



## City Research Online

### City, University of London Institutional Repository

---

**Citation:** Rocca-Ihenacho, L., Yuill, C. & McCourt, C. (2021). Relationships and trust: Two key pillars of a well-functioning freestanding midwifery unit. *Birth*, 48(1), pp. 104-113. doi: 10.1111/birt.12521

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

---

**Permanent repository link:** <https://openaccess.city.ac.uk/id/eprint/25563/>

**Link to published version:** <https://doi.org/10.1111/birt.12521>

**Copyright:** City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

**Reuse:** Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

---

---



**Relationships and trust: two key pillars of a well-functioning freestanding midwifery unit**

**Authors:**

**Lucia Rocca-Ihenacho, RM, PhD, City, University of London**

**Cassandra Yuill, PhD, City, University of London**

**Christine McCourt, PhD, City, University of London**

**Short running title:** Relationships and trust pillars of midwifery units

**Affiliation:**

Centre for Maternal and Child Health Research, School of Health Sciences  
City, University of London, 1 Myddelton Street, London, EC1R 1UW

**Funding:**

This work was funded via a Clinical Academic Training Doctoral Fellowship by the National Institute for Health Research to Dr Rocca-Ihenacho (CDRF 2009-24)

**Address for correspondence:**

Dr Lucia Rocca-Ihenacho

Centre for Maternal and Child Health Research  
School of Health Sciences  
City, University of London  
1 Myddelton Street  
London  
EC1R 1UW  
Email: Lucia.Rocca-Ihenacho@city.ac.uk  
Office telephone number: 0044 20 7040 5766

**Manuscript wordcount:**

**Acknowledgements:**

We would like to acknowledge the Barkantine Birth Centre staff and management team and all the service users' who participated in this research for their generosity and enthusiasm.

## **Building relationships and trust: two key components of a well-functioning freestanding midwifery unit**

### **Abstract:**

#### Background

Despite strong evidence supporting the expansion of midwife-led unit provision, due to optimal maternal and perinatal outcomes, cost-effectiveness, and positive service users and staff experiences, scaling up has been slow. Systemic barriers associated with gender, professional, economic, cultural and social factors continue to constrain the expansion of midwifery as a public health intervention globally. This article aims to explore relationships and trust as key components of a well-functioning freestanding midwifery unit (FMU).

#### Method(s)

A critical realist ethnographic study of an FMU located in East London, England was conducted over a period of 15 months. Recruitment of the 82 participants was purposive. Data collection included participant observation and semi-structured interviews, and data were analysed thematically along with relevant local guidelines and documents.

#### Results

Twelve themes emerged. *Relationships and Trust* was identified as the core theme. The other 11 themes were grouped into six families: *Ownership, Autonomy and Continuous Learning; Team Spirit, Interdependency and Power Relations; Salutogenesis*, all of which will be covered in this paper. The remaining themes, *Friendly Environment; Having Time and Mindfulness; Social Capital*, will be covered in a separate paper.

#### Conclusions

A relationships-based model of care was crucial for both the functioning of the FMU and service users' satisfaction and may offer a compelling response to high levels of stress and burnout among midwives.

## **Introduction**

There is strong evidence that for healthy women with uncomplicated pregnancies in high-income countries, midwife-led birth settings, including midwifery units (MUs, also called birth centres) are associated with improved maternal and similar perinatal outcomes (1; 2), better service user experiences (3; 4) and high cost-effectiveness (5), yet the expansion of this model of care has been slow (6, 7).

Systematic barriers related to gender, professional, economic and social disempowerment intersect with “powerful precedents” to constrain midwifery’s progress globally (8, p 397). Obstacles persist to establishing the full scope of midwifery practice, including the normalisation of MUs (2; 8; 9). Ethnographic studies have explored aspects of organisational culture which support MUs, such as quality of leadership, equitable power dynamics, supportive inter- and intra-professional relationships and the development of midwifery skills and confidence (10-12).

The importance of integrated services has been iterated both in England and globally (13; 14). McCourt et al. (10;11) stressed the need for integrated services that foster positive inter-professional relationships as key features for service quality and safety, yet their study also highlighted the risk of tense relationships between MUs and Obstetric Units (OUs) (11). Sandall et al. (15) argue that relationships are the pathway to safe, high-quality maternity care, and Liberati et al. (16) also stress that an organisational culture underpinned by teamwork, cooperation and positive working relationships is a key characteristic of safe maternity units.

However, MU performance can suffer from a lack of focus on philosophy of care, and MUs sometimes struggle with a low number of annual births and/or with high transfer rates (10-11). There is also evidence that malfunctioning healthcare organisations with poor inter-professional relations are associated with catastrophic, avoidable harm to service users (17; 18), and that the current level of stress and burnout among midwives is not sustainable (19).

In 2018, the MU Standards for Europe were published, building on a review of existing evidence and expert opinion (20; 21). The 29 Standards, divided into ten themes, describe what a well-functioning MU should have in place (20; 21). Theme one describes a bio-psycho-social model of care that is based on integrating relational and personalised care with support for physiology. A well-functioning MU is described as meeting most of the MU Standards, demonstrating clinical outcomes in line with or better than national averages, and reporting positive service users' experiences (1; 3; 12). Nonetheless, more work is needed to identify which key components of a well-functioning MU are essential, as well as how best to implement them into practice; attention must also be paid to understanding barriers and facilitators for effective scaling up of MU care (12; 16).

