

Accepted Manuscript

The experiences of midwives and women during intrapartum transfer from one-to-one midwife-led birth environments to obstetric-led units

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PII: S0266-6138(18)30202-X
DOI: [10.1016/j.midw.2018.07.001](https://doi.org/10.1016/j.midw.2018.07.001)
Reference: YMIDW 2302



To appear in: *Midwifery*

Received date: 24 January 2018
Revised date: 13 June 2018
Accepted date: 2 July 2018

Please cite this article as: Georgina A. Sosa PhD, MSc, BA (Hons), RM, RGN ,
Kenda E. Crozier PhD, MSc, BSc, RN, RM (Professor of Midwifery) , Andrea Stockl PhD, MA, MSc (Lecturer in Medical Sociology)
The experiences of midwives and women during intrapartum transfer from one-to-one midwife-led birth environments to obstetric-led units, *Midwifery* (2018), doi: [10.1016/j.midw.2018.07.001](https://doi.org/10.1016/j.midw.2018.07.001)

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Highlights

1. Transfer needs to be recognised as a part of the spectrum of support when providing care within midwife-led birth environments.
2. Territorial behaviours between midwives causes anxieties when transferring women from a midwife-led birth environment to obstetric-led units.
3. Working cultures with maternity services should reflect respectful and compassionate working relationships.
4. Midwives accompanying women from the midwife-led birth environment to the labour ward improves women's experiences.
5. When women have a positive experience of transfer they build resilience to cope with the changing situation.

ACCEPTED MANUSCRIPT

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1. *Conflict of interest*

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Georgina Sosa, Kenda Crozier and Andrea Stockl have no conflict of interests to declare.

2. *Ethical approval*

Ethics for this study was granted by the London (Brent) National Research Ethic Service Committee 19th September 2011 (Ethics reference: 11/LO/1283).

3. *Funding sources*

The study was funded by the NHS East of England Clinical Academic Awards in 2010. A four year scholarship was awarded. Georgina Sosa self-funded the remaining time for her PhD.

4. *Clinical Trial Registry and Registration number (if applicable)*

Not applicable

5. *Acknowledgement*

We would like to thank the women, midwives and NHS Trusts who participated in the study. We would also like to thank Professor Jill E Robinson, a Professor of Healthcare Practice, University of Suffolk for her contribution to the early development of understanding of the concept.

The experiences of midwives and women during intrapartum transfer from one-to-one midwife-led birth environments to obstetric-led units.

Introduction

Intrapartum transfers from a midwife-led birth environment (alongside midwife-led unit (AMU), freestanding midwife-led unit (FMU) and women's home to an obstetric-led unit (hospital labour ward) is quite a common event within maternity services in England, but there is very little research about the process from the perspectives of midwives and women.

The Birthplace study (Hollowell et al., 2011) showed that transfers to hospital labour wards from the AMU, FMU and women's homes were markedly higher for nulliparous women compared with multiparous women. For nulliparous women, rates varied from 36% in planned FMU births to 45% in planned home births compared with rates of 9-13% in multiparous women. Failure to progress, fetal distress and meconium staining were the most

common reasons for transfer during labour, although epidural request was more common as a reason for transfer in the AMU group. Following birth perineal repair and retained placenta were the most common causes for transfer (Hollowell et al., 2011).

Intrapartum transfers to hospital labour wards can be an anxious time for women and midwives. Interviews with women in England have revealed that anxiety is connected to women's disappointment and uncertainties about their arrival in hospital and who will be looking after them in hospital (Rowe et al., 2012). Interviews completed with women in Australia also revealed that women's perceptions of their transfer experience were influenced by their feelings of exhaustion and being in pain (Kuliukas et al., 2017). There is consensus among studies that women experience a more positive transfer and less anxiety if the midwife accompanies and continues their care when transferring them to the hospital labour ward (McCourt et al., 2011; Rowe et al., 2012; Kuliukas et al., 2017).

The stipulation that midwifery one-to-one support should be continued during transfer to the labour ward was supported from 2014, when the National Institute for Health and Care Excellent (NICE, 2014) published up-dated intrapartum guidelines. Midwifery one-to-one support was considered to decrease women's anxiety and promote safety through a face-to-face handover of care on the labour ward with a midwife who had been caring for the woman in labour:

'In order to maintain provision of one-to-one care... the woman's attending midwife should accompany her when she is transferred from one birth setting to another.... This would minimise anxiety caused by the need for transfer, improve safety by ensuring an expert in intrapartum care is with the woman throughout labour and improve communication with the receiving midwife by facilitating a face-to-face handover of care' (NICE, 2014:308).

