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## Title page

### **‘KEEPING BIRTH NORMAL’: EXPLORATORY EVALUATION OF A TRAINING PACKAGE FOR MIDWIVES IN AN INNER-CITY, ALONGSIDE MIDWIFERY UNIT**

**Running title:** ‘Keeping Birth Normal’: Exploratory evaluation of a training package

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#### **Highlights**

- Participants viewed Keeping Birth Normal training as formation of a community of practice.
- Balanced content included evidence sources, videos, stories, activities and local statistics.
- Perception of consultant midwives as inspirational and influential was motivating.
- Suggested improvements focused on more multi-disciplinary training.
- Periodic repetition was felt to be key to the sustainability of the initiative.

**‘Keeping Birth Normal’: Exploratory evaluation of a training package for midwives in an inner-city, alongside midwifery unit**

**Running title:** ‘Keeping Birth Normal’: Exploratory evaluation of a training package

**Abstract**

**Objectives:** to gain understanding about how participants perceived the value and effectiveness of ‘Keeping Birth Normal’ training, barriers to implementing it in an along-side midwifery unit, and how the training might be enhanced in future iterations.

**Design:** exploratory interpretive.

**Setting:** inner-city maternity service.

**Participants:** 31 midwives attending a one-day training package on one of 3 occasions.

**Methods:** data were collected using semi-structured observation of the training, a short feedback form (23/31 participants), and focus groups (28/31 participants). Feedback form data were analysed using summative content

analysis, following which all data sets were pooled and thematically analysed using a template agreed by the researchers.

**Findings:** We identified six themes contributing to the workshop's effectiveness as perceived by participants. Three related to the workshop design: 1) balanced content, 2) sharing stories and strategies and 3) 'less is more.' And three related to the workshop leaders: 4) inspiration and influence, 5) cultural safety and 6) managing expectations. Cultural focus on risk and low prioritisation of normal birth were identified as barriers to implementing evidence-based practice supporting normal birth. Building a community of practice and the role of consultant midwives were identified as potential opportunities.

**Key Conclusions and Implications for Practice:** A review of evidence, local statistics and practical skills using active educational approaches was important to this training. Two factors not directly related to content appeared equally important: catalysing a community of practice and the perceived power of workshop leaders to influence organisational systems limiting the agency of individual midwives. Cyclic, interactive training involving consultant midwives, senior midwives and the multi-disciplinary team may be recommended to be most effective.

**Key words:** birth centres; consultant midwives; evaluation; models of care; normal birth; training

## Introduction

In the last decade, much work has focused on reducing childbirth interventions in order to minimise maternal morbidity, improve service users' experiences of care and reduce costs (Healthcare Commission, 2008; Khunpradit et al., 2011). Midwifery units (commonly referred to as birth centres) have demonstrated improvements in maternal outcomes, transition to parenthood and satisfaction, and lower rates of intervention while maintaining neonatal outcomes equivalent to those on obstetric-led labour wards (Birthplace in England Collaborative Group, 2011; Macfarlane et al., 2014a, 2014b; Overgaard et al., 2012). They are also cost-effective (Schroeder et al., 2011, 2017). For staff, midwifery units offer opportunities for midwives and doctors to become familiar with the physiological processes of birth, due to the high concentration of normal births which occur in these settings (Hodnett et al., 2012; Stone, 2012; Walsh and Devane, 2012). Alongside midwifery units (AMUs) integrated within a hospital setting can face additional challenges in developing midwives' confidence to support physiological birth due to their proximity to the obstetric unit (OU) and frequent lack of core staff (McCourt et al., 2011, Rayment et al., 2015). The ability of midwifery units to provide the safer, more personalised care required of maternity services depends on successful strategies to develop midwives' skills and confidence to work in these settings (McCourt et al., 2012, 2016).

