Homebirth in England: Factors that impact on job satisfaction for community midwives

Abstract

This study explored the uptake of homebirth by healthy pregnant women from the perspective of community midwives (CMs). This paper presents factors that CMs expressed contributed to and/or detracted from their job satisfaction. Interviews were conducted with four practising CMs who were employed by a large acute NHS Trust in England providing a non-continuity model of care. Data were analysed thematically and are presented in two categories: (1) continuity of care and (2) working relationships and workloads. Findings suggest that if maternity service providers attended to factors that enhanced the job satisfaction of CMs inclined to support homebirth, this may contribute to increasing its uptake by pregnant women.

Keywords: Homebirth, Continuity of care, Community midwives, Job satisfaction, Qualitative

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Homebirth rates in England have been persistently low for more than 5 decades, with just 2.3% of women giving birth at home in 2013 (Office for National Statistics, 2014). While homebirths currently represent a relatively small proportion of births in England, the National Institute for Health and Care Excellence (NICE) has published new national guidelines on intrapartum care that recommend healthy, low-risk pregnant women should be advised that birth at home or in a midwife-led unit is now particularly suitable for them (NICE, 2014). The recommendations are informed by research that has demonstrated that healthy women can give birth safely and cost-effectively if they choose a non-obstetric unit setting (Brockelhurst et al, 2011; Blix et al, 2012). This revised previous guidance (NICE, 2007) that urged caution, and has the potential to affect hundreds of thousands of births in England.

In 2014, the NHS Chief Executive launched the *Five Year Forward View* (NHS England et al, 2014), which set out a vision to review future models for maternity units, make efforts to ensure that the NHS funding tariff supports women's choices, and make it easier for groups of midwives to set up their own NHS-funded midwifery services. The National Maternity Review is expected to conclude and publish proposals by the end of 2015.

A cultural and social shift that positions homebirth as acceptable to more women will be needed to realise this policy vision (Coxon et al, 2013). Arguably, at least three interdependent streams of activity require alignment:

- Models of care that offer safe and sustainable levels of homebirth need to be adopted by more providers
- Significant cultural and social shifts that position homebirth as acceptable to more service users need to take place
- A highly motivated and dynamic workforce of community midwives (CMs) will need to be empowered to inform and support birth in settings other than obstetric units.

In England, CMs provide care to all women during the antenatal and postnatal phases of their maternity. In 2013–14, midwives also provided intrapartum care at home for about 2.3% of the 646 904 babies born (National Audit Office, 2013; Health and Social Care Information Centre, 2015). If the current policy direction is that more intrapartum care is to be located away from obstetric units, the CM role may need to be modernised in ways that make it a more appealing career option for a new generation of midwives. Equally, if employers were mindful of modifiable factors that increased the job satisfaction of CMs, recruitment and retention may be improved.

Studies have demonstrated that high levels of job satisfaction are protective against stress, associated with positive self-esteem and increased motivation for self-development, and help to improve the health and safety of both professionals and the people they care for (Warmelink et al, 2015). Diminished job satisfaction is associated with the inverse of all of the above, as well as workforce attrition (Warmelink et al, 2015)—something that NHS employers will be seeking to avoid as the current shortage of midwives in England has been estimated as high as 2300 (House of Commons Committee of Public Accounts, 2014).

This paper reflects on interviews with CMs who

had a favourable disposition towards homebirth and the factors they identified as contributing to and/or detracting from their job satisfaction. It aims to inform those involved in maternity services who are seeking to improve underdeveloped or underperforming homebirth services.

Research context

This small qualitative study was designed as part of a postgraduate research master's degree. Four CMs were interviewed who worked for a large English NHS Trust—hereafter referred to as 'City'—providing maternity care to around 10 000 women annually. City has two large obstetric units (OUs), one with an alongside midwifery unit (AMU), and women may also choose a homebirth. City does not have a free-standing birth centre. Between January and December 2012, 1.2% (n=118) of births took place at home supported by a CM. For at least 3 decades, homebirth rates in City have fallen below the national average (BirthChoiceUK, 2014).

