



## Improving the quality and content of midwives' discussions with low-risk women about their options for place of birth: Co-production and evaluation of an intervention package



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### ARTICLE INFO

#### Keywords:

Place of birth discussions  
Midwifery  
Behaviour change  
Co-production

### ABSTRACT

**Objective:** Women's planned place of birth is gaining increasing importance in the UK, however evidence suggests that there is variation in the content of community midwives' discussions with low risk women about their place of birth options. The objective of this study was to develop an intervention to improve the quality and content of place of birth discussions between midwives and low-risk women and to evaluate this intervention in practice.

**Design:** The study design comprised of three stages: (1) The first stage included focus groups with midwives to explore the barriers to carrying out place of birth discussions with women. (2) In the second stage, COM-B theory provided a structure for co-produced intervention development with midwives and women representatives; priority areas for change were agreed and the components of an intervention package to standardise the quality of these discussions were decided. (3) The third stage of the study adopted a mixed methods approach including questionnaires, focus groups and interviews with midwives to evaluate the implementation of the co-produced package in practice.

**Setting:** A maternity NHS Trust in the West Midlands, UK.

**Participants:** A total of 38 midwives took part in the first stage of the study. Intervention design (stage 2) included 58 midwives, and the evaluation (stage 3) involved 66 midwives. Four women were involved in the intervention design stage of the study in a Patient and Public Involvement role (not formally consented as participants).

**Findings:** In the first study stage participants agreed that pragmatic, standardised information on the safety, intervention and transfer rates for each birth setting (obstetric unit, midwifery-led unit, home) was required. In the second stage of the study, co-production between researchers, women and midwives resulted in an intervention package designed to support the implementation of these changes and included an update session for midwives, a script, a leaflet, and ongoing support through a named lead midwife and regular team meetings. Evaluation of this package in practice revealed that midwives' knowledge and confidence regarding place of birth substantially improved after the initial update session and was sustained three months post-implementation. Midwives viewed the resources as useful in prompting discussions and aiding communication about place of birth options.

**Key conclusions and implications for practice:** Co-production enabled development of a pragmatic intervention to improve the quality of midwives' place of birth discussions with low-risk women, supported by COM-B theory. These findings highlight the importance of co-production in intervention development and suggest that the place of birth package could be used to improve place of birth discussions to facilitate informed choice at other Trusts across the UK.

**Abbreviations:** COM-B, Capability, Opportunity, Motivation – Behaviour; MLU, Midwifery-Led Unit; OU, Obstetric unit; PoBL, Place of Birth Lead

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<https://doi.org/10.1016/j.midw.2018.01.016>

Received 1 June 2017; Received in revised form 10 January 2018; Accepted 23 January 2018

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## Introduction

Women's planned place of birth is gaining increasing importance in the UK, with recent guidance from the National Institute for Health and Care Excellence (NICE) recommending that all low risk women are given information about the safety, intervention and transfer rates of giving birth in different settings, to promote informed choice (NICE, 2014). Their recommendations state that for low risk multiparous women, there is no difference in the composite perinatal outcome for those who give birth in an obstetric unit (OU), a midwifery-led unit (MLU), or at home, with fewer interventions at home and a low transfer rate of 12%. For low risk nulliparous women, there is a small but significant increase in babies born with poor outcomes at home compared to an OU or MLU, with fewer interventions in midwifery-led settings and a transfer rate of around 40% (NICE, 2014). Planned birth at home has been shown to be the most cost-effective birth setting (Schroeder et al., 2012) and studies have reported increased maternal satisfaction with non-OU settings (Hodnett et al., 2010; Royal College of Midwives, Royal College of Obstetricians, 2007). Increasing the uptake of non-OU settings for intrapartum care may also relieve pressure on inpatient maternity service capacity, with substantial increases in the birth rate placing it under significant strain (Royal College of Midwives, 2015; NHS England, 2016).

