Home birth and the English NHS:

Exploring the dynamics of institutional change in the context of health care

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Abstract

Research aims and objectives

This study explored factors that shaped the institutional work of a non-dominant professional group in a mature institutional field that sought to maintain or transform existing institutional practices. It aimed to understand and explain the work involved in creating, maintaining and disrupting divergent models of health service organisation and delivery, with a specific focus on maternity care provided to healthy women who chose to give birth at home.

This study investigated questions about the priorities that frame the allocation and management of health service resources and sought to understand how opportunities to advance new institutional practices were recognised, created or resisted by different stakeholders.

Particular consideration was directed towards legitimacy contests associated with advancing or preventing change in strategic action fields[1]. It explored how practitioners captured attempts at reform to maintain or extend their influence or counter the interests of others.

The degree to which intra- and inter-organisational relationships are developed, established and maintained to influence institutional change were explored in this study. Further, the mechanisms by which service user experiences were sought, articulated and integrated into scripts that either promoted or delegitimised new institutional practices at both the micro- and macro-levels were examined.

Research gaps

Critiques of existing approaches to institutional change have questioned the relative neglect of bottom-up change and the improvisations initiated at practitioner level (Smets, Morris, & Greenwood, 2012). This

[1] A definition is provided in chapter section 3.2 (footnote 8).

study had added to understandings of the micro-level origins of institutional change through the actions of "individuals at the front line", while at the same time sought to extend understandings of the micro-level processes that maintain the status quo and prevent change (Reay, Golden-Biddle, & Germann, 2006:979). This study examined the degrees by which change emerges from the innovations enacted by the everyday work of non-dominant professional groups; whether this led to these innovations consolidating at an organisational level; and the potential there was for new innovations to radiate up to the institutional field level (Smets et al., 2012) and become 'taken for granted'.

This study drew upon concepts of deinstitutionalisation to examine why the disappearance of older institutional practices [in this instance, home birth] were not always inevitable when a newer practice [such as an obstetric unit birth] became prevalent or dominant. Work examining mature institutional fields exposed to modernising influences has suggested that non-dominant professional groups appear to engage in countervailing activities that maintain the persistence of older institutional practices while making efforts towards reinstitutionalisation. To date, studies have tended to focus attention at the top of organisations or on embedded or dominant occupational groups. This study has expanded and developed understandings of the agentic activity undertaken by non-dominant professional groups that sit largely outside governance, management and funding structures that sought to re-legitimise institutional practices which had been eroded or threatened with extinction.

Methodology and methods

This was a multiple case site study that employed a social constructivist approach to use a variety of qualitative research methods to explicate particular phenomena. This was compatible with institutional theory which has sought to examine how enduring social patterns and

arrangements are constructed, become taken for granted and treated as inevitable. This study engaged with three separate organisations providing maternity services and a range of organisations and individuals associated with, or affected by this activity. The case sites were selected to represent a range of settings, conditions and relationships that are recognisable across the English National Health Service (NHS).

Intended contribution

The theoretical contribution of this study is to organisational and medical sociology questions about occupational relationships and the priorities that frame the allocation and management of health service resources. This was achieved by identifying institutional work both seeking to reinforce or resist existing medicalised and acute-focused maternity services. Practically, this study engaged with the socio-cultural and political complexities of maternity services' organisation and delivery. It provides information for policy-makers, service leaders and innovators who are contemplating implementing changes in contexts where home birth services are under-developed or under-performing.

Publications, presentations and dissemination

Published work

Common, L., and Shepherd, E. (2007) Paradox of Power: Drivers of Maternity Services. RCM student midwives conference. **The Practising Midwife**. 10(4):14.
Common, L. (2007) Student's view: a tale of two conferences. **RCM Midwives**. 10(7):7.
Common, L. (2007) Studying: ways to survive and thrive. **RCM Midwives**. 10(10):466-467.
Common, L. (2007) Organising an Elective Placement in Zambia. **Midwifery Matters**. 114:16-17.
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Common, L. (2008) Negotiated placements: enhancing midwifery education. **British Journal of Midwifery**. 16(3):187-8.
Common, L., and Maslin-Prothero, S (2010) Getting ready to study in **Baillière's Study Skills for Nurses and Midwives. Fourth Edition.** London: Baillière Tindall Elsevier. pp.3-22.
Common, L., and Maslin-Prothero, S. (2010) Learning skills and learning styles in **Baillière's Study Skills for Nurses and Midwives. Fourth Edition**. London: Baillière Tindall Elsevier. pp.23-44.
Walsh, D., Common, L., Noble, S. (2014) Redressing the balance. **Midwives**. 17 (5) pp. 42.3.
Common, L. (2015) Homebirth in England: Factors that impact on job satisfaction for community midwives. **British Journal of Midwifery**. 23 (10) pp. 716-722.

Publications in development

Working title	**Target journal**
Capitulation, compromise and counteraction: The deinstitutionalisation of home birth in the English NHS	Organization Studies
Changing the balance of power: Relativism, critique and justification in how women talk about their home births	Midwifery or Journal of Advanced Nursing
Home birth, community midwives and paramedics: Do we understand each other?	Midwifery or Journal of Advanced Nursing
What might explain the failure of maternity policy in England to deliver an increase in women choosing home births?	Midwifery or Journal of Advanced Nursing

The failure of maternity policy implementation: A Multiple Streams analysis	Organization Studies
Friends or Foes? Analysing the potential strategic entry deterrents for new maternity care providers in the English NHS	Health Services Research
Moral Panic and Maternity: AQPs as modern 'folk devils' in the NHS	Sociology of Health and Illness
An English perspective on the New Zealand maternity services	Midwifery
Clinical academic careers. What value can a midwife doing post-graduate research add to their clinical practice areas?	Midwives or British Journal of Midwifery

Oral presentations

June 2014	"Exploring the barriers: Community Midwives' perception of factors that influence their ability to support home birth." International Confederation of Midwives, Prague
August 2014	"How change is successfully introduced to maternity services that enables more women to safely give birth to their children at home." Pub PhD. Details at: https://pubhd.wordpress.com/previous-events-2014/
December 2014	"Home birth and the NHS: Exploring the dynamics of institutional change in the context of health care" Maternity Research Group, King's College London
June 2015	"Home birth and the NHS. Institutional change in the context of health care" PhD protocol presented to Midlands Regional Doctoral Colloquium in Birmingham
October 2015	"Great Expectations: Can the NHS deliver more home births?" Economic and Social Research Council (ESRC) Doctoral Training Centre Conference
May 2016	Oral presentation at University of Auckland Department of Population 'Think Tank'
June 2016	Pecha Kucha presentation to ESRC DTC multi-disciplinary students
April 2017	"Great Expectations: Context is everything" Association of Radical Midwives conference
March 2018	"Friends or Foes? Analysing the potential strategic entry deterrents for new maternity care providers in the English NHS." Nottingham University Hospitals NHS Trust, Research Showcase

Poster presentations

November 2013	"Exploring the barriers: Factors that influence community midwives' abilities to support home birth." Royal College of Midwives National Conference
March 2015	"How are models of care that support home birth in the NHS introduced and sustained?" Annual General Meeting of the Collaboration for Leadership in Allied Health Research – East Midlands (CLAHRC-EM)
June 2015	"Great Expectations: Can the NHS deliver more home births?" University of Nottingham Graduate School Research Showcase – awarded 2nd place in the Media Prize category resulting in a visit to the local BBC television and radio studios with one of my academic supervisors and my press release featuring on the university website. My poster was also highly commended in the artistic flair prize category.
June 2017	"Friends or Foes? Analysing the potential strategic entry deterrents for new maternity care providers in the English NHS." International Confederation of Midwives Congress, Toronto, Canada

International visits

April – May 2016	Spent one month at the University of Canterbury in Christchurch, New Zealand 1-30 April 2016. Spent one month at the University of Auckland in Auckland, New Zealand 1-31 May 2016. Both were arranged by me as part of my ESRC funded Overseas Institutional Visit application. I visited a number of primary, secondary and tertiary health care facilities; I interviewed a range of different healthcare professionals and service users; I met with a number of professionals and consultants involved in the regulation, policy development and implementation of maternity services in New Zealand; I met with a number of academics from three additional universities as well as academics researching and working on different aspects of the healthcare system in New Zealand; and I was invited to present and discuss my work at two formal events i) for academics in population health and ii) service-users interested in maternity services.

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Glossary of terms and abbreviations

AMLU	Alongside Midwifery-Led Unit
Antenatal	During pregnancy, before birth
AU	Acute Unit (hospital location)
Caesarean	Surgical delivery of a baby through the abdomen
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CM	Community Midwife
Comorbidity	The presence of one or more additional diseases or disorders co-occurring with a primary condition e.g. pregnancy
CQC	Care Quality Commission
CTG	Cardiotocography (fetal heart rate monitoring equipment)
ESRC	Economic and Social Research Council
EWTD	European Working Time Directive
Forceps	An instrument consisting of two long narrow arms used by obstetricians to assist the birth of a baby
FMU	Freestanding Midwifery-Led Unit
GP	General Practitioner
Hypnobirthing	Birth education that teaches self-hypnosis, relaxation and breathing techniques
ICF	Informed Consent Form
IRAS	Integrated Research Application System
Intrapartum	The time spanning the act of birth, from the onset of labour to the delivery of the placenta
IU	Integrated Unit (where consultant-led and midwife-led care is combined)
LTP	Long Term Partnership
MSLC	Maternity Services Liaison Committee
Multiparous	A woman who has experienced one or more previous childbirths
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
Normal Birth	Sometimes considered to be a vaginal birth of a baby. Technically described as an infant born spontaneously [without help] in the vertex position [head down] between 37 and 42 completed weeks of pregnancy
NMC	Nursing and Midwifery Council
Nulliparous	A woman who has not given birth
ONS	Office of National Statistics

Participant	An individual who takes part in research
PCT	Primary Care Trust
PFI	Private Finance Initiative
PI	Principal Investigator
PIS	Participant Information Sheet
Postnatal	A time period after giving birth
QIP	Quality Improvement Plan
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
REC	Research Ethics Committee
RQ	Research Question
THF	The Health Foundation
UK	United Kingdom
USP	Unique selling point
WHO	World Health Organization

1.0 Introduction

1.1 Background context for this thesis

Giving birth to a baby is now the most common reason for admission to hospital within the NHS (National Audit Office, 2013). Of the 646,904 live births in England in 2013-4, 2.3% took place at home (Health and Social Care Information Centre, 2015). Research evidence and health policy have consistently and increasingly recognised home birth as an appropriate option for healthy low-risk women in terms of safety, cost-effectiveness and service-user satisfaction (Birthplace in England Collaborative et al., 2011; Bourke, 2013; Schroeder et al., 2012). These findings led to revisions of national clinical guidelines – which previously urged caution if a home birth was planned – to now state that healthy women with low risk pregnancies[2] should be offered a choice of birth settings (National Institute for Health and Care Excellence, 2017).

Key conclusions from a large prospective study involving nearly 65,000 low-risk pregnant women in England that used intention-to-treat analysis were that their;

> '*…results support a policy of offering healthy nulliparous and multiparous women with low risk pregnancies a choice of birth setting. Adverse perinatal outcomes are uncommon in all settings, while interventions during labour and birth are much less common for births planned in non-obstetric unit settings. For nulliparous women, there is some evidence that planning birth at home is associated with a higher risk of an adverse*

[2] Definition of a 'low risk pregnancy' is the absence of medical conditions or situations detailed in tables 6-9 of the NICE Intrapartum care for healthy women and babies guidelines (CG190) (National Institute for Health and Care Excellence, 2017).

perinatal outcome.' (Birthplace in England Collaborative et al., 2011. p.4)

Analysis in Birthplace in England (2011) for all pregnancies had demonstrated that the incidence of adverse perinatal outcomes[3] was 4.3 per 1,000 births. However, when the data was stratified, a statistically significant difference between nulliparous and multiparous pregnancies was identified. Much professional critique and media commentary has subsequently focused on these particular findings [**Table 1**]. Due to the low event rates for individual perinatal mortality and neonatal morbidities the authors chose a composite primary outcome (see footnote 3). Buekens and Keirse (2012) have highlighted that while this was to achieve sufficient statistical power, much debate continues around every adverse outcome has equal status e.g. a baby requiring neonatal care for a few days cannot be equated with a baby dying.

Table 1: Summary of key findings from the Birthplace in England Research Programme (Birthplace in England Collaborative et al., 2011)

Where women planned to give birth	**Hospital**	**Home**
Numbers of births	19,688	16,825
of which were normal births	57.6%	87.9%
of which were caesarean sections	11.1% (n=2,158)	2.8% (n=458)
of which were forceps deliveries	6.8% (n=1307)	2.1% (n=372)
Adverse outcomes[3] for baby of low-risk multiparous women	3.3 per 1,000	2.3 per 1.000
Adverse outcomes[3] for baby of low-risk nulliparous women	5.3 per 1,000	9.3 per 1,000

[3] For clarity, the primary composite outcomes used in Birthplace (2011) were perinatal mortality and neonatal morbidities as follows: a) stillbirth after the start of care in labour; b) early neonatal death (within 7 days); c) neonatal encephalopathy; d) meconium aspiration syndrome; e) brachial plexus injury; and f) a fractured humerus or clavicle.

How findings from the Birthplace in England cohort study (2011) have been interpreted to support the rhetorical positions of a range of stakeholders was of interest to this study. The work of Coxon, Sandall, and Fulop (2015) reviewed the evidence and found that first labours are often articulated as riskier than second or subsequent births historically. This has led to assumptions that all first births should take place in hospital. Coxon et al. (2015) found evidence to demonstrate that women's birth place preferences for subsequent pregnancies were indeed influenced by the place they gave birth to their first child i.e. an obstetric unit, a midwifery-led unit or a home birth. These findings challenge the notion that nulliparous women will be more open to non-obstetric unit birth in future pregnancies.

Since the publication of a key maternity report called *Changing Childbirth* (Department of Health, 1993) there has been a sustained national policy commitment to increase the plurality of provision in maternity services. Despite this, considerable centralisation of birth into large obstetric hospitals has continued, often predicated on assumptions that this was the most cost-effective way to provide care. Cost effectiveness estimates of alternative planned places of birth however, challenge this [**Table 2**]. Schroeder et al. (2012) concluded that overall, and for low risk multiparous women, planned birth at home generated the greatest mean net benefit with 100% probability of being the optimal setting across all thresholds of cost effectiveness when perinatal outcomes were considered (page 1). For low-risk nulliparous women, planned birth at home is still likely to be the most cost effective option but is associated with an increase in adverse perinatal outcomes [**Table 1**] (Schroeder et al, 2012). With an annual birth rate of over 640,000 per year, there should be clear economic benefits for the English NHS to develop the availability of home birth for more women.

Table 2: Cost comparisons for hospital versus home birth by parity (Schroeder et al, 2012)

Where women planned to give birth	Hospital	Home
Nulliparous (first)	£2,075	£1,793
Multiparous (second or subsequent)	£1,142	£780
Mean cost saving (weighted, adjusted and bootstrapped)		£366 per home birth

The most recent guidance from NICE preceded an announcement by NHS England for a national review of maternity services assessing how current maternity care provision should be developed to meet the changing needs of women and babies (NHS England, 2015). This has now been expressed as an ambition to increase the national home birth rate for 2% to 4% by 2021 (NHS England, 2019).

Care provision designed to support home birth could be said to inhabit disputed social, cultural and historical spaces within the mature institutional field of the NHS (Fligstein & McAdam, 2012). This study seeks to address a gap in understanding the factors that shape the institutional work of non-dominant/non-medical professional groups and individuals attempting to create, maintain and disrupt institutional change. As such, this study will provide meaningful lessons for health service leaders and policymakers interested in change as well as academic communities interested in the dynamic processes of institutional work.

1.2 The aims and objectives of the research

Healthcare systems are notoriously difficult to change. Even where evidence-based interventions exist, change can often be impeded by policy imperatives, institutional pressures and professional cultures. This study aims to develop new theoretical and empirical insight into the strategies and activities involved in making and inhibiting localised or 'bottom-up' institutional change within healthcare settings.

In developing its theoretical analysis, the study draws upon and makes connections between sociological and organisational theories of institutional work, focusing in particular on the strategies used by service leaders to a) identify new institutional opportunities for change; b) mobilise different rhetorical arguments for change among stakeholders; and c) utilise additional social networks and resources.

With specific reference to home birth, this includes a) the new opportunities created by recent healthcare reforms with respect to Any Qualified Providers (AQPs); b) the different forms of evidence and knowledge pertaining to home birth; and c) the development of new inter-organisational networks and supplier confederations to introduce new services. These strategies highlight the important 'institutional work' of various leaders to confront, change and maintain established institutions.

This study's contribution to knowledge is to produce new theoretical insights relevant to broader organisational and medical sociology questions about occupational relationships and priorities that frame the allocation and management of health care resources. Further, the strategic impact will be the development of specific evidence for healthcare leaders interested in understanding the barriers and drivers to change. At an operational level, it should inform conversations that seek to increase the plurality of choice for pregnant women, assisting commissioners and providers of maternity services who may be striving to develop models of care to support home birth that deliver quality, safety and cost savings for the NHS.

1.3 Outline of research methodology

This study was undertaken in a contemporary, open system where the researcher had little to no control over events and behaviours. Given

the exploratory nature of the research, it has sought to adopt a constructivist epistemology to explore how historical, social and political processes have shaped knowledge and reality. This is underpinned by an ontological perspective that views reality as subjective and that 'truth' can vary between individuals. The researcher's axiology has an emancipatory inclination, seeking to problematise the historical and cultural realities around home birth.

The methodology applied to this qualitative study has been predominantly inductive and used what Blaikie (2007) describes as a 'retroductive' approach – inductive through initial observation, and then seeks to develop plausible explanations which may be informed by previous work in the field. It has sought to situate its findings in the theoretical fields of organisational institutionalism, focusing in on deinstitutionalisation[4] and the sociology of the professions. In light of the exploratory and explanatory nature of this research, a multiple case study approach has been adopted (Yin, 2014).

1.4 The structure of this thesis

This thesis is comprised of nine chapters in total, with additional supporting sections providing references and appendices.

In Chapter Two that follows this introductory chapter, I conduct a review of literature that seeks to position 'place of birth' in context. I have structured the review to firstly provide a working definition of home birth and then I move to explore historical dimensions in more detail. I then define coexisting philosophies of care that assist in informing the following section on contextual perspectives. I have

[4] Deinstitutionalisation refers to processes by which institutions weaken and disappear. 'Institutions' as a term refers to "*more or less taken-for-granted repetitive social behaviour that is underpinned by normative systems and cognitive understandings that give meaning to social exchange and thus enable self-reproducing social order*." (Greenwood et al, 2008. Page 4.)

deliberately sought to give voice to deviant and negative perspectives in this chapter in order to give light to the social, political and professional tensions that exist around home birth as a practice.

Within Chapter Three, I conduct a critical review that explores a range of literatures situated in the fields of organisational institutionalism and the sociology of the professions. I have regarded these as the 'sensitising concepts' that have offered ways of seeing the overall research issues being explored.

The research methodology that I adopted is presented in Chapter Four. Here I engage in reflexivity and demonstrate the philosophical orientation that has informed my approach to the research questions, data gathering and analysis in some detail.

In Chapters Five, Six and Seven, I present empirical data generated during the research process from documentary analysis, participant interviews and focus groups with non-service users.

Chapter Five discusses the case site I have called 'Willow', an NHS maternity service that had a home birth rate which has performed below the national average for at least 20 years. I have analysed the data using two themes and have sought to demonstrate how home birth has become deprioritised and its utility re-evaluated by Willow as an organisation. How rhetorical strategies and defensive institutional work has been employed to re-capture the whole maternity market in the face of new competition is also explored.

Chapter Six presents the case of 'Sycamore', an NHS maternity service that had home birth rates which performed above the national average since 2004. I have analysed data using three themes here which has demonstrated how service change in relation to home birth was

reactive, rather than proactive. How the organisational response to regulatory scrutiny impacted on the home birth service is explored and how this recalibrated the role of community midwife workforce in ways which reconceived them as a complimentary and flexible workforce to enhance safety in the acute unit is scrutinised. Attempts to resist and modify the impact of this organisational response is also captured in this chapter.

In Chapter Seven the case of 'Oak', a private limited company that established in 2010, who were authorised by NHS commissioners to provide free maternity care in partnership with the NHS to local communities is presented. Oak were achieving a home birth rates that exceeded local and national averages by some margin. I have analysed data using two themes. The first explores the data around how entrepreneurial tendencies to maximise the opportunity created by a new commissioning landscape were exploited. The second identifies data collected that revealed some of the challenges and resistance that was met by Oak from providers, regulators and commissioners.

In Chapter Eight, I have employed a cross-case synthesis approach to the data collected from Willow, Sycamore and Oak. This was an iterative process that was data-driven and underpinned with the theoretical literature associated with deinstitutionalisation. Each of the case sites are mapped to two over-arching themes and then a conceptual framework is presented that demonstrates the conditions by which erosion or survival of home birth is reinforced.

Finally, in Chapter Nine, I present concluding statements and recommendations based on the findings from this study. I also discuss how the concept of 'post-deinstitutionalisation' could be developed and tested and my estimation of the implications of this study for policy makers, service leaders and innovators. I also comment on the

limitations of my research, as well as posing suggestions for future avenues of inquiry.

2.0 Literature Review: Place of birth in context

2.1 Maternity services: The contextual background for the study

This section will outline how the location of childbirth is understood to have changed historically as a result of social, political and professional developments. It will first outline a working definition for home birth and then go on to discuss some of the barriers to change, which have often been understood within the healthcare literature as the professional project[5] of the medical profession to dominate this field in terms of their status and skills in relation to the profession of midwifery. It will then go on to explain conflicting institutional logics within maternity before outlining some contemporary contextual issues.

2.1.1 Working definition for home birth

For the reader unfamiliar with maternity services, a planned home birth may be understood as childbirth taking place in a woman's home, attended and supported by at least one midwife. Generally, these are healthy women with uncomplicated pregnancies (low-risk) (see footnote 2, page 1 of this thesis). However, some women with health conditions (e.g. diabetes) or complicated pregnancies (e.g. twins) also plan to give birth at home and these would be regarded as high-risk. Some women also give birth at home unexpectedly. These are known as unplanned home births and commonly occur when labour begins prematurely or progresses rapidly.

2.1.2 Historical developments in maternity care

Midwifery has traditionally been primarily an occupation for women reflecting deeply-rooted attitudes and assumptions about modesty, propriety, and appropriate sexual roles. However, childbirth began to

[5] Larson (1977) conceives the 'professional project' as a concern with establishing high social status for individual professionals based on translating specialist knowledge and skill into social and economic rewards.

migrate from the private, domestic sphere and enter the public domain from around the seventeenth century (Fahy, 1998). Offering childbirth services to wealthy clients became a lucrative pursuit for medical men as it was likely to give them access to providing continuing health care to the whole family (Donnison, 1988; van Teijlingen, 2015).

Consequently, women became increasingly marginalised from participating in midwifery and medical practice as formal regulation, education and training were usually not available to them in the seventeenth century. As male midwives began to transform childbirth from a social into a medical and mechanised process, female midwives and birth attendants found that they were excluded from all but the most straightforward births, and were largely attending the poorer women who did not present a lucrative client group for the medical men (Donnison, 1988; van Teijlingen, 2015).

By the nineteenth century the general practitioner (GP) and the obstetrician were emerging as recognised specialisms. GPs sought to exclude midwives from independent practice and absorb midwifery into their own sphere of work; while obstetricians wanted to restrict the scope of midwives' practice to the cases they did not want to attend and control midwives' registration (Donnison, 1988; van Teijlingen, 2015). The establishment of "lying-in" hospitals provided doctors with opportunities to practice on women experiencing straightforward labours and births, which further undermined the concept of independent midwifery practice.

The twentieth century saw the passage of the Midwives Act 1902. This was the culmination of over 40 years of protracted debates for a state-sponsored system of midwives' registration and where the division of labour and inter-occupational relations and control between medicine and midwifery were openly contested (Witz, 1992). Obstetrics

established itself as the new authority on childbirth by creating a division between normal and abnormal birth and then expanding these definitions to take control of both (Pilley-Edwards, 2005). All birth was gradually moved into hospitals by successfully convincing society about the unpredictability of birth in which obstetrics alone were the authority (Pilley-Edwards, 2005). The publication of the Peel Report (Ministry of Health, 1970) which recommended that hospitals accommodate all women, regardless of health risk, parity or social need, was written at a time when relevant causative factors contributing to improvements in perinatal and maternal mortality were overlooked (McIntosh, 2013; Tew, 1998). These included improvements in public health and the availability of contraception, as well as improvements in nutrition, living conditions, rising education standards, social welfare changes and the growing economic independence of women. It also came at a time when the post-war baby boom was tailing off and obstetric hospital beds were under-occupied (Tew, 1998).

In the 1980s, government reports focused on the risks of perinatal mortality and argued for labour and delivery suites to have full-time obstetricians, anaesthetists and neonatologists present at all times and to operate in a similar way to an intensive care unit (Social Services Committee, 1980). However, McIntosh (2013) has explained that another debate which foregrounded emotional and psychological well-being instead of death and disability was gaining momentum. The Department of Health explored the landscape of maternity care in England and produced a report known as 'Changing Childbirth' (Department of Health, 1993). This reflected the interests of consumer groups, midwifery organisations, and the wider government agendas of offering choice, continuity and control to consumers at the same time as advocating for a low-cost alternative to consultant-led care (McIntosh, 2013). This report continues to resonate within maternity services and the principles have been carried forward into subsequent

national policy documents (Department of Health, 2004, 2007). However, the increasing medicalisation of childbirth can be evidenced by the numbers of caesarean sections in England climbing from 12% in 1992, to 26.2% in 2014 (Health and Social Care Information Centre, 2015).

The historic struggles between midwives and doctors have most recently been evidenced in a report into failures at the University Hospitals of Morecambe Bay NHS Foundation Trust which identified that there were poor working relationships between midwives, obstetricians and paediatricians and a 'them and us' culture (Kirkup, 2015). On the same day, NHS England announced a major national review of maternity care in England (Cumberledge, 2016) to assess current maternity care provision and to consider how services should be developed to meet the changing needs of women and babies.

Historically, obstetrics as a dominant professional group that is embedded within governance, management and funding structures has been largely credited with constructing the case to abandon home birth in favour of birth in hospital since before the early twentieth century. On one hand, the midwifery profession has developed education and research cultures, agendas and questions that have sought to justify constructing new services from the remnants of home birth services in an effort to reverse its abandonment. On the other hand, there may also be questions about the degree to which midwives themselves have presided over the dissipation and rejection of home birth. In keeping with other sociological changes to working patterns, midwives are thought to have different expectations in terms of their work-life balance when compared to their predecessors. At a structural level, all requirements to complete midwifery education could arguably be undertaken in the acute setting alone – student midwives are required to attend 40 births, and there is no requirement for any proportion of

these to be home births. Equally, rising litigation, punitive professional regulation and perceptions about the low status of 'community midwives' might also be implicated in deinstitutionalisation. Equally, contemporary narrative discourses of risk, blame and responsibility constrain women's decisions and effectively limit opportunities for planning birth in settings other than hospitals (Coxon, Sandall, & Fulop, 2013).

Abandoning established ways to deliver health care in favour of new ways presents many challenges. However, when discontent with established practices is perceived as part of an exclusionary strategy aimed at securing professional dominance by diminishing the value and status of a competing profession, then any suggestion that a field level consensus explains deinstitutionalisation should be challenged.

2.1.3 Philosophies of care

In maternity, two models of care coexist, namely the medical (or biomedical or technocratic), and the midwifery (or social or holistic) models of care (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). The medical model gives a central role to doctors and focuses on the pathological potential of pregnancy and childbirth, sometimes introducing interventions before any deviation from normal is detected. In the midwifery model, the midwife is given the central role and the approach is to support childbirth as a normal physiological process and to only intervene when a deviation is detected. Both models have one thing in common: proper and timely identification of upcoming complications and access to interventions are at the heart of good care. Otherwise their focus is different (Olsen & Clausen, 2012). This rather simplifies clinical reality as representing opposite ends of a spectrum, when in fact regulators and many employing organisations expect maternity professionals to incorporate both into their practice.

Institutional theory may help to inform how the seemingly stable and effective institutional practice of home birth has been historically eroded by a dominant biomedical philosophy of care. The competing institutional logics within maternity care have unequal status and lend insight to the organising principles of the field. Thornton and Ocasio (1999) have defined institutional logic as "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organise time and space, and provide meaning to their social reality" (p.804). The biomedical and midwifery logics are simultaneously in play and vying for legitimacy.

2.1.4 Contextual perspectives on home birth

As outlined above, a number of national documents concerning maternity services in the United Kingdom (UK) have stated an aspiration to increase the plurality of place of birth provision over recent decades (Cumberledge, 2016; Department of Health, 1993, 2004, 2007). More recently, the National Institute for Health and Care Excellence (NICE) published new national clinical guidelines (2017) that explicitly recommend that healthy women should be advised that planning to give birth at home is particularly suitable for them, and that commissioners and providers should ensure that home birth is available to all women. This revises NICE's previous recommendations that urged caution if a home birth was planned (NICE, 2007) and has the potential to affect thousands of births each year in England.

While national level policy for expanding home birth as a choice for women exists, reform may be limited by a lack of determination and/or the absence of institutional entrepreneurs at local levels to implement policy, particularly if the policy involves a service provided by a non-dominant professional group. Institutional entrepreneurs might be characterised as advocates for ideas who are willing to invest their time, energy and reputations to promote change in health care. The

significance of these institutional entrepreneurs to implement policy at the micro and meso levels and attach solutions to problems and issues when the political climate is conducive and receptive is of interest in this study. The degree to which there is a lack of coherence between a compelling problem and a plausible solution that is politically feasible is investigated within this study.

2.2 Acknowledging home birth as a contentious issue

This section sheds light on some of the perspectives of the opponents of home birth. In the UK, around 90% of women will give birth in a hospital (Health and Social Care Information Centre, 2015). Indeed, for many people, including many health professionals who work in maternity care settings, the theoretical advantages of hospital birth are considered to outweigh any perceived adverse effects. A rationale that only hospital facilities have the capacity to rapidly deliver, and rescue women and babies because they are equipped with professionals, technologies and protocols (Olsen & Clausen, 2012) is underpinned by a conviction that birth can only be considered 'normal in retrospect' (World Health Organization, 1997). However,

It is recognised that there are a range of definitions for what constitutes a normal birth and that this remains constantly under discussion and revision. The international definition provided by the World Health Organization is as follows:

> *"Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously (without help) in the vertex position (head down) between 37 and 42 completed weeks of pregnancy. After birth mother and baby are in good condition." (World Health Organization, 1997. Page 3)*

2.2.1. Safety

Beliefs that pregnancy and childbirth are inherently risky inform medical approaches that seek to manage and eliminate all risks where possible. For Grünebaum et al. (2015) the absence of all the benefits that a

hospital environment affords childbearing women and babies, means that they are exposed to inadequate patient safety measures and unacceptable preventable adverse outcomes:

> *"The tools of obstetric patient safety include teamwork, team training, emergency drills, audits, best-practice protocols, safety checklists, outside review of performance, caesarean delivery, and access to specialised care. It takes a clinical village to improve safety in childbirth – that clinical village is absent in homebirth."* (Grünebaum et al., 2015:1235).

Opponents tend to disparage any research that concludes that healthy women with low risk pregnancies should be offered a choice of birth settings. A prominent reason for this is that any delay in transferring women and babies in a critical condition from a home location increases their risk of mortality and morbidity[6]. For Chervenak, McCullough, Brent, Levene, and Arabin (2013) it is ethically unacceptable for clinicians to relegate women and babies to the category of 'collateral damage' and that any claim that planned home birth can be a safe option is regarded as a 'clinical fiction'.

A study by Roome, Hartz, Tracy, and Welsh (2015) examined the different position statements on home birth of midwifery and obstetric colleges, including those from the UK, USA, Australia, New Zealand and Canada. Despite the colleges accessing and citing much of the same research evidence base for home birth, limited consensus on interpretation existed. de Melo-Martin and Intemann (2012) have suggested that this could be attributed to a lack of objectivity given that the colleges have divergent ethical and social values. Roome et al. (2015) concluded that the differing values around safety, risk and

[6] The Birthplace in England Collaborative et al. (2011) acknowledged that the generalisability of their findings to other settings was uncertain given that the English NHS was an integrated healthcare system with care almost always provided by NHS midwives, with clear referral pathways to obstetric units if complications occur, and using a comprehensive ambulance network with trained staff (page 4).

childbirth could partly be attributed to an interpretive bias of the extant literature, where a subjective standpoint that seeks to confirm existing beliefs is in evidence. For opponents of home birth, patient satisfaction, respect for women's rights and cost-effectiveness are ideologically incompatible with patient safety. Moreover, they believe these other factors have been inappropriately introduced to dilute and distract from what they regard as the fundamental issue of the prevention of maternal and neonatal mortality at all costs. In contrast, proponents of home birth privilege informed decisions made by women about their own maternity care and believe this contributes to enhancing patient safety.

Further concerns of those opposed to home birth are that midwives lack the extensive expertise required to manage a range of complex conditions and adverse outcomes away from the hospital environment (Grünebaum et al., 2015) and that their risk assessment skills, at best, are suboptimal (Chervenak & Grünebaum, 2015). This aligns with the assertion by Exton (2008) that the de-medicalisation of birth is a foundational belief of midwifery education and that midwifery students are inappropriately inculcated with a 'doctrine' that birth is a normal life event, resulting in an anti-doctor and gender politics bias that has led to failures in patient safety. This was echoed in the findings in the Report of the Morecambe Bay Investigation (Kirkup, 2015) into serious failures in maternity care at Furness General Hospital that resulted in avoidable harm to mothers and babies including tragic and unnecessary deaths;

> *'…Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth 'at any cost'; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care…' (page, 7)*

Exton (2008) believes that the education of midwives lacks effective instruction in basic practical nursing skills and that this is leading to a 'myriad of poor outcomes'. Recent work by Lawton, Filoche, Geller, Garrett, and Stanley (2015) has raised concerns that pregnancies cared for by newly qualified midwifery graduates were associated with a 33% increase in perinatal mortality. Although adverse outcomes are frequently encountered in hospital settings, opponents believe that the delays involved in transferring in from a home birth to reach the hospital's 'clinical village' diminishes the chances of women and babies being saved. For these reasons, doubts that direct entry midwives have the necessary training or skills to facilitate birth safely in a home setting, without immediate access to medical expertise, is an ongoing debate.

2.2.2 Environment and experience

Opponents of home birth have sought to counter suggestions that women might labour more naturally and safely at home by arguing that the 'aesthetic appeal' (RANZCOG, 2014:4) of a woman's home can be recreated in the hospital environment so that they can be within reach of medical assistance if and when required. They suggest that much can be done to 'create a home-like, psychologically, and socially supportive hospital birth to support the legitimate expectations of women for a humane, safe, and undisrupted labor [sic]' (Chervenak & Grünebaum, 2015:34). Further, women that choose home birth are often criticised for prioritising their own 'birth experience' ahead of the safety of their baby. This is summed up in an anonymous editorial that stated 'women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk' (The Lancet, 2010:303).

2.2.3 Cost-effectiveness

Evidence that home birth is a cost-effective option when compared to other birth settings is problematised by its opponents who believe this misleads public and policy officials. The evidence from the Birthplace in

England Study (Schroeder et al., 2012:7) that concluded that 'for multiparous women at low risk of complications, planned home birth is the most cost-effective option [and] for nulliparous low-risk women, planned birth at home is likely to be the most cost-effective option but associated with an increase in adverse perinatal outcomes' is regarded as both selective and defective (Chervenak et al., 2013). For opponents of home birth, any idea that the risks to the lives of mothers and babies can be costed in this way is unacceptable. They highlight that language such as 'adverse perinatal outcomes' obfuscates the reality of individual tragedies. Opponents also believe that the significant costs associated with perinatal and maternal damage or death, which can run in to the millions, are deliberately downplayed.

2.2.4 Women's rights and autonomy

Chervenak et al. (2013) argue physicians and obstetricians have a professional responsibility in their relationship with patients that is a powerful antidote to what Chervenak and Grünebaum (2015:3) call 'the maternal rights-based reductionism, i.e. the view that the rights of pregnant women are absolutely determinative in the ethics of obstetric practice'. Licqurish and Evans (2015) describe this dichotomy as the difference between working with women and not changing their minds versus informing women of the risk of home birth to sway them towards the obstetric position. Proponents that argue for justifiably limiting a woman's right to choose to give birth at home believe it is fundamentally about upholding their professional integrity which prohibits them from agreeing to clinical management that is unsafe. In practice, this means that clinicians who ascribe to this position believe they have a duty to present hospitals as the rational default location for birth and to strongly recommend against home birth citing the authority of the evidence about its outcomes and quality.

2.2.5 Political dimension

The work of Coxon et al. (2013) has explored the polarisation of 'natural' and 'technological' views of birth and how this contributes to

place of birth decisions in an historical context of beliefs around non-obstetric unit settings by women. Further, Douglas and Wildavsky (1982) have discussed how some risks are selected for political reasons. In the context of the contemporary shift towards authoritarianism globally, home birth can be derided as a form of 'virtue signalling'; positioned as anti-neo-liberal, anti-capitalist and anti-authority. Similarly, the resurgence of religious fundamentalisms in the face of modernisation and secularisation has placed female reproductive rights and fetal rights in conflict. Misogyny cloaked in piety, coupled with anxieties around falling fertility rates, can lead to women being regarded as mere vessels for a precious fetus and potentially not being permitted to give birth without medical intervention in the future. This is an extremely controversial area of the debate and will not be explored here and is beyond the scope of this thesis.

2.3 Summary

The practice of home birth brings into stark relief the well-documented rivalries and tensions that exist between the philosophically polarised positions of a biomedical care/risk minimalisation approach and a holistic care/risk management approach to maternity care. This chapter has endeavoured to demonstrate how for opponents of home birth, safety is provided by an institutional environment, staffed and equipped to deal with all potential emergencies. Giving birth away from this environment is perceived as exposing women and babies to unacceptable risks. It has sought to explain how research evidence is cited and interpreted in ways that seek to demonstrate how adverse outcomes at home births could have been ameliorated if the birth had taken place in a hospital. This is why opponents of home birth believe that clinicians have an ethical duty to actively discourage women from considering it. The chapter has then briefly touched on how the reproductive and human rights of women intersect at a political, ethical and religious junction. Finally, it has described how the concepts of patient satisfaction, women's rights and cost-effectiveness are regarded

as ideologically incompatible and ultimately subordinate to the primary objective of preserving life.

The partial abandonment of home birth in the UK in favour of obstetric unit birth is an empirical phenomenon that has long been criticised by the midwifery profession as well as social movements and organisations interested in the protection of women's human rights in childbirth.

Chapter Three will position these social, political and professional tensions within a body of theoretical approaches that have helped to inform the engagement with, and analysis of the data collected. As a result, a conceptual model and framework has been developed in Chapter Eight that strives to present new insights into how certain institutional practices are exposed to legitimacy contests associated with advancing or preventing organisational behaviour and change.

3.0 Literature Review: Theoretical perspectives

3.1 Introduction

This study has explored factors that shaped the institutional work of a non-dominant professional group (midwifery) in a mature institutional field (the English NHS) that were seeking to maintain or transform an existing institution (home birth). By seeking to understand and explain the work involved in creating, maintaining and disrupting divergent models of health service organisation and delivery, this study drew on a range of literatures discussed in this chapter.

This critical review of the literature explores the synergies and interdependencies of institutional work, deinstitutionalisation and theories of professional power that have informed the development of the conceptual model and framework presented in Chapter Eight. These literatures might be viewed as 'sensitising concepts' that have provided general directions along which to look (Blumer, 1954) or as Charmaz (2003 p.259) has described:

> *"…those background ideas that inform the overall research problem… and offer ways of seeing, organising, and understanding experience; they are embedded in our disciplinary emphases and perspectival proclivities. Although sensitising concepts may deepen perception, they provide starting points for building analysis, not ending points for evading it. We may use sensitising concepts only as points of departure from which to study the data."*

The literatures presented here have informed the starting point for this qualitative doctoral study. However, while offering potential approaches to aspects of the researched phenomena, these theories and concepts have also directed attention away from other important literatures (Bowen, 2006). Throughout this study remaining sensitive to "emergent concepts [that] may supplement or displace them altogether" (Padgett, 2004 p.301) has been an active process.

This review has sought to identify important gaps and opportunities for theory development. The summary that concludes this chapter signals how the literature will be incorporated into the development of the study's conceptual model and framework, discussed in more detail in Chapter Eight. Further, it seeks to position the institutional tensions surrounding home birth in a landscape that provides new insights and understandings of the phenomena.

3.2 Institutional Theory and Change

An over-arching approach that will inform this study is institutional theory and the concept of institutions. Institutions are commonly understood as enduring social patterns that go through periods of change and stability (Zietsma & Lawrence, 2010)[7]. Research into the work required to reinforce and preserve institutions has helped to explain their permanence once formed (Berger & Luckmann, 1967; W. Scott, 2001). Developing the work of P. Dimaggio and W. Powell (1983), W. Scott (2014) explains how regulative, normative and cultural-cognitive 'pillars' introduce coercive and mimetic pressures around an institutional norm. The regulative pillar identifies the ability to establish and monitor the compliance and conformity to established rules. The normative pillar influences behaviour by defining social and moral obligations that are considered appropriate or expected in given situations. The cognitive pillar is based on "shared conceptions that constitute the nature of social reality" and define the prevailing orthodoxy (W. Scott, 2014 p.57).

Maintaining institutions is thought to involve work that reinforces established patterns of behaviour to strengthen and preserve their legitimacy by manipulating the experiences and behaviours of the individuals within these structures (Haunschild & Chandler, 2008) and to create regularities in human behaviour (Meyer & Rowan, 1977). The

[7] For the purposes of this thesis, home birth should be regarded as 'an institution'.

tendency of institutional theory has been to explain stability and reproduction through the maintenance of all three of Scott's (2014) pillars. However, scholars have problematised this approach by demonstrating that one dominant pillar can be responsible for sustaining or collapsing an institutional practice (Maguire & Hardy, 2009).

The mechanisms of institutional change have been articulated through the work of Fligstein and McAdam (2012) who have described the constructed social order of life as 'fields' and have conceptualised institutions as located within 'strategic action fields'[8]. This draws together a macro-level analysis, where institutions are shaped both by internal dynamics and external events. Within a mature institutional field like the English NHS, institutional change may be viewed as highly incremental and be visible as normative or mimetic isomorphism.

Zietsma and Lawrence (2010) describe three triggers for crisis within a strategic action field: (i) invasion by outside groups; (ii) changes in the field to which the institution is dependent; and (iii) rare macro-events. In terms of the NHS, the global financial crisis in 2008 triggered: a constant cycle of health service re-organisation and changes to commissioning arrangements that permit new organisations to offer services to patients and service users; and national level policy and clinical guidance changes, that may be considered as the 'perfect storm' for institutional change in health care. How the boundaries of the elite and powerful occupations are challenged in this climate by embedded

[8] "Strategic Action Fields are fundamental units of collective action in society… a constructed mesolevel social order in which actors (who can be individuals or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has the power and why), and the rules governing legitimate action in the field. A stable field is one in which the actors are able to reproduce themselves and the field over a fairly long period of time." (Fligstein and McAdam, 2012: p.9).

social actors exploiting opportunities to change norms and practices within their field will form a significant focus for this study. Fligstein and McAdam (2012) have suggested that challengers rarely pursue a wholesale turnover of incumbent interests, being more likely to work towards complementarity – seeking to service a niche in the same strategic action field. Further, how the entry of those new to the field and less bounded by the existing institutional conventions, such as those of the NHS, can trigger defensive responses will also be explored.

Understanding how institutions work is particularly important for those who wish to change them or wish to understand why they may find their attempts to change or reform them so difficult and challenging. The logic of institutional theory suggests that while the actual threat posed by challengers may be initially small, it may trigger a disproportionately defensive response from incumbent elites invested in preserving existing institutions. Ultimately, this resistance may explain stability and the enduring nature of institutions. How this dynamic plays out between dominant and subordinated professional groups within the NHS has been a key interest in this study.

3.3 Institutional Work

> *"Institutional change can proceed from the most micro interpersonal and sub-organisational levels to the most macro societal and global levels. It can take place in relatively brief and concentrated periods or over time measured in decades or centuries. And it can take place incrementally, so that observers and participants are hardly aware of any change, or abruptly, in dramatic episodes that present large discontinuities with former patterns."* (Dacin, Goodstein, & Scott, 2002 p.48).

The work of Lawrence and Suddaby (2006) describes the concept of institutional work as "the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions" (p.215). Traditionally, institutional approaches to organisational theory have typically explored the fields in which they operate, their processes of governance and relationships with other organisations. Institutional

work seeks to focus on understanding how intentional actions, some nearly invisible and mundane such as adaptations, compromises and adjustments, and others highly visible and dramatic, such as those provoked by global crises, affect institutions. Lawrence, Suddaby, and Leca (2009) suggest that the concept of institutional work aims to "establish a broader vision of agency that avoids depicting actors either as 'cultural dopes' trapped in institutional arrangements, or as hyper-muscular institutional entrepreneurs" (p.1). Arguably, neither of these extremes comfortably describe what may happen within a subordinate healthcare profession.

The paradox of embedded agency proposes that although those privileged by existing institutional arrangements have the power to instigate institutional change, they are unlikely to express the motivation to pursue it (Battilana & D'Aunno, 2009). This embedded agency may be reflected in the organisational dimensions of healthcare that situate both acute hospitals and medical professionals working within them at the apex of the healthcare hierarchy (Currie, Lockett, Finn, Martin, & Waring, 2012). In contrast, the work of Reay et al. (2006) has reworked the prevailing construction of embeddedness. They proposed that a series of micro-processes are enacted by endogenous actors that take advantage of established networks and their intimate knowledge of work environments to legitimise new institutions. Others might consider any bid to expand professional power within an organisational structure as boundary work, where demarcationary tactics of encroachment or consensual delegation are undertaken (Witz, 1992). Nancarrow and Borthwick (2005) have suggested that unwanted, lower status or less well-paid tasks are discarded during a time of prosperity by high status clinicians to other practitioners. Less attention has been given to times of austerity when an under-supply of practitioners may force a 'letting go' of practices that are closely associated with a profession's unique identity. In the

context of financial austerity, this study was interested in exploring the degrees to which a non-dominant professional group was willing or encouraged to let go of their professional practices as a pragmatic solution to manage workload and staffing pressures. In addition, it examined how the same professional group used the narrative around financial austerity to argue for the re-institutionalisation of the same practice using the logics of quality, safety and cost-effectiveness as rhetorical devices.

3.4 Deinstitutionalisation

Deinstitutionalisation "refers to the process by which institutions weaken and disappear" (Scott, 2014 p.166). For Oliver (1992a) it is "the process by which legitimacy for an established or institutionally organised practice erodes or discontinues" (p.564). A number of studies have suggested that longitudinal and historical approaches to the investigation of deinstitutionalisation are necessary. These have included the work of Ahmadjian and Robinson (2001) who studied the gradual abandonment of permanent employment in Japan; the work of Hardy and Maguire (2010) who explored the abandonment of the use of the insecticide dichloro-diphenyl-trichloroethane (DDT); and Delacour and Leca (2011) who examined the progressive decline of the Paris Salon. These studies draw attention to a critical period of incubation that is followed by precipitating events that lead to searches for alternatives.

This critical period of incubation is alluded to in the work of Pierson (2004) who has identified a number of ways in which poor institutional design leads to failure. These included: i) institutional designs that presumed that contexts and interests, will remain static and unchanged; ii) how long-term effects frequently differ from original aims, sometimes as a result of institutional designers having short time-horizons; iii) failing to recognise that a situation has undergone significant change prior to implementation; iv) the application of ready-

made solutions that fail to take account of whether they are appropriate for current context; and v) limited appreciation and mapping of how changes to institutional arrangements may lead to unexpected, unintended or unwelcome effects (Pierson, 2004).

In contrast, some analysts have emphasised how the erosion of the regulative, normative or cultural-cognitive institutional pillars (W. Scott, 2014) are instrumental in the deinstitutionalisation process (Maguire & Hardy, 2009). Tham (2012) has suggested that deinstitutionalisation happens when no adjustments are made to poorly performing institutions and that this triggers perceptions of irrelevance and obsolescence. Delacour and Leca (2011) have signalled how failures to undertake defensive maintenance of practices or to engender support from a critical mass of supporters can accelerate the decline of institutions. Lawrence and Suddaby (2006) have developed the concept of insider-driven deinstitutionalisation. They suggest that this is usually carried out by the elite and most powerful members of a field in order to deliberately destabilise a practice informed by a competing institutional logic. Developing this further, Lawrence and Suddaby (2006 p.235) have proposed that "disruptive institutional work" takes place gradually and incrementally and has three aims: 1) "undermining assumptions and beliefs" about practices; 2) "dissociating moral foundations" from practices; and 3) "disconnecting sanctions" from practices through changes in legal and professional regulation.

Ultimately, there is little consensus regarding the strategies and dynamics of how institutional forms and practices fall into disuse. Additionally, whether natural erosion, a failure to innovate, deliberate destabilisation or different combinations or explanations can be implicated in deinstitutionalisation remains a key area of debate.

A framework developed by Oliver (1992a) has been refined and extended by Dacin and Dacin (2008) and is reproduced in **Figure 1**. In **Table 3**, Oliver (1992b) describes three general types of pressure towards deinstitutionalisation. *Political* pressures often emanate from shifts in underlying power structures. Problems associated with the performance of an institutional practice are *Functional* pressures and involve perceptions of inadequacy leading to substitution or replacement as problems accumulate. Finally, *Social* pressures are associated with increasing fragmentation of a normative consensus (W. Scott, 2014).

While the primary purpose of **Figure 1** is to hypothesise the predictive and moderating factors that contribute to the dissipation and rejection of an institutional practice, the identification of 'institutional remnants' in the model suggests there will be agentic activity aimed at 'institutional creation' or 're-institutionalisation' which is not fully theorised when applied to non-dominant professional groups.

Figure 1: An extended deinstitutionalisation framework (Dacin and Dacin, 2008 p.348).

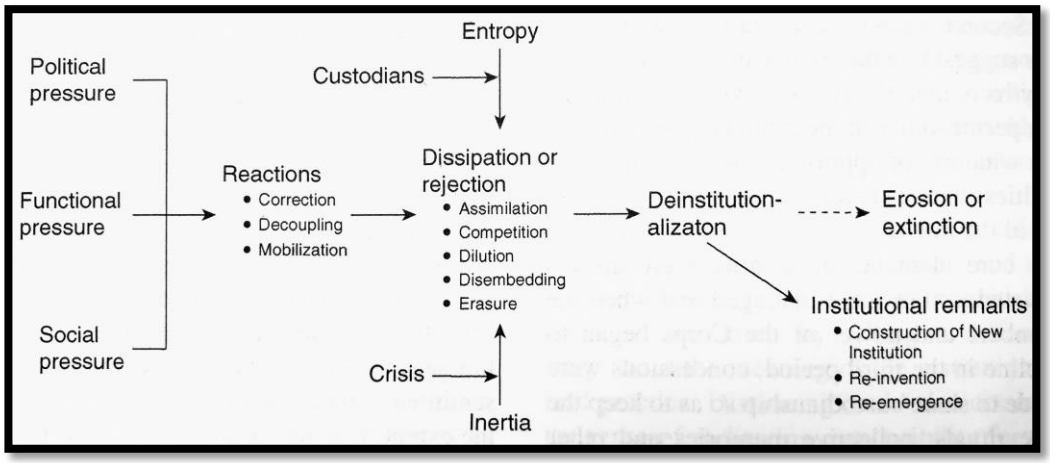


Table 3 summarises the political, functional and social pressures within an organisation and in an organisation's environment that are

hypothesised to cause the deinstitutionalisation of an established organisational practice (Oliver, 1992b).

For this study, financial austerity impacting on the English NHS and the drift towards a risk minimalisation approach to maternity care, could both be argued to have led to increasing criticality and the delegitimisation of home birth. Further, a political dissensus around the value of home birth to NHS organisations has led to reconsidering its contribution to organisational interests and viability (Oliver, 1992b).

At a functional level, for at least three decades, state endorsement for choice of place of birth was lacking in key policy and guidelines which was linked to uncertainty around the technical quality of home birth and heightened competition for scarce resources (Birthrights, 2018; Department of Health, 1993, 2004). Similarly, the professional status and autonomy of community midwives has been re-evaluated and the rewards associated with sustaining home birth have been eroded and withdrawn in many NHS organisations. Home birth has become regarded as burdensome from a compliance perspective and requiring elaborate occupational safety guidelines. Further, softer performance measures such as service-user satisfaction have until recently, tended to be discounted in favour of normatively constructed definitions of success and regulatory metrics in maternity such as those collected by the Care Quality Commission (Bourke, 2013; NHS Resolution, 2019).

In terms of social pressures, increasing technological change in maternity care including advances in fertility treatments, the widespread use of pain relief methods such as epidurals, an increasing use of caesarean surgery and changing tolerance and perceptions of risk could be said to have contributed to societal expectations that have discouraged women from considering home birth (Coxon et al., 2013). Equally, there is pressure for isomorphic change and conformity to

institutional birth at an organisational level. Further, many community midwives and obstetricians have become geographically dispersed from each other and non-interactive. This has led to structural differentiation and an obstruction of shared perceptions. Similarly, for the midwifery workforce there has been increasing normative fragmentation in terms of the increasing expectations that midwives work increasingly in acute hospital settings; high turnover associated with an ageing workforce leading to weak transmission of favourable attitudes and the skills required for supporting home birth to new midwives; deficits in leadership; and increases in workforce plurality (Chief Nursing Officers of England, 2010; Health Education England, 2019; Royal College of Midwives, 2015, 2018).

Table 3: Antecedents of deinstitutionalisation (Oliver, 1992a p.567).

Level of Analysis	Political Pressure	Functional Pressure	Social Pressure
Organisation	Mounting performance crisis	Changing economic utility	Increasing social fragmentation
	Conflicting internal interests	Increasing technical specificity	Decreasing historical continuity
Environment	Increasing innovation pressures	Increasing competition for resources	Changing institutional rules and values
	Changing external dependencies	Emerging events and data	Increasing structural disaggregation

The antecedents of deinstitutionalisation are detailed in **Table 3**. Both exogenous (environment) and endogenous (organisation) political, functional and social mechanisms, alongside the pressures of entropy and inertia are proposed as the determinants of deinstitutionalisation (Oliver, 1992a). The framework in **Figure 1** suggests a consensus

evolves that an institution no longer has efficacy, or that a new institution has superior legitimacy.

A contrasting model developed by (Greenwood, Suddaby, & Hinings, 2002) describes institutional change processes occurring as a result of social, technological or regulatory 'jolts' that precipitate deinstitutionalisation. They argue that the socially constructed field level consensus is disrupted by these 'jolts' and can facilitate the entry of new players (or service providers in the case of healthcare) or the ascendancy of actors and 'institutional entrepreneurs' (both incumbent and challengers, exogenous and endogenous to the field) to introduce new ideas (Greenwood et al., 2002). They go on to explain four more stages that involve pre-institutionalisation, theorisation, diffusion and re-institutionalisation and suggest that these are a neglected area of research both conceptually and empirically.

Scott (2014) has used the term *bricolage* to describe "the creative combination of symbolic and structural elements garnered from varying sources and traditions" (p.173) that lead to the construction of new institutional practices, re-invent old or threatened ones, or facilitate the re-emergence of a practice experiencing dormancy from its institutional remnants. In practical terms, this may involve a hybridisation of an old and a new institution, or the creation of fuzzy boundaries that resist the total erosion or extinction of a valued institutional practice (W. Scott, 2014). A key role in this re-institutionalisation of institutional remnants is that played by 'custodians'. These are actors that operate in much the same way as institutional entrepreneurs. They can be seen to act as a counterforce to the entropy of an institutional practice, have resilience to overcome the inertial tendencies within organisations and the ability to recognise a crisis as an opportunity to galvanise others into action (Dacin & Dacin, 2008).

Further work has sought to highlight how institutions are constantly evolving and to understand what influences the oscillation between stability and change that is often evident (Zietsma & Lawrence, 2010). One perspective is that incumbent and challenger actors are constantly manoeuvring their positions, the rules and the resources they have to maximise their advantages (Fligstein & McAdam, 2012). An alternative perspective is that exogenous events or actors create short-lived destabilising, dramatic or critical 'shocks' that precipitate change or new settlements, but quickly result in an adaptation and return to established rules and hierarchies (Fligstein & McAdam, 2012). In contrast Maguire and Hardy (2009) have hypothesised that it is harder for outsiders to bring about field-wide change as they are not located in dominant elite positions.

This thesis seeks to examine ideas about the ways in which the prevalence or dominance of new institutional practices do not necessarily lead to the disappearance of older forms. The countervailing activities of non-dominant professional groups suggest that the persistence of older institutional practices involve a different kind of institutional work that is under-theorised in the extant literature. Research to date has predominantly focused attention at the top of organisations or on embedded or dominant occupational groups (Abbott, 1988; MacDonald, 1995a). This thesis has sought to expand and develop understandings of the agentic activity undertaken by non-dominant professional groups that sit largely outside governance, management and funding structures who seek to re-legitimise institutional practices that have been eroded or threatened with extinction.

Institutional work and the sociology of the professions are inextricably linked in the literatures involving healthcare professions. The work of Currie et al. (2012) has illuminated the institutional work of elite

professions to maintain their dominance. These are described as having both coercive and normative dimensions. These include a) enabling; b) policing; c) deterring; d) valorising/demonising; e) mythologising; and f) embedding and routinizing. Indeed, they are likely to privilege their jurisdictional claims by shaping institutional arrangements that privilege them in the division of labour. For this reason, literature situated with the discipline of the sociology of the professions has also been explored in this chapter.

3.5 Sociology of the professions

The literature that has explored professional power has examined the conflicts and interactions between and within occupations (MacDonald, 1995b) and has sought to reveal how a complex sociology of cultural, professional and organisational conflicts can favour professional interests, ahead of policy or improvement agendas (Abbott, 1988; Friedson, 2001; Witz, 1992). Efforts to make improvements to safety, quality and efficiency are hugely sensitive to the professional context into which they are introduced.

