An exploration of midwives' experiences of caring for women seeking asylum

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“To meet people from different countries is a privilege, it is. We don’t appreciate things, they come from nothing sometimes, absolutely nothing, and we have got so much. And we don’t appreciate it, we want more. It humbles you really. When you realise how little they have, but they are rich in faith.” Midwife 6
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Executive Summary

This study has explored midwives’ experiences of caring for women seeking asylum in order to identify how improvements can be made to the care and maternity outcomes for this group of women and their children. Previous studies have investigated asylum seeking women’s experiences of maternity care in UK and have suggested that midwives lack understanding of the experiences and needs of women seeking asylum and have been interpreted as rude or indifferent (Waugh 2010, Briscoe and Lavender 2009, Nabb 2006, Homeyard and Gaudion 2008, Page 2004, McLeish 2002).

With an increase in births to women who have migrated to the United Kingdom (UK), it is inevitable that midwives in many NHS Trusts are increasingly caring for women seeking asylum. Under the government dispersal programme these women are now located throughout the UK with around 20% of asylum applicants supported in the Yorkshire and Humber (Y&H) region and between 2002 and 2008 (Lewis et al 2008). This client group have specific health and social care needs and a significantly higher maternal mortality rate than that of the white British women (Burnett and Peel 2001, Lewis 2007).

In this qualitative study, semi-structured interviews were conducted with ten midwives. Ethical approval was granted through the Integrated Research Application System (IRAS) and the local Research Ethics Committee (REC). Thematic analysis was used to analyse the data.
A valuable and unique insight into the experiences of midwives caring for women seeking asylum has been revealed in this study which recommends that: dedicated midwives work in teams to provide continuity of care to women seeking asylum; midwives are provided with support systems to de-brief their experiences of caring for these women; the dispersal of pregnant and postnatal women around the UK should cease; pre and post registration midwives are educated in the specific needs of this client group; an up to date web resource be developed to provide midwives with easily accessible up to date information and resources.

This was a small study undertaken in just one NHS Trust and will not represent all midwives however, themes and recommendations that have been described will seem authentic to the majority of practicing midwives. It will be disseminated through conference, journals and supervisory networks. Supporting and educating midwives in their work with women seeking asylum has the potential to enhance care, improve maternity outcomes and increase satisfaction in the workforce.
Chapter 1  Background and review of literature

1.1  Brief context of asylum situation in UK

In the UK the Home Office (HO) process applications for asylum and provide accommodation and support for people whilst a decision about their application is being made. Over the past decade there have been a significant number of people applying for asylum in UK. Although the numbers of UK applications have fallen steadily from 71,700 applications in 2001 to 24,485 applications in 2009 (HO 2010), around 30,000 asylum seekers from 117 countries have been dispersed in Y&H since 2000 (Lewis et al 2008). 41% of those dispersed in Y&H are women. There remain significant numbers of women who are awaiting an asylum decision, or who have received a negative decision and remain in the UK and are experiencing maternity care in Leeds. Actual numbers are difficult to establish as the local maternity system does not record the woman’s UK status, however twenty three percent births in Leeds in 2009 were to mothers born outside of the UK. Furthermore, of the 2132 maternity payments paid by the HO to women in Y&H over the past eight years, one quarter were paid to women in residing in Leeds (Home Office 2011). Many of the Local Supervising Authority Midwifery Officer (LSAMO) reports to the Nursing and Midwifery Council (NMC) over the last decade have indicated large and growing numbers of women seeking asylum (NMC 2011) indicating that this is an issue for midwives throughout the UK.
1.2 Operational Definition

The United Nations Convention (UN 1951) provides a legal definition of a refugee as someone who is outside of their country owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion. An asylum seeker is a person who is seeking safety and applying for refugee status in another country (Papadopoulos et al 1998).

1.3 Review of indicative literature


1.4 Maternity Policy and care of asylum seekers

Policies and standards such as The National Service Framework for Children, Young People and Maternity Services (NSF) (DH/DES 2004) and Antenatal Care (NICE 2008) have recognized the importance of embracing cultural differences and providing appropriate, flexible sensitive care for women from different ethnic backgrounds including women seeking asylum. In order to implement these policies and standards, midwives need knowledge, skills and information about ethnic beliefs and practices, including education about the asylum process, whilst remaining flexible and responsive to the needs of the
individual. This, therefore, has implications for the training needs of health professionals including midwives, as a “prerequisite to professional caring is that we should understand our clients, in their own terms before we intervene in their lives” (Gerrish et al 1996, p20). Furthermore, The NHS Constitution for England (DH 2010), policy that set out the principles that guide the National Health Service, identifies the core values that patients can expect from the service. These include dignity and respect, quality compassion and working in partnership with patients. Professional organisations including the Royal College of Midwives have produced guidance for professionals around providing appropriate maternity services for refugees and asylum seekers (RCM 2003) however, providing sensitive care to women seeking asylum continues to remain a challenge that is posed by policy, but is an area for which all midwives may not feel prepared (Katbamna 2000, Gerrish et al 1996).

1.5 Health of Pregnant Asylum seekers

The health of pregnant asylum seekers is compromised by poor nutrition arising from poverty, violence and torture (Burnett and Peel 2001). Some women have had little or no professional antenatal care. Reasons for this include lack of trained birth attendants/health workers, poverty and lack of education. The majority of women who come to the UK to seek asylum have escaped conflict (Crawley 2010). Many have suffered torture, rape, oppression and long difficult journeys before seeking refuge (Crawley 2010, Luanaigh 2005, Burnett and Peel 2001). All these factors are known to impact outcomes. Twenty percent of maternal deaths reported between 2003 and
2005 in UK were directly or indirectly related to a pregnancy where women had booked late, had poor attendance or no antenatal care (Lewis 2007). Maternal mortality during this period was six times higher for black African women and four times higher for black Caribbean women than for white women, with thirty six maternal deaths of asylum seekers and refugees in UK (Lewis 2007).