Despite policy recommendation, the provision of FMUs in England has not changed substantially, and the number of units has remained stable (6; 7). Publications on FMUs have also been limited (1; 12). Given the significant challenges faced by midwife-led units and efforts to scale up FMUs, a deeper understanding of what works, and how, is critical. Thus, the aim of this study was to describe the philosophy, organisational culture and practices within FMU models of care and to identify the key components of a well-functioning FMU (12). Specifically, we explored the following research questions: 1) How do service users, midwives and other staff experience maternity care within a freestanding midwifery unit?; 2) How are midwifery philosophy, culture and practice enacted within a freestanding midwifery unit?; and

3) What are the key components which describe a well-functioning FMU? In this article, we focus on two core components of a well-functioning freestanding midwifery unit (FMU): relationships and trust. We examine how these two components were reciprocal for staff and service users and were associated with the creation of a sense of wellbeing.

## **Methods**

This paper draws from an in-depth, ethnographic study of a freestanding midwifery unit in England, which was selected because it was the first purpose-built inner city FMU and was newly established when the study was conducted. We employed an ethnographic approach, underpinned by a constructivist epistemology that views the production of knowledge as socially constructed (23). Ethnography is an ideal methodology to study organisational culture, focusing on ‘why people do what they do’ and how groups function (24). This methodology was selected to address the research questions because it has proven an effective way to explore participants’ experiences, beliefs and philosophies (25).

The participants in this study were all the stakeholders involved with the FMU. All FMU staff were invited to participate, and all consented to take part. A purposive sample of midwives, doctors and managers from the referral hospital nearby were also invited to participate (see Table 1). Service users were selected based on variation in parity, ethnicity and socio-economic background and were invited to participate while in the FMU waiting room or during a tour of the unit. Hospital staff were invited based on role, ethnicity and years of experience (see Table 1). Key senior managers and medical leaders were invited to participate, including the head of midwifery, consultant midwives, the matron, the linked obstetric consultant and the neonatologist. FMU staff were approached during team meetings at the beginning of the study, and hospital managers and leaders were invited via email and followed

up on through a one-to-one meeting. Written informed consent was acquired from all participants before participant observation and interviews began. Ethics approval was obtained from the Health Research Authority and local Research and Development Office prior to starting fieldwork. Fieldwork was conducted over a period of 15 months, divided in two 'waves': February 2011 to August 2011 and November 2011 to June 2012.

Reflexivity and positionality are two key tools for an ethnographer: the first is defined as the ongoing analysis of the researcher's own values, views and emotions in the field and critical reflection on how these can influence their perception of the fieldwork (27-28); and the second refers to the 'need for finding a serviceable and responsible way of situating oneself in 'the field', (29-30). The lead author was an insider researcher and midwife previously employed at the FMU. She clarified her positionality to the FMU at the beginning of the study while discussing informed consent. The change of role from colleague to researcher was explicitly discussed and agreed upon across the FMU team.

Participant observation occurred over 30 shifts (approximately 360 hours) at different times and days of the week and included everyday activities at the FMU such as team meetings, office administration time, antenatal and postnatal appointments, active birth workshops, breastfeeding support groups, drop-in sessions and intrapartum care. If a woman had agreed antenatally to participant observation in labour, the first author would be on call for her birth. The first author immersed herself in the everyday activities of the group studied (29) but did not participate in providing clinical care, except in case of immediate need to fulfil her duty of care as a professional midwife (1 case). The field notes (written on the basis of jotted notes and voice memos within 24 hours from the shift observed) aimed to generate a 'thick description' and to give a sense of environment, events, emotions and perceptions of people involved in the set (observer included) (29-30). Four points guided the observation and field notes: physical



setting and persons involved in the scene, events, timing, observer's feelings and impressions. Participant-observation (PO) progressed in three steps: descriptive, focused and selective (29).

In addition to participant observation, 45 interviews were also conducted, taking the form of a 'guided conversation' wherein both researcher and participant can share and benefit from each other's understanding and experience, ideally establishing a 'democratic' approach to data collection and knowledge construction (30). All the FMU staff participated in the study and 21 agreed to be interviewed (midwives, care assistants, team leader and administrator). Interviews were scheduled across the entire duration of the two waves of data collection following participants' availability. Interviews took place at the FMU, the OU or at service users' homes. Four interviews were conducted with the support of a bilingual English-Bengali research interpreter.

All data were analysed thematically using Atlas.ti software, with some initial coding and analytical memos developed simultaneously during fieldwork. Midwives who worked at the FMU, as well as the Patient and Public Involvement (PPI) group (six service users), provided participant validation during the whole duration of the study by meeting with the first author to discuss the interpretation of the data and make suggestions. The focus of this article is on the internal aspects (micro-level) of the FMU and its culture, whereas the meso- and macro-levels of the ethnographic study, such as relations with the obstetric unit and hospital management, will be reported separately.

