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Empowering change: Realist evaluation of a Scottish Government programme to support normal birth

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ABSTRACT

Background: midwife-led care has consistently been found to be safe and effective in reducing routine childbirth interventions and improving women's experience of care. Despite consistent UK policy support for maximising the role of the midwife as the lead care provider for women with healthy pregnancies, implementation has been inconsistent and the persistent use of routine interventions in labour has given rise to concern. In response the Scottish Government initiated Keeping Childbirth Natural and Dynamic (KCND), a maternity care programme that aimed to support normal birth by implementing multiprofessional care pathways and making midwife-led care for healthy pregnant women the national norm.
Aim: the evaluation was informed by realist evaluation. It aimed to explore and explain the ways in which the KCND programme worked or did not work in different maternity care contexts.
Methods: the evaluation was conducted in three phases. In phase one semi-structured interviews and focus groups were conducted with key informants to elicit the programme theory. At phase two, this theory was tested using a multiple case study approach. Semi-structured interviews and focus groups were conducted and a case record audit was undertaken. In the final phase the programme theory was refined through analyses and interpretation of the data.
Setting and participants: the setting for the evaluation was NHS Scotland. In phase one, 12 national programme stakeholders and 13 consultant midwives participated. In phase two case studies were undertaken in three health boards; overall 73 participants took part in interviews or focus groups. A case record audit was undertaken of all births in Scotland during one week in two consecutive years before and after pathway implementation.
Findings: government and health board level commitment to, and support of, the programme signalled its importance and facilitated change. Consultant midwives tailored change strategies, using different approaches in response to the culture of care and inter-professional relationships within contexts. In contexts where practice was already changing KCND was seen as validating and facilitating. In areas where a more medical culture existed there was strong resistance to change from midwives and medical staff and robust implementation strategies were required. Overall the pathways appeared to enable midwives to achieve change.
Key conclusions: our study highlighted the importance of those involved in a change programme working across levels of hierarchy within an organisation and from the macro-context of national policy and institutions to the meso-context of regional health service delivery and the micro-context of practitioner's experiences of providing care. The assumptions and propositions that inform programmes of change, which are often left at a tacit level and unexamined by those charged with implementing them, were made explicit. This examination illuminated the roles of the three key change mechanisms adopted in the KCND programme – appointment of consultant midwives as programme champions, multidisciplinary care pathways, and midwife-led care. It revealed the role of the commitment mechanism, which built on the appointment of the local change champions. The analysis indicated that the process of change, despite these clear mechanisms, needed to be adapted to local contexts and responses to the implementation of KCND.

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Implications for practice: initial formative evaluation should be conducted prior to development of complex healthcare programmes to ensure that (1) the interventions will address the changes required, (2) key stakeholders who may support or resist change are identified, and (3) appropriate facilitation strategies are developed tailored to context.

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Introduction

The Winterton Report (HoC, 1992) heralded a profound shift in the direction of maternity care in the UK; mothers and midwives voices were heard in parliament and normal birth and midwife-led care received government endorsement. Subsequent policy reports and guidelines recommended an extended role for midwives (DH, 1993, 2004, 2007) and the UK Royal Colleges' Safer Childbirth consensus report (RCOG, 2007) highlighted the autonomy and accountability of midwives in the care of healthy pregnant women. However, despite consistent evidence of benefits of midwife-led care (Hatem et al., 2008), implementation in the UK has remained patchy, routine intervention in normal childbirth persists and the rate of caesarean section continues to rise (Kings Fund, 2008). It appears that availability of evidence alone has been an insufficient driver for change and further impetus was required. This paper reports on the evaluation of a Scottish Government initiative (Keeping Childbirth Natural and Dynamic – KCND) to support normal birth through increasing access to midwife-led care for healthy pregnant women and introduction of multiprofessional care pathways.

Background

The United Nations Millennium Development Goals four and five (UN, 2012) aim to reduce infant mortality and improve maternal health. Access to quality midwifery care has been acknowledged to be one of the most cost effective means of achieving these aims (UNFPA, 2011). In low income countries the key issue is lack of access to midwifery care or emergency obstetric facilities. However, inadequate access to midwifery care may also be an issue in high-income countries where over medicalisation of birth, inappropriate use of birth technologies and fragmentation of care between professionals groups has resulted sub-optimal care. Midwife-led care that involves the midwife acting as the lead professional for women experiencing straightforward pregnancies and having a co-ordinating role within the multidisciplinary team for women with more complex pregnancies (Midwifery 2020) has been shown to be effective in reducing some key birth interventions, with no increase in clinical risks and more positive evaluation of care among women (Hatem et al., 2008).

Scottish Government maternity care policy, in common with UK health policy over 20 years has consistently, endorsed pregnancy and childbirth as normal life events and recommended midwife-led care for healthy pregnant women, provision of care tailored to risk and evidence informed practice (Scottish Office Home and Health Department, 1993; Scottish Executive, 2002; Scottish Government, 2011). Implementation of these policies, however, has been inconsistent. Although in some locations considerable progress had been made in fully developing the role of the midwife, others continued to support medical led models of maternity care resulting in fragmentation and poor continuity of care. Interventions unsupported by evidence had become embedded in practice, in particular, routine use of intrapartum electronic fetal monitoring (EFM) and routine admission EFM, while the rate of caesarean section had reached 30% in some hospitals (ISD, 2011); in this paper we describe this as a medicalised model of care. In response, the Scottish Government Health Directorates developed and introduced KCND, a maternity care programme which aimed to increase rates of normal birth through provision of evidence based care, reduction of unnecessary intervention and midwife-led care for healthy pregnant women; we describe this approach as pro-normal birth.

The KCND programme

KCND was initiated in 2007 with step-wise implementation of key elements over a three year period. A national steering group was established to oversee programme development and monitor progress towards targets. The group was chaired by the Chief Nurse for Scotland and comprised representatives of the main professional, policy, consumer and management stakeholder groups involved in maternity care in Scotland. A senior manager in each health board was identified as programme lead with responsibility for reporting back to the national steering group. Central funding was provided for the appointment of a consultant midwife in each health board for a three year period, to support programme implementation. The programme had four specific objectives:

- *Discontinuation of routine labour admission EFM*: This intervention was specifically targeted as a key practice change to support normal birth (implemented September 2008).
- *The lead maternity care professional based on risk*: Midwife-led care would be the norm for all healthy women through pregnancy, birth and postnatal care with one to one midwife care in labour (implemented December 2009).
- *Development and implementation of multiprofessional care pathways* (http://www.healthcareimprovementscotland.org/our_work/reproductive,_maternal__child/programme_resources/keeping_childbirth_natural.aspx): The pathways comprised risk assessment tools and care pathways for antenatal, intrapartum and postnatal care. They used a traffic light approach, women identified as low risk (green pathway) received midwife-led care, those identified as higher risk (red pathway) received maternity team care, led by an obstetrician. An amber alert triggered referral for medical assessment but not necessarily transfer to the red pathway. The pathways provided guidance for low intervention care in healthy labour (implemented December 2009).
- *Establishment of the midwife as first point of professional contact for women in pregnancy*: The midwife would undertake early risk assessment and streaming of women to the appropriate care pathway (implemented 2010).

The evaluation

KCND was a complex heathcare programme that comprised multiple components working at multiple levels of the service. Some components represented complex interventions that had been found to be effective in randomised controlled trials; however, evidence was required about how and why they worked (or not) when implemented together in practice. Therefore, the evaluation, conducted over a three-year period from 2008 to 2011,

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