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Citation: McCourt, C., Rayment, J., Rance, S. & Sandall, J. (2012). Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. Midwifery, 28(5), pp. 636-645. doi: 10.1016/j.midw.2012.07.004

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Permanent repository link: https://openaccess.city.ac.uk/id/eprint/3295/

Link to published version: https://doi.org/10.1016/j.midw.2012.07.004

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ORGANISATIONAL STRATEGIES AND MIDWIVES' READINESS TO PROVIDE CARE FOR OUT OF HOSPITAL BIRTHS: AN ANALYSIS FROM THE BIRTHPLACE ORGANISATIONAL CASE STUDIES

Abstract

Objective: The objective of the Birthplace in England Case Studies was to explore the organisational and professional issues that may impact on the quality and safety of labour and birth care in different birth settings: Home, Freestanding Midwifery Unit, Alongside Midwifery Unit or Obstetric Unit. The objective of this analysis is to examine the factors affecting the readiness of community midwives to provide women with choice of out of hospital birth, using the findings from the Birthplace in England Case Studies.

Design: Organisational ethnographic case studies, including interviews with professionals, key stakeholders, women and partners, observations of service processes and document review.

Setting: A maximum variation sample of four maternity services in terms of configuration, region and population characteristics. All were selected from the Birthplace cohort study sample as services scoring 'best' or 'better' performing in the Health Care Commission survey of maternity services (HCC 2008).

Participants: Professionals and stakeholders (n=86), women (64), partners (6), plus 50 observations and 200 service documents.

Findings: Each service experienced challenges in providing an integrated service to support choice of place of birth. Deployment of community midwives was a particular concern. Community midwives and managers expressed lack of confidence in availability to cover home birth care in particular, with the exception of caseload midwifery and a 'hub and spoke' model of care. Community midwives and women's

interviews indicated that many lacked home birth experience and confidence. Those in midwife units expressed higher levels of support and confidence.
Key conclusions and implications for practice: Maternity services need to consider and develop models for provision of a more integrated model of staffing across hospital and community boundaries.

Keywords: birthplace, homebirth, community midwives, maternity services

Introduction

The analysis reported here draws on a set of organisational ethnographic case studies, conducted as part of the Birthplace in England research programme (McCourt et al. 2011). This large-scale programme sought to investigate the quality and safety of birth in different settings in England, including clinical outcomes and cost effectiveness (Birthplace Collaborative Group 2011, Hollowell 2011). It included a series of study components: a Delphi exercise to define unit types, a national Mapping Survey of provision, a Cohort Study of clinical outcomes, an Economic Study and the Organisational Case Studies discussed here. This qualitative component of the programme aimed to meet two key research objectives: first, to investigate women's experiences of choice of birth setting, and of labour and birth when escalation or transfer of care was required; second, to explore the organisational and professional issues that may be impacting on the quality and safety of labour and birth care in the different birth settings. This article focuses on the latter objective. It draws on the Institute of Medicine's (2001) definitions of 'safety' and 'quality', where safety is defined as 'avoiding injuries to patients from the care that is intended to help them' (2001) and quality is understood as a composite of a number of dimensions including safety, effectiveness, patient or woman-centredness, timeliness, efficiency and equity.

The Birthplace Case Studies involved ethnographic case studies of four maternity services. This article focuses on the analysis of interviews with midwives, obstetricians, service managers and key stakeholders, plus observations of practice, to illuminate issues relating to midwives' preparedness to provide labour and birth care in a range of settings, including midwife units and home births. This topic emerged empirically during our data analysis, rather than through a pre-determined study framework. The analysis of staff perspectives is complemented and supported by our analysis of women's and their partners' reports of choosing birth in different settings, labouring in out-of-hospital settings and transfers of care, particularly in cases of planned home birth.

The Birthplace in England study was commissioned in response to a lack of evidence on quality and safety in different birth settings, or on the capacity and organisational arrangements to underpin the national policy of choice in England (DH 2004, 2007). While home and midwife-unit birth in the UK forms part of a formally integrated service, levels of provision have been low in recent decades and there has been very little UK research investigating organisational and staffing arrangements and capacity to support birth in different settings. Research on women's experiences suggests that a strong moral agenda operates when women choose birth in a non-traditional setting and that women have to deal with accusations of irresponsibility (Houghton et al. 2008), or conflicting advice and 'cultural ambiguity' from a maternity service that in theory at least, supports home birth (Viisainen 2000).

Unlike many countries, the UK has a community midwifery service. Midwives are formally defined as autonomous practitioners, and community midwives provide care for homebirth, in addition to antenatal and postnatal visits, but the rate of home birth is low. In a study of community midwives' views and experience of home birth in the

UK, Floyd (1994) identified low levels of home birth experience, and negative feelings relating to a lack of skills and inadequate support networks. Sandall's study of occupational stress and burnout in UK midwives indicated that community midwives had higher levels of stress and burnout compared with hospital-based or caseload practice midwives (Sandall 1997, 1998). Similarly, Stevens' (2003) study highlighted work dissatisfaction amongst community and hospital midwives in London, compared with caseload midwives (McCourt and Stevens 2009). Whilst the evidence suggests that midwives working in midwife-led settings find their work more emotionally sustainable than those in obstetric settings (Hunter 2004), these advantages may be diminished by alienation, isolation and poor relationships with colleagues from other parts of the service when working outside of the obstetric unit (Rayment 2011).

