Report
to the
Chief Executive Officers of the
Health Boards

Domiciliary Births Group

December 2004
Amended version
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## Acknowledgements
Executive Summary

The Chief Executive Officers of the Health Boards recognized the need to address the area of domiciliary births. In January 1997 they established an Expert Group on Domiciliary Births who commissioned three pilot projects throughout the country. The Domiciliary Births Group was established in 2003 to make recommendations arising from the outcomes of the pilot projects. An evaluation of these pilot projects confirmed their feasibility and safety. Where adequately resourced these pilot projects demonstrated high levels of satisfaction for clients and staff.

The guiding principle for the work of the Domiciliary Births Group was to identify safe, acceptable and feasible options of maternity care, which are woman centred, facilitate choice and continuity of care. These options promote partnerships and support professionals involved in care.

At the outset the Group considered it important

- To arrange an external evaluation of the three Pilot Projects and the South Eastern Health Board Integrated Hospital and Community Midwifery Service that was developed in Waterford
- To undertake a literature review
- To hold information sessions in the four project areas
- To consider the statutory framework and indemnity issues
- To examine the role of midwives
- To identify any difficulties and barriers.
Chapter 1. Introduction
The Health Strategy *Quality and Fairness A Health System for You* identified that women want more choice in the type of maternity service they receive and where birth takes place. Action 58 states that a plan to provide responsive, high quality maternity care will be drawn up with the objective of having woman-centred maternity care that is equitable across different parts of the country, accessible to all, safe and accountable.

Over the last century there has been a notable shift in how maternity services are delivered from a predominantly home birth service to a hospital service, with less than 1% of births taking place at home in 2001. The debate about the best setting for birth is influenced by a complexity of social, historical, political, economic, professional and technological factors.

Chapter 2. Summary of External Evaluation
The external evaluation concluded that the aims and objectives of the four home birth projects were achieved. More choice was offered to women and skilled midwifery-led services were provided to low-risk women to facilitate home births or a Domino-type arrangement.

In general, it was found that the projects were well set up and the processes worked effectively where adequately resourced and funded. Individuality and continuity of care were prominent features of the services provided.

Chapter 3. Report of the Information Sessions and Written Submissions
There was a general consensus from the wide range of stakeholders consulted that there is a desire for continuity of care, choice in how care is delivered and options for midwifery-led care and home birth where feasible. Emphasis was placed on the importance of the recruitment and retention of experienced and competent midwives. Workforce planning is essential to provide for different models of midwifery care.
Chapter 4. Literature Review

There is no strong evidence to favour either planned hospital birth or planned home birth for low risk pregnant women where it is possible to establish a home birth service backed up by a modern hospital system in case a transfer proves necessary. The available evidence demonstrates there is a need to change the way maternity care is delivered. The polarisation of the argument on the location of birth is outdated. There is a need to re-orientate maternity services, offering greater choice of care for women with low risk pregnancies and promoting continuity of care.

A lower rate of intervention and increased satisfaction has been associated with continuity of care. There is no evidence to support the need for high levels of monitoring and intervention for all pregnant women and early postnatal discharge is not associated with adverse outcomes.

Chapter 5. The Role of the Midwife

Midwives are key providers of care to pregnant women throughout pregnancy, childbirth and the postnatal period. Midwives provide clinical care and emotional support in both community and acute care settings and should be the lead carers throughout pregnancy and childbirth for low risk pregnancies. Their expertise is in normal pregnancy, childbirth and postnatal care and in making referrals to appropriate medical professionals and others if they detect deviations from normal. Midwives also have a significant role in health education and in supporting the mother and family in the transition to parenthood.

The role of the midwife is integral to models of care which promote normality. The establishment of appropriate models of care will enable midwives to further enhance the development of midwifery.

Specific changes in the provision of maternity services including the setting up of domiciliary services, midwife-led units, and the expansion of community based midwifery-led services are providing midwives with new
opportunities to develop their role within the Irish health services. Midwives must be supported to meet the challenges of these changes, in particular the need to provide responsive, high quality maternity care which is woman centred, equitable across different parts of the country, accessible to all, safe and accountable.

The An Bord Altranais competency framework governs midwifery practice. Clinical governance structures should be established at national, regional and local level to support the development of new models of maternity care.

Chapter 6 Statutory Framework and Indemnity Issues
Currently there appears to be no statutory basis for the provision of domiciliary births. The 1985 Nurses’ Act requires Health Boards to supervise midwives who practise outside health care institutions, however there are no regulations to implement this provision.

A variety of arrangements concerning payment of grants for domiciliary births continue in different Health Board areas. Indemnity for practitioners who wish to be involved in the care of women who opt for a home birth is unclear or non-existent.

Chapter 7. Progress Report
There are inconsistencies throughout the Health Boards with regard to standard information, options available for maternity services and grants for home births.

Chapter 8. Recommendations
The Domiciliary Births Group recommends that women have a greater choice of maternity services. This recommendation is based on evaluation of the projects, the literature review, a review of strategy documents, information sessions and written submissions. More choice can be offered to women by the effective utilisation of midwifery skills.
The Group recommends the establishment of a National Implementation Committee to progress the recommendations of this report under the auspices of the Health Service Executive.

National guidelines should be developed for the selection criteria used by women and their health care providers to determine the appropriate models of care.

Detailed findings and recommendations are in the body of this report.
Chapter 1. Introduction

In February 2003, the Chief Executive Officers Group established the Domiciliary Births Group. The terms of reference for the group were

(a) Prepare an up to date progress report on the implementation of the recommendations from the Expert Group on Domiciliary Births (1997)

(b) To make recommendations on the long-term approach, arising from the outcome of the pilot schemes, and to establish protocols and procedures (as at c in the original terms of reference)

(c) To commission an external evaluation of the three pilot home birth projects

Membership of the Group

- Ms Sheila O’Malley – Chairperson – Director, Nursing and Midwifery Planning and Development Unit, Eastern Regional Health Authority
- Mr Joe Cahill – Assistant Chief Executive, Northern Area Health Board
- Ms Mary Brosnan – Assistant Director of Nursing/Midwifery, National Maternity Hospital, Holles Street, Dublin
- Ms Patricia Hughes – Maternity Services Manager, Cavan General Hospital, North Eastern Health Board
- Dr Michael Mylotte – Consultant Obstetrician/Gynaecologist, University College Hospital, Galway
- Dr BethAnn Roch – Specialist in Public Health Medicine, South Eastern Health Board
- Ms Norah Mansell Quirke – Principal Midwifery Tutor, Southern Health Board
- Ms Mary Cronin – Community Midwife, Southern Health Board

(from 27th April, 2004)
• Ms Irene Walsh – Consumer Representative (from 15th June, 2004)
• Dr Krysia Rybaczuk - Consumer Representative (from 15th June, 2004). Replaced by Ms Pádraicín Ní Mhurchú (from 6th September, 2004)
• Dr Zelie Gaffney – General Practitioner, ICGP representative (from 27th July, 2004)

Secretary to the Group
• Elaine Corrigan - Senior Executive Officer, Eastern Regional Health Authority.

