Enabling access to birth in a midwife-led unit: Implementation of a co-produced evidenced-based guideline


Published in:
The Practising Midwife

Document Version:
Publisher's PDF, also known as Version of record

Queen's University Belfast - Research Portal:
Link to publication record in Queen's University Belfast Research Portal

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ENABLING ACCESS TO BIRTH IN A MIDWIFE-LED UNIT: IMPLEMENTATION OF A CO-PRODUCED EVIDENCED-BASED GUIDELINE

BACKGROUND
The majority of healthy women (both nulliparous and multiparous) with a straightforward pregnancy are generally at low risk of complications during labour and childbirth. For these women and their babies, planning and giving birth in a midwife-led unit (MLU) (freestanding or alongside) if they choose, is highly recommended, as they are ‘particularly suitable’ because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit’ (National Institute for Health and Care Excellence (NICE) 2014). Other studies support this recommendation, as they have found great benefits of midwife-led care (MLC); therefore experience the health and social benefits of midwife-led care (MLC); many MLUs offer complementary therapies as part of their service provision.

The significant benefits of midwife-led care (in particular within the context of an integrated maternity care system where there is referral and transfer to medical obstetric and neonatal specialist care) when required, are evident (BECG 2011; Homer et al 2014). The benefits for women who have had a straightforward pregnancy and giving birth in an MLU, when compared to an obstetric unit include significantly increased likelihood (nearly twice the odds) of having a normal labour and birth (Scarf et al 2018; Alliman and Philippi 2016); and experiencing less maternal morbidity from unnecessary intervention(s) (including amniotomy, augmentation of labour, instrumental vaginal birth, opiate or regional analgesia) (Hollowell et al 2015). For the baby (and the new mother), there are increased rates of established breastfeeding (Schoeder et al 2017); no significant impact on rates of infant mortality (Scarfe et al 2018); and babies are less likely to need admission to a neonatal unit (Hollowell et al 2015). Women’s experiences of care in a MLU are also found to be positive (Overgaard et al 2012; Macfarlane et al 2014a; Macfarlane et al 2014b).

In addition to the health benefits, evidence also illuminates the economic benefits of midwife-led care (Devane et al 2010; Schoeder et al 2017). A comparative micro-costing of intrapartum maternity care for ‘low risk’ women who chose to birth in a free-standing MLU in England, to women who chose to give birth in hospital, highlighted a saving of approximately £850 per mother and baby (Schoeder et al 2017). Levet et al (2018) noted recently the significant cost savings from implementing antenatal complementary therapies for labour and birth, with a significant increase in women experiencing a normal vaginal birth, with the cost savings identified from the reduced caesarean section rate. Many MLUs offer complementary therapies as part of their service provision.

Sandall et al (2014) suggest that approximately 45 per cent of all pregnant women using the NHS are healthy and at low risk of complications during birth. In 2015, the Welsh Government wrote to all seven health boards requesting them to plan and invest in maternity services, emphasising the evidence that up to 45 per cent of women can safely begin labour care in a midwife-led setting (Consultant Midwives Cymru [CMC] 2017). A considerable number of women and babies can therefore experience the health and social benefits of midwife-led care (MCL); which is further endorsed by the World Health Organization (WHO) antenatal and intrapartum care guidelines (2016; 2018).

PRACTICE CHALLENGE 1
What is the definition of a straightforward pregnancy?

RATIONALITY FOR GUIDELINE TO ENABLE ACCESS TO BIRTH IN A MLU
There are two types of midwife-led units, an alongside unit (AMU) or freestanding (FMU). In Northern Ireland (NI) there are currently eight MLUs (five AMUs and three FMUs), Healy (2013) undertook an EU-funded STSM (short term scientific mission) and found inconsistency in the admission criteria. In addition, both women and maternity care professionals across NI were keen to have guidelines that would assist their decision-making for planning birth in a MLU. The Guideline Audit and Implementation Network (GAIN) (now Regulation Quality Improvement Authority [RQIA]) granted funding in 2014 for the development of regional guidelines through collaboration and co-production with key maternity care stakeholders.

