



The Royal College of
Midwives

The Royal College of Midwives
Survey of Midwives'
current thinking
about home birth

Final Report

Acknowledgements

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Executive Summary

This survey was initiated as a strand of work within the Royal College of Midwives (RCM) Campaign for Normal Birth (CNB) activities, in the context of continued debate about the safety and availability of home birth services. The information gained through the survey will inform and direct the CNB strategic objectives, identify any education, practice and training needs for the continuing development of good practice and highlight areas for service improvement. The survey explores midwives' experience in this area as students and qualified midwives, perceived support by other health professionals when undertaking home births, opinions of the obstacles to providing the service, perceptions of whether women are given enough information to make an informed choice, and their confidence in offering the service.

Objectives of the survey

- To gain a national picture of midwives' current thinking about home birth practice
- To identify areas of concern by midwives and education and practice needs in this area

Methodology

To obtain a current picture of midwives' views on home birth, midwives were invited to participate in an on-line survey through the RCM website, e-mail networks, and the RCM Midwives magazine between March and May 2011.

The survey questions were designed to collect data on the midwives'

- experience of home birth
- training and continuing professional development (CPD) in home birth
- opinions about the adequacy of information given to women
- perception of support for their home birth practice
- perception of the obstacles to providing home birth practice

2 open questions were asked on

- areas where they thought separate training for home birth is required
- other comments about home birth practice

Prior to the main survey, the questionnaire was tested and piloted amongst a group of 6 midwives.

Results

A total of 553 midwives completed the survey. It was not possible to obtain a denominator to calculate the response rate as a particular number of midwives had not been targeted, and encouragement to participate was through several routes. As there were a missing number of answers, when midwives presumably thought they were not relevant to their practice, the total for each question is the denominator for that question. The percentages in the tables have been rounded up or down to whole numbers as appropriate.

Profile of respondents

The midwives responding to the audit broadly reflected the four country (England, Wales, Scotland and Northern Ireland) geographic spread of midwife members of the RCM. The midwives responding in England were spread throughout the regions, with the highest response rates coming from London (17%), and the south west (14%). The majority of midwives (56%) responding to the survey were working in the community, or an integrated community and hospital setting, 10% in midwifery led units, and 22 % in a hospital obstetric unit.

Key Findings

- the majority of the respondent group of midwives were very positive about the importance of home birth and their confidence in this area practice
- 61% of the midwives reported that they had attended a home birth as a student midwife, but only 52% said that home birth was part of the curriculum in their initial training
- 58% of the midwives had not attended any CPD explicitly focussing on home birth
- further training is necessary in emergency drills in the home environment as well as normality, discussion about risk, promoting home birth, appropriate methods of pain relief, and training together in the multidisciplinary team
- only 58% of the services represented here provide a home birth service all of the time, and 2% never provide it
- respondents suggest that home birth needs more promotion
- the main obstacles to providing a home birth service are the on-call demands

within the current staffing levels and other midwives' lack of confidence

- midwives reported a perceived lack of support and negative attitudes towards home birth from other members of the obstetric team, including hospital midwives
- only 50% of the midwives in this survey thought that women are given adequate information about home birth
- there were comments made indicating a concern about women getting appropriate information to make a choice

Key Recommendations

- student midwives have adequate exposure to and experience of home birth, supported by evidence and theory
- more resources be developed for midwives' further training in the areas identified through national CPD
- mandatory training days on emergency drills should always incorporate scenarios in different environments
- the content of the RCM home birth handbooks be further promoted as a suite of individual papers
- the potential for more multi-disciplinary training in home birth practice be investigated
- opportunities be developed for regular multidisciplinary case review to learn from good practice, from mistakes made, and to develop collaborative relationships
- services become more responsive to the needs of midwives when staff shortages and on-call arrangements are affecting the home birth service
- these findings be cascaded through the midwifery community to actively inform education, practice and research
- the potential for new research triggered by these findings be further explored

Introduction

This survey was initiated as a strand of work within the Royal College of Midwives (RCM) Campaign for Normal Birth (CNB) activities, in the context of continued debate about the safety and availability of home birth services. The information gained through the survey will inform and direct the future CNB strategic objectives, identify any education, practice and training needs for the continuing development of good practice and highlight areas for service improvement.

Background

Few issues in childbirth engender as much debate as the place of birth (Overgaard et al 2011, De Jonge et al 2009, MIDIRS 2008, Walsh 2000, Olsen & Jewell 1998, Tew 1998, Chamberlain et al 1997). Home birth emerged as a great issue of contention again during 2010, with loud opinions being voiced in the medical press and the media, following the publication of the Wax et al study (2010) that questioned its safety. Despite the methodological weaknesses of this meta-analysis (Gyte et al 2010), the paper received considerable publicity through an editorial in the *Lancet* (2010). Alongside these debates, concern has continued about the availability of home birth services (Dodwell & Gibson 2009).