The AMU on which this study is focused opened in 2008 within a London hospital as part of the service's commitment to offering high quality, safe and

personalised care to women and their families, tailored around their needs, and in line with United Kingdom national recommendations (NICE, 2014). In order to develop midwifery services further within St George's University Hospital NHS Foundation Trust, two Consultant Midwives, for Normality and Public Health, were appointed in 2014. The role of the consultant midwife in the United Kingdom is to provide clinical leadership, analogous to the consultant obstetrician role within a maternity service, rather than service management (Robinson, 2012). Together they created a training package for midwives and maternity support workers, entitled, 'Birth centres: the hub for a social model of maternity services,' designed to strengthen physiological birth skills and knowledge within the team, create a base for a shared philosophy and culture, empower midwives to feel ownership of the service, promote woman centred care, and develop midwives' critical thinking and communication skills.

The overall training package included workshops devoted to antenatal education, communication skills, and baby massage, and a core workshop, called 'Keeping Birth Normal' (KBN). City, University of London, as an academic partner, was funded to evaluate the KBN training. The workshop structure was divided into three main themes: 'Why?' to remind participants why normality matters; 'How?' to provide tools to promote a KBN culture; and 'What?' to enhance recognition of normal physiology and strategies to enhance it. Workshop content was guided by previous evaluations of normal birth training packages (Sandall et al., 2010) and by on-going research about AMUs and factors contributing to their success (McCourt et al., 2014). Three

KBN workshops were delivered all by the consultant midwives who designed the training, including the third author, on three dates in January/February 2015.

## **Methods**

Our evaluation strategy aimed to gain understanding about how participants perceived the value and effectiveness of the training they received, barriers they perceived to implementing it, and how the training might be enhanced in future iterations. It followed an exploratory interpretive design.

### *Ethical Considerations*

Ethics approval was obtained through the City, University of London, School of Health Sciences Research Ethics Committee. Participants gave consent to participate. Although their participation in the workshop necessarily entailed involvement in the observational aspects of the evaluation, additional participation in focus groups and completion of the feedback forms were voluntary. The research team included: one midwifery lecturer (author 1, lead) and a midwife affiliated with St George's Hospital (author 2), who collected and analysed the data; one of the consultant midwives who designed and delivered the training (author 3), who contributed to the design and writing up of the paper; and a Professor of Maternal and Child Health (author 4), who provided guidance at all stages of the research. Digital data were stored on a password-protected, encrypted laptop and shared drive on the university

network, as per ethics approval. Physical data were stored in a locked cabinet in an office within the university.

### *Recruitment*

A total of 31 midwives participated in the training, in roughly equal groups across the three days. Participants were recruited to participate in the training through a call for expressions of interest that included information about the evaluation. All 37 staff who applied were invited onto the training; no midwifery support workers applied. Staff were given paid leave to attend the training, and all evaluation activities were scheduled to take place within the day. The 31 midwives who participated held various roles within St George's maternity services, including AMU midwives, the AMU manager, members of the home birth team and their team leader, senior midwife co-ordinators working on the obstetric unit (OU), and newly qualified rotational midwives. An attempt was made to involve midwives working across settings so that all could contribute to promoting and protecting the AMU's philosophy. This strategy also addressed research examining the high rate of tensions between AMU and OU midwifery colleagues, stemming at least partly from the lack of confidence or understanding amongst midwives working in other areas (McCourt et al., 2014).

### *Data collection*



Methods of data collection included a short anonymous feedback form containing open-ended questions [Table 1], observation of the training days, and focus groups with the participants at the end of the training days. The observation notes and focus groups were guided by a semi-structured list of prompts and questions [Table 2 and Table 3]. Questions and guidance notes were based on Kirkpatrick's four-level model for evaluating training programmes (Yardley and Dornan, 2012) and agreed by the research team. Data collection forms had been designed and pilot-tested by the same research team in an earlier pilot study of KBN workshops delivered in another maternity service. The forms were found by researchers to be easy to use and suitable to capture key relevant data. The feedback forms were completed by participants within five minute sessions immediately following the pilot-test workshops with a good completion rate and no concerns expressed regarding clarity or acceptability. These were amended and agreed by the research team for this evaluation in light of this previous experience.

Observational notes of the workshops were undertaken by the first and second authors throughout each of the three training days. The researchers were introduced as non-participant observers, and sat separately but aside from the participants, who sat in a circle together. The training was not video recorded. Approximately 30 minutes was allocated at the end of each workshop for a focus group discussion, facilitated by the first author, with the second author providing practical support. The focus groups were video recorded and transcribed by the first author. The first two researchers met

after each workshop to review the data collected and enhance consistency in recording observations.

