FINAL REPORT

Birth Place Choices Project

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Executive summary

Background
The Birth Place Choices (BPC) Project was commissioned and funded by the Department of Health and was carried out from May 2003-May 2005 as a collaboration between Southampton University Hospitals NHS Trust and Portsmouth Hospitals NHS Trust. The Project findings contribute to evaluation of the national policy for NHS maternity services that women should receive convenient, high quality services that offer greater choice and flexibility.

Aims
The overall aims of the BPC Project were:
1. To identify factors that influence women’s decisions about where to give birth
2. To determine whether the introduction of specially designed information and educational initiatives increase women’s knowledge of choices for place of birth
3. To determine whether implementation of these initiatives was associated with an increase in the number of women choosing to give birth outside main consultant-led maternity units.

Method
The BPC Project was carried out in two phases at the same time in both Trusts. In Phase one, data was collected to answer the first aim. Four methods were used: a systematic literature review of existing evidence, analysis of locally collected routine statistics relating to birthplace, a cross-sectional survey of local women and focus groups involving local women and midwives. Phase Two addressed all three aims. Information and educational initiatives (such as parent information leaflets, re-launching of birth centres and a multi-professional guideline) were designed using the findings from Phase One, and these were implemented in both Trusts. Evaluation comprised analysis of locally collected routine statistics relating to birthplace, a repeat of the cross-sectional survey of local women and a cross-sectional survey of local midwives’ views on birthplace choice.

Main findings
- A higher proportion of women in the Phase 2 survey reported being aware of the birthplace choices open to them and a higher proportion planned to give birth at home or in a birth centre than in the Phase 1 survey (see sections 10.2-10.4).
- Comparisons of 2003 and 2005 baseline data showed a rise in the number of births in most of the stand-alone birth centres and in one co-located birth centre (see section 9.1).
- A wide-range of stakeholder involvement was essential to develop and implement effective strategies to provide accessible information that women could access and use in making choices about birthplace (see sections 7 and 12).
• Strong midwifery leadership was required to initiate, develop and sustain a culture in maternity services in which a genuine choice about place of birth could be made (see section 12).

Recommendations
To support women’s choice about place of birth:
• Clinical and service leaders should use interlinked and focused initiatives to implement cultural change so that the impact is synergistic and the overall impact more profound (see section 12.2.1).

• Heads of maternity services should develop and implement initiatives such as
  o parent information leaflets
  o multi-professional guidelines
  o education for midwives
  o staffing and capacity strategy (see sections 7.3.2, 7.2., 7.4 and 12.2.1).

• Trusts should provide sustainable staffing to support birth outside the consultant-led unit (see sections 10.2-10.4, 11.3, 12.3.3).

• Service managers and educationalists should work together to maximise midwives’ opportunities for professional development so they are confident and proactive in offering choices about place of birth (see sections 7.4.4- 7.4.6, and 11.3).

• Heads of midwifery services should work collaboratively with local service users at strategic level to develop and offer information to ensure that the option of choosing home birth, birth in a birth centre birth, or consultant-led maternity unit is openly available to all women accessing maternity care (see sections 12.2.3).

Conclusions
Limitations and challenges inherent in such action-oriented evaluation included working with the reality that service provision changes over time, and resource constraints. However, the clear strength of the BPC Project has been to generate findings and recommendations which have resonance for maternity services at a time when there is both a national mandate and opportunity for offering genuine choice about place of birth for women accessing maternity care.
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1. Introduction to the Birth Place Choices Project

The Birth Place Choices (BPC) Project began in May 2003, with the remit of:

- Identifying factors that influence women’s decisions about where to give birth.
- Determining whether the introduction of specially designed information and educational initiatives, aimed at health professionals as well as maternity service users, increase women’s knowledge of choices for place of birth.
- Determining whether implementation of these initiatives was associated with an increase in the number of women choosing to give birth outside main consultant-led maternity units.

This two-year project was funded by the Department of Health and was a collaboration between Southampton University Hospitals NHS Trust and Portsmouth Hospitals NHS Trust. It arose from the need to evaluate national policy for NHS maternity services, which had been founded on the principle that women should receive convenient, high quality services, which offer greater choice and flexibility. This is linked to the Modernisation Agency’s agenda that health services need to move from professionally focused and institution-led to multi-disciplinary services.

The Independent Reconfiguration Panel (Department of Health 2003a) was established with the responsibility of advising on proposals for major service change, and was the source of funding for the Birth Place Choices Project.

1.1 Government drivers

The purpose and vision of the NHS Plan was a health service designed around the needs of the patient (Department of Health 2000). This involved modernisation of the health service to include setting national standards and spreading best practice, and it was envisaged that health professionals should have greater opportunities to extend their roles and that users of the service should have a voice in NHS policy development and local service provision. These proposed changes aimed not only to improve the quality of care but also to influence where and how services were delivered (Department of
Health 2003a). The National Service Framework for Children, Young People and Maternity Services was published in September 2004, a year and a half after the beginning of the BPC Project (Department of Health, 2004). Therefore, while it called for greater choice regarding place of birth (including the provision of midwife-led units in the community and adequately supported home birth services), it was not a driver for this particular project. However, its recommendations are of great relevance to the BPC Project; therefore implications for their implementation in maternity services development is discussed in the final section of this report.

1.2 Keeping the NHS local
The document “Keeping the NHS Local – A New Direction of Travel” (Department of Health, 2003b) described the potential for delivery of a range of effective, high-quality and safe care in smaller hospitals. It challenged the philosophy that “biggest is best” and aimed to demonstrate that modernisation and improving the quality of care involves working with local communities and staff to develop services around patient needs. The Modernisation Agency’s working time directive project ‘The Hospital at Night’ advocates a multidisciplinary night team that has competencies to cover a wide range of interventions in a number of settings, calling in specialist expertise when necessary. This contrasts with the traditional model of junior doctors and midwives working in relative isolation within the acute hospital setting.

1.3 Environments for care
It is within this climate that new models of care within maternity services have been proposed, one being to concentrate obstetric-led services in fewer units, with an increase in the number of midwife-led units (MLU), either “stand-alone” with no obstetric cover on-site, or on the same site as the main obstetric unit (co-located). A number of different terms are used in the literature to describe birth environments and models of care in which women receive midwife-led care (Stewart et al, 2004). In the Portsmouth area, prior to the project initiatives, these places were referred to as midwife-led units (MLU); in Southampton they were referred to as Birthing Centres. After the project initiatives were introduced all the units were relaunched as Birth
Centres. For this reason the environments are referred to in the early part of the report (Phase One) as MLUs or Birthing Centres, and in Phase Two as Birth Centres. As described above, they may be either “stand-alone” or “co-located”.

1.4 Number of women birthing in midwife-led units
In England in 2003, stand-alone midwife-led units only catered for 2% of women who gave birth (NHS Maternity Statistics 2003). A further 2% gave birth at home. From these sources of routinely collected statistics it is not possible to differentiate births that occurred in MLUs where the MLU is situated on the same site as the main consultant-led unit. The number of births in MLUs is therefore likely to be greater than those recorded in routine national maternity statistics.

1.5 Evidence about safety
For women without identified complications, there is no evidence that hospital birth is any safer than home birth or than birth in midwife-led units (Campbell and MacFarlane 1994, Tew 1998). In contrast, there is mounting evidence that hospitalised intrapartum care comes with its own set of inherent problems, such as inappropriate use of interventions leading to higher numbers of operative deliveries (Feldman and Hurst 1987; Rooks et al 1992; Spitzer 1995; David et al 1999). One response to this in the UK has been the gradual expansion in the numbers of midwife-led birth centres (Walsh 2001; Coyle et al 2001b; Birth Centre Network 2001; Hodnett 2003). In particular, the success of the Edgware and Crowborough birth centres (Walker 2001; Gowers 2002) has led to an increasing interest in this type of facility (Robotham and Dennett 2001; Tinsley 2003; Birth Centre Network 2003).

There is a large body of evidence that demonstrates the safety of community-based intrapartum care for healthy women with a normal pregnancy (Albers and Katz 1991; Rooks et al 1992; Campbell et al 1999; Walsh 2000; Birth Centre Network 2001), but there is a paucity of knowledge relating to women’s views of MLUs (Lavender and Chapple, 2003).
1.6 Choices and information for women
Central to the modernisation of the NHS is a commitment to improving patient choice. Over the past decade a national driver for change in the maternity services has been “Changing Childbirth” (Department of Health, 1993) and one of its fundamental principles was that a woman should be free to choose the care she feels is most suitable for her, particularly with regard to place of birth:

‘Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born’ (Department of Health, 1993)

However, choice can only be a reality when individuals have unbiased, ‘user-friendly’, information to inform their choices, and access to services that provide different options to choose from (Birth Centre Network, 2003).

1.7 Philosophy of care
Care in birth centres has been described as based on a:
‘Commitment to pregnancy and birth as normal processes and to personalised care that recognises and respects the rights and wishes of individual women and their families, aimed at empowering them to take responsibility and retain control of this significant life event’ (Birth Centre Network, 2001, p2).

Care provision reflects this philosophy with the limited use of technology and a focus on active birth and individualised care. Studies have demonstrated that this approach is associated with significantly lower rates of intervention and higher levels of satisfaction among maternity service users and midwives when compared to matched groups of women giving birth in consultant-led units (Waldenstrom and Nilsson, 1994; Waldenstrom et al 1997). It has been proposed that 45 - 65% of pregnant women accessing maternity services are suitable for this type of care (Birth Centre Network, 2001).
1.8 Women’s choices about place of birth
Studies that have explored why some women opt for giving birth in birth centres found that they preferred the more individualised style of care in contrast to the systemised, fragmented care found in hospitals (Coyle et al 2000a). Yet the majority of maternity service users give birth in mainstream obstetric units. Some studies have suggested this may be to do with women’s perceived concerns around safety, and the availability of medical and perinatal services or the desire for epidural anaesthesia (Fordham 1997; Lavender 2003). However, other authors have asserted that the reason has more to do with the information women receive, or do not receive, from health professionals regarding the choices available (Campbell and MacFarlane 1994; Leap 1996; Weigers et al 1996; Zander and Chamberlain, 1999).

1.9 Local Context
Portsmouth Hospitals NHS Trust and Southampton University Hospitals NHS Trust both have stand-alone and co-located MLUs within their maternity services. In Portsmouth city there is the Mary Rose MLU, located two floors below the consultant led unit. Outside the city, but part of Portsmouth maternity services, are three stand-alone MLUs: Grange in Petersfield, Blake in Gosport and Blackbrook in Fareham. The Trust also offers a home birth service within a ‘traditional’ midwifery service, whereby the community midwives provide a home birth service according to their on-call capacity. Antenatal, intrapartum and postnatal care within the MLU is provided by both MLU and community midwives working alongside health care support workers1.

In Southampton there is a co-located MLU, Broadlands Birthing Centre. This is situated in the Princess Anne Hospital, one floor above the consultant-led unit. This Trust also has three stand-alone MLUs situated in the New Forest. These are: Lymington Birthing Centre, Hythe Birthing Centre and Romsey

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1 Healthcare support workers and maternity care assistants have a similar role: they work under the guidance of midwives, having undergone a short period of training locally, which may or may not include an NVQ qualification.
Birthing Centre. Maternity care assistants staff these birthing centres\(^1\), with team midwives attending to the care of women in the birthing centres and surrounding communities as needed. As part of the service, Southampton also has other forms of team and ‘caseload’ midwifery services in operation, in which each full-time equivalent midwife has a caseload of around 36 women per year, for whom she provides total antenatal, intrapartum and postnatal care. This includes attending most women at home as their labour begins.

In 2002-2003, each co-located MLU provided care for about 14% of the total number of births in each Trust. In addition, in Southampton, 6% of the total number of births in the Southampton University Hospitals area took place in the stand-alone birthing centres. In Portsmouth the stand-alone MLUs provided care for nearly 10% of the total number of births occurring in the Portsmouth Hospitals NHS Trust area. At the start of the project the national average for home births was 2.2%; Southampton Hospitals Trust had a rate higher than this at 3.2%, whereas Portsmouth’s home birth rate was just below the national average, at 2.1%. The average intrapartum transfer rates from the stand-alone MLUs for Portsmouth was 13% and for Southampton, 24%. In total, the number of births occurring outside the consultant-led units in 2002-2003, the year preceding the start of the BPC project, was 25% (Portsmouth) and 23% (Southampton) of the overall local birth rate. While this may seem a substantial amount compared with the national home birth and stand-alone birth centre rates of 4%, it was believed that the number of women who could access this form of care could be significantly increased.

\[\text{1.10 Aims of the Birth Place Choices Project}\]

The Birth Place Choices Project was therefore set the task of describing what was influencing local women’s decisions about where to give birth and then exploring whether new information and education strategies could increase the number of births in the midwife-led units and at home in the Portsmouth and Southampton areas. It was decided the project would be conducted in
two phases. Phase One would include a literature review to determine the current evidence on the issue of place of birth choices, a collection of local baseline data to enable comparative work at the end of the project, and qualitative and quantitative research with local midwives and maternity service users. Phase Two would involve utilising the findings of Phase One to explore whether new marketing, education and change management initiatives could increase local women’s awareness of the choices of place of birth. This would be followed by an evaluation component, comprising a repeat of the maternity service user survey carried out in Phase One, as well as a survey of local midwives. The Project would conclude with a collection of local birth rate data to determine whether there had been an increase in out of hospital births since the commencement of the project.

The Birth Place Choices Project therefore had three main aims:

- To identify factors that influence women’s decisions about where to give birth.
- To determine whether the introduction of specially designed information and educational initiatives, aimed at health professionals as well as maternity service users, increase women’s knowledge of choices for place of birth.
- To determine whether implementation of these initiatives was associated with an increase in the number of women choosing to give birth outside main consultant-led maternity units.

1.11 The Project team

The Birth Place Choices Project was led by Dr Jane Rogers, Consultant Midwife for Southampton University Hospitals NHS Trust and Southampton University, and managed by midwives seconded from each Trust: Toni Barber in Portsmouth (from May 2003 to May 2005) and Diane Henty (from May 2003 to July 2004) and Sarah Marsh (from August 2004 to May 2005) in Southampton. This Project team worked in collaboration with the Project steering group that included midwives from Portsmouth and Southampton Trusts, researchers and educationalists from the education providers for the
Trusts, a medical representative from Portsmouth and the lay public. The constitution and representation of this group are given in Appendix 1. This collaborative group had substantial experience in midwifery practice, maternity services development, innovation, education and research. The individuals are leaders in their field, pioneering local maternity service developments and contributing to national and international initiatives. The contexts in which they currently work are well known for ground-breaking work in Sure Start initiatives, interagency working, midwife managed caseloads and clinical research.

The terms of reference for the project steering group were to:

a) Set and oversee the strategic working of the Project, including agreeing a realistic timetable, and deviations from this where appropriate;

b) Advise on operational management issues such as contracts, working space and equipment;

c) Raise the profile of the Project locally in relevant meetings city wide to facilitate networking for the Project managers and implementation of marketing strategies;

d) Identify key personnel to be involved in the strategies and working groups set up to increase the numbers of out of hospital births;

e) Provide support and direction to leaders of the above groups;

f) Advise on use of funds during the Project;

g) Work with the Advisory group to make amendments to the Project design and strategies if necessary;

h) Facilitate the dissemination of the evaluation, including its presentation at local and national meetings.

An Advisory Group for the Project was also set up to advise on local operational issues, suggest amendments to the Project strategies and raise the profile of the Project in the local area. This group was chaired by Catherine McCormick, Professional Advisor Midwifery/Family Health at the Department of Health, and was comprised of members of the steering group in addition to local health professionals and maternity service users, whose names are given in Appendix 2.
Within the first few weeks of the start of the Project two launches took place to raise the awareness of the Project with local midwives and the lay public. These were hosted by Blackbrook MLU in the Portsmouth area and Hythe Birthing Centre in the Southampton area. Representatives of the local media were present and ran features in the press, radio and television.

The following section, the literature review, is the first of four elements that contribute to the data gathering exercise carried out in Phase One. It is followed by “baseline data”; the survey of local women; and focus groups with local women and midwives.
2. Literature review

A literature review was undertaken regarding women’s decision-making and informed choice about place of birth. Research studies that have been undertaken in the last 20 years examining women’s views about their experience of maternity services were identified. A summary of the most recent and relevant papers is presented here.

2.1 Method

The two Project managers, Toni Barber and Diane Henty, carried out the literature review in May and June 2003. A search was made for relevant papers published in the last 20 years via a number of electronic databases (Medline, Ovid, Cochrane, MIDIRS) using defined search terms. Key words used in the search were birthplace, informed choice, women’s views, birth centres and home birth.

The abstracts of all articles were examined by the Project managers to ensure they were relevant to the Project, and the appropriate articles and reports retrieved. In addition, following the electronic search, the reference list of papers retrieved was scrutinised to identify any further relevant studies. A number of studies of limited publication carried out in the UK were obtained by contacting the primary researchers/authors.

2.2 Findings

- Women are not offered all the options regarding place of birth, in particular the option of home birth
- Although a proportion of women give birth outside consultant led units, more women want that option and feel home/birth centre is the best place to have their baby
- The way maternity care is organised appears to affect women’s reported preferences
- Having a choice of place of birth is very important to women
• Written information alone was not useful to women in terms of helping them decide on their birthplace choice.

The majority of maternity service users give birth in mainstream obstetric units, with only about 4% of women nationally having home or birth centre births (NHS Maternity Statistics, 2003). Some studies have suggested this may be as a result of women’s perceived concerns around safety, and the availability of medical and perinatal services or the desire for epidural anaesthesia (Fordham 1997; Lavender 2003). However, many authors assert that the reason has more to do with the information women receive, or do not receive, from health professionals regarding the choices available (Campbell and MacFarlane 1994; Leap 1996; Weigers et al 1996; Zander and Chamberlain, 1999).

Research studies that have been undertaken in the last 20 years examining women’s views about their experience of maternity services highlight the fact that a large minority (up to 48%) of women are not offered all the options regarding place of birth, with many perceiving that either they have no choice or the options are not discussed with them, particularly with regard to home birth (Department of Health, 1993; Gready et al, 1995; Chamberlain et al, 1997; Exeter District Community Health Service NHS Trust (EDCHST), 1998; Garcia et al, 1998; Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH), 1999).

A MORI opinion poll commissioned by the Department of Health carried out in 1993 to provide information to the Expert Maternity Group reported that the respondents’ (n=1005) choices were often limited with regard to place of birth. Forty eight per cent of women questioned said that they had not discussed any options about place of birth with their GP. Fifty one per cent of respondents thought that they had no choice and only 12% said that they had discussed the option of a home birth. Seventy two per cent of the sample would have liked an option other than delivery in a consultant unit. The finding that women may not be offered a choice about where to have their baby is supported by other studies. Gready et al (1995) surveyed a sample of 850
women who had given birth in the North Essex Health Authority in 1994. Only 54% of women who responded felt fully involved in the decision about where they booked to have their baby and 13% were offered the choice of a home birth.

A survey by the National Birthday Trust Fund (Chamberlain et al 1997) of 6044 women planning home births and 4724 births in hospital was carried out in 1994. It found that women intending to give birth in hospital had usually made their decision before pregnancy (63%) or in early pregnancy (33%), while respondents choosing to give birth at home had taken longer to make their decision, with 41% before pregnancy, 39% in early pregnancy and 20% undecided by mid-pregnancy. Only 18% of respondents planning to give birth in hospital had considered an alternative.

The Peterhead Maternity Project (Grampian Healthcare NHS Trust,1997) surveyed 331 women at two stages in their pregnancy and at six weeks after the birth. One of the aims of the project was to determine the factors that influenced women’s decisions regarding place of birth. Sixty seven per cent of the women who were asked during pregnancy thought that the best place for their baby to be born was the local MLU. The midwife was cited as the professional most involved in discussing place of birth options, but not all women said they had been given information about all the options available when faced with making a decision. Seventy five per cent of respondents felt they were involved in the decision about where to have their baby. The women also reported that health professionals were selective in the information they presented to them about place of birth options. The factors that influenced the respondents’ decisions about place of birth differed according to parity, with second time mothers often citing previous experience as an influential factor on their choice.

In 1996, the Exeter and District Community Health Service NHS Trust (EDCHST) received funding from the Changing Childbirth Implementation Team to undertake a survey of women and health professionals within its rural community units based at Honiton, Tiverton and Okehampton (EDCHST
1998). Over 500 births per year took place in these community hospitals, with cover provided by local GPs and obstetricians. One of the aims of the project was to elicit opinions about the views of service users relating to choice of delivery site and style. The project involved a postal survey of maternity service users (N=315), GPs (N=83), midwives (N=44) and in-depth interviews with maternity service users (N=27) and health professionals (19 GPs and 15 midwives). The main findings were:

- The GP was the first professional approached by women when pregnant, but the women went on to discuss a broader range of topics with midwives.
- In relation to women’s autonomy in choosing patterns of care, the GPs’ responses appeared to indicate they were more conservative in their views and ‘more aware of potential dangers’ than midwives.
- 49% of the women who responded wanted to give birth in their community hospital, citing it as more convenient and friendly.
- 13% said they would choose to have a home birth if there was no community hospital.
- 75% of women were offered more than one option for place of delivery.
- 42% of women said they did not know they could change their booking regarding place of birth.
- More women decided on place of birth by discussing the subject with their midwife than by discussing it with either their GP or partner.
- 37% of women were offered the option of a home birth.

