Factors influencing the utilisation of free-standing and alongside midwifery units in England: a mixed methods research study

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Authors’ objectives
Women in England have three choices for where to have their baby: in traditional labour wards in a maternity hospital, in midwifery units (MUs) or at home. MUs are run by midwives and are suitable for women having a normal pregnancy and expecting a normal birth. There are two types of MUs: alongside midwifery units (AMUs) attached to a maternity hospital and freestanding midwifery units (FMUs) geographically separate from a maternity hospital. Only 11% of women in England have their baby in a MU. This is despite very good evidence that having a baby in a MU results in better outcomes than having a baby on a traditional labour ward and is cheaper. For example, the risk of caesarean section is reduced by two thirds and mothers satisfaction with care is significantly improved. Not all maternity services have MUs and of those that do, some are not being fully utilised. We want to explore why usage varies so much and why many maternity services have never developed MUs. We will address this by examining two areas of England where 20% or more of women are having their babies in MUs, two areas where 10% or less of women give birth in MUs, two areas where there are no MUs and other maternity services that have opened a MU and then closed it. We estimate that by increasing provision so that 20% of all women give birth in MUs, the caesarean section rate for these women would reduce and the normal birth rate increase. Care would also be cheaper and mothers satisfaction with childbirth would improve. The reasons why changes in service provision occur are complex. In order to properly understand this process and provide guidance for improving policy and practice, we need a research method which is of proven worth in investigating such issues. We have thus chosen a case study approach. Comparative case studies are a good way of exploring large, complex organisations like maternity services and they will enable us to understand the differences between services that have led to the variations in MU provision. Following a mapping of the organisation of maternity services nationally, we will choose 6 areas to study in depth. In each place we will gather information from women who have used maternity services, midwives, and NHS managers and commissioners using interviews and focus groups, and will analyse the policies of each organisation. We will also look at how the local press and television have covered maternity provision issues. We will compare the results of the individual case studies with each other and explore how what we learn can be transferred to other NHS hospitals and services. These methods will help us identify why some services are successful in opening and promoting MUs and others are not. In collaboration with service users and other key people, we will develop guidance for local maternity services in England to help increase the provision and uptake of MUs. We are fully involving many kinds of people in the study, including service users, health professionals, commissioners and academics who will advise the research team and help with dissemination. The team is multi-disciplinary including service users and is highly experienced in undertaking this kind of research. We believe the project represents good value for money. The research has the potential to significantly improve the experience of maternity care for thousands of women and make considerable cost savings (3% of maternity care budget) for the NHS.

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