submissions of women who experienced traumatic birth, as well as 100 maternity professionals. Part of the summary notes that: *"The picture to emerge was of a maternity system where poor care is all-too-frequently tolerated as normal, and women are treated as an inconvenience. We have made a set of recommendations that aim to address these problems and work towards a maternity system that is woman-centred and where poor care is the exception rather than the rule (p. 9)"* (APPG, 2024).

This research project investigated why quality of maternity care is not as high as it should be, despite all the recommendations and efforts made in the past years to improve care for women and babies.

1.2 Aims and objectives

Aims

The aim of this study was to generate knowledge around how quality of maternity care is defined and conceptualised by the different constituencies involved in maternity care, and to gain understanding of the underlying culture that influences how quality of maternity care is implemented in maternity services in England.

The overarching research question was:

How is quality of care conceptualised by the different constituencies involved in maternity care in the UK?

Objectives

- To carry out a meta-narrative review to develop a comprehensive overview and synthesis of the existing views of quality of maternity care by different stakeholders and different disciplines from different philosophical perspectives involved in maternity services over time.
- To analyse the international Babies Born Better survey[1] to generate knowledge and a deeper understanding of how women who had their babies in the last three years define quality of maternity care.
- To examine how quality of maternity care is defined and implemented by the different constituencies involved in maternity care in two diverse settings with common organisational and governance structures using an organisational ethnography and critical realist lens.
- To identify recommendations to inform further research, policy, education, and practice.

1.3 Thesis structure

This thesis consists of nine chapters. The first three chapters give in-depth information about 'what is already known' (the context and background), and which theoretical lens this thesis was based on. Furthermore, these three chapters describe the reasoning behind the methodology and methods used. Chapters four and five represent the two first research phases which are the meta-narrative review and analysis of the babies born better survey, looking at quality of maternity care from various angles. Chapter six introduces the third research phase, which is the organisational ethnography, followed by chapters seven and eight representing its results. Chapter nine brings the different research phases together, highlighting the novel insights derived from this study and what lessons can be learned.

[1] Babies Born Better survey: https://www.babiesbornbetter.org/

Table 1: Overview of the structure of the thesis

Chapter 1 introduces the study.
Chapter 2 provides the background information which this study is built upon.
Chapter 3 presents the chosen theoretical lens, methodology and methods.
Chapter 4 outlines the results of phase 1: the meta-narrative review, which looked at how the different constituencies involved in maternity care have defined quality of maternity care over time.
Chapter 5 presents the findings of phase 2: the analysis of the Babies Born Better survey, giving an overview on how women defined quality of care in view of their own maternity care experience.
Chapter 6 sets the scene for the organisational ethnography, which looked at how quality of maternity care was defined by the different constituencies involved in maternity care, and subsequently, how it was implemented.
Chapter 7 includes the results of the organisational ethnography, of the dimensions of 'safety', 'personalisation', and 'equity'.
Chapter 8 discusses the findings of the interviews, focus-groups, observational data, and from the documentary analysis on the topics of 'efficiency', 'effectiveness', and 'timeliness'.
Chapter 9 presents a synthesis of the three phases and theoretical interpretation of all data. Furthermore, it provides an overview of the study's original contribution to knowledge, a discussion of how the findings relate to other existing literature, strengths, limitations, implications, and my final thoughts and conclusions.

CHAPTER 2: BACKGROUND

2.1 Introduction to the chapter

The previous chapter introduced the PhD project, drivers for conducting the research, and the overall structure of the thesis.

This chapter introduces the philosophical meaning of quality, its evolution and how it has been implemented in society and healthcare over time. Drawing upon robust international evidence, I establish how quality of care is defined globally and more specifically in maternity care. Additionally, I demonstrate that a substantial body of evidence exists on the endemic variation of quality of (maternity) care provision around the world. Furthermore, I elaborate on the available research that has examined what women find important in the provision of maternity care.

I set the scene of this research project, which is taking place in the United Kingdom, by taking a deep dive into how healthcare systems, including maternity care and service user involvement have evolved in the UK context. Despite having robust evidence around definitions and frameworks for quality in maternity care and policies in place, current flaws in maternity care quality in the UK are apparent and are discussed.

I draw this chapter to a close by giving a clear argument on why this PhD project is timely and of great importance.

2.2 Quality, what is it?

The concept of quality has a rich and intricate history. Despite centuries of philosophical debate, a universally accepted definition of quality remains elusive. The word quality stems from the Latin words qualitas (quails = "of what kind"), which can be traced back to 45 B.C and was created by Cicero (a Roman statesman and philosopher) (Lévy, 2008). It is a word-for-word translation of ποιότης poiótēs, a technical philosophical word in Greek (Tomás & Ruano, 2022). The ancient Greek philosopher Plato touched on the concept of quality when in his dialog Theaetetus he asked the question: "what is knowledge"? (Cooper, 2015). His view on quality was different from that of relativists such as Heraclitus and Protagoras who believed that *"Man is the measure of all things (p. 152)" (Kattsoff, 1953).* This stance is still very present in our current society and more specifically in definitions of quality in business where the quality of a product/service can only be judged by whether it meets the customer's expectations (Grönroos, 2000; Hartatie & Haksama, 2018; Veselova, 2018). Plato, on the other hand, explained quality as a property of an object that exists by its very nature (Plato, 1930).

Aristotle, a pupil of Plato and one of the most influential philosophers in Western History, played a significant role in shaping our understanding of quality, even though he did not explicitly define this

concept in his 'Organon' (written 350 B.C.E). Nevertheless, his broader philosophical framework and understanding of concepts such as quantity, substance, and relation, provided an understanding of quality as an inherent and objective property of an object. In Aristotle's categories, he talked about the ten supreme categories of being, of which quality is one. In his work, he suggests that qualities are characteristics of things or people which enable them to function in a specific way, e.g. intelligence is a characteristic of a person which allows a person to acquire knowledge (Barnes, 1995). He elaborated further on this subject in Metaphysics by differentiating dispositional qualities from habitual qualities. Where dispositional qualities are temporary, habitual ones are lasting characteristics of things or people (Ross, 1925). Aristotle's concept of quality has been influential in philosophical discussions of quality and remains relevant in diverse fields such as business, ethics, aesthetics, education, and healthcare. His emphasis on the objective and inherent nature of quality provides a framework for understanding quality as a property that an object possesses by virtue of its relationship to its purpose (Smith, 2007).

Quality was defined as an idea of a perception or sensation by the English philosopher John Locke, who made a distinction between primary and secondary qualities. Primary qualities are intrinsic to a person, thing, or object. Secondary qualities depend on how it is interpreted and in what context (Bolton, 1976).

Immanuel Kant highlighted how quality and human cognition are related in his "Critique of Pure Reason". Quality, in his view, is not solely determined by the object itself but is influenced by our subjective perception and mental frameworks (Kant, 1953).

According to the Oxford English Dictionary, while originally, quality meant "the nature, kind or character (of something), quality currently means: "the standard of something when it is compared to other things like it" (OED, 2023). As a noun, quality can be both countable (a property or attribute that differentiates a thing or person) and uncountable (level of excellence). When looking at quality as an adjective, it means "being of good worth, well made, fit for purpose" and can be used to compare (more quality) or as a superlative (most quality) (Wordsense, 2023).

Conceptualisation and implementation of quality in society

The concept 'quality' has existed in English since the medieval period (OED, 2023). Over the years, it has filtered through the different aspects of human society (Turner, 2013). Meanings have differed depending on the context, including excellence, effectiveness, and value. It has shaped people's aspirations, had an influence on cultural norms, social structures, and the manufacturing of goods and services (Hanushek & Wößmann, 2007; Juran, 1992).

Before the Industrial Revolution, when craftsmanship was the main way of producing and selling goods, quality was primarily defined by the skill and attention to detail possessed by individual craftsmen. They had a relationship with their customers, which made immediate feedback and adaptation to the specific needs of the customers possible. Quality inspection existed through

Guilds which set the standard for materials and workmanship by the enforcement of apprenticeships and inspections (ASQ, 2023).

The evolution of ideas of quality has always reflected the state of the economy and technological advancements, and so on how societal values changed (Juran, 1992). In history, one of the main events that effected the conceptualisation of quality was the Industrial Revolution. As part of this change, the model of production based on craftsmanship that lasted till the early 19th century evolved into a mass production model in the later 19th and early 20th Century (Garvin, 1988). Factories were designed to use standard processes to increase efficiency, productivity, and this consequently enabled mass production (Blake & Moseley, 2011; Hesser, 2011; Taylor, 2004). Concern over quality in every single individual product shifted to the quality across large batches of products (Hesser, 2011). Craftsmen who made whole products were replaced by skilled workers who could perform specific specialist tasks as part of a product, which made it necessary to find different methods of monitoring quality. Inspections were put in place to identify and remove flawed products at the end of the production line (Blake & Moseley, 2011; Taylor, 2004).

During the late Industrial Revolution and after, quality as standardisation of particular norms became the focal point. Products had to adhere to predetermined specifications and measurements to be rated as high quality. Statistical tools or charts were created for quality control as a way of monitoring and analysing the production processes for variability and trends (Best & Neuhauser, 2006; Shewhart, 1925). It was not until the 20th century that quality management emerged as a distinct field of study and practice (Fisher & Nair, 2009). The philosophy of '*Total Quality Management*' (TQM) shifted the focus from inspection of products to the prevention of defects by improving the process and involving employees in the process (Dahlgaard-Park et al., 2013).

According to Hanushek and Wößmann (2007), the consumer's demand for goods has been a driving force in shaping the economy and market competition. Thus, the success of a business depended on the consumers perceived quality of the goods produced or services offered, and subsequently their satisfaction and return for more (Hanushek & Wößmann, 2007). Other authors have argued that standardisation and mass production have negatively influenced quality by focussing on quantity over quality, limited customisation, and stagnated innovation (due to overly rigid standards) (Hu, 2013; Wang et al., 2016).

The importance of quality in industry influenced other diverse areas in society such as the education sector. In education, quality was used by policy makers and institutions to build a skilled workforce and empower individuals to strive for innovation and improve their socio-economic status (Hanushek & Wößmann, 2007). The main focus was on educational infrastructures, standardisation of high-quality teaching, and learning outcomes (Barrett et al., 2006). However, these are now measured on simple, standardised approaches, that have been heavily criticised for

missing important values, exception to rules, and human qualities that are critical to effective education (Case et al., 2000; Gilroy & Wilcox, 1997).

In healthcare, the implementation of evidence-based practices, research, investing in innovation, and focussing on the provision of patient-centred care have been focal points of governments and healthcare providers, as these are being seen as ways of increasing the health and wellbeing of society (DHSC, 2021; WHO, 2022). Though, external oversight organisations aimed at assessing and improving quality in healthcare (e.g. by the Care Quality Commission in the UK) through standardised processes have not brought forth an increase in the quality of care (Castro, 2018).

Not only tangible things such as goods and services, but social structures and cultural norms have been subject to the conceptualisation and implementation of specific interpretations of what 'quality' is. Societies develop goals and shared values based on their concept of quality. Furthermore, quality has influenced what individuals' want and aspire to, what guides their individual aspirations. The individual's pursuit of quality has often functioned as a driving force for personal and professional growth, and consequently to progress in society (Juran, 1992).

In recent decades, quality has been transformed mostly by globalisation and innovations in digital technology, highlighting the need for responsiveness, adaptability, involving customers in all aspects of the design, production, and distribution process (Christopher & Towill, 2001; Flynn et al., 1995; Womack et al., 2007).

The implementation of standardisation and quality control in healthcare

Over the past two decades, quality assurance, mainly quality and safety, has influenced the way healthcare has been organised. Lessons were learnt from other industries such as the airline and car industry which has made its implementation in healthcare easier (De Jonge et al., 2011).

For instance, the airline industry's dedication to safety (in terms of reducing lives lost) and consistent performance using standardisation and quality control (meaning rapid re-institution of standard norms if a deviation is detected) has been a strong influence on concepts of 'quality' in the health service. Electronic health records for consistent documentation and data analysis, pre-defined medication orders or procedures to streamline the delivery of care, and clinical pathways or evidence-based checklists defining steps for managing specific conditions to reduce variability all stem from the airline industry (Webster et al., 2020). Ways to provide quality control like what happens in the airline industry are the use of performance indicators to track key metrics, performing a root cause analysis to investigate adverse events, and the continuous improvement by regularly reviewing processes by collecting feedback from patients and staff (Kapur et al., 2015; Uberoi et al., 2007).

Another example of how these concepts of standardisation and quality control were translated into healthcare is 'Lean principles' (Becker, 1998). Since 2000, Lean healthcare, which stemmed from the Toyota car industry, contributed to a paradigm shift towards a patient-centred, efficient, and

sustainable healthcare models rhetoric. The Toyota Production System (TPS) is known for its multifaceted emphasis on waste reduction, quality control (as in returning deviating products and systems to the norm), and continuous improvement (Clark et al., 2013). In healthcare, TPS principles are increasingly being applied in an attempt to improve efficiency (optimise staffing and workflows, minimise resource waste, and reduce patient wait times), empower employees (boost staff morale, foster teamwork, and a culture of continuous learning), and enhance quality (standardise processes, minimise errors, and improve patient outcomes) (Wickramasinghe, 2014). Opinions about the success of TPS are varied, the literature review of Moraros et al. (2016) argued that Lean interventions have not led to improvements in efficiency, satisfaction, cost-effectiveness, and overall healthcare quality (Moraros et al., 2016).

A neoliberal bureaucratic post-industrial healthcare system

Rhetorically, 'quality' is one of the most important factors on which the healthcare system is built upon (De Jonge et al., 2011). However, as mentioned above, the way quality is defined is influenced by many different philosophical and historical factors. Though contemporary healthcare systems often display complex mixes of different ideologies or approaches, the process of globalisation has influenced similar changes in health policy agendas in the global north/industrialised societies (Hendricks et al., 2009). Today's industrialised world's healthcare systems are characterised by neoliberal, bureaucratic, and post-industrial principles.

The healthcare system started to be influenced by neoliberalism in the 1980's. 'Neo' means new and 'liberal' in this context means free from government control. It is a powerful ideology, with the notion that private markets are more consumer-friendly and cost-effective (McGregor, 2001). Under this ideological driver, policymakers and their advisors attempt to reform healthcare by moving it towards the free market, focussing on cost-effectiveness and efficiency by an increased reliance on private healthcare providers and making use of insurance companies. In a neoliberal healthcare system, there is an emphasis on the responsibilities of the individual for their health and healthcare costs. Robust management systems are put in place locally to decentralise the power of the government (Ham, 1997; Hendricks et al., 2009; McGregor, 2001).

Bureaucratic systems, hierarchical structures, administrative procedures and complex rules are well embedded in contemporary healthcare. There is a focus on compliance, rather than individualised care and innovative practices. Furthermore, a strict adherence to protocols, guidelines and other regulations potentially hinders flexibility and patient-centred care (Salvino, 2014).

The post-industrial healthcare system can be described as highly reliant on technology, is data-driven, and focuses mainly on complex medical interventions and chronic diseases (Hendricks et al., 2009).

In the last two decades, even though the National Health Service in the UK is part of a welfare programme, healthcare policies in the UK have also moved towards a more neo-liberal, post-industrialised, bureaucratic healthcare system (see point 2.5. below for more information) (Martin, 1989; Oakley, 1984). This means that notions of health care 'quality' are also heavily influenced by standardisation, managerialism, preservation of organisational reputation, and 'safety' as avoidance of death and physical harm (Timmermans & Berg, 2003b).

2.3 Quality of (maternity) care globally

World-wide, no universally accepted definition of quality of care exists due to the variability in, and complexity of health care systems as well as the different perspectives of health care providers, policy makers, and patients (WHO, 2016).

The Alma Ata Declaration published in 1978 shifted ideas around global healthcare. The core principle was to achieve "health for all" by using primary healthcare as the cornerstone of affordable, accessible, and community-based care focussing on prevention, curation, and rehabilitation. The idea was that the intrinsic 'quality' or nature of healthcare should embody equity and easy access for all, and positive wellbeing (not just an absence of ill health) no matter the socioeconomic background. Furthermore, it should be adapted to the individual's cultural needs by community participation in healthcare planning and delivery. It highlighted the need for a holistic approach to health, considering the influence on health outcomes by social determinants such as education, sanitation, poverty, and housing (Hixon & Maskarinec, 2008; WHO, 1988)).

Donabedian, who is seen as the founding father of quality in healthcare, focused on biomedical outcomes and defined quality as *"the application of medical science and technology in a manner that maximises its benefit to health without correspondingly increasing the risk (p. 5)"* (Blaize-La Caille, 2018; Donabedian, 1980).

Two decades later, as a response to high morbidity rates which was perceived as low-quality care, in 2000 and 2001, The Institute of Medicine (IOM) published two reports, calling for healthcare reforms in the United States:

1. "To Err is Human: Building a Safer Health System" - 2000
2. "Crossing the Quality Chasm: A new Health System for the 21st Century" – 2001

The overall focus of the first report was that the healthcare environment was not fit for purpose due to medical errors being found to be a leading cause of death in the US (Donaldson et al., 2000). The second report argued that, even though a huge number of resources are spent on healthcare, the quality was poor due to a high morbidity and mortality. The IOM committee identified six dimensions of quality on which the healthcare system failed: safety, effectiveness, patient-centred care, timeliness, efficiency, and equity. They argued that these six are applicable to most western

countries and that only by improving them, will future demands to the increasingly complex healthcare system be manageable. Solutions that were brought forward by the IOM were the need for standardisation using evidence-based guidelines, information technology, and setting clear standards of performance (IOM, 2001; Timmermans & Berg, 2003a)

Following these reports, in the last two decades, WHO has been trying to work towards high quality care for all by the creation of a conceptual framework (WHO, 2016). They described the key characteristics of quality of care as: effective, safe, people-centred, timely, equitable, integrated, and efficient. Their definition based on several other definitions found in the literature (including but not limited to the six dimensions of the IOM) is: "*Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge (p.15)".* In this analysis, the authors described that good care encompasses continuous measurement and improvement, using evidence-based information and considers the wishes and needs of communities, families, and individual patients, alongside attention to prevention and treatment of diseases, rehabilitation, palliation, and health promotion (WHO, 2016, 2020).

From quality of healthcare to quality of maternity care

One of the first definitions of quality of maternity care (QOMC) was developed by Louise Hulton in 2000 (Hulton et al., 2000). It was based on the definition for quality of care by the Institute of Medicine (IOM, 2001). In this definition Hulton et al. (2000) includes a focus on women's rights in addition to the IOM factors (see above). Hulton summarised the definition as follows: *"The degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and uphold basic reproductive rights (p. 9)" (Hulton et al., 2000).*

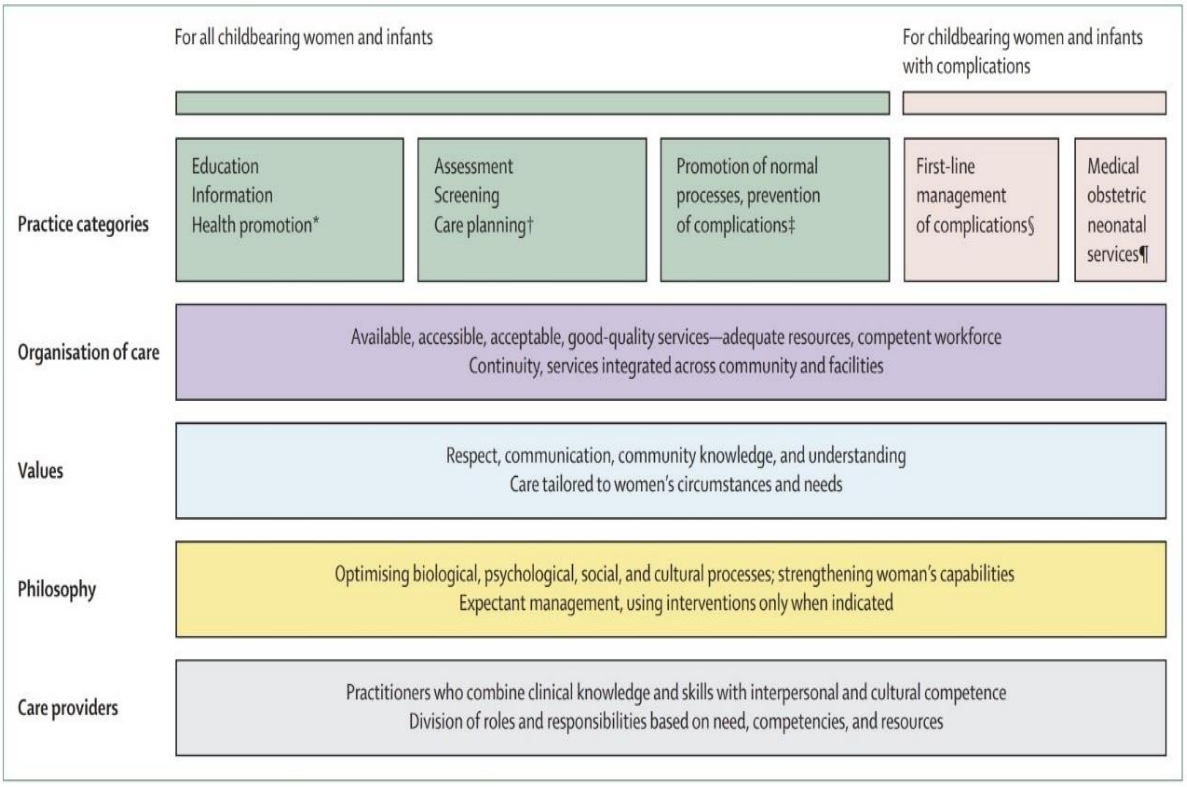
In 2002, Pittrof et al. published a paper in which he proposed another specific definition for Quality of Maternity Care: *"High quality of care maternity services involves providing a minimum level of care to all pregnant women and their newborn babies and a higher level of care to those who need it. This should be done while obtaining the best possible medical outcome, and while providing care that satisfies women and their families and their care providers. Such care should maintain sound managerial and financial performance and develop existing services in order to raise the standards of care provided to all women* (p. 278)*" (Pittrof et al., 2002).* This definition was based on four early, medically orientated definitions (Donabedian, 1980; Leebov, 1991; Palmer, 1981; Roemer & Montoya-Aguilla, 1988) and one more recent and more comprehensive definition (Wilson & Goldsmith, 1995).

Many definitions specifically for quality of maternity care published in the years after were built on the work of Donabedian (1966), the IOM (2001) or Hulton et al. (2000). Raven et al. (2012) for instance, conducted a literature review to examine maternity care quality and concluded that there

are many different perspectives from which quality has been described (women, healthcare providers, managers, etc.) but no agreed single and comprehensive definition was available in the literature. The authors combined different models, mainly based on the six dimensions of the IOM in one comprehensive framework aiming at assessing and defining quality of maternity care (Blaize-La Caille, 2018; Raven et al., 2012).

From 2014 to 2016, a significant amount of work was published around the need for high quality maternity care. Renfrew et al. (2014) created an evidence-based framework around how trained and licensed midwives can contribute to the quality of maternal and newborn care (see figure 1 below). The team included (short-, medium-, and long-term) outcomes that could be improved by midwifery care. A framework was put together with evidence-based interventions to reduce preterm births, stillbirths, morbidity and mortality for mothers and babies, decrease the use of unnecessary interventions, and positively influence physical and psychosocial outcomes and public health (Renfrew et al., 2014).

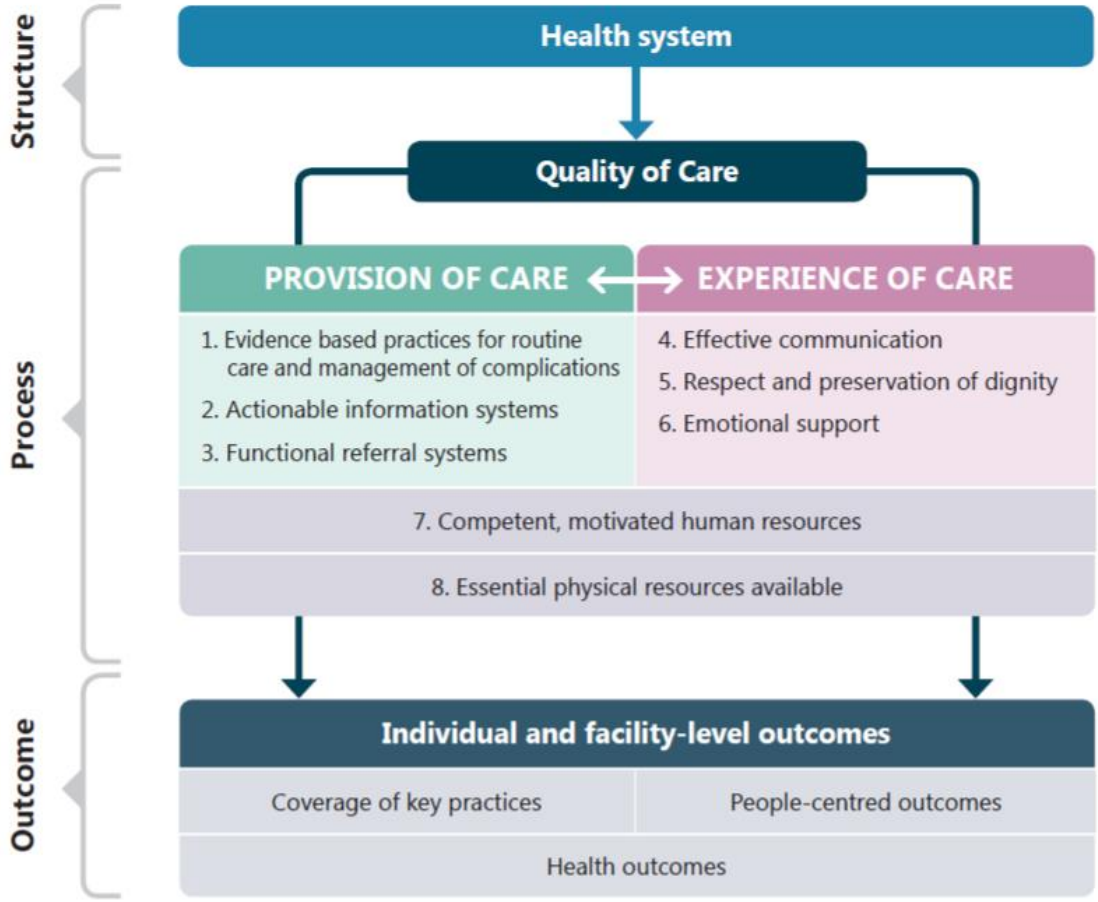
Figure 1: Framework for quality maternal and newborn care (Renfrew et al., 2014)



The Global Strategy for Women's, Children's and Adolescents' Health was launched in 2015, setting progressive intentions aimed at enhancing women's health in line with the Sustainable Development Goals (SDGs). The three themes were Thrive (promotion of health and wellbeing), Survive (ending preventable deaths), and Transform (expand enabling environments) (Kuruvilla et al., 2016). A systematic scoping review by Downe et al., published in December 2015, highlighted that for all women, no matter their socio demographic or cultural background, a positive pregnancy

experience in the antenatal period is what is most important (Downe et al., 2015). Using the knowledge derived from the scoping review, WHO's antenatal care guidelines were published. The aim of WHO's antenatal guidelines was to put women at the centre of care and to improve their experience of pregnancy while ensuring the best start for babies at their start in life (WHO, 2016). On a broader level, in July 2016, the WHO published standards for improving quality of maternal and newborn care in health facilities. They defined Quality of Maternity Care as: *"safe, effective, timely, efficient, equitable and people centred"*. In their framework, WHO has made a clear distinction between provision and experience of care. Both are essential to achieve health and wellbeing for pregnant women and their newborns, ensuring a positive life-changing experience for the whole family and how it is seen in the world at large (WHO, 2016).

Figure 2: WHO framework for the quality of maternal and newborn health care (WHO, 2016)



A systematic review published in 2018 concluded that for women quality of maternity care meant a holistic and seamless experience through all phases of maternity care with continuing practical and emotional support from chosen companion(s) (Downe et al., 2018). Clinical staff should be kind and sensitive and show good knowledge and skills while being reassuring. Women around the world valued being empowered to use their own psychosocial and physical strength to labour and give birth to a healthy baby in a clinically safe place where their culture and psychosocial wellbeing

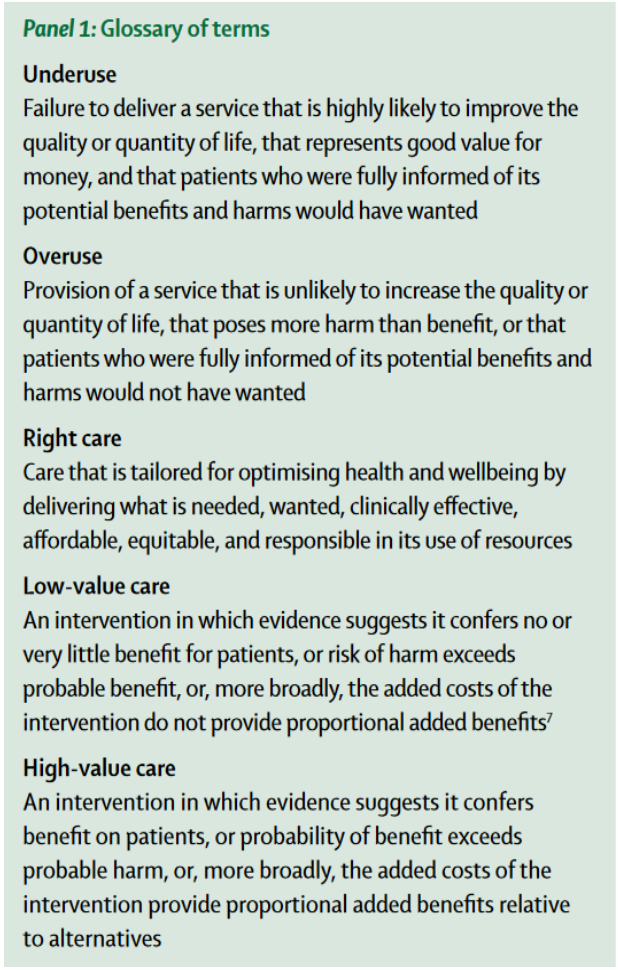
is put at the forefront (Downe et al., 2018). Consequently, WHO published recommendations for intrapartum care for a positive childbirth experience, based on the findings of Downe et al. (2018) literature review (WHO, 2018). Four years later, the recommendations for a positive postnatal experience were issued. WHO defined a positive postnatal experience as follows: *"one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support in a consistent manner from motivated health workers; where a resourced and flexible health system recognizes the needs of women and babies and respects their cultural context (*p. vii*)"* (WHO, 2022).

Variation in quality of care is endemic around the world

As identified above, despite efforts to create definitions and theoretical frameworks on quality of (maternity) care; outcome indicators; standardisation; and evidence-based medicine, practice (and therefore the intrinsic nature of 'quality' of, and the values that shape the understanding of the attribute of 'good quality' maternity care) varies around the world.

The Alma Ata Declaration was published in 1978 in an effort to reduce inequities in healthcare and to provide holistic healthcare for all (Hixon & Maskarinec, 2008; WHO, 1988). Four decades later, in 2017, The Lancet Series on Right Care was published, highlighting the ubiquitous presence of poor care due to both underuse and overuse of healthcare services (see figure 3 for the definitions used). Simultaneous underuse and overuse seem contradictory, but they demonstrate how resources are used inappropriately and ineffectively and how harm can be caused to millions of people globally on a psychological, social, and physical basis when they either cannot access care they need, or they are provided with treatments they do not need (and may not want).

Figure 3: Glossary of terms from the Lancet Series (Elshaug et al., 2017)



Panel 1: **Glossary of terms**

Underuse
Failure to deliver a service that is highly likely to improve the quality or quantity of life, that represents good value for money, and that patients who were fully informed of its potential benefits and harms would have wanted

Overuse
Provision of a service that is unlikely to increase the quality or quantity of life, that poses more harm than benefit, or that patients who were fully informed of its potential benefits and harms would not have wanted

Right care
Care that is tailored for optimising health and wellbeing by delivering what is needed, wanted, clinically effective, affordable, equitable, and responsible in its use of resources

Low-value care
An intervention in which evidence suggests it confers no or very little benefit for patients, or risk of harm exceeds probable benefit, or, more broadly, the added costs of the intervention do not provide proportional added benefits[7]

High-value care
An intervention in which evidence suggests it confers benefit on patients, or probability of benefit exceeds probable harm, or, more broadly, the added costs of the intervention provide proportional added benefits relative to alternatives

Elshaug et al., 2017 noted that *"remedying this problem is a morally and politically urgent task (p. 1)" (Elshaug et al., 2017)*.

The overuse of treatments and procedures to prevent rare clinical outcomes indicate that, over the years, physical outcomes have been valued over psychological and emotional ones (Lipitz-Snyderman & Bach, 2013). Furthermore, Elshaug et al. (2017) described a disparity in access to healthcare due to a focus on expensive treatments, overmedicalisation and the reliance on interventions, and an overall reductionist view of health in which preventative care, social determinants and the patient's experience are neglected (Elshaug et al., 2017). This demonstrates that the underlying 'quality' or nature (ontology) of health care is currently not in line with the value-based notion of 'good quality' health for all set out in the Alma Alta agreement (Elshaug et al., 2017; Rifkin, 2018).

Variability in the quality of maternity care in the world

This misalignment between the ontological quality expressed in the Alma Ata agreement and that in operation in current health care is replicated in maternity care in many countries around the

world. In addition, even though there have been significant improvements over the past 50 years, inequalities in access to women's healthcare exist around the world, including in the UK, where significant variations in the provision (EBCOG, 2014), practice, and outcomes of maternity care can be observed (Macfarlane et al., 2016).

Similarly to the over- and underuse of services in healthcare mentioned above, there is a growing body of evidence around an over- and underuse of interventions in maternity care (Renfrew et al., 2014). In 2016, The Lancet presented a paper in which they highlighted the urgent need for "*A global approach to quality and equitable maternal health, supporting the implementation of respectful, evidence-based care for all (p. 2176).*" The authors based this comment on their observation of two antithetical phenomena which are too little, too late (TLTL) and too much, too soon (TMTS) (Miller et al., 2016).

While both TLT and morbidity and mortality are more often seen in low- and middle-income countries, TLTL refers to care that is unavailable or withheld, and where resources are inadequate, and/or below evidence-based standards. On the other hand, TMTS, is mostly found in middle- and high-income countries with variability and inequality seen in treatment according to social status of the individual women. Miller et al. (2016) describes this as routine overmedicalisation of the physiological processes, and/or the use of interventions that are non-evidence based or evidence-based but inappropriate in that specific situation. Both situations can be associated with harm for mother or baby (Miller et al., 2016). Other studies have also shown that increased rates of maternity interventions around the world are not always clinically justified, and that unnecessary interventions can be associated with iatrogenic morbidity and mortality in mothers and babies (Allen et al., 2003; Hollowell et al., 2015; Jansen et al., 2013; Liu et al., 2007; Petitti, 1985; Sukainah Al Khalaf et al., 2023). Uncertainty exists about both short- and long- term health effects associated with labour and birth interventions (Peters et al., 2018). While there is little doubt that when birth interventions are optimally employed, lives are saved, the lack of sensitivity and specificity associated with most interventions, and very scant knowledge about long term consequences of many procedures, means that many authors warn that researchers and clinicians should remain critical of their routine use (De Jonge et al., 2017).

Sadler et al. (2016) note that: *"it is a fact that in many countries, including high-income ones, the best available evidence is not always used to inform maternity care; rather practice is driven by local beliefs about childbirth, and professional or organisational cultures (p. 48)" (Sadler et al., 2016).* This becomes apparent when intervention rates between and within countries; institutions and healthcare workers are compared (Sadler et al., 2016). In 2016, Macfarlane concluded that a reduction in current variation in practice through the implementation of evidence-based care, could improve public health while respecting women's human rights and being responsive to research findings on women's wellbeing (Macfarlane et al., 2016).

In the opening of Chadwick's book '*Bodies That Birth'*, she points out that globally, "all is not well with birth (p. 4)" (Chadwick, 2018). She refers to the predominant risk discourse, rise in medical interventions, high rates of unnecessary maternal deaths and increased visibility of the prevalence of obstetric violence and birth trauma. Furthermore, the illusion of choice, especially in high income countries, has made the gap between birth plans and women's lived experiences larger (Chadwick, 2018). Birth is a life-changing event (NHS England, 2014), and the impact of the experience is long-lasting, especially emotionally. More evidence is becoming available on labour and birth as risk factors for postpartum post-traumatic stress disorder (Grekin & O'Hara, 2014).

A scoping review around women's experiences of birth trauma published in 2021 found that the existence of birth trauma is strongly influenced by system dysfunctions in maternity care, and negative interactions with the healthcare provider. Furthermore, limited support and education made informed consent difficult, leading to feelings of powerlessness and lack of control (Watson et al., 2021). The recently published report by the UK All-Party Parliamentary group on Birth Trauma in May 2024, reported that psychological distress is usually caused by the combination of experiencing complications (emergency caesarean sections, instrumental births, third- or fourth-degree tears, their baby needed to spent time in intensive care) and poor care by frontline staff (APPG, 2024). Sub-standard quality of care during pregnancy and birth and/or a traumatic birth experience moreover can negatively influence subsequent care seeking (Miltenburg et al., 2016) or alter a woman's future reproduction by triggering a bigger interval between subsequent children. Some women who have traumatic birth experiences (physical and/or psychological) decide not to get pregnant again, despite previously wanting more children (APPG, 2024; Gottvall & Waldenström, 2002). In other cases, a negative experience triggers women to decide to freebirth (birth without a registered birth professional attending) with subsequent babies due to having lost faith in both the system and the healthcare providers (Feeley & Thomson, 2016).

Given the enduring emotional effects of maternity care, the experience and view of mothers and their families should be treated as equally important as the clinical outcomes to reduce variability of care and increase public health for women world-wide.

The prevalence of disrespectful care, and the respectful care movement

According to The Lancet article "Accountability for respectful maternity care" published in 2019, there has been a shift from a focus on increasing maternity service utilisation in low-income countries, towards the improvement of quality of care. In this case, they conceptualised 'quality' as being about how women are treated during facility-based care (Afulani & Moyer, 2019).

Despite the general agreement that respectful maternity care is a fundamental right and important ingredient of quality of maternity care, there is a growing body of evidence around disrespectful and abusive behaviours in some institutional settings around the world (Bohren et al., 2015; Downe et al., 2018; Freedman & Kruk, 2014).

In 2011, the White Ribbon Alliance (WRA) launched an international campaign which asked more than one million women what they wanted from their maternity care. The top priorities found were respectful and dignified care (WRA, 2011). Over the past 24 years, the organisation has strived towards partnerships with all constituencies involved in maternity care to start a people-led movement improving women's understanding of their own health and right to high quality healthcare (respectful and dignified care) (WRA, 2022).

2.4 What matters to women and how is this translated into maternity care?

Ideally, the design on which the maternity service is built should be based on the qualities (ontological and values based) that are required by the women and birthing people who use the service (Renfrew et al., 2014). This is usually measured by women's 'satisfaction' scores. However, satisfaction, a common quality metric, faces criticism due to its subjective nature and lack of a universally agreed-upon definition (Crow et al., 2002). Furthermore, asking women about their experiences of care can be problematic as women may accept low-quality care if their expectations are very low. This is especially problematic when there is limited local maternity care provision, limited choices, and an unawareness of better alternatives (Downe et al., 2018; van Teijlingen et al., 2003).

As mentioned above, the systematic review of Downe et al. (2018) found that women want to give birth to a healthy baby while having a seamless experience and holistic care from kind, sensitive, knowledgeable, and skilled clinical staff. Women want to feel safe and be empowered to use their own inherent strength to give birth to their babies. They want to be informed and in charge of the decision making, and feel their psychological wellbeing is put at the forefront (Downe et al., 2018). Vedeler et al. (2021) analysed data from 8401 women responding to the international Babies Born Better survey who had given birth in Norway. They found that women reported a positive experience when they received care that authentically focused on bio-psycho-social factors. Care was especially well received when it was respectful and compassionate and where the whole family was seen as a unit in need of inclusion and attention. Women valued a sense of continuity and consistency (Vedeler et al., 2021). A study conducted in Australia also found that women across models of care preferred relational care which is adapted to their personal wishes, needs and values. The same study found that women experienced more often than not fragmented care, not feeling listened to by their healthcare provider, having to repeat their own medical history, and getting conflicting information and advice (Pelak et al., 2023).

Kennedy et al. (2018) noted that, even though, for decades, considerable investments have been made in improving maternity care quality, a lot is still to be done to recognize and implement care that achieves positive experiences and minimises adverse outcomes for women, babies, and their

families. According to the authors, a focus needs to be put on 'right care', which is care that is tailored to the individual. Outcome measures such as benefits and harms should be adapted to the individual and care should be woman-centred and equitable. Care during pregnancy, labour, birth and the postnatal period should be seen as a continuum and informed by the latest evidence, while cost-effectiveness is also taken into account (Kennedy et al., 2018).

2.5 Setting the scene

Data collection for this PhD project took place in the United Kingdom. The next paragraphs introduce contextual information about the UK context for the study, and the relevant historical background. Furthermore, the ontological and values-based notions of quality are unpacked while looking at the UK realities.

The evolution of the healthcare system in the United Kingdom

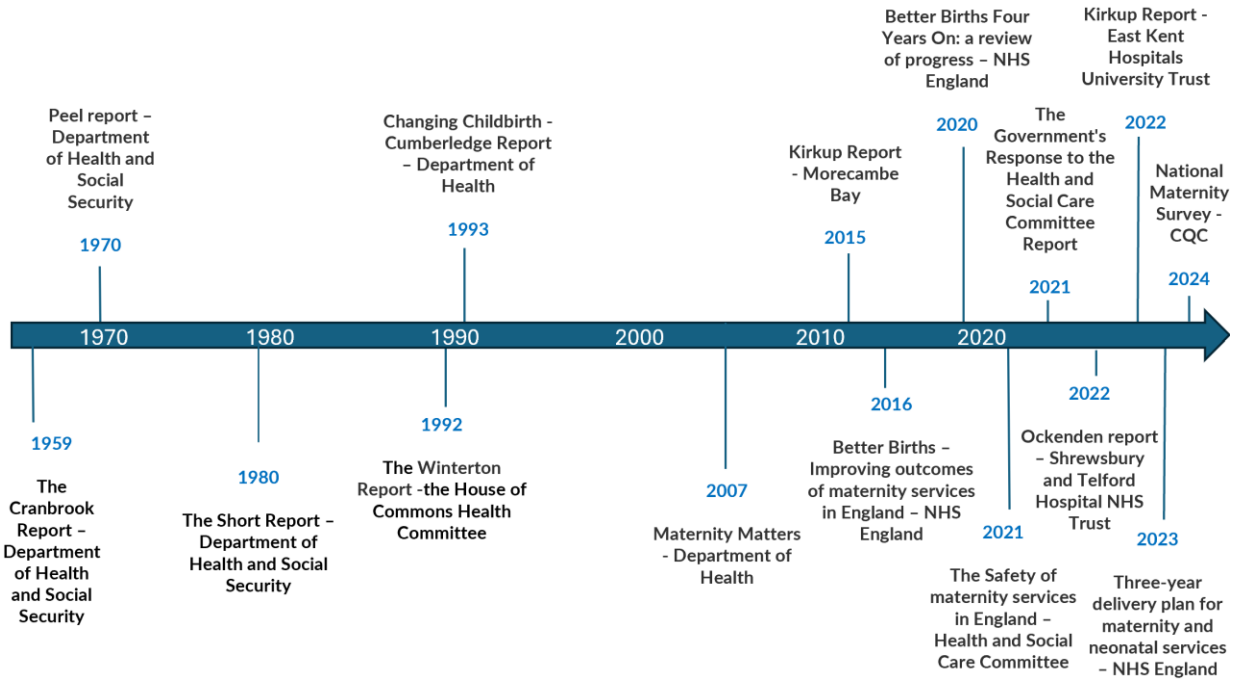
The UK National Health Service (NHS) was set up in 1948, following the Second World War, as part of a broader wave of social reforms which aimed to create a welfare state. It reflected a shift towards a more collectivist approach to society, in which the government actively aimed to ensure the wellbeing of its citizens by providing them with social and economic security through healthcare and education, regardless of their social status. The groundwork for the welfare state was laid by the Beveridge report in 1942, proposing a comprehensive social security system. The NHS was part of this vision, fulfilling the need for universally accessible and quality medical care for all. Quality of care meant a robust healthcare system, which was universally accessible, covering a wide range of healthcare needs, mainly focused on prevention, and improving public health (Beveridge, 1942). From the beginning, taxation was the primary way of funding the NHS, signifying a collective responsibility shared by all citizens to provide free essential healthcare at the point of delivery, regardless of income or background. While the NHS is still a cornerstone of the UK welfare state to this day, it has faced many challenges (Alderwick et al., 2021). Since the early 90s, concerns about rising healthcare costs, changing demographics and technological advancements have initiated discussion about funding sustainability and service delivery models. The belief among the majority of the population that the NHS model promotes efficiency and equity is in stark contrast to more recent neo-liberal ideas in favour of market-based reforms to increase competition and choice. The notion that this alternative framing might be a better way of providing healthcare solidified in 1991 through the introduction of a 'purchaser-provider split', based on the free-market ideology as a remedy to perceived inefficiency of the NHS among the political elite. Healthcare services, including maternity services were consolidated into hospital based '*Trusts*'. A philosophy that equated quality with efficiency meant that models and methods of care were implemented that prioritised productivity and minimised time consumption through task-oriented systems (Martin, 1989; Oakley, 1984).

The shift towards more service user involvement

In the UK, a gradual shift towards greater participation and involvement of service users has taken place. In the 1970s this was seen in social care services, where people started to become active participants in shaping their own care (McLaughlin et al., 2019). Similar movements took place in maternity care, with feminism and activism influencing a push back against perceived high rates of medical interventions such as induction of labour (Kitzinger, 2011; Oakley, 2016). A similar emancipatory movement happened in mental health, where international service user groups (including those based in the UK) worked together to stimulate the growth of user-led advocacy movements (Rush, 2004). The NHS and Community Care Act published in 1990 became the first document that mandated the need for service user involvement in the design and planning of health services (Bowl, 1996). From the Millenium onwards, service user involvement remains one of the cornerstones of healthcare policy in the UK. In the last two decades, a larger emphasis has been put on the power dynamics between the different stakeholders involved to ensure user voices are truly heard (Rush, 2004; Stickley, 2006).

The evolution of the notion of maternity care quality in the United Kingdom

Figure 4: Maternity care reports timeline (1970-2024)



In 1959, the Cranbrook report, a review of maternity services was published in England/Wales. This report was published after concerns were raised about the way responsibilities for maternity care were divided between three sectors (hospitals, GP executive councils, and local authorities), with substantial variations in service delivery per region. The argument of The Royal College of Obstetricians and Gynaecologists (RCOG) was that a better cooperation and so unified obstetric management was needed. The RCOG at this point vouched for all women having hospital births,

as they believed this was the safest for women. However, the report did not explicitly define quality of care. The Cranbrook committee focused on an increase in access to hospital births, with the assumption that hospitals offered better resources and so could improve outcomes (MoH, 1959). The essence of maternity care quality was having services that were fit for purpose. It was believed that that meant that at least 70% of women should give birth in a hospital. However, from the perspective of changing views on maternity care 15 years later, Ferster & Pethybridge (1975) criticised the Cranbrook report based on their aim to improve maternity services by pushing for hospital births, despite a lack of evidence. Furthermore, that the report primarily addressed the issue of safety from a system-level perspective, neglecting the preferences and needs of the women giving birth (the virtue of quality) (Ferster & Pethybridge, 1975).

In fact, both maternal and infant mortality were falling steadily from 1948 onwards, even though, up to the mid 1960's, one third of births were taking place at home. This significantly changed after the Peel report was published (Nove et al., 2008).

The Peel Report (1970), formally titled *"Report of the Committee on Chief Professional Advisers on Obstetrics and Gynaecology"* (DHSS, 1970), had a significant impact on maternity care in Great Britain. The report concluded that all women and babies should be able to access modern medical care in hospital. It therefore recommended 100% hospital births, since (despite a lack of evidence) home birth was seen as unsafe. The essence of maternity care and so the ontological perspective coming out of the Peel Report, was the notion that high quality care can only be provided in-hospital, so women and babies can be kept safe from physical harm using medical technologies when complications arise (DHSS, 1970).

Some authors have claimed that the knowledge and practice that was normative for obstetricians gradually became the gold standard of maternity care, both in terms of a focus on safety, and as a means of ensuring efficiency as birth moved into hospital settings on a large scale (Davis-Floyd, 2001; Martin, 1989). Some have characterised this as a move towards an industrialised, medicalised system (Sandall, 1995) characterised by routinised care and potentially harmful interventions without a good evidence base, such as enemas, perineal shaving, and episiotomies (Chadwick, 2018, Sandall, 1995). Romney (1980) and Oakley (1984) claim that, during this time, childbearing women were expected to be a 'good patient', accepting what was provided for the benefit of their baby, rather than expecting care that revolved around their needs and wishes (Oakley, 1984; Romney, 1980). One criticism that could be levelled against these arguments is that the move towards service user involvement in decision making in health care was not a societal expectation in the 1970's, and that the focus of health care was primarily on safety at a time when maternal and foetal mortality was still relatively high.

The Short Report (1980), published by the British Department of Health and Social Security (DHSS), similarly to the Peel Report, emphasised the need to prioritise safety (defined as lower mortality) for mothers, and stated that this could happen by increasing hospital births. By focusing on hospital

development, the report suggests that the notion of quality is linked to having access to a wider range of specialists and technology available in hospitals (DHSS, 1980).

In the early 1990s, the public health policy agenda put women's choice and role in their care to the forefront of maternity care (Department of Health, 1991). This was because consistent reports were coming out about women receiving poor quality of care during pregnancy, birth and in the postnatal period. Strong activism from consumer groups in combination with high quality clinical evidence (e.g. Chalmers et al., 1989) challenged the notion that quality of maternity care is purely about physical safety, or that this could be guaranteed by hospital birth (Declercq, 1998).

Because of this, a committee was brought together, led by Nicholas Winterton, a Conservative MP, which brought together the voices of independent midwives, the Royal College of Midwives (RCM), paediatricians, and obstetricians and service user organisations. The product of this collaboration was the Winterton Report (1992), published by the House of Commons Health Committee (HSCC, 1992). The report highlighted the importance of listening to women, respecting their choices, and ensuring effective communication. The Peel Report's recommendations that all women should give birth in hospital on the grounds of safety was rejected as the expert committee agreed that there was no strong statistical evidence supporting the notion that home births were less safe for women with uncomplicated pregnancies (HSCC, 1992).

While the Winterton Report created a foundation for change, a new expert group was established to build on the report and set out a path for reform by investigating the findings further. The Changing Childbirth report, published in England in 1993 by the Department of Health and Social Security was a government response to the Winterton Report. The expert group was chaired by a government minister (rather than an obstetrician) and included the National Childbirth Trust president. The expert panel followed the argument of "*Where to be Born; the Debate and Evidence*" of Campbell & Macfarlane (1987) which in the absence of clinical trials, reviewed observational data. The book called for better research and data to inform decisions about where to give birth, taking into account women's preferences, safety and available resources (Campbell & Macfarlane, 1987). Safety in childbirth was now highlighted as not an absolute concept, but a spectrum. When prioritised to the extreme, the analysis of the committee was that it can morph into a justification for unnecessary interventions and technological monitoring, ultimately detracting from the mother's experience. At this point, the English national policy rhetoric of quality maternity care moved towards a more value-based definition. High quality maternity care meant that women should be given high quality information, the opportunity to discuss their options with their healthcare provider and furthermore, have a good experience (Department of Health, 1993).

Both the NHS and Community Care Act which came in place in 1990 (DHSS, 1990) and the implementation of Changing Childbirth positioned maternity care within the purchaser-provider model. This was an attempt to improve the public sector and 'quality' of services through competition and choice for service users (Bartlett & Le Grand, 1992; Greener, 2009). Quality in this

case was defined as efficiency, optimal outcomes, and responsiveness to service user needs (Department of Health, 1993).

Even though Changing Childbirth is often referred to as a groundbreaking report, little changed in terms of women's choice in practice, evidenced by the lack of increase in the uptake of alternative birth settings such as home birth and midwife led units in England & Wales (Redshaw et al., 2011).

To boost the implementation of the recommendations of Changing Childbirth, the Maternity Matters policy was published by the Department of Health England (Department of Health, 2007a). While, as with the earlier reports, it did not explicitly define quality of maternity care, it emphasised several key aspects that contribute to good outcomes and positive experiences. Maternity Matters reiterated the importance of listening to women, effective communication, and respecting women's autonomy by increasing choice of place of birth, pain relief options and involving birth plans. Furthermore, it highlighted the importance of continuity of care, where possible, allowing women to build relationships with the same midwife throughout pregnancy and birth. While safety was not the main focus, it remained a crucial aspect of quality. The report acknowledged that achieving safe outcomes, does not necessitate overmedicalisation or unnecessary interventions. The notion of quality was clearly set out in the targets to improve maternity services which included an increase in women having midwife-led care, in the hope that this approach enabled more woman-centred care and positive outcomes (Department of Health, 2007b).

The Kirkup Report, formally titled "*The Report of the Morecambe Bay Investigation*", was published in March 2015 by Dr. Bill Kirkup. It investigated serious concerns about maternity services provided by the University Hospitals of Morecambe Bay NHS Foundation Trust (England) between January 2004 and June 2013. Key findings were significant failures in care which were linked to three maternal deaths and the deaths of 16 babies shortly after birth. Systemic issues, beyond individual failings were found regarding communication, leadership, and a culture that did not prioritise physical safety. The report also criticised the Trust's failings to learn from past incidents and subsequently a failure to implement the necessary improvements. Recommendations made were aimed at improving maternity services, including better staffing, improved training, and enhanced communication (Kirkup, 2015).

"Better Births: Improving outcomes of maternity services in England" (2016) was published by NHS England as a response to the Kirkup Report (2015). It aimed to address concerns about safety, choice, and the overall experience of childbirth for women in England, and to transform maternity care in the UK. The focus of the report was on making maternity care safer (reduce stillbirth, neonatal deaths, and serious brain injuries), more personal (respecting women's choices and preferences), kinder (positive experience for women), more professional (skilled and compassionate staff delivering high-quality care), and more family friendly (including the chosen birthing partners more) (NHS England, 2016b). The report served as a roadmap for improvements,

but some critics argued that the report did not go far enough in addressing inequalities in access to quality maternity care (Crowe & Manley, 2019).

"Better Births Four Years On: A review of progress" (2020) by NHS England provided an update on the progress made towards achieving the goals outlined in the original *'Better Births'* report (2016). The report highlighted the progress made which included a significant reduction in stillbirths between 2010 and 2018 and a reduction in the stillbirth and neonatal mortality rate. Ongoing efforts and goals were the implementation of continuity of carer pathways to improve communication and build trust between women and midwives, and a focus on staff training. The report acknowledged variations in the quality of care (as defined in the original Better Births report) across regions and Trusts, and highlighted that continued efforts were needed to ensure consistency and access to high-quality services for all women (NHS England, 2020).

A year later, the Health and Social Care Committee (HSCC) published a report called*: "The Safety of maternity services in England"*. In this report, the committee held the Government to account for its shortcomings to deliver on its targets regarding safety failures (maternal and neonatal deaths and stillbirths) in maternity services. The investigation was built on independent enquiries into incidents at the University Hospitals of Morecambe Bay NHS Trust, East Kent Hospitals University Trust and Shrewsbury and Telford Hospitals NHS Trust. The expert panel evaluated four main Government commitments on maternity services including safety (halve the rate of stillbirths, neonatal deaths, brain injuries, maternal deaths, reduce the pre-term birth rate to 6%), continuity of carer (by 2024, 75% of women from BAME communities and a similar percentage for women from most deprived groups), personalised care and support plans for all women, and lastly safe staffing. In total, fifteen recommendations were made to the Government (HSCC, 2021).

In September 2021, the English government published a response to the report from the Health and Social Care Committee, acknowledging that even though improvements had been made in the past years, more work needed to be done to increase the quality of maternity care. The Government responded to all 15 recommendations of the HSCC clarifying how improvements will be made (DHSC, 2021).

The final reports of the independent enquiries of Shrewsbury and Telford Hospital NHS Trust (The Ockenden report) and East Kent Hospitals University Trust (The Kirkup Report) were published in England in 2022. The Ockenden Report's key findings identified extensive failures in care between 1985 and 2017, including a lack of foetal monitoring during labour, poor communication between staff and families, delays in responding to emergencies, and a culture that failed to prioritise to listen to women's concerns. The impact of such failures was reported to be devastating, resulting in avoidable deaths of mothers and babies. The report criticised the organisations failure to adequately investigate past incidents and implement the necessary improvements. A series of recommendations for improvement were made, including increased staffing levels (midwives and

obstetricians), improved training on foetal monitoring and safe clinical practices, improved communication, and the establishment of a culture that learns from mistakes (Ockenden, 2022).