An Audit Commission survey (Garcia et al, 1998) asked a nationally representative sample of 2406 recent mothers in England and Wales about their experience and views of maternity care. Less than half the number of women in this sample perceived that they had a choice about birth location, and only 17% reported that they had an option of a home birth.

A similar national audit of maternity services was undertaken in Scotland - (SPCERH, 1999). The aim was to assess the services against 28 audit criteria relating to four principal themes. One of these was “equipping women
to make informed choices about their care”. The audit included a cross-sectional survey (The Scottish Births Survey) of all women giving birth in Scotland over a ten-day period (n=1137). Sixty one per cent of respondents felt that they had a choice about where they could have their baby and 41% felt that they had a choice about having a home birth. Less than 25% of women were offered the choice of a Domino² delivery, with nearly 46% indicating that they did not know what this was. The survey concluded that not all women were given information on all the options available and there was evidence that unit policy relating to birthplace choice has a significant effect on women’s preferences (Hundley et al, 2002). This was one of the few studies that assessed women’s views on the specific information given to them on birthplace choices. There is very little evaluation in the other studies regarding information given to women.

In 1994, the Department of Health made funding available for MIDIRS (Midwives Information and Resource Service) and the NHS Centre for Reviews and Dissemination to produce ten evidence-based leaflets, one of which is on place of birth. The leaflets have been in use since 1996 and in 1997 the Informed Choice in Maternity Care study was commissioned to evaluate their effectiveness in promoting informed choice (Kirkham, Stapleton, 2001). The study was undertaken in two phases, the first comprising an ethnographic study which informed the development of the second phase. This second phase consisted of a cluster randomised controlled trial and qualitative fieldwork. The study concluded that the leaflets did not change the proportion of women who reported exercising informed choice, with less than 50% of women perceiving that they had exercised informed choice regarding place of birth. It was found that midwives had very little discussion with women about place of birth, and in the absence of such discussion, information alone did not appear to enable women to make an informed choice.

² Domino: birth undertaken in a hospital by a community midwife often known to the woman
A more recent study was commissioned to address the lack of knowledge of women’s views of current models of MLUs (Lavender, 2003). In this, a questionnaire was used to obtain women’s views in the antenatal period (n=1805). The sample was taken from 12 units in England selected to include women giving birth in a range of settings. The full report is not yet available but a summary has been included in the Maternity and Neonatal Workforce Group report (Lavender, 2003). Fifty per cent of respondents reported that they were not offered a choice about place of birth. There was little knowledge or understanding of home births, and only 8% had considered it.

A qualitative study of information about available options for childbirth venue and pregnant women’s preference for place of delivery was recently published (Madi and Crow 2003). This study was carried out in the south of England and aimed to explore the “level of information” about possible venues for childbirth among pregnant women, and to establish midwives’ involvement in giving information and helping women to make choices about where they wanted to give birth. The study involved interviewing 33 pregnant women, with 20 planning a hospital birth and 13 planning a home birth. The main findings were:

- Women planning a home birth were well informed about the options available to them, while the majority of those planning a hospital birth were less well informed about the availability of a home birth and assumed that hospital was the only option.
- Midwives did not initiate a discussion about the option of home birth but supported those who already knew about and asked for it.

2.3 Conclusion
In conclusion, the evidence from these studies highlights the fact that a large minority of women are not offered all the options regarding choice of place of birth, with many perceiving that either they have no choice or the options are not discussed with them. This is particularly with regard to choice of home birth. The information that women were given on which to base their choices was often limited, with many having little knowledge or understanding of home
birth. Many midwives appeared to have had very little discussion about place of birth with women and, in the absence of such discussion, information alone did not appear to enable women to make an informed choice. Evidence from studies about women who experienced a high level of continuity of care (Sandall et al, 2001; Page et al, 1995; Saunders et al, 2000) suggests that in these contexts a much higher percentage of women are given a choice of birth location and feel more involved in the decision about where to have their baby.
3. Phase One Baseline data

3.1 Birthplace data

The number of births according to location in Portsmouth and Southampton maternity services was determined at the start of the Project. The figures below are for a 12-month period preceding the start of the Birth Place Choices Project in May 2003 for which data were available. Each unit collected its statistics slightly differently, so for Portsmouth these relate to the 12-month period January 2002 – December 2002 and for Southampton April 2002 – March 2003.

At the start of the BPC Project both the co-located midwife-led units: Mary Rose in Portsmouth and Broadlands in Southampton, were busy and thriving, accounting for about 14% of the total number of births in each Trust. The stand-alone MLUs had lower birth rates, with the Southampton New Forest MLUs accounting for 6% of the total number of births occurring in the Southampton University Hospitals NHS Trust area. In Portsmouth, Grange, Blackbrook and Blake MLUs accounted for nearly 10% of the total number of births occurring in the Portsmouth Hospitals NHS Trust area at the start of the BPC Project. In terms of home births, Southampton Hospitals had a rate above the national average at the start of the project (3.2%), whereas Portsmouth’s home birth rate was slightly below the national average of 2.2%, at 2.1%. In total, the rate of births occurring outside the consultant-led units in the year preceding the commencement of the BPC Project was 23% in Southampton and 25% in Portsmouth of the overall local birth rate (Table 1).

Table 1: Births by location in Portsmouth and Southampton areas n (%)  

<table>
<thead>
<tr>
<th></th>
<th>Southampton April 2002-March 2003 n = 4766</th>
<th>Portsmouth January-December 2002 n = 5165</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home births</td>
<td>154 (3)</td>
<td>113 (2)</td>
</tr>
<tr>
<td>Stand-alone birth MLU</td>
<td>261 (6)</td>
<td>493 (10)</td>
</tr>
<tr>
<td>Co-located birth MLU</td>
<td>687 (14)</td>
<td>706 (14)</td>
</tr>
<tr>
<td>Consultant unit</td>
<td>3664 (77)</td>
<td>3853 (75)</td>
</tr>
</tbody>
</table>
3.2 Transfers from MLUs

Baseline data relating to planned place of birth and peripartum transfers (transfers either in labour or in the immediate postnatal period) from the MLUs to the consultant-led units are shown in tables 2 and 3.

Table 2: Peripartum transfers into consultant-led unit in Portsmouth January - December 2002 by planned place of birth - n(%) 

<table>
<thead>
<tr>
<th>Number of women who planned birth</th>
<th>Blake MLU stand-alone n= 291</th>
<th>Blackbrook MLU stand-alone n= 119</th>
<th>Grange MLU stand-alone n= 155</th>
<th>All stand-alone MLUs n=565</th>
<th>Mary Rose MLU (co-located) n=990</th>
<th>Home n=113</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred multigravid</td>
<td>12 (4)</td>
<td>7 (5)</td>
<td>3 (2%)</td>
<td>22 (4)</td>
<td>92 (9)</td>
<td>not available</td>
</tr>
<tr>
<td>Transferred primigravid</td>
<td>33 (11)</td>
<td>8 (7)</td>
<td>9 (6)</td>
<td>50 (9)</td>
<td>192 (19)</td>
<td>not available</td>
</tr>
<tr>
<td>Total women transferred</td>
<td>45 (15)</td>
<td>15 (13)</td>
<td>12 (8)</td>
<td>72 (13)</td>
<td>284 (29)</td>
<td>not available</td>
</tr>
</tbody>
</table>

Rates of peripartum transfer appear higher overall in the Southampton area stand-alone Birthing Centres compared to the stand-alone MLUs in the Portsmouth area, with a similar gradient of increase in rate of transfer according to parity in both areas. Transfer rates for the co-located Broadlands Birthing Centre are not given because they were not routinely collected for the time period described. The transfer rate for women who planned birth in the co-located MLU in Portsmouth was higher than that observed for women who had planned birth in stand-alone MLUs. There were

Table 3: Peripartum transfers into consultant-led unit in Southampton April 2002-March 2003 by planned place of birth - n (%) 

<table>
<thead>
<tr>
<th>Number of women who planned birth</th>
<th>Hythe Birthing Centre stand-alone n=153</th>
<th>Lymington Birthing Centre stand-alone n=104</th>
<th>Romsey Birthing Centre stand-alone n=86</th>
<th>All stand-alone Birthing Centres n=343</th>
<th>Broadlands Birthing Centre (co-located) n=687</th>
<th>Home n=154</th>
</tr>
</thead>
<tbody>
<tr>
<td>transfers (multigravid)</td>
<td>10 (7)</td>
<td>9 (9)</td>
<td>5 (6)</td>
<td>24 (7)</td>
<td>*Not available</td>
<td>*Not available</td>
</tr>
<tr>
<td>transfers (primigravid)</td>
<td>26 (17)</td>
<td>21 (20)</td>
<td>11 (13)</td>
<td>58 (17)</td>
<td>*Not available</td>
<td>*Not available</td>
</tr>
<tr>
<td>Total women transferred</td>
<td>36 (24)</td>
<td>30 (29)</td>
<td>16 (19)</td>
<td>82 (24)</td>
<td>*Not available</td>
<td>*Not available</td>
</tr>
</tbody>
</table>
no statistics available for transfer rates relating to birth planned at home in either service.

The crude rates of transfer from planned place of birth were derived from the available non-standardised routine data collection systems in the Southampton and Portsmouth trusts. Therefore any differences between units/centres and between areas could be a result of chance, inconsistencies in data collection, or explained by factors such as differences in populations of women accessing care or in systems of care. Crude rates of transfer are therefore a poor gauge of quality and such measurements can only be indicative.
4. Phase One Survey

4.1 Introduction
Phase one of the Birth Place Choices Project involved collecting information on the views of women about birthplace choices in the Portsmouth and Southampton areas. This included a cross sectional survey of pregnant women in both areas during a three-week period in November 2003. The questionnaire asked about information on place of birth and making choices and decisions about place of birth. This questionnaire may be found in Appendix 3.

The aim of this survey was to obtain descriptive data from local maternity service users about what information is given to them and by whom and whether or how this influenced the choices they made regarding place of birth. The objectives were to determine if the experience of pregnant women in and around Portsmouth and Southampton concurred with previous studies and to identify areas open to improvement within local maternity services.

4.2 Design and Method
In the on-going debate about appropriate methodology within health and social research the use of surveys that have a quantitative approach has been criticised in terms of its inability to capture the essence of individual experience (Kellehear, 1993). However, ‘social surveys’ have been shown to generate reliable information on women’s experiences (Cartwright, 1987). This can be especially so if a survey is used in conjunction with other methods and approaches (triangulation) in order to ensure the information collection includes a range of perspectives (McCourt and Page, 1996). According to Klima (2001), utilising a feminist approach to healthcare research ensures that women are approached to determine how their health care needs might be met based on their lives and experiences, and that services might be designed to meet these needs.

Draper (1997) argued that midwives are in a unique position to engage in feminist research, in that well-executed feminist midwifery research could
utilise research designs that put women at the centre of the research, be motivated by an intention to improve midwifery services, and demonstrate awareness of the power relationships between the researcher and the "researched". Ensuring that maternity service users are involved in the development, design and application of a survey is one way that midwifery researchers can try to ensure feminist principles are being applied to a 'traditional' method, hence the involvement of maternity service users in the development of the BPC Project questionnaire.

The work of a number of recent authors influenced the design of the BCP Project questionnaire. Holroyd et al (2002), in conducting a postal questionnaire survey of professional attitudes to the Changing Childbirth Report's recommendations, used focus groups to develop the statements used within the questionnaires, thus attempting to ensure that the participants' words were used in the final research tool. Proctor (1999), in developing a questionnaire to ascertain women's reactions to their experience of maternity care, used exploratory focus groups to identify key issues. These were then incorporated into a series of statements in a questionnaire regarding antenatal, labour and postnatal care; for example, using questions that asked what had 'impressed' or 'bothered' the participants.

The questionnaire for the BPC Project survey was therefore not only developed using the principles described above, but also instruments used in other studies (Emslie et al 1999; Kirkham and Stapleton 2001; Lavender and Chapple 2003) and a number of exploratory discussions at formal and informal meetings with women and midwives in Portsmouth and Southampton. This approach tried to ensure that the questionnaire incorporated the viewpoints of local maternity service users and midwives.

As women's views and knowledge change as pregnancy progresses (Green et al 1998), it was decided to collect participants' views as late as possible in pregnancy. By timing the questionnaire and pregnant women's focus groups between 30 and 40 weeks gestation it was hoped as many influences on women's decisions as possible could be taken into consideration. In order to
provide the opportunity for non-English speaking women to participate in the survey, maternity service users from ethnic minority groups were approached prior to publication of the questionnaire to ask about their needs. The general consensus from these groups was that they would not require questionnaires in their own languages as they could always access someone to help them fill in the questionnaire, in the same way they have to seek help with their maternity notes and leaflets.

4.2.1 Ethical approval
Following approval of the research protocol by the Research and Development Consortiums in the two hospital Trusts, ethical approval was obtained from the Southampton and Portsmouth Local Research Ethics Committees.

4.2.2 Pilot
The questionnaire was formally piloted in the autumn of 2003 in both Portsmouth and Southampton. Two mother and baby groups were accessed through local health visitors, and the women (n=20) were asked to complete the questionnaire and comment on its content and style. A few minor changes were made to the questionnaire in light of these responses.

4.2.3 Sample
Women accessing maternity care in Southampton and Portsmouth, who were between 30 and 40 weeks pregnant during three weeks in November 2003, were approached by their midwife about involvement in the Birth Place Choices Project. In the course of routine antenatal consultations, midwives identified women fulfilling the following inclusion criteria:

- Women between 30 and 40 weeks gestation
- Women over 16 years of age
- Women for whom the midwife could detect a fetal heartbeat.

The midwives were asked to exclude women:

- Who were tearful or upset
• Who made it clear they were not interested in participating in the survey
• Who required urgent hospitalisation.

Midwives were asked to reassure all women that it was up to them to decide whether or not to take part in the BPC Project and that their maternity care would remain the same whatever they decided. Midwives gave women who met the inclusion criteria, and agreed to take part, a written information sheet about the BPC Project (Appendix 4) along with the study questionnaire for self-completion and a Freepost envelope to return the questionnaire to the Project office.

4.2.4 Data collection
Two thousand questionnaires were produced and distributed to midwives caring for women in the antenatal period. During the three-week period agreed for data collection the midwives gave questionnaires to 925 women during routine antenatal appointment sessions. Of these, 398 were returned, giving an overall response rate of 43%.

4.2.5 Analysis
Data were analysed using a statistical package developed for the social sciences (SPSS). Descriptive statistics were then produced for both Project areas (producing separate Portsmouth and Southampton area data) and these data were then merged and re-analysed to generate the overall results published in this report.

4.3 Results
Three hundred and ninety eight completed surveys were received, a response rate of 43%. (n=398/925). The questionnaire was divided into five sections:
Section A – Your children
Section B – Information about where you can have your baby
Section C – Making choices
Section D – Decisions about place of birth
Section E – You and your family

The denominator used in the following tables is the number of women who responded to the survey (n=398) unless otherwise indicated.

4.3.1 Respondents

Table 4 shows in detail the respondents’ demographic profile.

<table>
<thead>
<tr>
<th>Table 4: Demographic profile of survey respondents: Phase One  n=(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n= 398</td>
</tr>
<tr>
<td>Parity</td>
</tr>
<tr>
<td>• Primiparous</td>
</tr>
<tr>
<td>• Multiparous</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Age (years) mean [SD]</td>
</tr>
<tr>
<td>Ethnic group: White</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Lives with partner</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Partner is in full-time employment</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>English first language</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Had last baby at home*</td>
</tr>
<tr>
<td>In full-time employment</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Has GCSE or equivalent</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Has degree or equivalent</td>
</tr>
<tr>
<td>No response</td>
</tr>
</tbody>
</table>

* Denominator = 199 multiparous respondents

As is often the case with social surveys, the respondents were older and more likely to be white, English speaking and graduates compared to the local maternity service user population information, obtained from the maternity service database. The respondents were between 29 and 40 weeks gestation,
and their mean age was 29 years. The questionnaire asked about parity and whether any previous children had been born at home. A majority of the multiparous respondents had given birth in hospital.

4.3.2 Information

The questionnaire asked about the information the respondents had received regarding birthplace choices during their pregnancy. The majority (93%) reported having been given some information, with the majority reporting that the first information came from a midwife (Table 5).

Table 5: Sources of information n (%)*

<table>
<thead>
<tr>
<th>n=398</th>
<th>GP</th>
<th>Midwife</th>
<th>Hospital doctor</th>
<th>Family/friends</th>
<th>Other</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who did information come from?*</td>
<td>69 (18)</td>
<td>354 (95)</td>
<td>27 (7)</td>
<td>69 (18)</td>
<td>25 (7)</td>
<td>44 (11)</td>
</tr>
<tr>
<td>Who gave first information?</td>
<td>45 (11)</td>
<td>293 (74)</td>
<td>8 (2)</td>
<td>16 (4)</td>
<td>11 (3)</td>
<td>105 (26)</td>
</tr>
</tbody>
</table>

* Respondents could give >1 response, therefore percentages total >100

The questionnaire also asked what type of information was received and which the respondents used to help them choose where they wanted to have their baby (Table 6).

Table 6: Information received/used n (%)

<table>
<thead>
<tr>
<th>n=398</th>
<th>Spoken</th>
<th>Written</th>
<th>Both</th>
<th>Neither</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of information did you receive?</td>
<td>186 (47)</td>
<td>14 (4)</td>
<td>162 (40)</td>
<td>N/A</td>
<td>36 (9)</td>
</tr>
<tr>
<td>Which information did you use to help you choose where to have your baby?</td>
<td>187 (47)</td>
<td>14 (4)</td>
<td>116 (29)</td>
<td>68 (17)</td>
<td>13 (3)</td>
</tr>
</tbody>
</table>

The mean gestation when women first received information on birthplace choices was 12.9 weeks. It became apparent from the responses that most of
the information women used to help them make a choice came from the conversations they had with their midwife. Most women visit their GP when they first become pregnant, but only 11% of women said that GPs were the first to give information about the various birthplace choices open to them.

4.3.3 Choices

The questionnaire went on to ask about the choices the respondents had been offered. The majority, 312 (78%), agreed that they had been offered a choice about where to have their baby, with 52 (13%) reporting that there was no choice. Most had been given these choices by the midwife (Table 7) and said it was very or quite important for them to have a choice of place of birth (87%). However, while 96% were offered hospital, only 58% were offered the option of home birth.

Table 7: Who offered the choice? n (%)  

<table>
<thead>
<tr>
<th>Who offered the choice?</th>
<th>n= 398</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
<td>282 (70)</td>
</tr>
<tr>
<td>GP</td>
<td>48 (12)</td>
</tr>
<tr>
<td>Hospital Doctor</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Other</td>
<td>12 (3)</td>
</tr>
<tr>
<td>No response</td>
<td>44 (11)</td>
</tr>
</tbody>
</table>

While most agreed that they had been given enough information and had enough discussion on the various options available (Table 8), when the choices were broken down in terms of types of place of birth the respondents were offered (i.e. hospital, birth centre or home), it was apparent that only 52% were offered a choice of birthing at home or in a birth centre, as well as the choice of a hospital birth.
### Table 8: Assessment of amount of information/discussion n (%)

<table>
<thead>
<tr>
<th></th>
<th>Information n=398 (%)</th>
<th>Discussion n=398 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too much</td>
<td>3 (1)</td>
<td>1</td>
</tr>
<tr>
<td>Enough</td>
<td>247 (62)</td>
<td>245 (61)</td>
</tr>
<tr>
<td>Needed more</td>
<td>43 (10)</td>
<td>41 (10)</td>
</tr>
<tr>
<td>No information given</td>
<td>5 (1)</td>
<td>9 (2)</td>
</tr>
<tr>
<td>None needed</td>
<td>8 (2)</td>
<td>9 (2)</td>
</tr>
<tr>
<td>No response</td>
<td>92 (23)</td>
<td>93 (23)</td>
</tr>
</tbody>
</table>

### 4.3.4 Decisions

When it came to making a decision about where to have their baby, 77% of respondents said they had felt involved in the process. Nearly 60% said they were planning to have their baby in either a local or neighbouring consultant-led unit (Table 9).

### Table 9: Planned place of birth and Best place of birth n (%)

<table>
<thead>
<tr>
<th></th>
<th>Planned place of birth n=398</th>
<th>Best place of Birth n=398</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>17 (4)</td>
<td>18 (5)</td>
</tr>
<tr>
<td>Co-located birth centre</td>
<td>78 (20)</td>
<td>75 (19)</td>
</tr>
<tr>
<td>Stand alone birth centre</td>
<td>62 (16)</td>
<td>25 (6)</td>
</tr>
<tr>
<td>Consultant-led unit</td>
<td>191 (48)</td>
<td>191 (48)</td>
</tr>
<tr>
<td>Other</td>
<td>36 (9)</td>
<td>38 (10)</td>
</tr>
<tr>
<td>No response</td>
<td>14 (4)</td>
<td>51 (13)</td>
</tr>
</tbody>
</table>

Around 40% were planning to give birth in a midwifery-led birth centre or at home. The questionnaire also asked the women where they felt was the best place to have their baby (Table 9) to discover any differences between what the participants thought they would do (their planned place of birth), with where they felt the best place was to give birth. However, there was virtually no difference, with 48% responding that they felt a consultant-led unit was the best place. Only 3% (n=12) said they did not know which was the best birthplace choice, and less than 2% (n=7) said they did not mind where they had their babies.
The most important influences on the women’s decisions appeared to be their own personal views/beliefs (n=349, 88%) and those of their partner (n=281, 70%). However, the midwife (n=301, 76%) appeared to have by far the greatest influence of all the health professionals with whom the women had contact. In terms of other factors that influenced women’s decisions, the good reputation of the unit, availability of specialist facilities and a homely relaxed atmosphere were cited as very important, as was previous experience of childbirth for multigravid women.

