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## **What makes alongside midwifery-led units work? Lessons from a national research project**

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**SUMMARY:** The findings of the Birthplace in England Research Programme showed that midwife-led units are providing the safest and most cost-effective care for low risk women in England. Since the publication of the updated National Institute for Health and Care Excellence (NICE) intrapartum guidelines, there is likely to be even more interest in the development of midwife-led units to promote birth outside obstetric units (OUs) for low-risk women. Professional bodies, policy makers and trusts have focused their energies on alongside midwife-led units (AMUs), which are seen to provide the 'best of both worlds' between home and an OU. Between 2012 and 2013, we carried out a study of the organisation of four AMUs in England and the experiences of midwives and women who worked and birthed there. Learning from their experiences, this article presents five key factors which help make AMUs work.

**KEYWORDS:** Alongside midwife-led units, birth centres, management, sustainable services

In November 2011, the findings of the Birthplace in England study were published. They showed that midwifery-led units (commonly called birth centres) were providing exceptional care for low-risk women in England, and that freestanding midwifery units (FMUs or stand-alone birth centres), in particular, were providing low-risk women with a high quality, safe and cost-effective service. When it has come to developing national policy on place of birth, it is alongside units (AMUs) that have been most promoted by the key professional bodies. These units are a relatively new way of providing care (although FMUs have been in existence in the UK in some form for much longer), so there has been little research carried out on how AMUs operate and the experiences of those who provide and who use the services.

### **Research project**

Through a new national research project we set out to answer some questions about what trusts planning an AMU could learn from existing units that might help them to provide good quality care and keep their new AMU sustainable. Were there any unintended or unanticipated consequences of having an AMU and how had the units and trusts dealt with these? How can AMUs help to promote choice for women and respond to health policy in the UK? How can AMUs help to support

midwifery satisfaction with their work and their skills in providing midwifery-led care?

### **Different units**

To try and answer these questions, we selected four case study AMUs from different parts of England. These units were all different from each other – some were longstanding and some new; some were very urban, some more rural; some were situated right next to an OU and some were on a different floor; for two of them, women ‘opted in’ to the AMU, but for the other two, the AMU was the usual option for all eligible women.

In order to get a sense of how the AMUs worked, we observed life on the units – for example clinical handover, activities and conversations in the staff room and moments when decisions were made. We reviewed documents, such as admission and transfer criteria, and across the four sites we interviewed 35 managers and key stakeholders (for example local commissioners), 54 clinical professionals, including midwives working on the AMU and the OU and obstetricians, and 47 postnatal women and their partners. Bringing all this information together, we identified five key elements that these AMUs had developed, or aspired to, that help to keep them working effectively.

#### **1. Staff skilled in normal birth**

It was often assumed that all midwives had good normal birth skills and experience in using them. However, our research found that this was not always the case in practice, especially for midwives who usually worked on an OU. In addition, we found that some midwives’ lack of confidence in working in an AMU setting could cause tensions between midwives on the OU and the AMU.

Whilst skill in dealing with obstetric emergencies is of course essential in midwifery practice, staff training was frequently solely focused on the management of high-risk scenarios and obstetric emergencies, with less attention paid to skills for supporting physiological birth. Some people we spoke to thought this was because of the requirements of the Clinical Negligence Scheme for Trusts (CNST), which is highly focused on litigation risk. However, it also reflected a ‘skills hierarchy’ amongst staff, whereby medical skills were valued more highly than skills for supporting normal physiological birth. We know from the Birthplace case studies (McCourt et al 2011) that, in many cases, trusts provide additional midwifery education for midwives working on FMUs, but not on AMUs, because it is assumed that there will be rapid obstetric back-up available. Proximity was often taken as a proxy for safety.

### **What works to ensure skilled and confident staff?**

- Inter-professional, all-risk training based in midwifery units, in normal birth and in obstetric emergencies
- Giving staff the opportunity to develop experience of working on a midwife-led unit
- Mentoring and 'buddying' of experienced and novice midwives in birth centres

## **2. Collaborative professional relationships**

Relationships between midwives across the AMU and OU were frequently difficult, whereas midwives working within each area generally had good working relationships with each other and with obstetricians. In all four trusts, the development of the AMU had exacerbated preexisting divisions, for example between midwives who were expert in the management of highrisk birth, and those who preferred supporting physiological birth in a home-like environment. These poor relationships were, fundamentally, a problem of communication and experience, as often midwives did not understand (nor respect) the reality of each other's work and some had fears about working in areas where they were less experienced and comfortable. The differences between the environments of the OU and the AMU also sometimes caused resentment from those working in the OU, where less effort and care appeared to have been invested. All four of the trusts we studied had not yet been able to resolve the tensions between teams and AMU midwives were often very conscious of these pressures.