Background
The report of The Maternity and Infant Care Scheme Review Group (the McQuillan report) was published in 1994. The review, the first since 1980, had been initiated by the Department of Health in order to assess the role of the Maternity and Infant Care scheme in the context of maternity services generally and to make recommendations to the Minister of Health as was considered appropriate. The review group considered the location of births in some detail, and the following pertinent points were made:

• The underlying objective of the Maternity and Infant Care Scheme continues to be (a) a safe outcome of a live and healthy mother and baby, and (b) a satisfied and happy family unit.

• The review group fully endorsed the view of the Institute of Obstetricians and Gynaecologists and the Royal College of Gynaecologists that the best place for delivery is where full emergency services are immediately available and accessible.

• Based on submissions to the group, there is a growing demand by women for more freedom and choice with regard to where the delivery takes place.

• The review group recognised that when a decision is made by a woman to give birth in her own home, health service personnel should respect that decision and make provision for the mother and baby.
The review noted that under section 62 of the Health Act, 1970, a woman is entitled to receive free medical, surgical and midwifery services in respect of motherhood. However, at present health boards are generally experiencing difficulties in providing services for home confinements.

In response to these and other issues addressed by the group, the review group recommended that two pilot projects be established and evaluated:

1. **Home environment in a maternity hospital.** Accommodation be set aside at a number of maternity hospitals to facilitate delivery in a homely non-clinical environment where the mother would have freedom to move around and her partner and children would be welcome. While a birth in these circumstances would not be a home birth, such an arrangement may prove desirable for those women who would wish to have a delivery in a homely atmosphere but who would be afraid for whatever reason not to be close to hospital services.

2. **Domino approach.** The Domino (Domiciliary Care In and Out of hospital) approach would allow the midwife and/or the general practitioner to monitor the mother throughout her pregnancy, be with her in hospital and to continue to provide her with care when she returns home. This approach would give mother continuity of care, facilitate a hospital-based birth and provide an early return from hospital. This pilot domino project should be established for a period of two years.

The review group recognised the dilemma that confronts the Department of Health and the Health Boards in cases where women, regardless of policy or professional advice, would insist on having a home birth. In such cases the group recommended that each Health Board put in place arrangements with the local maternity hospital/unit to provide for a midwife to attend such home births. Subsequently, in 1996, the Ombudsman pointed out inconsistencies that had developed between Health Boards in the handling
of the issue of home births, and that this inconsistency resulted in unfair discrimination (Office of the Ombudsman, 1997).

In January 1997, the Chief Executive Officers of the Health Boards established an Expert Group on Domiciliary Births. One of the terms of reference was “to suggest locations for pilot schemes in respect of a hospital outreach service (as recommended by the Review Group on the Maternity and Infant Care Scheme) and Community Midwives Scheme (as favoured by some Health Boards), to draw up protocols for this and assess their outcomes”.

Following submissions to the group, the establishment of three pilot projects was recommended:

A Community Midwifery Service in Cork
- Submitted by the Southern Health Board

A Community Midwifery Service in Galway
- Submitted by the Western Health Board

A Domiciliary Outreach Programme
- Submitted by the National Maternity Hospital, Holles Street, Dublin

These three pilot projects were authorised by the Chief Executive Officers in 1998 for a period of two years. The pilots were subject to ongoing audit and review and there was a commitment that there would be a full evaluation following the completion of the pilot phase. The fourth project, initiated as a service rather than a project, was the South Eastern Health Board’s Integrated Hospital and Community Midwifery Service, offering Domino and home birth options; it commenced in June 2001 and is based at Waterford Regional Hospital. The Domiciliary Births Group was asked to include this service in the final evaluation.

Context
The need for change in how health care is delivered is widely recognised. The Government has demonstrated this in the strategy documents *Quality and Fairness A Health System for You* and *Primary Care A New Direction* (Department of Health and Children, 2001a and b).

The strategy documents are underpinned by four key principles:

- Equity and fairness.
- A people centred services.
- Quality of care.
- Clear accountability.

Four national goals give direction to the strategies:

- Better health for everyone.
- Fair access.
- Responsive and appropriate care delivery.
- High performance.

In line with these strategy documents the Interim Health Service Executive (iHSE) has three principles which underpin the reform programme: better quality services to patients/clients/service users, better working environment for staff and better value for money for the tax payer. The public are well informed and some individuals are choosing alternatives to current service delivery.

During the consultation process for *Quality and Fairness A Health Strategy* for You in 2001, consumers highlighted the importance of continuity of care throughout pregnancy and the need for community midwifery services. *Quality and Fairness* noted that models of maternity care are changing because women request more choice in the type of care offered and location of service. Action 58 in the Health Strategy states “A plan to provide responsive, high quality maternity care will be drawn up”. The objective of the plan will be to ensure that maternity care is woman centred, equitable across different parts of the country, accessible to all, safe and accountable.
According to *Primary Care A New Direction*, primary care is the appropriate setting to meet 90-95 per cent of all health and personal social service needs. The services and resources available within the primary care setting have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier hospital discharge. The Primary Care strategy proposes the introduction of an inter-disciplinary team-based approach to primary care provision. The Primary Care Team will include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. The team must match the needs of the area and the clients in the area. The essential competencies of the team will be identified and the key competencies include nursing and midwifery.

“Primary care needs to become the central focus of the health system. The development of a properly integrated primary care service can lead to better outcomes, better health status and better cost-effectiveness. Primary care should therefore be readily available to all people regardless of who they are, where they live, or what health and social problems they may have. Secondary care is then required for complex and special needs, which cannot be met solely within primary care” [Department of Health and Children, 2001b].

**Childbirth**

Historically, childbirth has been regarded as a natural event unrelated to sickness (Robins, 2000). Over the last 100 years there has been a notable shift in how maternity services are delivered from a predominantly home birth service to a hospital service. In the 1950s 1 in 3 births took place at home but in 2001 less than 1% were born at home.

<table>
<thead>
<tr>
<th>Live births 2001</th>
<th>Birth rate per 1000 population</th>
<th>Domiciliary births</th>
</tr>
</thead>
<tbody>
<tr>
<td>57,854</td>
<td>15.1</td>
<td>313 (0.5%)</td>
</tr>
</tbody>
</table>

Also in the last 50 years the number of infant deaths during the first year of life, in the neonatal and postnatal periods has fallen markedly. Similarly stillbirth and perinatal mortality rates have fallen.

The decline in infant mortality and decreasing maternal mortality have contributed to the increase in life expectancy.
During the last century life expectancy has increased dramatically in Ireland. In the last quarter of the nineteenth century life expectancy at birth for men and women was about 50 years. By comparison, in 2002 life expectancy at birth was 75.1 years for men and 80.3 years for women. Life expectancy at birth has increased consistently for both men and women since 1926.
In Ireland the debate about the best setting for birth is influenced by a complexity of social, historical, political, economic, professional and technological factors. The most important consideration for all professionals and parents is a safe delivery for mother and child.

