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Midwifery Unit Standards



Foreword

We welcome the development of these Standards on the philosophy and organisation of care in midwifery units throughout Europe.

There is now a convincing and expanding body of evidence indicating that continuity of midwife-led care is particularly suitable for healthy women with uncomplicated pregnancies in settings with well-trained midwives and good health systems. This has been translated into policy at the national and global level. In similar contexts, with well-functioning referral systems, midwife led care in out of hospital settings is associated with maternal reports of more positive pregnancy and birth experiences when compared to women using hospital-based maternity care. Better outcomes are also reported for healthy women of any parity, along with similar perinatal outcomes, especially for second and subsequent babies. These findings are also reflected in national policy documents.

However, there are still too few well supported and resourced midwife-led units available around the world, and this limits the opportunity for provision of optimal, consistent, high-quality, safe, cost-effective care for women and their babies.

If midwives, other healthcare professionals and policymakers can show leadership in Europe in developing the kind of services these Standards represent, this could provide a powerful model for best practice both in and out of hospital settings. As health systems strengthen in low and middle income countries, the Standards could also be a catalyst for change in settings where both in and out of hospital maternity care provision is sub-optimal.

We congratulate the Midwifery Unit Network in taking this initiative and developing Standards using an inclusive, co-production methodology.

We would encourage professional organisations and individual leaders to use this tool as part of local quality improvement and to take the initiative to move maternity care forward into the future.

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Midwifery Unit Standards

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*These standards accurately reflect
recommendations in the NICE guidance
on intrapartum care for healthy
women and babies. They also support
statement 1 in the NICE quality
standard for intrapartum care.*

*National Institute for Health and Care
Excellence*

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EXECUTIVE SUMMARY

One important aspect of implementing evidence-based care in maternity is extending midwifery care settings, and increasing women's access to them (Renfrew et al., 2014; Miller et al., 2016; WHO, 2016).

The Midwifery Unit Network (MUNet) and the European Midwives Association (EMA) have been working collaboratively to influence the implementation of maternity policies that relate to the safety, the health of women and their babies, and access to evidence-based maternity care.

Promoting and supporting the implementation, development and growth of midwifery units which provide holistic care to women and their family throughout Europe, is one of the aims of the MUNet. We envisage midwifery units becoming the main care pathway for healthy women with straightforward pregnancies. In order to scale up the implementation of midwifery units across Europe safely, quality standards are necessary.

The creation of the Midwifery Unit Standards is the first joint output of the collaboration between MUNet and EMA. These Standards have been developed to guide midwives, managers and commissioners across Europe in creating and developing midwifery units. They focus on philosophy of care and the organisation of services.

The aim of the Midwifery Unit Standards is to improve the quality of maternity care, reduce variability of practices and facilitate a bio-psycho-social model of care. They address the guidance gap in implementation of midwifery units (both in hospitals and in the primary care settings).

The development of the Standards has used a robust and inclusive, co-produced, evidence-based process. Full details of the methods and methodology can be found in Appendix 1. In summary, this involved the following steps:

- 1) A systematic review and synthesis of the qualitative evidence on the provision of good quality care in midwifery units was conducted between January and October 2017.
- 2) A Delphi study was conducted, using clear expertise criteria, which involved two online surveys with 122 invited experts and an overall response rate of 48 percent. The first Delphi survey was launched in May 2017 and the second in February 2018.
- 3) Semi-structured interviews were conducted with the service leaders of high-performing midwifery units to expand the themes which were under-represented.
- 4) The findings from the evidence review were integrated into the Delphi survey questions.
- 5) A series of stakeholder meetings were organised to review the initial items and then the draft Standards document at each key stage of development. The first stakeholder meeting was held in London and the second at the International Confederation of Midwives in Toronto in June 2017. A third stakeholder meeting was held in London in December 2017.
- 6) Peer review was conducted by 12 interdisciplinary European stakeholders.

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| Theme 2 | Equality, diversity and social inclusion |
| Standard 2 | The midwifery unit has a policy relating to respect, diversity and inclusion |
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| Standard 3 | There is a shared written commitment to mutual respect and cross-boundary working across the whole maternity service |
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BACKGROUND

More than five million women give birth each year across the European Union (EU). Despite a significant improvement in maternity care, inequalities persist in access to women's healthcare in the EU Member States, including significant variations in maternity provision (EBCOG, 2014), practice and outcomes (Macfarlane et al., 2016). Increasing the implementation of evidence-based care and reducing variation would lead to improved public health. It is also important to respect women's human rights and respond to research findings on women's satisfaction. Alongside this, developments in maternity care need to be planned in a context of constrained economic and human resources for healthcare (Macfarlane et al., 2016). One important aspect of implementing evidence-based care is extending midwifery care settings, and increasing women's access to them (International Confederation of Midwives, 2011; Renfrew et al., 2014; WHO and UNFPA, 2014; Miller et al., 2016; WHO, 2016).

The Global strategic directions for strengthening nursing and midwifery in the period 2016-2020 (WHO, 2016) stressed that midwives can provide 87% of the essential care for women and newborns, when educated and regulated to international standards, as well as being the most cost-effective healthcare providers for childbearing women. Europe has a large cadre of well-educated midwives, so is well placed to develop further provision in the short and medium term. The Global Strategy for Women's, Children's and Adolescents' Health (Kuruvilla et al., 2016), launched in 2015, set ambitious objectives to enhance women's health in line with the Sustainable Development Goals (SDGs). These were grouped within three themes: 1) Survive (end preventable deaths); 2) Thrive (promote health and well-being); and 3) Transform (expand enabling environments). Midwives are a crucial resource for achieving these objectives.

In February 2018, The World Health Organisation published guidance on the need for more holistic maternity care (WHO, 2018). They asserted that in addition to delivering maternity care that is clinically effective, 'more needs to be done to make women feel safe and comfortable about the experience (of labour and childbirth)' (WHO, 2018). The report found that the medicalisation of childbirth, a phrase used to describe regular use of medical interventions to initiate, accelerate, regulate and monitor pregnancy, may have undermined women's confidence and capability to give birth, and potentially diminished 'what should be a positive, life-changing experience'. They recommended a need to focus on providing respectful care, emotional support, continuity of relationships with carers, encouragement of mobility and other measures to address this problem (WHO, 2018). The White Ribbon Alliance statement on Respectful Maternity Care, which sets out the universal rights of childbearing women, also emphasises the importance of respectful care and women's autonomy (White Ribbon Alliance, 2012). Many of these approaches and principles are central to the values of midwifery unit care.

The International Confederation of Midwives (ICM) has created many valuable global standards, on topics such as midwifery education, capacity assessment and competencies (International Confederation of Midwives, 2013), however to date there have been no specific standards put forward for midwifery units.

WHAT IS A MIDWIFERY UNIT?

In some European countries, including England, Wales and Scotland, maternity units, community units or birth centres managed and staffed by midwives have a long history. Before hospital birth was common, maternity units in community settings were the main form of provision, alongside home birth.