Forty per cent of women said they thought they should be free to make their decision about where to have their baby at any time during their pregnancy, while only 28% of the respondents said they thought the first meeting with their GP or midwife was the right time. When asked who should make the decision about place of birth, nearly 60% said it should be they, the mother, after considering the midwife or doctor’s opinion. Less than 1% of respondents said they thought the decision should be left entirely to the midwife or doctor.

In summary, having a choice of place of birth was very important to women in Portsmouth and Southampton. The midwife had the most important influence amongst health professionals on women and their birthplace choices and women wanted the option of home/birth centre. Written information alone was not as useful as a combination of written and spoken information from the midwife in terms of helping women decide on their birthplace choice.
5. Focus Groups

5.1 Introduction
The aim of Phase One of the Birth Place Choices Project was to establish a baseline perspective on the issues surrounding local birthplace choices. Focus groups were held in both Southampton and Portsmouth, with the purpose of collecting information from women and midwives to supplement data collected via the survey and to generate qualitative data on participants’ thoughts and feelings around information giving, choice and decision making on place of birth.

5.2 Design and method
Focus groups are regarded as an appropriate method of data collection where the focus of the research is a specific topic about which the participants hold particular knowledge (Sanders et al, 1999). In this case, they were seen as useful because the objectives of the Phase One research required a range of perspectives and information and therefore more than one method of ascertaining these, as recommended by McCourt and Page (1996).

5.2.1 Sample
Separate focus groups were organised for maternity service users and midwives in order to gain different perspectives on the topic in question, therefore forming two ‘Key Informant’ samples. However, within these two groups variation of sampling was obtained in terms of the diverse areas in which they lived or worked (i.e. inner city, rural, suburban), in an effort to gain as full a range of comments and experiences as possible on the local birthplace choices.

Maternity service users were invited to participate in a focus group by written invitations distributed via community clinics, GP surgeries and antenatal classes. Posters were displayed in these venues providing details about the Project, and an invitation, information sheet and consent form was provided for women to take away. The invitations had a tear-off reply paid section that the woman was invited to complete and return, with the consent form, to the
local Project office. The maternity service users were offered help with transport costs and told a crèche and refreshments would be provided.

Midwives were invited to participate in the focus groups by an invitation pack distributed via internal post to their work place and also by posters displayed within both Trusts. The invitation pack included an information sheet, consent form, invitation with tear-off reply section and pre-addressed envelope for the midwife to return to the local Project office.

Twenty maternity service users and 16 midwives took part in the focus groups. There were five maternity service user focus groups (three in the Portsmouth area and two in the Southampton area), and two midwife focus groups (one in Portsmouth and one in Southampton).

Four experienced focus group facilitators who had no other connection with the Project and were not midwives facilitated the groups. The groups were organised in or near the two Trusts. The Portsmouth Project manager attended Southampton focus groups and the Southampton Project manager attended the Portsmouth focus groups. The Project managers took notes on the key issues raised as well as endeavouring to ensure the sessions ran smoothly and according to the ethical standards relating to anonymity, confidentiality and verifiability of data collected.

5.2.2 Data collection
The focus groups were facilitated using a semi-structured approach and cue questions focusing on the main themes on birth place choices contained in the survey:

- Information
- Choices
- Decision making

Each facilitator phrased the questions slightly differently and with different emphasis and chronology, but focused on the three main themes. In so doing, the maternity service user participants were prompted to think about their
individual journeys through their pregnancies and reflect on the different influences that impacted on their birth place choices, with the hope of gaining a deeper understanding of their decision making processes, in contrast to the ‘snapshots’ provided by the survey participants. For example, the facilitators asked:

‘First question then, to get us talking, what information did you receive about the different places that you could have your baby?’

The midwives were asked to reflect on and discuss issues on and around birthplace choices, within the thematic purpose of determining their thoughts and feelings around information giving, choice and decision-making on place of birth. In particular, they were asked how their practice, and that of other health professionals, might have impacted on the choices their clients made.

5.2.3 Transcription
Each focus group was tape-recorded and the recordings transcribed by a clerical assistant who had not attended the sessions and did not know the names of the participants. Transcripts were produced and checked against the recordings for accuracy by the Project managers.

5.2.4 Analysis
The ‘focus’ of the sessions was deliberately constrained to the topics of major interest. One purpose of the analysis was therefore to identify which parts of the group discussions contributed to the three main categories of:

- Information on birthplaces;
- Choices of birthplaces;
- Decision making on birthplaces.

The focus group transcripts were analysed in stages: Firstly, the two Project managers independently read and re-read all the transcripts and categorised all the text into an unlimited number of key words and phrases, in that the text was reviewed line-by-line and relevant points highlighted. Significant words and sentences that recurred more than twice
and were re-iterated by more than one focus group participant were then identified and copied into a new file relating to each focus group. These were then grouped under the broad headings of a) Information, b) Choices, and c) Decision making.

Initial themes from within these three categories emerged from each transcript. For example, within the category of information, initial themes included:

- Better written information is needed;
- Got information from midwife at about 12 weeks;
- Too much information too early on.

The transcripts were then re-read in light of these initial themes and themes common to all the Portsmouth women’s focus groups emerged, as did themes common to the Southampton women’s and the two midwives’ focus groups.

The transcripts were edited to remove dialogue that was completely irrelevant to the subject in question and combined into three central texts:

- The Portsmouth women’s focus group common themes;
- The Southampton women’s focus groups common themes;
- The midwives’ common themes

The Project managers then met and discussed these common themes. From their discussions and from further reflection on the texts, an agreement was reached on the grouping of the key themes under each of the three categories of information, choice and decision making for the three groups. At each stage in this process, the Project managers returned to the original transcripts to reflect on the authenticity of each theme. Key themes common to both groups of midwives eventually emerged, resulting in the final analysis of the midwives’ focus groups. Key themes common to both the Southampton and Portsmouth women’s focus groups emerged from the re-reading and further reflections.

The Project leader, Jane Rogers, also independently verified the transcripts. She carried out content analysis on the original transcripts by categorising key
phrases/words that related to the themes of information, choice and decision-making, and her findings corroborated the analysis carried out by the Project managers.

5.3 Results
The findings of the focus groups are presented here using verbatim quotations to illustrate the themes common to both Trusts that emerged from the content analysis. Pseudonyms have been used to protect anonymity.

5.3.1 Women’s focus groups
Key themes that emerged from the Southampton women’s focus groups pointed to the pivotal role of the midwife in information and choice giving, while at the same time highlighting the over-riding influence of obstetrics and the medical hegemony of childbirth:

- Midwife gave good information on choices, GP did not
- Past experience important
- Continuity with midwife is best
- Doctors favour hospital
- Natural choice home, but have no choice
- Hospital is safest
- Midwife emphasised home birth
- Need information early on in pregnancy on birth place options

Key themes that emerged from the Portsmouth women’s focus groups highlighted the pressure the participants felt to make a decision about where to have their baby early on in pregnancy, as well as having their choices limited by health professionals:

- A lot of information from midwife early on in pregnancy
- Don’t want to have to decide place of birth early on
- Only an option if ‘they’ allow it
- Past experience influences decision
- Tours would be useful
- Going to co-located MLU best
• Need better information
• Choices depend on midwife

Themes common to both Trusts
Key themes common to both the Southampton and Portsmouth women’s focus groups were as follows:

Information
• A lot of information from midwife at booking
• Need better information
• Need information early on in pregnancy
• Don’t want to have to decide place of birth early on

A central theme of the maternity service user focus groups was the amount and appropriateness of the information the participants received from their midwife. While many praised the comprehensive amount of information they received from their midwife on birthplace choices (in contrast to the very little received from many of the participants’ GPs), others described being almost overloaded with information, combined with a pressure to make a decision at the first appointment with the midwife about where they wanted to have their baby. For example:

‘Thinking back to 2½-3 years ago when I was in the early stages of my first pregnancy, I was still trying to comprehend the fact that I was pregnant, let alone trying to decide where I should be having this baby.’
(Pauline)

However, while the verbal information from the midwife was highlighted as a key source of knowledge on birthplace choices for the focus group participants, many also decried the poor quality or total absence of written information on the subject, particularly information with a local focus. For example:

‘I wouldn’t really mind whether it was verbal or written, just that I would have liked it to have been really clear about what my personal choices were, based on my situation...initially when you are pregnant you should be given a pack that gives you, umm, all the choices in your area.’
(Sarah)
Choices

• Midwives offer choices
• Choice often limited
• Midwives more likely to offer home or birth centre than GP
• Doctors favour hospital

As with the information giving, it emerged from the maternity service user focus groups that the midwife was a key person when it came to giving the women a choice over where they could have their baby. For example:

‘I don’t think I knew. I just assumed the hospital. Until I was speaking to a midwife and she mentioned there were choices’
(Carol)

However, while for some this meant being clear that the choice over where they had their baby was theirs, others described this choice giving as being about the midwife pointing out what she believed to be the best choice. For example:

‘You don’t get much choice. It is not like you might have to change your options, your options will be changed - you can’t go there. If they anticipate a problem with your birth, then they just send you straight off to the consultant and it is as simple as that. I suppose you just feel that some of the control has been taken away from you then’
(Christine)

Midwives appeared to be the group that was most likely to offer out of hospital births. While a small number of participants said their GP did offer these choices, overall it was clear that the women only saw midwives as being the health professionals who actively encouraged women to think about these options. For example:

‘When you go to the parent craft classes, which are obviously run by midwives, who are linked here, that’s when it really comes across that not necessary how bad epidurals are, pethidine, but they value the benefits of having a more natural, one on one experience here, really does come out in your parent craft classes. That is what changed my mind, a calming, and a better experience. Without them openly saying “don’t go to hospital” which they won’t do anyway....’
(Claire)
It also emerged that, for focus group participants, the medical profession (notably GPs and obstetricians) favoured hospital. For example:

‘The consultant and the GP that were looking for problems were saying “you need to come into hospital in case something goes wrong” and I think there is a difference between the consultants and the people that deal with pregnancies that go wrong and midwives services, because they are looking for issues and problems when there aren’t necessarily any there.’

(Karen)

Decision-making

- Hospital safest, especially with first child
- Previous experience an important influence
- Professional conflicts make decision making difficult
- Midwives are influential

When it came to making a decision about where to have their baby, a key theme that emerged from maternity service user focus groups was that of hospital being the safest place to give birth. While this theme could be said in part to have its origins in the words and deeds of health professionals, for example:

“My midwife, my GP all said if something goes wrong with your first child, it is best to have it in hospital”

(Karen)

For the focus group participants who had given birth before, it became clear that their personal experience was an important influence. For example:

“Because I have been through it once, I am happy to come up to a unit 15 minutes away from a main unit. So I am happy to take this further risk.”

(Pauline)

When it came to making decisions, it also emerged from these focus groups that conflicting views on place of birth among health professionals caused problems for the participants. For example:

“…You get conflicting… you get a midwife that is anti-homebirth and you are trying to get your views across. You have to get a midwife that says ‘right we will do you at home’.”

(Sharon)
Midwives were an important influence when the time came for women to make their final decision, and this had something to do with midwives being supportive and empathetic regarding the women’s choice. For example:

‘I think the midwives view, a woman’s choice is a woman’s choice and we will be supportive of that, whatever it is. Whereas they consultants are like, ‘Well make the choice as long as it is our choice.’
(Karen)

5.3.2 Midwives’ focus groups

The following themes emerged from the midwives’ focus groups, some in common with the women’s focus group findings, while others revealed the contrasting perspectives of the maternity service users and the midwives:

Information

- Information giving begins with booking visit
- There used to be a leaflet/need a leaflet on choices

The midwives corroborated the findings of the survey and maternity service user focus groups that information giving about birthplace choices most commonly occurred during the ‘booking in’ visit to the women’s homes at about 12 weeks of pregnancy. However, the midwives made it clear this was not just for the women’s benefit, but also so that the midwives could find out at an early stage where the women wanted to have their babies. For example:

‘If they haven’t decided when I first arrange to meet them, then we chat about it and on the day that I do meet them…I really need to know. where they are going to have their scan and that’s the driving force really.’
(Lisa)

The midwives agreed with the maternity service user focus group participants that a leaflet on the local birth place choices would be useful, but said they did not have access to one. For example:

‘Used to have a local leaflet, outlining all the choices, now only have the MIDIRS informed choice one, would like a leaflet describing services in stand alone birth centres, as well as all the other choices’
(Liz)
Choices

- GPs have quite a lot of influence and tend to favour hospital
- The women have already made up their mind
- Midwives have a responsibility to offer choice
- Home birth a difficult choice to offer

Unlike the women’s survey and focus group participants, the midwives saw GPs as highly influential when it came to birthplace choices, and this led to fewer women choosing ‘out of hospital’ births:

‘Their GP’s attitudes are where they want to have their baby and …you know at the booking because they say that my GP said that I have to have it at the main unit because you know and you mentioned home and that the GP said that.’
(Julie)

The midwives said they thought women often knew where they wanted to have their baby long before meeting their midwife. They cited “cultural attitudes” towards childbirth as being a main influence. For example, midwives working in a Sure Start area said the shift towards home-birth encouraged by the team of midwives working there seemed to have resulted in homebirth becoming more of a norm, for example:

‘Tide of change’ in case-loading area, as more and more women having home birth, more and more women want them.’
(Sandra)

However, in other areas where this was not the case the norm to give birth in hospital was something the midwives found difficult to challenge:

‘Pregnant teenagers influenced by their mothers who say, ‘We weren’t allowed babies at home, why are you?’
(Diane)

Despite these difficulties, the midwives also seemed to regard themselves as having a responsibility to give women informed choices. For example:

‘On the other hand if the advice you’ve been given by the GP is wrong … I think it’s our responsibility to explain all the choices’
(Louise)
The pressure that providing a home birth service put on midwives seemed to be central to the way midwives gave information and choices and assisted in women’s decision making around place of birth. The midwives talked at length about the strain home births put on themselves and their colleagues. At the root of this seemed to be the assumption that the main role of community-based midwives was antenatal and postnatal care, with intrapartum care being an added extra that was fitted in when staffing levels were adequate. In essence, the pressure of providing a home birth service manifested itself in four ways:

- **Resource issues**
  
  ‘But there is an issue about feeling a little bit uncomfortable with staffing levels. It’s very elitist care. Really, women should receive that but a lot of women in the main ward don’t receive that care. Some of the midwives are looking after two or three women in early labour, where’s you are with the woman, really from the time that she wants you to be there but it’s satisfying for the midwives, I think.’ (Jenny)

- **Lack of support from colleagues**
  
  ‘Had somebody say to me, ‘I’m glad you didn’t call me.’ (Lisa)

- **Safety worries**
  
  ‘A lot of us go in pairs; we shouldn’t be going out on our own; you need to have back up; you should always go in twos at night’ (Maddie)

- **GPs don’t support home birth**
  
  ‘GP at my practice told a lady, ‘Don’t expect me to be called for your home birth because I’m not going to be supporting you,’ - I wouldn’t dream of a million years calling a GP.’ (Louise)

**Decision making**

- **Partners are influential**
- **Midwives have some influence**
- **The women can change their minds**
- **Women care about the environment they give birth in**
• Dominance of hospital-focused obstetrics

When it came to making decisions about place of birth for an individual, midwives concurred with the survey findings that women’s partners were an important influence. For example:

‘Partners also influential… Cite main consultant unit as place of safety.’
(Jane)

However, the midwives also said that they themselves were influential:

I think that also has quite a lot of influence on them, how the information is delivered…from the midwife.
(Liz)

Although midwives stated that they needed to know where the women wanted to have their babies from the beginning of pregnancy, they also agreed that women could change their minds later on about their birthplace choice. This seemed to be in part about making the system work for all concerned, in that midwives could complete their paperwork efficiently, the women could access the screening tests they wanted (for example some hospitals, near the borders of the Portsmouth and Southampton catchment areas, offer free nuchal translucency tests but do not have the option of birth centres) and women could choose to give birth where they wanted. For example:

‘Right up till the day they go into labour, they phone up and say ‘Look I’ve changed my mind where I want to have my baby’. Where’s before oh…she’s change her booking…you had to change it on the form…so I think it’s changed just in the last few years’
(Tracy)

Another key theme that emerged from the midwives was the notion that the birth environment swayed women who were undecided about where to have their baby, and described it as an important influence on women who had previously had babies in birth centres. In particular, the home-from-home atmosphere of the birth centres was something the midwives were clearly proud of and felt gave women a better birth experience. In particular, midwives who worked in birth centres argued that birth centres had key advantages over both hospital and home birth. For example:
'We're talking black and white – home or hospital, when there is the birth centres as well.'...It's a much smaller group of midwives...Noise not an issue like it is at home (women crying out during labour, neighbours hearing)...‘Amazing quality experience.’...‘Really individual and personal.’

(Grouped comments)

However, some midwives said that if the choice were between a clinical hospital that had been newly decorated and an old-fashioned birth centre with flock wallpaper, the hospital would win every-time. For example:

‘I had a lady moved from the Mary Rose to the main unit. It was because the main unit looked much nicer and you know’
(Jenny)

In summary, the maternity service user focus group participants reported that while they received a lot of information from the midwife at the beginning of their pregnancy about their birthplace choices, some wanted better information and less pressure to make a decision during the first trimester. The midwife focus group respondents agreed there needed to be better information on local birthplace choices to give women at the beginning of their pregnancies.

When it came to choices offered, it was clear from the maternity service user focus groups that it was the midwives who offered the choices, if at times in a limited way. They implied that doctors did not offer different birthplace choices because they preferred women to give birth in hospital, and the midwives also reported this view. When it came to making a decision about where to give birth, the women reported experiencing a lot of pressure to go to hospital, and cited professional conflicts between midwives and doctors as something that made their decision making process difficult, but that midwives had an important influence. The midwife focus group participants regarded GPs and obstetricians as key influences on women’s birthplace choices, but acknowledged midwives had an important role to play in this process. The midwives talked at length about the difficulty of offering a home birth service and pointed to the dominance of hospital focused obstetrics.
6. Phase One Discussion

6.1 Introduction
For women and midwives, information giving, making choices and coming to a
decision are by their nature complex processes that involve high levels of
communication, listening and information analysis. The survey was not
intended to gain a deep understanding of how maternity service users utilise
the information given to them, nor how they view their choices in terms of their
own personal contexts, nor the various processes they go through to come to
a decision. It was simply aiming to gain an insight into what and who was
influencing local women’s birthplace choices, and what has become apparent
from these results is that midwives play a central role in this process.

The focus groups involving maternity service users were carried out to test out
the findings of the survey, as well as to gain an understanding of why and how
women were making their birth place choices, and again it became clear that
midwives had considerable impact on this process. The focus groups
involving the midwives were designed to gain an insight into midwives’
thoughts and feelings on the issue of birthplace choices for women, and it
became apparent that midwives seemed to lack awareness regarding the
influence they had on women’s choices.

6.2 Information
While the responses indicate that the large majority of women (93%) were
given information in their current pregnancy about where they could have their
baby, further analysis revealed that the information a large number of
respondents received was probably of a limited nature and tailored according
to the health professional’s (most often the midwife’s), view of the
appropriateness of each birth place choice for the women in question. For
example, women living in certain geographical areas tended to be offered only
their local birth centre or hospital, rather than home birth or the option of a
different birth centre.
Women participating in the focus groups also pointed to the apparent “postcode lottery” when it came to the information and choices they were given. Most of the survey respondents said their midwife gave information about their birthplace choices to them verbally and/or in writing during their first antenatal appointment (usually around 12 weeks gestation). This was also the most common time the respondents said they were asked to make their birthplace choices, suggesting that it is expected that the choice will be made on the same occasion as the information is given. However, only 28% of the survey respondents said they thought this was the right time to make a decision about where to have their baby, suggesting that the majority needed time to come to their decision. The focus group participants corroborated this finding, saying they did not want to be pressurised into making a decision early in pregnancy.

A common finding from patient satisfaction surveys is that respondents tend to report that what they experienced must be the norm and therefore “must be best”. It is interesting to note that this was not the case with this study, suggesting a high level dissatisfaction with the requirement of the service that the women should make a birthplace choice before they are ready. This points to key flaws in service delivery, such as paperwork taking priority over service users’ needs and a lack of cohesive, cross boundary working. It also suggests a need for locally focused information that clearly spells out women’s birthplace choices, while making clear they can change their mind at any time during their pregnancy.

