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


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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 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 an MLU, when compared to an obstetric unit include significantly increased likelihood (nearly twice the odds) of having a normal labour and birth (Scaf et al 2018; Alliman and Philipp 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 (Scaf 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 an 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). Levett 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).

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

RATIONALE 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.

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The majority of healthy women with a straightforward pregnancy are generally at low risk of complications during labour and childbirth.
Laminated copies – highlighted in the green box within antenatal point of contact (Health and in NI are signposted and supported by at the point of labour, though women a straightforward singleton pregnancy predominantly relates to women with a green box).

Table 1) RQIA (GAIN) Guideline for 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

**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 ≥18.5 kg/m² and ≤35kg/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 SEHSCT 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(6b)
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 is 16 years or >40 years
2. BMI at booking >35 kg/m² and ≤40 kg/m² with good mobility
3. Last recorded Hb >185g/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 ≥24hrs, in established labour and no signs of infection
7. Women on Tier 2 of the SEHSCT Integrated Perinatal Mental Health Care Pathway, following individual assessment(6f)
8. Previous PPH, not requiring blood transfusion or surgical intervention
9. Previous extensive vaginal, cervical, or third degree perineal trauma following individual assessment
10. Postpartum haemorrhage resulting in the need of resuscitation(6f)
11. Group B Streptococcus positive in this pregnancy with no signs of infection(6f)

**Additional supporting midwifery practice recommendations**

(6a) South Eastern Health and Social Care Trust (SEHSCT) (2013: 3) 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).

### Practice Challenge 5

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

Laminated copies of the guideline were made available in each MLU, antenatal ward, assessment unit, labour ward and community midwifery facility.
IMPLEMENTATION OF THE GUIDELINES

In order to promote and support normal physiological birth processes (along with positive labour and birth experiences) (WHO 2018), awareness raising education sessions for implementation of the guideline and pathway were provided free of charge to midwives in all four MLUs involved in the MLU service provision across NI. These were provided by midwifery 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, CoG数据库 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.

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 continue development of knowledge, skills and training. The GAIN/RQIA guideline (2016a) is endorsed within the midwifery unit standards as an evidenced-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 initiatives in a number of other 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-UNFPA global consultation midwifery meetings held at the WHO, Geneva in March 2018, Dr Healy 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.

CONCLUSION

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 midwifery unit standards (MUNet 2018). Women and midwives require easy access, evidence-based information to enable individual care and personalised decision-making when planning their place of birth. TFM

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

REFERENCES


HSC (2016). Health and social care maternity services care pathway for antenatal care, Belfast: HSC.


Northern Ireland