City operated a non-continuity model where CMs provided antenatal and postnatal care to mixed-risk caseloads, and sometimes intrapartum care to planned and unplanned homebirths. CMs did not routinely rotate into the OU. Between 9–5pm, CMs would ideally be facilitated to attend homebirths of women on their caseload. Two CMs were on duty to attend homebirths out-of-hours (5pm–9am) for the entire geographical area covered by the Trust.

In the 5 years preceding this study, City had undertaken a high degree of organisational change. Vacancy freezes were followed by difficulties recruiting and retaining CMs in City. At the time of the study, a preceptorship programme was being trialled that involved compulsory rotation for new recruits into the community. Existing CMs were required to support this trial by sharing an enlarged caseload with preceptees. Participants in this study provided anecdotes about preceptees who had no preference to work as CMs, no interest in promoting or attending homebirths, and some who did not have their own transport or a full driving licence. Sickness/absence levels were reported to be as high as 50% in some CM teams.

Aim

An overarching aim was to explore the CMs' perceptions of factors influencing the uptake of homebirth by healthy women in City. Questions were informed by a literature review that preceded data collection. The interviews were semi-structured and questions explored:

- Personal motivation to become a midwife
- Personal philosophy towards homebirth
- The concept of informed choice
- Attitudes towards risk management
- Reflections on organisational factors that may have an impact on homebirth provision.

Method

Participants

The original target was to recruit 12–20 CMs from a workforce of over 100 in City. CMs were invited to participate in the study by letter, email, posters and flyers. Four CMs were eventually recruited within the time frame. *Table 1* aggregates data collected from the participants. The aim was to contextualise participant responses so that when publishing results, others could consider how typical the participants were to CMs in other areas with similar models of care. It was not possible to validate participants' answers as they were from their self-recollections. Significantly, each participant self-identified as having a favourable disposition towards homebirth, which is relevant to the analysis and findings.

Data collection

All four interviews were conducted by the author between April–June 2013. Interviews lasted an average of 68 minutes, were digitally recorded and transcribed, then stored and managed on the university's secure network. The study was inductive and exploratory.

Ethical approval

Approval for the study was granted by the University of Nottingham and permission was granted to approach participants by service heads.

Method of data analysis

Thematic analysis provides a concise, coherent, logical, non-repetitive and interesting account of the story the data tell. To achieve this, the researcher spent time engaging with the data, reading the interview transcriptions and listening to the audio recordings. Manual analysis and coding was undertaken, reflecting the small number of interviews, and these were discussed and reviewed with an academic supervisor.

Findings

Continuity of care

All four participants described being able to provide continuity of care for their own caseload of women as the most rewarding aspect of their role and something they strived to achieve. This was closely associated with being enabled to practise in a defined geographical area and getting to know, and become known by, local families.

Table 1. Summary of participant profiles

Participant pseudonym	Anna	Bella	Cara	Deeta
Gender	All female			
Age of participants	Mean = 47 years			
Contracted hours	Between 22.5 and 37.5 hours per week			
Tenure as a practising midwife	>5 years	>10 years	>10 years	>10 years
How many homebirths experienced as a student midwife	0	3	1	1
Births at home attended in preceding 12 months	2 (as primary) 1 (assisting) 2 (BBA)	6 (as primary) 2 (assisting) 0 (BBA)	3 (as primary) 4 (assisting) 3 (BBA)	2 (as primary) 1 (assisting) 1 (BBA)
Homebirths currently booked on own caseload	1	2	7 (Cara said this was atypical for her caseload)	3
Training update on homebirth	None of the participants could recall receiving any specialist or specific training in supporting homebirth			
Training update on neonatal resuscitation	None had ever attended or completed the Newborn Life Support* training All had attended or were planning to attend mandatory Emergency Skills Study Day with employers (usually includes adult and neonatal resuscitation component)			