Since the 1970s however, despite the lack of evidence, women in most European countries have been advised to give birth in hospital and many birth centres closed. Following the first review of intrapartum care by the National Institute for Health and Care Excellence (NICE, 2007), a large national cohort study was commissioned in England to address questions of safety and economic costs (Brocklehurst et al., 2011).

This study found that in healthy women with an uncomplicated pregnancy, labour care initiated in midwifery units (both in the community and within hospital settings), with transfer to the obstetric unit as required, was associated with lower levels of intrapartum interventions and maternal morbidity. The outcomes for babies were no different than for those of similar women receiving all of their intrapartum care in an obstetric unit (Brocklehurst et al., 2011).

NICE revised guidance on intrapartum care following the publication of more robust evidence on places of birth (National Institute for Health and Care Excellence, 2014).

The revised guidance emphasises that for both healthy multiparous and nulliparous women who are experiencing straightforward pregnancies, giving birth is generally very safe for both the woman and her baby. NICE recommended that those women should be advised that planning to give birth in a midwifery unit (freestanding or alongside) is 'particularly suitable for them

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, 2014).

Women's experiences of care were also more positive when they were cared for in midwifery unit settings (Overgaard, Fenger-Grøn and Sandall, 2012; Macfarlane et al. 2014a, 2014b). Furthermore, economic evaluation of comparative care pathways for women without pregnancy complications has concluded that midwifery units (both in the community and in hospital) are less expensive and more cost-effective than obstetric unit care (Schroeder et al., 2011).

Scarf et al. (2018) have concluded that provision of midwifery-led settings should be expanded and systems to support change, including staff training and guidance, should be implemented.

Clinical recommendations for the care of women in midwifery units, and the integration of those midwifery units into maternity services (including governance arrangements, transfer policies, and recommendations for assessment and care in labour) are found in NICE clinical guideline CG190 'Intrapartum Care for healthy women and babies', which is therefore a key resource. This is guidance to the NHS in England and, we believe, useful for informing practice in other countries in Europe.

DEFINITION

A midwifery unit (MU) is a location offering maternity care to healthy women with straightforward pregnancies in which midwives take primary professional responsibility for care. Midwifery units may be located away from (Freestanding) or adjacent to (Alongside) an obstetric service.

Alongside midwifery unit (AMU) - during labour and birth, medical diagnostic and treatment services, including obstetric, neonatal and anaesthetic care are available to women in a different part of the same building, or in a separate building on the same site.

This may include access to interventions that can be carried out by midwives, for example electronic fetal heart monitoring. To access such services, women will need to transfer to the obstetric unit, which will normally be by trolley, bed or wheelchair.

Freestanding midwifery unit (FMU) - medical diagnostic and treatment services and interventions are not available in the same building or on the same site. Access is available as part of an integrated service, but transfer will normally involve a journey by ambulance or car.

Modified from: Rowe, R. and the Birthplace in England Collaborative group, 2011

WHAT IS THE PHILOSOPHY OF CARE OF MIDWIFERY UNITS?

Researchers have demonstrated how midwifery units adopt and promote a bio-psycho-social model of care that addresses physical, psychological and social needs, also referred to as a social model of care (Walsh and Newburn, 2002). The model promotes equality between women and their carers, bodily autonomy and informed decision-making (McCourt et al., 2012; Overgaard, Fenger-Grøn and Sandall, 2012; Macfarlane et al., 2014a, 2014b; McCourt et al., 2014). Services are organised around the social needs of women and families, so aim to provide a comfortable, homely atmosphere, rather than a clinical environment, which can seem impersonal, cold and frightening.

Services aspiring to work within this philosophy of care seek to respect and empower women and their birth supporters during pregnancy and birth, as well as facilitating a positive transition to parenthood. In order to deliver this kind of service, it is important to offer an empowering working environment for midwives and maternity support workers to ensure that the team embraces a positive working culture which fosters learning and continuous development (McCourt et al., 2011, 2014; Rocca-Ihenacho, Newburn and Byrom, 2017).

WHY WERE THE STANDARDS DEVELOPED?

The growing evidence of the positive outcomes from midwifery units (MUs), particularly evidence from the Birthplace in England Programme in 2011, has fed interest in developing MUs across Europe. In the UK, the National Institute of Health and Care Excellence (NICE) updated their guidelines, recommending that healthcare professionals offer unbiased information and should advise healthy women with uncomplicated pregnancies that MU care is particularly suitable for them, while supporting them in whatever decision about birth setting they make (National Institute for Health and Care Excellence, 2014).

Similar recommendations and changes in policy are also likely to occur across mainland Europe. With the numbers of MUs growing, the first Midwifery Unit Network European meeting in 2016 raised the need for practical guidance on what midwifery units are, what care they provide and what the characteristics of well-functioning MUs are.

These Standards follow extensive work by the American Association of Birth Centres, which approved the first Standards for Birth Centres in 1985. In the UK, the Royal College of Midwives published the Standards for Birth Centres in England in 2009, which to date has remained the only Standards document published for midwifery units in Europe.

WHO ARE THE STANDARDS FOR?

- Anyone who is setting up, running, or working in a midwifery unit;
- Stakeholders responsible for the organisation of national, regional and local health services and allocating resources;
- Professionals providing support to a midwifery unit, such as ambulance services, obstetric unit clinicians and service managers;
- Providers of midwifery unit care to self-assess their provision against key quality criteria and for planning service improvements.

HOW CAN THE STANDARDS BE USED IN DIFFERENT EUROPEAN COUNTRIES?

The Standards focus on philosophy of care and organisation of services and they are intended to be used alongside clinical guidelines.

In some countries, midwife-led care for healthy pregnancy and birth is more established than others. Some countries do not yet provide midwifery-led care and do not have midwifery units according to the definition used for this document, and some are in the process of implementation. We recognise that although midwifery has been regulated at the European level, there is great diversity in care models and clinical practices between and within countries (Macfarlane et al., 2015). The Standards will enable different services to self-assess their philosophy of care, service organisation and related practices, enabling them to benchmark their provision and to identify objectives and develop implementation plans.

WHAT IF THE CURRENT CULTURE HAS NO CONCEPT OF MIDWIFERY UNITS?

Change in the provision of services often happens slowly. A range of different factors can be the catalyst for change.

It is important to consider local circumstances, opportunities and needs. There is no 'one size fits all' prescription. For example, midwifery units come in different sizes and use different staffing models. In terms of the number of women and families they support, in England the annual number of births varies from <100 up to around 2,000 (Walsh et al., 2018). Despite some MUs still restricting their provision to intrapartum care, others provide a wide range of services with financial contributions from different sources, such as child health, smoking cessation or mental health services. Some units are opened by community-based midwives when a woman is in labour but are closed at other times.