The report "*Maternity and neonatal services in East Kent: Reading the signals"* by Dr Bill Kirkup looked at serious failings in maternity and neonatal care between 2009 and 2020. Similar to the enquiry in Shrewsbury and Telford Hospital NHS Trust, systemic issues such as understaffing (due to staff shortages), poor communication and teamwork, and a culture that did not prioritise listening to women or safety. Over 200 families using the services suffered significant harm due to poor care, including avoidable deaths of mothers and babies, birth injuries, unnecessary interventions, and emotional distress caused by poor communication and a lack of kind and compassionate care. Four areas of action were proposed: (1) Monitoring safe performances – finding signals among noise; (2) Standards of clinical behaviour – technical care is not enough; (3) Flawed teamworking – pulling in different directions; (4) Organisational behaviour – looking good while doing badly (Kirkup, 2022).

The three-year delivery plan for maternity and neonatal services published by NHS England in 2023 aimed to make maternity and neonatal care in England safer, more personalised, and more equitable for women, babies, and families. The delivery plan was built upon previous reports and initiatives aimed at improving the quality of maternity care in the UK. The notion of quality was mainly focused on improving safety (the reduction in avoidable harm and improved outcomes), equity of access (ensuring all women have access to high-quality maternity and neonatal services by addressing inequalities), and personalised care (respecting women's choices and preferences). Better staffing, the importance of listening to women, a culture of safety and learning, open communication, continuity of carer, and improved standards to ensure consistent high-quality care across all maternity services were also highlighted as key areas of focus (NHS England, 2023b).

Nevertheless, a negative trend in the England continues to be evident (to 2024 when this thesis was submitted) in terms of both clinical outcomes and women's experience of care. The results of the 2023's national maternity survey by the Care Quality Commission (CQC) published in February 2024 showed that improvement is needed in the availability, interactions, and communications of staff. However, a positive trend was seen in women's experiences of antenatal care, and in mental health support, compared to the previous surveys conducted (CQC, 2024). Additionally, in May 2024, the All-Party Parliamentary Group on Birth Trauma reported on the results of their birth trauma enquiry in which they found many accounts of experiences of low-quality maternity care (a lack of kindness, information, informed consent, pain relief, and women reporting on traumatic experiences) (APPG, 2024).

The prevalence of inequitable care

In 2022, Birthrights UK© launched an inquiry into the racial injustice and human rights in maternity care in the UK. The name of the report is: "*Systemic racism, not broken bodies'".* With this inquiry,

they called for urgent and immediate action to tackle the deeply rooted and evidenced systematic racism within maternity care (Birthrights, 2022).

The ninth annual report from MBBRACE incorporates data from 2019-2021 and includes women in the UK who died during pregnancy and up to one year after birth. The report highlights a significant racial disparity in maternal mortality. Black women were approximately 3.8 times more likely to die in pregnancy or childbirth compared to white women, with women from Asian ethnic backgrounds facing an almost twofold (1.8x) increased risk of mortality compared to white women. The numbers of women who died from direct causes such as suicide, infection, pre-eclampsia and PPH increased compared to the data presented in the preceding report (MBRRACE-UK, 2023).

Not only is there a significant disparity between morbidity and mortality rates of women from black, Asian and mixed ethnicity women compared to white women (MBRRACE-UK, 2023), there is a difference in their experience of care. Stories of over 300 women from minority backgrounds highlighted how they are disproportionately affected by structural barriers to maternity care. Furthermore, stories were told of feeling ignored or disbelieved, unsafe, not being given true informed consent, and feeling coerced and dehumanised. Five main action points were proposed to increase maternity care quality for these women, including the creation of working cultures that are safe and inclusive, change in national policy to remove structural barriers to racial equity, commitment to being anti-racist, maternity curriculums and guidance to be decolonised, and ensuring black and brown women are the decision makers in their care (Birthrights, 2022).

2.6 Conclusion

The term 'quality of care' is used widely and uncritically. Two people discussing the 'quality' of care may think they have a shared understanding of the term. However, this chapter demonstrates that organisations, professional bodies, and policy makers, define or conceptualise quality in very different ways, depending on the personal values, beliefs, and social surroundings of those who comprise these groups.

The analysis of definitions of quality which emerge from ancient philosophy indicates that there are two aspects. In one, quality is seen as an intrinsic characteristic, the nature of a phenomenon. The second one relates to values or virtues, or how people idealise quality, such as personalised care, or optimal clinical outcomes.

Whichever definition is used, evidence relating to women's experiences of maternity care, suggests that what matters to them is often not provided. Additionally, the variability in the type and standard of care provided, especially for women of Black, Asian, or other minority backgrounds, is associated with much worse outcomes. There is an urgent need for a globally agreed approach to the

definition and implementation of quality and equitable maternal health, which supports implementation of respectful, evidence-based care.

There is an existing debate in UK maternity care about whether 'quality care' is measured (only) by lack of short-term adverse physical outcomes (and, critically, avoidance of death), or whether longer term outcomes, experiences and psychosocial wellbeing are also (ontologically and in terms of values) critical components of quality. This dichotomy is often characterised as an ideological split. Others have argued that, rather than taking an 'either/or' stance, the optimum measure of quality is 'both/and'). This raises important questions about which different definitions or conceptual frameworks underpin notions of the quality of maternity care. Negative consequences at all levels of maternity care and for mothers, birthing people and their newborns could surface if these discrepancies are not understood and resolved.

The next chapter provides information about the methodology used in this research study, including the decision-making process and rationale behind the choices made.

CHAPTER 3: METHODOLOGY

3.1 Introduction to the chapter

The previous chapters explored why conducting this research was important, provided knowledge about the history and philosophical meanings of quality, and gave contextual information on the political history of maternity services in England, where this study was conducted.

This chapter presents the decision-making process and rationale behind the methodology of this research study. Throughout this journey, ideas continuously evolved, and this chapter, gives an understanding of the initial ideas, explores the rationale for change as my methodological stance evolved, and then describes the design and methods that were used.

Next, the theoretical underpinning and so philosophical stance is described, which consequently led to choosing the methodology used. Furthermore, an overview of the different phases, explaining the research methodologies adopted is given. Additionally, an explanation of the data collection methods; and description of the ethical considerations, including ethics approval, data management and analysis is provided.

3.2 Theoretical underpinning

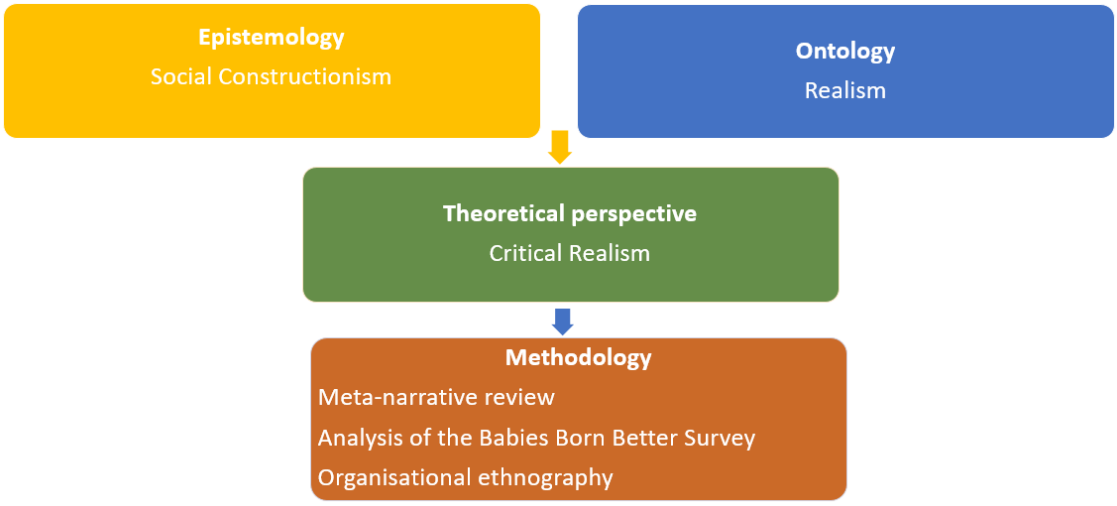
This chapter describes the theoretical underpinning of this study, including the ontological and epistemological assumptions that frame it, the theoretical perspective that informed the methodology and therefore led to the choice of methods used. In social sciences and health care research, these terms have been applied in various ways or often are not distinguished from each other and put under one umbrella term (e.g., 'approaches', 'perspectives', etc.). There are many different defendable ways in which these concepts can be used or structured (Al-Ababneh, 2020; Crotty, 1998; Polit & Beck, 2008; Tuli, 2010). Having considered this multiplicity of approaches, I decided to apply the definitions used by Crotty (1998), as they seemed to be clear and logical.

Childbirth specifically, and maternity care in general, are life events affected by social, environmental, and psychological factors. There is a growing critique of the tendency to super-value quantitative positivist research in health and maternity care, to the exclusion of other theoretical and methodological approaches that capture a broader picture of the nature, outcomes and experiences of care (Guise et al., 2017; Petticrew, 2011, 2013; Rutter et al., 2017; Tuli, 2010). Quantitative methods capture effectiveness and efficacy, but they assume cause-effect, linear relationships that are certain and straightforward (Downe & McCourt, 2008; Lincoln & Guba, 1985; Rutter et al., 2017; Tuli, 2010).

In contrast, labour and birth experiences, and, therefore, interpretations of the quality of care, are multifactorial. Multiple methods are required to capture the complexities of the maternity services environments. Walsh and Evans (2014) noted that: *"As midwifery researchers, we need a theoretical underpinning that can accommodate this complexity and prompt us to examine phenomena more holistically, researching it from multiple perspectives (p. 2)"* (Walsh & Evans, 2014).

Figure 5 below summarises the approach taken for this study, based on the dimensions proposed by Crotty (1998).

Figure 5: Theoretical underpinning and methodology of the study



Epistemology and ontology

To understand the theory of knowledge which was embedded in the theoretical perspective, and so which viewpoint to read this thesis from, the adopted epistemological stance will be explained. Crotty (1998) defines epistemology as *"the philosophical study of the nature, origin and limits of human knowledge (p. 8)"* (Crotty, 1998). In other words, epistemology deals with the nature of knowledge and ways of learning about- and knowing social realities (Maxwell, 2012).

Ontology on the other hand, refers to the study of being. It defines the structure of reality, the nature of existence, 'what is' (Al-Ababneh, 2020; Crotty, 1998).

Epistemology and ontology therefore underpin theoretical frameworks for research, in terms of both 'what is' (ontology) and 'what it means to know' (epistemology) (Crotty, 1998; Maxwell, 2012).

Epistemology: Constructionism

This thesis is built on a constructionist epistemology which signifies that meaning in relation to a situation or fact is constructed in various ways by different individuals (Crotty, 1998). A constructionist stance enables an emphasis on the complexity of humans in social environments, the ability to notice and capture the individual, holistic, and dynamic experiences of the people that

are studied, and the ability to understand and capture people's lived experiences wholly within the context of the people who are experiencing them (Polit & Beck, 2008).

The alternative approaches of subjectivism and objectivism were unsuited for this research project. Pure subjectivism would not be able to capture the complex social reality, constructed within the maternity environment as from this viewpoint, meaning is personal and unique to each person. It arises from their internal world, not some external source (Crotty, 1998). According to Saunders et al. (2009) *"social phenomena are created from the perceptions and consequent actions of social actors (p. 111)"* (Saunders et al., 2009). In subjectivism, meaning is imposed on a certain object by the person, without the object having any contribution to it (Al-Ababneh, 2020; Crotty, 1998). Nor is pure objectivism suited to be used as the basis for this research. Saunders et al. (2009) note that objectivism accepts "*the position that social entities exist in reality external to social actors (p. 110)*" (Al-Ababneh, 2020; Saunders et al., 2009). From this perspective, reality exists independent of human knowledge, or of the meaning humans make of it. Crotty (1998) explains this phenomenon as *"The tree in the forest is a tree, regardless of whether anyone is aware of its existence or not (p. 8)"*. It is the object itself that carries its own meaning and when someone sees the object, they simply discover the meaning which already existed (Crotty, 1998). Since the concept of maternity care quality is inevitably socially constructed in the interaction between the care provided and the expectations, norms and values held by both those who receive it, an objectivist epistemology cannot capture the phenomena of interest to this study.

In interacting with each other and the wider social context within the maternity services, quality of care is experienced, constructed and interpreted by the people or stakeholders involved, therefore, the social constructionism stance is used to underpin this thesis (Lincoln & Guba, 1985; Maxwell, 2006).

Social constructionism

Conceptually, this study is based on the assumption that the social environment shapes individual perceptions and vice versa (Crotty, 1998).

From the late 1960's onwards, social constructionism as a formal term emerged through the work of Thomas Luckmann and Peter Berger. These authors synthesised the ideas of Émile Durkheim and George Herbert Mead, inspired by the work of Alfred Schütz (Berger & Luckmann, 1966; Knoblauch & Wilke, 2016). Berger and Luckmann (1966) conceptualised social constructionism as the mental representation of each other's actions that are created over time when social groups are interacting. Eventually, these concepts are adopted in reciprocal roles in society and the reciprocal interactions are institutionalized. Meaning is embedded in society and so people's beliefs and knowledge of what reality is become immersed in the 'institutional fabric in society'. Therefore, reality is said to be socially constructed (Berger & Luckmann, 1966). According to Fish (1990), and

in direct contrast to objectivism, the concept of meaning for any object is not an inherent property, but rather a product of social construction processes and established conventions (Fish, 1990).

Critics have argued about the perceived conceptualisation of relativism and realism in social constructionism (Craib, 1997). Andrews (2012) notes that *"this is to confuse epistemology with claims about ontology and is a fundamental understanding of the philosophy that underpins social constructionism (p. 42)" (Andrews, 2012).* Going back to the roots of social constructionism, it only focuses on epistemology (the social construction of knowledge), without making any ontological statements about what that knowledge 'is' (Andrews, 2012; Berger & Luckmann, 1991).

Though the criticism that social constructionism does not recognise an objective reality is common (Andrews, 2012; Bury, 1986; Craib, 1997; Schwandt, 1994), such criticism is not valid because it recognises that multiple realities can co-exist (Burningham & Cooper, 1999). However, findings of social constructionist processes are usually not presented as definitive. This sometimes leads to the criticism that, as there isn't anything the findings can be judged against; in other words, the shortfall of findings based on a constructionist epistemology is that it cannot make any changes (Bury, 1986). To the contrary, it is argued that change can also stem from results that resonate with stakeholders, where debate around different viewpoints (discourses) can trigger practical action (praxis) (Burningham & Cooper, 1999).

Ontology: Realism

According to Andrews (2012) *"realism and relativism represent two polarised perspectives on a continuum between objective reality at one end and multiple realities on the other (p. 42)"* (Andrews, 2012).. He argues that both can potentially be criticised. Relativism for implying that no one reality is superior to another, and that nothing can ever be known for sure. Realism for the assumption that what is found is a true clarification of a distinct reality, not considering the interpretation constructed by the researcher, or anyone else engaging with the same phenomenon (Andrews, 2012).

Crotty (1998) on the other hand, argues that social constructionism is both relativist and realist, in that; *"The existence of a world without a mind is conceivable, meaning without a mind is not (p. 10-11)"* (Crotty, 1998). In this case, the world exists without interpretation (it is 'real' in that sense), but once human minds become engaged with it, it is always interpreted through the relative meaning that humans attribute to it. In social constructionism, what is relative is the way the interpretations that people make create the way things 'are'. These interpretations are influenced by culture and history. When a similar phenomenon is investigated by different people or at different stages in time, interpretations or meanings of that phenomena and ways of knowing are usually different (Crotty, 1998). In contrast, for positivists, social reality is grounded in empirical facts which are ruled by cause and effect and completely separate from ideas or thoughts of individuals (Marczyk et al., 2010). Social constructionism does not limit the existence of reality in this way (Crotty, 1998).

The ontological stance of this work lies in realism, as far as maternity care has a physical effect on physical bodies: *"To say that meaningful reality is socially constructed is not to say that it is not real (p. 63)" (Crotty, 1998)*. Schwandt (1994) agrees with this as he supports the vision that one can be a social constructionist and a realist at the same time (Schwandt, 1994). This realist-type approach was used to investigate the 'mechanisms' of quality of maternity care and how it fires differently in different contexts. Although this study is not a realist evaluation, in which context-mechanism-outcome parameters are developed (Pawson & Tilley, 1997), it does use the philosophical underpinning of critical realism, and some of the concepts of the realist approach.

Theoretical Perspective: Critical realism

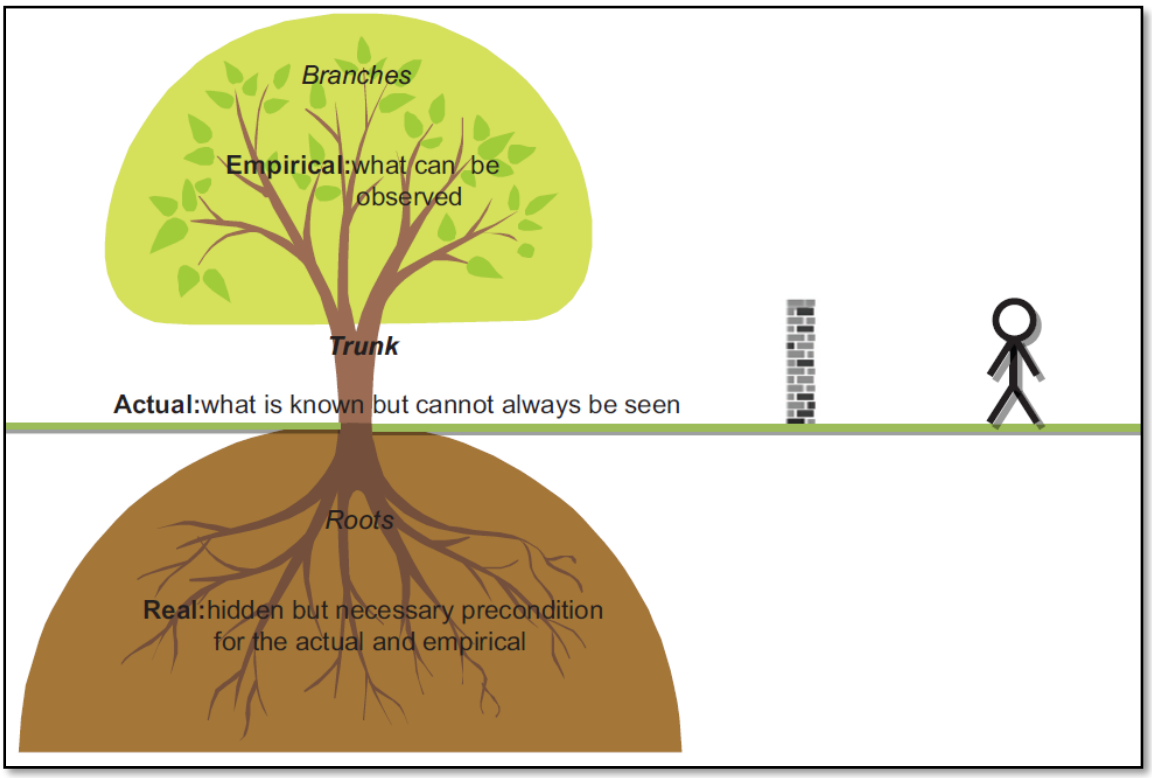
The theoretical perspective that frames this study is critical realism. The critical realist approach provides an ideal framework for complex social investigations as it aims to increase the understanding of the thinking and behaviour of individuals in specific contexts (Hammond et al., 2014; Walsh & Evans, 2014).

Critical realism was first described in the 1970's by Roy Bhaskar (British philosopher and sociologist) in his book "*A realist theory of science"* and is seen as an ideal approach to research people in a social and health context (Bhaskar, 1997, 2013; Walsh & Evans, 2014). This theoretical framework suggests that all individuals see the world from a unique point of view (Hammond et al., 2017; Maxwell, 2012). Critical realism unites a *realist ontology*, which is described by Maxwell (2012) as *"the belief that there is a real world that exists independently of our beliefs and constructions (p VII)";* combined with a constructionist epistemology, which, according to Maxwell (2012) is *"the belief that our knowledge of this world is inevitably our own construction created from a specific vantage point, and that there is no possibility of our achieving a purely 'objective' account that is independent of all particular perspectives* (*p. VII)"*. This is because people cannot observe anything without letting prior understanding (theoretical presuppositions/understanding of theories and concepts adopted by society) influence interpretations. This is often referred to as a 'theory-laden' position (Maxwell, 2012). Bhaskar (2013) stance is that both physical (real objects, things and places) and non-physical (feelings, thoughts, memories, social) structures are equally real and can influence things taking place in the universe. Bhaskar (1997) divides his vision of the world through critical realism in three levels, visually presented by Walsh and Evans (2014) using a tree diagram (see figure 6). The branches of the tree are always visible and present '*the empirical*', what is observable. There are things that are known, but cannot always be seen, which is represented by the trunk and called '*the actual*'. The roots represent '*the real*' as they are hidden but are necessary aspects for the actual and empirical to exist (Bhaskar, 1997, 2013; Walsh & Evans, 2014).

Therefore, critical realism is an ideal framework to explore '*the empirical*', which, for this study, is the culture of the maternity care organisation which can be physically seen or observed, '*the actual*' which is the healthcare providers and women's beliefs and thoughts about their experience of the

quality of maternity care and lastly, '*the real*' which is the nature of 'quality' (Bhaskar, 1997; Walsh & Evans, 2014).

Figure 6: Tree diagram (Walsh and Evans, 2014)



Walsh and Evans (2014) have recommended using this philosophical stance in midwifery research, arguing that *"knowledge of the stratified layers of reality is always partial, incomplete and revisable in the light of new research (p. e3)"* (Walsh & Evans, 2014). This is in line with the theoretical perspective of this study as set out in the previous chapter. While individuals discover and uncover complex phenomena, knowledge is constructed, in line with the constructivist epistemology. Individuals in dialogue also co-construct their ontological truth, in line with constructionism. Asking different individuals (mother, her partner, the midwife) who have been present during the same labour and birth about their experiences, will produce contrasting answers. This is because how people interpret situations is at both an individual and a social level. Critical realism offers a distinct advantage over other perspectives like positivism or subjectivism when it comes to exploring childbirth. It acknowledges the existence of an objective reality (the biological process) while recognizing how individual experiences and social factors (co-constructed knowledge) shape our understanding of childbirth (Walsh & Evans, 2014).

Together with the supervisory team, I reflected a lot on combining social constructionism and critical realism. The critical realist thinking that underpins realism is not necessary the same for all realists. As mentioned before, the decision was made to use a realist-type approach to investigate the ideas, mechanisms, and implementation of quality within maternity services. Critical realism in

its purest form argues that there is an underlying reality that we can never really understand. Social constructionism on the other hand argues that there is no such thing. I believe that there is a real phenomenon of optimal maternity care, that meets the needs and values of all those providing and receiving it. How 'needs and values' are interpreted, creates different manifestations of this phenomenon. What maternity services physically look like, the care that can be observed, the existing guidelines, policies and organisational standards that are in place, the audits done, and outcome measures are all part of the 'empirical' in realist terms. They all influence the 'real' - how 'quality' is interpreted locally, and, therefore, implemented.

Given these observations, the design and methods used in this study need to uncover the nature of quality and how it is socially constructed. The solutions to this need are described in the next section.

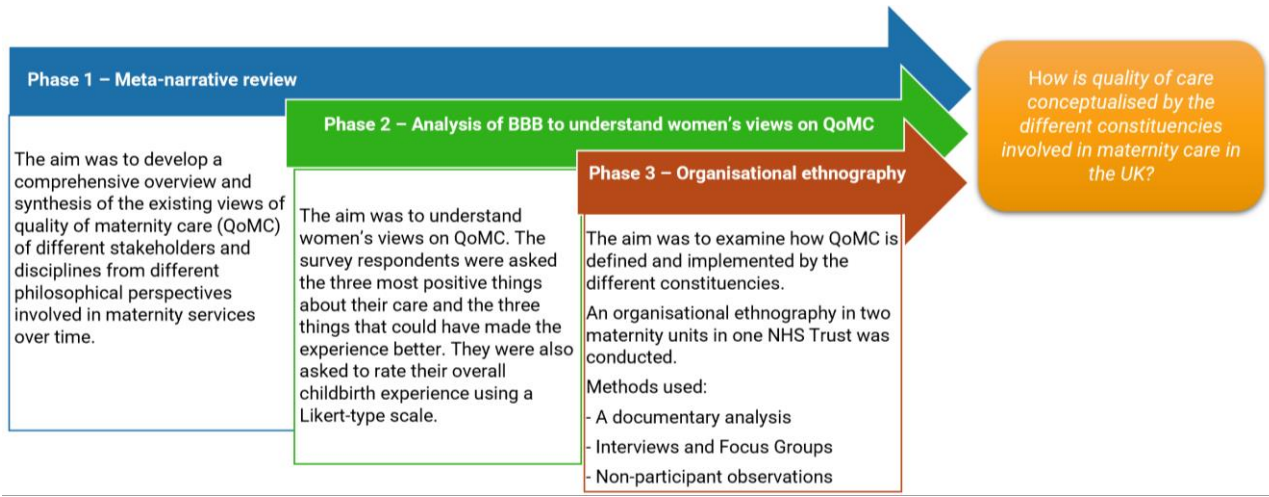
3.3 Research design

The research design consists of three phases (see figure 7) and has been registered on a public database (https://www.researchregistry.com/) on 26/02/2021.

In the next paragraphs, my perspective, positionality and reflexivity is explained. This is followed by an in-depth description of the methodology and methods of the three different phases, in the light of the theoretical perspective that forms the lens for the study. More about the analysis, findings and conclusions can be found in the next chapters.

Adopting a social constructionist epistemology asks for flexible, evolving methodology and methods to capture the data emerging from the experiences of the participants, which were stakeholders in maternity services in this case. The aim was to highlight the social, holistic and dynamic aspects of the culture within the context of the maternity services investigated (Polit & Beck, 2008).

Figure 7: Research Design



Changes in the original design

The research design changed and evolved from the initial research plan. Originally, the intention was to use the results of the meta-narrative review and data from the Babies Born Better survey (version three) to develop a tool to identify high performing maternity services. This tool would then be used to choose which high performing maternity units would be enrolled in the organisational ethnography. As I am Belgian (Flemish speaking), the plan was to analyse the Babies Born Better data from both Flanders, as well as the UK and to compare two high performing Flemish maternity units with two high performing ones in the UK. Due to a delay in the closure of the Babies Born Better survey of over six months, four units being a lot for one PhD student to investigate, and the Coronavirus pandemic, a decision was made to reduce the case studies to two units in the UK and include a much smaller sample of the Babies Born Better survey in the final project. See figure 7 above for the research phases used and p. 37 (Design, study population and methods of the three phases) for an in-depth explanation of the methods used.

Perspective: Insider, outsider and in-between

Besides thinking about the suitability of the theoretical framework, research methods and my ability to implement and use these methods, I considered my positionality and role before commencing my ethnographic research (Saidin, 2016).

According to Griffith (1998) "*Where the researcher enters the research site as an Insider - someone whose biography (gender, race, class, sexual orientation and so on) gives her a lived familiarity with the group being researched - that tacit knowledge informs her research producing a different knowledge than that available to the outsider. The Outsider is a researcher who does not have an intimate knowledge of the group being researched prior to their entry into the group (p. 362)*" (Griffith, 1998). Outsiders are the 'non-members', where insiders are members of a collective or group or individuals who occupy a specific social status (Merton, 1972). Saidin (2016) notes that some researchers investigate a topic which is completely new to them and so they do not have any knowledge or experience dealing with it. In other cases, researchers investigate the topics or groups they are interested in, associated, related or familiar with (Saidin, 2016).

According to Griffith (1998), researchers are rarely completely outsiders or insiders because the construction of research usually happens in relationship with others. *"The interaction of individual biography and social location shape the research relation in complex ways which undercut the common-sense translation of historical familiarity into epistemological privilege (p. 361)"* (Griffith, 1998).

Traditionally, ethnography has been carried out by 'objective' external observers or outsiders (Jones, 2010; Wolf, 2012). In the past decade, there has been an increase in researchers in healthcare who perform ethnographic research in their own workplace. The trustworthiness of the findings has often been questioned due to insider-researchers being viewed as biased or over-

involved. On the other end of the spectrum, the outsider researcher has been seen as someone that might not be able to fully understand, access or comprehend the dynamics at play behind the scenes (O'Reilly, 2008). Merton (1972) has highlighted that, the differences between the insider- and outsider researcher are debatable. Both positions have their advantages and disadvantages and there are many significant factors (besides culture and ethnic group, that are usually cited) influencing the success of the research done (Merton, 1972; Saidin, 2016).

Merton (1972) notes that individuals do not belong to one single status and so the insider or outsider roles are a product of the context in which the research is taking place. This means that one researcher can be an insider in one situation and an outsider in a different context or moment (Kusow, 2003; Merton, 1972). Furthermore, Kusow (2003) notes that the status of the researcher is continuously negotiated by, and so depends on, the interaction with participants. The collaborative process in which the researcher and participants make meaning, which is central to constructionism, defines the 'outsiderness' or 'insiderness' of the researcher. Because it is impossible to define the actual relationship between the participants and researcher in advance, the researcher cannot be categorised as being an insider- or outsider researcher (Kusow, 2003).

Reflexivity and positionality

The chosen philosophical stance for this work makes it possible to use my own personal knowledge and expertise in the field as a strength rather than a disadvantage, which would have been the case if the chosen ontology was a positivistic approach. At the start of my PhD, I was interviewed about my experiences working as a midwife, my research knowledge derived during previous jobs and my view on quality of maternity care. The interview was transcribed, analysed, and then added as another layer to the research (see chapter six: Setting the ethnography scene).

I have kept a reflective diary throughout the research project as a means to stay aware of my own role, position, ideas and to ensure sufficient reflexivity. The monthly supervision meetings and using the supervisors as my sounding board helped to clarify ideas.

I will briefly explain my background to create a basic understanding of my role as a midwife, researcher, and my position in this project.

I was born and raised in Belgium and in 2009-11, I studied a direct entry Bachelor (BSc) in midwifery at the university college of Leuven, Belgium. My passion for quality in maternity care was born during a 12-week placement in a maternity service in Ecuador (El Sotomayor, Guayaquil). Care was divided in three levels (public, intermediate and private care) and my two fellow Belgian student midwives and I were allocated to work in the public part of the service and to look after the socio-economically deprived women. Care provided by the local staff was unkind and inhumane, women were completely by themselves, there was no privacy nor dignity, and no consent was asked at any point in time. The place was dirty and dark, and the practice was everything except evidence based. I was 21 and had a very difficult time coping in this place, which at first, made me feel ashamed.

Only later and on reflection, I realised that everything happening in that maternity service was going against my own values. At that point in time, I learned to use the experience as fuel to ignite my passion to improve equity, quality, choice, and respect in maternity care.

Due to a lack of job opportunities and not feeling ready to start working in the field after successfully completing the BSc, I decided to study the Master (MSc) in midwifery at the University of Leuven, Belgium. It turned out to be a great opportunity to broaden my knowledge around the different models of care, research, quality of healthcare, human factors and learn how to think critically. I wrote my MSc thesis about the perceptions of obstetricians and GPs around the implementation of midwife led care.

After finishing the MSc, I decided to move to England. I realised that the well-established midwife-led model of care in the UK was going to enable me to become an experienced midwife in all facets of my role. In Belgium, the obstetric-led model prevails in most hospitals and existing midwifery jobs are closer to the role of an obstetric nurse than that of a midwife as an autonomous practitioner.

After working one year as a rotational midwife in one NHS Trust and completing my preceptorship programme, I moved to the NHS Trust where I am currently still employed. In the past nine years, I got to know many of the colleagues while working on the labour ward, antenatal and postnatal ward, in triage, but mostly on the alongside midwifery unit which is where I have been based since 2016. This is also the year in which I was awarded a research grant from the charity of the NHS Trust I worked at and where my clinical academic career started. For three years, I worked as a research assistant on a National Institute for Health and Care Research (NIHR) implementation science project around the implementation of the NICE guidelines for women with straightforward pregnancies for which Dr Lucia Rocca-Ihenacho was the PI. Over the years and almost simultaneously, I gained experience in my clinical career as well as experience in conducting research. The birth centre team has always been very supportive towards my research career and so the need to reduce hours in clinical practice as well as the needed flexibility around shift work.

Furthermore, in 2018, I became one of the co-directors of the Midwifery Unit Network and I was the co-author of the European Midwifery Unit Standards document developed to improve women's access to high quality midwifery units. In the meantime, I started facilitating workshops for the Midwifery Unit Network around optimal birth, safe care, transfer and skills and drills in midwife led settings, women's autonomy and partnership in decision making all catered for multidisciplinary teams.

This was my baseline, when I was awarded a PhD fellowship at the University of Central Lancashire in 2019. I started to work on a full-time PhD and fulfilled a 0.3 FTE band six role in clinical practice. Being a band six midwife meant that I was a qualified midwife with a few years of experience, providing a range of midwifery care including prenatal, intrapartum, and postnatal care. The

organisational ethnography and so data-collection took place at the NHS Trust where I work. The colleagues I work most closely with in the alongside midwifery unit were aware of my background and experience and so my position in the field. Only very few members of the wider multidisciplinary teams within the two sister hospitals (one NHS Trust, two maternity units) had a full insight in my background. Some of them did not know me at all until I started data-collection in the units. For some I was perceived concurrently as a complete insider; for many an outsider; and for others something in-between. I was known to part of the team and aware of the culture, certain dynamics and relationships and I had access to all maternity services as a member of staff, which made it easier at times to get stakeholders to engage and participate in the study.

As previously mentioned, when I first started data collection, I was a band six midwife and so not responsible for managing a team. For the staff participants, this seemed reassuring, and my impression was that staff found it easy to talk openly and freely to me, knowing what they said would not have any influence on their job. In January 2022, I became a band 7 birth centre team lead in job-share with a colleague. As I was only responsible for managing a small team, the impact of changing role did not seem to have a massive influence on my ability to achieve honest and open accounts from frontline staff and women and their partners. Participants were always made aware of my positionality before I would commence data-collection.

Continuous reflection on my positionality, role, the potential influencing factors, and possible need for adaptations was a big part of the research process. Writing in my research diary has helped to keep an overview of how all these factors evolved during the project.

See chapters six and nine for an in-depth description of my positionality, my ideas around 'quality of maternity care' at the start of the PhD, and my reflexive accounting throughout.

Design, study population and methods of the three phases

Phase 1 – Meta-narrative review

A systematic literature review was conducted, adopting a social constructionist position. The main question was: *"How has quality of maternity care been conceptualised by different stakeholders over time?"* The aim was to develop a comprehensive overview and synthesis of the existing views of quality of maternity care by different stakeholders and disciplines from different philosophical perspectives involved in maternity services (social scientists, managers, frontline staff (midwives/obstetricians), policymakers, service-users, etc.) over time.

The meta-narrative review methodology was chosen as the most appropriate approach to seek commonalities, find differences between the assumptions, to explore tensions, find patterns and understand where ideas about quality of maternity care have been conflicting between different stakeholders and disciplines over time (Kingdon et al., 2019; Wong et al., 2013).

In line with the study's theoretical perspective, the guiding principles used while conducting this review were: pragmatism, pluralism, historicity, contestation, reflexivity and peer review (Kuhn, 1962). Five key phases were used: planning, searching, and mapping of the literature, synthesis, and recommendations. As part of the synthesis phase paradigm bridging, paradigm bracketing, interplay and meta-theorising were applied (Greenhalgh et al., 2004). The detailed process used to conduct the meta-narrative review is explained in chapter three.

Phase 2 – The analysis of the Babies Born Better survey

The Babies Born Better (BBB) project is a multi-country citizens' science project, including women who had their babies in the last three years at the time of completing the study. It aims to generate knowledge and understanding about women's perceptions of the quality of their care during childbirth, focussing on the principle of salutogenesis (see definition in the Glossary of terms, p. ix) (Antonovsky, 1987b). This entails an orientation towards what creates health, wellbeing and positive outcomes in public health, as well as taking into account ill-health and death. The philosophy stands in contrast to the normative health care lens that is highly focused on the identification and prevention of pathology, almost to the exclusion of positive wellbeing. The designers of the BBB survey wanted to create a tool to identify which maternity units, across Europe, provide outstanding care as defined by the women using them, through postcode information on the place of birth for each respondent. While the survey lens focuses on good practice, poor experiences and bad practice can also be highlighted by the data (Balaam, 2015; Vedeler et al., 2021; Weckend, 2015).

Data are collected through an online survey containing 27 questions (see table two, p. 42-43) shared through social media, a website and word of mouth. It has been translated into 26 languages. Over the three waves of the survey around 100,000 responses have been received from women in 106 different countries (UCLan, 2017).

The survey was not designed to be a psychometric tool. The content and face-validity were checked by experts, maternity professionals and service users in five different countries at the time of the initial development. Questions were refined in each wave of data-collection (Balaam, 2015; UCLan, 2017; Vedeler et al., 2021; Weckend, 2015).

The analysis of the Babies Born Better survey was performed to contextualise the findings of the organisational ethnography (phase three). The survey was not created with constructionism in mind, however, for the current study, a constructionist lens was applied to the qualitative data in the English dataset, to capture the lived experiences of respondents who had given birth within the study sites (Polit & Beck, 2008).

Study population Babies Born Better survey

Women who have filled out the Babies Born Better survey are self-selected. The BBB Survey version three was launched in June 2020 and was closed in June 2022. The initial plan, when the study

was going to be run in both the UK and Belgium, was to include all responses from the UK and Flanders. To boost recruitment in the countries of interest, I made videos in both Flemish and English. I disseminated those multiple times on social media (Facebook and Twitter) to invite women who had their babies in the past three years to participate. I also disseminated around 200 postcards at the maternity sites in which the organisational ethnography was taking place, to try to make women enthusiastic to participate in the study and collect as much as possible data from these two units.

In the end, due to time limitations, a pragmatic decision was made to only look at the responses of the women who had their babies in the last three years in any of the available places of birth (home, labour ward, alongside midwifery unit) at the two chosen maternity units in England. This was done to allow me to have a clear idea about what the most important aspects of quality of care were for women who used these services in the past three years.

Phase 3 – Organisational Ethnography

The driver for this study is the critical realist ontological hypothesis that good quality of maternity care is a 'real' phenomenon, but that, at the empirical and actual level, different stakeholder constituencies construct its definition differently, leading to misunderstanding and dysfunctional institutional cultures and service provision. An organisational ethnography was conducted in two maternity units of one English NHS Trust to enable a multidimensional examination of this hypothesis. Ethnographic methods were used to describe the organisational approaches and practices.

Ethnography has its origins in anthropology and involves observation of, and participation in particular settings using a holistic and interpretative approach (McCourt et al., 2011; Neyland, 2016). This method is aimed at studying people and concepts in a social context (Garsten & Nygvist, 2013; Ybema et al., 2009). The organisational ethnography has enabled an in-depth exploration of maternity units through its focus on the organisational culture, social relations, social actors and ability to identify the nature of underlying relationships (Garsten & Nygvist, 2013; Ybema et al., 2009). The social constructionism lens underpinned the intention to understand and describe the customs, values and norms of the members of the cultural group in the chosen maternity units, and how these customs values and norms reciprocally constructed definitions of quality among the social group (Polit & Beck, 2008).

The use of qualitative methods was informed by looking at previously conducted organisational ethnographies in the field. Conducting interviews, focus-groups, and observations facilitates uncovering the widely varying perspectives from the heterogeneous group of constituencies involved in the research. This allows everyone to have a voice in answering the research question. The Covid-19 pandemic and the pressures on the NHS (e.g., staff shortages/availability to participate) forced me to have a flexible approach and use both virtual as well as face-to-face methods. The analysis of the data derived from the organisational ethnography included

observational and field notes, a reflective diary, and transcripts of both the interviews and focus-group discussions.

Study population Organisational Ethnography

The site selection was based on critical case purposive sampling (Battaglia, 2008; Etikan, 2016). The participating Trust was chosen both as it meets the criteria of having two sites that are similar in terms of overall management structure, but contrasting in terms of other organisational variables, and for convenience of access for myself as I was going to do all data collection.

Critical case purposive sampling is used to collect samples which are most likely to give the information the researcher is looking for. In this case, I used it to gain extensive and in-depth knowledge about how the different constituencies in maternity care conceptualise quality, and subsequently, the underlying culture affecting the quality of maternity care provision (Battaglia, 2008; Etikan, 2016). Although the original intention was for four sites across two countries, the concentration on two sites in one Trust allowed for a more detailed and in-depth analysis of how similar phenomenon were socially constructed in two sites with the same management, but different organisational cultures, case mix, staffing, and sizes of the units. Furthermore, it helped to identify key characteristics which in future can be tested in a larger study (Etikan, 2016).

Purposive sampling was used to recruit participants (Ritchie et al., 2003). A range of people involved with maternity care were purposively selected to take part, including professionals providing care, service managers and service users and their partners. The plan was to recruit professional participants that reflect the diversity of stakeholders involved (in terms of job title, years of experience and highest level of education) and to recruit women and their birth partners reflecting the diversity of local communities and people using the service in terms of ethnicity, social class, age, and parity.

Because ethnographic observation can involve both those who have directly consented to take part, and those who engage with them during the observation period, a clear distinction was made between stakeholders and participants.

A *participant* in this study was someone who was officially asked for informed consent to enable official data-collection by giving their personal demographic data, and agreeing to participate in an interview, focus-group, or observation.

A *stakeholder* was someone who did not contribute actively by disclosing demographic data, personal views and/or who was not observed as an individual. They might have been involved in meetings, education days, conversations on the work floor, etc. for which reports, or observational data might have been written only to describe the overall culture or atmosphere. No formal consent was obtained, and no identifying data were collected for these participants.

A formal statistical calculation is not used in ethnography to decide on the number of participants, but the research team estimated that the inclusion of around 130 total stakeholders and participants would ensure sufficient involvement from each of the groups I was interested in, across each of the two sites. However, the final sample size was determined through on-going assessment of the emerging findings, with the intention of continuing sampling until data saturation (see Glossary of terms, p. ix) was obtained. Interviewing, transcribing, and analysing transcripts can be very time-consuming so time constraints also influenced decisions about how many participants were included. Automatic transcription with the software Sonix minimised transcription time and therefore maximised recruitment and data collection

Service user & Public Involvement

Giving service users an active role in research has the potential to increase the relevance as well as the quality of the projects and outcomes due to adding these individuals' unique perspectives (Chalmers, 1995; Entwistle et al., 1998). Brett et al. (2014) found in his systematic review that including service users helped figuring out which topics were most important to prioritise, gave an insight into the timeliness and appropriateness of the data collection tools used and how to best recruit participants, as well as helping with a multiple-perspective interpretation of the data collected. Furthermore, sharing and implementing the research was found to be easier and done in a more user-friendly way (Brett et al., 2014).

To get valuable insights and advice from the public on conducting the organisational ethnography, I consulted a service user group associated with the Trust in which data collection took place. During a Maternity Voices partnership meeting (an NHS working group consisting of women and their families, commissioners, and frontline staff) seeking to contribute to the development of local maternity care, I presented the research project and asked for feedback around the design and aims of the study. I received valuable and novel insights into specific factors to consider in the study (e.g., who I should talk to, what kind of questions are important to ask etc.). The group mainly emphasised the importance of including women and their partners and asking them about their expectations of- and perceived quality of maternity care.

3.4 Research methods

In the following paragraphs, I give an overview of the main data collection methods used in phase two (Survey, p. 42) and three (Observations, p. 43, Interviews, p. 44, Focus-groups, p. 46, and Documentary Analysis, p. 47) of the project. I mainly used qualitative methods and some descriptive statistics to describe participant demographics.

Survey

From the point of view of Sackett et al. (1996) evidence-based medicine (EBM), consists of three aspects, clinical expertise, scientific evidence and the individual needs and choices of the person accessing health care (McKibbon, 1998; Sackett et al., 1996). Service user experiences have played a fundamental part in the provision of quality care since the emergence of EBM, forming part of the management of performances of the healthcare systems in place (McKibbon, 1998). Maternity service user involvement in care design predated the general evidence-based practice movement (Cumberlege, 1993; HMSO, 1992; Prowse, 1994; Stocking, 1991).To ensure both evidence-based and person-centred care, it is important to involve service users in decision making and to understand their needs and preferences, especially when determining the nature of 'good quality' health care (Engle et al., 2021).

Maternity services are continuously changing and evolving, and the preferences and needs of service users co-evolve in parallel (Henderson & Redshaw, 2017). From a healthcare policy perspective, surveys offer the opportunity to regularly assess the quality of maternity care received by large numbers of people who have recently used the services (Redshaw et al., 2019).

Regular surveys of women's experiences of maternity care are undertaken by the NHS but these are not reported at Trust level (Redshaw et al 2019). The BBB survey collects data in multiple languages. It includes the postcode and/or name of the site of where the woman gave birth, meaning that data can be interpreted by specific hospitals or birth centres, along with simple summary measures of quality from the respondent's point of view. It includes 27 questions, including simple demographics (see table 2). There are both open-ended and closed or multiple-choice response options. The survey is distributed via social media, and all women who have given birth in the three years previous to the date they respond to the survey are eligible.

Table 2: The Babies Born Better survey (version 3) questions

Section	Topic	Questions asked
1.	Eligibility	Have you given birth within the last three years?
2.	Demographics	What was your age when your youngest baby was born? What country do you live in? Which country were you born in? How many years have you been in the country where you are now living? Why did you move to this country? What is your civil status? How many years did you spend in formal and higher education? Your employment. Compared to most people in this country, I think my standard of life is…

3.	Other maternal characteristics	How many children have you given birth to? What is the date of birth of your youngest child(ren)? Did you give birth to more than one child at this time? How many weeks pregnant were you when your youngest child was born? Did you experience problems during the pregnancy?
4.	How was the baby born?	How was your most recent baby born? (normally with no assistance, instrument, planned/emergency caesarean, other)
5.	Where you had your labour and birth	Where did the labour and birth of your last baby take place? (Hospital, AMU[2], FMU[3], Home, other) How was your care funded? (private/public care) Which country did you give birth in? Postcode, town, or name institution
6.	Main care provider?	Which health care provider made most of the decisions with you during labour and birth?
7.	Open questions	In the place where you gave birth, what were the three most positive experiences of your care? What do you think could have made your experience better? Your advice to someone you care about: - I think you should give birth at the place where I did because… - I think you should not give birth at the place where I did because… How do you feel about your labour and birth experience? (five-point Likert scale) any other comments
8.	End of the survey	How did you find out about the survey?
References (UCLan, 2017; van den Berg et al., 2022; Vedeler et al., 2023)		

Observations

Ethnographic or social research often relies heavily on the observation of participants. It can be argued that the social world cannot be studied without playing a part in it (Atkinson, 2007). See p. 34-37 above, for my perspective, reflexivity and positionality.

All participants were given information around why the research was being undertaken and before any data was collected, I reassured participants that despite having my own preconceived ideas around this topic, in this work, the intention is to see this topic from their point of view.

Although I was an 'insider' (a member of staff in the Trust), I undertook non-participant observations, in that I did not take part in any clinical care while I was actively undertaking the

[2] AMU: Alongside Midwifery Unit
[3] FMU: Freestanding Midwifery Unit
(see p. ix glossary of terms)

ethnographic research, nor did I give input in the education days or meetings I observed. This fitted within the 'complete observer' role (Atkinson, 2007) or passive participation role as described by Spradley (2016) (Aktinson & Hammersley, 1998; Spradley, 2016). Throughout, I reflected consciously on the insider-outsider orientation that I was adopting.

Observations were conducted including handovers, education days, staff meetings, multidisciplinary discussions, and the everyday life of the maternity setting. Pictures of information boards on the wards were taken, ensuring data protection and within the ethical permissions received. The structure and design of the maternity settings and other important visual observations were focused on using an observational guide based on the observational schedule by Spradley (1980) (see appendix A).

'Grand tour observations' were used to guide the observational data-collection in all the maternity settings that were available in the study sites (Spradley, 2016). These grand tour observations are the equivalent of showing or being shown around in a house. In this case it was the maternity sites, in which the most important features of the local context were identified. The following nine dimensions of the social context were investigated (Spradley, 2016):

Can you describe in detail all the:

1. -places?
2. -objects?
3. -acts?
4. -activities?
5. -events?
6. -time periods?
7. -actors?
8. -goals?
9. -feelings?

All observations were recorded in the research diary and analysed with MAXQDA with the rest of the qualitative data (interviews and discussion groups). This helped me to map the dynamic relationships between the data sets.

Interviews

It is very common and well accepted to use interviews to collect data in ethnographic studies. The kinds of interviews undertaken range from in-depth and open, to short follow-ups after observing specific actions or activity. Participants are not seen as passive contributors but rather as 'meaning makers' (Holstein & Gubrium, 1995). The interview process is aimed at enabling interpretations from the conversation with the participants on how they experience the world, through asking questions, listening and getting answers (Warren, 2002).

For this study, a semi-structured approach using an interview schedule with main questions and possible probes was used (see appendix B). The interview schedules for women and their partners and professional stakeholders were constructed in discussion with the supervisory team and shown to the PPI group for feedback. Support was given by the supervisory team to ensure that the questions fitted the research methodology, the participants, and context.

I informed and then recruited participants for the study (see appendices C and D for the information leaflets, and E and F for the consent forms). All staff members were eligible. Both pregnant women and women in the postpartum period who had had maternity care in the Trust could participate. Purposive sampling aimed to recruit key stakeholders such as user representatives, service managers, commissioners, frontline staff including but not limited to midwives, obstetricians, maternity care assistants and women and their birth partners.

Before commencing any interview, I explained my insider/outsider position. It was important to mention that I was a midwife myself, and an employee of the NHS Trust, but that my main job currently was to undertake research towards a PhD. By being transparent about working for the NHS Trust, I declared my conflict of interest.

The women and service users who took part were asked to talk about what their expectations of maternity care were before they got pregnant. Next, I asked them to tell me the story of their actual experience of maternity care, starting from the moment they realised they were pregnant until they were postnatal and going home after the baby was born. Then I went on to ask them if the care was in line with what they expected, needed and wanted. I asked them what their hopes for maternity care of the future are. Lastly, I asked if they wanted to contribute anything else before closing the interview. I always gave the opportunity for a debrief after the interview was finished.

Before the interview, staff and professional stakeholders were asked to think and take relevant pictures, where possible, of three critical factors reflecting what they feel makes their unit a good place to work; and three things they would like to change. During the interview, they were asked to describe these events or snapshots and why they had chosen them. Next, I asked them how they felt about the overall quality of care pregnant women receive from the multidisciplinary team in the maternity unit they work in. Lastly, I asked if they wanted to add any information which they believed was missing, then I announced the end of the interview and gave an opportunity for debrief.

For both the pregnant and postnatal women as well as the professional stakeholders, after about five interviews, questions about safety, personalised care and management or leadership styles were added. This because these topics were often touched upon by participant's without being talked about explicitly. For the professional stakeholders, I asked them to describe what 'safety' means in the context of 'high-quality' maternity care. I also questioned them about their perception of personalised care in the context of 'high-quality' care and how they felt about the current management or leadership style in the Trust and the site where they worked. Women and their

birthing partners were asked around the aspects of care that made them feel particularly safe or unsafe. For them, I also asked if they felt they received individualised care, and, if yes, how this was facilitated.

Participants were offered the opportunity to take part in interviews either virtually or face-to-face. All interviews were audio and/or video recorded, with the participants' permission. All were transcribed using the password protected transcription software Sonix and analysed using MAXQDA software.

Focus groups

Focus groups have the potential to bring different in-depth knowledge and insights, and to understand how groups think, via their discussions with each other. A focus group usually consists of a small group of six to twelve participants where the interviewer asks questions about a specific topic, while explicitly observing group interactions (sometimes using a separate observer, but in this case without). For this project, the group focus was on how 'quality' in maternity care was conceptualised both by each participant, and collectively. The most important focus during focus-groups is the interactions and tensions between the interviewer and participants, and between participants (Morgan, 2012). The benefits of focus groups are that in a small period of time, a large number of interactions on a chosen topic can be observed (Smithson, 2008). Focus groups are not immune to groupthink and oppressive power dynamics between group members. This might lead to ambiguous self-disclosure declarations which potentially can have a negative impact on the participants if they are not facilitated well (Ziebland et al., 2013). It is important for focus group researchers to be aware of these risks, and to have plans in place to deal with them if they arise.

To deal with this possibility, focus group topic guides were prepared and used after they were reviewed by the supervisory team and PPI group. The alignment with the research methodology, the participants and context were checked (see appendix G).

Similar to the interviews, before commencing the focus-groups, I always declared my insider/outsider position and conflict of interest.

The focus-group topic-guide for staff and professional stakeholders consisted of six main questions with additional probes. First, I asked the groups to imagine and discuss their description of what an 'ideal' and/or the 'highest quality' maternity service would look like. I followed up by asking which of the aspects of the 'ideal' or 'highest quality' maternity service were already present within their unit. Next, I asked what (if anything) they felt was missing or what prevented the place they worked from being an 'ideal'/'highest quality' unit. Furthermore, I asked if they felt their unit was responsive to women's and pregnant people's individual values, beliefs, and needs. Before the focus-groups were organised and as a response to what I was finding in the interviews and literature review, I added a question on how they felt about the current management and/or leadership style in place and to define both safety and personalisation as these were both found to

be important aspects of quality in the literature. Lastly, I asked if the participants wanted to add any more information that could help me to understand what 'good quality maternity care' is. I also built in time for a debrief after the interview had finished.

A focus group topic guide for postnatal women and their birthing partners (see appendix G) was created but not used in the end as the Covid-19 pandemic made it impossible and unethical to bring a group of women, babies, and partners together in one room.

Documentary analysis

Documentary analysis as part of an organisational ethnography is done to investigate how the maternity service organisation represents itself both internally, culturally, as well as to outsiders, through the construction of documents. Questions that were helpful while looking into documents were: *"what kind of reality is this document creating, and how does it do it?"* (Atkinson & Coffey, 2004). A documentary analysis in combination with other data-collection methods (such as interviews and focus-groups), gives an insight in the organisational social constructs of reality (Prior, 2003).

Key documents relevant to the study were collected, mapped, and analysed to gain knowledge about the organisation of the services (staffing, structure, stakeholder involvement, formal care pathways, etc.) and get insight in clinical practices (audit, guidelines, safety and risk management tools, etc.).

This gave an insight into the organisational rhetoric of optimal care (in the documents), which can be seen as 'work-as-imagined', versus what actually happened on the ground (as revealed in the observations, and to an extent, in the interviews) which can be seen as the 'work-as-done'. These concepts are used in the theory of resilient healthcare (Hollnagel & Braithwaite, 2019). For a theoretical analysis of these findings, see chapter nine.

3.5 Data analysis

Survey

The demographic data and overall rating of the experience of care were uploaded in the Statistical Package for Social Sciences (IBM© SPSS©) software version 28. Some of the original variables were re-coded into created variables that grouped the data differently (e.g., age organised from interval level data to categorial groups to enable easier understanding of the nature of the dataset). Descriptive statistics such as frequencies and percentages were used to summarise key demographic data collected in ordered or nominal categories.

Representativeness of Babies Born Better survey responders was assessed by making a comparison with the demographic data of women using the Trust.

The answers to the open questions were analysed using a simple thematic analysis including familiarisation with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes and lastly, writing up (Clarke et al., 2015). This was done to find out how women and people in the postnatal period talked about concepts that related to their perceptions of what worked and what didn't, as a proxy for their definition of 'good' or 'poor' quality maternity care. Concepts which were found most important for women were compared with the findings of the meta-narrative review.

An in-depth overview of the analysis and results of the Babies Born Better survey can be found in chapter five.

Observations, Interviews, focus-groups and documentary analysis

The aim of phase three was to understand the maternity services as a whole. Letting the data and thus the participants speak as much as possible for themselves and so using an inductive approach is usually preferable in qualitative research (Kennedy & Thornberg, 2018). However, philosophers have criticised 'pure induction' as researchers will always have preconceived ideas and come into research with their own socio-cultural and conceptual lens. Undertaking data collection is always influenced by theory. The deductive approach sits at the other end of the continuum where the main aim is to test *a priori* arguments and theoretical frameworks. The danger is that researchers become insensitive to the nature of the data collected, including the participants and context under study (Flick, 2017; Kennedy & Thornberg, 2018).