From women's perspectives, a study of transfers from planned home birth in Sweden found that the availability of a midwife at the start of labour and continuity of care from one midwife through pregnancy and birth were key factors associated with need for transfer (Lindgren et al. 2008). Although research has been conducted in the U.S., Canada and Australia, the role of midwives and organisation of services in these countries is very different from that in the UK and so the findings are less applicable to the context of the NHS.

Findings from the Birthplace Programme

The Birthplace Mapping Survey was conducted in collaboration with the Healthcare Commission to include all maternity services in England (HCC 2008), providing a description of maternity facilities and staffing in 2007 and 2010. A key finding was a nationally low rate of provision for choice in birth setting (Redshaw et al. 2011). Despite an overall increase in the numbers of Alongside or Freestanding Midwifery Units between 2007 and 2010, many maternity services lacked provision and

continued to provide only obstetric units. Provision for home birth could not be measured, and experience of data collection for the Birthplace cohort study indicated that systems for recording and planning home births are generally poor. Services had difficulty in accounting for their current rates of home birth, or future capacity to provide choice of birth setting.

The Birthplace Cohort Study examined neonatal and maternal outcomes of births planned at the onset of labour in Obstetric Units (OUs), in Freestanding Midwifery Units (FMUs), Alongside Midwifery Units (AMUs) and at home. It found no significant differences in neonatal outcomes for low-risk women by place of birth planned at the onset of labour. Levels of obstetric intervention were reduced for women planning to give birth in midwife units and at home compared with obstetric units. However, a significantly higher rate of adverse neonatal outcomes in nulliparous women was identified for home births, raising questions about the quality of home birth provision (Birthplace Collaborative Group 2011). These findings highlighted unanticipated differences in outcomes for births in freestanding midwifery units versus births at home when compared with the reference group of obstetric units, even though physical transfer over a distance would be required from either setting. Our case study analysis was conducted simultaneously with the cohort study analysis and without access to its findings, and we discuss here themes raised in our independent analysis that may illuminate areas for improvement in quality and safety of care.

Methods

Design

Although limited in its time frame compared to a traditional ethnography, the fieldwork for these case studies was ethnographic in terms of its holistic, interpretive approach, focus on organisational culture, social actors and their relationships, and ongoing use of observational data to frame the interview questions. Our use of organisational

ethnographic case studies (Hunter 2007) involved a focus on the systems of care. This systems approach is founded on two principles: first, that the outcomes or effects of a system do not occur in isolation, and so must be studied and analysed within their relevant context (Vaughan 1999; Waring 2007; West 2000) and second, that the boundaries between different clinical spaces are as important and revealing as the clinical spaces themselves (Lamont and Molnár 2002).

In her evaluation of the use of ethnography in studies of patient safety, Mary Dixon-Woods (2010) found that 'risk-related reasoning and practices at the sharp end were institutionally structured and heavily influenced by what was happening at the blunt end' (2010: 15). Her findings emphasise both the influence of institutional context on individual practice and the value of ethnography as a method that allows for an exploration of the context behind professional practice and patient experience: a way to explore the blunt end as well as the sharp.

The use of case study as a method in this project also enabled the examination of the movement of people and resources around each maternity service, which formed a case, rather than simply looking at individual elements such as discrete clinical areas (Huby 2011). Examining the boundaries of the services also helped us to see women's experiences as a journey through the maternity system, rather than a series of discrete encounters with different healthcare practitioners. The use of ethnographic case studies therefore worked to gather information on the overall configuration of the service; how staff and other resources were deployed within that configuration; and women's journeys through the maternity system.

Sampling

The selection of case study sites was based on a 'best practice' approach, used in Hodnett and colleagues' study of practices relating to caesarean section rates in

North American maternity units (OWHC 2000, 2002), which proved valuable for identifying and illuminating common features of units achieving good outcomes. The selection criteria were quality of care, configuration and region, using the findings of the Mapping component on the Birthplace programme (HCC 2008, Redshaw et al. 2011). The scoring system for this survey was based on three key areas of practice: woman centred care, clinical care and efficient care

The number of case studies was pragmatic – reflecting the need to balance depth of coverage with breadth of issues and contexts to be covered, within the resources available. Each case study site was an NHS Trust's maternity service, including all the maternity units within its remit.

Table 1 Case study sampling frame

Site (pseudonym)	**Seaview**	**City**	**Hillside**	**Shire**
Geography	Suburban	Inner City	Rural	Rural
Configuration	OU	OU/AMU	OU/FMU	OU/AMU/FMU
Deprivation level	Low	High	Moderate	Low

Setting

The settings were in 'better' or 'best' performing sites (HCC 2008), covering the range of NHS Trust maternity configurations: Obstetric Unit (OU) only, Obstetric and Alongside Midwifery Unit (AMU), Obstetric and Freestanding Midwifery Unit (FMU), or all types of unit. All would, in accordance with NHS policy in the UK, be expected to provide for home birth.

Data collection

The data collection included four main components: review of key documents (e.g. guidelines and protocols, service user information leaflets, audit tools and procedural forms) (n=200), observation of key 'nodes' in the service (n=50), interviews with service providers and other key stakeholders (n=86) and interviews with service users (n=64) and birth partners (n=6). Selection of observations and professional stakeholder interviews was based on purposive sampling, while interviews with women and partners were based on maximum variation sampling of women who had experienced escalation or transfers of care from a range of planned birth settings. Professional interviews included midwives, support workers, general practitioners, obstetricians and neonatologists. Stakeholder interviews included local service managers, Maternity Services Liaison Committee and user-group representatives, supervisors of midwives, commissioners, managers and personnel involved with transfer services and risk management. All interviews were conducted in a location chosen by the participant, using a semi-structured approach, and were audio-taped with permission, or notes taken.