The processes of professionalisation in healthcare and the social construction of professional identities have been of longstanding interest to sociologists. Friedson (2001) identifies professionalism to be a set of "interconnected institutions providing the economic support and social organisation that sustains an occupation's control of work" (p.2). Mature professions, such as those evident in healthcare, can be seen as constantly subdividing under various pressures, leading to different types of settlements between professions that create temporary stability, but are likely to remain continually contested (Abbott, 1988).

This is developed by Nancarrow and Borthwick (2005) who highlight how demands for inter-professional collaboration and workforce flexibility within healthcare have accentuated professional boundary

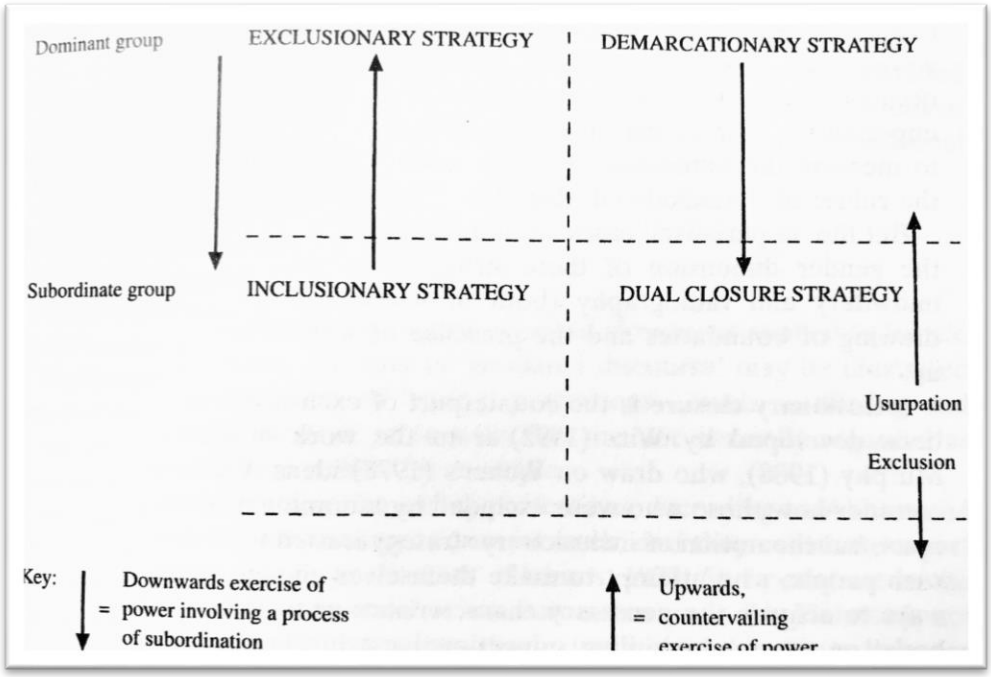
activities. This is where professions employ offensive or defensive strategies when they perceive a threat to their autonomy, wish to expand their occupational sphere or seek to monopolise a domain (Gieryn, 1983). These new pressures have been created by unmet demand for services, neo-liberal management philosophies that include cost-containment and efficiency mantras, and a greater emphasis on consumer preferences for service flexibility (Nancarrow & Borthwick, 2005). In terms of the healthcare workforce, new professional identities are emerging as a consequence of specialisation (adoption of an increased level of expertise by a select group of a profession involving specific training); diversification (the addition of a new task to an occupational repertoire); vertical substitution (delegation or adoption of a task across a disciplinary boundary where the power and autonomy of workers are not equivalent); and horizontal substitution (delegation or adoption of a task where there is a similar level of expertise and training between disciplines) (Nancarrow & Borthwick, 2005).

The model developed by Witz (1992) [**Figure 2**] seeks to offer "a basis for understanding the progress (or otherwise) of the professional project… and a means of grasping the nature of discriminatory actions" (MacDonald, 1995b p.35). In healthcare, doctors are positioned at the apex of a hierarchy, which create opportunities to extend their remit, or engage in processes of diversification, specialisation and substitution (Currie et al., 2012).

Exclusionary strategies seek intra-occupational control over the internal affairs of, and access to the ranks of a particular occupational group (Witz, 1992). In its simplest sense, professionalism has been described as a set of institutions that permit the members of an occupation to make a living while controlling and legalistically regulating their own work. Further, that the occupation is defined as inaccessible to others without specialised training or experience (Friedson, 2001). Larson

(1977) locates the rise of professionalism within a historical matrix of competitive capitalism: "an attempt to translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards. To maintain scarcity implies a tendency to monopoly…" (Larson, 1977 p.xviii).

Figure 2: Strategies of occupational closure: A conceptual model (Witz, 1992 p.45)



Downwards arrows = exercise of power involving a process of subordination
Upwards arrows = countervailing, exercise of power

In practical terms, dominant professions employ exclusionary strategies to constitute and control a market for their expertise. In order to do this, dominant professions often seek to diminish the value and status of competing professions, who may have previously occupied the market exclusively (Abbott, 1988). In healthcare, educational

monopolies, developing profession specific research cultures, agendas and questions, and advancing technologies and interventions exclusive to the dominant profession are familiar strategies.

Demarcationary strategies can be explained as efforts towards inter-occupational control over the affairs of related or adjacent occupations. Differential access to exterior power structures are evident in strategies such as 'encirclement' (Witz, 1992); where governance, management and funding structures within an organisation are dominated by individuals that share attitudes and perspectives that favour a dominant profession. These demarcationary strategies are also evident when dominant professions define or re-categorise occupational activities within their exclusive domain and control.

Inclusionary strategies can be described as the upwards countervailing exercise of power by a subordinate profession in response to the exclusionary strategies of a dominant profession (Witz, 1992). This may involve efforts towards gaining acknowledgement that a subordinate profession has legitimate and unique contributions to make within a professional structure, such as being exclusively responsible for delivering a specific institutional practice. However, rather than being seen as an effort to maintain a safe, high-quality or cost-effective practice, this could be viewed as part of a battle for recognition or equality by a subordinate profession; or it might equally be understood as boundary work, a bid to expand their professional power within the organisational structure.

Dual closure strategies involve resistance on the part of subordinated professions to the demarcationary strategies of dominant professions, but they also seek to consolidate their own position within the division of labour by employing exclusionary strategies themselves (Witz, 1992). This may be evident where one segment of a subordinate profession

seeks to monopolise opportunities, such as setting up bespoke profession-led services outside of organisational control, or establishing inter-organisational networks and supplier confederations for new services that result in a devaluing or exclusion of other members of the same occupational group.

The stratification of healthcare professions into the producers (those who deliver clinical care), the knowledge elite (those involved in academia, research and education), and the administrative elite (who hold strategic management roles) problematises the concept of all members of a dominant profession being consciously engaged in a bid for hegemonic control (Benoit, 1994). Understandings of the degree to which individual members of professions are manipulated by the structures around them, or demonstrate agentic capacity to shape the nature of their work can provide insights into how new models of healthcare organisation and delivery can be introduced. Equally, an appreciation of how adjacent professions subscribe to competing institutional logics and understand, tolerate, negotiate with or challenge one another may prevent policy makers and analysts from confusing the disappearance of institutional practices with their substantive failure (P. Dimaggio & W. Powell, 1983).

3.6 Summary

The review of literature in this chapter has attempted to demonstrate how this can provide an interesting lens through which to view the data collected during this study. By applying the concept of deinstitutionalisation to home birth, the study will seek to offer novel insights for policy makers, service leaders and innovators.

The deinstitutionalisation of home birth is a complex phenomenon, distinct but related to a number of theoretical fields including organisational institutionalism and professional power. Midwifery is a relatively small occupational group and home birth represents a small

but significant part of their scope of practice. Why should home birth have eroded to such a significant degree when research evidence finds that it is safe, cost effective and leads to high levels of service user satisfaction? Competing institutional logics have pointed to insider-driven deinstitutionalisation (Lawrence & Suddaby, 2006), where failure to secure cognitive legitimacy for home birth from adjacent occupational and service user groups have exposed its vulnerability to being regarded as something that should be resisted or ignored (Greenwood et al., 2002). Further, the work of Pierson (2004) suggests that poor institutional design could be implicated in its deinstitutionalisation.

Understanding how maternity services work, and how embedded social actors exploit opportunities to change or reform them, is of significant interest to this study. An investigation of how and why institutional remnants persist, the characteristics of their custodians, what processes and activities are involved in maintaining, re-constructing and re-inventing institutional practices and the mechanisms and dynamics of how they may re-emerge will be undertaken. In practical terms, this work will build on the conceptual framework developed by Dacin and Dacin (2008) [**Figure 1**] and intends to propose a new conceptual framework to explain the subtleties of re-institutionalisation within healthcare, and maternity services in particular.

The interaction with sociology of the professions literature is anticipated to provide deeper insights into how boundaries are enacted. The degree to which non-dominant professions are positioned to manipulate the structures around them to create, maintain or disrupt models of healthcare organisation and delivery will be explored in ways that intend to provide useful insights into the occupational relationships and priorities that frame the allocation and management of health service resources.

3.7 Research questions

As a result of the literature explored in this chapter, three over-arching questions have been identified to guide this study:

- Question 1: What strategies are used by service leaders to identify institutional opportunities for change?
    - This will explore the role of maternity service leaders and commissioners in maintaining or transforming their local maternity services.
- Question 2: How are the rhetorical arguments for and against change mobilised by different stakeholders?
    - This will explore the accounts from a range non-service users' to argue for, or resist changes to local maternity services.
- Question 3: How do stakeholders utilise additional social networks to implement change?
    - This will explore the accounts of participants to interact with adjacent organisations, service users and national networks to resist or promote changes to local maternity services.

3.8 Conclusion

This chapter has critically discussed a number of sensitising theories and concepts, specifically: institutional theory, institutional work, deinstitutionalisation and the sociology of the professions. It has provided a rationale for integrating these concepts and theories to inform this thesis. In Chapter Eight, I revisit these theories in the development of a framework that conceptualises the data collected from the case studies discussed in chapters Five, Six and Seven. This will involve identifying the ways in which endogenous and exogenous individuals and groups enable or inhibit re-institutionalisation collectively, exploring how individual actors negotiate coexisting

institutional logics and whether they have the potential to survive and thrive, or diminish and erode.

The following chapter focuses on extracting and interpreting the meaning of socio-cultural experience through a qualitative approach to three case studies in a particular context, and at a particular point in time (Bloomberg & Volpe, 2012). I will provide an awareness of, and reflection on, the methodology and methods with which I engaged in during the course of my inquiries (Hammersley, 2011). The chapter will explain the iterative and qualitative methods used and the narrative approach to analysis that was applied.

4.0 Methodology and Methods

4.1 Introduction and overview

This chapter will provide a detailed account of how social histories were traced and gathered using documentary evidence and personal testimonies from a range of stakeholders.

Firstly, I discuss reflexivity and provide some insight into my own position within this study and my philosophical approach to the research. I then progress to discuss the rationale that was used for utilising a qualitative research approach. This chapter then provides detailed exposition of the overall research design and methodology. This will include elaboration of the methods of data collection and the processes employed for data analysis and synthesis. It will then move to explore ethical consideration and issues of trustworthiness before identifying limitations and delimitations of the study.

4.2 Reflexivity: The researcher's own position

The significance of the role of the researcher in the construction of knowledge is now widely acknowledged (Bryman & Bell, 2007). Indeed, there is an expectation that all researchers identify and articulate the philosophical assumptions that shape the processes and conduct of their work. Crotty (1998) has proposed that there are four major elements in the design of each study. At the broadest level, the epistemological and ontological foundations of the study will express the paradigm in which the study is situated. This in turn is said to inform the theoretical stance that the researcher uses, and it follows that this informs methodological choices, which ultimate inform the methods used to gather, analyse and interpret the data (Cresswell, 2009).

Rosenberg (2005) claims that philosophy is unavoidable for researchers as it both challenges and defends the positions they hold; and raises questions about the limits of research and justifies the use of specific

methods. He goes on to argue that researchers cannot remain entirely objective when politics, history, social status, personality types, financial/economic incentives and power are all in play (Rosenberg, 2005).

Bryman and Bell (2007) explain that reflexivity has several meanings in the social sciences. Originally a term derived from ethnomethodology referring to the way in which speech and action are constituted in the social world in which they are located, it is now more widely understood in terms of business research as being associated with the implications of the methods, values, biases, and decisions made for the acquisition of knowledge from the social world that the researcher generates. Reflexivity therefore involves noticing and evaluating the relationship between the researcher and the phenomenon and requires that they remain uneasy about their voice, the text and ethical conduct.

Johnson and Duberley (2003) distinguish between three different forms of reflexivity in management research; i) *methodological reflexivity* which they associate with objectivism, positivism and empiricism in that it seeks to generate knowledge based on observable reality and requires the researcher to monitor their impact on the phenomena and social setting being investigated; ii) *deconstructive reflexivity* which they associate with constructivism and interpretivism and invites the deconstruction of texts to reveal their narrative logic and requires the researcher to decentre themselves as a privileged voice within the narrative and to question their taken-for-granted beliefs; and iii) *epistemic reflexivity* which relates to constructivism, interpretivism and critical realism and seeks new modes of engagement with subjects that are both participatory and consensus based, with a view that the engagement with subjects can lead to some notion of truth (Bryman & Bell, 2007).

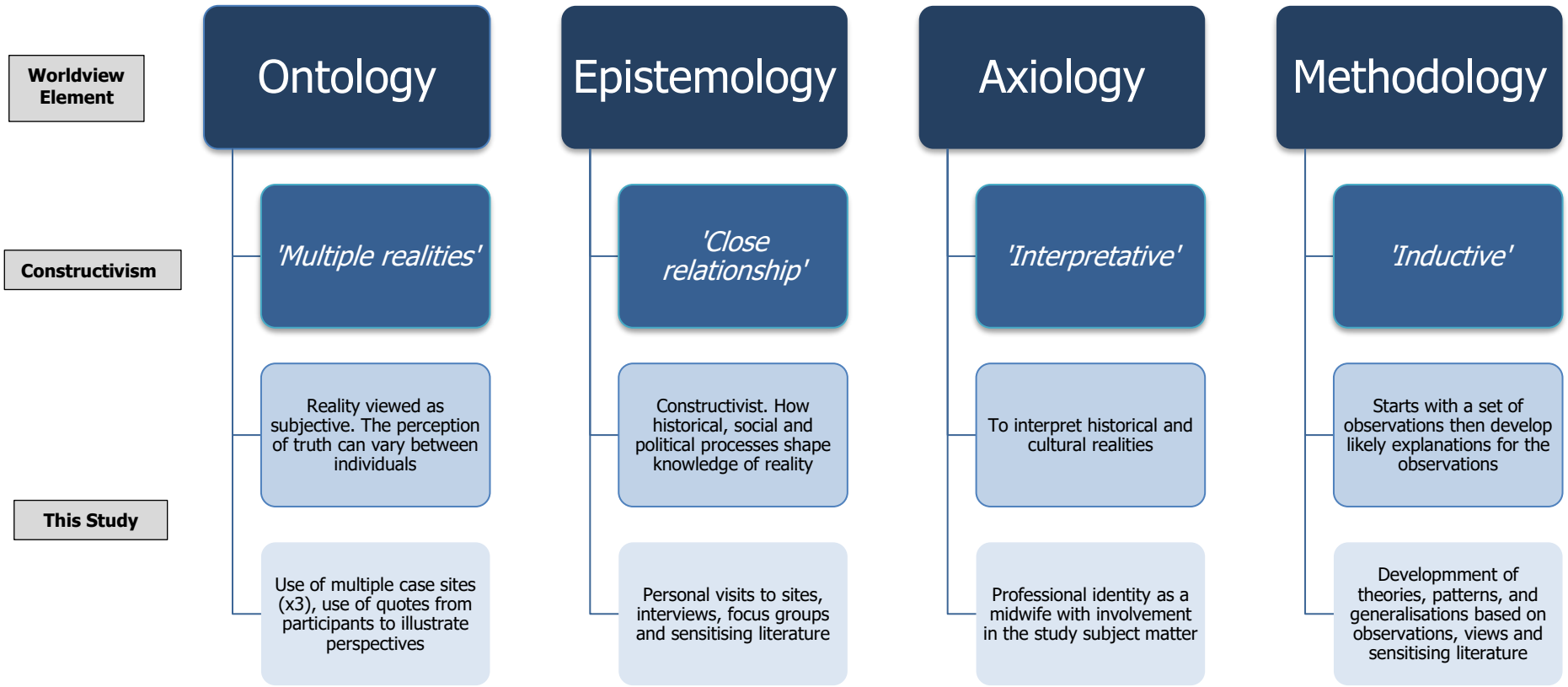
Bourdieu and Wacquant (1992) suggest that epistemic reflexivity denotes reflection on the social conditions under which disciplinary knowledge comes into being and gains credence. Its goal is to 'crack the code' within a discipline and consider the invisible assumptions that pervade everyday theorising and practice, interrogate it and, if necessary, imagine new possibilities (Kinsella & Whiteford, 2009). This approach was conceptually interesting for me as a researcher, who is also a health professional, seeking to take a proactive stance in terms of the knowledge development of my profession. This has demanded that I consider:

i) how theories in a discipline are constructed and adopted;
ii) whose voices are included and excluded in the process;
iii) how politics and social policy shape theory construction and theory promotion;
iv) how dominant theoretical discourses are potentially a form of social control that exerts powerful influences on behaviour;
v) whether uncritical adoption of theories may be a form of hegemony within a discipline;
vi) which values members of the field wish to embrace and advocate;
vii) whether the theories that are adopted are in line with espoused philosophies.
(Kinsella and Whiteford, 2008 p.256).

Philosophically, this study takes a constructivist approach, whereby I have assumed that 'reality is socially constructed…rather than there being]… one pre-existing, stable reality out there waiting to be discovered (Green & Thorogood, 2009). It seeks to use site data and participant views to construct broad themes that will inform the generation of theoretical constructs. Benton and Craib (2001) explain that this approach involves drawing away from grand narratives to explore specificity at a micro-level, with the ultimate aim of explaining the higher levels of organisation. Constructivism as a paradigm or worldview, is typically associated with qualitative approaches where the understanding or meaning of phenomena is shaped by the subjective

views or participants, their social interactions with others, and their own personal histories. At an ontological level, this can mean the expression of multiple realities; at an epistemological level it requires close engagement between the phenomena, participants and researcher; at an axiological level the researcher acknowledges and foregrounds their own constructed interpretations of history and culture' and at a methodological level it is inductive whereby the research is shaped from the bottom up from individual perspectives and will structure its broad patterns and understandings (Cresswell & Plano Clark, 2011). [**See Figure 2a**].

Figure 2a: The researcher's philosophical positioning: Constructivist Worldview adapted from Cresswell and Plano Clark (2011) and Crotty (1998)



4.3 About myself as a researcher

I trained to be a midwife between 2005-2008 and once qualified, began working as a junior rotational midwife at a large acute obstetric unit. This role enabled me to care for women on antenatal and postnatal wards as well as the labour suite. After about a year I applied to work as a community midwife and was appointed to a caseload in one of the most socially deprived areas of the city where I cared for women antenatally, postnatally and at home births. After 14 months in that role I applied to work in the core labour suite at the acute hospital again, caring predominantly for women giving birth in hospital and have continued to work clinically as a midwife during this doctoral study.

As a community midwife with an interest in feminism and human rights, I was motivated to ensure that women were fully informed and aware that they had a choice of place of birth, and I took time to explain the benefits and risks of all locations to them. It was my experience that when women were given time to consider a range of factors about place of birth, more of them chose their own homes. I noticed that a small but significant proportion of the women on my personal caseload were expressing an interest in home birth and this suggested to me that there was potentially unmet demand locally. I hypothesised that the home birth rate of around 1% for my employing NHS Trust may be less to do with women actively choosing hospital birth, and more to do with how the model of care for supporting home birth was being offered or provided. I conducted a small piece of research as part of my Masters in Research Methods asking what factors influenced community midwives' abilities to support home birth. I concluded that in an area where home birth rates were low, the model of care could be a discouraging factor for both women to choose, and midwives to offer support for home birth. The literature that was explored in chapters two and three did not provide a 'toolkit' to understand how an area with an under-developed or under-performing home birth service could

change the model of care successfully. I decided to take my curiosity into this doctoral study and explore how more plurality of choice could be diffused to benefit all women who choose to give birth under NHS care in England.

Choosing where to give birth is mediated by cultural and historical associations between birth and safety, and contemporary narratives of risk, blame and responsibility (Coxon et al., 2013). These discourses limit opportunities to plan a birth anywhere other than a hospital labour ward by constraining women's decision making (Coxon et al., 2013). One of my aims, as a clinical academic researcher, was to contribute to providing knowledge, imagination and language for society to resist the powerful norms and expectations placed upon women. This was underpinned by my interest in seeing respect for women's human rights in childbirth.

My interest in home birth is interactional and contiguity-based. That is to say, although my mother gave birth to me at home, I have not experienced giving birth at home myself. My own son was born in an acute hospital after three days of uncertainty and a fair degree of fear and jeopardy during the whole process. During my career as a midwife, I have seen the transformative power of a 'good birth', and the destructive power of a 'bad' one. These can happen in any birth location and I should be clear that I support women to choose a birth location wherever they believe they will feel empowered, safe and in-control, be that in a home or institutional environment. Kitzinger (2006) has used the term institutional violence to describe women in childbirth who are treated like products on a factory conveyor belt and are not cared for as human beings but are like 'fish on a slab' (p.4). Institutional, or 'structural violence' can be defined as patterned relationships among a social system that constrains human behaviour associated with the unequal distribution of power and resources

(Weigert, 2008). Kitzinger (2006) argues it can have far reaching consequences for the way she feels about herself, her baby and her partner and that it may have catastrophic effects on every aspect of her life and relationships subsequently. My motivation as a clinical academic midwife is to see a more evidence-based, reasoned and compassionate maternity care system that allows women to fulfill their aspirations and where their rights to self-determination, privacy and dignity are respected.

4.4 Research strategy

In view of this study being undertaken in a contemporary, open system where I had little or no control over events and behaviours, and that it intended to apply 'how' and 'why' questions when conducting exploratory and explanatory research, this study employed a case study approach to comparison (Yin, 2014).

A defining feature of multiple case study research is to explore multiple perspectives which are rooted in a number of specific, but related contexts (Myers, 2013). Therefore, to aid in depth exploration into the research phenomenon I studied it in context, intensively and in detail, and used multiple data-collection methods.

Yin (2014) developed a twofold definition for case study. The first part deals with the scope of a case study; and the second part reflects the lack of sharp distinction between phenomenon and context and considers methodological characteristics that are relevant features of a case study.

> *"A case study is an empirical inquiry that (i) investigates a contemporary phenomenon (the 'case') in depth and within its real-world context, especially when (ii) the boundaries between phenomenon and context may not be clearly evident…*
>
> *"A case study inquiry (i) copes with the technically distinctive situation in which there will be many more variables of interest*

> *than data points, and as one result (ii) relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and (iii) benefits from the prior development of theoretical propositions to guide data collection and analysis" (p.16-17).*

The value of case study designs are that they can establish an in-depth understanding by integrating different perspectives where understanding needs to be holistic, comprehensive and contextualised (Myers, 2013). Ultimately, for this study, a single perspective would be unable to provide a full account or explanation of the issues that were explored. However, this presented challenges for this study to identify and gain access to adjacent organisations that have interdependencies and synergies in terms of commissioning or providing services.

4.5 Rationale for a qualitative research approach

Denzin and Lincoln (2011) have described qualitative research as:

> *"a set of interpretive, material practices that make the world visible. These practices… turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to self… qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them." (p.3).*

Ormston, Spencer, Barnard, and Snape (2014) suggest common characteristics of qualitative research include; (i) aims and objectives seeking to make sense of participants social and material circumstances, experiences, perspectives and histories; (ii) sensitivity to the social context of the study and participants by adapting methods of data generation as emergent issues reveal themselves; (iii) generation of data that is detailed, rich and complex; (iv) analysis which is nuanced, complex and draws cross-cutting themes together; (v) remaining open to emergent categories and theories at both the analysis and interpretation stages; (vi) outputs which are grounded in the perspectives and accounts of participants; and (vii) reflexivity, where the role and perspective of the researcher is acknowledged.

Myers (2013) has argued that the underlying philosophical assumptions for case study research can be positivist (Yin, 2014), critical (Myers, 1995) or interpretive (Walsham, 1993), but also acknowledges that these research 'paradigms' may be accommodated within one study. Positivist research tends to make use of formal propositions, quantifiable measures of variables, test hypotheses, and draw inferences about a phenomenon from a sample of a statistical population (Myers, 2013). Critical research assumes that social reality is historically constituted and seeks to draw attention to the restricting and alienating conditions of the status quo by challenging prevailing beliefs, values and assumptions which may be taken for granted by participants (Myers, 2013). Interpretive research focuses on the complexity of human sense-making and attempts to understand phenomena through the meanings that individuals assign to them (Myers, 2013). An interpretivist approach to epistemology assumes that:

> *'there is no objective knowledge independent of thinking. Reality is viewed as socially and societally embedded and existing within the mind. This reality is fluid and changing and knowledge is constructed jointly in interaction by the researcher and the researched through consensus. Knowledge is subjective, constructed and based on the shared signs and symbols which are recognised by members of a culture. Multiple realities are presumed, with different people experiencing these differently' (Grbich, 2007:8).*

As part of the reflexivity for this study and in an attempt to resist potential biases, an interpretative, rather than critical approach was adopted. As a practising midwife, I continually reflect on my own pre-interpreted constructions of the world. I also sought to acknowledge that my own understandings, interpretations and translations of the participants' life-worlds would be influenced by my own professional background (Myers, 2013).

Inductive approaches to research are understood to build knowledge from the 'bottom-up' to develop theories, whereas deductive approaches are considered to take a 'top-down' approach, testing theories and hypotheses by observation. However, Blaikie (2007) suggests that there is no 'pure' induction or 'pure' deduction. The questions and analytical categories that inductive researchers use are deductively derived from previous work in their field. Likewise, deductive researchers draw on bodies of theory that are inductively derived from prior observations (Ormston et al., 2014). In light of the theoretical literature examined in Chapter Three, I chose to employ a predominantly inductive methodology to devise possible explanations for patterns in the data, rather than a deductive approach as there was no pre-existing hypothesis to test which could explain the observations.

Qualitative research might be best characterised by the overall aim of the study, rather than the kinds of data produced or methods used to in its production (Green & Thorogood, 2009). This study followed methodological traditions that focus on social, cultural and historical traditions and behaviours in context. It therefore adopted a social constructivist perspective with an underlying epistemology that was interpretive. Constructivist approaches take issue with concepts of pre-existing realities and aim to challenge common-sense assumptions. In this sense, constructivist approaches contrast with positivist approaches that can seek to explain reality as entirely separate from human perception.

This study faced challenges due to ongoing changes to the policy, economic and professional landscapes of maternity care within the NHS. This included announcements of a major reviews in terms of the commissioning and regulation of NHS maternity services (NHS England, 2015); and ongoing financial and organisational turbulence in the English NHS. Therefore, the methods applied in this study have been selected to account for and learn from these complexities.

4.6 Research questions

I identified three over-arching questions to guide this study:

- RQ1: What strategies are used by service leaders to identify institutional opportunities for change?
- RQ2: How are the rhetorical arguments for and against change mobilised by different stakeholders?
- RQ3: How do stakeholders utilise additional social networks to implement change?

4.7 Research design

4.7.1 Research question 1 (RQ1)

To identify what strategies were used by service leaders to identify new opportunities for institutional change, particular consideration was given to the ways that different stakeholders identified opportunities for change. It also explored how individuals and groups create, maintain and disrupt established ways of working. In particular, it sought to understand sociocultural, management and structural barriers that included policy imperatives, institutional pressures, professional cultures and social movements within health services. This component of the study analysed non-participant observation data from strategic and operational meetings, participant interviews and focus groups, and documentary review.

4.7.2 Research question 2 (RQ2)

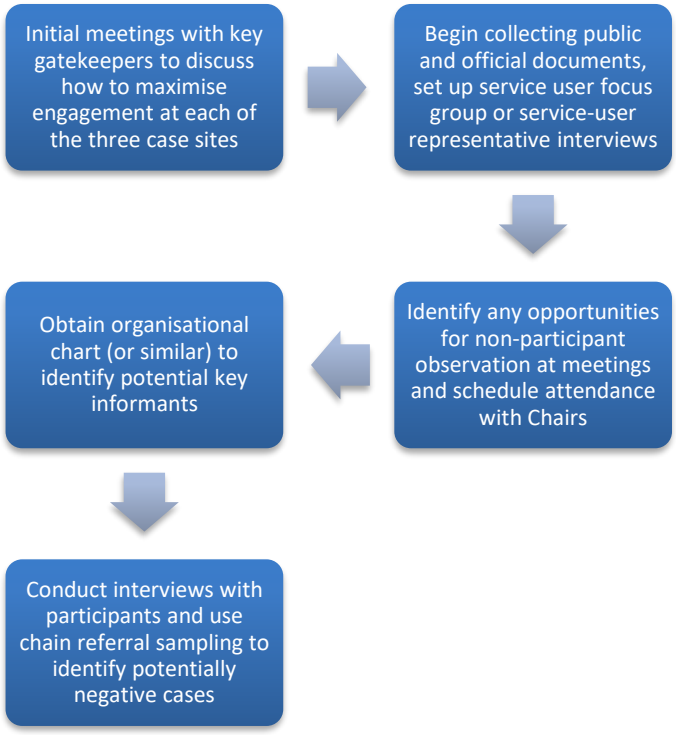
In assessing the rhetorical arguments that were mobilised by different stakeholders for and against change, this study focused on the agendas and discourses pertinent to healthcare used to either promote or obstruct change. Documentary review, non-participant observation at strategic and operational meetings, participant interviews and focus groups permitted observed or perceived changes to be analysed in the context of changes that had taken place at both the macro- and micro-levels. The study of the macro-level, in terms of research agendas and national standards and policies was enhanced by also exploring the micro-level, in terms of the actions and motivations of individual actors.

4.7.3 Research question 3 (RQ3)

Attention was also directed towards legitimacy contests associated with maintaining and transforming institutions in strategic action fields. This research has explored how different healthcare professionals captured attempts at reform to maintain or extend their influence, or counter the interests of others. The degrees to which different stakeholders utilised social networks and supplier confederations to implement or disrupt institutional change was also explored in this study through the use of non-participant observation, participant interviews and focus groups, and documentary analysis.

4.8 Case site selection

Figure 3: Schematic diagram of study stages



Case selection for this study was purposive, in the sense that it involved choosing sites because they illustrated a feature or process of interest to the research. It was also emergent in that sampling was informed by reflections as data was gather and analysed (Gray, 2014).

A two-phase approach to case selection was adopted. Potential sites were initially screened as a result of my familiarity with the landscape

and current developments within English maternity services through networks, professional journals and websites. This was followed by reviewing publicly available quantitative data on potential research sites and from informal discussions with key informants situated within the organisations under consideration. There was also a pragmatic aspect to the case site selection as it was necessary to identify organisations with gatekeepers that had both a favourable disposition towards research, and the capacity to accommodate an unknown researcher within their organisation.

This initial case selection identified three strong potential sites which I approached and therefore had planned to become the focus of the study. At the initial planning stage, all three sites had senior gatekeepers who committed in principle to participate once NHS ethical approval was granted. To gain ethical approval, I submitted a comprehensive online application via the Integrated Research Application System (IRAS) [Project ID: 164243]. This was then considered by the NHS Health Research Authority Research Ethics Committee (NRES) – East Midlands, Nottingham 2. On 26 January 2015, I attended the NRES committee with academic supervisor and received a provisional opinion that required confirmation of agreement of participation of the two NHS sites to be used in this study. This was subsequently supplied and 'a favourable ethical opinion' was confirmed on behalf of the committee (REC ref: 15/EM/0056) on 26 March 2015 [**Appendix 1**].

As the project developed and time passed, it became evident that two of these potential sites would ultimately withdraw. One site had been approached by a large research collaboration led by senior academics from their local university. Both myself and my academic supervisors made attempts to negotiate this study to be 'tagged-on' to the larger project, but this was declined. Another site became subject to

enhanced surveillance from regulators due to adverse outcomes for service users, and the senior members of staff who had been favourable to supporting the research left the Trust. Attempts were made to forge links with the interim service leaders but participating in research was not felt to be a priority for them. The remaining site from the initial shortlist became Oak. But at this stage, I was unable to submit for NHS REC approval as Oak was not an NHS organisation.

Further work was therefore undertaken to identify alternative NHS sites and approaches were made to 12 other organisations. This included cold-calling, approaching service-heads, research and development departments, and also approaching high-profile academics and practitioners to broker access, as well as putting messages out on email groups and Twitter feeds. Multiple telephone calls, emails and face-to-face approaches were made. There was a consistent message that many services were experiencing financial and staffing pressures and did not feel they had capacity to participate in research at the present time. Some more candid individuals revealed that they anticipated unfavourable findings if they opened themselves up to scrutiny because their home birth rates had plateaued or were falling. A colour brochure [**Appendix 8**] about the study was sent out to the providers who were yet to give a definitive 'no'. As a result, three providers responded positively and subsequently agreed to participate.

Table 4: Final case site selection

Site 1: Willow	Site 2: Sycamore	Site 3: Oak
NHS provider – predominantly urban NHS acute provider of maternity services that employed community midwives who attended home births. This provider performed **below** the national average for home births	**NHS provider – urban and rural** NHS acute provider of maternity services that employed community midwives who attended home births. This provider performed **above** the national average for home births	**Non-NHS provider – predominantly urban** Limited Company provider of maternity services that employed midwives who attended home births. This provider performed **above** the local and national averages for home births

These three case sites represented a range of settings, conditions and relationships that would be familiar within English maternity services. In addition, the case sites were chosen as they provided opportunities to understand parallels and differences in the dynamic approaches of different health service organisations that were identifying opportunities for change and innovation. The primary organisation at each case site was the provider of home birth services. Secondary organisations were also approached at each case site in recognition of the interdependencies and synergies with commissioning, other providers and regulators of health care.

The chosen case sites represented three different strategies to provide models of care to support home birth through NHS commissioning. They also each highlighted the important 'institutional work' of various leaders to confront change and maintain established institutions.

I have chosen to anonymise the three case sites using names of trees in line with ethical codes to protect the identity of each organisation and individual participants. However, Oak represented a dilemma as it was unique and was likely to be identifiable to those associated or

involved in maternity services in England. An option to create a composite identity for Oak was considered but this was discounted as it would be impossible to balance disguise and distortion (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2014). This was discussed with leadership team at Oak, who considered that they viewed this research as an opportunity to create more transparency around their organisation. Further, striving to reduce potential bias associated with gender, neutral personal pronouns were applied wherever possible within data extracts used in the chapters.

Willow was an acute NHS Trust that was responding to a competitive local environment where pregnant women lived in close proximity to a number of different maternity care providers. Sycamore was an acute NHS provider that has sustained a home birth service with levels above national and local averages. Oak had introduced a model of care associated with increasing numbers of women choosing to give birth at home and had been contracted by a number of Clinical Commissioning Groups (CCGs) in both their original locality and further afield.

Willow was approached in 2014. At one stage in the recruitment process when it was proving difficult to recruit any NHS sites, I considered approaching the NHS Trusts in three of the geographical areas where Oak were establishing. It would have re-orientated the study to explore how NHS Trusts experienced Oak – a non-NHS organisation – establishing their service in the same geographical footprint as themselves. Initial conversations with Willow revealed that they were planning to compete with Oak in an effort to win a contract as the 'alternative provider' to themselves. Willow stated that they were planning to innovate with their own home birth provision and this presented themselves as a viable case site in their own right. At the time of data collection, Willow were operating a non-continuity model of care. They had overlapping boundaries and interdependencies with

Oak and this was beneficial for data collection purposes as many of the adjacent organisations such as commissioners, acute, community and ambulance Trusts were shared.

Oak were approached in 2013 and they had expressed their interest in participating in this study. This was followed up via emails and telephone calls during 2014 and Oak was formally recruited in February 2015. Oak were a private limited company that offered a continuity model through the antenatal, intrapartum and postnatal phases of care. At the time of data collection, they were the only company offering this model of care in England. The care provided by Oak is free at the point of access to women who live in areas where their Clinical Commissioning Groups (CCGs) have agreed that women can access services via GPs or self-referral. Oak had been granted 'Any Qualified Provider' (AQP) status which meant they had met the requirements of NHS England and national regulators to provide NHS funded maternity care.

Oak and Sycamore became my principle case sites as they both had home birth rates above the national average. I originally recruited Willow as an adjacent organisation for Oak. What became evident during data collection and documentary analysis was that Willow was extremely similar to Sycamore in terms of their organisational size, birth rate and population demographics. However, Willow and Sycamore were very dissimilar in terms of their performance and attitude towards home birth. What I hypothesised was that with very small movements in one direction or the other, both sites could move towards each other's performance levels. This aside, Willow presented itself as a typical NHS provider who had centralised birth into a hospital setting. This is what P. J. Dimaggio and W. W. Powell (1983) discussed as 'institutional isomorphism' – where coercive, mimetic and normative processes act on organisations in ways that encourage them to modify

their characteristics to make them increasing compatible with similar organisations. For this reason, I considered that Willow would be highly recognisable to many maternity stakeholders who were uncertain about the maternity transformation agenda and could be presented as a separate case site. I anticipated that the story the data could tell to similar services could inform the way they may choose to act or react to competitive pressures or service transformations proposed by the National Maternity Review (Cumberledge, 2016).

I made a deliberate decision not to approach the institution where I was employed as a midwife to be a case site, even though there may have been advantages in terms of ease of access and ready collaborations. Green and Thorogood (2009) have described some of the challenges of researching 'taken for granted knowledge' and maintaining a balance between insider and outsider perspectives. On one level, I was an insider at the three case sites, as I sought to explore aspects of my own speciality. I was also an outsider at each case site, as I chose to place myself in unfamiliar settings interacting as a researcher. At times, there was role confusion for myself because participants often sought to engage with me as a clinician or subordinate; or at times I found that I interacted as a clinician rather than a researcher in order to establish rapport. In addition, I was conscious that role confusion may manifest in me making assumptions about the culture, not seeing the site or participants objectively, allaying fears of participants that I had a hidden agenda or that I was there as a 'problem solver' (Asselin, 2003). I actively sought to overcome any confusion or misconceptions, by presenting myself at the case sites as a 'researcher from a business school' and sought to avoid disclosing my status as a midwife wherever possible.

Hibbert, Coupland, and MacIntosh (2010) have described the concept of a fractured reflexivity. This is where the researcher becomes

conflicted, distressed and disorientated by their internal doubts or their role. In terms of negotiating my dual identities of health professional and applied social researcher, I found this somewhat challenging. I suspect this came from habits developed as a registered midwife to adhere to the values and standards set out in a professional code (NMC, 2018) that requires registrants to act in an open and honest way. In practice, the conscious act of concealing my professional identity was difficult to maintain and I found that I would quickly reveal my professional identity when asked by participants about my background. However, I still found that my 'strangeness' to the research site having never worked there, meant that I was able to ask naïve and more exploratory questions than would have been possible for a local clinical academic.

Myers (2013) has identified some of the challenges involved in case selection and the composition of each case. In terms of this study, a number of different service providers who had changed or sustained a model of care to support home birth were explored. Mapping the full range and diversity of key stakeholders at each site required a large overall sample in terms of qualitative research. Using the criteria identified by Myers (2013), a case study must be interesting, display sufficient evidence, should be 'complete', must consider alternative perspectives, be written in an engaging manner and should contribute to knowledge. Further, Yin (2014) asserts that the cases selected should shed light on theoretical concepts or principles, and should not be considered as a sample.

Sycamore was an NHS Trust that had a home birth rate that was higher than their geographical neighbours and the national average and they had managed to sustain this performance over several years. Sycamore operated a non-continuity model of care. They were remarkably similar to Willow in terms of their organisational size, geographical position in

relation to other NHS Trusts with maternity units, as well as the demographic and socio-economic indicators for their populations. I anticipated that this would create opportunities for cross-case comparisons between Willow and Sycamore.

I felt that these three sites were complimentary for my original research aim and questions. Although Willow and Sycamore had similarities, they had significantly different home birth rates. Oak and Willow were serving the same population but achieving very different outcomes, particularly in respect to place of birth.

4.9 Participants and recruitment

4.9.1 Participants

Table 5 is an indicative list of participants I aimed to recruit at each case site. Given the emergent design however, sampling required what Pollack (2012) describes as the application of 'micro-ethics' which required me to apply judgement and integrity as a researcher in the field. This involved going beyond the formula outlined here to resolve genuine data dilemmas. **Table 5** therefore represented the starting point to guide my sampling.

Table 5: Indicative participants for each case site

	Number
Service Leaders	3
Midwives	5
GPs and Commissioners	5
Hospital Service Leaders	3
Obstetricians/Neonatologists	3
Focus group of postnatal women or further interviews with service user group members or social movement members	6

My objective was to recruit participants who had expertise, responsibility or authority for home birth services, or who had had personal exposure to home birth i.e. to have achieved a planned home birth with either Willow, Sycamore or Oak's midwives themselves in the

past three years. My intention was to achieve maximum variation in perspectives on the models of care that were being offered to support home birth. These perspectives were sought from a range of individuals both within and beyond the three home birth provider organisations. I actively sought to recruit participants who might represent extreme/negative/deviant cases.

4.9.2 Recruitment – non-service users

My initial approach to employees of organisations in each case was via local collaborators such as the Clinical Leads or Heads of Service who I asked to identify potential key participants. I then provided information to send out on behalf of the study that invited individuals to contact me directly, either by telephone or email [**Appendix 6**]. Permission was also sought to place posters advertising the study in staff areas and on staff noticeboards [**Appendix 4**]. Following contact from potential participants, I established whether the individuals met the eligibility criteria and with their agreement, sent them copies of the participant information sheet (PIS) [**Appendix 2**] and informed consent form (ICF) [**Appendix 3**] in advance of the meeting by email or post. This is shown in **Figure 4**.

For non-participant observation at meetings, verbal consent to observe was sought through the individual chairing the meeting and wherever possible, an information sheet [**Appendix 7**] explaining the study was circulated with any meeting agenda in advance.

4.9.3 Recruitment – service users

The initial approach to service users was originally planned to be through midwives familiar with women who had experienced home births and asking those midwives to send out information about the study which would invite potential participants to contact me either by telephone or email [**Appendix 5**]. However, a different approach to recruitment, informed by the service leaders at each site, was followed:

- Willow asked me to prepare a mailshot that the locality lead midwives would send directly to all women who had given birth at home in the last three years. This was to maintain patient confidentiality so that I, as a researcher, would not have access to names and addresses. I prepared 100 envelopes with invitations with a PIS enclosed and a second-class stamp on the outside to the team at Willow who then informed me that they would send these out to women directly.
- At Sycamore, the approach to service users was via a senior midwife who asked community midwives via SMS text to identify women they had cared for who would be willing to participate and to arrange for them to share contact details with me so that I could approach them directly about the study. The community midwives then contacted me directly via text with details for individuals who could be contacted about the study.
- For Oak, the approach agreed was via a posting on their service user Facebook group. I invited women to contact me directly if they were interested in participating in the study.

I had also considered alternative methods of recruitment such as approaching the local Maternity Services Liaison Committee (MSLC) or other established service-user/provider networks, local mother and baby groups, local social networks or other online forums populated by postnatal women. Ultimately, recruitment was pragmatic and convenient. This was largely as a result of the timescales in which data collection needed to be completed. This is shown in **Figure 4**.

Further challenges experienced involved coordinating the service users at each site to attend one focus group:-

- At Willow, I organised a focus group in a café with a meeting room close to public transport and near the hospital for five

participants. Only one arrived to take part, with her baby. I followed the other participants up and conducted face-to-face interviews with three and a telephone interview with one.

- At Sycamore, I organised a focus group in a local library with a meeting room close to public transport for five participants. Only two arrived to take part, one with her baby. I followed up the other participants and managed to arrange a face to face interview with one at her home address. This participant arranged for a relative who had also had a home birth recently to join us and they were both accompanied by their babies. I was able to conduct telephone interviews with two of the other participants at a time that was convenient to them.
- At Oak, I invited five participants to a focus group at a local community centre. All five attended. There were three participants with babies and one who was pregnant with her second child. With this group, I was more proactive about reminding them of the date, time and location and did this with SMS texts and emails close to the event.

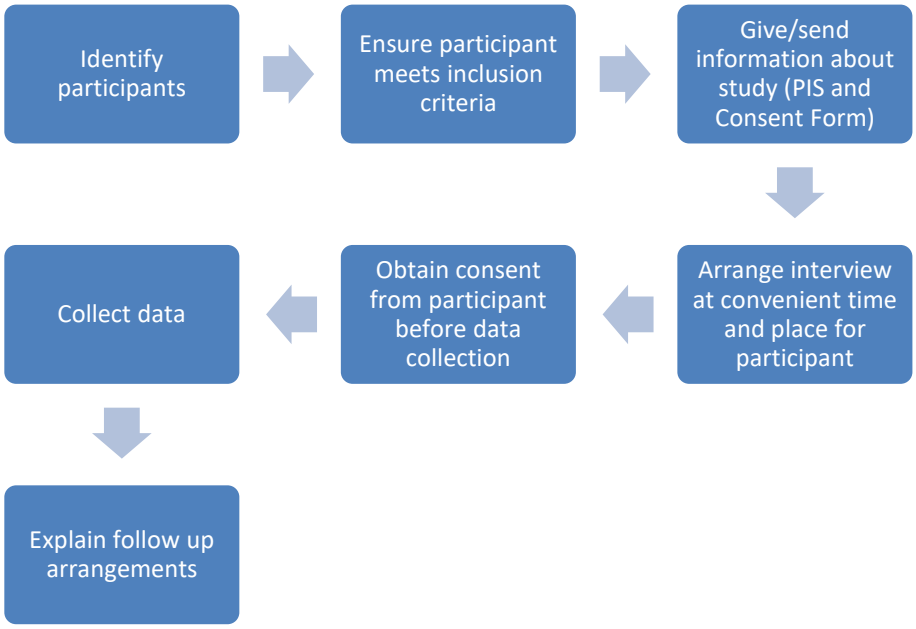
My experiences of recruitment and execution of the interviews and focus groups at Willow and Sycamore enabled me to refine my approach to communication with participants by the time I was engaging with Oak. In particular, I found that staying in touch with women and sending messages close to the date of the focus group was particularly helpful as this was the only site where all participants attended the focus group that were expected.

4.9.4 Recruitment procedures – informed consent

Both the PIS and ICF were sent or given to all participants in advance of interviews or focus groups. Printed copies of the PIS and ICF were also given to each participant before their interview and it was explained to them that their entry into the study was entirely voluntary. When I was undertaking telephone interviews, I read the ICF

statements out to the participants and asked them to state they consented to each statement, which was subsequently included on the transcripts. I also explained to all participants that no treatment or care was to be provided as part of this study, and that any future maternity care would not be affected by their decision to contribute in the study. It was also explained that the participant could withdraw at any time. The PIS and ICF were initialled, signed and dated by each participant before they entered the study. For telephone interviews, the forms were sent with a stamped addressed return envelope to me and participants were asked to return them in advance of the interview. None of the participants chose to withdraw, but they were all made aware that if they did, the information collected so far could not be erased and that it would still be used in the project analysis. This was to ensure any contributions that involved other participants as part of a group activity may remain in the study.

Figure 4: Schematic diagram of participant recruitment



Demographic and perceptual information was collected from all participants [**Appendix 9**] after they had completed the ICF. This information aimed to inform what the balance of data collection was

within and across sites from different participants and is show in **Table 6**.

Table 6: Demographic information collected from participants in advance of their interview or focus group

Non-Service Users	Willow	Oak	Sycamore	Total
Female, n =	12	12	12	36
Male, n =	6	2	3	11
Of which				
Registered Midwife, n =	7	13	9	29
Medical registration, n =	3	1	4	8
Other qualifications, n =	8	0	2	10
Mean time in post (years)	8.8	2.0	8.5	6.8
Mean hours worked per week	34.8	37.3	34.6	35.4
Mean age (years)	48.3	41.9	51.5	47.5

Service Users	Willow	Oak	Sycamore	Total
Female, n =	5	5	6	16
Male, n =	0	0	0	0
Mean number of children*	1.8	1.8	2.8	2.2
Mean age (years)	34.2	34.8	30.3	32.9

* National average = 1.92

Before each participant was interviewed they were asked the following three closed questions. This was aimed at ascertaining participant declared attitudes towards home birth before the interviews were conducted. It provided opportunities during data analysis to reflect on consistency or dissonance in their accounts. Their responses are detailed in **Table 7**:-

1. The research evidence for the safety of home birth is: a) convincing; b) problematic.
2. More home birth would be cost effective for the NHS: a) likely; b) unlikely.
3. If someone I cared about decided to have a home birth, I would be: a) concerned; b) supportive.

Table 7: Perceptual information collected from participants in advance of their interview or focus group

Non-Service Users	Willow	Oak	Sycamore
Q1 Convincing (%)	83%	46%	93%
Q2 Likely (%)	61%	100%	100%
Q3 Supportive (%)	94%	100%	86%

Service Users	Willow	Oak	Sycamore
Q1 Convincing (%)	75%	100%	100%
Q2 Likely (%)	75%	100%	100%
Q3 Supportive (%)	100%	100%	100%

What **Table 7** tells us at the pre-interview stage:-

- Participants from Willow were not unanimous in a view that the evidence for the safety and cost-effectiveness of home birth was convincing. However, they there was more agreement that they would be supportive if someone they cared about chose to give birth at home.
- While there was agreement among both non-service users and services users about the cost-effectiveness of home birth at Sycamore, there was evidence of non-service users being less convinced around the evidence for safety and willingness to be supportive of someone they cared about choosing home birth – while the service users who were unanimous.
- In contrast at Oak, non-service users only diverged from service users when expressing their attitudes to the evidence for the safety of home birth. During discussion at this stage with participants, they declared that while the evidence for safety was convincing, they preferred their answers to be recorded as 'problematic' because the evidence was not universally accepted by NHS providers, and this is what was 'problematic' for their

day-to-day experience of interfacing with NHS organisations. Essentially, answering 'problematic' for participants meant the evidence was practically difficult to implement in the face of institutional resistance from NHS service providers.

- Interestingly, the service users who had given birth at home with Oak and Sycamore were unanimous across all three questions. This is not particularly surprising as all these service users had chosen to birth a home for themselves with services that performed above the national average for home birth. What was interesting was that some service users at Willow were not convinced about the safety or cost-effectiveness of home birth. Willow is the service that was performing below the national average for home birth and this may indicate that information shared with service users more widely, may not be reassuring.

4.10 Data collection methods

The aim of collecting data using multiple methods is to corroborate the findings within the study with more than a single source of evidence (Yin, 2013). By developing convergent evidence, data triangulation provides multiple measures of a complex phenomenon and strengthens the construct validity (Yin, 2013). However, Denzin and Lincoln (2011) do not support the idea of triangulation as a tool for validation, but as a strategy to add rigor, breadth, complexity, richness, and depth to any inquiry. In terms of triangulating methods for this case study research, I applied different techniques for each of the methods used in an effort to exploit the contribution that each method brings to the study. Flick (2009) highlights that triangulation can lead to either converging, complimentary or contradictory results. The challenge of contradictory results is to look for more sophisticated explanations and to see these as presenting opportunities to look for theoretical explanations for the differences in the data and what the diversity means for the study.

Table 8. Data collection timeline

Case Site	Dates
Willow	June 2015 – January 2016
Sycamore	November 2015 – March 2016
Oak	June 2015 – February 2016

4.10.1 Documentary analysis

This part of the study focused on interpreting and analysing public and official documents and less on personal, media or virtual outputs. My aim was to collect documents that had not been created specifically for the purposes of this research i.e. non-reactive (Bryman & Bell, 2003). In terms of case study research, documentary analysis can be valuable in gaining a partial insight into past managerial decisions and actions, and in order to build up a timeline. Four criteria for assessing the quality of documents has been proposed by J. Scott (1990 p.6);

- *Authenticity*: Is the evidence genuine and of unquestionable origin?
- *Credibility*: Is the evidence free from error or distortion?
- *Representativeness*: Is the evidence typical of its kind, and, if not, is the extent of its untypicality known?
- *Meaning*: Is the evidence clear and comprehensible?

Public documents produced by the state or organisations/institutions, often meet the criteria for authenticity. However, the criteria for credibility and representativeness must be given greater consideration as documents may be written by managers who deliberately or unwittingly distort or obscure facts, or they may reveal interesting biases (Bryman & Bell, 2003). Choosing not to treat documents as objective depictions of reality was revealing for the study (Bryman & Bell, 2003).

Documentary analysis informed my understanding around the development and progress of the home birth services at each case site by providing detail on the chronology, the responsibilities and the time dedicated to managing the change as well as key processes such as local commissioning priorities, public consultations and regulatory activity. Further, analysing how the home birth services were provided (process measures) and how they performed in terms of standard outcome measures was also conducted where possible.

Due to a lack of consistent and reliable historical home birth data captured by the case site organisations, a decision was made to commission bespoke statistical data from the Office of National Statistics (ONS). The ONS were able to provide robust local and national data for each of the case sites, based on geographical and administrative boundaries in which the organisations were located for a 20 year period (Office for National Statistics, 2016). It must be acknowledged that data based on commissioning boundaries do have limitations, therefore should be viewed as indicative. The data supplied was provided in Microsoft Excel format, from which the data was transformed into figures included in each of the data chapters five, six and seven.

Table 9: Indicative documents used in this study

Contextual Information	Documentary sources
Organisational background, history and structures; mission; vision; values; services; organisational culture; leadership; staff and site description	Annual reports; mission statements; organisational charts; public consultations; service level agreements; local commissioning agreements; ONS databases; local commissioning priorities; external consultancy reports; CNST reports; CQC; minutes of meetings; policy statements and guidelines; external website; internal website; leaflets and marketing materials

4.10.2 Non-participant observation

The classic typology of observational methods was suggested by Gold (1958) and ranges through (i) the complete observer; (ii) the observer as participant; (iii) participant as observer; and (iv) complete participant. Non-participant observation is a method that involves the researcher observing, but not participating in what is going on in a social setting. I was able to achieve different levels of access at each site (Gold, 1958). At Willow and Oak, I was invited to strategic planning meetings at a regional network level, which allowed me to observe the interconnections and conflicts between groups and individuals. This involved sitting in on meetings to collect data. Anthropologists distinguish an emic perspective as the accounts of 'insiders' and their social world; and the etic perspective as that of the analyst (Green & Thorogood, 2009). The value to this study of conducting non-participant observation was the opportunity it afforded me to approach understandings of the motivations, priorities and rationality of those studied while also maintaining the capacity to analyse social interactions from a theoretical perspective (Green & Thorogood, 2009). Regrettably, I was not granted access to internal organisational meetings at Willow, Sycamore or Oak.

Observations were empirical, in terms of watching and not asking questions, simply collecting and describing data in a field journal, and later on a voice data recorder after the meeting or event. However, these journals were vital as I was able to follow up my reflections by talking to individual participants and asking naïve questions to elicit their understanding of the meanings of the interactions. This is often referred to as 'ethnomethodology'; where concepts or ideas that people use in everyday life to make sense of their world are uncovered through conversations or text (Ritchie et al., 2014).

4.10.3 Focus groups

A small focus group for each case site was organised to explore the views and experiences of 5-6 postnatal women. The purpose of these focus group interviews was to give participants an opportunity to engage in thoughtful discussion and voice collective views about the home birth services (Myers, 2013). This method uses the interaction of the group to stimulate participants to articulate opinions, attitudes and beliefs. The degree of spontaneity that arises in focus groups can encourage participants to display more of their own frame of reference and general understanding. The social context of a focus group allows language to emerge through conversation. However, focus groups are time-intensive and recruiting participants to attend on the same day, at the same time was often challenging – as described in section 4.9.3.

The intention of running focus groups with service users was to assess the novel components of the local model of care supporting home birth, what influenced their choice to use the home birth service, and to what degree they felt able to influence the priorities of the local maternity services [**Table 10**].

Table 10: Indicative questions to service users as part of the focus group, face to face or telephone interviews

Who or what influenced your decision to give birth at home?
How did you find out about the home birth service and what encouraged you to use it?
What were the reactions of different health professionals (GPs, midwives, hospital doctors etc.) to your choice to give birth at home?
What ways are you aware of that women can give feedback on the home birth service?
Are there any local support groups for women to join who want home births?

4.10.4 Interviews

Qualitative, in-depth, semi-structured face-to-face interviews that were undertaken as part of this study sought to explore the personal and shared histories of actors involved in the processes of making, supporting, sustaining or inhibiting change, including: their perceptions and views about home birth; their understanding of the institutional environment and new opportunities; the activities and strategies taken; and their relationships and network connections with other actors.

Table 11: Indicative questions for employees of organisations involved in providing home birth services

How does the home birth service in this organisation compare to others that you know of?
What do you see as the strengths and/or weaknesses of this Trust's home birth service?
In terms of cost-effectiveness and patient safety, in what ways does home birth represent an asset and/or liability for this area?
What role do you see for commissioners in shaping the future of maternity services in this area?
What mechanisms are there for engaging with service users to develop the maternity services in this area?

There are several advantages for choosing interviews ahead of questionnaires or surveys in the context of health care. They can be particularly advantageous for health professionals who have limited time. In addition, they provide researchers with the opportunity to reduce misunderstandings or clarify any questions while also encouraging in-depth responses that can lead to overall better-quality data, when compared to questionnaires. Equally, for participants, they may feel more valued and in control during semi-structured or unstructured interviews (Rees, 2003).

Silverman (2013) explains how qualitative interviews are concerned with the environment around the phenomenon, rather than the phenomenon itself. This is a particularly interesting point when developing thematic questions as it may be easy to drift away from the overall purpose of the study. Maintaining clear links between design, methods and analysis was necessary to demonstrate that there was clarity around the overall purpose (Green & Thorogood, 2009).