BBA–born before arrival (when birth occurs before the arrival of a midwife at home, or arriving at a maternity institution)
*Resuscitation Council (UK) training course

'So I love the fact that you see women for more than one pregnancy... It's really nice when they walk in for their next booking appointment and they're pleased to see you and they know who you are and you've seen them out and about as well with their babies.' (Cara, L61)

Continuity was felt to facilitate better preparation for normal birth, and lead to better outcomes and better experiences for women. Continuity for participants included a desire to conduct booking appointments at home with a view to developing a better understanding of family dynamics and the conditions at home. In City, antenatal home visits were generally only undertaken later in the pregnancy, and only after women had specifically requested a homebirth.

Each participant valued formally achieving some type of professional closure in the postnatal phase of care with women assigned to their caseload. A range of strategies were employed, including coordinating with colleagues to ensure women were booked into the postnatal clinic or had a scheduled home visit postnatally with their named midwife. When this was not achievable, CMs made telephone calls to women from their own caseload. Participants expressed less confidence about discharging women they had met only briefly in the postnatal period.

'I would like to be the one to say "yes, everything's good, you're happy, I'm happy, I can discharge you" and I don't think, when you don't know somebody, I don't think they're going to tell you if they're having any sort of problems, erm, you know, with bonding, or postnatal depression.' (Cara, L119)

All participants felt that by working exclusively in the community with low numbers of homebirths, it was difficult to maintain confidence in essential intrapartum skills. All participants indicated that they were interested in rotating into the OU as a way to maintain their skills, but felt it needed to be managed in a supportive and structured way because many CMs would be unfamiliar with current hospital practice. Requests to do this had been declined by managers on the grounds of staffing shortages. The suggested alternative solutions of managers were perceived as unrealistic and impractical.

'They say "oh you can go and update yourself on a night shift," but it's not

that easy is it, just wandering in onto a night shift?' (Deeta, L463)

All participants cited examples of seeking-out professional development opportunities above and beyond the mandatory provision of their employer. These included reading journals, attending conferences and study days on hypnobirthing. They also valued working in tandem with other CMs, and observing and discussing different ways of supporting women in labour with both experienced CMs and newly recruited CMs. Participants were able to reflect on some training and skills deficits. One participant was concerned that she had only ever simulated neonatal resuscitation on a mannequin. Anna expressed embarrassment that she could not suture, saying

'...it's the infrequency of us getting intrapartum experience that I just can't consolidate...' (L323)

and Bella was concerned that

'...nobody's ever taught me about physiological third stage.' (L233)

Working relationships and workloads

Unsurprisingly, all participants explained how amicable and flexible team dynamics contributed to their job satisfaction. The ability of the CM teams to have some collective control over the local distribution of work, staffing rotas and holidays was highly valued. Equally, participants appreciated the opportunity to have some autonomy and flexibility over how they managed their individual caseloads. However, all participants reflected on how daily work priorities had become increasingly centralised and controlled by managers, and described feeling pressurised by their managers to undertake additional work for overloaded, underperforming or absent colleagues.

'Things are the worst I've ever known them... Every single day... Can you help with visits, can somebody do a clinic here, can you do this, can you do that. And, and that's constant, and I don't mind helping other teams, but when you're trying to get on with things... it just feels like harassment.' (Cara, L393)

In terms of daily priorities and time management, these were sometimes challenged by managers and CMs described having to justify their professional judgements.