In this study, I made the decision to use a framework approach to collect all data, except for the observational data. As mentioned above, p. 45, the observational schedule of Spradley (2016) was used to collect observational data (Spradley, 2016). The framework method was used for the analysis of all data collected through the organisational ethnography. According to Gale et al, (2013) the framework method does not have any strong alliance with either the deductive or inductive approach but sits somewhere along the continuum. It builds on a third way of integrating data: the abductive approach (Gale et al., 2013). Abduction was developed by Peirce (1960, 1979) and is known to facilitate data analysis in an open and sensitive way (Peirce, 1960, 1979). While also accepting the use of pre-existing theories to inspire the researcher to find existing patterns in the data, abductive researchers transcend data and the pre-existing a priori theoretical framework by moving back and forth between them, by comparing, contrasting, finding patterns and best suitable explanations, rejecting theory where needed or even putting old ideas together in innovative ways to understand and explain data better (Bryant, 2009; Eco, 1981; Kennedy & Thornberg, 2018)

The framework method was created by Ritchie and Spencer in the late 1980s (Bonello & Meehan, 2019; Gale et al., 2013; Spencer et al., 2003). After consideration of the range of approaches available, I chose to use Gale's interpretation of the framework approach rather than following the

five steps of Spencer et al. (2003). This because Gale et al. (2013) allows for a more iterative way to approach data (Gale et al., 2013). MAXQDA qualitative data analysis software was used to ensure a systematic and rigorous analytic process (Bazeley & Jackson, 2019).

This type of analysis facilitated an insight in how Antonovsky's Sense of Coherence theory can influence quality of maternity care on an individual, group, or at an organisational level (see chapter nine) (Mittelmark et al., 2022).

3.6 Ethical consideration

The principles of research ethics (beneficence and non-maleficence, justice, autonomy, informed consent, confidentiality and data protection, integrity, and conflict of interest) were adhered to. This was done by aiming to create knowledge to improve quality of maternity care for all stakeholders involved (justice) without causing harm (beneficence and non-maleficence). Detailed information about these processes was provided in the information leaflets for participants (see appendices C and D).

Transparency about the risks and benefits of taking part in the study was ensured. I explained to participants that there should be no particular risks of taking part in this study, but that it might be difficult or distressing for some people to discuss negative experiences. In such cases, participants knew they would be offered a break in the interview or to stop the interview completely. Furthermore, I made clear that even though there were no direct benefits of taking part, I hoped that the project would be beneficial in improving maternity services in the future.

The supervisory team and I also thought through potential issues that may have arisen in terms of what to do if I witnessed malpractice, disclosure of information around malpractice, problems with the team or in case a participant got distressed and wished to stop participation in the study all together (autonomy). The information leaflets noted that if any concerns were raised in relation to the wellbeing or mental health of participants, they would be advised to talk to their health visitor, the obstetric team or consultant midwife, postnatal listening service, trust complaints service, etc. (for women and their partners) or line manager, occupational health service at work, etc. (for professional stakeholders). The leaflet also noted that if any risk to others (for instance intention to harm) was exposed during observation, a face-to-face interview or a focus group, the necessary and appropriate authorities were going to be notified by the researcher (police/safeguarding team). Additionally, contact details of the research team and an independent person outside of the investigatory team were provided ensuring that participants could ask questions or file a complaint. Participants were informed that, if they wanted to stop taking part, they were free to do so at any time, without any question or penalty for doing so. It was also noted that identifiable data collected would be withdrawn and destroyed accordingly but that non-identifiable data could still be used in the study.

Writing the research protocol facilitated reflection on the ethical considerations that needed to be made before and during the research process. The protocol helped to make my theoretical lens and positionality clear, and to ensure I had a plan for safe data storage and keeping participants' information anonymous (confidentiality and data protection). In the 'Extra information on data collection and usage' section of the information leaflets, detailed information was given on how the data was going to be collected, stored, anonymised, used, accessed, destroyed, and what measures were put in place to protect the security and confidentiality of the data.

The protocol also enabled me to make decisions about all the necessary ethics approvals in place to be able to conduct this research (see below). Information leaflets and consent forms (see appendices C, D, E & F) were checked for quality by the supervisory team, a group of stakeholders, and the ethics committee (informed consent). I ensured that the independence of research was clear and that any conflicts of interest were made explicit by explaining my positionality to all participants before data collection commenced (conflict of interest). The integrity of the study was maintained by keeping records of all that was done and ensuring transparency where appropriate (Integrity).

Professional stakeholders were approached by myself (personally or via email) using flyers (appendix O) or information leaflets. Women and their partners were approached only where appropriate and after approval was given by the healthcare providers.

In the end, no major ethical issue was encountered during the study. The research protocol was followed, including safe use and storage of data. No malpractice was disclosed or witnessed. Only one participant showed signs of distress during an interview. At the end of the interview, she was offered to be referred to the occupational health services. She declined, as she was already under care of her GP and mental health services. None of the participants asked to stop taking part.

Ethical approvals

Approval of the research proposal for the use and analysis of the data from the Babies Born Better survey was gained from the steering committee of BBB on the 6th of February 2020. The BBB team submitted an amendment for survey version three, for which approval was granted by the STEMH Ethics Committee at the University of Central Lancashire (reference number: STEMH 449 Amendment_Jun20) on the 1st of June 2020.

The Integrated Research Application System (IRAS) was used to apply for the necessary permissions and approvals to undertake the organisational ethnography, fitting under the health and social care and community care research in the UK. Ethics approval for the organisational ethnography (IRAS project ID: 2870400) was granted by the Research Ethics Committee (REC) on the 3rd of March 2021 (REC Reference: 21/SS/0018) and Health Research Authority (HRA) on the 12th of April 2021. On the 27th of May 2021, confirmation was given by the R&D office at the research site about capacity and capability and the readiness of the organisation to set-up and

conduct the research. (See Appendices H, I, J, and K for the ethics approvals of HRA, REC, UCLan, and the BBB Committee).

Due to both the constraints of the pandemic, and to the evolving nature of the study, some parts of the study were changed and so the protocol was updated, and a substantial amendment was requested at REC and HRA level.

The pandemic had a significant impact on the ability to recruit the planned number of participants and observations. I used a mix of face-to-face and virtual data-collection methods but was still limited by the amount of staff sickness and a significant increase in pressure on the healthcare system and subsequently on the healthcare professionals. The amended ethics approval reflected this.

The data collection period was extended, and the number of sites reduced (one NHS Trust with two sites, no Belgian site as initially planned). Recruitment was extended from the 31st of March 2022 till the 1st of October 2022.

The substantial amendment was approved by REC on the 13th of May 2022 and on the 26th of May 2022 by HRA (see appendix L).

Data management

Data collected via the Babies Born Better survey are owned and securely stored by the University of Central Lancashire (UCLan). The dataset was transferred securely to me using the UCLan OneDrive password-protected system. The data collected did not contain any identifiable information relating to the participants.

During the organisational ethnography, once informed consent was obtained, each participant was immediately given a secure code that was used on all data collected from that individual (including but not limited to interview recordings, demographical data, interview transcripts, observational data, etc.).

I was the only individual that had access to identifiable information, which was stored separately from the non-identifiable data on a password-protected OneDrive connected to my UCLan email address. A backup was made monthly using a password protected, encrypted external hard drive which was safely stored in my home. The videos and audio recordings of the interviews and discussion groups were deleted once the transcription was finalised.

An Excel file was used to keep track of the interviews, discussion groups and observations done (date, research activity and time spent). Demographical data was stored in this same file only using non-identifiable information and the individual codes assigned.

3.7 Conclusion

This chapter presents the logic for the choices I made for the theoretical perspective, methodology, and methods of this study.

Social constructionist epistemology, realist ontology and a critical realism theoretical framework were found to be most appropriate to answer the research question due to its capacity to investigate invisible dynamics in complex social environments.

The organisational ethnography methodology using mostly qualitative methods to collect data was the optimum method to investigate the way individuals conceptualise the quality of maternity care, and how this is translated and implemented in the organisational context of maternity services. To be able to make sense of the substantial amount of data collected, a range of approaches were used to understand the empirical, actual, and real phenomena of 'quality of maternity care'. These levels of analysis started with a description of the methods to collect data, including observational data using Spradley's taxonomy, then moved to the empirical through framework analysis guided by the Institute of Medicines' Quality of Care framework, followed by exploration of the actual through the theories of Resilient Healthcare and Sense of Coherence. These were integrated to reach some understanding of the 'real' nature of quality of maternity care.

Due to the Covid-19 pandemic and the pressures within the NHS, the scope of the project slightly changed, but the main aim and focus of the study remained the same.

The next chapter presents the results of the meta-narrative review that was undertaken to scope the existing evidence around how quality in maternity care has been defined by the different constituencies in maternity care.

CHAPTER 4: META-NARRATIVE REVIEW

How is quality conceptualised by the different constituencies in maternity care over time?

4.1 Introduction to the chapter

The previous background and theory chapters have laid the groundwork for this meta-narrative review chapter by giving an overview of the historical meaning behind 'quality' as a concept, and specifically in (maternity) care. So far, these chapters demonstrated that there is no existing taxonomy of views, beliefs, and experiences around quality of maternity care by stakeholder groups, between and within stakeholder groups, in different settings, and over time. Furthermore, currently there is no existing consensus amongst stakeholders in maternity care on how quality should be defined and conceptualised.

This chapter presents the findings of the meta-narrative review undertaken to investigate the extent and content of existing publications which consider quality in maternity care, and to establish which disciplines involved in maternity care have written and published about this topic. It provides an overview of the storylines of the different disciplines over time, looking at how their conceptualisations of quality have evolved, and considers differences and similarities between the different disciplines.

The chapter provides an overview of the rationale and aim, the methodology, methods, and synthesised findings, and lastly, a discussion and conclusion.

4.2 Rationale and aim

The aim of this review was to develop a comprehensive overview and synthesis of existing views of quality of maternity care expressed by different stakeholders and disciplines from different philosophical perspectives involved in maternity services over time.

4.3 Methods

This review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on the 8th of July 2020 with registration number: CRD42020171520.

A meta-narrative review approach was used. Meta-narrative methodology was developed by Greenhalgh et al. (2004). It is rooted in a constructivist philosophy of science, inspired by Kuhn's

work. Kuhn 1962 argued that the progression of science does not consist of a linear accumulation of new knowledge, but that it undergoes "paradigm shifts" or periodic revolutions in thinking (Kuhn, 1962). According to Wong et al. (2013) *"A meta-narrative review seeks to illuminate a heterogeneous topic area by highlighting the contrasting and complementary ways in which researchers have studied the same or a similar topic (p. 987)*" (Wong et al., 2013).

Other methodological approaches were considered such as: a narrative review, meta-analysis, meta-synthesis, realist reviews or scoping review. Conducting a scoping review would not have provided the depth of knowledge that was necessary for this project. A meta-analysis also would not have been a good fit due to it being designed to establish the effectiveness of an intervention across several studies, comparing statistical, quantitative data. Furthermore, realist review was found unsuitable as there is no complex intervention involved, and the aim was not to find out what works for whom in what circumstances. A meta-synthesis aims at bringing qualitative data together to create new theory. Even though this methodology had the potential to fulfil the aim of this phase of the study, other methods were found to be more suitable to address the research question. Having considered all these possibilities, narrative review methodology seemed to have merit, as this methodology incorporates historical context to generate a cohesive story on how quality was defined and conceptualised over time, although it lacks the ability to compare within and between the different disciplines (Polit & Beck, 2008). Given the intention to do such a comparison, the decision was made to use the meta-narrative methodology as described in this chapter.

Meta-narrative allows for identification of commonalities and differences between the assumptions of engaged groups and actors, and the exploration of tensions and patterns across the data, to understand where ideas have emerged, converged, or diverged. It uses inductive reasoning (going from specific to general), interpretive engagement (sensemaking) and cross-interrogation of the narrative (Wong et al., 2013). This cross-interrogation process aids the exploration of tensions, conflicts, and paradoxes that exist between the research traditions[4], in the context of a specific topic area (Greenhalgh & Heath, 2010). These characteristics made the meta-narrative approach the ideal one to explore a topic that I knew to be diffuse and contested. Meta-narrative review methodology uses storylines to unpack how the framing of topics has unfolded and changed over time within the different traditions. The main questions to uncover the storylines in each tradition used were: how has the topic been conceptualised in publications from people who have written within the tradition (e.g., midwifery, obstetrics, social sciences, etc.); what were the central theories that were cited; what methods were used to study this concept and what were the main empirical findings? This enabled me to answer the research question on how the different

[4] Research tradition: See below and 'glossary of terms' (p. ix) for a definition

traditions have interpreted quality of maternity care over time and how the 'normal science' of definitions and use of maternity care quality was shaped.

Research traditions are specific scientific communities or conventions (e.g. public health, social sciences, obstetrics & gynaecology) publishing research about topics of interest to build their body of knowledge. According to Jørgensen (2015), as research traditions mature, they engage in critical self-reflection, evaluating past achievements and discussing future directions. They can be seen as long-standing scholarly paths with their own unique characteristics. They involve shared conventions, literature, and sometimes methodologies. These traditions provide the foundation for specific research projects, acting as a base for more focused explorations. Within specific fields of study, research traditions influence both theoretical development and practical applications (Jørgensen, 2015). In meta-narrative reviews, researchers define traditions based on the paradigm or distinctiveness of their lens. The scope, key concepts, historical roots, assumptions, research questions asked, and lastly the methods used are considered (Kingdon et al., 2019). The following question, previously used by Greenhalgh et al. (2005): *"Is the paper part of a recognised research tradition – i.e. does it draw critically and comprehensively upon and existing body of knowledge and attempt to further that body of knowledge?* (p. 421)" guided the categorisation in this meta-narrative review (Greenhalgh et al., 2005). The categorisation of papers in the different research traditions enabled a comparison between and within the different groups on how quality of maternity care was defined and conceptualised over time. Furthermore, it helped to understand why certain aspects of quality have been implemented in maternity care by whom in the organisational ethnography (see chapter nine).

The guiding principles used while conducting this review were: pragmatism, pluralism, historicity, contestation, reflexivity, and peer review (Kuhn, 1962). These terms meant the following (Klingberg et al., 2021):

Pragmatism: Inclusion and exclusion criteria decisions were guided by pragmatism (only what was useful, made sense, and is disseminatable to the target audience was included).
Pluralism: The review included publications from multiple disciplines and methodological perspectives.
Historicity: The evidence used, and review findings were drawn from literature published in three decades so situated in a historical context.
Contestation: Evidence that conflicted with the findings of this review was used to critically reflect on the findings (see discussion, p. 82-83).
Reflexivity: Regular reflexive conversations took place with the supervisory team and as mentioned above, I kept a reflexive diary to critically reflect on my individual input.
Peer review: Feedback was sought on a regular basis from the supervisory team and external experts on the team and incorporated in the review process.

Greenhalgh et al. (2004) described 6 key phases in Meta-Narrative review (Greenhalgh et al., 2004; Greenhalgh et al., 2005): Planning, search phase, mapping of the literature, quality appraisal, synthesis, and recommendations.

1. Planning: As mentioned previously, an *a priori* protocol was developed and registered with PROSPERO. The protocol was created through regular meetings with the supervisory team consisting of multidisciplinary experts in maternity care.

2. The three steps described by Greenhalgh et al. (2004) were used in the search phase: Different perspectives were mapped by performing an initial search led by intuition, followed by an exploratory search for empirical papers by looking at references of references, and lastly, empirical papers were searched for using electronic key databases and 'snowballing'.

See table 3 for the in- and exclusion criteria used and Table 4 for the screening tool.

Table 3: In- and exclusion criteria

Criteria	Inclusion	Exclusion
Types of Studies	This is a meta-narrative review with no restrictions on type of study to be included as relevant evidence may be found in studies with various designs. Literature will include peer reviewed articles, book chapters, certain types of grey literature (dissertation and theses, academic papers, research and government reports, conference papers, newspaper headlines, etc.)	There are no restrictions on the types of study design eligible for inclusion.
Intervention(s) and exposure(s) (Phenomenon of interest)	The phenomenon of interest is how stakeholders and disciplines from different philosophical perspectives have defined quality of maternity care (QMC) over time. All studies reporting on the definition or description of quality of maternity care from the point of view of different disciplines will be included.	Studies with a focus on any subject not related to quality of maternity care. Studies about quality of care overall (not specifically about quality of maternity care)
Participants and population	Studies of stakeholders and disciplines from different philosophical perspectives involved in maternity services such as maternity teams, health institutions, professionals, service users, managers, policy makers, journalists, lawyers, judges, sociologists, and anthropologists.	No restrictions on type of participants/populations to be included as long as they are stakeholders in maternity services provision.

	Any study in high-, middle- or low-income settings.	
Time Period	No time restrictions	None
Language	All languages	None

Table 4: Screening tool (Adapted from Kingdon et al., 2019)

Answer the following questions in sequence:	**Yes**	**No**	**Maybe OR can't tell from the abstract**
1. Is it about Quality of Maternity Care? **The phenomenon of interest is how stakeholders and disciplines from different philosophical perspectives have defined quality of maternity care (QMC) over time.** **All studies reporting on the definition or description of quality of maternity care from the point of view of different disciplines will be included.**	Answer Q2	Discard	If the abstract does not define QMC, check the full text. If in the full text QMC is described, answer Q2. If not, discard.
If yes, then:			
2. What discipline is it from? **Inclusion:** **- Studies of stakeholders and disciplines from different philosophical perspectives involved in maternity services such as maternity teams, health institutions, professionals, service users, managers, policy makers, journalists, lawyers, judges, sociologists, and anthropologists.** **- Any study in high-, middle- or low-income settings.** **Exclusion:** **- No restrictions on type of participants/population to be included as long as they are stakeholders in maternity services provision.**			
	Yes	**No**	
3. Is it seminal?			

3. Quality appraisal: To minimise bias, the plan was for two researchers to independently quality assess the selected articles using the Walsh and Downe tool for qualitative research and appraisal (Criteria: Scope and purpose, design, sampling strategy, analysis, interpretation, reflexivity, ethical dimensions, relevance, and transferability (Walsh & Downe, 2006), for appraising qualitative papers the prevailing standards for the tradition for instance, the CASP (Critical Appraisal Skills Programme) tool for studies within the epidemiological tradition (CASP, 2018), the ACCODS checklist for grey literature (Authority, accuracy, coverage, objectivity, date, significance) (Tyndall,

2010). Furthermore, the plan was that if the two independent parties were not in agreement on the inclusion or exclusion of certain papers or grey literature, a third party would be brought in to make a final decision. This was not done in the end, (see p. 59 changes from the protocol) for the reasoning behind this.

4. A data extraction form (see appendix M) was developed, tested (using five papers across different research traditions) and continuously refined to map the literature for this specific meta-narrative review. It was based on previously published meta-narrative reviews (Greenhalgh et al., 2005). Key outcomes and knowledge were extracted and grouped per discipline and time in history using a table. A rigorous and transparent method was used to categorise the papers by discipline, see Table 5 for the criteria used to categorise papers.

Table 5: Categorisation criterion

IF the topic fits the definition of the scope of the discipline; AND the lead and/or main authors are in a relevant role; AND the paper is published in a relevant journal; THEN the paper is classified as being in that disciplinary area.

5. Synthesis: The synthesis was done on two levels. Level one was the synthesis within the different traditions or disciplines, by the unfolding storylines, which started in the mapping phase. A comparison was made on how the separate research traditions conceptualised and defined the topic and the methodological approaches used to study the topic. Secondly, by comparing the storylines and conceptualisation of quality of maternity care between the different groups. For level two, the following techniques were used to summarise and finalise the meta-themes. These were first developed by Wong et al. (2013) and used by Kingdon et al. (2019) in a meta-narrative review of concepts of stillbirth between disciplines over time. These techniques were utilised to summarise and finalise the meta-themes (Kingdon et al., 2019; Wong et al., 2013).

a. *Paradigm Bridging* (seeking commonalities in underlying conceptual and theoretical assumptions);
b. *Paradigm Bracketing* (to find and highlight differences in these assumptions);
c. *Interplay* (to explore tensions);
d. *Meta-Theorising* (to explore patterns which illuminate understandings which are conflicting).

6. Recommendations for research, practice, and policy were made in discussion with the supervisory team once the differences and similarities of the conceptualisation of quality between and within disciplines became clear (see p. 84 and chapter nine).

Changes from the protocol

Quality appraisal of the selected articles was not done per protocol, as the aim was not to synthesise the data. Consistency with the theoretical underpinnings of the chosen method, which is focused on how disciplines conceptualise phenomena over time, was maintained. Any description of quality of maternity care even in poor quality studies was relevant. The inclusion criteria were amended slightly so that only articles were included that had all the following: a discernible background, aim, findings and recommendations in which quality of maternity care was elaborated on.

4.4 Findings

Search results

The initial exploratory search was led by intuition based on my prior professional knowledge and experience, informal networking, and "browsing", to map the diversity of perspectives and approaches and yielded 11 papers (n=11) (Downe et al., 2018; EBCOG, 2014; Freedman & Kruk, 2014; Hulton et al., 2000; Kuruvilla, et al., 2016; McCourt et al., 2014; Miller et al., 2016; Tunçalp et al., 2015; van Teijlingen et al., 2003; WHO, 2016, 2018). Based on the key words in these papers, a series of search words and terms were drafted for the empirical search.

Using the search strategy, empirical papers, or papers from primary research of which the results are based on real life experiences (observations and measurement) of the concept of quality of maternity care from different viewpoints were located using electronic key databases (Embase®, MEDLINE®, Global Index Medicus, PsycINFO®, Historical abstracts, Humanities International Complete SocIndex) and "snowballing". The searches were conducted between December 2020 and January 2021 (n=384). The search strategy was adapted per database where necessary (see appendix N: Example systematic search strategy for more details).

Grey literature was included (n=110) to fill in the missing gaps in historical documentation and be able to show how debates about quality of maternity care have changed over time. Databases used were: OpenGrey, The North Grey Literature Collection, EThOS, Social Care Online, HIMC.

From the total number of papers found using the three steps explained as above (n=544), 43 duplicates were found and removed using Rayyan software (see PRISMA diagram, figure 8 below).

Screening papers for inclusion

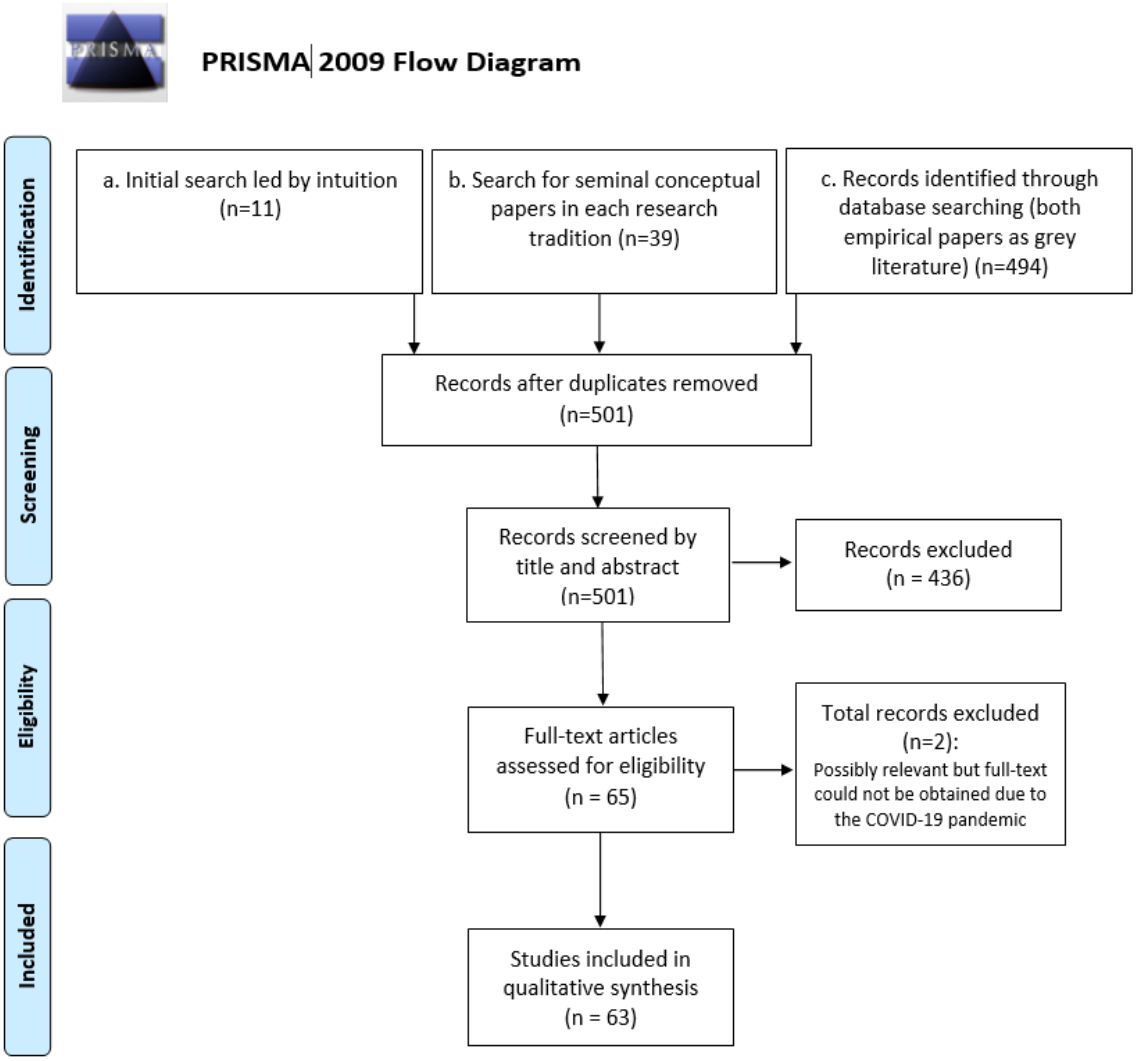
My Director of Studies (SD) and I performed the first screening (by title and abstract) independently and blinded using the Rayyan software (n=501). Where agreement was not reached in more than 10% of the selected references, we discussed and agreed on in- and exclusion. Once a minimum of 90% of the selection overlapped, I continued the rest of the selection of papers. Where I had any

doubts about inclusion this was discussed with my director of studies. If agreement could not be reached, this was discussed with other members of the supervisory team (CK, GP and MCB).

The second round of screening was done by looking at the full text of the articles selected during the first round and in total, 63 papers were included in the end for analysis. See table three for the in- and exclusion criteria.

Figure 8 provides a PRISMA flow chart for included and excluded studies.

Figure 8: PRISMA flow diagram (Moher et al., 2009)



Synthesis within traditions

Table six summarises the unfolding storylines by research tradition and their conceptualisation of quality of maternity care. 63 resources were used from seven different research traditions, published between 1990 and 2019. Superscript has been used for the in-text references included

in the meta-narrative review as the high volume of papers included otherwise made it harder to read the text.

The research traditions used are the following: Obstetrics & Gynaecology (n=5) (Biley & Freshwater, 1999; Dhar et al., 2010; Guzha et al., 2018; O'Donnell et al., 2014; Pittrof et al., 2002); Midwifery (n=11) (Denham, 2015; Downe et al., 2018; Gamedze-Mshayisa et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Mgawadere et al., 2019; Proctor, 1998; Raven et al., 2012; Sandall et al., 2010; Sandall et al., 2016; ten Hoope-Bender et al., 2014); Social Sciences (n=3) (Overgaard et al., 2012; Van Teijlingen et al., 2009; Wilde-Larsson et al., 2011); Healthcare Management (n=5) (Blaize-La Caille, 2018; Islam et al., 2015; Ladipo et al., 1999; Larson et al., 2014; Maurer et al., 2016); (Global) Reproductive Health (n=6) (Bhattacharyya et al., 2013; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Salgado et al., 2017b; Tuncalp et al., 2012); Public Health (n=27) (Creanga et al., 2017; Diamond-Smith et al., 2016; Hulton et al., 2016; Hulton et al., 2000; Jha et al., 2017; Johansen & Hod, 1999; Kambala et al., 2015; Karkee et al., 2014; Korst et al., 2005; Lattof et al., 2019; Miller et al., 2016; Mukamurigo et al., 2017; Munabi-Babigumira et al., 2019; Owiti et al., 2018; Oyugi et al., 2018; Prytherch et al., 2017; Siam et al., 2019; Spector et al., 2012; Tunçalp et al., 2015; Ueda et al., 2019; van den Broek & Graham, 2009; van der Kooy et al., 2017; WHO, 2009, 2014, 2016, 2018; Wickramasinghe et al., 2019); Clinical Audit (n=6) (Garcia et al., 1998; Guthrie et al., 1990; Knight, 2018; Kongnyuy & Uthman, 2009; Say et al., 2009; WHO, 2011). Overall, seven studies were categorised as grey literature. Most of the literature included was empirical research (n=63). In total, five quantitative studies, 26 qualitative studies, 28 mixed-methods studies, a study protocol, a PhD thesis, and two opinion pieces were included. Furthermore, papers included aimed at defining, conceptualising, measuring, or improving quality of maternity care.

As mentioned above, analysis was done in two phases. The table below (table 6) shows the results of the first-level analysis which started in the mapping phase and allowed for an overview of the different research traditions and how they conceptualised and defined quality of maternity care over time. The table shows the six research traditions with their academic discipline, definition and scope, and the number of papers included in that tradition and the storylines and definitions per tradition derived from the analysis.

Table 6: Summary of included research traditions

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
Obstetrics & Gynaecology	Medicine	The medical speciality/or field of the study in obstetrics and gynaecology exists of two subspecialties: obstetrics, which covers pregnancy, childbirth, and the postnatal period. Gynaecology on the other hand covers all research about the health of the female reproductive system. Over the years, obstetricians and gynaecologists have used research to improve the health of women at all stages of their lives and improve outcomes of pregnancy and birth related issues (RCOG, 2014).	The obstetrics & gynaecology storyline does not contain a clear evolution over time. Different methods for data-collection were used in the different papers included but a big overlap was found in the contributing factors to achieve QoMC. A key feature of all papers in this category is a focus on the right level of care for women (no over- and under medicalisation), and as a minimum unrestricted access to high quality emergency obstetric care where needed (Biley & Freshwater, 1999; Dhar et al., 2010; Guzha et al., 2018; O'Donnell et al., 2014; Pittrof et al., 2002). The three oldest publications in this category highlighted that, in order to achieve high quality maternity care, the best possible outcomes or women's desired outcomes need to be achieved (Biley & Freshwater, 1999; Dhar et al., 2010; Pittrof et al., 2002). After 2010, the emphasis shifted slightly towards aspects of woman centred care such as the importance of positive relationships, autonomy, and women's decision-making (Bayley et al., 2013; Dhar et al., 2010; O'Donnell et al., 2014). The most recent study in this category focused solely on the use of standardised outcome measures to compare morbidity and mortality rates (Guzha et al., 2018).	High QoMC means getting the right level of care to achieve desired medical (low morbidity and mortality, for mother and baby, low risk of complications) and non-medical (social, emotional, and financial) outcomes for the individual (Bayley et al., 2013; Dhar et al., 2010; Pittrof et al., 2002). Care needs to be safe (low morbidity and mortality) and effective (Bayley et al., 2013; Dhar et al., 2010; Guzha et al., 2018; O'Donnell et al., 2014; Pittrof et al., 2002) but also satisfying for the woman, her family, and the healthcare providers (Bayley et al., 2013; O'Donnell et al., 2014; Pittrof et al., 2002). The provision and experience of care are important factors along with having the necessary human resources who are motivated, have autonomy, practice in an evidence-based manner, (O'Donnell et al., 2014) and in-line with current professional skills and knowledge (Bayley et al., 2013; Dhar et al., 2010; Pittrof et al., 2002). Other factors needed for high QoMC are equitable care (Dhar et al., 2010; Pittrof et al., 2002), in line with patient rights, and positive relationships and communication with the healthcare providers (O'Donnell et al., 2014).	n=5
Midwifery	Midwifery	Midwifery is the health profession and health science that deals with the	The Midwifery category storyline draws on over 20 years of research about QoMC from the women's and	High quality maternity care means care that is woman-centred (Denham, 2015; Downe et al., 2018; Gamedze-	n=11

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
		sexual and reproductive health of women including pregnancy, birth, the postnatal period, and care of the neonate. A professional in midwifery is called a midwife, which means 'with women'. Research by midwives draws from both positivist and interpretive paradigms and uses a range of quantitative and qualitative methods (Biley & Freshwater, 1999; ICM, 2024; Kingdon et al., 2019).	healthcare providers point of view. In all 11 papers, quality is referred to as using woman-centred care aspects by putting women at the centre of the design, improvement and actual care in maternity services to achieve desired outcomes (Denham, 2015; Downe et al., 2018; Gamedze-Mshayisa et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Mgawadere et al., 2019; Proctor, 1998; Raven et al., 2012; Sandall et al., 2010; Sandall et al., 2016; ten Hoope-Bender et al., 2014). Most papers in this category have used pre-existing definitions or conceptual frameworks for QoMC to base their research on and very detailed accounts were given on which factors are needed to achieve high QoMC. The first paper in this category, published in 1998 highlights the need to focus on the 'consumer' and for staff to build understanding of what they want for their care. The author compared the perceptions of women and midwives in view to create women-focused services (Proctor, 1998). The second paper published in the same year adds that QoMC has both functional as well as technical aspects. *"Service quality is the degree and direction of discrepancy between perception and expectations of women"* (Martin-Hirsch & Wright, 1998). Twelve years after, a paper was published focussing mainly on midwife-led care, and so woman centred care and its outcomes for women (Sandall et al.,	Mshayisa et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Mgawadere et al., 2019; Proctor, 1998; Raven et al., 2012; Sandall et al., 2010; Sandall et al., 2016; ten Hoope-Bender et al., 2014) and always tailored to women's circumstances, beliefs, needs (ten Hoope-Bender et al., 2014) and values (Denham, 2015). This means continuity of care(giver) (Denham, 2015; Downe et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Proctor, 1998; Sandall et al., 2010; ten Hoope-Bender et al., 2014), and that care is relationship based (Denham, 2015; Downe et al., 2018), women feel in control (Downe et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Oyugi et al., 2018; Proctor, 1998; Sandall et al., 2010) and respected (Denham, 2015; Martin-Hirsch & Wright, 1998; Mgawadere et al., 2019; Proctor, 1998; Raven et al., 2012), and upholding basic human rights (Gamedze-Mshayisa et al., 2018; Mgawadere et al., 2019; ten Hoope-Bender et al., 2014). Care that is partly or completely based on the definition of the institute of medicine (IOM) (IOM, 2001; Sandall et al., 2010): Safe (Denham, 2015; Raven et al., 2012; ten Hoope-Bender et al., 2014), effective (Denham, 2015; Raven et al., 2012), timely (Gamedze-Mshayisa et al., 2018), efficient (Raven et al., 2012), equitable (Martin-Hirsch & Wright, 1998; Raven et al., 2012; ten Hoope-Bender et al., 2014), patient-centred (Sandall et al., 2010), acceptable (Raven et al., 2012; ten Hoope-Bender et al., 2014)	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
			2010). In the paper of Martin and Fleming (2011), some overlapping themes were found in their search for what affects women's birth satisfaction and so QoMC such as the positive effect of relationship based care. Findings were categorised in the following themes: quality of care provision, women's personal attributes, and stress experience during labour (Martin & Fleming, 2011). This was different for the next paper which presented a typology of quality healthcare using the quality of structure, process, and outcome as the main ingredients for QoMC (Raven et al., 2012). Both in the papers of Sandall et al. (2010) and ten Hoope-Bender et al. (2014), midwives are seen as a solution to improve QoMC by recognizing that people have legitimate expectations and rights for care that is equitable, safe, respectful, and of high quality (ten Hoope-Bender et al., 2014). How maternity care is designed and provided should incorporate what matters to childbearing women as this most likely leads to safe and human maternity care (Downe et al., 2018). According to Gamedze-Mshayisa et al. (2018), little is known about how women judge the quality of care received and which factors are associated with the perception and satisfaction but that, amongst other things, care should uphold basic reproductive rights (Gamedze-Mshayisa et al., 2018). This is in line with the	and appropriate care for both individuals as well as populations (Denham, 2015; Gamedze-Mshayisa et al., 2018; Raven et al., 2012). And that is accessible, available (ten Hoope-Bender et al., 2014), affordable (Sandall et al., 2016), respectful (ten Hoope-Bender et al., 2014), relevant to the need of the population and sustainable (Raven et al., 2012). Having adequate, knowledgeable, skilled, and available human resources (Mgawadere et al., 2019; Raven et al., 2012), that use effective referral systems and work evidence based, that ideally are divided in small teams which are accessible in the local community (ten Hoope-Bender et al., 2014) were seen as imperative for QoMC. Other important attributes of staff were that they would give sufficient support (Martin & Fleming, 2011), have a kind and caring attitude (Downe et al., 2018; Mgawadere et al., 2019), that involve the woman's family in care, and provide continuity of practical and emotional support (Downe et al., 2018; Gamedze-Mshayisa et al., 2018), while having community knowledge and understanding (ten Hoope-Bender et al., 2014). Staff that can work across contextual boundaries (medically inclusive) but with an ethos of normality (Downe et al., 2018; ten Hoope-Bender et al., 2014). Having adequate resources (Raven et al., 2012; ten Hoope-Bender et al., 2014) and clean (Denham, 2015), enabling environments are necessary for high QoMC. Achieving desired high QoMC outcomes:	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
			last paper in this category, which states that both the women's and healthcare providers views need to be incorporated to achieve high QoMC and that care needs to entail a rights-based approach (Mgawadere et al., 2019).	What women want is a normalised and humanised birth (Martin & Fleming, 2011; Sandall et al., 2010; ten Hoope-Bender et al., 2014), promotion of normal processes with a focus on prevention of complications (ten Hoope-Bender et al., 2014), a physiological labour and birth (without technical or pharmacological interventions) or 'normal birth' (Proctor, 1998) in which women are enabled to use their inherent psychosocial and physical strength, while acknowledging that birth can be unpredictable (Downe et al., 2018). Women want care in which the biological, psychological, social and cultural processes are optimised and only strengthened where indicated. Where complications arise, available first-line management of complications and having medical obstetric and neonatal services at hand (ten Hoope-Bender et al., 2014). Women highly value giving birth to a healthy baby (Martin & Fleming, 2011) in an environment which is clinically and psychologically safe and where both physical and psychological long and short term health and wellbeing for themselves, their baby, and families is created. There should be no avoidable harm or injury as the result of care, support and advice received (Denham, 2015). The experience of care is also an important component of QoMC. According to Downe et al. (2018), *"a positive experience consists of one that fulfilled or exceeded the a priori existing beliefs, which are constructed in a personal and socio-*	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
				cultural way. Women see the nature of birth as a 'psychological and physical embodied experience' in which the provision of care has the ability to 'enable or restrict what matters' to women the most" (Downe et al., 2018).	
Social Sciences	Sociology, psychology	At the heart of social science lies the human experience. It examines individuals, communities, and societies, exploring how we interact with each other, with the environments we shape (built environments), utilize (technology), and depend on (natural environments). Social science strives to make sense of the ever-changing human systems within our complex world (ACSS, 2024).	The social science storyline starts with an overarching view on the influence of history, culture, and political values of a country on the availability and meaning of QoMC (Van Teijlingen et al., 2009). In 2011 and 2012 papers were published emphasising that positive and negative feelings of women (Wilde-Larsson et al., 2011), the model of care received (Overgaard et al., 2012), their level of education and socio-economic status also have an influence on the perceived QoMC (Overgaard et al., 2012; Wilde-Larsson et al., 2011).	QoMC is socially constructed. Available care in HIC[2] is influenced by historical factors, political views, and cultural values that influences access to care, affordability of care, quality of hospitals, and subsequently has an effect on maternal and foetal morbidity and mortality and women's feelings of security (Van Teijlingen et al., 2009). The socio-economic (Overgaard et al., 2012; Wilde-Larsson et al., 2011) and emotional status of the women influences their perception of QoMC (Wilde-Larsson et al., 2011). To achieve high QoMC, women need patient-centred care including being active participants in decision making, attention for their psychological needs, being cared for by midwives who give information, are present and supportive, listen, show commitment, empathy and respect (Overgaard et al., 2012; Wilde-Larsson et al., 2011)	n=3
Healthcare Management	Management, leadership and administration of	Health management takes a broad approach, guiding individuals, organisations, and entire systems to achieve optimal health. It considers social, behavioural, and environmental factors affecting health, going	This storyline builds on five studies published between 1999 and 2018 which all used a mixed-methods approach. The red thread throughout this category is the importance of the women's voices, their perceived quality of care and the need for woman-centred care. All papers include detailed characteristics of what the ingredients	QoMC exists where women are active participants in their own care (woman-centred care) and in care-improvement (Blaize-La Caille, 2018; Islam et al., 2015; Ladipo et al., 1999; Larson et al., 2014; Maurer et al., 2016). QoMC measures should reflect women's concerns to improve their relevance (Maurer et al., 2016). High QoMC means that women have easy access	n=5

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
	health systems	beyond healthcare delivery to encompass prevention & community wellbeing. Healthcare management fosters collaborations across sectors like policy, education, and research. Health managers work with a wide range of stakeholders to create a shared vision and strategies, shaping conditions for the best health outcomes for everyone (EHMA, 2024).	for QoMC are (Blaize-La Caille, 2018; Islam et al., 2015; Ladipo et al., 1999; Larson et al., 2014; Maurer et al., 2016). The first paper voices the need for care that is more responsive to women's needs and choices but acknowledges that to do so, healthcare providers need to be involved and substantial resources need to be available (Ladipo et al., 1999). Fifteen years later, the next paper highlights that women's perceived quality of care is influenced by their expectations and prior and current care experience (including the mothers' health and wellbeing and socio-demographic factors). Where there is disrespect and abuse, women rate QoMC much lower. Healthcare facility characteristics do not influence the QoMC ratings (Larson et al., 2014). The third paper links how the available resources influence the morbidity and mortality for both mother and baby, and thus QoMC (Islam et al., 2015). In 2016, Maurer et al. concluded that public reporting efforts should be increased to improve the relevance of maternity care quality indicators (Maurer et al., 2016). External factors such as power, culture and conflict influence the quality of the healthcare system (Blaize-La Caille, 2018; Maurer et al., 2016). The most recent publication shows the creation of a new framework for QoMC as the author explored the gaps in maternal healthcare and diagnosed the weaknesses.	(Blaize-La Caille, 2018), the necessary resources (Islam et al., 2015), and the environment is spacious and clean (Islam et al., 2015; Maurer et al., 2016). Healthcare providers are skilled, knowledgeable, and have a sense of ownership and accountability (Maurer et al., 2016). They work in an evidence-based manner using guidelines and have access to adequate training and supervision. There is an adequate number of staff to provide optimal care for women (Islam et al., 2015) who collaborate and communicate well across the multidisciplinary team and with the women (Islam et al., 2015; Ladipo et al., 1999). Furthermore, high QoMC exists where care includes empowerment, adequate information, education, support, and respect for women's personal preferences (Blaize-La Caille, 2018; Maurer et al., 2016). Ideally, continuity of carer is available (Ladipo et al., 1999), chosen supporting people are welcomed, and care is responsive to expectations of the individual (Maurer et al., 2016). Respectful care is at the forefront and feedback of stakeholders is incorporated to improve care (Larson et al., 2014). Care should be safe, effective, efficient, equitable, and woman-centred (Blaize-La Caille, 2018; Ladipo et al., 1999). Achieving high QoMC is a product of both good person-centred outcomes, as well as good health outcomes (a low occurrence of five D's: death, disease, disability, discomfort, and dissatisfaction) for mother and baby (Blaize-La Caille, 2018). This includes prompt access to emergency obstetric care	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
			Main findings were that women were passive and didn't use their agency to choose, whereas healthcare providers were active but constrained by a weak healthcare system (Blaize-La Caille, 2018).	(Islam et al., 2015). Women take the cost of care also into account to assess QoMC (Larson et al., 2014).	
(Global) Reproductive Health	Inter-disciplinary	(Global) Reproductive Health is the field concerned with physical, mental, and social wellbeing of all aspects of human reproduction across life stages. This includes adolescent health, fertility, safe sex, family planning choices, maternal health, and global accessibility to these services. Research is often focused on impacting low- and middle-income countries (BMC, 2024).	In the storyline of (global) reproductive health, an emphasis lies on how QoMC is multidimensional: *'involving effective, timely, appropriate use of clinical and non-clinical interventions which take into account women's preferences and values' (Salgado et al., 2017a)* and that women, their families and healthcare providers need to be involved in every step of setting-up human-centred services (Bhattacharyya et al., 2013; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Salgado et al., 2017b; Tuncalp et al., 2012). The provision of human-centred and respectful care for women, their families, and the healthcare professionals and effective communication with all parties involved (Salgado et al., 2017a; Salgado et al., 2017b) functions as a red thread through this category, though there is no strong evolution of focus visible over time. From 2008 onwards, some studies have made a clear division between quality of provision of care / health outcomes and the quality of care experienced (Kongnyuy & van den Broek, 2008; Salgado et al., 2017a; Tuncalp et al., 2012).	High QoMC in this category is conceptualised as a maternity service in which substantial and competent human resources (Bhattacharyya et al., 2013), and physical resources (e.g. an enabling environment) (Tuncalp et al., 2012) are available. Care is accessible, affordable (Bhattacharyya et al., 2013) and helpful policy is in place (insurance and/or costs and resources allocated (Tunçalp et al., 2015). QoMC is seen as a multidimensional concept which involves the appropriate and timely use of clinical and non-clinical interventions which are effective and considers the values and preferences of the women. Continuous effective communication is needed to achieve respectful, human-centred care in which women, their families and the healthcare professionals involved are always included (Salgado et al., 2017a; Salgado et al., 2017b). The provision of care category of QoMC includes the need for well-working referral systems but also proper management of women's information and confidentiality (Kongnyuy & van den Broek, 2008), the use of evidence-based guidelines (Tuncalp et al., 2012), to support practice and appropriate medical care and interventions (Bhattacharyya et al., 2013; Salgado et al., 2017b). The experience of care category includes a lot of	n=6

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
				woman-centred aspects of care such as respectful treatment and attitudes towards women (Bhattacharyya et al., 2013; Kongnyuy & van den Broek, 2008; Salgado et al., 2017b), being able to trust the healthcare providers' competence, kindness and getting emotional and cognitive support (Bhattacharyya et al., 2013). Furthermore, it includes good interpersonal relations (Langer et al., 1998; Tuncalp et al., 2012), mechanisms that ensure women get a personal treatment in which they feel supported in their emotional, psychological, and physiological aspects and personal choices, and a good system in which women's preferences and options can be documented and acted upon (Langer et al., 1998; Salgado et al., 2017a; Tuncalp et al., 2012). Clear and seamless pathways of care are present in which women are helped promptly, face short waiting times and in which they feel safe and welcomed (Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Salgado et al., 2017b). High QoMC includes being treated with respect, privacy, and dignity and getting information that is needed or wanted by the women, adapted to her needs, including positive messages about health and wellbeing (Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Tuncalp et al., 2012). Indicators that are a sign of high-quality care: where women perceive care as emotionally and culturally sensitive, respectful, woman-friendly, and when the physical health	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
				outcomes (a low morbidity and mortality) are good (Kongnyuy & van den Broek, 2008).	
Public Health	Public health	Public health is the art and science of keeping everyone healthy. It tackles disease, promotes (physical, mental, and social) wellbeing, and addresses all the factors that affect health, from local issues to global challenges (Detels & Tan, 2015).	The biggest category, containing 27 papers from 1999 till 2019 includes the public health perspective of quality. Again, no clear evolution was seen in how QoMC is defined and conceptualised over time. Within this category, some comprehensive recommendations, indicators/assessment tools, and conceptual frame-works for QoMC are included. This category emphasised that, to achieve high QoMC, a well-structured public health system with strong infrastructure and processes are crucial (Jha et al., 2017; Munabi-Babigumira et al., 2019; WHO, 2018). Furthermore, woman-centred care that respects women's needs and preferences (Hulton et al., 2016; Hulton et al., 2000; Jha et al., 2017; Kambala et al., 2015; Karkee et al., 2014; Miller et al., 2016; Tunçalp et al., 2015; van den Broek & Graham, 2009; WHO, 2016) and easy access, both physical and financial are key to quality maternity care (Creanga et al., 2017; Korst et al., 2005; Owiti et al., 2018; Oyugi et al., 2018; WHO, 2009). The importance of elements of the structure of care for a well-functioning health system were discussed in all papers (Creanga et al., 2017; Diamond-Smith et al., 2016; Hulton et al., 2016; Hulton et al., 2000; Jha et al., 2017; Johansen & Hod,	Both the health system as well as facilities need a well-functioning structure to deliver high QoMC (Munabi-Babigumira et al., 2019; WHO, 2018). The Structure includes competent and motivated staff (Munabi-Babigumira et al., 2019; Tunçalp et al., 2015) that use evidence-based practices, standardisation, guidelines, and auditing (WHO, 2009) to assess and improve QoMC. Furthermore, having good leadership, governance and management (Karkee et al., 2014; Munabi-Babigumira et al., 2019; Tunçalp et al., 2015), quality and safety measures in place (Prytherch et al., 2017), good information systems (Munabi-Babigumira et al., 2019) and medical technologies (Hulton et al., 2016; Munabi-Babigumira et al., 2019), service delivery models in which financing (including cost-effectiveness) and an optimal use of resources (Hulton et al., 2016; van den Broek & Graham, 2009) are fundamental. Other elements of structure included but were not limited to financial and physical accessibility of the unit (Creanga et al., 2017; Korst et al., 2005; Mukamurigo et al., 2017; Munabi-Babigumira et al., 2019; Owiti et al., 2018; Oyugi et al., 2018; WHO, 2009), the necessary (clean and comfortable) infrastructure and resources (Jha et al., 2017; Kambala et al., 2015; Lattof et al., 2019; Munabi-Babigumira et al., 2019; Oyugi et al., 2018; Siam et al., 2019; van der Kooy	n=27

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
			1999; Kambala et al., 2015; Karkee et al., 2014; Korst et al., 2005; Lattof et al., 2019; Miller et al., 2016; Mukamurigo et al., 2017; Munabi-Babigumira et al., 2019; Owiti et al., 2018; Oyugi et al., 2018; Prytherch et al., 2017; Siam et al., 2019; Spector et al., 2012; Tuncalp et al., 2012; van den Broek & Graham, 2009; van der Kooy et al., 2017; WHO, 2009, 2014, 2016, 2018; Wickramasinghe et al., 2019) but one (Ueda et al., 2019).	et al., 2017; WHO, 2016, 2018; Wickramasinghe et al., 2019). High quality maternity care is in line with the expectations and responsive to the (socio-cultural) values and needs of the women, their families, and local communities (Kambala et al., 2015; van den Broek & Graham, 2009). Women have access to publicly available and well communicated information and evidence about how units can achieve their defined quality standards and services available (Hulton et al., 2016; Tunçalp et al., 2015). Studies in this category also emphasised the importance of high-quality processes which includes both clinical and non-clinical elements (Diamond-Smith et al., 2016). The main topics in this category covered aspects of the technical processes of care (Munabi-Babigumira et al., 2019), content and provision of care (Lattof et al., 2019; WHO, 2018), specific evidence-based childbirth practices (Miller et al., 2016; Spector et al., 2012) which should be offered timely and appropriate to cover key practices for individuals and populations (Hulton et al., 2016; Tunçalp et al., 2015; WHO, 2016) and consistent with current professional knowledge (Siam et al., 2019). Woman-centred and rights based care aspects, including seamless care pathways (Hulton et al., 2016; WHO, 2014, 2016), continuity, evidence-based information, choice, kindness, respect, dignity, equity, and understanding (Hulton et al., 2016; Jha et al., 2017; Kambala et al., 2015; Karkee et al., 2014; Miller et al., 2016; Tunçalp et	

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
				al., 2015; WHO, 2016) are central to high QoMC. High quality care achieves positive and desired outcomes for individuals and populations (Hulton et al., 2000; Lattof et al., 2019; Tunçalp et al., 2015; van den Broek & Graham, 2009) which means timely, effective, appropriate (van den Broek & Graham, 2009), safe (avoidance of preventable injuries, minimising risk and harm, providing adequate levels of care) (Diamond-Smith et al., 2016; Johansen & Hod, 1999; Owiti et al., 2018; Spector et al., 2012; Ueda et al., 2019; van den Broek & Graham, 2009; WHO, 2016), accessible, improving health (Oyugi et al., 2018), person-centred, and psychologically safe (Lattof et al., 2019). Good outcomes consider both physical health improvements and respect for women's choices throughout the process (Miller et al., 2016; Oyugi et al., 2018).	
(Clinical) Audit	Inter-disciplinary	Through time, audit is mainly used to evaluate (Knight, 2018), compare, understand (Say et al., 2009) and improve (Kongnyuy & Uthman, 2009; WHO, 2011) the QoMC. Furthermore, it is seen as a reliable, standardised, & consistent approach (WHO, 2011) to achieve high QoMC as long as it involves the study of the care process and that knowledge exists on which	Six studies were included in this category and published between 1990 and 2018. The oldest study included in this category focused on defining audit and noted *that "Audit as properly defined, hinges on inference: the inference that the quality of care was or was not of a high standard" (Guthrie et al., 1990)*. The next paper emphasised that not only technical aspects of care matter. A more holistic approach is needed to achieve high QoMC (not just bodies, but actual people), considering both the short- and long-term effects of their experiences (Garcia et al., 1998). The studies of Garcia et al. (1998) and Kongnyuy	QoMC exists in places where good audit is performed from both the health care providers and women's point of view (Garcia et al., 1998; Kongnyuy & Uthman, 2009; ten Hoope-Bender et al., 2014). Holistic outcome indicators that measure both long- and short-term effects of the care experience are important to achieve high QoMC. This includes measuring if relationship-based care was provided including continuity of a known healthcare provider, understandable information, being offered food and good facilities (Garcia et al., 1998). Furthermore, maternal health is seen as a public health issue and audit helps improving QoMC by enabling an insight in the	n=6

Table 6 – Summary of included research traditions

Research tradition	Academic discipline	Definition and scope	Unfolding storyline	Conceptualisation of QoMC[1]	References included
		practices maximize beneficial outcomes (Guthrie et al., 1990).	& Uthman (2009) criticize the lack of involvement of women in audit and highlight the importance of service user involvement in the evaluation of QoMC, because, some aspects of care can only be assessed by women (Garcia et al., 1998; Kongnyuy & Uthman, 2009). In this category, from 2009 onwards, the emphasis on measuring obstetric care processes increased, focussing mainly on technical processes, morbidity, and mortality as important aspects of QoMC (Knight, 2018; Say et al., 2009; WHO, 2011).	obstetric care processes (Say et al., 2009). Quality can be measured using information around the weaknesses and strengths of referral systems, how pregnancy-related complications are dealt with, the healthcare interventions and evidence-based practices used. Information about maternal near-miss events and maternal deaths gives in insight in patterns of maternal morbidity and mortality which in turn can help to compare services and used to make improvement plans (Say et al., 2009; WHO, 2011). Using an audit or assessment tool to evaluate maternity care from centrally available electronic maternity records has the potential to make pregnancy safer by detecting key areas for improvements (Knight, 2018).	

QoMC[1]: Quality of Maternity Care

HIC[2]: High Income Countries

The next table (table 7) gives an overview of how woman-centred care and safety were defined in the different categories. The first and second row contain the similarities (1) and differences (2) between the different research traditions on how woman-centred care was described. In parallel, the third row gives an overall idea of how safety was described in a similar manner in all research traditions. The fourth and last row presents the different elements of safety that were mentioned by the different traditions.

Table 7: Differences and similarities across traditions around safety and personalisation

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
1. Woman-centred care - **similarities**	Woman-centred care, in line with patient rights and an effort to achieve women's desired outcomes.	Using woman-centred care aspects by putting women at the centre of the design, improvement and actual care in maternity services to achieve desired outcomes. Care should uphold basic reproductive rights. High quality maternity care means care that is woman-centred and always tailored to women's circumstances, beliefs, needs and values.	Women need patient-centred care.	The red thread throughout this category is the importance of the women's voices, their perceived quality of care, and the need for woman-centred care.	The provision of human-centred and respectful care for women and their families, including appropriate use of clinical and non-clinical interventions which considers women's preferences and values.	Woman-centred or person-centred care which considers both physical health improvements and respect for women's choices throughout the process. Rights based care aspects.	Holistic outcome indicators are needed, and women should be involved in audit.
2. Woman-centred care - **differences**	Satisfying for the woman, her family. The importance of positive relationships, autonomy, and	Care is relationship based and relevant to the needs of the population, including continuity of care(giver) and women feel in control and respected.	Women are active participants in decision making and attention for their psychological needs. Being cared for by midwives who give	High QoMC exists where care includes empowerment, adequate information, education, support. Care that is sensitive to women's personal	Respectful treatment and attitudes towards women. Being able to trust the healthcare providers' competence, kindness and getting emotional and cognitive support.	High-quality maternity care is in line with the expectations and responsive to the (socio-cultural) values and needs of the women, their	Holistic outcome indicators that measure both long- and short-term effects of the care experience are important to achieve high QoMC. This includes measuring if relationship-based care

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
	women's decision-making.	A focus on midwife-led care, thus woman-centred care. How maternity care is designed and provided should incorporate what matters to childbearing women. A positive experience that is in-line with- or better than the expectations which are influenced by socio-cultural and personal characteristics.	information, are present and supportive, listen, show commitment, empathy, and respect.	needs and preferences and that respects their choices. Ideally, continuity of carer is available. Respectful care is at the forefront and feedback of stakeholders is incorporated to improve care. Women's perceived quality of care is influenced by their expectations and prior and current care experience (including the mothers' health and wellbeing and socio-demographic factors). QoMC exists where women are active	Furthermore, it includes good interpersonal relations and mechanisms that ensure women get a personal treatment in which they feel supported in their emotional, psychological, and physiological aspects and personal choices, and a good system in which women's preferences and options can be documented and acted upon. High QoMC includes being treated with respect, privacy and dignity and getting information that is needed or wanted by the women, adapted to her needs and includes positive messages about health and wellbeing.	families, and local communities. Seamless care pathways, continuity, evidence-based information, choice, kindness, respect, dignity, equity and understanding.	was provided including continuity of a known healthcare provider, understandable information, being offered food and good facilities. The importance of service user involvement in the evaluation of QoMC, because some aspects of care can only be assessed by women.