Elwood and Martin (2000) provide an interesting discussion regarding how location "…constructs the power and positionality of participants in relation to the people, places, and interactions discussed in the interview." (p.649). They suggest that the interview site provides an opportunity for participant observation and that by giving participants a choice of where to be interviewed, they may feel more empowered in their interaction with the interviewer. This was incorporated into this study and participants were offered a choice of location.

Interviewing is a highly skilled activity that requires training and practice. Participants can be influenced by the interviewer's status, characteristics or behaviour and are in danger of providing 'socially acceptable' answers, or may be unfamiliar or uncomfortable with expressing opinions or emotions openly to others. Equally, some participants can feel challenged by interviews and may feel they are put 'on the spot' or 'tested', or worry they will appear foolish or arrogant if they answer completely honestly.

Bergman Blix and Wettergren (2014) suggest that to gain and maintain access to the field some researchers may feel it is necessary to make compromises in terms of personal integrity and to endure perceived indignities e.g. being patronised or talked-down to. In contrast, Ostrander (1993) emphasises the appropriateness of expressing appreciation to elites, but warns against being too deferential,

recommending interaction with them as equals. In terms of this study, I recognised that I had been socialised as a member of a subordinate professional group during my midwifery career in a hierarchical organisational structure. Therefore, I endeavoured to prevent this becoming a barrier to effective engagement with elite participants. Goffman (1959) describes this as impression management and involves what Bergman Blix and Wettergren (2014) discuss as surface acting – pretending to feel equal and concealing feelings of inadequacy and uncertainty.

Interviews can also be time-consuming in terms of transcription and analysis when compared to questionnaires (Rees, 2003). In total, I recorded just over 98 hours of interview data. The industry standard for transcribing speech to text is one hour for 15 minutes of speech. This equates to around 420 hours of transcribing for this study. I undertook a large proportion of the transcribing work myself, and used my research budget to pay for a university approved transcription services to complete the remainder.

4.10.5 Closed online forum

I had considered including a participatory approach to aspects of data collection that would have involved using social media and a closed online forum to engage participants in the data once preliminary thematic analysis had been undertaken. This would have afforded a much more collaborative and inclusive approach with participants. Regrettably, due to the study's time limitations and the technical complexity of setting this up, this proved unfeasible.

4.11 Participant information

A participant information, eligibility and screening information data sheet were completed at the start of all the interviews and focus groups [**Appendix 9**].

4.11.1 Demographic information

To address reliability considerations, participants were asked to describe their history and background with the intention that this would help to frame any underlying perceptions, as well as similarities or differences. This information has been shared in section 4.9.4. Yin (2014) discusses reliability as a way of minimising errors and biases in a study and to demonstrate to other investigators that they should arrive at the same findings and conclusions if they conducted the same case study again.

4.11.2 Contextual information

Service user participants were asked how they identified and chose the home birth service. Non-service user participants were asked about their employment location, role, time in role, responsibilities, working hours/patterns [**Appendix 9**].

4.11.3 Perceptual information

This study also sought to gauge attitudes to the appropriateness of different settings for birth by asking participants to respond to the following statement about healthy low-risk pregnancies. This was discussed in section 4.9.4.

4.12 Data analysis and synthesis

Bryman (2012) has highlighted that despite a high number of qualitative research papers stating that they have used thematic analysis, it is a remarkably under-developed procedure. Green and Thorogood (2009) have described thematic content analysis as an essentially comparative process, where accounts are gathered, compared and classified into themes. Alternatively, thematic narrative analysis is more similar to methods such as grounded theory and interpretative phenomenological analysis (IPA) (Kohler Riessman, 2008).

Thematic narrative analysis gives primary attention to '*what is said, rather than how, to whom or for what purposes*' (Kohler Riessman,

2008 p.53-54). It also seeks to give attention to the macro contexts and make connections between life-worlds and larger social structures. This was the initial approach that I applied in my analysis, which morphed into a more loosely bounded version of thematic analysis. This decision was principally driven by my understanding that narrative thematic analysis is generally case-centred, and I sought to move beyond this to a macro level cross-case analysis.

For clarity, the use of thematic analysis and the term 'theme' in this study may be understood as a category that I have identified through the data that relates to the research focus and questions, which builds on the codes I identified in transcripts and field notes, and provides a basis for my theoretical understanding of the data that can make a contribution to the literature relating to the research focus (Bryman, 2012).

This approach offered the potential to provide a concise, coherent, logical and interesting account of the data. To reach this endpoint, it required that I spend time engaging with the data, reading the interview and focus group transcriptions and listening to the audio recordings of interviews. This provided the necessary platform for the development of early thoughts, ideas and reflections, prompted by the interview data. Engaging with the data generated understanding, insight and familiarity, which formed the building blocks for my analysis.

I then started to identify and code (by highlighting) sections of the data that I deemed to be about the same topic, concept or idea. Ryan and Bernard (2003) have recommended that when searching for themes researchers look for repetitions, indigenous typologies or categories, metaphors or analogies, transitions, similarities and differences, linguistic connectors and missing data (reflecting on what participants

omit). However, they also emphasise how identified themes should always relate to the research questions and focus – meaning that even though participants may talk about the same issues, these will not always warrant inclusion as a theme. Many sections of the data were given multiple codes, which signified that extracts were about more than one topic, or idea. As codes were developed, I revisited the rest of the data to see if that code also applied to other parts of the data. Even though I took exclusive responsibility for coding and analysing the data, regular meetings with academic supervisors provided a collaborative overview of the analysis.

The interview data was constructed interactively with an audience and context in mind (Ewick & Silbey, 2003) and prior engagement with the literatures explored in Chapters Two and Three formed a valuable resource in interpretation (Kohler Riessman, 2008).

Data for this study has been interpreted in light of emergent themes and a typology of behaviours emerged within the cross-case analysis. I have used brief, bounded segments of data to tell the story. I have also cleansed the data in ways that construct unambiguous plot lines by using ellipses to indicate deleted speech (Kohler Riessman, 2008). This can sometimes be regarded as problematic as the researcher can link seemingly insignificant acts and people together and be seen to be 'fracturing' the data in relation to the categories they identify, with individual identities becoming eclipsed (Kohler Riessman, 2008).

4.12.1 Organising and preparing the data

My process during data collection was to conduct the interview, and then record some field notes verbally on a digital voice recorder and in writing, soon after the interview. Later I would listen to the interview again straight through and make a summary transcript with key lines of discussion highlighted. Subsequently, using SimpleMind software, I would draw a mindmap of key themes for each participant attempting

to make links between different parts of the interview that talked about similar aspects of the case site. I would then type the transcript in full or would arrange for a specialist confidential service approved by the University of Nottingham to type the transcripts for me. The transcripts were then uploaded into NVivo 10 (service pack 5), which is a CAQDAS (Computer-assisted Qualitative Data Analysis) package. This allowed me to add comments and analysis. NVivo allows sections of the transcript to be tagged, highlighted and named with a range of codes and labels. Electronic data to be coded and searched, for notes to be written to accompany codes and data extracts, for the data to be more easily navigated, and for the accumulating analytical work to be located on a single data corpus. While early reading and immersion in the data was undertaken using hard copies of the transcripts, once a number of initial codes were generated, transcripts were imported into NVivo, with all coding of the data undertaken on the electronic versions of the transcripts from then on. In order to produce concepts that I could later group and turn into categories, I used an approach similar to open coding (Strauss & Corbin, 1990) whereby I broke down, examined and conceptualised the data from the interviews. I coded the interviews using a first pass, then first-order codes were developed from the notes and mindmaps, then a second pass with second-order codes to drill down further into the data. Examples of these codes are given in **Table 11a**.

Table 11a: Examples of codes used during analysis

First order codes	Second order codes
Change	Alternative providers, change of directorate, comparisons to other providers, integrated unit, merger, NMR, service change, strategic change
Home birth service	Autonomy, capability of CMs, continuity, equipment and IT, home birth rate comments, on-call, place of birth choice
Leadership	Medical leadership, midwifery leadership, 2H Board, 2H management culture
Local context	Geography, local demographic, perception of service, size of trust
Risk & governance	Commissioning, CQC, Jeremy Hunt, neonatal, regulating midwives, SUIs and safety, transfer issues, trust finance
Workforce	Shortage of CMs, staff morale, staff shortages, student midwives, teamwork, training
Working together	Familiarity of staff, multi-professional relationships, promoting services and communication

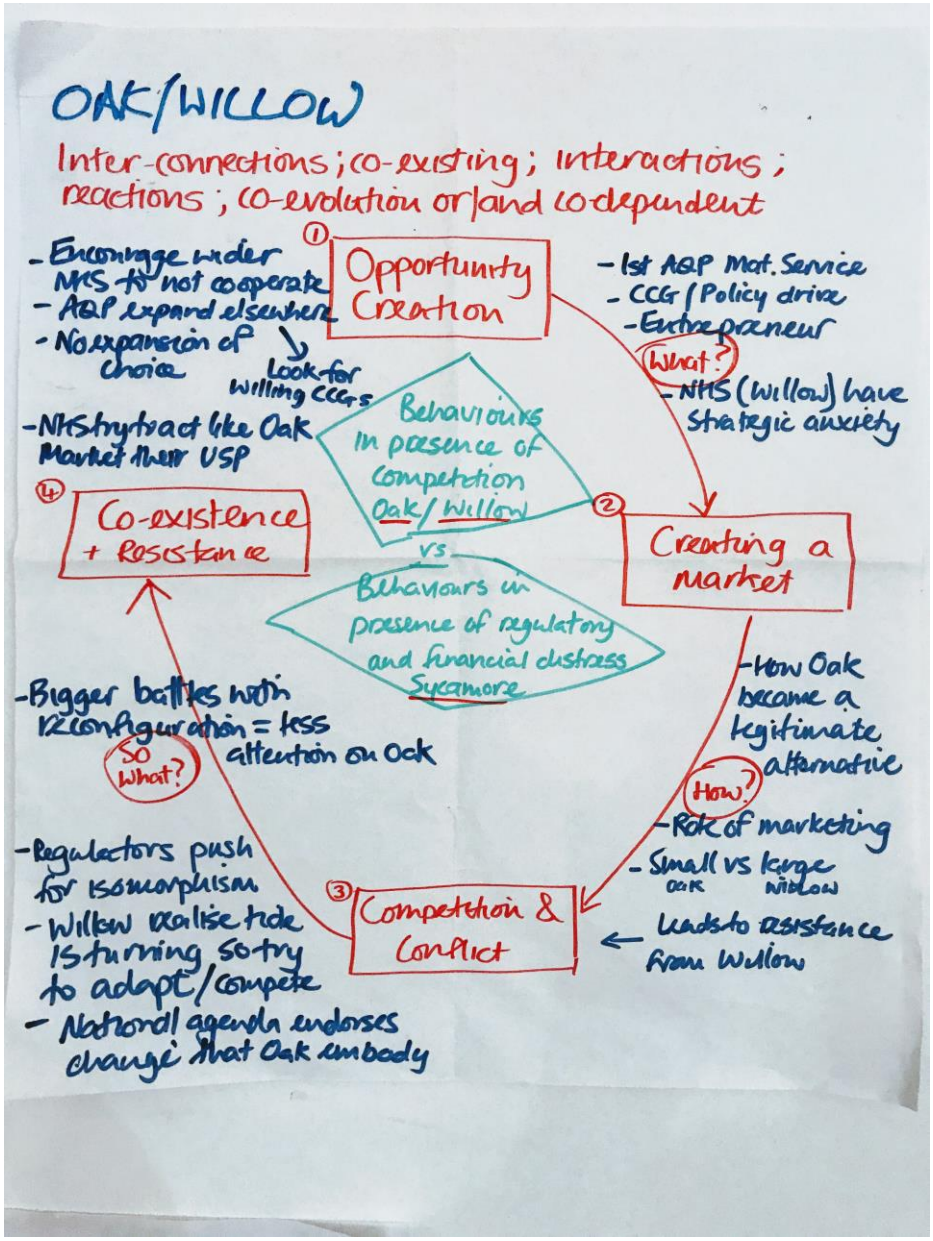
Once the data had undergone preliminary analysis, all the data extracts that had been coded were sorted in a more general sense, and examined to identify the wider themes into which they fitted, or of which they were representative. Developing themes was an iterative process that entailed selecting extracts from the data. Data extracts

were clearly labelled with the unique identifying code of the participant from which the extract originated.

As part of my academic supervisions, diagrams of the data themes would be drafted and re-drafted on paper and flipcharts and discussed. As I started to complete one case site, I would try to look for a story that would give voice to my participants in an authentic way. Some of this involved looking for directions of travel in the data and using frameworks to map the data across the sites to look for themes. At others, it involved making links to the sensitising literature I was exploring through my reading. An example is shown in **Figure 4a**.

Lastly, the sorted data extracts under each theme were organised into a consistent account, and accompanied by narrative that used the extracts to analyse what was of interest about each extract and why. For each theme, a detailed analysis was written, which identified the story of that theme, and used the data extracts to explore and defend the main overarching theme. The analysis was carried out alongside the data collection.

Figure 4a: Example of data theme story development



In terms of documents collected during the study, a narrative analysis was undertaken that structured the chronological sequence of the story at each case site. Looking for the partial and contested ways in which narratives were socially patterned was analytically valuable. Accounts that were both coherent and dissonant helped to explore and explain phenomena gathered using the other research methods (Green & Thorogood, 2009).

One of the biggest challenges I faced throughout data analysis was revisiting the sensitising concepts from my literature review and trying to make sense of the data at a theoretical level. At times I felt that deinstitutionalisation was a good fit, and at others, a new category of post-deinstitutionalisation or re-institutionalisation emerged as a potentially more appropriate fit. Equally theories of legitimacy and professional power seemed inextricably linked to this over-arching approach. At times, other theoretical approaches were explored e.g. Social Movement Theory (Spicer & Bohm, 2007; Tarrow, 1994) and Street Level Bureaucracy (Lipsky, 1980), in an iterative and data driven way with several models tested, refined and rejected before settling on deinstitutionalisation as the core theoretical concept for this study.

4.13 Ethical considerations

Ethical principles originate in international codes and declarations that emphasise voluntary participation, informed consent, the minimisation of risk, responsibility on investigators to protect individual wellbeing, health and rights, protection of vulnerable populations, respect for persons, beneficence/non-malfeasance and justice (National Institute for Health Research, 2012). All those involved in research in health settings must recognise and acknowledge disparities of power and protect the participant ahead of the institution, sponsor or investigator. This involves guarding against the coercion or exploitation of vulnerable populations; ensuring that informed consent procedures are followed in such a way that participants fully understand their involvement and that they are free to take part or withdraw from the study; and taking into account barriers to understanding (e.g. linguistic, educational, psychological or social) (Jadad & Enkin, 2007).

Undertaking Good Clinical Practice mandatory research training prescribed by the NHS helped me to address these principles. In addition, as a professionally registered midwife, I had additional

responsibilities that permitted confidentiality to be breached if individual safety is deemed to be at risk. This was made clear in the PIS and ICF. In terms of this study, a limited research budget meant that language translation costs were not factored into the study design. This could be problematic ethically as some potential participants from subordinated or vulnerable populations may have been excluded as a result.

Individual participant information obtained as a result of this study is considered confidential and will not be disclosed to third parties beyond myself and my academic supervisors and any regulatory monitoring or inspection procedures. Participant confidentiality has been further ensured by utilising identification code numbers to correspond to data in the database files. No information was disclosed during the study that posed a risk of harm to the participant or others. Had it been, I would have discussed this with my academic supervisors and where appropriate report accordingly.

4.14 Issues of trustworthiness

In qualitative research, the concept of trustworthiness is often used to establish the authenticity and accuracy of a study, in the same way that reliability and validity do in quantitative research. Green and Thorogood (2009) suggest that in terms of methodological rigour and clarity, reflexive awareness can be demonstrated by being open about the steps taken in the data production and analysis; the theoretical starting points and assumptions that shaped the study; an awareness of how interactions between participant and researcher resulted in co-constructions that are particular; and of how the wider social contexts shape or constrain the data.

Marshall and Rossman (2011) describe how triangulation needs to be built into the setup of data collection early on to give credibility to interpretations. Maxwell (2011) describes triangulation as using a variety of sources or methods to collect information in the same study.

Further, Green and Thorogood (2009) see triangulation as a way to validate analysis by offsetting any perceived weaknesses of the method used. This study was designed with a range of data collection methods. The employment of space and person triangulation was undertaken by collecting data from different research sites and interviewing participants with different characteristics as well as actively seeking out disconfirming evidence from deviant cases.

To some degree, trustworthiness was achieved by following the reflexive pragmatism approach proposed by Alvesson (2003) in which I made a conscious and consistent effort to view the phenomenon from different angles, moving between different interpretations and avoiding privileging my *a priori* positions. This reflexivity involved challenging and reconsidering assumptions and beliefs through conversations with my non-clinical supervisory team. I recognised this as a challenge, however my status as a health professional who has engaged in clinical practice reflection for a number of years had transferability to the research context. Reflection in clinical practice involves creating opportunities to consider why certain decisions have been made. These decisions may come from personal experience and education, from life outside the clinical world, or from somewhere less conspicuous such as personal memories or experiences, past problems, subconscious beliefs and needs, or even the level of distraction or stress that is prevalent at the time of the interaction (Siviter, 2008). Experience in using models and frameworks (e.g. Johns, 2006; Gibbs, 1988) to override implicit assumptions about the nature of reality and to go beyond straightforward interpretations, was utilised as a strength. This reflective process seeks to disengage from the automatic nature of actions and to pause and consider how biases and characteristics are affecting actions (Siviter, 2008). In addition, the clinical practice of 'reflecting in action' was adapted to help inform dynamic and ethical

decisions that I was required to make when working in the research field.

4.15 Summary

This chapter has provided a detailed description of this study's research methodology and methods. It has attended to the relationship between myself as researcher and the phenomenon being explored. Qualitative case studies have been generated that illustrate the factors that have shaped the institutional work of non-dominant professional groups in a mature institutional field. The participant sample constituted 66 purposefully selected individuals. Four data collection methods were employed including documentary analysis, non-participant observations, individual interviews and focus groups. The data was reviewed against literature as well as the emergent themes. Trustworthiness was accounted for through space triangulation.

Chapters Five, Six and Seven will now present the data collected from Willow, Sycamore and Oak respectively. I have intentionally presented data without overlaying theoretical concepts in order to give voice to the participants and themes as I have conceptualised them. In Chapter Eight I discuss the data in theoretical terms and present my conceptual framework.

5.0 Willow

5.1 Introduction

5.1.0 Chapter overview

This chapter begins by describing the background, context and participants for Willow – the research site explored in this chapter – and explaining the rationale for its inclusion in this study to address the three primary research questions. It will then proceed to explore two themes that emerged from the data analysis of case site principally from interviews with non-service users, documents journal notes and non-participant observation to situate this within the extant literature and to discuss the degree to which the findings both align with, and extend understandings.

5.1.1 Case description of Willow: Background and context

Willow serves a population of around 320,000, of which 5% were black and minority ethnic (national average 11.4%). According to the 2015 Index of Multiple Deprivation (IMD), the local authority areas served by Willow were in the lowest two quintiles. Willow serves an area where there is a predominance of groups at the extremes of the income spectrum and the area performs particularly poorly in three IMD domains of income, employment, health deprivation and disability and income. Willow covers five parliamentary constituencies and in the 2015 election, all were held by the Labour Party.

Willow became a Foundation Trust in 2007. It is one of the main acute hospital Trusts providing care across a disperse geographical area in England. There is one principle site where maternity care is provided. Willow has a consultant-led obstetric unit (AU) staffed by a multi-professional team, which includes midwives, obstetricians, anaesthetists and neonatologists. Facilities include antenatal and postnatal clinics and wards, a birthing unit that can support both vaginal and caesarean

births, and a neonatal intensive care unit (NICU). This site also has an alongside midwifery-led unit (AMLU) staffed by acute unit midwives and Community Midwives (CMs). The AMLU is separated from the main birthing unit by one set of double doors.

Data collection for this study was undertaken between June 2015 and January 2016. At this time, the local commissioners had tendered for renewal of the contract that had been held by the alternative provider. Willow had submitted a bid, alongside the incumbent alternative provider. However, the National Maternity Review (NMR) had also been launched in March 2015, and this had led to the commissioners suspending any decision to award this contract until the outcome of the NMR was known.

5.1.2 Justification for inclusion of Willow in this study

Between 1994-2010 there was an average of 3,625 live births per year at Willow. All were born at the hospital site (AU or AMLU) except an average of 32 (0.9%) that were born at home. **Table 12** provides an overview of local, regional and national birth data for maternity services. Willow had a lower than average home birth rate, when compared regionally and nationally [see **Table 12** and **Figure 5**] figures (Health and Social Care Information Centre, 2015; Kuypers, 2015)

Table 12: Comparative statistics for Willow against regional and national performance for period 1994-2010. (Health and Social Care Information Centre, 2015; Kuypers, 2015)

(2014/15)	Births	Planned home births
Willow	3,624	32 (0.9%)
Regional	27,127	373 (1.4%)
National	636,643	14,643 (2.3%)

Figure 5: Shows the percentage of home births in the Clinical Commissioning Group (CCG) area (or equivalent) that commissioned the majority of activity from Percentage home births in Willow between 1994-2014 (blue bars) and the national average over the same period (orange line). Data collected from the Office of National Statistics (2016).



Willow was selected as a case site for this study for a number of reasons. Firstly, Willow is an NHS maternity service which has performed below the national average figure for home births for at least 17 years [**Figure 5**]. It represents a typical example of an NHS provider that have centralised labour and birth care but continues to support a small number of home births each year. In addition, at the time of data collection, commissioners had contracted an alternative provider to deliver a midwifery service within a coterminous boundary with Willow. There was also another non-NHS midwifery service providing private midwifery care within Willow's boundary. Willow as a case site, presented an opportunity to explore the antecedents of deinstitutionalisation locally and the purposive actions of individuals involved in maintaining or disrupting expectations for place of birth locally. Secondly, Willow provides a close match for Sycamore (Chapter Six of this thesis) in terms of its population demographics, birth rates and organisational structures but diverges when it comes to performance relating to place of birth and presents an opportunity to perform a case comparison. Thirdly, Willow was receptive to participating in research and there were senior member of staff willing to broker access to participants.

Figure 5 demonstrates that Willow had performed below the national average for home births for 17 years between 1994-2011. However, from 2012 performance rose above the national average – where a peak just above 4% is recorded. It is important to note that from 2010, an alternative provider of midwifery services was offering care to women funded by the local commissioners – so at no cost to individual women. There was no agreement between Willow and the alternative provider for non-NHS employed midwives to provide intrapartum care in the AU or AMLU at Willow. However, the alternative provider's midwives could provide intrapartum care for home births. Between the years 2010-2014, the number of home births in this commissioning

area began to increase. Willow did not increase their home birth rates over this period, so this increase has been attributed to commissioners opening up the market to involve an alternative provider. I became aware that the performance data compiled at an organisational level for NHS England [**Table 12**] differed from data compiled by the Office of National Statistics (ONS) at a commissioning level based on populations [**Figure 5**] as the boundaries are not coterminous. Organisations in this study did not keep longitudinal data, so I requested data from the ONS to provide an indicative trend in each locality. Therefore, I made a judgement that the most reliable indicative data for all three case sites (Willow, Sycamore and Oak) came from the ONS.

5.1.3 Participants

This chapter presents data from interviews conducted with participants recruited for case site Willow. **Table 13** describes the 26 participants that were consented to this study for Willow; 21 were categorised as non-service users (employees of provider or commissioner organisations); and 5 were classified as service-users (women who had given birth at home supported by CMs from Willow). This chapter does not present data from the service users or the Ambulance Service at Willow. I considered writing separate chapters as part of this thesis dedicated to the data from the service users across all three case sites as there was high degree of homogeneity in their accounts. However, the focus of these participant accounts was predominantly around their relationships with midwives, rather than organisation. Decisions about the unit of analysis for this study were made once my conceptual framework began to emerge. I felt that the most coherent telling of the data came through a case site approach, rather than grouping stakeholders from across all three case sites together. I will however, be developing journal papers for peer-review to ensure the data from these participants is able to contribute to knowledge. The data presented in this chapter is from individuals who self-identified as having responsibility, authority or expertise relating to intrapartum care

– that includes the home birth service – at Willow. More information about the research protocol and procedures are available in Chapter Four of this thesis.

Table 13: Participants recruited for interviews and focus groups in Willow

Case Site	**Willow**
Clinical Commissioning Groups (CCGs)	4 = (Clinical Commissioning Managers and Programme Managers)
Service Leaders	3 = Head of Midwifery, Senior Midwife (Labour Suite), Directorate Manager (Finance)
Midwives	5 = (Locality Coordinator Midwives, Community Midwives)
Consultant Obstetricians	1
Consultant Neonatologist	1
Ambulance	4 = Medical Director, Consultant Paramedic, Advanced Paramedic, Paramedic
Local Supervising Authority Midwifery Officer	1
Service Users	5 = women who have given birth at home
Others (National)	2
Totals	**26 participants**

5.1.4 Addressing the research questions

This study's three over-arching research questions are addressed in this chapter:

- **RQ1**: What strategies are used by service leaders to identify new institutional opportunities for change?
- **RQ2**: How are the rhetorical arguments for and against change mobilised by stakeholders?
- **RQ3**: How do stakeholders utilise additional social networks to implement change?

In addressing these questions, consideration was given to the ways that different stakeholders discussed institutional changes (RQ1). Willow's leadership were preoccupied with maintaining the status quo

and minimising the impact of competitive tendering on their organisation more widely. This chapter demonstrates how an NHS maternity service with a historically low rate of home births behaved when confronted with local commissioners attempting to leverage service transformation through a competitive tendering process.

In assessing rhetorical arguments for and against change (RQ2), this chapter focuses on the perceptions of local demand for changes proposed by commissioners. In particular, it explores how Willow perceived the motivations of individuals and organisations involved in change and attempted to create a new narrative around safety, risk minimalisation and cost-effectiveness that involved problematising the motives and capabilities of those involved in transformation agendas.

The legitimacy of the received wisdom of national policy and evidence was resisted by service leaders at Willow, regarding it as inapplicable to their local context (RQ3). However, frontline midwives believed a marketing strategy that promoted and made visible the home birth service provided by Willow to the local population was essential to re-establish their monopoly of all provision of maternity care.

5.2 Thematic analysis

5.2.0 Introduction

My analysis for Willow focuses on participant accounts located across the following two themes in the data:

- Maintaining the status quo (section 5.3)
- Competition and conflict (section 5.4)

The data presented demonstrates how Willow sought to minimalise risk by favouring their centralised service in the AU and AMLU, and deprioritised investment in their home birth service. Consequently, commissioners sought to expand choice for local women by introducing

a competitive tendering process which Willow eventually responded to by bidding for the contract as the alternative provider to themselves.

The rhetorical arguments for and against change are explored in this study through participant accounts relating to their perceptions of local demand for more choice of place of birth. This created questions about the overt and implied motives of national policy and evidence for service change; the politics and agendas of local commissioners; and safety, quality and cost-effectiveness of competitive tendering for maternity services in general.

The motivations of different stakeholders to resist or modify changes to the home birth offer at Willow are presented in this chapter. Willow sought to harness a network of like-minded NHS organisations resistant to competition and privatisation of NHS services in order to protect their historical monopoly of maternity care in their locality. This involved engaging with their local service users in new ways to strengthen their market position and maintain loyalty to the local hospital, as a valuable but vulnerable local resource in the context of health service reconfigurations, for the local community.

Table 14: Research questions mapped to themes and sub-themes

		Research Questions		
		What strategies are used by service leaders to identify new institutional opportunities for change? (RQ1)	**How are the rhetorical arguments for and against change mobilised by stakeholders? (RQ2)**	**How do stakeholders utilise additional social networks to implement change? (RQ3)**
Themes	**5.3 Maintaining the status quo**	5.3.1 Concentration on hospital birth	5.3.2 Perceptions of demand for home birth and financial implications	5.3.3 Challenging the applicability of national agendas to the local context
		← Theory of deinstitutionalisation →		
	5.4 Competition and conflict	5.4.1 Contracting and commissioning	5.4.2 Defensive strategies	5.4.3 Protecting the monopoly
		← Theory of deinstitutionalisation →		

5.3 Maintaining the status-quo

5.3.0 Introduction

What is shown in this section is that the strategic focus of Willow was to centralise maternity care within their AU and AMLU and to diminish suggestions that local demand for home birth were not being met. Local demand for home birth will be shown to have been regarded as marginal, expensive, and exposing Willow and its workforce to unnecessary risk. This section will also explore the rhetorical arguments used by participants to justify opinions that demand for home birth was

virtually non-existent. This was apparently based on their expert knowledge of the local population, the inclinations of the CM workforce and Willow's financial status. Finally, it will examine Willow's attitude to national policies and agendas that sought to expand midwife-led, continuity models of care that included expanding services that supported home birth.

5.3.1 Concentration on hospital birth

For Willow, significant investment in refurbishing their maternity facilities so that women could be accommodated in single rooms was regarded as a luxury that local women appreciated and valued.

> *"…we're quite a forward-thinking unit so we… try new things. We're quite proud of our unit, you know all the work that was done… the ward upstairs, beautiful now, single room, everyone has a single room, all that sort of stuff. It's just you know, it feels like a nice place, you know, for patients, you know. I would be quite happy if my wife delivered [here]."* [**Consultant Obstetrician, 1Af-07**]

Staff regarded the hospital facilities with pride and that any fear or anxiety that women and families may have around childbirth would be alleviated by choosing to give birth in the AU or AMLU, rather than the 'hassle' of birthing in their own homes.

> *"[In the] AMLU now, which has got your five rooms, which is absolutely fantastic you know whether it's a water birth you want, or whether, you know it's erm, you know just sort of aromatherapy or anything else… actually, the women haven't got the hassle necessarily of having you know, all of that going on in their own home. If there is that element of a little bit of anxiety from a partner or whatever, then the fact that it's an [AMLU], you've always got that you know delivery suite that's sort of nearby, and a lot of the women that choose to deliver in the [AMLU] are home after a couple of hours…"* [**Head of Midwifery, 1Ab-02**]

To some degree, participants regarded the AMLU as an acceptable compromise for women to make so that staff could minimise the risks associated with childbirth for them and improve safety. This participant

believed that staff were more comfortable providing care in the hospital setting with colleagues and equipment close by. They go on to extend this belief to the women who accessed the maternity services as well.

> *"And it's not that they've [midwives] become obstetric, and it's not that they're not providing fantastic normal midwifery care, it's just that they can provide that in a [AMLU], in a group where you've got your mate next to you or four mates, or in a [AMLU], three other mates on site, you've got a resuscitaire on site, if things happen you can get advice from senior midwife all the time, it just feels more comfortable to them. They're still providing normal care and most of the time they don't need that help, but sometimes they do and they feel safe. You know, I would, and anyway we all, you know, why do I love working in a hospital? All these people around me you know that can help me if [I] need something. If everything's fine, I don't need them. But erm, and that's what patients feel as well, and I'm not putting words into patients' minds, because I'm actually pro, as a rule, as I said, I'm pro normal home birth, but they don't want it. I don't think we should force something on people."*
> [**Consultant Obstetrician, 1Af-07**]

Participants commonly described themselves as very pro normal birth and emphasised the benefits of working as a multi-disciplinary team. The concentration on providing a high-quality experience for women in the AU, meant that CMs were regularly asked to work there to support periods of high activity or sickness and absence. For this senior community midwife, the presence of CMs in the AU meant that a woman-centred approach to care in the AMLU had influenced and been adopted by hospital midwives working in the AU, and for those reasons, she regarded care provided in the hospital as excellent.

> *"I think going back to the safety… the progress on the unit, the [AMLU] is excellent and it's a good in-between thing. Also, we've got… all the new fetal monitors and there's quite a few with telemetry. So, they're [women] coming in to be induced at [the AU], but they can wander around, they can use their birth ball, erm, it's not, 'your being induced, you're on the bed now and that's it'. So, I think the mindset… midwives doing aromatherapy courses, hypnobirthing erm… they've coming on in leaps and bounds in low risk care because the hospital based [midwives] in particular just didn't do low risk care, but the [AMLU] has*

> *encouraged that and they now try to provide it for the high-risk ladies."* [**Local Coordinator, Community Midwifery, 1Ad-06**]

This perception that CMs were promoting and increasing normal birth in the AMLU was reinforced by the Head of Midwifery, who refers to a birth as a 'delivery'.

> *"…but I think what's helped improve confidence, erm, with community midwives is the fact that they do come into the [AMLU] at the end of the day they promote the normal, sort of labours as well, so we're benefitting two-fold not only are they updating, you know, as in they're getting a delivery, but actually they're the best placed midwives to promote normality and achieve a normal delivery for those women that choose to deliver in the [AMLU]."* [**Head of Midwifery, 1Ab-02**]

However, CMs themselves were less enthusiastic about the benefits to them professionally and regarded working in the AU as unfamiliar and challenging.

> *"… I feel like the new girl [laughter], because there's so many more new midwives come into the [AU], but also there's a lot more things like the technology, the computer system. Just the CTG [equipment that listens to fetal heart beat] is different. The pumps are different as well..."* [**Community Midwife, 1Al-16**]

Home birth was regarded as part of the portfolio of choice offered to women accessing care from Willow, however, there was lack of enthusiasm and a reticence expressed about the capacity to expand provision beyond its current level.

> *"We do it. We offer it… I see regularly in the notes – home birth offered – [laughs], So they [CMs] do actually sort of talk about it… but I don't think we can upscale. So, say like this month we, you know, 20 women decide to do home birth, we couldn't provide it… it would involve a huge investment of more staff and enthusiasm and work to get it up and running…"* [**Consultant Obstetrician, 1Af-07**]

Doubts about Willow's appetite to expand their home service were reinforced by their Finance Manager who conceded that home birth

may represent a cost-saving for the NHS. However, they perceived that an adverse outcome from a home birth and its associated litigation costs presented an almost unacceptable risk to the maternity services as a whole at Willow.

> *"…but there's a reality that we can't have a senior consultant presence or a medical presence on call for every, for a mum at a home birth because the financial climate doesn't allow it. And I get the bigger picture stuff around… if there are more home births, less… medical intervention… there is a bigger picture… and maybe a bit of a cost savings there for the NHS from that point of view. I think that cost saving… versus the clinical risk of [the] implications of something going wrong, you know one massively outweighs the other."* [**Directorate Manager, Finance, 2Aa-01**]

Despite senior staff articulating the benefits that CMs working in the AU brought, CMs themselves perceived that their contribution was under-valued at Willow and was impacting on their ability to advocate for women and promote home births.

> **Participant 1**: *"…we do feel like we are the jack-of-all-trades, y'know, because we, we have to cover so much so, something like a home birth, as much as it's a priority to us, it can't be because of the need for us to be…on the [AU] the next day, or to be in [AMLU]…We do feel very hard done to a lot of the time and I think, y'know, nobody would dispute the fact that… what is going on in there [the AU] takes top priority, nobody would dispute that, but it does wear thin, particularly when they call us [the CMs] all the time… it just starts to really get you down when it's all take…"*
> **Participant 2**: *"…the girls [CMs] are pulled from [pillar] to post, and they don't get chance on things like a home birth…"* [**Local Coordinators, Community Midwifery 1Ad-05 & 1Ad-06**]

It was recognised by commissioners that the CMs were finding it difficult to provide a quality community midwifery service at Willow that advocated for women, due to the multiple demands on their role to be flexible around the needs of the AU and AMLU.

> *"It's difficult. They're [CMs] in a situation where they're trying to provide a quality service and yet they're being pulled to provide*

> *support to other parts of the organisation, and it's layering of hats. What are you, a midwife first or an employee to the organisation first? Are you a woman's advocate? Where do these levels sit and which hat is on first?"* [**Clinical Commissioning Manager, 1Dc-12**]

As already noted, maternity leaders valued the contribution that CMs were making to care delivered in the AU and AMLU and felt this was benefiting the women and CMs too. Consequently, the professional culture of midwives and medics at Willow was perceived to be philosophically well-aligned and had resulted in an effective and collaborative working relationship.

> *"…there's a consistency in care, erm, and we trust each other to manage our patients… that [is] the huge benefit that we have here, that we work incredibly well together…"* [**Consultant Obstetrician, 1Af-07**]

However, from a commissioning perspective, there had been a drift at Willow towards a medicalised model of care and that the team were not appropriately sighted on the potential for this to have any detrimental impact on their abilities to advocate effectively for women accessing care from their organisation.

> *"…However, the maternity team has now come to a point where… they haven't realised that there's been a drift, it's been insidious. I won't say what I'm thinking but they are not the midwives that maybe they thought they were, that their service is not as active as an advocate of a woman, and the relationship between the team over there between that midwifery side and the obstetric side is really strong and they get on very well, very well… and I would say that the midwives have gone over to a much more of a medical model, and that the role that they were trained to do has been watered down, but they don't recognise that."* [**Commissioning Manager, 1Dc-12**]

What has been shown in this section, is that Willow demonstrated a clear concentration on their in-patient maternity provision and the necessity to focus resources and skills within the AU and AMLU. Participants justified this approach on the grounds of enhancing safety

and cost-effectiveness for the overall service at Willow. Despite concerns from commissioners about this approach, the subsequent deprioritisation of home birth at Willow as part of their portfolio of services, appeared to be meeting with very little resistance from within.

5.3.2 Perceptions of demand for home birth and financial implications

We have seen that participants were positive about the AU and AMLU services at Willow. What was also apparent in accounts, was that they reinforced this by emphasising how attuned they were with the local population and felt that they could articulate on their behalf based on their experiences interacting with local service users.

> *"I just don't think that society, my patients don't want it [home birth]. You know, they genuinely, they don't. There's no appetite for it. I think that the normal midwives who are out there who are doing the day to day job would give you the same answer so, our patients don't really want this."* [**Consultant Obstetrician, 1Af-07**]

> *"… everybody says you know, this is what women want [home birth], but, I don't think it is. I really don't hear that from the women here. And I know they say 'well you should be doing individualised care, and you know, personal care', if our women don't want to have a home birth then why are we all being tarred with the same brush and say you've got to… reach 4% for home birth rate. Why? When your women in your area don't want it?... It's like these women have choice, so if they don't choose that, that's their choice."* [**Local Coordinators, Community Midwifery, 1Ad-06]**

What was marked in participant accounts was the way service users were stereotyped into one of two extremes, where local demographics were presented as either socially deprived or economically affluent. This led to some generalisations about service user expectations and preferences.

> *"…[Willow] have this contrast of this clientele group. One who would, I think want home deliveries because it's the thing to do and NCT [National Childbirth Trust] type of persons, home deliveries can go well. The other end, they just want it at home*

> *because they want to be there with all their other kids and they go equally well… And quick. They don't like hospitals, why go up to the hospital, drag their family up there, the partners and all this and.. And yet on the other hand you do get lots of the girls from these groups who are saying, I want a few nights in the hospital on me own. You know, so I'm, no I'm not having a home delivery thank you very much because I'm gonna have a rest from the kids…"* [**Local Coordinators, Community Midwifery, 1Ad-06]**

> *"…[Willow] is a strange place because economically it's very different. Socially it's very different depending on which part of [Willow] that you live in. So, there's a demographic that's obviously more educated, more affluent, and those women traditionally want continuity. They want a Community Midwife. They want to know that Community Midwife. They want to see her antenatally and they want to see her postnatally. In an ideal world they probably would quite like her to deliver the baby but they know that's not how the system works here, and most of them are happy with that… but there's another demographic that actually they're not that bothered, and they'll see anybody really as long as they can be seen…they're quite high users of healthcare. They're the people who can't have a cold without going to their GP. So, they can't have a slight pain without going to see somebody… So, I think we do generally know what patients want in terms of what their needs are…"* [**Locality Coordinator, Community Midwifery, 1Ad-18**]

What can be seen from the preceding quotes, and was also apparent in other parts of interviews with service providers was a tendency towards a rather paternalistic approach to maternity care. These data extracts illustrate some of the strategies regarded as necessary to encourage women to comply with organisational or professional preferences. What is demonstrated is the idea of being 'sensible' associated with those women who comply with organisational preferences. We also see women who disagree with obstetric care plans as resisting obstetric wisdom.

> *"… but somebody that's got risk factor[s], obviously you know, two previous sections, something like that, we would say to them, 'Obviously we wouldn't encourage you to have a home delivery. This [the AU] is going to be your place of delivery.' And we always tell them that we'll support anybody having a home*

birth, you know, but I think most girls are sensible in that if they've got a risk factor, they know the best place. They want to come into hospital." [**Community Midwife, 1Al-16**]

"one of the issues I think with home birth at the moment is that the women who choose to have home births are a select group who perhaps aren't the right people to choose to have home births, and the people who are choosing to have home births are the slightly on the edge of… sensible decision making erm, and so we're not getting the ones we actually we would really like to have a home birth… more of my discussions about home birth [are] with people who've had traumatic previous experiences, who you know, want to not come to hospital. I spend a lot of time with these, and… the reason you had a traumatic experience is exactly why, from an obstetric point of view [you] need to be in hospital [laughs] and it's [women with complications] I seem to see who are choosing to have home birth and it's almost this sort of battle between the patient [the pregnant woman] and me, who just has a thing against authority or sees us [the obstetrician] as… [an] authoritative figure." [**Consultant Obstetrician, 1Af-07**]

"I think women have become more demanding [laughs]. That's one of the biggest challenges we've got, you know, women expect more. Very high expectations. Sometimes unrealistic and you're trying to, you know, actually bring them down to levels that are realistic." [**Locality Coordinator, Community Midwifery, 1Ad-18**]

In contrast, we see some motivation from service provider participants to frame access to the AU by women perceived to be from the deprived area of Willow, as achieving some equality of opportunity with the affluent demographic. This pride in the AU facilities meant that women were regarded as receiving something more valuable than a birth experience in their own homes.

'… when you have a young girl down there on [the AU], that has her baby in the pool, and the lights are down, and she's got her music on, and just been allowed to do what she wants to do, the power that they feel is unbelievable. And you hear them saying 'I never thought I could have this', 'why do you think you can't have it?' And it's getting that message across that they can have exactly the same as everybody else can have.' [**AU Manager, 1Ah-09**]

From interview accounts, it was evident that most service provider participants were mindful of the financial implications associated with providing a home birth service and that for an NHS service that has close budgetary monitoring, any overspend was scrutinised.

> **Participant 1**: *'And it, it is expensive. You know what they don't see is erm, all the input that we put in to provide the women with this home birth the people that go on call, the on-call payments that we're paying…'*
> **Participant 2**: *'Because if you're out, that's additional pay.'*
> **Participant 1**: *'Two of you [CMs] go out… where there was a risk of haemorrhage we'd made a plan… that three midwives would go out. And that's not built into our financial budget, you know, the on-call is, but not the on-call payments of people who are out. Then you get the finance people 'oh look, you're over your budget, you know, for this month, what's happened there?' and we're like 'yeah, well we're providing a service you know, you want… the home births to go up, but you don't want to fund it.'* [**Local Coordinators, Community Midwifery 1Ad-05 & 1Ad-06**]

Income generation was important to Willow. Willow had established a business relationship with a private provider of midwifery care – separate from the commissioned alternative provider. When the private provider used Willow's AMLU facilities, the pregnant women would pay the private provider for the clinical care directly, and Willow would be permitted to collect the tariff payment from commissioners as they provided the birthing facilities on their premises. This financial arrangement was looked upon favourably by service leaders and could be perceived as contributing to maintaining the status quo in terms of institutional birth, and reinforcing the desirability of the AU and AMLU facilities.

> *'We get the tariff and they [the private provider] get paid because they… charged the woman for that private care… But that works really, really well… if women do want private care… I'm more than happy to support that with them [the private provider]… then obviously we get the tariff as well so, yeah it's really good you know, we get the payment from what would*

equate to the tariff from [the private provider].' [**Head of Midwifery, 1Ab-02**]

In contrast, the alternative provider that had been commissioned locally was not greeted with the same enthusiasm. A lack of conviction that many women wanted home birth when Willow's superior AU and AMLU facilities were available, meant that when the alternative provider offered this service locally, it was regarded as motivated by profit, rather than to satisfy an unmet local need.

Participant 1: *'Well obviously [the alternative provider] take the woman's choice into consideration. But I do think, because financially they want to keep these women at home don't they to get home deliveries.'*
Participant 2: *'That's what I've heard anyway. It's what I've heard. I don't know for certain. They only get their payment if they've done the antenatal, the birth and the post [natal] care… So, the midwives that work there [the alternative provider], their managers tell them, 'Get home births because that gets income for our business.'*
Participant 1: *'Because it's a private company isn't it?'*
[**Community Midwives, 1Al-16 & 1Al-17**]

Feeding into the expressed lack of conviction that local demand for home birth existed, were perceptions by CMs that changing expectations around work-life balance and personal safety now meant that the traditional CM job remit that involved working long, unsocial hours, remote from an institutional base was becoming undesirable.

'I've done on-calls when you went out to a crying baby [at] two in the morning, got in your car, off you went, didn't think twice. Now there's, erm, a lot of concerns with safety and, erm, lone worker policy… I don't see the risks the same way as somebody newly qualified, [who has] work[ed] in a hospital, come out [to work] on community… their families are more concerned than anything, the midwives' families… 'you're going out?… who's going with [you]?' [**Local Coordinators, Community Midwifery, 1Ad-06**]

'…it's all very well, and the government say give choice… do caseloading… Move with the times. Midwives can't devote their lives to doing it [caseloading]. Erm, and you know, even if they

wanted to, they've got families, they've got work, you know, some midwives used to work and their husbands didn't, whereas now, they're both working, young families, erm, you can't make that commitment, and caseloading is a big commitment'. [**Local Coordinators, Community Midwifery 1Ad-05**]

This section has discussed the assumptions, generalisations and stereotypes applied to the local population of Willow, identifying some paternalistic and patronising language and behaviours that sought to limit local access to home birth as a choice at Willow. Financial and workforce considerations were cited as factors that limited Willow's capacity to expand their home birth service.

5.3.3 Challenging the applicability of national agendas to the local context

It has been shown that service provider participants at Willow maintained a position that there was little demand for home birth locally, and therefore no need to increase the supply of this choice to the local population. Participants were sceptical that the national policies and agendas were applicable in Willow on the grounds that they believed local people had not been consulted.

> *'I think… the commissioners have got to look at… where is the drive coming from? Who've they asked?... there's thousands and thousands of women live [in Willow locality], and if they've only got a [small] percentage that's saying 'we want home birth, and this is what we want', then that's not a true and realistic vision of what the women [locally] want because nobody… here's seen anything locally in the papers, or anything advertised about asking the women what they want, so where have the commissioners got that from?'* [**Senior Midwife, AU, 1Ah-09**]

When one participant from Willow was asked about how local women were involved in developing services at Willow, it appeared there was no effective local mechanism to facilitate that engagement.

> **Interviewer**: *'What mechanisms are there for engaging with service users, so the women, to develop the maternity services for [Willow]?*
> **Respondent**: *Well they [Willow] have the MSLC [Maternity*

Services Liaison Committee].
Interviewer: *Does that work?*
Respondent: *I don't think so.*
Interviewer: *Have you got many [women] that pitch up?*
Respondent: *No. That's about it really. I don't think there's much else that goes on really in engaging at a higher level with them [service users].'* [**Locality Coordinator, Community Midwifery, 1Ad-18**]

National policy was criticised for being inconsistent and sending mixed messages to pregnant women and their families. This participant felt that on one hand, large prospective trials – such as Birthplace in England Collaborative et al. (2011) – was being used to convince women that outcomes for certain low-risk pregnancies were better if that chose to give birth at home; but on the other, national strategies and targets to reduce the high rates of stillbirth in England were requiring more surveillance for a majority of pregnant women (Royal College of Obstetricians and Gynaecologists, 2015). Ultimately, this participant felt that national messages around minimalising risk during pregnancy, were far more visible to women than encouraging them to opt for home birth.

'*…I think it's fascinating at the moment because there's two different messages coming out of the [Royal] Colleges and the College of Obstetricians and, and Midwifery… which is essentially obstetrifying [sic] pregnancy… the most I've ever seen in my career… I think it's on the patient's, the forum, if you go to [the AU] twice you'll get induced, and they [pregnant women] want to be induced… Erm, so we've got that side. But on the other side we've got all this drive supposedly for home birth [laughs] which is, which is just these two just ridiculous, opposite extremes and it's a very schizophrenic message coming out of the Colleges… you're telling the patient that their baby's going to die, you know, at any moment, you're going to have a stillbirth… but that message is scaring more women. You really think you're going to increase home birth rates by scaring the population saying your baby's going to die?'* [**Consultant Obstetrician, 1Af-07**]

Further, the same participant was unconvinced that midwives involved in the national maternity transformation programme were

representative of clinical midwives working in current maternity services and they saw them as motivated to advance their own agendas which included promoting midwife-led care, and by extension, home birth.

> *'So, slightly controversially, I think the midwives that are the ones who are on the committees, who speak, are perhaps not really giving the true picture. Because the midwives who are speaking perhaps aren't at the front line as much anymore and have their own agendas that they're spouting… when you hear the vocal midwives speaking I think, 'they're not the midwives I work with'. I do worry that we're being driven by… midwives that end up on Radio 4… you know, you're thinking… 'where do they get these people'… They just come in with strange, far out ideas.'* [**Consultant Obstetrician, 1Af-07**]

Again, on the suspicion of ill-founded motives, this participant believed that commissioners were requiring Willow to increase their provision of home birth in order to reduce the expense of maternity services locally. This was juxtaposed with a theory that one adverse outcome at a home birth could lead to long-term financial expenses that would obliterate any small financial gains made from birth not taking place in an institutional setting.

> *'… the home birth tariff is cheaper for them [commissioners]… so if you do more births at home they're going to be paying out less complex tariffs. That's the logic behind it. But the reality is… if you get that one [home birth] that needs that clinical intervention… they [will] probably be paying out for that child a lot longer, for that family, from a health point of view …than the few thousand pounds they've saved on having the, the home birth… I, I agree that where you can, the home birth is for lots of ladies and families right and the right thing to do, forget clinically just a nice, you know, if that's what they wanna do if that's what people are happy with and it can be done safely then it's, it's a great thing. Erm, but the moment you throw finance into it, it complicates [it].'* [**Directorate Manager, Finance, 1Aa-01**]

Equally, the idea that more alternative providers could be permitted to bid for contracts to provide home birth care was regarded as a national cost saving strategy. Participants suggested that changes to

commissioning could have risk implications for women and babies, but that it may also be destabilising for NHS providers who would be unable to compete on cost.

> *'… it's spreading, isn't it, to other parts of the country where there's other providers providing home birth services. I mean from my point of view, I think from the commissioners, they just need to look at what they're providing is safe. I think there needs to be a level playing-field … that the midwives working are experienced and providing a good safe standard of care.'*
> [**Locality Coordinator, Community Midwifery 1Ad-18**]

For this obstetrician, defensive activity against an alternative provider was regarded as no longer necessary. They took the view that the local population may have been drawn to try something new in the short-term, but they would eventually recognise its inferiority to Willow's service. Ultimately, this approach was echoed by a number of participants who believed that Willow just needed to focus on what they did best – institutional birth – and they saw little value in expending effort increasing home birth provision locally.

> *'…whether [the alternative provider]… maintain their, their contract [in Willow's area] is still open to conjecture… they've been looking elsewhere, they've been spreading their wings… it's like all of these new things, our feeling on it is that soon [the alternative provider will] just wander off… Yeah because the population you know, the population are talking to each other and… we've just sat back and just said well we'll do what we do well and… the population will start to talk to each other and say look, [the alternative provider] is not good enough.'*
> [**Consultant Obstetrician, 1Af-07**]

Ultimately, the rationale that staff believed the local AU and AMLU facilities at Willow provided a safe, high quality experience for women and families on their doorsteps meant that they felt confident they were meeting the needs of their local population and that the expansion of home birth was not a priority for their service.

> *'I suppose because we have got an [AMLU] that's near most people, that has an effect on the number of women that want, you know, a home birth.'* [**Head of Midwifery, 1Ab-02**]

This section has demonstrated the level of scepticism among participants around the national policies and agendas for maternity and their relevance to Willow's context. They also had issue with inconsistencies and what they saw as vested interests in advancing midwifery agendas to seize more control of maternity care. The agenda to increase plurality of choice and more competition within maternity services was regarded as a cost-reduction strategy, and carrying the potential to introduce more risk into childbirth. The pervading attitude at Willow was to pay lip-service to wider expectations to increase home birth and that they would remain the dominant provider of maternity care.

5.3.4 Summary

This section has sought to demonstrate that the strategic focus of Willow had been on quality improvements in the centralised AU and AMLU which they perceived had diminished demand from the local population for home birth. Allied to this were claims regarding their intimate knowledge of the local population, the attitude and behaviours of the CM workforce and the financial burden that on-call support for home birth presented to Willow as an organisation. Despite the national choice agenda, Willow disputed its relevance to their service users and their approach to service delivery.

5.4 Competition and conflict

5.4.0 Introduction

This section explores the commissioning agenda and the degree to which the needs and preferences of the local population were perceived to be being met. Expanding choice in Willow's locality to include more continuity models of care from CMs meant that participants were confronted with national research and policy that they regarded as

unnecessary and for their population. Willow developed a strategy to re-capture the whole maternity care market in their locality by submitting a bid to win the contract that had been held by the alternative provider, while at the same time employing rhetorical strategies that questioned the whole legitimacy of competitive tendering for maternity services. Willow's CMs working at the frontline perceived subtle, but worrying changes in the inclination of service users to choose Willow as the default provider when they wanted a home birth. However, it will be shown how managers at Willow regarded competition from an alternative provider would be short-lived and that other strategies to increase their market share were unnecessary.

5.4.1 Contracting and commissioning

The maternity service provision in Willow's geographical area was predominantly provided by Willow, but two other small non-NHS providers were also operating; one commissioned alternative provider, and one private midwifery provider. There were a number of reasons cited by local commissioners that competitive tendering was required locally. Firstly, there was some frustration that the plurality of choice for place birth being offered by local NHS Trusts did not meet the national choice guarantees or evidence (Bourke, 2013; Department of Health, 2004, 2007). Commissioners regarded the alternatives to AU birth being offered were 'tokenistic', rather than substantive.

> *'And then obviously, looking at the national evidence to show that obviously, the huge majority of women actually don't want to end up delivering on an obstetric unit, but actually there's very, very little choice especially within [this region] where we are now. There's no stand-alone midwifery led units and there's [a] very, very small percentages of home births.'*
> [**Commissioning Programme Manager, 1Ec-14**]

> *'[As commissioners] we took a view that if women are actively going to seek [the alternative provider] because [of] the service that they're not getting at the [AU]… then we need to look at this seriously… we were concerned about our maternity unit in*

> *terms of the Maternity Matters of 2007 document. They had achieved almost all of those requirements but not the choice of place of birth, and we felt [their offer was] tokenistic… and we were not happy with that.'* [**Commissioning Manager, 1Dc-12**]

Secondly, commissioners regarded the current pathways as confusing for women to navigate or make fully informed choices and decisions about the type of care they would like to have.

> *'I think that the lack of input from GPs and probably community midwives has led to a real lack of [choice]. And what I'm picking up from women and families that I'm talking to is… that it's just so confusing to navigate the system. And really the first time they get any advice and support is at their booking appointment, by which point in time their choice has [already] been made.'* [**Commissioning Programme Manager, 1Ec-14**]

Thirdly, commissioners regarded competitive tendering as a tool to motivate NHS providers to move towards introducing models of care, such as caseloading, that would offer more women continuity of care – which again, was part of the national maternity policy targets (Cumberledge, 2016). This interview extract demonstrates how commissioning an alternative provider to offer a caseloading model with a zero-activity contract i.e. the provider is only paid for activity undertaken, was framed as satisfying the needs of the local population, presenting no additional financial burden to the commissioners.

> *`I hope that we have the guts in the NHS to walk the walk. Women want this model of care, women are highly satisfied with the experience. As a financial model, we as a commissioner are no worse off, it's a zero-activity contract… We asked [local NHS Trust] would they do a caseloading model and they told us they could not. That just added further grist really to us having to go out to procurement... We've commissioned the model of caseloading, not home birth.'* [**Commissioning Manager, 1Dc-12**]

Although commissioners stated that they wanted to procure continuity models of care, the message that appeared to be received by Willow was that increasing home birth provision locally was the real objective.

Willow appeared to find this particularly confronting, as they understood that their workforce did not want to work in continuity models of care, primarily citing issues around the undesirable personal commitment to work on-call; and organisationally, that if they did not increase home birth there would be a threat of a competitor encroaching on their territory.

> *'…so, we don't do a lot of home births, but where we do, you know, they work well. And we know that erm, we do have the support and infrastructure behind [it] if something is needed. Hopefully it's not needed… I think the weaknesses are, [if] we don't do… as many as we could… [that] leaves us vulnerable to people [commissioners] saying 'we want an alternative provider of home birth services.'* [**Directorate Manager, Finance, 1Aa-01**]

> *'the girls [Willow CMs] are saying 'are we going to be forced to be in the home birth team then? Are they going to make us do, you know, on-call all the time?'* [**Locality Coordinator, Community Midwifery, 1Ad-05**]

The evolution of a relationship with the commissioners that required Willow to behave as a contractor and be performance managed was not welcomed.

> *'If it was [up to] me I'd just go back to a block contract for maternity services you know, say well this is what you're getting for the year, deliver your services and if you, if it's affordable fine, if it's not affordable come back to us at the end of the year and argue why. Rather than worry every month are we gonna be up or down, or down, or down… what's my finances gonna be like at the end of the month?* [**Directorate Manager, Finance, 1Aa-01**]

Equally, the concept of commissioners using procurement as a tool for service transformation was resisted by participants at Willow who argued that maternity care was unsuitable on the grounds that it carried significant clinical risk.

> *'But I think that when you're getting into the more specialist services…giving birth ultimately… is one of… the most clinically*

> *risky… why would you put an element of competition in that?... I get it around maybe antenatally and postnatally, but… more home births… it carries an element of risk.'* [**Directorate Manager, Finance,1Aa-01**]

However, when the alternative provider's 'zero-activity' contract was approaching the end of its three-year term, the commissioners put it out for tender again. Willow made the decision to submit a bid for this contract. In order to meet the specification, they entered into a partnership with another local community NHS Trust. There was some suspicion at Willow that Willow's bid had been unexpected or unwelcomed by the commissioners, and that some political interference in the procurement process had led to the contract process being paused, on the grounds that the commissioners wanted to await the outcome of the National Maternity Review, which had been launched in March 2015.