Studies have also shown that transfer to labour ward is an anxious time for midwives. Interviews with midwives regarding transfers from home births have revealed worries about dealing with emergencies during transfers (Wilyman-Bugter and Lackey, 2013). Midwives feel under pressure to get the timing right for the transfer (Kuliukas et al., 2016). In addition, midwives transferring from home births (Harris et al., 2011), and midwife-led units (McCourt et al., 2014; Bedwell et al., 2015) have experienced being questioned about their clinical decision to transfer women. An ethnographic study by McCourt et al. (2014) revealed how some midwives working in AMUs felt under pressure from the labour ward staff to avoid transferring women as sometimes they perceived the transfers to be unnecessary. The study also showed that AMU midwives were criticised for failing to use certain interventions, such as augmentation to avoid transfers of women for slow progress in labour or for pain relief.

The criticisms were not one sided as AMU staff tended to criticise labour ward midwives for over-medicalising care. An earlier ethnographic study by McCourt et al. (2011) showed that the transfer process improved when there were good communication systems involving trust, confidence and respect between all staff groups. The stipulation for excellent interprofessional communication and collaboration between different birth environments has been supported in more recent research concerning transfers to labour ward from home births (Fox et al., 2018) and birth centres (Kuliukas et al., 2016).

The aim of this paper is to explore the transition from midwifery one-to-one support in labour within a midwife-led birth environment to an obstetric-led unit from the perspectives of midwives and women. Such a perspective is not evident in the present literature concerning transfer to obstetric-led units.

Methods

Design

The researcher did not set out to explore transfers in labour, data presented here comes from findings of an ethnographic study exploring one-to-one support in midwifery led environments (Sosa et al., 2018). During the course of the data collection the first author observed transfers to consultant-led obstetric environments and the power of the findings could not be ignored. Direct observations were used to identify and understand the activities inside and outside the birth environments. The researcher observed as a '*peripheral member*,' (Adler and Alder, 1987: 36) as not engaged in clinical activity. The researcher did however converse with the maternity team, to build rapport with staff, asked questions and wrote detailed fieldnotes. Inside the birth environment the researcher attempted to blend into the background to observe the labour and birth until one hour postpartum. This was unless the researcher was asked to leave, or eight hours of observations had been completed. Outside the birth environment observations were performed inside the staff room. Guidance from Spradley (1980) was used to structure fieldnotes to capture timings, environment, activities, events, conversations, interactions, emotions, positions of research participants and equipment used.

The original intention was not to accompany women once they were transferred to labour ward, as the care changed from midwifery one-to-one support in labour to one-to-many, as women were introduced to a large team offering their support. During the fieldwork however, the observations and interviews changed that assumption. It became evident that for women, and many midwives, one-to-one support in labour did not stop when the decision was made to transfer women to the hospital labour ward. Once on labour ward, although

other professionals entered the birthing environment, some women still had the one-to-one relationship with their midwives who accompanied them and continued their care.

Setting

Across the three study sites, there were thirty women whose labour care was observed. Of these thirty women, eleven (36.7%) were transferred to the labour ward. This paper is focusing on these eleven women which included five from an alongside midwife-led unit (AMU), two home birth transfers and four from the freestanding midwife-led unit (FMU).

Sample

Initially, purposive sampling was utilised to determine the geographical sites, midwives and women to target specific characteristics to explore midwifery one-to-one support in labour. Using 'Dr Foster' website (2007: accessed 12/02/11) hospitals and midwife-led units were identified that provided midwifery one-to-one support in labour. Midwives had to have at least one-year experience providing labour support, and were not under supervised practice. Women participants had to be low-risk, under midwife-led care, over eighteen years old and able to speak English.

For the purpose of this paper, all eleven women who transferred from the midwife-led birth environment to the labour ward were included. There were eight primigravida and three multigravida women transferred. At study site one the researcher witnessed within the fieldwork that transfer to labour ward was part of midwifery one-to-one support in labour. The decision was then taken to follow all women at the AMU when the midwife continued their care to the labour ward and when consent was provided. Four out of five transfers at the AMU were included as part of the labour observations as the midwives accompanied the women and continued their care in the hospital labour ward. Although this plan was accomplished at the AMU, because of the close proximity within the same hospital environment, it was not possible at the FMU and from women's homes. The logistics of transfer via ambulance at study sites two (home births) and three (FMU) meant that the researcher could not continuously follow the women, birthing partners and midwives. Additionally, as the labour environment was in a different geographical site, ethical approval would have been required to enter the hospital environments. Transfer to labour ward was however discussed within all the interviews with the women and midwives. All eleven women and eleven midwives consented to an interview which were audio recorded. Additionally, nine out of eleven maternity records were analysed as two maternity records at the FMU could not be located. The study site, ethnic group, parity and reasons for transfer are shown in Table 1. The years of experience of the participant midwives at each study site are

illustrated in Table 2. Care was taken to ensure research participants could not be identified and remain anonymised.