The three methods of data collection by two researchers enabled data triangulation (Flick, 2011), providing multiple perspectives from which to compare and confirm our interpretations. On anonymous feedback forms, participants could provide individual comments and note anything they were reluctant or unable to discuss in a group setting. Focus groups provided researchers a chance to delve into key topics more thoroughly and check group responses, as well as further opportunities for participants to discuss their feelings and understandings with each other (Wibeck et al., 2007). Observational notes taken during the study days and on reviewing the focus group discussions helped to highlight aspects of the training that worked particularly well, resulting in high levels of engagement, and also areas of tension or lack of focus.

### *Data Analysis*

Anonymous survey data were analysed descriptively, using summative content analysis (Hsieh and Shannon, 2005). Data from the open-ended questions was initially coded as positive, neutral or negative. Following this, individual response items for each question were recorded on a Microsoft® Excel programme spreadsheet. We grouped similar responses together, under a title using the language of the respondents wherever possible, in

order to record the frequency with which similar responses appeared within the collection of feedback forms.

Data from the observational notes and focus group transcripts were analysed using a template (King 2004) informed by the aims of the research and our initial analysis of the survey data. All data were extracted and included within the template on a Microsoft® Excel programme spread sheet. This enabled comparison within and across themes (King, 2004). Following the independent coding and extraction process, the two researchers met to discuss the results, and make adjustments to the template, in consultation with the other authors.

Our final thematic analysis was also informed by Massey's description of three types of data and interpretations when using focus groups in evaluation research (Massey, 2011). *Articulated data*, that given in response to a specific question from researchers, we analysed descriptively as described above. *Attributional data*, emerging from theory-driven thematic coding, we analysed by looking at inconsistencies, discrepancies and tensions between what people said and what they did, or what they did not say. This particularly informed our analysis of possible barriers to implementing the training. *Emergent data* are described by Massey as touching on "larger themes and unifying concepts that are invisible before the study begins but that offer explanatory power for events related by the group" (p.25). Identification and further exploration of unanticipated themes informed our understanding of emergent data, which we report below as potential opportunities. The findings

reported below reflect our synthesis of themes observed across the three sets of data.

**Table 1: Questions included in the Anonymous Evaluation Sheet**

1. What did you think about the workshop?

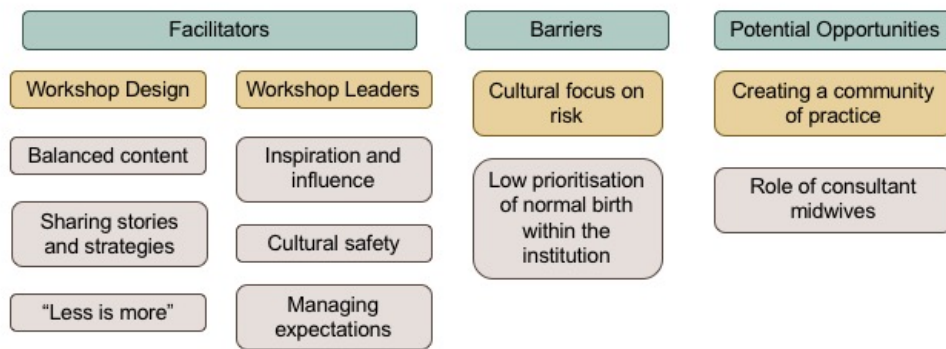
How did the workshop leaders put the content across?  
Was this helpful/convincing?  
What did you think about the balance between different activities and content?  
What part did you enjoy or find most helpful?  
What did you find less helpful?  
If you were leading such a workshop in future, what would you include?

2. Potential impact?

Did it have any impact for you personally?  
e.g. confidence, practice, knowledge  
Which aspect do you think will be most useful to you in practice?  
What do you think will help to make an impact in practice generally from the workshops?  
What do you think the main barriers will be?  
Any other comments you would like to add to help our evaluation?