> *'Because it's so politically [sic]… [this region] is always put up as this beacon of excellence and how wonderful it is… [the] CCG did put out a tender for the next three years which we tended for… we put in a fantastic tender… and [the CCG] were trying to get a competitive element and obviously we couldn't compete with ourselves [laughs] so although we provided the best tender [the CCG] then… withdrew the tendering process.'* [**Consultant Obstetrician, 1Af-07**]

> *'…if the, if the commissioners had used a different tool just to say 'well actually this year we wanna, we're gonna work into your contract that we just want you to increase the home births', we could have done that in a steady planned way throughout the year, rather than, right, there's a tender it's all or nothing… I'd much rather they say we want more home births and sit down and say ok let's, how are we gonna do it?... the current leadership of the CCG did the right thing and paused it. But I think it was erm, you know, I don't see, I don't think it was financially driven by the CCG I think it was probably a little bit more politically driven because they want to be seen to have some competition.'* [**Directorate Manager, Finance, 1Aa-01**]

There appeared to be some conflicting views at Willow on whether bidding for the contract was worthwhile or appropriate. From clinician

accounts, they believed the bid was high quality and would present the commissioners with a predicament if they did not award it to Willow's NHS partnership. From the business and finance side, there appeared to be less confidence that the bid was sufficiently different to their existing provision to be successful.

> *'…it seems odd doesn't it, ourselves [Willow] bidding as an alternative provider?… by ourselves… we wouldn't have enough clout to say we were an alternative provider to do home births… So, we recognised the only way we could be seen as alternative was… working with public health… we worked with the community Trust… around that bid, erm, 'cause I think from a business point of view it was the only way… we could have shown we're doing something different… We spent a lot of time… with our business development people, and our Execs here [at Willow] thinking about, well, what, what could we do to answer the tender requirements, what is different? Because, because at the end of the day it's just offering you know the same, you know the same, there isn't anything different, it's not alternative.'* [**Directorate Manager, Finance, 1Aa-01**]

Participants at Willow argued that their services were already meeting the needs of their local population and that this belief justified their resistance to commissioner ambitions to transform services. However, Willow were mindful that others in the region and nationally may regard the way in which Willow were responding to competitive tendering as signifying an admission that their service was inadequate. For this reason, we see this consultant obstetrician arguing that if competitive tendering in maternity had the potential to deliver transformation, then the alternative provider awarded the contract three years ago would now have 60% of Willow's activity.

> *'So right at the beginning we saw [competitive tendering] as a huge [threat]. Because yeah, most of our women are low risk, if [the alternative provider] had done their job properly they would have got all the, all the low risk women and they would have a huge business... you could say we bucked our ideas up, we improved community services… anyone looking from the outside could say, well actually [competitive tendering] has improved [Willow's] services… The threat. So, say [the alternative*

> *provider] had taken you know, 60% of our women who are completely low risk, we [Willow] wouldn't have been sustainable.'* [**Consultant Obstetrician, 1Af-07**]

And finally, we see how commissioning alternative providers is foregrounded as a financially inefficient on the grounds that it creates the potential for dual charging for women accessing both services.

> *'…so there is a lack of understanding, I think, from the women that use [maternity services], because some women try and use both [Willow and the alternative provider], and they do actually get care from both providers, because you know if they don't tell us they're with [another provider] and they don't tell [the other provider] they're with us [Willow] then actually the tariff from a CCG perspective is potentially being paid twice [laughs].'* [**Head of Midwifery, 1Ab-02**]

This section has discussed the stated motivations of commissioners to expand choice, improve care pathways and transform services in Willow's locality by introducing competitive tendering. This was received as confronting by Willow who understood that they were already meeting the needs of their local population. Ideas that new continuity models of care that had the potential to support more women to achieve birth outside of an institution were regarded as introducing potential risks to their service. As a defensive measure, Willow decided to submit a bid in partnership with a local community NHS Trust when the alternative provider contract came up for renewal. When the procurement process was paused, participants suspected that the quality of Willow's bid had surprised commissioners and had created a predicament for those who wished to re-award the contract to the existing contract holder.

5.4.2 Defensive strategies

As demonstrated in 5.4.1, the legitimacy of competitive tendering in maternity services in Willow's locality was contested by participants from Willow. What was also evident in interview accounts was that a number of defensive rhetorical strategies were aimed at raising doubts

about the motives of Willow's commissioners and competitors. For this participant, the power of commissioners was oppressive and unchecked. Equally, they questioned the clinical background of the decision makers and their legitimacy to make decisions about maternity services.

> *'It really drives me mad because commissioners in this area I think are very powerful… They really dictate in this area and I think, you know, who are they? Who are they? Have they actually spoken to the women of the area to find out what the women want? They say jump and we have to say, 'How high?' That's how I feel. We're sort of the little weak ones underneath and we just have to do what they say, and yet they're not Midwives [laughs]. Who are they?'* [**Locality Coordinator, Community Midwifery, 1Ad-18**]

In addition, local CCGs were understood to be controlled by GPs who were largely self-employed. Locally, there had been some scandals associated with the awarding of contracts to more private companies to take over local NHS services and this had led to rumours circulating about the probity of the commissioning process.

> *'…it's no, no particular secret that I think some of the GP leads at the time encouraged elements of private provision… maybe [private] providers that could work out of their practice that type of thing [would be] much more beneficial.'* [**Directorate Manager, Finance, 1Aa-01**]

At an organisational level, when the alternative provider was originally awarded the contract to provide maternity care in Willow's locality, participants described considerable anxiety about the long-term threat to Willow's survival as a provider in the local area, and more specifically as a threat to local jobs. For the AU, this threat appears to have dissipated over time.

> *'I think when [the alternative provider] first came in… it was seen as a threat… we were told they were gonna half our deliveries… it was a threat to jobs, [and] that if we didn't buck our ideas up and sell ourselves and promote ourselves, this is*

what was gonna happen. And that wasn't the case at all… it's had little impact on us.' [**Senior Midwife, AU, 1Ah-09**]

However, for CMs, the presence of the alternative provider was still a concern for them and was visible to one CM who was seeing a reduction in women using Willow in her clinics.

Interviewer: '*Do you feel that your job's under threat with an alternative provider taking a chunk of work away from [Willow]?'*
Respondent 2: '*Personally I do.'*
Respondent 1: '*Yeah. It's always been in the back of our minds. I mean obviously initially when they [the alternative provider] came out, you know, we were getting lots of our women were going with them.'*
Respondent 2: '*…I've two clinics a week at the same practice… and I always was full. I always had ten [pregnant women to see] every afternoon. But now I'm only getting about four or five.'*
[**Community Midwives, 1Al-16 & 1Al-17**]

What was also apparent in participant interviews was that there was a widespread perception that the alternative provider was motivated to make a profit from their contract. This was often framed in terms of the provider employing newly-qualified or inexperienced midwives and putting them under pressure to encourage, or more strongly – coerce – women who may be unsuitable to have a home birth due to pregnancy complexities or co-morbidities, to consider this option. Participants understood that the intrapartum (labour and birth) tariff was the most lucrative part of the contract and in order to be able to claim it, the alternative provider must have provided that aspect of the care. If women were attending the AU or AMLU, then Willow would not receive that part of the tariff payment.

'*…it needs to be safe and that's what concerns me with some private providers, that actually they're employing brand-newly qualified midwives and there's disasters happening that we see coming through the doors.'* [**Locality Coordinator, Community Midwifery, 1Ad-18]**

'*…I think they're [alternative provider midwives] told 'you do not take a woman in [to the AU], you do not. You keep her at home*

> *and deliver her'. And I think that they're frightened into doing it… it's frightening.'* [**Locality Coordinator, Community Midwifery, 1Ad-06**]
>
> *'[the alternative provider] don't necessarily erm, have women that are all low risk in the community and there have been problems with that service… from a neonatal point of view … it's just unfortunate that sometimes it's, you know, it's taken out of context or the wrong women are supported to have a home birth when really what would be better is you know to have an AMLU birth… [the alternative provider] advocate and encourage home birth for all of their women.'* [**Head of Midwifery, 1Ab-02**]
>
> *'We don't envy [the alternative provider], the midwives we have would not work for them because they don't like the way they work. They don't like the way that they don't give the women choice, they coerce them into having home births, which I don't think is good. And also, brag about the fact that they've got quite a few women who are having twins and breech on their home birth list. And that doesn't excite us… we worry and we're concerned for the women.'* [**Locality Coordinator, Community Midwifery, 1Ad-05**]

There were also frustrations for participants from Willow that women who had accessed maternity care from the alternative provider held them in high esteem, but lodged complaints about the care they had received from Willow.

> *'… the patients [of the alternative provider] end up putting in complaints about us [Willow]… it's incredible, because I manage these women who have disasters and it's incredible how, erm loyal they are to [the alternative provider]… because when you're looking at the way [the alternative provider] managed the labour… it's delivery at all costs as far as I am concerned.'* [**Consultant Obstetrician, 1Af-07**]

Despite assertions that the care provided to women by the alternative provider was inappropriate or clinically unsafe, when participants were asked whether their concerns had been escalated to regulators to be investigated, participants suggested that there was some leniency afforded to the alternative provider that an NHS provider would not have received, or that standards for quality assurance were different for the non-NHS providers.

'*…You can't be a sacred cow that nobody can touch. It has to be investigated in the same way as everybody else, you know, openly and honestly, and if it's deemed to be unsafe, then it has to stop.'* **[Locality Coordinator, Community Midwifery, 1Ad-18**]

'*…[Willow] are inspected, we have to have quality assurance, and that is an independent body which makes sure that they are assured by the quality of service we provide...whereas the alternative provider [pause], I'm not sure as to how they are governed from those aspects.'*[**Consultant Neonatal Paediatrician, 1Ae-04**]

Participant 1: '*Well they [the alternative provider] have been looked at by the CQC [Care Quality Commission]…'*
Participant 2*:* '*…and it's disillusioning for us [at Willow] to report things to them [the CQC]… you know we've given them enough cases there and, you know, they've [the alternative provider] talked their way out of it.'*[**Locality Coordinators, Community Midwifery, 1Ad-05 & 1Ad-06**]

In contrast, interviews with commissioners revealed a particularly sensitivity to any comments made about how they monitored the safety of services. One Commissioning Manager [1Dc-12] advised that the alternative provider had no legal cases 'in the system' (at the time of data collection) and that no NHS Trusts in the region could make the same claim. The commissioning participants were emphatic that safety considerations were at the forefront of how the contracts with alternative providers were managed but acknowledged that there had been some lack of clarity during evolution.

'*I think the issue is that if non-NHS organisations want NHS contracts then they should be subjected to exactly the same rigor and standards and guidelines and processes as anyone within the NHS. And I think because of the way that possibly services may have evolved, that hasn't been clear, not only for NHS providers looking externally, but also for those organisations who've now got an NHS contract. And I think that that is the tension.'* **[Commissioning Programme Manager, 1Ec-14]**

'*I can't give you more details, but trust me, [the alternative provider] are under more scrutiny than any other service I have*

ever worked with. They've had seven CQC inspections in two years. They are not perfect, but they certainly are not what is being [propagated] about them. Sometimes there's a reason that message is being forwarded around the system.'
[**Commissioning Manager, 1Dc-12**]

This section has demonstrated how rhetorical strategies were employed to question the legitimacy of competitive tendering in maternity; and how the motives of NHS competitors were perceived to influence women's choices for place of birth and be implicated in increasing risk to women and babies, despite assertions by commissioners that safety was their paramount consideration.

5.4.3 Protecting the monopoly

Section 5.4.2 focused on the rhetorical arguments for and against change mobilised by different stakeholders. What was demonstrated was the use of personal anecdotal evidence from participants who work at Willow who position themselves as embedded in the local community, stating that home birth is not something either they or their social networks are seeking out.

'Genuinely I don't… see a demand for it [home birth] now, I don't see… a lobbying for it now. [I'm] a dad… who's not long gone through the whole system with his wife, erm, and of an age where a lot of my peers are going through [a] similar thing. There isn't a clammer for it, in fact for some people, for some ladies isn't it, it's the furthest thing from their mind. Why would they wanna, have it at home, they wanna come into what they perceive to be the safety of a, safety of a hospital. So, no I don't.' [**Directorate Manager, Finance, 1Aa-01**]

'So, you sort of, you're erm, you've got a bit of an uphill battle so… my mum had all of us, I'm one of four, had all of us at home. My wife's one of five, they were all born at home… but I don't know anyone whose had a home birth. I don't think any of our friends had a home birth… I know patients but, [I] don't know them… no-one has that experience and so it's not part of people's consciousness.' [**Consultant Obstetrician, 1Af-07**]

'I personally wouldn't have mine at home [laughs]. Erm, my daughter is expecting my first grandchild and I wouldn't want her to have one, a home birth…' [**AU Senior Midwife, 1Ah-09**]

In contrast, it was evident from interviews with CMs that they believed the alternative provider was replacing Willow's pre-eminence as the provider of home birth locally.

> *'…[the alternative provider] put out that they are a home birth service and we've had girls [pregnant women in Willow] say to us, 'I've been going to [the alternative provider] because they'll deliver me at home', and you go 'yeah well we'll deliver you at home if that's what you want'. They don't see us as being a provider of home deliveries and yet we always have been… [the alternative provider is] much better with their marketing. Because we're midwives, we're not marketers you know, we don't, we've tried and tried to get some kind of leaflet to promote our service because of [the alternative provider]… there was an incident a couple of weeks back [where] there was erm, an open day… and the person that was organising it got in touch with our manager [at Willow] and she said, 'I just wondered if your midwives would like to come because [the alternative provider] are coming 'cause they provide the home births don't they in this area', and [our manager] said 'we provide the home births in this area as well'.* [**Locality Coordinator, Community Midwifery, 1Ad-06**]

CMs were mindful of a need to increase the visibility of Willow's home birth service, but as can be seen in the above quote, there was an inertia within Willow to create promotional leaflets for their service. Participants went on to demonstrate how they were attempting to push back against the perceived threats from competitors.

> `*So [the alternative provider] do go out and we feel that they poach [pregnant] women [from Willow]. Yeah, they, they have like coffee mornings in different areas and different things, and they stand outside ASDA with leaflets giving them out.'*
> [**Locality Coordinator, Community Midwifery, 1Ad-06**]

> *'… they have all these baby shows on… We've been to those. Now we wouldn't have dreamt of advertising our services [in the past]. We wouldn't have needed to, but we are now. Actually, we have got to get out there and we've got to sell ourselves.'*
> [**Locality Coordinator, Community Midwifery, 1Ad-18**]

In addition, participants were aware that a local reconfiguration of NHS maternity services was on the horizon and that neighbouring NHS Trusts were now encroaching on each other's territories to promote their services to women across their borders. In this extract, moves by a large neighbouring NHS Trust that took out a four-page advert in Willow's local newspaper was regarded as an 'aggressive' move.

> *'…the NHS is confusing, because we've got all these competitors, and Joe Public doesn't really, doesn't give a monkey's about that… but it just adds confusion, so…last year, [a neighbouring NHS Trust] took out a four page [advert], you know [in] the local paper… So incredibly aggressive… so you don't really need your neighbour you know, confusing the… patients.'* [**Consultant Obstetrician, 1Af-07**]

In order to protect their incumbent position as the leading provider of maternity care in the Willow locality, Willow had taken to using social media, in this case Facebook, to network and market their services to the local population.

> *'Facebook. Social media is phenomenal these days I find… we deliberately set up a Facebook site up erm, so that any we could show our service… that's how people communicate now isn't it through Facebook?... there was a bit of a business element behind it in as much as it's, it's free, it's an advert for us… we get likes, you know, from their families their friends, they'll be looking on our website.'* [**Directorate Manager, Finance, 1Aa-01**]

Equally, Willow described having a strategy not to turn any woman away from their service, even if they were accessing care from another provider. There was a recognition that the Willow's AU would be regarded as the default maternity service in the locality and that this presented a challenge in terms of claiming tariff payments. However, while managers at Willow saw these interactions as opportunities to showcase their quality of their service to women who had not chosen them as their main provider of maternity care, the frontline CMs were discouraging to any women seeking to transfer their care.

> *'I mean we never turn anyone away, ever. So, you know the message I always give to the midwives, and they get it is, you know, 'don't bother if someone comes from another provider and you've not heard of them [the pregnant woman]. Doesn't matter. You just treat them as you would anyone, treat them as safely, you know, and as best you can.'* [**Directorate Manager, Finance, 1Aa-01**]
>
> *'…we would never just say sorry we're not seeing you, sometimes they [pregnant women] say… they want to come and transfer their care, and we've learned because you'd think we'd say, oh yeah come back to us, we don't… we don't want to do one postnatal visit on somebody, because we don't get the money for that, and it's, it's a load of hassle.'* [**Locality Coordinator, Community Midwifery, 1Ad-05**]
>
> *'and if… we've booked them, we've sorted their home birth, and we've told them about the on-call and they say, 'oh, I'm going to [the alternative provider] because erm, they can guarantee me the same midwife'. 'Well no, you're thirty seven weeks now, you won't know her, will you? So, what does it matter who comes out from there?'* [**Locality Coordinator, Community Midwifery, 1Ad-05**]

Ultimately, the prevailing feeling among Willow's participants were that competition would not be a long-lasting phenomenon in Willow's locality. Participants suggested that women accessing an alternative provider was simple curiosity and that if Willow did nothing, women will return to them naturally.

> *'…the analogy I always use is, do you remember… there was Coca Cola and New Coke? Everyone tried New Coke, cause it's like 'oh it's new, I'll try it'. People try it, sales of New Coke go up, people don't like it, and now it's, it's disappeared. If there's an alternative to anything… it's human nature… your users changes slightly… but just come back to what [they're] used to. And I think it's similar in what we've experienced in maternity in as much as there's an alternative provider a generation try it, fine okay it was great, yeah, good, bad, no real difference, novelty wears off, let's just go back to what we were used to.'* [**Directorate Manager, Finance, 1Aa-01**]

What this section has demonstrated is that CMs working at the frontline perceived subtle, but worrying changes among Willow's service users.

These CMs believed there was a necessity to improve their marketing strategies to maintain their visibility as a viable home birth service provider. However, managers at Willow demonstrated some complacency and sought to disengage with the concept of competition, assuming that 'brand loyalty' to the NHS would prevail and that any effort expended on marketing would be wasteful or counter-productive. Indeed, the idea that competition was a 'flash in the pan' was reinforced by their own personal networks who they observed were disinclined towards choosing home as a place of birth.

5.4.4 Summary

This section has explored the theme of competition and conflict in relation to home birth provision in Willow's locality by examining participant accounts around their strategies used to engage with the commissioning environment. Ultimately, Willow sought out ways that would re-capture the whole maternity care market to re-establish their monopoly. In terms of the rhetorical arguments against competition, participants from Willow consciously denied the stated motives of commissioners to procure an alternative provider, suggesting ulterior motives that were financially and politically driven, and remained adamant that the local population did not want home birth as they were perfectly satisfied with the AU and MLU provision at Willow. The arguments proposed against alternative providers were that this involved the introduction of a service that they judged to be staffed by midwives lacking in suitable experience and was therefore unsafe for women to use. In contrast, Willow were happy to work with another private midwifery provider and allowed their midwives to provide care to women in the AMLU as there was a financial benefit for Willow in this arrangement. Ultimately, the same arrangement was not extended to the alternative provider as they would not agree to a similar financial arrangement with Willow – arguably forcing women who wanted continuity of carer to consider a home birth when this may not have been recommended from a risk perspective by the alternative provider.

Willow's CMs perceived that service users were no longer regarding Willow as the default provider of home birth care. However, despite early strategic anxiety from service managers that competition posed a significant threat to Willow, this had not materialised over the preceding three years of the contract. Ultimately, Willow had assessed that its core activity in their centralised service was unthreatened and therefore only limited practical effort was undertaken to resist the coexistence of their competitor in the form of submitting a bid for the contract put out for procurement by commissioners.

5.5 Discussion

5.5.1 Data findings

The data presented has explained how significant events have presented actual or potential threats to the dissipation of home birth provision at Willow. This particular case study presented an opportunity to explore the antecedents for the deinstitutionalisation of home birth, given that home birth had remained below the national average in Willow for over 20 years. Two main themes emerged within the data. The first involved the tensions caused by efforts to maintain the status quo at Willow by concentrating intrapartum care delivery in the hospital environment, rather than expanding it to the home environment. The second was how this was met with resistance from commissioners and ultimately created an opportunity for an alternative provider to move into Willow's territory.

Perceptions that there was unmet demand among the local population for home birth was resisted by many provider participants in Willow. However, this was contested by some commissioners who sought to increase supply through a competitive tendering process. The legitimacy of extending the option of home birth was disputed by provider participants at Willow on financial and safety grounds. Hostility to those within organisations involved in extending home birth provision was evident in the data collected during interviews with participants.

There was consistency in the accounts from all layers of the organisation that home birth was an eroded service at Willow, and there was a lack of evidence that individuals demonstrated significant practical commitment to increase supply. In addition, Willow appeared to perceive that their workforce was not prepared to work in new models of care that would expand this option within their organisation.

The home birth service at Willow was extremely fragile and its continued success less inevitable given the antecedents for dissipation than the participants in this study may be aware of. Perceived threats to the organisation of maternity services in the region and uncertainty around closures of units had created a siege mentality, and defensive and somewhat conspiratorial postures. Interestingly, during interviews participants from Willow revealed that they had been told not to talk about the alternative provider and when doing so, checked with me that the interviews would remain confidential and could not be traced back to them as individuals. This might have been related to suggestions being made that the alternative provider was coercing women to have home births; or 'gossiping' about the alternative providers' leadership credentials; or the qualifications and competence of their midwives and service; or suggestions that the certain individuals in commissioning organisations were unscrupulous.

The degree to which home birth enjoys a shared understanding of it as a legitimate practice is contingent on macro-level support in terms of national policy from NHS England and NICE; at the micro- and meso-levels in terms of local performance and delivery, particularly in terms of quality and safety. Allied to this is the necessity for CMs to be embedded within organisational structures that strengthen their confidence, and competence to support and facilitate home births. Finally, participants felt that this comes down to the service users needing to feel confident that Willow have an infrastructure that will

guarantee support for their choice. If CMs have the freedom to exercise more autonomy and control over their work, and that they have organisational support and confidence, they are likely to be more inclined to provide informed choice that maintains a pipeline of women interested in birthing at home.

To a large degree the medical personnel at Willow appeared to be unwilling to accept home birth as a reasonable or legitimate choice for local women. Despite this, home birth has not ceased to have a value or utility for some of its custodians at Willow (the CMs and the service users). However, with changing workforce demographics we see that seeking to balance work and personal life commitments in a more equitable way has meant that midwives are thought to be less inclined to seek out employment that demands lone working, long or unsociable hours – that are explicit in the CM role. At Willow, senior midwives displayed some dissonance around home birth; on one hand they said they supported it, but at others they said they would not want it for their own families and gave examples of being involved in incidents which had made them feel very differently about the risks involved. If the leaders are paying lip-service to the concept of home birth, the midwifery workforce is then acculturated to see the pathological potential of childbirth by working predominantly in a medical model of care.

5.5.2 Positioning Willow in the literature

The foundation building block of institutional theory is the concept of institutions, which can be understood as enduring social patterns that go through periods of change and stability (Zietsma & Lawrence, 2010). Maintaining institutions is thought to involve work that reinforces established patterns of behaviour to strengthen and preserve their legitimacy (Lawrence et al., 2009). At Willow, a significant period of challenge from commissioners and alternative maternity care providers created conditions that resulted in a range of defensive activities and

behaviours associated with protecting Willow's position as the dominant incumbent provider of maternity service in their locality. Willow sought to position themselves as a service that was safe and provided high quality care in contrast to new market entrants. To do this, they sought to establish that their acute unit (AU) and alongside midwife-led care unit (AMLU) were superior options to home birth provision. Indeed, they emphasised that their medically-led, high-technology provision was their unique selling point (USP) that could not be matched by the alternative providers. This establishes how strengthening the legitimacy of institutional birth on the grounds of safety minimisation, contributed to the accelerated erosion and de-institutionalisation of home birth provided by Willow.

The theory of institutional work seeks to focus on understanding how intentional actions, some nearly invisible and mundane such as adaptations, compromises and adjustments affect institutions. In response to national policy drivers, local commissioners at this case site sought to create more choice for local women by tendering a contract that opened a market for alternative providers to offer more plurality, particularly around continuity of carer and consequently home birth. Service provider participants at Willow consistently articulated incredulity that the local population were interested in home birth and regarded the commissioners' actions as introducing clinical risk to the local population, and financial risk to Willow as an organisation. Early in the commissioning cycle, Willow took a defensive posture towards competition, and sought to diminish and discredit the clinical activities and the business model of one of their competitor providers. When this alternative provider's contract came up for renewal, Willow bid in partnership with another community NHS Trust for the contract – essentially, Willow sought to recapture all contracted activity and regain their status as the sole provider of maternity services in their locality.

Oliver (1992b) defines deinstitutionalisation as 'the process by which legitimacy for an established or institutionally organised practice erodes and discontinues' (p.564). However, Dacin and Dacin (2008) have modelled the gradual deterioration of practices as being moderated by entropy and inertial pressures. Unlike the other two case sites in this study – Sycamore and Oak – there was little evidence in the data collected that either community midwives (CMs) or clinical leaders at Willow were actively motivated to expand the home birth service. Indeed, the long-term consequences of the 'business as usual' of a small yet stable numbers of home births annually at Willow, had led to diminished confidence of all stakeholders in an ability to provide home birth as a practicable choice. While it will be argued that commissioners undertook some countervailing activities to increase the choice of place of birth for women locally, provider participants at Willow disagreed with the commissioner assessment of the population's needs, and continued to prioritise the centralised AU and AMLU services in order to maintain the status-quo. The entropy and inertia at Willow combined with the entrance of a non-NHS competitor achieving an increase in the uptake of home births has led to an consistent pressure for deinstitutionalisation at Willow.

Ultimately, there is little consensus regarding the strategies and dynamics of how institutional forms and practices, such as home birth, fall into disuse. Explanations such as opportunistic destabilisation, lack of innovation, natural erosion, or a combination of these and other factors will be implicated in deinstitutionalisation. However, through this theoretical lens I have sought to understand and explain the sustained rate of erosion of home birth at Willow, an NHS service where home birth rates have persistently remained below the national average for over 20 years.

5.6 Summary

This chapter has identified how home birth became deprioritised and eroded at Willow. There are forces and mechanisms that resist the total erosion and extinction of home birth in this locality, such as the presence of commissioners, an alternative provider and a private provider that offer all-risk women a choice of place of birth alongside Willow. There are continuing expectations from commissioners that maternity providers deliver on the metrics for safety and choice as part of the Maternity Transformation Programme, which has been widely resisted by leadership at NHS provider Trusts.

5.7 Conclusion

The legitimacy of Willow's home birth provision has become vulnerable as its utility has become re-evaluated and has fallen into disfavour. The demands of commissioners to expand continuity models of care was greeted with scepticism at Willow as community midwifery had become a 'Cinderella service' that was hard to recruit to, and where home birth had become regarded as a service provided to a vanishing minority of service users. Finally, home birth had been deprioritised in favour of the birth taking place in a centralised institutional setting at Willow. A paradigm shift would be required to resist the complete deinstitutionalisation of home birth at Willow that would involve significantly rebuilding organisational and multi-professional confidence and capacity to extend the service to more of the local population.

To a large degree the service leaders at Willow appear to regard home birth as an unnecessary and awkward service to deliver, but as long as it did not threaten the resources of the AU and AMLU, service leaders would continue to tolerate it. Some CMs at Willow have continued to remain committed to home birth as a concept, however they are a dwindling force of custodians that are willing and confident to promote home birth.

6.0 Sycamore

6.1 Introduction

6.1.0 Chapter overview

This chapter begins by describing the background, context and participants for Sycamore – the research site explored in this chapter – and explaining the rationale for its inclusion in this study to address the three primary research questions. It will then proceed to explore three themes that emerged from the data analysis of the case site, principally from interviews with non-service users, documents and journal notes and situate this within the extant literature to discuss the degree to which the findings both align with, and extend understandings.

6.1.1 Justification for inclusion of Sycamore in this study

Sycamore was chosen for inclusion in this study because it had a higher than average home birth rate when compared regionally and nationally [see **Table 15** and **Figure 9**]. In addition, while Sycamore is located in a different part of England to Willow (see Chapter Five) – they are remarkably similar in terms of population demographics, birth rates and organisational structures. This presented an opportunity to perform cross-case comparisons to test theories of deinstitutionalisation.

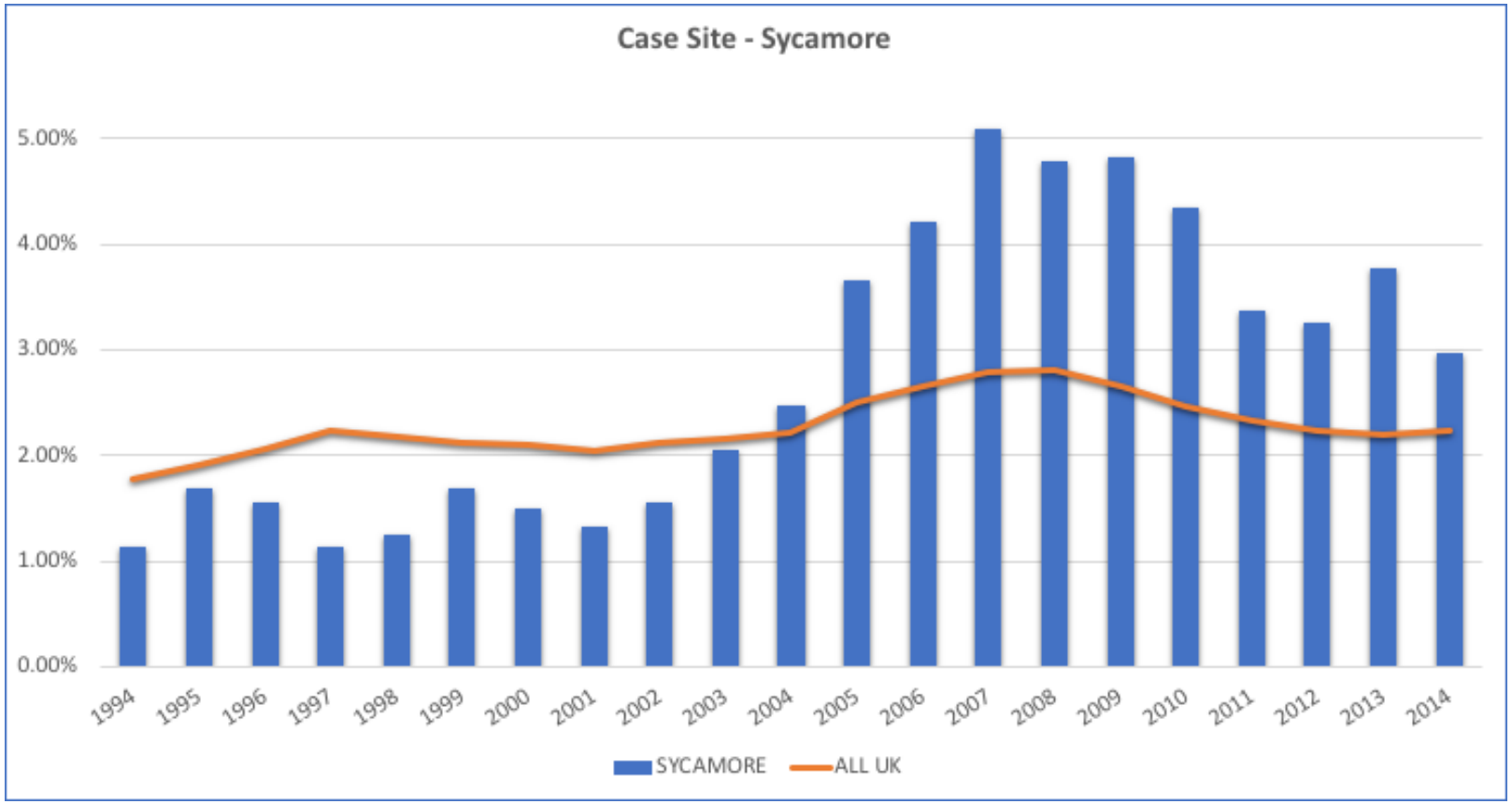
In 2014-15 there were 3,429 births at Sycamore. All were born at the IU except 154 (4.5%) that were born at home, and 27 (0.79%) that were born before arrival (BBA). A BBA refers to a baby that is either born before arrival at the hospital, or before the attendance of a health professional i.e. a CM or ambulance crew. BBAs are unexpected and unplanned emergencies and are counted separately to planned home births.

Table 15: Descriptive statistics of overall birth and homebirth for Sycamore against regional and national performance for period 2014-2015. (Health and Social Care Information Centre, 2015; Kuypers, 2015)

	Births	Planned home births
Sycamore	3,429	154 (4.5%)
Regional	37,837	534 (1.4%)
National	636,643	14,643 (2.3%)

Figure 9 demonstrates that Sycamore performed above the national average for home births since 2004. From 2007 there is a declining trend where the number of women giving birth at home with Sycamore fell, but Sycamore continued to perform above the national average. To some degree, participants in this study attributed increasing home birth trends at Sycamore to the presence of a community manager who actively encouraged CMs to book women for home births; and the falling trend in home birth to that manager leaving Sycamore and the opening of the appealing new maternity unit that was part of the PFI. I became aware that the performance data compiled at an organisational level for NHS England [**Table 15**] differed from data compiled by the Office of National Statistics (ONS) at a commissioning level based on populations [**Figure 9**] as the boundaries are not coterminous.

Figure 9: Percentage of home births for Sycamore (based on the demographic statistics compiled for the two primary commissioning groups by The Office of National Statistics) between 1994-2014 [bars] compared with national average over the same period [line] (Kuypers, 2015; Office for National Statistics, 2016).



6.1.2 Case description of Sycamore: Background and context

Sycamore is one of the main hospital Trusts that provide acute healthcare services to approximately 420,000 people across three counties in England. It was formed in 2001 and achieved Foundation Trust status in 2007. It employs around 4,500 staff across three hospital sites, of which, around 40-45 are community midwives (CMs). CMs at Sycamore usually have at least 12-24 months' post-registration experience of working as a midwife in the acute setting before working as a CM in the community setting.

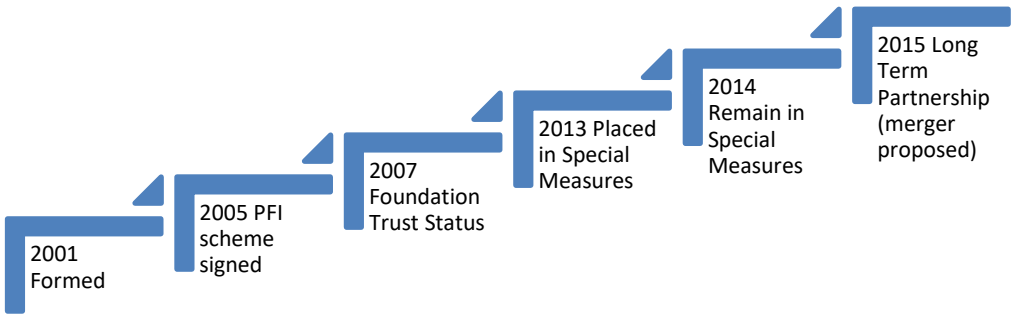
There is one principle site where intrapartum care is provided to over 3,000 women each year. This is an integrated maternity care unit (IU) staffed by a multi-professional team, which includes midwives, obstetricians, anaesthetists and neonatologists. Facilities include an antenatal/postnatal ward and clinics, the IU that can support vaginal, instrumental and caesarean births, and a neonatal intensive care unit. CMs at Sycamore predominantly provide care in primary care settings, such as health centres, GP surgeries and visiting women at home.

Two significant threats have impacted on maternity services at Sycamore which provide the context for this chapter. The first was an exogenous threat associated with regulatory and enforcement action against Sycamore, and more recently the maternity service. The second was an endogenous threat to the home birth service that has required reorganisation of the out-of-hours home birth service (the 'on call') provided by CMs at Sycamore.

At the time of data collection, Sycamore was an NHS Foundation Trust that was in significant financial distress, in part associated with a private finance initiative (PFI) scheme signed in 2005 to build new hospital facilities that had repayment costs far exceeding the original

predicted costs. Combined with the financial pressures, Sycamore was identified as having higher than expected mortality rates in 2013 (Keogh, 2013). This led to an external review and subsequently being placed in 'special measures' by Monitor, an executive non-departmental public body of the Department of Health (now part of NHS Improvement). Where there are serious concerns about the safety and quality of care that hospitals are delivering they are placed in special measures and are required to satisfy the Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority by developing and delivering on an improvement plan, usually within 12 months. Following a comprehensive inspection in 2014, the CQC recommended Sycamore remain in special measures. In 2015, further announced and unannounced inspection visits were carried out and the CQC judged Sycamore to be 'inadequate' and that they should remain in special measures. After October 2015, Sycamore, Monitor and the CQC agreed that a Long Term Partnership (LTP) with a neighbouring NHS Trust was in the best interests of patients and staff. Action was then taken to strengthen the strategic leadership team at Sycamore and new appointments were made to the Trust's Board. At the time of data collection, a preferred partner for Sycamore had been announced and work to oversee a merger was taking place.

Figure 6, Timeline demonstrating 14-year period between formation of Sycamore and plans by regulators to dissolve it into a partnership with neighbouring NHS Trusts



Data collection for this study was undertaken between November 2015 and March 2016. This followed closely after the CQC downgraded maternity services at Sycamore from an overall rating of 'good' in 2014 to 'requires improvement' in October 2015. Although participants had understood that Sycamore was under intense financial and regulatory scrutiny, maternity services had not previously been identified by the CQC as one of the services that required a specific Quality Improvement Plan (QIP). The CQC found that maternity services were effective and caring, but that they required improvement in the three domains of safety, responsiveness and leadership. Sycamore subsequently developed QIP work streams which included:

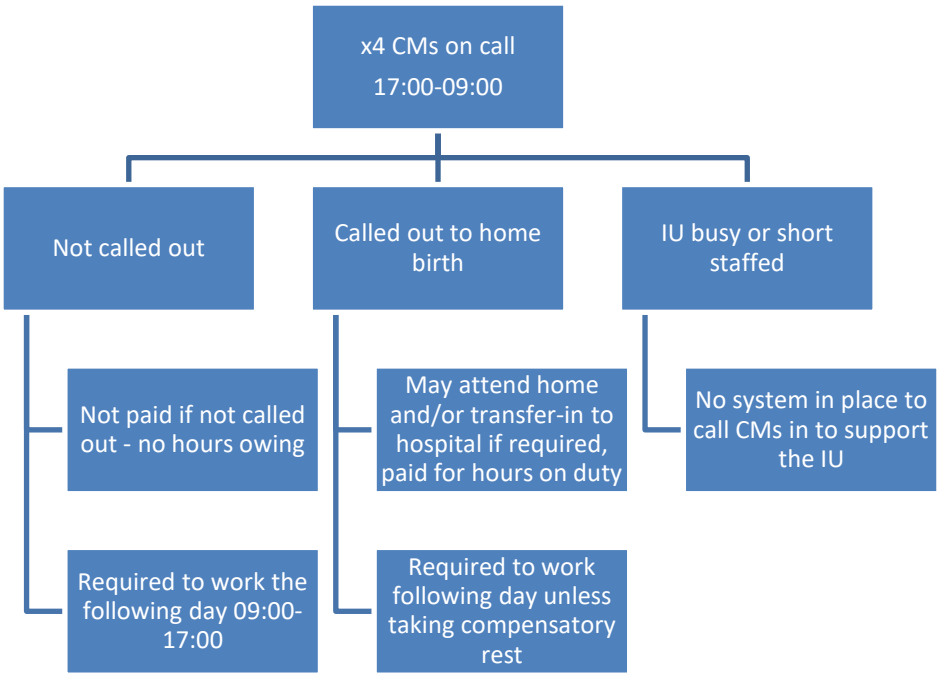
- Ensure that the model of care follows the best practice and is fit for purpose for the local population;
- Ensure that the management structure is appropriately set up to enable multidisciplinary working and swift actions to be taken to identify and mitigate risks;
- Establish clear governance processes which are part of the overall Trust systems for escalation;
- Ensure that high professional standards are maintained against best practice and national guidelines[9].

The second significant event that has informed the data analysis was the introduction of a change to the 'on call' system in 2014. CMs at Sycamore are required to support a duty rota or 'on call' that covers 24 hours per day, 365 days per year. Sycamore identified that it was non-compliant with the Working Time (Amendment) Regulations 2003, commonly referred to as the European Working Time Directive (EWTD) which was introduced to prevent employers compelling their workforce to work excessively long hours.

[9] No reference provided to preserve anonymity.

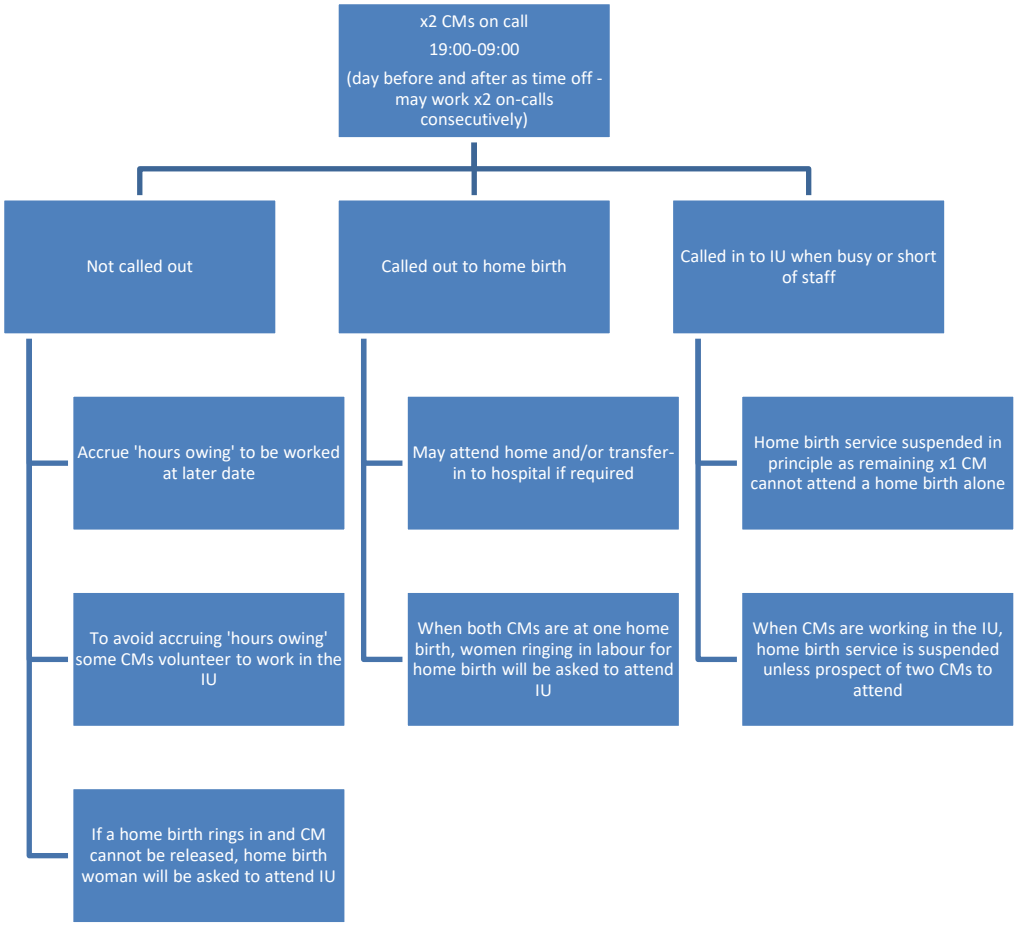
Before the change to the 'on call', four midwives who had worked 09:00-17:00 during the daytime, would then be 'on call' between 17:00-09:00 every night to attend any women in labour at home [**Figure 7**]. CMs would only be paid for the hours they worked 'on call' if they were called out to provide care. This system was designed so that two midwives could attend each birth if necessary. The CMs would usually also be scheduled to work the day after their 'on call', although if the CM had been called out overnight, they would be expected to assess their ability to continue to work the following day and may be given 'compensatory rest'. CMs were rostered to be 'on call' about four times per month – which was in addition to their contracted hours – although they would be given 'time off in lieu' or paid for hours worked 'on call' above their contracted hours. This system is referred to as a 'traditional on call' in the discussion below.

Figure 7: Traditional on-call system up to 2014



The new 'on call' system that was introduced in 2014 [**Figure 8**] had two, instead of four midwives 'on call' each night. The CMs would be paid to be 'on call' from 19:00 to 09:00, even if they were not called out, and would be given the day before and the day after off duty. If the midwife was not called out to work during her 'on call' period, she would accrue hours and be required to work them at another time as they were 'owed' to Sycamore. Depending on their contracted hours, CMs may work two 'on calls' on consecutive nights. This system will be referred to as the 'new 'on call' in the discussion below. The impact that the new 'on call' had on Trust and inter-professional relationships and behaviours is explored in this chapter.

Figure 8: New on-call system from 2014



In this section I have outlined two perceived threats that this study has identified as implicated in the diminishing home birth rate at Sycamore. The first involved the exogenous threat of regulatory actions against Sycamore; the second was an endogenous threat posed by adaptions made locally to address a change in the law regarding working hours. These threats have been used as the focus for thematic analysis.

6.1.3 Participants

This chapter presents data from interviews conducted with participants recruited for Sycamore. **Table 16** describes the 22 participants that were consented to this study for Sycamore; 16 were categorised as non-service users (employees of provider or commissioner organisations); and 6 were classified as service-users (women who had given birth at home supported by CMs from Sycamore). The data presented in this chapter is from individuals who self-identified as

having responsibility, authority or expertise relating to intrapartum care – that includes the home birth service – at Sycamore. This chapter does not present data from the service users or the Ambulance Service at Sycamore. As described in section 5.1.3, decisions about the unit of analysis for this study were made once my conceptual framework began to emerge. As previously discussed, I felt that the most coherent telling of the data came through a case site approach, rather than grouping stakeholders from across all three case sites together.

Table 16: Participants recruited for interviews and focus groups in Sycamore

Case Site	Sycamore
Clinical Commissioning Groups (CCGs)	2 = (Head of Patient Safety, GP Clinical Advisor)
Service Leaders	4 = Senior Midwife (Labour Suite), Senior Midwife (Inpatient Service), Senior Midwife (Community), Finance & Performance Manager
Midwives	4 = Community Midwives
Consultant Obstetricians	2
Consultant Neonatologist	1
Ambulance	1 = Senior Paramedic
Local Supervising Authority Midwifery Officer	1
Service Users	6 = women who have given birth at home
Others (National)	1
Totals	**22 participants**

6.1.4 Addressing the research questions

This study's three research questions are addressed in this chapter:

> **RQ1**: What strategies are used by service leaders to identify new institutional opportunities for change?
> **RQ2**: How are the rhetorical arguments for and against change mobilised by stakeholders?
> **RQ3**: How do stakeholders utilise additional social networks to implement change?

In addressing these questions, consideration was given to the ways that different stakeholders discussed institutional changes (RQ1).

Sycamore's leadership were immersed in delivering a QIP that sought to assure regulators and commissioners that maternity services were safe, effective, caring, responsive and well-led. This chapter demonstrates what happened with a service provided by a non-dominant professional group (midwives) to a minority of service users (less than 5% of pregnant women) in the presence of organisational crises and institutional pressures at Sycamore.

In assessing rhetorical arguments for and against change (RQ2), this chapter focused on the agendas and discourses around safety and risk minimalisation that were apparent at Sycamore. In particular it will focus on how maternity managers justified changes to the CM on-call system as necessary to achieve compliance with the EWTD and to create safer working conditions for CMs. This was contrasted with how this was received by the CM workforce, as diminishing their capacity to maintain the home birth service and their professional autonomy.

Legitimacy contests associated with maintaining and transforming the maternity service at Sycamore resulted in competing narratives from external and internal structures. An unforeseen consequence of focusing on delivering assurance that maternity services were both safe and financially viable was that the escalation processes to support institutional birth led to home births being suspended when CMs were called to work in the IU. This led to perceptions that the plurality of choice for place of birth at Sycamore was being eroded. In practice, some CMs undertook countervailing activities aimed at maintaining home birth as a choice for local women.

The analysis for Sycamore focuses on participant accounts located across the following three themes in the data:

- Regulatory scrutiny and service change (section 6.2)
- Organisational priorities and choice (section 6.3)

- Countervailing activity and inertia (section 6.4)

The data presented demonstrates how service change relating to the home birth service at Sycamore was reactive, rather than proactive. In response to regulatory scrutiny and the necessity to demonstrate a safe maternity service at Sycamore, service leaders adjusted the CM workforce on-call. The CM's were regarded as a valuable and complimentary workforce resource for the IU, and home birth did not surface as a threat to the core activity of the IU. However, by creating an escalation policy that was seen to strengthen the priority given to institutional birth over home birth, the managers at Sycamore may have contributed to the erosion of the home birth provision at Sycamore.

Intentional modifications were made to the CM on-call rota that meant the CM workforce contribution to the IU pressures was maximised. Participants not involved in the delivery of home birth care articulated an ambivalence towards offering it to women as a choice, perceiving that it introduced complexity and risk to the wider maternity service at Sycamore that could lead to compromising the safety of care being delivered in the IU. The managers articulated their justification for introducing the new on-call system as the need to comply with EU legislation and to create safer working conditions for CMs. However, CM participants reported that the consequence of this service adaptation was that less CMs were confident about promoting home birth, and women were more reluctant to opt for it if the attendance of a midwife could not be guaranteed pre-labour. In contrast, service leaders focused on the creation of a robust safety culture across the portfolio of maternity services at Sycamore and some conceded that this may lead to a higher birth rate at the IU, if service needs dictated.

The motivations of different stakeholders to implement, resist or modify changes to the home birth offer at Sycamore are presented in this chapter. A small social network that valued both the reputation and contribution of the home birth service described countervailing activities that sought to offer guarantees for some service users that a CM would be able to attend them if they opted for home birth. Attempts to resist or modify change have combined concepts of professional identify and professional power as CMs and midwifery managers strive to prevent the erosion of a profession specific service that performed above the national average.

Table 17: Research questions mapped to themes and sub-themes (numbers correspond to chapter sub-sections)

		Research Questions		
		What strategies are used by service leaders to identify new institutional opportunities for change? (RQ1)	**How are the rhetorical arguments for and against change mobilised by stakeholders? (RQ2)**	**How do stakeholders utilise additional social networks to implement change? (RQ3)**
Themes	**6.2 Regulatory scrutiny and service change**	6.2.0 Scrutiny and perceived failures	6.2.1 Communication issues	6.2.2 Staff response and morale
		← Theory of deinstitutionalisation →		
	6.3 Organisational priorities and choice	6.3.0 Responding to staffing issues	6.3.1 Impact at service level on home birth	6.3.2 Erosion of home birth
		← Theory of deinstitutionalisation →		
	6.4 Countervailing activities and inertia	6.4.0 Complementarity of CM workforce	6.4.1 Complacency and inertia	6.4.2 Protecting the home birth service through stealth
		← Theory of deinstitutionalisation →		

6.2 Regulatory scrutiny and service change

This section focuses on reactions within Sycamore to the scrutiny from regulators and commissioners. It shows how criticisms of the Board led to an erosion of confidence and trust through different layers of the organisation. Sycamore's reputation was perceived to have been damaged by failures identified by regulators and subsequently being

placed in special measures. The Board challenged individual services more rigorously and this meant that service leaders felt less able to reassure the Board that they were safe and well-led. This in turn impacted on how service leaders interacted with frontline staff. The public perception and confidence in care provided by Sycamore was felt to have been damaged by the level of scrutiny that Sycamore was under. This impacted on the confidence and morale of staff, and a general sense of uncertainty about the future of maternity services, including home birth services.

6.2.0 Scrutiny and perceived failures

All participants at Sycamore discussed regulator involvement and were aware there were long standing concerns about the capabilities of the Board. Participants were also aware of a significant amount of staff churn at the executive leadership level.

> *'We found the executive leaders in the Trust were not always sighted on the risks that we had identified, or where they had, they did not consider them to be significant. Evidence presented to us demonstrated how the Trust had received assurance that was not presented accurately which meant a false picture was being presented to the Trust Board.'* [**Excerpt from CQC report, 2015**]

Consequently, the strengthening of the Trust Board resulted in increasing demands for accountability and assurances at service level. Participants questioned the Board's allegiances and believed external influences were diminishing the level of confidence the Board could express in the maternity services. This was regarded by participants as contributing to a frustrating deterioration in the relationship between maternity services and the Board, commissioners and regulators.

> *'The Trust Board... are also, I think, getting some pressure from the commissioners… and they're [CCG] wanting assurance from the Trust Board, who are then seeking assurance from us [Maternity], that there aren't any developing themes and trends… I don't know where they're [Trust Board] aligning*

> *themselves, whether… they're aligning themselves alongside the commissioners and saying 'well they're not assured, so we're not assured' or 'we're not so they're not.'… the CQC are almost an external force that are driving it all.'* [**Consultant Obstetrician 2Hf-07**]

As part of Sycamore's remedial action plan, maternity services had been reorganised into a new directorate. Previously, maternity had been represented at Board by a general surgeon who they understood to have no expertise in obstetrics or paediatrics. This was articulated by participants as contributing to maternity's historic lack of visibility with the Board and cited as a factor in the erosion of trust between the Board and maternity services.

> *'…from the CQC report, we've [Maternity] been categorised overall as inadequate and I think maternity services have been singled out as a specialist area that needs a lot of intensive support to move forward. But a lot of that has come out of a misunderstanding of what we do because we've never had that ear to Board… We've been packed into an incredibly busy division, Planned Care and Surgery, where the agendas are massive… so a lot of our day-to-day concerns and business was either discussed in a very small way or not addressed at all… the frustration for maternity service is that they [Trust Board] don't understand what we do… you have to have that trusting relationship at Trust Board level which we haven't been able to achieve…'* [**Senior Midwife, 2Hh-01**]

> *'[The Board asking] 'are we another Morecambe Bay?[10]'… that phrase… is the one that makes me want to dive for the nearest brick wall and bang my head off it. Because it is just so frustrating that there is this absolute lack of understanding.'* [**Consultant Obstetrician, 2Hf-07**]

In the new structures that had come into place as data collection for this study commenced, Maternity was going to be represented by a paediatrician at the Trust Board.

> *'I think our voice won't be lost in quite the same way as it was before when we had a general surgeon… It's [Maternity] not*

[10] Referring to the Report of the Morecambe Bay Investigation (Kirkup, 2015).

important to a general surgeon. He's never worked in maternity, so it's not so much of a thing that he can embrace. Whereas somebody who looks after children and closely works with us, they know the importance.'[**Consultant Obstetrician, 2Hf-10**]

The scrutiny of maternity services at Sycamore was perceived to be stifling for service leaders. No longer did they feel they had the mandate to be proactive with service change, but instead found themselves stymied by the need to address the QIP.

'…whilst you're in a reactive phase [with the QIP], you struggle to get into the proactive phase… So, you know, whenever you're scrutinising, auditing, responding, investigating, you can't move that one step forward into something that proactively would be preventative…'[**Senior Midwife, 2Hh-01**]

'we don't have control in terms of the agenda items that we want to propose just at the moment. So, we are very much answering queries and concerns and trying to assure both the commissioners and the CQC and our own Trust Board to an extent, that what we're providing is a safe and demonstrably good service.'[**Consultant Obstetrician, 2Hf-07**]

In addressing the QIP, service leaders were also brought into conflict with the finance specialists at Sycamore, who had their own improvement plan to manage the Trust's financial deficit position more effectively. This meant that the reality for service leaders in Maternity was that there was no blank cheque to deliver the recommended quality improvements.

'…[the CQC has] changed the priorities but it's probably rightly changed. I mean we can't really argue with that … we've got to come out of CQC… we need to improve that quality, make it financially viable… we've got to do quality in a business way… but I don't think anyone was saying you do it at all costs… if we hit the national guidance in Maternity for every box, does that mean we bring far more business into the hospital and therefore generate the income? Because if we don't, it's what quality gets us above the bar, not just hitting this gold standard… I think we've all got focused on quality to such an extent that we're probably looking at something

that we just can't afford.' [**Finance & Performance Manager, 2Ha-08**]

Maternity leaders portrayed their service as somewhat encircled by external forces i.e. CQC, CCG and from a lack of advocacy at Board level. They also described feeling constrained by the Trust's financial distress which moderated opportunities to change their service.

6.2.1 Communication issues

For those with leadership roles in maternity, the regulatory scrutiny was felt to be damaging for both public and staff confidence in the service. Participants framed the inspection outcome as entirely unexpected and at the extreme 'a betrayal' [Community Midwife 2Hl-05] by the CQC inspection team.

> *'The CQC report has been a real body blow to us actually, it's knocked us all for six and everybody is so upset, especially the maternity unit.'* [**Senior Midwife, 2Hd-04**]

Participants were questioning how their professional standards and those of the Maternity service could have deteriorated without realising it themselves.

> *'…we were rated as good when they [CQC] came previously. You feel 'what are we doing differently? What absolute catastrophe has happened that we're now suddenly so much worse than we were a year ago?'… We don't know what the problem is and we don't know what we're doing so differently or so badly…'* [**Consultant Obstetrician 2Hf-07**]

This same obstetrician who was in their first consultant position, went on to explain how the CQC inspection outcome had caused them to question their competence and to lose confidence in their ability to lead the service.