The 'key nodes' in the service that were observed were chosen in order to witness interactions between staff, particularly between different professional groups from different parts of the service. These 'nodes' included Trust governance and risk meetings, multi-disciplinary case reviews, midwifery and obstetric clinical handovers and everyday ward life. Handwritten notes were taken during observation and these were dictated into fieldnotes that were then transcribed. The Trust documents collected gave details about the formal processes and policies in place, adding to the information about the organizational context in which daily practices occurred. They highlighted issues to follow up during fieldwork and enabled us to identify when

practice differed from policy and explore why this may have occurred, thus informing the later analysis.

Ethical permission was granted by the Wandsworth Proportionate Ethical Review Committee (09/H0803/143) and continuing attention was given to ethical issues of consent and confidentiality, given the open nature of research of this type. Interviews were conducted between March and December 2010. Pseudonyms were used for case study sites, and service details likely to identify individuals or particular units have been excluded.

Analysis

As is usual in ethnographic fieldwork, analysis of the data began during the fieldwork period when discussions amongst the research team informed the latter stages of data collection and honed our focus in the field (Brewer 2000). Following fieldwork, the analysis was carried out in two stages, moving from a thematic to a framework analysis. Two members of the research team (JR and SR) simultaneously produced lists of key themes from Trust documents, transcripts, fieldnotes, following the principles of thematic analysis. These themes were then consolidated into a single series of categories that formed 'tree nodes' in QSR Nvivo8. Through discussion amongst all the authors, nine main themes emerged from these categories which, informed by the original research questions, became an analytical framework of five: choice of birthplace, information and access; health system risks to safety; delivery of safe and high quality care and women's experiences when complications occur.

The development of an analytical framework was informed by the earlier thematic analysis and this multistep process helped to triangulate the analysis between the researchers (Pope, Ziebland and Mays 2000). The use of Nvivo to catalogue the data also helped to ensure a systematic and rigorous analysis. The analysis of the Case

Studies data was conducted prior to analysis of the Birthplace cohort study, but themes were then considered in the light of the cohort study findings once they became available (Birthplace Collaborative Group 2011).

Findings

First we set out the key features of midwifery staffing in each case study site and then discuss the themes that emerged in relation to midwives' capacity and preparedness for care for birth in out-of-hospital settings, in particular home birth.

Staffing arrangements in the four sites

Key features of the four case study sites are summarised in Table 2. In line with national patterns, the two services that included a Freestanding Midwifery Unit (FMU) were in more rural settings. Neither had high home birth rates, compared with national averages. The inner city service had an obstetric unit and an Alongside Midwifery Unit (AMU) and the final case study service opened an AMU during our study period. Only one of these Trusts had home birth rates above the national average.

Table 2 Case study site features and staffing

Service	**Seaview**	**City**	**Hillside**	**Shire**
Configuration 2011 and % of total births	OU 82% AMU 13% Home 5%	OU 80% AMU 18% Home 2%	2 x OU 98% FMU 1% Home 1%	OU 75% AMU 10% 4 x FMU 13% Home 2%
Number of births	4000	6500	3000	5000
Midwives (wte)	117 wte	211 wte	73 wte	174 wte
Births/wte midwife	34	32	44	30
Community midwifery and staffing models for midwife units	Community teams (minority conducting most home births).	Community teams and 3 caseload practices AMU core	Community teams in process of merger across two regions of large rural area.	Rotation of all midwives between hospital, AMU, FMUs

	New AMU to be staffed by on-call community midwives.	midwifery staffing	FMU core staffing, midwives and maternity support workers	and homebirth/ community Core staffing for midwife units and rotation of all midwives annually

Arrangements for the provision of home birth varied across all four case study sites. In Seaview, a small number of community midwives had focused on supporting home births, using an informal 'caseloading' approach. Although highly regarded by women and professionals, and with a home birth rate higher than the national average, this informal provision was dependent on individual community midwives' interests, and led to uneven provision of support for home birth in two respects. First, the level of home birth attendance and experience amongst the community midwifery teams varied widely, with some community midwives reporting rarely attending births; second, the 'offer' of home birth was reported by both service users and midwives to be inconsistent, with greater information and access to choice of birth setting in particular neighbourhoods (McCourt et al. 2011). An AMU was opened in Seaview during our data collection period, staffed by a core midwife co-ordinator and community midwives through their on-call rota.

In City, formally organised caseload midwifery teams operated in three socially deprived neighbourhoods. In contrast with conventional community midwifery in the UK, caseload midwives have a mixed high and low risk caseload, and attend a

relatively high number of births, since they move across service boundaries according to where women plan to give birth (McCourt et al. 2006). The patchy implementation of the caseload model in these services meant that the organisation of community midwifery support for home births varied both within and between the two services at Seaview and City. Similarly, unlike Seaview, the City AMU had core midwifery staffing, rather than being staffed by community midwives.