## Findings

A total of 28/31 midwives participated in the focus groups, and 23/31 returned the anonymous feedback forms. The training overran slightly on the first two training days, and some participants needed to leave early; two were called to a home birth. This influenced the participation and return rates, but answers provided were similar across the three days. Significant themes are explored below [Figure 1]. Direct quotations are in *italics*, identified by an anonymous participant number (P) and the day of the workshop they attended (D).



**Figure 1:** Thematic Evaluation of Keeping Birth Normal Training: Facilitators, Barriers and Opportunities

### *Facilitators: Workshop Design*

We identified three themes relevant to workshop design, which appeared to contribute to the effectiveness of the training: 1) balanced content, 2) sharing stories and strategies, and 3) "less is more." When discussing the content of the training, participants expressed appreciation of the balance of materials, mentioning in particular videos, lectures, and small group activities. Videos explored the movement of the maternal pelvis with positional changes, labour support activities, and atmosphere in normal births. Small group activities included role plays, discussions and opportunities to practice skills such as massage. Participants also valued references, statistics and the course packet containing the presentation materials, seen as useful tools to take away. A lively debate occurred in one session when the normal birth rates for St. George's were presented. Participants seemed engaged with collective self-knowledge: *Statistics ... make us realise that our work is making a difference or not* (P10 D1). When asked what they would recommend for future workshops, 11 participants recommended more information relevant to

the multi-disciplinary team and/or obstetric unit (OU). This included how to support more normal birth on the OU, and working across boundaries, such as during transfers from the AMU to OU.

Time spent sharing stories and strategies appeared particularly important to participants: *It's not just the knowledge. It's the sharing* (P20 D2). Interaction among the participants contributed to the perceived community-building and relational aspects of the training. Participants valued establishing a group identity: *I think I'll find it really useful in practice looking around me and seeing my colleagues here today ... I've got my sort of KBN colleagues that would support me* (P3 D1). The experienced midwives who shared their own stories were also clearly energised by doing so. Although the large majority of comments about workshop content were positive, negative and neutral comments revealed a desire for more interaction, case studies and practical skills components, each of which involved small group work.

The theme “*less is more*,” a phrase used by multiple participants, appeared repeatedly within survey responses and focus groups. Small groups offered safety and relationship building: *The group today – quite intimate* (P28 D3). “Less is more” also pertained to content: *There was a lot to do. It was too much in one day. It's such a political and philosophical bag of worms* (P6 D1). The ambitious goals set for the training sometimes meant that the schedule overran. Although the participants acknowledged that the area needing to be covered was very wide, they suggested *bite-sized chunks* (P8 D1) to address over a period of time. Rather than gaining large amounts of new knowledge,

participants' comments indicated the training reminded them of important things they already knew: *Reminds us of a sense of midwifery care that we forget because of the environment we are exposed to* (P10 D1). They felt it was important this was reinforced with regular workshops. Some felt a smaller focus would be particularly important in multi-disciplinary training:

*If people aren't on the same sheet to start with, keep it quite focused, actually less content in the day. Less would be more in that context* (P12 D2).

#### *Facilitators: Workshop Leaders*

We identified three themes pertaining to the workshop leaders that appeared to influence the effectiveness of the training: 1) inspiration and influence, 2) cultural safety, and 3) managing expectations.

The perception of the workshop leaders as a source of inspiration and influence within the organisation appeared to contribute to participants' openness to their message:

*As a junior midwife, hearing some of the discussions from the consultant midwives – it's like years of experience that have come into these conversations* (P9 D1).

On the anonymous surveys [Table 1], 16/23 participants referred to the workshop leaders as being engaging, encouraging and/or inspiring in response to what they enjoyed most. The knowledge that workshop leaders

held positions of influence within the organisation contributed to a sense of hope:

*I think there is fundamental change coming now, with these two new consultant midwives who are extremely dedicated and motivated. And they've actually managed this project really, really efficiently (P24 D3).*

The theme of cultural safety encompasses physical, emotional and social well-being. In presenting their strategy for increasing the normal birth rate, the workshop leaders discussed safety aspects of midwifery-led care at length. This was a clear priority, for women and babies, but also for the training participants. The small numbers and tone set by the workshop leaders fostered a sense of safety to participate openly in debates and to make mistakes in the role plays, as one participant noted: *Nice that the group's not too big ... You could really say anything. You don't have a room of people looking at you (P25 D3)*. Participants responded most enthusiastically to models of good practice which they could praise; negative examples that participants were invited to criticise diminished the overall mood of the group, possibly because it diminished the sense of safety. While many participants expressed an interest in multi-disciplinary training in the future, some revealed on the anonymous forms that they felt inhibited from speaking freely because their manager was present.