Mental health issues are prevalent amongst women seeking asylum. Asylum seekers often experience severe trauma from persecution including rape, and violence. These difficulties can be exacerbated by separation from family and experiences of racism in the UK (Lewis et al 2008). This can be compounded by experiences within the asylum system and fear of removal. A literature review of postnatal depression in migrant women, including asylum seekers, suggests that forty two percent may be affected (Collins et al 2010).

1.6 Women’s perspective of maternity care

With particular regard to maternity care, the literature suggests that women seeking asylum were generally satisfied with the midwifery care they received (McLeish 2002), although they had little control over the care they received and were in receipt of care rather than partners in its planning (Nabb 2006) as recommended in Maternity Matters (DH 2007). Midwives working with women during intra-partum periods were rated highly for their kindness, understanding and compassion (McLeish 2002). Information about maternity services (McLeish 2002), how to access care and how to make a complaint (Waugh 2010) were identified as areas for improvement. The Health Care
Commission report ‘Towards Better Births’ (2008) also identified that women from marginalised groups, including asylum seekers, do not access care in a timely manner, suggesting therefore that service improvements are required to ensure we have a service that is responsive to the needs of all women from marginalised groups. Some asylum seeking women reported racism (Waugh 2010), rudeness and indifference on the part of midwives (McLeish 2002). Morally, ethically, professionally and legally, midwives must treat women with respect and dignity. Midwives have a responsibility to advocate for women in their care and not to discriminate against them (NMC 2010). It could be argued that midwives are representative of the general population and therefore come in to the profession from a range of backgrounds and with a range of experiences. Racism remains a feature of UK society and therefore midwives are exposed to such attitudes. Waugh’s study (2010) raises questions as to the knowledge and training that midwives have had to prepare them for caring for women from minority groups and in particular for women seeking asylum in the UK.

In her work looking at why midwives return and why midwives stay in the profession Kirkham (2007) identified the culture in the NHS is another barrier to caring. Within the health service staff do not always feel cared for and this may have a negative influence the way they provide care for women. Kirkham found that structures to care for midwives are lacking: “we need a positive continuum of mutual support and cherishing of the NHS’s greatest asset” (Kirkham 2007).
Poor communication, both verbal and written, is a common theme within the literature. Inconsistent use of interpreting services resulting in miscommunication or lack of communication can contribute to lowering the quality of care provided and the lack of informed decision making on the part of the women (Nabb 2006).

1.7 Cultural Competence

The concept of cultural competence in the context of the midwifery practice was discussed by Atkinson (2003). Cultural competence has been described as “a set of congruent behaviour, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (Cross et al 1989 cited in Atkinson 2003, p 459). Midwives have been identified as a group of professionals who can be caught in a theory-practice gap in relation to cultural competence (Atkinson 2003, Gerrish et al 1996). Gerrish et al found that a third of student midwives who participated in the study did not feel prepared to meet health care needs of minority ethnic communities. An understanding of the literature around cultural competence (Campinha-Bacote 2002, Popadopoulos et al 1998, Rorie et al 1996) is deemed an essential component in the background reading for midwives but one that midwives have not had the opportunity to fulfil (Gerrish et al 1996). A recent review of maternity services for migrant women in the West Midlands (Phillimore et al 2010), included interviews with five midwives and identified the need for cultural competency training. This is in keeping with the recent publication,
Midwifery 2020: Delivering Expectations, which recommends that midwifery education places an emphasis on cultural competence.

1.8 Midwives’ experiences

Midwives’ experiences of caring for women seeking asylum are not so readily available within the literature; only one specific study undertaken in Australia (Cioffi 2004) was identified. The study explored caring for women from Chinese and Islamic backgrounds in Australia and it is not explicit as to whether these women were migrants, asylum seekers or part of the indigenous population. Twelve experienced hospital midwives were interviewed using an open question method. The study found that midwives were striving to meet their professional and ethical responsibilities to provide culturally congruent care that women find found culturally acceptable. The study recommended that continuing education programmes needed to continue to develop further knowledge and skills to meet everyday challenges faced by practitioners.

Having explored the literature and established that there is a relative dearth of work exploring midwives’ experiences of caring for women seeking asylum, the Mary Seacole Development Award project identified a significant gap in knowledge in this area. Semi-structured interviews were conducted with ten midwives to explore their experiences. The methodology and methods used can be found in Appendix 1.
Chapter 2  Findings

A huge amount of rich data was gleaned from the interviews. Participants’ enthusiasm indicated that they hoped they would contribute to the development of services for the benefit of women. The two overarching themes that emerged from the data were: **time** and **communication** with four sub-themes: **negotiating “systems”; the stress of caring; attitudes** and **learning “on the job”**, all of which can be influenced by time and communication.

**Figure 1 Themes**

2.1 Overarching themes: Time and Communication

Time was a resource limitation that affected midwifery practice with asylum seeking women, whilst communication was complex and central to care but limited by time constraints. All the participants talked about time in relation to all aspects of the care they provided. There were a variety of reasons given for the crucial need for additional time when caring for women seeking asylum. One key reason related to the complexity of communication with asylum seeking women. Communication was more than simply
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communicating with women; it was also about the need for robust communication between care providers and all the agencies that also interact with women.

2.1.1 Time

“Don’t make assumptions (...) you can’t if you don’t give them time”
Midwife 5

A large proportion of this client group do not access antenatal care until an advanced stage of pregnancy, often too late to take advantage of screening tests. Most participants indicated that late bookings are more time consuming as they often have no access to previous medical history and have to attempt to cover much of the care pathway that has been missed. Integral to this is the additional time that they need to build relationships with women in order to gain their trust. Relationships were recognised to be vital in the care of these women and time consuming to develop.

“They need the time to unravel the story. (...) there is a reason why they are refugees (...) Is it economic or are they fleeing some abuse or something. And they are pregnant and the pregnancy was not wanted and as a result of raping in their country or violence. And obviously they have fled. And then you have opened this huge emotional trauma and then you are feeling much more time and much more empathy”.
Midwife 4

Participants reported that they have less time due to increased capacity, reduced bed numbers and perceived inadequate staffing levels. The frustration this caused the participants was all too apparent. Some of the participants described the negative reaction they get from colleagues when they do ensure that they allocate additional time to listen to women and address their needs.
“If you were seen to spend too much time with one particular patient it was frowned upon and I have seen that with another midwife, another really lovely midwife who really pushes the boat out and dedicates time to a woman if she needs it”. Midwife 10

Providing care with interpreters is more time consuming than without.

