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Birthplace terms and definitions: consensus process Birthplace in England research programme. Final report part 2

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Glossary of terms/abbreviations

AMU	Alongside Midwifery Unit
EMU	Evaluation of Maternity Units in England research programme
FMU	Freestanding Midwifery Unit
GP	General Practitioner
HCC	Healthcare Commission
NPEU	National Perinatal Epidemiology Unit
OU	Obstetric Unit

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This is an abridged version of an earlier report drafted by Rona McCandlish and Rachel Rowe. Members of the Evaluation of Maternity Units in England (EMU) co-investigator group commented and suggested revisions on drafts of the report. Rona McCandlish led this component study; Peter Brocklehurst, Maggie Redshaw and Rachel Rowe facilitated the consensus process at the EMU Advisors Group meeting on 19th October 2006. Amy Darwin and Laura Murray White provided administrative support for this study.

Members of the Birthplace in England Collaborative Group are listed in the Birthplace programme overview report (Birthplace final report part 1).[1]

1 Introduction

1.1 Background

Imprecise and inadequate terms and definitions about place of birth have prevented valid comparison of outcomes in previous evaluations. This was evident, for example, when the NPEU carried out a structured review about outcomes associated with midwifery-led birth centres.[2] The review recommended:

> *"A standard baseline definition of the term 'birth centre' should be developed and implemented. Additional information, for example about proximity of a birth centre from maternity services which offer medical care, including obstetric and neonatal care, should be collected in a standard way. This would allow grouping of centres with similar levels of service provision and provide a basis on which to develop comparison studies."*

Agreement on terms and definitions for place of birth was therefore planned as the first step in the Evaluation of Maternity Units in England (EMU) research programme which now forms part of the Birthplace in England research programme. The aims of EMU were to evaluate and compare outcomes of births planned in different types of midwifery units and in hospital units with obstetric services.

This report focuses on the consensus process undertaken about terms and definitions for place of birth. Findings were applied in subsequent components of the Birthplace research programme.

1.2 Aims

The consensus process aimed to develop terms and definitions for place of birth for use in the EMU programme and for standard use

2 Methods

A two phase consensus process was undertaken.

2.1 Phase 1: Developing and testing draft terms and definitions

A document was prepared by the NPEU team which compiled a selection of relevant terms and definitions in current use from a variety of sources and which included a draft of potential terms and definitions for use in EMU. This was sent to members of the Advisory Group as background reading in advance of the first meeting of the group. The afternoon session of this meeting was devoted to the consensus process which aimed to achieve agreement on draft terms and definitions.

The format of the process is outlined below.

- A short presentation was made by an NPEU researcher which outlined the aims of the consensus process and proposed 'ground rules' for discussion of the draft terms and definitions.
- A voting sheet was given to each participant with the previously unseen draft terms and definitions for place of birth.
- Participants were asked to read these terms and definitions and vote, independently, on their level of agreement with them. They were also asked to note any changes or alternative wording they would suggest to improve the terms and definitions.
- Voting sheets were collected and participants divided into two groups, each with an NPEU researcher as facilitator, to discuss how to improve the terms and definitions.
- Finally, all participants joined a round table discussion to consider the main issues from group discussions and try and reach agreement on revisions to the draft terms and definitions.

In the light of the discussion and consensus achieved at the conclusion of Phase 1 the draft terms and definitions and the questionnaire voting sheet were revised by the NPEU team for use in Phase 2.

2.2 Phase 2: Widening participation and consultation

Three groups of stakeholders were invited to participate in Phase 2:

Group A: The seventeen members of the EMU Advisory Group (all members of the Advisory Group and nominated alternates) of whom 13 had taken part in Phase 1

Group B: The nine co-investigators for the EMU research programme (excluding those who worked at the NPEU), none of whom had taken part in Phase 1

Group C: A convenience sample of 12 senior midwives practising in England, none of whom had taken part in Phase 1

All three groups were sent the same questionnaire and voting sheet which asked the recipient to vote on their level of agreement with the revised draft terms and definitions. There was space at the end of the sheet in which respondents were invited to comment on the terms and definitions or on the questionnaire itself. Each participant was assigned a discrete alpha-numeric code according to their group (e.g. A401, B502, C606), which was used to identify their questionnaire. No other personally identifying details were marked on the questionnaire.

Members of Groups A and B were approached directly by post and by email with a letter of invitation to participate along with the questionnaire voting sheet on 6th December 2006 with a request for response by 13th December 2006. Non-respondents were contacted on 14th December 2006 and sent the same letter of invitation and questionnaire and asked to reply by 20th December 2006.

Members of Group C were sent a letter of invitation to take part in the study on November 28th 2006 with a request for response about whether or not they wanted to take part by 6th December 2006. Those who agreed to take part were sent the questionnaire with a request for response by 20th December 2006.

3 Results

Crude summary results of phase 2 are presented in Table 1. The overall response rate was 87%. Group A achieved a better level of agreement on the draft terms and definitions compared to the other two groups. Comments or suggestions for revisions were made by 10 (67%) respondents from Group A, 8 (89%) from Group B and 8 (89%) from Group C.