6.3 Choices
While it initially appeared that the majority of the respondents (79%) had been offered a choice about where to have their baby, it soon became clear that the actual number who had been given a choice of all the birthplace options available locally was much lower, with only 52% of respondents indicating they had been offered more than one option for place of birth. The respondents may have seen the offer of two different hospitals as choice, but when there are also the options of birth centres and home birth available, a choice between two different hospitals is a limited choice. Therefore, it could
be argued that almost half of the respondents (48%) were not fully informed of all the choices about where they could have their babies. These findings are in keeping with previous surveys which found a large minority of women were not offered all the options regarding place of birth, with many perceiving that either they had no choice or the options were not discussed with them, particularly with regard to home birth (MORI 1993; Chamberlain et al 1997; EDCHEST 1998; Garcia et al 1998; SPCERH 1999; Green et al 1998; Lavender and Chapple 2003).

Among the respondents who said there was no choice, the explanations the women most commonly gave for believing they had no choice included having had a Caesarean with their last baby, or carrying Group B Streptococcus during their current pregnancy. While it may be reasonable to assume that many women would opt for a hospital birth in these circumstances, the response that they had no choice suggests they had not made an informed decision after being given all the information on the risks and benefits of the various birthplace options. The focus group findings gave further insight into this issue, with the emergence of the key themes of ‘choice often limited’, and ‘hospital safest with first child’.

The report from the Expert Maternity Group for Changing Childbirth (Department of Health, 1993) found that health professionals assumed women would wish to go to hospital to give birth, with many expressing the belief that birth in a general hospital maternity unit was preferable, because of “safety factors”, to birth at home or in a stand-alone midwife-/GP-led unit. However, the overwhelming majority of women in our survey (87%) said that it was very or quite important to have a choice about where to have their baby and the focus group respondents also made it clear that they also wanted an informed choice.

6.4 Decision-making
Forty one per cent of women reported that they wanted to have their baby outside the main obstetric unit, either at home or in a midwife-led unit. While this may seem at first glance a substantial number, when one considers only
about half of the respondents were offered these choices, it might well be higher if all women were offered all the choices. Even allowing for some transfers to obstetric care during the antenatal period, this indicates there are maternity service users who would like the option of giving birth outside the consultant-led units, but are giving birth in mainstream hospitals. The report from the expert maternity group for Changing Childbirth pointed to a MORI survey of women who had recently given birth (98% had given birth in hospital). It showed 72% of respondents would have liked the option of a different system of care and birthplace. Of those who wanted an alternative option, 22% said they would have liked the option of home birth (Department of Health, 1993).

Different models of midwifery services operate within the Portsmouth and Southampton areas. For example, in Southampton some midwives belong to teams that offer care to a caseload of maternity service users (there are five teams, four with between 6.5 and 8 whole-time equivalent (WTE) midwives and one with two WTE midwives). Each team aims to offer continuity of care and carer, including during labour. This often means that when a woman being cared for by a caseload-holding midwife begins to labour, she is likely to be assessed at home by her midwife. It has been suggested that this may increase the likelihood of the woman choosing to stay at home to give birth (Rosser, 2003; Walsh, 1999).

The model described above contrasts with the ‘traditional’ model of midwifery services currently operating in Portsmouth, whereby women tend to see the same midwife for their antenatal and post-natal care, but at the start of their labour are asked to call a central number and attend either a hospital or birth centre for their labour (unless they have specifically requested a home birth). This means that a maternity service user in Portsmouth is unlikely to experience care during labour from a midwife who has worked with her during pregnancy.
Hundley et al (2002) also found that the ‘place of birth’ policy operated by a unit has a significant effect on women’s reported preferences (Hundley et al, 2002). Evidence from studies conducted where women experienced a high level of continuity of care (McCourt and Page 1995; Saunders et al 2000; Sandall et al 2001) suggests that in these contexts much higher numbers of women are given a choice of birth location and feel involved in the decision about where to have their baby. The results of this survey clearly show that midwives had by far the biggest influence on the respondent’s decision regarding place of birth. However, one needs to question that if the midwives in Portsmouth and Southampton had so much influence, why then did they not use it more effectively to ensure local women were aware of all their birthplace options.

Kirkham and Stapleton (2001) in their study on informed choice identified a number of features relating to the culture in which women accessed their maternity care that hindered their attempts to secure information and make informed decisions about their care. These included the paternalistic and hierarchical nature of the NHS and the highly medicalised stance of modern obstetrics, such that information that did not conform to medical opinion tended to be withheld from service users. One could therefore argue that perhaps the reason birth centres and home birth services are not offered to all maternity service users as a safe and viable alternative to a consultant-led unit is because this conflicts with the dominant medical model of childbirth. The findings of the focus groups seem to hint that this may well be the case, in particular those of the midwives’ focus groups where the strain of providing a service that operates outside the medical model (for example, a home birth service) was clearly evident. Midwife participants seemed to experience some dissonance in that they knew their responsibility was to offer all the various birthplace options, yet found providing an out of hospital intrapartum service a huge challenge. It is perhaps not unreasonable to assume that these difficulties experienced by the midwives directly impacted on the information and choices given to the women in their care. For example, while giving information to women about home birth they might also add the proviso that
actually being able to have a baby at home depended on the staff:patient ratios at the time.

While further work with local midwives should make it possible to examine this issue further, it is perhaps not unreasonable to conclude that while midwives do give information, offer choices and greatly influence the decisions of women on and around place of birth, the service and culture within which midwives work make it difficult for midwives to provide all the options supposedly available to maternity service users.

6.5 Limitations and strengths of Phase One research
Surveys clearly have their limitations when it comes to gaining an understanding of what influences health services users in making particular choices. For example, by far the greatest influence on the respondents of this survey, was the women themselves. Gaining an understanding of the origin of an individual’s personal views and values, and how these impact on decision making could be a research study in itself. While the focus groups enabled further insight as to why midwives were only offering certain options and why women were choosing them, group interviews by their very nature tend to inhibit the disclosure of deeply held personal views and beliefs.

The difficulties experienced in recruiting women to this study also limit the usefulness of the findings. There are several reasons for these difficulties: for example, the Data Protection Act (1998) prohibits the use of patient information for any purpose other than the delivery of healthcare, which meant the maternity service users’ names and addresses could not be accessed by the project managers. This resulted in the need to distribute the questionnaires via the midwives, rather than sending them directly to the maternity service users’ homes. The time pressures and workload of the midwives is likely to have had some part to play in the disappointing response rate of 43%.
Recruiting women to the focus groups also proved a considerable challenge, even though venues were chosen in the centre of communities with high numbers of young families, and refreshments, crèche facilities and transportation provided. This meant that while some of the maternity service user focus groups were attended by as many as eight women, at others there were only two. However, the effort put into recruiting women to the focus groups meant those who did attend came from a cross-section of the community, including very young women from disadvantaged areas, those with obstetric complications and older first time mothers.

The midwives’ focus groups were well attended at both sites, with participants coming from both hospital and community working environments. Despite the contrasting patterns of working between the two sites, common themes emerged from the two groups; in particular, the strain of providing a home birth service and the antagonism the midwives experienced from the medical profession with regard to out of hospital births. However, a clear weakness of the midwives’ focus groups is that those who attended were self-selected, and it can therefore not be claimed that their views were representative of all the midwives in Portsmouth and Southampton areas.

In terms of the baseline data, the Project team would have liked to have collected intrapartum transfer rates from home births to hospital and the intrapartum transfer rate from the Southampton co-located birthing centre to the consultant-led unit. Unfortunately, the only intrapartum transfer figures available were for the stand-alone MLUs and the Portsmouth co-located MLU. However, notwithstanding this limitation, it was considered that the baseline data collected during Phase One would allow a useful comparison of statistics between the year prior to the start of the BPC Project and the final year of the Project.

A strength of the survey was that it provided a snapshot of what information and choices were being offered within local maternity services and what was influencing women’s birthplace choices, thus pointing the way to areas for improvement within the maternity services. The fact that many of its findings
also concur with previous studies on this subject points to the potential
generalisability of the findings, and would hopefully aid dissemination of the
findings locally by demonstrating that the experiences of women in
Portsmouth and Southampton are not inherently different to other areas of the
UK.

**Development of Phase Two**

Consideration of the findings of both the survey and the focus groups led to
conclusions by the Project team about the best way for the Birth Place
Choices Project to proceed in order to meet its aims. It was decided that a
three point strategy should be developed and implemented; this consisted of
three sets of interconnecting initiatives aimed at improving women’s birthplace
choices in the Portsmouth and Southampton areas:

1) Change management, including the development of a multi-
   professional guideline on place of birth
2) Marketing, including the development of locally focused, evidenced-
   based literature on birthplace choices
3) Education, particularly around the midwife’s role in giving women
   informed choice about place of birth.
Phase Two

7. Project initiatives

7.1 Introduction

It has been seen that the aim of Phase One of the BPC Project was to gather material to inform strategies aiming to meet the goals of the Project. The results of this exercise, described in sections 2 - 5, used four different methods and enabled the Project team to clarify the initiatives that should be developed and implemented in the second phase of the Project. Phase Two was conducted over a period of 14 months (March 2004 – April 2005), within the Portsmouth and Southampton areas, and had two main aims:

- To determine whether the introduction of specially designed information and educational initiatives, aimed at health professionals as well as maternity service users, increase women’s knowledge of choices for place of birth.
- To determine whether implementation of these initiatives was associated with an increase in the number of women choosing to give birth outside main consultant-led maternity units.

The initiatives are described in detail in the following sections and a comprehensive evaluation of their contribution to the Project aims makes up the final section of the report. The initiatives were as follows:

- Change management, including the development of a multi-professional guideline on place of birth
- Marketing, including the development of locally focused, evidence-based literature on birthplace choices
- Education, particularly around the midwife’s role in giving women informed choice about place of birth.

7.2 Change Management Initiatives

This section describes inter-linked strategies relating to staffing and capacity issues and multi-professional guidance on a corporate approach to “Place of Birth”.

The initiatives are described in detail in the following sections and a comprehensive evaluation of their contribution to the Project aims makes up the final section of the report. The initiatives were as follows:

- Change management, including the development of a multi-professional guideline on place of birth
- Marketing, including the development of locally focused, evidence-based literature on birthplace choices
- Education, particularly around the midwife’s role in giving women informed choice about place of birth.
7.2.1 Staffing and capacity issues
A staffing and capacity working group within the BPC Project was formed, comprised of midwifery managers from both Trusts, the Project managers and Project leader (see Appendix 5). Its terms of reference were to:

- Raise the profile of the BPC Project in both Trusts;
- Discuss and evaluate maternity service changes in both Trusts that may impact on the success of the BPC Project;
- Discuss and evaluate BPC Project findings and initiatives and how these may impact on the maternity services in both Trusts.

This group, which was chaired alternately by the Heads of the participating midwifery services, met frequently (monthly/bi-monthly) in the early stages, as the Project initiatives were developed. Key issues raised at these meetings included: resource concerns in the event of a rise in numbers of out of hospital births; the closure of the birth centres and withdrawal of home birth services during times of staff shortages; and new ways of working to address these concerns.

7.2.2 Guideline Development
There was no formal guidance for health professionals in either Trust on place of birth at the beginning of the BPC Project. Results from the midwives’ focus groups conducted as part of Phase One of the BPC Project indicated that midwives, GPs and obstetricians used their own professional judgement when recommending a particular place of birth for pregnant women. Findings from the women’s survey and focus groups carried out in Phase One indicated that many health professionals tend to lean towards recommending consultant-led maternity units over alternatives. It was therefore clear that to meet the changes required there was an imperative to give health professionals information to underpin the expected changes in practice.
The apparent bias towards birth in consultant-led maternity units cannot be said to be evidence-based as, for women without identified complications, there is no research supporting the contention that giving birth at home or in a midwifery-led birth centre is any less safe than hospital (Campbell, MacFarlane 1994; Tew 1998). An evidence-based guideline on birthplace choices was therefore developed and implemented in collaboration with health professionals and maternity service users as part of Phase Two of the BPC Project. Adoption of a collaborative and facilitative approach to these activities was in line with the Government’s vision that health professionals and patients should have a real say in the NHS, including how and where services are delivered (DOH 2003a). This approach is supported by principles recommended by Nonaka and Takeuchi (1995), Bonham (1996) and Kaplan (1996), who suggest that involvement of employees and users of an organisation in such a process leads to ownership and professional development.

A series of meetings and a consultation process were held in order to ensure that as many local stakeholders as possible participated in the development of the guideline and had ownership of it, with the aim of having the final draft operational in both Trusts by the end of August 2004. However, an emerging antagonism towards out of hospital births among some senior clinicians in Portsmouth meant this process was not complete in that Trust until late Autumn 2004 (this is described in more detail later in this section).

**Project Guideline Group**

The Project leader and managers met and agreed a general strategy on the development of the guideline, including a timeframe and the constitution of the guideline group (see Appendix 6 for a complete list of members). The identified health professionals (including midwives, GPs and obstetricians) and maternity service users were then invited to attend a series of four meetings, the first being held on 31st March 2004. The meetings were held alternately on different sites in each Trust.
First meeting
The meeting was attended by eight clinicians and three service users. The remit of the BPC Project Guideline Group was agreed as follows:

- Represent and feed back to peers
- Contribute to the scope of the guideline
- Read and comment on drafts
- Take part in the discussions and negotiations regarding the final document

The general tone and content of the guideline was agreed, along with a contact list and an action plan. It was agreed that by the next meeting members would receive a literature review of place of birth and an initial draft of the guideline from the Project team.

Second meeting
At the second meeting at the end of April 2004, the literature review and first draft of the guideline were discussed. Changes agreed at this meeting included altering the tone of the wording to give it a more positive slant and adding information about national and local transfer rates. The meeting closed with an agreement that the amended draft would be circulated prior to the next meeting. The group members were also asked to discuss the document with their colleagues and peers to enable a broad perspective.

Third meeting
The third meeting at the end of May 2004 involved reviewing the second draft and discussing appropriate changes in light of comments from the group members and their peers. Changes agreed included adding a definition of birth place choice; including the term ‘with her consent’ in a section on recording women’s preferences and individual circumstances; and including specific details on rates of mortality and morbidity for each Trust and birth place. However, this last point proved contentious and difficult to realise for reasons that will be explored in the final discussion section of this report (see section 12.3.1). It was also agreed at this meeting that the third draft of the guideline would be sent out for full consultation at the beginning of June 2004,
with requests that any feedback should be given to the Project team by the end of June 2004. This third draft was therefore produced and sent to:

- All obstetricians in each Trust
- All midwifery managers and midwives in each Trust
- All Primary Care Trusts and GP representatives in Portsmouth and Southampton
- Maternity Service Liaison Committees in Portsmouth and Southampton
- All neonatologists in each Trust
- Representatives of local health visitors
- Maternity service user groups including the local branches of the National Childbirth Trust, home birth support groups and Sure Start.

Feedback from consultation process on guideline

As e-mails and letters flowed into the Project team’s offices throughout June 2004, it soon became clear that the guideline consultation process for some was being seen as an opportunity for expression of personal views on home and birth centre maternity services, rather than as a chance to take part in an informed debate on the issue of providing choice to maternity service users as to where they could give birth. For example, comments from General Practitioners included:

- ‘This practice does not want to be involved in home or GP unit intrapartum care’

- ‘I don’t think there really is a storm – that all blew over a few years ago, the midwife’s [sic] effectively won – the majority of GPs gave up and rolled over once the consultants stopped caring…99 per cent of GPs do not want to turn the clock back – they are happy letting the midwives get on with things – which is reflected in the new GMS contract nationally. But women really choosing themselves? – perhaps I’m too much of a sceptic! [sic]’

Comments from midwives were more supportive and constructive. For example:

- ‘These are great. I like the emphasis on ‘normal’ choices before mentioning hospital. It is also good to enable women to change their minds right up to labour rather than ‘book and stick’ which seems to have occurred previously’
Overall, the maternity service users welcomed the guideline, although questioned what other initiatives were to go with it:

- ‘I think it is good; the argument seems to be a valid one. I think that any leaflets given to mums to be are going to need to be very good. I hope that it is as easy to convince mums to be.’

- Specific training needs to be offered on techniques/skills for home births/birth centres. We hear from midwives that they need to learn/update/acquire skills to facilitate safe home births’

- ‘Congratulations to the Birth Place Choices Team. Implementing this document will benefit women, but getting everyone on board will be a challenge.’

Comments from Primary Care Trusts were mostly supportive of the document, with the occasional reservation. For example:

- ‘They do convey a sense of imbalance- there is a slight but perceptible emphasis on home births/alternatives to consultant care. If there is a serious intention around the provision of choice- the guidelines may benefit from being structured slightly differently? For example- would it be a useful starting point to quote the % of births which do not require intervention, those that do and why.’

A final draft was produced and agreed upon at the final meeting of the guideline group at the end of June 2004. At this point some senior clinicians in Portsmouth (mainly obstetricians and paediatricians who had not responded to the initial consultation) began to raise objections to the document and the length of time they had been given to review it. It was therefore agreed that in Portsmouth the guideline would not be submitted for validation by the Trust until clinicians had been given a further opportunity to meet and discuss the document. In Southampton the guideline was validated in August 2004.

Comments received from the Portsmouth clinicians in July tended to focus on the issue of perinatal mortality rates (PMR), with many stating there were local figures that showed these rates were higher for babies born in the MLUs and at home. This generated considerable debate, not least because during this month the BPC leaflet for maternity service users (see section 7.3.2) was also
sent out for consultation. The project team received the following from the person who compiled of the local PMR figures:

‘I am afraid which ever way you look at the data the evidence bases on very large numbers is that Community birth DOES carry a significantly greater risk to the BABY and this should not be glossed over. Hope this is of help and look forward to seeing how you incorporate these stats into your choices leaflet to ensure women are fully informed.’

Because there was not a consensus on the content of the parent information leaflet at this stage, when the guideline went to the Trust’s Clinical Governance meeting for validation in September 2004, it was rejected on the grounds that the leaflet consultation was not yet complete. As a result the guideline was not validated and placed on the Portsmouth Hospitals Trust intranet site until December 2004, after further negotiation and compromise, only a month before evaluation of the project initiatives began. The full guideline may be found in Appendix 7.

To summarise, issues relating to staffing and capacity were discussed at regular meetings with the Heads of midwifery services and disseminated to the appropriate midwifery managers. The multi-professional "Place of Birth" guideline was developed over a period of eight months (in Portsmouth) and five months (in Southampton), with contributions from a wide range of maternity service users and clinicians. Although the outcome of achieving publication of an evidence-based guideline about place of birth was successful, the process was frustrated by delays.

7.3 Marketing for birth centres and home birth
7.3.1 Background
The health communications field has been rapidly changing over the past two decades (Weinreich 2003). It has evolved from a one-dimensional reliance on public service announcements to a more sophisticated approach, which draws from successful techniques used by commercial marketers, termed as social marketing. Social marketing seeks to influence social behaviours, not to benefit the marketer, but to benefit the target audience and the general society (Anderson 1982). In the USA, where healthcare vies in a very competitive market, hospital marketers have identified that women accessing
maternity care have become key decision makers in the selection process (Anderson, 1982). Birth centres are the focus of hospital marketing programmes with strong emphasis on a satisfactory birthing experience in order to influence consumer preference and repeat purchase (Anderson, 1982) and ensuring that the service and image of the birth centre meets the expectations of the decision maker better than competing alternatives.

The results of the BPC Project survey of maternity service users in Phase One indicated that 97% (n=367) of the women who responded reported themselves to be an important influence on their decision of where to have their baby. Results of the focus groups with maternity service users of the BPC Project indicated that awareness of what choices were available locally was key to making decisions about where to give birth. Unless women were aware of the ‘product’ and its associated benefits, it seemed unlikely that they would be able to consider a change in action. Midwives in the focus groups of Phase One acknowledged the need for current comprehensive information to share with pregnant women but did not necessarily identify this as a tool to influence or support behaviour change. In the USA, midwives actively promote the midwifery model of care, birth centres and home birth, often in partnership with supportive organisations (Corry and Rooks, 1999), with an emphasis on quality of care and advancing public education. The introduction of the BPC Project marketing strategy aimed to influence the specific target audience (maternity service users) with the use of marketing intervention tools in order to affect a specific behaviour change goal: that of increasing the number of women birthing in the birth centres and at home by improving their knowledge of options available.

7.3.2 Marketing initiatives

In order to establish a marketing strategy and identify specific goals and objectives, it was important that the process was collaborative and involved members of the target audience, such as maternity service users, in the process. The Project team identified key stakeholders who included maternity service users, lay members, and midwives from both Trusts and invited them
to join the Marketing group. Names and designation of group members are listed in Appendix 8.

The first meeting in March 2004 set the terms of reference and identified the BPC Project marketing plan. The group identified that there were three main aims:

1. To increase the profile of birth centres and home birth

2. To increase women’s awareness of choices of place of birth

3. To increase the number of births within birth centres and at home.

Based on the findings of the Phase One study, the group identified that the key decision makers were women and therefore the marketing strategy would focus on current maternity service users, their partners and families. It was important to define the ‘product’ to enhance the target audience’s understanding and determine the most effective medium to deliver the message. The group gave consideration to resources, implementation, and evaluation. It agreed to meet monthly and set a time frame of six months within which to implement the initiatives.