At Hillside, community midwives worked in their own areas, often providing continuity of ante and postnatal care as well as attending births at home. One team of community midwives provided core staffing to the freestanding midwifery unit, which was open during day time hours, and at night on request. The homebirth rate was low compared to the national average and community midwives working outside of the freestanding midwifery unit reported attending few births in a year. The Trust faced challenges in providing adequate staffing and training for midwives in a large and often isolated rural area. At the time of fieldwork they announced plans for a reconfiguration that would combine community teams' on-call rotas to improve the availability of home birth out of hours, and introduce rotation of community midwives into the hospital.

One service, Shire, had long-established provision of midwife-units covering a wide rural area with a number of small towns. This enabled a relatively high rate of out-of-hospital birth, although home birth rates were average. In what could be described as a 'hub and spoke' model, the service was effectively highly integrated and community-based. Midwives rotated between different birth settings, ensuring that they all retained high levels of birth experience and experience of care for both high and low risk women, including community midwives. Professionals, managers and local stakeholders described the service as supportive and oriented towards the care

of normal birth, such that women could expect to receive care that was not routinely medicalised, regardless of where they planned to give birth and all midwives retained experience of attending births in a range of settings.

Our analysis of the community services in these four sites uncovered six overarching factors that positively or adversely influenced the provision of out of hospital birth. These were: the deployment of midwives in the community; organisational culture; midwives' participation in audit, review and institutional processes; midwives' confidence in birth care; midwives' preparation and skills for home birth care and midwives' communication with women about out of hospital birth.

The challenge of midwifery deployment in the community

Although our study sites were selected to represent well functioning services, respondents in each reported a number of challenges in the deployment and coverage of midwives across dispersed services. These challenges were shaped in particular by financial constraints and a perception from professionals and commissioners that home or out of hospital birth care was an unaffordable 'luxury'. This feeling was particularly acute at the time of fieldwork, which coincided with the publication of the White Paper 'Equity and Excellence: Liberating the NHS' (DH 2010) and was a period of uncertainty amongst commissioners:

> *I think it's kind of an unprecedented period of change for NHS commissioning, perhaps not so much for NHS providers. Um, and in [City] particularly we've been asked to accelerate the management cost savings (…) so we're anticipating 50% workforce reductions within the next six months. So within that context you can see that, you know, people's eyes will really focus on the absolute must-dos, and achieving kind of key performance with financial*

balance over the next six months. And some of what might be considered the more fluffy things like, you know, patient experience and supporting choice of location of birth, will probably not be heard strongly over that transitional period. [Commissioner S2-IV-31-S, City]

In urban areas, services were working to manage increasing workloads resulting from a rising birth rate and levels of clinical complexity. They reported that community midwifery services were highly stretched and considering withdrawal of routine postnatal home visits by midwives.

Midwife and obstetrician interviewees commented that making the opportunity to visit women at home in early labour could be helpful both to give women more flexibility in choosing home or hospital birth, and also to alleviate the perceived problem of women arriving for planned hospital birth in very early labour:

If you could get the midwife to go out and see [women in early labour] at home and say, 'Well actually you're fine, you're OK,' or you know, 'You can stay at home, do this, do that,' and keep them out of the hospital, because once you get into the hospital as well the intervention rates go up, especially for people who've been here for a long time. [Manager S3-IV-19-MA, Hillside]

However, only the caseload practices at City were organised to be able to offer this service and similarly, those midwives holding a caseload at City were the only ones who reported being able to provide effectively for home birth. Their experiences contrasted with the norm:

I do think it is, you know. I don't think we've ever fully been able to offer it [home birth], We try. Um, on the community we manage to do our home births

but if for instance there were two home births at the same time, one woman wouldn't get the choice. [Midwife S2-IV-31-MI, City]

Similarly, in the more rural settings, the requirement for midwives to travel long distances out of the usual 'community patch' to attend women's homes was a key challenge for provision of community midwifery services.

Despite Shire's well established and supported provision for out-of-hospital FMUs, their community-oriented service was still perceived as financially vulnerable:

We have what we believe is a good model of care, which supplies locally based, locally based obstetric practice, so patients are seen and can be delivered close to their homes supported by a central hub. But that style of practice has some major economic disadvantages. So one of the main issues is about maintaining the style of practice in an economic environment that's challenged. [Senior Obstetrician S4-IV-45-ME, Shire]

In this context, in all four settings, maintaining appropriate midwifery staffing for home births presented a challenge. As described above, the response to this challenge varied between and within the case study services. One service, Hillside, was engaged in reconfiguration of community midwifery services with the aim of developing more consistent home birth provision across its different areas, but attempts to combine community midwifery teams were challenged by the wide distances involved in its rural setting and the midwives' desire to retain their community 'patch', knowledge, presence and continuity of care within these deprived communities. Its freestanding midwifery unit was, in contrast, staffed by a core team of midwives and support workers. One manager commented:

I think it will be great if the other midwives in [Hillside] could come and work at [the FMU] because I think it would help their intra-partum skills. (…) I think community midwives, if you're doing home birth then you should have good intra-partum skills, more so than someone on delivery suite because you've no one to call. You can just press a buzzer in a hospital and people come to you; when you're in a community, a home birth, there's nobody. So you need to be really good at your intra-partum skills, and in other areas, you know, those midwives haven't delivered a baby maybe for three or four years and I'm not sure that's the safest care that we can be giving women. [Manager S3-IV-19-MA, Hillside]