Table 1: Characteristics of the women transferred to labour ward

No	Study sites	Ethnic Group	Parity	Reason for transfer
1.	AMU	Cauc'n	P1	Postpartum Haemorrhage
2.	AMU	Cauc'n	P0	Postpartum Haemorrhage and perineal trauma
3.	AMU	Cauc'n	P0	Labour progress
4.	AMU	Cauc'n	P0	Meconium in labour
5.	AMU	Cauc'n	P0	Perineal trauma
6.	Home	Cauc'n	P0	Labour progress
7.	Home	Cauc'n	P3	Meconium at birth
8.	FMU	Cauc'n	P0	Postpartum Haemorrhage and perineal trauma
9.	FMU	Asian	P0	Postpartum Haemorrhage
10.	FMU	Asian	P0	Postpartum Haemorrhage and perineal trauma
11.	FMU	Middle East	P2	Baby check for infection

Table 2: The years of experience of the midwives caring for women requiring transfer

Case study site	1-11 years of experience	>11 of experience
Case study site one (AMU)	3	2
Case study site two (Home)	2	0
Case study site three (FMU)	1	3

Data collection

The fieldwork for the three study sites was completed over 39 weeks between October 2011 and December 2012. Midwives introduced the research antepartum so that women made a decision regarding their consent prior to being in established labour. Midwives were also recruited and only those who agreed to be observed were included. When consent was provided by a woman and midwife the researcher was contacted to observe the labour. Following a labour observation, the midwife approached the woman prior to discharge and checked if consent was provided for a postnatal formal interview. Women who consented were interviewed two weeks postpartum. The researcher also approached the midwife

involved in the observation to check if they still consented for an interview at a time that was convenient for them.

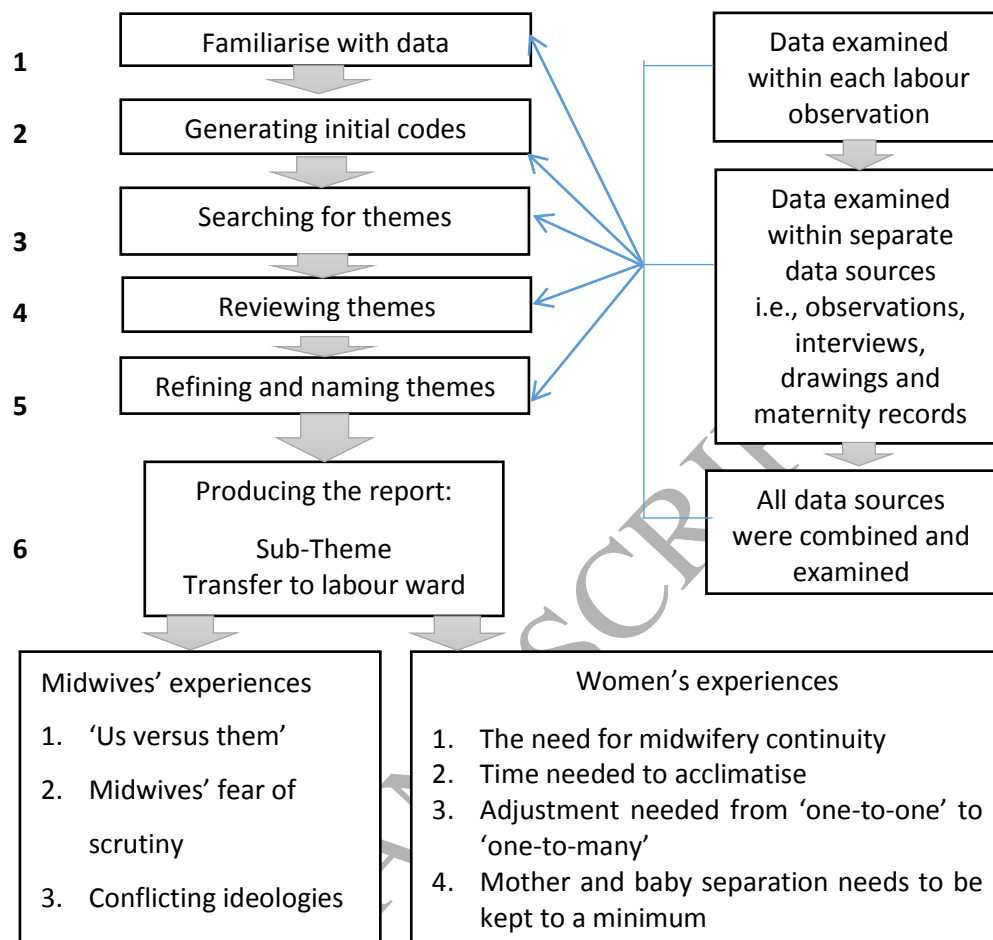
Reflexivity was an integral part of the study as '*every ethnographic description is a translation*' (Spradley, 1979:22). Reflexivity helped the researcher to capture and document conscious thoughts by critically examining assumptions and actions in relation to the data (Bonner and Tolhurst, 2002).