A formal marketing plan was agreed:

• To re-launch the birth centres within Portsmouth and Southampton areas, including re-naming and improving sign posting and media involvement.

• To provide local, evidence-based leaflets with balanced information on all the birth place options, including contact numbers and dates and times of tours

• To produce individual marketing folders and leaflets for each birth centre, including templates for press releases and posters.

• To develop Birth Place Choices website

• To encourage local women’s groups to have active involvement with the birth centres
Careful consideration of the costs of the marketing strategy were made by the group and the services of a graphic design company, Black and White Designs, were engaged in order to assess the anticipated costs. From the quotation prepared by the company, the group set a budget of £7,000 and agreed that the BPC Project would fund the following products:

- Leaflets (with inserts), approximately 5,000 for each Trust
  £5,000
- Website in each Trust
  funded by each Trust
- Signage for birth centres
  £1,700
- Marketing packs for each birth centre
  £200

Any additional funding would need to be met from public/private sources either by sponsorship from local organisations, the two participating Trusts or from local bids to voluntary organisations, for example, the League of Friends.

**Re-launching and re-naming birth centres**

In order to make the Southampton and Portsmouth MLUs more marketable and to increase the profile locally it was decided that they would be re-launched and re-named. Originally the MLUs were either described as hospital wards (eg Blake Ward) or as Maternity Homes/units (eg Blackbrook Maternity Home) so it was clear that there was a need to change in order to focus on what was the ‘business’ of the units. It was hoped that new customers would be able to tell from the name firstly, what the unit was for and secondly, where it was in the local area. The wider views of maternity service users, midwives and PCT trusts were sought, as ultimately these were the groups that were most affected by the change. Suggestions of possible name changes, including the term “natural birth centre”, were made by the marketing group; however, the “natural” component was the least favoured by midwives, so it was agreed to re-name all the MLUs as “Birth Centres”.

Following final agreement to the proposed change, new signs were ordered for the birth centres partly funded by the project, with additional funding from Southampton University Hospitals Trust and Portsmouth Hospitals League of Friends. Careful consideration was given by the BPC Project managers to
replacement of the new signs to ensure that they continued to provide clear
directions and that they conformed to the Trust/PCT Corporate format.

It was planned that the MLUs would be renamed/re-launched in early October
2004 and each MLU set up a small working group to plan the event. The
marketing group proposed that each MLU would help raise funds for
refreshments for the launch. In order to attract media interest to the launches,
it was decided to invite a local celebrity who might be a maternity service user
to unveil the new signs. It was not certain how much media interest would be
generated so both BPC Project Managers engaged the assistance of each
Trust’s Media and Communications Department for guidance in producing a
press release. There had been local television coverage for the initial launch
of the Project, so they were contacted again. With the help of the Project
managers, the midwives in the MLUs sent out invitations to maternity service
users, midwives past and present, local councillors, obstetricians, PCT
members, local GPs, midwifery lecturers, managers and supervisors of
midwives.

**Southampton University Hospitals Trust Birth Centres re-launches**
The first birth centres to be relaunched were those in Southampton.
Broadlands Birth Centre, which is the co-located birth centre based at the
Princess Anne Hospital, is a thriving facility with over 850 births in 2004. The
midwives working in Broadlands Birth Centre expressed concerns about
raising the profile of their birth centre as due to “staff shortages” they were
only just coping with the workload and did not necessarily want to increase
the birthing numbers. They invited Maggie Elliot, President of the RCM and
Catherine McCormick, Professional Advisor, Midwifery/Family Health at the
Department of Health, to celebrate the continuing success and to raise the
midwifery profile within the unit. A press release feature of the launch
appeared in the November 2004 issue of the RCM magazine (Royal College
of Midwives, 2004)

It had been acknowledged that, in contrast, the New Forest stand-alone units
were under utilised. The midwives in these units invited Baroness
Cumberlege, former Health Minister, Chair of the *Changing Childbirth* Report (1993) and member of the Birth Centre Network, to re-launch Hythe and Lymington Birth Centres (Fig 1). This proved to be very popular both for maternity service users and midwives, creating local media interest. The midwives at Romsey Birth Centre decided not to re-launch their birth centre as they were waiting for remedial building work and decoration to be undertaken.

![Baroness Cumberlege at Lymington Birth Centre Launch October 7th 2004](image)

**Portsmouth Hospitals NHS Trust Birth Centres re-launches**

The midwives in the Portsmouth MLUs re-launched their birth centres in November 2004. The three stand alone MLUs invited local celebrities who had been maternity service users. Blackbrook Birth Centre invited a local radio DJ, Emma Scott from Power FM who had given birth in the centre (Fig 2). Blackbrook was the most under utilised centre in the Portsmouth group so her support not only gave newspaper coverage, but the event was also publicised on her radio show and her website. Blake Birth Centre in Gosport invited a local Premiership football team member, Shaka Hislop, whose wife
had given birth to their fourth baby at the centre. This aroused significant media interest resulting in a prominent television feature on the local television news and coverage in the local newspaper. Grange Birth Centre in Petersfield invited Richard Gaisford, a news reporter for GMTV, whose wife had used the birth centre. The co-located centre in Portsmouth, Mary Rose, invited a retiring midwife celebrating 30 years in service. All the re-launches featured a ceremonial cutting of a ribbon by the invited guest, a speech and cake cutting.

Fig. 2 Guests at Blackbrook Birth Centre Launch November 3rd 2004

Parent Information Leaflet
For many years evidence has existed that demonstrates that childbearing women want more information and choices in their care (Kirkham, Stapleton, 2001). Results of the Phase One focus groups with maternity service users of the BPC Project indicated that awareness of what choices were available locally was key to making decisions about where to give birth. Midwives also acknowledged the need for current, comprehensive information to share with pregnant women that was different from other pregnancy related information. The development of the parent information leaflet aimed to assist local childbearing women to exercise informed choice by providing the best
Maternity service user involvement in development of the leaflet was essential in order to ensure that it was relevant and could easily be understood by the majority of women. It was decided by the marketing group that the leaflet should be generic so that it could be used in each Trust with individual inserts giving local information for each birth centre on facilities offered, contact numbers and tours. The marketing group agreed the wording of the leaflet, which set out the choices available to local women on home, birth centre and consultant-led unit births. It also gave additional information on best evidence available and what would happen “if problems occurred”. This was then sent out for wide consultation to midwives, maternity service users, obstetricians, neonatologists, BPC Project Advisory Group, and BPC Project Steering Group.

The leaflet content aroused significant debate amongst both obstetricians and neonatologists in both Portsmouth and Southampton. The debate mainly focused on how much detail to include about what facilities are (and are not) provided in a birth centre. Medical clinicians also wanted to include a statement saying that delay in transfer may affect the outcome. A number of extra meetings were convened between the Project team members, obstetricians and neonatologists with several e-mail communications being received, for example:

‘...I have seen your draft Birth Choices Leaflet and have a few comments:
1: Under “The Choices –Disadvantages” the leaflet states we may have to transfer mum to hospital. We should also be honest and explicit about the absence of facilities to deal with an extremely urgent or complicated delivery, and that there are NO facilities for advanced neonatal resuscitation. Failure to do this means we are not fully informing the mother and she is therefore not in a position to make an informed judgement about birthplace choice.’

The length of this highly charged debate resulted in significant delays in the leaflet text being agreed at the respective Directorate Clinical Governance groups, which was achieved in late September 2004 in Southampton, but not
until December 2004 in Portsmouth. The development of the leaflet also involved graphics, and, with parental consent, the marketing group decided to use local babies for photo shoots. The cover photograph and text of the leaflet may be found in Appendix 9.

**Website**

When developing the leaflet it was important to consider a range of options for making evidence based information available to women and health professionals. Many consumers have access to the worldwide web and it provides a cost effective alternative whilst improving access for women out of 'working hours'. Web Development Departments in both Trusts were approached to assess the feasibility of using the Trust's websites to access Birth Place Choice information. The process was different in each Trust, for example, in Portsmouth the website design was created by the Trust website designer using graphics and text that had been supplied by the BPC Project manager. In Southampton the BPC Project manager undertook a half day course in order to be able to create a website using existing templates with graphics supplied by the BPC Project, accessed via an electronic library. Women can now access birth place choice information and download copies of the leaflet and inserts via the public website. It has involved no set up costs as the domain names are shared with the Trust as provider: [www.Portshosp.org.uk](http://www.Portshosp.org.uk) and [www.suht.nhs.uk/birthplacechoices](http://www.suht.nhs.uk/birthplacechoices).

**Marketing folders for birth centres**

In order to continue the marketing momentum that had begun with re-launching/re-naming the birth centres and the publication of a local-evidence based leaflet, the Project team thought it important to leave the birth centres with a resource folder. This would enable them to have a guide for any future marketing activities, for example, celebrating the first baby of the New Year, in order to continue to increase the local profile. The resource folder contained the following:

- A guide with suggestions to marketing the birth centres
- A guide to press releases with 'dummy press releases'
- Templates for posters
Involvement of local maternity service users

The involvement of maternity service users has been a vital component to the success of the marketing initiatives, providing timely and relevant advice in the development of the marketing products. The relaunch/renaming of the birth centres involved many maternity service users, as did the development of the evidence-based leaflet, which went out for wide consultation, primarily to NCT groups.

7.4 Education Initiatives

7.4.1 Background

This section describes the education initiatives that were introduced to support the expected changes in practice and marketing strategies. The evidence-based guideline to inform the practice of health practitioners was an important component of the proposed strategy to provide a ‘superior alternative’ to practice prior to the implementation of the initiatives. However, Senge (1994) argues that initiatives aimed at changing the status quo are unlikely to achieve their full potential unless the building of learning capabilities becomes part of the change strategy. Therefore, providing a guideline is unlikely to produce sustainable change unless it is introduced alongside an educational programme that supports individuals in changing their practice.

Kirkham et al (2001), in their study on the use of Informed Choice leaflets in maternity care, highlighted the problems with the maternity services that they studied in having a culture that implicitly or explicitly hindered women’s attempts to secure information and make informed decisions about their care. They called for coherent strategies within practice settings that ensured truly informed choice for maternity service users, as opposed to ‘informed compliance’ (Kirkham et al 2001, p159). Whilst it was found that leaflets on their own did not promote informed choice, O’Caithain et al (2002) postulate...
that they may help to deliver it. It seems likely that it may be behaviours or practice that happens ‘alongside’ distribution of leaflets that affects their success or failure. Therefore it was considered important to include support for midwives in distributing and discussing the ‘Where to be born?’ leaflet as part of an overall education strategy.

Evidence from Phase One of the BPC Project survey suggested that local women were not offered all the options regarding place of birth, in particular the option of home birth, and that written information alone was not useful to women in terms of helping them decide on their birthplace choice. Local women also reported that the midwife was the biggest professional influence on their choice in place of birth, so it was important that the educational initiatives reflected this and that they were developed specifically for this target audience.

7.4.2 The Education Group
The Education Group had membership from midwives in both Trusts and local education providers (details of the full membership may be found in Appendix 10). It met in May, June and July 2004 and January 2005. It was the remit of the Education Group to develop educational initiatives for health professionals that would support the dissemination of the multi-professional place of birth guideline and the evidence based ‘Where to be born’ leaflet based on the findings of phase one of the BPC Project. Whilst a number of strategies were planned that would be similar in both Trusts and even shared in some cases, the group recognised that the way in which midwives tackled the issues regarding dissemination was likely to be different in each Trust. In an attempt to ensure that the challenges of dissemination were identified and solutions owned by the midwives, it was decided to use ‘action learning’ (Lee, 1999). Other types of educational activities planned included study days on informed choice and a BPC Project ‘road-show’ to present the findings of Phase One to local service users and clinicians. There was no attempt to provide identical educational strategies in each Trust, as it was appreciated that needs would be different and use of strategies would depend on the specific needs of the midwives.
7.4.3 Practice Educators
The BPC Project team appointed two part-time practice educators (one for each Trust) to facilitate the education initiatives. The Project leader and Chair of the Education Group had initially submitted bids for a full time practice educator in each Trust, for a six-month period, from funding allocated to educational developments from Hampshire and Isle of Wight Workforce Development Confederation. However, this proved unsuccessful and the posts were supported by BPC Project funds. This led to a re-evaluation of the variety and amount of education and support that could be provided. During the six months that the practice educators were in post informal meetings took place between members of the Education Group in each Trust to discuss issues pertinent to that Trust only.

Both practice educators were seconded from their substantive posts at their relevant Trusts. Due to the amount of time taken in agreeing a job description, advertising, interviewing and awaiting a mutually convenient date for commencement of the post, the practice educators did not start work with the Project until August 2004 (in Southampton) and September 2004 (in Portsmouth). Gill Thannhauser, a practice educator in Southampton University Hospitals Trust, was appointed to the Project for one day a week for six months; Sandy Cornish, a midwife working in clinical practice in the Labour Ward in St Mary’s, at Portsmouth Hospitals Trust, was appointed to work for two days a week for six months. The practice educators were asked to keep reflections using Gibbs reflective cycle (Gibbs, 1988) on the educational activities and evaluations were collected from the midwives at the end of each session. The following sections are based on material from these reflections and evaluations.

7.4.4 Educational strategies in Southampton
The following initiatives were undertaken as part of the education strategy in Southampton:

- Action Learning to facilitate dissemination of ‘Where to be born?’ leaflet for women
• Session on informed choice including role play
• Informed choice workshop
• Guideline launch
• Dissemination of multiprofessional guideline on place of birth
• Home birth workshops

Accessing midwives
During the BPC Project midwives in Southampton Maternity Services were working in many different ways, including: case-load holding in several Sure Start teams; case-load holding in three stand-alone birth centres; integrated teams; core staff in a co-located birth centre and core staff in the consultant-led unit. Following discussion in the Education Group, a decision was made to target the caseload holding teams to develop some ‘action learning’ initiatives. It was considered that midwives working in these teams would be relatively easy to target as they work closely together, having regular weekly team meetings, and are able to develop a good rapport with their ‘caseload’ as they provide continuity of carer. It was also planned that all sessions would be formally evaluated. With the exception of one stand-alone birth centre, meetings with the teams were easily organised by booking time during their regular weekly meetings.

Action Learning Groups
The dissemination of the content of the leaflet ‘Where to be born?’ and the multi-professional guidelines was used as the basis of the action learning groups. The midwives were encouraged to identify issues or difficulties they might need to overcome in order to provide a fully informed choice to women regarding place of birth and then for them to explore how they could address the issues. Action learning was used in this way due to the time constraints of the Project and the availability of midwives. There was a need to address each group’s problems regarding dissemination (such as where supplies of the leaflet should be stored and at what stage in pregnancy they could/should be given to women). Midwives were constantly under pressure to meet clinical commitments, but at the same time it was important to evoke some ownership
of the leaflets and their aim. The practice educator facilitated the groups and was prepared to help midwives find solutions to their problems and provide educational resources that might support them.

One of the first questions asked of the groups was whether they would be able to ensure the ‘Where to be born?’ leaflet was received by women prior to booking to enable them to then discuss it at the booking appointment. The majority felt that this was easy to achieve as women were provided in advance with a ‘pack’ containing other antenatal information including an Antenatal Screening booklet. Two of the groups, however, admitted that women in their care did not always receive the Antenatal Screening booklet prior to booking and agreed this was an issue that they needed to address and would take this forward as an action. It was stressed, however, that women were not expected to make a final decision on place of birth at this point.

Overall there was very little comment on the content of the leaflet and guideline although one group did express concern at the sentence ‘every woman can choose to have her baby at home’. Their anxiety was that this might result in ‘high risk’ women requesting to birth at home. This led on to a discussion on the ‘professional support’ part of the guideline, which appeared to offer a degree of reassurance. Linked closely with this was the issue of staffing and whether home birth was a “real” choice for all. In facilitating the discussion that followed this, an attempt was made to keep the situation in perspective in that it was unlikely that there would be a sudden, massive increase in demand for homebirth.

**Offering informed choice – knowledge and skills**

Two of the groups stated that ‘their’ women did not want home births and so they tended not to offer them; however, they said the women were happy to go to the local co-located birth centre. On further questioning, one group said this was due to cultural reasons and that the predominantly Asian population expected to go to hospital to have their baby and would be disappointed if they did not. The other group identified that it was due to the influence of
family, friends and the media. After exploring the issue they admitted that this meant they were not offering a fully informed choice to the women and they would endeavour to in the future. However, they conceded that if the housing was ‘unsuitable’ their offer of choice could be influenced. Midwives expressed particular concern that in certain cases they or their colleagues might be in danger if called out at night.

The issue of ‘informed choice’ soon became an issue apparent in each of the groups so a decision was made to organise a follow-up session to discuss this and any other issues identified at the initial meeting. A process of reflection was encouraged for midwives to consider their current practice in relation to informed choice and this was assisted by some ‘non-threatening’ role play - the practice educator taking on the role of the pregnant woman in the scenario. This provided some interesting discussion and insight not least around the difficulties inherent in role-play!

Almost without exception the groups made some comment about the influence of GPs. Generally it was felt that when a woman has seen her GP she may have received ‘misinformation’ which then has to be ‘undone’. Midwives were pleasantly surprised to be told that Phase One of this study found that it is the midwife, second to the woman herself, who has the most influence on the choice of place of birth. The groups were asked to explore how they could resolve any potential negative influence on women by GPs. Several of the groups were able to identify that they need to communicate directly with GPs and that they could do so with the support of the guideline. It was decided to attend GP practice meetings and present the guideline and leaflet. One group said they would like to organise someone “from outside” to talk to their GPs as the GPs had concerns about medico-legal aspects, believing that they are accountable for the actions of the midwife.

*Offering informed choice – faith in the system*

Whilst there was some feeling of lack of faith in the ‘system’ in facilitating birth outside consultant units there was also some feeling of ‘self-preservation’. In one of the groups a midwife stated that, despite her offering the choice, none
of the women she booked took up the offer. Later on in the discussion when exploring how midwives felt about birth at home, the same midwife recognised that she was lacking in confidence about it and that, perhaps, her reluctance was being conveyed to women in the way she presented the information. An action deemed necessary from this was the need for some education on home birth situations and equipment. The practice educator began asking midwives experienced in home birth for ‘real life’ situations that could be used in scenario-based teaching.

Before concluding these sessions each group was asked if they would use an A5 size laminated card (to keep in their diary) with evidence-based information that could be used when providing women with information to enable them to make a decision on place of birth. The response to this was positive and they were encouraged to consider the content to be included. The majority of them wanted detail on transfer rates and times, ambulance availability and information demonstrating that home birth is a ‘safe’ option.

**Guideline launch**

The guideline launch took place on September 21\textsuperscript{st} 2004 at the Princess Anne Hospital and included a presentation on the background of the Project, results of Phase One, plans for Phase Two, detail of the guideline (including how to access it electronically) and ‘Where to be Born’ leaflet. The project team invited Tricia Anderson, a local midwife researcher and independent midwife, to speak on ‘Informed Choice and Place of Birth’. Invitations were sent to a large number of health professionals but despite this there was limited medical representation at the meeting.

Once meetings had taken place with the caseload holding teams, dissemination continued amongst the other midwives working within integrated teams\textsuperscript{2}. This was, as had been anticipated, a much more challenging task in terms of organisation. A letter was sent to each midwife in an attempt to ascertain mutually convenient times. This was initially met with

\textsuperscript{2} Integrated teams: teams of 8-10 wte midwives, with individuals working in both community and hospital settings on a shift system
no response and then there was communication from a gradual ‘trickle’ of midwives. At least one member from each team was eventually contacted and the importance of cascading the information to their colleagues was stressed.

Following the launch, a similar format was adopted for the dissemination of the guidelines as for the leaflet but without the ‘action learning’ aspect. There was, perhaps, more cynicism within the integrated teams with regard to being able to provide the full range of choices on place of birth within the constraints of the service. It was apparent that some less experienced midwives felt anxious at being on call for potential home births as they were likely to be called to a house and woman they did not know. They acknowledged that this could influence their information sharing at booking. This resulted in some workshops being held, aimed at boosting the confidence of midwives with little or no experience of birth at home. The workshops included an explanation of the ‘home birth boxes’, on call arrangements, resuscitation equipment and a few homebirth scenarios.

7.4.5 Educational strategies in Portsmouth

The following initiatives were undertaken as part of the education strategy in Portsmouth:

- Action Learning to facilitate dissemination of ‘Where to be born?’ leaflet for women
- Sessions on informed choice including role play
- Informed choice workshop
- Study Day on “Normal Birth”, incorporating guideline launch
- Dissemination of multi-professional guideline on place of birth

Accessing Midwives

Accessing the routine team meetings for community midwives initially seemed the only way in which the practice educator was able to meet with the midwives. Midwives expressed their concerns that they were too busy and action learning was perceived as an extra responsibility that they did not have time for. A compromise was reached and the practice educator attended team
meetings at the midwives’ convenience. The questioning and problem solving approach of action learning was used to encourage midwives to identify ways, for example, in which the leaflet could be distributed effectively. Midwives were asked to focus on issues relating to informed choice and place of birth to help them recognise and solve underlying problems. It was, however, a compromise and for a number of reasons some midwives felt they were distracted or had difficulty concentrating. The large team meetings proved to be difficult for the practice educator to achieve effective learning and teaching, so another attempt was made to establish small groups. This was eventually organised and proved to be beneficial, as midwives had the opportunity to interact with each other and the practice educator. Some of the practical difficulties in providing informed choice were acknowledged and the groups worked to identify solutions.