Guidance from professional bodies in many countries recommends that home birth and informed choice about place of birth are made available to women (Vedam et al 2009). The National Institute for Health and Clinical Excellence (NICE) guidance on intrapartum care (2007) advises that women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG/RCM 2007) support home birth for women with uncomplicated pregnancies and suggest there is no reason why home birth should not be offered to women at low risk of complications. They refer to evidence showing that labouring at home increases a woman's likelihood of a birth that is both satisfying and safe and suggest that if women had true choice the rate could be around 8-10%. The most recent UK wide home birth rate as reported in *BirthChoice* (2009), was 2.6%. Reasons for the constraints on home birth rates are thought to include the values and beliefs of organisations and lack of staff with appropriate competencies (RCOG/RCM 2007, RCM 2002a, RCM 2002b).

This survey explores midwives' experience in this area as students and qualified midwives, perceived support by other health professionals when undertaking home births, opinions of the obstacles to providing the service, perceptions of whether women are given enough information to make an informed choice, and their confidence in offering the service.

Objectives of the survey

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- To identify areas of concern by midwives and education and practice needs in this area

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The survey questions were designed to collect data on the midwives'

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- opinion about the adequacy of information given to women
- perception of support for their home birth practice
- perception of the obstacles to providing home birth practice

2 open questions were asked on

- areas where they think separate training for home birth is required
- other comments that the respondent might wish to make about home birth practice

Prior to the main survey, the questionnaire was tested and piloted amongst a small, representative group of 6 midwives.

Results

A total of 553 midwives completed the survey. It was not possible to obtain a denominator to calculate the response rate as a particular number of midwives had not been targeted, and encouragement to participate was through several routes. As there were a missing number of answers, when midwives presumably thought they were not relevant to their practice, the total for each question is the denominator for that question. The percentages in the tables have been rounded up or down to whole numbers as appropriate.

Profile of respondents

The midwives responding to the audit broadly reflected the four country wide geographic spread of midwives that are members of the RCM, as shown in table 1.

Table 1 Respondents per country of the UK

	%	no	% RCM membership
England	81	446	80
Wales	4	23	5
Scotland	10	53	10
Northern Ireland	2	11	5
Other	4	20	
		Total	553

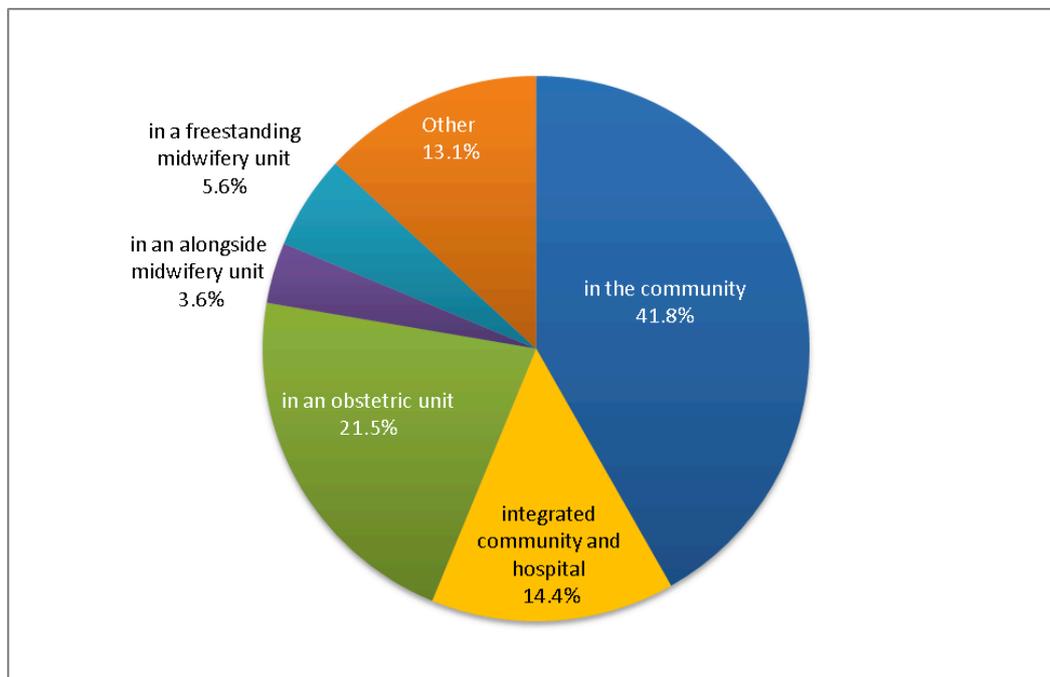
The 20 midwives, who selected the 'other' response, were 5 who were not in current practice, and 15 who were practising in countries outside the UK. As shown in Table 2, the midwives responding from England were spread throughout the regions, with the highest response rates coming from London (17%), and the south west (14%).

Table 2 Regions of England

	%	no
East of England	12	54
East Midlands	7	31
London	17	77
North East	3	13
North West	9	39
South Central	6	29
South East Coast	12	52
South West	14	61
West Midlands	11	48
Yorkshire and the Humber	8	36
Other	1	4
Total		444

As shown in Figure 1, the majority of respondents (56%) were working in the community or an integrated community and hospital setting, 22 % in a hospital obstetric unit and 10% in midwifery led units.

