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# An ethnographic organisational study of alongside midwifery units: a follow-on study from the Birthplace in England programme

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## Scientific summary

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# Scientific summary

## Background

Alongside midwifery units (AMUs) are a relatively novel hybrid organisational form consisting of separate units providing midwife-led care to low-risk women adjacent to maternity units run by obstetricians. They aim to provide a homely environment to support normal childbirth. Women are transferred to the obstetric unit (OU) if they want an epidural or if complications occur. A number of AMUs have been developed in the UK in the past decade, in response to government policy to offer women choices of birth setting and because of professional and consumer concerns about rising birth interventions, their costs and consequences. A large-scale study of the quality and safety of different birth settings (Birthplace in England) found that AMUs provide safe care for babies while achieving a reduction in birth intervention rates. AMU care is more cost-effective for low-risk women than care in an OU. The Birthplace study found similar findings regarding free-standing midwifery units (FMUs), with greater reductions in intervention rates. However, in the current political and financial climate, more emphasis is being placed on reconfiguring existing environments rather than new builds, along with concerns expressed regarding the rate of transfers in first time mothers and the time taken for transfer. Therefore, the development of AMUs is likely to continue to increase, raising important questions about management and sustainability of such services and their impact on those using and providing the maternity services.

## Aims and objectives

The study aimed to investigate the ways that AMUs are organised, staffed and managed. It also aimed to look at the experiences of women receiving maternity care in an AMU and the views and experiences of maternity staff, including both those who work in an AMU and those in the adjacent OU. Specific questions were:

1. How are AMUs organised, staffed and managed in order to seek to provide safe and high-quality care on a sustainable basis?
2. What are the professional and service user perceptions and experiences of care in AMUs?

Objectives included:

- Exploration and analysis of potential unanticipated, as well as intended, consequences of AMU development, including system effects.
- Analysis of models of organisation and staffing that address such aims and challenges and contributes to staff satisfaction and retention.
- Analysis of how AMU developments can respond to current policy directions, including provision of choice for service users, safe effective and equitable care.

## Methods

An organisational ethnography approach was used, incorporating case studies of four AMUs. The selection of case study sites was based on maximum variation in geographical context, length of establishment of the AMU, size of unit, management and leadership and physical design. Managers and staff at all levels of seniority across the service were interviewed about the services' functioning, for example the nature of the day-to-day work and working relationships, their perceptions of the strengths and weaknesses, and any lessons learned during the period since the unit was established. Decision making and transfer

points were observed to develop an understanding of interaction, processes and flows of information and people. Relevant documents such as guidelines and protocols were reviewed. A maximum variation purposive sample of service users was interviewed to map pathways through care and obtain their perceptions of their care in an AMU and their choice and information needs.

A total of 136 interviews were conducted: 47 with postnatal women and partners, 54 with clinical staff members (midwives, obstetricians and support workers) and 35 with managers and stakeholders (including midwifery and obstetric consultants with management roles, commissioners and user representatives).

Data were analysed using a framework approach, using a coding frame based on the findings of the Birthplace Organisational Case Studies and preliminary analysis and discussion of the current data during the course of the study. Qualitative data analysis software, version 10 [NVivo10, QSR International (UK) Ltd, Warrington, UK] was used to facilitate systematic and rigorous analysis.

## Findings

### *Organisation, staffing and management*

The origins of the four AMUs in this study were pragmatic rather than primarily philosophical. Finance was a key driver, despite the continuation of 'payment by results' at the time of the project, which managers reported did not favour increasing normal birth rates. In three of the four cases, their development formed part of a service reconfiguration, to facilitate a merger, the closure of other units or a drive to provide sufficient service capacity. Nonetheless, the aims of these units were informed by the desire to develop a birth environment that could more effectively support normal birth, a satisfying birth experience for women and a more satisfying working experience for midwives. Additionally, AMUs were seen as enabling effective triage and establishing appropriate care pathways for low-risk women.

The AMUs in this study were providing care for 10–14% of all births in their services (approximately 620–820 births per year), with two units having an 'opt-in' and two having an 'opt-out' approach to booking women. The units with opt-out approaches sought to establish AMU care as the standard birth pathway for low-risk women, with women able to choose the OU, home birth or (when available) a FMU as alternatives. This was in line with an aim to normalise midwife-led care for low-risk women, which had been found difficult to establish in obstetrically led settings. With opt-in approaches, women needed to specifically opt to book their labour and birth care in the AMU. Although we did not find evidence from this small number of settings that adopting an opt-in or opt-out approach made an appreciable difference to numbers of births in the AMU, staffing and capacity limitations of the units restricted the potential for such differences to emerge. However, the booking approach may have had an impact on the equity of access for service users from diverse backgrounds.