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
				participants in their own care (woman-centred care) and in care-improvement.	Where women perceived care as emotionally and culturally sensitive, respectful, and women-friendly. Women, their families and healthcare providers need to be involved is every step of setting-up human-centred services Achieving respectful, human-centred care in which women and their families are always included.		

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
3. Safety - **similarities**	Care needs to be safe (low morbidity and mortality). Standardised outcome measures are needed to compare morbidity and mortality rates. Safety is the right level of care for women (no over- and under medicalisation), and as a minimum unrestricted access to high-quality emergency obstetric care where needed.	Women highly value giving birth to a healthy baby. Where complications arise, available first-line management of complications and having medical obstetric and neonatal services at hand are important for safe care. There should be no avoidable harm or injury as the result of care, support and advice received.	Available care in HIC is influenced by historical factors, political views, and cultural values that influences access to care, affordability of care, quality of hospitals, and subsequently influences maternal and foetal morbidity and mortality.	The available resources influence the morbidity and mortality for both mother and baby, and thus safety and quality. Safe care is good health outcomes (a low occurrence of five D's: death, disease, disability, discomfort, and dissatisfaction) for mother and baby. This includes offering prompt access to emergency obstetric care.	Safety is when the physical health outcomes (a low morbidity and mortality) are good and where there is appropriate medical care and interventions. Safety is the appropriate and timely use of clinical and non-clinical interventions which are effective.	Safe care means avoidance of preventable injuries, minimising risk, and harm, providing adequate levels of care, having safety measures in place.	Low morbidity, and mortality are important aspects of QoMC. How pregnancy-related complications are dealt with.
4. Safety - **differences**		Care needs to be appropriate for both individuals as well as populations.		Achieving high QoMC is a product of good person-centred outcomes.	Safety is women being helped promptly, facing short waiting times and women feeling safe and welcomed.	High quality care achieves positive and desired outcomes for individuals and populations.	Using an audit or assessment tool to evaluate maternity care from centrally available electronic maternity records has the potential

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
		psychological and physical embodied experience in an environment which is clinically and psychologically safe. Where long- and short-term health and wellbeing for women, their babies and families is created How maternity care is designed and provided should incorporate what matters to childbearing women as this most likely leads to safe and human maternity care. promotion of normal processes with a focus on prevention of complications, a physiological labour and birth (without technical or pharmacological interventions) or 'normal		Safety is women's feelings of security.	Clinical and non-clinical interventions are provided considering the values and preferences of the women.	Women feeling psychologically safe.	to make pregnancy safer by detecting key areas for improvements. Information about maternal near-miss events and maternal deaths gives in insight in patterns of maternal morbidity and mortality and so make care safer.

Table 7 – Differences and similarities between research traditions							
Research traditions	**Obstetrics & Gynaecology**	**Midwifery**	**Social Sciences**	**Healthcare Management**	**(Global) Reproductive Health**	**Public Health**	**(Clinical) Audit**
		birth' in which women are enabled to use their inherent psychosocial and physical strength, while acknowledging that birth can be unpredictable.					

Synthesis across traditions

When applying paradigm bridging, paradigm bracketing and meta-theorising across the research traditions, two meta-themes became apparent. Both safety and woman-centred care were factors of quality that were found in all categories though their meaning was not always overlapping. In both themes, commonalities were found in the underlying conceptual and theoretical assumptions but equally, differences were identified. Across categories, patterns were found which highlighted conflicting understandings.

To ensure that these meta-themes were the most suitable ones to use, I looked for disconfirming data by using the techniques described above. No other topic aligned as well with the necessary criteria than 'safety' and 'woman-centred care'.

Meta-theme 1: An overarching presence of woman-centred care

Across time and research traditions, woman-centred care was seen as an integral and necessary part of high-quality maternity care, although differences between the traditions were found regarding its meaning, language used, and depth or detail.

The overarching theme in all traditions, from the earliest included papers in clinical audit and midwifery in 1998, up to the most recent ones, published in 2019, is that care needs to put women at the centre, using a human rights approach, to achieve women's desired outcomes (Biley & Freshwater, 1999; Blaize-La Caille, 2018; Dhar et al., 2010; Downe et al., 2018; Gamedze-Mshayisa et al., 2018; Garcia et al., 1998; Hulton et al., 2016; Islam et al., 2015; Ladipo et al., 1999; Larson et al., 2014; Lattof et al., 2019; Martin-Hirsch & Wright, 1998; Maurer et al., 2016; Mgawadere et al., 2019; Overgaard et al., 2012; Pittrof et al., 2002; Proctor, 1998; Raven et al., 2012; Salgado et al., 2017a; Salgado et al., 2017b; Sandall et al., 2010; Sandall et al., 2016; ten Hoope-Bender et al., 2014; WHO, 2016; Wilde-Larsson et al., 2011).

Even though a rights-based approach was present in all traditions, only the studies of O'Donnell et al. (2014), in the Obstetrics & Gynaecology category, and van der Kooy et al. (2017), in the Public Health categories mentioned women's autonomy explicitly as an important aspect of high-quality maternity care (O'Donnell et al., 2014; van der Kooy et al., 2017).

All traditions, (except for clinical audit) talked about the importance of women being active participants in their care, so women have choice and feel in control in a place where there is respect for their personal preferences and values (Bayley et al., 2013; Bhattacharyya et al., 2013; Blaize-La Caille, 2018; Dhar et al., 2010; Downe et al., 2018; Hulton et al., 2016; Jha et al., 2017; Kambala et al., 2015; Karkee et al., 2014; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Maurer et al., 2016; O'Donnell et al., 2014; Overgaard et al., 2012; Oyugi et al., 2018; Salgado et al., 2017a; Sandall et al., 2010; Tunçalp et al., 2015; van den Broek & Graham, 2009; WHO, 2016).

Furthermore, the paper of Garcia et al. (1998), rooted in the (clinical) audit tradition, highlights very clearly the importance of service user involvement in the evaluation of quality and the lack thereof (Garcia et al., 1998). Many other papers which were published over time highlighted the need for putting the woman at the centre of the design, improvement and actual care, especially in the Midwifery

tradition (Denham, 2015; Downe et al., 2018; Gamedze-Mshayisa et al., 2018; Martin-Hirsch & Wright, 1998; Martin & Fleming, 2011; Mgawadere et al., 2019; Proctor, 1998; Raven et al., 2012; Sandall et al., 2010; Sandall et al., 2014; ten Hoope-Bender et al., 2014), and the (global) Reproductive Health tradition (Bhattacharyya et al., 2013; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Salgado et al., 2017b; Tunçalp et al., 2015).

The main differences and tensions were found in the timing of the focus shift towards more woman-centred care within the traditions and how many papers included it as a core aspect of high-quality care. In Obstetrics and Gynaecology, after 2010 woman-centred care was mentioned and the importance of positive relationships, communication, and women's autonomy was described (Bayley et al., 2013; Dhar et al., 2010; O'Donnell et al., 2014). This meant that three out of five papers mentioned woman-centred care as a necessary ingredient. This is similar to the Social Sciences category in which from 2011 onwards, patient-centred care was mentioned. The importance of putting women at the centre was mentioned in two of the three papers in that research tradition overall. At least 11 of the 27 papers in the Public Health tradition included woman-centred care aspects such as continuity, evidence-based information, choice, kindness and respect, equity, dignity, and understanding. It was noted that the papers published more recently (in the last 15 years) had a larger focus on woman-centred care (Hulton et al., 2016; Jha et al., 2017; Kambala et al., 2015; Karkee et al., 2014; Lattof et al., 2019; Miller et al., 2016; Oyugi et al., 2018; Tunçalp et al., 2015; van den Broek & Graham, 2009; WHO, 2014, 2016). In contrast, in the tradition of (Clinical) Audit, only two of the six papers (published in 1998 and 2009) mentioned that service user involvement is important in the evaluation of care (Garcia et al., 1998; Kongnyuy & Uthman, 2009). One paper in this tradition talked about the importance of relationship-based care (continuity of a known healthcare provider) (Garcia et al., 1998).

In terms of the Midwifery tradition, 1998, the need for women to feel in control and respected, while ideally receiving continuity of carer, was highlighted consistently from 1998 onwards (Martin-Hirsch & Wright, 1998; Proctor, 1998). All eleven papers in this discipline mentioned this facet as a core-aspect of high-quality maternity care. This consistency is also evident in the Healthcare Management tradition, which included five papers (published between 1999 and 2018) (Blaize-La Caille, 2018; Islam et al., 2015; Ladipo et al., 1999; Larson et al., 2014; Maurer et al., 2016) and (Global) Reproductive Health tradition with six papers (published between 1998 and 2017) (Bhattacharyya et al., 2013; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Salgado et al., 2017a; Salgado et al., 2017b; Tuncalp et al., 2012) all of which included putting the woman at the centre as a main aspect of high-quality care.

This demonstrates that, even though woman-centred care was found to be important in all research traditions, for some disciplines, the importance of woman-centred care emerged ten or even fifteen years later compared to other disciplines and was less consistently evident.

Meta-theme 2: Safety and its different meanings

The lack of consensus and uncritical use of the word 'safety' was an important finding in the data. All research traditions, across the timeline of the included studies, referred to the notion of 'safety' as one of the main ingredients of high-quality maternity care. It was used uncritically when referring to morbidity and mortality in all disciplines (Blaize-La Caille, 2018; Denham, 2015; Diamond-Smith et al., 2016; Guzha et al., 2018; Islam et al., 2015; Johansen & Hod, 1999; Kongnyuy & van den Broek, 2008; Martin & Fleming, 2011; Owiti et al., 2018; Salgado et al., 2017b; Say et al., 2009; Spector et al., 2012; Ueda et al., 2019; van den Broek & Graham, 2009; Van Teijlingen et al., 2009; WHO, 2011, 2016). Furthermore, an appropriate level of care for women (as defined by the specific professional group) was deemed to be important for 'safety' in all traditions but one (Social Sciences) (Bhattacharyya et al., 2013; Biley & Freshwater, 1999; Denham, 2015; Dhar et al., 2010; Diamond-Smith et al., 2016; Gamedze-Mshayisa et al., 2018; Guzha et al., 2018; Islam et al., 2015; Johansen & Hod, 1999; Kongnyuy & van den Broek, 2008; Langer et al., 1998; Miller et al., 2016; O'Donnell et al., 2014; Owiti et al., 2018; Pittrof et al., 2002; Prytherch et al., 2017; Raven et al., 2012; Salgado et al., 2017a; Salgado et al., 2017b; Say et al., 2009; ten Hoope-Bender et al., 2014; Ueda et al., 2019; WHO, 2016). In some research traditions (Obstetrics & Gynaecology, Public Health, and (Global) Reproductive Health) an appropriate level of care was largely defined as the availability of emergency obstetric care (Bayley et al., 2013; Dhar et al., 2010; Diamond-Smith et al., 2016; Guzha et al., 2018; Kongnyuy & van den Broek, 2008; Langer et al., 1998; O'Donnell et al., 2014; Pittrof et al., 2002; van den Broek & Graham, 2009; WHO, 2009). In others (Healthcare Management, Public Health, and (Global) Reproductive Health), it was about using appropriate and timely clinical and non-clinical interventions that are effective and furthermore, that consider the values and preferences of the women involved (Blaize-La Caille, 2018; Oyugi et al., 2018; Salgado et al., 2017a; Salgado et al., 2017b).

As this more nuanced perspective suggests, in Public Health, Midwifery, (Global) Reproductive Health, Healthcare Management, Social Sciences, safety was more broadly conceptualised as both physical as well as psychological safety, rather than pure physical safety (no clinical harm and being alive), which opened further conceptual considerations around the differences in the meanings behind safety in the different traditions.

On further exploration, more discrepancies were found in how safety as part of maternity care quality was conceptualised. In the in the systematic literature review of Downe et al. (2018), which is rooted in the midwifery tradition, a link was made between providing woman-centred and humane maternity care, and the safety and wellbeing of mother and baby (Downe et al., 2018). This is in line with two of the papers in the tradition of Public Health in which the importance of both good physical health and respect for women's choices throughout the process to ensure psychological safety was highlighted (Downe et al., 2018; Lattof et al., 2019; Oyugi et al., 2018). In these traditions, safety goes far beyond no clinical physical harm or death. This seems a more recent development as only in the more recently published papers (2018 and 2019) is the connection made between woman-centred care and a pluralist view of 'safety' that includes physical, psychological and social feelings of being secure, protected from harm, and empowered to mother effectively.

4.5 Discussion

This review highlighted the disciplinary rhetoric on the important aspects needed for high quality care. Across all research traditions, the importance of different concepts of 'safety', as well as woman-centred care was highlighted, although in some cases, the meaning given to these concepts within and across traditions differed substantially.

The word safety especially was used uncritically in a lot of the literature found and so in some cases, it was unclear what was meant by it. This is in stark contrast to some research conducted and literature published on safety (not as part of quality), in which the concept is described in detail. For instance in the framework of Liberati et al. (2021), safety in maternity units exists of seven features: *"(1) commitment to safety and improvement at all levels, with everyone involved; (2) technical competence, supported by formal training and informal learning; (3) teamwork, cooperation and positive working relationships; (4) constant reinforcing of safe, ethical and respectful behaviours; (5) multiple problem-sensing systems, used as basis of action; (6) systems and processes designed for safety, and regularly reviewed and optimised; (7) effective coordination and ability to mobilise quickly"* (p. 448-449) (Liberati et al., 2021).

Similarly to the findings of this meta-narrative review, when looking for literature on safety specifically, different disciplines or authors define safe childbirth or maternity care in contrasting ways. For instance, the WHO Safe Childbirth Checklist focused only on avoiding common physical harm (morbidity and mortality) in low-income countries at different stages of maternity care. Safety purely meant physical safety in this document (WHO, 2015). This contrasts with the example given above in which safety existed of many different organisational aspects other than just clinical care (Liberati et al., 2021). According to Sandall et al. (2010), safety in literature is often portrayed as the woman having to compromise on a humanised childbirth to achieve physical safety. The authors criticised how safety is not seen as a positive aspect of the birth experience, but more as the absence of harm (Sandall et al., 2010). The results of the current review showed that some research traditions (particularly Public Health, Midwifery, and Global Reproductive Health) conceptualised safety as a concept that goes far beyond the avoidance of physical harm or death (see results above). This is in-line with the Quality Maternal and Newborn Care (QMNC) model which was based on the evidence of the Lancet series on Midwifery (2014). The model includes a more holistic outlook on quality, including but not limited to: *"Care that is tailored to women's circumstances and needs, and optimising biological, psychological, social, and cultural processes; strengthening women's capabilities"* (QMNC, 2024; Renfrew et al., 2014).

This meta-narrative review found that all research traditions emphasise the importance of woman-centred care to achieve high quality maternity care, but that in some traditions, this evolution started later in time. In some traditions, the concept was defined more superficially than in others. The issue of woman-centred care being underdefined was also found in other literature. The paper of Fontein-Kuipers et al. (2018) proposed a new and more comprehensive definition for woman-

centred care to ensure a clear and correct understanding of the concept. This definition is the following: *"Woman-centred care is a philosophy and a consciously chosen tool for the care management of the childbearing woman, where the collaborative relationship between the woman - as an individual human being - and the midwife - as an individual and professional - is shaped through co-humanity and interaction; recognizing and respecting one another's respective fields of expertise. Woman-centred care has a dual and equal focus on the woman's individual experience, meaning and manageability of childbearing and childbirth, as well as on health and wellbeing of mother and child. Woman-centred care has a reciprocal character but fluctuates in equality and locus of control (p. 8)* (Fontein-Kuipers et al., 2018)." The researchers of this study mentioned that the included papers around woman-centred care were published between 1998 and 2014 but that 75% was published in the last ten years (Fontein-Kuipers et al., 2018). These findings are in line with the findings of the meta-narrative review and show that woman-centred care has grown in importance in the last decade.

Even though authors in the different research traditions assume they are communicating a similar definition of quality in maternity care, this review has shown that the meanings behind certain terms used, might be different. This seems a common theme amongst both the conceptualisation of quality of maternity care as well as for the subcategories that are the building blocks needed to achieve the former.

Phase six of the meta-narrative review: recommendations

This review suggests that a clear and mutually agreed definition for quality in maternity care is urgently needed to improve the quality of maternity care worldwide. More particularly, clinicians and policymakers should have insight in their own definition of quality in maternity care and at the same time have the awareness that this definition might differ substantially from other stakeholders. The issue should be addressed by putting women's or service-users' needs and wishes first, followed by the needs and wishes of the other stakeholders involved to create a universal definition of maternity care quality. An implementation strategy for the mutually agreed definition should be developed to enable the sustainability of high-quality maternity services.

Future research in quality of maternity care would benefit from an in-depth analysis of the separate elements which form the building blocks to achieve high-quality maternity care. More research also should be done around how women conceptualise and define quality maternity care (see chapter five) and how the definitions found in the literature are implemented in clinical practice (see chapters six, seven, and eight).

4.6 Conclusion

A consensus exists between different constituencies involved in the maternity services that quality of maternity care is of great importance. There is an assumption that the different constituencies involved in maternity care define quality identically. This review revealed multiple conceptual frameworks and definitions for quality of maternity care, but no overall shared understanding was found. Although there is a lot of overlap between the different research traditions on what quality of maternity care means, a different definition and level of importance is given to the different concepts.

Across time, the prevailing message was that to provide high quality maternity care, woman-centred, and safe care should be implemented. Although these concepts were commonly cited, there was no consensus found on their meaning or on how these factors interact. The data showed that there is an existing debate about where the balance between safety and personalisation in maternity care lies (often seen as 'either/or', rather than 'both/and').

Maternity care must ensure reductions in morbidity and mortality, but, though necessary, this is not sufficient for high quality maternity care as defined by childbearing women and birthing people. A mutually agreed definition for high quality maternity care is urgently needed amongst the constituencies involved in maternity care, and those using the service, to enable its successful implementation. A first step to achieve this is to create awareness about the existing differences in conceptualisations and definitions around quality. This review provides a starting point to tackle the challenges to create a transdisciplinary understanding. Furthermore, it raises important questions about which different mental models underpin quality of maternity care in clinical practice.

The next chapter gives a detailed overview of phase two, the analysis of the Babies Born Better survey and what matters to women when it comes to quality maternity care.

CHAPTER 5: THE BABIES BORN BETTER SURVEY

5.1 Introduction to the chapter

The previous chapter introduced how different disciplines in maternity care have defined quality over time. Similar concepts were found to be important aspects of maternity care quality, but terms were used uncritically, and meanings differed within and across stakeholder groups.

Women and babies are at the heart of maternity care. Understanding what quality care means to them is crucial.

The aim of this chapter is to describe what women who responded to an international survey identified as the main characteristics of 'good' maternity care. Data from the Babies Born Better (BBB) survey was used to investigate what women who received care at the two maternity units included in the organisational ethnography (see chapter six) liked the most about care and what they felt could be improved.

Chapter three has provided detail on the background, theoretical underpinning, study population, data collection, and analysis of the Babies Born Better survey. This chapter first provides detailed information about the data preparation. It then presents the findings which include a description of the participants' demographics, details of the sample from which the analysis is drawn, overall ratings of the maternity care experience of the women included in the study, and overall themes, and perceptions of what matters to women. Finally, a critical reflection of the findings is provided.

5.2 Data preparation

As mentioned in chapter three, the Babies Born Better survey is a well-established data-collection tool, originating in the multicounty citizens' science Babies Born Better project. The survey was developed to explore women's self-reported experiences of maternity care. Using the principles of salutogenesis as its underpinning theory (See p. ix for a definition) questions were initially designed to explore what creates health, wellbeing, and positive outcomes. The survey was developed to identify maternity care settings around Europe that facilitate positive experiences, as a basis for more in-depth ethnographic study to identify what these sites did differently from those who were less well rated by childbearing women. While this was the underpinning philosophy of the survey, it has mainly been used to explore what matters to women in various countries, and to identify poor practice and experiences as well as good ones (Balaam, 2015; Benet et al., 2020; Eri et al., 2022; Hannon et al., 2022; Luegmair et al., 2018; Nilsen et al., 2021; Santos & Neves, 2021; Skoko et al., 2018; UCLan, 2017; van den Berg et al., 2022; Vedeler et al., 2023; Vedeler et al., 2021).

Women who have participated in the Babies Born Better survey are self-selected as the survey is shared on social media such as Facebook, Twitter, and Instagram. The survey was also promoted via activist and women's groups as well as by word of mouth. Women from the two units who participated in the current study all filled out the English version of the survey. The English language version of the third round of the survey was launched in June 2020 and closed in June 2022.

While conducting the organisational ethnography I decided to print postcards with a QR code to promote the survey (see appendix O). I attended the postnatal wards to give out the postcards and ask women if they wanted to participate in the study, giving them an explanation about the aims of the research project. All women that were on the postnatal ward at the time of my visit were asked to fill out the survey. If they were non-English speaking, I tried to explain using Google translate or through the person accompanying the woman on the ward.

Ethics approval was obtained, and the anonymous data from the Babies Born Better survey was sent to me securely via a OneDrive link. I used the name of the institution and in some cases the postcode to pick out the responses from the NHS Trust included in the organisational ethnography and deleted the others. Furthermore, cleaning the data also consisted of removing the questions and answers to those questions that were not going to be used for the analysis.

Next, the demographic data and overall rating of the experience of care was uploaded in the Statistical Package for Social Sciences (IBM© SPSS©) software version 28. Some of the original variables were re-coded into created variables that grouped the data differently (e.g. age). Where necessary, text responses were recoded into numbers and these numbers were labelled in an informative way prior to statistical analysis. Instead of conducting formal statistical tests, informal comparisons were made. Where dissimilarity was found, this suggested that Babies Born Better participants were not representative in terms of the relevant demographic characteristics. Descriptive statistics for binary or categorical variables were presented as frequencies and percentages. The open-ended questions and answers were uploaded to the MAXQDA Analytics Pro 2022 software to support thematic analysis.

Six phases were used for the thematic analysis of the qualitative open-ended data in the included responses (Clarke et al., 2015):

1. Familiarisation with the dataset
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining and naming themes
6. Writing up

The methodology chapter (chapter three) gives an in-depth outline of the 27 questions which include open-ended and closed questions asked in the survey. A decision was made to focus on

the following questions for the analysis (see table 8) as they give an idea of the study population (questions 1, 2, 3, and 4) and about how women rated their care experience (question 5). The answers to the open questions give a good idea about which aspects of care contribute to high quality care from the perspective of service users (questions 6, 7, 8, 9, and 10).

Table 8: Questions of BBB included in the analysis

1. Demographics
    - age (age groups 20-24, 25-29, 30-34, 35-39, >40)
    - parity (nullipara, multipara)
    - self-declared socio-economic status (standard of life compared to most people in this country: much worse, below average, average, above average, much better)
2. Did you experience problems during the pregnancy? (yes/no)
3. How was your baby born?
    - normally with no assistance
    - with the help of ventouse (suction) or forceps
    - by caesarean section (planned in pregnancy)
    - by caesarean section (due to an emergency in labour)
    - other (please describe)
4. Where you had your labour and birth
    - in a hospital
    - in a birth centre that is part of a hospital
    - in a birth centre that is not part of a hospital
    - at your home
    - other (please specify)
5. How do you feel about your labour and birth experience?
    - It was mostly a very bad experience
    - It was mostly quite a bad experience
    - Some of it was good, some of it was bad
    - It was mostly quite a good experience
    - It was mostly a very good experience
6. In the place where you gave birth, what were the three most positive experiences of your care?
7. What do you think could have made your experience better?
8. I think you should give birth at the place where I did because…
9. I think you should not give birth at the place where I did because…
10. Comments

5.3 Findings

Participant demographics

In total, 1944 women in the United Kingdom and Northern Ireland participated in the BBB survey version three. This included 37 women who had their babies in the last three years at the NHS Trust targeted for the organisational ethnography. There was no incomplete survey or missing results in any of the 37 surveys and so I was able to include all of them in the analysis. It is of note that the largest group of respondents (43.2%) had their baby in 2021, the second largest group (35.1%) in 2020. This means that most women (29 of 37) who participated in the survey had their babies during the Coronavirus pandemic in England.

Baseline characteristics

Table 9: Table of baseline characteristics of survey participants

Characteristic	Categories	Study sample (n=37)		NHS Trust[3]
		Frequency	Percentage	Percentage
Age Groups	20-24	2	5.4	9
	25-29	8	21.6	23
	30-34	19	51.4	38
	35-39	6	16.2	23
	>40	2	5.4	7
	Total	37	100.0	100.0
Your standard of life: Compared to most people in this country, I think my standard of life is:	Much worse	0	0	-
	Below avg.[1]	0	0	-
	Average	16	43.2	-
	Above avg.	16	43.2	-
	Much better	5	13.5	-
	Total	37	100.0	-
Parity	Nullipara	28	75.7	36
	Multipara	9	24.3	47
	Total	37	100.0	(17% missing)
Did you experience problems during the pregnancy?	No	21	56.8	-
	Yes	16	43.2	-
	Total	37	100.0	-

Please write down where you had your last baby	Site 1	16	43.2	61.8
	Home	1	2.7	1.1
	Site 2	20	54.1	37.1
	Total	37	100.0	100.0
Where did the labour and birth of your last baby take place?	At your home	1	2.7	1.1
	In an AMU[2]	12	32.4	12.7
	In a hospital	24	64.9	86.2
	Total	37	100.0	100.0

Avg.[1]: Average

AMU [2]**:** Alongside Midwifery Unit or Birth Centre that is part of a hospital (NHS England, 2023a)[3]

The majority of women who filled out the survey were between 30-34 years old (51.4%). This is in line with the age bracket in which most women had their baby at this NHS Trust. In February 2023, almost two-fifths of women booked at the NHS Trust were between 30 and 34 years old which was the biggest group of all age categories (NHS England, 2023a).

The self-declared socio-economic status showed that all women who had filled out the survey felt they had an average (43.2%), above average (43.2%) or even much better (13.5%) standard of living compared to other people in the UK. This is in stark contrast to the index of multiple deprivation which ranks areas in England and is based on seven different factors including crime, living environment, barriers to housing and services, health, education, employment, and income to tackle healthcare inequalities (healthcare access, experience, and outcomes). The index of multiple deprivation is divided in deciles from 1 (most deprived) to 10 (least deprived), and for this NHS Trust, 69% of women belonged to the five most deprived deciles at booking. NHS England also gathers information around complex social factors. 10% of pregnant women using this NHS Trust were identified having complex social factors (NHS England, 2023a).

Women filling out the survey were predominately (three-fourth) having their first baby (nulliparous), with the other one-fourth their subsequent baby (multiparous). In contrast, in February 2023, 36% of all women at the Trust were having their first baby with just under half having a subsequent live baby. The information about the parity of all the other women (17%) was missing/outside of parameters (NHS England, 2023a).

More than half (56.8%) of participants reported they did not experience problems during pregnancy and over two-fifths reported that they did. There is no public data available on this topic to be able to compare the study sample with at this NHS trust. Given that 35% of women in the Trust were

having inductions and just under half of women a caesarean section, it is likely that the survey respondents were not representative of women giving birth at the unit (NHS England, 2023a).

Within this Trust, the majority of the total births per year take place in the larger unit, site 1 (approximately three-fifth) and the minority, just under two-fifths in the smaller unit, site 2 (NHS England, 2023a). In contrast, over half of the respondents to the survey had their baby in the smaller unit.

When looking more specifically at where these women birthed their babies, most women (n=24) gave birth in the hospital on the obstetric unit. One woman had a home birth, and about 32.4% birthed in a birth centre that is part of a hospital. Data from the NHS trust (2022) reveal that around 12.7% of women give birth in the alongside midwifery unit (birth centres), around 1.1% give birth at home and around 86.2% of women gave birth on the high risk (obstetric) unit in the hospital (NHS England, 2023a).

Many differences were found when comparing the sample population with the population giving birth at the NHS Trust (e.g., parity, socio-demographic status, risk factors, place of birth, etc.). This means there are gaps in the data and that certain voices (such as women with lower socio-economic status) were not heard. The findings should be informative and interpreted with these differences in mind. However, the point of including these data was to find out what women using this Trust feel good care is.

Labour and birth experience

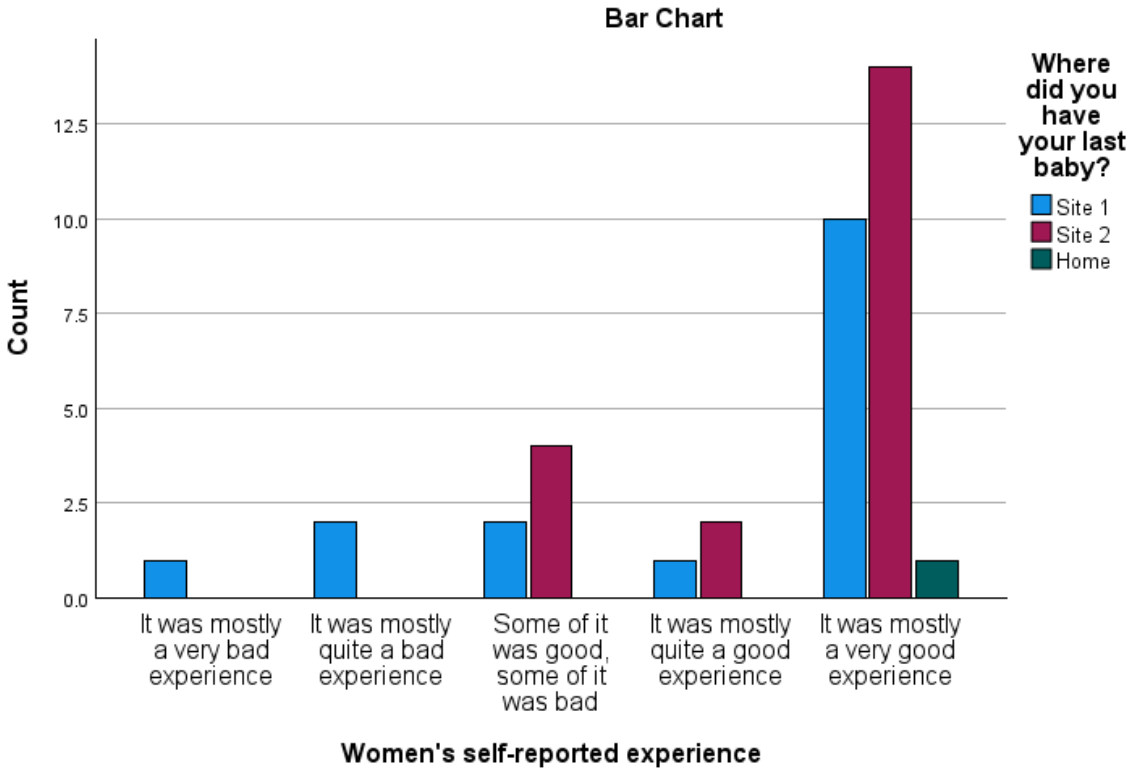
The majority of women reported a good experience of care during labour and birth. Overall, two thirds of women reported a positive experience (quite good and very good). However, about a quarter of women reported their experience was both good and bad, or bad (with three women a quite or very bad experience) (See table 10 below).

Table 10: Labour and birth experience

How do you feel about your labour and birth experience?		
	Frequency	Percent
It was mostly a very bad experience	1	2.7
It was mostly quite a bad experience	2	5.4
Some of it was good, some of it was bad	6	16.2
It was mostly quite a good experience	3	8.1
It was mostly a very good experience	25	67.6
Total	37	100.0

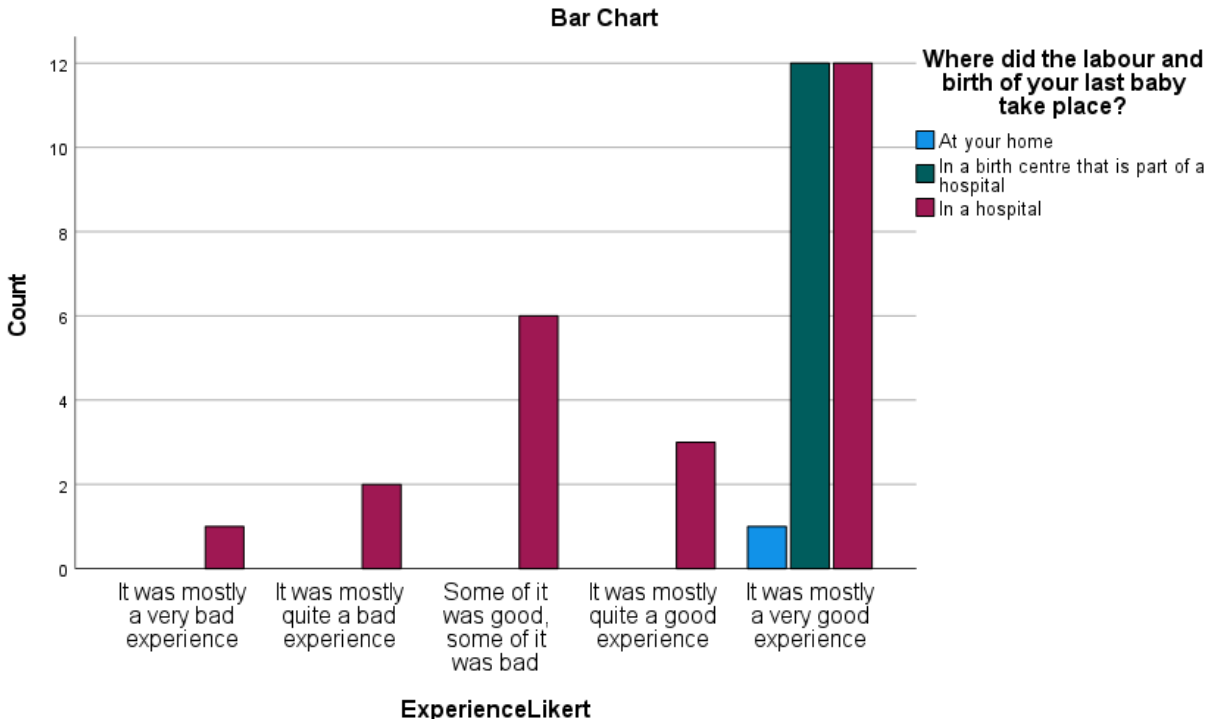
When comparing the experiences of women on the two different sites, there are noticeable differences. Three women who had given birth in site one reported that they had a predominantly negative experience. The participant who had a home birth reported that it was mostly a very good experience.

Figure 9: Birth experience by unit



When comparing the experience with the chosen place of birth using a cross tab, all women giving birth in a midwife-led service such as at home or in a birth centre, that is part of a hospital, reported that they mostly had a very good experience. The group giving birth in the hospital (on the high-risk unit) had very mixed experiences, with only about half of respondents reporting that they had mostly a very good experience. Three women in this group reported they had mostly quite a bad or even a very bad experience. One in four of the women giving birth in the hospital reported that some of it was good, some of it was bad.

Figure 10: Experience and place of birth



The Covid pandemic influenced the experience of maternity care. More than three quarters (78%) of respondents gave birth during the pandemic. Besides the stresses going through an unknown situation and having public health measures in place (lockdowns) from mid-March 2020, pregnant women in England also had to deal with other restrictions. For instance: restrictions in visiting their new-born baby, in pain relief options, in choices for place of birth, and in companionship throughout their maternity care journey. They also faced a reduction in the number of face-to-face appointments and the suspension of face-to-face antenatal classes. All of these changes happened suddenly and had a significant impact on women and on their rights during their maternity care (Coxon et al., 2020; Fallon et al., 2021; van den Berg et al., 2022). Most of the restrictions and changes put in place were unchanged by the end of 2021. A crosstab was made to compare experiences between women who had their babies before versus during the Coronavirus pandemic while restrictions were in place. In 2020 and especially in 2021 respondents answered that some of their experience was good, some of it was bad. This means that six of the sixteen respondents in 2021 reported having had an experience that leaned more towards the negative part of the scale. No other major differences were uncovered in the descriptive statistics.

Table 11: Experience of participants during the Coronavirus pandemic

		Experience			
		It was mostly quite a bad or very bad experience	Some of it was good, some of it was bad	It was mostly quite a good or very good experience	Total
Pre- (2017-2019) and during (2020-2021) the Coronavirus Pandemic	2017-2019	1 12.5%	0 0.0%	7 87.5%	8 100.0%
	2020-2021	2 6.9%	6 20.7%	21 72.4%	29 100.0%
Total		3 8.1%	6 16.2%	28 75.7%	37 100.0%

The quantitative findings set out above provide the lens through which the qualitative data were viewed.

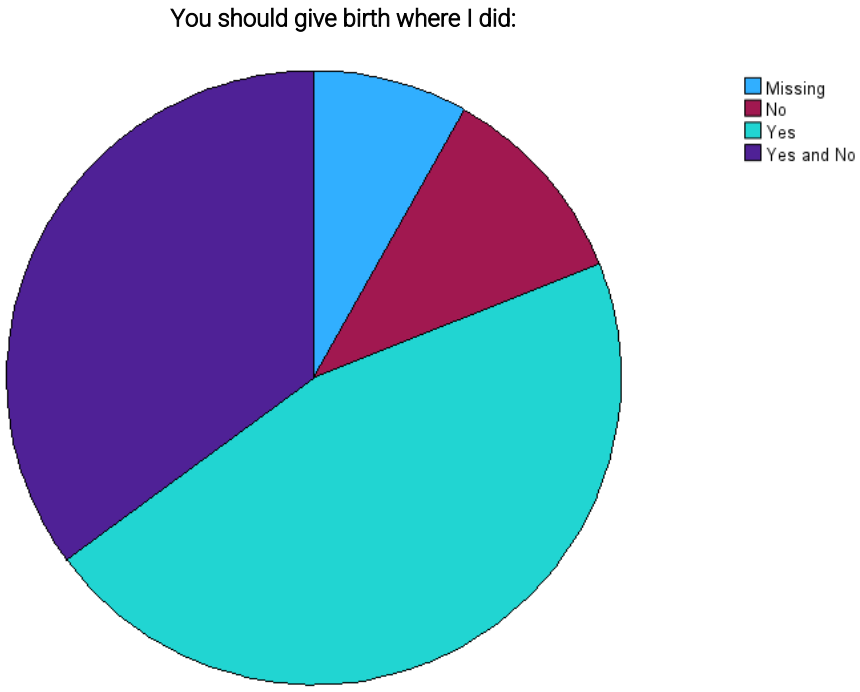
The friends and family question

When looking into how women responded to the questions:

- I think you should give birth at the place where I did because…
- I think you should not give birth at the place where I did because…

Overall, 13 respondents filled out both questions about why someone else should and should not give birth at the place where they did (Yes and No). Another 17 filled out only why someone should give birth where they did (Yes). Four of the respondents only noted reasons why someone should not have their baby at the place where they did (No) and another three did not fill out either of the two questions. As these participants did fill out all the other questions, their results were kept in the analysis.

Figure 11: Pie Chart friends and family question



What matters to women?

The data from all the open questions was combined to find out what the most important factors in care are for women. Women's responses to the open questions were added (in *blue and italic*) to illustrate the themes.

The following themes were developed:

a) Sense of emotional and physical security and wellbeing
b) Competence and attitude of the personnel
c) Mother and baby cared for with compassion and respect
d) The social and physical space of birth
e) Consistent care and continuity where possible
f) Family focused and culturally sensitive

a) Sense of emotional and physical security and wellbeing

Women spoke about a range of different aspects of wellbeing that could underpin the concepts of safety and security. These included emotional (having a choice/respectful care) and physical (no-clinical-harm) aspects of wellbeing as well as what made them feel (un)safe or (in)secure, what made them (dis)trust the healthcare provider, and some wrote about the importance of physical safety of their babies (no-clinical-harm).

There were different opinions around which model of care or approach women wanted and which would allow them to feel a sense of security (both no-clinical-harm and having a choice). For most

women, this meant a focus on physiology: *"No medical interventions"* or *"having the opportunity to have a water birth"*. Another participant noted that: *"it is midwife led and very low intervention. Care was outstanding. You will feel like home and feel safe under the care given."*

For some, this meant having the freedom to request care outside guidelines (e.g. elective caesarean section for maternal choice) and to be trusted in making that decision (see section C: Mother and baby cared for with compassion and respect).

Women wanted to feel medically safe (no clinical harm) and to feel that medical problems would be picked up by the healthcare providers. This was expressed in the following ways:

> *Looking after my existing health problems.*
>
> *Care was brilliant, could not fault it once complications were found in pregnancy through to delivery and discharge into care of local midwives and HV [health visitor].*

Timeliness of care to achieve a feeling of wellbeing was also mentioned both as part of what makes high quality care as well as one of the things that could be improved:

> *Every week I was held in a waiting area for approx[imately] 6 hours so the doctors could deliver bad news to me. I don't understand why I had to wait around for so long just to be told I had to increase my med[ication]s! Why couldn't the doctors send me home sooner? They stressed and exhausted me, where they could just meet me for 5 min[ute]s, give me the news and send me home.*
>
> *It tends to get very busy in the labour ward and you may have to wait for days to be admitted if it's not an emergency.*

Women not only wanted timely, appropriate, and their chosen physical care (ranging from highly medicalised, as physiological as possible, or something in between) to feel secure but support for their mental health was also a key ingredient. One woman noted that the best thing about her care was: *"Looking after my mental health."*

The information provided and the way this information was expressed by the healthcare providers had a big influence on the women's feeling of wellbeing. Some women reported they had a very good experience due to positive reinforcement and helpful signposting, others felt that doctors scared them without any reason which negatively influenced their care experience:

> *The care was so brilliant, and they thought about everything. I was discharged after care advice, with painkillers, and given information on how to speak to a counsellor due to my traumatic birth. I have never felt that I needed to speak to a counsellor due to how exceptional the team were. I know from speaking with friends who had babies in different*

hospitals in the U.K. around the same time, they did not have such positive experiences and it makes me even more grateful for the care I received.

Then, when they did see me, they would always say something along the lines of: we may have to deliver baby in 48 hours... or we are trying to avoid still birth! But they would say this BEFORE they had ran all the tests! I had so many melt downs and tearful moment episodes! Just because they doctors didn't wait for test results before scaring me.

Many women put an emphasis on how they felt reassured and were impressed by healthcare providers staying calm and maintaining a calm atmosphere, especially during emergency situations. Furthermore, they noted that they were still asked for their consent despite an urgent need for interventions (need for an episiotomy, instrumental birth, an emergency caesarean section or help in view of an acute loss of blood (haemorrhage), and this was valued. The midwife's and doctor's competence in the following cases was closely linked to a sense of security (feeling safe both physically and psychologically):

During pushing, the baby's heart rate was dipping and they recommended an episiotomy and ventouse. They explained why they needed to do this and even when the baby was delivered safely and I started to haemorrhage, they were so calm that I didn't panic.

The doctors and midwives stayed exceptionally calm and were reassuring when things started to go wrong.

From the midwife to the doctors the anaesthetist and all the hospital staff they are amazing. Even if the experience with the actual labour was horrible due to really bad pain and difficulty to give birth that end up with an emergency c[aesarean] section, the staff was so caring, kind and professional that I couldn't ask for more for me and my baby.

Trusting that the healthcare providers would listen and have their best interests at heart was a very important aspect to feeling psychologically safe and that they were in good hands. Women wanted to be able to relax and not have to worry about whether the healthcare providers were competent to do what was needed. Additionally, they wanted to know that they would listen to what their individual wishes were. This was expressed by participants in what was good about care or what could be improved:

I was listened to and given pain relief as soon as I asked for it.

My birth went very fast, and the midwife didn't trust my pain.

Being listened to more.

Certain behaviours of personnel were very closely linked to the feeling of emotional and relational security. One woman noted how she would have liked more consistency and continuity in labour by the midwife looking after her (see also point e: Consistent care and continuity where possible):

> *Midwife checking in on how I was feeling more often. Also not taking extended break leaving me without midwife for over an hour.*

Feeling safe and secure was closely interlinked with birthing a healthy baby (no-clinical-harm):

> *Safe, calm birth of a beautiful healthy baby.*
>
> *Healthy baby.*

b) Competence and attitude of the personnel

The personnel (mostly midwives and obstetricians) were very often named as the most negative, but equally as the most positive factors influencing the quality of maternity care received. This was particularly the case when personnel showed a caring attitude which meant women were treated as an individual, made to feel safe, at home, and at the centre of care:

> *The care I received was amazing, thoughtful, caring in every aspect. I felt like being at home and looked after by family. I couldn't imagine a better experience!*
>
> *It was an incredible experience where I felt safe and cared for.*
>
> *The staff are incredible, there is both a labour ward and birth centre on site so you can choose the setting you want to give birth and transfer between the two easily, care is very mother focused (I was very impressed consultant came to see us after birth to check if we had questions and understood what had happened and I felt this could have been very important for some mothers).*

On the other end of the spectrum, women gave accounts of how they were mistreated, dismissed, controlled or of staff being forceful during intimate examinations. These were mentioned to have a negative influence on their pregnancy and care experience:

> *I had a negative experience with one midwife who didn't listen to me or take me seriously and was rude.*
>
> *The doctors at Hospital X, turned my pregnancy into a nightmare! I loved being pregnant and I really wanted to enjoy every minute of it! But I feared coming in for my regular check-ups because of the way I was treated! Overall, it has been a nightmare of an experience.*

They just try scare you into submission instead of explaining the situation and looking for solutions as a team! It's full of short-tempered doctors who want to order you about rather than guide you to a good decision! I had one or two fantastic doctors but majority where harsh and awful at the way they delivered bad news (in my case this was a weekly occurrence).

One midwife was very forceful with the internal examinations and was very abrupt in her approach and did not take me seriously when I said my contractions were very strong and close together, she didn't want to transfer me to the labour ward.

The characteristics of staff that were most highly valued by women were those that made them feel cared for such as: kindness, attentiveness, supportiveness, friendliness, as well as being welcoming, caring, understanding, respectful, etc:

Labour ward and postnatal ward staff were exceptional, felt cared for throughout.

The kindness of the midwife who was there for delivery and held my hand in the surgery that followed.

Overall, considerable emphasis was put on the availability and supportiveness of personnel. Some women emphasised how they were never left alone during labour, which was one of the three most positive things of their care. Furthermore, women commented on the passion some of the staff exhibited about their work:

The staff is amazing, they really care about their job that is more a passion, I guess. They follow you in every single step. And make sure to support you.

Availability and understanding attitude of the staff.

Medical expertise and knowledge were also highly valued by women. When women felt safe in the doctors or midwives care, they expressed this by using phrases including: *"personnel being professional", "feeling looked after", "they rallied around me", "calm and knowledgeable", "immediate attention when complications arose", "they were excellent", "constant care", and "staff is amazing and very experienced".*

They were calm, professional, and as soon as I asked for pain relief, I was given it. I had a midwife who basically did not leave my side and was kind and supportive. When she had to finish her shift, she introduced another midwife with a great handover and made me feel really comfortable about the hands I was left in.

I believe I was looked after by doctors and midwives who knew exactly what they were doing and saved myself and my daughter's life.

Women who had a home birth, birth centre care and/or continuity of a midwife in the antenatal period valued this highly and reported these as the best things about their experience:

Home birth was better than I could ever have imagined

Continuity of antenatal care between community midwives and birth centre.

Women picked up on instances in which staff were overstretched and tired, which influenced their care in a negative way:

Staff were over stretched; staff promised to assist or provide support but never returned. This was the same for even to get a slice of toast. It felt awfully isolating.

Less tired doctors (there were several over worked doctors about).

One of the women also emphasised how midwives should get more credit for their job:

Midwives - pay them very well as they do a great and unparalleled job!

c) Mother and baby cared for with compassion and respect

In the previous theme, compassionate, respectful, and caring personnel were found to be very important to women to achieve a high-quality care experience. These were prerequisites to feel cared for but were not the only things that were necessary to achieve this.

Women regularly stressed the importance of their baby being cared for too for them to feel satisfied with their experience. For some participants, the way the doctors cared for their baby was the best thing about their experience:

They were making sure that myself and baby were always well looked after.

Doctor's care about baby.

Care and respect were also measured by how much their choices were respected and facilitated, how much they could trust in the organisation and that a rights-based approach, including the facilitation of an informed choice would be always ensured. This was a theme that came up often in the question around which three improvements they would like to see or in the reasons why not to give birth in the unit in which they did:

Staff asking for consent for all interventions and being honest about what they are about to do.

They just try scare you into submission instead of explaining the situation and looking for solutions as a team!

I had to be in the labour ward rather than the birth centre because my blood pressure readings earlier that day had been high. However, despite arriving 10cm dilated, no one paid attention to my birth preferences, and I ended up with episiotomy and instrumental delivery and was not

supported to use different positions even though I repeatedly requested this. The doctors used threatening language with me about how they would be back with instruments.

On several occasions staff 'forgot' to ask for my consent, e.g. before performing a membrane sweep or episiotomy.

Honesty and transparency were also mentioned as important measures of quality:

Honest.

Access to my notes during my hospital stay and afterwards. I was intrigued what was written but never got the notes back to read them.

Better explanation of issues and solutions.

A few times women commented that they felt a lack of trust and honesty from the healthcare provider towards them. Some commented on how they didn't feel listened to or felt that they weren't being taken seriously, which led to a feeling they had received low quality care. Furthermore, a sense of reciprocal distrust in the personnel by the women was noted:

I had a negative experience with one midwife who didn't listen to me or take me seriously and was rude.

Because they didn't trust me, I nearly didn't have a water birth.

They did not pay attention to my birth preferences.

Women noted how they would have liked to have been spoken to in a more empowering way by the healthcare providers (in this case, the doctors) or that they would like to have been empowered to make their own decisions. Others explained what personnel did to make them feel empowered:

Referral to birth options clinic was empowering.

Empowerment to make my own informed choices.

On the other side of the continuum, a lot of women talked about how they were taken care of well and how their decisions were respected:

I had a maternal request Caesarean section for my first birth for a vast number of reasons. […] I opted for MRCS [maternal request caesarean section]- my decision making was respected by the medical team, and I had a really wonderful experience with a rapid, complete recovery.

The care and dedication of the midwives and doctors during the labour. We felt so supported, informed and fully empowered during the labour.

Women seemed to feel cared for the most when their individual choices and preferences were taken seriously, they were always listened to with compassion and empowered and trusted to make their own decisions.

d) The social and physical space of birth

The physical space of birth was commonly cited when participants were asked what they liked the most about their care experience and the three things that women would like to see improved. Women talked about the environment, labour rooms, postnatal rooms, other facilities (e.g. on the alongside midwifery unit). Some participants mentioned more detailed aspects of the environment that they thought were good, such as: the comfortable bed, being able to dim the lights, and have an aromatherapy diffuser, having a clean and quiet environment. A few women spoke about how certain aspects of the environment could be improved such as a better maintenance of the building, showers, working air conditioning, call points lights in the postpartum bedroom, and having birthing centre facilities on the labour ward (e.g., double bed or a bed for the partner). Comments included:

Facilities (great private room with a pool and other things I wanted to use in labour).

It's a beautiful birth centre and the staff is amazing and very experienced.

It was slightly run down and needs updating.

Building did need some maintenance. Small things like lights not working or shower drains smelling and showers not having proper shower chairs mean staff were apologising for things they shouldn't have to.

Other women related to the birth environment as a social space in which togetherness with their partner and other chosen companions at all times was important. The women who were able to have their partner with them talked about how this was one of the best things about their experience, the ones who weren't allowed, talked about this being one of the main things to be improved:

Birth centre wonderful place to birth and stay with partner.

We paid to go private so my husband could be with me, it was very hard having a baby in a pandemic, even worse coming home and having no one allowed in the house to support.

Being allowed my husband throughout labour as labouring alone in a hospital is hard.

Was on the ward for a few days and myself and my baby were not well, and I did not feel well looked after quite a lot of the time. It was lonely as well as not being able to have visitors.

In addition to wanting a space in which partners and supporting people were welcomed, women also highlighted the importance of an environment that was conducive to their individual birthing and recovery process. They suggested that the reduction of unnecessary waiting times and time spent on the wards, and a calm, quiet environment that supports rest would facilitate a positive experience, and so high-quality care:

> *I was scheduled for induction of labour, but I had to spend 3 days in the hospital before I was actually induced and put into labour. That made me super tired and frustrated by the time I gave birth. I would have been much happier if would have come into the hospital straight for the induction.*

> *The postnatal wards are not somewhere you can recover from birth. They are noisy and it's not a restful environment.*

As mentioned above, the birth environment was closely related to how women felt about their recovery and overall wellbeing. Characteristics of the environment that were highly valued in this respect were a calm and private environment, in which the woman had the time and space she needed to birth her baby, recover, and adapt to her new role as a mother. When women felt good in the physical space, while getting care which felt right for them, a sense of security was reported. The birth centre was reported to be a better than expected or good environment. The conditions of the labour and postnatal ward were often found to be of low quality:

> *The birth centre was not how I thought it would be. No screaming, no beeping. Just calm and private and quiet and I had the time and space I needed.*

> *Privacy and private room with private bathroom.*

> *The conditions at postnatal ward are very basic and make it difficult to recover.*

> *The ward experience was great apart from the conditions. I had a smooth recovery after planned C-section, walked as soon as the epidural wore off, needed minimum pain relief and went home with the baby the next day.*

> *Stayed on the postnatal ward for a week - the level of noise is unbelievable, it's easier to rest in a train station than in the hospital. Had hardly any sleep for 4 days until I got transferred to a side room.*

Where women described how (non)conducive the environment was, in many cases, the sentence would also hold information about the importance of the behaviour of staff and how they were cared for within that environment:

> *The postnatal care is not great at all - noisy rooms, staff telling you off for being in pain and 'not trying harder'.*

The staff, care and facilities were great.

It was lovely, great care and a calm environment.

The place was amazing, it was so calm and the staff were so kind and good at their jobs.

Others spoke more about organisational aspects and their perceived issues with capacity in the units. One participant noted that she felt that the hospital overall booked too many women and saw a positive difference in how she was cared for when she was transferred to birth centre antenatal care:

Before our care was transferred to the birth centre, I often had the impression that the hospital had more expectant mothers registered than those they could comfortably look after.

The food provided as part of the physical care provided was also discussed as something that was better or worse than expected:

They offered breakfast but no gluten free option and had no idea about allergens.

Food was better than expected.

Care that is freely accessible was reported by one woman as one of the best aspects of the experience:

Free – NHS.

e) Consistent care and continuity where possible

This theme refers to the importance for women to receive care that from pregnancy, throughout labour, birth and the postpartum period is coherent and seamless. Factors that helped to achieve this were an individualised treatment and getting clear and consistent information to help with decision making.

Information giving that is clear and consistent was found to be something that could be improved to have a more positive experience:

Better communication.

Better explanation of issues and solutions.

Things being clearly explained to me.

To increase the feeling of consistency and continuity in the care provided, women noted that their individual feelings should be considered and that they would like the personnel to check in with them regularly and offer support to fulfil their individual needs. Some noted how insecure they felt due to not being given the right advice at the right time. Taking the time to speak to the women while providing clear information and referrals adapted to their personal needs could increase the quality of care received:

> *During labour, at times I felt I was not doing the right thing and I wasn't told what to do instead, I sometimes felt a bit undermined in my feelings as a first-time mum.*
>
> *Provide support for each patient. Allocating time to speak with patient once they are admitted rather than leaving them. Discuss how mum is doing and baby and offer support services.*
>
> *No consistency about the advice offered by midwives often contradicting one another.*

Some women referred directly to the existence of an industrialised model of care which was something that reduced their perceived maternity care quality. Women described care that is generic, especially when declining care that was offered in line with guidelines. Having to explain themselves multiple times and a lack of individualised approaches negatively influenced their experience:

> *Individualised care, not conveyor belt.*
>
> *If you have an uncomplicated pregnancy the care is less good but still ok. You will feel like you are on a conveyor belt and will have to really push for referrals or anything not the completely normal (e.g. referral to birth choices) and may have to explain yourself multiple times.*
>
> *Before this care was good but felt a little generic. When I refused assisted delivery options when planning my birth, it took explaining my reasoning 4 times to different staff to get referral to birth choices despite being promised the referral after every conversation. As it was medical need meant it was a caesarean section delivery which I was happy with.*

As mentioned above, quite a few respondents felt that care received was too standard(ised) and routine. A lot of women noted that continuity of healthcare provider or at least continuity of information would have been more reassuring and relaxing. Most of the women noted that they did not have continuity of a midwife or doctor. They talked about how they would have liked to build a trusting relationship with their healthcare provider that was caring and supportive of their birth choices:

> *I completely understand that a busy NHS hospital in London can't quite accommodate it and that all teams operate according to the same guidelines, but having the opportunity to have*

some continuity [of] communications would have probably made the last few weeks of pregnancy less stressful.