Figure 1 Main areas of Practice



The 68 midwives who reported that their main practice was other than any of those listed, were working in management, education, research and some specialist practice roles such as risk management, and teenage pregnancy.

Training in home birth practice

Respondents were asked whether theory and practice about home birth had been part of the curriculum in their initial midwifery pre-registration training. The word training was used for clarity in the survey question, but this referred to both education and training. As shown in Table 3, it was reported that it had been part of the curriculum by 52% of the midwives, but for 34% this had not been included.

Table 3 Theory and practice about home birth in initial training

	%	no
Yes	52	273
No	34	175
Unsure	14	73
Total		521

Experience of home birth

61 % of the midwives completing the survey had experienced home birth as a student midwife (Table 4) and 78 % as a qualified midwife (Table 5).

Table 4 Attendance at home birth as a student midwife

	%	no
Yes	61	316
No	37	197
Unsure	2	8
Total		521

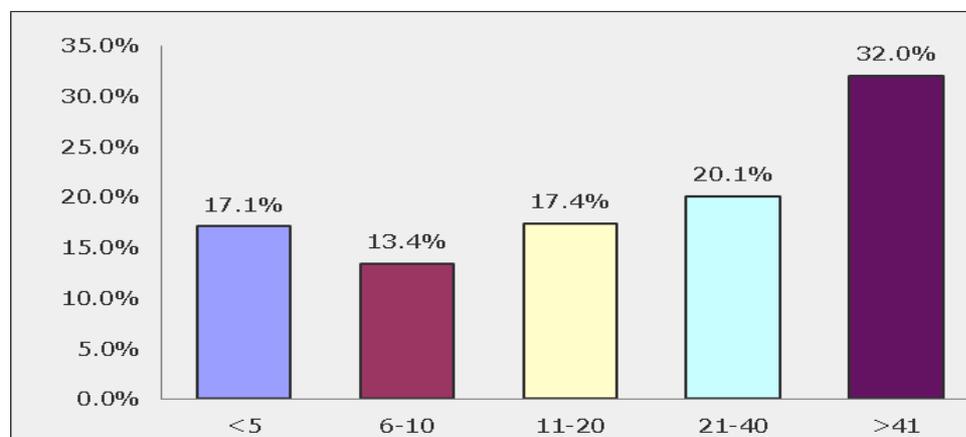
Table 5 Attendance at home birth as a qualified midwife

	%	no
Yes	78	406
No	21	110
Unsure	1	5
Total		521

This 21% who had not attended home birth as a qualified midwife may reflect the number of midwives responding to the survey whose main area of practice is currently in the hospital (22%).

Respondents were then asked how many home births they had attended as a qualified midwife. As shown in Figure 2, the majority of the midwives (52%) had attended more than 21 births.

Figure 2 Number of home births as a qualified midwife



As shown in Table 6, the majority (71%) of these midwives had attended a home birth in the last 12 months. This also suggests that the midwives completing this audit were very active in supporting home birth.

Table 6 Recent attendance at home birth

	%	no
< 12 months	71	287
1-3 years	13	54
3-5 years	6	24
5-10 years	5	18
> 10 years	5	20
Total		403

As shown in Table 7, the majority of the midwives (58%) had not attended any continuing professional development (CPD) explicitly focussed on home birth. In the context of the large number of this group that were active in undertaking home births, this finding suggests the availability of relevant CPD is lacking, and an important opportunity is being missed.

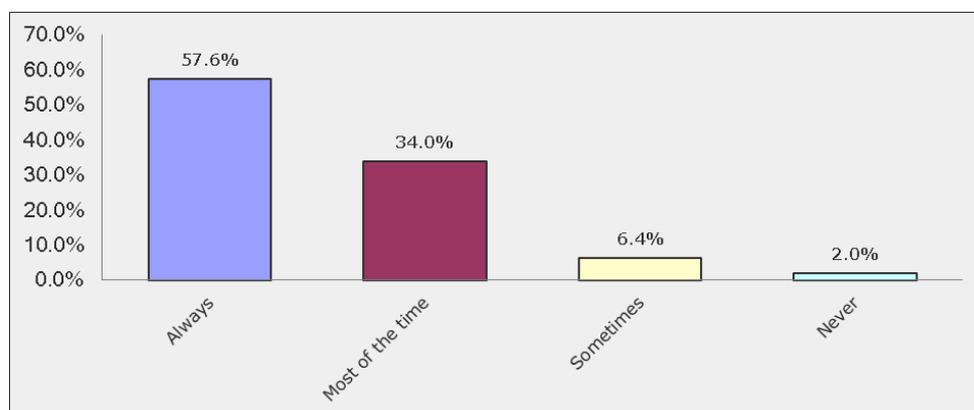
Table 7 Continuing Professional Development in home birth

	%	no
Yes	40	198
No	58	281
Unsure	2	9
Total		488

Provision of home birth services.

As shown in Figure 3, only 58% of the midwives reported that their maternity service provided a home birth service all of the time and 2%, seemingly never offered it.