The North Eastern Health Board (NEHB) commissioned two reviews of its maternity services. The Review Group on Maternity Services in the North Eastern Health Board concluded in 2000 (the Condon Report) while the Report of the Maternity Services Review group was published in 2001 (the Kinder Report).

The Report of the Maternity Services Review Group recommended three different levels of services for the North Eastern Health Board. A level three obstetric unit that would cater for all pregnancy complications in the region. A level two obstetric unit that would cater for pregnancies other than those with major complications. It also recommended that midwifery-led units be established in Cavan and Drogheda with the phased opening of units at Dundalk and Monaghan. The report further stated that these units would permit community midwifery development and give greater opportunity for the option of home births. The North Eastern Health Board commissioned the University of Dublin Trinity College to conduct a study to implement the recommendations regarding the development of midwifery-led services.

Developments in other areas include the establishment of an integrated hospital and community midwifery service in the South Eastern Health Board as a response to an increasing demand for home births, particularly in the Waterford area. While the future level of demand is undetermined the South Eastern Health Board developed a safe, flexible, effective and efficient service to meet the demand, not in isolation but as part of the overall provision of maternity services. A pilot Domino project was set up by the National Maternity Hospital, Holles Street, Dublin. Following a satisfactory evaluation of the pilot project a Domino service is now an integral part of the services provided by the National Maternity Hospital.
In Ireland there is still resistance by some to midwifery-led units and home births. The Department of Health and Children’s policy at the moment is that the safest place for childbirth to take place is in fully staffed obstetric units. The medical model of care has dominated how maternity care has been delivered, Davis (1994) identified that the medical model of maternity care has dominated for over 50 years.

New evidence, particularly from the WHO (1996), advocates evidence based care and the normalisation of childbirth with a move towards midwifery care for “normal births”. In order for the Department of Health and Children, the public, obstetricians and midwives and health care staff in general to have confidence in midwifery care, a change of mindset will be required. In order for the public at large to trust this new shift – a quality, evidence-based approach to care is needed.

The guiding principle for any new service or any new development must be a safe outcome for mother and baby.
Chapter 2. Summary of External Evaluation

The evaluation of the three pilot projects and the SEHB service was undertaken on behalf of the Domiciliary Births Group by Dr Harold Brenner, an independent Public Health Medicine Specialist. Dr Brenner had already evaluated the National Maternity Hospital Domino and Hospital Outreach Home Birth Service Pilot Project and the Southern Health Board Domiciliary Midwifery Pilot Project for Cork City and County (Southern Health Board Home Birth Pilot Project). These reports were incorporated in his final report which was submitted to the Group in November 2003. The other projects evaluated were the Western Health Board Integrated Home Birth Service Pilot Project and the South Eastern Health Board Integrated Hospital and Community Midwifery Service in Waterford.

The report is divided into a general section followed by individual reports on the four projects. The main findings of the report are summarized below and the main issues highlighted.

Objectives and methodology
The objectives of the evaluation were to determine the degree to which the aim and objectives of the projects had been achieved, to examine the main parameters of the outcome of births and associated costs and to assess the viability and safety of the projects. To this end the structure, processes, outcomes and cost of the projects were considered and information was obtained using a variety of methods. These methods included:

- Semi-structured interviews with key personnel
- Examination of protocols and guidelines
- Examination of clinical records
- Reference to ongoing internal audit and interim reports
- Questionnaires to clients
- Examination of the facilities for service provision
- Observation of a number of antenatal clinic visits and postnatal home visits

Outcomes
The projects commenced in January 1999, November 1999 and May 2001 respectively in the NMH, WHB and SHB. In each case post pilot period information is included until October 2003. Data from the SEHB service is for the period June 2001-August 2003.

In total there were 1281 bookings for Domino service and 416 bookings for home delivery. Approximately one third of bookings for both services were from women expecting their first child.

<table>
<thead>
<tr>
<th>Final bookings</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Domino</td>
</tr>
<tr>
<td>Primipara</td>
</tr>
<tr>
<td>Multipara</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

**Maternal outcome**

Overall the proportion of women who required consultant services ranged from 22% to 42% with an average of 33%. These transfer rates are similar to published projects. A greater number of women were transferred in the Domino service (466, 36%) than those intending home birth (98, 24%). Also a greater proportion of primiparous women transferred from both services (259, 55% from Domino and 54, 40% from home birth) than multiparous women (207, 25% from Domino and 44, 16% from home birth).

In the Domino schemes women requiring consultant services remained under the care of the same midwives. Women intending home delivery transferred to the respective Domino service in Dublin, Galway and Waterford. In Cork women referred from the SHB pilot were complete transfers and were not under the care of community midwives until discharged from hospital in the postnatal period.

<table>
<thead>
<tr>
<th>Time of transfer</th>
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<td></td>
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</tbody>
</table>
Most transfers (56%) occurred during the antenatal period with 43% requiring transfer during labour and less than 1% requiring transfer in the postnatal period. Among the transfers were two late fetal deaths and two stillbirths. In addition, there were 19 transfers in Waterford for perineal suturing.

All home births were spontaneous vaginal deliveries. Including women transferred from Domino and home birth, the overall caesarean section and overall forceps/ventouse rates were 7% and 9% respectively with higher rates for primiparous women (14% and 21%) than multiparous women (3% and 2%).

<table>
<thead>
<tr>
<th>Methods of delivery by parity</th>
<th>Spontaneous vaginal delivery</th>
<th>Assisted breech</th>
<th>Caesarean section</th>
<th>Forceps/Ventouse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primipara</td>
<td>392 (65%)</td>
<td>1 (0.2%)</td>
<td>85 (14%)</td>
<td>125 (21%)</td>
<td>603 (100%)</td>
</tr>
<tr>
<td>Multipara</td>
<td>1032 (94%)</td>
<td>3 (0.3%)</td>
<td>33 (3%)</td>
<td>26 (2%)</td>
<td>1094 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>1424 (84%)</td>
<td>4 (0.2%)</td>
<td>118 (7%)</td>
<td>151 (9%)</td>
<td>1697 (100%)</td>
</tr>
</tbody>
</table>

**Fetal outcome**
There were 1,693 live births (1,331 Domino births, 318 home births and 44 standard hospital births after transfer), two stillbirths and two late fetal deaths. There was one early neonatal death at 6 days.