We hope these Standards will stimulate reflection and debate about improving service provision for women and families and developing opportunities for midwifery care. Services may differ from these Standards in ways that make sense within their own context. Not all Standards will be currently achievable or entirely relevant in all countries, but we hope that whatever the current provision, positive changes can be made in relation to the key themes.

WHEN WILL THE STANDARDS BE REVIEWED?

As the available evidence increases, practical experience develops, and policy frameworks and national guidelines evolve, we envisage that there will be a need to revise and update the Standards and to reconsider their scope. We aim to review the Standards in five years, or sooner if significant evidence is published prompting the need for an earlier review. As a reader of these Standards you are invited to send us feedback and contribute insights from your experience of using them.

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THEME 1 – Bio-psycho-social model of care

The midwifery unit (MU) provides care based on the bio-psycho-social model of care (Jordan and Davis-Floyd, 1993; Davis-Floyd, 2001; Bryers and Van Teijlingen, 2010; Renfrew et al., 2014; Miller et al., 2016; WHO, 2016). This model recognises childbirth as a physiological process which has inherent sociocultural and psychological dimensions (Walsh and Newburn, 2002). It reflects evidence that these dimensions cannot easily be separated, and that high-quality maternity care should take account of all of them.

Midwifery units aim to encourage a sense of autonomy in women, active promotion of health and wellbeing, as well as protection from harm. These aims are encompassed by the two key concepts of salutogenesis and safety (Downe, 2010; Renfrew et al., 2014; Kennedy et al., 2018).

STANDARD 1

The midwifery unit has a written and public philosophy of care setting out shared values and beliefs

The MU has a written philosophy of care document which needs to be mutually agreed among stakeholders. This document needs to be in line with the philosophy of care and values of the wider maternity services and includes a commitment towards:

1.1 Facilitating a physiological pregnancy, labour, birth and care of the baby

- a) Supports staff skills and practices that facilitate physiological pregnancy, labour, birth, bonding, neonatal care and transition to parenthood;
- b) States that interventions should be considered and justified in relation to best clinical evidence, on the basis that the potential benefits outweigh the potential harms.

1.2 Offering personalised and supportive care that promotes physical and psychological wellbeing

- a) Recognises childbirth as a key life event and transition for mothers, babies, families and birth companions;
- b) Promotes emotional wellbeing in pregnancy, labour and birth and in the early days of motherhood;
- c) Respects women's human and reproductive rights to dignity, privacy and autonomy;
- d) Welcomes the woman's chosen companions;
- e) Commits to providing a positive start to caring for the baby, including working with Baby Friendly accreditation (UNICEF, 2017);

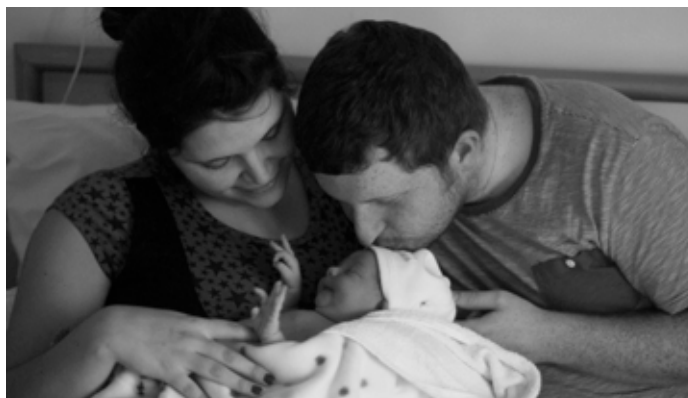


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- f) Endorses effective and prompt escalation and transfer to obstetric care, while still focusing on positive experiences and personalised supportive care;
- g) Acknowledges a clear understanding that caring for staff wellbeing helps to promote caring behaviours.

1.3 Promoting a social model of care

- a) Providing holistic, woman-centred and family-focused care that is responsive to the reality of people's lives and supportive of equal access, equality and cultural diversity;
- b) Offering a wide range of integrated services and activities including, but not limited to, active birth workshops, baby massage groups, breastfeeding groups and new parent support groups. In deciding on such provision, consideration will be given to effective ways in which the MU can promote women's sense of wellbeing and empowerment in preparing for birth. Additionally, freestanding midwifery units (FMUs) may function as a Community Hub and offer an even wider range of services not limited to the provision of maternity and health care;
- c) Welcoming any potential service users, by offering information and support relating to pregnancy, birth and the postnatal period, as well as the opportunity to have a tour of the MU;
- d) Reinforcing an understanding that all care providers in the broader maternity care system would benefit from awareness of and training in a social model of care, recognising their impact on the experiences of women and families and overall quality of care.

THEME 2 – Equality, diversity and social inclusion

Equality, diversity and social inclusion are key indicators of good quality maternity care (WHO, 2017).

When services are proactive in planning ways to reach and engage all women, to ensure that each is able to access the model of care that suits their personal circumstances, this can be very successful in addressing existing inequalities. MUs can provide a salutogenic health promoting environment in which women who are marginalised, discriminated against or in vulnerable situations, and their babies, can thrive (Overgaard, Fenger-Grøn and Sandall, 2012)

STANDARD 2

The midwifery unit has a policy relating to respect, diversity and inclusion

- a) Each MU has an analysis of use by socio-economic status and ethnicity of service users and will assess this against local population analysis and review the extent to which it is serving the diverse population;
- b) Each MU will periodically review the needs profile of its local population, in order to inform and align the services it offers with those needs;
- c) Before, and regularly after, the opening of a MU, managers and MU staff engage the local community and involve community leaders to understand population experiences and needs;
- d) The MU aims to maximise access to care with a specific focus on accessibility for women in vulnerable situations and improving timely and appropriate access to care;
- e) The MU has language and communication support available as required for people who have language and/or communication needs to ensure that they can understand information, be understood by staff and make fully informed decisions about their care, this can include cultural mediation;
- f) The structure of the MU respects minority rights and works in partnership with local networks which support socially disadvantaged families and children.



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THEME 3 – Working across professional and physical boundaries

Evidence suggests that positive interprofessional relationships based on mutual respect and trust are crucial for good clinical outcomes, positive service user experiences and satisfying professional working lives (EBCOG, 2014). Research conducted on MUs has highlighted that often relationships between MU and obstetric unit staff could be more positive; sometimes there is evidence of a ‘them and us’ culture of conflict between the settings (McCourt et al., 2011, 2014; Rocca-Ihenacho, Newburn and Byrom, 2017).

Evidence (Kirkham, 2010; McCourt et al., 2011; Rocca-Ihenacho, Newburn and Byrom, 2017) on MUs highlighted that often struggling MUs present common features, including:

- poor leadership;
- a culture where the obstetric unit is seen as the ‘norm’ and the MU is considered an expensive alternative;
- a lack of interdisciplinary collaboration, as well as challenges in relation to the boundaries between the obstetric unit and the MU.