> *'And it's dreadful for the staff on the floor… when we're [managers] feeding back we don't feel as though we can give them [the staff] reassurance to say 'No, no, no, you're doing fine'… I can't feel assured that I'm doing the right thing or*

leading people in the right direction.' [**Consultant Obstetrician, 2Hf-07**]

In relation to the home birth service, service leaders were struggling to understand the CQC comments that they should improve the home birth service. Several participants highlighted how Sycamore had home birth rates in excess of the national average and how the failure of the CQC to acknowledge that was frustrating and disheartening. The senior midwife for community midwifery [participant 2Hd-04] was particularly frustrated by remarks made by the CQC that Sycamore had failed to meet their target for home births, when she was adamant that the service had never set themselves a specific target.

> *'…the CQC have said that we require improvement… one of the things was about home birth, they said that we don't meet the quota, but we've never put a quota. So, I don't know… we haven't got a target… how have we not met a target? And actually, our home birth rate is higher than anybody locally.'* [**Senior Midwife, 2Hd-04**]

Further, the CQC inspection had challenged the service leaders to reconfigure services to offer a wider portfolio that included an alongside midwifery-led unit (AMLU). However, birth in the IU was the default for the majority of service users at Sycamore. This meant that service leaders tended to articulate a desire to strengthen and maintain this core element. A consultant obstetrician perceived the potential for more services to be led by midwives as presenting a destabilising threat to the status quo.

> *'…nationally the remit is that you should be able to offer [an AMLU]... Our birth choices are here in the [IU] or at home, which doesn't sound like many. I think that's the problem isn't it to a commissioner who's saying well NICE says that you should be able to have this offering of a midwifery-run unit. I'm not sure that it's necessary… I don't know if it's something that the midwives even think we need to do because we all work together so well… I mean we have not got the staff to cover the community midwifery team… and the impact that it might change on the dynamic of how care is provided… I sort of*

> *sometimes think it could be quite divisive… I think the only way you could do it really is to have really strong links between the doctors and the midwives still. And then is that a midwifery-led run unit? I don't know.'* [**Consultant Obstetrician, 2Hf-10**]

Despite rhetorical opposition from service leaders to the CQC findings, the organisational crises at Sycamore diminished their legitimacy to criticise.

> *'…whether we think it's right or not and they're [CQC] being harsh is irrelevant. We've got to deliver that agenda.'* [**Finance and Performance Manager, 2Ha-08**]

A consequence of this was that the Trust Board sought to closely control information and communication about Sycamore services, as there was a huge amount of sensitivity caused by the scrutiny they were under from regulators. This defensive posture meant that routine interaction between the Head of Midwifery and commissioners regarding service change was closely monitored. The following excerpt demonstrates how in the context of organisational crises, if the Head of Midwifery had wanted to raise service change issues beyond the QIP, it may have impacted on their professional reputation and job security.

> *'Okay, well if I'm going to be very honest, if [the Head of Midwifery] were to come to me [CCG] and say I've got a real problem with this [home birth] and I've seen this declining, I think she would get hauled over the coals… by the Board… I very much think at the moment they're [the Board] trying to control the information that comes out so that they will answer the exact question. Because they're feeling so defensive. And they [Sycamore] think because they're going to get penalised, 'are we going to get in trouble for something else?... Is this just going to uncover another problem that we're then going to have to fix?' And they're overwhelmed with the stuff that they've got to do and they wouldn't want to put anything else [in the QIP].'* [**CCG Head of Patient Safety, 2Ia-16**]

Regulatory scrutiny of Sycamore was perceived to have diminished public and staff confidence in the maternity service. This included the service leaders who sought to question the legitimacy of the CQC

recommendations for service change, suggesting that they may destabilise the 'core' function i.e. IU birth. However, sensitivities at Sycamore meant that pressure to conform and comply was exerted upon senior managers.

6.2.2 Staff response and morale

The regulatory action at Sycamore had created a great deal of uncertainty among the workforce as the long term impact on the service was still unquantified. This had the potential to impact on senior staff who questioned their own judgement and assessment of the current predicament for maternity services.

> *'And it just makes it quite demoralising… you start doubting yourself and you sort of turn to your colleagues and say 'Are we that bad? Are we just so caught up in it all? Are we absolutely blinkered in terms of what we're doing and how we're perceiving what's happening to us? Are we saying no, there aren't any themes and actually the theme is that we're just not aware?'* [**Consultant Obstetrician, 2Hf-07**]

Equally, managers were concerned that their midwifery workforce may reconsider their futures at Sycamore in terms of alternative employment or retirement options.

> *'…if you get too much pressure and scrutiny from outside… people feel a lack of confidence in [Sycamore] because something's happened and that takes a long time to heal. As a midwife… if you find yourself under scrutiny at the same time… that makes your colleagues around you feel very anxious as well.'* [**Senior Midwife, 2Hh-01**]

Services leaders acknowledged that recruitment was already problematic at Sycamore and budgetary spend on locums and agency staff was unacceptably high. Service leaders were mindful that that they were one of a number of local NHS maternity services that had rolling recruitment drives across obstetrics, midwifery and neonatology professions. The reputational damage of the regulatory scrutiny was considered a risk in terms of staff churn.

> *'…some of our key clinicians and nurses might decide 'I'll just go up the road and work for them because I'm indispensable.'*
> [**Finance and Performance Manager, 2Ha-08**]

The lack of connectivity between the Sycamore's executive and service management levels, and the lack of advocacy at Board level, meant the conditions to support service change were not fertile. Rather than staff feeling empowered to implement the QIP, they demonstrated disbelief, confusion and frustration.

6.2.3 Summary

This section has focused on reactions within Sycamore to the scrutiny from regulators and commissioners and its detrimental impact on service leaders to proactively initiate change. It has showed how criticisms of the executive leadership led to an erosion of confidence and trust in and between the different layers of the organisation at Sycamore. It has explored how a perceived lack of advocacy at Board level left service leaders feeling internally unsupported and encircled by external forces. Further, rhetorical strategies by service leaders questioned the legitimacy of the CQC recommendations on the grounds that they could lead to an erosion of the 'core' IU function and cause a destabilisation of the status quo. Rather than being a force for positive change, the CQC recommendations were met with disbelief and led to a demoralisation among the maternity workforce.

6.3 Organisational priorities and choice

This section focuses on service level changes made by senior managers in maternity services that were regarded by frontline community midwives (CMs) as contributing to the erosion of the home birth service at Sycamore. It will show how adjustments that focused on safety and escalation in maternity led to changes in the way that CMs were rostered on-call and required to contribute to alleviating clinical and staffing pressures experienced by the IU. With the background context of regulatory scrutiny covered above, risk minimalisation associated

with the care provided in the acute in-patient provision [the IU] led to home birth provision becoming vulnerable to suspension as the needs of the IU were prioritised. While managers articulated pride and confidence in home birth, CMs reporting feeling less confident about promoting it to women, and that women were increasingly less likely to choose home birth when the service was not guaranteed.

6.3.0 Responding to staffing issues

Managers and CMs had identified a number of issues with the 'traditional on-call' and seized an opportunity to address service priorities by introducing a system that was compliant with the EWTD legislation.

> *'We did used to run the system where you worked all day, then were on call, and then you were on working the next day and you were just praying that they [CMs] weren't called out because you knew that next day's diary would be scuppered… it was also dangerous, really, you know, to expect a community midwife to work all day, work all night, and then be driving a vehicle again the next day.'* [**Senior Midwife, 2Hd-04**]

> *'…I think we were told it's got to do with the European Working Time Directive. So, we could have worked all day, on ordinary shift, and then be on-call as well. So, we would have worked really too many hours.'* [**Community Midwife, 2Hl-03**]

The CMs were initially asked to work a night shift [usually 19:00-07:30] in the IU. This was the preference of service managers, but they compromised with the CMs who favoured being on-call from home instead. An unforeseen consequence of this was that due to the low numbers of home births, CMs were not always called out when rostered on-call. Therefore, they began accruing hours owing that would need to be worked at a later date.

> *'…So, they [CMs] only get paid if they get called in. Now the issue that that provides for community midwives is that unfortunately they then accrue a lot of time owing because they can't work the day after an on-call, can't work the day before an on-call.. it was their [CMs] choice that they didn't work a*

nightshift. My preference would have been that they were on a nightshift. They would come into the [IU] and they would work their nightshift… and obviously respond if there was a home birth. And I think there were two reasons they chose not. I think the first reason was because nightshifts are obviously quite a commitment and can be quite exhausting and antisocial, and the other thing I think was a fear that actually they'd get into the [IU] and then the home birth call would come and there wouldn't be the capacity to enable them to go out into the community to facilitate the home birth.' [**Senior Midwife, 2Hh-01**]

This perception that CMs feared that they would be kept in the IU, instead of being released to attend home births was frequently expressed by other participants.

'[Because of the European Working Time Directive] we had to change from working illegally, working all day and then being on-call at night… So obviously then [Sycamore] got a bit twitched and … [the managers] suggested that we would be on-call for 12 hours but we would have to go to [the IU] and be sat there in a room and then wait to be called out [to a home birth]… [the CMs thought] that we'd get on labour ward and [the managers] wouldn't release us, 'Oh yeah but we would', 'No, you wouldn't' you know. And it's terrible when you know that it's just all talk because actually, it wouldn't work.' [**Community Midwife, 2Hl-06**]

The CM workforce were not convinced that the new on-call system was about enhancing their personal safety or compliance with the EWTD. Participants expressed their suspicions that it was to achieve cost savings. The CMs saw this as being achieved by reducing the number of CMs on-call at night from four to two; consequently, increasing the home birth response times from 30 to 60 minutes. CMs regarded these changes as introducing and increasing the risks for women birthing at home.

'I think we were told it's got to do with the European Working Time Directive… but looking at it, I wonder if it was just an excuse. Because other Trusts, when you meet other midwives, they still do that kind of thing [traditional on-call] and that's like over a year after we're already doing this new [on-call]. So, I

> *was wondering if it was our 'safety', in quotation marks, or if it was just a different way of working which is more cost-effective for the Trust because obviously we've gone from four [CMs] on-call to two, we're covering a wider area. So initially we were supposed to be deployable within half-an-hour from home but now we cover up to one hour.'* [**Community Midwife, 2Hl-03**]

A further service adaptation that impacted on home birth provision was the suspension of CMs routinely rotating into the IU to work a day shift. Historically, this was to preserve their intrapartum (labour care) skills and maintain effective working relationships between the community and acute unit maternity staff. However, due to high sickness/absence and vacancy levels, this had not been possible for at least six months prior to data collection for this study.

> *'So at the moment we've not been able to do that but normally we would, we come in and do a day on the unit but with the, with the sickness levels and vacancy at the moment, we've just not been able to provide that but we're still, they're [CMs] still visible… so they're [CMs] visible on the ward and, you know, when it [the IU] is running like a train [it's busy in the IU], will… roll their sleeves up'* [**Senior Midwife, 2Hd-04**]

However, this adaptation to pressures in the CM service, appeared not to be visible to the obstetric team who still believed the CMs were rotating into the IU on regular basis and expressing a huge amount of confidence in their skills.

> *'I think [Sycamore have] a fantastic core of community midwives who are very skilled at normality and normal births but also absolutely tip-top on their emergency skills. They all come working at the hospital, they all come and do shifts and it won't be six months, nine months, a year since they've last [attended] a birth, let alone a home birth, they are really, really on top of their game.'* [**Consultant Obstetrician, 2Hf-07**]

Even though CMs were not rotating into the IU or working an on-call night shift in the IU at the time of data collection, as part of the Sycamore's 'Escalation Policy', when during times of high activity, bed shortages, or when staffing numbers fell below the agreed level, on-call

CMs would be regarded as an available resource within the service that could be called in to maintain quality care and to reduce clinical risk. In contrast to the obstetric perception of CM confidence working across community and acute settings, CMs regarded being called in during escalation as undesirable as they were seeing the IU 'at its worst' and were reluctant to be used as a flexible or reserve workforce for the IU.

> *'…when your phone rings in the middle of the night, you think, 'Oh please let it be a home birth and not calling me into the [IU]…'* [**Community Midwife, 2HI-03**]

> *'but I think it's, kind of, separated us a bit, so we did always used to be going in… whereas now we only get called in when it's going like a train, everyone's not had a break, nobody knows where they are and that's when we get called in, so we see it at its worst, maybe… So sometimes, I've been called in before just to cover people's breaks… you're running in and out of rooms to see women, it's not, it's not pleasant.'* [**Community Midwife, 2HI-05**]

> *'because of how the on-call has an impact on your days working or not working, we don't really do that [rotate in regularly to the IU] anymore. So, when you then do get called to the unit, you feel quite anxious and worried because it might have not been weeks or months since you've been in there and you don't necessarily end up with a straightforward low-risk lady. When I went in the last weekend… they said, 'Well you can have a choice. You can either have a very complex case on the Labour Suite or go to the Ward.' So, I said, 'Well I'll chicken-out then. I'll go to the Ward'… [I] had a choice, but that normally does not happen.'* [**Community Midwife, 2HI-03**]

In this section, the introduction of a new on-call system to comply with the EWTD was justified to CMs on the grounds of achieving legal compliance and improved personal safety. However, this led to some unintended consequences such as CMs resisting working their on-call in the IU at night and accruing hours owing to Sycamore due to low number of home birth call outs. CMs regarded the new on-call as inferior to the traditional on-call and regarded it as motivated by a cost saving agenda at the expense of safety. CMs were no longer rotating into the IU routinely, and this was leading to deskilling and erosion of

confidence, in part, due to how the IU were deploying the CMs that were on-call. However, due to staff shortages, CMs were now part of the escalation policy at Sycamore and were being called to provide care when on-call in the IU. This led to the potential for CMs becoming unavailable to attend planned home births.

6.3.1 Impact at service level on home birth

The tension between the necessity to ensure the IU had appropriate staffing to maintain the safety of women and babies, and ensuring that women who had chosen to birth at home could still be confident that a midwife would be available to attend her, was a primary concern for senior midwives overseeing community midwifery. For this senior midwife, maintaining a viable on-call rota to support women's choice to birth at home was essential. Note here that they say home birth has not been suspended; this is contradicted by CMs which is presented later in this chapter.

> '*…for me, is just making sure that my on calls are covered and, so that I'm not having to suspend the home birth, and touch wood, we've not had to suspend the home birth, but that for me is what I'm concerned about is to make sure that we've always got cover and the woman's wishes are actually fulfilled and she does get the home birth that she's requested.'* [**Senior Midwife, 2Hd-04**]

We see in the quote above that providing women with *choice* is a rhetorical device used by senior midwives to avoid suspension of home birth provision at Sycamore. Further, we see that senior midwives frame home birth as maintaining *safety* for women receiving care in the IU. They do this by suggesting that when all intrapartum care is condensed into the IU, this does not guarantee the safety of women and babies.

> '*… because [home birth] is such an integrated part of the service, we work very hard to keep it going and at times, you know, when activity in [the IU] is through the roof and we might be short on space, we have been known to still support a home*

birth because we can send a midwife to that woman and keep her safe at home. However, if we say, 'Well you need to come in because we're calling the community midwives in', in actual fact we might still not be able to keep you safe within the unit.'
[**Senior Midwife, 2Ho-02**]

For non-midwifery participants such as this GP commissioner, the IU was regarded as a 'safe haven' for all women. For this commissioner, bringing the CMs into the IU and suspending home birth enhanced the safety of all women. This rationale is based on a somewhat paternalistic or utilitarian approach that regards the needs of the many (IU birthers) outweigh the needs of the few (minority home birthers). Safety is therefore a fluid concept where a risk management approach, as indicated above by the senior midwife quotes, is in conflict with the risk minimalisation approach preferred by this commissioner, who sees home birth as introducing unacceptable complexity and risk.

***Participant**: '…my priority is about patient safety. So, it's about looking and saying we need to do the most effective action which will affect the most and not leave the least in a predicament. So, therefore, it's a case of if we know that the safe haven, the default, is the [IU]… more people are likely to come in there, it can't be just be leaving them on a skeleton staff if the dependency's greater because actually a community midwife going out to a home birth puts that, keeps the midwife out for the duration. Whereas rightly or wrongly if she's within [the IU] you could end up with a situation where [a CM] could be monitoring two [women] in early [labour]... So, it's about making sure that we, we don't look about how near we can get to breaking the guidelines, but we look about how far away from not breaking the guidelines we can go… I'm going to make sure that you're absolutely safe.'*
Interviewer: '*So safety before choice?'*
Participant: '*…if actually it is unsafe to do so [attend a home birth], then actually we can't… break our normal guidance… what we can't have, I don't think, is a woman saying, "Well I'm going to have my home birth because I know deep down at the end of the day you'll be here." That, that shouldn't be given as a fait accompli and I think it's really important that what we have is a, a consistent approach… one of, of quality and safety, that would be paramount.'* [**GP Commissioner, 2Hf-19**]

We see here a tension between choice and safety, where choice is to be sacrificed in order to create what is perceived as a safer option for birth in the IU. We can also see how the senior midwives recognise this rhetorical argument for safety and shape their narrative around creating and extending safety through choice. However, CMs regarded the increase in response times for CMs to attend home births (from 30 to 60 minutes) and there now only being two, rather than four CMs on call, as introducing more risk for women birthing at home and then feeling less confident to promote the service to women.

> *'…we have a lot of birth before arrivals [BBAs]… and this is where it can get tricky with long distance travel, because in that moment the baby is born, that woman's not been assessed. The placenta might not be [expelled]. That's when you have this critical time and you really want a midwife there as soon as. But it's no good if my travelling time is an hour.'* [**Community Midwife, 2Hl-03**]

In addition, CMs who provide frontline care see that once they are called to work in the IU, flexibility to provide choice of home birth becomes theoretical. This again, was regarded as a disincentive to promote home birth to local women.

> *'my huge issue is that if the [IU] is busy, and I'm called in, then she [a woman planning a home birth] won't get a home birth. The home birth service has gone at that point.'* [**Community Midwife, 2Hl-05**]

CMs were also conscious that women who were socially disadvantaged were less likely to be advocate for themselves to insist on a CM attending her home birth.

> *'I just think it's a very political thing… the women who are either educated enough or shouting loud enough to say, 'I want a home birth in the view of adversity', and then they get… what they want. But that's not fair either, because what happens to the woman down the road who is not as vocal or doesn't know her rights or hasn't got the education? She'll say, 'Oh well. Okay. If there's no service then I suppose this is what I will have to have.'* [**Community Midwife 2Hl-03**]

This section has demonstrated that the rhetorical arguments for and against change are framed around the challenges of providing choice of place of birth, and minimising risk within the whole ecosystem of maternity services. For some participants, choice is explicit in national policies; for others, it is a luxury that is optional to provide; it can be dynamic in terms of what pressures exist in other parts of the service; and it can be a human right that requires advocacy on the part of women and their care providers.

6.3.2 Erosion of home birth

Some of the antecedents for the deinstitutionalisation of home birth at Sycamore have been discussed in the sections above that have explored the rhetorical strategies around change. What became clear at Sycamore during data collection is that there was no shared understanding of the utility of home birth for Sycamore. When asked about the future of the home birth service at Sycamore this consultant obstetrician's view was that it would grow, but that the focus should be on maintaining the IU model, and not splitting the unit between obstetrician-led and midwife-led services – like in other areas of England.

> *'…I think we'll be doing more [home birth in next 5-10 years]. And I think that may be our compromise in terms of maintaining an [IU] as a consultant-led unit.'* [**Consultant Obstetrician, 2Hf-07**]

In addition, when a GP commissioner was asked what would be required to expand the choice for home birth provision at Sycamore, a significant number of hurdles would need to be overcome in order to convince them. This includes providing evidence of safety, quality and cost-effectiveness, other units where home birth is offered, involving local specialists and identifying if there is demand from women.

> *'I would look and say as a commissioner, I suppose part of my argument would be home birth rates, is there good evidence for*

safety? Is it high quality? Is it cost effective? And if someone can give me that evidence… if someone said to me it will cost x thousand pounds but it's half that for a homebirth, or it's twice that and it's the same safety profile but we need this in place, I'd probably turn round and say right, "Where is doing that currently?" And then that would, that would make me want to discuss and try and develop a case for change. And I suppose it's understanding whether we've got our local specialist on board. But more interestingly it's about making sure that there is a need, so I don't just want to say let's offer the service… if we only get three other [homebirths], that's it, no demand.'
[**Commissioner GP, 2It-18**]

To some degree, we see a level of complacency from maternity leaders who cite Sycamore's home birth service performing above the national average and that they have no doubts about its long-term future. In contrast, CMs stress that home birth is under threat from a lack of investment from the leadership and disinterest in the job satisfaction of their CMs – in particular, by using them as a reserve/flexible workforce to support the IU – which leave them feeling anxious and under-valued.

6.3.3 Summary

What this section has shown is that behaviours in the presence of regulatory scrutiny and financial distress at Sycamore have creating conditions that allow for permeability of boundaries i.e. community midwives working in the hospital and a resignation that the home birth provision should be suspended to protect the core activity of the acute unit. It can therefore be argued that opposition to midwife-led services which seeks to extinguish their perceived liability can use organisational crises to disrupt the inertial tendencies of the midwifery workforce to protect home birth.

6.4 Countervailing activities and inertia

This section explores participant accounts of how the CM workforce integrated with the demands and pressures within the IU. Some of this is informed by how senior managers perceived the level of enthusiasm that the CM workforce had for providing care in the IU; which diverged with what CMs would have ideally wanted to be valued as their

contribution to the maternity services i.e. effective continuity of care and a sustainable home birth service. Participants revealed some of their strategies and behaviours which were aimed at maintaining the levels of home birth at Sycamore. Despite the external scrutiny from regulators and commissioners about the safety culture at the Trust, CMs at the frontline were motivated by maintaining a viable home birth service for women, and did not appear to consider how their stealthy activities could impact on the wider service.

6.4.0 Complementarity of the community midwifery workforce

The CM workforce was regarded as experienced, confident and successful by the senior midwives and obstetricians at Sycamore. This regard was fostered by knowledge that CMs were attending home births on a regular basis.

> *'The midwives are confident in providing the home birth service… we're actually seeing women delivering at home and, and that's building up confidence… so I think we're really fortunate here that we've got midwives who are confident, they are all equipped, so they've got everything they need… so that if they go and walk in and the lady is, I don't know, advanced in labour and everything is fine, they could provide that home birth there and then.'* [**Senior Midwife, 2Hd-04**]

In addition, senior midwives believed that the majority of CMs were advocates for home birth and did not want to lose this aspect of their role.

> *'The home birth is a highlight of all the community midwives job satisfaction really and in the past when we've had talks about looking at home birth service… cutting down on the number of on-calls for everybody else… they're [the CMs] like, 'Whoa! Don't take the home births away from us.' So, we've got about forty-five community midwives and I would say forty of those are all very pro- home birth.'* [**Senior Midwife, 2Ho-02**]

> *'I know that we are quoted in lots of arenas… 'Oh, that's us again, for our home birth rate' …I think we're just fortunate that we've got some community midwives that are confident with*

home births… It… would… seem wrong to take that lovely part of their role away from them.' [**Senior Midwife, 2Hd-04**]

In contrast, the interviews with frontline CMs revealed a different picture, where many CMs do not wish to promote home birth for reasons such as a lack of desire to be on-call at night, or wanting to work a regular pattern of hours, rather than shifts. This led the CMs in this study to question if women would receive appropriate care from CMs who were not motivated to support home birth.

'…[Home birth is] part of your midwife role but you will have community midwives who say, 'I don't promote home birth because I don't want to be out in the middle of the night'. You do get that as well… if it's [home birth] not really your favourite topic, why are you made to do it, and you might not deliver the good care.' [**Community Midwife, 2Hl-03**]

'I've had a very big shock to the system in that I've suddenly found that lots of [community] midwives want to go to work and go home [9-5]… but I don't actually think you can.' [**Community Midwife, 2Hl-05**]

The CM participants in this study identified themselves as advocates for home birth and confident in providing intrapartum care in the home environment. However, they expressed little interest in being used as a flexible workforce for the IU and demonstrated reticence towards working in the IU.

'I'm happier and more confident delivering somebody at home than I am with machinery and doctors and hospitals. I'm a dithering wreck really, it's awful (laughs), I'm looking for people and thinking 'oh God, I hope they don't send me to the drug cupboard' and 'why's that beeping?' and 'what did she say I've to do again?'...if [the IU call and say] 'Oh, can you come to the [IU]?', I'm like oh … Clean my teeth slowly and … (laughs)' [**Community Midwife, 2Hl-06**]

Similarly, despite assertions by the senior midwives and obstetricians that the CMs were confident when working in the IU, it was apparent from the CMs interviews that this was not always the case.

> *'I know the normal. I know the low-risk… I'm not routinized with the abnormal…'* [**Community Midwife, 2Hl-03**]

In this section we see divergent narratives around the role of the CM at Sycamore. For senior midwives and obstetricians, CMs were a valuable and capable resource that enhanced the service provided to women attending the IU, who almost universally enjoyed providing care to women at home births and could be trusted to do this safely. From the data collected from CMs in this study, home births were comfortably within their sphere of competence, whereas being asked to work in the IU was associated with unfamiliarity and anxiety.

6.4.1 Complacency and inertia

Senior midwives believed that their leadership of the service and strong commitment to home birth was a contributory factor in maintaining the service at above average levels.

> *'It might be a culture thing where a [midwifery manager] can say, 'Actually home births are an important part of our service and we do need to work to protect them. We do need to work to keep it going.' Rather than it being the easy option to, 'Oh well. Don't do the home births. That's two midwives that can come here [the IU].'* [**Senior Midwife, 2Ho-02**]

> *'… we're in a position of being under the microscope at the moment… it's an uncomfortable position… my anxiety within my role is that we don't lose all of the good that we do, that we recognise it [home birth], we hold on to it, and then we improve on the things we can improve on.'* [**Senior Midwife, 2Hh-01**]

Equally, the senior midwives described Sycamore's home birth service as popular with women and expanding – despite evidence that it had been in slow decline since 2007 as demonstrated in **Figure 9**.

> *'We're very fortunate here at [Sycamore] that we've got a really good home birth rate, in fact, we are above the national average… I think the strength is… we do have a large number of women who do opt [for home birth], and it seems to be growing.'* [**Senior Midwife, 2Hd-04**]

For this obstetrician, home birth was acknowledged as performing well, however they caution that it must be integrated and contribute to the overall quality of maternity services.

> *'I am quite confident that it will continue to be a good part of our service but it has to be alongside the quality of the whole of the maternity services.'* [**Consultant Obstetrician, 2Hf-10**]

There was some evidence that the confidence in CMs to provide home birth was being extended to offer it to women who had not planned to give birth at home. Senior midwives implied there would be support for CMs to assess women at home when the IU was in escalation. This would mean normal procedures that require a risk assessment to be performed antenatally were not followed when the needs of the IU were being served.

> *'…we don't have a system where every home birth has to be, the notes have to be checked or, 'Was a risk assessment done? No it wasn't…'* [**Senior Midwife, 2Ho-02**]

> *'I think the guidelines themselves are quite comprehensive but they are guidelines… I think again we have a lot of autonomy even over guidelines because they [service managers] know that we're safe and that we're asking for help if we need it in the appropriate manner.'* [**Community Midwife, 2Hl-19**]

Arguably, these statements stand up when there are positive outcomes for the woman and baby. However, it is questionable whether these positions can be robustly defended if there was a poor outcome.

One of the countervailing arguments presented by CMs for increasing home births, involved rhetorical strategies that emphasised how more home births would complement and enhance the safety of maternity care delivered in the IU.

> *'…we've got to try and sort out a service that is promoting home births… actually if we got a decent service to work for women in the community, to encourage home births and make women*

realise how safe it is, it would reduce all these people going into the [IU].' [**Community Midwife, 2HI-06**]

To some degree, accounts that the home birth service was growing and successful may be misplaced, given the statistics cited in section 6.1.3. Equally, the idea that more women are asking for home birth does not stand up to scrutiny of the metrics. However, this section has demonstrated how participants chose to frame home birth as making a positive contribution to the whole maternity service, that women were increasingly choosing it as an option, presenting home birth as well-supported by the maternity leadership and competently delivered by the CM workforce.

6.4.2 Protecting the home birth service through stealth

CMs in this study perceived that home birth was becoming increasingly difficult to promote to women following changes to the on-call system which had reduced the number of CMs available out of hours. The new on-call had also led to CMs being required to provide support to the IU during escalation. Some CMs used countervailing activities such as making themselves available to attend home births using the traditional on-call system, when off-duty, for particular women on their caseloads. This was not Sycamore's policy and it created tensions within the CM teams.

'We used to have four midwives on-call for the night and now it's only two. So, we always had one per sector. So, all you had to do is let your team know, 'If someone still rings, please let me know and I might decide to come if I can free myself'. It depends as well on the relationship you have with the woman. I mean some women [on your caseload] you might say, 'I'll definitely come. I'm not on holiday or anything like that', and some of them you say, 'If I can, I will come', but we're not made by our Trust to do that…' [**Community Midwife, 2HI-03**]

'what has started happening now is that… because we've got so much sickness, we've only ever got one [CM] on call, so straight away, it doesn't matter whether [the IU] call you or not, you're already down to one [CM]… I've been offering, lots of other

> *midwives will offer and do a traditional [on-call]. But then other [CM] members of the team are [disagreeing with us] for doing that because, how can I put it? So how [managers] word it in a text [message], it'll say, 'Please can we have some volunteers to be on-call tonight… so you can just be on for a traditional on-call for home births if you like.' So, this is what I sign up to…'* [**Community Midwife, 2Hl-05**]

In addition, one CM participant revealed that she performs home assessments in labour for women who are not booked for home births, after being told by colleagues that they were doing this already. This was not Sycamore's policy, however, this CM believed there was tacit permission, despite direct instructions not to. Equally, she goes on to say that other CMs are supporting women 'by stealth'.

> *'…So, for a while I've been asking about doing labour assessments at home but it's very much a no. It's, 'No, that's not what we do.' I have to say, quite a lot, certainly over the last year, I've done a lot more [labour assessments], and I think I'll be alright to put this on tape… it's always better to ask for forgiveness than permission.'* [**Community Midwife 2Hl-05**]

> *'…when I was newly out to community, I used to be like, 'Oh I'll be able to go and look after the ladies who are on my caseload for their home birth.' [Then I] suddenly realised that I didn't feel very supported to do that [by] management… as well as colleagues. It would be like, 'well it depends if the service can do it.'… so, I started not asking if I could do it, just doing it. There's another couple of midwives who do the same and they told me to go down that route but they kind of almost did it by stealth really in the fact that they said, 'Look, we've been midwives years, what are they going to do? Sack us?'…I [will] always be above board, I'm always safe, I always tell them [Sycamore] where I am.'* [**Community Midwife, 2Hl-05**]

This 'rule bending' culture may have been facilitated by the managers offering the CMs the opportunity to do traditional on-calls, despite them being previously withdrawn on the grounds of safety and not being compliant with the EWTD. However, CMs were still willing to do these traditional on-calls in order to protect the home birth service from suspension due to staff sickness or absence. Further, some CMs were willing to give their work mobile numbers out to some service users on

their caseload in the event that they called in to the IU in labour and were told there were no CMs to attend. Again, this contravened Sycamore's policies.

> **Interviewer**: *'…managers have said to me, 'No. The escalation policy is that the home birth service never gets cancelled.'*
> **Respondent**: *'Lip-service… I know that a lot of women have called and said, 'Oh I'm in labour. I'm a booked home birth', and they were told they had to come in because there was no midwife… So sometimes you have to bend the rules a bit to maybe make that avoidable. So, if you want to give personalised care to a lady, you might occasionally give your phone number out. You can kind of bypass that because you might know if she was to ring and it was busy, she doesn't get her home birth, but if [the CM is] willing to go, they might still have to send a second midwife, but occasionally it has happened that there was no second available. So luckily nothing's happened during that time but it's not a nice scenario to know you are out there with no second to come if you needed to.'* [**Community Midwife 2Hl-03**]
>
> *'…our work mobiles, we're not allowed to give those numbers out… But, and this is unofficial, some of the women I give them my personal number and they'll ring me on mine. They're all women that I can trust, women that I've probably looked after a couple of times before and I've never had a problem with it… I'm happy to do that. And it is known, but it is just not talked about. And I'm not the only one that does it…'* [**Community Midwife, 2Hl-19**]

An appetite to maintain a viable home birth service has led to unspoken approval between CMs and managers to subvert the new on-call system. We have seen that CMs were making themselves available for 'traditional on-call' shifts. In addition, it became evident that the midwifery managers were also prepared to put themselves on-call in this way too, to cover gaps in the rota.

> *'The team are carrying some vacancy at the moment. So, on those occasions then, rather than saying, 'Well we've only got one midwife on-call, we're cancelling the home birth service', we'll say, 'Right. Let's… wait [and] see what happens', and it might be that it's myself, [or two other senior midwives] that's*

on-call… and we'd be happy to go [to home births] as [the supporting midwives] anyway'. **[Senior Midwife, 2Ho-02]**

The legitimacy of the new on-call system had been challenged from its conception. When it was proposed that the CMs would work an on-call from the IU, and attend home births when the women phoned in, a large proportion of the CMs went to see Occupational Health who then said this was not suitable for many of the workforce to work in this way. The CMs were concerned that if they were caring for a woman on the IU, they would not be available to be released for home births. When CMs resisted the proposed system en masse, managers were forced to seek a compromise that resulted in the new on-call system, where CMs were called from home, rather than released from a shift on the IU to attend home births.

'We [CMs at Sycamore] were going to work a night shift. But then a lot of the staff went to Occupational Health and were exempt from working nights for health reasons… So, they're on call from [home], through the night…' [**Senior Midwife, 2Hd-04**]

'The [CMs] all kicked up such a massive stink, so it was debated that we would do this system where we would be at home, in bed, but we'd have to have the day off before and the day off afterwards.' [**Community Midwife, 2Hl-05**].

'…a fear that actually, they'd [CMs] get called into the [IU] and then the home birth call would come and there wouldn't be the capacity to enable them to go out into the community to facilitate home birth.' [**Senior Midwife, 2Ho-01**]

However, a further adaptation had evolved which meant that CMs were now being asked to attend the IU during escalation. Again, the CMs were seeking to resist this by insisting on seeing policies and seeking limits on the length of time they should be asked to support the IU.

'I've had many an email with our [Head of Midwifery]… 'I'm just asking, I want to see a black and white copy of the escalation policy for [the CMs] who are becoming concerned, disgruntled, morale's dropping, causing stress and anxiety because when

> *they get to the [IU], they're not in [an] argument with the management or the [IU] staff that you know, I'm only going to be here for four hours or I'm only going to be here for five hours'.* [**Community Midwife, 2HI-06**]

This section has demonstrated how CMs were able to enact and resist change to the home service in ways that were separate from Sycamore's objective to provide assurance to regulators and commissioners about the overall safety of the service. By being a minority service, these activities remained largely invisible beyond the midwifery workforce.

6.4.3 Summary

This section has explored a range issues relating to the escalation and on-call systems and how these were received by the CM workforce. Managers presented their staff as enthusiastic to work in the IU, while the CMs demonstrated a strong reluctance to work as a flexible resource for the institution. The countervailing activities of CMs and to some degree, the midwifery managers, can be seen in the context of their motivation to ensure women who were choosing not to birth in the IU could continue to be supported at home. This acted as an inertial force against the erosion of the home birth service at Sycamore, where CMs and to some degree, the CM Managers were alert to the need to act in ways that protected the service despite the regulatory scrutiny and financial distress at Sycamore.

6.5 Discussion

6.5.0 Data findings

At Sycamore, a significant period of scrutiny led to requirements from regulators, commissioners and the Trust board for the maternity service to provide assurance that clinical care was safe. To demonstrate safety and the minimisation of risk, it was regarded as justifiable to reconceive community midwives as a flexible workforce that would be called upon to provide care in the IU during periods of high activity or staff sickness/absence. This established how strengthening the legitimacy of

institutional birth on the grounds of safety minimisation, was perceived by CM participants to be contributing to the erosion and de-institutionalisation of home birth at Sycamore.

Participants not involved in the delivery of home birth care at Sycamore, articulated an ambivalence towards offering it to women as a choice if it had the potential to destabilise the safety of care being delivered in the hospital. Protecting the safety of the majority of women who were choosing institutional birth had become regarded as a legitimate justification for requesting that the small minority of women planning home births at Sycamore be prepared to give birth in the IU instead. This intentional adaptation was introduced as the on-call CMs became required to work in the IU to cover periods of high-activity or short staffing. Yet this adaptation was nearly invisible as women denied home births would comply with the instructions of clinicians. Consequently, confidence in a robust home birth service was perceived to be eroding among service users.

The role of the 'custodians' as an inertial force at Sycamore resisting the elimination of home birth was also explored in this chapter. CMs and their midwife managers were undertaking countervailing activities to maintain a viable home birth offer for women, and were seeking to minimise the impact of the wider service demands on the women who wanted to choose a home birth.

This chapter has explored how significant events presented actual or potential threats to the dissipation of home birth provision at Sycamore. Despite my initial expectation that I was engaging with a research site that had one of the higher performing home birth services in England, what transpired was deinstitutionalisation in action. The intentional actions involved in making, supporting or inhibiting changes at Sycamore, provided novel insights into how a range of stakeholders sought, sometimes in nearly invisible and mundane ways, and at other

times in more explicit and obvious ways, to influence home birth provision.

Figure 10: The antecedents of deinstitutionalisation at Sycamore



6.6 Summary

In section 6.2, this chapter explored how external scrutiny by regulators and commissioners impacted on the relationships between a range of different stakeholders in maternity services at Sycamore and led to disruptions in trust, fears pertaining to the reputation of the organisation and issues with staff confidence and morale.

In section 6.3, how the co-existing agendas of quality, safety and cost-effectiveness were mediated at Sycamore were explored in the face of demands from external regulation. This included perceptions by CMs that a new on-call system that was promoted by managers as enhancing the safety for CMs, was inferior to the traditional on-call system. Moreover, they regarded it as a cost-saving initiative that was diminishing their capacity to support home birth consistently. Further,

using the CM workforce as a flexible resource for the IU during escalation was promoted as enhancing safety for women birthing in the IU. However, this was contested and resisted by CMs who feared that the home birth service was being deprioritised and eroded by service leaders.

In the final section 6.4 on countervailing activities and inertia there was consideration of the divergent narratives around the home birth service. On one hand, management regarded home birth as a self-sustaining service supported by competent and experienced CMs who would guarantee its continuing success. Meanwhile, CMs themselves regarded home birth as diminishing in the face organisational threats. The CM workforce were undertaking countervailing actions to ameliorate these perceived detrimental effects on the ability of women to access support for home birth.

6.7 Conclusion

Home birth has not ceased to have a value or utility for some of its custodians at Sycamore (the CMs and the service users). However, with changing workforce demographics we see that seeking to balance work and personal life commitments in a more equitable way has meant that midwives are thought to be less inclined to seek out employment that demands lone working, long or unsociable hours – that are explicit to the CM role.

The home birth service at Sycamore may be far more fragile and its continued success less inevitable given the antecedents for dissipation than the participants in this study are aware of. The default of hospital birth is both logical and justifiable in a context where over 95% of birth takes place in the IU. Home birth is not always framed as cost effective or that it contributes to normal birth rates and lower intervention rates, both of which are positive performance measures for Sycamore. It nests within a service with limited resources. While current research

evidence and policy promote it as a choice, its continued provision is regarded as stretching limited resources.

Changes within Sycamore, such as the necessity to be reactive to satisfying regulatory scrutiny, effectively mapping their workforce composition, and appreciating how it impacts on their service model design, suggests that the legitimacy of their home birth provision is vulnerable to its utility being re-evaluated and falling into disfavour. Equally, the organisational crisis that involved Sycamore being placed in special measures and moving towards a Long Term Partnership (LTP) and merger with a larger neighbouring Trust, exerts pressures that the maternity services have little control over. In the face of passive or unconscious responses from service leaders to the demands of regulators and commissioners that focus on concerns about the IU, there is a danger that a safe and effective service provided for a minority of service users will be diminished. If home birth becomes deinstitutionalised at Sycamore, the effort that will be required to rebuild confidence in the service will be significant.

The degree to which home birth enjoys a shared understanding of it as a practice that is legitimate is contingent on macro-level support in terms of national policy from NHS England and NICE; and at the micro- and meso-level in terms of local performance and delivery, particularly in terms of quality and safety. Allied to this is the necessity for CMs to be embedded within organisational structures that strengthen their confidence, and competence to support and facilitate home births. Finally, it comes down to the service users feeling confident that Sycamore have an infrastructure that will guarantee support for their choice. If CMs have the freedom to exercise more autonomy and control over their work they are more inclined to provide informed choice that maintains a pipeline of women interested in birthing at home.

To a large degree the obstetricians at Sycamore appear to be willing to accept home birth as a minority activity providing it does not threaten the resources of the IU. That is not to say that they were supportive, more that they appeared to be ambivalent towards home birth. This creates a dilemma for the midwives as they must compromise the model of care, in order to sustain this ambivalence and prevent it turning into resistance. Ultimately, some midwives at Sycamore have continued to remain committed to home birth as a concept despite its status as a practice which is in decline and they were even prepared to undertake countervailing activities to sustain it.

7.0 Oak

7.1 Introduction

7.1.0 Chapter overview

This chapter begins by describing the background, context and participants for Oak – the research site explored in this chapter – and explaining the rationale for its inclusion in this study to address the three primary research questions. It will then proceed to explore two themes that emerged from the data analysis of the case site, principally from interviews with non-service users, documents, journal notes and non-participant observation and situate this within the extant literature to discuss the degree to which the findings both align with, and extend understandings.

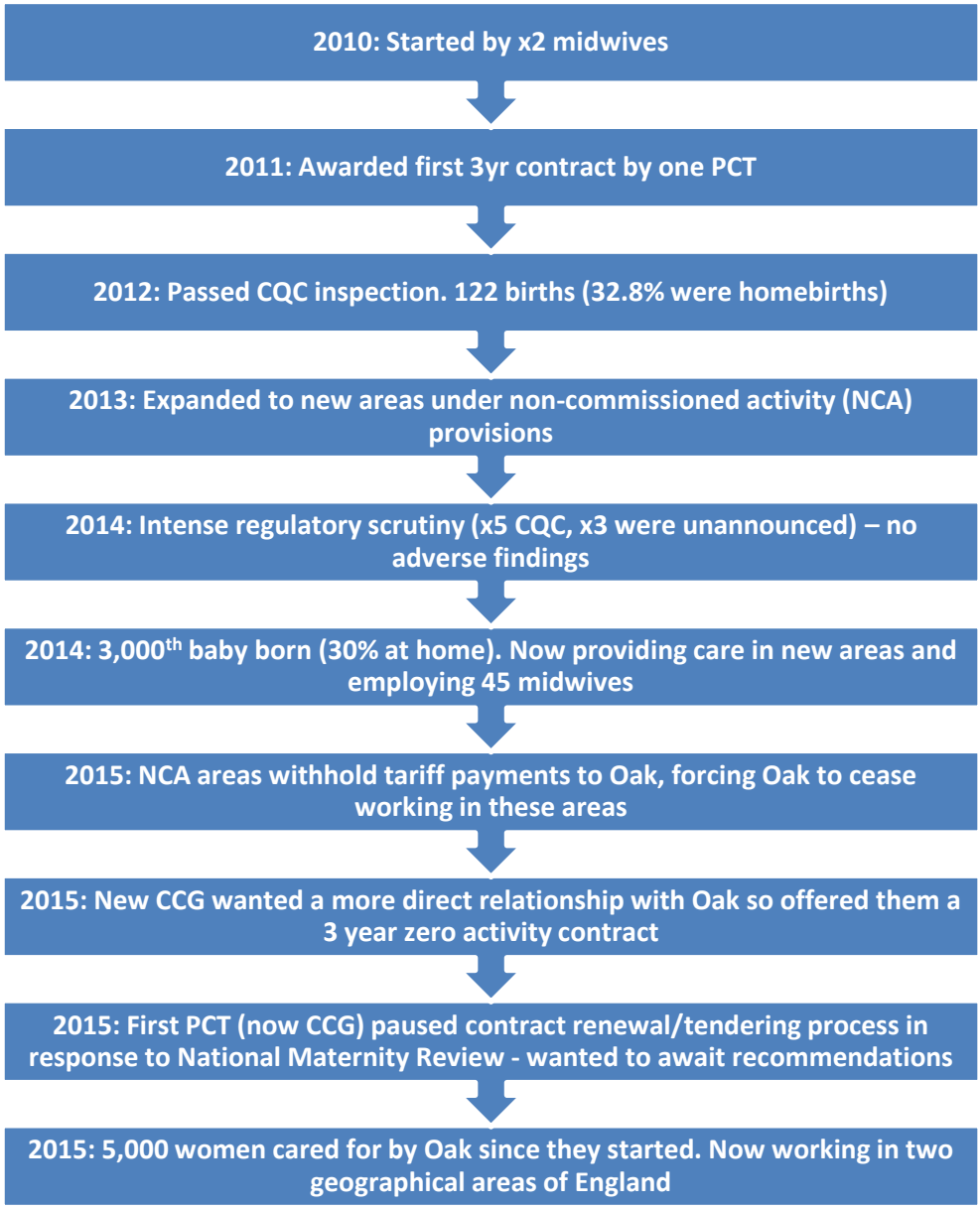
7.1.1 Case description of Oak: Background and context

At the time of data collection, Oak were a private limited company, authorised by NHS commissioners as an 'Any Qualified Provider' or AQP (Turner & Powell, 2015) to provide free maternity care in partnership with the NHS to local communities. Oak was a unique midwifery service in England at the time of the study which had emerged to offer a caseloading model that achieved home birth rates that outstripped the national average by some margin.

As summarised in **Figure 11**, Oak began providing midwifery services in one commissioning area with a staff of two midwives in 2010. In 2011 they were awarded their first three-year contract, and by 2012 had passed their first CQC inspection having completed care for 122 women, 32.8% of which had given birth at home. By 2014, Oak had provided care to over 3,000 women, with around 30% giving birth at home. By 2015, Oak were employing more than 40 midwives and had provided care for over 5,000 women across six CCG localities, and were

sustaining their home birth rate at around 30%. That equates to Oak caring for approximately 1,500 women giving birth at home in the five year period from 2010-2015.

Figure 11: Timeline of Oak's organisational development between 2010-2015.



Since establishing as a maternity service, Oak had been subjected to heightened scrutiny from regulators, often as a result of numerous referrals by adjacent NHS Trusts who questioned Oak's service on the grounds of public safety. Further, under the terms of their AQP status,

Oak had sought to provide maternity care in localities where they did not hold a contract with the local CCG. Oak found that despite assurances from NHS England that local commissioners were required to pay Oak for care provided, a number of CCGs refused, leaving Oak with a significant financial challenge.

In March 2015 (during data collection), the National Maternity Review (NMR) was launched (Cumberledge, 2016). This led to Oak's existing commissioners suspending procurement activity until the outcome of the NMR was known.

Oak's model of care was to provide continuity through each midwife caseloading approximately 32 pregnant women each year. Continuity extended through antenatal, birth (if home birth was chosen) and for up to six-weeks postnatally. Oak managed 'all risk' women in partnership with adjacent services including CCGs, local hospitals, community services, safeguarding services, mental health services and social care. They offered their own community scan clinics, screening tests, blood tests, parent education classes, hypnobirthing and had access to independent obstetric input should the need have arisen. The model of care at Oak did not require women to decide on place of birth until late on in pregnancy, which differed from NHS pathways where women were usually risk assessed at their booking appointment and an indicative place of birth identified.

7.1.2 Justification for inclusion of Oak in this study

Figure 12 demonstrates the rate of home births in the six CCG localities where Oak were commissioned for the 20 years, 1994-2014. Note that the combined performance on home births by the maternity care providers in these six CCG localities fell below the national average until 2012. Subsequent to Oak being commissioned in 2010, the combined performance in these localities rose above the national average for the first time in 2012. Combined with the **Table 18**, there

is statistical evidence that the presence of Oak in these six commissioning areas was improving the supply and demand for home birth.

Figure 12: The percentage of home births in the CCG areas (or equivalent) that commissioned Oak from 2010 onwards. What is evidenced is that between 1994-2011 [blue bars] these CCGs performed below the national average [orange line] for home birth, but by 2012, they were exceeding the national average for home birth for the first time in 20 years (Source (Office for National Statistics, 2014).

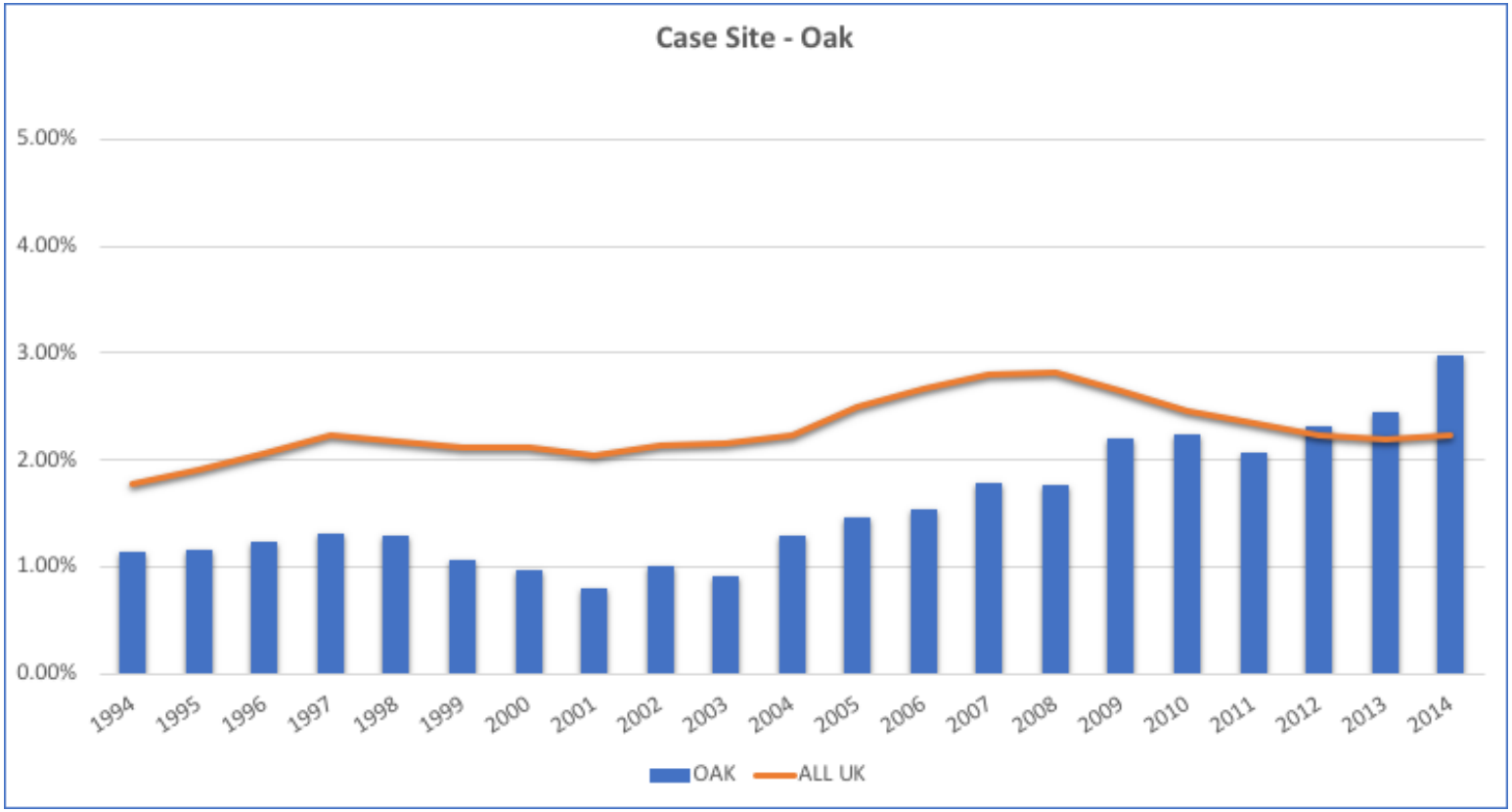


Table 18 demonstrates that, before Oak were commissioned across these six CCG localities, the average home birth rate across these CCGs was 1.3% in 15 years (1994-2009). This was below the average national home birth rate of 2.3% for the same period (Health and Social Care Information Centre, 2015). However, in the five years where Oak's service was contributing to the maternity care statistics in these specific CCG areas (2010-2014) the average annual home birth rate had increased to 2.4%, which exceeded the national annual average of 2.3% for the same period.

Table 18: Data for six CCG areas (or their historical equivalent) for the period before Oak's service was contributing to their overall home birth statistics (1994-2009); compared to the period when Oak were operating in the same locality (2010-2014). The national average number of births and planned home births for the same period is shown for comparative purposes. (Health and Social Care Information Centre, 2015)

	1994-2009 (Before Oak)		2010-2014 (With Oak)	
	Live Births	**Planned home births**	**Live Births**	**Planned home births**
Average annual figures in the x6 CCG areas	16,782	221 (1.3%)	17,520	422 (2.4%)
National average annual figures for England	612,714	13,997 (2.3%)	679,077	15,527 (2.3%)

Oak was selected as a case site for this study for the following reasons:

1. It was a unique service that had performed above the national average for home births for at least five years. Oak was atypical in that it only provided community-based care i.e. it did not provide labour and birth care in an institution, but it provided care to women who wished to use their service for antenatal and postnatal care, and home birth care if chosen.
2. Oak was understood to be the only midwifery service with AQP status at the time of data collection that had contractual arrangements with six CCGs.
3. As a case site, Oak presented an opportunity to explore how the rationale for the deinstitutionalisation of home birth was being counteracted by a model of care assumed to be unworkable on financial and workforce grounds by most NHS providers.
4. Oak entered a 'market' which was a close match for Willow and Sycamore in terms of population demographics and birth rates and where the existing NHS providers disputed that there was unmet demand for home birth from the local populations.
5. Oak provided an example of how caseloading and team midwifery may have potential to deliver the priorities outlined in the National Maternity Review (2016), one of the intended contributions for this study.
6. Oak was receptive to participating in research and there were senior members of staff willing to broker access to participants.

7.1.3 Participants

Data collection for this case site was undertaken between June 2015 and March 2016. **Table 19** describes the 40 participants that were consented for this case site that self-identified as having responsibility, authority or expertise relating to intrapartum care – that includes home birth – provided by Oak. 35 participants were categorised as non-

service users (employees of provider or commissioner organisations); and 5 were classified as service-users (women who had given birth at home supported by midwives from Oak). This chapter does not present data from the service users or the Ambulance Service at Oak for the same reasons explained in section 5.1.3.

Table 19: Participants recruited for interviews and focus groups for case site Oak

	Oak	Adjacent Organisations
Clinical Commissioning Groups (CCGs)	None	4 = Transformational Change Manager, Clinical Commissioning Manager, Programme Manager, Senior Manager Integrated Commissioning Team
Service Leaders	5 = Clinical Director, Consultant Midwife, Risk Manager, Quality and Governance Lead, Training Manager	7 = Finance Manager, Head of Midwifery, x3 Locality Coordinator, Community Midwifery, Delivery Suite Manager
Midwives	7 = Locality Coordinator Midwife, x6 Caseloading Midwives	2 = Community Midwives
Consultant Obstetrician	1	1
Consultant Neonatologist	None	1
Ambulance	None	4 = Medical Director, Consultant Paramedic, Advanced Paramedic, Paramedic
Local Supervising Authority Midwifery Officer	None	1
Service Users	5	None
Others (National)	None	2 = Paramedic and Consultant Midwife
Totals	**40 participants**	

7.1.4 Addressing the research questions

This study's three research questions that are addressed in this chapter:

- **RQ1**: What strategies are used by service leaders to identify new institutional opportunities for change?
- **RQ2**: How are the rhetorical arguments for and against change mobilised by stakeholders?
- **RQ3**: How do stakeholders utilise additional social networks to implement change?

In addressing these questions, consideration was given to the ways that different stakeholders discussed institutional changes (RQ1). Strategically, Oak had identified changes in the policy and regulatory landscape for maternity and employed their entrepreneurial skills to capture elements of the available market. Consequently, their leadership became immersed in recruiting midwives to keep up with demand for their service, and in sustaining their AQP status, which required them to have an NHS contract at all times. Oak's encroachment into new territory came at a time when there was strategic anxiety among NHS providers about service transformation and reconfiguration agendas. As a result, resistance from incumbent commissioners and provider organisations was met. At its best, this took the form of non-cooperation with Oak and/or attempting to replicate the model of care on offer from them; and at its worse, it involved maintaining antagonism and misrepresentation by NHS providers towards Oak's service and actively raising concerns with regulators and commissioners which appeared to be unsubstantiated following investigation.

In assessing rhetorical arguments for and against change (RQ2), this chapter focuses on how the agendas and discourses around the national evidence and policy for expanding choice and personalisation in maternity services were enacted in Oak's locality; alongside

regulatory pressures to demonstrate care which minimised risk and increased safety. It will focus on how Oak service philosophy was to regard safety and choice as interdependent, not mutually exclusive. Oak sought to embed the concept of human rights in childbirth as a core philosophy in their model of care. This contrasted with NHS providers, who might be regarded as having retreated towards a risk minimalisation approach to care.

Oak sought to identify new opportunities to expand their market share by networking and building relationships with both their existing commissioners and potentially new commissioning organisations (RQ3). Oak embraced the national conversations and sought to raise their profile and develop national maternity policy further. However, they were working with 'zero activity' contracts, which required them to generate income to survive. This led to Oak developing a marketing strategy that involved promoting their model of care to women and families not only through word-of-mouth, but more actively through social media, print media, attending events and shows and having a physical presence in the high street. This confronted the status quo enjoyed by the incumbent NHS providers and led to dysfunctional relationships between them and Oak. Oak's survival and expansion was dependent on establishing legitimacy for their model of care and their existence in the maternity market.

7.2 Thematic analysis

7.2.0 Introduction

The analysis for Oak will focus on participant accounts located across the following two themes in the data:

- Opportunity creation (section 7.3)
- Dysfunctional co-existence and compromise (section 7.4)

For the first theme of opportunity creation, Oak positioned their service as philosophically different to NHS alternatives. They sought to appeal

to a 'niche' market of service users who were perceived to be under-served by the current available providers. This chapter will show how Oak established their legitimacy through networks of service users and commissioners. They sought to market their midwifery model of care to commissioners as empowering women's choice and underpinned by a risk management approach to care that respected human rights. Oak nurtured networks and relationships in the maternity world and were cited in a national government document as a case study for how maternity could look in the future (Tyler, 2012). At the same time, Oak fostered deeply committed professional relationships with their service users and maintained a visible presence through a range of marketing strategies to grow their customer base.