Data analysis

Field notes and drawings were completed using a touchscreen tablet while observing the activities, interactions and events inside and outside the birth environments. The researcher compared their understanding of the events with the maternity records. As stipulated by Hammersley and Atkinson (2007), documentation analysis provided details concerning clinical decisions and priorities made by midwives. The data from the observations and maternity records helped the researcher to construct the questions for the interviews completed following the births with women and midwives to gain their perspectives. Interviews were audio recorded and transcribed by the researcher, with data organised and categorised using the software program NVivo 10. All data was anonymised and pseudonyms are used to present the report. Thematic analysis enabled the different data sources and different study sites to be compared. The guidance from Braun and Clarke (2006) (Figure 1) included familiarising the researcher with the data, generating initial codes, searching for themes; and reviewing, refining and naming themes until data saturation. The theoretical stance evolved from choosing ethnography as the methodology. Symbolic interactionism (Goffman, 1990; Blumer, 1986) was used as the analytical lens to interpret the meaning of interactions between individuals in relation to their relationship, situation and the environment.

A comprehensive understanding of how the continuity of the midwifery one-to-one relationship during transfer to the hospital labour ward influenced the experience of midwives and women, was not achieved until data analysis was completed for all three study sites. As part of the main study the data produced 'thick description' (Geertz, 1973) concerning two sub-themes named 'transfer to labour ward' and 'territorial behaviours.' It became apparent that midwives' experiences of territorial behaviours when providing one-to-one support within midwife-led birth environments increased during transfer to labour ward. Territorial behaviour manifested itself as a feeling of 'us versus them' behaviours, feeling under scrutiny and being aware of conflicting ideologies. Richer and deeper descriptions of the territorial behaviours were revealed within the observations outside the birth environments (e.g. staff rooms) and interviews while the maternity records provided information about the characteristics of the women, labour support required, timelines and decision making.

Figure 1: Thematic analysis framework adapted from Braun and Clarke (2006)



Regarding the experience of women, during data analysis one woman at the AMU described three elements that increased her resilience to cope with the transfer to labour ward. These included the midwife accompanying her, having a private room to adjust to the new circumstances on labour ward and that all staff introduced themselves. Additionally, two women at the FMU then highlighted the negative effects of being separated from their babies. The researcher then went back to the data of all women who had been transferred to labour ward to assess for these four themes.

The study was approved by a London NHS Ethics committee. Written consent was gained for all participants.

Findings

The findings are presented first from the perspective of midwives as they initiate the transfer process and then from perspective of women who have undergone a change of environment and often care provider. It is evident that the experiences of midwives sometimes have an impact on the women in their care especially when making the decision to accompany and continue their support on the labour ward.

The experiences of midwives when transferring women to labour ward

Territorial behaviours

Midwives providing one-to-one support in labour felt good about themselves and their accomplishments inside the birth environment, but outside the birth environment, midwives sometimes felt judged by their colleagues from other maternity wards and hospital sites. They felt that midwives in other maternity wards and hospital sites considered that midwives providing one-to-one support in labour did not work as hard and were less efficient.

This study found that transfer to the labour ward was an anxious time for midwives. The research observations outside the birth environments revealed territorial behaviours were heightened during intrapartum transfers to labour ward (Table 3). The decision for transfer was one of the last choices available for midwives and women to redress the balance (Sosa et al., 2018) to improve and resolve abnormal labour and/or postpartum complications. The major concern for midwives was for the safety of the women and babies, however midwives were also anxious about their one-to-one labour support activities being scrutinised by the labour ward staff. To understand the heightened anxiety during transfers it is necessary to first understand the 'us versus them' culture experienced between midwife-led birth environment staff and labour ward staff.

Table 3: Territorial behaviours

	Experiences of midwives	Impact
1.	'Us versus them'	Questioning efficiency and productivity
2.	Midwives' fear of scrutiny	Midwife will be blamed for transfer
3.	Conflicting ideologies	Two different models of care

'Us versus them'

Territorial behaviours created competitive working environments where each environment strived to be the busiest and most efficient. Such competitiveness was observed to create an 'us versus them' culture. Territorial behaviours were exhibited through real and perceived conflicts between different midwifery teams and departments. Territorial behaviours were apparent at all three study sites, but were more prevalent at the AMU as the maternity departments worked in closer proximity.

Territorial behaviours created a perception that midwives from other maternity wards did not value the contributions of midwives working within midwife-led birth environments:

One AMU midwife described staff working within the AMU as the ‘poor relation’
(Fieldnotes, AMU).

Midwives working within the midwife-led birth environments suspected that colleagues working in other maternity wards felt they did not work as hard. From observations, the perception that midwives providing one-to-one support were less productive, was not entirely incorrect. In one handover a senior midwife on labour ward expressed some resentment:

... it was not one-to-one care today, but one-to-six million on labour ward
(Fieldnotes, study site one: labour ward).

