***In this article we will be exploring the needs of continuity midwives, and how best to ensure the continued and optimum use of the MLU. In a model that has geographical, mixed risk continuity teams, the core staff on the MLU will become continuity midwives, whilst the OU retains its core staff. We suggest that this risks the decline of MLU births, and could damage birthing choices.***

### *Background*

Birth centres were created partly as a response to the medicalisation of hospital-based maternity care. The founders of birth centres placed importance on mental and social well-being rather than '*merely the absence of disease or infirmity* (WHO cited in Bradshaw 1994[i]). Following the publication of Changing Childbirth[ii], women*'s access to midwifery-led care became a central part of maternity policy. However - the uptake was slow. Little had changed by the time Better Births[iii] was published with many of the recommendations similar to that of Changing Childbirth. Research illustrating the benefits and safety of midwifery led units (MLUs)[iv] has greatly enhanced their standing. MLUs are now better established within the framework of maternity services but are consistently under utilised[vvi]. An estimated 36 per cent of births should be suitable for the MLU**[6]**, however in reality MLUs account for only about 15 per cent of births**[5]**.

### *Midwifery-led Units and Continuity of Carer*

Where MLUs work, they work very well. Outcomes for women* and babies are better, rates of normal birth are higher and birth experiences more positive. CoC is further expected to improve these outcomes and increase midwife-led births both at home and on MLUs **[3]**. As midwifery-led care results in fewer interventions this will ultimately lead to cost savings for maternity services. Based on this evidence, one could assume that the move to CoC would be a positive message for those of us working in MLUs.

With CoC, our MLU core staff are going to be redeployed to the community. The MLU manager role will no longer exist. There will be core midwives on the obstetric unit, but no core midwives on the MLU. The reality of having an unstaffed birth centre (which is effectively just a set of rooms) has begun to raise questions about how this birth environment will be nurtured and protected for women* to use.

***Better Births and the conversation about MLUs***

Better Births rightly recommends that core staff are required on the obstetric unit as we move into a continuity model. However there appears to be no conversation at all regarding core staffing on MLUs. Evidence has shown that where care is centralised in obstetric units there is limited capacity to effectively support a physiological labour and birth[vii].

Community and hospital midwives have varying levels of experience with intrapartum care. Some community midwives are exposed to home births and the MLU on a regular basis. Some choose never to 'come in', or have a workload that prohibits it. When these new CoC midwives come in to use the MLU they may be relatively inexperienced at providing low-risk care. Or they may feel quite confident, until a challenge arises. Just like on the OU, midwives want advice from more experienced colleagues. When this support is absent on the MLU, the midwife will turn to her core OU colleagues, whose expertise is in high-risk care.

When a woman arrives at the hospital in early stages of labour a core OU midwife will triage her. If the MLU is not being used, the lights will be off, the doors closed and the office empty. The OU midwife may be more inclined to triage the woman in an OU room, as the proximity is closer to her colleagues, and the idea of working alone on the MLU is unappealing. Once the woman enters this room it is very difficult to then change the environment and alter the woman's perception of where she will give birth.

Midwives train and work in a dominant obstetric model, and as a consequence tend to lack confidence in physiological midwifery skills[viii]. It may be wrongly assumed that the ability to support normal birth is an 'innate' midwife ability. There continues to be an overarching view of birth as 'risky' with mandatory staff training consistently focused on high-risk scenarios rather than on supporting physiological birth. In some regards, this reflects a skills hierarchy **[6]**. Medical skills are given more value than skills such as the use of aromatherapy, massage, water immersion, rebozo and understanding the biomechanics of labour. This is symbolic of the continued dominance of the medical model of childbirth and perception of MLUs as a costly optional extra or 'luxury'.

Midwives need energy and resources to continually stand up to this hierarchal structure which exists within maternity care. Where the organisational structure facilitates this

hierarchy, and in some ways encourages it - the midwife will have to fight even harder to challenge the dominant obstetric voice **[7]**.

***Considering the needs of the CoC midwife***

We question how the CoC model will be able to fulfil the promise of increasing women*'s choice of place of birth. When the MLU lacks a core team, there is potential for it to become unmanaged, un-stocked, disorganised and underused, without a team to fly the flag for normality.

We decided to utilise Maslow's hierarchy of needs to illustrate the needs of midwifery staff. Basic physiological needs – rest and food are at the base of the triangle, and are essential for people to function. Once these lower needs are fulfilled, humans can work their way up through the ascending order of other needs - safety, belonging and esteem, with self-actualisation at the apex of the pyramid.

