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NCT Policy Briefing: Midwife-led units, community maternity units and birth centres

NCT policy

- 1. All pregnant women should be able to make choices about their planned place of birth. There should be sufficient provision of midwifery-led services, based on a social model of care, to meet the demand in all areas. Women and their partners need respectful professional support and evidence-based information relevant for their particular circumstances so that they can decide what feels right for them and their baby.**
- 2. Women and their partners, across the whole of the UK, should be able to plan to give birth in a birth centre or community maternity unit. This midwife-led model of care focuses on supporting the woman and her family socially, emotionally and physically during pregnancy, birth and the postnatal period, while facilitating normal birth and breastfeeding.**
- 3. Women and their families need up-to-date evidence-based information, provided in an appropriate and accessible format, which addresses their questions, so that they can make well informed decisions about their baby's birth. Information about increasing the chances of having a straightforward birth is important, so that they can make choices in planning the birth to maximise the family's ongoing health and well-being.**
- 4. Booking and transfer protocols should be developed by a multi-disciplinary team, taking account of the best available evidence and NICE guidance to the NHS.¹**

This document provides an overview of the evidence underpinning NCT policy on birth centres. It explains the different terms used, discusses the social model of care, the environment and facilities available in birth centres, and who can book care in a birth centre. It summarises latest outcomes evidence (on safety and quality of care) associated with both freestanding and alongside midwifery units, including costs and cost effectiveness. There are sections on women's views and experiences and the contribution that midwifery-led care and community midwifery units can make to the public health agenda. It also provides a summary of policies and practice in the four countries of the UK.

MLUs, Community units and birth centres

Midwife-led units (MLUs) are maternity units, managed by midwives either in a community setting ('freestanding' or 'stand-alone') or on the same site as a hospital providing obstetric and paediatric services ('alongside'). In England and Wales, midwife-led units are often known as 'birth centres' (a term that was first developed in North America), and in Scotland

as 'community maternity units' (CMUs).¹ Birth centres in the United Kingdom offer care to women with a straightforward pregnancy who are at low risk of developing complications, and midwives take the primary professional responsibility for care.²

The social model of care

Birth centres often follow a philosophy of care and objectives consistent with a 'social model of care'.³ This means that birth is viewed primarily as a normal physiological and social process, rather than primarily as a risky clinical event, and midwives aim to work in ways that minimise the routine use of invasive interventions.^{4,5,6} Garrod and Byrom describe the social model of care as being 'synonymous with that of woman-centred care' on the basis that:

'Woman-centred care encapsulates terms such as trust, respect, empowerment, facilitation, and working in partnership with the woman and her family to maximise health outcomes. ... The social model acknowledges childbearing as part of the fabric of people's lives. Care is largely community-based, linked with other agencies. Social support is recognised to be of equal importance to professional input in influencing outcomes for the woman, her baby and family.'⁷

This philosophy of care makes it a priority to be welcoming to parents, to think about their needs and consider their point of view. There is a focus on keeping labour and birth normal and using emotional support and encouragement together with non-pharmalogical approaches for soothing pain, such as immersion in water (usually in a birthpool), the warmth and comfort of a shower or massage, and aromatherapy.⁸ This means that parents using a birth centre can expect to be listened to and supported to give birth using their own resources. Midwives working at birth centres often provide birth preparation classes, offering practical preparation for an active birth and evidence-based information about benefits and risks, preparing for breastfeeding and reasons for transfers to the labour ward if any risk factors develop at the end of pregnancy or during labour.

As well as being empowered at a personal level while using the birth centre, parents sometimes get involved in supporting the unit and helping to shape its future development.⁹ In this way birth centres can be a community resource and a focus for local identity and pride, contributing to local 'social capital'.¹⁰ Women often return for the births of subsequent children.¹¹

Birth centres usually aim to provide 'continuity of care' (a consistent philosophy of care and consistent advice) and maximise 'continuity of carer' (care from the same midwife on different occasions) and continuous support in labour.¹²

Environment and facilities

The environment in a birth centre is often described as more 'home-like' than a hospital labour ward (obstetric unit).¹³ Women often have a room that they and their family can use throughout their stay, with comfortable furnishings (though some use their larger rooms with plumbed-in birth pools for labour care). Clinical equipment is both kept to a minimum and screened from view where possible.⁵ Birth centres often provide a double bed or pull-out bed so that the woman's partner can stay overnight, and access to a parents' kitchen. As well as access to a birth pool, there may be a ceiling hanging, a Bradbury birth couch, a birth ball and plenty of pillows in each room, plus gentle, pooled lighting.^{14,15,16}

ⁱ Throughout the rest of this briefing, the term 'birth centre' will be used to include midwife-led units and community maternity units. The Birthplace study used the terms 'freestanding midwifery unit' (FMU) and 'alongside midwifery unit (AMU).