Additionally, midwives working within the midwife-led birth environments felt that the labour ward staff did not think they worked as efficiently:

Midwife Yani was questioning if she should have transferred Lola to hospital ... but she thought that Lola might have the baby in the ambulance. Yani said that she had to do an ARM [break the waters]. Yani added, ‘could you imagine if I had not done it [ARM] and transferred Lola to ... [labour ward] ... the midwives would have said ‘yes she had a normal birth after an ARM.’ Insinuating they would be talking about her in a derogatory way (Fieldnotes, FMU).

Midwife Sonia was reflecting with another midwife as to whether she had done enough this morning prior to transferring a woman to labour ward... Sonia explained that she had given ... [drugs to control bleeding] and emptied the bladder. Sonia said she felt that labour ward staff were not happy with her (Fieldnotes, AMU).

Again, the language and tones of the senior midwives on the labour ward handovers sometimes supported the impression that they did not always respect the midwife-led interventions completed on the AMU. A senior midwife illustrated such scepticism during a handover on labour describing the transfers from the AMU:

One for epidural

One for no [labour] progress and now on syntocinon [oxytocin]

One was ‘span to death’ [in reference to the ‘Spinning babies’ (2018) initiative] and then came over here and delivered.

The senior midwife added *‘I think the walk over to the labour ward did it’*

(Fieldnotes, study site one: labour ward).

Midwives’ anxiety about external scrutiny was also observed by women when transferring from the midwife-led birth environments to the labour ward. Hilda felt tension between the AMU and the labour ward staff when she was transferred:

Yes ... I thought there was a bit of tension just between the midwife and just the way the whole discussion kind of went. It felt there was tension between the midwife unit and the labour ward [...] I think there ... was an element of ... 'we will sort out your mess'... (Hilda, AMU).

These observations from Hilda resonates with another study by Rayment (2011: 231) which quotes labour ward staff saying, *'oh they've [AMU midwives] brought the cr*p around again.'* There is an implication that labour ward staff save the day as *'medical heroes'* (Rayment 2011:232).

Midwives' fear of scrutiny from the hospital staff

During transfer, some midwives such as Megan appeared vulnerable and close to tears at the thought of being questioned by the labour ward staff:

Midwife Megan explained that she was not looking forward to going in [to the labour ward] as she feels if anyone says anything she will burst into tears. Megan looks close to tears ... (Fieldnotes from Isabelle's birth, FMU).

While feeling such tensions, midwives continued to monitor and provide support to women, their partners and babies when born, and arrange the ambulance, inform labour ward and prepare their documentation for transfer.

Midwives were anxious that their labour care would be translated as inefficient and blamed for the transfer by the labour ward staff:

... I think she [Linzi] actually got annoyed with me ... she was saying 'no I don't want chocolate buttons.' ... I knew that when she would get into hospital ... they would test her wee [urine] straight away and say, 'you know that she has got ketones, the midwife hasn't been working hard enough' [putting on voice] and I was ...I was trying to shove the chocolate buttons down her mouth (Ava, Home birth midwife).

Documentation provided another opportunity to scrutinise practices when midwives transferred women to the labour ward:

We all have to be very, very ... alert ... about our documentation ... if we have written it down ... then that's proof ... I will always make sure my paper work is sound before it leaves the house (Florence, Home birth midwife).

This observed fear of reappraisal for omission of care is explained by Surtees (2010:88) who described how midwives ensured that they left an audit trail using their documentation, just in case they were *'called to account'* regarding their clinical practices in the future.

In addition to the anxieties around their care being scrutinised, midwives were conscious that their transfer rates to the labour ward also questioned the viability of their midwife-led services:

Midwife Yani said 'Well if someone is looking at the [FMU] activity from a strategic level they will be looking at the high transfer rates. It gives evidence to close us down' (Fieldnotes, FMU).

Midwives working at the AMU and FMU felt a constant threat that the midwife-led services would be closed due to the decreased birth rates and increased transfer rates.

Midwives' fear of scrutiny from the women

Midwives were also apprehensive that women would blame them for needing to be transferred. Within the one-to-one relationship, both the midwife and woman invested expertise, effort, emotions and trust in one another and therefore a sense of guilt was felt from both parties when things did not go to plan. The researcher on site was requested to leave the birth environment only once, when a FMU midwife wanted privacy to discuss transfer to labour ward and the management of a perineal tear with Isabelle. Midwife Megan later explained that she felt apprehensive that the woman may blame her for the need to transfer:

... she was apologising to me ... but it was me that felt bad. I felt, I felt that I let her down (Megan, FMU midwife).

It was evident that women like Isabelle also blamed themselves for transfers to labour ward:

... even now my husband and I are like 'oh, should you have pushed, shouldn't you have?' ... yes there were ... things ... I shouldn't have done certain things (Isabelle, FMU).

Midwives' self-scrutiny

External scrutiny was combined with self-scrutiny as midwives would often question their own actions. When midwives accompanied women during transfer to the labour ward, in the ambulance, their full focus was not always on the women. Instead, midwives were reflecting on their own activities within the birth environment and questioning if they had caused the need for transfer:

... What else could I have done? But even in the ambulance ... I go through things and think, is it my fault, what could I have done, there is nothing I could have done, and I was doing that pretty much all the way, as well as ... you know talking to Isabelle (Megan, FMU midwife).