Staffing for all four AMUs was by core staff at the time of the study; however, all were considering introducing rotation of staff between areas. These plans were being approached cautiously owing to the need to balance several priorities: to enable midwives to maintain all-round skills, while also ensuring sufficient consolidation of midwife experience of normal birth skills and ways of working, to facilitate better mutual understanding and teamworking between midwives and to protect or enhance continuity of care. The AMUs were mostly staffed by band 6 midwives with a band 7 midwife for day-to-day management and two units also had a consultant midwife overseeing the unit. The consultant midwife leadership was felt by midwives and managers to be important for maintaining the profile and role of the AMU within the service. The number of core staff varied from 8 to 18 whole-time equivalents (WTEs), typically with two midwives per shift (range from 1 to 4), and in three of the units these were supported by a maternity support worker (MSW) on each shift. All services reported experiencing shortages of staff and the regular 'pulling away' of staff to cover other areas, in particular the delivery suite.

Obstetricians were generally supportive of AMUs and considered these to provide more appropriate care for low-risk women, allowing them to focus more effectively on care for higher-risk women. Tensions identified between staff were mostly between midwives working in different areas, particularly AMUs and OUs. However, our interviews illuminated a tendency within services to view skills within a hierarchy when high-risk or acute care skills were implicitly regarded more highly than skills to support normal birth or caring skills. It was within this environment that tensions between groups of midwives were situated. Lack of support from midwives working outside the AMU appeared related to both resource and professional factors; competition over resources in a situation of midwife shortage and work pressure interacted with differing attitudes around skills, confidence, values and professional jurisdiction.

Guidelines and admission and transfer criteria were regarded as of key importance for the safety of the AMU and of practitioners, as well as for the safety of the women. Managers saw these guidelines as protecting a space for normal, low-risk birth, as well as a guide to, and a framework for, safe practice in a distributed system of care. Nonetheless, all four units had guidelines for low-risk or midwifery-led care rather than specific guidelines for AMU care. The focus of these guidelines was women's eligibility for the care and decision-making for transfer. In addition, managers viewed the processes for service audit and review as important for learning and communication and a tool for service improvement, as well as being a basic safety feature. They emphasised the need for participation of staff from all areas to such processes. Concerns were identified around pressures to include women 'out of guidelines', often for reasons of service pressures, and also because the AMU represented (to some) a compromise between OU and out-of-hospital care, which some women might otherwise have chosen.

### *Staff experiences and perspectives*

Interviews were conducted with 52 frontline staff from across the four sites, including midwives working in all areas and obstetricians at different levels of seniority.

Midwives enjoyed working in AMUs but were challenged by the boundary work that accompanied the development of a separate but proximate space for birth. Discussions were dominated by concerns about relationships with midwives from other areas. For the different groups of midwives there was a lack of understanding of the nature of each other's work, sometimes leading towards the feeling of a 'them and us' culture. This was reported as having an impact on transfer in labour. In two sites, managers were actively working on integration of community midwives with the AMU to enhance their birth skills and confidence and to increase their understanding and familiarity with the model of care.

All four AMUs aspired to having a homely and comfortable 'low intervention look' in order to promote normal birth, to incorporate features of a home-like environment and to distinguish the AMU from the labour ward. This included specialist equipment, birthing pools, soft furnishings and the status (or absence/concealment) of the bed in the room. Midwives took 'the bed' to symbolise a more obstetrically oriented philosophy of care, rather than an emblem of comfort and homeliness, which were also highly valued features of the AMU environment. Midwives' and managers' philosophies of homeliness or a relaxing environment were underpinned by physiological theory regarding the relationship between the environment and the processes of normal physiological birth. They also referred, but less explicitly, to gendered concepts of the AMU, as compared with the OU, symbolising domestic versus public space. Midwives sought to achieve an environment which was both relaxing, to support normal hormonal responses, and facilitative of active labouring, to support normal birth, and one which felt woman and family centred.

### *Women and partners' experiences and perspectives*

Interviews were conducted with 35 women and 12 birth partners, most of whom had planned birth in an AMU. Respondents were ethnically and socioeconomically diverse as evidenced in their areas of residence and current or past occupations.

Most women made their choice to use the AMU in the antenatal period as a setting where they could have a 'natural birth' and avoid drugs and medical interventions or to have access to the pool. They were also attracted to the environment, which promised to be relaxing and comfortable. Some clearly felt surprised and privileged to be offered an environment for birth that they viewed as more family centred and which felt like a 'spa' or 'hotel'.