NCT's Better Birth Environment Survey (see Table 1) found that women who had used a freestanding birth centre consistently reported having a greater sense of freedom, privacy and autonomy than those who had used either a hospital obstetric unit or an alongside birth centre. For example, they were more likely to say they had been able to walk around and had had a pleasant place to walk. They were more likely to be able to stay in the same room throughout their time at the unit. There were better facilities for them and their partner. They were more likely to feel they could control who came into the room and the light and temperature. Facilities that helped women to have the kind of birth they wanted - including space to move around, access to an en suite toilet and a birth pool - were more commonly available.¹⁷ More recent research found that mothers described MLUs as 'homely' 'calming' and 'clean', whereas obstetric-led units were more likely to be called 'stuffy' and were considered to lack privacy.¹⁸

Table 1: Women's access to facilities during their last labour

	% home (n 229)	% FMU (n 46)	% AMU (n 431)	% OU (n 1157)	% all women (n 1944)
Clean room *	96	98	89	88	89
Able to walk around *	98	87	75	61	69
Able to stay in same room *	96	91	78	73	76
Comfortable chair for partner *	87	67	62	57	61
Easy access to a toilet *	86	84	64	63	66
Control who came into room *	92	56	41	29	40
Bean bags, pillows and mats *	89	72	45	31	42
Unable to hear other women *	92	56	54	53	58
Control brightness of light *	96	66	50	41	50
Easy access snacks / drinks *	95	68	40	30	41
Room that looked homely *	96	78	40	22	37
Able to control temperature *	94	44	28	25	35
Easy access to a bath *	94	73	66	50	60
Sure others could not hear *	60	43	38	34	39
Pleasant place to walk *	93	60	32	21	34
Easy access to a shower *	89	69	56	46	54
Easy access to a birth pool *	48	76	56	39	46
Able to move furniture to suit *	95	51	42	28	40
Nicely decorated room *	97	89	59	51	59
Comfortable bed *	87	84	73	62	68
Resuscitation equip visible *	20	41	66	75	66

Note: The proportions represent women who said they had the facilities listed. Differences marked * are statistically significant using the Chi-square test (p < 0.05). Factors are listed in order of importance to women.

Source: NCT Better Birth Environment Survey, 2003

Who can book for birth centre care?

In the UK, there are eligibility criteria for booking care in a birth centre. These vary from unit to unit, but are developed with reference to nationally agreed guidelines^{1,2} so "the model of care is offered only to healthy women with a 'low-risk' pregnancy who are unlikely to develop complications".¹ There are some situations where professional judgement is required in assessing whether an individual woman would be suitable for birth centre care. Some managers feel that criteria can be more flexible when the birth centre is alongside an obstetric unit making very prompt transfer a practical possibility.

Outcomes associated with midwifery unit (birth centre) care

The 2010 Cochrane Review found that compared with receiving care in hospital, women giving birth in birth centres are significantly less likely to have medical interventions (such as oxytocin augmentation of labour, epidural anaesthesia, episiotomy and caesarean delivery); are more likely to have spontaneous vaginal births; and experience increased satisfaction. Mothers are more likely to continue breastfeeding at two months postpartum. No risks to mother or baby were found.¹³

The findings from Birthplace, a large landmark study in England, compared outcomes for women planning their care in different settings.¹⁹ Care for women planning to use freestanding midwifery units and alongside midwifery units was compared with care provided for those planning their birth in a hospital labour ward (obstetric unit). Planned home birth was also compared with planned obstetric unit care.

The study of almost 65,000 'low risk' women, including 28,000 planning to use a midwifery unit, addressed safety for babies and for women, the way care was managed and the costs of care planned in different settings.

Safety for mothers and babies

Overall, results showed that babies had the same very small risk (4.3/1000) of an adverse outcome when their birth was planned, at the start of care in labour, to take place in a midwifery unit as in an obstetric unit. Adverse outcomes for babies included death during labour or in the first week afterwards, and serious or potentially serious conditions including any brain injury (neonatal encephalopathy) and meconium aspiration syndrome. The analysis of births planned for a freestanding (FMU) or alongside midwifery unit (AMU) included those cases where the mother transferred during labour or there was a transfer immediately after birth. The results enable women deciding where to give birth to know the kind of benefits and risks this is likely to involve, as well as the likelihood of needing to transfer during labour.¹⁹

Freestanding midwifery units were as safe as alongside units. For all low risk women there were 3.5/1000 and 3.6/1000 'adverse events' for babies, respectively. The rates of adverse events for women having their first baby were a little higher (4.5 and 4.7) and for women who had previously had a baby a little lower (2.7 and 2.4).