Midwives often confided with trusted colleagues to informally debrief:

...you just think 'did I miss something?' or 'should I have done this?' You do doubt yourself... I talked to my colleagues, I find them a great source ...

(Megan, FMU midwife).

Conflicting ideologies

The AMU midwives and the home birth midwives at study sites one and two were sometimes able to accompany women to the labour ward and continue their care. Midwives had insight into the importance of the continuity of their presence to help women make the transition from one-to-one support within the midwife-led birth environment to one-to-many on the labour ward:

...I didn't want to leave her, because ... I was like a link between the two worlds ... I was ... the only point that remained in common between the two worlds ... I was afraid that they didn't allow me to carry on with the one-to-one care... (Diana, AMU Midwife).

Some midwives found it difficult however to recreate a calm atmosphere within the birth environment when continuing their care on labour ward due to regular interruptions from labour ward staff to obtain progress reports. Midwives appeared to have no power to stop these interruptions:

Yes, when I was in ... [labour ward] ... they kept on knocking on the door asking what was happening and ... also they wanted to know about the progress. There I really felt ... the one-to-one-care was disturbed. I felt upset, because I felt it was a really important moment. I couldn't follow her as I would have done, because I was continuously going out, in and out, in and out. Luckily anyway, there was progress (Diana, AMU midwife).

Not all midwives wanted to transfer with the women to labour ward. The reluctance observed on the part of midwives, could be explained due to the perceived territorial behaviours:

Midwife Lorna delayed a non-urgent transfer to labour ward as she said she did not want to go over. She asked if there were any more women coming to the AMU as she did not want to go to labour ward (Field notes, AMU).

The experiences of women when transferring to labour ward

The changing situation and environment challenged women's autonomy to make their own decisions. The findings revealed **four elements** that had an impact on the **experiences** of women transferring from midwifery one-to-one support within midwife-led birth

environments to labour ward (Table 4). When these **elements** were present, in general women had a more positive transfer experience. When one or more of these elements were missing, women had a negative experience during the transfer to the labour ward.

Table 4: Four elements that effected the experience of women when transferring to labour ward

	Women's experiences	Impact
1.	Midwife transfers with the woman and continues support on the labour ward	Continuity of support
2.	Private room available	Intimate space to acclimatise
3.	All staff introduce themselves	Helps mental transformation from 'one-to-one' to 'one-to-many'
4.	Mother and baby separation kept to a minimum	Promotes maternal bonding

Continuity of Support

Continuity of support did not just mean a continuation of care, it included a continuity of the emotional and professional connection formed within the midwife-led birth environment. Some midwives were able to stay with women until they were ready to transfer to the postnatal ward. The continuity of having the midwifery one-to-one support was reassuring. Women appreciated the commitment of midwives who stayed with them:

... she [midwife] stayed with me all the way through up until going to theatre ... which was brilliant and bless her as she had not stopped for a break ... she ... liaised with the surgeons ... and did everything so I had the same face ... I really, really appreciated that ... and that really helped me having the same face all the way through

(Terri, AMU).

For some women however, the continuity stopped at the midwife-led birth environment. This was observed more frequently at the FMU, as the midwives had to assess at each transfer if it was safe for them to leave the FMU if the midwifery support was not experienced working at the maternity unit. This situation sometimes meant that an unfamiliar midwife accompanied women to the hospital labour ward. In such situations women described the midwife as acting as an escort only:

It was nice that the midwife came with us to [named hospital] ... but it felt like ... she was a bit more of an escort, really. [It] didn't feel like she was there for us. She needed to be there, that was the protocol (Jasmine, FMU).

When the midwife did not stay to continue their care at the hospital labour ward, women felt vulnerable as the labour ward was unfamiliar to them and the staff were not connected to their previous labour experience:

...after having such a good experience ... it was very strange being somewhere that was very unfamiliar, the staff don't know you, what you have been through (Jasmine, FMU).

As the professionals on labour ward were not familiar to the women, women sometimes felt they were not listened to:

... I think the surgery was terrible ... I kept saying to the anaesthetist I feel sick, I feel sick, I feel sick and he was no, no you won't be sick you haven't eaten for twenty-four hours and I vomited like five times during the surgery and they wouldn't undo me, obviously because they are doing surgery, so I aspirated my vomit (Isabelle, FMU).

Intimate space to acclimatise

The second attribute which helped women to cope with the transfer to the labour ward related to having a private room to adjust to the situation, along with having time to bond with their baby and partner:

... even if it were for 15-20 minutes [staying in a private room] ... it's a case like for me that you have had a traumatic few minutes and you are being transferred ... just fifteen minutes to acclimatise yourself and calm down ... definitely really, really helps ... but the main thing was that [midwife Lorna] ... came with me ... (Terri, AMU).