Our observations suggested that moment-to-moment success of the workshops depended heavily on the leaders' abilities to manage expectations.



The presence of strong personalities within the groups and moments of tension required adept handling, and most of the time this was accomplished smoothly. At other times, members of the group were able to side-track discussion, noted by several respondents on the feedback forms and in our observations. This was complicated by an unclear focus on whether the training was intended to promote normality across the service, for all women, or promote the use of the AMU, with an aim to keep birth normal for women who began labour at low risk of complications. Comments made by participants indicated this distinction may have been unclear when they booked to attend the training.

### *Barriers to change*

Participants described a number of obstacles that they perceived would influence their ability to implement the training. We identified two over-arching themes concerning barriers to change: 1) cultural focus on risk; and 2) low prioritisation of normal birth within the institution.

### *Cultural focus on risk*

Within the feedback forms, a cultural focus on risk was mentioned by 14 participants as a barrier to their ability to create change as individuals, and 8 mentioned the medical model of care on the OU. Risk-focused culture was perceived as permeating the hospital environment, the surrounding community and the media, including social media, leading to increasing

intervention. This was described as something external to the group of participants, contrasting and impinging on their ability to focus on normality. But within the group, we also observed a tendency from some midwives who normally work on the OU to shift attention to OU problems, rather than AMU strategies:

*It's very easy, or easier, to keep things normal in a birth centre environment ... but you've got a woman with a BMI of 64 and you can't hear the fetal heart, and it makes it difficult ... increasingly our workload is very complicated (P4 D1).*

Simultaneously, doubts were expressed that focusing on strategies to keep birth normal for lower risk women would have an impact: *Sometimes I think it's like, if you follow this, then everything's going to be rosy. And it isn't (P4 D1).* When such doubts were expressed by senior midwives, other members of the group appeared withdrawn from the discussion, such as by looking down, focusing on their training booklets. Cumulative effects of negative attitudes among colleagues and emphasis on risk provided some insight as to why, in written feedback and focus groups, participants frequently referred to being *re-inspired* or having *restored my faith*, suggesting that they felt something had been lost or eroded within a negative working environment. The training was seen as contributing to recovery: *I need to surround myself with people who will bring me back into the right philosophy (P27 D3).*

*Perceived low prioritisation of normal birth within the institution*

Several participants' comments suggested that they felt normal birth was a low priority within the service. For example, although the economic advantages of midwife units was included as part of the training programme, participants expressed worries about how economic pressures would impinge on their ability to support normal birth. *The big issue at the moment is staffing. We don't have enough staff in the unit .... It's that culture of, "We need to save money."* (P21 D3) Some participants felt staffing the OU was seen as the priority: *Midwives are pulled down [from the AMU to the OU], and it doesn't work.* (P22 D3) Others doubted the motivations of some colleagues, who had not attended the training, to support normal birth. One participant described ... *those midwives who, when you talk about [the AMU] or women having a home birth, they sort of poo-poo it.* (P1 D2) Another participant questioned whether doctors were invested in women achieving a normal birth: *Surely it would make less work for them. But they don't want less work, they want experience* (P6 D1). Such doubts contributed to the desire for more multi-disciplinary training.

### *Potential Opportunities*

Our analysis indicated two areas arising from the training, but not directly related to content, which represent potential opportunities for future development.