**Dissemination of guideline and leaflet**

The routine team meetings for community midwives were used to disseminate the guideline and parent information leaflet to midwives and to encourage discussion relating to them. The delayed validation of the guideline and the “Where to be born” leaflet (described in sections 7.2.2 and 7.3.2) inevitably had an impact on the dissemination process. Failure to gain consensus within the consultation period delayed implementation of the educational initiatives, in particular dissemination of these documents, which were the foundation stones of the education strategy. There was no clear process in the Directorate for guideline dissemination and this, coupled with a perception of low morale, meant that the service was unprepared for the change in perspective that implementation of this initiative demanded.

During the discussions in the small groups there was an overwhelming focus on what was voiced as “staff shortages” and that this inhibited midwives from providing choice regarding place of birth. It was often difficult to get beyond this perceived difficulty and concentrate on other barriers to providing informed choice to parents. Many midwives said they did not concur with the findings of Phase One of the Project, refusing to believe that local women were not offered all the options regarding place of birth. The feeling of being
overwhelmed by work appeared to be exacerbated by the Project, in that some midwives expressed their concern that interaction with the Project was likely to result in commitment to additional work without any perceived benefits to themselves.

Midwives appeared to appreciate the opportunity to share issues of concern, but did not believe that any positive change would result. This is a finding identified by Kirkham (2003), who described the NHS as an ‘under-resourced’ and ‘damaging system’, ultimately rendering the workforce powerless, a phenomenon linked professionally with oppression. However, in time the groups became able to suspend the concerns about “staff shortages” and began to engage with the practical aspects of ensuring women received the ‘Where to be born’ leaflet.

**Offering informed choice**

Lack of confidence in practice was a factor identified by midwives as inhibiting the giving of informed choice. Some midwives were adamant they could not support choice if it meant that, for example, a woman with low haemoglobin might choose to give birth in a birth centre. Some midwives were fearful of birth out of hospital, even for women deemed to be at “low risk”, and therefore restricted women’s choice, but offered the co-located birth centre. These midwives were encouraged to seek support from supervisors when they had such situations. The practice development midwife was also available in the Trust to help midwives identify needs and gain new skills.

Midwives expressed concern that, once offered a choice, women would be disappointed if transfer to the consultant-led unit was necessary in labour. Midwives also voiced a fear of being criticised by other colleagues when transferring women to hospital. To help address this issue, they were challenged to discuss scenarios relating to the possible need for transfer and its implications. Midwives implied that they felt threatened by the reaction of their peers, particularly if supporting a woman in a choice that was contrary to local guidelines, for example, planning a home birth with a woman who had previously given birth by Caesarean section. Ideas emerged that facilitated
midwives in determining an action plan aiming to enhance communication amongst colleagues, improve documentation regarding information provided for women, and identify a midwifery support network.

Some midwives were concerned that women whose first language was not English were unlikely to be offered informed choice and would have difficulties gaining access to interpreters and written information. This was a very difficult problem to tackle and no immediate solutions were forthcoming.

‘Normalising Birth’ study day and guideline launch
The Project team in Portsmouth held a study day entitled ‘Normalising Birth’ in early November 2004 which included a launch of the guideline and parent information leaflet in that Trust. This was held at a local venue away from the main hospital and was specifically targeted at midwives. It was well attended and the invited speakers, local midwife educators Maddie Dean and Stephanie Meakin, facilitated lively debate amongst the audience.

Informed choice workshop
In both Trusts the educational input culminated in two informed choice workshops run by Nancy Kohner, an experienced teacher on the subject, for a total of 38 midwives, with the proviso that they would disseminate their learning to colleagues. There was positive feedback from these workshops, which ran for two hours each and were held in both Portsmouth and Southampton.

7.4.6 Reflection on educational strategies
Both Southampton and Portsmouth midwives had the opportunity to engage in a variety of educational initiatives to support them in disseminating the leaflet and implementing the guideline. The practice educators found that working with small groups was helpful. The need for the practice educators to respond to the particular needs of groups of midwives required them to be flexible, in both the content of the sessions and teaching methods they employed. Midwives generally responded positively to identifying barriers to dissemination and ways of overcoming them. This instilled a sense of
ownership and solutions were identified and implemented. Midwives in both Trusts identified that they required not only the skills to offer an informed choice but also the skills to care for women choosing homebirth. Scenarios and role-play were useful strategies for increasing their confidence. Midwives' readiness to offer women an informed choice was hindered if they lacked 'faith in the system' to deliver the range of choices. This included the mindset of the organisation and individuals as well as the resources available.

It required tenacity on the part of the practice educators to engage some midwives. Allowing midwives time away from clinical work commitments is likely to have increased their ability to concentrate on such sessions. In Portsmouth this difficulty was exacerbated by the perceived staff shortages and the considerable inter-professional differences of opinion relating to the guideline and leaflet, which delayed their implementation. This was perceived as a 'lack of support' for birth centres and homebirths from a range of professionals and is likely to have affected the drive to offer women a fully informed choice.
8. Evaluation of Initiatives

8.1 Introduction
This part of the report describes the evaluation of the initiatives, the final phase of the Project, which took place between January and March 2005. In the following sections the methods of evaluation are outlined and findings given; the report concludes with a discussion relating to the main findings about both the outcomes and the process of the Project and key recommendations are given.

The initiatives were evaluated collating local baseline data and the results of survey methods. The findings were then compared with the data collected in the same way during Phase One (see sections 3 and 4 for the results from Phase One).

The main aims of the evaluation were:

- To determine whether the introduction of specially designed information and educational initiatives, aimed at health professionals as well as maternity service users, increase women’s knowledge of choices for place of birth.
- To determine whether implementation of these initiatives was associated with an increase in the number of women choosing to give birth outside main consultant-led maternity units.

8.2 Method
A postal survey of maternity service users was carried out to assess whether any changes had taken place regarding information giving, choices offered and decision making with regard to place of birth since a similar survey was conducted during Phase One. The questionnaire (see Appendix 11) was a modified version of the one used in phase one of the BPC Project and was divided into five sections:
Section A – Your children
Section B – Information about where you can have your baby
Section C – Making choices
Section D – Decisions about place of birth
Section E – You and your family
Two extra questions (numbers 11 and 11a, see Appendix 11) were added with the aim of evaluating the effectiveness of the evidence-based informed choice leaflet.

A survey was also undertaken of midwives employed by Portsmouth and Southampton NHS Trusts. The aim of the survey of midwives was to assess the impact the initiatives had on midwives. Data were collected using a questionnaire based on instruments used in other studies (EDCHST 1998; Saunders et al 2000) and from themes generated during the Phase One focus groups with midwives. The questionnaire may be found in Appendix 12. Following ethical approval, an informal piloting process was carried out in Portsmouth NHS trust on three midwives and from this, no modifications were made.

8.2.1 Women’s Survey
During October and early November 2004, the midwife carrying out the ‘booking’ visit gave a letter to all women in both participating trusts at this time (see Appendix 13). This outlined the study and invited women to participate. The letter included a reply section for women to complete details of her name, address, estimated due date of birth and indicating her permission for a postal questionnaire to be sent to her home address when she was over 24 weeks gestation. The reply section was returned to the Project team in the Freepost envelope provided. The method of gaining consent was different to that used in Phase One: the intention was to give women information about the Project at an earlier stage in pregnancy than had been achieved in Phase One. As in the Phase One study, consideration was given to providing the opportunity for non-English speaking women to participate in the survey. However, unlike the Phase One study, measures were taken to actively recruit this group. This was achieved in partnership with the Patient Information service in both Trusts who provided the Project with the six most common languages spoken in the Portsmouth and Southampton area, with access to translation. Non-English speaking women were asked to contact their midwife if they needed a
questionnaire translated into their own language; this invitation was included in the letter text in the following languages: Arabic, Farsi, Cantonese, Bengali, Urdu, and Portuguese.

In January 2005 135 women over 24 weeks gestation who had given consent to be contacted in the early part of pregnancy, were sent a study questionnaire and information sheet (see Appendix 14). Hospital databases in both Trusts were accessed prior to sending out any questionnaires to ensure they were not sent to women to whom it might cause distress, for example, women who had had a miscarriage. The information sheet described the Project and clearly stated that a woman was free not to participate without prejudice to her care in any way. A Freepost envelope was provided to return the completed questionnaire to the local BPC Project office. Women who returned the completed questionnaire were deemed to have given consent to participate. The information sheet gave contact details of the BPC Project Managers should any woman wish for more information about the Project. All the General Practitioners in the Portsmouth and Southampton areas received a letter giving information about the survey before the questionnaire was sent out (see Appendix 15).

The numbers recruited by this method were small (n=135), so action was taken to adapt the recruitment strategy. It was identified that there would need to be a second recruitment method for women who were over 24 weeks on the 1st January 2005, which in effect extended the recruitment phase, but recruited from the same population of women who had been approached in October and November 2004. Chair’s action was sought from the Local Research Ethics Committee and approval granted in November 2004. Midwives in each Trust were asked to recruit women over 24 weeks to the study during a three week period in January 2005. This process was carried out in exactly the same way as in Phase One (see section 4.2.3).

8.2.2 Midwives’ survey
In February 2005 all midwives employed by both Trusts were sent an information sheet (Appendix 16) and questionnaire (Appendix 12) via the
internal post to their work place. The Heads of Midwifery in each Trust had agreed to supply a list of midwives along with their main place of work. The information sheet described the project and clearly stated that midwives were free not to participate. Midwives were provided with an envelope in which to return the completed questionnaire via the Trust internal post to their respective BPC Project Managers. Midwives who returned the completed questionnaire were deemed to have given consent to participate. The information sheet gave contact details of the BPC Project Managers should any midwife wish for more information about the project. A study number was added to each questionnaire prior to posting to ensure anonymity. The purpose of this number was explained to midwives in the covering letter. The respondents, both maternity service users and midwives, were able to request a copy of the study report by completing and returning a detachable, stamped addressed sheet at the back of the questionnaire.

8.2.3 Confidentiality and anonymity
Both questionnaires were designed with a front sheet, which contained only the title of the survey and the participant’s unique study number. The women’s questionnaires were returned by the respondents in a pre-paid envelope direct to the local BPC Project office and by the respondents to the midwives survey in an envelope via the Trust Internal post to each respective BPC Project manager.

8.2.4 Analysis and data protection
Questions were coded and data were entered onto a dedicated database. Descriptive statistics were used to report data using Statistical Package for the Social Sciences (SPSS). Results are presented as simple frequency distributions and cross-tabulations. The surveys consisted mostly of closed pre-coded questions and some open questions, which have been analysed by identifying significant words and sentences that occur more than twice from which recurrent themes have emerged. Findings are presented as tables and figures with accompanying text and quotations are used to illustrate key points. Both electronic and hard copies of data have been stored in accordance with the 1998 Data Protection Act.
9. Phase Two - Baseline Data

9.1 Birthplace data comparisons

Phase One included collection of baseline data relating to the birth rates in both Trusts for births taking place in the consultant-led units, birth centres and at home. Data were obtained from the central maternity databases with permission from the Heads of Midwifery of each Trust. At the end of Phase Two the data collection was repeated to determine whether there had been a change in the number of births taking place outside the consultant-led units, as well as to consider other information such as intrapartum transfer rates and perinatal mortality rate. It was acknowledged that any changes might have occurred as a result of circumstances or initiatives unrelated to the BPC Project. It was therefore anticipated that the surveys would demonstrate more clearly any role the project initiatives might have played in the outcomes evaluated.

The number of births in the different birthplaces within Portsmouth and Southampton maternity services was determined for the final 12 months of the BPC Project. These figures were compared with the baseline data collected at the beginning of the project. There was an increase in the numbers of women giving birth for most of the stand-alone birth centres, and overall an increase in the number of out of hospital births in Southampton. However, there was a fall in the proportion of out of hospital births in Portsmouth (see Table 10).

In Portsmouth there was no increase overall in the percentage of births in the stand-alone birth centres and a decrease in the number of births in the co-located birth centre. However there was an increase in birth numbers in the stand-alone birth centres in Portsmouth that had been targeted by the initiatives (Grange and Blackbrook).

In Southampton there was an overall increase in birth numbers in all the birth centres, in particular the co-located birth centre, where the increase was 4%, and a corresponding decrease in birth numbers in the Consultant-led maternity unit.

9.2 Transfers from Birth Centres
As in the Phase One study, data on transfers from the individual stand-alone and co-located birth centres were collected (Tables 11 and 12).

**Table 11: Peripartum transfers into consultant-led unit in Southampton January-December 2004 by planned place of birth n (%)**

<table>
<thead>
<tr>
<th>Number of women who laboured</th>
<th>Hythe Birth Centre n=172</th>
<th>Lymington Birth Centre n=207</th>
<th>Romsey Birth Centre n=100</th>
<th>All stand-alone Birth Centres n=479</th>
<th>Broadlands Birth Centre (co-located) n=1440</th>
<th>Home births n=227</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td>109</td>
<td>148</td>
<td>75</td>
<td>332</td>
<td>881</td>
<td>163</td>
</tr>
<tr>
<td>transfers (multigravid)</td>
<td>13 (8)</td>
<td>14 (7)</td>
<td>3 (3)</td>
<td>30 (6)</td>
<td>145 (10)</td>
<td>37</td>
</tr>
<tr>
<td>transfers (primigravid)</td>
<td>50 (29)</td>
<td>45 (22)</td>
<td>22 (22)</td>
<td>117 (24)</td>
<td>414 (29)</td>
<td>27</td>
</tr>
<tr>
<td>Total women transferred</td>
<td>63 (37)</td>
<td>59 (29)</td>
<td>25 (25)</td>
<td>147 (30)</td>
<td>559 (39)</td>
<td>64 (28)</td>
</tr>
</tbody>
</table>

**Table 12: Peripartum transfers into consultant-led unit in Portsmouth January-December 2004 by planned place of birth n (%)**

<table>
<thead>
<tr>
<th>Number of women who planned birth</th>
<th>Blake Birth Centre n=302</th>
<th>Blackbrook Birth Centre n=153</th>
<th>Grange Birth Centre n=227</th>
<th>All stand-alone Birth centres n=682</th>
<th>Mary Rose Birth Centre (co-located) n=980</th>
<th>Home births n=117</th>
</tr>
</thead>
<tbody>
<tr>
<td>transferred (multigravid)</td>
<td>17 (6)</td>
<td>6 (4)</td>
<td>18 (8)</td>
<td>41 (6)</td>
<td>75 (8)</td>
<td>not available</td>
</tr>
<tr>
<td>transferred (primigravid)</td>
<td>42 (14)</td>
<td>19 (12)</td>
<td>41 (18)</td>
<td>102 (15)</td>
<td>257 (26)</td>
<td>not available</td>
</tr>
<tr>
<td>Total transfers</td>
<td>59 (20)</td>
<td>25 (16)</td>
<td>59 (26)</td>
<td>143 (21)</td>
<td>332 (34)</td>
<td>not available</td>
</tr>
</tbody>
</table>
As in Phase One, the transfer rate was higher in the Southampton area than the Portsmouth area. The most common reasons for transfer from a Birth Centre in Southampton to the Consultant led unit in the first and second stages of labour were “failure to progress” and meconium-stained liquor. Postpartum, the most common reasons were for retained placenta and need for suturing, but these were very few. Postnatal transfer for concern about the baby’s well-being was extremely rare. Broadlands Birth Centre undertakes low risk inductions of labour (for postmaturity only) and for this reason their statistics are likely to reflect a higher transfer rate to the consultant-led unit, compared with the other Birth Centres.

Also as in Phase One, a woman having a first baby was more than three times more likely to transfer than a woman having a second or subsequent baby. There was no change in the overall perinatal mortality rate in either Trust from the year prior to the start of the Project to the final year of the Project, with a consistent stillbirth rate of between 0.4-0.56% per live births. The neonatal death rate in Southampton was 0.17% in 2002 and 0.08% in 2004.

10. Phase Two - women’s survey results

The questionnaire was divided into five sections:
Section A – Your children
Section B – Information about where you can have your baby
Section C – Making choices
Section D – Decisions about place of birth
Section E – You and your family

10.1 Respondents
Eight hundred and forty three questionnaires were distributed to women. The total number of surveys returned to the BPCP Project team was 270, giving a response rate of 32% (n=270/843). This was lower than in the Phase One study, which had a response rate of 43% (n=398/925). Table 13 shows the main characteristics of the respondents to the surveys in both Phases.
As indicated in Table 13 respondents were broadly similar in both phases except that there was a higher percentage response rate from primiparous women in Phase Two than in Phase One.

### 10.2 Information

Women were asked whether they had received any information about birthplace choices. The majority (94% n=253) had been given some information, with 82% of women reporting that the information first came from a midwife (see Table 14). This latter finding is similar to that of the Phase One survey.
Table 14: Sources of information n (%)*

<table>
<thead>
<tr>
<th>Total respondents N= 270</th>
<th>GP (19)</th>
<th>Midwife (90)</th>
<th>Hospital doctor (6)</th>
<th>Family/friends (12)</th>
<th>Other (3)</th>
<th>No response (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who did information come from?*</td>
<td>52</td>
<td>244</td>
<td>15</td>
<td>40</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Who gave first information?*</td>
<td>38</td>
<td>213</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

* Respondents could give >1 response, therefore percentages total >100

Women reported that they were more likely to use spoken information alone (49%) than written (2.3%) in making a choice about birthplace, with 29% of respondents using both, a similar response to the Phase One survey (see Table 15). The first information was received at around 12-13 weeks gestation (mean = 13 weeks), which concurs with findings of the Phase One survey.

Table 15: Information received/used n (%)

<table>
<thead>
<tr>
<th>n= 270</th>
<th>Spoken</th>
<th>Written</th>
<th>Both</th>
<th>Neither</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of information did you receive?</td>
<td>137 (51)</td>
<td>12 (4)</td>
<td>103 (38)</td>
<td>N/A</td>
<td>18 (7)</td>
</tr>
<tr>
<td>Which information did you use to help you choose where to have your baby?</td>
<td>130 (48)</td>
<td>6 (2)</td>
<td>76 (28)</td>
<td>52 (19)</td>
<td>6 (2)</td>
</tr>
</tbody>
</table>

Women were asked whether they had been given a leaflet specifically on birthplace choices in order for the Project team to assess what impact, if any, the evidence-based leaflet might have had. Less than half the number of respondents (n = 109 40%) reported having been given the leaflet, with 86 saying that it was very or quite useful.
10.3 Choices

The questionnaire then asked about choices the respondents had been offered. Two hundred and twenty five (83%) of respondents had been offered a choice of place of birth. Of the 44 women who reported that they had not been offered a choice 30 (68%) were either women with existing medical conditions or who had a high risk pregnancy and were anticipating delivery at the consultant led maternity unit:

‘Due to problems with my pregnancy’

‘Have a thyroid problem, advised to go to hospital’

‘As I have a twin pregnancy it will be best to be near the special baby unit’

Fourteen of the women who had not been offered a choice reported either that it had not been discussed or they had been given misleading information:

‘The Consultant said 37 was too old for midwifery led unit’

‘I was told that my first baby must be born in hospital’

‘No one has spoken to me about my birth’

The majority of women (n=208, 77%) reported that the midwife offered the choices, which concurred with the findings of the Phase One survey. As in Phase One, choices were offered during the booking visit between 12-13 weeks gestation. Most women (n=155, 57%) said that it was very important to have a choice about where to have their baby and that they had had enough information and discussion (see Table 16). This concurs with the findings in Phase One.

Table 16: Assessment of amount of information/discussion n (%)

<table>
<thead>
<tr>
<th></th>
<th>Information</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too much</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Enough</td>
<td>171 (63)</td>
<td>166 (61)</td>
</tr>
<tr>
<td>Needed more</td>
<td>42 (16)</td>
<td>36 (13)</td>
</tr>
<tr>
<td>No information given</td>
<td>4 (1)</td>
<td>9 (3)</td>
</tr>
<tr>
<td>None needed</td>
<td>7 (2)</td>
<td>12 (4)</td>
</tr>
<tr>
<td>No response</td>
<td>45 (17)</td>
<td>41 (15)</td>
</tr>
</tbody>
</table>
In terms of demographic profile, respondents who said they had had enough information and those who said they needed more discussion were similar. These respondents were more likely to be primigravid, white, speaking English as their first language and working full time. Of the seven respondents from ethnic minority groups, all reported that they had had enough information and discussion. All respondents were invited to give more detail to their answers, from which a content analysis was conducted and themes emerged:

- **Information**
  - ‘Not enough information offered about homebirth’
  - ‘Mothers should be given more information and their preferences need to be discussed’
  - ‘At present 31 weeks and in the dark about all the choices/options’

- **Choices**
  - ‘Choice offered, but pros and cons not explained’
  - ‘You choose a place where you feel safest’
  - ‘Unless it is known there will be complications with the baby it should be left to the individual’

- **Decision**
  - ‘Encouraged to follow my decision’
  - ‘I may change my decision at a later stage’
  - ‘I was asked too early on and did not want to make a decision before exploring my options’

- **Professional conflict**
  - ‘Midwives more supportive to homebirth than GPs’
  - ‘Different midwives offered different advice’
  - ‘GP inferred I had to go to hospital, whereas midwife said should be where I feel most safe/relaxed’

In the Phase Two survey, 72% of respondents reported that they were offered a choice of the consultant-led maternity unit (see Table 17) compared to 69% in the Phase One survey. There 59% of respondents reported being offered a stand-alone birth centre; in the Phase One study this was indicated by 56% of respondents.
Table 17: Birthplace choices offered n (%)

<table>
<thead>
<tr>
<th>What were the choices offered</th>
<th>n= 270</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>114 (42)</td>
</tr>
<tr>
<td>Co-located Birth Centre</td>
<td>98 (36)</td>
</tr>
<tr>
<td>Stand-alone Birth Centre</td>
<td>158 (59)</td>
</tr>
<tr>
<td>Consultant-led unit</td>
<td>195 (72)</td>
</tr>
<tr>
<td>Other</td>
<td>35 (13)</td>
</tr>
<tr>
<td>No response</td>
<td>7 (3)</td>
</tr>
</tbody>
</table>

There were local differences between the two Trusts with regard to the number of choices offered, with a higher proportion of women in Portsmouth reporting they had been offered three or more choices than in Southampton (72% and 38% respectively).