In contrast some women found themselves waiting alone in limbo outside the operating theatre for a surgeon to be available to repair a third-degree tear. Women in such situations were often separated from their babies for long periods of time:

... I had to go to surgery and I had to be away from her [baby] so long, and they kept me there because the doctor was busy ... Yes ... waiting for an hour ...before the doctor came, all that time I was away from her [baby] (Jasmine, FMU).

All staff introduce themselves: 'Hello my name is...'

A third attribute that helped women cope with the transfer to the labour ward was that all staff introduced themselves and described their roles in relation to the planned interventions.

These introductions supported women's mental transition from one-to-one care to one-to-many carers, including a surgeon, anaesthetists, theatre staff, porters and labour ward midwives:

... The surgeon came in ... to look at my tear again ... He had a student with him... and then I had someone come to prep, he was another surgeon ... and then ... I don't know if she helped with the surgery but she came in just to discuss what was going to happen ... so yes it wasn't a lot of people, one at a time sort of thing and it was quite nice, because they all sort of made themselves known and explained why they were there and what they were doing, it wasn't like who is this person? ...
(Terri, AMU).

Women struggled to connect with labour staff if they did not introduce themselves:

... [Labour ward] is a completely different environment because there are lots and lots more people around ... you have no idea who is who ... you don't know ... the actual person responsible for you ... there is no consistency ... (Birthe, FMU).

Mother and baby separation kept to a minimum

The separation of women from their babies had the most negative impact regarding women's experience of transfer to the labour ward. During the postnatal interviews women were still feeling a sense of grief for the time lost with their babies:

... I was covered in vomit when I came out to see my baby and I hadn't bonded with him ... it was 07:00 am when I came out of thingy [theatre] and he was born at nearly 02:00 in the morning, so it had been five hours and I thought I didn't even know my baby, I wouldn't recognise him ... (tearful) (Isabelle, FMU).

I just felt sad that I didn't even know this person (tearful) who had been alive for whatever five to six hours at that point and I didn't even know him (Isabelle, FMU).

This sense of loss expressed in this study raises questions on the long-term effects of such experiences and whether it impacts on women's relationships with their baby and partner.

Discussion

Transfer is part of the spectrum of care provided when supporting women one-to-one in labour within midwife-led birth environments. Some women will need more complex care to facilitate birth and a safe outcome for mothers and babies. Such requirements are sometimes not known until labour is established or following birth. However, this study revealed that rather than viewing transfer as part of the spectrum of care, many midwives felt

that transfer would be perceived as reflecting poor labour care. Blix et al. (2014) analysed literature portraying the reasons for transfer from planned home births within Western countries and concluded that transfer rates are not necessarily indicators of quality of care. In fact, Blix et al. (2014) advised that it is difficult to suggest an optimum transfer rate, but warned that low transfer rates may lead to avoidable cases of death and serious morbidity. The midwives in an Australian study by Fox et al. (2018:22) supported moving away from negative descriptions of transfer such as '*failed homebirth,*' and instead use terminology that celebrates smooth transfers as reflecting a successful maternity care system.

The territorial behaviours reported in this paper including an 'us versus them' culture supports other studies on transferring women from AMUs (McCourt et al., 2014; Rayment., 2011) and home births (Fox et al., 2018) to hospital labour wards. Midwives working at all three study sites had difficulty empathising with midwives working in different maternity departments and hospital sites, which was also found in the ethnographic study by McCourt et al. (2014). Evidence from the study by Rayment (2011), found that the rotation of midwives did not appear to decrease territorial behaviour, because staff became loyal very quickly to the unit or team in which they worked. Hunter (2004: 270) explained that the '*co-existence of conflicting ideologies of practice*' within different maternity departments led to the '*us and them*' phenomena. Conflicting ideologies was also a theme that was present in this study, but midwives felt that providing continuity helped the transition for women from the midwife-led units to the labour ward. One midwife described themselves as a '*link between the two worlds.*'

Another sub-theme under territorial behaviour was 'fear of scrutiny.' Midwives greatest fear was their labour support and clinical decisions being scrutinized by labour ward staff when they handed over the care. Feeling 'under scrutiny' was a main theme experienced by midwives during transfer from a home birth to the hospital labour ward in the phenomenological study by Ball et al. (2016). Midwives felt scrutinized about their decision making and again the apprehensions centred around the reception they would receive on labour ward as they feared being judged, mistrusted and disrespected. Such scrutiny was thought to exceed that experienced by hospital labour ward staff. Future research needs to explore whether the scrutiny described in this paper and Ball et al. (2016) could influence the decision-making processes of midwives during transfer which then may have an impact on women in their care.