## **Findings**

### *The setting*

This study took place in the first purpose-built urban FMU developed in an area of East London with a very strong history of culturally and socially sensitive primary care services (31; 32). A

177 longstanding commitment to community engagement characterises several of the local health  
178 clinics, often led by innovative General Practitioners (GPs), and located in one of the most  
179 economically deprived constituencies in the country (31; 32). The campaign to build a new  
180 FMU began in 2003, led by a diverse steering group. It took two years for the project to be  
181 approved, and five years for it to be implemented (31). The steering group was outspoken and  
182 influential in setting the foundations for an FMU focused on a social model for maternity care  
183 in which physiological birth could be supported (31).

184         The FMU is co-located in a health centre, one of the first Polyclinics in the city, that  
185 includes several primary and social care services. It opened for births in January 2008, and was  
186 designed to provide care for up to 1,000 women with straightforward pregnancies and to  
187 facilitate approximately 500 births per year. Though the model of care offered by this FMU  
188 was not based on case-loading, at the time of data collection midwives working there provided  
189 continuity of carer to about a quarter of the women booked at the centre (3; 32). Women who  
190 start care at the FMU but who develop complications are transferred by ambulance to an OU  
191 within a tertiary hospital, approximately 15 minutes away. The facilities include a common  
192 area, clinic, shared kitchen for staff and service users, breastfeeding room, and five birthing  
193 rooms each with a pool. The FMU booked 987 women in 2011 and facilitated 448 births with  
194 clinical outcomes in line with national averages (33).

195 From the initial analysis 98 codes were created, which were eventually sorted into themes and  
196 subthemes. The themes were organised in three groups: staff perspectives (11 themes and 11  
197 subthemes), service users' views (15 themes and 2 subthemes), and organisational aspects (10  
198 themes and 12 subthemes). Three figures were created from the analysis and the mind-mapping  
199 exercises, in order to find a visual representation and to convey the relationships between  
200 themes and subthemes. This organisation of the themes was pragmatic in order to speak to

different audiences. A fourth model was also created, which integrated the three perspectives by highlighting the common characteristics of the FMU. This model called ‘Key Components of a Freestanding Midwifery Unit’ emerged from identifying the commonalities among the accounts of the different stakeholders, formed the participant observation and it is presented in this paper (see figure 1).

Within the ‘Key Components of a Freestanding Midwifery Unit’ 12 themes emerged. *Relationships and Trust* was identified as the core theme. The other 11 themes were grouped into six families (see Figure 1): *Ownership, Autonomy and Continuous Learning; Team Spirit, Interdependency and Power Relations; Salutogenesis*, which will be covered in this paper. The remaining themes, *Friendly Environment; Having Time and Mindfulness; Social Capital*, will be covered in a separate paper.

### *Relationships and Trust*

The FMU fostered a culture which allowed and encouraged the team to develop positive relationships amongst themselves and others working in the Polyclinic. This positivity was evident in daily interactions between all staff members, including administrative, security and hospitality staff. The FMU team embraced a spirit of mutual support, enjoying work and valuing time spent with service users. The environment also played an important role in facilitating socialisation between staff and service users. Maria, a young midwife who had recently joined the FMU team commented:

*‘I found it more approachable—you come in the door and there is an area where staff sits and eats and talks, as well as the women and their family. That was quite great and interesting and even when you come in everyone greets each other. So lovely, and the women and midwives*

224 *talking to the families and the women. They know them [the midwives] and they have already*  
225 *built that relationship. I think that was great' (BC4-MW-F-INT).*

226 Shazna, a British-Bengali woman, who had her first baby at the FMU, described the trusting  
227 relationship she developed with her midwife this way:

228 *'I felt, because she was there with me during the labour, I felt like I could ask her for help. If*  
229 *it was any other midwife, I probably wouldn't have asked to be honest. I probably would have*  
230 *just struggled along sort of thing because he wasn't feeding, he hadn't fed for quite a while. I*  
231 *don't know why. So I asked [name withheld] and she, she helped me, she stayed with me for a*  
232 *little bit and she, she you know, told me what to do and that felt really reassuring.'* (SU10-W-  
233 *INT-PN).*

234 Many service users referred to a feeling of safety ('in safe hands') when cared for at the FMU,  
235 mostly linked to the support they received. Having established relationships was associated  
236 with a sense of trust. Trust was a precursor to a sense of safety as described by service users.  
237 The midwives also demonstrated trust in women's ability to give birth physiologically and  
238 avoided interference unless clinically necessary, exemplified in this extract from the fieldnotes:

239 *'Maria (the midwife) returns to the room. It is now 0030. Jane [a pseudonym] gets in the pool*  
240 *on all fours and as soon as she relaxes in the water, she says it helps a lot and smiles. Jane is*  
241 *able to relax very well with contractions; she is very focused. I leave the room for 5 minutes to*  
242 *get a coffee. On my return, Maria tells me that Jane is feeling some urge to push. Jane looks*  
243 *very calm and focused. Jose (student midwife) gets the mirror and has a look to see if the head*  
244 *is visible. Maria checks the fetal heart tones in the water. With the next contraction, Jane*  
245 *pushes involuntarily. Jose says he could see the head. Jane asks what to do, and Maria says to*  
246 *keep doing what she is already doing, and the baby will be born soon. Jose puts gloves on and*  
247 *looks a little agitated. He puts his hands by the head, but Maria tells him gently to keep his*

248 *hands off: Trust the process, you don't need to do anything'. With the next contraction, the*  
249 *head is born, and Maria keeps guiding Jane verbally with a calm and confident voice. Baby is*  
250 *born and Jose and Maria pass the baby between Jane's legs towards the front. Jane picks up*  
251 *the baby. It is a girl!' (Fieldnotes, shift 1- Night shift).*

252 Together, participants' narratives elevate the importance of shared space, continuity of carer  
253 and affirmations of a healthy body's innate ability to birth as central to building trust and  
254 therapeutic relationships.