Geographical boundaries can also influence the way groups of professionals work together and can create obstacles to seamless pathways of care. However, when stakeholders work in a collaborative manner to identify cultural or geographical barriers and prioritise cooperation to facilitate smooth, well-integrated, pathways of care, women and families benefit. This includes facilitating consultations with other professionals for women receiving midwife-led care, and transfer of care to the obstetric unit when this is required.

Maternity services can introduce policy and practices that acknowledge the importance of a positive organisational culture of working across boundaries, co-production and collaboration with all stakeholders (National Institute for Health and Care Excellence, 2014).

STANDARD 3

There is a shared written commitment to mutual respect and cross-boundary working across the whole maternity service

The document includes statements on:

- a) Promoting ownership among maternity staff;
- b) Fostering open and positive multidisciplinary communication within the maternity unit and between all parts of the maternity system;
- c) Holding co-production reviews and planning sessions and celebration events.

STANDARD 4

The midwifery unit has a linked lead midwife, a linked obstetrician and neonatologist

- a) The linked lead from each professional discipline is consulted for key organisational and clinical decisions;
- b) The linked professionals provide support to the MU.

STANDARD 5

There is a clear policy and procedures for transfers

The policy and transfer procedures include:

- a) Agreements with local ambulance services (if FMU);
- b) Operational transfer procedures that promote the integration of services and seamless pathways for women transferring between MUs and obstetric units;
- c) Joint vision and strategic planning across primary and secondary care settings, and between adjoining secondary care services where appropriate.

THEME 4 – Women’s pathways of care

Women’s pathways of care must be planned to be as seamless as possible and aim to engender positive experiences regardless of where the woman gives birth: at home, the FMU, AMU or OU. Evidence suggests that women want to receive reliable, evidence-based information about place of birth and its relevance for their individual situation early in pregnancy, with regular opportunities for respectful woman-centred discussion during the antenatal pathway (Coxon, Sandall and Fulop, 2013). Research also suggests that when care is well coordinated, and staff have a shared philosophy and values, the experience of women and their birth supporters is more positive (Rocca-Ihenacho, Newburn and Byrom, 2017).

A woman’s pathway may include a consultation with a more senior professional to discuss the woman’s specific situation and consider her options. The subsequent plan of care will be developed in partnership with the woman and taking into consideration the evidence-based advice of the clinician. This plan is continuously reviewed and re-discussed during the woman’s maternity care journey.

STANDARD 6

The midwifery unit commits to a philosophy of providing information as early as possible, and keeping decisions open

- a) Evidence-based information about pathways of care and place of birth is available at the commencement of antenatal care and thereafter;
- b) Women and their significant others have equal access to information about MUs and pathways of care regardless of sociocultural and clinical factors;
- c) All members of the multidisciplinary team should provide consistent, unbiased, evidence-based information about place of birth and pathways of care, which is respectful and recognises a woman’s autonomy.

STANDARD 7

The midwifery unit is a hub integrated with the local community

- a) All local women may access the majority of maternity services via the MU, regardless of where they intend to give birth;

- b) For an FMU, community integration could consist of a fully integrated team covering the MU, community and homebirth services and/or integration with caseloading midwives;
- c) For an AMU, community integration might consist of community midwives doing shifts at the MU and/or integration of caseloading midwives accompanying women to the unit in labour;
- d) All women and babies using the MU have access to supportive antenatal and postnatal services including proactive support with physical changes, emotional changes and infant feeding, as well as hearing screening, newborn examination, doctors’ review etc.

STANDARD 8

The midwifery unit pathway is open to all women for personalised and individualised care

- a) Every MU has evidence-based guideline for women’s suitability for midwifery led care (e.g. NICE, 2014; RQIA / GAIN, 2016 or Healy & Gillen, 2017 Guidelines);
- b) Every MU has the possibility to offer each woman a personalised care plan appointment to discuss her wishes, regardless of pregnancy complexities (e.g. birth options clinic);
- c) During such an appointment, the woman can discuss her options with a senior member of staff;
- d) There is a personalised care plan and named professional responsible for each woman and baby’s care.

STANDARD 9

The MU has specific referral pathways

- a) For the indications and the process of transfer to an obstetric unit or neonatal Unit (with a clear statement of acknowledgement of a woman’s autonomy);
- b) For local health and social care;
- c) Specific protocols for multi-disciplinary and inter-agency referrals;
- d) Referrals to primary care, family doctors or general practitioners.

THEME 5 – Staffing and workload

MU services are needed 24 hours a day, seven days a week. This can be offered by the MU being continuously staffed or by having midwives on call. The MU service recognises that spontaneous births are more likely to occur during night time hours than during the day and numbers tend to peak between 1 and 7am (Macfarlane et al., 2018). During pregnancy and postnatally, women often have a continuing and/or urgent need for midwifery care. Strong evidence suggests that continuity of carer models achieve the best outcomes (Sandall et al., 2016) and services should implement continuity of carer in MUs as much as possible, including when transfer to the obstetric unit occurs and during the postnatal period. This may involve having a team of midwives working across the FMU or AMU and homebirth, offering antenatal, intrapartum and postnatal care following the woman's preferences.

It may not be possible or necessary to have a physical unit that is staffed all of the time (24/7), but the principle is to offer care whenever it is needed, staffing the women rather than facilities. MUs offer a unique opportunity to implement continuity of carer and flexibility of midwifery services around women's needs and preferences.

STANDARD 10

Essential staffing includes a core staff team and midwifery leadership on site to promote high standards, a sense of ownership and an appropriate philosophy of care

There is a sufficient number of staff to ensure:

- a) A 24/7 service is available. In some contexts, this may involve midwives who are available to provide care at home or in the unit when required, rather than core staffing 24/7 (e.g. community or caseload midwives);
- b) 1-to-1 care and continuous presence in labour;
- c) Safe care for mother and baby, including a clear MU staffing escalation policy to ensure safe transfer
- d) Midwives providing care in the MU are able to transfer with the woman when she wishes or needs to transfer to obstetric unit care;
- e) Support from a senior midwife is always available (in person, by telephone, or on call);
- f) Midwifery staff who can perform the required examination of the newborn and discharge a well-baby;



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- g) A second midwife is available during the second stage of labour and present at birth;
- h) An appropriate number of maternity support staff as part of the core team to assist midwives.

STANDARD 11

Assessment of workload should include all activities on the midwifery unit, not just the intrapartum care and number of births

Care that the midwifery unit provides may include:

- a) Assessment by a midwife (ideally the named midwife or her team) by phone, at home, or at the MU when it is required by the woman for any need, both in pregnancy and in initial labour;
- b) Discharge from the midwifery unit;
- c) Breastfeeding support, examination of newborn, hearing screening etc.;
- d) Antenatal and postnatal appointments;
- e) Tours of the midwifery unit;
- f) Antenatal and postnatal groups;
- g) Other groups/sessions/community-linked activities which midwives lead and/or participate in.