### **What works to support collaborative professional relationships?**

- Collaboration between midwives and obstetricians in developing the AMU, its guidelines, audit and review
- Staffing and education models to ensure some experience of working in different birth environments
- Visible investment in and care for the OU environment

## **3. Staffing models that promote staff skills and collaborative relationships**

All four units had core staff teams and midwives did not routinely rotate to work in other areas, although they were regularly called to cover short staffing in the OU. However, at each site, managers were planning to introduce the regular rotation of midwifery staff between the AMU and the OU. They hoped this would improve

relationships between staff in different clinical areas and maintain a skill mix of expertise in normal and high-risk birth. They were cautious about how to approach this to ensure there were sufficiently skilled and confident midwives working on the AMU and to ensure continuity of care. It was reported that integrating community midwifery teams with the midwifery units in two of the trusts was helping to support community midwives' intrapartum skills. It also provided a more flexible approach to staffing where midwives could transfer to the OU with women when needed, but also unit midwives could support community-based visits and home births. In two sites, this infrastructure had supported the development of a FMU in the trust.

#### **What works when staffing AMUs?**

- Providing opportunities for midwives to work in obstetric and AMU settings as a normal part of their role, with special training, buddying and support to build confidence in working on the AMU
- Integrating community midwifery and midwifery unit staffing
- Enabling a midwife providing care on the AMU to transfer with a woman, when she needs or requests to transfer to the OU.

#### **4. Appropriate guidelines and systems**

Guidelines helped to ensure the safety of women and babies, but they also helped to protect the AMUs as a space for normal birth. Where the guidelines for admission to the AMU and transfer to the OU had been developed by a multi-professional team, including midwives, obstetricians and neonatologists, the AMU was more likely to be left to function with greater autonomy. Where all professionals felt ownership of the guidelines, they were also more likely to use them appropriately and to trust that others would, too. Novice practitioners were considered more likely to strictly adhere to guidelines, but as staff developed experience and confidence on the AMU, they were more able to accommodate women's choices and adapt guidelines within the framework that had been developed with their colleagues.

#### **What works to build safe and effective guidelines and systems?**

- Multi-disciplinary development of guidelines for admission and transfer (including midwives from the delivery suite)
- Ensuring flexibility in supporting women's choice within, and outwith, guidelines

#### **5. Information, preparation, support for women**

Women can only have equal access to midwifery-led units if they know about them. We found some women received more information than others. This inconsistency was particularly an issue when women needed to opt in to AMU care.

As well as knowing about the existence of the AMU, women needed more education and preparation for what a birth in an AMU might be like. We found that in some cases the choice to birth in an AMU was presented to women as a trade-off between a comfortable environment and access to pharmacological pain relief, without giving women information about the other ways in which a midwifery-led environment and care would help them to manage pain non-pharmacologically.

One AMU carried out late antenatal appointments (post-38 weeks) in the AMU, giving women an opportunity to visit the AMU and to receive more preparation for what labour and birth in the AMU would be like, as well as how and why transfers might occur. One service had caseload midwifery practices in some areas, where the caseload midwife would provide the birth care for women in their caseloads on the AMU and two had begun the process of integrating community teams, to improve continuity and information for women as well as to aide staff skills and communication.

#### **What works to inform and prepare women?**

- Consistent and evidence-based information for all women on the options for birth place
- Antenatal preparation for a birth centre birth
- Fuller and more evidence-based information about pain in childbirth and how it can be managed or relieved
- Late antenatal appointments in the birth centre to support preparation and continuity of care
- Caseload models of care, which have been shown to be associated with greater informed choice for women and greater confidence for midwives

The full report and executive summary can be found at: [www.bit.ly/amustudy](http://www.bit.ly/amustudy)

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## **References**

McCourt C, Rance S, Rayment J et al (2011). Birthplace in England research programme: organisational case studies final report 6, London: HMSO.

This and **all** Birthplace component study reports including the overview report can be accessed at:

<http://www.nets.nihr.ac.uk/projects/hsdr/081604140>