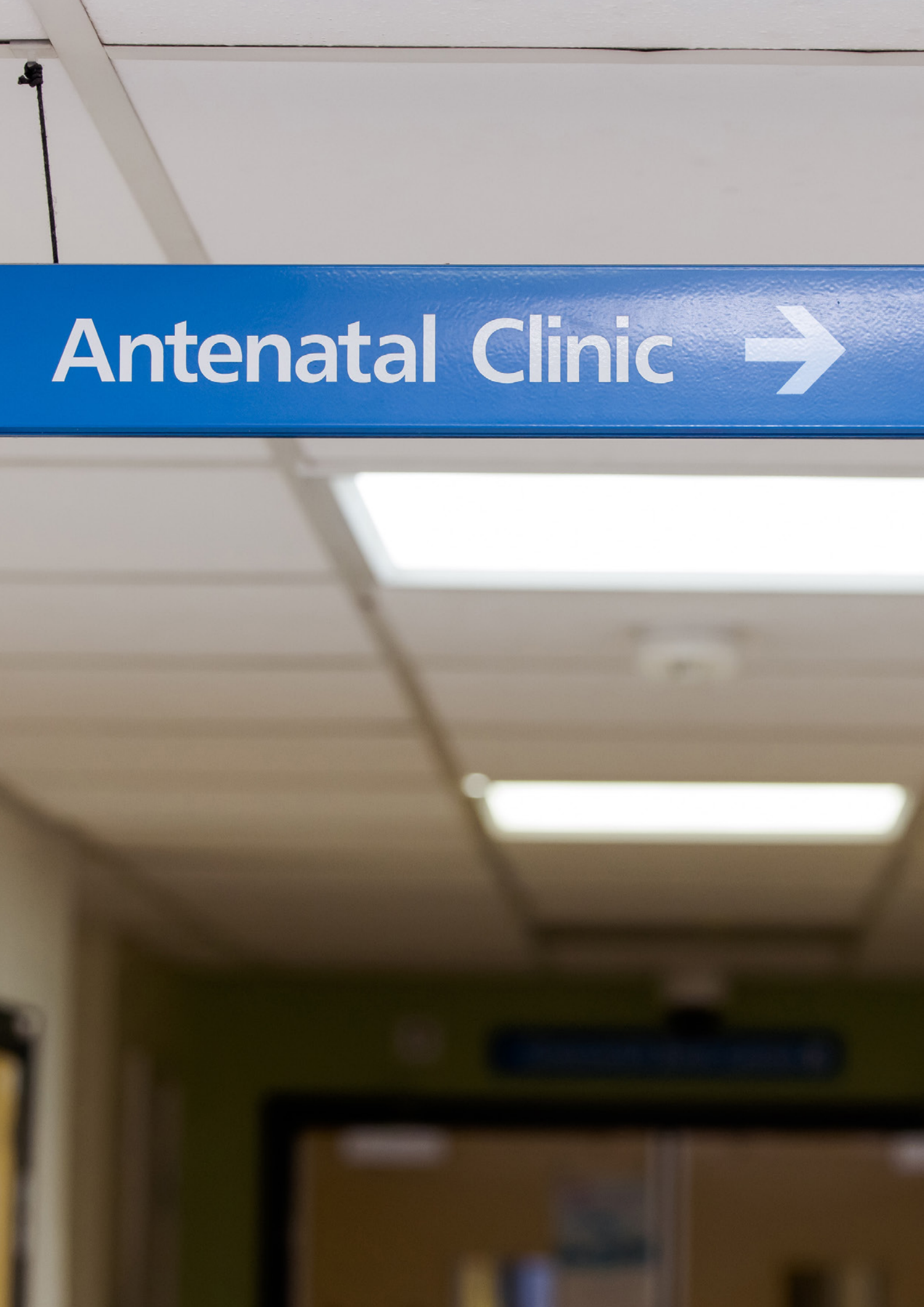
Royal College of Midwives

Position statement

reconfigurations

in maternity services


Antenatal Clinic

Our position

Proposals for merging or reconfiguring services should:

1. Be based on a robust and evidence-based case for change.
2. Demonstrate how the safety of mothers and babies will be optimised by the reconfiguration.
3. Give high priority to meeting the needs of disadvantaged women, and evidence how health inequalities will be reduced by the planned change.
4. Ensure that women's choice over where and how to give birth is optimised.
5. Maximise the opportunity for women to have continuity in the person who is caring for them.
6. Include robust arrangements for the safe and rapid transfer of women and babies to more specialist services when they are needed.
7. Align staffing and skill mix levels with the needs of women and babies, taking into account the demographic profile of the local population, case mix, and model of care.
8. Encourage multi-professional working and training.
9. Ensure that there will be sufficient physical capacity to deliver services in the new or modified settings.
10. Ensure staff wellbeing is supported through a safe work environment, access to refreshments and rest facilities, and safe routes between service locations.
11. Invite women and their families to be involved with service reconfiguration, and ensure their voices are heard
12. Be clear about how changes will be resourced, if they are not cost neutral.