For the second theme of dysfunctional coexistence and compromise, data will highlight how Oak was perceived as a threat to the incumbent NHS providers and created strategic anxiety for regulators and commissioners. This threat was met with countervailing activity from NHS providers such as close surveillance of Oak for any behaviour or activity that did not correspond to NHS norms and reporting this to regulators and commissioners. The response from Oak was to ensure their service performance was transparent and that they alerted the regulators and commissioners to any incidents before an adjacent organisation did.

Table 20: Research questions mapped to themes and sub-themes

		Research Questions		
		What strategies are used by service leaders to identify new institutional opportunities for change? (RQ1)	**How are the rhetorical arguments for and against change mobilised by stakeholders? (RQ2)**	**How do stakeholders utilise additional social networks to implement change? (RQ3)**
Themes	**7.3 Opportunity creation**	7.3.1 Entrepreneurialism and the maternity commissioning landscape	7.3.2 Philosophical differences around choice agenda	7.3.3 Marketing and promotion to the under-served 'niche'
		← Theory of deinstitutionalisation →		
	7.4 Dysfunction coexistence and compromise	7.4.1 Defending the territory	7.4.2 Responses to non-isomorphic change	7.4.3 Managing organisational boundary friction
		← Theory of deinstitutionalisation →		

7.3 Opportunity creation

7.3.0 Introduction

This theme presents data that explored Oak's entrepreneurial activity in a complex and challenging commissioning landscape. The importance of robust contracting arrangements was essential to the long-term sustainability of Oak. For this AQP, a current contract was critical to their survival. It will then move to explain how Oak captured an opportunity to deliver national policy with a viable model that enabled women to make choices about their maternity care. Oak described their caseloading model as woman-centric and relationship focused, rather

than institution focused. Oak positioned midwives as the facilitators of choice for women. Oak was largely a uni-professional organisation of midwives that shared a common philosophy and emancipatory inclinations to empower women in their care. Aligned to the essential need for a robust contract was the need to generate demand from local populations which necessitated the establishment of a communication and marketing strategy alongside a physical, visible presence in local towns where Oak were operating.

7.3.1 Entrepreneurship and the maternity commissioning landscape

Oak were commissioned to deliver a pathway of continuity of care by a Primary Care Trust (PCT) (later to become known as a CCG) that had had long standing frustrations with their incumbent NHS providers. This was due to a perception that this provider was failing to meet local maternity care needs. At that time, Oak were a small-scale independent midwifery service already operating in the PCT footprint. A GP with a special interest in maternity care identified that a potential solution was to commission a service that could provide the entire pathway of antenatal, intrapartum and postnatal care for low-risk women (Tyler, 2012). Oak's Chief Executive Officer (CEO) saw this as an opportunity to secure a robust contracting arrangement not only to expand the business, but as part of a longer-term strategy that was critical to Oak's future sustainability.

> *'CEO says that 'we've all worked in [NHS] home birth services that lasted five minutes, because as soon as the acute service is under strain the home birth service is disbanded.' The CEO believes that Oak's success is because they are external to that pressure. She said that 'when you have a contract, the commissioners can't renege on that. It makes the service sustainable as they can't just change their minds after 12 months.'* [**Field note, 1G-FN01-9**]

The CEO had studied other midwife-led services that had failed to sustain their service and identified that sub-contracting within a larger

(NHS) organisation created a vulnerability to the service being terminated at short notice (Harrington, 2010). Equally, she was mindful of a lack of homogeneity among commissioning organisations who were perceived to have varying levels of expertise and a range of attitudes towards expanding choice of provider in maternity. One commissioner was particularly motivated to contract a service from Oak as they perceived it was meeting the needs of women and presented no financial risk to their organisation. This particular commissioner had been invited to give evidence on the opportunities and challenges of commissioning non-NHS organisations to the National Maternity Review.

This commissioner believed it was beneficial for the PCT/CCG to have a direct relationship with Oak, and had decided to become a sole commissioner, rather than sharing a relationship with them through another lead PCT/CCG. To some degree, it appears that this commissioning organisation were embracing competitive tendering of smaller providers already, so maternity was not their first experience of using commissioning to expand choice for their local communities.

> *'When women locally started to use [Oak's] service we [the commissioners] then felt we needed to provide assurance and governance around the process… we wanted to have a direct relationship with this provider for speed of response… getting issues talked about on a face to face contact... We have another provider here… and they are a similar small organisation. The difference is they're a board comprised by about 10, I think, GPs locally… They provide hospital at home, they provide all walk-in type centre, so the issues that we've had in bringing them to a place of being a provider around a table with other big established corporate organisations is being mirrored with our maternity agenda.'* [**Commissioning Manager, IDc-12**]

The national policy agenda for choice was enthusiastically embraced by Oak, and cautiously implemented by those commissioners who were motivated to work with them. Midwives that were attracted to work in this alternative model of care regarded themselves as complimenting,

rather than competing with the existing NHS providers. This participant understood Oak as enhancing choice for local populations in a quality way.

> *'I think commissioners have got to get a little bit bolder and braver… So, when you look at [Oak's] outcomes compared to other [NHS] maternity providers, services, whatever, a lot of the time we [Oak} will have some better outcomes… So, it doesn't mean that we [Oak] would be the only maternity provider…'* [**Consultant Midwife, 1Gp-02**]

In contrast to the CCGs who worked with Oak, there was a significant majority of CCGs who made claims that Oak were an unsafe service that could not provide them with adequate levels of assurance. The leadership team at Oak perceived that these CCGs often had limited expertise in maternity commissioning and tended to defer to clinicians who had little or no expertise in primary maternity care or home birth. These CCGs tended to regard home birth as an inappropriate choice when a hospital with medical technology was available locally.

> *'It's really opened my eyes to the hurdles you have to jump through, how medicalised commissioning is. I think commissioning is way behind choice. I think there are some [NHS] Trusts that are really medicalised but I see that catching up, and midwifery is becoming a stronger voice. But in commissioning it's all, they still think doctors are the best thing since sliced bread. They still defer to medical staff for an opinion about a midwifery issue and there's a lot of fear about something new and that affects - that stops you being able to innovate and do things proactively because you're too busy helping people catch up… [commissioning] either works brilliantly or it doesn't work.'* [**Clinical Director, 1Gm-01**]

This perception was validated during an interview with one of the local CCGs who had declined all Individual Funding Requests (IFRs) from women seeking Oak's services. This participant had no professional background in maternity but had been given responsibility for it in addition to his role as a children's commissioning manager:

> *'I work very closely with [the] Lead GP and the Lead Nurse for the CCG… They make the clinical decisions…They will give me the decision and I will work with that decision. So I will not take a risk*

> *when we are talking clinical safety.´* **[Commissioning Manager, IFc-15]**

The leadership at Oak perceived that some CCGs were paying lip-service to the concept of pregnant women as autonomous entities with a right to choose their care provider. To some degree this interview extract from a commissioner whose CCG refused to work with Oak demonstrates this paternalistic approach to their population.

> *'Risk and assurance go hand in hand and we will not take risks without assurance, and letting a woman have a home birth with an organisation that we have no assurances from is a risk that we are not willing to take.´*[**Commissioning Manager, 1Fc-15**]

These types of commissioners were regarded by Oak's leadership as both aligned with and protective towards the incumbent NHS providers and hostile towards expanding choice.

> *'The CEO of Oak perceived that these commissioners preferred not to 'muddy the waters with multiple providers'. She went on to question what commissioning was for if they were only going to simplify what was on offer, rather than deliver quality and choice.´*[**Field Notes, 1G-FN01-11**]

When asked what Oak's strategy was for identifying potential new areas to expand to, it was evident that being customer-led had failed significantly in one particular county of England. Oak had been approached by women to provide care, and they had understood from NHS England that if they held AQP status they were permitted to provide care under the terms of 'non-contracted activity' in other areas, on the understanding that local commissioners were obliged to pay them under these terms.

> '*…so, we did a piece of work earlier this year… we were reactive to people approaching us, so for example, [in one county in England] we were approached by a commissioner. [Another county in England] we were approached by women. So, we went into [that county] for about eighteen months but it was a*

nightmare, because the commissioners didn't want us… they were all over us like a rash, refused to pay us, and that was a hard lesson for [Oak] to learn. We still have thousands and thousands and thousands of pounds owed to us by commissioners for care we've given, that nobody else has given, so they've not paid someone else, they just haven't paid us. [Oak CEO] and I were at a meeting last week with NHS England where they said 'that's not acceptable, they have to pay you and we will put pressure on that', but they've got no, what's the word?... [it] doesn't mean the CCG have to [pay]… so we've learnt our lesson'. [**Clinical Director, 1Gm-01**]

Because of this experience, Oak became more strategic about analysing their market opportunities and the risks that expansion into new areas may present for them as an organisation.

'…so, we came up with a matrix… where we listed every CCG in England, and then we had columns where it was, erm, have we been approached by the CCG? Have we been approached by the women? Was their local provider having problems? Erm, geographically where was it in relation to our head office? Erm… could we recruit in the area? There was five things and we scored them, and the ones, I think the ones that scored above twenty we proactively approached, and sent them letters about our service, sent them details about zero activity contracts… for us it was a good process because it made us think logically about where we were going... we're more structured about where we would go.' [**Clinical Director, 1Gm-01**]

The outcome of the National Maternity Review (NMR) was eagerly anticipated by Oak. In terms of their matrix for approaching different CCGs, it was a frustration that many were waiting for the NMR to be published before exploring their future commissioning options with Oak.

'The fly in the ointment for us has been a lot people [commissioners] have come back and said, yeah we're interested [in working with Oak] but we're gonna wait and see what the maternity review [NMR] does. We're not gonna spend lots of our time and effort coming up with contracting processes when the maternity review might say we can just let you come. Why waste our effort?... it's a bit frustrating for us because… the more contracts we can have, the more secure we feel as an organisation… the maternity review will guide us a bit more, depending on whether it says, you can go anywhere you just

> *have to be centrally accredited… or it might say we can only go to certain places where the CCGs feel they want you. In which case we'll just have to figure out which CCGs want us.'* [**Clinical Director, 1Gm-01**]

Oak as an organisation anticipated that the NMR would represent a moment in history for midwifery and that Oak was at the vanguard. Certainly, participants from Oak were optimistic that their continuity model of care would be endorsed and that this would facilitate more non-NHS providers to establish, with Oak out in front having five years of experience under their belts already. In addition, they anticipated that their philosophically different approach to the policy agenda of providing more choice for care in low risk settings, which had not yet been embraced by NHS commissioners and providers, would also be endorsed.

> *'I have a feeling if the maternity review [NMR] comes out like we think it is, and women will be able to choose who their care providers are, there'll be a lot of [alternative providers] springing up all over the place.'* [**Caseloading Midwife, 1Gl-09**]

> *'… if the Maternity Review [NMR] goes ahead the way we hope it will, then they [CCGs] won't be able to prevent us [Oak] going into [new areas] because women will have choice…They have a choice that they can go to [named hospital] or [named hospital] but they don't really have a choice [at the moment]… they can't choose [an alternative provider] unless the CCG says so, or a GP's signed something. But [even] then the CCG's [still] got to agree with the GP's signature.'* [**Senior Midwife, 1Gr-04**]

Oak's CEO believed that their business model was crucial. This included a non-negotiable model of care that placed women at the centre, enabled Oak to shape the business around the needs of a) the women who would be accessing the service, and b) the commissioners with the power to award contracts.

7.3.2 Philosophical differences around the choice agenda

On their website[11], Oak promote themselves as having;

> *'reinvented caseloading midwifery by providing a free personalised service that places women and their families at the heart of everything we do. Our service is delivered by teams of passionate, highly motivated midwives who are experts in all aspects of midwifery led care, and who will guide and support you through your pregnancy, birth and postnatal care, ensuring that you transition into parenthood as confident and competent parents.'*

Oak located the concept of 'woman-centred' at the heart of their philosophical approach to care. This is enshrined on posters in their head office and within their guidelines, stating 'we will advocate, support and empower women in our care in a non-judgemental and inclusive manner.' This is dovetailed with the concept of the right to self-determination which aligns with the NHS Choice Framework (Department of Health, 2016) and making informed decisions and increasing health literacy (NHS England, 2018).

> *'…for me, the right to self-determination is a foundation in [Oak] and extremely important. But at the same time, we have to work within that evidence-based environment, we have to make sure that women understand with choices come consequences, and these are the consequences of the choice. So, we have to talk about NICE guidance and RCOG and we do do that, but some women still say you know what, that's okay, it's my choice.'* [**Senior Midwife, 1Gr-04**]

For the midwives who had experience of working for the NHS, advocating for women to make informed choices since they had worked at Oak was felt to be empowering them to work more closely to professional standards set by their professional regulator (Nursing and Midwifery Council, 2015).

> *'… so, I think we [Oak] do give choice, I think… since I left [the NHS] women aren't getting the choices that I offered them…*

[11] No reference provided to protect case site anonymity

> *these were women that had said, if you don't support me doing this I'll go somewhere else… The choice in [Oak] is much better than in the wider NHS… I feel it's driven by people standing up and having a voice, sometimes you need professionals to be your voice, and sometimes you need women to be a voice.'* [**Clinical Director, 1Gm-01**]

By advocating for women who make choices that an NHS provider would not normally encourage or agree with, Oak midwives placed themselves in conflict with institutional expectations within the NHS. This commissioner recognised that Oak were striving to enable women to make informed decisions.

> *'…[Oak] do really support women's individual choice beyond anything I have ever seen which has huge complications for them to be very agile in how they react. A large organisation cannot meet the needs of individuals in the time factor that is often required whereas [Oak] as a provider of caseloading and the opportunity to have a home birth within that, do'.* [**Clinical Commissioning Manager**, **1Dc-12]**

This participant was typical of the midwives at Oak who were often passionate in their willingness to empower women who had deficits in their health literacy due to their social circumstances. This was often contrasted with experiences of working in the NHS systems that were perceived to require them to provide information in ways that encouraged compliance with provider preferences.

> *'… know[ing] that they could have a choice doesn't mean they do choose the thing which is against the norm, but they could do if they wanted to. And that's up to them to do… for [women] that are very tightly controlled, and the women who kind of don't have alternative options because of their social circumstances, [it can be] quite liberating for them to have that. Because I… think the women… who feel that they should comply with what's expected of them [by the NHS providers] don't always realise that they're being restricted.'* [**Locality Caseload Midwife, 1GI-07**]

> *'the main challenges are… people accepting the role of women in their decision-making, the role of the midwife in supporting women and not being seen to be coercive… at the beginning… it*

> *seem[ed] like the commissioners and the acute Trust thought we actively encouraged women to have their babies at home… If we were coercing them, 90% of them would have had them at home, wouldn't they? …'cause we would sell it so well that they want it. But actually, [a] tiny percentage choose to have it at home… so we must be giving them the information that [commissioners and NHS Trusts] expect us to give them…'* [**Clinical Director, 1Gm-01**]

The midwives at Oak were cognisant of NHS disapproval for all women to be offered a full range of choices. This was sometimes framed by NHS organisations as inexperienced midwives at Oak being coerced to encourage more women to give birth at home to maximise company income. Oak also perceived that NHS midwives had become acculturated to working defensively with women by discouraging them to make choices they would not be personally comfortable with supporting.

> **Participant 1**: *'They [NHS] feel that the [Oak] midwives are unsupported and put under duress to encourage women who are unsuitable for home birth. And they have this kind of perception that these poor newly-qualified [midwives]… this is how they phrase it… are kind of put under terrible duress…'*
> **Participant 2:** *'It's really, really interesting, I remember this from being a student in the community [with NHS]. And I remember [NHS] midwives saying you know 'I really just don't think women should be allowed to … and I really don't think that midwives should have to go to these women at home births'. And I remember thinking … I couldn't get my head around that at all. It's just so … it's just not the case… The way that we work, all we're doing that's different is giving women information that they understand in a balanced and unbiased way and then they make the decision for themselves and they know that we'll support them in whatever they choose.'* [**Caseload Midwives, 1Gl-05 and 06**]

The CEO of Oak saw recruitment of midwives who were philosophically aligned with the caseloading model of care as key to maintaining the purity of Oak's model.

> *Discussion with CEO: 'Just being a registered midwife is not enough. They have to have the right ethos… it is not a*

> *coincidence that years ago midwives were spinsters as the commitment required is demanding. It's not a career it's a way of life… So [Oak] provide a choice of a different employment arrangements.'* [**Field Note, 1G-FN01-13**]
>
> *'Because it's too challenging you know, they have to be thick-skinned, they have to be determined, they have to believe in the model… they have the challenges of working within an organisation that is new and innovative, which is really exciting.'* [**Risk Manager,1Gq-03**]

Many of the participants who had experience of working in NHS systems, described coming to work for Oak as 'finding a tribe' of like-minded professionals. Often, they had described feeling they had been inhibited or unable to be authentic midwives within the institutional setting and now felt liberated to work with women in a fulfilling way.

> *'I think it's just finding your tribe really, you know. And I think sometimes when you do work with the NHS model, and you do have this way of thinking, you very much feel like you're a bit of an odd-bod really and don't really fit into that way of caring. And that's certainly how I always felt, I always felt a little bit frustrated because nobody else seemed to be on that same wavelength… there'd be like, you know, raised eyebrows and rolling eyes… And just kind of coming somewhere like this [Oak] where you do meet other people who've got a similar way of thinking, you realise what a deep kind of sisterhood that develops from that, and how we support each other and how your knowledge develops from each other as well…'* [**Caseload Midwife, 1Gl-17**]
>
> *'I think because we [Oak] have you know, the caseloading model which is still quite unusual in this country. As a midwife it's brilliant to be able to work with women from the start of things all the way through to the end. Just because you know, we get to go into their homes, we get to know the families you know, you really get a feel for who your woman is and where she's coming from. And that does help you to tailor the kind of information you give and the way you give it as well.'* [**Caseload Midwife, 1Gl-08**

Oak regarded their training for midwives as key to embedding the model of care within their psyche. For the CEO, recruiting experienced midwives was challenging as they often required re-training, or re-

programming, to align with Oak's philosophical approach to care. Conversely, newly-qualified midwives aspired to work in caseloading models of care and were very receptive to adapting to Oak's model of care. This extract from an interview with Oak's training manager highlights the priority that training was given within the organisation.

> *'[Oak] obviously want to offer a comparable [training] programme to any of the [NHS] Trusts for the midwives who come and work with us. We also… want to keep the essence of [Oak] and how it is different from the [NHS] Trusts. And it is a different way of working. And we do have, you know, a very strong normality belief system as well and want to support the midwives in being able to work from that viewpoint and that philosophy… one thing which from the mandatory [training] programme we've currently got, we are looking to… keeping sessions about authentic midwifery, home birth you know, skills that midwives gain outside the medical model… training as applicable to the way we work as possible because it is different from nearly all the Trusts in the UK.'* [**Training Manager, 1Gu-10**]

What became evident from participant accounts was that the Oak midwives believed their model of care was superior to the standard NHS offer. While Oak midwives did not openly criticise NHS midwives, they displayed a sense of pity for the organisational circumstances that required NHS midwives to privilege institutional or professional needs ahead of the needs of the women they cared for. By identifying themselves as so different to the NHS, Oak may have contributed to the conditions by which opponents would attack their relationship-based approach to care arguing that they were not always cognisant of the risks that women were taking.

7.3.3 Marketing and promotion to the under-served 'niche'

The CEO of Oak had a clear five-year strategic ambition to expand her organisation to other parts of the UK and internationally. She believed that Oak could realistically provide care for up to 15% of all UK births. At the time of data collection, 38% of women accessing Oak's service

were giving birth at home. However, only 9% of women booked with Oak had planned to give birth at home.

Oak understood that their flexible approach to place of birth was valued by women. When a woman thought she was in labour, she would contact her caseloading midwife who would then visit her at home, perform an assessment of maternal and fetal wellbeing and then have a discussion with the woman about her preferences. Oak believed that this dynamic approach made visible to local NHS commissioners that NHS provider assertions that low-uptake of home birth rates were user-led may not be accurate. However, this approach was understood by many NHS commissioners and providers as confirming their suspicions that Oak's midwives were applying pressure for women to birth at home against their will.

In terms of marketing, Oak's principle source of referrals came from women who had previously or were currently using their service and had recommended it to their friends and colleagues.

> *'… our main referral source is from a previous user or friend or they've used it before you know… it's more around 'I used that service when I had my baby, it was great, I loved my midwife' or whatever.'* [**Consultant Midwife, 1Gp-02]**

> *'With all these new [policy] documents coming out you know I think there's a real demand for the kind of service [Oak] provide. We hear from women all the time, they're like 'Oh I wish I'd done this the first time I got pregnant' and they're recommending it to everyone.'* [**Caseload Midwife, 1Gl-08**]

Another source of custom for Oak was coming from women who might be regarded as the under-served niche. These would be women who had given birth previously with an NHS provider but had found the experience traumatic and were actively looking for an alternative.

> *'… we [Oak] have a lot of women that will choose home birth because of maybe a traumatic experience or whatever reason, they really don't like the [NHS] hospital. But interestingly we've had a few women that have said they've only got pregnant because the [Oak] service was in their area, because they couldn't bear to have gone to the hospital even for things like bookings and scans, they just wouldn't have had another baby.'* [**Senior Midwife, 1Gp-02]**.

In addition, women who felt under-served or had come up against barriers from the NHS in a current pregnancy by their chosen NHS provider, might also seek to transfer their care to Oak.

> *'… we [Oak] do get a lot of women who are already at that point where they're already like getting very angry or upset with the care that they've received already [from the NHS]. And then you can do a bit more damage control.'* [**Caseload Midwife, 1Gl-17**]

Where choice of providers was available, there was evidence of movement between providers by service-users. This was not particularly welcomed either by Oak or NHS providers as it created tension and hostility around who would receive payment for care provided on each of the pathways (antenatal, intrapartum and postnatal). When women contacted their local CCG to ask to move away from their NHS provider to Oak, this sometimes involved engagement in the Individual Funding Requests (IFRs) process, itself a somewhat complex system to navigate.

> *'[Oak are] a very woman-led organisation. So, we had [pregnant] women that were contacting us wanting to be part of [Oak]... So, then that generated conversations with the local CCGs.'* [**Risk Manager, 1Gq-03**]

Despite the reported reticence of many local GPs to refer pregnant women directly to Oak, anecdotally, caseload midwives remarked that several female GPs had sought care during their own pregnancies with

Oak. This suggests that health professionals were seeking out continuity for themselves and less so for their local populations.

Oak depended on income generated from the NHS maternity tariff. This is split into three modules; antenatal; delivery and postnatal. For the antenatal and postnatal pathway there are three case-mix levels; standard; intermediate; and intensive. For the delivery element of the pathway there is two prices split by whether or not there are complications and co-morbidities at a specified level that requires additional care. There is a single payment per women, per module paid to a lead provider. The lead provider is responsible and accountable for all care provided in that module, even if some elements are delivered by other providers (NHS England, 2014). Unlike NHS acute provider Trusts, Oak had zero-activity contracts that meant that if women did not book their care with them, they would have no income. With this purpose in mind, Oak rented shops in local town centres to increase their visibility and market their services to the local populations. From these Pregnancy Advice Centres (PACs) they ran community events, hypnobirthing classes and clinics etc. These PACs were a key marketing strategy for Oak.

> *'We [Oak] do a lot of community events and we have the PACs now, Pregnancy Advice Centres, in certain areas So they're quite a hub for the community… we do use Children's Centres and we do use GP surgeries etcetera in different areas for scan clinics, but we do set up these hubs now which are commercial shops.'*
> [**Consultant Midwife, 1Gp-02**]

What was particularly significant about the PACs was their open-door policy for women booked with Oak, and for any other families in the community who were not.

> *'Local people were welcome to come in and use the facilities to breastfeed or nappy change their babies and learn about the events and classes available from Oak. The receptionist at the [town name] PAC had received maternity care from Oak… She*

contrasted the emergency caesarean section she had had with the NHS for her first pregnancy, with the normal birth at home she had had with Oak for her second. She described how her second birth with Oak had 'healed the trauma' of her first birth. Women curious about Oak visiting this PAC would likely be told this personal story and take this as a clear recommendation to use Oak from a local woman... If a pregnant woman or her relative called into the PAC and were interested in booking with Oak, there was an iPad to enter their name and contact information and they were advised that a midwife would ring them back within 24 hours and arrange to come and see them at home at a time that was convenient for them.' [**Field Note 1G-FN01-18**].

Oak was actively outward-looking. This meant that they had a team that focused on communications and marketing and public engagement through local businesses, baby shows, leaflet drops in local health centres, GPs, leisure centres and through social media. Marketing and promotion were also something that the midwives were actively involved in.

'We have like a communications and marketing team, so they go out and we do quite a lot of community events. So, we go into Mothercare and put on a training event for women who are not booked with us necessarily, but to come and learn about how to wear a [baby carrier] sling or whatever it is that we're doing… Yeah, we have a really active social media with Facebook… [and] a Twitter account… we obviously have the website as well. We have lots of stories on there, service users send them in.' [**Consultant Midwife, 1Gp-02]**

'… we [Oak] have really strong support from our [service users]. You go on our Facebook page… we've got the most likes of a maternity service in the country… we value that sort of feedback… if women didn't believe in us, we wouldn't have the service, we wouldn't have lasted… we're growing, we're not the biggest organisation but we've got potential, I think people vote with their feet…' **[Clinical Director, 1Gm-01]**

In addition to this local engagement activity the CEO at Oak was networking at strategic events at local, regional and national levels to raise the profile of Oak and help inform the national conversation

around developments in maternity services. Oak had been featured in an NHS Commissioning Board resource pack for CCGs (Tyler, 2012); NHS England online as one of the pilot sites for new models of midwifery supervision (2016); NHS England Early Adopters in Maternity Services (2017); as well as attending and presenting at conferences around the UK.

7.3.4 Summary

This theme demonstrated how Oak depended on contracts, which were themselves dependent on Oak fostering effective working relationships with commissioners who were motivated to expand provider choice for their populations. Oak's sustainability was also dependent on maintaining a viable customer base that was willing to use its service. Oak were unique innovators delivering a new institutional model within maternity commissioning and provision. This meant that Oak expended energy negotiating, educating and reassuring adjacent organisations and service users that they were a credible, and safe alternative to the existing NHS provision. Oak had established a woman-centred philosophy that had a central tenet of respecting women's rights to self-determination. This relationship focused model positioned their midwives as facilitators of women's choice. This is contrasted with traditional provision that might be regarded as paternalistic and/or utilitarian – focusing on institutional and professional priorities, rather than an individual woman's priorities. A key contributor to Oak's growth has been their work in developing a loyal customer following with their service users. Beyond word of mouth, Oak adopted a proactive strategy to establish a physical presence through their PACs and engagement activities undertaken by their community-based workforce. This was alongside their virtual presence across social media and Oak's strategic networking at local, regional and national levels.

7.4 Dysfunctional coexistence and compromise

7.4.0 Introduction

The data presented in this theme tells the story of the reactions to Oak's encroachment into NHS territories that were exposed to new commissioning policy landscape that encouraged competitors to offer more choice to service-users. What will be shown is that the incumbent NHS largely responded to this policy strategy defensively. Oak's business model was dissimilar to NHS providers, which generated conflict and led to professional and public criticism of their philosophical approach to care. This took the form of rhetorical arguments that framed Oak as unqualified, unsafe and an unnecessary complication for a complex service like maternity. This theme demonstrates how tensions were played out at the organisational boundaries where obstruction, exclusion, hostility and misinformation were tactics used by a range of stakeholders to undermine Oak's foothold in the market.

7.4.1 Defending the territory

When Oak began providing maternity services to women who would have usually been cared for by their local NHS provider, this tended to be met with varying degrees of push-back from the incumbent NHS providers. Documentary analysis identified that this would usually take the form of NHS providers arguing that the spectre of competition from Oak posed an unacceptable threat to the economic viability of the local maternity unit, and at the extremes, may cause it to close; at others it might involve raising concerns about the safety of Oak's service to commissioners and regulators and framing this as a risk to women and babies; and at others it may involve NHS providers seeking to change their model of care and offer to change their service in a way that approximated Oak's service.

During data collection I was made aware of adverse media coverage about Oak that featured an interview with an NHS chief executive in an area where Oak had been providing care to women. The local

newspaper headline read '[Name of hospital] maternity unit under threat'. The article reported that if more women chose to use Oak's service, the local antenatal, postnatal and community services would have to go, and if they were not delivering babies, they would not require a neonatal unit 'which has only recently been rebuilt through a charitable appeal and the generosity of our local public' [**Excerpt from local newspaper, Jan 2015**[12]]. The editorial line of this article suggested that the future survival of the local NHS maternity and neonatal services were in jeopardy as a result of a private company competing for women to use their service instead.

> *'[redacted] Hospital's maternity unit could be forced to close if it can't fend off competition from a private midwifery company set up in [redacted]. The hospital, which has just been shortlisted for a top national award for the maternity services it provides, has found itself in direct competition with a company set up under a government initiative. [Oak] operates under a contract through the NHS – although it is still a private company. This week [redacted] Hospital chief executive [redacted] admitted to the Chronicle it could mean the end of maternity services at the [redacted] hospital if too many people opt for [Oak].'* [**Excerpt from local newspaper, Jan 2015**[13]]

I then approached the NHS Trust featured in the article and they shared a copy of a letter they had sent to their local CCG regarding their concerns around Oak being permitted to offer services in the same locality as them. This letter detailed concerns such as service fragmentation caused by a lack of shared documentation, a lack of shared processes and policies by the two organisations and the potential for this to impact on the safety of women and babies. Significantly, the Trust argued that Oak's presence threatened the economic viability for maternity services at that Trust.

[12] Names of units and location redacted to preserve anonymity.
[13] Names of units and locations removed to preserve anonymity

> *'…For a smaller unit like our own (<3,000 births) it is challenging to balance financial viable [sic] with meeting all the standards set out in Safer Child Birth and the DH Maternity Matters strategy (2007). [This Trust] achieves most of the standards by recognising a cost base that is greater than tariff and is therefore subsidised from other activities. Increased competition in a decreasing market means the amount we receive for maternity services will continue to reduce. This will call in to question the long term financial viability of the Maternity Unit at [name of hospital] because we are limited in what costs e.g. consultant presence on the labour ward, we can reduce without reducing the quality of the service we provide. This problem is exacerbated if Independent Midwives continue to grow and take more "low risk" births from [this Trust] and leave only the high risk/high cost pathway with us. It would be beneficial to understand the CCGs strategy and commissioning intentions in respect of Maternity Services to ensure this is aligned to our own and provides a complete service to the population that we serve.'* [**Excerpt from confidential letter from NHS Trust to CCG[14]**]

When I explored the issue of Oak featuring in anti-privatisation media coverage with Oak's CEO, she suggested that much of it was vexatious and that it was probably orchestrated by maternity units more worried about their own jobs and futures, and less about improving choice and quality of care for local women.

Oak fundamentally believed that their model of care needed to be different to the NHS model, and this is what was accounting for them achieving different outcomes i.e. higher rates of user satisfaction, higher rates of smoking cessation, higher rates of breastfeeding initiation, lower rates of birth interventions such as caesareans or epidurals, and higher rates of home births. However, participants who worked for Oak were aware that they had to manage external scrutiny and impressions of their service to provide assurance that women and babies were safe in their care.

[14] Names of unit and locations rremoved to preserve anonymity

'…We [Oak] meet a lot of different women with a lot of different needs and it's trying to facilitate safe care plans for them to enable their choice… and also balancing that with… meeting service demands and also outside requirements or impressions of the service, because we have been seen as a kind of 'risqué – we just do what we want – we don't follow any guidelines' sort of service. So, it's managing that to make sure that people see us as safe and are assured that we're safe, but actually providing them [women] with choice. So, it's quite a difficult job to stand in the middle of that, sort of towing the line and also providing real choice because that's what we do, in a safe way...'
[**Caseload Midwife, 1Gp-02**]

While serious incidents are unwelcome, they unfortunately happen in all maternity services. Participants at Oak perceived that any in which their service was involved were treated as more serious and came under more intense scrutiny than NHS providers and information about the incident would be spread across the NHS family. If an NHS provider was involved in a similar situation, participants believed there was a level of tolerance and acceptance because they were the NHS. Participants felt these organisations had their reputations insulated within the wider NHS 'family'.

'[Oak] can have a serious incident that occurs and we will follow all the processes and we do everything in our powers to reduce the risk of an incident occurring… People will know about it before [Oak] know about it. It's amazing how it spreads. But in a hospital because it's contained within that hospital… But what happens is [Oak] get judged… we're not on a level playing field at all… the whole of the [region] will know about [an Oak] birth that's not gone the way it should have done. But we won't all know about that incident where a baby's on special care in [an NHS hospital] and doesn't survive, we don't get to know about that in the same way.' [**Risk Manager, 1Gq-03**]

'So, it's public knowledge that [name of hospital] was having significant issues as a hospital and even more so as a maternity unit, but they are supporting them, their peers. [Another maternity unit] has had public acknowledgement of financial difficulties and lots of staff have left… and you have this scenario of certain organisations being protected regarding the reputation, but when we look at a new organisation it's set up

> *very differently such as [Oak] they do not have that level of buffer.'* [**Commissioning Manager, 1Dc-12**]

> *'1Gm-01 described attending a meeting with senior obstetricians when he was employed in a senior role at a large maternity unit. During the meeting, the clinical director said that 'Oak kill babies and we have a responsibility to the population of [name of city] to not let that happen'. This particular obstetrician and his maternity unit were apparently under review for five infant deaths occurring in the space of two months, but 1Gm-01 suggested that it had been 'all hushed up'.* [**Field note, IG-FN01-06**]

In terms of service users, participants offered several anecdotes about how women booked with Oak, had shared interactions with NHS providers and GPs who expressed derogatory and discouraging opinions about the safety of Oak's service with them. These anecdotes were presented as the incumbent NHS providers applying subtle and overt coercion to encourage women to use their service, rather than Oak's.

> *'I think for the women … you know, I have had women come to me and say 'Well you know there's a lot of hostility there from the hospital in them saying 'Well [Oak], we don't like them very much' and 'Oh they're all terrible midwives' and you know, you get that. So, they're trying to instil a bit of doubt into the women's minds as well and I just think that's really unprofessional. I've had a couple of women that have been to see their GP and their GPs have gone 'Well we don't really know who these midwives are and we don't know how safe they are, so you're best just going back to the hospital'.* [**Caseload Midwife, 1Gl-08**]

> *'The Learning and Development Lead told me that some women have said that because of what has happened at an acute Trust 'I can't be piggy in the middle, so I am going to stay with the acute Trust. It's nothing that you've done, but I can't be in an argument.' Women are frightened that if something happens and they need the hospital, [the hospital] may disadvantage the woman or not treat her properly when they go in… [the hospital] blackmail women at a very vulnerable time in their life.'* [**Field Note,1G-FN01-04**]

Oak were subject to repeated scrutiny because of referrals made by NHS providers to healthcare regulators about them. This was another

defensive strategy used by incumbent NHS providers. One commissioning manager commented that '*I can't think of any other organisation that could have had the level of scrutiny that they've [Oak] had and still be in existence.*' [1Dc-12]. Oak found the attention from multiple regulators disproportionate based on their relatively small scale. They also found it onerous in terms of preparing and responding to scrutiny which was regarded as inhibiting their capacity to innovate and expand.

> *'we're having to be reactive… every time we think that we're getting somewhere… being a little bit more proactive, being a little bit more innovative about the things that we want to introduce…we'll suddenly have to do another investigation or we'll be under another review… we'd already had an unannounced visit earlier on in the year from CQC because of somebody reporting us… I've now been informed that we're being [subjected]… to a peer quality audit assessment in July for our screening… and then I've had an email to say that the LSA [Local Supervising Authority] want to come and do their annual audit… this will be our third assessment from the LSA in 18 months, and it causes a huge amount of work… it just feels full-on constantly… the risk and quality team, there's two of us, that's it.'* [**Risk Manager, 1Gq-03**]

The general feeling among the participants employed by Oak was that the incumbent NHS providers wanted Oak to cease trading. This was on the grounds that women accessing Oak's services resulted in lost income for the incumbent NHS providers. To maintain their dominance in the local area, NHS resistance to Oak had taken the form of questioning the safety of Oak's service in anticipation that a regulator would eventually exercise powers to decommission Oak.

> *'It's all about finances… it's about [Oak] taking away [NHS Trust] money, it's about that. And if you take that out of the equation [NHS Trusts are] not bothered, they're not interested. So, they use the safety tool really to say [Oak are] an unsafe service, to try and get us decommissioned. They've done it a few times to try and get us to go away, to try and get NHS England to say that we're an unsafe service, they report us all the time to CQC to try and get them to close us down.'* [**Risk Manager, 1Gq-**

03]

Despite the national maternity policy pledge to offer four location options for women to give birth in their local area, only 12% of women reported having all four choices (Bourke, 2013). This had motivated some commissioners to work with their local NHS maternity units to increase access to all four locations and it had become evident to some commissioners that their maternity providers were unwilling to respond to requests to change. The lack of progress towards meeting the policy pledge had created conditions in which some commissioners were willing to contract Oak's service.

When Oak entered a new territory, this created strategic and financial anxiety for the incumbent NHS maternity units. Consequently, several Trusts sought to introduce or adapt their existing services to approximate the model of care offered by Oak and in so doing, aimed to negate the need for commissioners to invite Oak onto their territory. From my informal conversations with NHS colleagues in a number of different geographical areas, I established that this would often involve setting up of a 'home birth team'. The NHS midwives who set these teams up often found that they were well-received by women but perceived to be expensive to resource by the NHS maternity service due to on-call payments. Interestingly, once any threat from Oak dissipated, the NHS service tended to revert to their previous model of care and the newly-established teams were decommissioned or discontinued.

In another county, Oak were perceived to be 'poaching' women from the NHS by offering early booking appointments for antenatal care. The NHS maternity service in this area had typically booked women at around 10 weeks into their pregnancies. Consequently, the NHS maternity service decided to adjust their care pathway to match the early booking offer and created a single point of access for women.

Once Oak were regarded as a less significant threat over time, booking appointments returned to being scheduled for around 10 weeks.

What was found during data collection was that the incumbent NHS maternity services would respond to the perceived threat of the arrival of Oak into their territory by introducing a new model of care or adapting their existing approaches to service delivery. However, once the threat dissipated, the incumbent NHS provider tended to downscale adaptations or revert to their previous model.

7.4.2 Responding to non-isomorphic change

Maternity services in the NHS in England provide comprehensive care for almost all pregnant women. Services are usually configured as part of an acute NHS Trust, where the 'hub' delivers the majority of care through a multi-professional team in a hospital with access to obstetric theatres, neonatal care facilities and adult intensive care. In addition, care is provided in 'spokes' by midwives in primary care settings such as GP surgeries and health centres and women's homes, but the workforce is employed and managed by the acute provider.

The business model established by Oak represented a non-isomorphic change for the NHS maternity system. Firstly, they were a private limited company that was owned and managed by midwives. Secondly, they were a community-based organisation that did not incur the cost of providing the medical facilities normally associated with maternity care, although they referred women for shared care with NHS medical and obstetric providers as required. Thirdly, they were essentially a uni-professional organisation that employed midwives. Unlike GP-led organisations, the lack of a medical or multi-professional leadership at Oak left them open to criticisms from NHS regulators, commissioners and other providers that Oak were failing to perceive the risks that a caseload model posed, in the same way that the NHS organisations did.

> *'Oak explained that a Risk Summit had been undertaken over a week by a panel of external midwives that looked at Oak's clinical care. Oak brought the consultant obstetrician they worked with along to the last meeting with the reviewers and they said he spoke to them for 15 minutes. Oak said they received a letter following the summit that was 'very negative and derogative', but because an obstetrician had appeared 'they thought they could trust us'… the participants said that the panel of midwives preferred to believe a man and a doctor, rather than their female midwifery peers who had told them exactly the same information.'* [**Field Note, 1G-FN01-05**].

Oak used a different approach and method of documenting care provided by their midwives than the local NHS Trusts. This was not welcomed and led to the Local Supervising Authority Midwifery Officer (LSAMO) from NHS England visiting Oak to investigate further.

> `[*Oak's] maternity healthcare records… are very, very different… they only document or record care when the pathway of care deviates to high-risk… and that's a challenge for me who's always worked with fetal records. And we are exploring that because actually that's where there's tension because you know, [Hospital A] have detailed records… [Oak have] strived to almost be so very different that they struggle with me wanting to reel them in a little bit, which I deem to be acting in the best interests of everyone… Because they really want their own identity and that's really clouding some of their critical decision-making… I'm trying to say to them it's about decision, not choice. And you have to, as a midwife, say 'I respect and understand your choice but as a midwife the safest place now for you to have your baby is in the hospital'… And that's not easy to evidence because [Oak's] record-keeping doesn't demonstrate that level of conversation they've had.'* [**LSAMO, 1Lw-19**]

When one participant was asked if Oak had tried to work more closely with NHS Trusts, it was understood that they had explored this previously but found that NHS Trusts required Oak to deliver care in line with the guidelines written by the local NHS Trust that interpreted evidence in ways that often prioritised the institution ahead of the

service user. This was perceived to compromise Oak's philosophical approach to care and was therefore an incompatible arrangement.

> *'…it was really challenging because all of a sudden we had to start working under their [an NHS Trust's] policies and protocols and suddenly we weren't [Oak], the model was being compromised… so it was very difficult… '* [**Risk Midwife, 1Gq-03**]

Participants at Oak acknowledged that it was sometimes challenging for NHS commissioners and providers to assess Oak's service using familiar NHS systems and processes. In an effort to facilitate less friction between providers, Oak had attempted to engage local NHS Trusts by offering to formalise their relationships with service level agreements. However, it was reported that senior clinical leaders were apparently unwilling to enter into such agreements.

> *'[Oak] have a service level agreement that we try and have signed. So, [Oak's Clinical Director] would get in touch with the local [NHS] Trust, with the Head of Midwifery or the Director of Nursing or Midwifery, whoever it may be… and then we send that across and say 'This is generic, where do you want [it] changing? What do you want to put in? What will work for you?' So that we can try and agree some processes. [The] majority of [NHS] Trusts have all refused to sign them. So, it's a real challenge.'* [**Risk Manager, 1Gq-03**]

Indeed, it was seen that despite Oak having AQP status, which meant they had met the qualification criteria that technically permitted them to undertake non-commissioned activity within other CCG areas, several commissioners were still reticent about working with a non-NHS organisation like Oak.

> *'I think between 10 and 12 women were using the [Oak] service… we had concerns because [Oak] could not provide us with clinically quality data that would assure us of the service that those women were going to receive. Despite the fact that [Oak] were commissioned from another CCG, we did not receive anything that would give us assurance that it would be safe for*

women to go there. I am not saying that it is not safe, but we have not had assurances from our point of view'. **[Senior Commissioning Manager, 1Fc-15]**

Oak had contracted an experienced consultant obstetrician from one of the large NHS Trusts in London to work for them on a part-time basis to support them in developing care plans for women with complex health needs. During their interview, they perceived that NHS colleagues rumoured that women were being encouraged not to comply with clinical guidelines by Oak. However, from their direct experience of working with Oak, they had come to recognise that Oak worked hard to keep women within guidelines.

'I also found out… that there's lots of misunderstanding [in the NHS]… that organisations like [Oak] are actually pushing women… to do things that are outside the guidelines. Where[as] in my experience, it's the other way round…' [**Consultant Obstetrician, 1Gf-18**]

Oak found that their stakeholders often did not fully understand Oak's relationship with the NHS, how their business model worked, or had misconceptions about how their caseload model of care operated.

'… when I first worked for [Oak] and was setting up the [name of locality] team, it was the most political experience of my life probably (laughs). And I had really no idea how political it was going to be. So, I was really quite shocked actually at how much sort of backlash we got and just doubt, fear, it was really unbelievable.' [**Training Midwife, 1Gu-10**]

'[Oak are] perceived as a home birth service and it's like 'we're not, we're not a home birth service, we're a maternity service.'…it's more about that choice [for women]… some CCGs welcome us with open arms and want to really work and engage with us. Other CCGs work with us but more hesitantly and are anxious and feel like they're taking a big risk, I think… unfortunately [Oak] is deemed as outside[rs], as different (laughs).' [**Risk Manager, 1Gq-03**]

'Because [Oak] work well, on-call 24 hours a day, six days a week, it's hard for [NHS] people to understand what that actually is. That that's not working 24 hours a day, that it is safe,

> *that the midwives ourselves decide whether we've been working for too long… I think there's misconceptions… one of the midwives on labour suite [NHS] said to me 'That's absolutely ridiculous, absolutely ridiculous being on-call all the time, you'll burnout, you'll last one year, it's ridiculous, you'll never make it work, it's not sustainable'.* [**Caseload Midwife, 1Gl-06**]

In terms of their model of care, Oak were very clear that they wanted to distinguish themselves as philosophically different from the incumbent NHS providers. However, when it came to accessing services available to NHS providers, Oak wanted to be treated as equal in terms of standards costs, such as those associated with laboratory services or accessing university courses funded by the NHS for midwives for example.

> *'…because you're seen as a private service… everybody wants to charge you for everything. And it's like, 'well no, because we're providing NHS care, we're not a private service, we're an alternative provider but we give NHS care, it's free [to women]'… you're very much side-lined saying you're not NHS, it's a big divide. We've recently had somebody declined to do a university course because she was non-NHS, they said you can't do it because non-NHS, you're a private company and you can't have a place. So, we had to go back to say right, this is how it is and that's not been solved as yet but it's just that because we don't fit … we're not an NHS Trust.'* [**Consultant Midwife, 1Gp-02]**

7.4.3 Managing organisational boundary friction

In terms of dysfunctional co-existence, participants often drew attention to friction between Oak and NHS providers. Oak midwives had often worked in the NHS organisations that they were now competing with, and still had friends and colleagues working in those organisations who would talk to them about how Oak were being perceived.

At the strategic level, senior midwives from Oak were not afforded parity of esteem. While Oak staff acknowledged that Heads of Midwifery could be amiable with them on a one-to-one basis, as a group from across the region, they would generally show solidarity to

one another and resist Oak being given a seat at the table for key meetings such as the Heads of Midwifery forums or local service transformation meetings.

> *'And I know that there is a lot of [Oak] bashing within that environment. But… as long as they treat us well I really don't mind. But we should be… our Head of Midwifery, well we don't have a Head of Midwifery, but our Clinical Lead if you like, should be invited into those forums but we're not. We've been declined access to them.'* [**Quality and Governance Lead, 1Gr-04**]

At a practical level, Oak midwives often described interactions with some NHS provider staff as problematic for themselves and at times the women in their care. One participant from Oak reflected that going into an NHS hospital was the worst part of her job due to the hostility she perceived was directed at her from the NHS staff.

> *'There is a certain antenatal clinic manager who absolutely hates [Oak] and she used to be very rude to us. We haven't had to go in for a while, me personally. She's very rude to the women. She'd actually take them to one side in the room and tell them… we [the Oak midwife] can't go in [with them to see the obstetrician]… I think the Consultant [Midwife at Oak] reported her to the NMC [professional regulator] and said she's bullying the woman and she's bullying our midwives.'* [**Caseload Midwife, 1Gl-16**]

> *'Well [women have] been told [by Supervisors of Midwives] that you know, don't go to [Oak] because they have midwives there that aren't able to practice, they don't have a PIN [active professional registration as a midwife]. What?! (laughs) Why would you think that?'* [**Risk Midwife, 1Gq-03]**

At the time of data collection, Oak had not been granted permission by any NHS Trusts to provide midwifery care on a hospital premises. However, Oak as an organisation had asked their midwifery staff to consider accompanying women on their caseload into hospital to support them giving birth in the unofficial capacity of a doula. This participant described an experience where she had felt she had a professional duty as a midwife to advocate for a woman by challenging

how the hospital midwife was caring for the woman. She went on to describe how this had created a difficult atmosphere until after the baby was born.

> *'I just said to [Oak] because they did talk about us [Oak midwives] going in as doulas for our women who want to birth… and I said I'm not going. No, I'm not being put in that position and I'm certainly not putting my women in that position where really… they're kind of in the middle of two different philosophies.'* [**Caseload Midwife, 1Gl-09**]

Some participants were able to reflect and question whether this negativity was exacerbated by being disproportionately amplified across several large NHS Trusts by individuals who imagine Oak as a larger threat to the NHS than Oak perceive themselves to be. Suggestions that Oak represented privatisation of the NHS was regarded by Oak as a 'red herring' and propagated by those with vested interests in maintaining the status quo.

> *'Some GPs are spelling it out saying that '[Oak] kill babies'. 1Gq-03 tells me Oak have copies of 'horrible letters' from one particular area where GPs have told women that the Oak midwives aren't insured, that they will send you a bill at the end of your care, and that you'll have to pay for all your care. Says it is just completely made up lies and that they do not spare their language. 1Gq-03 says she thinks GPs and obstetricians see themselves as above legal remedy and that they can do what they like because Oak are 'only' midwives… CEO says privatisation pushes a lot of buttons, but regards it as rhetoric as she fells Oak are not taking enough women away from the NHS to be a problem.'* [**1G-FN01-04, 10**]

> *'I do get the sense that you know a lot of the animosity comes from [NHS Trusts]… because they think that, you know, we're being really negative about them and trying to turn the women against them. Whereas actually, you know, we try not to do that because it would be really unprofessional to do that.'* [**Caseload Midwife, 1Gl-17**]

To address these perceptions, Oak made efforts to visit different NHS providers through the Supervisor of Midwives forums to offer reassurances that Oak were seeking partnership with NHS providers

and not to threaten the hospital's survival, principally because a significant majority of their women would be choosing to birth in hospital.

> *'…I've gone in [to the NHS providers] and given presentations in the area from the supervision perspective, trying it a different way to try and get the supervisors engaged so that they can assure the midwives that they're not going to lose their jobs and that it's about partnership working and about choice. And yes, we have a home birth rate but we also have a lot of mums that choose to birth in hospital.'* [**Risk Midwife, 1Gq-03**]

It was evident within the data that Oak had limited resources as a small enterprise to counter the full weight of resistance from multiple NHS providers, commissioners and regulators. There was a tension between claims that Oak were threatening jobs and local maternity unit survival. However, it may be reasonable to conclude that claims that Oak's model of care was introducing unacceptable risk into the maternity care system was actually a rhetorical device aimed at side-lining or shutting down competition.

7.4.4 Summary

This theme has explored some of the challenges and resistance that Oak, a small company employing around 40 midwives, experienced when they entered the mature-institutional field of NHS maternity services. Women were opting to use Oak for their maternity care and this caused significant strategic anxiety on the part of NHS providers who had traditionally been the only providers of maternity care in their locality. What followed was rhetorical catastrophising where Oak and their collaborators i.e. commissioners or women that were opting to use Oak's service, were constructed as the potential architects of hospital closures caused by NHS maternity services losing revenue to Oak.

Resistance by NHS Trusts to the national policy agenda aimed at expanding consumer choice which sanctioned competitive tendering was generally considered futile. Therefore, the rhetorical arguments

against Oak entering the market tended to take the form of questioning Oak's risk and safety profile. This could be amplifying clinical incidents associated with care provided by Oak in one area, to NHS providers and media organisations in other areas with the intention of eroding Oak's reputation. It also took the form of Oak's opponents repeatedly referring them to regulators which resulted in Oak being diverted to defending their service, rather than growing and expanding it.

On a practical level, Oak found themselves to be encircled by NHS organisations that were largely unwilling to engage, cooperate or collaborate with them. This presented difficulties for Oak to create frictionless borders for the women using their service who also required input from local NHS providers. The feasibility of policies promoting more plurality of choice had been resisted or disputed as unviable from both workforce and financial perspectives by many acute maternity providers. Oak's arrival with their offer of a caseload maternity service being provided within tariff, appeared to be a proof of concept for the national policy for extending choice. By extension, this presented innovation pressures for NHS services who were comfortable with centralised models of care, rather than community-led models. For their part, Oak sought to be regarded as different to the NHS, but not separate from it. This fluidity in Oak's identity contributed to tensions with the NHS providers who suspected that Oak were not subject to the same regulatory standards as they were and that they cherrypicked the easiest clients.

7.5 Discussion

7.5.1 Reflections

Oak was an agile organisation that benefited from not have the weight of a large NHS maternity hospital to bear along with the associated costs. They were also able to select areas to target that were identified as struggling to meet the needs of their local population. They were

able to adapt and change their model rapidly, introducing new ways of working across a small workforce etc.

In terms of non-isomorphic change, several NHS trusts were unwilling to acknowledge that Oak achieved their results because they operated differently to the models of care they offered to local women. In terms of their governance and training programmes, Oak were expected to manage their organisation in the same way that large NHS providers did. While NHS Trusts employed teams of individuals to meet regulatory requirements and prepare for inspections, there was a relatively small dedicated resource at Oak to conduct the same level of activity which was often onerous and repeated, due to the number of referrals being made by other NHS providers to regulators.

Oak managed care planning using risk management approaches – where the women were described by non-service user participants as 'owning' the risks they were prepared to take. This was an anathema to many NHS providers who regarded Oak as coercing women to make inappropriate decisions to give birth at home so that Oak could benefit financially from the tariff payment system. Arguably, women were choosing to birth at home to receive continuity of care from their Oak midwife – this may have been against Oak's advice, but due to the NMC regulations midwives are not permitted to refuse to provide care for women in labour, in the same way that GPs and obstetricians can. From the accounts provided by non-service user participants from Willow, it was evident that when Oak supported women to birth at home outside of local NHS guidance, local NHS providers were appalled. NHS providers were also refusing to grant permission for women to receive midwifery care from Oak midwives in their hospitals, as Oak would only comply with their own guidelines and no agreements around what proportion of the tariff payment would go to each organisation could be reached.

It could be argued that the incumbent NHS providers response to Oak was a rational response to national concerns around high profile failures in maternity services (Kirkup, 2015) and high levels of litigation (The Supreme Court, 2015). This ongoing scrutiny of maternity services from central government may be implicated in a large-scale drift towards paternalism. Because of ongoing financial pressures, women are increasingly expected to access care in more centralised and institution-based settings.

In contrast, Oak sought to share decision-making in partnership with women. This involved discussions around ways to reduce the exposure to unnecessary risk and planning to mitigate those risks. This approach to relinquishing power to women, meant that Oak were able to serve a niche market of women that was steadily expanding through word of mouth, but also through active marketing and networking strategies. This involved building effective relationships with open-minded commissioners and being prepared to showcase their model of care to national networks and conferences.

Oak's willingness to engage in self-promotion came at the cost of diminishing their relationship with local NHS providers who regarded this as 'poaching' their service users. What NHS providers were potentially unaware of was that Oak had zero-activity contracts, which meant that they had to generate income from activity in order to survive.

The existence of Oak was heavily contested by adjacent NHS organisations on the grounds of safety i.e. that the care they provided was unsafe; or claiming it threatened the sustainability of existing NHS organisations. These arguments were often supported by those fearful that this would lead to privatisation of the NHS. Resistance to Oak came in many forms. These included raising complaints that led to

investigations by regulators and commissioners into Oak's practices, undermining women's confidence in Oak through rumours around safety, and creating an unwelcoming and difficult environment when women access maternity services.

Despite the hostile operating environment, Oak was continuing to grow as an entity and were re-institutionalising home birth as a viable option for women they provided care to. Through their counter-action, they actively opposed arguments that safety and choice were mutually exclusive, and rather, regarded them as interdependent. They also actively opposed the dominant rationale that hospital was the only safe option for women to give birth and sought to deliver a service that mitigated the effects of the safety minimalisation discourse through their contrary actions.

Oak have survived and plan to expand their services. To some degree they are relying on central government policy and commissioning level support to progress their model. They are a uni-professional organisation which is a strength on one level in that their philosophy is kept pure. However, from an outside perspective they are insular and risk 'group think' by not having a multi-professional input to their model of care. In striving to be different to the NHS, but also part of the NHS, this lays them open to criticisms of cherry-picking clients that are the easiest to care for. Oak's desire to present themselves as having a fluidity of identity within the NHS, brings them into conflict as they accused of seeking to exploit the NHS for favourable conditions for themselves and opt-out of the responsibilities that are expensive for NHS Trusts to deliver.

In response to national policy drivers, commissioners were incentivised to create more choice of place of birth for women by opening competitive tendering processes that created markets for AQPs. Oak

had met the established criteria to gain AQP status by 2010 and secured a hosted contract in one geographical area of England. It could be argued that these adaptations to the existing commissioning framework were regarded as a 'precipitating jolt' by the incumbent NHS providers and threatened their 'deinstitutionalisation' with the emergence of a 'new player' who was using entrepreneurial acumen to enter the market (Greenwood et al., 2002).

7.5.2 Positioning Oak in the literature

This chapter explores the relationships and interdependencies between Oak and the incumbent NHS network of providers and commissioners that were delivering services to the same populations. It details the activity that was involved in creating the opportunity for competition; how the market evolved and was shaped over time; the degrees to which the emergence of a competitive environment initiated conflict and resistance from incumbent providers; and how wider pressures have led to a form of co-existence with ongoing resistance, rather than a peaceful settlement between stakeholders.

Rogers (2003) suggests five categories of innovation adoption [**Figure 13**] to demonstrate how the type and amount of adoption changes over time, from the initial 'innovators' at the very start through to 'laggards' at the end of the process. For Oak, it could be argued that they are on a journey of innovation and will experience different 'adopters' at varying stages. At the time of this study, Oak's initial CCG contracts and their early service users could be regarded as the 'innovators' i.e. willing to cope with the uncertainty of a new non-NHS maternity service provision. Rogers (2003) describes these innovators as having 'venturesomeness' – a willingness to take risks. This was evident from data collected with local commissioners who were prepared to try this new idea from Oak. Similarly, service users were essential innovators for Oak, sharing their experiences through social media and word of mouth to encourage early adoption by their peers.