“So that was a real juggle as well” Midwife 6

Every participant interviewed spoke with skill and experience of using both the face-to-face and telephone interpreting services provided by the Trust. However, they also all reported the additional time that was required, the frustration and stress of caring when the workload was intense.

“You know that we are going to have to get interpreters and that’s going to take a long time and because it does, it doubles the time that you spend with a woman, which I think puts stress on members of staff and it does on me at times (...) but you know it has to be done, that’s the job”. Midwife 1

Time is always a factor for contemporary midwives however the findings of this study indicate that for midwives caring for women seeking asylum additional time is required in order to build relationships with traumatised women.

2.1.2 Communication

Everything comes down to communication. To know what’s going on, what they need, what you need, because it’s a partnership, isn’t it? Midwife 8

The key issues regarding communication for the participants included using interpreters, building a trusting relationship with women, interagency working and access to information. Using interpreters is vital in providing care to the majority of women seeking asylum as English is often not their first language,
or is not spoken/understood at all. Interpreters were clearly identified by participants as essential members of the team and the relationships fostered between midwives and interpreters described as enhancing the care provided to women.

“And the experience that we have depends on the quality of the interpreter a lot of the time. (…) if you’ve got a good interpreter you don’t really know the interpreter is there, you can be yourself, you can talk normally, do your normal care and the interpreter is there purely interpreting what you say and what the woman says back to you”.

Midwife 8

The relationship between the midwife and the interpreter was explained by some participants as being just as important as that between the interpreter and the woman. A good relationship ensures trust between the parties involved. This is fostered by participants re-booking the same interpreter wherever possible throughout a woman’s care.

“It breaks down quite a big barrier because if they can trust what they say is being said to me, and equally just as I can trust what’s going the other way. I think it’s a safety issue as well. It’s not just a barrier it’s a feeling of safety”.

Midwife 5

Some participants also recognised that they need to ensure that what has been communicated has been understood by the woman (Midwife 3).

Participants reported great confidence in the interpreting services available to them through the Trust. Occasional problems in obtaining face-to-face interpreters were reported and this was often overcome by using the telephone interpreting service. Some participants reported that on the Delivery Suite it is becoming increasingly difficult to secure an interpreter for a long duration (Midwife 9). This was not due to any financial constraints, rather due to the other commitments of the interpreters.
Midwives are very creative: building therapeutic relationships is challenging at the best of times, but when the woman has little or no English the challenge is even greater. Creativity in communicating was demonstrated well by many of the participants. The use of pictures, diagrams and hand gestures were commonly reported, especially when waiting for interpreters to arrive.

“What I tend to do is draw a lot to explain what I am doing so hopefully they can understand by my drawings and by using my hands and my fingers and trying to tell them what I am doing that way(...) I drew a series of pictures for the night staff so that when her family left she could just point to a picture. So there was one with back ache there was one with contractions and I sort of did zig zags”. Midwife 1

Communicating with the multi-agency team and further afield with other statutory and voluntary groups was also acknowledged as vital in caring for this client group. The participants all demonstrated clearly the need to engage other disciplines and agencies in delivering care.

“I am quite overwhelmed at times as to how complex these lady’s lives are and how much input they need, and how many different organisations are needed to meet their various needs”. Midwife10

Obtaining information from some agencies, including the Home Office, and from the women, was reported as a difficult feat and frustration was evident when participants did not feel they had all the information they needed about a woman, particularly about her reasons for seeking asylum.

“We don’t need to know the whole lot; we don’t need the whole case history (...) to have a bit more understanding”. Midwife 9

All the participants have clearly learned much from working with women seeking asylum. Their listening skills have been put to use to gain understanding of women’s cultural backgrounds, which has therefore enhanced the care they have provided.
2.2 Negotiating “systems”

“The day to day running of the ward didn’t fit in with a care that these ladies needed” Midwife 10

A concept that was new to the researcher was the reporting of “systems”. It was used to describe both organisational systems related to NHS maternity care and the Home Office and reoccurred throughout almost all the interviews. Firstly, in relation to the maternity service, participants described women as not fitting the “system”. By this they were referring to the fact that many of the women seeking asylum present for care “late” and come with absolutely no medical history. Participants also reported that women appeared to have no appreciation of the maternal and fetal monitoring that is involved in their care (Midwife 3). Traditionally maternity systems have been set up in a style that anticipates that women will present early for care and follow a predetermined pathway. Midwives were keen to point out that this did not work for women seeking asylum and greater flexibility, that is more responsive to women’s needs, is required.

The other “system” that participants discussed was the Home Office asylum “system”. Some Participants identified that women they have cared for are suspicious of people whom they perceive to work for authorities such as the Home Office and this culminates in a fear that information given to midwives may have a detrimental affect on their asylum claim. This can result their failure to present for screening tests or appointments (Midwife 2). These women are then perceived as non-compliant by some staff members.
All the participants expressed their concern at the way the Home Office frequently move women and their families around the country. This transience of the asylum population causes great frustration and concern for staff.

“She suddenly completely disappeared and we never found out what happened to her. So, I really would have liked to have known from the HO has she been sent back? What happened to her, but I find, we tried to find out, because obviously we can’t just have patients disappearing from our care, you know has she gone underground somewhere? Where is she? Does she need care somewhere? Is the baby cared for? You know, has she reappeared in another city?” Midwife 4

Midwives have a responsibility to ensure that women receive continuity of care. Participants reported very diligent attempts to hand over care to colleagues in other Trusts but the frustration of having to leave messages and then remember to follow them up was all too evident. Frustration and annoyance was expressed with the Home Office for moving the women so readily and without sharing information with other professionals. One participant said the Home Office are:

“Really not patient centred. We are patient centred and obviously they have another way of working”. Midwife 4

Participants were concerned not only at the human cost of moving women and their families from the support networks and services they needed but also how it impacted on their care. Another perceived impact that participants have had to come to terms with is the fact that pregnancy is not always the priority for the woman. This was due to many different reasons including their transience, over which they have no control; their lack of faith in Home Office and a many other medical and social factors.