255

### 256 *Ownership, Autonomy and Continuous Learning*

257 All the staff who worked at the FMU had a strong sense of ownership and autonomy. The term  
258 'ownership' in this study is conceived in the sense of self-determination and intrinsic  
259 motivation to improve the FMU and the quality of care. 'Owning your own work' was  
260 mentioned by several midwives as an important feature of their employment at the FMU and  
261 was connected with job satisfaction. This extract from Ella's interview describes ways  
262 midwives built ownership:

263 *'We didn't have a manager at the beginning, well we had the labour ward manager but she*  
264 *wasn't there. But in a way, it was good we had the opportunity to manage the place how we*  
265 *actually liked and many of the guidelines— they were not many but just a few guidelines—*  
266 *were changed, and we did try to improve at the birth centre. It was our ideas that they were*  
267 *going to be used' (BC10-MW-F-INT).*

268 This sense of ownership and pride in the space and the work applied both to clinical care and  
269 to organisational aspects:

270 *'It is 9 am and the meeting starts in the community midwives' room... The integration of the*  
271 *FMU with the community team has happened and the team is trying out different ways of*

272 *working and organising the workload... It gets agreed upon that the community shifts will*  
273 *change to long days and there will be clinics running in the evening. They are discussing issues*  
274 *in a pragmatic manner, trying to find workable solutions.’ (Fieldnotes, shift 15- Weekday shift-*  
275 *0800).*

276 This type of commitment to ongoing and continuous improvement of the organisation of the  
277 unit was observed across multiple aspects of the FMU, including the FMU environment, the  
278 organisation of services, the involvement of the community, and staff work-life balance.

279 The FMU staff described a culture which created a virtuous cycle of empowerment  
280 which supported learning. Pablo said:

281 *‘So I think that continuous feedback systems in which you own your own work and there is a*  
282 *culture that allows you to get satisfaction from your work, to be responsible for what you do—*  
283 *that’s what keeps you going and makes you better as a midwife’ (BC7-MW-M-INT).*

284 This sentiment was reinforced by Veronica:

285 *‘I am really happy that I came here to work because I feel like I learnt so much about midwifery*  
286 *from being here and midwifery—not in a medicalised way but in a ‘with woman kind of way’.*  
287 *Here it is a bit more relaxed and a bit more, you know, we are able to actually observe things*  
288 *rather than I think just going and getting it done’ (BC6-MW-F-INT).*

289 FMU staff commonly discussed how they had developed competencies and skills since  
290 beginning to work at the FMU. Working in a supportive environment and culture helped to  
291 maximise their learning. As Milly commented:

292 *‘My first impression is, I felt to be honest a little bit out of my depth because I was so used to*  
293 *high-risk care. Although this is what I wanted to do, I did not have a lot of experience talking*  
294 *to women in the kind of ways that the midwives did here. So I felt that I had to learn a lot, and*

295 *I worked alongside the [established] midwives to start with. I was just listening to the way they*  
296 *were with women, and I felt that I learned a lot from them. But to start with, I found it was a*  
297 *big change because there was a lot more choice for women and information-giving than what*  
298 *I have seen in the other hospitals before' (BC1-MW-F-INT).*

299

### 300 *Team-spirit, Interdependency & Power Relations*

301 The FMU team relied on a strong team spirit and mutual support, or interdependency,  
302 to organise their everyday care duties. Staff were observed systematically coordinating  
303 activities with each other, checking on one another regularly to ensure they could cope and  
304 offering help if a colleague was overloaded:

305 *'It is Wednesday 8 am, the shift just started. There are 2 midwives and a maternity support*  
306 *worker on. After the handover, the midwives have a tea together and discussed how to divide*  
307 *the jobs of the day. There is a busy antenatal clinic and two postnatal women in rooms 2 and*  
308 *5 who have given birth during the night. Nobody is in labour at the moment.*

309

310 *At 9 am the antenatal clinic starts. At 11, the midwives get quickly together in the staff room to*  
311 *check how the morning is going and to see if anyone needs help'. (Fieldnotes, shift 5, weekday-*  
312 *0800).*

313 Asking for a second opinion from a colleague was an embedded practice that  
314 disregarded organisational hierarchy. Midwives who were interviewed reported that the power  
315 relations and dynamics that they had experienced in the local OU teams were not prevalent in  
316 the FMU. The presence and role of the senior midwife on shift was described by staff as  
317 supportive rather than authoritative, and they felt that support was available when escalation  
318 plans needed to be developed. Melody commented:

319 *'I think that you have a hierarchy in the hospital which you don't have here in the birth centre.*  
320 *We're midwives and we make decisions together...'* (BC15- MW-F-INT).