<table>
<thead>
<tr>
<th>Project</th>
<th>Domino</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMH</td>
<td>640</td>
<td>66</td>
</tr>
<tr>
<td>SHB</td>
<td>n/a</td>
<td>207</td>
</tr>
<tr>
<td>WHB</td>
<td>345</td>
<td>34</td>
</tr>
<tr>
<td>SEHB</td>
<td>346</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>1331</td>
<td>318</td>
</tr>
</tbody>
</table>
Sixty two (4%) neonates were admitted to Special Care Baby Units including four (1%) transfers after home delivery.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight</td>
<td>10</td>
</tr>
<tr>
<td>Respiratory distress</td>
<td>9</td>
</tr>
<tr>
<td>Observation</td>
<td>8</td>
</tr>
<tr>
<td>Congenital abnormality</td>
<td>6</td>
</tr>
<tr>
<td>Jaundice</td>
<td>4</td>
</tr>
<tr>
<td>Antibiotic therapy</td>
<td>3</td>
</tr>
<tr>
<td>Hypotonia</td>
<td>3</td>
</tr>
<tr>
<td>Meconium aspiration</td>
<td>3</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>2</td>
</tr>
<tr>
<td>Poor feeder</td>
<td>2</td>
</tr>
<tr>
<td>Low cord pH</td>
<td>2</td>
</tr>
<tr>
<td>Flat baby</td>
<td>1</td>
</tr>
<tr>
<td>Tight cord around neck</td>
<td>1</td>
</tr>
<tr>
<td>Oesophageal reflux</td>
<td>1</td>
</tr>
<tr>
<td>Dehydration</td>
<td>1</td>
</tr>
<tr>
<td>Jittery baby</td>
<td>1</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

**Breast-feeding**
Breast feeding initiation rates in the projects were relatively high compared with rates for standard hospital deliveries.

<table>
<thead>
<tr>
<th>Breast feeding initiation rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Project</strong></td>
</tr>
<tr>
<td>NMH</td>
</tr>
<tr>
<td>SHB</td>
</tr>
<tr>
<td>WHB</td>
</tr>
<tr>
<td>SEHB</td>
</tr>
</tbody>
</table>

**Client satisfaction**

A postal satisfaction survey was undertaken in all four projects. Overall there were 135 responses from 181 questionnaires, a response rate of 75%. They included responses from both Domino and home birth clients; clients who had been transferred were also represented.

The level of satisfaction by mothers with their Domino and home birth experiences in the project was high in relation to antenatal visits, preparation for labour, care during labour, postnatal care and overall satisfaction. Mothers were asked if they would choose to have a Domino or home birth again rather than attending a maternity hospital and 98% responded affirmatively. When asked if they would recommend a Domino or home birth to a family member or friend, 98% of respondents responded affirmatively.

Satisfaction surveys were also carried out by the project teams themselves. In all cases levels of satisfaction were high. Recurring themes were choice of care, personalised care, less time in hospital, continuity of care, support and friendliness.

**Staff satisfaction**

The satisfaction of the 30 participating community midwives in the projects was sought in a short questionnaire. The overall response numbered 25, a response rate of 83%. A large majority of community midwives were very
satisfied with their involvement in the projects. Very few adverse comments were expressed in the surveys.

Staff were satisfied with the up-dating of skills and in-service training they received. All except four respondents indicated that their experience in the projects fulfilled their expectations. Most respondents considered their experience in the projects was more satisfying than their previous midwifery work. All except one of the respondents in the three pilot projects indicated they would consider participating in any future Health Board home birth projects. All the community midwives in the SEHB service wished to continue practising as community midwives.

General comments referred to the desirability of continuing and expanding home birth projects, the desirability of midwifery-led care and the autonomy of midwives, better publicity for the services, the need for wider recruitment of women and suggestions for improvement of services.

**Safety**

The central issue of health and safety was recognised in all projects. Detailed guidelines for care were developed for both Domino and home births in line with best clinical practice. In all projects there were detailed indications for transfer of clients at any stage of the pregnancy from the midwifery-led services to the hospital maternity services, and the mechanism for such transfer was agreed and clear. In all projects there was a built-in audit to monitor standards and outcome.

Only clients in a low risk category were accepted in all four projects and suitability was governed by a clear set of criteria, with exclusion based on specific medical, obstetric/gynaecological and social criteria. The criteria were very similar in all projects and were consistent with best evidence.

Key personnel in the projects considered that there was little or no compromise to the safety of women and children in the Domino programmes; however all recognised that there was a small, if unquantifiable, risk in relation to a home birth situation where an
emergency arises during labour, transfer to hospital is required, and the
distance to the hospital may be long (as may be the case in the SHB
project). There was concern that a newborn in need of emergency specialist
care would be at risk and that a woman and her partner should clearly
understand this risk.

In order to minimise risk, catchment areas were specified in all projects. In
three of the projects the catchment area was delineated by mileage from
hospital or stated as a ‘reasonable distance’ from the hospital, consistent
with a safe transport in case of emergency. In the Southern Health Board
project, clients lived up to 100 miles from the hospital (the average distance
was 26 miles) while the protocol stated that client residence should be
within 40 miles of the midwife’s residence.

The health and safety of community midwives was addressed in the Western
Health Board project. A leaflet was available raising awareness of risk to
themselves and suggesting ways to minimise personal risk.

Dr Brenner discussed the importance of working links with other health
professionals, in particular general practitioners, public health nurses,
hospital midwives and consultant staff.

Most general practitioners in the catchment area of the National Maternity
Hospital participated in the project. In the other projects, few general
practitioners co-participated. Although shared antenatal care was a feature
of the projects, many general practitioners were unwilling to participate in
the projects due to fear of litigation, uncertainty about insurance cover or
the perception that they might be involved with intrapartum care.

In all projects, prior planning ensured full co-operation with the public
health nursing service. Despite an occasional lapse in communication, the
hand over of responsibility for further care of mother and child in the
postnatal period from community midwife to the public health nurses
worked very well.
There was support from consultant obstetricians in three of the projects. However in the Southern Health Board consultant obstetricians were opposed to the involvement of independent midwives and the interface between the consultants and the domiciliary midwifery project personnel was minimal. In the SEHB service, the consultants actively encouraged an integrated midwifery service, indicating a desire that it be expanded to reduce their own level of involvement, especially antenatally, in the care of low risk women.

What worked well:

- Pre-publicity for the projects and ongoing public awareness, except for the WHB project where there was no media publicity
- Recruitment of clients, except in the WHB project where recruitment of clients was slow
- Recruitment of community midwives, except for difficulties in recruiting replacements in the WHB project
- Communication and co-operation with other primary health care services: except for occasional delay contacting the public health nurse
- Communication and co-operation with secondary health care services: the transfer of women to hospital maternity services; the interface with obstetricians (with the exception of the SHB project); the interface with other maternity hospital departments and service
- Well-prepared protocols and guidelines
- Record keeping. Computerised databases, except for the SEHB service in which computerisation started late in the service and was not optimally designed
- Internal audit incorporated in the projects

What did not work well:

- The majority of general practitioners in the catchment areas did not wish to be involved with the project for shared antenatal care, with the exception of the NMH project
• The interface between the project and obstetricians in the SHB project due to opposition to the involvement of independent midwives
• In some Domino cases the discharge home of mother and baby was delayed for non-clinical reasons
• In some instances the time of postnatal transfer of responsibility to the public health nurse did not conform to guidelines

**Protocols for dealing with women who do not meet the inclusion criteria.**
There was no common procedure to deal with the situation where a mother insists on home birth against medical, midwifery or Health Board advice. This situation arose in three of the four projects and was dealt with in different ways.