### *Building a Community of Practice*

Participants perceived a potential opportunity to counteract the dominance of risk-focused culture through the creation of a community of practice around normal birth:

*If there's a core group of people who make a change, it's a very small thing, but gradually that filters through and then other people will start to think it's not so strange (P4 D1).*

The groups wanted the discussion and role modelling they experienced during the training day to continue, making suggestions for how it could go on after the workshop:

*I think the [social networking] forum and the strategies they were talking about will help. It's all very well having this one day, but then before you know it, it's gone out the window, so you need to continue it (P25 D3).*

Some participants spoke about how the training made them aware of the need to become visible, initiating change within their maternity services community. This included visibility to women: *What about information for the women? ... so women coming in are kind of primed with the language that we use here and that we are doing this here (P3 D1).* They also discussed a need to become visible to the rest of the staff: *We do have to challenge, we can't sit back and hide. We've got now a programme, a community. I feel really encouraged today (P24 D3).* Again, the participants recognised that becoming visible was a process, beginning with the training, but taking place over time: *It may need a different approach, step-by-step (P25 D3).* For example, one midwife felt the workshop made her skills and knowledge visible as expertise, and she could now have confidence to:

*Take it back to the shop floor and help you encourage and bring others on board. Reminder that it is research and evidence-based, that there is backing to what we believe in (P28 D3).*

### *The role of consultant midwives*

An unexpected finding concerned the workshop leaders' roles as consultant midwives within the NHS Trust. Participants perceived them not only as facilitators of this specific training, but were very aware of the potential of their roles as change leaders within the institution:

*They will sit on the right committees, the right meetings. It's about those top down changes. We can all do our little bit. But until the powers that be take on board what they're saying ...*

(P14 D2)

They were perceived as being in a position to change organisational systems in a way that individual midwives did not feel able to: *Because it's the system that needs to change (P22 D3)*. Frequent mentions were made to the role of the consultant midwives, suggesting the appointment of clinical midwifery leaders held significance for other midwives. This was related to their remit as change champions, more than any individual training activity: *I don't think any specific training we have is going to make a specific difference. It's the idea of it, the principle behind it (P12 D2)*. Due to the high level of interaction within the workshops, the consultant midwives were also able to learn directly about the needs and perceptions of the participants. In our follow-up discussions with the consultant midwives and managers, it was apparent that some of the

views offered by participants were acted upon promptly, such as the formation of a core team of AMU staff and protection of their allocation to work on the AMU. Any potential impact of the training was likely due to a dynamic, interactive and on-going process catalysed by the workshop, rather than the result of specific training content, as suggested by participants.

## **Discussion**

Studies of knowledge implementation have highlighted that strategies for change should focus on context, culture and systems within the health services and should use active and inter-disciplinary approaches to sharing and learning (Grimshaw et al., 2012; Rycroft-Malone et al., 2013). Discussion and negotiation is a necessary step in the adoption of innovations (Greenhalgh et al., 2004). KBN content varied discussion of the evidence and local birth statistics with video resources, hands-on practice of active birth skills such as massage, and small group activities such as role play, which explored the communication culture within the service. Opportunities for storytelling and sharing strategies resulted in increased engagement. Some researchers have suggested storytelling contributes to increased cognitive learning, enhanced role transition, emotional clarification, development of personal resilience and creation of interpersonal bonds (Hunter and Hunter 2006, East et al., 2010). Each of these were suggested in our data and indicate avenues for future research around the creation of normal birth networks and on-going internal training programmes. Workshop leaders' promotion of cultural safety also resonates with evidence that effective

midwifery unit cultures promote the well-being of midwives who work in them as well as better outcomes for the women who birth in them (McCourt et al., 2016).

As this training was only delivered to midwives, it did not address the need for interdisciplinary approaches advocated in implementation literature and other evaluations of similar training (Sandall et al., 2012). Participants' suggestions for improvement mostly concerned the need for multi-disciplinary training and inclusion of strategies to promote normal birth in an OU setting. However the simultaneous finding that 'less is more' suggested that this may be best accomplished by recurrent sessions with a varied, but clear and narrow focus. The incorporation of normal birth updates into periodic mandatory skills training for all staff, alongside refreshers in emergency skills, has been suggested by other research concerning midwives' confidence with physiological birth (Nicholls et al., 2016, Rayment et al., 2015), and may be another direction for future research.