In a follow-up to the study of the Birthplace in England Research Programme (BECG 2011), a recent paper by McCourt et al (2018) has highlighted the importance of guidelines in enhancing safety of care in the development and sustainability of MLUs. The GAIN/RQIA guideline for admission to midwife-led units and the normal labour and birth care pathway in NI (GAIN/RQIA 2016a) (along with an information resource for women and their partners entitled Planning birth in a midwife-led unit in NI (GAIN/ RQIA 2016b)), and a transfer proforma were developed and launched following consultation and peer review in January 2016. The comprehensive process undertaken is detailed in Healy and Gillen (2016).

The guideline is evidenced-based and was written using carefully chosen, inclusive wording, with additional midwifery
practice recommendations indicated in superscript (see Table 6). This guideline predominantly relates to women with a straightforward singleton pregnancy at the point of labour, though women in NI are signposted and supported by the midwife to plan their birth in a MU setting if they choose to find the first antenatal point of contact (Health and Social Care Board NI [HSC] 2016). There are two sets of criteria: the criteria to be used for decision-making which enables women to access any MLU (FMU or AMU – highlighted in the green box within Table 6), and expanded criteria to assist decision-making for women to plan their birth within an AMU only (highlighted in blue box).

Table 1 RQIA (GAIN) Guideline for admission to midwife-led units in Northern Ireland

**Planned birth in any MU (FMU and AMU) for women with the following:**

1. Maternal Age >16 years and ≤40 years
2. BMI at booking ≥18.5 kg/m² and ≤35 kg/m² (5)
3. Last recorded Hb ≥100g/L
4. No more than four previous births
5. Assisted conception with Clomifene or similar
6. SROM ≥24hrs and no signs of infection
7. Women on Tier 1 of the SEHST Integrated Perinatal Mental Health Care Pathway(6a)
8. Threatened miscarriage, now resolved
9. Threatened preterm labour, now resolved
10. Suspected low lying placenta, now resolved
11. Medical condition that is not impacting on the pregnancy or the woman’s health
12. Women who have required social services input and there is no related impact on the pregnancy or the woman’s health
13. Previous congenital abnormality, with no evidence of recurrence
14. Non-significant (light) meconium in the absence of any other risk
15. Uncomplicated third degree tear
16. Serum antibodies of no clinical significance
17. Women who have had previous cervical treatment, now term

**Planned birth in AMU only for women with the following:**

1. Maternal age >16 years or ≥40 years (a)
2. BMI at booking ≥18.5 kg/m² and ≥40 kg/m² with good mobility
3. Last recorded Hb ≥85g/L(3d)
4. No more than five previous births(3d)
5. IVF Pregnancy at term (excluding ovum donation and maternal age ≥40 years)
6. SROM ≥24hrs, in established labour and no signs of infection
7. Women on Tier 2 of the SEHST Integrated Perinatal Mental Health Care Pathway, following individual assessment(3d)
8. Previous PPH, not requiring blood transfusion or surgical intervention
9. Previous extensive vaginal, cervical, or third degree perineal trauma following individual assessment
10. Prostaglandin induction resulting in the onset of labour(3d)
11. Group B Streptococcus positive in this pregnancy with no signs of infection(6h)

Notes relating to planned place of birth

1. Straightforward singleton pregnancy, is one in which the woman does not have any pre-existing condition impacting on her pregnancy, a recurrent complication of pregnancy or a complication in this pregnancy which would require ongoing consultant input. If it has reached 37 weeks gestation and ≥ 4 cm...
2. The NI normal labour and birth care pathway provides an evidence-based framework for normal labour and birth.
3. It is the responsibility of the professional undertaking the assessment to document in the maternity care record the reasons for change of lead maternity care professional.
4. FMU = Freestanding midwife-led unit, AMU = Alongside midwife-led unit (i.e. adjacent to consultant-led unit).
5. Women with BMI 16-18 kg/m² require medical review to assess suitability of birthing in MLU.

