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Qualitative evaluation of an innovative midwifery continuity scheme: lessons from using a quality care framework

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Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

AS conceived of the study in discussion with the local Chief Midwife. AS and SS were instrumental in the study's development, including data collection, data analysis, writing and reviewing successive drafts of the paper and approving the final manuscript.

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Abstract

Introduction

Innovative midwifery schemes must be robustly evaluated to establish whether they should be modified or can be replicated. Assessing quality of care can help to ascertain a scheme's acceptability and effectiveness. We used an established quality care framework as a benchmark in our qualitative evaluation of a combined continuity of carer and planned home birth scheme in Scotland.

Methods

Qualitative evaluation of stakeholder perceptions using the Quality Maternal and Newborn Care Framework was the basis for six focus groups and two one-to-one interviews with stakeholders (new mothers, partners, midwives). A thematic analytical approach was used.

Results

The qualitative evaluation found universal approval among participants. Flexible working patterns helped to nurture positive relationships, and information and support were highly valued. The principal themes—Organisation of Care/Work Culture; Information and Support; Relationships—were strongly inter-related. They shared several sub-themes, notably continuity of carer, flexible family-centred care, and the benefits of being at home. Flexibility and mutual respect helped women to express autonomy and develop agency. Women related their birth experiences to friends, family and colleagues, thereby helping to normalise home birth.

Conclusions

This qualitative evaluation of an innovative scheme used an established quality framework as a benchmark against which to assess stakeholder experiences. This approach helped to identify the critical co-dependence of factors involved in care delivery, which in turn helps to identify lessons

for others considering similar schemes. While our evaluation relates to one specific scheme, identifying the scheme's critical quality care aspects may assist others when planning similar schemes.

Keywords

Relationships Quality care Communication

Midwifery Continuity of carer

Introduction

Continuity of midwifery carer is integral to United Kingdom (UK) maternity policy[1,2] and various continuity schemes are being implemented in different locations nationwide. Driven partly by pregnant women's desire to know their midwife, this development also reflects growing evidence of improved clinical and psychosocial outcomes, as well as cost effectiveness.[3] Innovative schemes must be formally evaluated to ensure they are fit for purpose. In an accompanying paper (this volume), we report how maternity care is provided in Angus, a county within NHS (National Health Service) Tayside, and the processes by which we evaluated the two principal clinical targets of an embedded continuity of carer and planned home birth care package. Initiated in 2016, the Angus Home Birth scheme ('the Angus scheme') targets were 80% continuity of carer with the primary midwife throughout pregnancy, labour and the postnatal period, and a 3% county-wide planned home birth rate.

It is increasingly accepted that subjective outcomes relevant to care quality should form part of any clinical evaluation.[4] In this paper, the second of two on the Angus Home Birth scheme, we report on our qualitative evaluation of new mothers' and midwives' perceptions of the scheme. We used a quality care approach based on the Quality Maternal and Newborn Care (QMNC) Framework[5] which has already proven effective in evaluating midwifery models of care.[6,7] This paper complements a process evaluation which assessed how well the scheme was meeting its clinical targets by elevating service users' and midwives' experiences of the scheme.

The Angus scheme

Three home birth midwives are co-located within a community midwifery team. The primary midwife provides, with one of two colleagues assisting when necessary, continuity of carer throughout pregnancy, labour and the postnatal period. A home birth is planned, with community colleagues assisting when required (Figure 1). All midwives refer to a tertiary unit when significant complications arise; a well-established ambulance service, including neonatal transfer facilities, is available. All facilities are provided by the taxpayer-funded NHS through NHS Tayside, one of 14 regional health boards in Scotland. Evaluations of service require the careful appraisal of the perspectives and experiences of key stakeholders: the women, their partners, the Angus scheme and other community midwives.

