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Task shifting Midwifery Support Workers as the second health worker at a home birth in the UK: A qualitative study

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ABSTRACT

Objective: Traditionally two midwives attend home births in the UK. This paper explores the implementation of a new home birth care model where births to low risk women are attended by one midwife and one Midwifery Support Worker (MSW).

Design and setting: The study setting was a dedicated home birth service provided by a large UK urban hospital.

Participants: Seventy-three individuals over 3 years: 13 home birth midwives, 7 MSWs, 7 commissioners (plan and purchase healthcare), 9 managers, 23 community midwives, 14 hospital midwives.

Method: Qualitative data were gathered from 56 semi-structured interviews (36 participants), 5 semi-structured focus groups (37 participants) and 38 service documents over a 3 year study period. A rapid analysis approach was taken: data were reduced using structured summary templates, which were entered into a matrix, allowing comparison between participants. Findings were written up directly from the matrix (Hamilton, 2013).

Findings: The midwife-MSW model for home births was reported to have been implemented successfully in practice, with MSWs working well, and emergencies well-managed. There were challenges in implementation, including: defining the role of MSWs; content and timing of training; providing MSWs with pre-deployment exposure to home birth; sustainability (recruiting and retaining MSWs, and a continuing need to provide two midwife cover for high risk births). The Service had responded to challenges and modified the approach to recruitment, training and deployment.

Conclusions: The midwife-MSW model for home birth shows potential for task shifting to release midwife capacity and provide reliable home birth care to low risk women. Some of the challenges tally with observations made in the literature regarding role redesign. Others wishing to introduce a similar model would be advised to explicitly define and communicate the role of MSWs, and to ensure staff and women support it, consider carefully recruitment, content and delivery of training and retention of MSWs and confirm the model is cost-effective. They would also need to continue to provide care by two midwives at high risk births.

Introduction

The National Institute for Health and Care Excellence in the United Kingdom (UK) recommends that for low risk women having their second or subsequent baby at home is a suitable option "*because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit*" (National Institute of Health and Care Excellence, 2014, P5). However, home birth is rare in the UK, accounting for only 2.3% of births in 2014 (McLaren, 2015). A UK hospital implemented two service innovations with the aim of increasing home birth: a dedi-

Abbreviations: FD, Foundation Degree; HBT, Home Birth Team; MA, Midwifery Assistant; MSW, Midwifery Support Worker; MW, Midwife; RCM, Royal College of Midwives; UK, United Kingdom.

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cated Home Birth Team and a new model of home birth care, involving Midwifery Support Workers (MSWs) and midwives. This paper reports findings of a 3 year qualitative study of the Service, focusing on the evaluation of the implementation of the MSW model.

In the UK, low risk births are routinely attended by midwives, rather than obstetricians. Although not mandated in policy, standard UK practice dictates that for home births, care is provided by two midwives. MSWs, on the other hand, are utilised to "*provide information, guidance, reassurance, assistance and support, for example… recording vital signs, that improve the quality of care that midwives are able to provide*" (Royal College of Midwives, 2014, P4). MSWs are not permitted to make clinical assessments or decisions, or initiate treatment (Royal College of Midwives, 2014), and they are not usually second attendants at home births. However, The UK Royal College of Midwives states "The RCM's view is that the pressure on NHS finances could make a home birth service unsustainable if it requires two midwives to be in attendance and that safety will not be compromised as long as the person in the support role has the appropriate competencies." (Royal College of Midwives, 2014, P7). In 2014 the hospital set up a dedicated Home Birth Team to provide reliable round the clock cover and improve the quality and uptake of care. This service was designed with MSWs as the second health worker at low risk home births. Clinical leaders at the hospital determined that with appropriate training, MSWs could be safely deployed as second attendants, freeing up midwife capacity.

Workforce redesign is a solution to delivering sustainable care in health services, and in terms of the wider literature in this area, the deployment of MSWs as second birth attendant constitutes a 'substitution' (Bach et al., 2008) for the registered professional, a second midwife. This can also be described as a 'redistribution' (Bohmer and Imison, 2013), where tasks are handed to another worker, or a 'deepening' (Hyde et al., 2005) of the MSW role, in that MSWs are given additional responsibilities.

