



## Mapping midwifery and obstetric units in England



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### ABSTRACT

**Objective:** to describe the configuration of midwifery units, both alongside & free-standing, and obstetric units in England.

**Design:** national survey amongst Heads of Midwifery in English Maternity Services

**Setting:** National Health Service (NHS) in England

**Participants:** English Maternity Services

#### Measurements

descriptive statistics of Alongside Midwifery Units and Free-standing Midwifery Units and Obstetric Units and their annual births/year in English Maternity Services

**Findings:** alongside midwifery units have nearly doubled since 2010 ( $n = 53-97$ ); free-standing midwifery units have increased slightly ( $n = 58-61$ ). There has been a significant reduction in maternity services without either an alongside or free-standing midwifery unit (75–32). The percentage of all births in midwifery units has trebled, now representing 14% of all births in England. This masks significant differences in percentage of all births in midwifery units between different maternity services with a spread of 4% to 31%.

**Key conclusions:** In some areas of England, women have no access to a local midwifery unit, despite the National Institute for Health & Clinical Excellence (NICE) recommending them as an important place of birth option for low risk women. The numbers of midwifery units have increased significantly in England since 2010 but this growth is almost exclusively in alongside midwifery units. The percentage of women giving birth in midwifery units varies significantly between maternity services suggesting that many midwifery units are underutilised.

**Implications for practice:** Both the availability and utilisation of midwifery units in England could be improved.

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## Introduction & background

Since 1993, maternity care policy in England has promoted women's choice of place of birth (Cumberlege, 1993). This became the national *choice guarantee* in Maternity Matters policy document in 2007 (Department of Health, 2007) with three options: birth in a maternity hospital (obstetric unit or OU); birth in two types of midwifery unit (MU), either alongside [AMU] or freestanding [FMU]; or birth at home. Midwifery units are home-like environments that avoid the routine use of technology and are considered especially suitable for women with a straightforward pregnancy and an anticipated normal birth. They are also referred to as 'birth centres' in the international maternity care literature (Hermuset al., 2017). Alongside midwifery units are situated within a hospital complex that has an existing OU. They may be in an adjacent corridor, on another floor, in another wing and occasionally in a separate building. What they all share is the facility to transfer labouring women to the obstetric units if complications occur in labour via walking, wheelchair or bed (McCourt et al., 2014). Freestanding midwifery units are geographically separate from their host obstetric units and women transfer via ambulance if complications develop in labour (Christensen and Overgaard, 2017).

Midwifery units exist in many other national maternity care systems, and, over the past three decades, a considerable body of evidence has accumulated demonstrating that both AMUs and FMUs reduce labour and birth interventions in women (Walsh and Downe, 2004; Hodnett et al., 2012; Alliman and Phillippi, 2016; Christensen and Overgaard, 2017). Women who use them express high levels of satisfaction and midwives who work in them a sense of well-being and autonomy (Bernitz et al., 2016; McCourt et al., 2016). Studies inside and outside of the UK suggest they are also more cost effective (Bernitz et al., 2012; Schroeder et al., 2012; Kenny et al., 2015).

The Department of Health (England) commissioned research into childbirth in different settings (home, MUs, OUs) in 2004, specifically examining low risk women. The subsequent Birthplace in England research programme consisted of a suite of studies including a mapping of MUs and OUs in England, a prospective cohort study of perinatal and maternal outcomes by planned place of birth and an economic evaluation of the cost effectiveness of different places of birth. The cohort study reported that outcomes for low risk women were better and care was less costly if births were planned in MUs, both AMUs and FMUs, rather than OUs, without compromising the safety of babies. In particular, having a baby in a MU reduced caesarean section rates by two thirds (Brocklehurst et al., 2011). There was also a reduced risk of instrumental delivery or of receiving medical interventions such as augmentation, epidural or spinal analgesia, general anaesthesia, or episiotomy and significantly greater likelihood of having a normal birth (Brocklehurst et al., 2011). The linked economic study also found that cost per woman was less than traditional labour wards and care more cost effective (Schroeder et al., 2012).

Subsequently, the National Institute for Clinical Excellence (NICE), the body that develops clinical guidelines for the English National Health Service (NHS), updated their guidelines on intrapartum care and now advises low risk women that MUs are particularly suitable for them (NICE, 2014). Specifically the guidelines state that 'the maximum choice for women would comprise access to an Obstetric Unit with an AMU and access to a FMU within the Trust boundaries or in a neighbouring Trust'. However, despite the advantages of MUs, a NAO survey (National Audit Office, 2013) found that MUs were not equally distributed with only 11% of women giving birth in one while the vast majority continued to give birth in OUs. In addition, MUs were not equally distributed across the country. A third of local maternity services (also called Trusts) had no MUs, and, in those that did, the percentage of women birthing in them as a proportion of all women birthing in the Trust was extremely variable with only a few achieving over 20% (National Audit Office, 2013).

The reasons for these variations are unclear. There may be a range of context-specific or more general barriers to establishing and operating MUs. It is possible that financial constraints currently impacting on the NHS (Iacobucci, 2016), a shortage of midwives (Wise 2014) and the increasing medicalisation of birth (Johanson et al., 2002; Beech, 2011) are among relevant factors. Little is currently known about such barriers or what facilitates MU provision. However, the unequal provision results in many low risk women birthing in OUs and therefore being exposed to an increased risk of caesarean section and to a birth experience that is less satisfying (Hodnett et al., 2012). In addition, local maternity services (Trusts) are not realising the cost savings of MUs.

The aim of this paper is to report on the types, numbers and utilisation of MUs in England 6 years on from the Birthplace study and presents the results from the first part of a larger funded study of the facilitators and barriers to optimal use of MUs. The paper compares the results with the Birthplace Mapping survey (Redshaw et al., 2011) and comments on the changes that have occurred over that time. In addition, it discusses in more depth the potential utility of MUs to birth a greater proportion of low risk women.

## Methods

### Definition of alongside midwifery units

To enable accurate mapping of service configuration it was first necessary to review how terms are operationalised. Midwifery units are defined as a clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. Whilst the definition of an FMU is clear (midwife led unit that is a geographical distance from a host obstetric unit and therefore requires a vehicle transfer if complications occur in labour), the definition of an AMU is less clear. The Birthplace Study defined it as a midwifery unit where diagnostic and therapeutic medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site (Redshaw et al., 2011). Transfer will normally be by trolley, bed or wheelchair. Follow-on research projects from Birthplace add that AMUs should be able to accurately identify their admissions and births in their record systems (Rowe et al., 2013). However, these criteria allow for a number of hybrid arrangements e.g.

- midwifery-led rooms within the physical space of a traditional labour ward
- a midwifery-led area adjacent to a labour ward but with no separate staffing or management
- midwifery-led area that allows for labour interventions like continuous fetal monitoring
- midwifery-led area that is regularly used for labour ward overflow
- no separate data collections of processes or outcomes within the MU

Within our team, we had extensive discussions before agreeing the following criteria for defining AMUs for the mapping stage of our study:

1. Midwifery-led care setting
2. 'Low risk' women, with case by case exceptions only
3. Separate physical space from OU with minimum demarcation being a line on the floor that excludes, for example, having a AMU-style room within an obstetric labour ward
4. Only emergency secondary/tertiary level care is permissible within the space; epidurals, continuous electronic fetal monitoring, medical induction/augmentation require transfer to the adjacent obstetric unit
5. Does not provide care for labouring high risk women when OU short of rooms (unless exceptional circumstances)
6. Ability to measure number of births/year in AMU

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