Figure 1 Care options for pregnant women in Angus

Methods

Recruitment was purposive. All women who had entered the scheme with an estimated due date between October 2016 and March 2018 were invited to participate. To include the partners' voices, the women were asked, if appropriate, to extend the invitation to them. We conducted four focus groups with 16 women (n=2, 3, 3, 8). Two one-to-one interviews were conducted when only one person turned up to a planned focus group; this included the sole partner to attend. We conducted a double interview with two Angus scheme midwives, and a focus group with six other Angus community midwives. AS and SS shared facilitator and note-taker roles. The interview guides were derived from the Quality Maternal and Newborn Care (QMNC) Framework's extensive analysis and synthesis of the global literature on quality care.[5] This approach, including the interview schedule, has been reported elsewhere.[6] It involved a principal and supplementary question for each of the QMNC Framework's five components of care. Participants were asked if all necessary care had been received or provided ('Practice categories') and whether care had been accessible, of good quality, adequately resourced, and had involved continuity ('Organisation of care'). We asked whether care had been respectful and tailored to women's needs ('Values'); whether normality and women's capabilities had been promoted ('Philosophy'); and whether care providers had demonstrated both knowledge and skills ('Care providers'). All interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using Ritchie and Spencer's thematic analysis approach.[8] This involved both deductive analysis, using the QMNC Framework's constructs, and inductive analysis, incorporating new themes as they emerged through open coding.

Results

We identified five themes, each with several sub-themes (Table 1). Three principal themes—'Organisational Structure/Work Culture'; 'Information and Support'; 'Relationships'—had also been identified in a previous study.[6] To these we added 'Autonomy and Agency', which developed largely during pregnancy, and 'Pregnancy and Birth Reflections', which arose postnatally. 'Autonomy' refers to the woman's right to determine what happens to her body; this deeply-

entrenched legal principle was discussed in an earlier analysis of women's choices in UK maternity care.[9] 'Agency' refers to the means by which a woman asserts such autonomy.

While each theme had several sub-themes, the integrated nature of care in the Angus scheme was seen in the three principal themes' inter-relatedness (Figure 2). The sub-theme 'Benefits of being at home', for example, was discussed in connection with all five themes by participants. These benefits included perceived improvements to the midwives' work culture and to midwives' abilities to information-share, which helped collaborative relationships to develop. Benefits of being at home also included women developing agency— a central feature of postnatal reflections.

Figure 2. Angus scheme qualitative evaluation: the inter-relationship of the five themes

For the midwives, providing domiciliary care was integral. It facilitated information-giving and support and helped relationships to develop. This, in turn, engendered women's autonomy and agency. Postnatally, many mothers reflected on how being at home had enabled them to achieve positive experiences. They talked about their experiences with their family and friends, providing information and support for other women, including those not initially considering home birth. To minimise the chance of unintended identification, we have used pseudonyms throughout and given the woman's parity but not her age (P0=Primiparous, P1=Para1, *etc*.). For the purposes of drawing out possible lessons for those considering implementing a similar scheme, we focus mainly on the three principal themes and their inter-relatedness.

Organisational structure/Work culture

The Angus scheme was conceptualised managerially around flexible working—a feature of the scheme that was described both by pregnant women and midwives as empowering. When asked how flexibility featured in working patterns, Fiona replied:

> "… the women really love the fact that we will see them any time of the day. So, if they say 'No, I really can't see you until teatime,' then we would make a point of just making our day different and going in and seeing them at that time." (Fiona, midwife, FG3:99)

This flexible approach quickly became part of the work culture. Kate (midwife) noted that flexibility—an inherent element of women's choice and control—was crucially dependent on

mutual respect. She characterised this as "partnership" working (FG3: 29), which involves listening to the woman and accepting her right to make decisions. This flexible, sensitive, family-centred care was one of the key sub-themes, linking as it did with the three principal themes (see Figure 2).