THEME 6 – Knowledge, skills and training

It is crucial that midwives working in FMUs and AMUs provide safe, competent, evidence-based care which is tailored around the needs of the women as well as their preferences (International Confederation of Midwives, 2013; National Institute for Health and Care Excellence, 2014).

As most midwives' training is still based in obstetric units, it is essential that all midwives are supported in developing the philosophy, knowledge and skills required to care for women in MUs (Rocca-Ihenacho, Newburn and Byrom, 2017; Walker et al., 2018).

Evidence also suggests that the organisational and team culture can strongly influence whether a positive learning environment is fostered (Alderwick et al., 2017). Previous research on MUs suggests that they function well when there is a philosophy of shared learning and sharing of good practice (learning from each other), as well as trusting relationships among the team (McCourt et al., 2011, 2014; Rayment et al., 2015; Rocca-Ihenacho, Newburn and Byrom, 2017).

STANDARD 12

There is a written agreed list of knowledge and skills required of midwives in order to work in a midwifery unit

The midwifery unit has a document in place detailing the knowledge and skills required of midwives including, but not limited to:

- a) Comprehensive understanding of physiology and anatomy in relation to pregnancy, birth and the postnatal period;
- b) Capacity to provide respectful care;
- c) Ability to deal with difficult interpersonal situations;
- d) Communication and supportive techniques for physiological labour and birth;
- e) Understanding and application of evidence-based practice;
- f) Understanding of how to use evidence and guidelines as guides, and not as rules for individual women;
- g) Reflective and reflexive skills;
- h) Fetal assessment, including intermittent auscultation;
- i) Use of water and water birth;
- j) Obstetric emergencies in the MU (including initial care, escalation and transfer);
- k) Maternal (Basic Life Support or BLS) & Neonatal (Neonatal Life Support or NLS) resuscitation;
- l) Drug prescription (where available) and administration;
- m) IV cannulation;
- n) Suturing;
- o) Decision-making skills in relation to initial assessment, ongoing assessment and decisions to recommend transfer to the OU.



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STANDARD 13

The midwifery unit has plans for education and continuing professional development

- a) MU staff have dedicated time for training, team building and team meetings;
- b) Interdisciplinary training days include midwives, obstetricians, maternity support workers, neonatologists, ambulance services and primary care doctors/general practitioners (with some of the study days to be located in the MU);
- c) Training for the whole interdisciplinary team including knowledge and skills on personalised care, women's autonomy, and physiological labour and birth;
- d) All staff are up to date with the most recent evidence and have communication skills to share this information with women;
- e) There are team meetings (at least monthly) to learn from each other and maintain a shared philosophy and vision of the MU;
- f) The organisation supports the achievement of accreditation frameworks, such as UNICEF Baby Friendly;
- g) Training (at least yearly) should include, but is not limited to:
 - how to support physiological birth;
 - communication skills;
 - partnership in decision-making and women's autonomy;
 - assessment of fetal wellbeing and intermittent auscultation;
 - obstetric emergencies in midwifery-led settings and skills for transfer;
 - maternal and neonatal (NLS) resuscitation.

STANDARD 14

The midwifery unit has a framework for preceptorship and orientation

- a) Maximise opportunities for different maternity care professionals and students to be exposed to normality, physiology and midwifery-led care so that the philosophy can be spread across the maternity service, whilst respecting the uniqueness of the moment and privacy of women;
- b) Each maternity care professional has an orientation in the midwifery unit to familiarise them with the environment, equipment and staff;
- c) The welcome pack and/or preceptorship booklet includes specific MU values and skills;
- d) All maternity care professionals and students have an opportunity for placement experience within a MU environment during their education.



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THEME 7 – Environment and facilities

The physical environment plays a key role in determining service users' experiences (McCourt et al., 2016). The midwifery unit environment influences and potentially promotes the health and wellbeing of the women, their families and staff using the facilities (Jenkinson, Josey and Kruske, 2013; Hammond, Homer and Foureur, 2017). It is important to consider the location of the midwifery unit in relation to the obstetric unit, as well as ensuring a salutogenic environment (McCourt et al., 2016) within the unit itself: one that promotes health, the establishment of positive nurturing relationships, the needs of the birthing mother, such as privacy, space to move and a calm atmosphere, and provision for the needs of birthing partners and family members.

Country-specific safety rules and regulation for safety in public infrastructures will be followed by the MU.

STANDARD 15

The midwifery unit offers an environment that promotes a bio-psycho-social model of care and building relationships

- a) The philosophy of the MU should be communicated throughout its physical environment and all of the visual and written images, including pictures of waterbirth, breastfeeding babies, relaxing landscapes, use of colours, fabrics and textures etc.;
- b) The MU includes communal social spaces, such as an area where women can spend time together, service users and staff can use communal kitchen space etc.

STANDARD 16

The midwifery unit offers an environment which supports mobilisation and active birth*

- a) Birth rooms in the MU have space for the woman to mobilise freely during labour and birth, and the bed does not occupy a dominant position in the room;
- b) The room is configured to facilitate movement of furniture and equipment;
- c) Equipment is provided to support active birth: birth mats, bean bags, birthing balls, etc.;
- d) In every birth room, there is a birthing pool and/or a large bath or shower;
- e) Access to external green space is provided if possible, to encourage women to walk about in natural environments during labour.

*Active birth is underpinned by 3 fundamental ideas:

1. The mother is encouraged to use instinctive upright birthing positions;
 2. Natural hormone responses are stimulated during labour;
 3. The woman is empowered to make her own choices about birth.
- (www.activebirthcentre.com, accessed November 2019)

STANDARD 17

The midwifery unit offers an environment that protects and promotes relaxation, privacy and dignity

- a) The birthing room allows for flexibility to regulate lights, filter external daylight, regulate colours and be adjusted to the personal preferences of the labouring woman;
- b) There is an area between the public space and the birthing rooms to protect privacy and ensure a quiet atmosphere. This can be achieved through the architecture of the room or, if necessary, using furniture;
- c) The windows in the birthing rooms and clinical consultation rooms need to allow for privacy, as well as creating a darker environment if needed.

Upper left: © Meadow Birth Centre (credited to Worcestershire Acute Hospitals NHS Trust).

Lower right: © Evelyn Gomes dos Anjos (evelynangelfotografia@gmail.com).