Using the model developed by Rogers, Oak could be said to be seeking to move beyond their innovators towards interesting a body of 'early adopters' and beyond in their service. These early adopters would be critical to enhancing Oak's status in the field by decreasing uncertainty about the new provider and putting their 'stamp of approval' on it. While the bell curve of adoption [**Figure 13**] is a generalised position and tends to average out the observations, only time will tell whether Oak's strengthening position in the market continues and their adopters move to become the average 'majority'.

Figure 13: Adopter categorisation on the basis of innovativeness (Rogers, 2003: p.281)



Oliver (1992b:564) defines deinstitutionalisation as 'the process by which legitimacy for an established or institutionally organised practice erodes and discontinues'. However, Dacin and Dacin (2008) have modelled the gradual deterioration of practices as being moderated by entropy and inertial pressures. Unlike Willow or Sycamore, Oak was a non-NHS provider of NHS funded care. Oak was philosophically different to NHS providers, in that they did not subscribe to a

consensus among the provider community that home birth was an outmoded option for place of birth. What can be seen in this case study is how strong the inertial force against any threat to deinstitutionalising birth in a hospital setting was, and how Oak navigated this landscape.

Ultimately, there is little consensus regarding the strategies and dynamics of how institutional forms and practices, such as home birth, fail to become completely extinct. Re-institutionalisation from an eroded base position suggests that there is a new consensus or societal paradigm shift that the existing way of managing birth in hospitals is flawed and needs to change. However, the idea that new players and actors emerge to drive change forward suggests that the AQPs will have sufficient credibility and capacity to demonstrate innovation and technical viability at a scale deliverable across the universal system of the NHS. However, in the case of Oak, there was little evidence that AQPs were able to achieve significant market penetration, potentially because at the time of data collection, less than five organisations were established to respond to the liberalisation of the maternity care market. Moreover, these organisations were predominantly uni-professional, female-led and were small to medium enterprises – rather than large international healthcare corporations e.g. BUPA, VirginCare, Circle etc. Through this theoretical lens I have sought to understand and explain the countervailing activities of Oak in a competitive environment to enact non-isomorphic change in the NHS.

7.6 Summary

This chapter has captured the story of a small midwife-led organisation that emerged as a contender for NHS maternity care contracts. At a macro level, this was facilitated by changes in the national policy landscape associated with commissioning and choice. At the meso-level, Oak emerged as a result of political and strategic will from local commissioners to tender a contract for an alternative provider to the

local NHS maternity unit due to their poor relationship with them. At a micro-level, Oak emerged because of the entrepreneurial tendencies of one particular midwife who used her social and reputational capital to capture the first contract of this kind in England.

7.7 Conclusion

Once Oak had the security of their first contract, they set about developing a market of service-users who had been under-served by the existing provision on offer from the NHS. This involved recruiting a 'tribe' of midwives who supported Oak's philosophy to provide relationship-based care, rather than care focused around an institution or professional group.

Alongside this activity, NHS providers responded with alarm to the perceived threat to their historic monopoly and canvassed support from commissioners, regulators, the media and service users to resist this intrusion. The complexity of NHS commissioning meant that NHS providers who had large overheads associated with providing acute care facilities and staff were not competing on a level playing field with a small, agile, uni-professional organisation like Oak. Oak needed just one CCG to commission them to maintain their market presence and for women to continue to choose them. While growth has been slower than Oak originally anticipated and they have felt the brunt of NHS non-cooperation, Oak have continued to satisfy regulators and they have made small adjustments and compromises that pay lip service to the NHS desire for isomorphism from Oak. Oak have continued to provide maternity care to increasing numbers of service users. Within the wider maternity transformation agenda, Oak have established themselves as an early-adopter with a track record of successful performance. However, they remain reliant on macro-level support for commissioning for choice, at the meso-level for ongoing contracts from CCGs, and at the micro-level for a workforce willing and able to deliver the model of care in a way that continues to achieve favourable outcomes despite

the lack of engagement, cooperation and collaboration that they have experienced up to the time of completion of data collection.

Oak have found themselves regarded a foe of the NHS. They were perceived by some of the adjacent organisations as exploiting the NHS system for financial profit and that their philosophical approach to informed decision making led to care which compromised the safety of women and babies. Some NHS commissioners and providers sought to prevent intrusions into their territory by creating regulatory barriers through raising complaints and concerns about Oak's service.

8.0 Discussion

8.1 Introduction

This discussion chapter will interpret and explain the study results from the three case sites – Willow, Sycamore and Oak – and relate them to the research questions, aims and objectives. It will then progress towards a cross-case analysis integrating the wider theoretical literature from within the field of organisational institutionalism.

8.2 Addressing the research questions

The three over-arching research questions for this study are:

- **RQ1**: What strategies are used by service leaders to identify new institutional opportunities for change?
- **RQ2**: How are the rhetorical arguments for and against change mobilised by stakeholders?
- **RQ3**: How do stakeholders utilise additional social networks to implement change?

8.2.1 RQ1: What strategies are used by service leaders to identify new institutional opportunities for change?

This study considered the ways that different stakeholders at each of the case sites identified opportunities for change. It also sought to understand how individuals and groups created, maintained and disrupted established ways of working. In particular, it sought to understand policy imperatives, institutional pressures, as well as professional cultures within maternity services.

At Willow, an organisational consensus had emerged that local women did not want to give birth at home. This led to a significant erosion of the legitimacy of non-institutional birth among maternity professionals. However, inertial forces to resist this consensus were apparent through the activities of commissioners, a non-NHS provider and a private

provider that offered women this alternative. Change was being driven by both endogenous and exogenous forces.

At Sycamore, change was also being driven by exogenous forces. The prioritisation of providing assurance to external regulators and commissioners that the acute unit maternity service was safe and effective impacted on the relationships between a range of key stakeholders. In tandem, changes to the CM on-call system was creating disruptions to their willingness to support and promote home births, contributing to its erosion as a core offer at Sycamore.

Oak emerged as a result of political and strategic will from local commissioners to tender a contract for an alternative provider to local NHS maternity units. At a micro-level, Oak emerged as a result of the entrepreneurial tendencies of one individual midwife who recognised a problem and proposed a plausible solution. Oak represented a non-isomorphic change to the strategic action field.

8.2.2 RQ2: How are the rhetorical arguments for and against change mobilised by stakeholders?

This study focused on the agendas and discourses pertinent to maternity care that were used to either promote or obstruct change at both the macro- and micro-levels. The study of the macro-level, in terms of research agendas and national standards and policies was enhanced by exploring the micro-level, in terms of the actions and motivations of individual actors.

Home birth at Willow was perceived as a risky, expensive and awkward service to deliver. Service leaders argued that their maternity unit was a superior choice as it was staffed by a multi-professional team, had modern resources and good facilities – including single rooms. They perceived competitors as exploiting the NHS system for profit and their model of care to compromise the safety of women and babies. Some

NHS commissioners and providers sought to prevent intrusions into their territory by creating financial and regulatory barriers. Some CMs at Willow have continued to remain committed to home birth as a concept, however they are a dwindling force of custodians that are willing and confident to promote home birth.

Sycamore's midwifery managers sought to present the CM workforce as complimentary to the acute unit and as highly flexible to cover periods of high activity in the hospital. The obstetricians expressed support for home birth, providing it did not pose a threat to the acute unit. Midwifery managers characterised the CM workforce as almost entirely positive about facilitating home birth. However, the CMs interviewed for this study regarded the new on-call system as a cost-saving initiative that was diminishing their capacity to support home birth consistently. Further, using the CM workforce as a flexible resource for the hospital was contested and resisted by CMs who feared that the home birth service was being deprioritised and eroded by service leaders.

For Oak, once their contract was established, they actively developed a marketing strategy that promoted their offer to service-users who had been under-served by the existing provision on offer from the NHS. Further, they looked to expand their workforce by recruiting midwives who were philosophically aligned with the concept of relationship-based care, rather than care focused around an institution or professional group. This continued to create tensions with adjacent organisations and Oak suffered from a lack of engagement, cooperation and collaboration from NHS provider organisations.

8.2.3 RQ3: How do stakeholders utilise additional social networks to implement change?

Attention was directed towards legitimacy contests associated with maintaining and transforming institutions in the strategic action field of the NHS. This research explored how different healthcare professionals

captured attempts at reform to maintain or extend their influence, or counter the interests of others utilising social networks and supplier confederations to implement or disrupt institutional change.

Willow responded with alarm when an alternative provider entered their territory as this posed a threat to their monopoly. They canvassed support from commissioners, regulators, the media, neighbouring NHS Trusts and service users to resist this intrusion. In addition, they sought to re-capture their market by bidding for the contract held by the alternative provider by partnering with a local community NHS Trust when it came up for renewal.

There were divergent narratives around the home birth service at Sycamore. One regarded it as a self-sustaining service that would continue to succeed. The other, presented by CMs themselves, believed it was diminishing in the face organisational threats. Participants in this study suggested that the CM workforce were undertaking countervailing actions based on the historically strong relationship-based model of care with women at Sycamore, to maintain their ability to support home birth.

Oak was a small organisation that needed just one NHS contract to maintain their market presence. It was also essential that women continued to choose them. Oak were a progressive and outward-looking organisation. They actively used social media and promotional strategies to enhance their visibility to potential service users. At a strategic level, they sought out relationships and representation with the 'movers and shakers' in maternity transformation at a regional and national level.

8.3 Overview of research aim and objectives

The principle aim of this study was to explore factors that shaped the institutional work of a non-dominant professional group (midwives) in a

mature institutional field (the NHS) who are seeking to maintain or transform the availability of an existing institutional practice (home birth). It sought to understand and explain the work involved in creating, maintaining and disrupting divergent models of health service organisation and delivery, with a specific focus on maternity care provided to healthy women who choose to give birth at home.

This study investigated questions about the priorities that frame the allocation and management of health service resources and sought to understand how opportunities to advance new institutional practices were recognised, created or resisted by different stakeholders.

Particular consideration was directed towards legitimacy contests associated with advancing or preventing change in strategic action fields. It explored how practitioners captured attempts at reform to maintain or extend their influence or counter the interests of others.

The degree to which intra- and inter-organisational relationships are developed, established and maintained to influence institutional change were also explored in this study. Further, the mechanisms by which service user experiences are articulated and integrated into scripts that either promoted or delegitimised institutional practices at both the micro- and macro- levels were examined.

Qualitative research methods have been particularly suitable for this study as it has sought to contribute to wider health agendas through new insights into the institutional work of non-dominant professional groups in a mature institutional field. In the tradition of qualitative health research, this study has sought to understand the processes involved in constructing legitimate models of maternity care that support home birth, who has or is seeking power to produce legitimatising classifications that maintain or transform existing

maternity care services, and what the implications of these classifications might be for a range of different stakeholders at practical and theoretical levels (Green & Thorogood, 2009) [see also section 1.1. of this thesis].

8.4 Overview of qualitative case study approach

In Chapter Four, the rationale for undertaking a qualitative case study approach to address the aims and objectives of the research questions was presented. An inductive strategy as a way to logically infer possible explanations for patterns in the data to identify structures or mechanisms that might have produced them was employed. Integrating different perspectives where understanding needed to be holistic, comprehensive and contextualised (Myers, 2013) meant that a case study approach with the prior development of theoretical propositions to guide the data collection and analysis was considered the most appropriate for this study (Yin, 2014). The research design involved a variety of data collection methods including: documentary analysis; non-participant observation; semi-structured interviews; and focus groups.

In this chapter, I have employed a cross-case synthesis approach to the data collected from Willow, Sycamore and Oak. The rationale for this is so that I can demonstrate how the exploratory nature of this research at each case site has contributed to my theory-building around rival cross-case patterns (Yin, 2014) which is presented in the conceptual framework that is revealed later in this chapter at section 8.12.

8.5 Revisiting the research problem

This study set out to understand how an institutionalised practice such as home birth which was regarded to have utility until the second half of the twentieth century, eroded over time but has never been completely extinguished in England. It can be argued that the success of home birth was premised on a model of relationship-based care between a woman, her family and a midwife. Over time, birth was

increasingly centralised into large acute hospitals by the NHS, arguably driven by profound societal changes, as well as professional, technological and regulatory agendas. Care began to be delivered in 'care episodes' with professionals following care pathways and algorithms based on risk factors. For over 20 years, national policy (for example: Cumberledge, 2016; Department of Health, 2007) and research evidence (for example: Birthplace in England Collaborative et al., 2011; Schroeder et al., 2012) has supported home birth as a particularly suitable, safe and cost-effective choice for certain pregnant women. Yet, the legitimacy for home birth being offered at an institutional level in the case sites in this study remained widely contested.

8.6 Key works used to develop theoretical interpretation

This chapter proposes a conceptual framework for post-deinstitutionalisation that extends the works of Oliver (1992b), Greenwood et al. (2002), Reay et al. (2006) and Dacin and Dacin (2008) in important ways.

Oliver (1992a) defined deinstitutionalisation as 'the process by which legitimacy for an established or institutionally organised practice erodes or discontinues (p.564). My intention was to identify a pathway from deinstitutionalisation to reinstitutionalisation and these theoretical works were particularly pertinent as they presented models for institutional change (Greenwood et al., 2002), a model of institutionalising (Reay et al., 2006) and the seminal work on deinstitutionalisation by (Oliver, 1992a) which was later extended by Dacin and Dacin (2008).

The insights gained during this research of home birth have allowed me to offer a contribution towards a fuller and richer understanding of

deinstitutionalisation and to extend it beyond that of Dacin and Dacin (2008).

I argue that the status of custodians in the institutional field have a significant impact on the process of reinstitutionalisation. This is in contrast to institutional remnants re-emerging and regaining legitimacy as a result of custodians reconstructing a new institution, or legitimacy being recaptured by institutional entrepreneurs from the micro to the macro level to achieve a density of diffusion (Dacin & Dacin, 2008; Greenwood et al., 2002; Oliver, 1992b; Reay et al., 2006). Further, I propose that home birth will not achieve density of diffusion and will continue to erode while it remains vulnerable to the strategies and interests of dominant occupations and powerful groups within the NHS.

I propose that this research demonstrates how the conditions in which a non-dominant (and feminised) professional group (midwifery) in a mature institutional field (the NHS) were unable to convince the field that this particular institutional practice (home birth) could be integrated successfully and provide value to established structures and systems. Despite extensive and robust evidence for safety, cost-effectiveness and service-user satisfaction associated with low-risk pregnancies, home birth has failed to re-capture or increase its legitimacy or become 'taken for granted'.

In the following sections, I discuss and position my research findings in the context of these theoretical models and show how they lead to a new conceptual framework that more adequately explains the phenomena encountered and observed.

8.7 Major findings from each case study

This section presents cross-case analysis and interpretation that links each case site to the theoretical approaches within organisational institutionalism.

8.7.1 Willow

Oliver (1992) has explained how deinstitutionalisation may be a political response to changing power distributions as well as a reaction to fears around imminent failure within the organisation. What was observed at Willow was a mounting performance crisis and conflicting internal interests. This is what Greenwood et al. (2002) would describe as a precipitating jolt. Demands from the commissioners to offer more choice to the local population, was met with resistance from Willow, which ultimately led to the competitive tendering process for an alternative provider. There was also a prevailing mentality among participants from Willow that the AU and AMLU were superior choices to home birth. Strategic change at Willow appeared to be 'top-down' leaving frontline CMs with little opportunity to participate in service redesign or collective engagement with women seeking choice.

In terms of the functional pressures (Oliver, 1992) associated with the erosion of home birth as a service at Willow, there appeared to be significant challenges to the perceived economic utility of home birth; but also, the comparative risk profile of home birth when compared with AU or AMLU birth. CMs were regarded as lacking in confidence and experience with home birth and that the on-call costs to support home birth were prohibitive. Despite the leadership at Willow recognising an opportunity to advance a new service by bidding for the AQP contract, there was little evidence that they believed this would translate into an increase in women choosing to birth at home. This is in contrast to the findings of Reay et al. (2006), as the AQP bid by Willow was not sufficiently different to the existing system for home birth, which already struggled to be regarded as legitimate.

In terms of social pressures contributing to the deinstitutionalisation of home birth at Willow, it can be seen that there was increasing social fragmentation and decreasing historical continuity (Oliver, 1992) in

providing this service to women. This took the form of a changing workforce demographic that was perceived to seek improved work-life balance at Willow and a lack of regular exposure to providing home birth care over the long-term. Oliver (1992b) also cites changing institutional rules and values and increasing structural disaggregation as external social pressures for deinstitutionalisation. At Willow, despite the requirement to offer the national choice guarantees (Department of Health, 2007), there was no consensus about the best way for this to be delivered. As an organisation, Willow had retreated to a risk minimalisation approach to maternity care, which ultimately favoured institutional birth, ahead of home birth.

8.7.2 Sycamore

Oliver (1992b) has explained how deinstitutionalisation may be a political response to changing power distributions as well as a reaction to fears around imminent failure within the organisation. At Sycamore, diminishing a marginal practice i.e. home birth, and taking advantage of the utility of a minority workforce i.e. community midwives were regarded as legitimate compromises to strengthen safety in the core service of the IU during a period of intense scrutiny. The political pressures brought to bear by regulators initiated a mounting performance crisis at Sycamore which surfaced as conflicting internal interests between the hospital and home birth. Using the model of Dacin and Dacin (2008), this can be regarded as a decoupling reaction that created both a crisis for the home birth service, and meant the service entropic drift towards deinstitutionalisation.

What can be seen at Sycamore is that the functional utility of an institutional practice such as home birth is called into question when efficiency or competition for resources from the IU appeared increasingly incompatible with the organisational objectives around safety and quality. Further, the necessity of home birth began to be challenged largely on economic grounds (Oliver, 1992b). In times of

austerity, the logic of limiting choice sits comfortably with resource management and for Sycamore, avoiding any pressure to provide a portfolio of choice to destabilise the core services in the IU. The complexities of providing a workforce that can attend birth in the community 24 hours per day, 365 days per year within traditional employment models are seen as challenging and problematic too. Having CM staff on-call and inactive is viewed as financially inefficient. Being able to utilise those staff in the IU is seen as cost effective, but it fails to recognise that CMs often make a conscious choice not to work in an acute hospital setting and resent being used as a 'flexible workforce'. This could be regarded as disturbing the socially constructed field level consensus in what the model in Greenwood et al. (2002) would suggest is a precipitating jolt that triggers deinstitutionalisation.

Deinstitutionalisation may also result from social pressures such as normative fragmentation and historical disruption (Oliver, 1992b). At Sycamore, these included workforce diversity and diversification i.e. CMs required to work across both the community and IU; eroding socialisation mechanisms i.e. CMs working in the IU during escalation, rather than rotating into the IU in a routine, planned way; mergers i.e. the threat of the LTP with a neighbouring NHS Trust; changing societal values and expectations i.e. the competing rhetorical arguments for and against choice and safety among participants; and geographical dispersion i.e. reducing the on-call cover in Sycamore from four to two CMs and the impact of this on the availability of CMs to care for women who had planned home births. So these changes, rather than radiating from the micro to macro level and gaining legitimacy among the CMs, it had precisely the opposite effect (Reay et al., 2006)

8.7.3 Oak

Mounting performance problems tend to create internal political dissensus and create a mandate for challenge (Oliver, 1992b). In the areas where Oak were commissioned, it was apparent that shared interpretations of the demand for home birth had fractured between NHS providers and commissioners. Oliver (1992b) has argued that 'reciprocal typifications' on the meaning, form and validity of an organisational activity, hospital birth in this case, is required for ongoing conformity. For the Oak case site, the reciprocal typification was for NHS providers to assert that there was no unmet demand for home birth and that institutional birth was the preferred option for 99% of women. Local commissioners perceived that incumbent NHS providers were failing to implement research evidence and deliver on the national policy agenda that required providers to offer more plurality of choice of place of birth. Commissioners in Oak were challenging the moral and pragmatic legitimacy of hospital birth and sought to increase the diffusion of this type of care to local populations (Greenwood et al., 2002).

The functional utility of home birth was regarded as threatening organisational performance and effectiveness. This was largely due to a climate of regulation that encouraged risk minimalisation in maternity, and where staffing an under-utilised home birth service was regarded as uneconomical. Oliver (1992b) states that an 'institutionalised practice is one which is perceived by organisational members to possess intrinsic worth or legitimacy beyond its technical requirements' (p.571). In terms of home birth, Oak's company philosophy was to support the right of all women to make an informed choice about their place of birth. In contrast, the perceived utility and technical instrumentality of home birth had been largely eroded and deinstitutionalised among the NHS providers in the localities where Oak were commissioned. Financial austerity had intensified the erosion of home birth by creating

competition for resources between acute and community maternity services. For Oak, the remnant of home birth provision in the localities where they were commissioned provided opportunities to construct and reinvent a new service for a niche market of women who were under-served by the existing NHS providers (Dacin & Dacin, 2008).

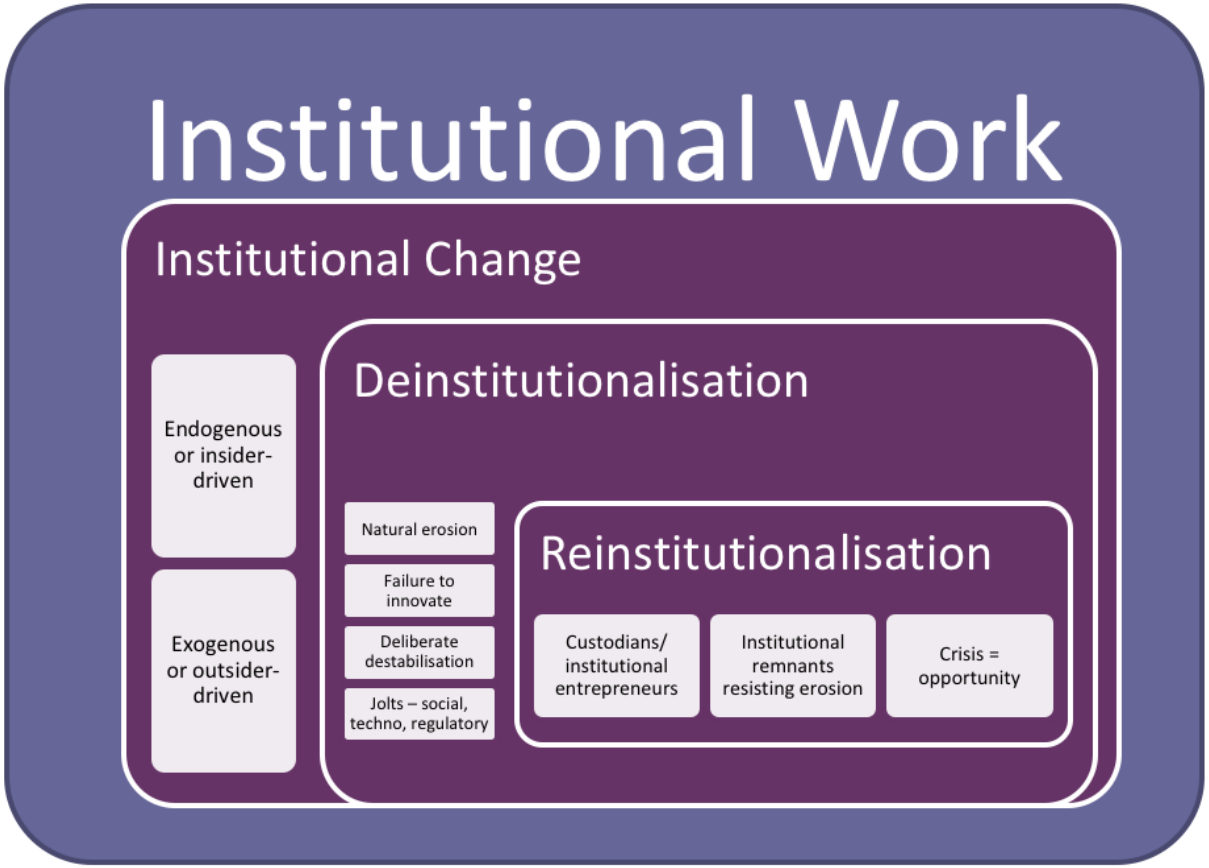
Ultimately, Oak remained vulnerable to deinstitutionalisation because their position in the institutional field was loosely-connected, dysfunctionally-interactive and locally differentiated within the NHS network (Oliver, 1992b).

8.8 Synthesis and interpretation of the data

The cross-case analysis and conceptual framework was iterative and data driven with several models tested, refined, rejected before settling in the field of organisational institutionalism.

One of the early concept models that was tested is presented in **Figure 14**. It seeks to position the relationships of theories and ideas that I was exploring to make sense to the data early in the collection and analysis phase. My focus began to concentrate towards an idea of reinstitutionalisation. However, as data collection progressed, I became less convinced that home birth was thriving in each of the case sites and that this would not explain what I was seeing in action. I was anticipating that home birth providers with rates above the national average would be demonstrating countervailing activities that would explain their higher performance. What became evident was that the priority given to home birth was very different in each organisational structure.

Figure 14: Pictorial representation of overlapping and related theoretical constructs



In a wider sense, there were also efforts to maintain and reinstitute home birth beyond the activities of midwives who were the 'custodians' (Oliver, 1992b) of a practice that some regarded as being on the verge of extinction. This included institutional entrepreneurs outside of the mainstream NHS seeking to offer a range of maternity services; consistent research activity that was informing parliament and national guidelines and policies; and a growing number of social movements that were campaigning for the right of women to choose where their children are born. These included: Birthrights; Association for Improvements in Maternity Services (AIMS); National Childbirth Trust; National Federation of Women's Institutes (Bourke, 2013); and Royal College of Midwives Better Births Campaign.

As data analysis and synthesis continued, it became evident that a more complex picture was emerging around how the extent to which a non-dominant professional group were prepared and/or enabled to challenge the status-quo to achieve institutional change. Out of this complexity four cross-cutting themes were developed.

Table 21: Themes from cross-case synthesis

	Safety	**Choice**
Themes	Risk minimalisation was a dominant narrative at all sites	Hegemonic struggles framed the priorities for the allocation and management of maternity service resources
Themes	Sanctions from regulators was a preoccupation & frustration	'Custodian' utilisation of social networks to maintain and develop home birth

8.9 Cross-case themes: Safety

8.9.1 Theme 1: Risk minimalisation

Risk minimalisation was dominant narrative at all sites.

Table 22: Summary of key features at each case site in relation to risk

Willow	Sycamore	Oak
• Focus on risk minimalisation for the service • Resisting change and competition • Obstetricians that lacked confidence in CMs	• CMs as flexible workforce to supplement the acute unit • Suspending home birth if in escalation • Needs of many outweigh needs of the few • Ambivalent obstetricians	• Risk management creates anxiety with adjacent organisations who have a philosophically different approach to risk and choice

The relevance of home birth to a society dominated by biomedical discourses that focus on risk minimalisation has been sustained over many decades. In times of austerity, the logic of limiting choice sits comfortably with resource management and avoiding any pressure to provide a portfolio of choice to destabilise the core services in the acute unit. At Willow and Sycamore, the complexities of providing a workforce that can attend birth in the community 24 hours per day, 365 days per year within traditional employment models were seen as problematic too, as having staff on-call and inactive was viewed as financially inefficient. Being able to utilise those staff in the hospital was seen as cost-effective. However, the CM participants in this study that worked in community settings often described fearing and resenting being pulled in to work in the hospitals. In contrast, midwives from Oak were prevented from providing midwifery care in NHS settings, and found NHS staff to be unwelcoming and at worst, hostile towards them.

For Willow and Sycamore, the default of hospital birth was both logical and justifiable in a context where over 95% of birth took place in an acute unit. Participants from Willow and Sycamore often expressed a preference for promoting hospital birth for all women, believing it was a safest and most cost-effective option for the majority. However, home birth was a choice that was provisional at both Willow and Sycamore, depending on staffing and how busy their hospitals were. Home birth was not always framed as cost-effective at these sites, or that it contributed desired metrics such as higher normal birth rates and lower intervention or surgical rates. For both these NHS providers, despite current research evidence and policy promoting it as a choice, the continued provision of home birth was unnecessary, unwanted by service users and regarded as stretching the services' limited resources too thinly. In contrast, participants who worked for Oak, regarded choice and safety as interdependent and were confident to facilitate home birth for a broad spectrum of women. This brought them into conflict with NHS providers and commissioners, who had a more paternalistic approach to choice.

At Willow and Oak, the competence of midwives to provide safe care was questioned by non-service user participants who believed their professional experience and regular opportunities to practice the skills required for safe home birth care were lacking. Interestingly, at Sycamore, there was general confidence in the experience and skills of midwives to facilitate home births safely from all participants. It was often highlighted how the CMs were regularly working shifts in the IU and therefore had practice skills currency.

8.9.2 Theme 2: Regulation and sanctions

Sanctions from regulators and commissioners were a preoccupation and frustration for all sites.

Table 23: Summary of key features at each case site in relation to sanctions from regulators

Willow	Sycamore	Oak
• Commissioners asking providers to extend home birth	• Being reactive, rather than proactive in face of 'special measures' • Encircled and under intense scrutiny	• Hostile competitors making vexatious referrals and complaints to regulators

For participants employed by Willow, there was a consensus that there was no local demand for home birth and conspiracy theories surrounding the motives of commissioners and local politicians were often shared to question the legitimacy of the practice. National policy was also called into question as were the motives of national midwifery leaders who were visible in the media promoting choice of place of birth. For their part, commissioners who had a special interest in maternity and who were willing to manage a contract with Oak were amenable to challenging provider inertia. In contrast, commissioners who had close relationships with their existing providers or who lacked clinical credentials would often defer to the opinions of GPs or nurses who had little to no experience of home birth.

The impact of sanctions from regulators on Sycamore's maternity services revealed far more fragility and less inevitability around the continued success of their home birth service than the participants in this study were aware of. Despite requests from commissioners to improve home birth provision, passive or unconscious responses to the demands of regulators, the commissioners and the Trust board to answer concerns about their in-hospital services had led to the neglect of the home birth service provided to a minority of service users.

Attempts to break into the monopolies of NHS services by Oak, provoked defensive strategies to limit intrusion in their 'market' of service users. These included exclusion from maternity provider networks, being refused access to provide labour care in NHS premises, being subject to repeated referral to a range of regulators who would conduct repeated inspections, they were also subject to leaks about adverse outcomes to local media outlets as well as neighbouring NHS Trusts, and some commissioners refused to pay them for care that had been provided legitimately. The consequence of frequent complaints to regulators was that as a small organisation, Oak allocated disproportionate resources to respond to this scrutiny, restricting their business development ambitions.

8.10 Cross case themes: Choice

8.10.1 Theme 3: Allocation of resources

Hegemonic struggles framed the priorities for the allocation and management of maternity service resources.

Table 24: Summary of key features at each case site in relation to the framing and allocation of resources

Willow	Sycamore	Oak
• AMLU as a preferable alternative to home birth • Hospital staff would choose the maternity unit for their own relatives	• Support for home birth from obstetricians contingent on IU being given priority for financial and workforce resource • Choice as a luxury, not a right	• Holding zero-activity contracts

The rhetorical strategies of participants from Willow and Sycamore involved praising the quality of the accommodation and facilities in the hospital and endorsing them for use by their own families and friends. Despite investments in new buildings and infrastructure in the hospital birth setting, there had been no equivalent investment in developing

the home birth services. To a large degree the obstetricians at Sycamore appear to be willing to accept home birth as a minority activity providing it does not threaten the resources of the obstetric unit and continues to recognise that doctors sit at the pinnacle in maternity services. Similarly, at Sycamore, commissioners took a utilitarian position regarding choice of place of birth. Given that 95% of women gave birth in the IU, this was perceived to be the default location, and women choosing home birth should expect to forfeit this if CM resources were diverted to the IU.

Oak was a fairly agile service with a relatively small workforce that was unencumbered by same financial pressures of a large acute service. While NHS Trusts are guaranteed activity and can 'overspend' their budgets; different rules apply to AQPs such as Oak, who have no guaranteed activity and cannot operate with a budget deficit. Therefore, with the NHS as their only client and no other source of income, Oak were wholly reliant on their NHS contracts for survival.

8.10.2 Theme 4: Social networks to maintain and develop home birth

'Custodians' or 'institutional entrepreneurs' were keen to utilise and exploit social networks to maintain and develop home birth.

Table 25: Summary of key features at each case site in relation to midwives and service users

Willow	Sycamore	Oak
• CMs and service users enjoy relationship-based care given and received • Leaders lack of enthusiasm for expanding home birth	• A critical mass of service users that want a home birth • Some CMs going above and beyond to support home birth • Support from midwifery managers to subvert the on-call system	• Tapping into a niche market of women who have been under-served by existing maternity services • A tribe of midwives who are philosophically enthusiastic about promoting home birth

For NHS CMs at Willow and Sycamore who participated in this study, providing home birth care was something that they enjoyed and looked forward to. However, the threat of the home birth service being suspended during times of high activity in the acute units', meant that they perceived an expectation from leaders to manage women's expectations and this had caused them to lose confidence in promoting home birth as a choice for all women. In contrast, the midwives from Oak did not have to give the same consideration to the demands in the acute unit, and so were free to guarantee that a midwife would be available to attend a home birth if women chose this option.

While Willow's leadership team submitted a bid for the AQP contract renewal, it could be argued that this was a defensive strategy against Oak, rather than a serious attempt to expand their home birth offer to more service users in their locality. Covert strategies were employed by some midwives at Sycamore to maintain the home birth service during escalation when it was threatened with suspension. These included giving their mobile phone numbers to women who were approaching their due date and planning a home birth, and the midwives being prepared to go on duty if the labour started during a service suspension. Equally, CM managers at Sycamore were prepared to collude with their CMs to ensure women who wanted home births would get the opportunity, where possible. Oak actively recruited midwives from the NHS who were frustrated and disillusioned by the organisational restraints placed on them, or were newly qualified and had not been acculturated into a medical model of care. Across all three case sites, midwives that were philosophically enthusiastic about home birth appeared to share a common belief that they would lose a touchstone for their sense of professional identity if home birth could no longer be supported. This may explain why some midwives have

continued to remain committed to home birth as a concept despite its status as a practice in decline.

8.11 Development of the conceptual framework

Given the historical erosion of home birth in England, the hypothesis proposed by Oliver (1992b) that sought to explain the antecedents of discontinuity and erosion of institutional practices was an interesting starting point. It was not always clear to colleagues and peers I engaged with during my study why I was interested in something they regarded had fallen out of favour and was withering on the vine. I had sensed from my own experience as a community midwife that, rather than individual agency on the part of midwives or women, it was organisational structures and processes that were the leading cause of erosion. It seemed crucial that 'taken for granted' explanations were challenged in the face of robust global research evidence of the safety, cost-effectiveness and service user satisfaction had demonstrated.

An interpretation of the hypothesis proposed by Oliver (1992b) might suggest that in response to the gradual atrophy in the use of home birth, midwifery were complicit in its dissipation and rejection. Yet, other models such disruptive innovation theory (C. Christensen, Raynor, & McDonald, 2015) sought to explain how smaller companies with fewer resources were able to challenge established incumbents. These smaller companies target 'low-end footholds' which are the overlooked segments of the incumbents' business that were usually less profitable, and then over time expand to deliver their service to more mainstream customers. I became aware of Oak while studying for my Master's degree and could see that their model of care to provide continuity for all-risk women was growing over time. Home birth was regarded as an inferior choice by many NHS providers – particularly by those who challenged the legitimacy of the evidence base that supported it. However, in areas where Oak operated, they were moving to expand

their services from beyond fringe, to more mainstream 'customers' (C. Christensen et al., 2015).

But this theory did not fit with the data collected at Willow or Sycamore. The behaviour of CMs at Sycamore aligned with the work of Lipsky (1980) around Street Level Bureaucracy. This theory exposes practices of frontline public service employees subverting institutional controls in pragmatic ways. Frustrations with efficient processing of women through care episodes appeared to have led to some CMs avoiding involving their superiors in decisions and bypassing the rules. This appeared to emerge out of both a passion for providing home birth care, and a sense of disillusionment with organisational changes that had taken place.

With the data from all three case sites, I wanted to test if I could map each case site to one of the stages in the models for institutional change presented in the work of Greenwood et al. (2002) and the model of institutionalizing presented in the work of Reay et al. (2006). What I attempted to do was combine these models with those of Oliver (1992b) and Dacin and Dacin (2008). My aim was to identify a pathway from deinstitutionalisation to re-institutionalisation – this is presented as **Figure 15** as a combined model for post-deinstitutionalisation.

In **Figure 15**, starting on the left hand side, deinstitutionalisation at macro level is impacted by political, social and functional pressures, and from a micro level by entropy and inertia (Oliver, 1992b). Three possible outcomes of deinstitutionalisation are proposed by Dacin and Dacin (2008) of extinction, erosion and institutional remnants. From institutional remnants, custodians (Dacin & Dacin, 2008) or institutional entrepreneurs (Greenwood et al., 2002) create isolated examples of success. Reay et al. (2006) suggests that these successes at both the micro- and macro-levels prove themselves to be valuable to others,

complimentary to existing provision and become integrated into established structures and systems. Both Greenwood et al. (2002) and Reay et al. (2006) suggest that this increases their pragmatic, moral and cognitive legitimacy at both the micro- and macro-levels, which leads to the practice being taken for granted and increasing its density of diffusion. Ultimately, Greenwood et al. (2002) suggests that this leads to reinstitutionalisation of a practice.

Mapping sections 8.7.1 and 8.7.2 above to the model, both Sycamore and Willow can be seen to have demonstrated their exposure to political, functional and social pressures that have contributed to behaviours that have led to entropy and inertia from a range of stakeholders to sustain home birth as a core offer to local women. Consequently, motivation at these case sites to resist extinction and erosion of home birth was compromised by the necessity to ensure the services provided in the acute units were not compromised. There were institutional entrepreneurs, predominantly among the frontline midwives who sought to ensure that home birth remained part of the portfolio of services at Willow and Sycamore, but limited senior endorsement, erosion continued.

Mapping 8.7.3 above to the model, we see that Oak retained sufficient 'institutional remnants' to deliver an isolated example of a successful home birth model. According to the model, this should lead to increasing legitimacy and ultimately reinstitutionalisation of home birth by radiating up to the macro field-level and leading to increasing numbers of providers replicating the new service. However, what has be shown is that the incumbent forces within the adjacent NHS organisations were having a stifling effect on proliferation of similar models of care.

The following figures demonstrate the theoretical contribution that existing conceptual models have made to the development of Figure 15.

Figure 14a: Oliver (1992) model 'Pressures for deinstitutionalisation'

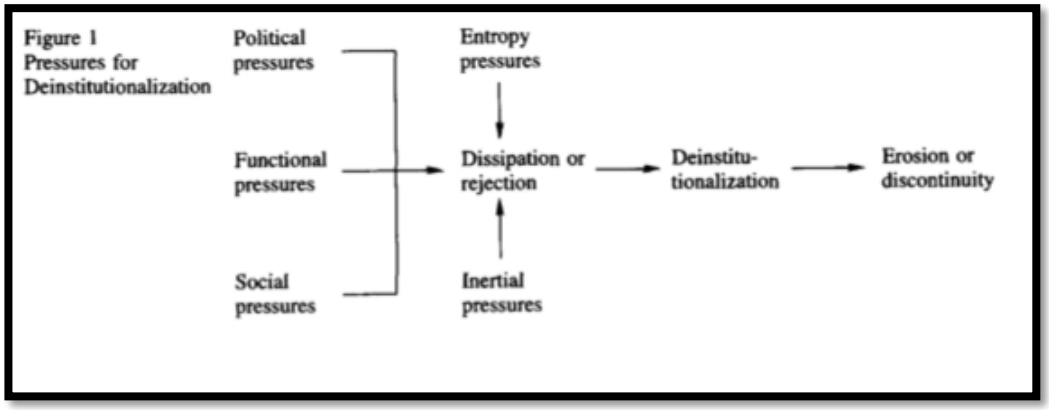


Figure 14b: Greenwood et al. (2002) model 'Stages of institutional change'

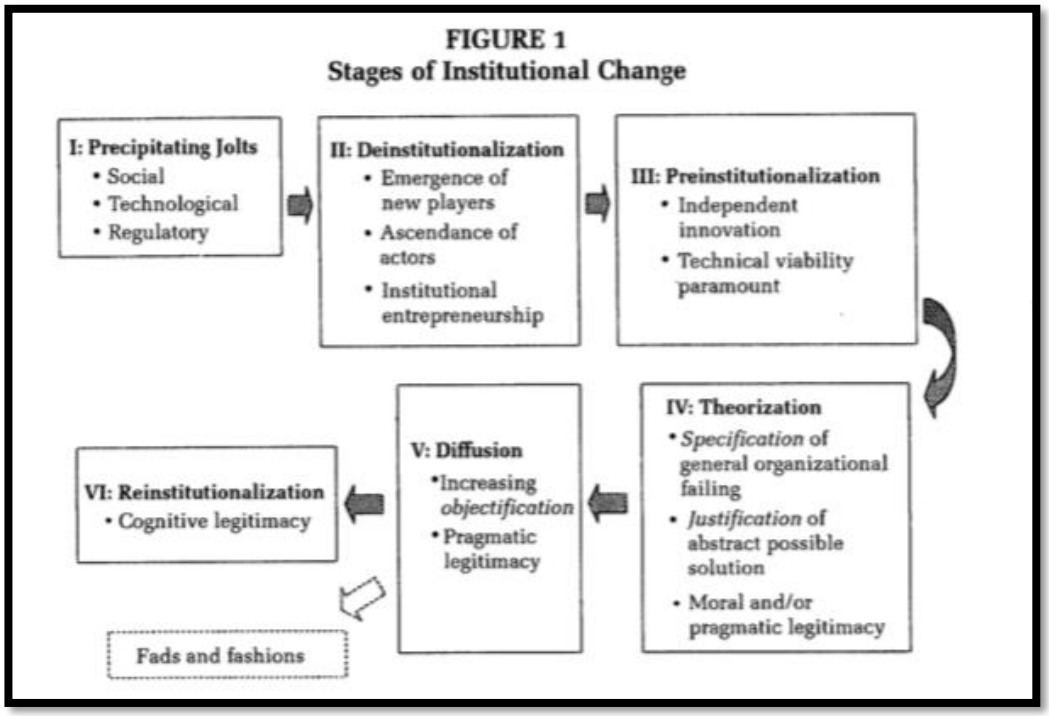


Figure 14c: Reay et al. (2006) 'Model of institutionalizing'

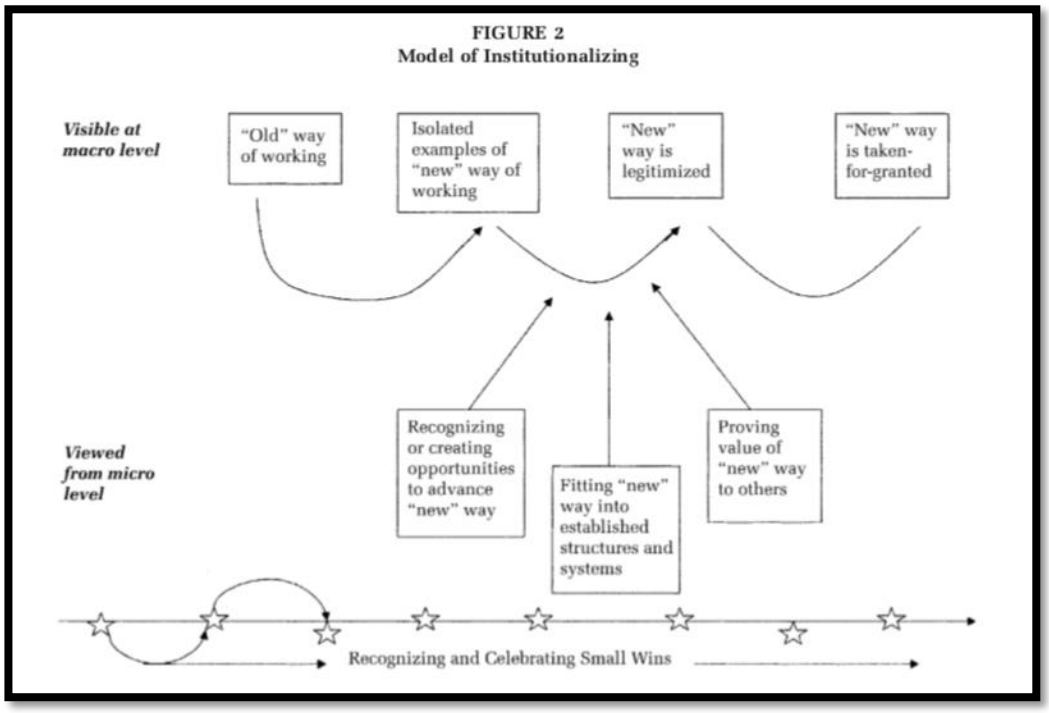


Figure 14d: Dacin and Dacin (2008) model 'An extended deinstitutionalisation framework'

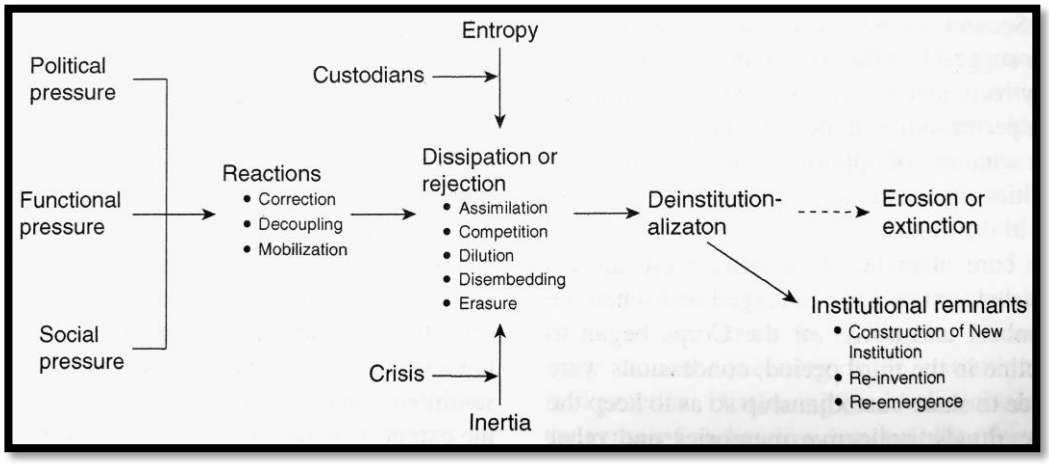


Figure 15 does not seek to theorise where resistance through different structures or by different stakeholders might disrupt progress from deinstitutionalisation to reinstitutionalisation. However, I would theorise that this might potentially involve arrows pointing from 'isolated

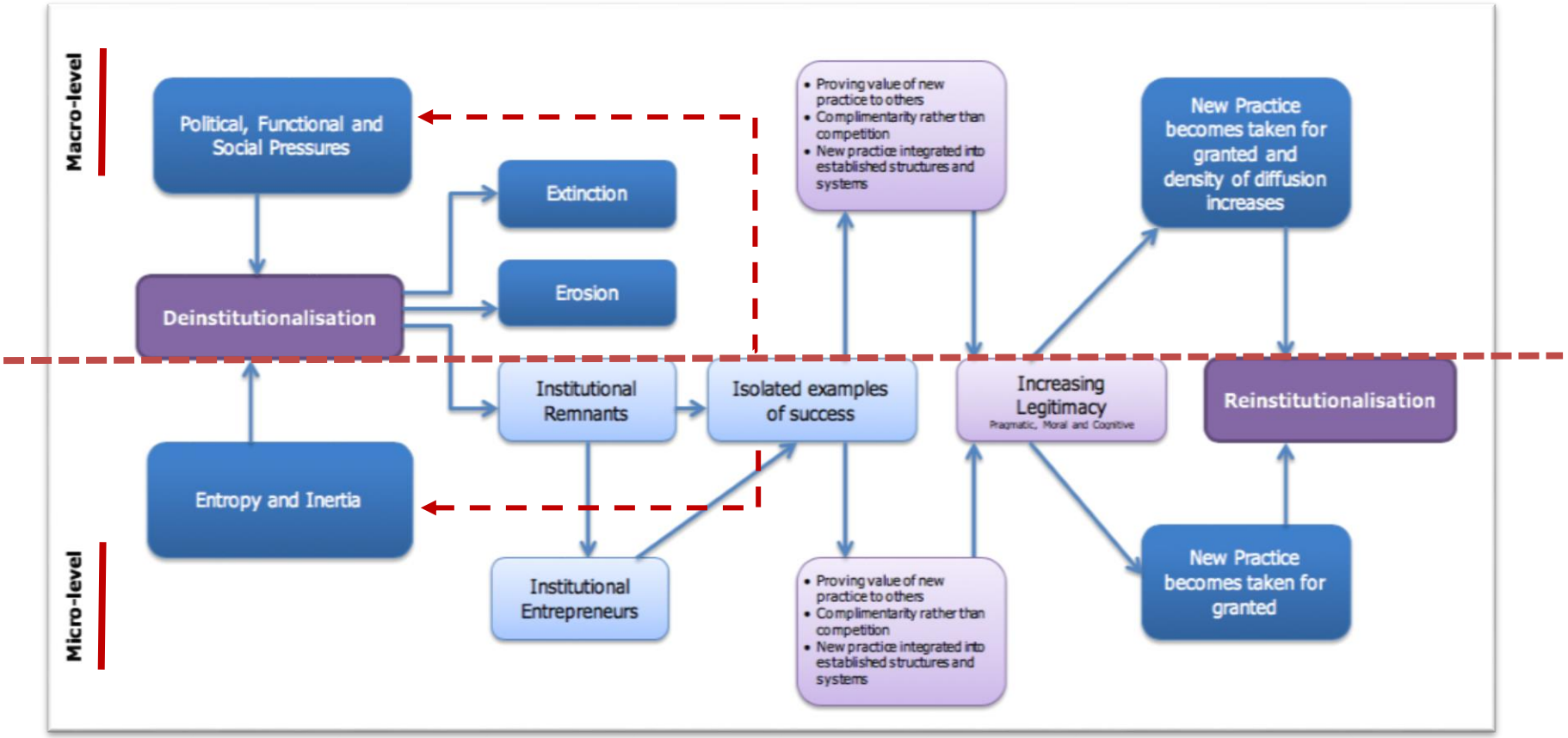
examples of success' back towards erosion and extinction. Equally the factors feeding into deinstitutionalisation – political, functional and social pressures, and entropy and inertia – may have double-headed arrows between them and 'isolated examples of success' – representing what might be conceived of as secondary deinstitutionalisation. Potentially, this may reflect how any poorly designed attempt to reintroduce a service by a non-dominant professional group could contribute to accelerating deinstitutionalisation and lead to further erosion or extinction at the micro-level of the institution and then radiate up to the institutional field level. Institutional entrepreneurs who are from non-dominant professional groups may find that a plausible solution to a compelling problem is not politically feasible unless they can establish moral, pragmatic and cognitive legitimacy among those who dominate governance, management and funding structures.

In terms of models of maternity care provided to women who choose to give birth at home, this framework may be 'read across' at a micro-level, without radiating up to the macro-level. In this scenario, a model of care supporting home birth could be introduced by exogenous or endogenous institutional entrepreneurs who are able to demonstrate success and engender legitimacy locally, without having a macro-level impact. Arguably, it could be theorised that success at the micro-level is vulnerable to political, functional and social pressures, as well as inertia and entropy. Defensive institutional maintenance would be an essential element of any model to resist secondary deinstitutionalisation. However, should there be a critical mass of new models of care that are introduced which are successful, it may be hypothesised that this is likely to achieve reinstitutionalisation at the macro-level.

The degree to which national policy and guidelines require micro-level policy and institutional entrepreneurs to be empowered to institute change may have been under-estimated. This may be more significant

and may help to explain the failure rate of non-dominant professional groups in the NHS to achieve service level change, as without sanction or support from those embedded in dominant structures, the consolidation of gains may remain vulnerable to deinstitutionalisation.

Figure 15: Combined model for post-deinstitutionalisation – adapted from (Dacin & Dacin, 2008; Greenwood et al., 2002; Oliver, 1992b; Reay et al., 2006)



8.12 The conceptual framework for this study

To distil the story of this research study and present my overall findings, I have constructed the framework presented as **Figure 16**. I have created it based on my data analysis as a way to explain the institutional work in response to precipitating threats where the custodians are a non-dominant profession in a mature institutional field.

In the first tier of the framework in **Figure 16**, a number of precipitating threats were identified that destabilised the non-core practice of home birth. These were not one-off 'precipitating jolts' but were a constant background 'noise' across the whole maternity field affecting all three case sites to a greater or lesser extent. These were:

- ***Social change***: e.g. 20th century sees fall in home births rates; changing family structures; construction of motherhood; less deference to 'doctor knows best'; improvements in housing;
- ***Technological change***: e.g. improvements in contraception; increasing anaesthesia and surgical interventions; complexity and co-morbidity; fertility advances
- ***Policy discontinuities***: e.g. NICE and NHS England presenting safety and choice as equal; new interpretations of the legal obligations of Trusts and professional regulation
- ***Regulatory enforcement***: e.g. NHS England, Monitor, CQC, CCGs; sanctions vs support; national inquiries i.e. Shipman (Smith, 2003); Mid Staffordshire (Francis, 2013); and Morecambe Bay (Kirkup, 2015).

In the second tier of the framework, the institutional work of individuals and organisations aimed at creating, maintaining and disrupting institutions is outlined (Lawrence et al., 2009). I have focused this on endogenous actors to the home birth service and therefore see this at the micro-level of the individual and institution where they work. This is

different for each of the three case sites based on their perceived dispositions towards home birth.

In the third tier of the framework, legitimacy of home birth is presented from the perspectives of those participants who are exogenous to its delivery. For the purposes of this framework, I have applied the inclusive, broad based definition of legitimacy that acknowledges the social audience and incorporates evaluative and cognitive dimensions (Suchman, 1995). Again, the positions taken in relation to home birth at a case site level include individual, professional and wider organisational perspectives.

> *"Legitimacy is a generalised perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions."* (Suchman, 1995:574)

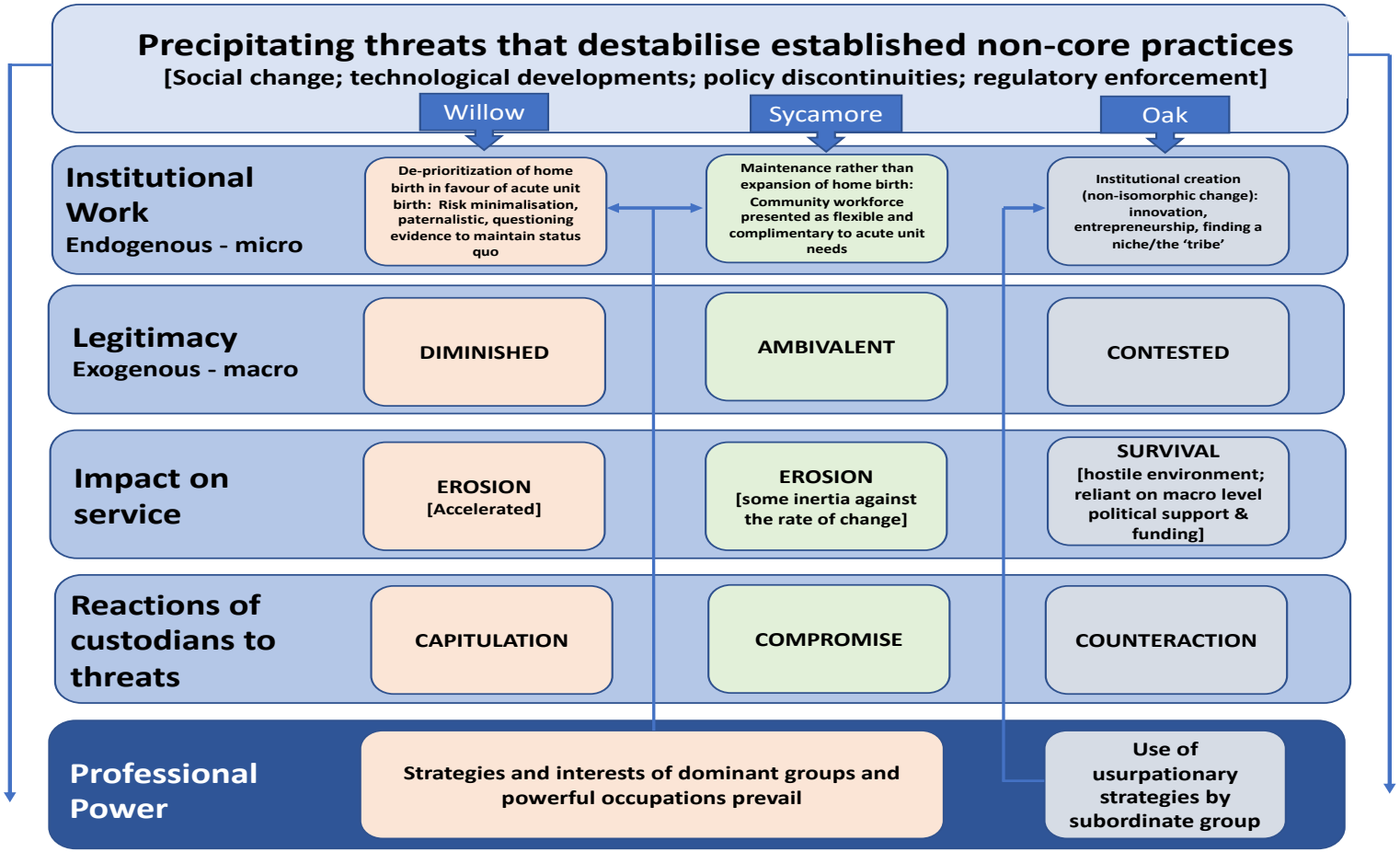
In the fourth tier of the framework, I evaluate the impact of the preceding three tiers on home birth provision at an organisational level and the degree to which it is eroding (deinstitutionalising) or surviving (re-institutionalising).

In the fifth tier of the framework, I have summarised how each of the case sites have responded to the precipitating threats from tier one, and what this means for the home birth service overall.

In the final tier of the framework, I have sought to demonstrate how the reaction of the 'custodians' or 'institutional entrepreneurs' create the conditions by which erosion or survival of home birth is reinforced. In Willow and Sycamore, where legitimacy for home birth was diminished or at best, ambivalent, the cycle of erosion towards discontinuity would continue without field level change. For Oak,

legitimacy for home birth was contested exogenously to the organisation, however they continued to use usurpationary strategies to counteract that resistance.

