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 generally at low risk of complications during pregnancy. There are two types of midwife-led units, an alongside unit (AMU) or freestanding unit (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.

There is an increasing emphasis on the need to support women in planning their place of birth. In order to make a truly informed choice, women and midwives can benefit from evidence-based guidelines that provide them with easy-to-access information that will support their decision-making. In Northern Ireland (NI) there are currently eight midwife-led units (MLU) [with potential for more], which are most suitable as the place of birth for a woman with a straightforward pregnancy. This paper provides an overview of the ‘GAIN (RQIA) Guideline for admission to midwife-led units in Northern Ireland’. The guideline was informed by the evidence, and co-produced by women and maternity care professionals.

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There are increased rates of established breastfeeding (Schooder et al 2017); no significant impact on rates of infant mortality (Scarf 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; Schroeder 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 (Schooder 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 (MLC); which is further endorsed by the World Health Organization (WHO) antenatal and intrapartum care guidelines (2016; 2018).

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] 2014-5). Other studies support this recommendation, as they have found great benefits and no significant difference in the adverse outcomes between births planned in labour wards and in MLUs (also known as birth centres) (Birthplace in England Collaborative Group [BECG] 2011; Laws et al 2010; Homer et al 2014).

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; de Jonge et al 2015). The benefits for women who have had a straightforward pregnancy and giving birth in a 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),
practice recommendations indicated in superscript (see Table 1). 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 MLU setting (if they choose) from 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 1), 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

**Planning place of birth**

This guideline predominantly relates to women with a straightforward singleton pregnancy at the point of labour(6a). It is important to note that, at each point of maternity care, all women should be assessed to ensure that they are receiving care from the most appropriate professional; that is, continue with midwife-led care (MLC), transfer to consultant-led care or transfer back to MLC(6b). Further clarification with regard to place of birth can be facilitated by a senior midwife. The following boxes provide specific criteria for planning birth within MLUs, Green box criteria relating to FMU and AMUs and Blue box criteria relating to AMU only.

**How would you support a woman who has a history of mental ill health to plan her birth in MLU?**

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

1. Maternal Age ≥ 16 years and ≤ 40 years
2. BMI at booking ≥ 18 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 SEHSC 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 pregnancy, a recurrent complication of pregnancy or a complication in this pregnancy which would require ongoing consultant input, has reached 37 weeks gestation and ≥ 4 cm
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
2. BMI at booking ≥ 18 Kg/m2 and ≤ 40 Kg/m2 with good mobility
3. Last recorded Hb > 85g/L(6b)
4. No more than five previous births(6b)
5. IVF Pregnancy at term (excluding ovum donation and maternal age ≥ 40 years)
6. SROM ≤ 48hrs, in established labour and no signs of infection
7. Women on Tier 2 of the SEHSC Integrated Perinatal Mental Health Care Pathway, following individual assessment(6b)
8. Previous PPH, not requiring blood transfusion or surgical intervention
9. Previous extensive vaginal, cervical, or third degree perineal trauma following individual assessment
10. Prosstaglandin induction resulting in the onset of labour(6b)
11. Group B Streptococcus positive in this pregnancy with no signs of infection(6b)

**Notes relating to planning 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, 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**

(6a) South Eastern Health and Social Care Trust (SEHSCST) (2013): Integrated perinatal mental health care pathway: NI. **Tier 1:** Women with mild depressive illness, anxiety, adjustment disorders and other 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.

(6b) 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).

**What is the definition of significant meconium?**

(1) Women who are aged > 40 years and >43 weeks and wish to give birth in an AMU should be no 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.

(6c) A woman presenting with last recorded Hb < 100g/L requires a repeat full blood count at point of admission. If rechecked Hb is <100g/L, secure intravenous (IV) access, take blood and send to laboratory for Group and Hold. Follow then the NI normal labour and birth care pathway for active management of third stage.
IMPLEMENTATION OF THE GUIDELINES
In order to promote and support normal physiological birth processes (along with professional labour and birth experience) (WHO 2018), awareness raising education sessions for implementation of the guideline and pathway were provided to midwives involved in the MLU service provision across NI. These were provided by midwife education consultants from the HSC Clinical Education Centre, further supported 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, 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 culture involving strong midwifery leadership, adequate infrastructure and staffing; and continuous 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.

DISSEMINATION OF THE GUIDELINES AND INTERNATIONAL IMPACT
During the development of the guideline and through presentation at local, national and international conferences and meetings, there have been opportunities to share the guidelines with multidisciplinary colleagues. This has been important in receiving feedback on their application in an international context, but has also led to the guidelines being shared with maternity care facilities in a number of countries. Further evidence of the importance of these guidelines in shaping practice in other countries is evidenced outside NI by their translation into other languages, including Spanish and Swedish, with others planned.

At a recent meeting of the joint WHO-ICM-UENPA global consultation midwifery meetings held at the WHO, Geneva in March 2018, Dr Henry presented an overview of how the guideline was developed and implemented in NI. Many of the global leaders present highlighted the potential of future impact through translation of the guideline and pathway into practice within lower- and middle-income countries.

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 midwifery 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 continuous 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.

Midwife-led units are particularly suitable for women with a straightforward pregnancy, as the evidence strongly suggests that the outcomes and benefits are good for them and their baby. Women’s experiences of MLC are also positive, with reduced likelihood of unnecessary interventions, and increased rates of established breastfeeding. These benefits can further enable women to care for themselves and their families post-birth. There is also the significant financial cost savings from MLU care provision. As a large percentage of women have a straightforward pregnancy, many women globally should receive the health and wellbeing benefits of giving birth in a MLU, if they choose. In order to provide optimum quality care, MLUs are strongly urged to demonstrate the midwife unit standards (MUNet 2018). Women and midwives require easily accessible, evidence-based information to enable individual care and personalised decision-making when planning their place of birth. TPH

For further information about the guideline including implementation or feedback, please contact us at The Practising Midwife and we will pass on your enquiry.

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GAIN/RQIA (2016a). Guidance for admission to midwife-led units in Northern Ireland and Northern Ireland normal labour and birth care pathway, Belfast: RQIA. https://www.rqia.org.uk/RQIA/files/3a/3a7a37bb-d601-4a02-96b0-5e583d5e4a02.pdf

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