“Most are very frightened and unsure as to what is going to happen to them, and don’t know where their life is leading at that time. They are
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*living in a sort of limbo and that can impact on access to services. It can impact on what’s actually important to them (…) It might be where am I going to sleep tonight? What’s happening with my claim? And am I safe?” Midwife 5

The financial cost and waste of this was also described as a concern by some of the participants.

“It’s a big issue on a very practical point of view, partly because we need to order immunoglobulin for Hepatitis B. That has been a recurring theme, and it’s a very expensive injection to give to baby. It’s quite expensive and it’s dispensed by one place in the UK and once they have dispensed it if it’s not been used in that Trust then it is discarded (...) we had a lady and she moved through 3 Trusts and every time she gets moved it is discarded”. Midwife 4

Participants questioned government “systems” that they perceive let women down.

“Why has the government allowed that to happen? (…) at the end of the day the systems are there and actually if they are not tough enough or they are not correct or the processes are not there it’s not the woman’s fault”. Midwife 7

Frustrations were evident where participants perceived that women had been admitted to the country without good grounds or not assisted to leave the country when asylum had been denied.

2.3 The stress of caring

Some of the feelings created within participants by the “systems” are explored further in this theme. Although midwifery texts do not explicitly deal with the emotional aspects of the work midwives undertake, it is becoming recognised that “there are many aspects of midwifery practice that have the potential to generate emotion work for midwives” (Hunter, 2001, p422).
When given the opportunity to discuss how they feel about caring for women seeking asylum, participants were very honest about the impact that the women’s experiences have on them and their inability to comprehend fully the lives these women have endured.

“I feel that sometimes when I hear their stories I feel very distressed. I can’t imagine that whole life, where you just have nothing and you have all this brutality and it’s normal to be brutalised in that way…because that’s their normal. But to me that’s totally and alien concept, I can’t imagine that at all I can’t, I can’t compute it sometimes”. Midwife 2

The feeling of responsibility and inadequacy that some participants expressed was very apparent, as was the fear of doing or asking something that might cause the woman distress or harm. This extended to apprehension about their lack of knowledge and understanding of the Home Office procedures. Trusting relationships were discussed by participants at length as was the need for boundaries within relationships where there is the possibility of dependence on the midwife.

Whilst midwives are themselves dealing with the stresses of caring for woman seeking asylum they are also often supporting and facilitating students in their learning. Midwives are very skilled at undertaking this role and ensuring that student midwives are supported during stressful periods of care, but there are no formal support structures for the midwives to be cared for in a similar way.

“It felt as if I had re-evoked a trauma and not really knowing what to do with that one. I don’t think we get any support”. Midwife 1

Sometimes it can be as simple as needing someone to talk through your intuitions,

“There is not really a service for me worrying!” Midwife 2
Some participants talked about seeking support from family and friends, one from her supervisor of midwives, and three who worked in well-structured multi-disciplinary teams talked about seeking support from colleagues. The specialist asylum team in Leeds was seen as a vital support, participants felt fortunate to have someone that they trust will deal with the situation if they hand over a woman’s care.

“That’s a huge huge relief, because you just know that (...) that the cogs were still turning”. Midwife 7

The participants in this study clearly enjoyed caring for women seeking asylum and were open about the impact that providing this care has upon them.

2.4 Attitudes

There were a range of attitudes discussed by participants from extreme prejudice to great compassion. This is not surprising as midwives represent a cross section of British society.

“I am also furious with some midwives’ attitudes. Not all of them, but there are a few around who are very disrespectful of these women, with their opinions of the sort of rubbish that you see in The Sun every day”. Midwife 1

Ethnocentrism was not widely acknowledged. Most participants did not think they or their colleagues were “racist” but there was little acknowledgement of the stereotyping of women that goes on:

“They behave very culturally in labour”. Midwife 2
Some explained the subtle racism they observed in colleagues who moan about the cost implication to the NHS and/or the taking up of beds by women seeking asylum.

“It was almost as if it was coming out of the midwife’s pocket, you know she had the purse strings and she should be spending it wisely, and spending it on an interpreter was not wise spending”. Midwife 6

These attitudes were acknowledged to be affecting tolerance and care.

“Why are we bothering? You know, they are just going to get moved on”. Midwife 3

“Bias” was used by one participant when she spoke about whether a woman’s claim was genuine.

“You don’t like to question the authenticity of where or how but at the same sort of time you can’t not think about the fact that actually the healthcare there you have to pay for, compared to England”. Midwife 7

Although participants did not talk about the impact that making these assumptions has on the way they practise, they demonstrated immense empathy with these women. They discussed ways in which they would strive to make the women’s lives more comfortable by providing basic essentials for both the women and their children and expressed some understanding of what women have endured and their need for a refuge.

“These women have got absolutely nothing. I think it’s hard for us to understand because we are so materialistic (...) I wanted to look after this woman”. Midwife 9

Midwives have biases; some are able to acknowledge them better than others, and have observed prejudice in their colleagues and the wider multidisciplinary team. However in contrast, all the participants demonstrated huge compassion and personal satisfaction in caring for women seeking asylum.
2.5 Learning “on the job”

The participants who had trained over 10 years ago talked about the lack of information in their basic training around caring for women from diverse backgrounds. These participants described their learning as

“On the job really” Midwife 2.

The participants who had undergone their undergraduate training in the last decade discussed holistic, individualised culturally sensitive care but still felt that they would have benefitted from specific teaching around the issues for women seeking asylum.