"The ability of the community midwife teams to have collective control over the local distribution of work... was highly valued. Participants appreciated the opportunity to have some autonomy and flexibility over how they managed their individual caseloads"

'We are, [sighs] we are reprimanded, I feel like Big Brother is watching over us... "Why is that woman having a home visit on day 12?" ... But I'm on duty that day... I want to see her again because I've got to know her and I know she got depression last time.' (Bella, L382)

For 5 years preceding the study, City had undertaken a process of reorganising CM teams. This involved moving CMs from areas where they had established recognition and networks with other health and social care colleagues to different localities within City. Being compelled by managers to move from happy and settled teams, sometimes at very short notice, into teams that had an imbalance in experience and skill-mix, or had sickness/absence issues or were less cooperative or supportive of one another, was often met with reluctance and feelings of persecution. Bella had worked in one locality for more than 10 years before she was asked to move to a new team on the grounds that her seniority was needed to balance the skill-mix:

'Can you go to [another] team for 6 months I was told, 6 months came and went... "Oh, you need to stay another year," and that year came to an end... They said, "erm, do you really want to go back?"... If I'd gone back, somebody else would have had to move... I would have liked to go back.' (Bella, L137)

> Time management was a priority... Participants all wanted smaller caseloads... to have more time to fulfil the full remit of the community midwife role and meet the needs and expectations of women

All participants questioned the suitability and enthusiasm of some of their colleagues for the CM role. This was associated with City's chronic staff shortages and long-term sickness/absence issues, which participants felt had demoralised the remaining workforce.

'Some of them you wonder why they're midwives because they, they don't like the women, they don't like the job, and I think if I hated it as much as they do I would leave, I, I think when you are that unhappy you shouldn't inflict yourself on pregnant women.' (Cara, L323)

'There's some midwives in our own team... that, erm, couldn't give two hoots about the women or the births, really. Come to work, get paid, want to retire as soon as possible... it's just a chore and stuff.' (Anna, L485)

Similarly, poor relationships between hospital midwives and CMs concerned participants. Many of the difficulties CMs had experienced were associated with interactions with hospital midwives who failed to recognise the challenges that working alone in the community context could present. In particular, such difficulties included being challenged about decisions to transfer an unplanned homebirth into hospital, failing to consider unsuitable or challenging conditions in homes, the lack of equipment carried by CMs, or a perceived threat at the scene that cannot be communicated via telephone. Equally, questioning a CM's decision-making in front of a woman once in the OU was regarded as inappropriate, as was challenging referrals to triage.

'Community midwives are so disrespected by hospital midwives... I've heard they call us "the tea and cake brigade"... I think they see us as amateur midwives.' (Cara, L429, L461)

Bella regularly worked 8–10 extra hours per week, and Cara and Deeta were both owed time off in lieu. Anna had made a deliberate decision not to work unpaid hours but recognised it as widespread among colleagues. Those who did work unpaid hours considered this necessary to complete their work to a standard they were satisfied with, or they wanted to ensure each day's tasks were completed in order to concentrate on the following day's workload.

'I do more than [my contracted hours]... I am not the only one... I think that a lot of midwives are there earlier in the morning, a lot of midwives don't get a proper lunch break, and a lot of midwives don't leave at 5pm.' (Deeta, L407)

Effective time management was a priority for all participants. Documentation and the computer-inputting element of the CM role was identified as time-consuming and diminishing the time available to spend delivering care directly. Participants all wanted smaller caseloads and saw this as a way to have more time to fulfil the full remit of the CM role and meet the needs and expectations of women. Participants found that the 1-hour booking appointment and 20-minute antenatal appointments were insufficient for this purpose. Equally, they were dubious about the value of postnatal clinics in terms of the short time allocated to perform all the required activities and deliver the quality of care the CMs were content with.

