Neonatal support for midwifery-led units

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The way in which perinatal care is delivered in the UK continues to evolve. The introduction of managed clinical networks for neonatal care has brought major organisational change. Ongoing nursing staff shortages as highlighted by a recent Bliss report[1] and exacerbated from a junior medical staff perspective by the European Working Time Directive, coupled with the current financial climate makes further change to ensure sustainability of services inevitable. It is likely that neonatal networks will have to link with emerging maternity networks, particularly with regard to the delivery of high risk perinatal care.

Given the situation outlined above there has clearly been a great degree of appropriate focus by the perinatal community on the delivery of high-risk care. At the other end of the spectrum there has also been increased interest in providing the choice of a 'non-medicalised' birthing environment for the relatively much larger number of women satisfying locally agreed criteria for low-risk births. This approach is also attractive for low-risk deliveries in small, often rural or remote communities where it is impractical for both workload or training purposes to maintain a consultant-led obstetric and/or paediatric service. These services are given a variety of names across the UK including stand-alone midwifery-led units, community midwifery units, free-standing midwifery units and birthing units, but can be considered under the generic heading of midwifery-led units (MLUs)[2,3]. The common feature to all of them is that they are not co-located within or alongside consultant obstetric units and do not have on-site access to neonatal or paediatric staff.

MLUs undoubtably provide an appropriate environment for mothers and their babies when no problems arise. However there has been some concern that in the rare event of unforeseen neonatal complications occurring, there is relatively little existing guidance at national level on ensuring the baby has timely access to appropriate on-going care. The operational interface between MLUs and local or network neonatal services needs to be clearly specified. Neonatal resuscitation, stabilisation and transfer to an appropriate level of on-going care are time critical processes and it is therefore key that MLUs have access to appropriate care pathways. The British Association of Perinatal Medicine (BAPM) has recently published a framework document to address these issues[4]. It is very clear that the approach to MLUs varies both across the UK and in the extent to which dealing with emergency neonatal issues has already been tackled. The framework document does not seek to be a 'one size fits all' solution. It does however address the potential neonatal issues faced within the MLU environment and is intended to be tailored to serve local need.

During consultation for the framework document it became clear that there were several common themes. The most contentious of these were around the provision of acute medical input for newborns who develop acute unforeseen problems and, where necessary, arrangements for subsequent transfer. Concerns were raised that there was a growing expectation in some areas that the responsibility for both acute support and subsequent transfer would fall by default on the neonatal transfer service. This is clearly impractical for a variety of reasons, not least because neonatal transfer services are configured for retrieval rather than acute resuscitation. Clearly there are regions such as the more remote areas of Scotland where the physical relocation is over such a distance and time that the neonatal transfer service is best placed to undertake this, following appropriate resuscitation where necessary. In the majority of cases it is anticipated that after initial resuscitation and stabilisation the transfer will be undertaken by the midwifery staff attending the delivery using standard emergency ambulance services; an immediate issue arising from this is that appropriate training for working in the ambulance environment should be provided.

Should the baby require resuscitation and stabilisation prior to transfer this should be undertaken by the MLU staff since availability of other appropriately qualified personnel cannot be guaranteed in all circumstances. Again, individual units may have access to additional resources at various times, and clearly these may be incorporated into local provision. Good communication links to local neonatal services and clear protocols for accessing immediate and continuing advice in emergency situations are key to providing appropriate care in these situations.

MLUs are likely to increase in popularity as they become established in maternity services. As with all areas of care, particularly when adverse events are very uncommon, accurate on-going audit is essential to highlight recurrent problems. Identification of particular issues may require the framework to be updated in the future. Neonatal networks are best positioned to co-ordinate the collection and dissemination of these data.

References

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