Image © Lucia Rocca-Ihenacho, Midwifery Unit Network
(Barkantine Birth Centre)

STANDARD 18

The physical layout and design of the midwifery unit conveys the bio-psycho-social values of the care model

- a) Consideration is given to the unit's location in relation to other services. MUs should be maintained as separate and independent physical spaces, with a separate entrance door, reception area, consultation rooms and facilities such as kitchen and social space;
- b) The number of birthing rooms required can be calculated on the basis of the estimated yearly number of births (36% of births achievable as per Walsh et al., 2018), considering the full yearly capacity of one room to be between 100 to 150 births (maximum);
- c) A midwifery unit includes:
 - consultation rooms for antenatal and postnatal care;
 - storage spaces e.g. to avoid clinical and other supplies and equipment being left on display and in communal areas;
 - spatial arrangements for disposal of domestic waste and soiled linen;
 - delivery of goods and services;
 - equipment for obstetric emergencies and neonatal resuscitation that is regularly maintained and ideally hidden from sight;
 - furniture that facilitates cleaning and conforms with infection control guidelines specific for the MU;
 - depending on the nature of the services offered, a space for antenatal and postnatal groups and classes (e.g. breastfeeding courses, active birth workshops, antenatal education), baby massage, training etc.

d) The birth room includes:

- a double bed for postnatal rest, which allows partners or companions to stay and be comfortable overnight;
- an en-suite bathroom;
- a birthing pool wherever possible;
- emergency and clinical equipment that is stored away when not needed;
- neonatal resuscitation equipment in the room (not visible) or portable resuscitaires stored outside the room;
- adequate equipment which could facilitate suturing when needed (stored when not in use).

e) Women should be able to be accommodated in the same room for labour, birth and the postnatal stay, if they wish;

f) The MU follows infection control guidelines specific for the MU.

STANDARD 19

The midwifery unit is visible and accessible in the community

- a) The MU is easily visible and accessible to the public, through a clear descriptive name and signage, clear signs to indicate the easiest way to access the unit, car parking facilities for staff and women using the facilities, and links to public transport;
- b) The MU is easily accessible and has the appropriate facilities to facilitate prompt transfer to an obstetric/neonatal unit when needed or in case of emergencies.

THEME 8– Autonomy and accountability

Despite strong evidence suggesting that midwifery-led settings are associated with improved outcomes for healthy women with an uncomplicated pregnancy and their babies, there is still lack of provision and under-utilisation. At national policy level and within health services, midwives in many European countries still struggle to be represented in systems and to have the structures and facilities in place to enable them to practice with professional autonomy (International Confederation of Midwives, 2011).

Maternity services across Europe have not always been constructed and organized around women's needs and right to make informed choices (White Ribbon Alliance, 2012). Midwifery units offer an environment where a woman's autonomy can and should be upheld, alongside midwives' autonomy in supporting women in their choices.

STANDARD 20

The midwifery unit has a policy acknowledging midwives' autonomy and accountability

The MU policy includes:

- a) A clear statement acknowledging midwives' professional scope and autonomy of practice in caring for healthy mothers and babies;
- b) A clear statement regarding midwives' obligation and capacity to provide personalised care;
- c) A support structure for midwives (and the interdisciplinary team) providing advice and care for women who request to give birth in a MU and have some element of complexity;
 - adequate time for midwives and senior midwives to be able to discuss care preferences and options with women;
 - a senior midwife or senior member of staff on call for clinical and professional advice;
 - a system for documentation of discussion with the woman, evidence-informed clinical advice given and her decision in her maternity notes.

STANDARD 21

The midwifery unit has a policy acknowledging women's autonomy

The MU policy:

- a) Avoids a rigid dichotomy of low-risk/high-risk women and promotes personalised assessment and holistic care;
- b) Provides for systems that ensure the support of women who have some element of complexity and still would like to opt for care in the MU;
- c) Includes a clear statement acknowledging and encouraging women's autonomy in decision-making;
- d) Includes arrangements to capture feedback from women and partners, including positive experiences, complaints, accounts of transfers, and personal impact statements and recommendations for when things go wrong.

THEME 9 – Leadership

Strong evidence associates quality, safety and sustainability of maternity care with high-quality leadership (Alderwick et al., 2018). Findings from research on MUs emphasised how well-functioning midwifery units are often characterised by strong, transformational leadership (McCourt et al., 2011, 2014). In the UK, this kind of leadership is often provided by consultant midwives and a recent study of uptake of midwifery units found that services with a consultant midwife in a lead role were also more likely to have good uptake of the unit (Walsh et al., 2018).

Regardless of slight differences displayed by high-performing MUs, qualitative research case studies often describe the following key attributes:

- Leadership focused on setting the right culture and philosophy of care
- Ownership by staff
- Respect of women and midwives' autonomy
- Active promotion of inclusive and positive relationships within the maternity service

In England, the role of the Consultant Midwife aims to include the above attributes to ensure effective transformational leadership for maternity services and midwifery units.

The role of the consultant midwife in the UK

The role of the consultant midwife was established within the UK National Health Service in 2000 following publication of a Health Service circular (1999). The purpose of the role was to help provide better outcomes for women and babies by improving services and quality, to strengthen leadership and to provide a new career opportunity with a view to retaining experienced and expert midwives in practice. The role was to contain four key elements:

- an expert practice function;
- a leadership function;
- an education and development function;
- a research and evaluation function.

They are experienced midwives with higher postgraduate qualifications, expert clinical skills and credibility who provide professional clinical leadership to midwives and other colleagues within the maternity team. A demanding feature of the role is to contribute to policy-making and strategic planning of services and many have set up new services such as birth centres, caseload practice for women with social complexities and personalised care plan appointment. Consultant midwives exercise a higher degree of personal, professional autonomy, making critical judgements and decisions where precedents do not exist. Many focus on strengthening and implementing clinically effective practice while supporting women's informed decisions. Consultant midwife posts require that at least 50% of the time available involves working directly with clients to maintain professional competence and sustain expertise.

Pauline Cooke, Consultant Midwife Imperial College Healthcare NHS Trust

STANDARD 22

There is a visible and consistent leadership within the midwifery unit

- a) There is a continuous presence of a clinical leader responsible for providing support to less experienced staff;
- b) There is a lead midwife at operational level for the midwifery unit. This person is responsible for the:
 - philosophy of the unit, staffing, quality and safety;
 - ensuring provision of equipment and materials;
 - safety, governance and infection control standards;
 - overall smooth running.

This person is visible on the MU, retains involvement in 'everyday' clinical practice, able to support staff through hands on clinic practice, able to share expertise (including plans for out-of-guidelines, on-calls etc).

- c) There is a strategic role responsible for making decisions about resources and policies and acting as an advocate for the midwifery unit. This person can be the same as b) or a different person.

STANDARD 23

The midwifery unit has high-quality transformational leadership

Leaders on all levels should have the following requisites:

- a) Relevant clinical experience of working in MUs;
- b) Ability to articulate a strong vision for the MU;
- c) Willing and demonstrable commitment to the role and sustainability of the MU;
- d) Knowledge – aware of relevant evidence and competencies;
- e) Positive and inclusive leadership style and approachability;
- f) Ability to advocate for the unit and its staff team;
- g) Supportive of women's choice;
- h) Professional approach and an ability to provide role modelling for service staff;

- i) Ability to establish good working relationships between senior staff and between professional groups;
- j) Shared decision-making with the team;
- k) Ability to respond in a timely and clinically appropriate manner to critical incidents.