Figure 3 Provision of home birth services



Informed choice

Midwives were asked whether, in their experience, women were provided with sufficient information in order to make an informed choice about where they should have their baby. As shown in Table 8, 41% of the midwives reported that they thought women were not given enough information to make this choice.

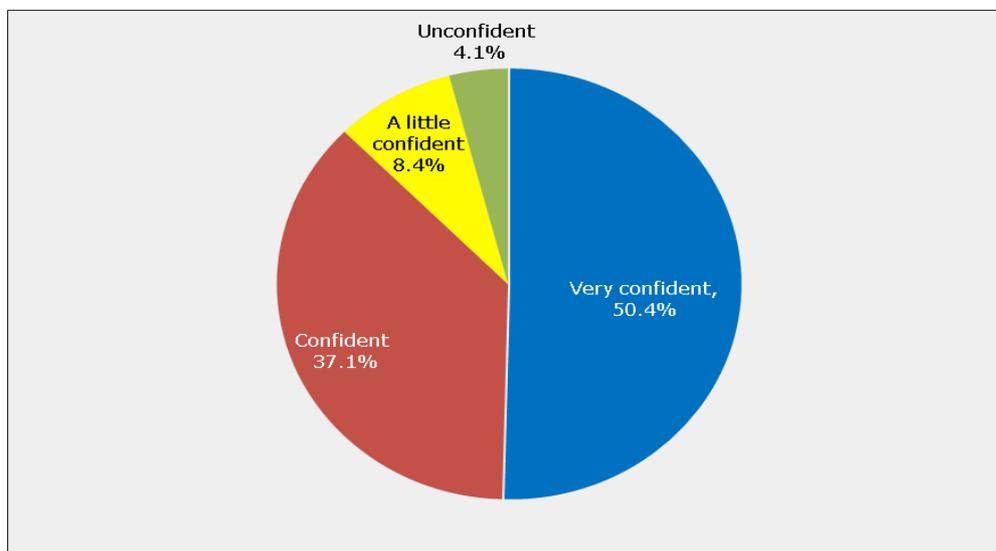
Table 8 Information and informed choice

	%	no
Yes	50	243
No	41	199
Unsure	9	46
Total		488

Midwives' confidence.

When asked about their confidence in supporting women during a home birth 87 % of the respondents reported feeling very confident or confident in this practice. 13 % had little or no confidence in this area (Figure 4).

Figure 4 Midwives' confidence in their home birth practice



Support from professional colleagues

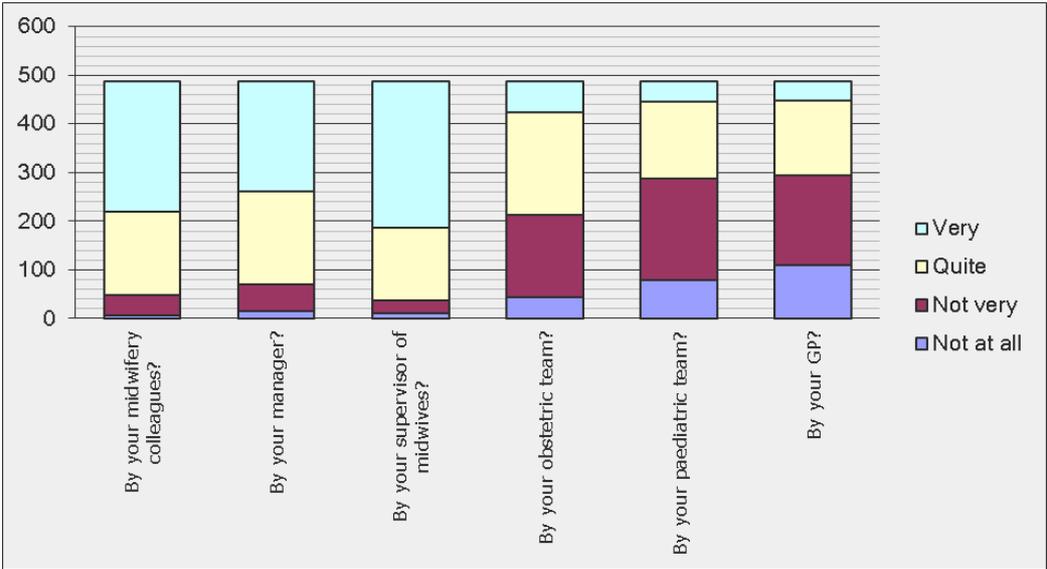
Midwives were asked how supported they felt in their home birth practice by different groups of colleagues. As shown in Table 9 and Figure 5, the majority of the midwives

felt very supported by their midwifery colleagues (55%), and their supervisor of midwives (62%) but only 46% felt equally supported by their managers. They felt there was little support in this practice from paediatricians (59%) and GPs (61%).