Ensure that women's choice over where and how to give birth is optimised

Safety and choice

Maternity services are integrated across home, community and hospital settings, and serve women with a very wide diversity of clinical and psychosocial needs.

In addition to the overriding need to ensure the safety of mothers and babies, they must also deliver nationally mandated services to increase women's choice and continuity of care, and to narrow inequalities in outcomes. Sustaining these priorities, and protecting midwifery's specific nature and role, can be challenging during reconfiguration.

Reconfiguration offers opportunities to innovate and improve the quality of maternity services. For example, a wider Trust or Board reconfiguration may include the development of community hubs or diagnostic facilities but overlook the potential benefits of these for increasing access to maternity care.

We urge RCM members to keep regional/national officers informed about proposed reconfigurations, so that we can support you and your colleagues in ensuring the interests of midwives, mothers and babies are upheld.

Reconfiguration offers opportunities to innovate and improve the quality of maternity services

Home births

Home birth is an essential part of every maternity service and it must be sustained by:

- Organisational commitment to support the service and sustain it through peaks and troughs of activity.
- Sufficient numbers of appropriately educated, competent and confident midwives.
- Aiming to ensure that the woman knows at least one of the midwives attending her home birth and has her contact details.
- Clear and agreed standards for the transfer of women from home in case of complications.

Ensure that the woman knows at least one of the midwives attending her home birth and has her contact details

Midwifery units

- There is no recommended minimum or maximum level of activity for midwifery-led units (MUs). Staffing levels and skill-mix should align with the number of women birthing in the MU, and with antenatal and postnatal activity, in order to ensure that the MU is financially sustainable.
- Selection criteria and practice guidelines for MUs should be agreed by the multi-disciplinary team and audited on a regular basis.
- There may be a strong case for commissioning a freestanding midwifery unit (FMU) if an obstetric unit is due to close or if the nearest obstetric service with an alongside midwifery unit (AMU) is a significant distance from a local community. Consideration should be given to providing antenatal and postnatal care at the FMU for women at all risk levels.
- It may be possible to deliver added value by co-locating FMUs with other health and social care services, particularly those relating to women's health or children's services, and these options should be scoped thoroughly.
- AMUs should be staffed by a midwife-led team and supported by strong local leadership. They should offer sufficient capacity to meet the needs of the majority of low risk women and deploy a flexible staffing model in order to ensure that the AMU remains open even during times of high pressure on the acute unit. They should be physically distinct from the delivery suite.

There is no recommended minimum or maximum level of activity for midwifery-led units

Obstetric units

- There is no recommended minimum or maximum level of activity for an obstetric unit. However:
  - There is a national shortage of consultant obstetricians, and this undermines patient safety, the training of the future workforce, and out of hours cover.
  - Units undertaking more than 8,000 births a year may require staffing by two teams of obstetricians.
  - Units undertaking fewer than 2,500 births a year may have difficulty in attracting sufficient numbers of trained medical staff to make them viable.
- If the future of an obstetric unit is subject to review, consideration should be given to:
  - The impact that closure will have on the time and distance that women will have to travel to their next nearest service.
  - The capacity of neighbouring units to absorb the additional activity that will result from the closure of the unit.
  - Whether, for smaller obstetric units, arrangements can be made with a larger unit for referral of women and interchange of staff (bearing in mind the implications for out of hours cover and training pathways).
  - Establishing a midwifery-led service on the site of the obstetric unit.
  - The impact on training programmes and pathways for postgraduate doctors who may be allocated to a unit which is then going to close.
- The closure of a hospital A&E department and associated emergency services should not automatically lead to a decision to close the remaining obstetric unit without first exploring alternative ways of managing women at expected risk.

There is no recommended minimum or maximum level of activity for an obstetric unit

The midwifery workforce

- Midwifery staffing levels should be sufficient to ensure that models of service delivery based on continuity of carer can be safely developed and that all women can receive one to one care in labour.
- The labour ward should be safely staffed at all times and this should not be achieved at the expense of other areas, such as community or home birth services.
- Reconfigurations should explicitly address staff wellbeing, including the need for safe working environments, safe access to workplace locations, availability of hot food and refreshments, and adequate changing and rest facilities.

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