The themes' co-dependence is evident: flexibility shaped work culture, but also contributed to relationship-building and information-sharing. A family-centred approach combined with flexibility generated positive relationships:

> "Sophie (midwife) was really good fitting in my family life round about when she was coming in. … Jessica (daughter) was three at the time and she was just fab with Jessica … Jessica was full of questions, a million questions, and Sophie, she would just answer them without thinking anything of it." (Nancy, P3; FG2:38)

The midwife's positive response helped to create a trusting family-centred relationship. Providing care in the home also helped to encourage confidence and empowerment, as recognised by Nicole:

> "Because we're inviting the midwife into our home … they are kind of more… respectful of your space and what you're wanting to do." (Nicole, P0; FG6:154)

Information and Support

Underpinning this flexible and collaborative organisation of care was the drive to ensure continuity of *carer*. Participants connected continuity to the need for effective communication between all parts of the care team. Kate, a midwife, noted (FG3: 74) how she and her colleagues made communication a priority, whether in person or by email. This included sharing information about home visits so that other midwives could come along and meet the woman and her family. Nicole said:

> "I had met the other two midwives as well but having Sophie come every week just made me feel very confident" (FG6: 8).

The Angus scheme did not operate in isolation. Dr. White, a senior obstetrician, jointly oversees the scheme with the local Chief Midwife. Tanya noted how good communication between the home birth and hospital teams was needed:

> "Dr. White was supportive of home birth, however … she recommended that I don't have a home birth on this occasion, but after every appointment I would speak to Sophie (midwife) about it, and she would then in turn speak to Dr White, and so I always felt like everyone was in loop." (Tanya, P2; FG7:87)

The midwives' approach to information-sharing with the women was part of their work culture and contributed to relationship-building. Grounded in continuity of carer, it generated trust during awkward conversations:

> "Kate was my midwife, and I love her to bits. She just really makes you feel comfortable because if you've got any questions that you might have felt were a bit, I don't know, silly or intimate or whatever, it felt comfortable ... because you knew the midwife and you didn't have to keep re-explaining things to new people..." (Rebecca, P1; FG6:10)

Trust and effective information-sharing were essential when planning a home birth. This helped women know, for example, when to call the midwife. Mia explained that being aware of the midwives' shift rotation meant she knew whom to call when she needed advice. This could be particularly important when more urgent issues arose. Hannah described how the feeling of being supported by a particular midwife had helped her to persevere with breastfeeding:

> "… I would have stopped breast feeding … she was like 'We should be discharging you now, but I'm going to come back out and see you because I want to make sure that you're, you're definitely okay with this'. (Afterwards) I had text messages to say 'Is everything okay? Do you need us?' So, I felt really supported with that … had I not had that I would have stopped breastfeeding." (Hannah, P1; FG4:73)

Participants, both midwives and service users, described trust as much more likely to develop when relationships are based on mutual respect; this is a key feature of continuity models.[10]

Relationships

To gauge the scheme's replicability, we asked women what characteristics the midwives needed to provide high quality home birth care. Elaine felt valued, and contrasted the midwives' culture of working with her previous experiences:

> "(They're) obviously really passionate about (home birth) … they really made you feel safe, secure, valued... sometimes you just don't get that same vibe (in hospital), you know you're just another number in for your appointment: bloods, routine, everything, and away you go. … (Angus scheme midwives) always took more time, took an interest ... you felt they genuinely were interested." (Elaine, P1; FG2:26)

That experience of effective care was an important sub-theme. Kate (a midwife) talked about how seeing the woman in her own home helped a 'bond' to develop. Home visits are a planned organisational feature; over time they engender trust and good information-sharing which are both a cause and a product of positive relationships. Over and above the benefits of continuity of carer in a clinic, this feature improved the midwife's understanding of the woman's situation. Generating this level of trust and understanding requires openness within the care giver-family relationship. The sole male participant confirmed this:

> "Yeah, I think it was a 50/50 thing, there was never anything like you were told or anything like that, it was always discussion…" (Douglas, FG8:121)