“What I would like, I think, is a greater understanding, more education about the trauma that these women have gone through and how we should be mindful of that, and just hold that when we go and see these women”. Midwife 1

One of the most outstanding difficulties participants discussed was the inability to identify if a woman was an asylum seeker or not. Some of the participants expressed feelings that they were practicing outside of their depth of knowledge. The participants did not seem to recognise that they were developing expertise with each woman whom they cared for. “Holistic” care was what they strived to achieve, treating women as individuals, however, there were several requests for “tick box” style forms to be created to ensure that nothing was missed in a woman’s care. This contradiction may be a request for a form of anxiety management and they need to recognise their developing skills and be supported in their reflective practise.

Accessing training varied across the participants interviewed. Some had attended training sessions outside of work time. Knowledge was more readily gained from others sources however. These included a local newsletter,
mandatory training sessions, midwifery literature and the internet. Time was identified as one of the barriers to learning; this is compounded by staffing levels that do not always allow staff to attend training. Many of the participants could not express what additional training they required even though they said they needed it. One area that was identified as an area that training could be offered on was around mental health. Participants identified that woman seeking asylum often had mental health needs and would have liked to have been able to understand these better.

Participants expressed need for the wider multi-disciplinary team to have access to training around communication, and in particular for using interpreters.

“This person is an asylum seeker, their English is not good please use simple language with them, please don’t shout at them. Please take time to communicate with them”. Midwife 1

This was linked to the concept that information increases understanding and therefore tolerance, as discussed earlier.

The findings of this study are extremely valuable and contribute to our understanding of the experiences, learning and support midwives have had in caring for women seeking asylum. They will be discussed further in relation to current policy and practice.
Chapter 3  Discussion

This explorative study aimed to gain an understanding of midwives’ experiences of caring for women seeking asylum and to identify how they developed their expertise enable them to provide care to women seeking asylum. The findings of this study will be discussed in terms of the implications for **midwives**; for **service delivery** and for **education**.

3.1  Limitations

Following the publication of the Leeds Health Needs Analysis (Ladd 2008) work was undertaken to develop an Integrated Maternity Care Pathway for Women Seeking Asylum (Leeds Health Pathways 2010). Care for these women is now delivered by a dedicated team of midwives, and continuity of carer is maintained when women are moved around the city. This model was introduced in the autumn of 2010 and is currently being audited and evaluated. As the author of the Integrated Care Pathway and the leader of the dedicated team, I recognise that my position in the Trust will have had some influence on participant’s decision to discuss their experiences. The risk of coercion was reduced by advertising widely and allowing midwives to volunteer. The participants, unsurprisingly perhaps, were all very responsive to the needs of women seeking asylum and enjoyed caring for them. This will not represent all midwives, but I believe that the themes that have been described will seem authentic to the majority of practicing midwives.
3.2 Midwives

One of the primary themes that emerged throughout this study was that of the amount of additional time that is required when caring for women seeking asylum. The well documented national shortage of midwives (Kings Fund 2008, RCM 2011) is a cause of great concern, as midwives are increasingly caring for larger case loads and therefore feel that time is limited. This is compounded by the rising birth rate. It seemed that what participants wanted most was the recognition of the additional time that is required to care for women seeking asylum and some understanding from colleagues and managers. This is recognised nationally, such as in recent guidance which recommends that midwives "allow enough time for interpretation" (NICE 2010, p 10). Although this is something that can be controlled by case loading midwives, it is more difficult to facilitate in hospital clinic settings and on busy maternity wards.

In addition to time, participants described their heightened emotions when caring for women seeking asylum. I observed immense pride and great distress in the participants. Hunter and Smith (2007, p860) suggest that we “live in a world where the feelings aspect of life is increasingly acknowledged.” Midwives’ major source of motivation and job satisfaction comes from relationships with women (Kirkham, Morgan and Davies 2006). Despite this, there is little acknowledgement of the emotional wellbeing of midwives, and therefore the emotional cost to midwives of caring. Many of the participants in this study were unable to identify a support structure for their emotional wellbeing. Midwives practise within the code of practise set out by their
regulatory body, The NMC (NMC 2010). They “treat people kindly and considerately” and they “help them (…) access support” (NMC 2010 p1) but who provides this for the midwives? The tension between identifying women’s needs and the midwives ability to meet those needs was another ethical dilemma identified.

It has been recognised that midwives are at risk of leaving the profession if they are unable to practice in a supportive “with woman” environment (Kirkham 2011). Midwifery is fortunate and unique in its system of supervision of midwives. All midwives have the opportunity to be supported by their named supervisor of midwives, however in this study only one participant mentioned discussing her support needs with her supervisor (Midwife 6). Kirkham and Stapleton (2000) examined midwives support needs. They identified that midwives described “the culture of midwifery in the NHS as a female culture of caring expressed through service and sacrifice, operating within institutions which did not acknowledge the importance of such caring work” (Kirkham and Stapleton 2000, p467), in doing so midwives discounted their support needs. This study also found that although supervisors are often identified as providers of support, some midwives felt unable to trust their supervisor, particularly if she held a managerial role. The model of clinical supervision that is embedded in psychiatric nursing is one that Kirkham and Stapleton (2000) suggest may be adapted and embedded in midwifery supervision in order to provide a safe space for defence mechanisms to be discussed.
3.3 Service Delivery

Women seeking asylum have particular needs. They often present late or have little or no antenatal care (Lewis 2007). They have often suffered trauma in their escape from conflict (Crawley 2010). This study has shown that maternity services need to be flexible to adapt to these issues in order to enable the provision of woman centred care. The participants in this study demonstrated creativity in their approach toward women centred care. They all had experience of working with women who had received care under both the current and former model and commented on the changes from their perspective. They all referred to the new dedicated midwifery team for women seeking asylum as providing them with greater reassurance as they now have a source of advice and information.