321 An approach to care based on the concept of partnership in decision-making was  
322 described by the FMU midwives as a philosophy of care in which relationships, trust and  
323 respect for women's autonomy were at the core. The midwife offered information to the  
324 woman and discussed pros and cons of different options. The partnership element meant that  
325 there was support offered by the midwife to facilitate a personalised plan of care.

326 As Farida commented:

327 *'...at the fourth contraction, I kind of pushed. She [the midwife] got a mirror and she said 'oh*  
328 *I can see the head coming out, and right at the end when the baby was coming out she said to*  
329 *me 'you can either catch the baby or I can do it.' My sister said: 'I don't think she can do it,*  
330 *so you get the baby' and as soon as the baby came she passed the baby to me, and I looked at*  
331 *the baby and that was amazing, even though I had three other babies, that moment, it so*  
332 *special'* (SU8-W-INT-PN).

333 For many midwives, working at the FMU allowed a fundamental shift in the power  
334 relationships with women they cared for. Emily, in her interview, said:

335 *'Now I feel more satisfied because I now realise, the woman is actually, she'll actually be the*  
336 *leader, because it's about her, it's about her pregnancy. But the fact that I am able to support*  
337 *that, if there is an agreement about her birth plan, that gives me satisfaction'* (BC13-MW-F-  
338 INT).

339 Participants appreciated the way staff discussed options and offered choice as well as the  
340 support they provided. This approach of partnership in decision-making was one of the values  
341 shared by most staff at the FMU.



342 *Salutogenesis*

343 Within the FMU, fostering of well-being was central to both staff and service users’  
344 experiences. For the staff, it was built on the interconnections between their relations to one  
345 another and to the FMU space, and from feeling valued by the team and the families they cared  
346 for. Pablo recalled how he felt when first arrived at the FMU:

347 *‘The reality was better than the expectation. When I came I was very pleasantly surprised and*  
348 *the first thing that shocked me was the positive effect by the building itself, that the birth centre*  
349 *itself has, because this was fresh, it was new and it was nice and it felt like you were respected*  
350 *more, in a way, like your work could become more valuable. I don’t know, it’s weird. But it*  
351 *gave you this new steam to work in such a beautiful place. I think it was just the mood from*  
352 *day one’ (BC7-MW-M-INT).*

353 The accounts of the FMU staff point to the fact that the positive working relationships and  
354 being able to enjoy work had positive effects on stress levels and general wellbeing. This, in  
355 return, had an impact on the quality of the service cascading to service users. In Emily’s words:

356 *‘...You don’t go home half as stressed and the other thing is that we probably smile a lot more.*  
357 *We’re a lot more welcoming. We’re a lot more relaxed...’ (BC20-MW-F-INT).*

358 Most of the staff described how the environment, the team and the organisational culture made  
359 them feel well as opposed to their experience of the hospital setting. Margarida commented: *‘I*  
360 *feel people are happy here and people are not happy there (in the hospital)’ (BC5-MW-F-INT).*

361 The FMU environment was also described by staff as having a strong impact on service  
362 users. Emily said:

363 *‘...We were talking the other night about how our primips seem do very well. They seem to*  
364 *progress very quickly, so why is that? You know, it’s got to be that they come here... the*

365 *atmosphere is a good atmosphere and everything that needs to get going, just gets going and,*  
366 *and they're active...'* (BC20-MW-F-INT).

367 A team culture which focused on building relations among staff and with women led to the  
368 creation of a sense of wellbeing for both in a reciprocal and mutually reinforcing manner. Mia  
369 commented:

370 *'...The Birth Centre is a place where you can go into partnership with women, to get the best*  
371 *outcome for the woman, and actually the best outcome for the midwife as well. You understand*  
372 *because when you are able to support the woman, and the outcome is fantastic, then you feel*  
373 *well in yourself as well'* (BC13-MW-F-INT).

374 The FMU was described by all as an environment of wellness and happiness which created  
375 positive impacts on both service providers, as well as service users.

## 376 **Discussion**

377 Building relationships created a sense of trust, meaning, safety and motivation for both women  
378 and midwives (34-37). Being 'with-woman', however, cannot be a prescription and obtains  
379 meaning only when organically arising from a reciprocally meaningful relationship (35).  
380 Aspects of 'knowing the woman and being known' (35) emerged consistently during  
381 interviews and participant observation. Reflecting on what well-functioning FMUs and case-  
382 loading teams have in common, some of the key elements are conditions that enable building  
383 relationships, autonomy, ownership and interdependency (38-39). The importance of having a  
384 sense of ownership and control over work patterns was evident in this study and consistent  
385 with other research on FMUs (39-41), as well as with work on caseload midwifery (35; 36).  
386 Research on midwives' burnout suggests that the work setting is of critical importance for  
387 emotional wellbeing (19), and that 'the most commonly reported source of satisfaction was  
388 relationships with colleagues and feeling like part of a team' (43:5).

Salutogenesis, defined as the creation of health (44), was mediated via relationship building within the FMU, as evidenced by the accounts from both women and midwives. This could be due to the reduction of anxiety and stress resulting from trusting relationships between women and midwives and among midwives themselves. At the individual level, different forms of social support, such as relationships with friends and neighbours, are linked to indices of psychological wellbeing (34). For midwives working in the FMU, this sensation of wellbeing was linked to the environment, as well as the team spirit and culture. The midwifery staff at the FMU were aware of the concept of salutogenesis and routinely referred to it while talking about their own well-being as well as that of the service users they cared for.