**Comparison with hospital births**
Comparisons were made between the outcomes of the projects and those of their associated maternity hospitals. Most differences were due to differing policies especially in the management of labour. These differences included reduced intervention rates in the Domino and home birth group. For example, in the NMH the induction rate for Domino/home births was 13% compared with 28% for low risk hospital births and the episiotomy rate was 9% for Domino/home births compared with 29% for hospital births while an intact perineum was noted in 51% Domino/home births compared with 21% hospital births.

**Project development**
After completion of the two-year pilot phase the National Maternity Hospital project continued as a fully integrated part of hospital services.

Several changes occurred:
• In the antenatal period women are no longer routinely seen by a hospital consultant
• Midwifery-led continuity of care is emphasised in advertising the service
• An increased number of general practitioners are participating in shared antenatal care
• Selection criteria have been modified to include some women with minor psychiatric problems, and there is good liaison with the consultant psychiatrist in such cases
• Since the end of the pilot phase there has been a large turnover in the complement of eight community midwives, due to re-location for personal reasons.
• The report on the independent evaluation of the pilot project was launched by the then Minister for Health and Children, Mr. Micheál Martin in March 2003. During his address the Minister acknowledged and endorsed the achievements of the project

Similarly the Southern Health Board Project continues to date pending the recommendations of the National Domiciliary Births Group. It was the only project to contract the home birth maternity services to independent midwives. Following completion of the pilot project, the service was extended to include County Kerry.

The Western Health Board Project continued from the end of the pilot phase in November 2001 until its services ceased in October 2003, no new bookings were taken after March 2003 due to the redirection of funding to meet core obstetric service need. In August 2003, the High Court refused an application by the support group “Parents for Choice” to prevent closure of the project; the group appealed the decision to the Supreme Court.

**Comparative costs**
The costs of the projects were estimated, but attempts to compare with the costs of standard hospital births were difficult, and the relative costs differed in the projects. There are confounding factors, for example the
integrative relationship of the two services in which the community midwives utilise certain hospital resources, the cost of maintaining the hospital infrastructure, the hospital caring for all-risk women, and bed-days saved in the pilot project. Furthermore, it could be argued that the deliveries in the pilot projects could have been absorbed into the hospital activities at little extra marginal cost, apart from the postnatal bed-day costs.

<table>
<thead>
<tr>
<th>Estimated average cost per delivery</th>
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</thead>
<tbody>
<tr>
<td>Project</td>
</tr>
<tr>
<td>NMH Excludes neonatal costs</td>
</tr>
<tr>
<td>SHB Includes start up costs</td>
</tr>
<tr>
<td>WHB Based on pay</td>
</tr>
<tr>
<td>SEHB Pay and non-pay costs</td>
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</table>

Dr Brenner concluded that taking into account the effectiveness of the projects, their cost in monetary terms must be weighed against the gain both to the Health Boards and to the enhancement of women’s’ choice in relation to place of birth, engendered by the services provided.

**Conclusions**

The evaluation concluded that the aims and objectives of the four home birth pilot projects were achieved, more choice was offered to women and skilled midwifery-led services were provided to low risk women to enable them to have their babies at home or in a Domino-type arrangement. In
three of the four projects, the services were limited to women residing within a certain radius of the hospital providing maternity services. The only project which was not continued was in the Western Health Board due to the redirection of funding to meet service need.

In general Dr Brenner concluded that the structures put in place for the projects were well set up and the processes worked well. Individuality and continuity of care were prominent features of the services provided.

Key critical factors were identified which are crucial for success.

- The support of senior management, hospital clinical staff and other primary health care services - less than full support and commitment of any of the key stakeholders will compromise the safety and success of the project.
- Effective structures, addressing issues such as:
  - Recruitment and training of project staff.
  - Recruitment of experienced midwives with appropriate midwifery experience and good management and interpersonal skills.
  - Appointment of a Team Leader/Co-ordinator early in the project.
  - Appropriate further training for midwives, for example participation in the Advanced Life Support in Obstetrics course and in a neonatal resuscitation course.
  - Appointment of a multi-disciplinary steering group to direct, monitor and advise on the project and to review guidelines and protocols on an ongoing basis.
  - Adequacy of physical resources including physical space and equipment.
- Establishment of protocols and guidelines which are clear and unambiguous with regard to
  - Inclusion and exclusion criteria for expectant mothers/families
  - Clinical practice guidelines based on best practice.
- Clear lines of accountability and responsibility
- Explicit focus on safety and risk management

- Establishment of agreed protocols between maternity care and primary care, including the participation of general practitioners and public health nurses, in order to facilitate a smooth interface between the various services.

- Clear dedicated funding for the project to ensure viability.
Chapter 2  Summary of External Evaluation

Findings

- Home birth is a safe option for low risk women where adequately resourced and supported
- Various models of maternity care are successful, where adequately resourced and supported

Recommendations

1. Models of maternity care, which integrate hospital and community services, should be developed and adequately resourced nationally.

2. The National Maternity Hospital Domino and Hospital Outreach Home Birth Service has been established as a service. We recommend
   (i) the continuation and development of the South Eastern Health Board Integrated Hospital and Community Midwifery Service
   (ii) the continuation and development of The Southern Health Board Home Birth Service which has already expanded to include County Kerry
   (iii) the re-establishment and development of The Western Health Board Integrated Home Birth Project with adequate human and financial resources as a priority.

3. New services should have evidence-based guidelines, protocols and standards, which are subject to ongoing audit and review.

4. A steering group involving all relevant stakeholders should be established at local level to provide support for staff and clients and consider applications which do not meet inclusion criteria.
Chapter 3. Report of the Information Sessions and Written Submissions

The Domiciliary Births Group held information sessions for key stakeholders in each project area and Waterford in March 2004. These sessions were designed to provide information on the work to date of the group, to seek feedback on specific areas and to discuss any other concerns. An independent consultant was employed to facilitate the information sessions and to write a report.

As part of the information sessions, separate meetings were held with staff involved in the projects and with some consumer groups, namely Birth Choice Cork and Parents for Choice, Galway. Some participants in the process expressed a wish to make written submissions. In order to facilitate this, the Domiciliary Births Group agreed to receive written submissions up to 24th April 2004. A total of 11 written submissions were received and an analysis of their content is included below.

Information Sessions

The information sessions took the following format:

The Domiciliary Births Group met with staff from the pilot project sites and staff from the Waterford project prior to the main meetings.

The main meeting started with three presentations:

1. *Background and work of the Domiciliary Births Group on Home Births.* Ms. Sheila O’Malley, Director, Nursing and Midwifery Planning and Development Unit, Eastern Regional Health Authority (chair of Domiciliary Births Group)

2. *Literature Review.* Dr. BethAnn Roch, Specialist in Public Health Medicine, South Eastern Health Board (member of Domiciliary Births Group)

After the presentations stakeholders were given the opportunity to ask questions and then break into small groups to discuss key issues. Following their deliberations each sub group was invited to report to the main group. At their request some community midwives and their clients at the Dublin session formed a specific sub group. The process was different in Cork where participants decided not to break into sub groups and instead stayed together to ask questions and make comments directly to the Domiciliary Births Group.