Amy commented on how it felt comfortable to have a known face at visits:

> "Yeah to have a familiar face if you're a bit unsure about anything if you got to know them and yeah you did feel more reassured when you were speaking to them about things and it just felt more comfortable with them." (Amy, P0; FG5: 22)

Trust also produced a sense of care and responsibility between midwives and women that participants described as being helpful, especially during difficult times as when transfer to hospital was required:

> "It makes a huge difference to the women, because often you're leaving them there and they're going 'Please don't go' … that feeling of almost being abandoned because something's changed, it must be horrendous.... And to be able to say to

them 'Do you know what? I'm actually going to stay and care with you for longer.' This is such a weight off their mind…" (Kate, FG3:152)

Autonomy and Agency

A by-product of the care design was that the women's sense of autonomy; a sense of being in control was augmented, particularly in relation to planning a homebirth. With regard to wanting to control the birthing environment, Nicole said:

> "I think with something like birth, you know … (in hospital) it can just spiral out of control and I just, I wanted to just not that have that fear … on my mind, I just knew I wouldn't be comfortable." (Nicole, P0; unplanned postnatal transfer; FG6:131,133)

This feeling was shared by a partner:

> "… you sometimes feel a bit like the spare part (in hospital), whereas in your own home if I just wanted to nip out, even just stupid things like going to the toilet, I didn't have to consult the midwife…" (Douglas, FG8:23)

The midwives also discussed this sense of women's autonomy in association with home birth:

> "If you're going into their home, they have control to an extent… (Fiona, FG3:49)
> "And it's a lot about their choice." (Kate, FG3:50)

With care being delivered in the woman's home, participants experienced the traditional hierarchical care-provider/care-receiver relationship as largely flattened.

> "I loved the fact that they came to the house it made a big difference…….I don't know; it just maybe a lot less, not stressful but it just I made it feel like you had ownership of your birth rather that it being some medical procedure. It was more like because it was in your familiar setting it was more about you, it was much more personal." (Mia, P1; FG6: 16)

However, setting is not the only determinant of perceived autonomy and agency. Women are more likely to exert autonomy when cared for by midwives compared with doctors.[11] In the Angus

scheme, domiciliary care, midwifery care and continuity of carer co-exist, and this combination may be particularly impactful.

> "I had Fiona and it was just great to have her at every appointment and yeah, she made me feel so comfortable right from the very start and yeah I wouldn't have a birth any other way." (Nicole, P0; FG6: 2)

Birth reflections

Women indicated that they had reflected during pregnancy on their options, often involving their partner in the process.

> "(I)… did the reading and I spoke to my husband about it and I said, 'Well, there's no harm in speaking to the team about it and just get a bit more information'. And it was after that initial meeting that I thought I actually want to do this (give birth at home)…" (Amy, P0; FG5: 112)

Douglas, the one partner we interviewed, was initially "dead against" home birth but eventually came around to his wife's point of view. Similarly, Vivien (P2; FG4: 23) reported that her partner had taken "a little while to come 'round to it". Arlo's partner had voiced safety concerns, but explained how this allowed them to discuss home birth practicalities.

All the mothers interviewed reflected postnatally on their experiences, which were overwhelmingly positive, even when transfer to hospital was required. Almost all reported that they had shared their birthing stories with family, friends and colleagues. Participants noted the role that hearing about someone else's home birth experience can play in decision-making. Knowing someone else had given birth at home safely, opened up a set of options that may not have been part of the decision-making process otherwise. As such, we coded these sections of narratives as 'Normalising home birth':

> "I have a friend who's pregnant just now and, and she's actually now planning a homebirth because I told her my story …." (Hannah, P1; FG4:144)

This enthusiasm was shared by partners too:

"Douglas talks about it all the time, he thinks it's the best thing ever now." (Hannah, FG4:165)

Interviewer: "Because that's how you spread the stories."