More research is needed regarding the experience of midwives during transfer and the territorial behaviours experienced between maternity departments and wards to help NHS organisations to support a working culture that acknowledges the range of skills and expertise of all midwives working in all areas, creating respectful compassionate working

relationships. Maternity services need to move from a '*blame culture to a learning culture*' (Department of Health, 2016). This study supports previous research (McCourt et al., 2011; Kuliukas et al., 2016; Fox et al., 2018) that stipulate good communication and collaborative systems involving trust, confidence and respect between all maternity staff groups are needed to positively support transfer from midwife-led birth environments to hospital labour wards. The first course of action may be to examine how territorial behaviours can be avoided at handover of care as these appear to cause the most fear for midwives. The language at handover is not isolated to those where the transfer midwife and labour ward staff meet. The findings in this study, demonstrate that the language and tone of the shift handovers led by the senior midwives was not always respectful regarding midwifery one-to-one support within midwife-led care birth environments.

Evidence from the literature, has shown that women knowing the midwife who escorts them to the labour ward improved the transfer experience from the home (Edwards, 2010) and midwife-led units (Macfarlane et al., 2014; McCourt et al., 2014). Rowe et al. (2012) explains that when midwives continue their care on the labour ward, women feel safe because they have an advocate that they trust while they adjust to their changing situation. To enable best outcomes for women the interchange between staff from midwife-led settings and labour ward needs to be collegiate and supportive. If midwives feel too threatened to transfer then women will lose continuity of carer and the negative impact may result in consequential outcomes.

The separation of women from their partners and babies was identified as another stressor in this study and it is important to consider how this can be minimised when a transfer to a maternity theatre is required. An example of a service innovation from Derby shows promise. The Royal Derby Hospital (@DerbyBOTB, 2017) supported a change in policy to ensure that women, their partners and babies should not be separated as it caused women to be '*heart-broken.*' Such recommendations have evolved from a project referred to on twitter as the *#theatrechallenge* where maternity staff have attempted to experience through role play how women and their birthing partners feel during transfer and the care received within the maternity theatre. Clearly such innovations require multi-professional support planning and services which should as stipulated by the National Maternity Review (2016), value personalised care solutions which centre on women, their babies and families.

Implications for practice

The findings from this study indicate that when possible midwives should accompany women and continue their one-to-one support following transfer to the labour ward. However, NHS organisations need to acknowledge that transfers to the labour ward are sometimes

stressful experiences for midwives and women.

To alleviate the stress experienced by midwives and any negative after effects, NHS Organisations should have experienced midwifery support available to midwives, when needed, for the decision making and transfer process. Following the transfer to the labour ward a de-brief session for midwives should be offered, where they can discuss any anxieties that may have arisen from the episode of care which ended with the transfer to the labour ward. Further research on communication strategies to support smooth transition from midwife-led to obstetric-led setting is needed.

The experience of women when they transfer to the labour ward, does not need to be negative. There are four recommendations for practice that should be followed:

1. Midwives providing one-to-one support in labour should accompany women to the labour ward to continue one-to-one care.
2. Privacy should be provided within the hospital labour rooms for women, their babies and partners to bond and readjust to their new situations in-between treatments required.
3. All staff should introduce themselves during transfer and within the hospital labour ward.
4. Women should not be separated from their babies. If separation is required, the time interval should be as short as possible.

The latter three inventions only require a professional behaviour change and will require no organisational changes or financial investment. This study demonstrated that the presence of all four recommendations helped women to build resilience to cope with the change of location, situation, medical interventions and new carers. Additionally, babies and partners should accompany women into the maternity operating theatre when surgical repairs are performed. Given that women in this study felt a sense of loss when their babies were removed from them, it would seem logical that partners and babies were separated as little as possible. The long-term consequences of this sense of loss were not identified in this study, but the issue warrants further research and a change in policy. The cumulative impact reported here supports a previous study by Grigg et al. (2015). The study revealed elements including women feeling in control, receiving good communication and continuity from a known midwife as having a positive impact on their experience during transfer to labour ward. However, when these elements were not present there was a negative impact on women's experiences.

Lastly, postnatal discussions should also be offered to women and birthing partners to de-

brief about their transfer to labour ward to understand if further support is required.

Limitations

The limitations in this study included not understanding the relevance of transfers being an important part of midwifery one-to-one support in labour until the fieldwork. Consequently, the observations of transfers from the midwife-led birth environment to the labour ward were only accomplished at the AMU and not from the home births and FMU. Secondly, focusing on the perspectives of the midwives and women, the partners' experiences were not captured during transfers to labour ward. This means that the emphasis is woman centred rather than family centred.

Conclusion

Transfer from a midwife-led birth environment to a hospital labour ward is a stressful situation for women and midwives. These anxieties need to be acknowledged as transfer to labour ward is part of the spectrum of support when providing care within midwife-led birth environments. For women, the continuation of the one-to-one support to extend from the midwife-led birth environment to the labour ward improves their experience and decreases their anxieties. For midwives, more research is required to examine territorial behaviours within maternity services and support mechanisms which can decrease midwives' stress levels when making the decision, communicating, organising and undertaking a transfer to labour ward.

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