Table 9 Support from professional colleagues

	Very	Quite	Not very	Not at all
By your midwifery colleagues?	268 (55%)	172(35%)	42(9%)	6(1%)
By your manager?	226 (46%)	191(39%)	55(11%)	16(3%)
By your supervisor of midwives?	302 (62%)	149(31%)	27(6%)	10(2%)
By your obstetric team?	64 (13%)	211(43%)	170(35%)	43(9%)
By your paediatric team?	42 (9%)	158(32%)	208(43%)	80(16%)
By your GP?	39 (8%)	155(32%)	184(38%)	11(23%)
Total	488			

Figure 5 Support from professional colleagues



Obstacles to providing a home birth

As shown in Table 10, the main obstacles that respondents identified to providing a home birth were the on-call demands and shortage of midwives followed by midwives’ lack of confidence. This documentation of midwives’ lack of confidence is interesting as the majority of midwives in this survey (87%) described themselves as very confident or confident, and implies that they are referring to midwives other

than themselves. The women's (47%) and partners' (45%) lack of confidence was also seen as a significant obstacle. This would merit further research to explore in detail exactly what the concerns might be.

Table 10 Main obstacles to providing a home birth

	%	no
On-call demands	74	360
Shortage of midwives	64	310
Midwives lacking in confidence	50	242
Women's concerns about safety	49	237
Women lacking in confidence	47	227
Birth partner lacking in confidence	45	219
Lack of support from the unit	28	138
Lack of training	21	101
Other (please specify)	18	87
Transferring into hospital	15	75
No demand from women	12	57
Lack of equipment	9	44
Total		488

The 81 midwives who responded to the 'other' option mainly reiterated concerns about inadequate staffing levels, and lack of support from their unit and medical colleagues, including restrictive policies. A few midwives suggested it was *"the wrong women requesting home birth who are not low risk"*, others highlighted *"negativity in the media"* and the *"public perception of unavailability"*. Some midwives suggested that the *"distance to hospital causes concern to the women in the event of any problems"*, and 3 respondents suggested that *"women's concerns about the mess"* was an issue. Only 2 respondents highlighted the lack of continuity of care: *"It is unlikely we get to be with our 'own women'. Women feel more confident birthing with a midwife known to them"*. This would be expected to be a disincentive for midwives as well as women. Disturbingly, one midwife gave the reason that *"our entonox and O₂ are being withdrawn, to save servicing costs!"*

Separate training for home birth practice.

The majority (61%) of the midwives responding thought that separate training was required for home birth practice but 28% did not think it was necessary and 12 % were unsure. The view about it not being necessary was expressed by this midwife

"I do not think separate training is needed as all midwives should be confident in providing a home birth service. The problem of midwives not being confident is due to the system, many midwives never get the opportunity to become confident in home birth. Hospital midwives need to have the opportunity to work with midwives experienced in home birth"

292 midwives responded to the open question on what area separate training was necessary. 45% of these responses focused very clearly on the need for training in emergency drills in the different environment where there were 'no buzzers to push'.

"resuscitation of the newborn and dealing with emergencies in the home.... All these are covered in mandatory training but as community midwives encounter emergencies less often than hospital midwives, they often feel less confident in dealing with them..."

"I also feel many midwives are afraid of home births due to lack of experience and not being able to have a buzzer and help on hand within seconds. Specific training for home births would need to address this but in terms of the actual clinical care there should be no difference..."

Some midwives reported that training was necessary in 'all aspects of home birth'. The other main areas they suggested where midwives needed particular training were: normality, discussion about risk, promoting home birth, managing on-call, appropriate methods of pain relief, and training about home birth in the multidisciplinary context. Examples of these comments are documented below.

Training in normality

Midwives clearly thought that extra training was necessary in normality which they defined in the following ways:

"Managing 'normal labour'! Sad to say but normal labour care - hydration, relaxation, knowledge of the normal physiology of labour (particularly latent phase)...."

"That watching and waiting embodies midwifery intuition, without the need to perform procedures to conform to time limits on policy stipulated normality. The culture of medicalised birth so deeply embedded in hospital based midwives leaves them lacking in confidence in their abilities and also in women's abilities to birth without intervention (such as VEs and ARMs). Training in normality NOT being retrospective but expected would be beneficial"

"philosophy of home birth, impact of the environment, thinking on your feet and adaptability, confidence in dealing with healthy, normal women"

"Reaffirming the normality of home birth, and how to support women who request to give birth at home. Understanding of why women should consider this as a viable option. Understanding of the difference between a normal birth and a natural birth - it is a very different concept. Natural birth requires a very different relationship - a true partnership that trusts the woman to have faith in her own body. The midwife also needs an understanding of the psychological and physical barriers that may get in the way of the woman achieving this. It is about giving a realistic service that doesn't promise unrealistic expectations, but also doesn't intimidate the woman into compliance with local policies and guidelines that do not support/understand normality"

Training in discussion about the risks and benefits of home birth

Some midwives clearly thought that training in being able to undertake the discussion about place of birth was important. This may suggest that midwives think this discussion is often inadequate, and there is lack of confidence in debating the evidence.