"Yeah, we've had a few people, I've had a few people that have gone for homebirths after I've spoken to them…" (Vivien, P2; FG4:167)

Discussion

Stakeholder perceptions and experiences are key in determining whether a scheme is acceptable and appropriate. Our qualitative evaluation found many positives. Women appreciated negotiating and receiving flexible and family-focussed care in their own home. This helped communication with the midwives and encouraged positive relationships to develop. In turn this helped service users to feel supported and empowered, even when things had not gone according to plan. The midwives were committed to what was evidently a well-organised and adequately-resourced working pattern which was integrated with the wider provision of maternity care in Angus.

As Figure 1 indicates, the identified themes were inter-related, with several sub-themes shared between three or more of the themes. While the many sub-themes contributed significantly to the development of the five main themes, it is the interplay of the principal themes and sub-themes which is vital to understanding the Angus scheme's success. For example, a conversation about continuity of carer might start in a discussion about the organisation of care; then evolve to illustrate how such continuity promoted good information-sharing and support, and then to describe how trusting relationships had developed.

An understanding of this interplay may benefit other systems planning similar continuity schemes, whether or not they include home birth. The three principal themes are inter-related—a set of interactions that we have modelled as a wheel (See Figure 1).

Organisational structure / Work culture

Core to the Angus scheme was its organisation; managerial and financial support were essential. Some midwives resist working in continuity models because of the anticipated disruption to family life from on call requirements.[12] Consequently, any new scheme is likely to be comprised of a self-selecting core of practitioners. Home birth and continuity of carer schemes may alter the dynamic of those working within and around them, so care must be taken to involve practitioner stakeholders in discussions about the practicalities of on call requirements to help prepare them for some inevitable disruption.

It helped in this instance, that midwifery practice is the norm in Angus; the scheme could draw upon a strong tradition of midwives liaising with women to generate interest and support for this particular organizational structure. The scheme built upon what had existed previously around involving women and their families in decision-making about birth setting, though prior to the scheme, home birth had been rare in this area.

The mothers' enthusiastic reports testified to the Angus scheme midwives' commitment to it. However, care must be taken that offering flexibility – for example over antenatal visit timing – does not lead to unsustainable working practices. In the early days of the scheme, the midwives sometimes worked on their days off to accommodate women's wishes. Over time, and with the growth of the team to three full-time midwives, they learned to manage this workload more effectively. Surprisingly, managing women's expectations of response times and availability, particularly around the home birth, was not considered an issue by participants. It appears that negotiating these boundaries was relatively straightforward, given the respectful and trusting relationships that developed in conjunction with continuity of carer.

While those choosing to work in a home birth scheme might be expected to show commitment to communication with service users and other midwives in their practice, working effectively with other colleagues, especially across disciplines, is also vital. Mothers and midwives referred to constructive communication with hospital-based staff. Ensuring effective communication requires careful planning and mutual respect. Transfer to a tertiary unit can be stressful, including women feeling they have 'lost their dream'[13] and community-based midwives feeling under-supported by unit staff.[14] Such problems can be off-set by proactive planning of transfer protocols by all relevant personnel.[15] In Angus, where the overseeing obstetrician strongly supports the scheme, a transfer protocol was included from the outset. The total transfer rate was 22.7% (or 15.3% when excluding

women who were ineligible, but who nevertheless requested a home birth (see accompanying paper, this volume).

The scheme's effective organisational set-up, based on continuity of carer, appeared to allow for other positive factors to emerge, such as effective and family-centred care. In turn this encouraged good information-sharing and women feeling well supported, which then helped trusting relationships to develop.