STANDARD 24

There is a multidisciplinary and service users advisory group, which sets out a vision for the midwifery unit

- a) The advisory group is composed of service users who are representative of the local population, MU staff, other clinicians, ambulance services and commissioners. The aim of this group is to enable community engagement and involvement, facilitate co-production with service providers, and support a culture of accountability to the public;
- b) The advisory group needs to be established while planning the opening of a new MU;
- c) The advisory group meets at least quarterly, to be reported to, and to advise on, place of birth bookings and transfer trends, information provided to expectant parents, marketing, relationships with related services and specialties, staff and unit development, service user feedback etc.

Other activities and outputs may include: an annual report, multidisciplinary clinical reviews to include best practice cases, audit of transfers, yearly showcase day to the local community.

THEME 10 – Clinical Governance

It is important that a strong clinical governance structure supports the MU. There is a need to develop an organisational culture which instils a sense of ownership for staff and inclusion of service users in the continuous improvement of the MU (Ross and Naylor, 2017). A culture of openness at the MU and across the wider maternity services - in which cases are reviewed and causes of any adverse outcomes or poor experiences are identified and reflected on - will encourage learning and facilitate continuous service improvement (Jabbal, 2017).

STANDARD 25

The midwifery unit has evidence-based guidelines, policies and procedures subject to regular review

- a) Guidelines and procedures are co-produced and agreed by a multidisciplinary team, including the obstetric unit, neonatal unit and emergency services;
- b) Transfer guidelines promote the integration of services and pathways for women and their babies transferring between midwifery and obstetric units;
- c) There is an annual review of the operational policy and guidelines;
- d) A staffing escalation policy in the event of workforce shortage is in place, which acknowledges the distinct staffing of the MU. Labour ward has its own on-call system for staffing to avoid 'pulling' midwives from the MU;
- e) There is a written risk-management policy and a system for auditing compliance;
- f) Maternal and neonatal guidelines and MU documents are based on evidence-based guidelines (including using international guidelines where appropriate).

STANDARD 26

The midwifery unit has guidance on eligibility criteria and choice of place of birth

- a) Agreed threshold characteristics that would trigger discussion between the women, the MU staff, and linked obstetric staff to determine the optimal plan of care and the chosen place of birth;
- b) Where there is both a freestanding MU and an alongside MU, the written guidelines state whether there are differences in the threshold characteristics for care in the different units.

STANDARD 27

The midwifery unit demonstrates commitment towards continuous improvement

The MU promotes continuous improvement of the service by:

- a) A monitored complaints procedure for both staff and service users;
- b) Routine collection and monitoring of staff and service user feedback;
- c) Continuous improvement processes drawing on clinical outcomes and the experiences of service users and staff;
- d) Rapid dissemination of learning from incident reviews;
- e) Dedicated professional time for audit;
- f) Continuous audit of number of women booking, births, outcomes and transfers;
- g) Six-monthly presentation of audit to the whole maternity unit.

The MU collects data in line with what is suggested by national programmes with particular regard to improving public health and reducing health inequalities around:

- h) Increasing physiological births;
- i) Reducing unnecessary interventions (e.g. caesarean sections);
- j) Reducing maternal and infant morbidity (including both physical and mental health outcomes);

- k) Improving early access to care;
- l) Increasing breastfeeding;
- m) Smoking cessation, maternal nutrition, substance misuse and alcohol abuse;
- n) Supporting women in vulnerable situations.

STANDARD 28

The midwifery unit has a robust information system

The MU has an information system which is in line with the European regulations on data protection and storage that ensures:

- a) Record keeping and storage of data that is rigorous, contemporaneous and subject to regular audit;
- b) Robust information systems and data collection tools facilitating reporting and auditing of activities and outcomes;
- c) Primary and secondary care providers share the same information system;
- d) Electronic collection of information regarding activities and outcomes of care;
- e) A system to report incidents and demonstrate a transparent investigation and resolution of any incidents;
- f) Electronic records are accessible across geographical boundaries with regular statistics made available to the public.

STANDARD 29

The midwifery unit includes plans for communication and marketing

- a) Promotion and links with the community through:
 - regular staff newsletters reporting on activities, outcomes, incidents, positive stories and celebrating successes;
 - regular public newsletters which include information about the services available on the MU, recent stories and experiences.
- b) Information and education for women through:
 - availability of regular tours;
 - use of social media to promote the MU;
 - antenatal/postnatal education and preparation for birth.
- c) Marketing of the MU through:
 - systems to facilitate word-of-mouth marketing within the community;
 - opportunities for families to learn about the midwifery unit during pregnancy (for example through using the MU as a venue for groups and classes and antenatal appointments).
- d) The MU should have a marketing strategy in place that considers the four stages of decision-making that considers theories of decision-making, such as the AIDA four-stages of decision-making model – Awareness, Interest, Desire and Action (Priyanka, 2013) - to ensure that local women's choices are supported.
- e) Fundraising activities provide opportunities for the MU to raise awareness in the community and involve them in the MU activities, increase ownership of the MU amongst service users and staff, generate income which could be used for different purposes such as events, training, conferences, equipment etc.

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APPENDIX 1 – Methods for the creation of the Midwifery Unit Standards

The development of these Standards has brought together knowledge from two key sources:

A. Published research literature

We carried out a **systematic review** of qualitative literature relating to midwifery units (freestanding and alongside). Publications were included if they were peer-reviewed research or unpublished doctoral theses and included qualitative literature on the organisation, management and experience of midwifery units in high-income countries. This review identified 24 relevant articles, one report and 3 PhD theses.

A **metasynthesis** of the literature was conducted, identifying and coding themes arising in the findings sections of all studies, using NVivo software. This generated a list of 43 themes that each appeared at least once in the dataset (a full account of the review methods and findings will be presented separately).

B. Expert knowledge

1. Delphi surveys

A range of midwifery unit experts were invited to participate in two surveys. A call for expressions of interest was placed on a range of relevant forums and targeted invitations sent to well-known experts and those recommended by relevant professional organisations. Expert status was defined as having experience in developing (consultant midwives, managers etc.), managing (heads of midwifery, team leaders etc.), evaluating (researchers, lecturers etc.) or working clinically (minimum 2 years' experience) in midwifery units. They also included midwives, obstetricians and neonatologists linked to a midwifery unit, and support staff. Some international experts were included to attain their view on the wider international issues. A total of 120 experts were invited to participate in the first survey and 122 in the second survey.

The Delphi survey involved two rounds, conducted online using Qualtrics software.

The initial survey form was based on the RCM Standards (2009), thus utilising the original expert knowledge that underpinned the production of that Standards document. Ninety-eight experts started to complete the first Delphi survey and 64 respondents completed it.

For the second Delphi survey, 64 started the survey and 52 completed it. The overall response rate was 48%.

In each case, participants were asked to score each of the Standards on a Likert-type scale from 1 to 5 (from 'extremely important' to 'not important at all') and to add open text responses or suggested new Standards on any aspects of the document. Standards were then eliminated if 75% or more of participants scored them between 3 and 5 (less important).