"describing areas where home birth is the same as any other uncomplicated pregnancy, labour and birth. Discussing the evidence with women and partners in particular. Being confident in discussing that it's not a home birth at all costs, the midwife is there to monitor labour and make professional decisions and ensure family's safety"

"... how to present home birth as a realistic option to low risk women and gain confidence and experience in offering home birth"

"... evidence based information regarding safety of home births"

Training in promoting home birth

Some midwives said that they felt that as home birth was not being effectively promoted, that training was necessary in this, which as above suggests that some midwives are not confident in using the evidence.

"Promoting the 'art' of midwifery, watching and listening... identifying women not suitable for home birth, instead of identifying those that are, because the majority of women are suitable. We should be shifting our mindset from childbirth being pathological to it being a bio-social event"

"Promoting home birth to other professionals as well as women and their families..."

"How to promote home birth in a positive way, recognising that home birth is a normal part of midwifery and to have confidence"

Training in how to manage on-call

Two midwives said there was a need for training in this area. This might suggest that midwives are not accessing the RCM Home Birth Handbook (2003), where techniques for coping are discussed in detail.

" how to cope with on-call, being called out & lack of sleep"

"staying awake when having worked all day, only to be expected to work the following day when tired, but can extra training help in a dangerous practice?? One that compromises women's safety and a midwives registration on the UKCC (sic) register"

This may also highlight important CPD needs for midwives in getting to grips with real life practice, and balancing the work life balance. Considering the anxiety about this expressed in the further comments below, this proposition could merit further educational research.

Training in appropriate methods of pain relief

Again it appeared that respondents thought that different training was necessary for the use of pain relief in the 'out of hospital' environment. The area that came up most frequently was the need for training in waterbirth.

"waterbirth, third stage management, alternative therapies, how to support active birth, home birth courses should be developed for all midwives to incorporate the above"

Training in the multidisciplinary context.

Midwives commented on the importance of multidisciplinary training, including hospital midwives, to integrate the service effectively. This links with the findings above of perceived lack of support by other members of the team.

"obstetricians and midwives should receive training together, on the whole process of home birth"

"Confidence in interacting with ambulance services, leadership in emergency situations occurring at home, working in partnership with a number of woman's birth supporters. Use of SBAR type tools to give clear handovers to ambulance colleagues, obstetric, neonatal and midwifery colleagues when necessary"

"Increasing knowledge and confidence in the physiology of normal birth. Rotate community based midwives onto delivery suite intermittently, as some community MWS may go months or years without attending a birth, which is bound to be of detriment to their confidence and knowledge"

"Education for hospital medical team as to the safety of home births"

"Hospital midwives need training in home birth"

Further comments about home birth

280 midwives responded to the open question inviting them to make further comments about home birth practice. The main themes that emerged from these comments were the importance and joy of home birth, concerns about the

maintenance of the service, concerns about the lack of support and the need for more promotion and appropriate information giving.

The joy of home birth

Many of these midwives talked very positively about the 'wonderful experience of home birth' and its importance to midwifery as below.

"Home births can be the most wonderful and fulfilling experience for both families and midwives"

"Home births make me feel like its Christmas every time I have the privilege of waiting for 'the call'"

"I love it. I love going into women's homes, seeing them doing things their own way, assisting and monitoring as required, but essentially being a TRUE midwife in a way that we can't in the hospital"

"Home birth is midwifery at its best"

"When done properly, a home birth epitomises the role of the midwife and it gives the woman control and empowerment. The best deliveries I have ever had the pleasure to be involved with, have been home births"

They also expressed concerns and sadness about its potential disappearance.

"I think it's a fabulous service for any woman and should always be supported. It would be such a shame for this service to disappear from any unit"

"I believe that offering a home birth service is essential. Maintaining this has become more difficult in the light of staff shortages and increasing demands on the time of the community midwives"

A few midwives described very positive experiences in the current climate - where they were very confident about promoting it as an option.

"We have a very high home birth rate and are all very confident, as a team, in providing this service. We promote it and support women's choice and have

made it the "norm" when telling women their choices for place of birth. We explain that it is all part of our service and that we are very experienced and confident in supporting women birthing at home. Partners are advised about our skills and drills training and reassured that we would not offer this service if it was in any way dangerous. Because we are supportive and confident we give the women and their partners the confidence to have a home birth! It works really well I can tell you! And it is something that our team of 12 midwives in a rural setting, are very proud of"

Concerns about the future

Many midwives made comments about current staffing levels and the ability to continue to offer home birth because of the on-call demands, the lack of staffing and the impact of this on midwives' enthusiasm, as illustrated in the quotes below.