Information and Support

Information-sharing and support between midwives and women were believed to be highly effective in this model. Effective information sharing and support underpinned and were products of the positive relationships and the positive work culture that developed. This demonstrates again the co-dependence of the themes we identified. While social support networks are vital to pregnant women,[16] the provision by health professionals of "relevant, appropriate and timely information", as found in this evaluation, is also important.[17] This feature was helped by having continuity of carer, which in turn promoted tailored information-sharing. Having sufficient time for effective communication is essential,[18] not least because communication failures and negative experiences are strongly associated.[19]

Relationships

The interplay of the common themes and sub-themes in this evaluation is crucial. Effective relationships spring from a positive working environment, which in this package includes continuity of carer; and in turn they reinforce that environment. Relationships arise partly as a result of providing support and effective information-sharing, but they also help to promote these factors. Good relationships entail trust, which critically, works both ways.[20] Trust helps to ensure that people know when to communicate. Having time to consider options, preferably with a trusted health professional, is essential,[21] as there is clear evidence that women from marginalised social groups are less involved in shared decision making.[22] The value of investing in practitioners who are good at establishing relationships on an equitable basis can hardly be over-stated. Ideally they would be skilled at reducing tension by conducting a respectful and open dialogue with the woman, enabling her to consider her options carefully.[23]

The location of care in the Angus scheme was also a critical factor. 'The benefits of being at home' (*cf.* Murray-Davis et al[24]) were emphasised by mothers and midwives. Being at home helped mothers to feel at ease, which in turn promoted their autonomy and agency; and the midwives related how information-gathering and sharing were much better when seeing the woman in her own surroundings. The contrast with the hospital setting – which, as Kirkham long-ago noted, "is not designed to foster two-way communication in any depth"[25] - is stark.

Strengths and limitations

We used a quality care framework approach for this evaluation, a method that has already been used successfully in different contexts.[6,7] We are confident that the very positive evaluation reflected the reality of the Angus scheme, and that this will be appealing to those considering implementing similar schemes elsewhere, However, it should be noted that the relatively low numbers in the scheme allowed for time and flexibility that will not be available everywhere. Other contextual factors may also limit the transferability of our findings. Scotland has a strong history of autonomous midwifery, particularly within community settings, offering a solid foundation for developing the scheme. Nevertheless, by describing the scheme's critical features those in different situations may be helped to identify how these features can be nurtured in their own setting.
Angus has a range of deprivation (discussed in the accompanying paper, this volume), yet little ethnic diversity, and mothers in this evaluation were all married or had a partner. Our population sample, therefore, is reflective of larger and more diverse populations. An inherent positive bias in women and partners agreeing to participate is likely in any evaluation such as this.

Conclusion

Any innovative scheme must be robustly evaluated. In addition to ensuring good clinical outcomes, a qualitative assessment of perceptions and experiences is crucial. We found the Lancet Series on Midwifery's quality care framework to be a robust basis for exploring perceptions of care quality. The co-dependence of the principal themes in this analysis of a continuity of carer and planned home birth scheme reflects the complex interplay of organisational, individual and relational features. Integral to the scheme's success was the midwives' operational flexibility in managing their workload. The midwives' evident commitment and skill helped to nurture trusting

relationships, which in turn, promoted effective communication, a factor strongly associated with improved outcomes. The Angus scheme is also embedded in a wider community-based service provision that includes access to tertiary services when required. Midwives seeing the women over time in their own surroundings helped the midwives to understand the women better, leading to better communication, better care and effective relationships, even when a transfer to a higher level of care was needed. Good relationships were also a mitigating factor when outcomes were not optimal.

In addition to the commitment of a core group of skilled midwives, such schemes require strong support from managers (including financial backing) and colleagues. We hope that demonstrating this scheme's clinical safety (accompanying paper) along with an analysis of the acceptability and experience of care among stakeholders will give confidence to other communities and systems considering implementing home birth with continuity of carer schemes.