Participants were asked to consider the following questions:

**Question 1.**

Based on the combined evidence of all four evaluations, five critical success factors were outlined in Dr. Brenner’s presentation:

- support from senior Health Board and hospital clinical staff
- thorough project set up
- establishment of protocols and guidelines
- establishment of protocols between maternity hospitals and primary care
- clear dedicated funding

*Are these, in your view, the right critical success factors for projects such as these?*

*Are there other critical success factors which you think should be included?*

**Question 2.**

*How do we maximise the availability of services while minimising the risks?*
Question 3.

Select 3-5 priority issues from your deliberations to feed back to the main group (and for inclusion in the final report).

Outcomes from the Information Meetings

Question 1: Critical success factors

Overall, there was general agreement with these critical success factors. Nuances in emphasis, adjustments and additions are categorised below by critical success factor.

1. Support from senior Health Board and hospital clinical staff

Participants agreed that in the ideal situation projects would receive support and advocacy from senior staff. It was emphasised, however, that lack of support from some consultants should not be cited as a reason to end services.

Participants placed emphasis on:

- removing health politics from the provision of care
- maternity hospitals providing support to community/independent midwives and their clients, with particular reference to hospitals in the Eastern Region
- the need for all stakeholders to develop a shared vision for provision of integrated services and support
- the importance of practical supports such as regular multi-disciplinary meetings
2. **Thorough project set-up**

Participants placed emphasis on the recruitment and retention of experienced, confident and competent midwives. Participants stressed that planning must start now to ensure that Ireland has competent midwives for home births and Domino (Domestic Care In and Out of hospital) births in the future.

Comments on this issue included:

- projects should provide opportunities for the development of staff at all levels, including the development of clinical skills and an education framework
- midwifery training should include experience in community midwifery
- the importance of ensuring that projects had appropriately skilled staff and a team leader
- the need for a formal support structure for community midwifery teams
- the importance of peer review
- the need for an evaluation process.

Participants further emphasised facilities and accommodation, including the need for appropriate, adequate and (often) separate settings for birthing. Some sub-groups emphasised the need for the provision of integrated services and a range of choices for women (e.g. off-site facilities, collaboration between midwives and public health nurses), while others stressed the need for independent services, based on autonomy for community midwives.

3. **Establishment of protocols and guidelines**

In their discussion of protocols and guidelines participants emphasised the following issues:

- the importance of paying attention to the process by which protocols and guidelines are established
- the necessity to involve stakeholders in the process
• guidelines should promote equity and accountability
• guidelines should be evidence-based, with objective appraisal
• guidelines and protocols should be drawn up nationally but should be adaptable to regional/local circumstances
• guidelines should be subjected to ongoing assessment.

Participants recommended that guidelines and/or protocols be developed on:

• communication between maternity carers and primary care personnel (see below)
• integration within acute service
• integration between home birth and other services
• integration between primary and secondary health care specialists.

Participants were divided on the issue of the distance-from-hospital guidelines, with some sub-groups voicing concerns and many others asserting that such guidelines were unhelpful and should not be operated. Some sub-groups also stated that any guidelines on distance should refer to distance from the midwife and not the hospital. The importance for the mother of having a midwife with her if problems occurred was stressed. This issue was linked to the importance of the midwife being able to join the mother in the hospital.

4. Establishment of protocols between maternity care and primary care

Participants expressed the view that these protocols should be all-inclusive, involving:

• hospital midwifery staff
• community/independent midwives
• General Practitioners
• public health nurses
• ambulance staff
• laboratory staff
• clinical risk assessors
- paediatricians
- obstetricians
- anaesthetists
- social workers
- porters

A structured communications framework, a framework for addressing compliance with protocols, a mechanism for feedback and a framework for addressing client dissatisfaction are required.

The following specific guidelines were mentioned:

- timeframes for transfer between the midwifery and PHN services
- the role of General Practitioners is very important because:
  - some are not engaging with the projects
  - their position as first point of contact in providing information on the range of choices to women is vital

5. **Clear dedicated funding**

Participants were in agreement that dedicated funding is a key critical success factor. Many sub-groups prioritised the importance of costing the projects more fully. Some believed that midwifery-led services would offer better value than hospital-based services. Funding sources require clarification, ie acute or community funding.

6. **Additional critical success factors**

Additional critical success factors identified by participants are grouped below as general, service and midwifery issues.

**General**

- Service users and community/independent midwives should be represented on all relevant national and local policy making forums
- critical success factors should take account of all stakeholders – parents, for example are invisible within the critical success factors under discussion at present
- Political support and legislative change are critical
Comparative research on customer satisfaction with the Domino, home birth and hospital experience of birthing is required

The issues should be examined in the context of the future health reforms

More information on the current review, the process, the possible models for service etc would have been useful.

Service

Mainstream, permanent services are required, as projects are seen as short-term

The unclear and confused messages concerning consultants’ support for the projects should be clarified

There should be official recognition of women’s right to choose where and how to give birth, along with legal recognition of the right to choose one’s own midwife

Women’s legal entitlement to free home birth service should be restored. Until then the home birth grant should be paid uniformly by all Health Boards

A single model may not suit all areas and clients may require a combination of services. There is room for more than one model of care

There should be continuity of care and a seamless service

Ongoing audit, review and consumer satisfaction surveys are required

There should be a review of caseload and team numbers in the projects

Domino services should be autonomous, with distinct/dedicated facilities provided in hospitals

A forum for dealing with conflict between service providers should be set up

Risk management issues associated with the whole process should be assessed

All services should be responsive to the needs of women and should take account of ethnicity and cultural diversity
• The independent, autonomous midwifery model is the ideal model for care in community.

**Midwifery issues**

• The balance of power in the review process should be addressed to ensure that midwives and clients have a stronger voice
• Legislative change is required to give prescribing authority to midwives
• Midwifery training, the provision of specialisation and clinical career pathways and the issue of midwifery leadership in birthing services all require attention
• Legal recognition of midwifery as an independent profession is required
• Insurance issues for midwives should be resolved.

**Question 2: Maximising access, minimising risk**

Contributions are divided into:

• service issues
• staffing and midwifery issues
• communication and collaboration issues.

Many sub-groups suggested that similar issues would both maximise access and minimise risk. The categorisation below is therefore somewhat arbitrary.

1. **Maximising access**

This question related to how the pilot initiatives could be extended to the maximum number of women.