In Seaview, a reconfiguration of community midwifery was prompted by the opening of an Alongside Midwifery Unit, which was to be staffed by the rota of on-call community midwives. Although midwives expressed concern that this would impact on home birth provision, which was relatively high in this service, local audit data indicated no decline in the home birth rate in the study period. Our findings indicated that the provision of homebirth had been highly uneven, with a minority of midwives providing a high proportion of the home births, while some attended births only rarely. Some local women reported not being informed about home birth options, while others reported being refused planned home births due to the unavailability of community midwives:

They said, 'Oh, there's no midwife, you're going to have to come in.' And [husband] said, 'No, [name]'s said she's having a home birth, we've been told by our midwife we are entitled to a home birth, you need to send somebody out.' Um… and er… she said, 'Oh well, call us back in half an hour, or…' you know. (...) ... when [husband] then phoned again, they said, 'We haven't got

anybody.' He's like, 'No. You're sending somebody out.' Um… I'm trying to think what time they then said that they were sending someone - she was just getting her kit together and packing up some stuff.

(…)

That day there was … the woman from Middlesea that ended up going in, and there was another lady that had to go in, she had nobody come out to her, she had to go in by ambulance in the end to hospital because there was no one to go out to her. So that's three home births that night that were spoiled. [Postnatal woman and local Support Worker S1-IV-13-HP, Seaview]

For some women, such staffing issues led to admission to hospital late in the first stage of labour:

*'So… and you know, the outcome wasn't a bad outcome, you know, I had my baby, I was only in hospital for an hour, but obviously travelling to hospital fully dilated… [laughs] ready to push your baby out's not really the experience that I'd hoped for.' [*Postnatal woman S1-IV-21-W, Seaview]

Organisational culture

The four services we studied were characterised by positive inter-professional relationships. Their leadership attempted to foster communication, openness in tackling problems, a sense of accountability for and learning from errors and an attention to processes, rather than blame (McCourt et al. 2011). Whilst these kinds of features have been widely associated with service quality and safety (Mannion et al. 2005, McCarthy et al. 2009, King's Fund 2009), we found that community midwifery services were relatively peripheral to the rest of the organisation and did not benefit in the same way from this positive culture:

Sometimes part of working in Community is it can be quite isolating, you know, you lose a lot of your social context of work that you'd get working on a…if you work on a unit, as well. [Community midwife S1-IV-12-MI, Seaview]

In City, a midwife commented that though community midwives could and should seek support from colleagues in other parts of the service, their relative isolation tended to discourage this:

If you work in the community you are a lot on your own. You don't have all the colleagues around you giving you the second opinion, people to reflect with. You are very alone out there in the community. But my argument is that (…) if anything doesn't look normal to us you are not totally alone on this earth, you've got a telephone, you call [labour ward]. You call your community manager or whoever is appropriate for that time being. You call switchboard and you ask them to bleep the obstetric registrar. (…) It's not as easy as walking out of the room and asking somebody, but you can ask somebody. [Midwife S2-IV-7-MI, City]

When midwives were connected to and supported by colleagues this had a positive impact not just on their personal wellbeing, but on the safety of their care, as in this account of an emergency transfer:

One of our midwifery assistants, sorry, midwifery assistant, she's brilliant, she kept the phone. And so we got all this stuff [going on] but in the middle of it I was having to ring around for the 999, um … [midwife name] catheterised her. Then we got her over onto all fours. We filled the bladder, but in between all

this we rang 999 and we rang [the obstetric unit]. [FMU Midwife S3-IV-14-MI, Hillside]

Midwives' participation in audit, review and institutional processes

This relative isolation of community midwives within the wider service was highlighted particularly by their low participation in services' clinical governance and audit procedures. Close attention was paid to these, as might be expected in these high performing services. Professionals reported positively that audit procedures were opportunities for learning and review, rather than simply externally imposed burdens. In each site, the focus was on professional and service level learning and accountability, and understanding the processes and structures that related to quality and safety, rather than simply on blaming individuals:

We've tried to stay ahead of the game, not behind the game. So we've tried to develop our governance processes that other people will be at in about three years' time. And so we spend a long time looking at process, um, and a reflection of governance is that usually it's not bad decision-making by individuals, bad care by individuals, it's usually a process issue, and it's to try and understand process. [Senior Obstetrician S4-IV-45-ME, Shire]

In all the services studied, midwives were actively involved with audit and review, and these processes were commonly valued as opportunities for learning and service improvement, rather than being seen only as externally imposed requirements. Midwives in Shire Trust, for example, described giving attention to the prompt completion of incident reports, because these were responded to rather than ignored. Midwives and managers in this service also saw value in protocols and guidelines not

only being integral to safe care, but also clarifying and protecting the midwifery-led sphere of practice:

> *If they [the midwives] step outside those guidelines they have to have a very good reason to step outside those guidelines, because at the end of the day those guidelines are those that support them in court. And we keep obviously all the guidelines dating back for years and years and years, so that if any litigation in the future does come up we can say, OK, what guideline were we following at that time? We can pull it off the shelf and say, 'there's our evidence, that's what she did, that's what's documented in the notes. She's followed that guideline; no issue.' So that's how it works really. [Manager S4-IV-47-MA, Shire]*

However, the participation of community midwives in such processes was reported and observed to be generally low, as the nature of their work and their absence from the hospital on an everyday basis made it more difficult for them to attend meetings and development sessions. In interviews, some community midwives reported difficulties in prioritising or setting aside time for training opportunities:

> *If I'm working as a hospital midwife I'll just get released for the one or two days a week for the study and my working, most of my working week, I'll just make up my hours working on the Unit whenever I need to. I won't have a caseload to worry about, I won't have, you know, visits to worry about organizing and that sort of thing, as well as study and everything. [Midwife S1-IV-12-MI, Seaview]*

The key exceptions here were the caseload midwife groups in City, who worked in an integrated fashion across different service settings, and the community midwives in Shire, where all midwives rotated between areas of practice annually (and three-monthly in the first year post-qualification). In addition, all midwives participated in relevant training in Shire in a rolling programme, with priority given to the needs of those furthest from hospital sites.