One of the biggest frustrations that the participants disclosed to me in this study was around the policy of the Home Office in the dispersal of women and families. Women are distressed by the policy of dispersal on a no choice basis (Waugh 2010 and Mc Leish 2002) and the participants were hugely concerned about the impact this has on women’s physical and emotional health as well as the resource cost. Maternity Matters (2007) emphasizes the choices that are given to women around their care needs, but this study has highlighted the fact that choice is not available to women seeking asylum and that current policies may actually place women and children at risk (Midwife 4).
The participating midwives were practising in an area where the provision of interpreters is adequate, and they were confident in providing care through interpreters. It is not always the case that interpreters are provided for women who need them (Waugh 2010) but it is the responsibility of all midwives to ensure that they “make arrangements to meet people's language and communication needs” (NMC 2010, point 11). Therefore it is essential that midwives have access to interpreting services, both face-to-face and over the telephone.

3.4 Education

Using interpreters is one area of training that was identified as a need by participants. Simply providing a service is not sufficient. Participants identified that whilst they called upon interpreters in providing care, other disciplines (housekeeping, reception and medical staff) within the organisation did not. “Top down, bottom up” (Midwife 1) education around effective communication is essential to providing a quality holistic service to women and their families. The findings indicate that current pre-registration training for midwives in the Leeds does not include specific training around caring for women seeking asylum. However, by the end of their training student midwives need to be able to demonstrate sensitive and responsive care and self-awareness, communication, and interpersonal skills to enable them to provide sensitive, individualised care, congruent with the values of working with diversity and difference. The National Centre for Clinical Excellence (NICE 2010) recommend that health care professionals should be given training on the specific health needs of women who are asylum seekers including specific
social, religious and psychological needs and also training on the most recent policies on access and entitlement to care. This recommendation is welcome, and as many participants acknowledged, information increases understanding and reduces frustration, hence training may also reduce the prejudice that midwives and women (Waugh 2010 and McLeish 2002) report. However the current working environment of many midwives does not allow them to have study leave or expenses for studying. *Midwifery 2020* acknowledges that learning continues after graduation and that midwives need access to relevant education and have sufficient time to participate in that education. Increasing the midwifery work force is a key issue in this. The cost implication has been addressed by Maternity Action; a voluntary organisation that has secured funding form Comic Relief to provide free training for midwives around improving care for refugees and asylum seekers. This consists of an Introductory Course looking at the asylum process, refugee experience, entitlements and provides information and tools for effective support; and an Advanced Course looking at the barriers to accessing services and how to provide woman-centred care. This training has evaluated well (Maternity Action 2011), is accredited by RCM, and is now being offered to organisations to host around the country.
Chapter 4  Recommendations

This study was small in size and was undertaken in just one UK NHS Trust. The findings are therefore, not generalizable but do reveal a valuable and unique insight into the experiences of midwives caring for women seeking asylum. The following recommendations are aimed at enabling midwives to enhance the care that they provide and improve the outcome of the maternity experiences of women seeking asylum.

4.1  Recommendations for Midwives

Midwives caring for vulnerable women including asylum seekers should be supported with opportunities to debrief and share experiences. Working in dedicated teams can assist in the facilitation of this. Supervisors of midwives can also have a role in offering midwives supervision of their case load. This could be on an individual level or in group sessions.

Midwives have demonstrated creativity when caring for women. Several midwives identified the need for up to date information that they could source easily. A one-stop web-based information resource is recommended. This will be a resource that midwives will find easily accessible and will include information, services, and policies with links to other useful sites all in one place.
4.2 Recommendations for Service Delivery

The additional workload in caring for women seeking asylum needs to be recognised in work force planning. In areas like Leeds where there are significant numbers of asylum seekers, a dedicated team of midwives is recommended to ensure that additional time is available for midwives and women, and that continuity of carer can be provided.

Increasing midwifery capacity is a vital element of this and may require increasing midwifery establishments to reflect the local health needs analysis and ensure adequate numbers on university midwifery training programmes in the future.

Effective multi-disciplinary teamwork aids effective communication and sharing of information and knowledge. Interpreting services should be available to all multi-disciplinary staff and supported by training in their use.

Maternity services need to be able to identify and address factors affecting women seeking asylum such as offering flexible appointment times and timely access to care for those presenting late. Work needs to continue in the community to build on encouraging and enabling women to seek midwifery care as soon as pregnancy is recognised.

Pregnant women have the right to expect respect, dignity and choice in their care. Continuity of carer is an essential element in ensuring women seeking asylum receive the information they require to make choices. The dispersal of
pregnant women on a no choice basis denies women these rights and puts women and children at risk. Women should not be dispersed or moved around the UK during pregnancy and the postnatal period, but allowed to stay in the area they have settled where they have often built vital social and maternity networks. Mechanisms for sharing information between the Home Office and with maternity services should be established in order for seamless care to be continued should a move be unavoidable (RCM 2011).

4.3 Recommendations for Education

Pre-registration training should be enhanced to include specific training around issues for woman seeking asylum, cultural competency and the mental health needs of women in exile. This will prepare our midwives of the future for the client group that they will be caring for.

Post-registration training needs to be made available for midwives to enhance their knowledge and skills in caring for women seeking asylum. The availability of the education programme offered by Maternity Action must continue to be an option for midwives. An alternative on-line training programme should be developed to offer a choice of learning styles to midwives. Further research, including the evaluation of such an on-line training programme is also recommended.
Chapter 5 Conclusion

This study set out to gain an understanding of midwives' experiences of caring for women seeking asylum. Midwives have been criticised in the literature for their lack of understanding of the needs of women seeking asylum, and have been interpreted by these women as rude and racist. This study has enabled a valuable insight into the experiences of ten midwives working in Leeds. This insight has enabled me to make a series of recommendations for midwives, service providers and providers of education in order to enhance the care that is provided to this vulnerable minority population of women in the UK. Supporting and educating midwives in their work with women seeking asylum has the potential to enhance care, improve maternity outcomes and increase satisfaction in the workforce.
An exploration of midwives’ experiences of caring for women seeking asylum

References


An exploration of midwives’ experiences of caring for women seeking asylum

Home Office (2010) Control of Immigration, Quarterly Statistical Summary United Kingdom. [link]


Sarah Bennett Mary Seacole Development Awardee 2010
An exploration of midwives’ experiences of caring for women seeking asylum


An exploration of midwives’ experiences of caring for women seeking asylum


Appendix 1

Methodology

A phenomenological approach was used to collect qualitative data due to the relative dearth of information in this area.