"It has, in my experience of over 30 years as a midwife got harder and harder to offer this service mainly because of a shortage of willing midwives. Fewer and fewer midwives are wanting to work on the community because of the on-call service and being called out and still expected to do a full days work after"

"Most midwives dread being on-call and being called. Many have not attended a delivery in many years and lack confidence. The practice of calling community midwives on-call into busy delivery units is very frightening to community midwives. We are out of our area of confidence. Having worked all day, I am not fit to be called out overnight. If the women knew the facts they would not be happy with the service offered"

"It requires a huge commitment from community midwives, who may have to work all day and attend a home delivery most of the night and still work the next day, or if on a day- off, spend some time catching up on sleep. When things go well, home birth is a wonderful experience ... I am very happy to promote home birth, of which I have had positive personal experiences, but we need more midwives to fully offer a home birth to everyone who wishes, especially to first time mothers-to- be, who are likely to be in labour for a long time. Managers also need to be realistic about the number of hours a midwife can safely work"

"The biggest barrier to our home birth service is having to provide the night cover on an on- call basis. If the service were staffed from a dedicated night shift this would prevent many midwives reservations about providing a service. Having to be alert and competent for a full night after having worked a full busy day and carrying out home commitments in the evening, I don't feel competent to be alert all night"

Promotion of home birth

Midwives described the particular problem of the lack of promotion of home birth amongst their colleagues, which is reflected in their suggestions above that midwives needed training in how to promote it:

"home births need to be more widely talked about for women to see it as a normal part of choice of birth place"

They also felt the media had significant responsibility in this:

"whilst persistent negative media attention and lack of support from obstetricians and GPs surrounds home birth, it will continue to have challenges"

"It would be great to have more positive feedback about home birth in the media and support from our medical colleagues"

"There needs to be more of a positive promotion through means such as the media because that's how we live these days ... should just give Channel 4 reels of tape with home births on it!"

Support from the obstetric team

As was apparent in Table 9 there were serious concerns expressed about lack of support from other members of the obstetric team. This survey was only targeted at midwives, it would be interesting to gather views of other members of the team on this.

"There seems to be a lot of ill-informed opinion about home birth based on a culture of fear rather than solid research-based evidence"

"Home birth is as safe or safer than hospital birth, this fact should also be conveyed to doctors at all levels as the current vibe I feel from them is that they truly believe home birth is way more dangerous than hospital birth, this is not a helpful or supportive attitude"

"I have witnessed occasions when some midwives were very unsupportive and unhelpful of their colleagues, when they were transferring women into hospital from a home birth. Equally, some GPs are very supportive, and some aren't. Generally, I have found neonatologists the least supportive; this includes SCBU nurses"

"...am sad that medical/midwifery staff who haven't experienced it, feel its ok to frighten women who are considering it. Sometimes our ladies are made to feel guilty or irresponsible"

This unsupportive attitude was seen to be impacting on appropriate information giving for women to make their choice about place of birth.

" from the home birth meetings I have attended, I have observed that the option of home birth is not always discussed with women, and is initially dependant on the midwives attitude towards home birth...unless the woman brings up the topic herself. Women have reported when they have said that they would like a home birth, why not go to the birth centre?"

"Often not mentioned as a choice of place of birth - due to staffing and lack of support from management"

As discussed above in the training needs, a few midwives articulated concern about the need for continual risk assessment and thought that this was not always happening.

"Also, recently high risk women have been demanding home births and in the current legislation, midwives must attend. Women have choice but midwives have none."

"Good risk assessment is key and as long as women are low risk Home Birth should be fully supported. High risk women are not suitable but some high risk

women opt for home birth. When this happens community midwives are in a very vulnerable position and this is when the support of managers, GPs, colleagues and the wider obstetric team is paramount and often found wanting"

"There should be a stringent check list including an assessment of the area for birth - for example if it is upstairs and access by paramedics would be difficult"

"Concerns about the boundaries being pushed by more healthcare professionals and mothers for home birth. For example, there are VBAC (Vaginal Birth after Caesarean Section) women requesting home births and some with GBS (group B Streptococcus). This poses considerable challenges for midwives who may be asked to attend to the mother in labour and only have confidence for attending to low risk women at home"

It is disappointing that there was little discussion about the role of Supervisors of Midwives here, as they have a key role in supporting midwives in such cases to ensure risks are minimised (RCM 2002).

Limitations

The audit findings only represent the views of 533 midwives across England, Scotland, Wales and Northern Ireland and 20 midwives working in other countries or not in current practice. The subject appeared to attract a particular group of midwives to respond, who had an interest in home births as 71% had attended a home birth in the last 12 months. Encouraging responses to a survey through calls via the website and journals, does not appear to be the most effective way of gaining a large response. A larger response appears to be gained by emailing midwives directly (RCM 2010b). Some midwives clearly thought this was not relevant to them as expressed by this midwife. *"I am a hospital based midwife working in fetal medicine. This survey was not relevant to me"*. However, it did get a response from midwives very experienced in home birth, or interested in the subject.

Discussion

For many midwives in this survey, home birth is clearly a vital part of their practice that represents childbirth's essential normality (Walsh 2000) and as Barrowclough (2009) describes, nurtures a 'faith in normality'. As Stephens suggested in 2005, home birth is seen to be at the 'heart of midwifery led care'. Midwives' confidence in

home birth is known to be strongly influenced by their exposure to it during education and practice (Vedam et al 2009). The majority of midwives in this survey describe themselves as confident in their home birth practice. The fact that they report that one of the main barriers to home birth is midwives' lack of confidence implies that they are referring to midwives other than themselves, and suggesting this could be resolved by the 'other midwives' having more training. The majority of the midwives felt that separate training was necessary for home birth and the areas in which they felt it was necessary included normality, discussion about risk and alternative methods of pain relief including waterbirth. These skills are very relevant in all settings, therefore this finding suggests that these midwives do not witness these skills being used in the hospital. The recommendation for more training in normality is unexpected as it challenges the claim that midwives confidently held for so long that they are the 'specialists of normal childbearing' (Mead 2004). The context of midwives being trained in a midwifery model and then going to work in very busy technology dominated labour wards is probably an inevitable pathway to losing confidence in normal physiology that is the premise of offering home birth (Stephens 2005). The fact that only 52% of the midwives had home birth training as student midwives and 58% had not attended any CPD in this area, rather implies that home birth is not seen by the educationalists to need separate training, a view different to that of the midwives expressed here.