Downe (45) has proposed the shift from a maternity service culture based on risk-management to one based on salutogenic factors that are linked to a notion of 'coherence'. Individuals who see their world as manageable, comprehensible, and meaningful read their life as coherent and are more resilient in adversity (45). Participants in this study felt emotionally rewarded by working in an environment where there was coherence between their identity and philosophy and where they saw opportunities to build relationships with the women and among themselves.

Midwives expressed positive experiences in the FMU related to the possibility of following up on the outcomes of care provided and being able to provide continuity of care to women. This 'deconstruction of the assembly-line' as described by Walsh (40) had positive consequences, generating new ways of learning through observing undisturbed physiology of birth as well as the practice styles of other midwives working. Being able to collaborate when asking for a second opinion from colleagues and receiving feedback from other staff, women and their birth supporters also contributed to a sense of connection and coherence.

The social norms and the physical space in the FMU in this study encouraged relationship-based care and a sense of distributed decision-making rather than authority and top-down hierarchy (39-42), which aided in the establishment of an equitable, rather than oppressive, organisational culture. Within this working environment, staff were engaged with their colleagues and the families in their care. Engaged staff perform better and share a pride in continuously improving self and the service provided (16; 46).

The staff within the FMU reported being very gratified by their jobs during interviews, which was repeatedly observed during fieldwork. The relationship-based model of care, which was at the core of the FMU, offers a promising solution to high levels of stress and burnout among midwives (19; 43). However, it is crucial to acknowledge how the organisational culture of the wider maternity services and the hierarchical structures therein could constrain the effective implementation and scale-up of MUs, particularly if excessive workload and shortage of staff are present (43).

#### *Strengths and limitations*

To our knowledge, this is the first ethnographic study conducted in an urban, purpose-built FMU that also reported the views and experiences of service users from diverse backgrounds. A strength of this study was the prolonged participant observation which provided in-depth knowledge of participants' perspectives coupled with the use of multi-stakeholder interviews. The first author's 'insider' status is both a strength and a limitation, allowing a depth of embodied knowledge, but also invariably shaping interpretations. The inclusion of multiple voices, returning findings to participants for comments, and co-authorship with 'outsider' experts helped to insure multiple perspectives could be identified and elevated.

#### *Conclusions*

This ethnographic study identified 12 key components of a well-functioning FMU and explored how they are foundational for a relational and personalised model of care. Relationships and trust were at the core of the FMU's functioning, staff wellbeing and service user satisfaction. Ownership, Autonomy and Continuous Learning were connected to high staff performance and improvement of the unit, while the themes of Team Spirit, Interdependency and Power Relations highlighted the importance of mutual support. The final theme, Salutogenesis, may offer a compelling response to high levels of stress and burnout among midwives. The findings indicate that a relationship-based model of care is crucial for the functioning of the FMU and is associated with wellness for both service users and staff. Further research is needed to explore whether the themes that emerged from this study are common to other high-functioning FMUs.

## References

1. Scarf V, Rossiter C, Vedam S, Dahlen HG, Ellwood D, Forster D, Foureur MJ, McLachlan H, Oats J, Sibbritt D, Thornton C, Homer CSE. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. *Midwifery* 2018;62:240-255.
2. Renfrew MJ, McFadden A, Bastos MH, Campbell J, et al. Midwifery and Quality Care: Findings from a New Evidence Informed Framework for Maternal and Newborn Care. *The Lancet* 2014; 384:1129-1145. doi.org/10.1016/S0140-6736(14)60789-3
3. Macfarlane AJ, Rocca-Ihenacho L, Turner LR. Survey of women's experience of care in a new freestanding midwifery unit in an inner city area of London, England 2.

Specific aspects of care, *Midwifery* 2014.

4. Overgaard C, Fenger-Grøn M, Sandall J. The impact of birthplace on women's birth experiences and perceptions of care, *Social Science & Medicine* 2012;74(7):973-81.
5. Schroeder L, Petrou S, Patel N, Hollowell J, Puddicombe D, Redshaw M, Brocklehurst P. On behalf of Birthplace in England Collaborative Group. Birthplace cost effectiveness analysis of planned place of birth: individual level analysis, *Birthplace in England research programme*. London: Final Report part 5: NIHR Service Delivery and Organisation programme; 2011.
6. Walsh D, Spiby H, Grigg CP, Dodwell M, McCourt C, Culley L, Bishop S, Wilkinson J, Coleby D, Pacanowski L, Thornton J. Mapping midwifery and obstetric units in England. *Midwifery* 2018;56:9-16.
7. Blotkamp A, NMPA Project Team. *National Maternity and Perinatal Audit: Organisational Report 2019*. London: RCOG; 2019.
8. Renfrew MJ, Ateva E, Dennis-Antwi JA, Davis D, Dixon L, Johnson P, Kennedy HP, Knutsson A, Lincetto O, McConville F, McFadden A. Midwifery is a vital solution - What is holding back global progress?. *Birth* 2019;46(3):396.
9. Walsh D, Spiby H, McCourt C, Grigg C, Coleby D, Bishop S, Scanlon M, Culley L, Wilkinson J, Pacanowski L, Thornton J. Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study. *BMJ open* 2020;10(2).
10. McCourt C, Rance S, Rayment J, Sandall J. *Birthplace Qualitative Organisational Case Studies: How Maternity Care Systems May Affect the Provision of Care in Different Settings, Birthplace in England Research Programme. Final report part 6*. London: NIHR Service Delivery and Organisation programme; 2011.
11. McCourt C, Rayment J, Rance S, Sandall J. *An ethnographic organisational study of*