I met several midwives during my pregnancy journey, some of them were very caring and empathetic, while others were not. It would have been nice to have only one midwife with you throughout the journey, it means being supported by someone that gets to know you and with whom you can build a relationship based on trust.

I had a complete change of birth plan from vaginal delivery for elective caesarean section for a breech baby. Being low risk throughout pregnancy and not having had any interaction with a consultant, I felt there was a slight lack of continuity of care. I had three consultant appointments in the lead up to delivery and never saw the same person twice.

One of the participants spoke about how her decision making around her method of birth was influenced by the lack continuity and the uncertainty of who might look after her when she would be in labour/birthing her baby. She valued personnel that provided individualised care highly and was not sure if she would get someone that embodied that:

[…] unpredictability of out of hours medical or midwifery staffing means you could have anything from very junior midwives and registrars taking care of you to excellent patient oriented senior clinicians. Based on these factors I opted for MRCS […].

f) Family focused and culturally sensitive

Women found it crucial to always have a loved one with them when in the hospital. They clearly saw birth as a family event and especially wanted their partners but also other relatives to be included and involved, and for their needs and feelings to be met as much as possible. Women wanted their partners' physical (rest) and psychological needs (feeling included) to be met, and to be enabled to spend time together as a family. In the participant demographics section, it was noted that most women gave birth during the Coronavirus pandemic and so for them, restrictions around visiting were likely in place:

Husband allowed with me despite covid restrictions.

This was particular to the time of our birth, when there were still many Covid-19 related restrictions in place, but the healthcare providers allowed my partner to be there from the beginning of my induction drip rather than waiting until 4cm dilated which I know was the case in other trusts/hospitals. Having him present from the beginning of the drip was so pivotal to our experience!

Having my partner sleep during the night after the birth.

Being allowed to have my mum AND my partner.

Both in the three most positive, but also in the three things that could be improved about their experience, women expressed their need to feel surrounded by their chosen people, especially during labour:

> *During active labour was never left alone.*
>
> Birth centre wonderful place to birth and stay with partner.
>
> *Being allowed my husband throughout labour as labouring alone in a hospital is hard, and hardest most painful bit is contractions after induction!*
>
> *Let them have their birth partners throughout, not just at end of active labour in pushing stage. Pushing is not necessarily the most painful nor the most difficult bit!*

One woman commented on how she felt that there wasn't a family focus and that her individual needs were ignored:

> *Was told that my partner needs to wait in the car despite me explaining that I suffer from anxiety and need them with me. Never had a chance to see the same midwife or doctor twice throughout my pregnancy so didn't know anyone when I arrived.*

Another woman spoke about how care was not culturally sensitive at all and that they experienced racial profiling, and unconscious bias towards her partner who felt victimised as a result. This reduced their sense of quality of maternity care significantly:

> *There was an incident in hospital where the midwife racially profiled my partner. He apparently smelt of marijuana, instead of speaking to him they spoke to me, a white lady. All she wanted to say was that he can't hold our newborn if he's smoked it which he was quite aware of but this situation was made worse because three people went on separate occasions to check on our child because he was crying and my partner couldn't console him, two white ladies and a lady of Asian background, instead of speaking directly to my partner they spoke to me. My partner felt victimised and that they had unconsciously stereotyped him. I would never have let him hold our child or be anywhere near him if that was the case.*

5.4 Discussion

The analysis of the Babies Born Better survey results has given an insight in how women perceived care at the maternity units chosen for the organisational ethnography and what aspects of care were emphasised as most important. However, it needs to be considered that it was a small and non-representative sample of the unit investigated. The biggest gap existed in women of lower socio-economic status, which are known to have worse outcomes (MBRRACE-UK, 2023).

The findings highlight that the bio-psycho-social aspects of care, more specifically safety (covered by theme a, b, and d), personalisation, and relationship-based care (covered by themes a, b, c, d, e, f) were the most significant influencing factors in women's ratings of their experience and so perceived quality of maternity care.

Most of the findings were in line with results from previous research. More particularly, they align with the results of other research from the Babies Born Better project such as Raboteg-Šarić et al. (2017); Santos and Neves (2021); Skoko et al. (2018); van den Berg et al. (2022); Vedeler et al. (2023); Vedeler et al. (2021), and the qualitative systematic review of Downe et al. (2018) on what matters to women during childbirth (Downe et al., 2018; Raboteg-Šarić et al., 2017; Santos & Neves, 2021; Skoko et al., 2018; van den Berg et al., 2022; Vedeler et al., 2023; Vedeler et al., 2021). This systematic qualitative review found that women want to give birth to a healthy baby in an environment in which they feel secure, both emotionally as well as physically (Downe et al., 2018). The presence, caring attitude, and competence of healthcare providers is very important (Raboteg-Šarić et al., 2017; Santos & Neves, 2021; Skoko et al., 2018; van den Berg et al., 2022; Vedeler et al., 2023; Vedeler et al., 2021). Furthermore, women report that continuing companionship and support of chosen birth partners was crucial to have a good experience (Downe et al., 2018; Raboteg-Šarić et al., 2017; Skoko et al., 2018; Vedeler et al., 2023).

The importance of the environment/space in which women are cared for from a physical, psychological and social point of view and how this influences their experience significantly has been documented by other researchers (Kuipers et al., 2023; Setola et al., 2019). The results suggest that a family focus, treating the birthing woman and her partner as a unit, is pivotal for women. The chosen birthing partners should be welcomed, included, and made comfortable both in a physical and psychological way for the women to be satisfied with care (Eri et al., 2022; Ledenfors & Berterö, 2016; Steen et al., 2012; Vedeler et al., 2021). This concept is also referred to as companionship and has been clearly documented as something that is valued by women (Eri et al., 2022). Where partners feel welcomed and find their role, they are more comfortable and feel enabled to support their partners better (Ledenfors & Berterö, 2016; Steen et al., 2012). Looking after birthing partners means looking after or caring for the woman as she can focus and submit completely to her labour and birth without worrying about her partner's wellbeing (Eri et al., 2022; Vedeler et al., 2021).

The vast majority (around three-quarters) of women included in this study had their baby during the Coronavirus pandemic. This meant that for them, restrictions might have been in place, or they might have heard of other women who could not always have their partners or relatives with them. The uncertainty about companionship restrictions at the hospital during childbirth added a layer of anxiety to their already heightened worries, making them feel incredibly vulnerable. (Eri et al., 2022; Vazquez-Vazquez et al., 2021). Findings from the study suggest that having chosen support people always present, significantly enhanced the participants' experience.

Most participants reported the need to feel secure. Overall, women rely heavily on characteristics such as presence, support, and trust of personnel to feel safe and secure which has been documented in previous research (Werner-Bierwisch et al., 2018). Relationship-based care in which a healthcare provider that the woman trusts is present where needed is key to making women feel secure, thus an important aspect of high-quality care (Halldorsdottir & Karlsdottir, 1996; Karlström et al., 2015b; Melender & Lauri, 2001; Werner-Bierwisch et al., 2018).

Women talked about the importance of being offered continuity and consistency of care, especially as something that could be improved. For some, this meant consistent information and kind personnel that made them feel listened to. Women want their psycho-social and emotional needs met by getting holistic care, which can be facilitated by having care by a team with a similar philosophy (Boyle et al., 2016). Others talked about relationship-based care and so seeing the same midwife and/or doctor throughout pregnancy, a common finding in previous studies (Green et al., 2000; Perriman et al., 2018; Sandall et al., 2016). According to Kuipers et al. (2023), the relational dimension of care is lacking or coloured by a hierarchy and so where authority and control exist, women are more likely to evaluate their experience as negative or even traumatic (Kuipers et al., 2023). Some participants in this study reported a lack of choice, disrespect, and even coercive control. Similar accounts of disrespectful care were described in the BBB studies of Vedeler et al. (2021; 2023) emphasizing that 'respectful maternity care encompasses more than absence of disrespectful care or mistreatment during childbirth' (Bohren et al., 2015; Vedeler et al., 2023; Vedeler et al., 2021).

Women in this study mentioned the importance of not being left alone by the midwife during labour. Other research has documented that continuous support during labour and birth is beneficial for the neurobiological process (reduces pain, stress, and anxiety due to an increase in oxytocin) and possibly improves outcomes for women and babies. (Bohren et al., 2017; Olza et al., 2020; Vedeler et al., 2021)

The NHS maternity survey report specific to these two maternity units found that the units need to focus more on women's mental health by asking them if they need support and offering help where needed (NHS England, 2022). This is in line with some of the findings of this study. Furthermore, women want to be listened to, but recent investigations have shown continuous failure of maternity services in the UK (Kirkup, 2022; Ockenden, 2022).

Similar to other research, the physical environment was mentioned often as a very important aspect of care that can positively influence physiological processes and the transition to motherhood, including long term effects such as a good health, a better recovery and better overall experience (Kuipers et al., 2023; Olza et al., 2020).

Even during the Coronavirus pandemic, when women's rights and choices were restricted, most women reported having had quite a good or even very good experience. This is in line with the study

of van den Berg et al. (2022) in which women's experiences in the UK and the Netherlands were compared using data from the Babies Born better survey. Women were adversely affected by the restrictions during the pandemic, reporting a lack of choice and support. However, compared to women giving birth before the pandemic, women who gave birth during the pandemic were, on average, as likely to have experienced childbirth as a positive event. The authors described that even though certain things were seen as standard care before the pandemic, women seemed to value them more during the pandemic due to having lower expectations and a seemingly increased effort by healthcare providers (van den Berg et al., 2022).

5.5 Conclusion

The Babies Born Better survey was used to provide insight into what women who have experienced maternity care in the selected units in the last three years felt were the most important aspects of quality of maternity care. The main strengths and weaknesses of these units were discussed by the women by answering the open questions.

More than three-fourths of respondents rated their care as mostly quite a good or very good experience. The minority of women reported that some of it was bad or even that it was quite a bad or a very bad experience. However, even though it was the minority, it needs to be considered that this was one in four participants.

Women want a sense of emotional and physical security. This is achieved by making the women and their families feel safe, listened to, having a choice, trusting the healthcare provider, and being always asked for consent. Physical safety meant that they could choose the type of treatment they wanted (highly medicalised, as physiological as possible or something in between), and that no clinical harm was caused to the woman or her baby. Women did not talk about safety in terms of 'not dying'. The medical expertise and knowledge, presence, and caring attitude of staff was often seen as the best thing about the care received, though for some women, these attitudes and competencies of the healthcare providers were lacking. A few participants gave accounts of being treated in a disrespectful way, in which their choices were not respected, and consent was not secured. Where the baby was cared for well and in instances in which honesty, transparency, trust, and respect for choices prevailed, the care experience was reported to be good. Women see the physical environment and space where care takes place as a social space in which their chosen supporting people should be welcomed and always supported. An emphasis was often put on how the physical space influences the process of birth, recovery, and even long-term health. Getting consistent information, healthcare providers with the same philosophy of care that is in line with their own, and ideally continuity of carer are also key characteristics of high-quality care. Lastly, looking after the family means looking after the woman. When personnel welcome and support the

family or chosen birthing partners and cares in a culturally sensitive way, the woman's experience is rated very positively.

Conducting the analysis to find out what women find important was the second step in this study to find out how the different constituencies define and conceptualise maternity care quality. Women's views on what quality of maternity care means are the foundations on which maternity services should be built. This work has provided a background for the organisational ethnography, starting from the perspective of the main stakeholders involved.

In the next chapter, the organisational ethnography conducted to explore how the different constituencies define quality of maternity care, and subsequently, how quality is implemented, is presented.

CHAPTER 6: SETTING THE ETHNOGRAPHY SCENE

6.1. Introduction to the chapter

In the previous two chapters, phase one and two of the research project were outlined. Phase one described how quality of maternity care is conceptualised by the different constituencies in maternity care over time by conducting a meta-narrative review. The review found that clear consensus about the importance of quality of maternity care (QoMC) exists, but there is variation in definitions used. No overarching definition or framework was found.

Phase two was based on the qualitative data in the Babies Born Better survey. This revealed the main factors of importance from the point of view of women who had given birth in the three years prior to completing the survey. Women highlighted the following aspects of care as most important: having a sense of emotional and physical security and wellbeing, highly skilled and competent personnel with caring, compassionate, respectful, culturally sensitive and family focused attitudes, consistent care, continuity and a social and physical space of birth which is conducive to the desired care experience and both short- and long- term health.

In chapter three, I explained in-depth the theoretical framework and methods used for this organisational ethnography.

This chapter sets the scene for the organisational ethnography. First, my personal preconceived notion of quality is explained. Next, an overview of the method of recruitment, local setting, and methods for data analysis is provided. Lastly, the framework adopted for analysis is explained and a brief overview of the findings is given.

6.2. Reflexivity

At the start of the PhD, on the 22nd of January 2020, I did an interview with a senior researcher with expertise of the field of maternity care to uncover what my preconceived ideas were around going into the field of the organisation. I have kept a reflexive diary and made field notes throughout the PhD project, and during the monthly supervision meetings, I discussed my views with the supervisory team. See chapter three: methodology chapter, for a detailed account of my positionality at the start of the PhD.

Overall, when talking about how I would define a high performing unit, I said the following:

> *"So, to me, a high performing unit is a unit in which there is great multidisciplinary teamwork and communication. The team looks at pregnancy and birth as a healthy event and tries to keep women as much as possible healthy and well. Interventions only happen when necessary. Uh. And they [the healthcare providers] are great communicators with the women,*

they give the women balanced evidence-based information. And women have choices. Um, and their choices are respected, and their privacy is respected, and their integrity is respected, and even if things don't go the way that the woman first aimed for, the woman still feels she has got choices and knows what's happening next, and she is listened to and she is given time to make decisions. And her partner is involved or other family members or friends or whatever person she chooses to be with her during her labour. And I guess it's clean, it's fair [equitable], and they feel welcome. So, it's like a service where you can walk in and you feel at home, they make it as homely as possible. It's the environment especially I think what sometimes sets women up not to be able to have a physiological birth just due to how things look and what the atmosphere is. So, I think that it [the environment] is a very important thing."

See appendix P (Reflexivity continued) for a more detailed description of my preconceived notions of quality of maternity care.

6.3. Data collection

To date, a limited amount of evidence exists around how the 'real' phenomenon of quality in maternity care (at empirical levels) is constructed differently by the different stakeholders involved and how this influences organisational cultures and service provision. This research gap is the rationale for the overall study question: *"How is quality of maternity care conceptualised and implemented in the maternity organisation by the different constituencies involved?"*

Data collection was done using interviews, discussion groups, observations and a documentary analysis. Due to the ongoing pandemic at the time (Covid-19) traditional ethnographic approaches were combined with virtual/online methods for data-collection (Hart, 2017).

Field work for the four case studies was ethnographic in terms of its holistic and interpretative approach (McCourt et al., 2012; Neyland, 2016). This method enables an in-depth exploration of the chosen maternity units due to its focus on the organisational culture, social relations, social actors and ability to identify the nature of underlying relationships (Garsten & Nygvist, 2013; Ybema et al., 2009).

Sample and Recruitment

As mentioned in chapter three, the site selection was based on critical case purposive sampling to gain extensive and in-depth knowledge around the underlying culture of maternity services and how it affects the implementation of quality of maternity care (Battaglia, 2008; Etikan, 2016). Purposive sampling was also used to recruit participants, ensuring that the sample would reflect the diversity of stakeholders involved in the services (Ritchie et al., 2003).

I approached professional stakeholders working at the Trust by giving out or emailing the information leaflet (see appendix O). A verbal explanation of the study was offered to all potential

participants. Women and their birthing partners were approached in the Trust only if the midwife had a conversation with them beforehand and they were happy for me to approach them. I created a separate flyer containing my email address, so they could contact me if they were interested in participating. Potential participants were offered at least 24 hours to decide if they wanted to participate and there was always an opportunity to ask questions directly to me or via email, ensuring an informed decision could be made.

Table 12: Eligibility criteria

Participants are a range of people involved with maternity care in the chosen Trust:

- ✓ Managers and key stakeholders in the maternity unit
- ✓ Professionals working within and in relation to the selected maternity units (midwives, obstetricians, paediatricians, healthcare support workers, cleaners, admin staff, student midwives/doctors, etc.)
- ✓ Women who are pregnant or postnatal and their birth partners

Inclusion criteria	Exclusion criteria
✓ Any gender ✓ Adults from 18 years and over ✓ From any ethnicity ✓ From any socio-economic grouping ✓ Anyone attending the selected maternity units ✓ Speaking any language* *Under the condition of having a language line or translation services available at the Maternity Unit.	✓ Any person below 18 years old ✓ Any person who has declined to sign the consent form/ anyone who does not want to participate in the study

Local setting and population

An agreement was made with the participating maternity services of the NHS Trust that the organisation would be kept anonymous in this thesis and further publications. This is why I decided to keep the information about the local setting and population limited. The included NHS Trust covers several hospitals, serving a population of over one million every year and employs over 14,500 members of staff. The maternity services roughly serve 6000 women a year from local communities in several areas. The population served is very diverse. Like most maternity units in the UK, the services exist of labour wards, community services including a home birth team, alongside midwifery units, specialised obstetric and midwifery services, triage, foetal medicine, postnatal wards, and other associated services.

6.4. Data analysis

Focus-groups and interviews were transcribed using the Sonix transcription software. All qualitative data retrieved from the interviews, discussion groups and observational notes were uploaded in MAXQDA software to aid the data management and analysis.

The framework method, created by Ritchie and Spencer in the late 1980s and then adapted by Gale et al. (2013) was used (Bonello & Meehan, 2019; Gale et al., 2013; Spencer et al., 2003). Seven stages for analysis: transcription, familiarisation, coding, developing a working analytical framework, applying the analytical framework, charting the data into the framework matrix and interpreting the data were applied to guide the framework strategy in this study (Gale et al., 2013).

The analysis was reviewed and then discussed by the supervisory team and another PhD student (ML) to achieve triangulation.

A detailed explanation of what was done each of the seven steps, and subsequently, how the framework was build can be found in the results section (6.5. Results) below.

6.5 Results

Forty-eight participants (managers, frontline staff, women and their birthing partners) were recruited for the organisational ethnography. Twenty-four interviews and two discussion groups were conducted. One hundred eighty hours of observation took place, and twenty documents were collected (including but not limited to: guidelines, information leaflets, standard care pathways, the regional dashboard, etc.). Lastly, a case-study, including one follow-up interview and two first interviews were conducted to investigate a specific problem that was arising in the units. See table 13 for the size of the dataset below.

Table 13: Size of the dataset

Data collection method	Date / time period	Time	Size of the dataset or participant number
Interviews	28/07/2021 to 07/09/2022	19 hrs 55 mins total Average: 44.26 mins / interview	24 interviews 3 case-study interviews - 10 virtual - 17 face-to-face 30 participants (24 individual interviews, 3 interviews with couples)
Focus-groups	06/04/2022	1hr 16 mins	Virtual 6 participants

	08/06/2022	44 mins	Face-to-face 4 participants
Observations	09/06/2021 to 10/06/2022	180.5 hrs	14 separate word-documents, 2-7 pages long (A4)
Field notes	10/06/2021 to 07/09/2022	n/a	24 separate entries in OneNote
Documentary analysis	09/06/2021 to 01/06/2023	n/a	20 documents
Reflexive interview and diary	07/11/2019 to 01/06/2023	1 hr n/a	Reflexive interview 14 separate entries in OneNote

The following table, table 14, gives an overview of the self-reported demographics of the participants in the study.

Table 14: Demographic data of participants

Demographical information	Professional participants	Women and partners
Number of participants	42	6
How would you identify yourself in terms of gender? (female, male, any other)	39 females 3 males 0 other	3 females 3 males 0 other
How old are you? (range)	21-63	35-47
How would you describe your ethnic background?	White British White Danish White Irish White Italian White Polish White German White Spanish White Hungarian Any other white Asian British Asian (Iranian) Asian (Filipino) Black African/British Black British Caribbean Black British	White European/South American White European British (Iranian) British (Jamaican) Black British

How many years have you practiced? (range)	0-38	n/a
Would you describe yourself as clinically trained?	100% yes	n/a
Is this your first baby?	n/a	100% yes
How many weeks pregnant were you when your baby was born? (range)	n/a	40 – 42
Was your baby admitted to the neonatal unit at any point?	n/a	100% no
Stakeholder groups	Midwifery management (n=10) Obstetricians (n=3) Midwives (n=22) Maternity support workers (n=5) Members of the wider multidisciplinary team (n=2)	Postnatal women and their partners (n=6)

The seven-phase approach proposed by Gale et al. (2013)

1. Transcription: Sonix transcription software was used to do a rough transcription of the interviews and focus-groups. Next, I cleaned the transcripts by checking and correcting them against the original video or audio data which helped to get immersed in the data.

2. Familiarisation process: I re-read some of the interviews, observational data, collected documents and field notes and listened to a selection of the interviews again to gain an overall level of understanding of the data. Going back and forth between the data and aims and objectives of the study helped to keep a clear focus. At this stage, I started making some notes in MAXQDA.

3. Coding: After familiarizing with the documents and transcripts, I started reading and coding the transcripts line by line. The framework that emerged from the meta-narrative review was used in this phase as a rough guide for coding. I aimed at keeping a holistic view and added new codes or sub-codes to the existing framework where the data did not fit within the other codes (sub-codes in blue font colour in table 15 below). A coding trail was kept for transparency to how and why certain codes or sub-codes were added.

Table 15: Coding trail based on the results of the meta-narrative review

Theme	Codes	Sub-codes
Structure/infrastructure of the health system (external and internal influences)	External influences	Litigation (fear of litigation)
		Political support
		Financing/Cost
		Hospital support system
		Information system/referral systems/networks of care
		Access and availability
		Media
	Internal influences	Accountability and ownership
		Organisational capacity
		Guidelines, evidence-based practice and auditing
		Leadership, Management, policies and governance
		Human resources/Staffing 1. Staff needs/wellbeing 2. Multidisciplinary teamwork or working across boundaries 3. Skills, knowledge, behaviour expected of staff
		Environment and physical resources
Process (quality in action)	Provision of care	Technical quality
		Routine Care/coverage key practices
		Emergency obstetric care/complex medical care/managing complications
		Information systems
		Care pathways/seamless referrals/Networks
		Safety (care provided)
	Experience of care	Relationship with the healthcare provider
		Values (dignity, respect, etc.)
		Personalisation
		Rights based approach
		Emotional support
		Communication and information
		Safety (experienced)

4. Developing a new working analytical framework: Throughout the process, I discussed the analysis with the supervisory team. All interview and focus-group transcripts, the collected documents and the observational notes were coded into the theoretical framework using MAXQDA at this point. To be able to generate findings rich in nuance and able to explain the complex social environment of maternity services, staying flexible and adaptable was very important during the analysis of the data. A typical feature of the qualitative research that also applies to the framework method is that the process is not linear. Going backwards and

forwards into the data collection and analysis and development of theory, following potential logical arguments is a given (Gale et al., 2013).

Together with the supervisory team, I discussed how all the data could be used to generate novel empirical knowledge. It became apparent that I needed to find a way to visually show how disparate the constituencies defined aspects of maternity care quality. It also became clear that, how the different stakeholders defined quality, and what mattered to women, fitted into the six dimensions of quality of care of the Institute of Medicine (safe, effective, patient-centred, timely, efficient and equitable) (IOM, 2001). The framework therefore seemed a useful starting point for beginning to make sense of the ethnographic data.

Table 16: Background information about the framework used

In 2001, the Institute of Medicine (IOM) published the report: 'Crossing the quality chasm: A new health care system for the 21st century' in which they outlined six dimensions for improvement (IOM, 2001). In 1990, the IOM defined quality as: "*the degree to which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge (p. 2-3)" (Lohr, 1990).* In 2001, they added six key dimensions: equity, efficiency, timeliness, patient-centredness, effectiveness and safety. They proposed that each of these should be clearly defined and met by any quality healthcare system and that relevant outcome measures for each dimension should be based on what matters to patients. However, they also noted that, in achieving this, healthcare professionals should not be compromised in their ethical belief system (IOM, 2001). As mentioned in chapter four (the meta-narrative review chapter), the definition of quality of care by the Institute of Medicine and the six dimensions for improving quality of care were found repeatedly and in all categories of literature looking at how quality of maternity care has been defined over time. Starting from Donabedian's model of quality, which the six dimensions of the IOM were based upon (Donabedian, 1988). Well known quality frameworks for maternity care that stemmed from the framework of the IOM are for instance the framework for evaluation of quality of care in maternity services of Hulton et al. (2000), followed by the standards for improving quality maternal and newborn care in health facilities by WHO (2016) (Hulton et al., 2000; WHO, 2016).

5. Applying the new analytical framework: At this stage, the pre-existing codes and sub-codes form the results of the meta-narrative review in MAXQDA which most closely matched the six dimensions of quality of care from the IOM were now pulled out and coded into the new, six-dimensional analytical framework (see table 17). All codes from the previous framework fitted within one or even multiple dimensions of the IOM.

Table 17: Examples of how the codes evolved to the six dimensions of the IOM

Six dimensions of IOM	Corresponding *theme* and codes	Corresponding sub-codes
1. Safety	Process (quality in action) - Provision of care and experience of care Structure/infrastructure of the health system – Internal and External influences	Safety as experienced and safety of care provided Communication, information Emergency obstetric care/complex medical care Litigation (fear of litigation) Guidelines, evidence-based practice and auditing Accountability and ownership Leadership, management, policies and governance
2. Woman-centred	Process (quality in action) - Provision of care and experience of care	Personalisation/choice Relationship with the healthcare provider Rights-based approach Values (dignity, respect, etc.) Emotional support Communication, information Media
3. Timely	Process (quality in action) - Provision of care Structure/infrastructure of the health system - External influences	Routine care/coverage of key practices Care pathways/ seamless referrals/networks, Emergency obstetric care, Access and availability
4. Effective	Structure/infrastructure of the health system - Internal influences Process (quality in action) - Provision of care	Guidelines, evidence-based practice, and auditing Information systems Technical quality
5. Efficient	Structure/infrastructure of the health system - Internal influences and External influences	Organisational capacity Environment and physical resources Human resources/staffing (staff needs/wellbeing, multidisciplinary teamwork, skills, knowledge and behaviour expected of staff) Financing/cost Political support Hospital support system

		Information system/referral systems/networks of care
6. Equitable	Process (quality in action) - Experience of care	Equality, diversity, and social inclusion

6. Charting data into the framework matrix: Due to the large number of data coming out of qualitative research, six matrices, matching the six dimensions of the IOM, were created. This was done to bring confirming and disconfirming elements in the data to the surface, and compare and contrast between the different conceptualisations of quality of maternity care of the different disciplines involved. I charted the data into the matrices, finding a balance between reductions of the copious amounts of data but maintaining my interpretation of the meaning behind the accounts of the interviewees (by incorporating many quotes from participants). Rows were used to separate the accounts of the different disciplines, observational data, and documents. Columns contained all the information on how the disciplines defined the domain. This way, the definitions of quality of the different constituencies could be compared within and between groups. Furthermore, the observational data and the included documents added information around the organisational culture and how maternity care quality was implemented. Triangulation by key informants at this stage was achieved by the supervisory team and a fellow PhD student (ML) looking into the matrices and providing feedback.

7. Interpreting the data: Throughout the research and especially at every interview or focus-group, I made field notes of my raw impressions of the context, content, and interactions. These notes have been helpful throughout the data-analysis, enabling me to explore certain ideas more in depth and discussing these during the monthly supervision meetings. An in-depth discussion of the findings can be found in chapters 7 and 8.

6.6. Findings: Organisational culture

In this section, an overview of the observational data and the data of the documentary analysis is presented. This also includes some results of the Babies Born Better survey (chapter five). Table 18 aims at providing an insight into the organisational social constructs of reality. In other words, how the organisation represented itself internally and culturally in view of maternity care quality. The data is categorised per IOM dimension.

Table 18: Overview of the observational data and documents per dimension of the IOM

IOM dimension	Observational data and documentary analysis
Safety	The regional **maternity dashboard** was used as a tool to benchmark the quality of maternity care. The 'Safety' sub-category mainly focused on morbidity and mortality of the baby and SI's (Anonymous, 2024). To have a good **overview,** the obstetric and midwifery team was very often found in the staff office of the obstetric units, which had a big white board (in unit one) and a big TV screen (in unit two) showing which women were in what room on labour ward. The boards also provided detailed information about the women's medical history, obstetric history, and current pregnancy related complications. Other screens showed the foetal monitoring (CTG or continuous cardiotocography) of all women admitted. At the start of every shift, doctors would do a ward round and make a plan of care for all women (Observation 2 and 10, dates 25/05/2022 and 6/06/2022). The **guideline** called: **"Criteria for intrapartum care at home and in the midwifery-led unit"** was created to support doctors and midwives in their discussions with women about place of birth planning. It was created to help diagnosing women at risk, to advise and to facilitate choice (Anonymous, 2019). All emergency equipment was accompanied by a **checklist** of the necessary material that needed to be present and within expiry date (Anonymous, 2011) (Observation 12, Date: 8/06/2022). **Intranet** (a private network sharing organisational information) was available for all staff and included information, guidance, and an online form for incident reporting (Anonymous, 2021d). Furthermore, it included **Trust-wide evidence-based guidelines** (e.g. Clinical Risk Assessment in Labour guideline) on different topics in maternity care which could easily be downloaded by staff (Anonymous, 2020a). The yellow **informed consent form** for emergency caesarean sections (Anonymous, 2021c) was mentioned during one of the interviews with a woman and her partner (Date: 20/12/2021, Interview 7, Couple 1).

Person- or woman-centred	The **maternity dashboard,** used in both units to measure and compare outcomes across the region consisted of a 'choice & personalisation' sub-category. The items measured are: number of women offered a personal care plan, number of women who have a personal care plan, who are offered choice of all three birth settings, and number of women giving birth in midwifery settings (home births + midwifery led birth units). 'Continuity' was another sub-category and measures the number of women booked into continuity of carer pathway (Anonymous, 2024). **Notice boards** in the clinical areas reminded staff of the recommendations made by the Ockenden report such as 'listening to women and families' (Anonymous, 2022e; Ockenden, 2022). **The NHS Trust values** were mentioned as an important aid to look after staffs' wellbeing and facilitate teamwork. These were seen as the necessary prerequisites to provide personalised care (Anonymous, 2022d). **The 'Birth Choices guideline'** in place offered guidance to frontline staff caring for women requesting care outside of the existing clinical guidelines (Anonymous, 2021a). **The guideline called: "Criteria for intrapartum care at home and in the midwifery-led unit"** was created to support doctors and midwives in their discussions with women and their families about place of birth planning. It is there to help facilitate choice (Anonymous, 2019). **Information leaflets such as the 'Induction of labour' leaflet** (Anonymous, 2020c), containing information about the risks and benefits, and process of induction of labour was observed to being used on the midwifery units to provide informed choice to women. The written information was accompanied by clear verbal explanations and the opportunity to ask questions (observation 8, Date 30/05/2022). In the triage area, leaflets were not given and information about induction of labour was imbalanced and insufficient to make an informed decision (Observation 6, Dates 25/05/2022). **A staff booklet called**: 'Looking after our people, Staff wellbeing support' 2023/2024 was found on the intranet (Anonymous, 2021/22a).

	Information boards on the wards contained information on staff wellbeing (Anonymous, 2022e) (Observation 7, Date 26/05/2022). **The regional maternity dashboard** used in both units to measure and compare outcomes across the region consisted of short-term outcome measures that don't focus on long-term health, nor did it provide any information on collaborations with other services (Anonymous, 2022g). Women were **observed** to be referred to birth options clinics where there was a request for care outside of guidelines (Observation 10, Date: 6/06/2022). The **handheld maternity notes** for all women contained a **birth plan. The care pathway** notes that at the 36 weeks pregnancy follow-up appointment the birth plan will be discussed (Anonymous, 2021b). **Observation during a midwifery mandatory study day:** In a session around women's feedback a woman's negative lived experience was read out-loud. After that, the atmosphere in the room changed as staff did not seem to agree with this feedback. Responses were defensive and the conversation ensued was no longer constructive (Observation Midwifery study day 1, Date: 10/05/2022)
Timely	Twice a day, the senior management team would organise **huddles** (virtual meetings) to keep an overview of staffing levels, available beds, and implement action plans to resolve urgent issues (observation 1, date 17/05/2022). A **presentation given by the senior management team** on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that, at that point, the main challenges in maternity care were problems with workforce including staff sickness, a high staff turnover, and a midwifery vacancy rate of 15% (49 FTE). Additionally, there was an increased acuity and rising induction and caesarean section rates. As a result, the birth centres were consolidated, homebirth services needed sector support, there were delays in inductions of labour, and challenges with patient flow (Anonymous, 2022f). **Observation:** good teamwork ensured that when maternity support workers were busy, midwives would take on tasks such as making beds to improve timely care for women (Observation 10, Date: 6/06/2022).

	A presentation given by the senior management team on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that estates are very old in one of the units, which posed challenges to patient flow (Anonymous, 2022f). On **observation,** one of the units had very small labour ward rooms, which made it difficult in emergency situations for the multidisciplinary team to get in the room and for fast transfer to theatres where needed due to narrow corridors (Observation 5, date 24/05/2024). The **handheld maternity notes** for all women contained **the standard care pathway** that was followed for all women. Furthermore, it contained an **information leaflet** that explained at what stage in pregnancy, what screening tests were offered (Anonymous, 2022c). I **observed** a situation in which a woman got very distressed from waiting in the waiting area in triage for two hours while feeling ignored and having to deal with unkind behaviours from frontline staff (Observation 3. Date: 21/05/2022) In March 2022, **the final Ockenden report** was published, in which the immediate and essential action was to abandon the continuity of carer model until safe staffing was present (Ockenden, 2022).
Effective	**The regional dashboard** allowed for comparison of outcome indicators between neighbouring hospitals so problems could be identified and improvement plans made (Anonymous, 2022g). In the triage areas, women were **not always given leaflets or balanced information** to make informed decisions about their own care (observation 6, Dates 25/05/2022). The **NHS Trust values** were mentioned as an important aid to provide effective care (Anonymous, 2022d). **Information leaflets** such as the **'Induction of labour' leaflet, 'pre-labour rupture of membranes leaflet', 'GBS screening in pregnancy' leaflet,** etc. were available to staff in some different clinical areas as a means to provide balanced and consistent information (Anonymous, 2020c, 2020d, 2022b).

	The Intranet (a private network sharing organisational information) was available for all staff and included evidence-based guidelines which were updated on a regular basis (Anonymous, 2021d). **Emergency equipment** such as the post-partum haemorrhage trollies contained charts with the order, dose, and route of drugs to give (Observation 12, Date: 8/06/2022). ***Data Babies Born Better Survey (see chapter five):*** *"They just try scare you into submission instead of explaining the situation and looking for solutions as a team! It's full of short-tempered doctors who want to order you about rather than guide you to a good decision!"*
Efficient	**A presentation given by the senior management team** on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that, at that point, the main challenges in maternity care were problems with workforce including staff sickness, a high staff turnover, and a midwifery vacancy rate of 15% (49 FTE) (Anonymous, 2022f) **The clinical guideline with the title: 'Handover of care'** provided instructions on how effective communication between healthcare providers can be facilitated using SBAR (Situation, Background, Assessment, and Recommendation) *(Anonymous, 2020b). This method was commonly used by midwives and obstetricians on antenatal, labour, and postnatal ward (Observation 2, Date: 18/05/2022).* **The Intranet** (a private network sharing organisational information) was available for all staff and included evidence-based guidelines which were updated on a regular basis (Anonymous, 2021d). **Yearly multidisciplinary training** on emergency situations to improve communication and teamwork (Observation 4, Date: 23/05/2022). **The handheld maternity notes** for all women contained an information leaflet that explained at what stage in pregnancy, what screening tests were offered (Anonymous, 2022c).

	Availability of **Language line and face-to-face translation services** (Observation 13, Date: 9/06/2022).
Equity	Different **initiatives** have been put in place by the management team to reduce inequities such as regular **'Cultural Safety & Wellbeing Meetings'** (Anonymous, 2022a). Availability of **Language line** and **face-to-face translation services** (Observation 13, Date: 9/06/2022). **The Female Genital Mutilation Specialist midwife** works together with service-users from different ethnic and cultural backgrounds who speak the woman's language and can connect with the women coming to the clinics to support them (Observation 6, Date 25/05/2022). **The 'Workforce equality, diversity and inclusion annual report 2021/22'** provided information around how the Trust aims to ensure equity for staff and to create a culture in which everyone takes shared responsibility in improving equality, diversity, and inclusion (Anonymous, 2021/22b)**.** **The Intranet (**a private network sharing organisational information) (Anonymous, 2021d) was available for all staff and provided links to information leaflets about screening tests in different languages (for instance, gov.uk 'Screening tests for you and your baby' available in 12 different languages) (NHS England, 2019c).

See the methodology chapter (chapter three) and this chapter above for in-depth information about my perspective (Insider, outsider, and in-between), reflexivity & positionality, and the reasoning behind the methods for data collection used.

As mentioned in chapter three, my positionality was continuously negotiated depending on the participants interviewed or observed. Some of the wards investigated were familiar to me, others were completely new environments. I always considered that my presence and being a member of staff in one of the maternity units might have an influence on the behaviours posed or accounts shared by participants. To mitigate the risk of bias, it was important to look and feel like a visitor when performing the ethnography by wearing my own clothes (instead of scrubs or a uniform like most other staff on the ward). I was very open about my positionality, conflict of interest, and the information leaflets for participants (see appendices C and D) explained the processes in place if malpractice or distress in participants occurred. Furthermore, the observational guide by Spradley

(2016) (Appendix A) ensured a fresh eye approach as it forced me look at the environment with a new lens. My reflexive notes and discussions with the supervisory team helped me to reflect on my impressions and observations during the ethnography and to reduce personal bias in what I saw and recorded as being important.

The documents and observations gave an insight in the existing organisational culture around quality in maternity care. They reflected the organisational priorities on quality, the implementation strategies of the management team, and how frontline staff enacted the cultural vision on high quality maternity care. Some of the documents gave an idea of the external influences of NHS England, the government, and recommendations of independent enquiries on the quality of maternity care agenda in the maternity services investigated.

The documentary analysis, observational data, and some data of the results of the analysis of the Babies Born Better Survey indicated that quality in the units was mainly focused on clinical safety (e.g., the safety indicators of the clinical dashboard, evidence-based guidelines, checklist for emergency equipment, etc.). Even though documents and observations demonstrated that the organisation valued personalisation to a certain extent, in practice, this often seemed more a tick box exercise that needed to be completed (e.g., the completion of birth plans, personalised care indicators in the maternity dashboard, evidence-based guidelines in place, etc.).

The combination of the interview, focus-group, documentary analysis, and observational data provided a unique insight of how quality of maternity care was defined, but also implemented by the different constituencies involved in maternity care (see chapters seven & eight). The different methods of data collection and framework analysis allowed for a deep dive into the organisational culture and to visualise disconfirming data (e.g., interview data versus observational data).

In the table below, a definition of the six dimensions of the IOM is given, followed by an overview of how the stakeholders involved in the study defined the same dimensions of quality.

Table 19: Summary findings of all participant groups per IOM dimension

IOM dimension	**Summary findings of all participant groups per IOM dimension**
Safety	The Institute of Medicine defines safety as: *"Avoiding injuries to patients from the care that is intended to help them"*. They note that this also means no harm should come to anyone working in the healthcare setting (IOM, 2001). The word 'safety' was used in the dialogue around quality of maternity care in most interviews.
	The study uncovered various perspectives on maternity care safety. While all groups prioritised preventing physical harm, midwives emphasised a broader

	definition that included respect for women's autonomy and the importance of their psychological wellbeing. Obstetricians attributed safety to timely intervention and good infrastructure, while maternity support workers highlighted the importance of the readiness and availability of emergency equipment and well-rested staff. A key challenge was balancing immediate needs with long-term quality, with strong governance offering benefits but potentially hindering personalised care.
Person- or woman-centred	Person (for this study, 'woman') -centred is defined by the IOM as *"providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions"* (IOM, 2001). All participants involved in the ethnography talked about this topic.
	Despite agreeing on the importance of personalised care, each stakeholder group offered slightly different perspectives. Midwives saw it as holistic care with clear communication and continuity, aligning with women's desire for respectful care tailored to their needs. Support workers linked it to kindness, listening, and good experiences. Obstetricians echoed the need for kindness and compassion but stressed the need for staff wellbeing to avoid burnout. They also valued continuity, respecting bodily autonomy, and mental health collaboration. The wider team emphasised understanding individual situations, respecting choices, and focusing on long-term health. Midwifery managers saw personalised care as building trust, empowering women, and respecting choices, alongside individualised care and continuity. Overall, everyone recognised its importance but acknowledged that challenges remain to achieve consistent implementation.
Timely	Information around timely care was not always obvious in the interviews. The IOM has defined timely as part of QoC as *"reducing waits and sometimes harmful delays for both who receive and those who give care"* (IOM, 2001).
	Maternity staff across stakeholder groups (support workers, midwives, doctors) all agreed timely care means for women to receive care without delays. This requires sufficient resources (beds, staff), smooth care pathways, and good communication. They highlighted the importance of early and continuous care for timely interventions. Uneven resource distribution and overmedicalisation were seen as barriers to timely care, especially for women experiencing a low-risk pregnancy. Women and partners emphasised the need for timely care that addresses their individual needs, with concerns raised about long waiting times and lack of timely access to named healthcare providers. Effective care pathways,

	strong communication, and continuity of care were seen as crucial for timely and positive experiences.
Effective	The IOM defines effective care as "*Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)"* (IOM, 2001).
	The maternity support stakeholder group did not discuss effective care. Management defined it as evidence-based, woman-centred care aligned with women's choices, delivered by skilled staff. Their focus was on efficiency and measurable outcomes. Both midwives and women prioritised informed consent, individual choice, and a balance between intervention and observation. They saw overmedicalisation as something negative and preferred interventions only when necessary. They valued clear guidelines and up-to-date information but emphasised that standardized care isn't always the most efficient. There was a tension between respecting women's autonomy and doctors prioritising safety using their preferred methods of intervention.
Efficient	*"Maximizing the benefit of available resources and avoiding waste, including waste of equipment, supplies, ideas and energy"* is how efficient care is defined by the IOM (IOM, 2001).
	Across all professions, staff wellbeing and adequate resources were identified as essential for efficient service delivery. Midwives emphasised the need for investment in staffing, while maternity support workers highlighted the importance of teamwork and a supportive environment. Managers acknowledged the complex link between staff wellbeing, efficient care, and the different models of care. Obstetricians viewed efficiency as a holistic approach encompassing staff wellbeing, communication, resource management, infrastructure, and collaboration. Notably, the wider team showcased resourcefulness even with limitations. For midwives, efficiency meant providing evidence-based care centred on women's needs and informed consent. From the perspective of women and their partners, it meant timely care, attentive and kind staff, rapid response when needed, and good teamwork. Women also identified inefficient use of resources.

Equity	The Institute of Medicine defines equity as part of QoC as: *"providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status"* (IOM, 2001). Overall, not many stakeholders talked about equitable care as part of the interview around what maternity care quality means to them.
	Equity was not explicitly discussed by the obstetricians involved in the study. There was a shared understanding of equity in maternity care as ensuring individual needs are met for both staff and women, while addressing existing disparities. Communication, cultural competency, training, and resources were seen as key factors. Midwifery managers felt responsible for reducing inequalities and midwives emphasised individualised care and choice for all. Language barriers were a concern for achieving equitable care. Maternity support workers desired fair treatment and feeling valued. For women and their partners, equitable care meant having providers that are knowledgeable about the increased risk for women from minority backgrounds. They desired guidelines and interventions to address health inequities, along with antenatal education and knowledge of their rights.

Chapter seven and eight will provide a more in-depth exploration of the analysis of the observational data and data of the documentary analysis (relating to how quality was implemented) together with the data derived from the focus-groups and interviews (how quality was defined). Combining these highlighted which aspects of quality as defined are implemented in practice. In chapter seven, a detailed overview of the findings of 'safety', 'woman-centred care', and 'equity' is given.

CHAPTER 7: SAFETY, PERSONALISATION, AND EQUITY

7.1. Introduction to the chapter

The previous chapter has set the scene for the organisational ethnography and provided a summary of the results of the observations, documentary analysis, interviews, and focus-groups.

This chapter describes the results of the organisational ethnography, conducted to investigate how definitions for quality in maternity care were embedded in maternity services. An in-depth overview of the findings of the interviews, focus-groups, observational data, and from the documentary analysis on the topics of 'safety', 'woman-centred care', and 'equity' are presented. Quotes of the interviews and focus-groups, excerpts of observational notes and documents are included to enrich the analysis made and clarify the sense-making. At the end of this chapter, a short discussion and conclusion on the data presented are provided.

7.2. Safety

The primary focus for both the midwifery management and obstetric team was to prevent physical harm (morbidity and mortality). Obstetricians added that safety exists in a place where, when things go wrong, this is only due to natural causes and not due to a lack of care. Labour and delivery were seen as the most critical time in the woman's journey through maternity care and to safely deliver babies, the process of labour and birth needs to be controlled. The wider multidisciplinary team also defined safety as achieving good physical outcomes and noted the importance of prevention of clinical harm.

Members of the midwifery management team said the following:

> *"Well, I think safety means having the lowest possible perinatal maternal mortality and morbidity, you know, so women are coming in, they're not getting infections, they're not getting DVTs [deep venous thromboembolism's]. They're going out with a live baby that's born at term. Yeah. You know, that's the, those are the sort of... and they're surviving. That's the absolute fundamentals. But also, they have, you know, that birth is not affected their mental health in a negative way or the physical health as much".* Midwifery Manager 5 - SQ-MAN-RM8-M-19

> *"It's very kind of managed and it's very safe to have your baby here. We don't have a lot of SI's [serious incidents]. Uhm, you know, you could count them on one hand, really in the last five years. Uhm, so it's a safe place to have your baby."* Midwifery Manager 4 – S-LIN-RM8-F-18

> *"It means no serious shit really happens, basically, like you know, nobody dies, babies don't go to neonatal unit, women don't lose their uteruses and things like that."* Midwifery manager 9 - SQ-MAN-RM8-F-43

A consultant obstetricians said:

> *"I'm not blaming anybody, but I think it is just fighting fire at the moment and trying to get through the day and trying to get through that day as safely as you can. Absolutely. Getting those women safely delivered." Consultant obstetrician 2 - SQ-ROT-CO-F-32*

This was echoed in the observational data. The importance of having a good overview of the women on the ward provided a sense of control and safety to staff as they felt it enabled timely intervention:

> To have a good **overview,** the obstetric and midwifery team was very often found in the staff office of the obstetric units, which had a big white board (in unit one) and a big TV screen (in unit two) showing which women, were in what room on labour ward. The boards also provided detailed information about the women's medical history, obstetric history, and current pregnancy related complications. Other screens showed the foetal monitoring (CTG or continuous cardiotocography) of all women admitted. At the start of every shift, doctors would do a ward round and make a plan of care for all women (Observation 2 and 10, dates 25/05/2022 and 6/06/2022).

One of the main challenges to achieve safety according to midwifery management was the balance between immediate safety needs versus long-term quality. Having strong governance (guidelines, audits, checklists) in place was viewed as increasing safety (meaning no physical harm), but acknowledgements were made that in turn, this might reduce individualised care.

One midwife noted how she is expected to do quality improvement projects, but that for instance, the current lack of staff, causes immediate safety concerns for women and their babies, which leads her to focus on governance and short-term solutions only:

> *"Half of my day is spent doing the operational things, making sure things are safe on the ground, which makes it difficult to look forward to what could be. I'm very much of the mind-set that what we've always done isn't always like, just because it's the way we've always done it isn't the way it always should be. So, I do want staff to think innovatively."* Midwifery Manager 8 - Q-MAN-RM8-F-28

However, there were exceptions, for example, one of the midwifery managers talked about how she does not feel that a rigid governance structure in place increases safety:

> *"And I don't actually think it [all the checklists] makes anything safer as I think it sort of disconnects you from the human side of it".* Midwifery manager 9 - SQ-MAN-RM8-F-43

One of the midwives highlighted that some national recommendations that are implemented, in this case the 'Saving Babies Lives' care bundle (NHS England, 2019b), has not made the unit any safer, thus has not reduced the stillbirth rate in the unit:

> *"So, we [the maternity services in this NHS Trust] have always been very medicalised, but it has... 'Saving Babies Lives', the whole agenda has moved, you know, reducing our stillbirth rate. We haven't reduced our stillbirth. It hasn't changed."* Band 7 Midwife 2 - SQ-RI-RM7-F-9

The wider multidisciplinary team also saw the benefit in having good governance, including standardised protocols and a culture that strives for continuous improvement as a facilitator of safe care. Obstetricians on the other hand saw safety as ensuring timely intervention by having a good labour ward overview and timely referrals. One of the obstetricians noted that safety exists where complications only arise due to natural causes, not due to a lack of care.

One of the participants in the wider multidisciplinary team category noted:

> *"They, they do some amazing serious incident reports and really like drill down and find out what's happened. They take you know, they take their safety and improvement very, very seriously"* Women's Specialist Pharmacist - Q-ROT-PHA-F-29

For the maternity support workers, safety evolved around having the essential equipment, checked and ready for emergencies and adequate and well rested staff. The latter was echoed by professional stakeholders in the other categories. Other members of the multidisciplinary team also identified having the necessary emergency equipment to enable faster and safer care.

One of the maternity support workers said:

> *"If it's [the resuscitaire] not checked and there is missing stuff and you know, yeah, yeah, you have to do that. And it's something really simple. If it is a category one section (emergency caesarean section) you don't want to go through the draws."* Maternity support worker 2 – Q-ROT-MSW-F-33 – Focus-group

A member of the wider multidisciplinary team noted that:

> *"A tray like a box full of major, major haemorrhage drugs ready to go, checked every day in a Tupperware box, and right above written exactly how to draw it up. Really small things that can actually save like you know, a few minutes or quite a bit of time"* Anaesthetic specialist registrar (SpR) 1 - S-LW-RA-M-27

The observational data (see table 18) indicated that the wider organisation also valued having the emergency equipment checked and ready:

> The equipment was always accompanied by a checklist of the necessary material that needed to be present and within expiry date (Observation 12, Date: 8/06/2022).

Good multidisciplinary teamwork and having a solid infrastructure, kind staff ensuring emotional safety for the women were mentioned by the obstetric team as contributing factors. Although the rhetoric among the managers observed and interviewed was that it was important to keep staff happy and safe, they acknowledged that some of their actual decisions, made in the name of 'safety' (not-harm) for the women, were a cause of staff unhappiness:

> *"When I first started the role, I found it really horrible. But now I kind of think we just have to go where the work is. And yes, it's disruptive. And yes, no one wants to do it and no one wants to go to another site [site two]. And there's nothing worse than going to your shift and then thinking, where am I going to end up today."* Midwifery Manager 1 - SQ-BC-RM8-F-5

> *"I need to look at the safety of everyone in the hospital, if there is a woman without a midwife, there is a woman without a midwife."* Midwifery Manager 1- SQ-BC-RM8-F-5

Midwives included in the study advocated for a more holistic and broader definition of safety. They criticized the system for being overly focused on litigation and medical interventions, hindering personalised care, trust in women's decisions and furthermore negatively influencing staff morale:

> *"The medical model dominates and the value is attached to that."* Band 6 Midwife 3– S-BT-RM6-F-14 – Focus-group

> "I mean, there's a big safety agenda, but I don't necessarily think that this is making anybody any safer." *Band 7* Midwife - SQ-RI-RM7-F-9

> "Because our obstetric teams are practising almost totally defensively now. They're, the woman isn't their centre, it's defending, its litigation is their centre, their focus not the woman." Band 6 Midwife 3 – S-BT-RM6-F-14 – Focus-group

> *"Because there's no members of the public who will put themselves in obvious danger unless they feel that the risk that they take is worth it in comparison to what they're being offered or being told to do. And because for our life, we always have to make decisions around which risk we're willing to take. And that is exactly what's happening. So if you're being told you have to do something, they will weigh that up thinking, actually, I'm going to do this because I feel that's less harmful to me emotionally and psychologically. And the midwives somehow the advocacy, I think, has been lost."* Band 8 Midwife 1- SQ-MAN-RM8-F-47

One of the senior midwives agreed that there is the need for a culture in which women, babies, their families, and staff are feeling and being safe, emphasising the need for both physical as well as psychological safety:

> *"So, there are two levels of safety, there is physical safety. So that means that you're cared for by a skilled clinician who is trained and monitored, registered and observed to be able to be what we call the skilled clinician. And that's kept up to date with mandatory training and*

practice. And then there's the psychological safety, which is the other aspects where women feel safe in the area they come into that they are in control of the area where they give birth and they don't feel bullied, undermined or controlled during the experience." Band 8 Midwife 1 - SQ-MAN-RM8-F-47

"But where I find that I feel is lacking in the unit is the psychological safety of trusting that the clinicians are there to facilitate rather than control." Band 8 Midwife 1 - SQ-MAN-RM8-F-47

This was in line with women and their partners point of view. Safety extends beyond physical wellbeing to feeling informed, respected, and in control. Clear communication and personalised care were crucial.

One of the women was asked if she felt safe and she answered the following:

"I'd say me personally I did (feel safe). And a lot of it was the reassurance that's given. And the way that, the way that things were delivered or how we were spoken to about things, kind of things being explained and kind of not felt that you were just another number, that you're actually a person going through this life changing experience." Couple 3 – Postnatal woman - Q-PN-SU-F-45

The midwives and women's point of view and the accompanying quotes (see above) illustrate that for some participants, safety is strongly connected to personalisation. Despite this rhetoric, though, observational data indicated that the organisational culture overwhelmed the intention for personalisation in actual practice:

The regional **dashboard** was used as a tool to benchmark the quality of maternity care. The 'Safety' sub-category was mainly focused on morbidity and mortality of the baby and SI's (Anonymous, 2022g).

Intranet (a private network sharing organisational information) was available for all staff and included information, guidance, and an online form for incident reporting. Furthermore, it included Trust-wide protocols and guidelines on different topics in maternity care which could easily be downloaded by staff (Anonymous, 2021d).

Though from an organisational culture point of view, efforts were made to have conversations with women, aiming at providing individualised care and informed consent:

The **guideline** called: **"Criteria for intrapartum care at home and in the midwifery-led unit"** was created to support doctors and midwives in their discussions with women about place of birth planning. It was created to help diagnosing women at risk, to advise and to facilitate choice (Anonymous, 2019).

The yellow **informed consent form** for emergency caesarean sections (Anonymous, 2021c) was mentioned during one of the interviews with a woman and her partner as

something that could not facilitate actual informed consent in an emergency. The woman noted that she had never seen or read this form before and felt unable to read and understand it at a time in which a quick decision needed to be made as her baby was in distress (date: 20/12/2021, Interview 7, couple 1).

"it was like, okay, I have to sign something. They told me in two sentences what it was about. I can't remember what it was about. Of course, I wasn't going to read this A4 page. You know, I guess it was a consent that if anything happened to me, I wasn't going to sell the house. Couple 1 – Postnatal woman - S-PN-SU-F-25

Healthcare providers who had attention for detail, who were honest when they did not have an answer to a question, who adapted well to the atmosphere in the room were important. Meeting familiar faces with whom they had built rapport, having a lot of people around to help and assist where needed, quick and professional multidisciplinary teamwork in emergency situations, and a debrief from a consultant after the emergency made the couples feel they were in good hands:

"I was actually ok with it [the emergency caesarean section] because I knew we were in the right place." Couple 1 – Postnatal woman - S-PN-SU-F-25

Two different women spoke about situations in which they did not feel physically and emotionally safe. One woman recollected an antenatal appointment with an unknown midwife in which she was told her baby was big. She felt something was wrong with her baby, but no follow-up appointment was made and she did not know who to go to with her worries:

"The midwife kept on saying, oh, he's big, he's big. I am not going to lie to you." Couple 3 – Postnatal woman - Q-PN-SU-F-45

Another woman spoke about having to remind healthcare providers of their reason for being in the hospital. She recalled not feeling at ease when small things in their care were missed and when it felt really busy on the ward:

"I did think to myself, at some point I will become high risk, so is someone going to do something about it? Couple 2 – Postnatal woman - S-PN-SU-F-30

"Now I've always got that kind of thing in my head. Oh, if they're not doing something, it's probably because it's just missed or he's busy and it doesn't make me feel completely reassured". Couple 2 – Postnatal woman - S-PN-SU-F-30

For the woman from BAME background, equity was part of safe and personalised care. During her interview, she explained that she sought out a service in which she envisaged feeling safe and getting individualised care. She listened to stories of her friends to avoid places in which she might have to deal with prejudices. The woman explained how she felt the need to skill herself and her

partner up so they could have their voice heard and wishes always granted during their pregnancy, birth, and in the postnatal period:

> *"I think you kind of get geared up in your head that not everyone has your best interests at heart and maybe they are just doing the job or whatever it is."* Couple 3 - Postnatal woman and her partner - Q-PN-SU-F-45 and Q-PN-SU-M-46

> *"Making sure you have your voice very clear and making sure that he [my partner] could advocate for me."* Postnatal woman 3 - Q-PN-SU-F-45

7.3. Personalised or woman-centred care

While all participant groups involved in maternity care (midwives, midwifery management, obstetricians, maternity support workers, and women themselves) agreed on the need for personalised care, there were differences in emphasis and challenges faced in achieving it consistently. All participant groups agreed that kindness and compassion, women's choice, continuity of care, and staff wellbeing are essential ingredients to provide woman-centred care (see the quotes below).