Ethical considerations

Ethics approval (appendix 5) was granted by The Leeds Research Ethics Committee (REC) as the study involved members of National Health Service (NHS) staff and took place on NHS premises. The application was made through the IRAS with the support and permission of the LTHT Research and Development (R&D) Department.

Confidentiality was maintained throughout by preserving the anonymity of participants by allocating them a number and referring to them by that number only. Participants were informed that they could withdraw from the study at any time. Consideration was given to the potential for the interview to cause distress to the participant and plans were made for dealing with this. Participants were also informed that should they discuss any issues that compromised safe practice these would be discussed outside of the interview and referred on to a Supervisor of Midwives if required.
Methods

Sampling, Eligibility and Recruitment

A pilot interview was first conducted with a midwife outside of the Leeds Teaching Hospitals NHS Trust (LTHT) in order to ensure that the trigger questions were clear for the participant and elicited information related to the study aims.

The potential for coercion was overcome by ensuring that the researcher did not approach potential participants. Details of the study were disseminated by the Head of Midwifery using existing communication networks. Midwives were invited to contact the researcher. The study was open to all qualified midwives who had practised for a minimum of one year post registration, working within both community and hospital settings in LTHT. Midwives with less than one year post registration experience were excluded due to their relative inexperience in caring for the client group.

Twelve midwives responded; all of them fitted the inclusion criteria and were sent an Information sheet (appendix 2) about the study and a consent form (appendix 3). Table 1 demonstrates the role and experience of the participants. Due to the nature of the Mary Seacole Award, the study was designed to fit the time scale of the award process. Further, given the nature of the topic and the study aims, it was decided that a sample size of 10 midwives would be reasonable for an exploratory study. All the participants were volunteers.
Table 1 Profile of the sample recruited to participate in the study

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<th>Less than 10 year’s post registration experience</th>
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<td>2</td>
</tr>
<tr>
<td>Rotational Midwives</td>
<td>3</td>
<td>1</td>
</tr>
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<tr>
<td>Delivery Suite Midwives</td>
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Data collection

The semi-structured interviews were held outside of the participants’ workplace in order to create a relaxed atmosphere. The opening question was broad, inviting the participant to talk about his/her experiences of caring for women seeking asylum and allowed the midwives to take the conversation wherever they desired within the remit of the study aim. Subsequent questions sought clarification on what the midwife said or were drawn from a prompt style trigger list (appendix 4). Flexibility within the questioning schedule was essential in order that emphasis can be placed on points of interest as they arise. The interviews were audio-recorded so that the responses could be reviewed repeatedly during the data analysis process. Notes were taken throughout all stages of data collection in order to keep account of topics that were covered and for the researcher to reflect upon her role and potential influence. This also acted as an aide memoir in order that points could be repeated and clarified as necessary.
Data analysis

Audio-recording allowed the researcher to concentrate on what was being said during the interview rather than on writing notes and also enabled positive non-verbal communication. The interviews were then transcribed by the researcher providing additional opportunities to become immersed in the data, and codes began to emerge during the process.

Once the interviews were transcribed they were read and re-read. Using a thematic analysis (Bryman 2008), lists were made in the margins of words or short phrases that occurred and re-occurred that appeared relevant to the study aim. These lists were then collated and first discussed with the research supervisor and then compared against one another. These lists became codes and links and connections between codes were identified (Bryman 2008). Themes began to emerge at this stage. These themes were discussed reviewed and grouped into two overarching themes and four interconnected sub themes.

Rigour

Enhancing the consistency and quality of qualitative research requires rigour (McBrien 2008). In this study the researcher returned to half of the participants and shared her finding and asked the participants if the interpretation reflected their experiences (Holloway and Wheeler 2002). The participants added additional insights, assisted in the visual representation of the findings and confirmed that the interpretation was correct. In addition, a reflexive diary was maintained throughout the study. This enabled the
researcher to reflect upon the effect she was having on the process and decisions she made. This also informed and recorded discussions with the research supervisor. In this way a clear audit trail of the data analysis provided additional evidence of rigour.
Appendix 2 Information Sheet

PARTICIPANT INFORMATION LEAFLET

Study Title: An exploration of midwives’ experiences of caring for women seeking asylum

What is the purpose of this study?
The purpose of this study is to address a gap in the evidence of midwives’ experiences in providing care to women seeking asylum. Studies have been undertaken examining women’s experiences of receiving maternity care both in Leeds and elsewhere in the UK. This study intends to examine midwives’ experiences of delivering care to women seeking asylum in Leeds in order to make recommendations for education, practice and further research.

Who is doing the study?
The study is being undertaken by Sarah Bennett, who has received a bursary from the Mary Seacole Award. Sarah is being supported by academic and professional colleagues allocated by the Mary Seacole Steering Group and by colleagues in the Leeds Teaching Hospitals NHS Trust.

Why have I been asked to participate?
You have been invited to participate in this study because you have experience of caring for women seeking asylum. The researcher would like to hear about the care you have given and any rewards or challenges you have faced.

What will be involved if I participate?
You will be invited to participate in a semi-structured interview. The interview will take no longer than 90 minutes and will be audio-recorded. It will take place at a time and place that suits you. Refreshments will be available. Around 10 midwives will be invited to be interviewed for the study. Audio-recordings will then be transcribed by the researcher. Should you agree to participate in the study you will be required to sign a consent form. You will be given a copy of the signed consent form.

Can I withdraw from the study at any time?
Should you consent to the study, you will be able to withdraw from the study at any time prior to or following the interview. Any data collected before withdrawal will be retained and included in the data analysis in the study.

Should you wish to complain about any aspect of your treatment during the study you can contact Leeds Teaching Hospitals NHS Trust Research and Development Team.
An exploration of midwives’ experiences of caring for women seeking asylum

Will the information I give be kept confidential?
Each participant will be allocated a study number and the data will be anonymised and stored using only that number to reference it. All data will be stored in a locked cabinet by the researcher. It will be stored for 3 years.