Table 1: Phase 2: Response rate and agreement with terms and definitions

Participant group Respondents/total surveyed	**Agree**	**Agree to some extent**	**Disagree**
	n (%)	**n (%)**	**n (%)**
All surveyed: N= 33/38 (87%)			
Obstetric unit	20(61)	9 (27)	4 (12)
Freestanding midwifery unit or freestanding GP unit	17 (52)	10 (30)	6 (18)
Alongside midwifery unit	19 (58)	11 (33)	3 (9)
Group A Advisors: N =15/17 (88%)			
Obstetric unit	11 (73)	3 (20)	1 (7)
Freestanding midwifery unit or freestanding GP unit	12 (80)	1 (7)	2 (13)
Alongside midwifery unit	12 (80)	3 (20)	0
Group B Co-investigators: N=9/9 (100%)			
Obstetric unit	4 (44)	3 (33)	2 (22)
Freestanding midwifery unit or freestanding GP unit	3 (33)	3 (33)	3 (33)
Alongside midwifery unit	4 (44)	3 (33)	2 (22)
Group C External stakeholders: N= 9/12 (75%)			
Obstetric unit	5 (56)	3 (33)	1 (11)
Freestanding midwifery unit or freestanding GP unit	2 (22)	6 (67)	1 (11)
Alongside midwifery unit	3 (33)	5 (56)	1 (11)

3.1 Main areas of disagreement

3.1.1 Obstetric unit

The main reason for not agreeing with the definition of an obstetric unit was because it did not adequately encompass the care that midwives give to all women irrespective of their level of risk. One respondent said:

"I find the concept of an obstetric unit very difficult. Many low risk women give birth in an obstetric unit and midwives often take responsibility." [Respondent A402]

Another commented:

"For Obstetric we need to make clear that midwifes are involved in care and will take the lead in delivery a lot of the time." [A412]

3.1.2 Freestanding midwifery unit or freestanding GP unit

Some respondents wanted the fact that medical care was not immediately available made clearer and that the distance from 'back-up' should be covered.

The use of the term 'straightforward pregnancies' was problematic for some, for example:

"…straightforward pregnancies should be changed to 'low-risk' pregnancies." [C501]

3.1.3 Alongside midwifery unit

Comments from respondents who disagreed with this definition were mainly about whether this definition was sufficiently precise, for example:

"…midwifery birth facilities which may be located in a consultant unit?? i.e. some designated 'midwifery beds' not only usually used for women with straightforward pregnancies." [A413]

"The reference Group for the secondary Uses Dataset suggested that there may be a distinction between a Midwifery Unit alongside an Obstetric Unit and a Midwifery Unit alongside general hospital facilities that whilst did not offer specialist obstetric/ neonatal facilities did have access to anaesthetic/ theatre facilities." [E611]

"The 'alongside' definition may be tricky as there are 'midwifery-led' beds or similar located within a consultant-led labour ward, or units that have been designated a 'high-risk' and 'low-risk' labour ward .." [C503]

3.1.4 General issues

Respondents suggested that the term 'low risk' should be used rather than 'straightforward pregnancies' in the definitions covering freestanding and alongside midwifery units.

3.2 Revision of the terms and definitions

In the light of the comments and suggestions for improvements the draft terms and definitions were revised and a final version produced (Table 2) for use in the future Birthplace component studies.

Not all of the suggested amendments were made. For example, although many respondents preferred the term 'low risk' or 'normal' to 'straightforward' to describe a pregnancy, the term straightforward was retained because (a) it was agreed that 'normal' was a difficult term in this context because the implication is that any aspects of a pregnancy which are not 'normal' are 'abnormal', and for conditions such as a twin pregnancy this did not appear reasonable; and (b) the term 'low risk' is too broad. It is not clear whether this means the pregnancy is at low risk of adverse outcomes of pregnancy, or low risk of labour complications or low risk of pregnancy complications. For example, a woman may be at high risk of preterm birth until the pregnancy reaches term when the risk of preterm birth becomes irrelevant to care in labour. And although the term 'straightforward' is less precisely defined, and therefore less likely to be interpreted in a particular way, it was for this reason that it was retained.

Table 2: Terms and definitions on place of birth for use in the Birthplace in England research programme

Obstetric unit (OU): an NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day.
Alongside midwifery unit (AMU): an NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair.
Freestanding midwifery unit (FMU): an NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance.

4 Discussion

During this study it became clear that development of standard definitions to describe clinical locations for place of birth for use in all circumstances was unrealistic. For example, a glossary developed during the course of this process published by the Department of Health in the report Maternity Matters[3] also offers terms and definitions that cover place of birth which are different from those developed in this study.

Furthermore, because a woman's risk status, and hence eligibility for birth in different settings, can change over the course of pregnancy (see section 3.2) it was subsequently decided to adopt the term 'low risk' in the prospective cohort study since the term straightforward pregnancy did not adequately capture the concept of risk of complications at a particular time point, i.e. labour onset.

4.1 Key message

- The terms Obstetric Unit (OU), Alongside Midwifery Unit (AMU) and Freestanding Midwifery Unit (FMU) as defined by this consensus process will be used in the Birthplace component studies.
- The term 'low risk' risk' will be used in the Birthplace prospective cohort study.

References

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3. Department of Health/Partnerships for Children Families and Maternity. Maternity Matters: Choice, access and continuity of care in a safe service. London; 2007.

Addendum

The Birthplace in England Research Programme combines the Evaluation of Maternity Units in England (EMU) study funded in 2006 by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme, and the Birth at Home study in England, funded in 2007 by the Department of Health Policy Research Programme (DH PRP). This document is part of a suite of reports representing the combined output from this jointly funded research. Should you have any queries please contact Sdoedit@southampton.ac.uk