**Service issues**

• Secure funding
• Well-planned mainstreamed services - no more pilots
• National guidelines that can be adapted at local level
• Ensure women are offered a real choice and that their opinions are listened to
• Develop a framework with a range of options for women
• A clear policy requiring professionals to indicate the choice available, irrespective of their personal opinion
• Promotion of the services to health board staff
• Educate the public
• Provide service in all areas
• Decide the issue of distance-from-hospital locally
• Provide a dedicated and flexible service
• Assess potential uptake of service
• Ensure there is access to public hospital services for all pregnant women
• Develop criteria for home birthing for low risk women living near hospitals
• Develop “home-from-home” services for women living at a distance
• Extend provision of home birth kits to community/independent midwives.

Staffing and midwifery issues
• Ensure the provision of appropriate staffing levels
• Maximise continuity of care and carer in the case of transfer from community to hospital setting, so that, for example, a midwife can accompany her client
• Renumerate midwives in line with their roles and skills
• Develop and mainstream direct entry into midwifery
• Introduce an apprentice scheme for hospital midwives to shadow community/independent midwives, and introduce experience in community midwifery into all midwifery training
• Re-orientate hospital midwives to community/Domino midwifery
• Provide midwifery-led/run units and birthing centres as part of a national plan for the development of midwifery services
• Develop autonomy for midwives
• Provide continuous professional development (CPD) for midwives
- Give prescribing powers and home birth kits directly to community midwives
- Ensure that obstetricians will accept referrals from midwives
- Set up midwifery networks
- Survey midwives who are leaving the profession
- Provide insurance for midwives
- Introduce the CSFs
- Take account of evidence and models from other countries.

*Communication and collaboration issues*
- Increase the involvement of GPs
- Instigate a communications strategy with health service providers and encourage information sharing
- Find ways to depolarise the positions of the professionals involved
- Include community/independent midwives in the strategy development process.

2. **Minimising risk**

This question sought to identify how, within the context of maximising access, any potential risks could be kept to a minimum. Some participants questioned the assumption of risk at all, arguing that evidence suggests and research shows that the care of experienced midwives is at least as safe as that of obstetricians.

*Service issues*
- Well-informed and educated clients
- Comprehensive assessment of clients
- Adherence to national evidence-based clinical criteria, protocols and guidelines
- Ongoing evaluation and continuous quality improvement
- Ongoing risk assessment
- Development of national standards, including the number of clients per midwife
- Ongoing evaluation, using a nationally-agreed template
- Review distance-from-hospital criteria in the light of expected closure of hospital maternity units
- Learn from national and international best practice
- Integrate Domino with hospital services.

**Staffing and midwifery issues**
- In the case of home births, decrease the distance to the midwife.
- Facilitate community/independent midwives to use hospital services if required
- CPD for midwives
- Establish structure for clinical supervision of community midwives.

**Communication and collaboration issues**
- Good emergency back-up
- Establish protocols for collaboration with ambulance service to ensure safe, timely transfer to hospital if required
- Collaboration with consultants and support from senior staff
- Establish multidisciplinary approach in the community, with real sharing of care, for example with GPs
- Find common link between all relevant service providers
- Increase communication and co-operation between professionals, involving recognition and respect for each other’s roles and the enhancement of trust
- Stress the need for multi-disciplinary involvement in birthing services, including hospital staff, midwives, PHN, community-based personnel, GPs etc
- Collaboration between the professionals involved, including discussions with consultants.

**Question 3: Priorities**
Aggregated feedback on other prioritised issues appears below.
1. The involvement of key stakeholders, particularly consumers and independent/community midwives, in the process of developing models and guidelines and on the Domiciliary Births Group,
singled out by many participants as a particular priority. Other concerns voiced about the process included:

- Issues relating to the evaluation, particularly that some home birth services were not included and that comparisons between models were not made
- Regret that the evaluation report was not available prior to the sessions
  - The need for further clarity about the process
  - A request for further involvement when models are being compared or final recommendations proposed

2. The pilot projects should not be closed down. Women should be offered choices in relation to birth. The choices mentioned spanned the spectrum from hospital births via Domino schemes to home birth with an Independent/Community Midwife.

3. The outcome of the evaluation of the projects makes it clear that the projects deserve and should receive the full support of the Domiciliary Births Group, the Health Boards and senior personnel including consultants. There was a strong request for dialogue in those areas where it is perceived that this support is being withheld. Equally, participants felt that services should not suffer (e.g., through reduction of services such as bloods, scans, etc.) or face closure due to refusal on the part of the consultants to enter dialogue. Participants favoured the development of an evidence-based collaborative approach which did not prohibit the development of services, to involve consultants, hospitals and independent/community midwives.

4. Several of the critical success factors were restated as priorities, including:

- Information, so that prospective clients are aware of their options
- Midwifery training, the provision of specialisation and clinical career pathways and the issue of midwifery leadership in birthing services
- Dedicated resources, to ensure appropriate levels of staffing, facilities, accommodation, training and education
- A seamless service with continuity of care
- Procedures, evidence-based guidelines and role clarity, particularly for the interface between services
- Emphasis on communications and teamwork between all involved
- Ongoing evaluation
- A forum for resolving disputes

5. There was support for a coherent national framework with a range of models of maternity care, to involve a level of integration, common training and an agreed philosophy.

6. In Dublin particularly, there was support for the development of midwifery, including direct entry, peer supervision, prescribing and legislation to enable midwives to assume the role of lead clinician in birthing.

7. Many groups also prioritised legislative change to ensure a woman’s right to a home birth and to enable midwives to take the role of lead clinician, including prescribing powers.

8. The issue of insurance for midwives was also prioritised.
Written submissions

The main themes and recommendations from the written submissions are summarised below. These submissions were received from individuals and organisations listed in Appendix 1.

Choice

- Home births should be an integral part of any modern maternity service. Domino births, home births, birthing centres etc must form part of the maternity services.
- Maternity service providers should be obliged to provide choices for women where possible. While some women will want a home birth service, many women would prefer a domino service with antenatal and postnatal care provided in the community.
- Most women make the choice of where to give birth according to where they feel safe and comfortable. If a woman is relaxed and in control of her environment, her birth is likely to be quicker and less painful.
- The preparation of birth plans, in discussion with the midwife, allows women have greater input into the type of care they receive.
- Women have the right to refuse unnecessary intervention and medical treatment without proper consultation.

Positive aspects of home births

- Fathers can play a central role in a home birth; other children and family members can be involved.
- Home births offer more privacy and seclusion before, during and after birth.
- There is freedom of movement.
- Freedom to choose carers and the place of birth.
- Instances of breastfeeding are higher in home births.

Review of the Domino Scheme

- Overall there were very positive experiences of pregnancy and birth under the Domino/Home Birth Scheme.
The support given by the midwives was invaluable at all stages of the pregnancy, during labour and postnatal periods. Been cared for by the same midwife throughout enabled the establishment of a trusting relationship between mother and midwife.