Choice of place of birth has long been enshrined in UK policy (Department of Health, 1993) and has been reinforced by the 2016 National Maternity Review which found that despite policy and evidence advocating choice, many women remain unaware of their options (NHS England, 2016). Many women consider hospital birth the “default option,” with recent history and social norms strongly influencing women choosing hospital birth (Coxon et al., 2014). Midwives have the opportunity to raise awareness and provide women with information and discussion, to open up choice about place of birth. Currently this discussion takes place at a woman's booking visit, ideally being revisited later on during pregnancy. However, in the 2014 National Perinatal Epidemiology Unit *You and Your Baby* survey, a third of women were only aware of one option for where to give birth (NPEU, 2014). In addition, midwives' own beliefs and experiences, alongside variation in service availability, can influence the type of decision-making support midwives give women (Henshall et al., 2016) and they may present risk differently depending on their medical or sociological outlook (Dahlen, 2009; Henshall et al., 2016). Indeed, a recent systematic review of the literature found that organisational pressures, professional norms, the influence of colleagues, inadequate knowledge and confidence of midwives, together with variation in what midwives told women, influenced midwives' place of birth discussions with women (Henshall et al., 2016). Existing interventions to assist midwives in undertaking place of birth discussions have not provided sufficient evidence of effectiveness, and the papers reporting on these interventions include a number of quality issues (Henshall et al., 2016).

Discussion between midwives and women about their options for where to give birth is clearly important for women and maternity services, yet the detail of the quality of the content and delivery of these discussions are unclear. Additionally, midwives often face challenges integrating place of birth discussions into their practice (Henshall et al., 2016). Thus the aim of the study was to improve the quality and standardise the content for place of birth discussions with low-risk women. The study comprised of three discrete stages, ‘identifying influences on place of birth discussions’, ‘intervention development’ and ‘evaluation of the package in practice’, using a mixed methods design.

## Setting

All stages of the study took place at an NHS Maternity Trust, in the West Midlands, UK between March 2015 and September 2016. The Trust is a tertiary centre, with over 8000 births per year. It comprises

an obstetric unit, an alongside midwifery-led unit, four community midwifery teams and a homebirth team.

The study was developed in collaboration with community and homebirth midwifery services at the participating Trust. Clinical midwifery managers, strategic leads and women were consulted throughout and were invited to comment on the research idea, how the project design would best fit with the service and how best to engage community midwives. Ethical approval was sought and obtained from the University Research Ethics Committee for both research stages of the study (ERN\_15-0059S and ERN\_16-0239). Individual written consent was taken from all participants by the researchers prior to their study involvement.

## Stage One – Identifying influences on place of birth discussions

### Methods

The first stage of the study aimed to understand midwives' behaviours relating to place of birth discussions with low-risk women and to develop an intervention package to address these behaviours. A qualitative approach was taken to address the first stage of this study to obtain rich, in-depth data, and to generate new insights on this phenomenon (Miles et al., 2013). Focus groups were used to gather qualitative data, as the interaction between participants enables differing views to be shared, explored and reflected upon (Finch et al., 2014). Focus group discussions also allow researchers to assess the level of agreement and disagreement on a topic in a short period of time (Kitzinger, 1994).

Six focus groups were conducted with midwives from the homebirth team, the four community teams and the community team managers, to explore any challenges to carrying out place of birth discussions with women. Access to midwives was gained through contacting the community matron and team managers and seeking their permission to take part. Following this, the researchers visited the teams to introduce the project and address any comments or concerns. Participants were selected using ‘convenience sampling’; all midwives who were available were eligible for inclusion, and were given a participant information leaflet by their team manager and invited to participate. Focus groups (of 4 – 10 midwives) were held at midwifery bases during convenient times, as advised by the team managers. Sessions lasted around one hour and were moderated and facilitated by two members of the research team who are experienced qualitative researchers (authors 1 and 2). A topic guide containing open ended questions such as ‘what do you feel works well in place of birth discussions?’ and ‘how long do you tend to spend on place of birth discussions with women?’ was used to guide the discussions. Discussions were digitally recorded and transcribed verbatim for analysis.

Data were thematically analysed and managed by the two researchers who undertook the data collection using the Framework Method (Gale et al., 2013). This involved deductively identifying which of the emerging data themes had already been uncovered in a previous systematic review of the literature (Henshall et al., 2016), and inductively identifying any newly emerging themes. A selection of the transcripts were double coded and any emerging themes were discussed and debated regularly. This ensured that the data analysis process was as transparent as possible and ensured that the researchers were in agreement in terms of their interpretations of the data. The COM-B framework (Michie et al., 2014) was then applied to the focus group data to categorise the influences on midwives' place of birth discussions with women and identify issues relating to the capability, opportunity and motivation of midwives to carry out high quality place of birth discussions with women.

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