Midwives' confidence in birth care

The accounts of women planning home birth suggested that support from community midwives was variable, with some midwives appearing to lack the confidence or capacity to support home birth care. Additionally, the discourse of some groups of community midwives observed in our fieldwork, also suggested lack of confidence and feelings of being unsupported as well as a pre-occupation with women who request home birth 'out of guidelines'. The difficulties that community midwives experienced attending training opportunities may also have impacted on their confidence in attending births.

Hillside community midwives raised specific concerns about distance of travel, unfamiliarity with areas outside their local community, unreliability of mobile phone signals and a community midwifery service stretched thinly over a wide area. The midwives did not refer explicitly to a lack of confidence in providing care for home births, but interviews with postnatal women and their partners indicated that this may have been a factor in some community midwives' reluctance to attend births at home:

> *It would depend which midwife I saw. Some of them would wheel off all the hazards of having a home birth, you're so far away, and some of them sort of painted a more gloomy picture. I mean I did still try and go ahead with it, but*

… yeah, it … I mean, again, the main midwife that I should have seen, she was great. None of that from her. She was all very factual, you know, [she'd ask] 'have you thought about the distance?', but she'd back it up with that it was positive, you know: 'but you are in your own home, you'd be comfortable.' (...) unfortunately she wasn't [there for the birth]! [Laughs] Because you don't, you don't get your pick, which is … you know, you don't get to stick to one midwife. [Postnatal Woman S3-IV-32-W, Hillside]

In contrast, the midwives staffing Hillside's FMU described a confidence in their service and feelings of being supported by their peers, support workers and obstetric unit colleagues. This level of support and teamwork was reflected in the cases of transfer that we observed, and in midwives' reports, which indicated a high level of co-operation involving well-prepared and briefed staff, and good telephone communication. This FMU midwife, for example, described effective support and action during the transfer of a woman with a prolapsed cord to the Central Obstetric Unit:

[The senior obstetric unit midwife] kept, you know, in touch the whole time. She put the phone down then she would ring back, and we would ring her. And then, you know, it was … we were talking to each other all the time. And the paramedics were sent for. (…) We rang [the obstetric unit] to say we were turned onto the motorway. (…) We rang again then and said, 'we won't be a minute.' And then … so we were straight upstairs and we went straight into theatre. All of us. [FMU Midwife S3-IV-14-MI, Hillside]

These experiences of positive relationships were also echoed in the comments of a Shire FMU midwife:

You know the cut off point for transfer and you might call and talk through your quandary with the Shift Leader on Labour Ward at the OU. Sometimes she has called the ambulance and made them wait outside because she thinks they're going to transfer but then it's been ok and she's sent them away. [Notes from an interview with an FMU midwife S4-FN-3, Shire]

While a Shire manager commented:

[A group of doctors and midwives carried out some research into] the safety of the midwife-led units. And the reasons for the safety of them are … you've got experienced midwives, you've got good guidelines, um … you've got good relationships with consultants, you haven't got any issues with referrals. Um … and I suppose the midwives knowing the guideline know what type of women can deliver within those settings. [Manager S4-IV-47-MA, Shire]

In contrast to community midwives, those based in FMUs expressed greater confidence, and discussed the benefits of working with colleagues and support workers, in addition to having a defined space in which to practice. Their views were also echoed by this FMU support worker:

You would learn to sneak out the room without the patient actually knowing that you'd disappeared, because you knew by … especially two of the midwives' faces I knew that we were in for either a hell of a delivery or something was potentially going to happen, without even doing a VE or anything. But that was physically working with those specific people for such a long time you would know what they needed, they didn't have to ask you unless it was something that wasn't the normal sort of thing. [Support Worker S3-IV-21-MI, Hillside]

Midwives' preparation and skills for home birth care

In Shire, midwives' rotation between areas of the service, combined with a relatively high rate of births in freestanding midwifery units ensured that midwives providing birth care outside hospital settings had high and sustained levels of labour and birth experience. They reported confidence in providing care to women at different levels of clinical risk, but also in being able to support normal birth in different birth settings. Rates of home birth, however, were relatively low in this service, but some midwives and other stakeholders commented on the high numbers of women who wanted to labour and birth at home outside medical guidelines. We did not have data available to assess this claim, but eligibility criteria for freestanding midwifery units were strongly adhered to, as they were perceived to protect both the women and the midwives' wellbeing.

