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Enquiries: 0300 33 00 770  
Press Office: 0208 752 2404  
Email: [policyresearch@nct.org.uk](mailto:policyresearch@nct.org.uk)  
Website: [www.nct.org.uk](http://www.nct.org.uk)

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

### **What are midwife-led units and birth centres?**

Midwife-led units are maternity units, managed by midwives either in a community setting ('freestanding' or 'stand alone') or on the same site as an obstetric unit ('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).<sup>1</sup>

The NCT's Head of Policy Research was an advisor to the National Perinatal Epidemiology Unit (NPEU) group who developed a structured review of birth centre outcomes. She contributed to the NPEU's definition of a birth centre for the purposes of the review:

'A birth centre is an institution that offers care to women with a straightforward pregnancy and where midwives take primary professional responsibility for care. During labour and birth medical services, including obstetric, neonatal and anaesthetic care are available should they be needed, but they may be on a separate site, or in a separate building, which may involve transfer by car or ambulance.'<sup>1</sup>

Booking and transfer protocols vary between units but should be based on the best available evidence and developed by a multi-disciplinary team. The NICE *Intrapartum Care* criteria are likely to make protocols in different settings more consistent in future.<sup>2</sup> There are many 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.

### *Philosophy of care*

Birth centres and community maternity units are associated with a particular philosophy and way of working, often referred to as a 'social model of care'.<sup>3</sup> Edwards and Byrom describe the social model of care as being 'synonymous with that of woman-centred care' (p15) 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.'<sup>4</sup>

Birth centres following this philosophy of care make it a priority to be welcoming to parents, to think about their needs and consider their point of view. Maternity units can be frightening, alienating places, with unfamiliar equipment and many different staff. Birth centres, particularly free-standing birth centres,

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<sup>1</sup> Throughout the rest of this briefing, the term 'birth centre' will be used to include midwife-led units and community maternity units.

are small in scale with relatively few staff. There is often a focus on making the environment as attractive and as much like a social, 'homely' space as possible, with accommodation for the family as well as for the woman. In addition to play areas, a comfortable chair for the birth partner, and access to a place where drinks and snacks can be made, individualised decoration and furnishings for each room, and aids to help a woman keep comfortable and active during labour, some units provide a double bed or pull-out bed so that the woman's partner can stay overnight.

Parents using the unit are listened to, supported in their preferences, and given tailored information based on research evidence to help them make decisions about their care. The philosophy, the facilities and the care provided by the staff all encourage high rates of normal birth and breastfeeding.<sup>5</sup> Midwives working at birth centres often provide birth preparation classes, and support the use of water, massage, aromatherapy and/or homoeopathy. Parents are not only empowered at a personal level while using the birth centre, but are often encouraged to get involved in supporting the unit and helping to shape its future development. In this way birth centres can be a community resource that parents use during pregnancy, birth and in the months after their baby is born. Many get to know the staff and other parents using the service. They will go back there for subsequent children. The birth centre and those who use it and work there form part of a local parents' support network, contributing to local 'social capital'.<sup>6</sup>

### *Location*

The location of birth centres is highly important. They should be close to the communities that want to use them, and/or communities who lack suitable local services and have particular needs. Community-based birth centres that are separate from a hospital with an obstetric unit have been reported as more 'home-like' in important ways than alongside units. The NCT's Better Birth Environment Survey carried out in 2003 (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 help women to have the kind of birth they want, including space to move around, access to an en suite toilet and a birth pool, were more commonly available.<sup>7</sup>

The situation may be changing. Since publication of *Maternity Matters* in England, more alongside birth centres have been planned to meet the policy commitment to offer all women the choice of a home birth, and access to a birth centre as well as birth at an obstetric unit.<sup>8</sup> For example, the physical environment of the new purpose-built St Mary's Birth Centre, in Paddington, London, meets a very high standard, providing large, beautifully designed rooms with great facilities, including birth pools, ceiling hangings, Bradbury birth couches, double beds and a family kitchen.

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.

### **Social and emotional needs of the family**

Childbirth represents a psycho-social transition, as well as a biomedical event. Birth centres aim to address the social and emotional needs of families, rather than narrow clinical or medical issues. They aim to consider the woman's needs around the time of birth, along with those of the baby, the baby's father or another partner, and of other family members including older children.<sup>9,10</sup> However, further research is needed to show how this works in practice in different units.

**Table 1: Women's access to facilities during their last labour  
(NCT Better Birth Environment Survey 2003)**

	% home birth (n = 229)	% free-standing midwife-led (n = 46)	% unit alongside hospital (n = 431)	% hospital unit (n = 1157)	% all women (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 (see Table 1).