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Figure 1. Care options for pregnant women in Angus

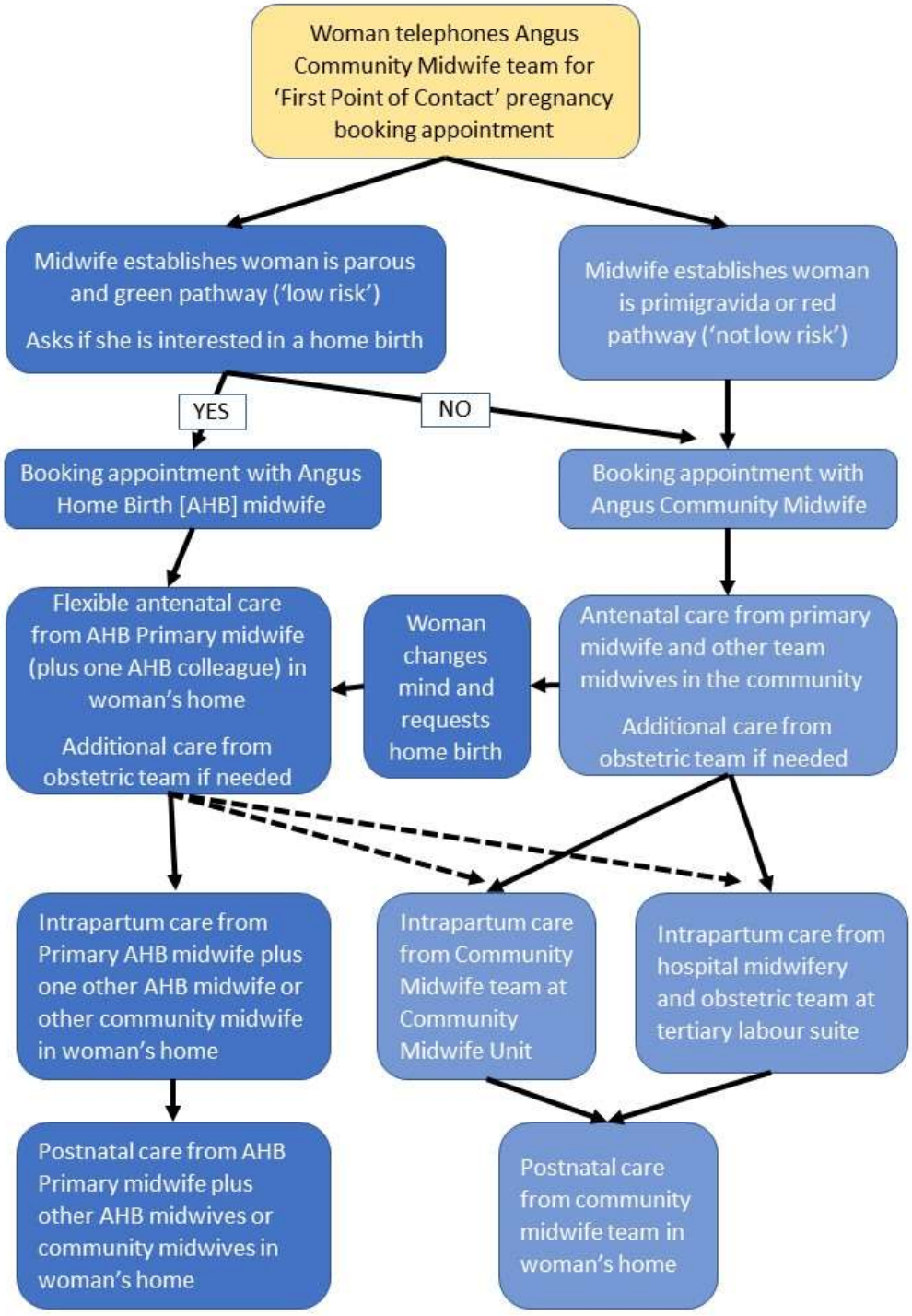

Figure 2. Angus scheme qualitative evaluation: the inter-relationship of the five themes