In two of the services studied, neither of which had a freestanding midwifery unit, only caseloading midwives retained this higher level of out-of-hospital birth experience. As we have noted, although the informal caseloading arrangement at Seaview appeared to support a relatively high home birth rate, birth care experience was concentrated with a small number of community midwives, while some attended births only occasionally:

> *I mean, we do have quite a high home birth rate here in this area. A lot of that was down to our - well, is down to our two midwives who provide that sort of 24-7 (care), although all the community midwives do offer home births in the area. [Manager S1-IV-7-MA, Seaview]*

In Hillside, covering a relatively remote and deprived rural area, home birth rates were low and community midwives described considerable concerns about their capacity to support it:

> *Sometimes I would have to travel (…) an hour and a half to get to a delivery if the woman called. But then once you're there, is it worth coming back? So if it's such as [remote town] and we go down we've got arrangements we can stay in the hospital at [remote town], if the woman's not in that much labour or, you know, but she's not … we don't feel safe to go all the way back an hour and a half and then an hour and a half back that way. And sometimes mobile signals are a bit of a problem in areas. [Community Midwife S3-IV-15-HP, Hillside]*

One community midwife, when asked if she could recount an experience of transferring a woman from home could only remember one case from the previous year and then responded:

> *I've had very few home births. I had one where… no, that was a home birth, she didn't transfer in that one, she just… where I felt that the second midwife who came was very unsupportive. [Community midwife S1-IV-12-MI, Seaview]*

This contrasts with women's assumptions that community midwives are highly experienced with birth and home birth:

> *Um… but, you know, I think that you've got this thing that you know that if they're community midwives and they're doing home births, that they're… the*

perception is anyway that they're the more experienced midwives and, you know, there's a comfort in that. You know, having a home birth, you are literally putting yourself in the hands of… some, a person, you and your baby, and you know, that's quite a big… that does take some faith, I think, to do that, you know. [Postnatal Woman S1-IV-21-W, Seaview]

Communicating with women about out of hospital birth

Community midwives' attitudes and feelings towards home birth were indirectly reflected in the reports of women and their partners about their access to information antenatally, and their midwives' response when they chose to birth at home. The women's stories illuminated some contradictions in midwives' attitudes towards home birth. This woman, for example, wished to transfer to hospital because she lacked confidence in the midwives called to attend her from a more distant community patch. Her partner explained:

They weren't, they didn't seem to be game for the home birth, you know what I mean, they didn't seem to be … of that persuasion. (...) I don't know, maybe they'd just become desensitised a little bit probably. It's probably a natural thing when you've worked at that full-time. But they just sort of … um, I don't know. I think it was the fact that they were telling stories which … didn't have happy endings, if you know what I mean, and … (...) Yeah, they were grim in sort of … grim in the sort of attitude towards the whole thing, really, I thought. (...) I don't know what they'd say now, but I think they were like, in some ways flustered by it all, weren't they? I don't think they were … I don't think they were like, um, they didn't know what … I think part of it they didn't quite know what to do. [Partner of postnatal woman S3-IV-31-W, Hillside]

Despite clear signals that the midwives lacked confidence, the woman reported them being so reluctant to transfer her that she and her partner had to demand it insistently:

> *I just didn't want to stay at home any more. Because I just felt like everything, all the control had gone, I didn't feel safe. [Postnatal Woman S3-IV-31-W, Hillside]*

This can be contrasted with the narratives of women who were attended at home by caseload midwives, or community midwives with a specific focus on homebirth. This woman, for example, recounted a very positive experience, despite the need to transfer to hospital for a complication:

> *The waters broke, and… she very calmly just said, 'Right, the baby has poo-ed inside you, it's not a big deal, it's fine. All we have to do now is call an ambulance.' So I said, 'OK, that's fine, not a problem.' (…) And then that's when it all started really, everything started, I wanted to push, and the contractions were really heavy then and I needed to sort of… but [midwife, C] always kept me very focused and in control of the situation, we were… worked very well together as a team.* [Postnatal Woman S2-IV-31-W, City, Caseload Midwife care]

Discussion

The Birthplace Qualitative Case Studies were undertaken to enable greater understanding of the Birthplace Cohort Study findings. Whilst the fieldwork and initial analysis of the case studies was carried out before the cohort study findings were known, the case studies can begin to build hypotheses about those organizational factors that may contribute to the national trends observed by the findings of the

cohort study. As is the nature of case study research, the findings from four best practice case studies can not be generalized to the national maternity service. However, the findings have uncovered a number of challenges that may have implications for community midwives' readiness to provide out of hospital birth. Examining midwives' deployment, organisational culture, participation, confidence, skill and communication with women can help develop an understanding of the differences in outcomes between birth at home and in FMUs observed in the cohort study findings.

Tensions between quality and equality

Our case study sites were chosen using 'good practice' criteria and to represent variation in configuration and region. All four services were characterised by relatively strong and positive leadership, good inter-professional communication, and a culture of accountability and learning, rather than blame (McCourt et al. 2011). In all services, we gathered evidence of strong inter-professional support for choice of birth setting and for midwife-led care, which has not always been demonstrated in prior studies of home or midwife-unit care (Bick et al. 2009, Rayment 2011).

Despite these enabling features, reservations were expressed about Trusts' capacity to support choice of birth settings, and particularly out of hospital birth. It was perceived to be an expensive add-on rather than a fully integrated part of the maternity service: perceptions that were not supported by the findings of the Birthplace Economic Study (Hollowell 2011) that found that births planned out of hospital to be more cost effective those planned in an obstetric unit. Even in the most highly integrated and community oriented service – 'Shire' – concerns circulated about sustaining the service in the face of beliefs that it was too expensive.