- 484 *alongside midwifery units: a follow-on study from the Birthplace in England*  
 485 *programme*. London: Health Services and Delivery Research; 2014; VOL. 2 NO. 7.
- 486 12. Rocca-Ihenacho L. An ethnographic study of the philosophy, culture and practice in  
 487 an urban freestanding midwifery unit. Unpublished PhD thesis. London: City.  
 488 University of London; 2017.
- 489 13. Mannion R, Davies HTO, Marshall MN. Cultural components of “high” and “low”  
 490 performing hospitals. *Journal of health organization and management*; 2005.
- 491 14. McCarthy D, Mueller K. *Organizing for Higher Performance: Case Studies of*  
 492 *Organized Delivery Systems*. Commonwealth Fund, New York; 2009.
- 493 15. Sandall J, Coxon K, Mackintosh NJ, Rayment-Jones H, Locock L, Page L.  
 494 Relationships: the pathway to safe, high-quality maternity care: Sheila Kitzinger  
 495 symposium at Green Templeton College, Oxford: Summary report. Green Templeton  
 496 College, Oxford; 2016.
- 497 16. Liberati EG, Tarrant C, Willars J, Draycott T, Winter C, Kuberska K, Paton A,  
 498 Marjanovic S, Leach B, Lichten C and Hocking L, 2020. Seven features of safety in  
 499 maternity units: a framework based on multisite ethnography and stakeholder  
 500 consultation. *BMJ Quality & Safety*.
- 501 17. Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry:*  
 502 *Executive summary*. London the Stationery Office; 2013.
- 503 18. Kirkup B. *The Report of the Morecambe Bay Investigation. An independent*  
 504 *investigation into the management, delivery and outcomes of care provided by the*  
 505 *maternity and neonatal services at the University Hospitals of Morecambe Bay*  
 506 *NHS Foundation Trust from January 2004 to June 2013*. London: The Stationery  
 507 Office; 2015.

19. Hunter B, Fenwick J, Sidebotham M, Henley J. Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. *Midwifery* 2019;79:102526.
20. Rocca-Ihenacho L, Batinelli L, Thael E, Rayment J, Newburn M, McCourt C. *Midwifery Unit Standards*; London: City, University of London; 2018.
21. Rayment J, Rocca-Ihenacho L, Newburn M, Thael E, Batinelli L, McCourt C. The development of midwifery unit standards for Europe. *Midwifery* 2020;86.
22. Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, McCourt C, Marlow N, Miller A, Newburn M, Petrou S and Puddicombe D. Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 343: d7400.
23. Crotty M. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage; 1998.
24. O'Reilly K. (2009) *Key concepts in Ethnography*. London: Sage.
25. Hammersley M, Atkinson P. *Ethnography: Principles in Practice*. London and New York: Routledge Taylor & Francis Group; 2007.
26. Azungah T. 2018. Qualitative research: deductive and inductive approaches to data analysis. *Qualitative Research Journal*.
27. May T. *Social Research: Issues, methods and process*. Maidenhead: Open University Press; 2001.
28. Geertz C. *The interpretation of cultures: Selected Essays*. New York: Basic Books; 1973.
29. Spradley JP. *Participant Observation*. Belmont: Wadsworth, Cengage Learning; 1980.



30. Agar M. *Speaking of Ethnography*. Beverly Hills, CA: Sage Publications; 1980. Sage University Paper Series on Qualitative Research Methods, Vol. 2.
31. Rocca-Ihenacho L, Redfearn R. Creating the Barkantine birth centre: the successes and challenges, *New Digest* 2010;5:12.
32. Macfarlane AJ, Rocca-Ihenacho L, Turner LR and Roth C. 2014. Survey of women's experiences of care in a new freestanding midwifery unit in an inner-city area of London, England–1: Methods and women' s overall ratings of care. *Midwifery*, 30(9), pp.998-1008.
33. Yuill C, Soria J, Rocca-Ihenacho L, Reeve-Jones C, McCourt C. *The Barkantine Birth Centre: Celebrating 10 years as a Community Hub*. London: Bart's Health NHS Trust; 2018.
34. Helliwell JF, Putnam RD. The social context of well-being. *Philosophical Transactions of the Royal Society* 2004;359(1449):1435–1446.
35. McCourt C, Stevens T. Relationship and reciprocity in caseload midwifery', in Hunter B and Deery R. *Emotions in Midwifery and Reproduction*. New York: Palgrave Macmillan; 2009.
36. Kennedy HP, Bisits A, Brodie P. (2019) Building Support Midwifery Collaborative Continuity Relationships of Care to. *Midwifery Continuity of Care: A Practical Guide*; 2019; p.93.
37. McCourt C, Rayment J, Rance S, Sandall J. Place of Birth and Concepts of Wellbeing: An Analysis from Two Ethnographic Studies of Midwifery Units in England. *Anthropology in Action*; 2016; DOI: 10.3167/aia.2016.230303.
38. Homer C, Brodie P, Sandall J, Leap N. *Midwifery continuity of care: a practical guide*. Elsevier Health Sciences; 2019.