10.4 Decision-making

When asked about decision-making regarding where to have their baby, 77% (n=208) of respondents said they had felt involved in the process compared to 74% (n=293) in the Phase One survey. Twenty six per cent of women planned to have their baby in a stand-alone birth centre compared to 16% (n=62) in the Phase One study. Overall, fewer women planned to have their baby in either a co-located birth centre (19%) or a consultant led maternity unit (44%) than in the Phase One study (21% and 50% respectively). Fewer women also reported the co-located birth centre (19%) and consultant led maternity unit (41%) as the best place to have their baby. More women reported that home would be the best birthplace (6%) than in the Phase One study (5% n=18) (Table 18).

Table 18: Planned place of birth and Best place of birth n (%)

<table>
<thead>
<tr>
<th></th>
<th>Planned place of birth n=270</th>
<th>Best place of Birth n=270</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>14 (5)</td>
<td>16 (6)</td>
</tr>
<tr>
<td>Co-located birth centre</td>
<td>52 (19)</td>
<td>51 (19)</td>
</tr>
<tr>
<td>Stand alone birth centre</td>
<td>70 (26)</td>
<td>71 (26)</td>
</tr>
<tr>
<td>Consultant-led unit</td>
<td>118 (44)</td>
<td>110 (41)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (5)</td>
<td>11 (4)</td>
</tr>
<tr>
<td>No response</td>
<td>3 (1)</td>
<td>11 (4)</td>
</tr>
</tbody>
</table>
Respondents were asked about what influenced their decision and 211 (78%) reported that they themselves were the greatest influence with the partner being the next greatest influence (n=119, 44%). The midwife was said to be to be the greatest professional influence (n=107 40%). These findings are similar to those of Phase One. The eight women who had given birth to four or more babies (n=8/200) reported the GP as the greatest professional influence on where to give birth. The majority of women (n=208, 77%) said they had been involved in the decision about place of birth “a lot”.

Other factors that influenced women’s decisions concurred with Phase One findings, with primiparous women more likely to consider the good reputation of the unit as very important (n=106, 39%). Of the 144 multiparous women, 101 (70%) reported previous experience as the most important influence. When asked to specify other influences on making a decision on a birthplace, responses included:

‘Being treated as a person rather than a patient’
‘Don’t want to feel less important than others’
‘Faith in personnel working there’
‘With my first I didn’t have a choice because of my age, now going to do what I want’

Forty two per cent of women reported that they should be free to make their decision about where to have their baby at any time during their pregnancy (see Table 19).

Table 19: When should decision be made? n (%)
When asked who should make the decision about place of birth, 173 (64%) women said, after considering the midwife’s or doctor’s opinion, it should be them. No respondents reported that the decision should be left entirely to the midwife or doctor, findings which concur with the Phase One study. Only eight said they did not know which was the best birthplace choice, and four women said they did not mind where they had their babies.

In summary, having a choice of place of birth is very important to women in Portsmouth and Southampton. The midwife has the most important influence amongst health professionals on women and their birthplace choices. In the Phase Two study, more local women were offered all the options regarding place of birth than in Phase One, particularly the option of stand-alone birth centres, with women in Portsmouth more likely to be offered that choice than in Southampton. More women wanted the option of home/birth centre and felt that to be the best place to have their baby. Of those who had seen the new ‘Where to be born?’ leaflet, the majority found it very/quite useful. However, written information alone was still not as useful as a combination of written and spoken information from the midwife in terms of helping women decide on their birthplace choice.
11. Midwives’ survey results

11.1 Respondents

All midwives in the participating trusts were sent a questionnaire: 523 in total (286 in Portsmouth and 237 in Southampton), and 150 were returned completed. This gives an overall response rate of 29%. The questionnaire was divided into four sections:

A. Information giving
B. Education and Practice development
C. Your views
D. About you

The mean age of the respondents was 43 years (SD 8.7) and the mean number of years as a practising midwife was 14 years (SD 9.6). The largest proportion of responses came from community-based midwives. When asked where they mainly worked, 89 (59%) indicated they worked outside of hospital, either in birth centres, as community midwives or within integrated teams, while the remainder worked solely in a consultant-led maternity unit (see Table 20). Almost a quarter of the respondents were qualified to degree level.

The questionnaire asked about midwives’ experiences of out of hospital births in the preceding 12 months, and almost half said they had attended at least one birth centre birth, while the same percentage said they had attended home births. Nineteen per cent of hospital midwives (n=11) reported they had attended birth centre births in the last twelve months; although this seems unlikely, it was difficult to determine from this survey whether this was actually the case or whether they had misunderstood the question.
Table 20: Area of work by NHS Trust n (%)

<table>
<thead>
<tr>
<th>Area of work</th>
<th>Southampton</th>
<th>Portsmouth</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=62</td>
<td>n=84</td>
<td></td>
</tr>
<tr>
<td>Integrated</td>
<td>16 (26)</td>
<td>9 (11)</td>
</tr>
<tr>
<td>Hospital only</td>
<td>24 (39)</td>
<td>33 (39)</td>
</tr>
<tr>
<td>Birth Centre</td>
<td>13 (21)</td>
<td>14 (17)</td>
</tr>
<tr>
<td>Community only</td>
<td>9 (15)</td>
<td>28 (33)</td>
</tr>
<tr>
<td>No response</td>
<td>3 (5)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

11.2 Information giving

Midwives were asked whether they had seen the new leaflet for women on birthplace choices and, if they had, what they thought of this leaflet. Over 70% (n=105) had seen the leaflet and most found the leaflet either useful or very useful.

The midwives were also asked if they had access to supplies of this leaflet and whether the leaflet had made their job easier or more difficult. Forty six per cent (n=70) said they did have access to supplies. However, cross-tabulations with ‘main area of work’ revealed that the vast majority of community midwives, and birth centre midwives had access to the ‘Where to be born?’ leaflet.

Midwives were somewhat ambivalent about whether the leaflet had made their job easier, with only 38 stating that it had. However, only six of the midwives who said that they had seen the leaflet indicated that it made their job more difficult (Table 21). Examples of reasons given for the latter response were:

‘Another thing to remember to give to clients.’
‘Some women may be inflexible.’
‘Ladies sometimes expect one-to-one care throughout labour.’
‘Some women choose birth centre who are at risk of complications/risk factors’
‘Feel [the leaflet] comes across as quite negative about main unit, i.e. information on episiotomy.’
Table 21: Has the leaflet made your job easier/more difficult? n (%)  

<table>
<thead>
<tr>
<th>n= 150</th>
<th>Leaflet made job easier</th>
<th>Leaflet made job more difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38 (25)</td>
<td>6 (4)</td>
</tr>
<tr>
<td>No</td>
<td>33 (22)</td>
<td>83 (55)</td>
</tr>
<tr>
<td>Don't know</td>
<td>30 (20)</td>
<td>10 (7)</td>
</tr>
<tr>
<td>No response</td>
<td>45 (30)</td>
<td>47 (31)</td>
</tr>
</tbody>
</table>

The midwives were asked what other types of information they gave to women on birthplace choices and 129 (86%) responded that they gave verbal information. They were also asked whether they were selective about what information they gave women about their birthplace options and 113 (75%) said they were. Of those who said they were selective, examples of reasons for this response included:

‘Advise high risk to deliver in hospital.’

‘Aware that I am biased towards birth centre/home birth.’

‘My client group do not have home birth due to family pressure.’

‘Depends on past obstetric and current obstetric history.’

11.3 Education and practice development

The midwives were asked what opportunities they had had to look at the issue of informed choice since entering midwifery. The respondents could tick as many of the options as they liked, but the majority responded that these learning opportunities came from personal reading and study days. They were also asked if they had seen the new Trust guideline on Place of Birth and 53 (35%) said they had and of these respondents, 47 said it was useful/very useful. Only 43 (29%) of midwives said they had been given enough information on the guideline.

Eighty one per cent (n=122) of the respondents said they knew about the BPC Project before receiving the questionnaire. However, only small numbers reported that that their practice had changed in any way since the introduction of the BPC Project initiatives. For example, of the fifty three midwives who
had seen the guideline, only 14 said it had changed their practice in any way. Those who said their practice had changed gave responses such as:

‘I feel I have more backing to promote birth centres and home birth.’

‘Feel more empowered giving choices to clients as feel there is more choice.’

‘I give more details more openly.’

‘Have more information so feel more confident discussing it with women.’

‘Tried to persuade GPs to provide the options open to women.’

The midwives were asked to rate the BPC Project education initiatives they had accessed (i.e. group work with the project practice educator, project study days and project presentations). Less than 50% of respondents had accessed the initiatives; however, of those that had, the majority found them useful/very useful. Midwives said that the parent information leaflet and study days were the most helpful of the initiatives in changing their practice.

The midwives were also asked if there was anything more that would help them to facilitate informed choice, and 29 (19%) said there was. Asked to comment on what would help, typical replies included:

‘Access to yearly statistics from each unit.’

‘Equality of antenatal screening tests.’

‘Higher number of community midwives.’

‘If GPs were informed as well, would not have to contradict the misinformation they give women.’

Ninety two per cent (n=138) of the midwife respondents said all women should be given a choice about place of birth and 73% (n=110) said that the women themselves should be the ones to make the final decision about their birthplace choice. When asked when this decision should be made, 65% (n=97) said at any time, with only 7% (n=11) stating that their first meeting with the women was the time when this decision should be made.
The midwives were asked if they found this decision-making process more difficult with particular groups of women and 47% (n= 70) said that they did. A content analysis was conducted on the comments elaborating on this response and the key themes were:

- Women from minority ethnic groups who speak little or no English
- ‘High risk’ women who want to birth in a ‘low risk’ environment
- Less educated women – too eager to comply
- Highly educated, upper/middle class women – too challenging
- Middle class, older primigravida – high expectations
- Women lacking in confidence/language skills and influenced by partner/family.

Eighty eight (59%) of respondents said that their own personal experiences (work and life experiences) had affected the way they thought about birthplace choices. Nearly half the respondents said their experiences affected the type of information and support they gave maternity service users (see Table 22).

### Table 22: Work and life experiences of midwives and effect on information/support offered to women n (%)

<table>
<thead>
<tr>
<th></th>
<th>Experiences affect way you think about birthplace choices?</th>
<th>Experiences affect support given?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (59)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No (33)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know (7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>58 (39)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>58 (39)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27 (18)</td>
</tr>
</tbody>
</table>

Content analysis of the reasons the midwives gave for these responses generated the following themes:

- Working in hospital makes one more aware of complications and brings the tendency to err on the side of caution and puts one off home and birth centre births
• Years of experience in all areas makes one confident to offer all choices, i.e. confidence comes with experience
• Positive personal experience of home birth makes you want to promote it
• Cascade of intervention, dirt and defensive practice in hospitals create problems and dilemmas and make one want to offer birth centres/home birth to all.

Midwives were asked what they thought influenced women’s decisions about where to have their baby. They could tick as many responses as they liked, and the highest numbers of positive responses were given to the woman herself, followed by past experience, family and friends, and the woman’s partner. The findings from the women’s survey concurred with the midwives responses in that amongst health professionals, the midwife is the greatest influence.

When asked about their attitudes to the different out of hospital birthplace options, 91% (n=137) of respondents said births in co-located birth centres should be increased, 90% (n=136) said the same for stand-alone birth centres, and 93% (n=140) said the number of home births should be increased. When asked where they would choose to have their baby if they were pregnant, 17% said they would have their baby in a consultant-led unit, with 43% responding that they would opt for a home birth (see Table 23).

Table 23: Where would you choose to have your baby? n (%)

<table>
<thead>
<tr>
<th>Where would you choose to have your baby?</th>
<th>n= 150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>65 (43)</td>
</tr>
<tr>
<td>Stand alone birth centre</td>
<td>18 (12)</td>
</tr>
<tr>
<td>Co-located birth centre</td>
<td>34 (23)</td>
</tr>
<tr>
<td>Consultant-led unit</td>
<td>26 (17)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (2)</td>
</tr>
<tr>
<td>No response</td>
<td>3 (1)</td>
</tr>
</tbody>
</table>
Finally, midwives were finally asked if they had any more comments to make about place of birth, and many did. Their replies were analysed and the following themes emerged:

- **“Shortage of midwives” limits women’s choices**
  ‘Would love to give greater home birth service, but can’t staff it properly.’
  ‘Not enough midwives to offer stand-alone birth centres and home birth at night.’
  ‘Need more midwives – seen so many women denied home birth because of lack of midwives.’

- **Women should have choice, but only if safe**
  ‘As far as possible women should be supported in their decisions and choices.’
  ‘Safety is paramount.’
  ‘Shouldn’t look at women making decisions in isolation.’
  ‘Women should be fully informed and guided by professionals.’

- **Midwives in community under-valued**
  ‘Feel community and birth centre midwives are greatly under-valued.’
  ‘We need more support and encouragement to work at birth centres. We are not acknowledged for our hard work.’

- **GPs and obstetricians not supportive of midwifery-led care**
  ‘Difficult to manage midwife-led care in hospital with attitudes of higher management and obstetricians.’
  ‘If GPs and obstetricians could give a more positive message about birth centres and home birth…’

**11.4 Summary**

In summary, the majority of midwife respondents knew about the Birth Place Choices Project and agreed all women should be given a choice about where to give birth. Of those who had used the new ‘Where to be born?’ leaflet, the multi-professional guideline on place of birth and the education initiatives, most found them useful, and a small number said they had changed their
practice as a result. The midwives concurred with the maternity service user surveys in indicating that verbal information at the booking visit was the way they normally gave information about birthplace choices. However, only 7% said this was the right time for women to make a decision about where to give birth. Nearly half of respondents said their personal experiences had affected the type of information and support they gave maternity service users. The majority of respondents agreed births in birth centres and at home should be increased, with 43% saying that, if pregnant, they would choose to have their baby at home.
12. Phase Two - Discussion

12.1 Introduction

The aims of Phase Two were:

- To determine whether the introduction of specially designed information and educational initiatives, aimed at health professionals as well as maternity service users, increase women’s knowledge of choices for place of birth.
- To determine whether implementation of these initiatives lead to an increase in the number of women choosing to give birth outside main consultant-led maternity units.

The purpose of this section of the report is to discuss the main findings resulting from the evaluation with regard to the development of maternity services and implications for policy, particularly with reference to the National Service Framework for Children, Young People and Maternity Services (NSF) (Department of Health, 2004). Barriers to achieving the aims of the Project are highlighted, as are lessons that can be learnt from the process; within this final section the main limitations and strengths of the Project are explored and recommendations for further research are given.

12.2 Key achievements of the Project

In terms of meeting its aims, the BPC Project succeeded in a number of ways, which are detailed in the following three sections.

- More women became aware of the birthplace choices open to them and more women planned to give birth at home or in a birth centre. This contributes directly to one of the aims of the NSF – namely, promoting normality and choice in maternity care.
- The comparisons with the 2003 and 2005 baseline data showed a rise in the number of births in most of the stand-alone birth centres and one co-located birth centre.
12.2.1 Inter-linked initiatives

It appears that adopting a package of interventions rather than just one (for example simply producing a leaflet) was a successful strategy. Although it is not possible to determine exactly what influenced the results, this is a tactic also recommended by others who have attempted similar exercises (Kirkham and Stapleton, 2001; Demilew, 2004). It was also intended that the BPC Project was integral to both Southampton and Portsmouth maternity services strategies from the very beginning, and this was achieved in many respects.

The following illustration gives an example of this collaborative working between the Project team and the maternity services managers. Prior to the onset of this Project, one of the Trusts had frequently closed the stand-alone birth centres for periods of time during episodes of staff shortage. Work from the BPC Project marketing group made recommendations to the staffing and capacity group that closing birth centres would always be counter-productive as women would be less inclined to book to have their babies in birth centres that were constantly threatened with closure. As a result, the management teams in both Trusts made a commitment to keep the birth centres open in the interests of increasing the birth numbers in these centres. This proved particularly challenging for Portsmouth Hospitals NHS Trust during the summer of 2004, when high sickness levels among midwives coincided with the August holidays. However, instead of closing the birth centres to free up more birth centre midwives to work in the consultant-led unit, agency staff nurses were employed on the post-natal wards in the hospital so midwives from these wards could staff the main Labour Ward. It is interesting to note that, following the adoption of this strategy, the two stand-alone birth centres that had been closed most often in the past saw a rise in their birth numbers after years of seeing little or no change in these numbers.

Similarly, Southampton also experienced a challenge relating to staffing deployment due to a Trust-wide freeze on recruitment to midwifery posts during the project. However, due to the commitment of the management team and birth centre midwives, they were able to keep their birth centres open.
Therefore the work with the maternity service users in the marketing group ultimately resulted in their local birth centres being given a higher priority than had previously been the case. This kind of working is in line with the Government vision that women and their families are involved in the planning and delivery of maternity services (Department of Health, 2004). The National Service Framework for Children, Young People and Maternity Services also calls for Primary Care Trusts and maternity service providers to design, review and improve maternity services through programmes that include surveys and focus groups involving local community groups. It is the reflection of the Project team that a key strength of the BPC Project was utilisation of local data, alongside current literature, which enabled clear justification for this and other Project initiatives.

12.2.2 Comparisons between services

Although the Project was not set up to make formal comparisons between services, it presented the opportunity to see where contrasting working patterns might be making a difference. Southampton had already implemented a radical approach to staffing deployment issues prior to the start of the BPC Project: from the beginning of 2003 the stand-alone birth centres were staffed 24 hours a day, seven days a week by trained Maternity Care Assistants (MCAs), with the team midwives attending the birth centres when needed for births and some aspects of post natal care. This meant the midwives were able to be much more flexible in terms of meeting the needs of the service and their on-call commitments to the birth centres and home births. This may be one of the reasons that Southampton saw a percentage rise in their out of hospital birth rate by the beginning of 2005 and Portsmouth did not. However, as the education work with the midwives and the marketing initiatives were not implemented until Autumn 2004, it was probably unrealistic to expect any significant rise in out of hospital births until mid to late 2005.

It is also perhaps worthy of note that the birth centre that had the highest percentage rise of births between 2003 and 2005 (Lymington Birth Centre) had been closed between March and May 2003 for staff development and building work, so probably had a greater potential for improvement in terms of
total birth numbers compared to the other birth centres. Therefore, while the Phase Two survey results indicate the BPC Project had some effect on these outcomes, it is probably fair to assume that this had more to do with the Project team being able to capitalise on structures and strategies already in place, rather than the Project initiatives per se.

It is also important to note that both Portsmouth and Southampton had a high percentage of out of hospital births compared to the rest of the UK at the start of the BPC Project, with nearly a quarter of maternity service users opting for home or birth centre births. In contrast, national statistics show that about 4% of maternity service users give birth at home or in a stand-alone birth centre. Therefore, aiming for any significant rises in out of hospital birth rates in Portsmouth and Southampton may have been somewhat ambitious. However, one could look at it another way and argue that three quarters were still opting for the consultant-led unit at the start of the Birth Place Choices Project in these areas, despite the availability of eight birth centres and the provision of a home birth service. Phase One of the Project revealed that nearly half of the survey respondents did not know they had a choice other than hospital, leading to the development of initiatives with the central premise that if more women knew they had a choice, more would choose to give birth in a birth centre or at home. This again is in line with the National Service Framework for Children, Young People And Maternity Services (Department of Health, 2004) that calls for all pregnant women to be offered clear information on the full range of birth environments available to them, and that maternity services should enable every woman to choose her birth place based on her wishes and preferences.

12.2.3 Maternity service users
Another key success of the BPC Project was the level of input and involvement with local maternity service users and health professionals. In particular, the development of the ‘Place of Birth’ multi-professional guideline and the ‘Where to be born?’ leaflet were written in close collaboration with maternity service users, midwives and obstetricians. This collaborative process proved particularly useful when it came to consulting the wider
community, as the majority of those consulted were very supportive of the aims of the BPC Project. The results from the maternity service users’ and midwives’ surveys in Phase Two also showed that, of those who had seen these documents, the majority found them useful.

