Position Statement
Reconfigurations

THE ROYAL COLLEGE OF MIDWIVES

Promoting • Supporting • Influencing

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RCM position

Proposals for merging or reconfiguring maternity services should:

- be based on a robust and evidence-based case for change
- ensure that women are able to choose where to give birth, including at home or in a midwifery unit
- provide women and families with information, in a variety of formats, about all of its maternity facilities
- align staffing and skill mix levels with the needs of women and babies, the chosen model of care, the demographic profile of the local population and case mix
- maximise the opportunity for women to have continuity in the person who is caring for them
- encourage multi-professional working and training
- ensure that there will be sufficient physical capacity to deliver services in the new or modified settings
- include robust arrangements for the safe and rapid referral and transfer of women and babies to more specialist services when they are needed.

Background and Context

Home births

Home births must be offered to women as a guaranteed service to underpin their choices, and the best way of doing this is to have a service model that is underpinned by:

- organisational commitment to support the service, regardless of clinical activity within the acute provider setting
- sufficient numbers of appropriately educated and competent midwives
- ensuring 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.

Midwifery units

- There is no recommended minimum or maximum level of activity for midwifery 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.
- While FMUs are by definition separate to an obstetric service, there is no reason why they cannot be co-located with other health and social care services.
- 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.

Obstetric units

- There is no recommended minimum or maximum level of activity for an obstetric unit. However:
  - 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
  - establishing a midwifery-led service on the site of the obstetric unit.
- 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.

Workforce issues

- Midwifery staffing levels should be sufficient to ensure that models of service delivery based on continuity of carer can be developed and that all women can receive one to one care in labour.
- The labour ward should be safely staffed at all times but this should not be achieved at the expense of other areas, such as community or home birth services.
- On the effectiveness of 24/7 consultant labour ward cover, a review of evidence by the National Perinatal Epidemiology Unit (NPEU) concluded that such a model appears to be viable only in large urban hospitals.

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