Birth centres usually offer opportunities for continuity of care (a consistent philosophy of care and consistent advice) and for continuity of carer (care from the same midwife on different occasions). They provide high levels of continuous support during labour. Continuous support during labour is associated with less need for pharmacological pain relief, episiotomy, forceps or caesarean section and fewer babies needing resuscitation.<sup>11,12</sup>

Half of the 960 women in an NCT survey felt that they needed more emotional support from health professionals in the first three days after birth.<sup>13</sup> The report found that '*Women who had their babies in hospital were ... less likely to believe that they have been offered all the help, support and information that they required, compared to those who had given birth at home, at a birth centre or at a midwife unit.*' Results from the Edgware Birth Centre show that 95% of women surveyed felt the birth centre provided woman-centred care and evidence that women are highly satisfied with midwife-led care is strong.<sup>10</sup>

## Policy and practice

Currently, most women in the UK give birth in an obstetric unit staffed by a range of professionals including midwives, obstetricians, anaesthetists and paediatricians, though the number of birth centres is increasing. Using estimates of population growth and historic trends for London, it is estimated that by the year 2015/16 40 per cent of women will be 'low medical and low social risk' at the end of pregnancy, and a further 20 per cent 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).<sup>14</sup> Depending on interpretation of need and judgement about good practice, this suggests that around half to 60 percent of women may meet criteria for care at a birth centre. There are also those women who prefer to give birth at an

acute unit, for example because they may want to have an epidural. This indicates that clinically, midwife-led units could be a mainstream choice for around 50% of all births in the UK. The maternity services frameworks across England, Scotland and Wales all emphasise the importance of access to midwife-led care, and that women in established labour have one-to-one care from a midwife.

### *England*

The Government backs the development of midwife-led units and birth centres in England. *Maternity Matters*, which described how the National Service Framework for Children, Young People and Maternity Services was to be implemented, included a 'choice guarantee' from the Government, that, by the end of 2009, 'depending on their circumstances', women and their partners will be able to choose between three different options including home birth, birth 'in a local facility' under the care of a midwife, and birth in a hospital setting.<sup>8,15</sup>

However, there is currently no accurate figure for the percentage of women who have access to a midwife-led birth centre in England, or the percentage who give birth in a birth centre. In 2008 estimates suggested that there were approximately 70 freestanding midwife-led units in England and Wales and 50 co-located alongside an obstetric unit (Miranda Dodwell, BirthChoiceUK, personal communication). These figures indicate that there is no easily accessible birth centre in many areas. Official statistics suggest that births in midwife-led units currently account for approximately seven percent of births in England.<sup>16</sup> However, this may be an underestimate as data are incomplete and the classification categories are out of date. The NCT's 2005 Better Birth Environment Survey of a broadly representative sample of women who experienced labour, found that 16% said they had used a midwife-led unit.<sup>17,18</sup> In the 2006 national survey of maternity care in England, 1.9% of women reported giving birth in 'a birth centre separate from a hospital'.<sup>19</sup> This statistic therefore excludes women using 'alongside' birthcentres. Following their extensive enquiry into the provision of maternity services in England in 2007, the Healthcare Commission concluded that 'Choice is limited by lack of availability of midwife-led units'. They found that 'about two-thirds of trusts (65%) had only obstetric units. The remaining trusts had combinations of obstetric and midwife-led units; either alongside the main unit (AMUs), or midwife-led units in separate freestanding premises (FMUs). A few trusts had all three kinds of unit. Two acute trusts had midwife-led units only'.<sup>20</sup>

### *Scotland*

In Scotland, in addition to the Framework for Maternity Services which supported a woman's right to choose where to give birth, the Expert Group on Acute Maternity Services found that community midwifery units "have an integral role within the intrapartum care continuum."<sup>21</sup> The national framework for service change in the NHS in Scotland followed this up by reiterating that maternity services "should continue to be delivered as locally as possible".<sup>22</sup> This means ensuring that there are community maternity units 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 three percent 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.<sup>23</sup> 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 recommendations included the following: '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.'<sup>23</sup>

The Montrose Community Unit, Scotland, attracts a majority of local women (52% in 2005), after transfers for clinical and any other reasons, plus women from outside of the immediate area. Gradually as midwives' experience and confidence has increased, transfer rates for women in labour have come down (from 21% in 2002 to 8% in 2005).<sup>24</sup>

## *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.<sup>25</sup> The National Service Framework for Children, Young People and Maternity Services in Wales also fully supported choice of place of birth, suggesting that midwifery-led birth centres can provide 'a family-centred, less technologically intrusive' service.<sup>26</sup> The All-Wales Clinical Pathway for Normal Labour<sup>27</sup> has also supported midwife-led care.<sup>28</sup> In Wales there are around 11 established birth centres,<sup>29</sup> six of them in Powys, where around a third of women have an 'out of hospital' birth.<sup>30</sup>