This rhetoric was demonstrated in some of the units' documents:

> The regional dashboard used in both units to measure and compare outcomes across the region consisted of a 'choice & personalisation' sub-category. The items measured were number of women- offered a personal care plan, who had a personal care plan, was offered choice of all three birth settings, gave birth in midwifery settings (home births + midwifery led birth units). 'Continuity' was another sub-category and measured the number of women booked onto continuity of carer pathway (Anonymous, 2022g).

Overall, midwives believed that personalised care is essential for high-quality maternity services:

> *"We can't simply decide that something is the same for everybody".* Band 6 Midwife 2 – SQ-HB-RM6-F-13 – Focus-group

> *"Every woman should have a [named] midwife, that's number one".* Band 8 Midwife 1 - SQ-MAN-RM8-F-47

Observational data on care provision supported the above statements:

> Information leaflets such as the 'Induction of labour' leaflet, containing information about the risks and benefits, and process of induction of labour where often observed to be used on the midwifery units to provide informed choice to women (Anonymous, 2020c). The written information was accompanied by clear verbal explanations and the opportunity to ask questions (observation 8, Date 30/05/2022).

Though disconfirming data was also found in other observational data:

> *In the triage area, leaflets were not given and information about induction of labour was imbalanced and insufficient to make an informed decision (Observation 6, Dates 25/05/2022).*

Having a birth options clinic and midwife-led services was seen as helpful to give more individualised care:

> *"I think that what we've described, the birth centre, the home birth team, case-loading, these are areas or models where the woman is at the centre and, and they tend to be models of care where the woman feels heard and also the woman saying, well, I don't want that or I'm not sure about that isn't considered deviant [laughter]."* Band 6 Midwife 3– S-BT-RM6-F-14 – Focus-group

> *"Even women who do not fall into the category of the low-risk pathway, they still have the choice of, you know, normalizing their pathway, their care as much as they want, even if they might go against our recommendations and then we support them with it."* Band 7 Midwife 1- SQ-EDU-RM7-F-8

Some of the observational data and documents support the statements above:

> *The 'Birth Choices guideline' in place offered guidance to frontline staff to care for women requesting outside of the existing clinical guidelines (Anonymous, 2021a).*

> Women were observed to be referred to birth options *clinics where there was a request for care outside of guidelines (Observation 10, Date: 6/06/2022).*

> *The handheld maternity notes for all women contained a birth plan. The care pathway notes that at the 36 weeks pregnancy follow-up appointment the birth plan will be discussed (Anonymous, 2021b).*

Barriers for implementation discussed were limited resources, weak midwifery leadership, a lack of supportive culture, and lack of midwife empowerment:

> *"We were, two days ago, we were down 16 midwives across sites. Right now, the biggest pressure is safety. And I know exactly what you are going to say... where is personalisation? But right now, when you are down 16 midwives, it is really challenging." Band 8 Midwife 2 - SQ-M-RM8-F-6*

> *"It's not really on the menu. Why are you not epiduralised at at least 2 cm? It's just bizarre. But it's the way that then it comes back to you and the women are talking about it. It makes you realize, actually, it's uhm. That's not how we should practice. And that is certainly not what quality care looks like."* Band 8 Midwife 1- SQ-MAN-RM8-F-47

"We worked like this in 1930s, and we are still somehow working like this where the voice of the midwife is also somehow not being heard within, within that clinical picture. And I think, sadly, what has happened over the last couple of years is that before the woman, the midwife has always been an advocate for the woman, and she is supposed to be the voice for the woman when negotiating with the obstetric care. However, I do feel at the moment that that has somehow become lost". Band 8 Midwife 1 - SQ-MAN-RM8-F-47

"But if we kind of sometimes step back a little bit and move away from the bigger platform and come and come right to the fundamental and the basics of why we all went into midwifery in the first place. We all wanted to do what? To be there for the woman, isn't it? And being there for that woman means, what does that mean? That means I want to understand you. I want to know all about you, and I want to consider all about you." Band 7 Midwife 7 - Q-PN-RM7-F-44

"But it's, it's the lack of either engagement, interest or ability to have that conversation. And I think at the moment, unfortunately, frontline staff think, why bother [providing balanced information to facilitate informed choice]?" Band 8 Midwife 1 - SQ-MAN-RM8-F-47

Ideal care was seen by the participating midwives as having a holistic approach (care for both physical and mental needs), choice and respect for autonomy, clear communication, continuity of care, and a supportive environment in which women feel safe, respected, and listened to:

"A holistic approach, active listening to families, trying to meet their needs as much as we can in the safest way." Band 6 Midwife 2 – SQ-HB-RM6-F-13 – Focus-group

"So, quality for me is quite, quality is not straightforward. Quality is what the patient makes of it. That is quality for me. If the care that I've provided to that woman, if she is happy with it, that is, that for me is quality." Band 7 Midwife 7 - Q-PN-RM7-F-44

"So, I think for me, high quality has to be knowledgeable practitioners, up to date practitioners, respecting and facilitating women's choice in whichever site they want to be and continuity." Band 7 Midwife 3 - Q-SSC-RM7-F-37

"Shared decision making, getting the family or the woman or the birthing people involved in their care plan... I think that is definitely on top of my list because they need to know exactly what is happening with them and be involved in the decision making. So, no decisions should be made without them". Band 7 Midwife 7 - Q-PN-RM7-F-44

"Always inform them about the risks and benefits and leave them the decision after they have everything clear in their head." Band 6 Midwife 2 – SQ-HB-RM6-F-13 – focus-group

Even though the participating midwives highlighted the importance of listening to, and respecting women, hearing a woman's negative feedback was observed to be difficult:

Observation during a midwifery mandatory study day: In a session around women's feedback a woman's negative lived experience was read out-loud. After that, the atmosphere in the room changed as staff did not seem to agree with this feedback. Responses were defensive and the conversation ensued was no longer constructive (Observation Midwifery study day 1, Date: 10/05/2022).

Benefits of woman-centred care were discussed such as improved short- and long- term health outcomes for women and babies and reduced trauma (as more positive birth experience). But according to some of the participants, this type of care wasn't always provided. To the contrary:

"It's the fact that people are so opinionated about what a woman might choose for herself." Band 8 Midwife 1- SQ-MAN-RM8-F-47

"There is physical safety… and there is psychological safety, which is the other aspects where women and birth people are both feeling safe in the area they come into, that they are in control of the area where they give birth and they don't feel bullied, undermined or controlled during the experience". Band 8 Midwife 1 - SQ-MAN-RM8-F-47

"I don't think most people get what they want". Band 7 Midwife 6 - S-BC-RM7-F-10 – Focus-group

Despite this rhetoric, the documentary analysis indicated that the organisational culture, as illustrated above, aims to help healthcare providers in facilitating informed choice.

The guideline called: *"Criteria for intrapartum care at home and in the midwifery-led unit" was created to support doctors and midwives in their discussions with women and their families about place of birth planning. It is there to help facilitate choice (Anonymous, 2019).*

This was very much in line with what women described as woman-centred care. The three women included in the study desired respectful, personalised care that considers their unique needs and preferences.

"No, I definitely agree. I think you kind of get geared up in your head that not everyone has your best interests at heart and maybe they are just doing the job or whatever it is. And it was completely the opposite, do you know what I mean, so free. And I think that that helped towards me feeling so comfortable" Couple 3 - Postnatal woman and her partner - Q-PN-SU-F-45 and Q-PN-SU-M-46

"It's amazing that the partner can stay with you. It helped me to be relaxed and get into the family kind of groove, especially as a first-time mum, I think that that was something really important" Couple 3 - Postnatal woman and her partner - Q-PN-SU-F-45 and Q-PN-SU-M-46

Communication, information, and a dedicated point of contact were key. Furthermore, women wanted to feel safe and respected, their birth plans to be acknowledged and discussed and to receive proactive support, especially after childbirth:

> *"Yeah, that was definitely good. And even, like the aftercare, like explaining everything. So it's like, yes, I know you do want vitamin K but do you still want that? Do you still want delayed cord clamping, do you still... Uhm and that was all really good. And so it showed that they read it [the birth plan], and they knew, and that reassured me."* Couple 3 - Postnatal woman and her partner - Q-PN-SU-F-45 and Q-PN-SU-M-46

The overall opinion of the couples was that care was personalised if they asked for it. It wasn't always automatically offered as the staff were very busy.

> *"They can't constantly be offering, offering, offering, because everyone's going to accept or ask for help and they just don't have enough time, maybe, you know."* Couple 1 – Postnatal woman and her partner S-PN-SU-F-25 and S-PN-SU-M-26

Personalised care for women meant having the feeling that they were at the right place at the right time while being treated humanely. Small gestures of the staff made their experience fantastic, even if it differed a lot from their desired experience:

> *"Well, I understood that it was pretty serious. It wasn't about me and my desires. It was about getting the baby out safely. So, whilst it was a disappointment, and it was sad and shocking because I wasn't expecting that. I understood straight away that it's, it's what we need to do. Otherwise, there's no baby."* Couple 1 – Postnatal woman and her partner S-PN-SU-F-25 and S-PN-SU-M-26

The maternity support workers linked personalised care to a good experience for mothers, including kindness, listening, and clear information as key. However, they felt staff wellbeing or basic resources weren't prioritised, hindering staff's ability to provide woman-centred care:

> *"I think all of the midwives are trying to listen carefully and take time as much as possible. Explain the situations, explain the options."* Maternity support worker 1 - S-BC-MSW-F-21

Even though maternity support workers and midwives felt that staff wellbeing was not looked after, some of the collected documents showed organisational efforts were being undertaken to support staff-wellbeing:

> The NHS Trust values were mentioned as an important aid to look after staffs' wellbeing and facilitate teamwork. These were seen as the necessary prerequisites to provide personalised care (Anonymous, 2022d).
>
> Information boards on the wards contained information on staff wellbeing (Observation 7, Date 26/05/2022).

A staff booklet called: 'Looking after our people Staff wellbeing support' 2023/2024 was found on the intranet (Anonymous, 2021/22a).

The maternity support workers opinion was in line with what the participating obstetricians highlighted. They noted that kindness & compassion are key ingredients for personalised care, but this can only be provided if staff wellbeing is looked after too. Documentation and observations were found supporting this statement: Within this discipline, continuity of care was seen as beneficial for women, bodily autonomy should be respected (and caesarean sections offered based on preference), and collaborations with mental health services was seen as needed.

> *"Women only get continuity if they are so lucky to have a midwife they see regularly and they feel they have a good rapport with".* Consultant obstetrician 1 - S-LW-CO-F-23

> *"I think our approach to uhm, to kind of high-risk situations can be quite different from other units and that has been criticised in the past and we have had to kind of stick our neck above. Our c-section rate has been high, and it turns out that everybody now is kind of in line with our view that if you want a caesarean, I don't make you jump through hoops, we talk about it and that is your choice. We've always worked like that here, whereas that seems to be new to other people using caesarean sections as a marker of quality and good, good care was irrelevant."* Consultant obstetrician 1 - S-LW-CO-F-23

> *"The only saving grace is that I rely on is that they [women with mental health issues] tend to get continuity of care from a midwifery point of view, and I rely very heavily on them [the midwives] being the people that have got oversight and let us know if we need to do anything from a medical point of view."* Consultant obstetrician 2 - SQ-ROT-CO-F-32

The wider multidisciplinary team contributed importance to the understanding a woman's unique situation, respecting her choices, and focusing on long-term health through collaborations with other services. Participants included respecting autonomy (empowering and informing women to make informed decisions), understanding women's needs and priorities, and a focus on long-term health:

> On high quality care: *"So, I suppose it would be care that is appropriate and, and expert but also includes the women and makes sure that the woman is, is being understood in her priorities and her needs."* Women's Specialist Pharmacist - Q-ROT-PHA-F-29

> *"I do think maternity services are a really unique opportunity to improve long term health outcomes and also to build relationships and to kind of provide health care as a, as a health thing more that this might be something they do."* Women's Specialist Pharmacist - Q-ROT-PHA-F-29

This illustrated how quality was seen as a continuum, in which the holistic individual needs are fulfilled. This contrasted with the main outcomes that were measured to compare the quality of care provided in the different units in the region:

> The maternity dashboard used in both units to measure and compare outcomes across the region consisted of short-term outcome measures that don't focus on long-term health, nor did it provide any information on collaborations with other services (Anonymous, 2022g).

The rhetoric of personalised care in the midwifery managers group meant listening to, building trust, empowering women to make informed decisions, and respecting choices:

> *So, for me, that good care looks like emphasizing, listening, taking time and being responsive."* Midwifery Manager 8 - Q-MAN-RM8-F-28

> *"I think we respect women's choices a lot, more than we did [used to]."* Midwifery Manager 1 - SQ-BC-RM8-F-5

> *"Because our midwives are gold dust. We're not having a high percentage of home births, but we must, we want to offer choice that's really important. But we have to be very realistic about where we are and the future."* – Midwifery Manager 2 - SQ-M-RM8-F-6

> *"That's part of being responsive. We're responsible to be able to provide them with the information or access to certain information. And once they've come to their own conclusion, support them with that regardless."* Midwifery Manager 8 - Q-MAN-RM8-F-28

The importance of listening to women was clarified on the notice boards, nudging the staff into complying to the set standard:

> *Notice boards in the clinical areas reminded staff of the recommendations made by the Ockenden report such as 'listening to women and families'* (Anonymous, 2022e; Ockenden, 2022).

Additionally, individualised care and continuity were mentioned as desirable:

> *"And personalisation is hugely important, but you can't even give that if you don't have safe staffing."* Midwifery Manager 2 - SQ-M-RM8-F-6

> *"Women being seen by the same midwife much more regularly now, it's just, midwives love it, women love it, even just that small improvement"* Midwifery Manager 1 - SQ-BC-RM8-F-5

> *"I'd like to improve our continuity, that's the head scratch. It's a work in progress".* Midwifery Manager 1- SQ-BC-RM8-F-5

> *"Some kind of continuity, knowing women's story that they're not just on a conveyor belt."* Midwifery manager 9 - SQ-MAN-RM8-F-43

Some managers noted they felt concerned about the potential downsides of excessive choice for women and they were sometimes conflicted about care choices outside of guidelines:

> *"I think we have to get over our anxieties, it's not really about us. Is it. It is about them so…"* Midwifery Manager 1- SQ-BC-RM8-F-5

> *"So, I'm involved in birth options, women are asking for things that I would never want myself in a million years and I think it's, it's not medically indicated, for example caesarean sections, but we have to be so trusting in what women want, and as long as they don't make the decision out of like fear or lack of information and as long as they got all that information, and it's not that they are in charge of their own health care and their own plans for their own care."* Midwifery Manager 1 - SQ-BC-RM8-F-5

Challenges to provide woman-centred care mentioned were staff shortages and time constraints, defensive medical practices that limit choice, and the difficulty in balancing safety protocols with women's autonomy:

> *"What you don't want is you don't want someone who is outside of recommendations and then something happens and it's kind of I told you so. But when we have, when it's the other way around, when we have people that are, that birth outside of recommendations and it goes really well, you don't kind of get any kind of acknowledgement that it went well, if that makes sense… It was almost kind of like that was lucky that nothing really bad happened to that woman."* Midwifery manager 9 - SQ-MAN-RM8-F-43

Overall, a recognition of the importance of personalised care existed but there was an emphasis on which challenges remain to achieve it consistently.

7.4. Equitable care

Equity was not explicitly discussed by the obstetricians involved in the study.

All other constituencies defined equity as individual needs being met (both for staff and the women), and that disparities are addressed. Communication, cultural competency, getting the necessary training and resources were also found to be contributing to equitable care.

Evidence was found of tools that were put in place by the management team to increase equity for women in the unit:

> The availability of Language line and face-to-face translation services (Observation 13, Date: 9/06/2022).

> The Intranet (a private network sharing organisational information) was available for all staff and provided links to information leaflets about screening tests in different languages

(for instance, gov.uk 'Screening tests for you and your baby' available in 12 different languages) (Anonymous, 2021d; NHS England, 2019c).

Additionally, true informed consent was seen as integral to equitable care:

> *"I think we're trying. But again, the resources and measures that we're putting in to mitigate against are still quite rigid. It still doesn't treat the human as a human. It's okay, you can't speak English, so I've got language line. But have we exercised choice to say, would you like to use this service?"* Midwifery Manager 7 - S-MAN-RM8-M-22

Midwifery managers acknowledged that it is their responsibility to help reduce inequalities and that inequity worsens outcomes for disadvantaged women. But some contradicting messages were found in the interview transcripts around the achievement of equitable care in the unit (see the quotes above and below):

> *"…We make sure that women are treated based on their needs because equality is very difficult to achieve, because equality does not only mean that you treat everybody equally, but you have to look at equity because some people need more than others. You cannot say that you treat everybody equally. So, some people might need more, some people might need less. So actually, we try to tailor women needs according to their needs. So, I think that's what we are good at."* Midwifery Manager 7 - S-MAN-RM8-M-22

Midwives highlighted equitable care as individualised care and choice for all, regardless of background. They acknowledged that disparities in access exist:

> *"Looking at how we can improve care for women of black, Asian, ethnic minority, but also intersectional issues. So, LGBTQ plus women in general, those that identify as non-gendered, so non-binary or even male. So, looking at how we can actually look at some of these complex issues within maternity services".* Midwifery Manager 8 - Q-MAN-RM8-F-28

> *"[*women want to feel that] *'I'm safe as a black woman', if anything. Because I've got all these risk factors, because I'm getting this extra monitoring, it's likely to pick up issues."* Band 7 Midwife 7 - Q-PN-RM7-F-44

Both midwives and maternity support workers noted that language barriers are a concern to achieve equitable care. The focus on the maternity support workers was on getting a fair treatment, regardless of background (religion, ethnic):

> "It's like we have to be fair for everybody, you know, we can't say when you can have it and you can't." Q-ROT-MSW-F-34 – Focus-group

Though this quote is in dissonance with the quote of one of the midwifery managers (see above), who clearly stated that equality (everyone the same) is different to equity (see the definition of IOM in table 19 above).

One maternity support worker added the importance of feeling valued and treated with equity as an employee:

> *"When I ask them [my colleagues] a question, they just answer it in a way you do not feel ashamed of the silly question. So, you can ask again and again." Maternity support worker 1 - S-BC-MSW-F-21*

In the documentary analysis, evidence was found on how the organisation aimed for equity amongst staff:

> The 'Workforce equality, diversity and inclusion annual report 2021/22' provided information around how the Trust aims to ensure equity for staff and to create a culture in which everyone takes shared responsibility in improving equality, diversity and inclusion (Anonymous, 2021/22b)..
>
> Different initiatives have been put in place by the management team to reduce inequities such as regular 'Cultural Safety & Wellbeing Meetings' (Anonymous, 2022a).

For one woman and her partner, equitable care meant being looked after by healthcare providers that have the knowledge around outcomes of women from Black, Asian, and minority backgrounds. Guidelines and interventions to address health inequalities were desired. Antenatal education and knowledge of their rights were seen as tools to combat inequities. One couple felt that NHS services lacked desired amenities and expressed a preference for paying for extras.

> "I *tried to skill myself up on things… we did lots of hypnobirthing… and then there's a lady out on women's rights, like your rights… making sure you have your voice very clear and making sure that he [my partner] could advocate for me because definitely knowing that pain, I wouldn't be able to."* Postnatal woman 3 - Q-PN-SU-F-45
>
> *"I'd still do it on the NHS, but I just feel as though there could be options available to you if you wanted to pay for certain perks, you know, like these private rooms.* Postnatal woman 2 - S-PN-SU-F-30

Relationship based care, continuity (including after discharge) and the integration of social care within healthcare were mentioned as tools to provide equitable care. According to one member of the wider multidisciplinary team, as a minimum, staff needed to be adaptive towards the individual that is in front of them (e.g. language and clinical needs) to increase equity:

> *"Making sure that you know, maybe you are, uhm the lady from a minority background could be paired with obstetricians and midwives from a minority background because that has shown to have better outcomes."* Women's Specialist Pharmacist - Q-ROT-PHA-F-29

One example found of care being adapted to the woman in practice was the following:

> The Female Genital Mutilation Specialist midwife works together with service-users from different ethnic and cultural backgrounds who speak the woman's language and can connect with the woman coming to the clinic to support her in a culturally sensitive and appropriate way (Observation 6, Date 25/05/2022).

One anaesthetist felt that working with people from all kinds of backgrounds was found to be interesting and exciting and facilitated extra skill development in healthcare providers:

> *"We have a lot of non-English speaking people here, and that makes it quite interesting and sometimes quite exciting to work with because you have to use different skills."*
> Anaesthetic specialist registrar - S-LW-RA-M-27

7.5. Discussion

The analysis of the data retrieved during the organisational ethnography has given an insight in how the different stakeholder groups and individuals involved in maternity care define safety, personalisation, and equity as an element of maternity care quality. The observational data and documentary analysis facilitated an overview on how these concepts were implemented in the maternity care organisation.

Finding dissonance

Though the decision was made to use the six dimensions of the Institute of Medicine as a framework to analyse the data of the organisational ethnography, it was not always a perfect fit. Members of the obstetric team did not explicitly speak about equity as one of the main ingredients of maternity care quality. This contradicts the results of the meta-narrative review, in which equity was seen as an important facet by some authors (Dhar et al., 2010; Pittrof et al., 2002). Overall, this dimension of quality of care of the IOM was spoken about the least during interviews and focus-groups. This raises important questions about how the campaigning around the necessary reduction in inequalities in the UK, and so the improvement of outcomes for women of BAME and socio-economically disadvantaged backgrounds is implemented in practice (Birthrights, 2022; MBRRACE-UK, 2023).

Similarly to the study of Rönnerhag et al. (2018), in this study women did not explicitly talk about safety in terms of 'not dying' but more about safety in terms of what gives them a sense of security (e.g. being listened to, informed choice, getting information, etc) (Rönnerhag et al., 2018).

Furthermore, the organisational definition of quality as found in the documentary analysis and observational data, evolved around 'clinical safety'. Personalised care which was mentioned in all stakeholder groups as an important aspect of maternity care quality, was not prioritised within the organisational culture. Documents included and observations made indicated that the provision of personalised care and choice for women was seen as a luxury rather than a necessity. This is in

contrast with the Better Births (2016) report, which noted in the personalised care section that: *"Choice is not a tick box exercise and is not just about place of birth, although that is important for many women. Women want to make decisions about a range of aspects of their care … (p. 44)"* (NHS England, 2016c).

See chapter nine, for an in-depth discussion of the findings of the organisational ethnography.

7.6. Conclusion

In all stakeholder groups, safety and personalisation were mentioned as the main ingredients of maternity care quality. A tension was found between a dominant safety-focused culture (largely but not only expressed by midwifery management, obstetric team, and the wider multidisciplinary team) versus one where person-centred care was more highly emphasised (often, but not always, among midwives, maternity support workers, women and their partners). The safety versus personalisation dilemma surfaced in the data. Nevertheless, all participants involved agreed that a balance between evidence-based practice, while respecting women's autonomy, is of great importance.

Except for the group of obstetricians, the organisational ethnography found a clear understanding of equity amongst all other stakeholder groups. Equity was defined as addressing existing disparities and meeting individual needs. The midwives and managers actively implemented tools to achieve this, like language services and cultural competency training. However, there were some inconsistencies in how equity was interpreted, with some focusing on treating everyone the same (equality), while others understood the need for tailored care (equity). Overall, the focus was on ensuring all women felt safe and received appropriate care, regardless of their background.

For some midwives and women, safe, personalised, and equitable care were all closely intertwined. Personalisation promotes equitable and safe care.

In the next chapter, a detailed overview of the findings of the organisational ethnography relating to 'efficiency', 'effectiveness', and 'timely' is given. Quotes from interviews and focus-groups, documents retrieved, and observational data are used to illustrate the findings of the analysis.

CHAPTER 8: EFFICIENCY, EFFECTIVENESS, AND TIMELY

8.1. Introduction to the chapter

In the previous chapter I described the findings of the organisational ethnography in relation to the dimensions of 'safety', 'personalised or woman-centred care', and 'equity'.

In this chapter, the findings of the interviews, focus-groups, observational data, and from the documentary analysis on the topics of 'efficiency', 'effectiveness', and 'timeliness' will be discussed. Observational notes, interview and focus-group quotes, and excerpts of the documentary analysis are added to clarify the analysis. At the end of this chapter, there is a short discussion and conclusion on the data presented.

8.2. Efficiency

The red thread in this dimension in all professional categories involved was the need for staff-wellbeing and workforce support to enable the provision of efficient care. Midwives added that investment in staffing was crucial and maternity support workers noted that teamwork, adequate resources, and a supportive environment is key to efficiency.

Midwives said the following:

> *"We're trying to, we're asking midwives who are already exhausted already at the end of their tether and certainly underpaid to step up and do even more and asking more and more of them. But what needs to happen is a seismic shift. We need A yeah, thousands more midwives. We need to start supporting our students with a bursary again so that they can afford to become midwives, even if they've done a degree before. We need to start giving visas easy, easy visas to overseas students so that they can come and become midwives in this country."* Band 6 Midwife 2– SQ-HB-RM6-F-*13*

> *"So there are so much that currently is not working in the NHS and this is affecting a lot the safety of the NHS. I'm speaking in my experience; the understaffing is a critical point. Where, we started a cycle where there is less staff. The staff that is left is moved to other wards where is needed, but in other wards, the midwife or other healthcare professionals are not confident, are not happy there because it isn't their first choice. And as much as you can be used to it, you can, you can everything everyone can [get] used to everything, I think. But how there, as we talk before, the morale and attitude changes. Therefore, the cycle continues with unhappiness. Therefore, unkind staff that are frustrated and upset."* Band 6 Midwife 5 - SQ-HB-RM6-F-48

"There's a big drive for recruitment and, and I said at senior level, I think if you address, uh, retention as a first, you know, probably you're halfway through your recruitment problems. Try to keep the people that you have trained, that are familiar with the system, they are teams that work together". Band 7 Midwife 4 – S-RI-RM7-F-40

On this topic, the maternity support workers noted the following:

"I don't know, changing the beds or making the tea. When they see that you busy, they do it themselves. They don't ask you to do it. So you're just like a teamwork. You just like you help them, they help you. This is the way it's running smoothly." Maternity Support Worker 1 – S-BC-MSW-F-21

"I want to do something, but I can't do anything more than this because I don't know where to put the woman. I feel guilty sometimes. Imagine if your family is treated like this. How would you feel?" Maternity Support Worker 2 - Q-ROT-MSW-F-33

One of the consultant obstetricians, some midwifery managers and midwives also highlighted the current lack of resources, making it difficult to provide efficient care:

"I don't have any solutions to any of this, but for me, the themes come back to lack of finances, lack of bodies on the ground, and the fact that we haven't been looked after from government, top down." Consultant obstetrician 2 - SQ-ROT-CO-F-32

"The obvious thing at the moment is just staffing. I think it's a really difficult time to go into this role because I've not had the opportunity to be a manager when, when things have been functioning normally, if that makes sense. So, I just feel like it's always in, in crisis mode. So, you can't really, so I think you're expected to come up with all these innovative ideas, but I'm not really sure when they expect you to do them." Midwifery manager 9 - SQ-MAN-RM8-F-43

"So, I mean, for example, the Trust have set aside funding and put systems in place for... uhm Health care systems to go on the nursing apprenticeship program, the nursing degree apprenticeship program. Unfortunately, the midwifery degree apprenticeship program came a bit later, and because of COVID, it's all been paused. But I'm still fighting to get recognised in the same way to make sure the money is laid aside." Midwifery Manager 5 - SQ-MAN-RM8-M-19

"I genuinely feel the staff that I have are doing their best. I feel that they're facing that conflict too, internally, of them wanting to do their best, but then being but doing that with the minimal resources that they do have. And that's not just resources physically on the wards, that's the resources they have within them. They're depleted of energy." Midwifery Manager 8 - Q-MAN-RM8-F-28

> *"Yeah, I think finance plays a role and a lack of midwifery staffing certainly plays a role. But simple communication between antenatal ward, labour ward, postnatal ward I think could be improved."* Consultant obstetrician 2 - SQ-ROT-CO-F-32

Most participants commented on the lack of human resources during the data-collection period. Furthermore, evidence of a significant shortage of midwives was found in the included documents:

> A presentation given by the senior management team on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that, at that point, the main challenges in maternity care were problems with workforce including staff sickness, a high staff turnover, and a midwifery vacancy rate of 15% (49 FTE) (Anonymous, 2022f).

Asking staff what they need to provide efficient care can be helpful according to one of the midwifery managers:

> "You go to a community midwife; they tell you exactly what they need. Yes. They know exactly where they're wasting time in a day." Midwifery Manager 6 - SQ-MAN-RM8-F-20

Overall, midwifery managers highlighted the complex relationship between staff wellbeing, efficient service delivery, and service models. Addressing workforce challenges and overmedicalisation were found to be crucial for long-term efficiency and quality of care:

> "And we've got an increased dependence on our support workers. So, things like discharge talks might be given by a support worker, but the level of training that goes into that is inconsistent." Midwifery Manager 8 - Q-MAN-RM8-F-28

A midwifery manager highlighted that, where there is a high level of staff happiness and wellbeing and staff can work in an environment which is in-line with their own philosophy, care provided was found to be more efficient and high quality due to staff going above and beyond:

> *"I think we have midwives who go above and beyond who, you know, kind I think it's about even personal attributes, many, many, midwives. It they're a pleasure to work with, and I suppose, again, I go back to the areas that I am that have been part of me, is working in our midwifery led units, was like working, like in... It was like you enjoyed coming to work so much because you were working with like-minded people. We were all coming from the same philosophy."* Midwifery Manager 2 - SQ-M-RM8-F-6

Efficiency in maternity care according to the participating obstetricians' hinges on a holistic approach that addresses staff wellbeing, communication, resource management, infrastructure, and collaboration across specialities.

Three members of the obstetric team and one midwife said the following about how pressures on staff causes inefficiencies:

"And it was on Twitter the other day that the junior doctor salary has gone up by £60 in about 15 years. And so, when people finish work at five or 6 p.m., I mean, where is the energy to keep going if we're not valued?" Consultant obstetrician 2 - SQ-ROT-CO-F-32

"The time that you give a midwife is the exact same that you were having 20 years ago and you still, you have tripled the amount of work to do if not more." Band 7 Midwife 2 - SQ-RI-RM7-F-9

"But I just yeah, I think the wellbeing, you know, I'm fighting to get us staffed to baseline and we're short. And if the staff felt that there was investment in staffing, you know, when you come on and you're fall short, you're find sure every day isn't great." Consultant obstetrician 1 – S-LW-CO-F-23

"Because not only are the midwives looking after the women, but they're helping with the babies, they're doing NIPE's [Newborn and Infant Physical Examination], they're helping with feeding. And yes, there are you know maternity support workers up there, but I think the staffing level, I think that's the most crazy staffing levels I've witnessed. There are some days where there's one or two midwives on the post-natal side and it's a big postnatal ward. So, I think maybe that's not prioritised as much as our labour ward is. And I don't think, that's necessarily right." Senior House Officer (SHO) 1 - S-ROT-SO-F-24

"Yeah, huge inefficiencies there. And it really does impact on the patients. It really does. Like I cancelled a lady yesterday. We only had two elective sections yesterday and we could, apart from ODP, we could have run two theatres all afternoon, but we couldn't because we didn't have the ODP." Consultant obstetrician 1 - S-LW-CO-F-23

Communication and good teamwork were also high on the organisation's agenda:

The clinical guideline with the title: 'Handover of care' provided instructions on how effective communication between healthcare providers can be facilitated using SBAR (Situation, Background, Assessment, and Recommendation) (Anonymous, 2020b). This method was commonly used by midwives and obstetricians on antenatal, labour, and postnatal ward (Observation 2, Date: 18/05/2022).

This also included:

Yearly multidisciplinary training on emergency situations to improve communication and teamwork (Observation 4, Date: 23/05/2022).

How busy the ward is, was found to be affecting the efficiency according to one of the obstetricians:

"I think from speaking to patients, they have a really varied experience and typically I think that relates quite highly to what quite strongly correlates to how busy we are, because when

we're less busy there's more staff around, they're seen quicker, things are picked up quicker." Senior House Officer (SHO) 1 - S-ROT-SO-F-24

Having a good infrastructure, including good logistics in place, working estates, enough space in the rooms for the whole multidisciplinary team to enter in case of emergency or to easily move the woman out to go to theatres was also discussed by the obstetric team as something that could improve efficiency:

"When you're faced with an emergency situation and the beds don't fit down the corridors because the corridors are so small and the rooms are tiny, the logistical side of things you could say that's probably one of the downsides of working at site 2." Senior House Officer (SHO) 1 - S-ROT-SO-F-24

It was felt that efficiency was about good prioritisation by staff. The wider multidisciplinary team noted that even though there is a lack of resources, including a lack of staff, the multidisciplinary team has shown to be resourceful:

"There will be times that I will see a lady who's been waiting like a day for an epidural. And it's not because there's not an anaesthetist availability, it's because there's not a midwife to look after that patient once the epidural is in." Anaesthetic specialist registrar - S-LW-RA-M-27

"So, I think I feel uhm, I think I used to get really frustrated by that sort of thing. I try not to get frustrated now, because I understand the resourcing pressures across National Health Services is just so difficult. But you know, it, I try and be as productive as possible and I try and help where I can with elements that aren't necessarily my job but will help potentially speed things up. And I think a lot of people are like that, not everyone, but a lot of people are like that." Anaesthetic specialist registrar - S-LW-RA-M-27

Additionally, the wider multidisciplinary team and one of the participating midwives spoke about how the team is resourceful even when there is not always the right human or physical resources available to enable efficient care:

"I think we are good at using our resources, but I think that's again, I think that is quite typical of anaesthetics because anaesthetics is... Right from the start, you are kind of managing the hard part. The hard part is being like, what case do you take to theatres first? What, which patient needs your help more? That's resourcing. So, something we kind of taught quite early and I think it's nice to have those kinds of discussions with other specialties and hopefully they sort of pick up from that." Anaesthetic specialist registrar - S-LW-RA-M-27

"Sometimes the estates don't run as well as they could do. The environment isn't as conducive to giving the best care. So, you know, sometimes we need more scanners. So, it's a really a resource thing." Women's Specialist Pharmacist - Q-ROT-PHA-F-29

> *"Basically, I think with that kind of support from each other, everyone is open to new ideas. And you kind of... I find it easier to come forward with new ideas or more innovative working or ways we can implement better pathways. I think that's quite easy to, uhm to bring forward and also to be taken seriously."* Band 7 Midwife 1 - SQ-EDU-RM7-F-8

One midwifery manager echoed this and added that even though the facilities are not ideal and causing inefficiencies, this does not affect some of the quality of care aspects provided:

> *"I think one thing that others can learn from us is actually demonstrated that, you know, you could provide a really good care, even despite challenges of estates and facilities. We know we're wasting resources because we have to fit around our estates, but it is possible to get people in site 2. When I first started, I thought, really, you must be joking [laughter]. How can we call this a labour ward? But you watch women coming through. It works. Yeah, they have good outcomes and it... and they come back. They come back and have other babies in here."* Midwifery Manager 6 - SQ-MAN-RM8-F-20

To the contrary, one of the participants gave accounts of care in which the available resources were used in inefficient ways:

> *"And I think a big problem is that they keep pouring resources into the labour end of the, of the, of the pathway. And actually, if we had a lot more and probably moving on to a follow up question here, but if we had a lot more resources put into antenatal and community care, then that would actually relieve an enormous amount of the pressures that exist on labour ward and antenatal wards sort of induction processes."* Band 6 Midwife 2 – SQ-HB-RM6-F-13

The anaesthetist noted that, to reduce inefficient use of resources, there should be a focus on proactive care (avoid issues) instead of responsive care (resolve issues). It was believed that staff needed to embody accountability and good decision-making skills:

> *"People will find themselves doing reactive kind of medicine as opposed to proactive medicine. And I think that's where quality and safety can be affected, basically."* Anaesthetic specialist registrar - S-LW-RA-M-27

Additionally, midwives defined efficient care as the provision of evidence-based care (using guidelines and recommendations, and informed consent) in which the focus lies on what women need (respect for women's choices, relationship-based care, focussing on what matters to her).

The availability and easy access of guidelines was evidenced in the included documents:

> The Intranet (a private network sharing organisational information) was available for all staff and included evidence-based guidelines which were updated on a regular basis (Anonymous, 2021d).

One respondent noted that the 'efficiency' of a 'conveyer belt system' was not the kind of efficiency that provided good quality of care when it was applied to human interaction:

> *"I mean, that's not to say this not great midwives. They are... some of them are great. But a lot of them no longer care enough. It's a job. They come to work to do a job. They don't care. They don't really care about the woman in front of them. What, what is it that's going to make a difference to her? You know, it's all kind of like the old machine. You know, we just get them in, get them out, get them in, get them out. And we're back to that system. We're back to the conveyor belt system."* Band 7 Midwife 2 - SQ-RI-RM7-F-9

Another midwife criticised the large number of inductions happening in the unit:

> "I mean, this whole induction business. How can you replace one set of risk with another set of risks? And that's what you're doing actually." Band 7 Midwife 3 - Q-SSC-RM7-F-37

One of the midwifery managers noted that overmedicalisation has a negative effect on the efficiency of care provided. The lack of midwifery leadership was seen as a contributing factor. Furthermore, one of the midwives voiced that the management does not always understand and support the needs of midwives:

> *"But I think in other areas [other than birth centre or the home birth team], I feel there's a real absence of midwifery. I think it's; I think when you say multidisciplinary, I think I don't think that's really true. I don't think that really happens. I think, very often midwives are not really having a big say in, in things. I think we're just down such a medicalised route. I don't really understand the... Why we've not pushed a bit back about things. thinking of inductions. It's frightening the life out of me. That completely changed the, the workload. I can't believe how much they've changed the workload."* Midwifery manager 9 - SQ-MAN-RM8-F-43

> *"What you want the managers to do is to recognise the time that it takes for a midwife to be able to do her job. I think all too often we're not. We're given an hour to do a booking on somebody who can't speak English, who has complex needs, and that is going to take you know [laughter] A lot longer than an hour."* Band 7 Midwife 3 (private services) - Q-SSC-RM7-F-37

On the other side of the spectrum, midwives noted that they felt from an organisational and managerial point of view, that midwifery units were often seen as inefficient, costly, and luxury services. One of the midwives saw midwifery units as essential:

> *Some aspects of care [midwifery units] may be seen as a luxury, where actually, we should be advocating for it as being an, you know, essential aspect of care".* Band 8 Midwife 1- SQ-MAN-RM8-F-47

During my observational period, all midwives working in the home birth team resigned in a very short period of time. When I asked one of the midwives who used to be on the team why she did, she explained that they did not get the right support and resources to enable them to safely provide the home birth services:

> *"Because we were covering the service ourselves at our own, expense of our own time. That it was, it was not being recognised that we needed, we needed the support from management because we were a very self-contained team. But that doesn't mean we didn't need to feel that there was also a backup in place."* Band 6 Midwife 2 – SQ-HB-RM6-F-13

The home birth team reported they were going above and beyond, trying to keep the service running in spite of a shortage of midwives but realised this was not sustainable and so not efficient as they were not taking the rest they are supposed to be taking, which they felt had an influence on the provision of safe care:

> *"We didn't feel listened to. We didn't have safe staffing. We didn't have enough backup. We were not paid enough. We were all tired. We didn't feel supported well enough."* Band 6 Midwife 5 - SQ-HB-RM6-F-48

Accounts of not getting enough resources and support were frequently given during the interviews. The quote of the following midwife indicates that she feels that resources are not always allocated in the most efficient way:

> *"They [the management team] give out drinks and biscuits and you know, which is fine. But, you know, midwives that... give us urine bottles, we, we lack, we lack equipment to provide the basic care".* Band 7 Midwife 4 – S-RI-RM7-F-40

One of the midwives elaborated on how requests from women for care outside of guidelines can be seen as inefficient due to a lack of the necessary staff to enable both safe and personalised care:

> *"So yeah, I think I mean, you've got women that want to birth outside of guidance, you know, and yes, that would be fine if we had enough staff to support them, you know, but we don't. And that creates anxiety for the midwife and the woman and also puts pressure on the unit itself, you know, so it's a knock-on effect".* Band 7 Midwife 7 - Q-PN-RM7-F-44

Efficient maternity care from the postnatal women and their partners' point of view meant timely care (fast check-ups, interventions, and triage access), available staff (showing patience, helpfulness, and timely information), a quick response in emergency situations by the multidisciplinary team, good teamwork, and kindness:

> *"Everyone was very friendly and communicative, and it was very efficient. Like, you're going to do this, you're going to do that and you're going to do it. And I was literally like, wow, but they just, I just felt in really good hands."* Couple 1 – Postnatal woman - S-PN-SU-F-25

> *"And they told me that they had to scramble around the hospital to get staff to perform the operations, especially after the first two morning ones. So, the fact that that happened the way it did, given the circumstances, was just incredible."* Couple 1 – Partner - S-PN-SU-M-26

To ensure efficient care, including timely information the following tools were in place:

> The handheld maternity notes for all women contained an information leaflet that explained at what stage in pregnancy, what screening tests were offered (Anonymous, 2022c).

> Availability of Language line and face-to-face translation services (Observation 13, Date: 9/06/2022).

The lack of resources and problems with the infrastructure of the hospital affected some of the women's experiences. One woman would have liked a private room in the postnatal period but could not get one as there wasn't any available. Another woman reported she wanted a waterbirth but due to issues with plumbing (no hot water running), she could not.

> *"And so, we opted for the water birth. The bath didn't work, because there was no water anywhere, they were bringing the engineers down."* Couple 3 – Postnatal woman - Q-PN-SU-F-45

8.3. Effectiveness

In the maternity support worker's category, effective care was not spoken about.

According to participants from the management team, effective care meant evidence-based (informed by the latest research), woman-centred care that aligns with the woman's informed choices and provided by skilled practitioners. This discipline focused mainly on efficiency and measurable outcomes, including benchmarking against other units so improvements can be made.

Respondents noted that in practice, effective care is not always provided:

> *"And then even the information giving about it is really very, very poor, It's completely imbalanced. I feel that they get information about the risks to the baby if they don't want the induction. They don't get any information, hardly at all about the risks of an induction."* Midwifery manager 9 - SQ-MAN-RM8-F-43

> *"And I think if you say that, they go oh they were high risk, that's why they were induced … But I think we made them high risk by inducing them."* Midwifery manager 9 - SQ-MAN-RM8-F-43

> *"It is that kind of control where there's a certain dictation to, we must do this and this and this because the guidelines are saying we should and there is no compromise, although guidelines are not rules, they are just guidance. And actually, the voice of the service users will always override those because all we need to do is facilitate and offer evidence-based advice, but also ensuring that actually we're not doing anything to people because we're not legally, we can't do that."* Band 8 Midwife 1 - SQ-MAN-RM8-F-47

Evidence of benchmarking from an organisational perspective existed in the form of the regional dashboard:

> *The maternity dashboard allowed for comparison between neighbouring hospitals so problems could be identified, and improvement plans made (Anonymous, 2022g).*

As mentioned above, evidence-based guidelines were available to all staff and were found to be important tools to provide effective care:

> *The Intranet (a private network sharing organisational information) was available for all staff and included evidence-based guidelines which were updated on a regular basis (Anonymous, 2021d).*

The wider multidisciplinary team aligned with the view that effective care can only be provided by a skilled team that wants to share expertise and that research drives innovation and improvement. Additionally, they noted that effective care should involve clear guidelines, use of standardised tools, and a good introduction of the unit for new staff:

> *"I knew day one, my first on-call here, I just knew where all of it was. And within five minutes of me being here, I knew what I needed to turn to in certain scenarios. And there have been places I've gone to, a week in and I don't even know where anything is."* Anaesthetic specialist registrar - S-LW-RA-M-27

> Emergency equipment such as the post-partum haemorrhage trollies contained charts with the order, dose, and route of drugs to give (Observation 12, Date: 8/06/2022).

Similarly to the midwifery management and wider multidisciplinary team, one of the obstetricians involved in the study expressed the importance of a team that collaborates and follows the NHS Trust values, which she felt currently was lacking. Both interview data and observational data showed a tension between respecting women's autonomy and doctors prioritising safety through their preferred treatment methods:

> "I think if everybody worked by the trust values every day, the unit would be a far better place for patients and the staff." Consultant obstetrician 2 - SQ-ROT-CO-F-32

> *"I don't think, you know, yes, it is depressing when you see the 20-year-old who's been given an elective caesarean for something that could easily be overcome." Band 6 Midwife 2 – SQ-HB-RM6-F-13 – Focus-group*

> The documentary analysis included the Trust values, which are publicly available on the website. To keep the NHS Trust anonymous, they were not included in the thesis (Anonymous, 2022b).

A tension was found between the belief that women should have autonomy to decide about their treatment and what effective care is for them versus feeling safe as a doctor and doing what they feel is going to be most effective:

> Data Babies Born Better Survey (see chapter five): "They just try scare you into submission instead of explaining the situation and looking for solutions as a team! It's full of short-tempered doctors who want to order you about rather than guide you to a good decision!"

> "I think patients notice more kindness than clinical competence." Consultant obstetrician 2 - SQ-ROT-CO-F-32

Especially midwives mentioned the importance of investing in the resources to conduct research and to innovate. They felt this could positively influence leadership, clinical practice, and subsequently, the quality of care.

> "And then you've obviously got staff shortage, you know, so until we tackle these other things, we're not really going to be effective implementing things like personalised care. We can probably touch on it and say that we've done it, but has it been effective?" Band 7 Midwife 7 - Q-PN-RM7-F-44

> "And also X [the NHS Trust] takes the initiative to improve their guidelines, the guidelines and actually research into new things and how this can help our demographics." Band 7 Midwife 7 - Q-PN-RM7-F-44

> "But I think other units can also learn that, you know, that we're taking new learning on board and we actually actively try to collaborate really well with research." Band 7 Midwife 1 - SQ-EDU-RM7-F-8

Randomised controlled trials were mentioned by midwives as a means to increase effectiveness, but only if they were done appropriately, and if they were found to have positive effects on women's and babies' long-term health:

> *"If we were doing it properly, we'd be okay. But we're not. We're doing a mishmash, you know, of you know, if you're going to do inductions of labour on this scale, you have to go*

> *through the Dublin model and have them in and out and in and out. And then they don't have a chance to get infected. They don't have a chance to get the baby distressed."* Band 7 Midwife 2 - SQ-RI-RM7-F-9

Views of midwives and women & partners around effective care were similar. They agreed that standardised care is not always effective care. Midwives highlighted that guidelines need to be balanced with choice and that effective care means the right balance between intervening and observing (sometimes, the most effective thing to do is non-intervention or finding alternatives).

Consistent information giving, based on the latest research evidence and ensuring informed consent, were seen by some midwives as necessary ingredients for effective care:

> *"And if I'm about to recommend anything to a woman, I will look at the evidence and I will try and sort of make sure that the evidence I am giving is as up to date and not a personal view."* Band 7 Midwife 3 - Q-SSC-RM7-F-37

On the other hand, during focus-group one, all participants agreed that some evidence is interpreted and disseminated differently by the different disciplines:

> *"We don't talk about CTG monitoring in the same way. We don't tell them that there's no evidence to support it. We do, you know, it's very much what suits the medical establishment is how we model or present the evidence."* Band 6 Midwife 3 – S-BT-RM6-F-14 – Focus-group

In addition, observational notes argued that the available evidence is not always used to inform women:

> Information leaflets such as the 'Induction of labour' leaflet, 'pre-labour rupture of membranes leaflet', 'GBS screening in pregnancy' leaflet, etc. were available to staff in some clinical areas as a means to provide balanced and consistent information (Anonymous, 2020c, 2020d, 2022b)..
>
> *In the triage areas, women were not always given leaflets or balanced information to make informed decisions (Observation 6, Dates 25/05/2022).*

Women ideally wanted to give birth in their own strength and for interventions only to be introduced where needed (no over- or under medicalisation).

8.4. Timely

One of the participating midwifery managers noted that having time for the women is of great importance:

> *"It's giving ideal care. It's giving people time. I think that's what we've lost a lot is the time aspect."* Midwifery Manager – S-LIN-RM8-F-18

One of the maternity support workers defined timely care as having readily available resources (beds and staff) and smooth care pathways:

> "Sometimes like, you look and what you want to do with the patient? You can't do anything because you don't have the facility to put them to wait downstairs (on the antenatal ward)." Maternity Support Worker 2 - Q-ROT-MSW-F-33

Midwifery managers and obstetricians echoed this by defining timely care as having a focus on efficient workflows, clear care pathways, while having well working technology, multidisciplinary effort, good infrastructure, and sufficient staffing. They also emphasised the provision of early antenatal care, and ideally, continuity of care to aid timely interventions:

> *"So, it's not just about the workforce is around pathways is about patient flow, it's about lots of infrastructure that we can get right. And we just seem to just be looking at nurses and midwives and doctors. But what about porter services? What about transport? What about digital technology?"* Midwifery Manager 2 - SQ-M-RM8-F-6

> "And what about some of the things that actually, um, healthcare assistants can support midwives and nurses. It is really releasing time to care." Midwifery Manager 2 - SQ-M-RM8-F-6

> *"I think other pressures like, you know, our staffing. So, if you bring someone in for induction, we don't start it off straightaway. The difficulty moving people from the antenatal to the labour ward, it's really frustrating. And then the postnatal care feels a bit disjointed because we never get to see them again after they go home."* Consultant obstetrician 2 - SQ-ROT-CO-F-32

> *"From my experience of antenatal care, I think that's pretty spot on. I've really enjoyed being a part of women's antenatal care. I think it runs smoothly from my own personal experience. I think we're pretty hot on our scanning. I think our MDAU [maternity day assessment unit] runs really well. I think that's something that, works nicely I think from doctor provision it should be better staffed."* Senior house officer (SHO) 1 - S-ROT-SO-F-24

Observational data illustrated how the midwifery management team tried to ensure a smooth workflow:

> Twice a day, the senior management team would organise huddles (virtual meetings) to keep an overview of staffing levels, available beds and implement action plans to resolve urgent issues (observation 1, date 17/05/2022).

Observational notes of one of the two labour wards highlighted that the infrastructure in that particular unit was not conducive for a fast response in case of an emergency:

> *On observation, one of the units had very small labour ward rooms, which made it difficult in emergency situations for the multidisciplinary team to get in the room and for fast transfer to theatres where needed due to narrow corridors (Observation 5, date 24/05/2024).*

A document included in the documentary analysis confirmed that estates were a barrier to timely care:

> A presentation given by the senior management team on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that estates are very old in one of the units, which posed challenges to patient flow (Anonymous, 2022f),

Obstetricians added that timely care is a core aspect of safe care, and that teamwork, coordination and consistent oversight are aspects that aid timeliness of care. Furthermore, ensuring that women and babies receive care without delay was how members of the obstetric team defined timely care:

> *"The second place I think that would be failing the most would be the throughput on antenatal ward when women come in for inductions. It's a slow throughput and I think for site two particularly, the throughput, that journey from when that patient enters, to actually making the postnatal ward is not time efficient. No, it's just not. And I don't know how to improve it. I think the improvement needs to come from top down."* Consultant obstetrician 1 - S-LW-CO-F-23

Maternity services need to be supported politically and financially to be able to have the necessary resources to give safe and timely care:

> *"We are cancelling sections at half four in the evening because there's no formal, there's not enough cover after five [of anaesthetists] to do, you know, elective work that might run over just for another half hour. Whereas at site one, that would be no problem at all."* Consultant obstetrician 2 - SQ-ROT-CO-F-32

> *"Huge inefficiencies there. And it really does impact on the patients. It really does. Like I cancelled a lady yesterday. We only had two elective sections yesterday and we could, apart from ODP [Operating Department Practitioner], we could have run two theatres all afternoon, but we couldn't because we didn't have the ODP."* Consultant obstetrician 1 - S-LW-CO-F-23

> *"So yeah, I mean, I don't have any solutions to any of this, but for me, the themes come back to lack of finances, lack of bodies on the ground, and the fact that we haven't been looked after top down from government."* Consultant obstetrician 1 - S-LW-CO-F-23

Participants in all professional stakeholder groups emphasised that resource limitations had a negative influence on timely care. A member of the wider multidisciplinary team added that good logistics and facilities, good communication, anticipating potential issues, and well-defined care plans all contribute to faster response times:

> *"I think logistically it can be difficult sometimes because we're away from the main hospital and like. Sometimes, you know, like the lifts break. And if you need to take someone to ITU [intensive care unit], I don't know if you can get them there. Or like sometimes if there's a code red going on trying to get blood over here, it's like nearly impossible."* Anaesthetic specialist registrar - S-LW-RA-M-27

In-line with maternity management, the Anaesthetic specialist registrar interviewed also believed that better communication could foster more proactive care, which was found to be timelier compared to reactive care:

> *"I think sometimes, there is a... At times there is sometimes a lack of communication between different elements of a patient's care. And I think there are potentially some things that can be done earlier on to try and prevent problems that we encounter later on."* Anaesthetic specialist registrar - S-LW-RA-M-27

> *"But eventually that will happen and I'm sure it's happened to some of my colleagues and people will find themselves doing reactive kind of medicine as opposed to proactive medicine. And I think that's where quality and safety can be affected."* Anaesthetic specialist registrar - S-LW-RA-M-27

Lots of similarities were found in the participating midwives, where timely care was defined as using evidence-based practices, having adequate staffing, strong collaborations between healthcare professionals, and clear communication so informed consent can be achieved, even in emergencies. One of the midwives noted the following:

> *"It's difficult to, to do that and especially maternity where sometimes everything is so based on the ad hoc, you know. Oh, we have to go for a section and sometimes because of the situation, you kind of cannot have a thorough conversation. You know, yes, women are informed of what's happening, but actually what we would really want is to discuss it with them, give them some protective time to take it all in and then make that decision."* Band 7 Midwife 7 - Q-PN-RM7-F-44

An example of strong collaborations to ensure timely care was observed:

> *Good teamwork ensured that when maternity support workers were busy, midwives would take on tasks such as making beds to improve timely care for women (Observation 10, Date: 6/06/2022).*

Some midwives added the opinion that uneven resource distribution (high-risk units are well-staffed, but lower-risk areas lack resources) causes delays and missed complications in lower-risk areas. Furthermore, overmedicalisation (high induction and caesarean section rates) was found to reduce timely care for women in need of emergency care due to the increase in activity on high-risk units:

> *"On the X [postnatal] ward, getting women up to labour ward with their inductions of labour, and it's not related to being too busy. I think that there's something else happening. The coordinators blocking the women coming up or... I don't know what happens then, or they ignore the women because it's the same, it's the same complaint you get all the time at site 2."* Band 7 Midwife 2 - SQ-RI-RM7-F-9

Participating women and their partners noted their care was not always timely. Standardised care did not always address their individual needs:

> *"And then it got to week 20 and we had a final scan on the NHS and I remember the sonographer saying the next time you see your baby will be at the birth. And I thought that is also completely crazy because 20 weeks to 40 is this halfway through".* Couple 2 – Postnatal woman - S-PN-SU-F-30

> The handheld maternity notes for all women contained the standard care pathway that was followed for all women. Furthermore, it contained an information leaflet that explained at what stage in pregnancy, what screening tests were offered (Anonymous, 2022c).

Waiting times in triage were found to be too long by some women, especially when they were worried:

> *"So, I went to hospital and I remember there was a lot of waiting around. A lot. I had to wait long. Yeah, and the triage was on the maternity unit. There were pregnant women everywhere and I was like, Oh my goodness, I'm not going to get a CTG [cardiotocography] for ages, which I understand. But I was worried that my baby wasn't moving, and it was really awful having to wait."* Couple 2 – Postnatal woman - S-PN-SU-F-30

> *I observed a situation in which a woman got very distressed from waiting in the waiting area in triage for two hours, while feeling ignored and having to deal with unkind behaviours from frontline staff* (Observation 3. Date: 21/05/2022).