The midwives' opinion that women did not have enough information reflects other literature on the provision of information for women to enable them to make a choice about place of birth (Madi and Crow 2003, Hagelskamp et al 2003, Stephens 2005, Mclachlan & Forster 2009, Vedam 2010) but is disappointing in the context of the high focus on the importance of information giving and birth planning discussions (NICE 2007). This could be linked to the 'over-busy' midwife's day, as reported in the recent audit of midwifery practice (RCM 2010b) where some midwives said they did not have time to discuss birth planning.

The need for training in the promotion of home birth and in the discussion of the benefits and risks, suggests a lack of confidence in discussing the evidence in this area. In the context of the wide debate about the evidence this is hardly surprising. This problem will need to be addressed in detail following the publication of the National Perinatal Epidemiology Unit (2008) '*Place of Birth*' study (due for publication November 2011).

The perceived lack of support described here from other members of the obstetric team is concerning. Good integration of home birth practice via access to emergency services, consultation and transfer of care are known to be vital for an effective and safe home birth service (Hutton et al 2009). Good co-operation between community midwives and the hospital obstetric team is also known to be influential on increasing the rate of home birth (Weigers et al 2000). This lack of support impacting on evidence based information giving to women, is concerning in that it could be demonstrating the ease with which practitioners simply communicate their own attitudes, beliefs and biases (Stephens 2005, Klein et al 2009). Supervisors of midwives are reported as supportive of these respondents home birth practice yet there is little discussion in the open questions of their active role in developing confidence in the challenging situations. This could reflect some lack of clarity between the role of supervisors and management, when midwives are not actively using this resource.

The main obstacle that respondents identified to providing a home birth was the on-call demand. The demands of being on-call are well documented (Bakker et al 1996, Sandall 1998, 1999). Techniques for coping with such irregular hours are discussed in detail in the *Home Birth Handbook: Practising Home Birth* (RCM 2003). The findings here may suggest that midwives are not accessing this resource. It is interesting that some midwives, describe the on-call in such a positive way "*like its Christmas every time I have the privilege of waiting for 'the call'*". The different perceptions of the anxieties and demands of the workload, compared to the enthusiasm for being able to attend home births, perhaps reflects changing concepts of the role of the community midwife. In a modern context many midwives are unwilling to accept intrusion into their personal lives, whilst others value the satisfaction and autonomy they gain from the continuity of care. The model of care is likely to be a significant factor here. Midwives who practice in a case holding model, know the women they are on-call for and are more able to offer this rewarding continuity of care (Stevens & McCourt 2002).

The women's and partners' lack of confidence as a significant obstacle identified here, would merit further research to explore in detail the concerns.

Conclusions

The key findings of the survey are

- the majority of the respondent group of midwives were very positive about the importance of home birth and their confidence in this area practice
- 61% of the midwives reported that they had attended a home birth as a student midwife, but only 52% said that home birth was part of the curriculum in their initial training
- 58% of the midwives had not attended any CPD explicitly focussing on home birth
- further training is necessary in emergency drills in the home environment as well as normality, discussion about risk, promoting home birth, appropriate methods of pain relief, and training together in the multidisciplinary team
- only 58% of the services represented here provide a home birth service all of the time, and 2% never provide it
- respondents suggest that home birth needs more promotion
- the main obstacles to providing a home birth service are the on-call demands within the current staffing levels and other midwives' lack of confidence
- midwives reported a perceived lack of support and negative attitudes towards home birth from other members of the obstetric team, including hospital midwives
- only 50% of the midwives in this survey thought that women are given adequate information about home birth
- there were comments made indicating a concern about women getting appropriate information to make a choice

Key Recommendations

The emergent findings support the recommendations that:

- student midwives have adequate exposure to and experience of home birth, supported by evidence and theory
- more resources be developed for midwives' further training in the areas

identified through national CPD

- mandatory training days on emergency drills should always incorporate scenarios in different environments
- the content of the RCM home birth handbooks be further promoted as a suite of individual papers
- the potential for more multi-disciplinary training in home birth practice be investigated
- opportunities be developed for regular multidisciplinary case review to learn from good practice, from mistakes made, and to develop collaborative relationships
- services become more responsive to the needs of midwives when staff shortages and on-call arrangements are affecting the home birth service
- these findings be cascaded through the midwifery community to actively inform education, practice and research
- the potential for new research triggered by these findings be further explored

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