Methods

Methodology/research design

A 3 year longitudinal service review of the Home Birth Service was conducted in the autumn of 2014, 2015 and 2016. A qualitative approach to data collection was taken, to "*discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved*" (Merriam, 1988, P11). The researchers took a theoretically interpretive, generic qualitative approach (Kahlke, 2014).

Data collection

The work was undertaken in an urban maternity unit providing community and hospital care for approximately 8000 births each year. All members of the Home Birth Team (HBT) were invited to be interviewed. These individuals were dedicated home birth midwives, distinct from 'community midwives', as they provided care only for women requesting home birth. Sampling was determined by the total participants available, rather than saturation. All local strategic and commissioning staff involved with the Service were also invited for interview. This included clinical and professional managers responsible for the HBT at the provider hospital trust, and individuals in the 'Clinical Commissioning Group' who were responsible for funding and monitoring performance of the HBT. Focus groups were conducted with midwives from the community, obstetric-led delivery suite and midwife-led birth centre, using a convenience sampling approach. Community midwives provided antenatal and postnatal care to women in the community, and were not responsible for first attendant home birth care at the time of the evaluation (distinct from the dedicated HBT midwives). A pragmatic approach was taken to sampling, with the service able to accommodate one focus group in each setting, each year of study. Midwives and MSWs were recruited by managers, and other participants were approached by email. Participation was voluntary and confidential, and data were collected at participants' workplaces, using structured topic guides. All focus groups and interviews (conducted by [author 1] and [author 2]) were digitally recorded and transcribed. [author 1], [author 2], and [author 4] are clinical researchers experienced in qualitative methods, [author 3] is an experienced qualitative researcher. All authors are female. [Author 4] is a registered midwife, and [author 1] has experienced giving birth at home. The research team works closely with the participating hospital and undertakes a range of research (this study included) funded by the Collaborations for Leadership and Applied Health Research and Care (CLAHRC) Programme.

Data analysis

To provide timely findings to an evolving Service, a rapid analysis approach developed by Hamilton (2013) was used. Documents and transcripts were reviewed, with researchers spending approximately 1 h with each data item. Key issues were entered into 'summary templates' that were structured according to the original study objectives. The templates included additional space for inductive themes and key quotations. Data were then entered into a matrix for comparison across sources. Initial transcripts and documents were dual reviewed and template structure refined by [author 1] and [author 2] in year 1 and 2, and [author 1] and [author 3] in year 3. Findings were interpreted directly from the matrix, organised according to the review objectives, and then organised into subthemes by [authors 1–4]. Participants were invited to comment on findings.

Ethical considerations

Ethical approval for this study was obtained from the University of Birmingham Research Ethics Committee, reference ERN_15-0906S.

Results

The participants across the 3 years of the study are described, followed by a description of the Service context and MSW role, and finally themes relating to implementing the MSW role.

Participants

Seventy three individuals participated across the 3 years (see Table 1). Twenty-one documents were reviewed, including business plan, reports and policies.

Service context and MSW role

This Home Birth Service was a new service innovation, with the model and staff put into place in 2014. The MSW second attendant role was also new in the UK context, and the MSWs were recruited specifically to train and work in the new Service. Most MSWs had little or no prior experience in normal birth before recruitment, but often had clinic or theatre experience.

The Service was designed as a team midwifery model, where women were cared for by a small team of midwives and MSWs throughout their maternity care (antenatal, birth, and postnatal care). Women could book with the team at any stage in pregnancy. Women were allocated to their own named midwife who coordinated care and provided as much of the direct care as possible, with other members of the HBT providing care when she was not available. The midwife and MSW team covered a 24 h rota, with the intention that MSWs would be the second attendant at all low risk births. The Service was designed to have full time equivalents of 5.8 MSWs and 6.2 midwives to cover antenatal, intrapartum and postnatal duties. The MSW intrapartum role was under the direction of the midwife at all times. MSWs performed some tasks autonomously in the antenatal and postnatal period (e.g. breastfeeding support, blood tests)