Additionally, staffing shortages caused delays in critical situations:

> A presentation given by the senior management team on the 28th of September 2022 in view of an Ockenden Assurance Visit reported that, at that point, the main challenges in maternity care were problems with workforce including staff sickness, a high staff turnover, and a midwifery vacancy rate of 15% (49 FTE). Additionally, there was an increased acuity, and rising induction and caesarean section rates. As a result, the birth centres were consolidated, homebirth services needed sector support, delays in inductions of labour, and challenges with patient flow (Anonymous, 2022f).

Effective care pathways such as clear referral systems, ensuring women received the right care at the right time, strong collaborations between healthcare professionals, timely access to their named healthcare professionals, continuity of care, and calm, professional communication when undergoing emergency situations were all seen as contributors to timely care:

> *"I stopped eating like 9 p.m. the night before, thinking that the ECV [external cephalic version] would be in the morning. But obviously it being Saturday the teams were reduced. I'm low risk so we were just kept getting bumped down and down and down. So, we didn't get, I didn't get seen by somebody until 7.30 at night, which for pregnant woman, 14 hours of not eating was unbearable."* Couple 2 – Postnatal woman - S-PN-SU-F-30

To the contrary, one of the partners was very impressed with the timely and professional response in an emergency situation:

> "And no one panicked. apart from the... At the beginning, when it was like, oh, my God, this is bad. When they were talking to X [Mother 1]. None of the staff panicked. It was pure professional. Bang, bang, bang, bang. Let's get you in there. Very good. They didn't have to be as kind, as polite as they were. But actually, I was like, I was gobsmacked by the whole thing. I thought it was absolutely unbelievable." Couple 1 - Partner - S-PN-SU-F-25

Despite continuity of care being seen by staff as facilitating timely care, this was not supported by the following Ockenden recommendation, that had been implemented in the organisation:

> In March 2022, the final Ockenden report was published, in which the immediate and essential action was to abandon the continuity of carer model until safe staffing was present (Ockenden, 2022).

8.5. Discussion

The analysis of the data retrieved during the organisational ethnography has given an insight in how the different stakeholder groups and individuals involved in maternity care define effectiveness, efficiency, and timeliness as elements of maternity care quality. The observational data and documentary analysis facilitated an overview on how these concepts were implemented in the maternity care organisation.

Finding dissonance

Similarly to the findings in chapter seven, the framework used for the analysis (the six dimensions of the IOM) was found to be suitable. Nevertheless, in the maternity support worker's category, a gap was found in the framework, as effective care was not discussed.

In the dimension of efficient care, a tension was found between who decides what efficient care looks like. The participants in the group of obstetrics were aware of the importance of respecting women's autonomy but despite that, they felt an inner conflict, wanting to prioritise clinical safety (avoid clinical harm). Within the conceptualisation of efficient care, the safety vs. personalisation dilemma re-surfaced. This internal conflict is in contrast with the framework that the UK law provides to ensure that safety and personalisation cannot be separated (Montgomery vs. Lanarkshire) (Abrams, 2014; Campbell, 2015).

Midwives and women saw midwife-led models of care, including personalised care as a facilitator to achieve efficient, timely, and effective care. Midwives felt that the organisational culture was not supportive of this idea. They noted that their perception was that other members of the multidisciplinary team saw woman-centred care aspects such as midwifery units or continuity of care as inefficient. The documentary analysis data uncovered that midwife-led services were closed or consolidated in times where there was shortages of staff and that care for all women was centralised on the high-risk units (Anonymous, 2022f). This is in line with other studies, which highlight that the healthcare system was influenced by neoliberal post-industrialised consumerist values, which aim for healthcare that is performance driven (Chadwick, 2018; Sandall et al., 2009).

See chapter nine, for an in-depth discussion of the findings of the three phases.

8.6. Conclusion

The interviews, focus-groups, observations, and documentary analysis of the organisational ethnography were effective data collection tools to collect the necessary rich and in-depth information. Subsequently, the framework analysis was instrumental to uncover how the different individuals in the different groups defined and implemented maternity care quality.

The results showed an insight in how the delivery of high-quality maternity care, requires a delicate balance between efficiency, effectiveness, and timeliness.

Efficient service delivery was broadly defined by the participants as good teamwork, collaboration and communication, good resource management, and overall being resourceful as a team. Effective care on the other hand was conceptualised by the stakeholders involved as care that fulfils individual needs after informed consent was obtained, while using evidence-based practices. Both over- as well as under medicalisation were seen as ineffective. Lastly, timely care evolved around smooth care pathways, and good communication. Early care and care along the pregnancy, birth and postnatal continuum was seen by the professional participants as crucial to ensure timely interventions. Similarly to how effective care was defined, timely care was seen by women and partners as care that addresses the individual needs, in this case by having access to named healthcare providers, short waiting times, and timely interventions.

Even though people think they are communicating a shared concept when they talk about 'quality' in maternity care, this study suggests that their underlying definitions and conceptualisations for the term may differ substantially.

Based on the findings of the organisational ethnography, high quality maternity care goes far beyond preventing morbidity and mortality. Overall, quality maternity care requires a holistic approach that considers different perspectives, prioritises efficiency, effectiveness, timeliness, equity, and both safety 'and' personalisation. The implementation of a clear and shared vision on maternity care quality is of great importance.

The next chapter brings the three research phases together. The results are discussed using the critical realist lens. Furthermore, a brief overview around how the findings could be theorised using Resilient Healthcare and Sense of Coherence perspective is given. The original contributions of this work are presented, and insight is given in how this work fits in the wider literature. Lastly, recommendations, personal remarks, and final conclusions are made.

CHAPTER 9: SYNTHESIS, DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

9.1 Introduction to the chapter

The previous chapters have given an overview of the research that was conducted to find out how maternity care quality is defined and implemented by the different constituencies involved in maternity care. A three-phase research project was carried out including a meta-narrative review to uncover how quality of maternity care was defined by the different stakeholders over time, analysis of the Babies Born Better survey to find out what maternity care quality meant to women and their partners, and an organisational ethnography, to understand how quality of maternity care is defined and implemented in maternity units. From a critical realist perspective (Bhaskar, 1997; Walsh & Evans, 2014), the analysis allowed for a deep dive into an examination of the 'real' but invisible phenomenon of 'quality of maternity care' through empirical exploration of the 'actual' manifestation of it in the observed practices and narrated beliefs, values, and experiences of the managers and front-line staff putting it into practice, and the service users receiving it.

Through the analysis, the findings of the meta-narrative review have revealed that there is no clear evolution in how maternity care quality has been defined and conceptualised over time by the different disciplines involved in or commenting on maternity care. The same basic ingredients of quality such as safe, efficient, effective, equitable, timely, and individualised care have been used by the different disciplines over time but no universal definition of quality in maternity care exists. Individual and disciplinary interpretations of the phenomenon can be influenced by the culture in which they work, the history of the discipline, the previous experiences, and the belief system and social environment in which the individual exists.

The majority of women who responded to the Babies Born Better study reported having experienced high quality maternity care. However, this was not universal. The findings generated additional insights into which aspects of care are needed to achieve high quality maternity care from the point of view of those using it. In line with many other studies (Downe et al., 2018; QMNC, 2024; Skoko et al., 2018; van den Berg et al., 2022; Vedeler et al., 2023; Vedeler et al., 2021), BBB respondents wanted continuity and consistent care, in which they and their babies received compassion and respect from competent personnel. Ideally, the care would be focused on the whole family as a unit and be culturally sensitive. Women saw the space of birth as a social space in which they could welcome their loved ones. The physical lay-out and facilities available are important aspects of how quality is rated. In addition, women want a sense of emotional and physical security and wellbeing. Feeling safe for women meant emotional (individualised, respectful care) as well as physical (no clinical harm) safety.

The accounts of the stakeholders involved in the organisational ethnography revealed nuanced insights into how quality of maternity care is defined in various ways by the different individuals and groups involved. The data suggests that the operationalisation of these definitions into practice was influenced by the specific context and organisational culture.

The purpose of this chapter is to bring the three phases of the study together, and to ground them in the wider conceptual literature. In this chapter the contribution to knowledge, strengths and limitations, and recommendations for practice, research, policy, and education are discussed. Lastly, it contains my final personal reflections and final conclusions, drawing this thesis to a close.

9.2 Synthesis

Bringing the three phases together

When bringing the three phases together, the safety 'or' personalisation dilemma can be seen as the red thread through the thesis. Safety and personalisation are two aspects that have come back repeatedly as two necessary ingredients of quality maternity care. Even though, in this study, similar words were used by the different constituencies involved in maternity care to define quality, I uncovered that the meaning, weight, and coherence of these concepts were different. For example, the quote on page 139 (Midwifery manager 2) suggests that 'personalisation' is an add on, only to be applied when clinical 'safety' was assured, whereas in the quote on page 132 (Midwifery manager 5), the staff member concerned explicitly said that personalisation is a fundamental part of 'safety', both clinical and psychological.

So, even though people thought they were communicating a shared concept when they talked about 'quality' in maternity care, this study suggests that their underlying mental models for the term differed, sometimes substantially.

The meta-narrative review (phase one) showed that both the words 'safety' and 'personalisation' are used in an uncritical manner as only a few papers clearly define what they mean and furthermore, give an idea around how they saw the relationship between the two. Participants in the BBB survey (phase two) overall reported a positive experience but where there were negative experiences, this was usually due to a lack of personalised care and as a result, feeling unsafe. The organisational ethnography (phase three) showed that most women, most midwives, and some midwifery managers, especially the ones that work in midwife-led settings saw woman-centred care as a core aspect, necessary to provide safe and thus high-quality care, as also found in a series of prior studies and recommendations (Downe et al., 2018; Miller et al., 2016; NHS England, 2016a; Sandall et al., 2016). Nevertheless, some participants reported a lack of feeling safe due to not being 'known' and frustrations with the lack of woman-centred care, which was confirmed by my observations (see table 18 for the relevant observations and documents). Based on the documents, quality as implemented in the units focused on clinical safety (e.g. the maternity dashboard's safety

indicators are focused on the occurrence of serious incidents and clinical harm of the baby (morbidity and mortality) (Anonymous, 2024). While 'personalisation' was measured, this tended to be through completion of documents (birth plans, for instance (Anonymous, 2021b)) rather than through checking if women actually got the care they wanted. This appeared to render the provision of personalised care a tick box exercise that needed to be completed as a supplement to the 'real' business of clinical care.

The next section draws onto two existing theories, providing a more in-depth understanding of the safety 'or' personalisation dilemma found in the research project.

Resilient Healthcare

Some authors have claimed that healthcare (and so maternity care) in the UK is strongly influenced by neoliberal post-industrialised consumerist values. Some argue that this is the driver for the super-valuation of the healthy baby as the 'product' of the maternity system (Chadwick, 2018; Sandall et al., 2009). The move towards performance-driven health care, which is explored in chapter two, triggered dissatisfaction due to the identification of a high number of medical errors, resulting in preventable harm (Donaldson et al., 2000; IOM, 2001). The landmark report "To Err is Human" highlighted that systemic failures rather than individual incompetence were the basis of most adverse events (Donaldson et al., 2000). It has been argued that problems in healthcare in the modern world (long waiting lists, missed diagnoses for example) can be attributed to a rise in demand of care due to the existence of chronic diseases, an ageing population, and technological, diagnostic, and therapeutic progress (Elshaug et al., 2017). To be able to provide the right care, to the right person at the right time has therefore become more difficult (Miller et al., 2016), due to the rise in demands and work pressures on healthcare staff in the context of shortage of staff, and rising healthcare costs (Hollnagel & Braithwaite, 2019; Pedersen, 2016).

In phase two and three of this study, shortages of staff and staff pressures, (financial) demands on the maternity care system, and not always having the right physical resources or conducive environments became clear. According to Hollnagel and Braithwaite (2019), many unsuccessful attempts have been made to fix these problems using solutions that have come from other industries (the airline industry and factory systems, for example). The focus of these solutions has been mainly on the symptoms, as a proper diagnosis of the core issues does not seem to have been undertaken (Hollnagel & Braithwaite, 2019). This organisational ethnography has shown that attempts to improve the quality of maternity care are focused on control and the standardisation of work., in line with the IOM dimensions of safety and effectiveness in which benchmarking, governance, standardised protocols, and other tick-box exercises are proposed as hallmarks of high-quality care. This is in line with other research giving examples of how root cause analysis, standardised programmes, clinical guidelines, and managerialism and bureaucracy were seen as important aspect to provide quality of care (Kapur et al., 2015; Singh et al., 2024; Wickramasinghe, 2014).

In exploring this field, analysts have argued that health care cannot be reduced to simplistic production lines and so cannot be controlled as such (Braithwaite et al., 2015; Hollnagel, 2014; Verhagen et al., 2022). According to Hollnagel et al. (2006), a multifaceted solution is needed to this complex problem, one that he also found in industry. This involves a new way of thinking about safety, termed 'resilience engineering'. Hollnagel adapted this into healthcare as 'resilience health care' (Hollnagel et al., 2006). The term resilience refers to the adaptability and adjustability of a system before, during, and after changes and disturbances so that it can continue its performance smoothly, in contrast to a reaction followed by recovery model. It is the ability to thrive rather than just survive after problems arise and to exploit the opportunities that lie within (Hollnagel & Braithwaite, 2019).

Resilient Healthcare is defined by Hollnagel and Braithwaite (2019) as: *"the ability of the health care system to adjust its functioning prior to, during, or following changes and disturbances, so that it can sustain required performance under both expected and unexpected conditions (p. xxv)*" (Hollnagel & Braithwaite, 2019; Hollnagel et al., 2006). In most cases, safety is determined by its absence, rather than its presence (Braithwaite et al., 2015; Verhagen et al., 2022). Following this theory, safety is divided in Safety-I and Safety-II. In summary, Safety-I looks at what goes wrong, and its success is defined as the absence of adverse events. Furthermore, Safety-I focused systems assume that by finding, weakening, or eliminating the cause of adverse events, safety can be provided (however 'safety' is defined in a specific context). Safety-II, on the other hand looks at what continues to go right in everyday complex systems, and at what is needed to reach and maintain what goes right ('safety') under varying conditions so that intended outcomes can be achieved (Hollnagel & Braithwaite, 2019; Hollnagel et al., 2006; Verhagen et al., 2022). Resilient healthcare and so Safety-II increases the appreciation and visibility of healthcare providers' collective efforts to provide safe and high-quality care in challenging circumstances. From a Safety-II perspective, 'work-as-done' is a more realistic indicator of how the system operates on a daily basis than 'work-as-imagined', which is an idealist view of 'quality', captured in guidelines, protocol documents, and high-level reports and recommendations, that fails to acknowledge how teams and individuals actually function in complex, dynamic situations. Studying 'work-as-done' is crucial to understand what goes right most of the time, and to improve the safety and quality of care (Verhagen et al., 2022).

Using a critical realist lens enabled me to apply the theory of Resilient Healthcare and therefore Safety-II to my data. It allowed me to look at how the maternity care system works rather than only looking at how it fails. The meta-narrative review (phase one) mainly gave a glimpse of work-as-imagined by the various constituencies included. This was evident in the definitions, conceptual frameworks, and indicators for quality that were found. The analysis of the Babies Born Better survey gave a glimpse of the actual lived experience of the women who responded, which could be seen as the consequence of 'work as done' rather than of 'work as imagined'. Lastly, for the organisational ethnography, framework analysis was used to compare the data within and across the different stakeholder groups. Table 20 shows how work-as-done/imagined was evident in the

data. This shows that, even though quality was mainly conceptualised through a Safety-I ideology (with greatest focus on the (clinical) safety dimension of the IOM), some aspects of resilient healthcare also emerged in 'work-as-done', especially where staff 'worked around' the business and stresses of the unit to provide care that incorporated a wider range of the IOM quality dimensions.

Table 20: Example matrix work-as-imagined versus work-as-done

Discipline	Work-as-imagined	IOM dimensions	Work-as-done
Wider multidisciplinary team	Standardised guidelines and protocols make care safer. Having good IT systems with all the necessary medical information about the patients in place. Safety is where the unit has good outcomes, there is serious incident reports and a drive to know what happened so improvements can be made.	Safety	*"To be resourceful and stay safe even when there is sub-optimal staffing."* Anaesthetic specialist registrar *"A tray like a box full of major, major haemorrhage, drugs ready to go, checked every day in a Tupperware box, and right above written exactly how to draw it up. Really small things that can actually save like you know, a few minutes or quite a bit of time"* Anaesthetic specialist registrar
Maternity Support workers	Maternity support workers work at a ratio of 1:25 beds (some beds occupied by a pregnant woman, some beds occupied by a woman and her baby) There are checklists in place on all emergency equipment to aid efficiency in emergency situations (Anonymous, 2011). The emergency equipment should be checked daily by a maternity support worker or midwife.	Efficient	Good teamwork ensured that when maternity support workers were busy, midwives would take on tasks such as making beds to improve timely care for women (Observation 10, Date: 6/06/2022). *"I don't know, changing the beds or making the tea. When they see that you are busy, they do it themselves. They don't ask you to do it. So, you're just like a teamwork. You just like you help them, they help you. This is the way it's running smoothly." Maternity Support Worker 1 – S-BC-MSW-F-21*

Impact of health system pressures on work-as-done

Data collection for phase three happened just after the Coronavirus pandemic. At that time, there was a shortage of all frontline staff, and especially midwives. This problem was attributed to multiple reasons such as a high number of midwives being at a retirement age, Brexit (fewer midwives coming in from Europe), a higher leaving rate due to the increased pressures of Coronavirus pandemic, etc. In September 2022 it was documented that in both units, an overall gap of 49 (15%) full time equivalents existed. Many participants spoke about this shortage of human resources and its influence on safety and personalised care (see chapter seven). Furthermore, in March 2022, the final Ockenden report was published, in which the immediate and essential action was to abandon the continuity of carer model until safe staffing was present (see chapter eight) (Ockenden, 2022). Here too, the safety versus personalisation split became apparent. Below, I have set out an example of how work-as-imagined differed significantly from work-as-done. It shows that some evidence of resilient healthcare in the units was present.

Work-as-imagined

In the section on health system pressures (see above) it was explained that, under growing evidence of system crisis, 'work-as-imagined' in official documents arising from reviews and pandemic consequences has increasingly framed quality of maternity care around a limited set of IOM criteria – mainly reducing mortality and severe morbidity. As an example, while some of the Ockenden review recommendations have been praised (such as increasing teamwork) others have been critiqued for a lack of evidence and personalisation (including restrictions of the continuity of care model).

> Ockenden, 2022, p14: *"Suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present."*
>
> Midwifery Manager 2: *"We were, two days ago, we were down 16 midwives across sites. Right now, the biggest pressure is safety. And I know exactly what you're going to say... where is personalisation? But right now, when you're down 16 midwives, it's really challenging."*

External recommendations and the focus of midwifery management in the work-as-imagined category pointed at safety over personalisation in this instance. The Ockenden report (2022) advised to discontinue the drive towards midwifery continuity of carer until safe staffing was present (Ockenden, 2022) and *Midwifery manager 2* embodied that recommendation in the way she was leading the maternity teams. In her work-as-imagined, safe staffing and so safety needed to prevail first, before staff were expected to continue putting woman-centred care, thus continuity at the forefront.

Work-as-done

Nevertheless, aspects of resilient healthcare (Safety-II) were identified in the observational data and interview data from the wider multidisciplinary team and maternity support workers (see table 20). Here I focused mainly on the ability of the maternity teams to provide personalised as well as safe care where staffing is very short and expected to compromise the quality of care given. The analysis of the Babies Born Better survey showed that most women reported a good experience and aspects of safe- and woman-centred care, with a wider range of IOM dimensions than in some of the governance documents. In the ethnography, women reported they had felt safe because they were treated in a personalised way, showing how 'doing quality' meant 'both-and' not 'either-or'. An Anaesthetic specialist registrar explained how the team still managed to provide high quality, safe care, despite the staff shortages. Furthermore, one of the midwifery managers discussed how frontline staff go above and beyond to provide good care. Lastly, midwives explained how they kept their home birth service and so continuity of carer model running, under immense pressures due to shortages of staff.

> Mother 3 (site 1): "*I'd say me personally I did [feel safe]. And a lot of it was the reassurance that's given. And the way that, the way that things were delivered or how we were spoken to about things, kind of things being explained and kind of not felt that you were just another number, that you're actually a person going through this life changing experience."*
>
> Anaesthetic specialist registrar: *"What can they learn from here? That's the question, right? I think how to be resourceful and stay safe. When... because you're always going to have time in NHS here your sub-optimal on your staffing and it's about how to try and stay safe doing that. And I think by having open conversations and flattening of hierarchy and things like that."*
>
> Midwifery Manager 2 (midwife-led services): *"I think we have midwives who go above and beyond who, you know, kind of… I think it's about even personal attributes, many, many, midwives, they're a pleasure to work with, …"*
>
> Band 6 Midwife 2 (home birth team): *"[we provide] a holistic approach, active listening to families, trying to meet their needs as much as we can in the safest way."*
>
> Band 6 Midwife 5 (home birth team): *"…increasing our hours were a matter of safety for the families, but in the long term, it wasn't good enough for us."*

The social constructionist epistemology combined with the critical realist lens used in my PhD study enabled me to not only see the empirical and actual but also allowed an insight into the real, which can be seen as examples of resilience in the socially constructed organisational culture. The above illustrations show that, even when the necessary human resources are not in place to provide safe and personalised care, staff attributes such as good teamwork, communication skills,

and the willingness to go above and beyond were seen as enablers to continue providing high quality care, across multiple IOM dimensions.

There were, however, barriers to achieving high quality care across the IOM dimensions in the data illustrating work-as-done. The case study looking more in depth into the reasons why all midwives of the home birth team resigned in a timespan of just three months can be seen as a very clear example of how a strong, resilient team can crumble under long-lasting pressures that aren't resolved (see more details below on pages 177-178, section: 'An illustrative case study').

This insight led to another question: What makes an organisational culture resilient?

The need for 'Sense of Coherence'

While some attributes of resilient healthcare were present in the unit investigated, a lot of barriers were identified. As mentioned before, individuals defined quality maternity care differently. The organisational culture observed, predominantly prioritised safety over personalised care. This posed significant cultural conflict for frontline staff that embodied the notion that safety cannot exist without personalisation. For these participants, functioning in an environment that was not in line with their values, was extremely difficult. Could the conflict in values around quality of maternity care have caused a lack of 'Sense of Coherence'?

Salutogenesis is a term that was introduced by the medical sociologist Aaron Antonovsky in his book "Health, Stress and Coping" (1979). The term refers to the study of the origin of health and wellbeing. In his theory he focused on factors that create health, wellbeing and positive outcomes in public health, as well as considering ill-health and death. The philosophy stands in contrast to the normative health care lens that is highly focused on the identification and prevention of pathology, almost to the exclusion of positive wellbeing (Antonovsky, 1987a, 1996; Magistretti et al., 2016)

According to Antonovsky (1979) the sense of coherence is defined as: *"A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (p. 124)"* (Antonovsky, 1979).

The three dimensions of the Sense of Coherence, which is the main concept in Antonovsky's theory of Salutogenesis are the following: (1) comprehensibility (the degree to which a person feels their world and experiences are understandable, predictable, and structured), (2) manageability (the perceived resources a person has available to deal with the challenges they face, including illness or stressful situations), and (3) meaningfulness (Explores the purpose and value associated with life experiences) (Eriksson, 2017; Mittelmark et al., 2022).

An illustrative case study: the organisation's home birth team

A case study built from the data can illustrate this point, showing what happens when there is a irreconcilable conflict between the quality of care model in work-as-imagined by the maternity service organisation and that of staff within it, meaning that work-as-done cannot overcome this conflict: and how this results in a loss of Sense of Coherence, and, eventually, loss of the staff affected.

Through the various organisational pressures noted above on page 174, members of the Trust home birth team tried to keep providing both safe, as well as personalised, high quality maternity care. However, their resilience was not endless. The following quotes make clear that even though they tried to provide care that was in line with their values and beliefs, they were not supported enough to maintain it.

> Band 6 Midwife 2 (home birth team): *"Because we were covering the service ourselves at our own, expense of our own time. That it was, it was not being recognised that we needed, we needed the support from management because we were a very self-contained team. But that doesn't mean we didn't need to feel that there was also a backup in place."*

> Band 6 Midwife 5 (home birth team): *"We didn't feel listened to. We didn't have safe staffing. We didn't have enough backup. We were not paid enough. We were all tired. We didn't feel supported well enough."*

In my tenth month of data collection, the whole home birth team had resigned. While listening to these midwives' stories, it seemed that they initially tried to 'work-around' what the organisation required of them in the 'work-as-imagined' structures, but, eventually, they could not compensate sufficiently in their 'work as done'. Consequently, they did not feel that their work was manageable, and so they were not able to carry out the work they felt to be meaningful. They could not comprehend why the organisation allowed this to happen.

The midwives didn't understand the predominant definition of quality and culture present in the organisation as it did not align with theirs. Furthermore, they didn't feel understood by the management team regarding their values and needs. One of the midwives noted she found a new job as a home birth midwife in a different unit and expressed what her hopes for the new jobs were:

> Band 6 Midwife 5 (home birth team): "*So, I'm hoping to start fresh. To meet a different. Let me find the words [laughter]. I really, I'm hoping, I'm not sure if it will happen to find somebody that listens to us and prioritises safety, first of all, of the staff. Therefore, everything will work out well. I know that."*

Secondly, they felt they couldn't cope with the pressures any longer.

> Band 6 Midwife 5 (home birth team): *"I've got depressed for the first time in my life and I've got off sick for the first-time kind of long term in my life. It [the lack of support and pressures on the team] affected me this much. I was always happy about my job [getting emotional]. And the last month it wasn't."*

Thirdly, the pleasure they used to get out of their jobs while it was manageable diminished as their work-life balance became more and more compromised.

> Band 6 Midwife 2 (home birth team): *"But I think she [the teammate that resigned] probably represents the person that gave so much more than she had to give to maintain the service. Her commitment to providing continuity, to ensuring that every single person on that caseload got the care plan that they wanted to have, I think. And because, again, when we became short staffed, the demands on the rest of us increased. She you know, we would have sort of running jokes about her work life balance, slightly humorous, but also slightly like, are you okay? And wanting to make sure that she was taking time to rest. And I think actually she went very, very hard for quite a long time. And that is reflected in the amount of money that she is owed for the, for the on-calls that she took up. And I believe that she probably had a very strong urge to take a step back from quite such a high demand job."*

> Band 6 Midwife 5 (home birth team): *"I know for 100% that we [the midwives of the home birth team] loved what we do, and we would have done it for ages, if we could. But some of us were just too tired and the working on-call is known to be harder for the lifestyle for the wellbeing. Many midwives decide to change and not be on-call for a while. But in these circumstances, I feel like it's being forced for other reasons. I don't know if you know, but I am going to do the same job, but in a different hospital."*

What is meant by 'Quality Maternity Care'?

This contrasting perspectives of childbirth within and between stakeholder groups involved in maternity care in this study illustrates how childbirth takes place between two different belief systems. One perspective is broadly 'salutogenic', where pregnancy, birth, and the postnatal period are seen as normal life events with life-course implications, a focus on a continuum which ranges from complete health and wellbeing through to ill-health and death. Many working from this perspective characterises pregnancy, labour, and birth as healthy ('normal') until proven otherwise (Downe et al., 2020; Downe et al., 2022; Magistretti et al., 2016). On the other hand, the 'pathogenesis' perspective puts the emphasis on avoiding short term physical ill-health and death. In this analysis, pregnancy, birth, and the postnatal period can only be categorised as 'normal' (i.e., healthy) in retrospect (Blaaka & Eri, 2008). This implies a stronger emphasis on physical safety than on the values and experiences of childbearing women. While this may reduce adverse outcomes for some, it has a price for others. An indication of the potential consequences can be found in the

Babies Born Better survey results cited in this thesis (chapter five). Nine out of thirty-seven participants of the Babies Born Better survey (about 1:4) rated their care as partly or completely bad. These women spoke out about being given inconsistent information, generic care, which was not adapted to their individual needs, no continuity, no attention to their birth preferences, disrespectful treatment (no informed consent asked), interactions with tired, stretched, and forgetful staff which consequently had an influence on their feeling of safety and security.

In maternity care, researchers have highlighted the need for a whole-system approach instead of providing fragmented maternal and newborn healthcare (Renfrew et al., 2014). Some have argued that, under the dominance of the biomedical paradigm, the social, cultural, spiritual, and psychological factors which enhance safety are often being ignored (Campbell & Macfarlane, 1994; Davis-Floyd, 2001; NHS England, 2016a; Vedeler et al., 2021).

The dimensions of quality of the Institute of Medicine, were a recurring theme in the meta-narrative review and the framework was a good fit for the data obtained during the observational ethnography. Nevertheless, gaps existed, and disconfirming data were uncovered (see chapters seven and eight). As mentioned in chapter six, equity was not talked about in all stakeholder groups (e.g. obstetricians). The limited conceptualisation of equity in the stakeholder groups needs to be taken into account, especially given the recent evidence around women from minority ethnic and socially deprived backgrounds having worse physical outcomes in the UK (MBRRACE-UK, 2023).

Compared to the framework of IOM, other conceptual frameworks for quality maternity care such as the WHO framework and the Quality Maternal and Newborn care framework (QMNC) consist of more dimensions (IOM, 2001; QMNC, 2024; WHO, 2016). When these other frameworks are judged against the data derived, it becomes clear that the dimensions of IOM can be used as the overarching themes for the sub-themes used in the other frameworks.

However, even if the IOM model does capture the critical components of quality maternity care, the findings of this study suggest there is no mutual agreement between the constituencies involved in maternity care about how these components should be defined and implemented. It is likely that those within the organisation will not have a sense of coherence at work, and that work-as-done will not be in line with work-as-imagined. The logic model could be that, if people don't feel understood in their own philosophy and needs, they don't see the meaning and importance of their work as they don't get acknowledgement, and lastly, they won't get the support they need and so are more likely to leave their jobs (or even their profession). All the above might have a knock-on effect on the resilience of the organisational culture and overall quality of maternity care.

9.3 Original contributions

The original contribution to knowledge described in this thesis include the application of the dimensions of quality of the Institute of Medicine in maternity care, the notions about what quality of maternity care means which sometimes was and sometimes wasn't overlapping between the different stakeholders. Furthermore, the implications of these differences in terms of the organisational and staff Sense of Coherence, including the alignment (or not) between organisational 'work-as-imagined' and frontline 'work-as-done'.

This is important because recent independent investigations in maternity and neonatal services, Care Quality Commission ratings, and the recent health and social care committee report about safety in maternity services, noted that an urgent need has risen for national policy to focus on quality of maternity services in the UK (CQC, 2024; HSCC, 2021; Kirkup, 2015; Kirkup, 2022; Ockenden, 2022). Current policies in place in England highlight the need to listen to women and families with compassion, develop and sustain a culture of safety, support the workforce, and to meet and improve standards and structures. Even though the National Maternity Safety Ambition which was launched in 2015 set out to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries occurring during or soon after birth by 2025 (DHSC, 2021), it is unlikely that the reduction rate of stillbirths will be met. The Government's 2022 Women's Health Strategy for England has set out plans to address the health disparities that are currently present as explained in the background chapter (chapter two) (NHS England, 2023b).

This implied the need for an empirical study that looked at quality from a different perspective, to find out why current quality improvement efforts aren't effective. This study aimed at addressing the existing research gap in relation to how quality in maternity care is constructed.

This was the first study looking at quality in maternity care using a social constructionist combined with a critical realist lens. To my knowledge, no meta-narrative review was conducted comparing how this topic was investigated by the different disciplines over time. The Babies Born Better survey has been used many times to analyse what women find important regarding their maternity care. The results of this study are in line with what most researchers have found in the different participating countries (Kuipers et al., 2023; Nilsen et al., 2021; Santos & Neves, 2021; Skoko et al., 2018; van den Berg et al., 2022; Vedeler et al., 2023; Vedeler et al., 2021). In this study the novelty lies in how the Babies Born Better survey data was used to complement and enrich the findings in the other two phases. Ethnography is a methodology that has been used often to examine the contextual factors and underlying mechanisms in maternity care (Coates & Catling, 2021). To my knowledge, this was the first organisational ethnography looking at how quality of maternity care is conceptualised and implemented by the different constituencies involved in maternity care in the UK.

Keeping the data of the three phases separately, and per discipline, made it possible to make interesting comparisons between and within groups and get an insight into how definitions around quality of maternity care are socially constructed. Furthermore, using critical realism made it possible to see the contextual factors of what is real, which has an influence on the actual and empirical (Walsh & Evans, 2014). By using the methodology described, novel insights were found around the existing safety 'or' personalisation dilemma. The use of the theories of resilient health care (Safety-II) (Hollnagel & Braithwaite, 2019) and salutogenesis (Mittelmark et al., 2022) have provided original insights into the Sense of Coherence in maternity staff in relation to the match or mismatch between their definition of maternity care quality and that of the organisation they work in. This in turn might have an influence on the ability of staff to provide Safety-II.

The potential relationship between these has not been described in the literature before. This first exploration of combining these theories opens the way for more in-depth research to find out if these concepts influence each other and furthermore, influence the ability to provide high quality maternity care.

9.4 How the findings are embedded in the wider literature

In chapters four, five, six, seven, and eight, a discussion was provided on the methods and findings of each of the three phases of this research project. As mentioned before, these analyses generated a more in-depth overview of the 'real' nature of 'quality', which has an influence on the 'actual' (what is known but cannot be seen in terms of the nature of quality) and 'empirical' (what can be observed in this area).

Realities and consequences of the safety 'or' personalisation dilemma

In the three phases of this research project, it became clear that the organisational culture in the research sites generally prioritised operational efficiency within a medicalised and standardised framework. While some respondents felt that the consequent focus on physical safety was sufficient, others felt that it undermined evidence-based practices and limited women's and midwives' autonomy. For these individuals, this approach compromised quality of care, particularly in terms of the dimension of personalisation, but also in terms of timely and efficient care provision. Other researchers have noted the impact of technocratic biomedical models of care on choice and individual care (Davis-Floyd, 2001; Davis-Floyd, 2023). Researchers have also critiqued organisational cultures that prioritise biomedically managed births and strict adherence to guidelines, particularly in relation to midwives' autonomy and how they limit their ability to provide woman-centred care (Einion, 2017; Newnham & Kirkham, 2019). This finding reflects broader concerns about overmedicalisation in childbirth (Johanson et al., 2002; Miller et al., 2016). It can be argued that healthcare that is very guideline-centric (Anjum & Mumford, 2017; Kotaska, 2011) has the potential to ignore the current available evidence (Greenhalgh et al., 2014; Wieringa et al., 2017).

Some of the professional stakeholders were of the impression that the woman-centred philosophy of midwifery care was weak due to the lack of strong midwifery leadership (Department of Health, 1993, 2007b; NHS England, 2016c). This had a negative effect on the provision of high-quality care from the midwives and women's points of view who saw personalised care as a key aspect of safe and high-quality care. Despite existing knowledge about the limitations of guidelines (Greenhalgh, 2018; Wieringa et al., 2017), the risks associated with over-medicalised birth (Miller et al., 2016; Renfrew et al., 2014), and the available reports from the independent enquiries vouching for better communication, teamwork, and more woman-centred care (Kirkup, 2015; Kirkup, 2022; Ockenden, 2022), safety (meaning no clinical harm) was still the focal point in the maternity care organisations investigated.

In the organisational ethnography, a culture of blame associated with fear of litigation was mentioned as a contributing factor to overmedicalisation and a lack of women centred care and consequently, low quality care for some women (see p. 135). Other research has described this blame culture and subsequent fear as being associated with an increase in defensive clinical practice (Robertson & Thomson, 2016; Wier, 2017; Alexander & Bogossian, 2018). Some participants noted that the focus on physical safety exacerbates the issue and leaves practitioners more vulnerable to litigation. They saw relationship-based and woman-centred care as an antidote to the litigation issues (see chapter seven). The phenomenon of women reporting a better experience of maternity care and better outcomes when having received relationship-based or a continuity of care model, has often been described in the literature (Kuliukas et al., 2016; Leap et al., 2010; Perriman et al., 2018; Sandall et al., 2016).

Especially for the midwives in the home birth team who took part in this study a disparity in ideologies was evident about what quality of care was. This seemed to be due to the lack of coherence between their desire to be 'with-women' and provide woman-centred care in an organisational culture that prioritised institutional needs and physical safety above all. The absence of support they received to enable them to provide care that was in-line with their philosophy of care became so challenging that all the home-birth midwives resigned in a very short time span. These findings reflected existing evidence in which midwives felt they were unable to provide the high-quality maternity care they believe is right (Davies et al., 2011; Feeley, 2023; Hunter, 2006). Research suggests that this may lead to stress, burn out, emotional distress, health problems and subsequently taking time off, going on sick leave, leaving the job or even the profession (Hunter et al., 2019; Mollart et al., 2013).

Resilient healthcare in other maternity care literature

Only one other study was found which used the theory of resilient healthcare in the context of maternity care. This study, titled '*Promoting resilience in the maternity services*' was written by Heggelund & Wiig (2018). This research project was a case study in two Norwegian maternity services that aimed to explore the mechanisms that shape resilience in maternity care. More

specifically, the researchers applied four concepts which are seen as the cornerstones of resilience (anticipation, monitoring, response, and learning). Even though no theoretical lens was mentioned, the study focused more on the empirical (what can be observed) and the actual (what is known but cannot always be seen) rather than on the real (hidden but necessary preconditions for the actual and empirical). The authors found that, when comparing the two different maternity services, similar mechanisms seemed to shape resilient maternity care (Heggelund & Wiig, 2018).

Even though both the current study and that of Heggelund and Wiig (2018) had very different aims, some similarities in the methodology, methods, and results were found. When taking a deeper dive in the results, similar facets of resilient healthcare were noted in the qualitative data such as the need for inter-professional collaborations and training, having good IT systems and organisational learning, evaluating and adapting clinical practices by learning lessons from incidents, having the necessary resources available, and collegial and professional support. In terms of quality of maternity care, Heggelund and Wiig (2018) argued that a process of organisational diagnosis would be a good starting point to find out how to promote resilience in maternity services with different contextual settings and operationalise the resilience theory further (Heggelund & Wiig, 2018).

An organisational Sense of Coherence?

Studies have been undertaken looking at sense of coherence in both childbearing women (Ferguson et al., 2014, 2015; Sjöström et al., 2004) and maternity staff (Gebriné et al., 2019). However, none have considered this in relation to different conceptions of quality of care.

Based on the data, this study has generated a theory about Sense of Coherence in maternity staff in relation to the match or mismatch between their conception of quality of care and that of the organisation they work in, that will need to be tested in future studies.

While a clear cause-and-effect relationship between staff sense of coherence and patient sense of coherence is not yet fully established in research, some studies highlight the potential benefits of fostering a supportive work environment for healthcare staff on the quality of care (Beardsmore & McSherry, 2017; Catling et al., 2017; Downe et al., 2010). Staff who feel empowered, have access to resources, and experience a strong sense of coherence may be better equipped to provide compassionate and effective care, which can contribute positively to wellbeing in childbearing women (Gebriné et al., 2019).

Looking at the maternity units investigated as a whole, it could be argued that the organisational Sense of Coherence was low. There was a low comprehensibility around the meaning of quality amongst the different constituencies involved in maternity care. For some staff, this led to a lack of coherence in vision around which domains of quality should be provided by the frontline staff and supported by the management team. Due to a lack of support and shortages of both human and physical resources, some participants in the study mentioned how sometimes work felt

unmanageable. Lastly, frontline staff also noted that they did not always feel valued, which reduced the meaningfulness of the care they provided.

When looking at the literature, limited research has been done about organisational sense of coherence, or about the association between this and Safety-II principles. In one of the few examinations in this area, Vaandrager & Koelen (2013) note that modern businesses need healthy (both physical as well as mental wellbeing), skilled and motivated employees, and learning opportunities. The authors claim that, to achieve a 'salutogenic organisation', employees need to be involved, and have a supportive environment in which they can do work that is comprehensible, manageable, and meaningful. This environment should offer resources to empower both employees and employers, fostering a system in which everyone can thrive (Vaandrager & Koelen, 2013). Given the interest of the health system in learning from business, this could be a useful direction of travel. However, no prior research was found on the organisational Sense of Coherence in maternity services, and the effect it might have on quality of maternity care.

9.5 Strengths and weaknesses of this study

The strength of this study was the overall richness of the data collected, using various qualitative methods, including a diverse sample of stakeholders from different disciplines in maternity care. Stakeholders included ranged from midwifery managers, frontline staff such as midwives and student midwives, obstetricians and student doctors, maternity support workers, other members of the multidisciplinary team, to women and their partners in the postnatal period. This facilitated the inclusion of varied perspectives on how maternity care quality is constructed by individuals in their social environments. The rigorous and multi-layered data collection using different methods such as the meta-narrative review, analysis of a survey, and organisational ethnography including interviews, group discussions, a documentary analysis, and observations was another strength of this research. This way, not only the different views of the participants could be examined, but also compared to how these views are implemented in maternity care.

The inclusion of two diverse maternity units with the same management structure was also a strength, even though no major differences in the cultures were identified.

One of the main challenges was the synthesis of the high volume of data, which is inherent to a multi-method approach. Rigorous reflexivity, discussions with the supervisory team, having external experts on the team, and keeping detailed accounts around the decisions made along the way helped to find direction and stay on track of the meaning making within this work.

The preceding Coronavirus pandemic made data-collection challenging due to the high amount of staff sickness, increased pressures on the system, tiredness of staff, etc. so the time to collect data was prolonged, and less participants than intended were included. However, even though, the

number of participants included in the end was much lower than first anticipated, the aims of the study were preserved and reached due to the richness of the data collected.

Although a contribution to theory, methodology, and maternity care was generated by conducting this study, there are some limitations to the findings. The risk of over- and under- interpretation of data is always present when conducting qualitative research. Through a critical reflection about my positionality, investigating my own notions around quality before starting data collection, overall reflexivity at every step of the way and supervision, ensured that the risk of my own beliefs and values obscuring important data was minimised.

Continuous negotiation in my role as an insider-outsider researcher was both a strength as well as a limitation. I knew my way around the hospital and so had immediate access to the clinical areas after ethics approval was obtained. Being a band 6 midwife at the time of data-collection also helped to be seen as the researcher, who is also 'one of the midwives', rather than anyone who can have a negative influence on their day-to-day life at work due to a potential power imbalance. My insights and experience as a midwife contributed to the richness of the end-result.

9.6 Recommendations

The findings of this study hold a few important implications for maternity care practice, policy, research, and education.

Education and Practice

These findings should be considered in the education of all constituencies involved in maternity care. Awareness needs to be built around the complex and multifaceted meanings behind quality of maternity care and the need for a holistic approach that includes safety (physical, emotional, social, psychological, and cultural) and personalisation. Both concepts cannot be separated, since safety depends on personalisation of care, not least in the law (Montgomery vs. Lanarkshire) (Campbell, 2015). To improve communication between and within the different disciplines involved in maternity care, from early in the education programmes to when working together in maternity services, multidisciplinary education should be facilitated. This will aid the flattening of hierarchies while also building a strong understanding of each other's philosophies and values around quality.

Policy

Recommendations for quality of maternity care need to take into account that personalised care is safe care. Rather than tick box exercises, and to avoid superficial implementation of important concepts that are needed to facilitate high quality care, guidance and quality assurance need to involve service users and all other constituencies involved in maternity care. Clear policy needs to be written about how safe care is defined and should be implemented, based on women's voices.

Research

More research is needed to explore if and how the safety 'or' personalisation dilemma can be addressed and resolved. Additionally, the theory of Resilient Healthcare and how this relates to the Sense of Coherence should be explored further, especially in settings where safety and personalisation are well integrated. Finally, research around how to implement these findings in clinical practice to ensure that not only the dominant voices are heard but that service users are truly able to influence how high-quality maternity services are designed and delivered.

9.7 Final personal reflections

An important aspect of this study has been my personal reflections which I made in my reflexive diary (OneNote), but also during the reflexive interview at the start of my journey, and during the monthly supervision meeting discussions with my supervisors. The belief that the quality of maternity care women receive is far from good enough and the accompanying anger have been the drivers to commence and complete this thesis.

One of the biggest challenges during this research was performing data-collection in the NHS Trust where I work clinically, and the immersion in the heartbreaking accounts of poor-quality maternity care. My own unique background as a woman and midwife has made it both more difficult as well as more enriching. I have evolved through both insider- as well as outsider roles, depending on the context I was in (see chapter three: Methodology chapter). I was well known by some participants, but not by others. This made data-collection at times more difficult as I constantly needed to reflect on how my presence, role, knowledge, and experience was perceived by the interviewee and so how it would influence the honesty and depth of their accounts given. Even though I knew people in the organisation, gatekeeping was a struggle, and I needed to employ a lot of time and patience to be granted access to the units to start my data-collection. The lack of staff, high sickness rates, and burnout of staff just after the Coronavirus pandemic made recruitment of participants difficult at times. At least two focus-groups that I organised had to be cancelled due to no attendees, another two transferred into face-to-face interviews due to only one individual attending. At the end of the organisational ethnography, I have tried very hard to organise a 'finding resonance' meeting, to check my findings with the constituencies involved in the two maternity units. After a few months trying and getting many rejections to present and discuss my research in different multidisciplinary meetings, usually with the excuse of 'not enough time' or not appropriate in this meeting, I had to cease my attempts. Ever since, it has felt a little that the research did not get the appropriate closure.

With the luxury of hindsight, there would be a few things I would do differently. First, I would make a slightly narrower research proposal that focuses more on depth or quality than quantity. Ambition easily carried me away and as described in the methodology chapter; the actual project reduced

quite significantly in size compared to the initial plans made. Next, I would gather a bigger team around me to help complete the selection of papers and data-extraction for the meta-narrative review. This is because the review took me much longer to complete than anticipated. In the end, these time constraints led to the analysis of a much smaller sample of the Babies Born Better survey. It would have been interesting to look at the data of the UK and maybe even of Flanders (Belgium) too, to be able to compare and contrast women's perceptions of quality. Again, due to time constraints and maybe not always great time management on my part, so far, I was unable to publish any papers on the findings of the PhD in a peer-reviewed journal. This is something I would try to manage better in the future.

While writing the PhD, I have encountered myself a lot. My perfectionism played a big part in the periods (sometimes months) in which I was unable to make any progress, no matter how hard I tried. Writing the PhD for me meant that I had to pull myself out of my comfort zone on a daily basis. I definitely underestimated the effects of feeling out of depth a lot, not knowing how to perform or use the theory and methods in the separate parts of the research project, the loneliness of working on your own project, what it takes to stay focused and motivated, the social sacrifices I had to make and what it takes to work on a full-time PhD while still working 0.3FTE in clinical practice as a midwife, with a few other projects on the side. Not to mention the personal events that happened, such as breaking both my wrists during a winter sports holiday. I have learnt that, in times when the discomfort is worst, the biggest growth and learning happens.

One of the most surprising things that I found was that some of the people I have closely worked with, and for whom I had preconceived ideas on how they would define quality, gave totally surprising answers during their interview. I was also pleasantly surprised about how easily work-as-imagined and work-as-done surfaced in the analysis and never expected to find such clear examples of resilient healthcare (or Safety-II).

Writing this PhD was an amazing opportunity for self-development and growth. I have learnt so much about the theory, methodology and methods used, and gained a lot of new research skills in the process. Many opportunities for dissemination were given in which I practiced my presentation skills, and I gained confidence in speaking to a diversity of audiences. This also led to an expansion of my international network and has opened the door for new collaborations and future research projects and publications. The in-depth knowledge I gained around how quality of maternity care is defined and implemented by the different constituencies involved in maternity care in the UK has helped me to grow as a person and a clinical-academic. The niche knowledge I have derived is very timely and I am hoping I will get the opportunity to use this knowledge to help improve services. As a clinical leader, I hope to be a great example and inspiration for other midwives, leading the way to a better understanding of high-quality maternity care in practice. Lastly, as a midwife, an auntie, a sister, a friend, I would like to help build a brighter future, in which women can thrive, rather than merely survive after childbirth.

9.8 Final conclusion

Through a social constructionism and critical realism approach, this thesis generated theoretical and practice-based knowledge around the broad research question: "*How is quality of care conceptualised by the different constituencies involved in maternity care in the UK?"*. By using a meta-narrative review and different methods of data collection (a survey, interviews, focus-groups, documents, and observations) from a diverse group of 85 stakeholders involved in maternity care in two maternity services in England and applying diverse analytical methods, an original contribution to maternity care practice, policy, research, and education was provided.

A unique insight in how quality of maternity care is defined and implemented by the different constituencies over time was achieved by comparing the literature from the different disciplines over time and by collating a vast number of people's perceptions while comparing them to how quality has been implemented. The six dimensions of the IOM were a recurrent theme in the meta-narrative review as they were used as a foundation for several conceptual frameworks and definitions of quality.

The organisational ethnography demonstrated that the dimensions of IOM capture the critical components of quality maternity care as defined by the participants involved in the organisational ethnography. Nevertheless, the findings of this study suggest that there is no agreement between the constituencies involved in maternity services about how these components should be defined and implemented. The dominant and most powerful voices within, but also outside of maternity services dictated how quality was implemented in the units investigated. A clear example of this was the safety 'or' personalisation dilemma, in which physical safety is seen as a more important aspect of quality of maternity care. Personalised care was stated to be important by all disciplines but was sidelined when organisational constraints (such as poor staffing levels) came into play.

The data from all three phases of the study was theorised within *Resilient Healthcare*, which provided new insights into the notions of 'work-as-imagined' and 'work-as-done' in maternity care. Some aspects of Resilient Healthcare were found in the unit, including staff that went above and beyond to facilitate personalised and clinically safe care to women regardless of staffing levels. Furthermore, a connection was made to the *Antonovsky's Sense of Coherence theory*, which has given insight in the perceived comprehensibility, manageability, and meaningfulness of the different constituencies involved in the study around the quality of maternity care. This has led to a hypothesis about a potential link between the Sense of Coherence, or the lack thereof, between the organisational and staff beliefs about what is 'real' about quality of maternity care, and the organisational resilience. Though more research is needed to verify if there is a causal relationship between these theories, both could be useful tools to get an in-depth understanding of the 'real' (in this case the drivers that shape the actual quality provided).

Even though people think they are communicating a shared concept when they talk about quality in maternity care, this study suggests that their underlying notions of the domains that make up the term can differ substantially. This study has shown that high quality maternity care goes far beyond preventing morbidity and mortality. This is why, the implementation of a clear and shared vision about what goes well, for all constituencies involved, is necessary for staff working in and women using maternity services to thrive.

Appendices

Appendix A: Observational guide

(Spradley, 2016)

	SPACE	OBJECT	ACT	ACTIVITY	EVENT	TIME	ACTOR	GOAL	FEELING
SPACE	Can you describe in detail all the *places?*	What are all the ways space is organized by objects?	What are all the ways space is organized by acts?	What are all the ways space is organized by activities?	What are all the ways space is organized by events?	What spatial changes occur over time?	What are all the ways space is used by actors?	What are all the ways space is related to goals?	What places are associated with feelings?
OBJECT	Where are objects located?	Can you describe in detail all the *objects?*	What are all the ways objects are used in acts?	What are all the ways objects are used in activities?	What are all the ways objects are used in events?	How are objects used at different times?	What are all the ways objects are used by actors?	How are objects used in seeking goals?	What are all the ways objects evoke feelings?
ACT	Where do the acts occur?	How do acts incorporate the use of objects?	Can you describe in detail all the *acts?*	How are acts a part of activities?	How are acts a part of events?	How do acts vary over time?	What are the ways acts are performed by actors?	What are all the ways acts are related to goals?	What are all the ways acts are linked to feelings?
ACTIVITY	What are all the places activities occur?	What are all the ways activities incorporate objects?	What are all the ways activities incorporate acts?	Can you describe in detail all the *activities?*	What are all the ways activities are part of events?	How do activities vary at different times?	What are all the ways activities involve actors?	What are all the ways activities involve goals?	How do activities involve feelings?
EVENT	What are all the places events occur?	What are all the ways events incorporate objects?	What are all the ways events incorporate acts?	What are all the ways events incorporate activities?	Can you describe in detail all the *events?*	How do events occur over time? Is there any sequencing?	How do events involve the various actors?	How are events related to goals?	How do events involve feelings?
TIME	Where do time periods occur?	What are all the ways time affects objects?	How do acts fall into time periods?	How do activities fall into time periods?	How do events fall into time periods?	Can you describe in detail all the time *periods?*	When are all the times actors are "on stage"?	How are goals related to time periods?	When are feelings evoked?
ACTOR	Where do actors place themselves?	What are all the ways actors use objects?	What are all the ways actors use acts?	How are actors involved in activities?	How are actors involved in events?	How do actors change over time or at different times?	Can you describe in detail all the *actors?*	Which actors are linked to which goals?	What are the feelings experienced by actors?
GOAL	Where are goals sought and achieved?	What are all the ways goals involved use of objects?	What are all the ways goals involve acts?	What activities are goal seeking or linked to goals?	What are all the ways events are linked to goals?	Which goals are scheduled for which times?	How do the various goals affect the various actors?	Can you describe in detail all the *goals?*	What are all the ways goals evoke feelings?
FEELING	Where do the various feeling states occur?	What feelings lead to the use of what objects?	What are all the ways feelings affect acts?	What are all the ways feelings affect activities?	What are all the ways feelings affect events?	How are feelings related to various time periods?	What are all the ways feelings involve actors?	What are the ways feelings influence goals?	Can you describe in detail all the *feelings?*

Appendix B: Interview schedules

Interview schedules

Staff and professional stakeholders

Pre-interview

Professional stakeholders and frontline staff will be asked to take pictures of three things that reflect what they feel makes their unit a good place to work, and three things they would like to change. (Participants will be asked not to take pictures of people and if anyone is in the picture to make sure they are made unidentifiable.)

Provisional interview questions:

1. Please describe the pictures you have taken of the three things that reflect what makes your unit a good place to work and explain in detail why you have chosen to take pictures of these specific aspects.

Possible probes:
Please talk about why these aspects of your unit are so important in your view.
How do these aspects affect your enjoyment of your job?
How do these aspects affect your job performance?

2. Please describe the pictures you have taken of the three things which you would like to improve?

Possible probes:
Please talk about why you think these things might be important?
How do these aspects affect your enjoyment of your job?
How do these aspects affect your job performance?
What kind of improvements would you like to see?

3. How do you feel about the overall care pregnant women/people receive in your maternity unit by the multidisciplinary team?

Possible probes:
Please talk about what you feel is really good.
How is health created for women/pregnant people, babies and staff?
Please talk about what you feel could be improved.
If, in your experience, your unit has a culture of continuous improvement, how is this done?
What can other maternity units learn from this unit?
Please describe why you would/would not advise your own friends and family members to receive care at this maternity unit.

4. Please describe what safety means in view of high quality maternity care.

Possible probes:
How would you define safety from a healthcare provider's point of view?
What do you think safety means to the women, babies and their families?
Is it safe to cause an actual harm to a woman to avoid/prevent a larger theoretical harm to a larger population or yourself as a healthcare provider?

5. Please describe what personalisation (individualised/personalised care) means in view of high quality maternity care.

Possible probes:
Is personalised care offered in the unit and if yes, can you give some examples?

6. How do you feel about the current management style and/or leadership in place?

7. End of the interview and debrief

Pregnant or postnatal women/people and their birthing partners:

Provisional interview questions:

1. Please tell me what your expectations about maternity care were before you had experienced any maternity care.

Possible probes:
How did you imagine it would be?
Where do you think these expectations came from (TV, social media, stories of female friends, upbringing, culture, etc.)?
How did these expectations make you feel?
What were your hopes?
Was safety something you were actively looking for in a maternity service or was it something you took for granted?
What did you feel you needed to feel safe?

2. Please tell me the story of your care. Start from the first moment you realised you were pregnant until you went home after your baby was born.

Possible probes:
How did you decide where you would have your maternity care?
Who was your main care professional?
What were the key events/experiences?
How did these experiences make you feel?
What were the aspects of your care that particularly made you feel safe or unsafe?
Did you feel you received individualised or personalised care and if yes, how was this facilitated?
How does this experience compare to a previous pregnancy/previous pregnancies if there were any?

3. Was the maternity care you got in line with what you expected, needed, and wanted?

Possible probes:
If yes/no, can you give examples of situations in which this became apparent.
How do you feel about the way maternity care is provided currently?
Has the experience of the care you got during pregnancy and birth impacted on your life and the way you feel now and, if yes, how?

4. What are your hopes for the maternity care of the future in this hospital, for yourself in another pregnancy, or for a family members/friends who might become pregnant?

Possible probes:
Is there anything you would like to change and why?
Is there anything you would like to keep exactly as it is and why?
If you were to need/use maternity services again, what would you hope for particularly?
If close family or friends were to need maternity care, what would you hope for them?