Additional supporting midwifery practice recommendations

- South Eastern Health and Social Care Trust (SEHST) (2013): Integrated perinatal mental health care pathway NI: Tier 1: Women with mild depressive illness, anxiety, adjustment disorders and other more minor mental illnesses associated with pregnancy or the postnatal period are unlikely to require referral to psychiatric services. In general, they can be managed within the primary care team, by their own GP, health visitors and practice-based counsellors if required. Social factors should always be considered and social support offered. Most of these women will not require medication.
- Definition of significant meconium: ‘Dark green or black amniotic fluid that is thick or tenacious or any meconium-stained amniotic fluid containing lumps of meconium’ (NICE 2014: 32).
- Women who are aged >40 years and ≥43 weeks and wish to give birth in an AMU should be more than 40 weeks gestation. Primigravid women who are >40 years of age and women who are 44 years and older also require individual assessment with a consultant obstetrician. In the case of a pregnant teenager who is under 16 requiring intravenous fluids in labour, the paediatric fluid protocol must be followed, and care transferred to a consultant-led unit.
- A woman presenting with last recorded Hb <100g/L requires a repeat full blood count at point of admission. If rechecked Hb <100g/L, secure intravenous (IV) access, take blood and send to laboratory for Group and Hold. Then follow the NI normal labour and birth care pathway for active management of third stage.

What is the recommended midwifery practice for a woman presenting in labour with her last recorded Hb <85g/L?

- A woman with more than five previous births should normally have IV access secured (on a straightforward singleton pregnancy) and blood taken and sent to laboratory for Group and Hold and follow the NI normal labour and birth care pathway for active management of third stage.
- SEHST (2013: 3) integrated perinatal mental health care pathway NI: Tier 2: These are women with more significant illness who may require medication as well as some form of psychological intervention. In some trusts women may be referred to antenatal perinatal mental health clinic. However, some women may be managed by their own GP, midwifery/health visitor. If a significant illness develops and if GPs have concerns about prescribing in pregnancy or in the postnatal period, they should be referred to mental health services via the mental health assessment centre. The referral will then be seen as a priority, triaged and forwarded to the relevant team, depending on a woman’s past mental health history, current mental health service input and severity of illness. At this level most of the referrals will be assessed by the mental health assessment centre staff, which can include assessment by a psychiatrist if it is deemed appropriate. Medication may be started or a brief focused psychological intervention may be offered. In this event those women who are within midwife-led services will be referred to a consultant obstetrician due to the need for medical management of their mental health condition.
- A woman who has gone into labour following induction with either one Proges® or up to two Prostino® only.
- Women with Group B Streptococcus positive in current pregnancy require intravenous antibiotics in labour as per NICE Guideline 149 (2012). In the absence of a midwife prescriber, the doctor on call should be consulted to prescribe antibiotics as per the guideline.
To ensure quality of maternity care within midwife units, along with reduced variability of practices that promote a bio-psycho-social model of care, a collaboration between the Midwifery Unit Network (MUNet) and the European Midwives Association (EMA) recently published midwife unit standards (MUNet 2018). These standards follow a bio-psycho-social model of care and emphasise equality, diversity and social inclusion for all women.

In addition, the midwifery standards promote interdisciplinary collaboration; encourage a positive organisational culture involving strong midwifery leadership, adequate infrastructure and staffing; and continue development of knowledge, skills and training. The GAIN/ RQIA guideline (2016a) is endorsed within the midwife unit standards as an evidence-based guideline for decision-making relating to individual women’s suitability for planning birth in a MLU.

**IMPLEMENTATION OF THE GUIDELINES**

In order to promote and support normal physiological birth processes (along with positive labour and birth experience) (WHO 2018), awareness raising education sessions for implementation of the guideline and pathway were provided to all MLU midwife teams involved in the MLU service provision across NI. These were provided by midwife education consultants from the HSC Clinical Education Centre, further to support from the Chief Nursing Officer.

Co-production and collaboration during the development of this guideline have been seen it being accepted in all five trusts across NI. For ease of access for midwives and women, key elements have been included in the Health Social Care (HSC) maternal hand held record and a link to the RQIA web page is highlighted in the Public Health Agency pregnancy book, CECOS, which is given to all women at booking. Laminated copies of the guideline were made available in each MLU, antenatal ward, assessment unit, labour ward and community midwifery facility across NI. The review of the NI maternity care strategy (RQIA 2017) acknowledges how the guideline and pathway promote the care of women with an uncomplicated pregnancy.

**REFERENCES**


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