All mothers planning to give birth in a midwifery unit had safe outcomes themselves and received substantially fewer interventions compared to those planning births in obstetric units (OU). These include epidurals, episiotomies, assisted deliveries (forceps and vacuum) and unplanned caesarean sections (CS). (Unplanned CS rates: for OU planned births – 11%; FMU planned - 3.5%, AMU planned 4.4%). In addition, more women had a 'normal birth', meaning that they had no major obstetric interventions throughout their labour and birth, labour started spontaneously, there was no use of epidural, spinal or general anaesthesia and the baby was born without the assistance of episiotomy, ventouse, forceps or caesarean (normal birth rates: OU planned births – 58%, FMU planned – 88%, AMU planned 83%). Women planning birth in an FMU were actually less likely to need admission to higher level care because they were unwell.¹⁹

Benefits for mothers and babies

Birthplace measured three 'positive' outcomes for mothers and/or babies: immersion in water (i.e. use of a birth pool at any stage during labour), having a normal birth, and whether the mother breastfed her baby at least once. Compared with planned 'low risk' OU births, the results are:

- immersion in water – four times greater for births planned in FMUs and three times greater for AMU planned births

- normal birth – as described above
- initiated breastfeeding - higher for births planned in an FMU.¹⁹

Transfers

During labour and birth, medical services such as obstetric, neonatal and anaesthetic care are available should they be needed, but in the case of FMUs they are on a separate site, involving transfer by car or ambulance.¹² It is important that there are good communication and transfer links between free-standing birth centres and obstetric units so that if midwives need a medical opinion or a woman requires additional care, it is readily accessible. Facilities for accessing laboratory tests, and test results, and consulting consultant obstetric and paediatric colleagues, directly, are vital. Transfer arrangements must enable women to be transferred to the obstetric unit with a minimum of delay and be provided with care on arrival by a senior midwife and obstetrician, as appropriate.

The Birthplace study found that transfers to hospital from midwifery units were relatively frequent among first-time mothers (planned FMU transfers - 36%; planned AMU transfers – 40%) and considerably less common for those having a subsequent pregnancy (planned FMU transfers – 9%; planned AMU transfers – 13%).¹⁹ Most transfers occur in non-emergency situations. The most common reason in the FMU group was ‘failure to progress’.²⁰ Transfer for an epidural was more common from AMUs than from FMUs.²⁰ Transfers are one of the reasons why planned midwifery unit births are as safe as they are, enabling additional care to be provided when it is needed. Local studies also provide valuable evidence about reasons for transfer.^{14,15}

Birthplace findings generally support women with healthy, straightforward pregnancies having free choice of place of birth, based on where they would feel most comfortable giving birth.

Costs and cost effectiveness

The Birthplace economic evaluation compared the costs to the NHS of care planned in each of the four different settings. On average, costs per birth were highest for planned obstetric unit births and lowest for planned home births. Average costs were as follows:

- £1631 for a planned birth in an obstetric unit
- £1461 for a planned birth in an alongside midwifery unit (AMU)
- £1435 for a planned birth in a freestanding midwifery unit (FMU)
- £1067 for a planned home birth.

These figures include all NHS costs associated with the birth itself – for example midwifery care during labour and immediately after the birth, the cost of any medical care and procedures needed in hospital, and the cost of any stay in hospital, midwifery unit, or neonatal unit immediately after the birth either by the mother or the baby. The costs for planned home and midwifery unit births take account of interventions and treatment that a woman may receive if she is transferred into hospital during labour or after the birth. They do not include any longer term costs of care.²¹

Community-based birth centres have faced financial pressures,²² however, an RCM report concluded that, ‘community units can contribute significantly to providing antenatal and postnatal care, take postnatal transfers from more distant obstetric units, and provide a centre where parents can attend preparation for birth and breastfeeding support sessions, as well as providing intrapartum care’.²³

Women's views and experiences

Women who use birth centres generally have high regard for the philosophy of care, the support and communication with midwives^{24,25} and the physical environment.^{17,26} NCT research has contributed to a growing literature which suggests that women value small community units because they are more comfortable than a hospital environment and provide individualised care.²⁷ The advantages have been identified as 'a homely and relaxed atmosphere', 'having my own room', 'freedom to do what feels right' and 'not being attached to any monitors and high-tech equipment' and, compared with home birth, 'not having to clear up any mess' and 'home and children not disrupted'.¹⁴ Edgware Birth Centre evaluation reported that 95% of women felt the birth centre provided woman-centred care and were highly satisfied.¹⁴ Another important indicator of women's satisfaction may be the proportion transferring for an epidural. Rates as low as one percent have been reported for FMUs.¹⁵ A study of an alongside birth centre found that women valued what they described as 'the best of both worlds', being close to the labour ward in case they needed medical care or an epidural, yet separate, in a 'nurturing environment in which a woman's physiological, psychological, and social needs are actively addressed' and which protected normality.¹⁶