A clear aim of the BPC Project was to encourage more women to choose to give birth at home and in birth centres, and therefore both the ‘Where to be born?’ leaflet and the guideline promoted these two options, whilst also giving information about the consultant-led units. One of the drivers behind this was the national agenda for public health, whereby community based maternity care gives midwives the opportunity to provide locally responsive, client-led services that tackle inequalities in health (Birth Centre Network UK, 2001). It is therefore hoped that by involving maternity services users, the on-going impact of the BPC Project in Portsmouth and Southampton will benefit maternity service users, in that there will be increasing numbers of women giving birth outside the consultant-led units, leading to a decrease in the morbidity associated with obstetric interventions (Feldman, Hurst 1987; Rooks et al 1992; Spitzer 1995; David et al, 1999) and an increase in local women and their families benefiting from midwife-led care.

It is also the reflection of the Project team that local midwives reported that they have benefited from the impact of the BPC Project, in particular community-based and birth centre midwives, not least because the central aims and focus of the Project highlighted their pivotal role in providing woman-centred, midwife-led care. Therefore, perhaps the positive changes identified through the surveys and birth rate data are in part due to a Hawthorne effect on the midwives, in that being part of (or even simply aware of) the BPC Project made them more conscious of their own practice and the expectation that they should maximise the facilitation of informed choice relating to place of birth.

12.3 Barriers to success of the Project
In the process of carrying out this Project, the team met with a number of obstacles that limited its effectiveness:
• The prevailing culture of hospital birth being the norm
• Philosophical differences between and within professional groups
• Medical dominance
• The tension for midwives between providing a service and accessing education

The nature of these barriers to success and strategies for overcoming (or accommodating) them are discussed in the following sections.

12.3.1 Birth in hospital is the norm

While the BPC Project initiatives were successful up to a point, it is the case that the majority of women in Portsmouth and Southampton, by the end of the project, were still opting to give birth in a consultant-led maternity unit. Of those who were given a choice of place of birth and chose hospital, the factors influencing this decision are not entirely clear. The findings of both the Phase One and Phase Two surveys showed that the midwife had an important role to play in terms of information giving, offering choices and influencing decision-making around place of birth. It is possible that the educational work with the midwives needed to have been far more extensive and comprehensive. However, the surveys also showed women’s own personal beliefs and those of her partner were key influences. While the project may have had an effect in increasing awareness of the different birth place choices, and resulted in an increase in the number of women planning/choosing to give birth in either a birth centre or at home, it was not the remit of this Project to determine whether these changes occurred among women who were simply not aware they had a choice, or among those who formerly believed hospital was the best place to give birth. There are therefore clear opportunities for further research in this area. However, it is hoped that further dissemination and use of the maternity service user leaflet and multi-professional guideline will continue to raise awareness of the various local birth place options and the benefits of giving birth at home or in a birth centre.

The fact that the majority of women choose to give birth in hospital points to this choice being a social norm, and it is argued that social norms are not due
to chance, but social constructs that come about because they serve the interests of a dominant group within society. Lazarus (1997) proposes that maternity service users may have been socialised into this hegemony of technocratic childbirth, which, it is further suggested, serves the interests of science and medicine. The majority of the survey respondents, in citing hospital as the best place to give birth, give credence to the effectiveness of this socialisation process, while the focus group participants alluded to its manifestation within the themes of ‘doctors favour hospital’, ‘hospital safest, especially with first child’, and ‘choices often limited’.

Hunt and Symonds (1995) argue that it has become the norm in Western societies for the transition to motherhood to involve taking part in the ‘traumatic rush to hospital’, ready to act out the ‘sick role’. In contrast, women who choose to give birth at home are seen as not following social norms and are likely to be chastised for their deviance (Szurek, 1997). The hospital has therefore been described as a crucial institution within modern systems of healthcare, and symbolic of the social power of the medical profession. As an institution, the hospital is recognised as the locus of contemporary political conflicts which are not simply economic, but ideological and cultural (Turner, 1995). Ideological and cultural conflicts were not simply a theme identified by the focus group participants in Phase One of the BPC Project, but were also very much in evidence during the attempts to implement the marketing and education initiatives.

In particular, the development and validation of the multi-professional ‘Place of Birth’ guideline and the maternity service user leaflet, ‘Where to be born?’ proved especially difficult. This was in part due to a fundamental disagreement, mainly between professional groups, about what constituted “good evidence” in terms of perinatal outcomes. National and international studies, including systematic reviews, have concluded that for women without identified risk factors for birth there is no evidence that hospital birth is any safer than home birth or birth in midwife-led units. A recent structured review carried out by Stewart et al (2004) confirmed this finding with regard to birth centres, while acknowledging poor quality of available data. However, these
studies and reviews did not find credibility with some of the neonatologists and obstetricians in Portsmouth. Instead, these groups focused on locally produced statistics regarding outcomes of births in birth centres and at home. The statistics were not reliable and there were no figures for comparable groups of women who gave birth in the consultant-led unit. Medical staff also objected to the positive slant given in both guideline and the leaflet to home and birth centre births, saying they believed both documents showed the consultant-led unit in a bad light.

A chasm developed between the Project team and medical clinicians, which resulted in considerable delays to the validation of the guideline and leaflet. The Project team therefore put considerable effort into negotiating a way forward with the clinicians in Portsmouth. This involved a large amount of email correspondence, informal discussions with some members of the medical team, as well as attendance at medical staff meetings to put forward the Project’s case. A specially convened meeting was also arranged, attended by midwifery managers, the directorate’s Clinical Directors, and Catherine McCormick, the Midwife Advisor to the Department of Health, with the aim of determining the level of support and ownership of the BPC Project in Portsmouth. Following this meeting and further negotiations, a number of changes were made to the maternity service user leaflet in response to the concerns voiced by the neonatologists and obstetricians. However, it was acknowledged that total consensus on the documents was unlikely to be reached. It was therefore agreed that efforts would be made to achieve majority consensus with the clinicians, and provided that more than 50% of them accepted the amended documents, they would go forward to validation at the Trust’s Clinical Governance group. This was eventually achieved, and the documents were validated at the beginning of December 2004, with the proviso that the leaflet would be reviewed once the BPC Project came to an end in May 2005.

12.3.2 Midwifery leadership
The Clinical Governance process in Portsmouth further demonstrated the relative impotence of midwives. The group that had the final say on whether
the documents should be validated by the Trust did not include a midwife and was chaired by a paediatrician. At no point was the Project team invited to their meetings and given the opportunity to outline the extensive consultation process both documents had gone through and the amount of approval the documents had received from key stakeholders including the majority of local midwives, managers and maternity service users.

In contrast, Southampton maternity services already had a collaborative, multi-professional Clinical Governance structure in place at the start of the BPC Project. Therefore, while there were similar objections to the leaflet and guideline from some of the medical staff in Southampton, the strength of midwifery representation within the Clinical Governance group enabled a reasoned debate and ensured that midwives and maternity service users had an influence on the content of the documentation.

Buchanan and Badham (1999) argue that change agents should always expect resistance to new initiatives and ideas, as organisational change tends to intensify political issues and behaviours. They claim that the most significant organisational decisions are only partly influenced by evidence and rational argument, while one group is able to influence the organisation according to their values. Where groups within an organisation have different objectives and interests, such as the type of information given to service users, their desire to defend their interests is likely to be an important determinant of behaviour and the relative power of these groups is a major determinant of outcomes (Harrison et al, 1992). However, a clear way forward would be the adoption of truly multi-professional fora for professional and service development, thus fostering a greater understanding and trust between professional groups. In particular, the experience of the BPC Project team has been that where midwives have a strong voice and influence, the views of maternity service users are more likely to be heard and acted upon.

While there was success for the Project team in that the integrity of the guideline and leaflet were not compromised by non-evidence based statements, the delay caused by a lengthy interprofessional debate limited the
effectiveness of these documents in bringing about the desired changes within the lifetime of the project.

12.3.3 Midwives in the middle
It emerged from the midwives’ survey, education sessions and focus groups that some midwives limited information to certain groups of women depending on risk assessment and their own personal experiences and had difficulties offering and providing a home birth service. However, they also claimed that they offered all the choices of birthplace. In addition, 83% of the midwives who responded indicated that, if pregnant, they would choose to give birth at home or in a birth centre. This suggests that, while midwives clearly understand the benefits of giving birth outside hospital, they work in a system that makes it difficult for them to promote and provide these options. It has been argued that contradictions such as these have their origins in the conflict between dominant ‘scientific’ knowledge and subordinate experiential knowledge (Levy, 1998), in that while midwives may have gained a deep understanding of why out of hospital births would be good for them and therefore also good for the women in their care through their own experience, they are also aware that their knowledge and experience might be accorded little value by the medical profession.

Again, the Project team suggest that comprehensive development of multi-professional Clinical Governance fora is likely to go some way to negating this effect. However, this requires strong and experienced midwifery leadership and support of midwives in their professional development, thus strengthening their confidence in their own practice and the value of midwife-led care in the wider community. The Nursing and Midwifery Council (NMC, formally the UKCC), in calling for midwives to be fit for autonomous practice and the purpose of delivering woman-centred care, argue that it is essential to strengthen the links between education and service provision (UKCC, 2001). The tension felt by midwives to provide an acceptable service to women while simultaneously continuing their professional development was painfully visible during the project. Education and support sessions facilitated by the practice educators were readily available, but the immediate needs of the service were
inevitably prioritised over a long-term investment in staff development, resulting in fairly poor attendance at the sessions.

The NMC also supports the facilitation of interactive teamwork to promote inter-professional working through teaching strategies such as tutorials and problem-based learning in small mixed groups. The BPC Project team found that some of the more positive feedback came from sessions where the issues of place of birth and informed choice were explored with a multi-professional forum.

Billie Hunter (2004), in her ethnographic study on maternity working environments, pointed to the strain that working within conflicting ideologies placed on midwives. She found that differences between community and hospital environments presented midwives with the challenge of working in settings with diverse values and perspectives. Hospital midwifery was dominated by meeting service needs, primarily a medicalised approach to care, with the ideology being ‘with institution’. In contrast, community-based midwifery was more able to support an individualised, natural model of childbirth, reflecting a ‘with woman’ ideology. Hunter suggested that when some midwives were able to work according to the ‘with woman’ ideal there was congruence between ideals and practice and the midwives experienced their work as emotionally rewarding. However, she found that it was often impossible for the same midwives to maintain this approach in a hospital environment, as the institution often demanded their priorities should be successful completion of tasks according to obstetric policies and protocols.

The ‘emotional work’ of dealing with the frustrations these conflicting ideologies created for midwives was particularly evident when midwives were required to accompany a woman from a community setting (for example a home birth) to hospital. Hunter described midwives as feeling ‘geographically dislocated’ on these occasions and that their autonomy was compromised. While this was only a small, locally focused study, it could be argued that there are parallels with the community-based midwives in Portsmouth and Southampton, in that their struggle to provide a home birth service, centred
within a ‘with woman’ ideology, had its origins in the needs of the consultant-led maternity unit dominating both maternity services.

If she were to extract only two words to classify contemporary obstetric practice, Jo Murphy-Lawless (1998) said they would not include birth, but risk and death, in that obstetrics operates on the one hand to deny death as a possible, though not very likely, outcome and on the other to treat it as an all pervasive threat. She argued that the medical profession ensure childbearing women keep going to obstetricians and their hospitals to give birth by the use of ‘shroud-waving’ and ‘atrocity stories’. In this context of medical clinicians holding and articulating a philosophy of fear relating to childbirth, it is perhaps not difficult to understand why so many women ‘choose’ to give birth in hospital and why midwives find it so difficult to challenge the status quo. It has been shown that in hospital, midwives are subject to considerable pressures to conform to the medical model of childbirth, reinforced by hierarchical disapproval or horizontal violence (Hunt, Symonds 1995; Kirkham, Stapleton 1999; Hadikin, O’Driscoll 2000).

A proposed solution is for increasing numbers of midwives to have the opportunity to work within the ‘enabling culture’ of birth centres, as suggested by Kirkham (2003, p255): ‘The philosophy and the small scale of birth centres make it possible to develop the skills and confidence of midwives who choose to work there’. Within such work environments midwives are likely to be less vulnerable to “burn-out” because they experience fewer of the alienating work experiences reported by those who leave midwifery (Ball et al 2002, as cited by Kirkham 2003).

The government’s new National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) calls for all pregnant women to be offered the full range of choices regarding birth environments, including birth centres and home birth: ‘Local options for midwife-led care will include midwife-led units in the community or on a hospital site, and births at home for women who have been appropriately assessed.’ It also calls for maternity service providers to ensure that: ‘The
capacity of the midwife-led and home birth services are developed to meet the needs of the local population.’ (Department of Health, 2004, p28). However, Kirkham argues that the answer to providing truly informed choice is to focus on addressing the problems inherent in current structures: ‘The behaviour of all concerned is logical within a public service bureaucracy, it is not the fault of individual midwives or obstetricians. The rhetoric does not work because of the context.’ (Kirkham, 2004, p287).

Some recently “reinstated” midwifery practices have been associated with a change in the choices women make regarding place of birth. For example, where midwives practice early labour assessments within women’s homes, women appear more likely to opt to stay at home to give birth (Sandall et al 2001; Walton 2003; Henty 2004). The Albany Midwifery Practice in London, a caseload-holding team of self-employed midwives contracted to Kings College Hospital since 1997, provide a service whereby women have continuity with a named midwife throughout their pregnancy and labour. When a woman’s labour begins the named midwife attends them at home and stays with her for the birth, often remaining at home. An evaluation of the Albany Midwifery Practice conducted between 1999 and 2001 revealed a home birth rate of 43% among women cared for by the Albany midwives, compared to 11% in other nearby practices and 2% nationally (Sandall et al, 2001).

It has been suggested that another way that could change the inherent structure of maternity services would be to adopt a policy that is the antithesis of the Peel Report (HMSO, 1970). Home and birth centres, as opposed to hospital, become the default options when booking a woman’s birth place: women with uncomplicated pregnancies would be offered home birth or a birth centre and would need to deliberately ‘opt out’ to give birth in a consultant-led unit. The weight of the information and the enthusiasm would start with home, moving to other options after debate and discussion about the advantages and disadvantages of home birth, as suggested by Walton (2003). While such a policy could be criticized as being service or resource-led, rather than woman-led, such a strategy could be a valuable measure to
redress the balance between current obstetric-led maternity services and community-based services.

12.4 Strengths of the BPC Project

- perseverance by a team with a belief in the Project aims and combining key skills
- two sites

One of the key strengths of the BPC Project was that the team that took it on had a clear interest in midwife-led, woman-centred care. The collaborative nature of the project, and the fact that it took place on two sites, with different models of midwifery working but similar service provision, was also central to the success of the Project. The significance of these elements came sharply into focus when the Project team was faced with difficult obstacles, such as antagonism from the medical staff towards the parent information leaflet.

Having a strong team of experienced midwifery researchers and negotiators, supported by individuals within senior management teams, resulted in most of these barriers being overcome. The involvement of maternity service users in the overall strategic direction of the Project, as well as key elements of it, also made the Project more credible and relevant to the local communities.

The Project managers were midwives with birth centre and community based backgrounds, were already employed by the respective Trusts, and were committed to midwife-led care. “Insider” and local knowledge was useful in engaging both midwives and maternity service users in the project. Between them, the three Project managers had diverse and complementary skills and personal qualities that facilitated the smooth running of the project. Examples of these are: a background in media involvement and journalism; skills related to graphic design and marketing; first-hand research experience; tenacity; a sense of humour and the ability to work well in a team and to enthuse others.

The Project leader had considerable experience of working with local midwifery managers, obstetricians, paediatricians and educationalists, which
was crucial to driving the project forward at a strategic level. She held a consultant post that included an explicit research remit and therefore had the experience and networks that were necessary to bring together the different strands of a project of this nature. Finally, the Project team had the support and experience of both the Steering and Advisory groups. Many individuals in these groups were not employed by either Trust and gave their time generously, often at short notice: their expertise was invaluable in helping to make difficult decisions at critical moments in the project and in completion of the report.

12.5 Limitations of the BPC Project

- Delays and time management issues
- Working with local political change and resource restraints

Despite the support from senior management for the BPC Project, the Project team experienced a number of difficulties in getting started in terms of obtaining office space and computer facilities. This was largely due to the length of time necessary to organise such things in two large, bureaucratic institutions. Debates within the team about the content of the research ethics proposals also took longer than anticipated which, in addition to on-going changes in the local research ethics procedures, resulted in frustrating delays. These elements meant the marketing, education and change management initiatives were not implemented until late in the life of the Project, therefore undermining the project’s impact and effectiveness. Ideally, a project with this aim should have been planned to run over three years rather than two, allowing 18 months for the Phase One research and development of the initiatives, another year for the implementation of the initiatives and six months to evaluate the Project’s impact.

Situating the Project in two Trusts was identified as a strength, which indeed it was in many ways. However, it also presented practical difficulties and resource issues, in that many things had to be done twice, with research ethics applications, validation of guidelines, and planning for education initiatives being some examples. This was very time-consuming and required
much patience on behalf of the Project team. Inevitably, a considerable amount of time and money was spent in travelling between sites for meetings.

Two other important aspects that are likely to have limited the success of the Project were resource limitations in the wider NHS and local political change. These were factors that the Project team could not influence but were called upon to accommodate. For example, in Southampton, financial restraints within the Trust towards the latter part of the Project resulted in a staff recruitment freeze that may have impacted on the ability of midwives to give time and support to the Phase Two surveys. In Portsmouth, a planned relocation of the main maternity services included the proposed closure of the co-located birth centre in Portsmouth City. These plans received significant media attention between 2003 and 2005, with one local newspaper story being highly critical of birth centres, claiming they were not as safe as hospital. While it may be not be possible to make clear links between the effect of this and other news stories, and the attitudes of local women to out of hospital birth, the co-located birth centre in Portsmouth saw a 2% reduction in its birth rate during the life of the BPC Project.

Another factor related to Portsmouth birth rates during the BPC Project was the reconfiguration of neighbouring maternity services, resulting in a significant increase in the number of women requiring high levels of obstetric support being transferred to Portsmouth from a nearby Trust. This is believed to have resulted in an increase in the birth rate in Portsmouth’s consultant-led unit.

Finally, the geographical location of the birth centres is likely to have some influence on how much capacity can be increased. For example, all the birth centres in the Portsmouth area are well spaced out, and serve four discrete populations. There was therefore a reasonable expectation that capacity could be increased. In comparison, three of the birth centres in the Southampton area are situated in the same geographical area, so the potential for increasing their capacity was limited.
12.6 Conclusion
The BPC Project was successful in increasing local awareness about birthplace choices, and may have influenced an increase in the number of births in some of the stand-alone birth centres and one co-located birth centre. However, it is crucial to recognise that, in the time available, it would have been unrealistic to expect it to have achieved a more noticeable shift towards out of hospital births considering the current cultural emphasis on hospital-based obstetrics.

Despite the limitations of the Project, the team believes a great many of the components of the initiatives could be transferable to other maternity services wishing to increase awareness of choices about place of birth and the number of births in their birth centres or at home. In particular, where the out of hospital birth rate mirrors the national average of 4%, there is likely to be huge opportunity for change and many aspects of the BPC Project’s marketing, education and change management initiatives would prove useful.

In the long term it is clear that what is required to deliver sustainable choices in maternity care is a fundamental adjustment in allocation of funding and organisation of midwifery services to support midwives to work more autonomously and flexibly. Alongside this requirement it is important to ensure that women are aware of and use community-based services that reduce their chances of unnecessary medical interventions and increase their psychological well being. It is also essential to provide educational and development opportunities for midwives so that they are competent and confident to deliver such a service.

12.7 Recommendations for supporting women’s choices around place of birth:

- Clinical and service leaders should use interlinked and focused initiatives to implement cultural change so that the impact is synergistic and the overall impact more profound
• Heads of maternity services should develop and implement initiatives such as
  o parent information leaflets
  o multi-professional guidelines
  o education for midwives
  o staffing and capacity
• Trusts should provide sustainable staffing to support birth outside the consultant-led unit
• Service managers and educationalists should work together to maximise midwives’ opportunities for professional development so they are confident and proactive in offering choices about place of birth
• Heads of midwifery services should work collaboratively with local service users at strategic level to develop and offer information to ensure that the option of choosing home birth, birth in a birth centre birth, or consultant-led maternity unit is openly available to all women accessing maternity care.

12.8 Recommendations for future research and evaluation
The following recommendations for further research are made in the light of the findings from the BPC Project and the process of its implementation:
• Exploration of the significance of the geographical location of birth centres with regard to place of birth
• Qualitative and quantitative studies exploring midwives’ and obstetricians’ attitudes to place of birth
• Ethnographic study on factors within our culture that influence women’s belief systems in terms of place of birth
• Further studies examining the impact of caseload-holding midwifery practice on place of birth.
• Development and implementation of standardised evidence-based criteria of likely benefits and harms of consultant-led units, birth centres and home births, to support women’s decisions about place for birth.
• Development and implementation of a standardised system of data collection in NHS Trusts, including transfer rates, reasons for transfer
and outcomes of transfer, including clinical, women’s satisfaction and economic outcomes.