5. End of the interview and debrief

Appendix C: Participant information sheet professional stakeholders

University of Central Lancashire
UCLan

Participant Information Sheet - Professional Stakeholders

1. Title of Study

Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography

2. Invitation

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why we are conducting this research and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please contact us using the contact details of the investigatory team below if anything in this information sheet is not clear, or if you would like more information.

3. What is the study about?

Worldwide inequalities exist in access to women's healthcare, and there is significant variation in the provision, practice and outcomes of maternity care. The implementation of evidence based care could improve public health as long as this also respects woman's human rights, and their desire for a positive experience. Ideally, the design on which any maternity service is built should be based on local women's needs and wishes.

This PhD study will identify four contrasting maternity sites based on the findings of the Babies Born Better (B3) survey* in England and Belgium, general maternal and neonatal outcome indicators, and the current evidence around the meaning of 'high quality' in maternity care. The aim is to explore which organisational approaches and practices in these sites are associated with good outcomes and positive experiences for mothers, babies and families.

*The Babies Born Better survey (B3) is an international, anonymous, mixed methods online survey capturing the views of women in regards to their experience of maternity care.

The findings of this PhD study could be used as a resource for the improvement of maternal and childbirth care in the world, for example, as the basis of a tool or programme to optimise the organisational performance of maternity units.

4. Why have I been invited to take part?

Because you are one of the following:

- A manager or key stakeholders in the selected maternity unit
- A professional working within or associated with the selected maternity units (midwife, obstetrician, paediatrician, healthcare support worker, cleaner, admin staff, student midwife/doctor, etc.)

5. Do I have to take part?

No, it is entirely up to you if you want to take part or not. You can choose not to participate in part of or all of the project and you are free to avoid answering any questions you do not wish to. If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw at any time and without giving a reason.

6. What will happen if I take part?

You can be involved in one or several of the following research activities:

Interview: You can take part in an interview, which will take up to one hour and will be audio or video recorded. Depending on the Coronavirus regulations in place, the interview will take place online (via Microsoft Teams) or at the maternity unit you work in.

You may be contacted later in the project, to invite you to take part in a follow-up interview.

Focus Group: You can take part in a focus group. Depending on the Coronavirus regulations in place, the focus group will take place online (via Microsoft Teams) or at the maternity unit. Each focus group will include between four to ten participants, will take up to two hours at a time and will be audio and video recorded. In these sessions, you and your co-participants will be asked about your views and experiences.

Observation by a researcher: Observations will take place at times which include (but will not be limited to) handover, staff meetings, management meetings, multidisciplinary meetings, a moment where a particular type of care is provided (such as giving information to women/parents), during the everyday life of the maternity unit. For participants who give specific permission, notes will be taken, and/or audio recordings will be collected and analysed.

Ellen Thaels, the student researcher on the project will undertake all of the above activities. She is a qualified midwife. None of the data collected will be transferred overseas. There is no automated decision making, machine learning or profiling involved in this study.

7. How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. You can find the University privacy notice for research participants on the following link: https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

See further information on data collection and usage in the attachment below.

8. Are there any risks in taking part?

There should be no particular risks of taking part in this study; however, in some cases discussing experiences of stressful aspects of the workplace can cause distress to some individuals. In such cases, you can take a break in the interview, or stop the interview completely if you prefer.

If any concerns are raised in relation to your wellbeing or mental health, you may be advised to talk to your line manager, occupational health service at work, etc. Information about these services will be available during the data collection phase.

If any risk to others (for instance intention to harm) is exposed during observation, a face-to-face interview or a focus group, the necessary and appropriate local authorities will be notified by the researcher (police/safeguarding team).

9. Are there any benefits from taking part?

While there are no direct benefits of taking part, the research team hopes that the project will be beneficial in improving maternity services in the future. Often professionals find research such as this useful as a means of reflecting on their own professional experiences.

10. What will happen to the results of the study?

The findings of the study will be used to write a project report (PhD thesis) and articles for professional journals. Anonymity will be maintained throughout the project. If you want a copy of the final report, we will collect your contact details to enable us to send you the report.

11. What will happen if I want to stop taking part?

If you wish to do so, you are free to withdraw from the study at any time, without any question or penalty for doing so. When you withdraw from the study, identifiable data collected is withdrawn and destroyed accordingly. If you choose to withdraw after participating in focus groups, it may not be possible to exclude all the data of you as an individual as it may be difficult to identify individual comments out of a group discussion. Non-identifiable (anonymous) data such as interview comments collected until the point of withdrawal could still be used in the study. Please contact the student researcher on the project (see contact details attached below) if you would like to withdraw from the study.

12. What if I am unhappy or if there is a problem?

If you have any questions, if you are unhappy, or if there is a problem, please feel free to let us know by contacting Prof. Soo Downe or Ellen Thaels (see contact details below) and we will try to help. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

13. Who can I contact if I have further questions?

Please do not hesitate to contact the study principal investigator or student researcher on the project if you have any queries. If you have questions you would like to ask to an independent person, outside of the investigatory team, please contact Susan Barry who is the consultant midwife at Imperial College Healthcare NHS Trust (see contact details below).

Contact details of investigatory team:

Principal Investigator
Prof. Soo Downe
Brook Building, BB223
Victoria St, Preston PR1 7QR
+44 (0) 1772 89 3815
SDowne@uclan.ac.uk

Student Investigator
Ellen Thaels
Brook Building
Victoria St, Preston PR1 7QR
EThaels@uclan.ac.uk

Thank you for taking the time to read this information sheet.

Extra information on data collection and usage:

How will my data be collected?	Data will be collected via observations, one-to-one interviews and focus groups (online or in person).
How will my data be stored?	All the information you provide will be held securely and in line with data protection requirements on a secured online drive (OneDrive) at the University of Central Lancashire until the data is fully anonymised. Once interviews have been transcribed, the audio recordings will be deleted.
How long will my data be stored for?	Your personal data (e.g. contact details) will be destroyed at the end of the project, and the consent forms will be destroyed after six months.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored on a secured online drive (OneDrive). The interviews will be transcribed by in vivo voice-to-text software (SONIX) and checked by a member of the research team. We will not share your research data outside of the research team until they have been anonymised. Quotes from the interview will be used in reports, publications, teaching and presentations, but we will remove identifying information so that you will not be identifiable.
Will my data be anonymised?	All participants identifiable data will be made anonymous by replacing them with a code. The code will be used on all the data which will be collected from you (such as interview transcripts, when using quotes in publications, etc.).
How will my data be used?	This research project aims at finding out which cultural, organisational and clinical factors contribute to a good experience, safe and high quality care for women and babies. Your input while participating in focus-groups, interviews and observations will be very important to find an answer to this question. A report will be written and papers will be published disseminating the results of this research project.
Who will have access to my data?	Only the research team at UCLan will have access to your data during the study period. No external company will be used for data processing.
Will my data be archived for use in other research projects in the future?	Once this study has been finalised and results have been published, the fully anonymised data and report will be deposited in the UCLan archive (called CLOK) for sharing and use by other authorised researchers to support other research in the future.
How will my data be destroyed?	After the interview, we will download the interview recording onto a password protected online drive (OneDrive) and delete the interview from the recording device. Once a typed transcript of the interview has been produced, the interview recording will be deleted.
Which identifiable data will you collect from me?	We will collect your first and last name (consent form). Other identifiable data which might be collected from you but only after consent is given are: video- or audio recordings of interviews. If you want a copy of the final report, we will collect your contact details to enable us to send you the report.

Appendix D: Participant information sheet for women and birth partners

Participant Information Sheet –
Women/people who are pregnant or postnatal and their birth partners

1. Title of Study

Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography

2. Invitation

We would like to invite you to take part in our research study. Before you decide if you want to join the study, we would like to let you know why we are doing it, and what it means for you. Please read the following information carefully and discuss it with others if you wish. Please contact us using the contact details of the investigatory team below if anything in this information sheet is not clear, or if you would like more information.

3. What is the purpose of the study?

Across the world, there is inequality in the outcomes of women's health care. There are important differences in how maternity services are provided, and in the quality of care during pregnancy, birth, and afterwards. Making sure that all women have care that is based on the best information and on what matters to them could improve health and wellbeing for them, their babies, and their families. Ideally, the design on which any maternity service is built should be based on local women's needs and wishes.

This PhD study will include two maternity units that are part of the same Trust in England and two in Belgium where women have different kinds of experiences (based on a worldwide survey* of women's views) and different outcomes, along with different levels of quality of care. In these places, we will explore which cultural, organisational and clinical approaches contribute to a good experience, safe and high quality care for women and babies.

*The Babies Born Better survey (B3) is an international, anonymous, mixed methods online survey capturing the views of women in regards to their experience of maternity care.

The findings of this PhD study could be used as a resource for the improvement of maternal and childbirth care in the world, for example, as the basis of a tool or programme to optimise the organisational performance of maternity units.

4. Why have I been invited to take part?

Because you are pregnant or you have recently had a baby or you are a birth partner.

5. Do I have to take part?

No, it is entirely up to you if you want to take part or not. You can choose not to participate in part of or all of the project and you are free to avoid answering any questions you do not wish to. If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw at any time and without giving a reason.

6. What will happen if I take part?

You can be involved in one or several of the following research activities:

Interview: You can take part in an interview, which will take up to one hour and will be audio or video recorded. Depending on the Coronavirus regulations in place, the interview will take place online or at the maternity unit you have your maternity care.

We might contact you later in the project, to invite you to take part in a follow-up interview.

Focus Group: You can take part in a group interview. Depending on the Coronavirus regulations in place, the focus group will take place online or at the maternity unit. Each focus group will include between four to ten participants, will take up to two hours at a time and will be audio and video recorded. In these sessions, you and your co-participants will be asked about your views and experiences of the maternity care you received.

Observation by a researcher: If you are pregnant, in the postnatal period or you are a (birthing) partner, observation by a researcher might take place when receiving care or interacting with healthcare professionals. For participants who give specific permission, notes will be taken, and/or audio recordings will be collected and analysed.

Ellen Thaels, the student researcher on the project will guide all of the above activities. She is a qualified midwife. None of the data collected will be transferred overseas. There is no automated decision making, machine learning or profiling involved in this study.

7. How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. You can find the University privacy notice for research participants on the following link: https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

See further information on how we will collect and use your data in the attachment below.

8. Are there any risks in taking part?

No, there should be no particular risks of taking part in this study.

It might be difficult or distressing for some people to discuss negative experiences of care received during pregnancy, labour, birth and the postnatal period. If this is the case, you can take a break in the interview, or stop the interview completely if you prefer.

If any concerns are raised in relation to your wellbeing or mental health, you may be advised to talk to your health visitor, the obstetric team or consultant midwife, postnatal listening service, trust complaints service, etc. Information about these services will be available at all times.

If any risk to others (for instance intention to harm) is exposed during observation, a face-to-face interview or a focus group, the necessary and appropriate local authorities will be notified by the researcher (police/safeguarding team).

9. Are there any benefits from taking part?

While there are no direct benefits of taking part, the research team hopes that the project will be beneficial in improving maternity services in the future. Often pregnant people or people in the postnatal period and their (birthing) partners find research such as this useful to reflect on their own personal experiences

10. What if my English is limited or what if I don't speak English at all?

Language line* will be put in place where there might be a language barrier. Your chosen language will be used when explaining the aim of the study, asking for informed consent and when you participate in an interview.

*Language line is an on-site translation service that provides interpreters on-demand via phone.

11. What will happen to the results of the study?

The findings of the study will be used to write a project report (PhD thesis) and articles for professional journals. Anonymity will be maintained throughout the project. If you want a copy of the final report, we will collect your contact details to enable us to send you the report.

12. What will happen if I want to stop taking part?

You are free to stop taking part in this study at any time, without any question or penalty for doing so. If you do so, identifiable data collected is withdrawn and destroyed accordingly. If you choose to withdraw after participating in focus groups, it may not be possible to exclude all the data of you as an individual as it may be difficult to identify individual comments out of a group discussion. Non-identifiable (anonymous) data such as interview comments collected until the point of withdrawal could still be used in the study. Please contact the student researcher on the project (see contact details attached below) if you would like to stop participating in the study.

12. What if I am unhappy or if there is a problem?

If you have any questions, if you are unhappy, or if there is a problem, please feel free to let us know by contacting Prof. Soo Downe or Ellen Thaels (see contact details below) and we will try to help. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

13. Who can I contact if I have further questions?

Please do not hesitate to contact the study principal investigator or student researcher on the project if you have any queries. If you have questions you would like to ask to an independent person, outside of the investigatory team, please contact Susan Barry who is the consultant midwife at Imperial College Healthcare NHS Trust (see contact details below).

Contact details of investigatory team:

Principal Investigator
Prof. Soo Downe
Brook Building, BB223
Victoria St, Preston PR1 7QR
+44 (0) 1772 89 3815
SDowne@uclan.ac.uk

Student Investigator
Ellen Thaels
Brook Building
Victoria St, Preston PR1 7QR
EThaels@uclan.ac.uk

Thank you for taking the time to read this information sheet.

Extra information on data collection and usage:

How will my data be collected?	Data will be collected via observations, one-to-one interviews and focus groups (online or in person).
How will my data be stored?	All the information you provide will be held securely and in line with data protection requirements on a secured online drive (OneDrive) at the University of Central Lancashire until the data is fully anonymised. Once interviews have been transcribed, the audio recordings will be deleted.
How long will my data be stored for?	Your personal data (e.g. contact details) will be destroyed at the end of the project, and the consent forms will be destroyed after six months.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored on a secured online drive (OneDrive). The interviews will be transcribed by in vivo voice-to-text software (SONIX) and checked by a member of the research team. We will not share your research data outside of the research team until they have been anonymised. Quotes from the interview will be used in reports, publications, teaching and presentations, but we will remove identifying information so that you will not be identifiable.
Will my data be anonymised?	All participants identifiable data will be made anonymous by replacing them with a code. The code will be used on all the data which will be collected from you (such as interview transcripts, when using quotes in publications, etc.).
How will my data be used?	This research project aims at finding out which cultural, organisational and clinical factors contribute to a good experience, safe and high quality care for women and babies. Your input while participating in focus groups, interviews and observations will be very important to find an answer to this question. A report will be written and papers will be published disseminating the results of this research project.
Who will have access to my data?	Only the research team at UCLan will have access to your data during the study period. No external company will be used for data processing.
Will my data be archived for use in other research projects in the future?	Once this study has been finalised and results have been published, the fully anonymised data and report will be deposited in the UCLan archive (called CLOK) for sharing and use by other authorised researchers to support other research in the future.
How will my data be destroyed?	After the interview, we will download the interview recording onto a password protected online drive (OneDrive) and delete the interview from the recording device. Once a typed transcript of the interview has been produced, the interview recording will be deleted.
Which identifiable data will you collect from me?	We will collect your first and last name (consent form). Other identifiable data which might be collected from you but only after consent is given are: video- or audio recordings of interviews. If you want a copy of the final report, we will collect your contact details to enable us to send you the report.

Appendix E: Consent form professional stakeholders

University of Central Lancashire
UCLan

Consent form

Professional Stakeholders

Version number & date: Version 4 – 25/02/2021
Research ethics approval number: IRAS 287040
Title of the research project: 'Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography'
Name of researcher(s): Ellen Thaels, Prof. Soo Downe, Dr. Gordon Prescott, Dr. Carol Kingdon, Marie-Clare Balaam, Prof. Christine McCourt, Prof. Katrien Beeckman

Please initial box

1 I confirm that I have **read and have understood the information sheet** dated 25/02/2021 for the above study, or someone has read it to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 **I agree that information about me can be collected in writing, or using audio or video recording.** I understand that all activities will be on-line, unless COVID19 restrictions are lifted. Taking part in the study involves **a choice of taking part in several activities** (please only tick those that you are happy to take part in):

- I agree to take part in a **one-to-one interview** as outlined in the project information sheet. ☐
- I agree to take part in a **group interview** (focus group) with 4-10 co-participants. ☐
- I agree that meetings, handover or other work activity can be **observed**. ☐
- I agree that information about me is collected using **audio recording**[1]. ☐
- I agree that information about me is collected using **video recording**[2]. ☐

3 I understand that all the information I provide will be **held securely and in line with data protection requirements** on a secured drive at the University of Central Lancashire until it is fully anonymised. My personal information will be destroyed at the end of the project, and consent forms will be destroyed after six months. My personal information will not be shared beyond the study team. ☐

[1-2] Audio and video recordings will be destroyed after transcription of the face-to-face or group interview.

University of Central Lancashire
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4	I understand that once this study has been finished and results are published, the fully anonymised data then will be **deposited** in the UCLan archive (called CLOK) for sharing and use by other authorised researchers to support other research in the future.	☐
5	I understand that any information I provide is **confidential** and that it will not be possible to identify me in any reports, presentations or publications arising from the research. In addition, I agree that some of the things I say during the research can be added to outputs of the study, but only if I can't be identified.	☐
6	I understand that the information I provide will be safeguarded and won't be released without my consent unless I say anything which raises concerns about the safety of myself or others. In such cases, the researcher will let me know that they are required to **disclose** this to the relevant authorities.	☐
7	I understand that my participation is voluntary and that I am free to stop taking part and can **leave the study** at any time without giving any reason and without my rights being affected. I understand that if I leave study, information that doesn't identify me will be kept for the study, but no further data will be collected. In addition, I understand that I am free not to answer any question.	☐
8	**I agree to take part in the above study.**	☐

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Principal Investigator
Prof. Soo Downe
Brook Building, BB223
Victoria St, Preston PR1 7QR
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SDowne@uclan.ac.uk

Student Investigator
Ellen Thaels
Brook Building
Victoria St, Preston PR1 7QR
EThaels@uclan.ac.uk

Participants Code: _____

Appendix F: Consent form women and birth partners

University of Central Lancashire
UCLan

Consent form

Women who are pregnant or postnatal and their birth partners

Version number & date: Version 5 -- 25/02/2021
Research ethics approval number: IRAS 287040
Title of the research project: 'Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography'
Name of researcher(s): Ellen Thaels, Prof. Soo Downe, Dr. Gordon Prescott, Dr. Carol Kingdon, Marie-Clare Balaam, Prof. Christine McCourt, Prof. Katrien Beeckman

Please initial box

1 I confirm that I have **read and understood the information sheet** dated 25/02/2021 for the above study, or someone has read it to me. I have been able to think about the information and to ask questions. I am satisfied with the answers. ☐

2 **I agree that information about me can be collected in writing, or using audio or video recording.** I understand that all activities will be on-line, unless COVID19 restrictions are lifted. Taking part in the study involves **a choice of taking part in several activities** (please only tick those that you are happy to take part in):

- I agree to take part in a **one-to-one interview** as outlined in the project information sheet (and I am happy for language line[1] to be used if my English is limited). ☐
- I agree to take part in a **group interview** (focus group) with 4-10 others. ☐
- I agree that meetings/treatments I have with health care staff can be **observed.** ☐
- I agree that information about me is collected using **audio recording[2].** ☐
- I agree that information about me is collected using **video recording[3]**. ☐

3 I understand that all the information I provide will be **held securely and in line with data protection requirements** on a secured drive at the University of Central Lancashire until it is fully anonymised (so that I cannot be identified). My personal information will be destroyed at the end of the project, and consent forms will be destroyed after six months. My personal information will not be shared beyond the study team. ☐

[1] Language line is an on-site translation service that provides interpreters on-demand via phone.
[2-3] Audio and video recordings will be destroyed after transcription of the face-to-face or group interview.

University of Central Lancashire
UCLan

4	I understand that once this study has been finished and results are published, the fully anonymised data then will be **deposited** in the UCLan archive (called CLOK) for sharing and use by other authorised researchers to support other research in the future.	☐
5	I understand that any information I provide is **confidential** and that it will not be possible to identify me in any reports, presentations or publications arising from the research. In addition, I agree that some of the things I say during the research can be added to outputs of the study, but only if I can't be identified.	☐
6	I understand that the information I provide will be safeguarded and won't be released without my consent unless I say anything which raises concerns about the safety of myself or others. In such cases, the researcher will let me know that they are required to **disclose** this to the relevant authorities.	☐
7	I understand that my participation is voluntary and that I am free to stop taking part and can **leave the study** at any time without giving any reason and without my rights being affected. I understand that if I leave study, information that does not identify me will be kept for the study, but no further data will be collected. In addition, I understand that I am free not to answer any question.	☐
8	**I agree to take part in the above study.**	☐

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Principal Investigator
Prof. Soo Downe
Brook Building, BB223
Victoria St, Preston PR1 7QR
+44 (0) 1772 89 3815
SDowne@uclan.ac.uk

Student Investigator
Ellen Thaels
Brook Building
Victoria St, Preston PR1 7QR
EThaels@uclan.ac.uk

Participants Code: _____

Appendix G: Focus-group topic guide

Focus group - topic guide

Staff and professional stakeholders

Questions:

1. Please imagine and then discuss your description of what an 'ideal' and/or the 'highest quality' maternity services would look like to you.

Possible probes:
Can you talk about why you think these aspects might be important?
How would it make you feel working in this 'ideal' environment and why?
How would this 'ideal' environment influence the experience of women and their families?
What would the norms, values or the overall culture of this unit look like?
How would you define safety in this ideal environment both from the women's and your own point of view?
What do you feel is needed to create this 'ideal' maternity unit?

2. Please discuss which of the aspects of the 'ideal'/'highest quality' maternity services are present within this unit.

Possible probes:
What do you feel works really well within your service?
Can you give some examples of situations in which these aspects have become apparent?
What are the facilitating underlying factors or drivers for these positive features to exist within your unit?
Are there any factors within your unit that create health (salutogenesis)?
Are there any factors within your unit that create safety?
How do these aspects affect your enjoyment of your job?
How do these aspects affect your job performance?
What can other maternity units learn from this unit?
What are the existing norms or values within the unit?
How would you describe the culture amongst professionals and management?
Is there currently anything in place within the unit that is a driver towards this 'ideal' maternity unit?

3. Please discuss what you feel is missing that prevents your unit from becoming this 'ideal'/'highest quality' maternity unit?

Possible probes:
How does it make you feel and how does this affect the culture at work?
What would you need as a professional group/multidisciplinary team to be able to make these changes?
Are there any barriers that you would need to overcome and, if yes, what are they?
Are there any facilitators available to make these changes more easily?

4. Do you feel your unit is responsive to women's/pregnant people's individual values, beliefs and needs?

Possible probes:
If yes, can you give some examples?
If no, why do you feel this is not happening?

5. How do you feel about the current management style and/or leadership in place?

6. According to the literature, high quality maternity care includes both safety and personalised care. Can you define safety and personalisation?

Possible probes:
Is safe care implemented in the unit and if yes, can you give some examples?
Is personalised care offered in the unit and if yes, can you give some examples?

7. End of the focus group and debrief

Postnatal women/people and their birthing partners:

Questions:

1. Please imagine and then discuss your description of what the 'ideal' and/or the 'highest quality' maternity care would look like to you.

Possible probes:
Can you talk about why you think these aspects might be important?
How would it make you feel receiving this 'ideal' maternity care?
How would this care respond to your personal values, beliefs and needs?
How would you define safety in this ideal environment?
How would this 'ideal' environment influence the experience of women and their families?
What would the norms, values or the overall culture of this unit look like?
What do you feel is needed to achieve this 'ideal' maternity care?

2. Please discuss which of the aspects of the 'ideal'/'highest quality' maternity care were present within the unit in which you received care.

Possible probes:
Did your maternity care fulfil your expectations and, if yes, how?
How did the care received make you feel?
Where you made to feel safe and if yes, how?
What made your experience good? Was there anything you would have liked to see done differently?
Can you give some examples of situations in which these aspects have become apparent?
What do you think might be helping the things that are going well in this unit?
Based on all of your experiences in this hospital, do you think that any particular aspects of maternity care improve women's health, or their sense of wellbeing?
What can other maternity units learn from this unit?
How would you describe the culture amongst professionals?
Do you know if there is currently anything in place within the unit that is a driver towards this 'ideal' maternity unit?
Did you feel you received individualised or personalised care and if yes, how was this facilitated?

3. Please discuss if there was anything missing that prevented you from having the 'ideal'/'highest quality' maternity care?

Possible probes:
If yes, what was missing?
How did it make you feel?
Is there anything you can do as a woman/person or partner of someone who has used the services to improve or make desired changes?
Are there any barriers that would need to be overcome, and if yes, what are they?
Are there any facilitators available to make these changes more easily?

4. Please discuss whether you feel your maternity care was responsive to your individual values, beliefs and needs.

Possible probes:
If yes, can you give some examples?
If no, why do you feel this was not the case?

5. End of the focus group and debrief

Appendix H: Ethics approval Health Research Authority

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

qProf. Soo Downe
Professor of Midwifery Services
University of Central Lancashire
Fylde Rd
Preston
United Kingdom
PR1 2HE

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

12 April 2021

Dear Prof. Downe

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography**
IRAS project ID:	**287040**
Protocol number:	
REC reference:	**21/SS/0018**
Sponsor	**University of Central Lancashire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **287040**. Please quote this on all correspondence.

Yours sincerely,
Rachel Katzenellenbogen
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: Prof StJohn Crean

Appendix I: Ethics approval Research Ethics Committee

Lothian NHS Board

South East Scotland Research Ethics Committee 02

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

www.nhslothian.scot.nhs.uk

Date 3 March 2021
Your Ref
Our Ref

Enquiries to : Joyce Clearie
Email: Joyce. Clearie@nhslothian.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

03 March 2021

Prof. Soo Downe
Professor of Midwifery Services
University of Central Lancashire
Fylde Rd
Preston
United Kingdom
PR1 2HE

Dear Prof. Downe

Study title:	**Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography**
REC reference:	**21/SS/0018**
Protocol number:	**n/a**
IRAS project ID:	**287040**

Thank you for your response letter of 25 th February 2021 , responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Receipt of a copy of the topic guide/interview schedule once finalised. That is once the results of the currently on-going meta-narrative review available, and after feedback from the local MVP group has been incorporated.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are

defined as the first four project categories in IRAS project filter question 2. Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

If you have not already included registration details in your IRAS application form, you should notify the REC of the registration details as soon as possible.

Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [5.c. Consent form Photographs - Eva Rose - 14Dec20]	n/a	14 December 2020
Copies of materials calling attention of potential participants to the research [9.a. Inviation for participation cover letter - NHS Trust - IRAS 287040 - Imperial College Healthcare NHS Trust - V4 - 19Feb21]	4	19 February 2021
Covering letter on headed paper [0. Cover Letter UCLan - IRAS 287040 - 21Jan21 - V2]	2	21 January 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [10. Indemnity client information letter UCLan - IRAS 287040 - 3Aug20]	n/a	03 August 2020
Interview schedules or topic guides for participants [6. Provisional topic guide - IRAS 287040 - Version 2 - 1Dec20]	2	01 December 2020
IRAS Application Form [IRAS_Form_01022021]	287040/1474891/37/82	01 February 2021
IRAS Application Form XML file [IRAS_Form_01022021]		01 February 2021
Letter from funder [7.c. Approved - RPA (no conditions) - IRAS 287040 - Apr 2020]	n/a	15 April 2020
Letters of invitation to participant [5.a. Flyer Service Users - V4 - 14Dec20]	4	14 December 2020
Letters of invitation to participant [5.b. Flyer Professional Stakeholders - V3 - 14Dec20]	3	14 December 2020
Other [1. Research Protocol - IRAS 287040 - Version 9 - February 2021]	9	25 February 2021
Other [Provisional opinion of REC - IRAS 287040 - Response research team - 25Feb21]	1	25 February 2021
Other [Provisional opinion of HRA - IRAS 287040 - Response research team - 21Feb21]	1	21 February 2021
Participant consent form [4.a. Consent form Service users - IRAS 287040 - 25Feb2021 - Version 5]	5	25 February 2021
Participant consent form [4.b. Consent form Professional Stakeholders - IRAS 287040 - 25Feb2021 - Version 4]	4	25 February 2021
Participant information sheet (PIS) [3.a. Participant information sheet- Service Users - IRAS 287040 - 25Feb2021 - Verison 6]	6	25 February 2021
Participant information sheet (PIS) [3.b. Participant information sheet- Professional stakeholders - IRAS 287040 - 25Feb2021 - Version 5]	5	25 February 2021

Summary CV for Chief Investigator (CI) [2.a. CV Soo Downe - 30Oct20]	0.1	30 October 2020
Summary CV for student [2.d. CV - Ellen Thaels - IRAS 287040 - 27Oct2020]	0.1	27 October 2020
Summary CV for supervisor (student research) [2.a. CV - Soo Downe - 30Oct2020]	0.1	30 October 2020
Summary CV for supervisor (student research) [2.b. CV - Carol Kingdon - 18Aug2020]	0.1	18 August 2020
Summary CV for supervisor (student research) [2.c. CV - Gordon Prescott - 29Oct2020]	0.1	29 October 2020
Summary, synopsis or diagram (flowchart) [8. Gantt Chart - IRAS 287040 - 28Oct20 - V1]	1	28 October 2020

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 287040 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Mr Lindsay Murray
Chair

Email:joyce.clearie@nhslothian.scot.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Prof StJohn Crean

Appendix J: Ethics approval University of Central Lancashire

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

27th May 2022

Soo Downe / Ellen Thaels
School of Community Health & Midwifery
University of Central Lancashire

Dear Soo

Re: Health Ethics Review Panel Application
Unique reference Number: HEALTH 0323

The Health Ethics Review Panel has granted approval of your proposal application 'Quality of Maternity Care – An Organisational Ethnography'. Approval is granted up to the end of project date*. It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by the Ethics Review Panel
- you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to the Ethics Review Panel
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Pro Forma).

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely

K. Chatfield

Kate Chatfield
Chair
Health Ethics Review Panel
* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals gained.

Appendix K: Ethics approval steering group Babies Born Better

FW: B3 research proposals for steering committee approval

MM **Marie-clare Balaam <School of Community Health & Midwifery> <MBalaam@uclan.ac.uk>**
06/02/2020 08:24

To: Ellen Thaels; Katrien Beeckman

Save all attachments

B3 - Research Proposal Form...
638.97 KB

B3 - Research Proposal Form...
37.39 KB

Hello
The steering committee are very happy with your proposals.
Regards
Marie-Clare

From: Marie-clare Balaam <School of Community Health & Midwifery>
Sent: 29 January 2020 11:35
To: 'Alessandra Battisti' <alessandra_battisti@hotmail.com>; Elena Skoko <elena.skoko@gmail.com>; evteijlingen@bournemouth.ac.uk; 'Fatimaleon@us.es'; Lucy Frith <L.J.Frith@liverpool.ac.uk>; Marie-clare Balaam <School of Community Health & Midwifery> <MBalaam@uclan.ac.uk>; marina@weckend.net; Mario Santos <mariojdssantos@gmail.com>; Mechthild Gross <'Gross.Mechthild@mh-hannover.de'>; Naseerah Akooji <Lancashire Clinical Trials Unit> <NAkooji4@uclan.ac.uk>; Soo Downe <School of Community Health & Midwifery> <SDowne@uclan.ac.uk>
Subject: B3 research proposals for steering committee approval

Hello everyone
Please find attached two research proposals for your attention.
If I do not hear back from you within 7 days I will assume that you are happy with these proposals.
Regards
Marie-Clare

University of Central Lancashire
UCLan

Babies Born Better approval amendment

B3 Amended research proposal for Ellen Thaels

Marie-clare Balaam <School of Community Health & Midwifery>
Fri 06/05/2022 09:21
To: Ellen Thaels

B3 - Amended Research Prop...
651 KB

Hello Ellen
The steering committee, following the circulation of the email below, are happy for this research project to go ahead.
Good luck with the project and please send us a copy of/links to the results of the research so we can share this on the BBB website.
Regards
Marie-Clare
On behalf of the B3 Steering Committee

Please note I work part time my usual days are Tuesday to Thursday.

Marie-Clare Balaam
Research Associate
Research in Childbirth & Health (ReaCH unit)
School of Community Health and Midwifery
University of Central Lancashire

Appendix L: Ethics approval for amendments

South East Scotland Research Ethics Committee 02

South East Scotland Research Ethics Service

2nd Floor, Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

NHS Lothian

Enquiries to: Sriparna Pal
Email: sriparna.pal@ nhslothian.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

23 May 2022

Prof. Soo Downe
Fylde Rd
Preston
United Kingdom
PR1 2HE

Dear Prof. Downe,

Study title:	**Organisational features associated with women's experiences of good quality care in maternity units in the UK and Belgium: A multicountry organisational ethnography**
REC reference:	**21/SS/0018**
Protocol number:	**n/a**
Amendment number:	**Amendment 1**
Amendment date:	**13 May 2022**
IRAS project ID:	**287040**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee had no ethical concerns regarding the amendment.

Our Values Into Action

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Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Interim Chair Esther Roberton
Chief Executive Calum Campbell
Lothian NHS Board is the common name of Lothian Health Board

IRAS Project ID 287040. HRA and HCRW Approval for the Amendment

amendments@hra.nhs.uk <noreply@harp.org.uk>

Thu 26/05/2022 14:58

To: Soo Downe <School of Community Health & Midwifery> <SDowne@uclan.ac.uk>;IRAS Sponsor <IRASSponsor@uclan.ac.uk>

Cc: Ellen Thaels <EThaels@uclan.ac.uk>

Dear Prof. Downe,

IRAS Project ID:	287040
Short Study Title:	Quality of Maternity Care – An Organisational Ethnography
Amendment No./Sponsor Ref:	Amendment 1
Amendment Date:	13 May 2022
Amendment Type:	Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact [amendments@hra.nhs.uk]amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Kind regards

Dr Ashley Totenhofer
Workflow Monitoring Manager
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.amendments@hra.nhs.uk
W. www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

Appendix M: Data extraction form

DATA EXTRACTION FORM (DEF) How is quality of care conceptualised in maternity units? A meta-narrative review Adapted from: TG, drawing (2001)	
Research Tradition - (Medical) Sociology	1(12)
Discipline - Sociology	**Sociology**
Author(s)	Van Teijlingen, Edwin; Wrede, Sirpa; Benoit, Cecilia; S; all, Jane; DeVries, Raymond;
Title of paper	Born in the USA Exceptionalism in maternity care organisation among high-income countries
Year of publication	2009
Country of publication	USA
Country where study has taken place	USA
Name reviewer	Ellen
Managed to get the full text?	Yes
A. [FIRST SIFT] Is the paper relevant to our research question and worthy of further consideration?	
1. Relevance. Is the paper about Quality of Maternity Care (QMC) or does it explain how QMC is conceptualised in maternity units?	Yes
2. Worth. Does the paper go beyond superficial description or commentary – i.e. is it a broadly competent attempt at research, enquiry, investigation or study? [If a confident 'no' to either of these, reject now]	Yes

B. How does the paper fit into our organiser?	
1. Paradigm. What is the predominant theoretical 'lens' used?	Comparative study / 'Exceptionalism'
If more than one - Other	
Notes	
2. Type of paper. How does the paper fit into our taxonomy [classify as the MAIN pitch of the paper]	Peer Reviewed Article
Notes	
3. Perspective. What is the paper's main unit of analysis?	National
Notes	International comparison
4. Aspect of Maternity Care. Which part of maternity care focuses the conceptualisation of quality of care on?	Intrapartum care
C. Bottom line for this meta-narrative review	
1. Relevance. Does the paper have an important message for our research question? (Essential to include, relevanmt, relevant but not essential, marginal relevance).	Relevant
2. Methods.	Comparative techniques.
3. Aim. Overall aim of the research/paper	In lay terms, childbirth is regarded as a purely biological event: what is more natural than birth and death? On the other hand, social scientists have long understood that 'natural' events are socially structured. In the case of birth, sociologists have examined the social and cultural shaping of its timing, outcome, and the organization of care throughout the perinatal period. Continuing in this tradition, we examine the peculiar social design of birth in the United States of America, contrasting this design with the ways birth is organised in Europe.

4. Critical factors. What factors does the paper identify as critical to the concept or definition of Quality of Maternity Care? (HYPOTHETICAL OR ASSUMED / ACTUALLY DEMONSTRATED)	Background: Finland is one of the Nordic countries that since the 1960s have had one of the lowest maternal and fetal mortality figures in the Europe Euro-Peristat 2008). In all of these countries, as in the US, there are high-quality hospitals and doctors with the most up-to-date technologies available. The US differs from these three countries in birth outcomes and maternity care arrangements. Apart from geographical disadvantage, many US women's experience barriers to quality maternity care because they do not have private health insurance and cannot afford to pay out of pocket for professional services. The dynamics of private markets and competition, together with the lack of national health insurance (or other systems of compulsory health insurance) frame the issue of access to maternity care in the US in a different way from how it is framed in European nations where access to health care is secured through such arrangements (Woodhandler & Himmelstein 2007). Finland midwives, maternity care advocates, and services users have tried to improve the quality of existing maternity care offered by the state, rather than trying toestablish a new provision as was the case in parts of the US. *Conclusion:* The dominant cultural values held by the US populace have had a decisive influence on the way care during pregnancy and birth is organised. There is a noticeable lack of popular support for a publicly-funded health care system, which is central to the notion of exceptionalism in the US system. Yet at the same time these general cultural values interact with each other and the socio-economic environment. Thus the kind and quality of maternity care available to certain groups of US women (and not others) is influenced by historical developments, the portrayal of childbirth in the mass media, the way in which both the health care system and the accompanying health insurance system is organised, the risk of litigation experienced by obstetricians, and by inter-professional conflict rather than collaboration. 7.2 Studying such wide-ranging concepts comparatively helps us understand why greater use of birth technology is equated so strongly with 'safety' in the US. This approach also provides insight into the question of why midwives are slowly making their way back into the US maternity care system (Ettinger, 2006).
a. What?	Life and death are biological/natural events which are socially constructed. Sociologists have examined the social and cultural shaping of its timing, outcome, and organisation of care. The dominant cultural values held by the US populace have had a decisive influence on the way care during pregnancy and birth is organised. A lack of popular support for a publicly-funded health care system (central to notion of exceptionalism. General cultural values interact with each other and the socio-economic environment. The kind and quality of maternity care available to certain groups of US women (and not others) is influenced by historical developments, the portrayal of childbirth in the mass media, the way in which both the health care system and the accompanying health insurance system is organised, the risk of litigation experienced by obstetricians, and by inter-professional conflict rather than collaboration. This helps us understand why greater use of birth technology is equated ='safety'.
b. So What?	In the US (vs. Europe) - dominant cultural values influence how maternity care is organised. The kind of QMC available (to certain groups of women and not to others) is influenced by historical dvelopments, portrayal of childbirth in media, organisation of health care and health insurance system, risk of litigation experienced by obstetricians, inter-professional conflict vs. collaboration, greater usse of technology is equated strongly with greater safety.
5. Critical Factors. Does this paper identify the existence of stabilization of the notion of QMC in multidisciplinary teams? If yes, which factors does the paper identify as critical to this concept? (HYPOTHETICAL OR ASSUMED/ACTUALLY DEMONSTRATED)	**No**

Appendix N: Example systematic search strategy

OVID-Medline

maternity OR "maternal-child nursing" OR midwi* OR *birth* OR “natural childbirth” OR “birth setting” OR "birth* unit" OR "midwifery unit" OR "midwi* led care" OR "birth* centre" OR "birth* center" OR "midwi* care" OR “delivery suite” OR “labo#r ward” OR parturition OR “birth* suite” OR obstetric* OR “nurse-midwi* Service” OR “maternal health*” OR *Home Childbirth/ OR *pregnancy/ OR *labor, obstetric/ OR *pregnancy outcome/ OR *parturition/ OR *birth setting/ OR *natural childbirth/ OR *term birth/ OR *midwife/ OR *Maternal-Child Nursing/ OR *maternal health services/ OR *maternal-child health services/ OR *Hospitals, Maternity/ AND “quality of health care” OR “health care quality” OR “quality of healthcare” OR “healthcare quality” OR “quality of care” OR “care quality” OR “quality improvement” OR *Quality Improvement/ OR *"quality of health care"/ OR *quality assurance, health care/ OR *quality improvement/ OR *quality indicators, health care/ OR *"health care quality, access, and evaluation"/ AND standard* OR streamlin* OR regulat* AND definition OR Concept OR perception

Keywords or Search Terms - Ovid Embase - Date Searched: 7th of January 2021	Ovid - Embase	Keywords or Search Terms - Ovid Medline - Date Searched: 7th of January 2021	Ovid - Medline
1 Maternity.mp.	28972	1. Maternity.mp.	20838
2 "maternal-child nursing".mp.	116	2 "maternal-child nursing".mp.	1979
3 Midwi*.mp.	41183	3 Midwi*.mp.	32937
4 Birth.mp.	457340	4 Birth.mp.	310889
5 Childbirth.mp.	36868	5 Childbirth.mp.	19896
6 "natural childbirth".mp.	2512	6 "natural childbirth".mp.	2536
7 "birth setting".mp.	283	7 "birth setting".mp.	151
8 "birth* unit".mp.	145	8 "birth* unit".mp.	91
9 "midwifery unit".mp.	78	9 "midwifery unit".mp.	60
10 "midwi* led care".mp.	281	10 "midwi* led care".mp.	189
11 "birth* centre".mp.	278	11 "birth* centre".mp.	192
12 "birth* center".mp.	465	12 "birth* center".mp.	339
13 "midwi* care".mp.	1076	13 "midwi* care".mp.	776
14 "delivery suite".mp.	597	14 "delivery suite".mp.	259
15 "labo#r ward".mp.	1381	15 "labo#r ward".mp.	591
16 parturition.mp.	16827	16 parturition.mp.	22012
17 "birth* suite".mp.	67	17 "birth* suite".mp.	31
18 obstetric*.mp.	182307	18 obstetric*.mp.	174707
19 "nurse-midwi* Service".mp.	34	19 "nurse-midwi* Service".mp.	33
20 "maternal health*".mp.	10295	20 "maternal health*".mp.	20214
21 -- 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	667915	21 -- 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	504587
22 "quality of health care".mp.	10534	22 "quality of health care".mp.	143783

23 "health care quality".mp.	246526	23 "health care quality".mp.	2863
24 "quality of healthcare".mp.	4032	24 "quality of healthcare".mp.	2338
25 "healthcare quality".mp.	3345	25 "healthcare quality".mp.	1990
26 "quality of care".mp.	75343	26 "quality of care".mp.	46583
27 "care quality".mp.	250727	27 "care quality".mp.	7019
28 "quality improvement".mp.	63486	28 "quality improvement".mp.	47949
29 -- 22 or 23 or 24 or 25 or 26 or 27 or 28	349201	*29* -- 22 or 23 or 24 or 25 or 26 or 27 or 28	206977
30 standard*.mp.	2287941	30 standard*.mp.	1732810
31 streamlin*.mp.	20062	31 streamlin*.mp.	10127
32 regulat*.mp.	2831893	32 regulat*.mp.	2147635
33 stabili*.mp.	904268	33 stabili*.mp.	565709
34 Stable*.mp.	736491	34 Stable*.mp.	449678
35 -- 30 or 31 or 32 or 33 or 34	6249044	*35* -- 30 or 31 or 32 or 33 or 34	4563412
36 Definition	7503	36 Definition.mp.	109192
37 Perception	10324	37 Perception.mp.	338891
38 Concept	16349	38 Concept.mp.	275220
39 -- 36 or 37 or 38	34134	39 -- 36 or 37 or 38	698184
40 --- 21 and 29 and 35 and 39	10	**40** --- 21 and 29 and 35 and 39	272
Mesh terms		Mesh terms	
41 (Keyword given: Maternity) (exp maternity ward/	3818	41 (Keyword given: Maternity) *Hospitals, Maternity/	1496
42 (Keyword given: Maternity) *maternal health service/	472	42 (Keyword given: Maternity) *maternal health services/ or *maternal-child health services/	10594
43 (Keyword given: "maternal-child nursing") *maternal child health care/	348	43 (Keyword given: "maternal-child nursing") *Maternal-Child Nursing/	1317
44 (Keyword given: Midwi*) *midwife/	13588	44 (Keyword given: Midwi*) *midwife/	14382
45 (Keyword given: Birth) exp birth/	26926	45 (Keyword given: Birth) *parturition/ or *birth setting/ or *natural childbirth/ or *term birth/	9696
46 (Keyword given: "natural childbirth") exp natural childbirth/ or exp obstetric delivery/	152969	46 (Keyword given: "Labo#r ward") *pregnancy/ or *labor, obstetric/ or *pregnancy outcome/	70080
47 (Keyword given: "Birth setting") *birth setting/	30	47 (Keyword given: "Birth setting") *Home Childbirth/	2063
48 -- 21 or 41 or 42 or 43 or 44 or 45 or 46 or 47	739457	*48* -- 21 or 41 or 42 or 43 or 44 or 45 or 46 or 47	534285

49 (Keyword given: "quality of health care") *health care quality/	74005	49 (Keyword given: "quality of health care") *"quality of health care"/ or *quality assurance, health care/ or *quality improvement/ or *quality indicators, health care/ or *"health care quality, access, and evaluation"/	89606
50 (Keyword given: "quality improvement") *total quality management/ or *quality control/	55944	50 (Keyword given: "quality improvement") *Quality Improvement/	13680
51 -- 29 or 49 or 50	384773	*51* -- 29 or 49 or 50	206977
52 (Keyword given: Standard*) standard/ or *gold standard/	339615	52 (Keyword given: Standard*)*"Standard of Care"/	1241
53 -- 35 or 52	6259044	53 -- 35 or 52	4563412
54 --- 39 and 48 and 51 and 53	12	**54** --- 39 and 48 and 51 and 53	275
Total amount of articles found	12		275
Duplicates found within the search	0		2
Duplicates found (combined searches)	0		6
Total amount of **new** articles found	**12**		**267**
Timespan of database searched?	1 hour		1 hour

Appendix O: Postcards to promote the Babies Born Better survey

We would love to know your opinion around which key ingredients are needed to provide high quality maternity care!

RESEARCH PROJECT

This project is funded by the University of Central Lancashire and aims to explore the meaning of 'high quality' in maternity care, and to explore which organisational approaches and practices are associated with good outcomes and positive experiences for mothers, babies and families!

Are you a manager or key stakeholder in this maternity unit? Are you a professional working within the maternity unit such as a midwife, obstetrician, paediatrician, cleaner healthcare support worker, admin staff, student midwife/doctor?

Then we would love to hear from you!
Please email researcher Ellen: ethaels@uclan.ac.uk for more information and how to participate!

IRAS: 287040 V0.03

University of Central Lancashire
UCLan

We would love to know about your experience of maternity care!

RESEARCH PROJECT

This project is funded by the University of Central Lancashire and aims to explore the meaning of 'high quality' in maternity care, and to explore which organisational approaches and practices are associated with good outcomes and positive experiences for mothers, babies and families!

Are you pregnant or in your postnatal period?
Are you a partner/birthing partner/supporting person of someone who is pregnant or in the postnatal period?
Then we would love to hear from you!

Please email researcher Ellen: ethaels@uclan.ac.uk for more information and how to participate!

IRAS: 287040 V0.04

University of Central Lancashire
UCLan

Appendix P: Reflexivity continued

Without realising at that time, I integrated all six dimensions of quality of the IOM in my perception around what a high performing unit looks like. To me, these dimensions are very closely interlinked with each other as one can't really exist without the others. In the following section, I have organised my own preconceived ideas about QoMC using the six dimensions of quality of the IOM. I have used information from my reflexive diary, field notes, and added excerpts of my reflexive interview.

Safety

I believe that, to achieve high quality maternity care, both the physical as well as psychological safety of mother and baby should always be maintained. The healthcare providers' knowledge, skills and attitude can have a big impact on whether the woman or birthing person feels safe. I personally think that honesty, transparency, clearly stating your intentions of putting the woman or birthing person at the centre of all you do and always giving balanced information and options to facilitate informed consent, builds trust and subsequently a feeling of safety:

> *"So, I mean, its different things, so many different skills. But I guess, it's also for women, it's so important that you communicate well that they feel safe and that they know that you know what you're doing, and that they trust the fact that if there's anything wrong, that you will tell them as well. That you will put in place the things that need to be put in place for them if they agree with it."*

Safety is what the woman feels safety is for her. It is not just about no clinical or physical harm. When I think about feeling safe as a woman going through maternity care, safety is about being listened to, being informed and in control over the decision making. It is about being in an environment that makes you feel comfortable with people that embody the same philosophy around birth and people whom you trust. It is about easily accessible, freely available, equitable, effective care that considers and acts upon the bio-psycho-social needs of the woman/pregnant person, baby and the family:

> *"I have seen some bad situations, where I would go to labour ward with a woman and pre-warned staff that she would have her other child with her (which is normally not allowed). She came in because she couldn't feel her baby move anymore, she didn't have a babysitter, and couldn't wait to come in. I mean, even when I pre-warned the labour ward staff, you come in and then they're so rude to the woman straight away and don't make her feel welcome. And I think that's so important when people just smile."*

It is about achieving short- and long-term health for the individual and population of women and the next generations to come.

For safe care to be provided, I believe that safety for staff needs to be ensured. The right resources (both human and physical resources) need to be in place, knowledge and skills need to be updated regularly, the availability of kind leaders with an open-door policy, mental health support should be easily accessible, a safe culture including equity, outstanding communication, and teamwork:

> *"If midwives or doctors feel completely overloaded, you just get a culture like that [unkind and unwelcoming]. It's not that these people are like this, it's just that the whole situation has made them feel out of their depth and then people just turn inwards. They're not going to be friendly; a phone call is going to be too much to answer because they have other things to do. I think it's all about staffing as well. And having good management, good leadership is so important. So having leaders who just do whatever they want to do, who don't listen to the frontline staff, nor to the women then I think that's not a good unit."*

> *"And it makes such a different the place (maternity service) you go to, how people speak to women. And I do feel as somehow, like if your team is strong and they don't allow that [being unkind/disrespectful] to happen or they speak up about these things. It's a cultural thing, isn't it? If your team is always speaking nicely to the women and you've got someone coming in who doesn't do that, they won't fit in. It's a very strong core team and a core culture. And in a way, I think that it's got a big influence on how people get treated."*

Person or woman-centred

If I were to imagine the perfect person or woman-centred care, it would be summarised as follows: care in which the woman is authentically put at the centre of everything we do. The woman or person decides what quality of care means to them. As practitioners, we would be fully enabled to try to adapt ourselves to their individual wishes and needs:

> *"So what would be a low performing unit? A unit where women don't feel listened to, they have no choice, a unit which they feel completely out of control. Where they can't dim the lights or they can't make the space their own. Where they have to sit on the bed and can't really choose the position they want to be in or do what feels right for them."*

> *"Sometimes it's about small things. You don't have to have the newest luxury kind of equipment and the ward might be super old. But still, at least it's like if that woman can play her own music and she can dim the lights a little bit, and people knock on the door before they enter, and they can make it a little bit their space, I think that makes all the difference."*

All healthcare providers would give evidence-based and up-to-date, balanced information about options, risks and benefits and the woman should be empowered to decide on her pathway, healthcare providers, place of birth and interventions she accepts or does not accept:

> *"It's the communication with women and really asking them for permission. I think it's very important."*

Chosen birth companions of the woman would be made to feel welcome and would be supported:

> *"Her partner is involved or other family members or friends or whatever person she chooses to be with her during her labour."*

Timely

Not only safety and personalisation are closely interlinked. Timely care in my opinion is also dependent on the woman's individual circumstances and wishes:

> *"You're able to give all that information in a very balanced way that women can have a beautiful experience, without having to be traumatized. However, things go, that you kind of along the way, can make sure that these people feel they can make choices and that they are involved and that they're not overlooked. That they are in the picture as the main character in that whole story. And that they get what they need at the right time, both physically and emotionally."*

Timely care is safe care. When healthcare providers know how to act in a timely manner, they are safe practitioners. Knowledge and skills on physiology and pathophysiology are of great importance. Providing high quality care is also knowing how to communicate, inform and make room for choice in situations where quick and timely interventions are needed:

> *"And basically, and obviously that you're knowledgeable enough that when something does not go the way you hope for, that you have that knowledge to transfer in time, refer to another person. That you're a safe practitioner and not sure that you're able to be with the women and that you have time for the women and that you can. Say the right things, I guess, at the right time to really reassure them and to really kind of. Give them that, explain, the options, make sure they have a choice."*

Teamwork is a key ingredient to achieve high quality and so timely care, especially in the case of an emergency:

> *"Not long ago we had an emergency on birth centre (AMU). I call the emergency number and in two minutes, I had ten people [of the multidisciplinary team] in the room. So, there was a woman whose baby was having a bradycardia [prolonged significant drop in the foetal heart rate], and the heart rate wasn't coming up. But we saw the vertex visible, so the baby was coming, but my colleague and I were like, it needs to come now. There is no other way, and we can't move her up [to labour ward] anymore. So, I put out the crash call and we had, I think there was a senior house officer, a registrar, a consultant obstetrician in the room. We had an anaesthetist in the room, a paediatric nurse, registrar and consultant in the room and the midwife in charge from labour ward."*

On the other hand, having time to care for women gives a lot of job satisfaction and I believe

consequently, a higher quality of care. Healthcare providers should be enabled to have time to care for the women:

> *"We have time for women, so that's the sort of thing that I really like, I really enjoy and I get a lot of joy out of my work. The fact that we have consultations of 30 minutes with our women, an hour if they come for a booking appointment, which is different than a normal clinic, actually, which is not really a fair system. Uh, so we are able to sit down with the women and do a class twice a week. We can really actually be with them. We can sit down with them personally for breastfeeding support."*

Effective

If I had to describe what effective care means to me, I would say it is optimal care for all women, pregnant people and their babies. It is about offering care that is timely and appropriate, always assessing if the benefits outweigh the risks. Both the introduction of interventions where they are unnecessary and not intervening where needed at the right time can be harmful for mothers and babies. Care offered should be evidence-based but in the end, the woman or pregnant person decides what outcomes she finds most important. Women should be able to make decisions about what effective care means to her after she has been informed about all the options, benefits and risks. Great teamwork and consistency of information is a must to be able to give effective care:

> *"So to me, a high performing unit is a unit in which there is great multidisciplinary teamwork and communication, they look at pregnancy and birth as a healthy event and they try to keep women healthy and well as much as possible. Intervention only happens when necessary or wanted."*

> *"A unit where the teams don't communicate, every doctor does something completely different or they all give different advice to the women. Having unnecessary high intervention rates."*

> *"It's all very transparent. I guess it's a smaller service [AMU] as well, which makes it easier to all have the same vision and give the same information to the women. And I think that's important for the women as well, that they don't get five different opinions from five different people."*

To assess if an intervention is appropriate and timely, as mentioned before, healthcare providers should have in-depth knowledge of physiology and physiopathology:

> "Just great, great knowledge of the theory and practice and physiology knowing how a body works, how the uterus works, how that baby can rotate and turn, and how the mechanics work and knowing a lot of like, I guess it's also about knowing a bit of massage and hypnobirthing, etc."

Efficient

Efficiency to me is about having the necessary human- and physical resources, including time to give high quality care. As mentioned before, the environment needs to be fit for purpose, supporting the physiological process and short- and long- term health and recovery.

> *"Or the bed, which very often is still the main thing in the room, which doesn't really allow for a lot of movement or a lot of upright positions to help the baby turn in the right position or help gravity and reduces the production of the necessary hormones. It's just I feel like a lot of maternity services are set up…. I think we fail the women a lot in that way because it's just not set up for having a physiological birth, and then we still have to say that it was failure to progress or failure of the woman of this and that. And I think a lot of women take that very personally and don't trust in their own bodies anymore, which is a shame, I think. Because that's what I do find back in birth centres where we really are able to get the women to trust in their bodies and to kind of, yeah, to have more that flow going into it [labour & birth]."*

But equally, have everything needed to respond to emergency situations in a safe and timely manner while keeping the woman and her baby at the centre of care. A space in which the multidisciplinary team can function well, where the overarching vision and information given to women is consistent, and so time spent with the women is helpful and efficient.

> *"So I think, you know, the teamwork, the multidisciplinary work, the communication with the women, being kind to women, having a mutual vision, I think that's very much transferable to labour ward. Or having a nice environment, making sure that the privacy of the women is being maintained. Listening to the women. Communication, give them the same [consistent] advice."*

There is certain attributes or characteristics in healthcare providers that can aid the provision of efficient care.

> *"Be a good team player, great communication skills, um, feeling what a woman needs, so having quite a high emotional intelligence to see from the first moment or to feel what a couple needs. Being very knowledgeable about all parts of your job, basically, and also know when to refer to your colleagues and doctors. I think you have to be creative sometimes; to know a bit of everything and be creative in situations where sometimes you don't have everything you need. Or you, you know, it's simple things… to be kind, be gentle, have a lot of patience."*

Equitable

This means that whichever background women are coming from, they would be met with the necessary care and treated with respect. Research has shown that women from low socio-economic backgrounds and women from Black or Asian ethnic backgrounds are more likely to face

morbidities and even mortality as a result of pregnancy and birth related causes. We need to make sure that especially these women are getting the care that is needed to reduce these inequalities. Especially for women who don't speak the language or have disabilities, care should be easily accessible and adapted to their needs.

> *"And her partner is involved or other family members or friends or whatever person she chooses to be with her during her labour. And I guess it's clean, it's fair [equitable], and they feel welcome."*

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