Following analysis and synthesis with other data sources (see below), a revised Draft Standards Document provided the format for the second survey round. Sixty-four experts participated in the second Delphi panel questionnaire using the same scale as the first Delphi questionnaire. Again, low-scoring Standards were removed using the same threshold.

2. Stakeholder meetings and focus groups

The Delphi survey was supplemented by three stakeholder group meetings. The first one had 28 attendees and was held in London on the 8th of June 2017. The second was held on the 21st of June 2017 in Toronto, during the ICM Triennial Conference. The stakeholders who attended (around 50 conference delegates) formed working groups to discuss the existing RCM Standards. In December 2017, the Standards were presented and discussed during the third stakeholder meeting in London. This group of experts (18 participants) focused on key issues arising from the revised Standards that had been newly generated by the Delphi survey Round 1 (but had been found to be under-represented in the original RCM Standards). The notes from these discussions were fed into the analysis process and the revised draft.

3. Case study interviews with Birth Centre Beacon Site midwifery leaders

Following the literature review, the first stakeholder engagement event and Delphi survey, three themes remained under-populated: forming links with the community, working across boundaries, and women's autonomy. Three case study interviews were carried out with staff in the Midwifery Unit Network Birth Centre Beacon Sites: high-performing sites with particular expertise in these three areas, in order to obtain more content. This new content was checked and scored for consensus during the second Delphi survey (see analysis section overleaf).

Analysis

The project team brought together:

- The remaining Standards from the RCM 2009 document (following the Delphi survey, round 1 rankings)
- Additional Standards and themes suggested by the Delphi survey in open text comments
- Key themes from the first stakeholder focus group discussions
- The 43 themes generated by the metasynthesis
- Additional content generated by the case study interviews

These data sources were then synthesised using a systematic approach:

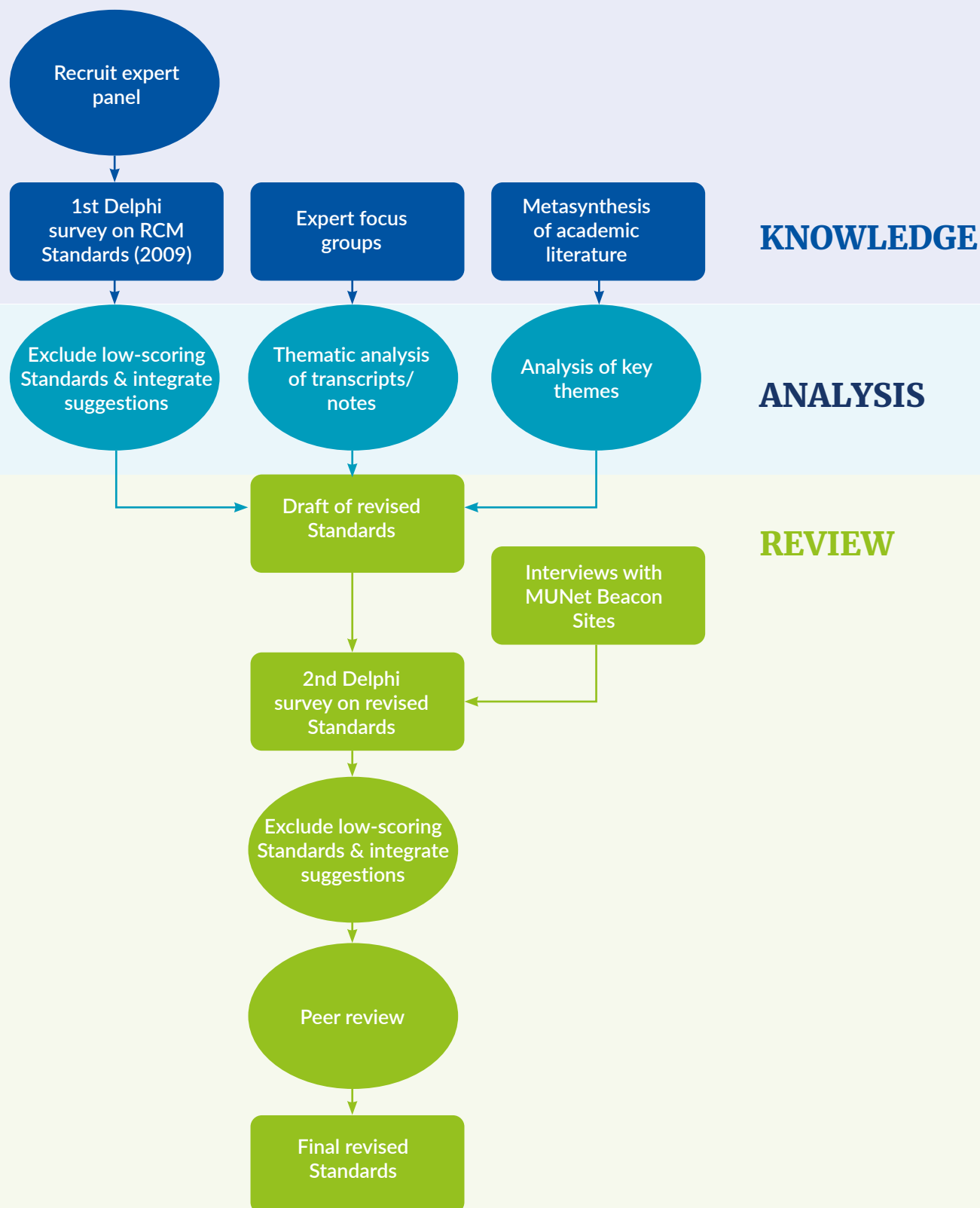
Each item (i.e Standard or theme) was written on a separate piece of paper, duplications were eliminated and codes were then grouped under emerging, overarching categories. The aim was to generate the smallest number of categories that could accommodate all of the codes.

The categories were refined in a subsequent meeting and the final 10 then formed the revised themes for the new Standards. These were then tested in the Delphi survey Round 2, using the ranking process described above.

Peer Review

The final draft of the Standards was peer reviewed by 12 interdisciplinary European expert reviewers (see appendix).

Figure 1- The process of creation of the Midwifery Unit Standards



APPENDIX 2 – Acknowledgements

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Lancashire Teaching Hospitals NHS Trust: Joanne Goss and Emma Ashton

Stakeholder organisations

RCM Royal College of Midwives (UK)

ICM International Confederation of Midwives

FNOPO Federazione Nazionale degli Ordini della Professione Ostetrica (Italy)

FAME Federacion de Asociaciones de Matronas de Espana (Spain)

APODAC Asociace pro Porodní Domy a Centra, (Czech Republic)

Contributors during ICM event

We would like to acknowledge all the participants who attended the Midwifery Unit Standards stakeholder meeting on the 21st of June 2017 at the 31st ICM congress in Toronto.

Expert contribution

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