Figure 16: Conceptual framework for post-deinstitutionalisation developed by L Common



8.13 Summary detail of each case study within the framework

The following three tables provide a broad summary of which issues were used from each case site to map the conceptual framework in **Figure 16**.

Three words captured the institutional work of the midwives who were the custodians of home birth at each case site: ***capitulation***; ***compromise***; and ***counteraction***. Maguire and Hardy (2009) have described insider-driven deinstitutionalisation as a process of new subject positions emerging that cause field members to abandon a practice. For Willow and Sycamore, there appeared to be weak and diminishing organisational commitment to home birth remaining a robust part of their portfolio of services. There was minimal evidence of champions for home birth at either case site. Further, Hardy and Maguire (2010) describe outsider-driven deinstitutionalisation where translation (interactions between various parties) and organisational discourse signal a practice as illegitimate. Arguably, Oak's challenge to the dominance of obstetric unit birth could be positioned as an attempt from a non-dominant workforce, informed by evidence and supported by national policy to invert the historic positioning of obstetric unit birth in favour of home birth.

Table 26: Willow: The capitulation of midwifery in favour of institutional birth

This table summarises the themes from the accounts of participants in terms of the strategies, arguments, behaviours and actions that were revealed at Willow. ***Capitulation*** is the over-arching word I have used to capture and categorise my overall impression of how the non-dominant professional group (midwives) have reacted to the threats to their home birth service.

Willow = CAPITULATION	
Precipitating threats	Demands to expand home birth seen as threat to financial and workforce stability; competition vs collaboration with new entrant to the market; adopt a risk management approach that favoured a medical/technological approach to birth
Institutional work	Focus on minimalising risk; resistance and lethargy towards innovation and innovators; ignore or question the validity of research evidence underpinning the safety of home birth
Legitimacy	DIMINISHED: Lack of confidence in CM workforce and home birth; argue that current supply meets low demand – 'we know 'our ladies' and there's just no demand around here'
Impact on service	EROSION (Accelerated): Lack of critical mass of custodians willing to promote home birth as a choice
Reactions to threats	CAPITULATION: Little or no resistance to demands that erode home birth
Professional power	Institutional birth managed by obstetric team prevails and reinforces/strengthens the reactions to precipitating threats

Table 27: Sycamore: The compromises for midwifery to maintain home birth

This table summarises the themes from the accounts of participants in terms of the strategies, arguments, behaviours and actions that were revealed at Sycamore. ***Compromise*** is the over-arching word I have used to capture and categorise my overall impression of how the non-dominant professional group (midwives) have reacted to the threats to their home birth service.

Sycamore = COMPROMISE	
Precipitating threats	Regulatory surveillance requiring focus on acute unit safety to provide assurance; legislation that required changes to on-call system for CMs
Institutional work	Strive for maintenance of home birth, not expansion; acute unit needs trump choice for local women; CMs to concede that acute unit is the priority and they act as flexible workforce to strengthen it; some invisible/concealed behaviours by CMs to promote home birth
Legitimacy	AMBIVALENT: Support from doctors appears contingent on home birth not posing a threat to the dominant (acute unit) service or reputation
Impact on service	EROSION (but some inertia against the rate of change): Diminishing critical mass of custodians willing to promote home birth as a choice
Reactions to threats	COMPROMISE: Concede the acute unit has priority but seek to promote home birth as complimentary and CM as a flexible workforce for acute unit
Professional power	Obstetric preference for IU ahead of introducing AMLU prevail; using CMs during escalation leads to deficits in workforce morale and reinforces/strengthens the reactions to precipitating threats

Table 28: Oak: The counteraction of midwifery in favour of birth

This table summarises the themes from the accounts of participants in terms of the strategies, arguments, behaviours and actions that were revealed at Oak. ***Counteraction*** is the over-arching word I have used to capture and categorise my overall impression of how the non-dominant professional group (midwives) have reacted to the threats to their home birth service.

Oak = COUNTERACTION	
Precipitating threats	National policy promotes plurality of provision, but NHS commissioning act as a monopsony – lack of familiarity with commissioning private AQP providers; regulators expect isomorphism but perform above NHS norms;
Institutional work	Institutional creation (non-isomorphic change); innovation; entrepreneurialism; finding a 'niche' market and service users who have been under-served by incumbent providers; finding staff who are looking for a 'tribe' of like-minded midwives who are frustrated/disillusioned by NHS models or who have not been acculturated into NHS ways of thinking
Legitimacy	CONTESTED: Opposed by adjacent NHS Trusts and commissioners on grounds of safety; poor communication and trust between Oak and neighbouring Trusts; perceived as a financial threat to the sustainability of NHS providers who are co-terminus; anti-privatisation of the NHS rhetoric; undermining women's confidence in alternative to NHS; reporting (sometime vexatious) to regulators

Oak = COUNTERACTION	
Impact on service	SURVIVAL (in a competitive environment): Reliant on central/macro level funding and support; no internal professional conflicts as uni-professional with philosophical alignment; remain agile with low fixed assets costs e.g. estates
Reactions to threats	COUNTER-ACTION: Actively oppose arguments that safety trumps choice – sees them as interdependent, not mutually exclusive; oppose the dominant rationale that hospital is only safe option for birth; maintain a strong core commitment to human rights in child birth
Professional power	Usurpationary strategies to win greater share of resources by biting into the privileges of the dominant/incumbent services

8.14 Sociology of the Profession

What is presented in the conceptual framework [**Figure 16**] is that in direct response to the precipitating background threats of social change, technological developments, policy discontinuities and regulatory enforcement, the interests of dominant groups and powerful occupations appear to prevail. Not only that, but in the case sites at Willow and Sycamore, what was evident in from data was a cyclical pattern that exerted a persistent pressure. For Willow, this appeared to result in accelerated erosion; for Sycamore, the erosion was moderated by the institutional work of midwives to protect and insulate home birth to a greater extent.

For Oak, the uni-professional nature of the organisation created flexibility to undertake what Witz (1992) describes as a revolutionary usurpationary strategy. This involved countervailing activity by an essentially subordinate occupational group in the strategic action field

to change the structures within maternity services that would achieve legitimacy as an incumbent. Regardless of this, both intra-professional and adjacent dominant professionals groups maintained sustained pressure against Oak. Arguably, should macro-level policy support for Oak's model of care diminish, Oak's future in the action field is less certain.

8.15 The novel contributions of this study

My novel contribution is the conceptual framework for post-deinstitutionalisation developed as **Figure 16**. I propose that this framework suggests potential explanations for why institutional practices provided by non-dominant 'custodians' find themselves in a constant state of threatened erosion. It also endeavours to explain why the monopsony of the English NHS is likely to guarantee that new models of care will remain contested and marginalised despite the innovative and entrepreneurial tendencies of non-dominant occupational groups. I propose that this is due to the unfavourable commissioning and regulatory context in which non-isomorphic institutions are expected to operate within and align with. This framework could potentially be tested with other non-dominant professional groups going forwards.

The findings in this study suggest that the antecedents of deinstitutionalisation are constructed in a different way when a non-dominant professional group (midwives) in a mature institutional field (the NHS) is involved. I argue that there is an expectation from the professional, strategic and knowledge elites that midwifery will concede to a 'one size fits all' model and accept any prevailing utilitarian rationale that services provided to a minority of women seeking to choose their home as their place of birth are an illegitimate luxury that disadvantages other women in the system. Rather than champion better care for all, dominant professional groups, including those from medical, financial, commissioning and regulatory bodies tend to

articulate a resentment towards those not receiving 'standard care' and believe the majority of patients are being disadvantaged by a minority of service users. The irony is that what replaces a relationship-based model of care, is often a more centralised, impersonal service that is likely to be more expensive and lead to more costly interventions and risk than the service it replaces.

What was observed in this study were legitimacy contests associated with advancing or preventing change. Service leaders at Oak captured attempts at reform by offering a service that was philosophically different to the local NHS model of care. They achieved a home birth rate that exceeded all historical achievements of incumbent NHS providers. Oak offered a risk-management approach to care – where safety and choice were regarded as interdependent. This approach challenges the NHS where there has been a drift towards a risk minimalisation approach to care that prioritises safety ahead of choice. Healthcare regulators expected Oak to look and behave like the NHS, but failed to acknowledge that they achieved their improved outcomes by operating in a very different way to existing providers.

8.16 Summary

This chapter presented the major findings from each case site and integrated them with the literature pertaining to organisational institutionalism. It then discussed the early theoretical concepts that were considered. It then provided a cross case synthesis and interpretation of the data by exploring four themes that informed the development and presentation of a combined model [**Figure 15**] and a conceptual framework [**Figure 16**] for post-deinstitutionalisation. Then followed the rationale for refining it to take account of the particularities of the phenomenon under scrutiny. Finally, this chapter suggests how this work offers a new insight into the concept of deinstitutionalisation.

The final chapter in this thesis will present concluding statements and recommendations based on my findings. It will also address study limitations and suggest points for future lines of inquiry.

9.0 Thesis conclusion

9.1 Introduction

This chapter presents concluding statements and recommendations based on the findings from this study and the concept I have proposed of post-deinstitutionalisation. It will also briefly revisit the contextual background for this study. Finally, I then present limitations as well as suggest some potential for further lines of enquiry.

9.2 Background summary

Evidence suggests that home birth represents a safe, satisfying and inexpensive solution to the NHS's funding crisis.

The seismic shift towards women giving birth to their children in hospitals has created an inter-generational discontinuity for home birth. Women giving birth at home today often have no familial experience of home birth, so there are rarely shared experience or collective memories to draw on. This is mirrored in the midwifery profession who now rarely see home birth either during their professional training or post-qualification. Therefore, maintenance of home birth as an institutional practice relies on the limitations and imaginations of those who continue to facilitate it. Women's expectations in terms of safety, competence and the skills of CMs may not be matched by the service provision and current workforce as CMs are not facilitating home birth as frequently as they were historically.

The unequal relationships between occupational groups within the maternity services at both macro and micro levels prevent the spread of innovations that would be beneficial for service users. This can be explained by outcomes being valued (or not) by different communities of practice who do not share each other's social and cognitive boundaries.

My reading of the theoretical literature pertaining to the field of organisational institutionalism suggested that existing explanatory models when applied to non-core practices (home birth), where non-dominant custodians (midwives) operate in a mature institutional field (the English NHS), was insufficient when applied to phenomena of this nature and led me to create and present a new model and framework for post-deinstitutionalisation.

9.3 The concept of post-deinstitutionalisation

As outlined in the foregoing chapters and section 9.2, the legitimacy of home birth as a practice has diminished in the face of social, technological and regulatory changes. While there are still 'custodians' of home birth within the midwifery profession who continue to galvanise women to choose home birth through research and policy at strategic, organisational and operational levels; it remains an eroded institutional practice that may arguably be on the brink of extinction in many areas of England.

Using a cross-case analysis approach, a combination of endogenous and exogenous forces were identified as driving institutional change at all three sites. Home birth at Willow and Sycamore were regarded as being either eroded or eroding as a consequence of factors which included: natural erosion, failure to innovate, deliberate destabilisation, and social and regulatory jolts. In contrast, Oak recognised the crises but capitalised on it as an opportunity. Doing so challenged the prevailing orthodoxy that there was no demand for home birth and they introduced a model of care that began to demonstrate untapped demand from service users.

The concept of disruptive innovation (C. M. Christensen, Bohmer, & Kenagy, 2000; Omachonu & Einspruch, 2010; Schmidt & Druehl, 2008) explains that where the needs of customers are not being met by existing service providers, opportunities for challengers open up. In

terms of home as a place of birth, some women are likely to be interested in less technological and more relationship-based care provision. What resonates about this concept is that dominant providers often make decisions that frame the idea of providing a service to a small 'niche' of customers as being unprofitable or unappealing for them. This was evidenced in participant accounts at Willow and Sycamore who regarded the acute maternity unit as superior on the grounds of safety and that the on-call service for home birth was expensive and awkward to resource. Oak represented a disruptive innovation, as they had identified a market open to new providers and were happy to service a small niche initially. They incrementally improved their offer and expanded their reach to a wider market over time.

For Willow, I argued that the organisational leadership were philosophically aligned to providing a centralised model of care. Midwives and obstetricians articulated that they worked well together, but this appeared to be at the cost of aligning to a largely medical philosophy of care where weak resistance to the erosion of home birth was offered. They shared rhetorical strategies that questioned the validity and relevance of research evidence for home birth and were united in their resistance to competitive drivers from their commissioners. Senior clinicians and leaders expressed doubts about the confidence and skills of CMs to provide home birth and CM staff increasingly recognised home birth as a marginalised practice. Ultimately the strategies and interests of dominant professional groups and powerful occupations prevailed and were reinforced by the cyclical capitulation of the midwives and the lack of committed innovators or innovation.

For Sycamore, I argued that their midwifery workforce was clearly able to identify with a more social model of care. However, the midwives

appeared to be willing to concede that the acute unit must be prioritised. In order to demonstrate this to their obstetric colleagues, the midwifery leadership effectively transformed the CM workforce into a flexible resource that would complement the needs of the acute unit. Similarly, local women who had planned home births would be asked to attend the acute unit if the CMs were supporting activity in the hospital. Choice of place of birth for women at Sycamore was increasingly perceived to be regarded as a luxury, rather than a right. Some CMs who were committed to maintaining home birth would be prepared to undertake countervailing activities, not always sanctioned in advance by their managers. Unlike Willow, senior clinicians and leaders at Sycamore expressed confidence in the skills of their CMs to provide home birth. Ultimately the strategies and interests of dominant professional groups and powerful occupations were in ascendance. I theorise that the cyclical compromises being made by midwives however would result in erosion, but at a slower rate of decline compared to Willow.

The midwifery workforce at Oak, as a uni-professional organisation, benefited from having no obstetric unit to divert their resources. This meant that they were able to express a strong commitment to their philosophy of care and were not encumbered by any necessity to mediate this for the benefit of a more dominant or powerful occupational group. Despite widespread hostility to private sector involvement in the NHS and their contested position in the market, Oak has continued to grow their geographical reach, client base and staff numbers. Oak's strategy for counteracting the inertia that maternity transformation has been greeted with, brings them into conflict with those dominant occupations invested in the status quo. At the macro-level, Oak remain dependent on policies that continue to commission for choice. In order to survive and expand, Oak also require ongoing

contracts from CCGs, and a willing workforce able to deliver their model of care.

9.4 Implications for policy makers, service leaders and innovators

Service improvements can appear straightforward and intuitive, yet ultimately fail to realise the desired effect. A critical ingredient of any quality improvement approach is to map the context in which it is introduced (The Health Foundation, 2013). For a non-dominant professional group that fails to champion their own professional identity, transformation projects are likely to be destined to falter without effective advocacy. Where the prevailing strategies and interests of those who stand to lose their dominant position in the field are threatened, disproportionate resistance is likely to be evident.

Equally, it is important to understand how the external context which includes regulatory, political and technological environments shape the effectiveness of change and can prevent unrealistic expectations of a change or improvement initiative (The Health Foundation, 2013). In practice, non-dominant professional groups need to actively move into knowledge and bureaucratic elites in order to influence policy and strategy that is true to their core principles so that sustainable change can be achieved. What Kingdon (2011) describes as the problem, solution and political streams also need to be aligned by institutional entrepreneurs at both the macro and micro-levels[15]. How tacit knowledge is mobilised by elite professionals to invoke concerns that

[15] Kingdon (2011) suggests that to transform knowledge into policy actions, a compelling problem must be articulated in ways that can make use of plausible solutions that are politically feasible. In maternity, although the problem and solution streams are aligned, and there are 'policy entrepreneurs' at the macro level, a lack of 'policy entrepreneurs' at the meso/organisational level to influence the political stream and identify when 'windows of opportunities' are open appear to be largely lacking.

institutional change brought about by groups other than their own introduces risk to the organisation (Currie et al., 2012) presents significant hurdles for non-dominant professionals to overcome. Similarly, factors which include an organisation's leadership, size, stability and culture can have a significant impact on the adoption of a change or intervention (The Health Foundation, 2013). For transformation led by non-dominant professional groups, the ability to recognise that small scale micro-level changes can radiate up to the field level is ambitious given the resistance to non-isomorphic change in a mature strategic field. Being insulated from the wider demands of an obstetric unit for Oak, meant that any financial success could be reinvested directly back into their core services. In contrast, any cost savings realised by NHS home birth services are likely to be re-absorbed into their acute unit's deficit position, preventing the expansion of services provided by non-dominant professional groups.

9.5 Limitations

In view of the qualitative nature of this research and its constructivist approach, this study has predominantly made a series of logical inferences based on observations rather than trying to make factual claims in an attempt to test pre-existing hypotheses. There is no absolute way to know whether the findings, concepts and conclusions I have drawn can be transferred to other groups or locations or indeed other maternity services in England. However, by providing detailed narratives of the context and background for the study, and providing rich and detailed description, I believe that this knowledge could be assessed for its applicability and applied appropriately to other contexts (Bloomberg & Volpe, 2012).

Careful thought was given to account for certain limiting conditions contained in this study that related to qualitative research methodology generally, and some inherent in the research design. Mindful of my 'insider' status as a midwife-researcher, I took measures to moderate

this which included choosing case sites where I was an 'outsider' in terms of having never been employed to work for any of the organisations included. In addition, I reflected both in, and on actions in the field and discussed these with my academic supervisors. In terms of data analysis, coding schemes and analysis were also scrutinised by academic supervisors.

In preparing this thesis, decisions were made about the unit of analysis. As a result, significant sections of the data collected have not been presented in this thesis. However, as the primary researcher in this study, I have not 'bracketed' the accounts provided by service users and members of ambulance Trusts. Those accounts have actively influenced how I have built my overall analysis and made choices about developing my arguments. My intention is to develop the 'missing' data into future publications in peer reviewed journals.

A limitation placed on the scope of this research has included the funding window which created a fixed timescale in which to complete the study. The identification of research sites required pragmatic decision to be made. I encountered significant barriers to recruiting 'ideal' sites with a documentary or human organisational memory, especially in terms of how the models of care had evolved and changed over time. Equally, the study was complicated by the challenges involved in recruiting multiple adjacent organisations to the provider organisation. This may limit the generalisability of the study to other groups and locations.

Finally, external conditions beyond the study's scope have played a part in the overall outcomes. These have included significant structural changes across the NHS, a lack of clarity around commissioning priorities and a national level review of maternity services and payment tariffs. Ultimately the context of the NHS involves continuous change

and learning. Undertaking research in the unstable institutional field of the English NHS has been an effective training ground for me as an aspiring applied health researcher.

9.6 Potential further lines of enquiry

I believe that my conceptual framework for post-deinstitutionalisation in section 8.12 of Chapter Eight, provides a basis for continuing the important development of understandings of deinstitutionalisation in a health service context that have emerged since the work of Oliver (1992b). In particular, it offers a model to test whether other non-dominant occupational groups respond in the same way to threats to the institutional practices they are the custodians for.

This study has explored the mechanism of dissipation by examining a non-dominant professional group. Further work around how reinstitutionalisation can be achieved would provide insights into how to deliver transformation agendas successfully in this field in the context of ongoing cost-containment pressures (Dacin & Dacin, 2008).

Tensions between the policy imperatives of safety and choice have underpinned the foundations of this study. It has also drawn attention to friction between the concepts of risk minimalisation and risk management and how these manifest in maternity services and the wider healthcare economy. Further work to explore these interactions may provide insights into how non-dominant professional groups may overcome barriers to implementation of evidence-based policy and research.

Future research could explore if 'patterns of enhancement and erasure are similar in other contexts' (Dacin & Dacin, 2008). This could include how midwifery as a feminised professional group has been decoupled from a touchstone for their professional identity through lack of exposure to home birth. Changes to midwifery education programmes

to include an element of caseholding for student midwives have produced a generation of midwives who aspire to deliver this care in their careers. Creating the conditions in which pre-registration training requirements for midwives include exposure to a minimum number of home births before qualification would be an interesting longitudinal project.

It may be worthwhile to consider the degree to which home birth inhabits a politically charged sphere that has been infiltrated by the contemporary shift towards neoliberalism, capitalism, far-right popularism etc. that positions maternal and fetal rights in opposition and the degree to which this inhibits progress around safety and choice.

9.7 Concluding statement

Research has a role in bringing about change. It can create knowledge that challenges rather than supports dominant structures by being constantly attentive to histories, experiences and perspectives that are unnoticed, unfamiliar and too easily neglected or misrepresented. By writing for, rather than about those we study, researchers can re-orientate knowledge production towards the needs of the people, rather than the hegemony.

Some have argued that in the modern fragmented NHS, home birth represents a systems-challenging praxis (Cheyney, 2008); others that it represents an effective, safe and inexpensive solution to the NHS's funding crisis if more low risk pregnancies could be cared for in this way. The expansion of home birth should not be seen as a sentimental return to the past, or a rejection and devaluation of technology. It should be understood as a humanising and sustainable path to the future (inspired by Ricardo Herbert Jones' quote cited in Davis-Floyd et al. (2009), p.1).

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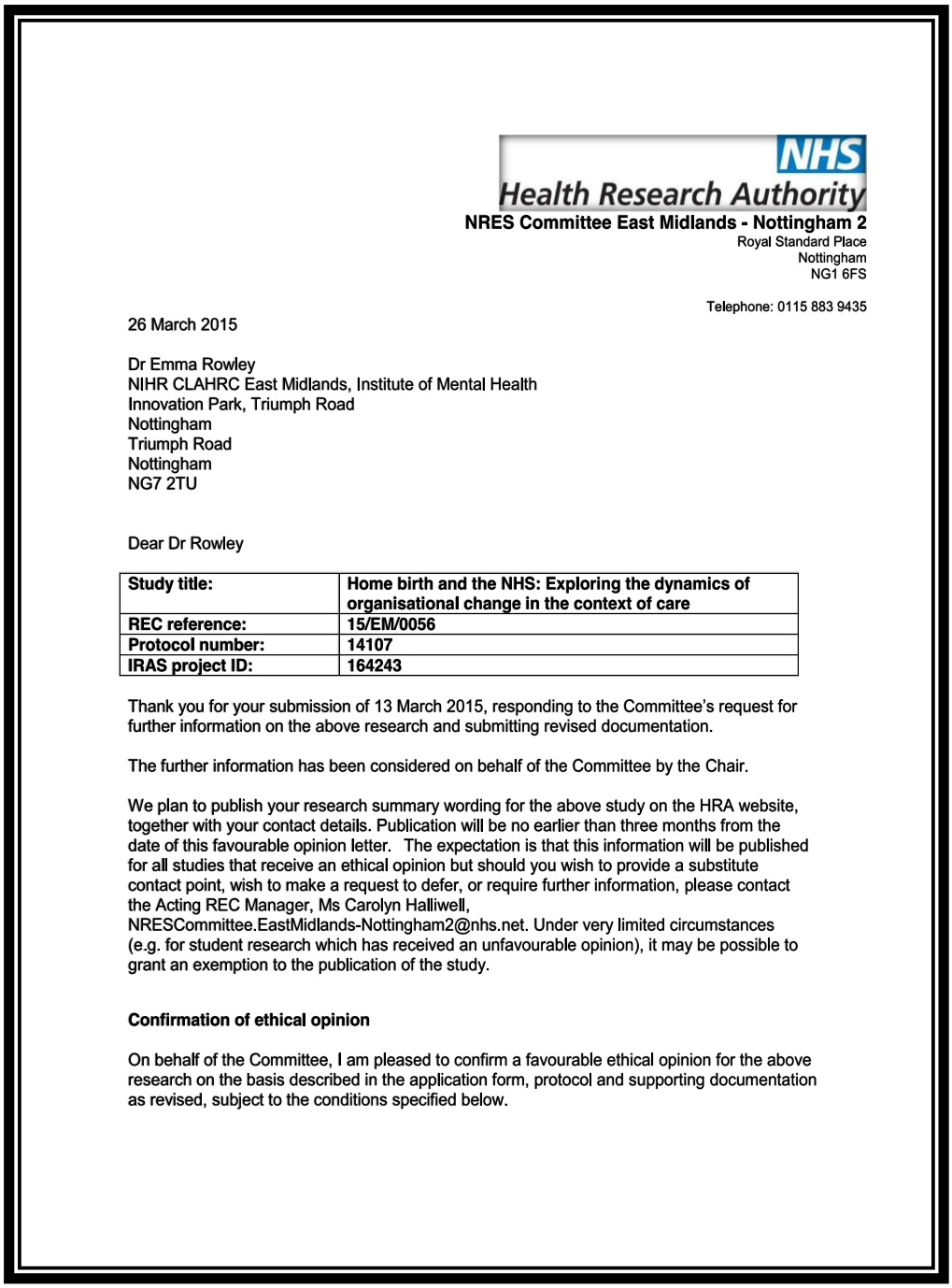
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Appendix 1: Health Research Authority approval



NHS
Health Research Authority

NRES Committee East Midlands - Nottingham 2
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 883 9435

26 March 2015

Dr Emma Rowley
NIHR CLAHRC East Midlands, Institute of Mental Health
Innovation Park, Triumph Road
Nottingham
Triumph Road
Nottingham
NG7 2TU

Dear Dr Rowley

Study title:	**Home birth and the NHS: Exploring the dynamics of organisational change in the context of care**
REC reference:	**15/EM/0056**
Protocol number:	**14107**
IRAS project ID:	**164243**

Thank you for your submission of 13 March 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the Acting REC Manager, Ms Carolyn Halliwell, NRESCommittee.EastMidlands-Nottingham2@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see

"Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [POSTER SERVICE USERS]	1.2	04 March 2015
Copies of advertisement materials for research participants [POSTER NON SERVICE USER]	1.2	04 March 2015
Covering letter on headed paper [COVERING LTR]		14 January 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [SPONSOR PUBLIC LIABILITY INSURANCE]		12 January 2015
Interview schedules or topic guides for participants [TOPIC GUIDE]		12 December 2014
IRAS Checklist XML [Checklist_13032015]		13 March 2015
Letter from funder [ESRC OFFER LTR]	1.0	12 December 2014
Letter from sponsor [SPONSOR LTR]		12 January 2015
Letters of invitation to participant [PIS COVERING LTR]	1.0	12 December 2014
Letters of invitation to participant [PIS COVERING LTR]	1.1	04 March 2015
Other [SUPERVISOR_JORDAN_CV]	1.0	12 December 2014
Other [STUDENT GCP CERTIFICATE]	1.0	05 November 2014
Other [LTR TO REC RESPONDING TO PROVISIONAL OPINION]	1.0	10 March 2015
Other [NHS site 1 participation]		10 March 2015
Other [NHS site 2 participation]		10 March 2015
Other [NHS site 1 participation]		11 March 2015
Participant consent form [CONSENT FORM FOCUS GRP]	1.1	04 March 2015
Participant consent form [CONSENT FORM INTERVIEW]	1.1	04 March 2015
Participant information sheet (PIS) [PIS NON PARTICIPANT OBS]	1.0	12 December 2014
Participant information sheet (PIS) [PIS SERVICE USER]	1.1	04 March 2015
Participant information sheet (PIS) [PIS NON SERVICE USER]	1.1	04 March 2015
REC Application Form [REC_Form_20012015]		20 January 2015
Referee's report or other scientific critique report [ANNUAL REVIEW FEEDBACK SUMMARY]	1.0	17 June 2014
Research protocol or project proposal [PROTOCOL]	1.0	12 December 2014
Summary CV for Chief Investigator (CI) [EMMA ROWLEY CV]	1.0	12 December 2014
Summary CV for student [STUDENT ACADEMIC CV]	1.0	12 December 2014
Summary CV for supervisor (student research) [JUSTIN WARING CV]	1.0	12 December 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

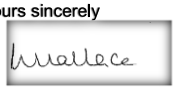
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/EM/0056	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

PP 

Dr Frances Game
Chair

Email:NRESCommittee.EastMidlands-Nottingham2@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Angela Shone*
Ms Lisa Common

Appendix 2: Participant Information Sheets (non-service user and service user)



Participant Information Sheet
(Final Version 1.1: 4 March 2015)

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Name of Researcher: Lisa Common, BA, MA, RM

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Do ask if there is anything that is not clear.

What is the purpose of the study?
The purpose of this study is to explore the strategies and activities of service leaders and other stakeholders that are involved in introducing and sustaining home birth services so that other areas where home birth services are under-developed or under-performing might learn from them.

Why have I been invited?
You are being invited to take part because you have had some experience and understanding of home birth services, either professionally or personally. Around 25 people are being invited to take part locally. This may be that you have authority or expertise relating to the home birth service, or you have been a user of the home birth service. I want to discuss your experiences with you to help understand how home birth services are introduced and sustained.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?
This research project will take place between January 2015 and October 2016. It is anticipated that you will be interviewed once and that it will take up to one hour of your time. The interview will take place at a time and location convenient to you. With your consent, the interview will be recorded with a digital device and the researcher may also make hand written notes. You will be given the opportunity to read a transcript of your interview and clarify any issues. At a later date, you may be invited to take part in an optional online discussion group to offer your comments and feedback on the findings. If you only wish to be interviewed and not to take part in the online discussion group, you can still participate in this study.

Expenses and payments
Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
Although what you say in the interview is confidential, should you disclose anything to me which I feel puts you or anyone else at any risk, I may feel it necessary to report this to the appropriate persons.

What are the possible benefits of taking part?
I cannot promise the study will help you but the information I collect through this study may help to influence changes to the home birth services elsewhere.

What happens when the research study stops?
The research study will be presented to the University of Nottingham as part of a PhD in Business and Management.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher and they will do their best to answer your questions. The researcher's contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from the NHS Choices website here:
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx.

Will my taking part in the study be kept confidential?
The researcher will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some data will be collected about your personal and professional background and experience and will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and will do their best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the University of Nottingham will be anonymised and a unique code will be used so that you cannot be recognised from it.

Your personal data will be retained for a maximum of 12 months to enable the researcher to contact you if necessary. Research data will be kept for a maximum of 7 years after the end of the study. After this time all data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only the researcher will have access to your personal data.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you request that the information collected so far be erased this may not be possible if your contribution was part of a group activity involving other participants who are remaining in the study.

What will happen to the results of the research study?
The results will be written up as part of an education qualification [PhD in Business and Management], but you will not be identified in any report or publication. The results may be published and if you indicate that you would like to be notified of the details the researcher will keep you informed as this happens.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and I am supported with PhD studentships from the Economic and Social Research Council and The Health Foundation.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by an NHS Research Ethics Committee.

Further information and contact details

Lisa Common
Doctoral Researcher
Nottingham University Business School
Email: lixlmc@nottingham.ac.uk
Dedicated study mobile phone number: 07538 464363

C/O Dr Emma Rowley
Senior Research Fellow & Implementation Theme Academic Lead
NIHR CLAHRC-NDL
University of Nottingham
Institute of Mental Health
Innovation Park
Triumph Road
Nottingham
NG7 2TU
Phone: 0115 823 1313
Email: emma.rowley@nottingham.ac.uk

Participant Information Sheet
(Final Version 1.1: 4 March 2015)

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Name of Researcher: Lisa Common, BA, MA, RM

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Do ask if there is anything that is not clear.

What is the purpose of the study?
The purpose of this study is to explore the strategies and activities of service leaders and other stakeholders that are involved in introducing and sustaining home birth services so that other areas where home birth services are under-developed or under-performing might learn from them.

Why have I been invited?
You are being invited to take part because you have had some experience and understanding of home birth services, either professionally or personally. Around 25 people have been invited to take part locally. This may be that you have authority or expertise relating to the home birth service, or you have been a user of the home birth service. I want to discuss your experiences with you to help understand how home birth services are introduced and sustained.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?
This research project will take place between January 2015 and October 2016. It is anticipated that you will be interviewed once, most likely as part of a small group of 4-8 other postnatal women, and that it will take up to one hour of your time. If this is not possible, then an individual interview will be arranged with you instead that will take up to one hour of your time. Any group interviews will take place at a time and location convenient for all participants, most likely at a local community or health centre. With your consent the interview will be recorded with a digital device and the researcher may also make hand written notes.

Expenses and payments
Participants will not be paid to participate in the study. However, a £10 gift voucher will be given to all service user participants at the end of the interviews as a gesture of appreciation for taking part. In addition, any out-of-pocket travel costs, parking fees or bus fares will be reimbursed to each participant on production of a receipt up to the

value of £10. Although there will be no childcare facilities while you take part in the interview, you may bring your baby along with you.

What are the possible disadvantages and risks of taking part?
Although what you say in the interview is confidential, should you disclose anything to me which I feel puts you or anyone else at any risk, I may feel it necessary to report this to the appropriate persons.

What are the possible benefits of taking part?
I cannot promise the study will help you but the information I collect through this study may help to influence changes to the home birth services elsewhere.

What happens when the research study stops?
The research study will be presented to the University of Nottingham as part of a PhD in Business and Management.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. Contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from the NHS Choices website here:
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx.

Will my taking part in the study be kept confidential?
The researcher will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some data will be collected about your personal and professional background and experience and will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and they will do their best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the University of Nottingham will be anonymised and a unique code will be used so that you cannot be recognised from it.

Your personal data will be retained for a maximum of 12 months to enable the researcher to contact you if necessary. Research data will be kept for a maximum of 7 years after the end of the study. After this time all data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only the researcher will have access to your personal data.

Please be advised that although the researcher will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents them from guaranteeing

confidentiality. The researcher will remind all participants to respect your privacy and not repeat what is said in the focus group to others.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you request that the information collected so far be erased this will not be possible.

What will happen to the results of the research study?
The results will be written up as part of an education qualification [PhD in Business and Management], but you will not be identified in any report or publication. The results may be published and if you indicate that you would like to be notified of the details the researcher will keep you informed as this happens.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and I am supported with PhD studentships from the Economic and Social Research Council and The Health Foundation.

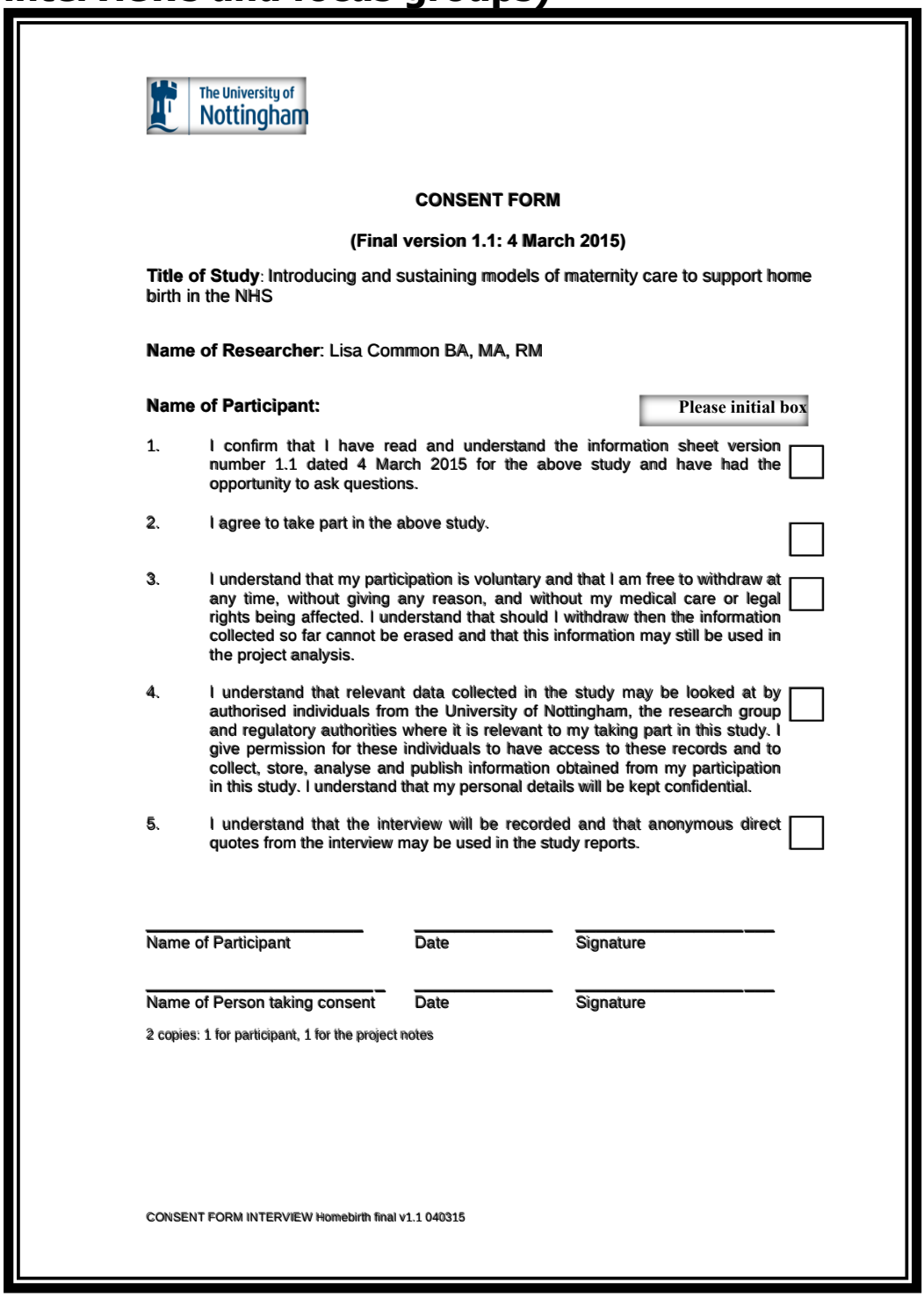
Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by an NHS Research Ethics Committee.

Further information and contact details

Lisa Common
Doctoral Researcher
Nottingham University Business School
Email: lixlmc@nottingham.ac.uk
Dedicated study mobile phone number: 07538 464363

C/O Dr Emma Rowley
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NIHR CLAHRC-NDL
University of Nottingham
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Appendix 3: Informed Consent Forms (for interviews and focus groups)



The University of Nottingham

CONSENT FORM

(Final version 1.1: 4 March 2015)

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Name of Researcher: Lisa Common BA, MA, RM

Name of Participant: Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 4 March 2015 for the above study and have had the opportunity to ask questions. ☐
2. I agree to take part in the above study. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
4. I understand that relevant data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
5. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

CONSENT FORM INTERVIEW Homebirth final v1.1 040315

CONSENT FORM

(Final version 1.1: 4 March 2015)

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Name of Researcher: Lisa Common BA, MA, RM

Name of Participant:

		Please initial box
1.	I confirm that I have read and understand the information sheet version number 1.1 dated 4 March 2015 for the above study and have had the opportunity to ask questions.	☐
2.	I agree to take part in the above study.	☐
3.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.	☐
4.	I understand that relevant data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
5.	I understand that the focus group or interview will be recorded and that anonymous direct quotes from the focus group or interview may be used in the study reports.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Appendix 4: Non-Service User Poster



Appendix 5: Service User Poster

Introducing and sustaining models of maternity care to support home birth in the NHS



I am a researcher with the Nottingham University Business School and I am undertaking a study asking postnatal women about their experiences of the local home birth service. If you gave birth at home during the last 3 years I would like to invite you to take part in a small discussion group with other home birth mums. I expect it to take up to one hour of your time in a place that is local for you.

As a gesture of thanks for taking part, each woman will be offered a £10 gift token and a contribution to their travelling expenses.

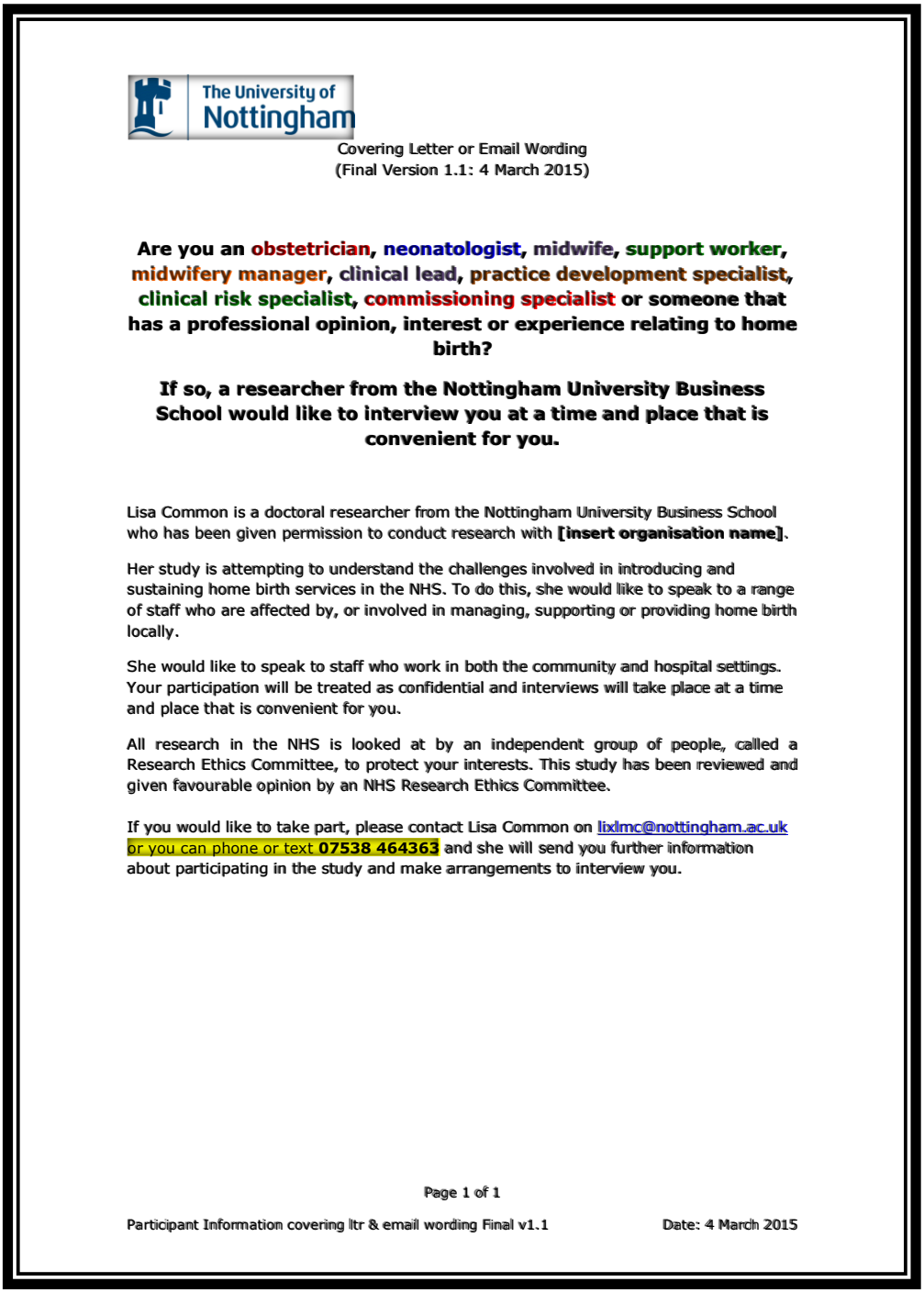
For more information, please contact: Lisa Common on

lixlmc@nottingham.ac.uk

Telephone: 07538 464363

POSTER SERVICE USERS Homebirth Final v.1.2 040315

Appendix 6: Non-Service User Covering Letter



The University of Nottingham

Covering Letter or Email Wording
(Final Version 1.1: 4 March 2015)

Are you an obstetrician, neonatologist, midwife, support worker, midwifery manager, clinical lead, practice development specialist, clinical risk specialist, commissioning specialist or someone that has a professional opinion, interest or experience relating to home birth?

If so, a researcher from the Nottingham University Business School would like to interview you at a time and place that is convenient for you.

Lisa Common is a doctoral researcher from the Nottingham University Business School who has been given permission to conduct research with **[insert organisation name]**.

Her study is attempting to understand the challenges involved in introducing and sustaining home birth services in the NHS. To do this, she would like to speak to a range of staff who are affected by, or involved in managing, supporting or providing home birth locally.

She would like to speak to staff who work in both the community and hospital settings. Your participation will be treated as confidential and interviews will take place at a time and place that is convenient for you.

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by an NHS Research Ethics Committee.

If you would like to take part, please contact Lisa Common on lixlmc@nottingham.ac.uk or you can phone or text **07538 464363** and she will send you further information about participating in the study and make arrangements to interview you.

Page 1 of 1

Participant Information covering ltr & email wording Final v1.1 Date: 4 March 2015

Appendix 7: Non-participant observation information sheet



Information Sheet
(Final Version 1.0: 12 December 2014)

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Lisa Common is a doctoral researcher from the Nottingham University Business School who has been given permission to attend and observe strategic and operational meetings within our organisation.

The study is exploring the organisational strategies and activities of service leaders and other stakeholders who are involved in the provision of home birth within their maternity services. The researcher will sit-in on meetings and make hand written notes relating to any discussions that may impact on how the home birth service is delivered locally.

The researcher will follow ethical and legal requirements and all information about those attending the meeting will be handled in confidence.

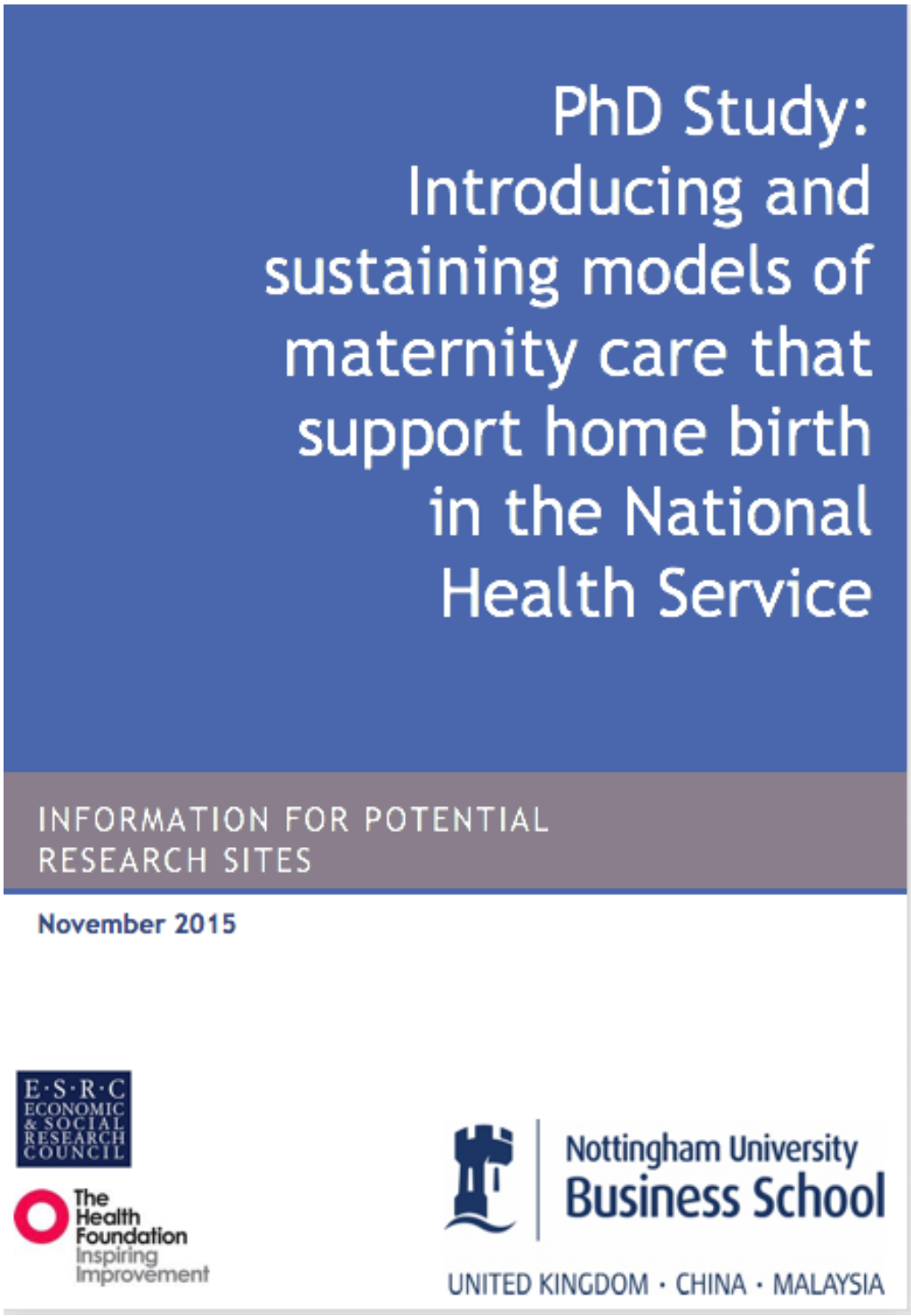
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by an NHS Research Ethics Committee.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researcher's contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints.

Lisa Common
Doctoral Researcher
Nottingham University Business School
Email: lixlmc@nottingham.ac.uk

C/O Dr Emma Rowley
Senior Research Fellow & Capacity Development Lead
NIHR CLAHRC East Midlands
University of Nottingham
Institute of Mental Health
Innovation Park
Triumph Road
Nottingham
NG7 2TU
Phone: 0115 823 1313
Email: emma.rowley@nottingham.ac.uk

Appendix 8: Colour brochure used to promote study to potential case sites



BACKGROUND TO THE STUDY: KEY FACTS

£2.6bn

Cost of NHS maternity care in 2012-13

646,904

Live births in England in 2013-14

26.2%

Percentage of women having caesarean births 2013-14

2.3%

Percentage of women giving birth at home in 2012

In 2014, the House of Commons Public Accounts Committee reported that "there is confusion around the Department [of Health's] policy for maternity services, what it wants to achieve and who is accountable for delivery" and recommended that they set out clear "objectives for maternity care, explicitly stating who is accountable for their implementation and how success against its objectives will be measured".

NEW EVIDENCE, NEW GUIDELINES

In December 2014, NICE revised its previous advice which urged caution if a birth at home, or in a midwife-led unit was planned. They now state that these options are particularly suitable for low-risk pregnant women.

This change in national guidance has the potential to affect hundreds of thousands of births in England.

There is a need for further research into the effectiveness of care across geographical, professional and organisational boundaries.

The organisational case studies conducted as part of the Birthplace Study (McCourt et al 2011, 2012) described and explored the features of a range of maternity care systems and drew attention to the challenges experienced in providing integrated services to support choice of place of birth. It detailed the variation in models of care to support home birth and identified how the deployment, organisational culture, participation, confidence and skill, and communication with women may be implicated in different outcomes between birth at home and in different settings.

RESEARCH OUTLINE AND BENEFITS FOR PARTICIPATION

STUDY OUTLINE

- Those that work for, or with the NHS know that healthcare systems are notoriously difficult to change.
- The aim of this study is to understand and explain the activities and challenges involved in introducing and sustaining models of health service organisation and delivery, by focusing on maternity services that support home births.

QUESTIONS FOR THIS STUDY

1. What strategies are used by service leaders to identify new opportunities for change?
2. How are the rhetorical arguments for and against change mobilised by stakeholders?
3. How do stakeholders utilise additional social networks to implement change?



The University of Nottingham

WHY HAVE YOU BEEN APPROACHED?

This study seeks to recruit three case sites that have organisational features suggesting they have some special expertise or innovative approach to providing a choice for home birth. They may be a service that has changed and improved performance over time, have significantly different levels of home birth when compared to their geographical neighbours or are situated in an area where women have a choice of different providers.

BENEFITS OF INVOLVEMENT IN THIS STUDY FOR YOUR ORGANISATION

This research will be conducted through the University of Nottingham, distinguished as one of the world's best universities.

You will be associated with an independent research organisation that has both credibility and authenticity.

You will be given opportunities to shape the design of the research in ways that meet your needs.

It is a free opportunity for your organisation to learn about yourselves through the production of reports and summaries by the researcher.

3

THE PROPOSED STUDY

This will be a qualitative study that engages with three separate providers of home birth services nationally.

The documentary analysis will consist of drawing together local policies, strategies, business models, commissioning and contract documents, media and advertising materials at each research site.

Where available, a ***small focus group*** at each research site exploring the views and experiences of postnatal women will be undertaken. Alternatively, where it is not possible to recruit service users, representatives of user groups and social movement organisations will be asked to take part in one qualitative interview.

Depending on the levels of access, ***non-participant observations*** will be undertaken at strategic and operational meetings at each research site.

Qualitative interviews exploring with those involved in the processes of making, supporting, sustaining or inhibiting change will be undertaken.

Interview participants will be invited to take part in a ***closed online discussion group*** after initial data analysis for all three case sites has been completed to provide comment on findings and interpretation.



DURATION OF THE STUDY

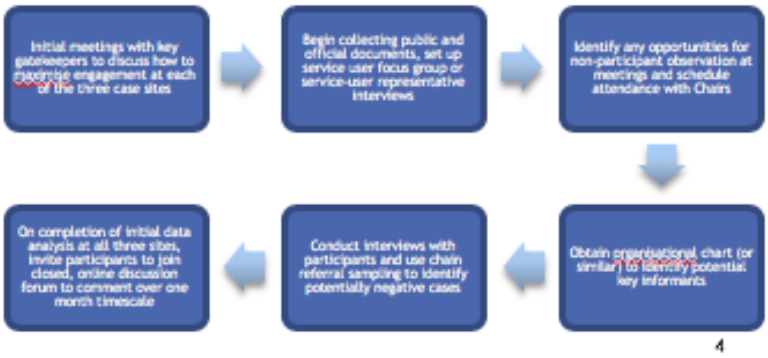
This study will take place between January 2015 and October 2016. It is anticipated that the researcher will be studying your locality for 2-3 months. Each interview or focus group participant will be involved for approximately one hour.

PARTICIPANTS

It is anticipated that around 25 participants will be recruited for each case study. This may include:-

- 3 Service leaders
- 5 Midwives
- 5 GPs and Commissioners
- 3 Hospital Service Leaders
- 3 Obstetricians/Neonatologists
- 6-8 Postnatal women or service-user representatives

SCHEMATIC REPRESENTATION OF STUDY STAGES



4

WHO IS INVOLVED?

THE RESEARCHER AND HER SUPERVISORS



PhD Student: Lisa Common is a qualified and practising midwife who was awarded a distinction in her Masters in Research Methods in 2013 which was supervised by Dr Denis Walsh.

Academic Supervisors for this PhD: Professor Justin Waring, Dr Simon Bishop and Dr Jenelle Clarke, (Dr Emma Rowley and Dr Melanie Jordan currently on maternity leave), Nottingham University Business School, Centre for Health Innovation, Leadership and Learning:- (http://www.nottingham.ac.uk/business/businesscentres/chill/index.aspx)

FUNDING SUPPORT

Lisa and this project have been awarded competitive and prestigious funding to undertake this study by the Economic and Social Research Council:- (http://www.esrc.ac.uk/about-esrc/) and The Health Foundation:- (http://www.health.org.uk/about-us/)

CONTACT INFORMATION

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M: 07966 782433

C/O Dr Emma Rowley
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T: 0115 823 1313

REFERENCES

House of Commons Committee of Public Accounts (2014). Maternity Services in England. Fortieth Report of Session 2013-14. House of Commons. London, The Stationery Office Ltd.

McCourt, C., Rance, S., Rayment, J. and Sandall, J. (2011). Birthplace qualitative organisational case studies: How maternity care systems may affect the provision of care in different birth settings. Birthplace in England research programme. Final Report part 6., NIHR Service Delivery and Organisation Programme.

McCourt, C., Rayment, J., Rance, S. and Sandall, J. (2012). Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. **Midwifery** 28(5):636-645.

National Collaborating Centre for Women's and Children's Health (2014). Intrapartum Care: Care of Healthy Women and Their Babies During Childbirth. London, National Institute for Health and Care Excellence (NICE).

Appendix 9: Demographic and perceptual information collected from all participants

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Non Service User Participant Information, Eligibility and Screening

Date of completion: _____ Researcher completing: _____

Eligibility Criteria

	a) Aged over 16 years of age and under 75 years.
	b) Individuals who have had exposure or involvement in the home birth service professionally or personally.
	c) Have authority, information, expertise or resources relating to the home birth service or have been user of the home birth service.
	d) Individuals who have the ability to give informed consent and speak fluent English.

Demographic information

Name	
Date of Birth	
Gender	
Professional registration/qualifications	
Professional and/or clinical role	
Time in current occupation	
Do you have expertise, authority, information or resources relating to home birth service locally	

Contextual Information

Employing organisation	
Location of employment	
Working hours/pattern	
Responsibilities	

Perceptual Information

1. The research evidence for the safety of home birth for healthy women is ...	
a) Convincing	b) Problematic
2) Is it a) likely or b) unlikely that more home birth would be cost-effective for the NHS?	
a) Likely	b) Unlikely
3) If someone healthy I cared about decided to have a home birth I would be ...	
a) Concerned	b) Supportive

To be asked at the end of the interview

Would you like to view or comment on a transcript of your interview?

Yes No (delete as appropriate)

Would you like to be contacted at a later date (before September 2016) and invited to take part in an online discussion forum about this study's findings?

Yes No (delete as appropriate)

If Yes, please provide an email address that you would like the invitation to be sent to:

_____

Title of Study: Introducing and sustaining models of maternity care to support home birth in the NHS

Service User Participant Information, Eligibility and Screening

Date of completion: _____ Researcher completing: _____

Eligibility Criteria

	a) Aged over 16 years of age and under 75 years.
	b) Individuals who have had personal exposure or involvement in the home birth service in the last three years.
	c) Have personally had a home birth in the past three years.
	d) Individuals who have the ability to give informed consent and speak fluent English.

Demographic information

Name	
Date of Birth	
Gender/Ethnicity	
Highest Level of Education	
Disability	
Number of Children	
Location of Birth for Each Child OU/AMU/FMU/Home/ Free Birth/BBA	

Contextual Information

How did you choose the home birth service you used? i.e. recommendation, previous experience, wanted to try something new, did not choose etc.	
GP or self-referral or automatically	

Perceptual Information

1) If someone healthy I cared about decided to have a home birth I would be …	
a) Concerned	b) Supportive
2) The research evidence for the safety of home birth for healthy women is …	
a) Convincing	b) Problematic
3) Is it a) likely or b) unlikely that more home birth would be cost-effective for the NHS?	
a) Likely	b) Unlikely