Description

‘NICE’: The Impact of Midwifery Unit Closures on Women Who are ‘Low-risk’

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Women and birthing people should have the option of birthing in a midwifery unit, at home or an obstetric unit.[1] In the UK the continued pressures on the midwifery workforce often impact on the availability of midwifery-led birth options (midwifery units and home birth). The wider impact of restricting birthplace options is often not considered as midwife-led birth options may be viewed as a ‘nice’ extra without considering the potential impact of the underpinning evidence.

Evidence-Based Practice

Midwifery practice should be underpinned by evidence-based practice (a key tenet of safe and effective care).[2] Maternity Services in the UK have been aware of the importance of facilitating births at home and in midwifery units for women who are low-risk since the publication of the ‘Birthplace in England cohort study’.[3] However, it is important to revisit the findings of this study to ensure that those working in maternity services are aware of the impact of midwifery unit closures (see table 1). Language used in the table will be in line with recommendations made from the ‘Re:birth

summary report'.[4]

Table 1. Outcomes for health women at low risk of complications

	First baby	Second, third or fourth baby
Spontaneous vaginal birth	46% of women where birth is planned in an obstetric unit vs. 62% of women where birth is planned in an alongside midwifery unit	70% of women where birth is planned in an obstetric unit vs. 91% of women where birth is planned in an alongside midwifery unit
Unplanned caesarean birth	16% of women where birth is planned in an obstetric unit vs. 8% of women where birth is planned in an alongside midwifery unit	5% of women where birth is planned in an obstetric unit vs 1% of women where birth is planned in an alongside midwifery unit
Birth with forceps/ventouse	23% of women where birth is planned in an obstetric unit vs 8% of women where birth is planned in an alongside midwifery unit	5% of women where birth is planned in an obstetric unit vs. 1% of women where birth is planned in an alongside midwifery unit
Neonatal outcomes	5 per 1000 babies have a poor outcome where birth is planned in an obstetric unit vs. 5 per 1000 babies have a poor outcome where birth is planned in an alongside midwifery unit	3 per 1000 babies have a poor outcome where birth is planned in an obstetric unit vs. 2 per 1000 babies have a poor outcome where birth is planned in an alongside midwifery unit

NB: It is worth noting that births planned in non-obstetric settings are considerably less expensive than births planned in obstetric units (cost saving of £366.8 for home births and £129.3 for alongside midwifery unit births).

Women and birthing people should be offered the opportunity to labour in water for analgesia however, it has been identified that those who plan to birth in midwifery units have greater access to water whereas obstetric units often restrict access (related to lack of pools installed).[5] The consequence of this means that when access to midwifery units is restricted (for example due to staffing pressures) that women are not able to access the evidence-based benefits of water:

- Reduced use of epidural
- Reduced use of injected opioids
- Reduced use of episiotomy
- Reduced maternal pain
- Reduced rates of postpartum haemorrhage
- Increased maternal satisfaction
- Increased odds of an intact perineum.[6]

For women at low risk of complications medical interventions including augmentation, epidural or spinal analgesia, general anaesthesia, or episiotomy are increased when birth occurs on an obstetric unit rather than in a midwifery-led setting.[3] Therefore, by restricting/removing midwifery-led birth options women may experience iatrogenesis or other ill effects simply by not birthing in the most suitable environment.

NICE: an acronym to support effective decision making around midwifery unit closure

In the event of midwifery staffing pressures the below acronym might support open and transparent decision making to ensure that women are not affected by decision related to midwifery unit closures.

N – Not evidence-based. The closure of midwifery units including re-deployment of staff is not supported by evidence, when women have reduced access to midwifery units there is the potential for undesirable outcomes that may have both short- and long-term consequences for health and wellbeing.

I – Increased intervention. The likelihood of unnecessary medical intervention is increased outside of midwifery-led birth settings. It is important to note that timely intervention can be lifesaving however, the concept of 'too much too soon' can be counterproductive and can lead to iatrogenesis.

C – Consequences. The consequences of midwifery unit closures include increased rates of unplanned caesarean birth and birth with forceps/ventouse. There is no difference in neonatal outcomes for women having their first baby when planning birth in an obstetric unit vs. an alongside midwifery unit. However, when women are having a second, third or fourth baby there is a slight increased likelihood of a poor outcome when birth is planned in an obstetric unit vs. an alongside midwifery unit.

E – Experience and Exposure. Women who plan to birth in a midwifery unit (freestanding and alongside) are more likely to have a positive birth experience. The closure of midwifery units may influence negative birth experiences with the potential for increased rates of birth trauma and formal complaints about care. Furthermore, midwives who work in midwifery units who are redeployed to other areas may experience decreased job satisfaction which may impact retention. Additionally, reduced exposure to spontaneous vaginal births in midwifery-led settings will negatively impact both student midwives' and qualified midwives' confidence to facilitate birth outside of the obstetric unit.

Conclusion

Decisions related to closures of midwifery units needs to include the multi-disciplinary team and the risk associated with this needs to be thoroughly assessed. Midwifery-led settings need to be prioritised rather than being seen as 'nice' extra for women during labour and birth. The evidence for out birth outside of obstetric settings for women without complications is clear and should be considered to prevent the likelihood of iatrogenic harm and negative short- and long-term effects.

References

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