There was a tendency among some service providers and commissioners to see women's choice as a threat to equity and safety in their service because FMU and home birth demanded time, money and resources during a period of rising birth rates, high complexity and shortages of midwives. It seems that managers saw out of hospital birth itself as a challenge to the quality of the service, rather than the way it was organised. The experiences of the midwives working in the community demonstrated the impact the organization had on all facets of the quality of the service: its safety, effectiveness, timeliness, efficiency, equity and on women's choice of place of birth. These constraints meant that Trusts appeared to promote areas of quality, such as equity, by moving towards the lower common denominator, for example by dissuading community midwives from holding an informal caseload because this gave some women better access to home birth than others.

The findings from Stevens (2003) suggests that midwives working in conventional community settings are less satisfied with their work than those holding a caseload, despite the personal demands that caseloading brings (Sandall 1998). The move towards conventional models in order to ensure equity may have unintended consequences for the wellbeing of community midwives as they change their working patterns to fulfill the demands of a resource poor institution, rather than the women in their care. This is something Hunter (2004) has recognised as a key source of emotional labour and difficulty for midwives.

Meeting midwives' needs

Efforts to improve other sources of dissatisfaction amongst community midwives: poor relationships with colleagues, isolation from other parts of the service and requirements to rotate to the hospital, may have mixed results. Whilst the evidence suggests that a change to integrated services would have benefits for midwives' relationships, education and skills, community midwives who worked in their own

'patches' expressed concern about the loss of continuity of carer, especially for women in vulnerable circumstances. The evidence from Lindgren (2008) suggests that loss of continuity may result in a rise in rates of transfer for women from home.

However, it was clear that the key challenges facing community services: the deployment of staff, intrapartum experience and relationships with hospital midwives were having an impact on women's care. Much of this was due to midwives' lack of confidence in their own skills, particularly in the services where they did not do many births and this was less of a problem where midwives regularly rotated to work in other areas.

The impact of organisational culture

The Birthplace Cohort Study (Hollowell 2011) found a difference in outcomes for primaparous women planning birth at home compared to those planning birth in other birth places, including freestanding midwifery units. This difference persisted despite women's similar risk profiles and the same need for ambulance transfer in case of complications at home and at FMUs. This difference remains unexplained, but the findings from the Case Studies suggest that the conditions of midwives' work and their place within the wider organisation may be important.

Whilst community midwives suffered from isolation, limited intrapartum experience, difficulties accessing training and opportunities to engage in institutional processes, these problems were not experienced to the same extent by those working in FMUs. Whilst midwives working in freestanding midwifery units remained marginal and their units under almost constant financial threat, they reported being more supported by support workers, midwifery and obstetric colleagues and their managers. Their higher birth rate meant they were confident attending births and arranging for transfer, when many community midwives working in women's homes were not.

These findings demonstrate the importance of the blunt end of the organisation in shaping the action at the sharp end (Dixon-Woods 2010). The care of women, particularly those who develop complications during labour and need transfer to obstetric care, is shaped by the institutional relationships and context in which they occur. Furthermore, this examination of the factors that influence the incidence of and the experience of transfer – that is, work at the boundaries of maternity care – has shed light on the wider conditions of community midwives' work.

Conclusions and Implications for Practice:

Models of care to support choice of birth settings

The findings of this study indicate the need for careful consideration and development work on models of midwifery care that can support choice of birth settings effectively and sustainably, and in particular home birth. They indicate that despite the continuing presence of a community midwifery service in the UK, relatively little attention has been given to the training and preparation of community midwives, their level of integration within the overall service and their effective deployment for home birth care.

Two models observed within these case studies showed particular potential for organisation of a home birth service offering good quality and safe care. The first was midwives carrying a personal caseload within small teams or practices, catering for a balanced low and high-risk caseload and working across service boundaries. Our analysis indicated more consistent availability of care for women's planned birth setting, particularly home births, capacity to transfer with the woman and to make dynamic assessment and choices with the women at home in early labour. A mixed caseload and higher rate of birth attendance, as compared with standard community midwifery practice in England, appeared to support midwives' experience and

confidence with respect to providing midwife-led care, attending birth and managing escalation or transfer of care.

The second was an integrated system, which could be described as a ‘hub and spoke’ model with midwives rotating between all settings to maintain their experiences and skills in normal and higher-risk birth, a positive focus on normal and out-of-hospital birth and care in home or FMU as well as hospital settings. However, midwives in this service did express some reservations about the impact of the model on continuity of carer. A third potential model was identified in one service – Seaview – where community midwives with an interest in home birth cared for a high proportion of planned home births. However, this was not organised as a specific home birth team and some women in the Seaview area did not receive equal access to home birth care with experienced midwives. This perceived lack of equity had prompted the service to trial a further model of community midwives on call for home births also staffing an Alongside Midwifery Unit. Their role in the AMU had the potential to give them more birth experience within a midwife-led setting.

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Authorship

Jane Sandall and Christine McCourt were joint Chief Investigators and were responsible for the design, contributed to the analysis, and the writing of the article. Susanna Rance and Juliet Rayment collected the data, and were responsible for the analysis, and contributed to the writing of the article.

Funding Body acknowledgement and disclaimer

This study was funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme and the Department of Health Policy Research Programme (DH PRP).

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

Acknowledgements

We acknowledge our thanks to the women, their partners and staff who gave generously of their time and to Nicola Mackintosh and Kylie Watson in the NIHR King's Patient Safety and Service Quality Research Centre, and Wendy Carter who were also involved in data collection for this project.