Rycroft-Malone et al's (2013) work highlighted the complex interplay of individuals, evidence and context in the process of implementing evidence-based practice. Our exploratory analysis indicated that the training element participants perceived would have the greatest impact on their practice was the establishment of a visible community of practice, focused on promoting normality in childbirth and woman-centred care by sharing evidence and strategies. The participants viewed involvement with a group of like-minded people as transformative and strengthening, counteracting the resistance to

normal birth noted by our participants and in other studies of establishment of birth centre culture (Walsh 2007). The need for a visible and active community of practice resonates with ethnographic research around free-standing midwifery units in an urban setting (Rocca-Ihenacho, 2017), and the development of skill and expertise in complex physiological births (Walker et al., 2017). Research indicates that communities of practice are dynamic social structures which require cultivation over a period of time (Cambridge et al., 2005). Our findings suggest that future training development should foreground how they will catalyse and cultivate on-going communities of practice, and the importance of workshops being embedded in a wider and sustained change programme involving the multi-disciplinary team, also noted by Sandall et al. (2010).

This evaluation also adds to literature about the role of consultant midwives. Robinson's (2012) study into the role indicates that consultant midwives' positions of power rest on clinically acquired wisdom, transformational leadership skills and belief in woman centred care. Delivery of KBN training made each of these dimensions visible within the midwifery team. Further evidence suggests that opinion leaders, who are seen as likeable, trustworthy and influential, are effective at disseminating evidence-based practice (Flodgren et al., 2011), and that consultant midwives can be effective change champions (Cheyne et al., 2013). Because the importance of the workshops being led by consultant midwives was so apparent within our analysis, it is not possible for us to say whether or not this package of KBN would function the same way as a stand-alone package delivered by independent facilitators,



who were not also viewed as inspirational and influential leaders within the institutional governance structure. One of the potential applications we were asked to consider as part of the evaluation was whether the KBN training could be developed into a Masters-level module. If such training were included in Midwifery Masters programmes, it may be useful to orient it toward developing experienced midwives into future workshop leaders, equipping them with skills to implement it according to the needs of the local context and community.

#### *Change in use of the Birth Centre*

This evaluation was not designed to correlate the KBN training with any specific quantified change in practice or outcome, so we can only offer a cautious description of subsequent changes observed in use of the birth centre. St George's maternity care statistics from July – December 2014 indicated that approximately 605 (12.6%) of all births at the hospital occurred in the Carmen Suite AMU (40 births on average per month) and that the intrapartum transfer rate to delivery suite in labour was 43%. Following the KBN training in January/February 2015 and the associated staffing changes, the rate of births occurring within the birth centre subsequently increased, reaching 796 (15.4%) by September 2015 and continuing to increase to 878 (17.2%) by March 2016. The transfer rate had fallen by the end of 2015 to 23% and for the first six months of 2016 was 22%. In association with KBN training, a new Lead Midwife for the AMU was appointed and KBN-trained

midwives were appointed as 'core staff' on the birth centre. All stakeholders contributed to improvements in the physical environment of the birth centre.

During the training, the participants identified lack of a core birth centre team and fragmented professional relationships as key barriers to implementing the project's proposed changes. This feedback was acted upon, and a core team who attended KBN training together were appointed. Again, this suggests that much of the value of the training package arises from the relationships and communication it fostered. The time spent together may have enabled the consultant midwives to take the needs of participants on board to more effectively lead change, as much as it enabled the midwives attending training to acquire specific knowledge, skills and inspiration from perceived experts (Simpson, 2010). As the midwives suggested, this is perhaps a benefit in the smallness-of-scale of the training, somewhat analogous to the benefits attributed to smallness-of-scale in birth centres themselves (Walsh and Devane, 2012).

### *Strengths and Limitations*

Many evaluations demonstrate a positive initial reaction from participants and self-assessed impact from training, but few use an exploratory approach to gain more understanding about why participants react in the way that they do. Using observation and focus groups, this study was able to gain deeper insight into how and why the participants perceived the workshops to be effective, which may help to guide others who hope to implement similar

training to promote normality and cultural change in maternity services. A limitation is that we did not use an instrument enabling us to detect change in attitudes before and after the training. It was harder to detect whether the training was effective in changing the minds of those who were not pre-disposed to agree with the message of the day. It would also be useful to gather feedback from participants after time spent in practice, to enable reflection on implementing the learning.