## *Northern Ireland*

In Northern Ireland, after a period of consultation, stand-alone community midwifery units were given the go ahead in July of 2004. In 2004, there was a midwife-led unit adjacent to the consultant obstetric unit at Craigavon hospital, with additional alongside and stand-alone units being planned.<sup>31</sup> The Minister with responsibility for Health, Social Services and Public Safety, in announcing the development of these units, emphasised the importance of choice for women and involvement local people in planning their development. However, currently, in Northern Ireland there are very few 'out of hospital' births. The acute services review by Price Waterhouse Cooper reported that in 2004/05 there were 32 planned home births and 38 unplanned births outside of the hospital setting.<sup>32</sup> It included modelling work for future development of services, suggesting that 'over 8,500 women in NI could deliver outside of the acute hospital setting (over 5,600 in a midwifery led units and around 3,000 at home)'.<sup>32</sup> The first midwife-led birth centre in Northern Ireland is due to open in Downpatrick in the autumn of 2009 following campaigning by NCT members and lobbying by the local maternity services liaison committee.<sup>33</sup> ([www.4ni.co.uk/northern\\_ireland\\_news.asp?id=75621](http://www.4ni.co.uk/northern_ireland_news.asp?id=75621)).

## **What is the clinical and social evidence on birth centres?**

The available evidence shows that women who book to give birth in a 'stand-alone' birth centre have a reduced rate of interventions, including caesarean section, and higher rates of normal birth, with less perineal trauma, and more maternal satisfaction. Their babies also have lower rates of admission to neonatal units.<sup>12,10</sup>

Women booking to give birth in alongside birth centre also have reduced rates of both pharmacological pain relief and augmentation of labour. Women are more likely to be mobile during labour than in an obstetric unit and are less likely to have operative deliveries. Women assigned to care in an alongside unit are less likely to report dissatisfaction with care.<sup>1</sup> Women who use birth centres generally have high regard for the philosophy of care, the support and communication with midwives and the physical environment.<sup>12,34,10,35,7</sup> The NPEU review concluded that:

'Birth centre care can offer the possibility of accessible, appropriate, personal maternity care for women and their families. There is substantial support from women accessing care, their families, maternity care health professionals, and service managers for care in birth centre settings which are clearly differentiated from obstetric-led maternity services.'<sup>1</sup>

## **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. Generally, the closer services are to people's homes, the less costly it is for them to attend for care in terms of time, out of pocket expenses for travel, and childcare, and time off work.

Midwives can make a major contribution to the national agenda for public health,<sup>3</sup> as they have the opportunity to develop a trusted and supportive relationship with women and their partners at a time in the life

course when they are uniquely well motivated to safeguard their child's health and well-being. 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. Unlike hospital obstetric units, birth centres that care for healthy, low-risk women, don't 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.

## Cost effectiveness

The estimated costs of maternity services vary widely, and the best way to calculate the cost of running free-standing birth centres is debated. Small units cannot benefit from economies of scale, but they can provide highly valued and important services for local communities as part of a broader maternity, women's health and family services network, and contribute to local amenities for the community and the childbearing population, specifically. The RCM conclude that, 'calculated on a cost-per-birth basis birth centres will always appear expensive' but note 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.<sup>36,37,23</sup> They also point to the potential cost of closing small units, including an increase in hospital acquired infection and caesarean rates, and reduction in breastfeeding rates.<sup>36</sup> Midwife-led care has the potential to save pharmaceutical, theatre, and medical staffing and post-operative nursing costs. In fact, given the reduction in interventions and complications, and the absence of, the costs saved can in fact be significant. The evaluation of Edgware Birth Centre included the economic implications. The authors concluded that the mean cost to the health service of a woman giving birth at Edgware Birth Centre was £392.30, compared to £608.90 and £635.81 respectively at the two local acute units (Barnet and Northwick Park).<sup>10</sup> Assessments by other commentators have also concluded that small, midwife-led maternity units can provide cost-effective high quality care.<sup>38</sup>

## 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. In England, from 2009, access to a birth centre will be 'guaranteed', if policy is fully implemented.

Birth centre care is usually more flexible and individualised than care in an obstetric unit, and the culture and environment support normal birth and are responsive to the needs of families. Healthy women booking care at a birth centre are less likely to experience procedures such as continuous electronic monitoring, augmentation of labour or to have an epidural, forceps, ventouse or caesarean section, though evidence suggests that appropriate transfers are made when medical care is needed.

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.

Provision of antenatal and postnatal care and other services, such as parent education, child health, family planning and well woman clinics, can help to off-set the costs of running a free-standing birth centre.

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