Women also report that postnatal care is better in birth centres than on hospital postnatal wards. Over half (59%) of the 1260 first-time mothers in an 2010 NCT survey felt that they needed more emotional support from health professionals in the first 24 hours after birth. Those who gave birth in hospital '*consistently reported a bigger gap between their need for emotional support, physical care and information about their own health in the first 24 hours after birth compared with women who gave birth in a birth centre or at home*'.²⁸

Midwifery-led care, health inequalities and the public health agenda

It is widely accepted that those with the poorest health, and therefore the greatest need for health services, are those least likely to receive them. Whilst many health inequalities are created by socio-economic factors, the structure of health services often contributes to inequalities and disempowerment. Community-based maternity units may enable parents to access services closer to home,^{29,30} reducing the costs of time and direct out of pocket expenses for travel, childcare, and time off work. Birth centres that are based in the community and staffed by local midwives can be more accessible and responsive to local needs than large hospitals where there is more emphasis on processing large numbers of patients and less scope for individualised care.

Midwives can make a major contribution to the national agenda for public health,³ when they have the opportunity to develop a supportive relationship with women and their partners. During pregnancy parents are particularly well-motivated to re-consider their own health and lifestyle and to safeguard their child's health and well-being. Unlike hospital obstetric units, staff in birth centres that care for healthy, low-risk women, do not need to prioritise medical complexity and clinical emergencies. Instead, they can devote more time to building relationships, providing explanations and guidance about pregnancy, labour, birth and feeding, including what to expect and things parents can do to help themselves.

Policy and practice

The maternity services frameworks across England, Scotland and Wales all emphasise the importance of midwife-led care and one-to-one midwifery care for women in established labour. In the UK, however, over 90% of women give birth in an obstetric unit. Despite the benefits of birth centres for women with a straightforward pregnancy, and governments' commitments to normal birth, lack of provision limits access to birth centres.³¹

Using 2008 data, NCT estimated that over 95% of women in the UK did not have a full choice about different settings for birth.³² Over 40% of women lived in areas where they were not able to make a choice between having their baby in a birth centre or in an obstetric unit. This finding was used to underpin an NCT campaign for more extensive provision.³³

England

In 2007 the Government's implementation plan for the maternity services framework for in England³⁴ recognised midwifery-led community services as contributing towards "more primary care based services; accessibility of services, particularly for 'hard to reach' groups; and the potential for a reduction in interventions in labour".³⁵ It announced a 'choice guarantee' that by the end of 2009, 'depending on their circumstances', women and their partners would be able to choose between home birth, 'birth in a local facility under the care of a midwife', and birth in a hospital setting.³⁵ The Coalition government has not yet published detailed policy guidance for development of maternity services, but has indicated that there will be 'choice of where to plan to give birth - for example, at a hospital or midwifery unit or at home'.³⁶ Royal College of Midwives standards for birth centres in England, address issues of safety, staffing, organisation, family focus, public health, communication, environment and facilities.⁸

Extent of provision

Birthplace researchers estimated that about 50-60% of women meet the NICE 'low risk' criteria, but in 2007 only 2% of birth took place in an FMU, 3% in an AMU and around 3% at home. Although the number of AMUs has increased since 2007 – there were 53 identified AMUs in England in 2010, up from only 26 in 2007 - as many as 50% of NHS trusts still had no midwifery unit in 2010, so this effective and valued option for birth is very far from universally available. Birthplace also identified 59 FMUs in England in 2010, up from 56 in 2007 (four having closed and seven new units having opened).³⁷

Using estimates of population growth and historic trends for London, it is estimated that by the year 2015, 40% of women will be 'low medical and low social risk' at the end of pregnancy, and a further 20% will be 'low medical risk and high social risk' (including unemployment, single mothers, socially deprived families, non-English speakers, teenagers, domestic abuse, previous children in care).³⁸ Depending on interpretation of need and judgement about good practice, this estimate also suggests that 50-60% of women may meet criteria for care at a birth centre.