### **Conclusion and Implications for Practice**

The social ties and communication channels fostered within KBN training appeared to contribute to the establishment of a core team dedicated to promoting normal birth and a social model of maternity care on an AMU. In future training of this type, providers should emphasise community-building and opportunities for participants to form and strengthen relationships with each other and consultant midwives in order to implement and sustain evidence-based practice. Effective training may need to be cyclic in nature in order to maintain its effect, and should involve consultant midwives, other senior midwives and other members of the multi-disciplinary team. The potential for contribution to improving physiological birth skills and support for normal births within obstetric units should also be considered.

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**Table 2: Observation Guide**

**Focus of the observation**

The aim is to be semi-structured: open note taking, but with particular aims and questions in mind. This will be used to:

- Guide the design of the workshops in future
- Assist in evaluating the effectiveness of the training
- Develop/define research tools for future research

**Key questions to frame the note taking:**

1. What is the style of this workshop?

How are the workshop leaders putting the content across?  
What is the balance between leader and participants talking?  
What is the balance between talking and activity?  
Is the tone facilitative or authoritative? (record how they talk, etc)  
What is the content? (additional observation to the written materials)  
Balance of research knowledge, philosophy, practical skills, expert voice

2. How do participants react?

How are participants responding to this?  
e.g. Do they look interested, switched-off, sceptical, defensive?  
Are they keen to participate actively?  
Do they respond to direct questions or come up with their own?  
Do they raise concerns they have?  
If so, what kind of concerns?  
Do they respond more positively to some activities rather than others?  
Do you notice any change in response from beginning to end of day?

3. Your own reactions as an external observer

What is most noticeable to you?  
Anything surprise you?  
Did you observe what you expected?

**Examples of Data Collected:**

(Day 1) Instructors seem very comfortable with each other.

(Day 1) Lots of talking among participants. Invited to say one thing they wanted to learn → renewed interest.

(Day 2) Participants now nodding to more impassioned speeches from facilitators. They seem a lot more on board with philosophical issues, issues around consent, etc. The practical activities have warmed them up.

(Day 3) Today the room is smaller, the seats closer in a semi-circle. Introductions are friendly, intimate.

(Day 3) Workshop leader is talking about how the film [of a home birth] makes her feel emotional.

(Day 3) Consultant midwives seem quite down on the situation, but participants say how much it is encouraging them to have the consultant midwives now working for change.

**Table 3. Focus Group Discussion Guide: Questions and Examples of Data Collected**

**Key questions to frame the evaluation discussion:**

The intention is to facilitate a reflective discussion on how the participants found taking part in the workshop, their ideas for improving it and their views on facilitators and barriers to implementation and effectiveness in practice.

1. What did they think about the style of this workshop?

How did the workshop leaders put the content across?

Was this helpful/convincing?

What did you think about the balance between different activities and content?

Do you have ideas or suggestions for improving the workshop design and delivery in future?

2. How do participants react?

What part did you enjoy or find most helpful?

What did you find less helpful?

If you were leading such a workshop in future, what would you change?

3. Views on potential impact?

Did it change anything for you personally?

e.g. confidence, practice, knowledge

What do you think will help to make an impact in practice from the workshops?

What do you think the main barriers will be?

**Examples of Data Collected:**

(1<sup>st</sup> day) *Sometimes with the best will in the world, you can get women to do all these things and they just are not progressing.* [Other participants looking down to their papers.]

(1<sup>st</sup> day) *I might make us little badges.*

(2<sup>nd</sup> day) [Discussion around wanting junior midwives to have someone visible to refer to for help in care planning with a normality focus.]

(2<sup>nd</sup> day) [Discussion around being able to voice what they are scared of.] *It's doing it in a safe space. That's the difference. When you are at work, with other people around you, it's not private, it's not quiet ...*

(3<sup>rd</sup> day) *On [the AMU] you may [be able to implement new practices] because it's a smaller team. You can bounce off your other midwives ... But if you are gonna go back to Delivery Suite [negative face] ...*