'You've got 20-minute slots, you're seeing women that you've never met before, so 20 minutes is barely enough to do a physical examination, check the baby, never mind asking "how are you feeling?" and if they do then open up, although you are trying to be there for them, you're very conscious the time's ticking by and you're running late and there's other people waiting outside.' (Cara, L128)

Discussion

When discussing continuity of care, participants tended to articulate this in relation to the

antenatal and postnatal phases of care. Continuity in the intrapartum phase was communicated as desirable for CMs and women, but most likely unachievable. Potentially, CMs who have worked in a non-continuity model of care without opportunities to rotate into an OU or AMU may be less inclined to perceive continuity through all phases of pregnancy as realistic or achievable. In addition, a lack of a robust system that would cover scheduled activities such as clinics and visits if a CM was called to attend a homebirth positions intrapartum care as 'a massive spanner in the works' (Anna, L759). In keeping with the work of Baston and Green (2002), attention focused on achieving continuity antenatally and postnatally for women might be viewed as an acceptable compromise for CMs in non-continuity models of care and a way for them to maintain a self-concept of themselves as true CMs and to continue to derive job satisfaction.

The work of McCourt et al (2011; 2012) has recommended the development of more integrated models of staffing across hospital and community boundaries, and identified two models of care that showed particular potential to offer good-quality and safe homebirth care: caseload midwifery and 'hub and spoke' models of care. Evidently, the participants in this study articulated an interest in rotating into the OU or AMU to maintain skills and improve their integration with hospital colleagues.

Again, aligning with the work of McCourt et al (2011; 2012), which explored the features of 'better'- or 'best'-performing maternity services that were expected to provide homebirth care, this study also found that relatively little attention had been given to specific training and preparation of CMs and their level of integration within the overall service. CMs in City felt that their managers had constructed a model of care that did not inspire confidence among CMs that homebirths could be reliably promoted to women, principally because both continuity of care and CM cover could not be guaranteed in times of high activity or sickness/absence. Equally, CMs in City identified that because they had limited opportunities to practise intrapartum care, some essential training and skills, such as perineal suturing, could not be consolidated.

Arguably, overwhelming organisational demands may account for the dysfunctional team dynamics identified by participants when discussing their relationships with managers and CM or hospital midwifery colleagues. The participants in this study described behaviours corresponding with the concept of horizontal violence. This is where people's frustrations and dissatisfaction are directed towards one another, rather than at the system that oppresses them and excludes them from power (Kirkham and Stapleton, 2004), ultimately detracting from their job satisfaction.

Key points

- Homebirth rates in England have been persistently low for more than 5 decades. In 2013, just 2.3% of women gave birth at home
- National Institute for Health and Care Excellence (2014) intrapartum guidelines now recommend that healthy women be advised that giving birth at home or in a midwife-led unit is particularly suitable for them
- A cultural and social shift that positions homebirth as acceptable to more women will be needed to realise this policy vision, and community midwives will be a key component of this
- Providers of care may need to introduce different models of care that offer safe, quality and cost-effective care away from obstetric units
- NHS employers will benefit from developing a better understanding of what contributes to the job satisfaction of community midwives who are inclined to support birth away from obstetric units, in order to make adjustments to current models of employment

Limitations

The small sample size reflects the challenges experienced recruiting within a strict time frame. Despite being permitted to take part during working hours, all participants wished to conceal their participation from their managers; three participants asked to be interviewed when off-duty and off-site. Participation may have been overshadowed by the low levels of morale among the CM workforce at the time of the study, or influenced by a desire to highlight dissatisfaction with the current local organisational structure.

Conclusion

If there is to be a national drive for CMs to support more homebirths in an effort to provide more choice to women, as well as fiscal efficiencies for the NHS, then a clearer understanding of what will motivate and enable a CM workforce to deliver this agenda is essential. This study adds to evidence that there is scope for maternity providers that have homebirth services which are underdeveloped or underperforming to explore opportunities to introduce continuity models of care and facilitate the integration of CMs across service boundaries. Going forward, if providers are able to appreciate the extent to which they can modify extrinsic factors that have an impact on the level of job satisfaction among their CMs, they may see profound improvements in their homebirth rates. By crafting transformative solutions that

enhance the job satisfaction of CMs, maternity care providers and commissioners are more likely to be able to deliver policy and research agendas aimed at improving the quality, safety and cost-effectiveness of maternity care. BJM

***Conflict of interest**: The author has declared no conflict of interest.*

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