Scotland

In Scotland, the Framework for Maternity Services supported a woman's right to choose where to give birth and the Expert Group on Acute Maternity Services found that community midwifery units "have an integral role within the intrapartum care continuum."³⁹ The framework for service change also states that maternity services "should continue to be delivered as locally as possible".⁴⁰ This means ensuring that there are community maternity units (CMUs) as well as obstetric units, particularly in remote and rural areas where long distances make travel to hospital during labour a barrier to women and families accessing care that meets their needs.

The 2005 audit of community maternity units in Scotland found that 3% of all births took place in 22 'stand alone' CMUs serving over a third of the geographical area of Scotland and nine different NHS Boards.²⁹ Ten percent of all antenatal care bookings in Scotland are made by CMU midwives, demonstrating that CMUs were a key feature of the maternity services infrastructure. The audit report said 'CMUs make an enormous contribution to maternity care in Scotland. This contribution could be increased by further extending the core skills of midwives to include greater involvement in ultrasound scanning, prescribing,

and routine examination of the newborn. Telehealth technology should be used to support midwives in these extended roles.¹²⁹

The Montrose Community Unit, has a reputation for attracting local women. Gradually as the unit became more established and midwives' experience and confidence increased, transfer rates for women in labour came down (from 21% in 2002 to 8% in 2005).⁴¹

The Refreshed Framework for Maternity Care in Scotland states "The choice of where and how to give birth should be reached using a process of decision making where the clinician and the woman are partners in ensuring the woman and baby are as safe as possible. ... The planned choice of birth made by the woman in the antenatal period should be provided where possible, ensuring the safety of the woman and her baby"⁴²

Wales

In Wales, in acknowledgement that choice of place of birth had been restricted and that medical interventions in labour were unnecessarily high, a 10% target was set for home birth by the end of 2007.⁴³ This target was not reached, but significant progress was made.³³ The framework for maternity services in Wales supports choice of place of birth, suggesting that midwifery-led birth centres can provide 'a family-centred, less technologically intrusive' service.⁴⁴ The All-Wales Clinical Pathway for Normal Labour has also supported midwife-led care.⁴⁵ In Wales there are around 11 established birth centres,⁴⁶ six of them in Powys, where around a third of women have an 'out of hospital' birth.⁴⁷ According to a 2009 report, 89% of births took place in obstetric led units, so more access to birth centres and promotion of non-hospital options is needed.² The Strategic Vision for Maternity Services in Wales pledges 'adequate capacity to enable women to give birth at home, in a birth centre or midwife led unit where that is their choice'.⁴⁸

Northern Ireland

In Northern Ireland, after a period of consultation, stand-alone community midwifery units were given approval by the Department of Health, Social Services and Public Safety in July of 2004. At that time, the then health minister Angela Smith, voiced the importance of widening choice for women as well committing to increasing the number of alongside midwife-led units. However there are still very few 'out of hospital' births in Northern Ireland; in 2008 only 0.3% of births took place at home, compared to the UK average of 2.7%.⁴⁹ Yet an acute services review by Price Waterhouse Cooper found that, in theory, 'over 8,500 women in Northern Ireland could deliver outside of the acute hospital setting (over 5,600 in a midwifery led units and around 3,000 at home)'.⁵⁰ There has been some positive news, however. Following years of campaigning by NCT members and lobbying by the local maternity services liaison committee,⁵¹ the first stand-alone midwifery unit in Northern Ireland opened March 2010. Located in the Downpatrick area, it will serve up to 300 births a year.⁵²

The Department for Health, Social Services and Public Safety has stated, in the Maternity Strategy for Northern Ireland 2011 that 'Women should be supported to make an informed decision about place of birth. Women with straightforward pregnancies should be encouraged to consider Midwife Led Units or home births'.⁵³

Summary

Planning to give birth in a birth centre (or at home) is a good option for women who are healthy and have a straightforward (low-risk) pregnancy. Government policy across the whole of the UK is to increase women's choice of place of birth and access to midwife-led care. Yet, only a small minority of births actually take place in an FMU or AMU and women's choice is severely limited.

Birth centre care is usually more flexible and individualised than obstetric unit care. The culture and environment support normal birth and the 'social model' of care underpinning many birth centres recognises birth as a family event.

It is important that there are good communication and transfer links so that if a medical opinion or additional care is needed at any stage, women can be transferred to an obstetric unit without delay, and be assessed and cared for by a senior member of staff.

Midwifery units provide cost effective care for low 'risk women'. Provision of antenatal and postnatal care and other services, such as parent education, child health, family planning and well woman clinics, can also contribute to the income for a free-standing birth centre.

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The NCT wants all parents to have an experience of pregnancy, birth and early parenthood that enriches their lives and gives them confidence in being a parent.

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