39. Walsh D. Subverting assembly-line birth: Childbirth in a free-standing birth centre, *Social Science & Medicine* 2006;62:1330-1340.
40. Walsh D. A birth centre's encounters with discourses of childbirth: how resistance led to innovation, *Sociology of Health and Illness* 2007;29(2):216-232.
41. Stone N. Making physiological birth possible: birth at a free-standing birth centre in Berlin', *Midwifery* 2012;28:568-575.
42. McCourt C, Rance S, Rayment J, Sandall J. Organising safe and sustainable care in alongside midwifery units: Findings from an organisational ethnographic study. *Midwifery* 2018;65:26-34.
43. Cull J, Hunter B, Henley J, Fenwick J and Sidebotham M. 2020. "Overwhelmed and out of my depth": Responses from early career midwives in the United Kingdom to the Work, Health and Emotional Lives of Midwives study. *Women and Birth*.
44. Antonovsky A. The implications of salutogenesis: an outsider's view, in AP Turnbull, HR Turnbull. (Eds.). *Cognitive coping, families, and disability*. Brookes: Baltimore; 1980.
45. Downe S, McCourt C. From being to becoming: reconstructing childbirth knowledges, in Downe S. (ed.) *Normal Birth: Evidence and debate*. Oxford: Elsevier; 2008.
46. Salanova M, Agut S, Peiro JM. Linking Organisational Resources and Work Engagement to Employee Performance and Customer Loyalty: The Mediation of Service Climate, *Journal of Applied Psychology* 2005;90:1217-1227

578 Table 1.

Participants	Subcategories	Number
FMU staff	Midwives	23
	Maternity care assistant	6
	Administration	1
Hospital	Midwives	2
	Obstetricians	1
Students	Student midwives	3
	Midwifery placement	2
Stake holders	Managers	2
	Consultants	2
	Steering group	2
	Commissioners	1
Service users	Women	18
	Partners	15
	Other birth supporters	4
Total		82

579

580

581 Table 2.

Staff Age	25-34	35-44	45-54	Over 54
Midwives	13	7	3	0
MCA	3	2	2	0
Total	26	9	5	0

582

583

584 Table 3.

Ethnicity	British Asian	Black British	White UK	Mixed British	White EU	Japanese	Total
FMU Midwives	2	3	10	1	7	0	23
MCA	3	1	1	0	1	0	6
Hospital staff/ Steering group	2	5	2	2	5	0	16
Service users	12	2	2	0	1	1	18
Birth partners/family	12	1	4	0	1	1	19
Total	31	12	19	3	15	2	82

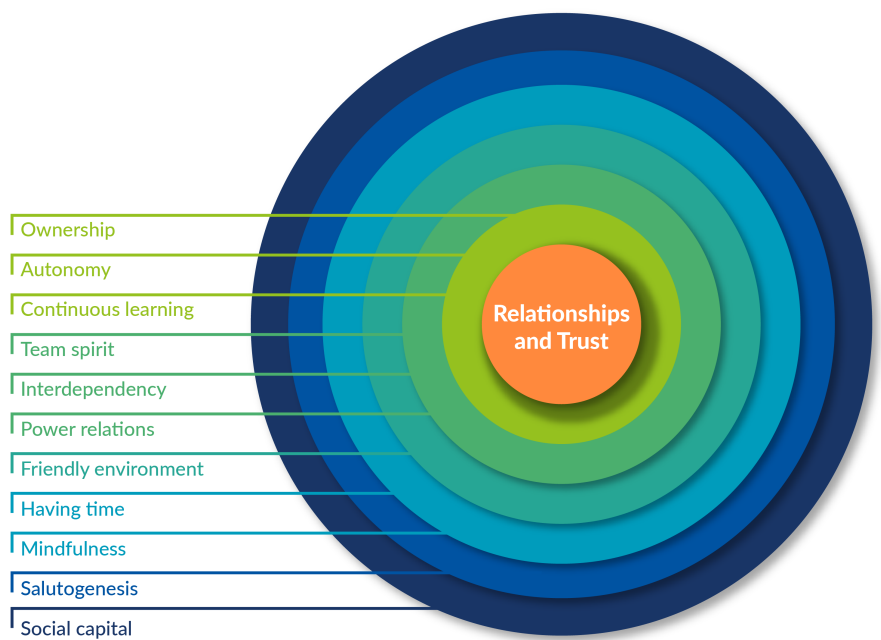
585

586

587

588

589     Figure 1: Key Components of a Freestanding Midwifery Unit



590

591

592

593

594

595     Table and Figure Legend

596     Table 1. Research participants by group and occupation

597     Table 2. The age profile of the midwives working at the FMU

598     Table 3. Ethnicity profile of the participants

599     Figure 1. Key Components of a Freestanding Midwifery Unit

600