Basic necessities such as meal breaks, equipment, supplies, and peer support decrease staff stress. Once these basic needs are satisfied, staff can provide care, but to realise their potential they need to feel a sense of belonging in their environment and to feel nurtured and supported in their practice. Once staff have this they can achieve 'self actualisation' - the highest level of function where they can utilise their skills to the best of their abilities[ix].

There are significant parallels with Maslow's needs and the needs of midwives working on the MLU. These midwives need to feel '*holistically safe'* in the practice setting. This encompasses physical, emotional, social and intellectual safety[x]. Hawamdeh suggests that if midwives basic needs are not met then they lose the capacity to be forward thinking autonomous practitioners, ready to challenge and innovate.

We would suggest that these skills are especially required on the MLU given the political context in which it sits. Disregarding the need to support the provision of physiological care feeds into the dominant narrative of the obstetric model, with MLUs not seen as equal but as a form of complementary care **[8]**.

Without structure and support, staff are unable to move through Maslow's pyramid and ultimately perform at their best. Core staffing would meet the basic needs of the CoC midwife by ensuring the environment was clean, stocked, looked after and protected. Core staff would allow for the CoC midwife to have effective break relief, and a 'second'

midwife who was confident and competent in facilitating birth in the low-risk environment. This security and foundation would then facilitate the midwife to reach her/his full potential as an autonomous, innovative practitioner, able to stand up to the dominant obstetric model.

An MLU with no manager and core staff lacks identity and leadership. A common theme in safety reports investigating poor outcomes is absent or poor leadership[xi]. It is known that some birth centres fail because of a lack of management and political championing[xii]. So why would we want to risk all that we have gained by not addressing the core staffing of MLUs?

Midwives often encompass a daily struggle of negotiating between a risk-based approach and a physiological approach. The midwife may feel pulled in both directions, anxious not to be seen as 'going against guidelines' or arguing with the midwife in charge of the OU - but at the same time doing her best to facilitate a physiological birth **[7]**. This emotional dimension contributes to the psychological stresses experienced by midwives and is reported as a reason why midwives leave the profession. We need a strong MLU with a clear philosophy, midwives who 'fly to flag' for physiological birth so that the CoC midwives feel protected and secure in their practice.

As the Better Births report itself noted-

'When staff work in *well led, positive environments* and *are supported* to take pride in their work and to deliver high quality care, outcomes for women and their babies improve' **[3]** p 42

*and birthing persons

References:


[i] Bradshaw P. The conceptualisation and measurement of need. A social policy perspective. In: Popay J, Williams G, ed. *Research the people's health.* London, UK: Routledge.1994.

[ii] Department of Health. *Report of the Expert Maternity Group: Changing Childbirth (Cumberlege Report).* London. HMSO; 1993.

[iii] NHS England. Better Births. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf. Published 2016. Accessed 4th November 2020.

[iv] Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for health women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*. https://www.bmj.com/content/343/bmj.d7400. Published 2011;343: 1-13. Accessed 12th November 2020.

[v] Walsh D, Spiby, H, Grigg CP, et al. Mapping midwifery and obstetric units in England. *Midwifery*. https://pubmed.ncbi.nlm.nih.gov/29024869/. Published 2018. Accessed 12th November 2020.

[vi] Rayment J, Rance S, McCourt, C, Sandall J. Barriers to women's access to alongside midwifery units in England. *Midwifery*. 2019;77:78-85.

[vii] Darling F, McCourt, C, Cartwright, M. Facilitators and barriers to the implementation of a physiological approach during labour and birth: A systematic review and thematic synthesis. *Midwifery.* Published 2021;102861,(92):1-13.

[viii] Walsh D, Spiby H, McCourt C, et al. Midwifery units in England: Time for urgent change. *The Practicing Midwife Online.* https://www.all4maternity.com/midwifery-units-in-england-time-for-urgent-change/. Published 2020;23,(10). Accessed 12th November 2020.

[ix] Groff Paris L. Terhaar M. Using Maslow's Pyramid and the National Database of Nursing Quality Indicators to Attain a Healthier Work Environment. *OJIN.* 16 (1) https://pubmed.ncbi.nlm.nih.gov/21800926/. Published 2010; Accessed 12th November 2020.

[x] Hawamdeh S. Mental catalogue of attitude. *MIDIRS Midwifery Digest.* 2018;28(3):303-305.

[xi] Royal College of Midwives. Reviewing Maternity Services. https://www.rcm.org.uk/promoting/learning-careers/leadership/. Published 2020. Accessed 9th November 2020.

[xii] Association of Radical Midwives. A New Vision for Maternity Care. https://www.midwifery.org.uk/articles/a-new-vision-for-maternity-care/. Published 2013; Accessed 12th November 2020.