Information about the AMU given by midwives antenatally was variable and there was some evidence that community midwives in certain areas did not provide information to women. Only one AMU offered women antenatal appointments, in late pregnancy. Midwives at this service felt this was valuable for providing more detailed information and preparation to women and birth partners.

Women in areas with an opt-in approach to booking the AMU were less likely to have obtained information about the AMU in early pregnancy, and many found out about the choice in late pregnancy, through a hospital tour, an antenatal class or group, or through social contacts. Women in services with an opt-out approach to booking appeared to be more likely to receive information about the AMU. In both types of booking approach, women did not necessarily know that they would be having their baby in the AMU nor what care there might involve. Although most women did feel they had been given a choice, some felt their choice had been steered by midwives and some did not feel entirely clear about the differences in care involved. A further key area highlighted was quality of information and preparation about normal birth and particularly about managing pain in labour. Some women tended to view the choice to birth in an AMU as a trade-off between a relaxing, comfortable environment, attuned to normal birth, and the availability of epidural pain relief in an OU. There was evidence that this reflected ways in which some midwives informed women about the relationship between birthplace and labour pain, suggesting that both preparation of women and birth partners and midwives' confidence and skills, including communication skills, around pain management in physiological labour would benefit from development.

Admission in labour was a key issue for the women. Half of women presenting to the AMU in early or latent labour were sent home and were not given the choice to stay; while some were happy with the advice and explanation given and returned later with no problems, others found this experience stressful. A few women were subsequently admitted in late stages of labour and found this experience very distressing and even traumatic. Although this pattern of experience is similar to that observed in other studies for women seeking admission to OUs in the UK, these findings raise questions for midwives and managers about how the philosophy of care in AMUs relates to the rationale and policy around admission in early labour and normal birth pathways. It also highlights the need for sufficient quality of information and support for women at this stage and the role of more individualised care approaches for women and birth partners, especially those who express strong concerns.

## Conclusions and implications

There has been a particular growth in the provision of care in AMUs since 2007 and that experience is reflected in the experience of the four services on which this study focused. Each AMU was providing birth care for around 10–14% of women in the service. This proportion represented about one-third of women who had been classified as low risk for planning birth outside an OU at the end of pregnancy. This confirms evidence from other studies that the numbers of women clinically eligible for AMU care are far greater than currently provided for.

The units studied had been developed to become a key part of the maternity service and their role was increasingly being recognised as valid and as supporting the quality and safety of care in the maternity service as a whole. However, we did not observe any moves to scale up or plans to increase the capacity of AMUs to cater for a higher proportion of low-risk women. Nevertheless, three of the services had

developed FMUs, building on the establishment of the AMU to develop midwives' confidence and skills in providing midwife-led care and service-wide confidence in midwife-unit care.

The development of AMUs brings together a set of key motivations and policies, which can be in tension with each other. These units aim to increase normal, physiological birth by providing an environment that facilitates this type of care. They seek to improve or re-establish midwives' traditional normal birth skills, thus also improving midwife staff motivation and retention and providing a more woman- and family-centred birth environment. They also aim to improve triage, the effectiveness of care pathways and the professional division of labour. In our study, the tensions produced in the process were illuminated in particular through everyday conflicts between different groups of midwives, as well as more occasional conflicts with obstetricians. The tensions were also reflected in uneven and partial access to information for women, with some women – particularly in cases of opt-in units – not receiving information from midwives on choice of birthplace.

Some initiatives were identified which could potentially mitigate the effects of creating new boundaries or discontinuities in the service and potentially negative implications for quality and safety of care and the well-being of professionals as well as service users. These included a planned system of rotation for staff, with mentoring for midwives who were less experienced or skilled in caring for normal physiological birth and more integrated models, wherein midwives based in the community attended the women giving birth in the AMU in their caseload. Interdisciplinary training, situated in the AMUs and FMUs, and covering both low-risk and emergency skills, was also proposed. Further work is recommended to examine approaches to scaling up of midwifery unit provision. This could include exploration of the potential of integrated community teams to support both flexibility of midwifery staffing and community midwives' birth skills and confidence, and work on staff deployment, training and relationships, including appropriate approaches to midwifery rotation. Further consideration is also needed of the potential of caseload midwifery practice to support the development of midwifery unit care. Research is also recommended on how to support women effectively in early and latent phases labour and on approaches to improving evidence-based and supportive information provision for women and families.

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