In the event that during the interview you disclose any practice issues that cause concern to the researcher, she will discuss and attempt to clarify these with you after the interview. In the event that concern persists, she will follow Leeds Teaching Hospitals NHS Trust guidance “Managing Employee Capability” and inform your Supervisor of Midwives who will take action according to Yorkshire and the Humber LSA guidance. In this instance you will be notified both verbally and in writing.

What will happen with the results of the study?
This study is being undertaken in Leeds with the support of a Mary Seacole Development Bursary. The final report will therefore be the property of the Department of Health. The study will be discussed at professional meetings and conferences and may be published in professional journals.

Who has reviewed this study?
The study has been approved by the Research Ethics Committee in Leeds.

If you agree to take part in this study, would like any more information, or have any questions or concerns about the study please contact the researcher.

Contact details of researcher:

Sarah Bennett
Specialist Midwife for vulnerable women from black and minority ethnic groups.
0113 2066392
07786250857
sarah.bennett4@nhs.net

Research Supervisor:

Dr Janet Scammell
School of Health and Social Care
Bournemouth University
01202 962751
jscammell@bournemouth.ac.uk

Information Leaflet V2.1 February 2011
Appendix 3  Consent form

CONSENT FORM
Study Title: An exploration of midwives’ experiences of caring for women seeking asylum

- I have read and understood the information sheet, version 2.1 February 2011, for the above study and have had the opportunity to ask questions.
- I have received satisfactory answers to my questions and have received enough information about the study.
- I understand that the interview will be audio-recorded and transcribed by the researcher.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
- I understand that any information I provide will be confidential, stored securely and accessed only by the researcher.
- I agree to take part in the study and understand that the study findings will be published maintaining my anonymity.

Participant Name
Participant Signature     Date
Researcher Name
Researcher Signature     Date

Consent Form V2.1 February 2011
Appendix 4  Trigger list

- How long have you practised as a midwife?
- Can you tell me something about your experiences as a midwife caring for women who are asylum seekers?
- Can you tell me about a situation where things went very well or things didn’t go as well as you would have liked
- Do you find you have to adopt different ways of working with this client group?
- How do you feel about caring for this group of women?
- Have you ever observed your colleagues express negative behaviours in caring for these women?
- Do you feel you have had sufficient support and education in caring for these women?
- Tell me about how you have gained information and knowledge to care for women seeking asylum
- How could the service better support you to care for these women?

To conclude:

- To finish with, is there anything else you would like to tell me?
Appendix 5 Ethics Approval

National Research Ethics Service
Leeds (Central) Research Ethics Committee
Yorkshire and Humber REC Office
First Floor, Millside
Mill Pond Lane
Meerwood
Leeds
LS6 4RA

Telephone: 0113 3050127

02 February 2011

Mrs BS Bennett
Specialist Midwife
Leeds Teaching Hospitals NHS Trust
Haamla Office, Antenatal Clinic,
Gledhow Wing, St James’s Hospital,
Beckett Street, Leeds
LS9 7TF

Dear Mrs Bennett

Study Title: An exploration of midwives' experiences of caring for women seeking asylum.

REC reference number: 11/H1313/6

The Research Ethics Committee reviewed the above application at the meeting held on 21 January 2011. Thank you for attending to discuss the study.

Ethical opinion

The Committee asked you why your supervisor was situated in the South. You explained that the Mary Seacole Steering group had allocated you with a supervisor and the majority of the supervisors are based in the South. You reassured that Committee that you meet your supervisor regularly in London.

Members asked you how you would deal with any controversial statements or malpractice during the interviews. You stated that you would end the interview and address the issue and then assess whether it needs to be reported to a manager.

Members asked you about your research experience. You stated that you had worked in research, but mainly in data collection. You also stated that you used to be a NCT breastfeeding counsellor.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).
Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation’s involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

- The Committee requested that the confidentiality clause is included in the participant information sheet.

It is 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).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

Approved documents

The documents reviewed and approved at the meeting were:

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<th>Document</th>
<th>Version</th>
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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for
Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

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
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

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**11/H1313/6**  
*Please quote this number on all correspondence*

With the Committee’s best wishes for the success of this project

Yours sincerely

Dr Janet Holt  
Vice Chair

Email: Nicola.mallender-ward@leedspft.nhs.uk

**Enclosures:**  
List of names and professions of members who were present at the meeting and those who submitted written comments

“After ethical review – guidance for researchers”

**Copy to:**  
Dr Derek Norfolk
Leeds (Central) Research Ethics Committee

Attendance at Committee meeting on 21 January 2011

Committee Members:

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<th>Name</th>
<th>Profession</th>
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<td>Dr Chris Bennett</td>
<td>Consultant Clinical Geneticist</td>
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<tr>
<td>Mr Mick Burns</td>
<td>Senior Commissioning Manager</td>
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<td>Dr Margaret L Faull</td>
<td>Chair</td>
<td>No</td>
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<td>Mr Mark Godley</td>
<td>IT Consultant</td>
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<tr>
<td>Dr Janet Holt</td>
<td>Senior Lecturer</td>
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<tr>
<td>Ms Sarah Kirkland</td>
<td>Learning Disability Services Directorate</td>
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<tr>
<td>Mr Vernon Long</td>
<td>Consultant Ophthalmologist</td>
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<tr>
<td>Mrs Caroline Minchin-Burville</td>
<td>Social Worker Management Consultant</td>
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<tr>
<td>Mrs Claire M Ramsden</td>
<td>Health visitor</td>
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<td></td>
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<tr>
<td>Dr Jinous Tahmassebi</td>
<td>Senior Lecturer and Specialist in Paediatric Dentistry</td>
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<td></td>
</tr>
<tr>
<td>Ms Bren Torry</td>
<td>Lecturer/Programme Leader</td>
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Also in attendance:

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<thead>
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<tbody>
<tr>
<td>Mrs Nicola Mallender-Ward</td>
<td>REC Co-ordinator</td>
</tr>
<tr>
<td>Mr Marc Neal</td>
<td>Assistant Co-ordinator</td>
</tr>
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Funded by the Department of Health