**Midwifery training**

- All midwives should undertake regular and appropriate training designed to handle emergencies in both hospital and home settings. As Irish educated midwives have little experience of practising outside of an obstetric unit, they may need further education and support in relation to providing care in alternate settings.
- Community midwives should maintain skills by periodic attendance at hospitals and continuing professional education and similarly, hospital midwives should gain experience by working in the community.
- Student midwife placements should include community experiences.
- Good midwifery skills are critical and essential.
- The midwife should be recognised in legal and professional terms as the lead care giver in the provision of midwifery services for women who are deemed to be ‘low risk’ similar to UK policy documents.

**Safety**

- There should be the use of clinical practice guidelines in the selection of women for a home birth.
- Robust clinical governance systems should be in place including good documentation and record keeping and routine collection of audit data.
- Adequate backup and support from the local maternity unit is essential for the success of any new schemes. Women should access the hospital at least once during the pregnancy and appropriate investigations, including ultrasound scans and bloods, should be provided with subsequent referral or transfer to obstetric care if required.
- Services should be provided to meet the needs of women who do not meet the criteria for home birth but decline to attend hospital. Concern
that these women may deliver unattended with great risk to both mother and infant.

**GP and hospital service**

- The responsibility of GPs in relation to home births should be clarified. Some women have perceived that they have been ‘denied’ the option of a home birth by their GP.
- Facilities should be developed within hospitals to provide home-like environments for birth and further options for midwifery-led care. The development of these services may help meet the needs of women who wish for a less interventionist approach to childbirth while providing the back up of obstetric care where this is required.
- Consideration should be given to an *integrated model* for providing a home birth service, which involves the participation of hospital-based midwives and Public Health Nurses who are registered midwives. The participation of Public Health Nurses will ensure continuity of care for the mother, her baby and family throughout their lifespan.

**Geographical considerations**

- The planning, development and delivery of a home birth service, should be based on geographical considerations, such as urban/rural divide, distances for emergency transfer to a maternity unit and travel distances for midwives to attend a home birth.
- Under the Hanly proposals up to 8 maternity units are expected to close; home birth would give women in the affected areas access to local care, eliminating the need to travel long distances in labour, reducing the likelihood of an induced or accelerated labour or a caesarean section.

**Cost**

- It was asserted that hospital births cost over twice as much as home births.
- A high percentage of home birth mothers initially breastfeed their babies compared to mothers who deliver in a hospital. Breastfeeding
saves huge costs in hospital care by protecting babies from routine illnesses that require in-patient treatment.

Consensus Recommendations submitted by the National Birth Alliance, Parents for Choice (Galway): Birth Choice Cork and the Home Birth Association:

These recommendations referred to:

- Immediate representation of home birth/domino parents and independent midwives on the Domiciliary Birth Group.
- Publication of Dr Harold Brenner’s evaluation of the three home birth projects and the SEHB service.
- The SHB scheme to be maintained in the region and extended, as a model of service provision, to other health boards.
- The Domino/Home Birth Scheme to be reintroduced immediately at University College Hospital Galway.
- Women’s right to a home birth service from the State to be restored in the legislation currently being drafted to replace the 1970 Health Act; in the interim, home birth grants to be paid uniformly by all health boards.
- Full maternity hospital/unit facilities to be made available to all home birth mothers, including routine blood testing and ultrasound scanning.
- Full maternity hospital/unit cooperation with independent midwives, including, in cases of hospital transfer, accepting referrals and midwifery notes from independent midwives and permitting them to remain with their clients, continuing to care for them if they so wish, where the birth is normal.
- Full health board cooperation with home birth midwives and their clients, including the supply of home birth kits to independent midwives.
- The tax relief currently granted under the Finance Act 2001 to hospital birth parents (14 days) should be extended to home birth and domino parents.
- Prescribing powers should be extended to midwives.
- The extension of the Maternity Infant Care Scheme, under which community antenatal and postnatal services are provided free of charge by GPs, to midwifery service providers.
Chapter 3. Report of the Information Sessions and Written Submissions

Findings

- Women expressed high levels of satisfaction with the pilot projects
- People want a woman-centred maternity system which offers
  - continuity of care,
  - choice in how care is delivered
  - options for home birth and midwifery-led care.
- Women want to be supported in their choices
- The recruitment and retention of experienced, confident and competent midwives is essential.
- Some women receiving care from self-employed midwives experience difficulty accessing hospital and laboratory services
- Self-employed midwives highlighted current structural difficulties in combining and integrating care

Recommendations

1. Low risk pregnant women should be offered choices in maternity care, including home birth where feasible.
2. Continuity of care should be a feature of all models of maternity care
3. Integrated hospital and community midwifery services should be developed and extended nationally.
4. The clinical governance structure should determine:
   (i) access to hospital and laboratory services
   (ii) access agreements between services and self-employed midwives
5. In the absence of a structured, funded domiciliary service, a standard grant should be paid, which should take cognizance of the presence of a second authorized practitioner
Chapter 4. Literature Review

A literature review was carried out to collate the best scientific evidence and practice guidelines available. This chapter also includes a summary of relevant studies in Ireland and a summary of policy documents and reports from other countries. Of key importance in the consideration of location for birth are the selection criteria used to minimise risk and ensure the safety of mother and infant. Therefore the final section gives a brief summary of the selection criteria used in different countries to determine the appropriate level and location of service.

Different levels of evidence inform health care decisions. Muir Gray (1997) refers to five different levels of evidence ranging from the strongest evidence provided by systematic reviews of multiple randomised controlled trials to opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees. He acknowledges that many healthcare decisions have to be made in the absence of high quality evidence. In this chapter emphasis is given to the strongest available evidence.

A literature search was performed in electronic databases, including the Cochrane Library, PubMed, NHS Centre for Reviews and Dissemination, using defined search terms (see Appendix 2). Relevant systematic reviews in the Cochrane Library are provided by the Cochrane Pregnancy & Child Birth Collaborative Review Group. Individual reviewers may have a personal bias but reviews are multidisciplinary, highly structured and systematic and the evidence from clinical trials is included or excluded on the basis of explicit quality criteria, thus minimising bias. A Cochrane Review by Hatem et al is underway entitled ‘Midwifery-led versus other models of care delivery for childbearing women’ and will be available in 2005.

In addition, the reference lists of articles retrieved were scrutinised to identify any further relevant studies. Only articles and guidelines in English
were obtained. There was no systematic search of the ‘grey literature’ (conferences, theses and unpublished trials).

**The international evidence**

Current best evidence is based on many studies from different countries. However, variations in models of care can lead to difficulties in comparing data and also limit the extent to which findings may be generalised from one country to another. Waldenstrom and Turnbull (1998) comment on the variation in different models of alternative and standard maternity care and the subsequent problems associated with pooling data from different trials. Differences in the complex packages of care and variations in standard care may reflect differences in policies and organisation of maternity services between countries, variation in provider skills and differences in definitions, for example, of fetal monitoring, perinatal mortality and neonatal transfer.

In measuring the successful outcome of childbirth, maternal and perinatal mortality are so low in low risk pregnancies that these outcomes cannot be the primary outcome measures (Olsen and Jewell, 2003). Additional measures for study are rates of interventions, complications and morbidity. When reviewing the best available evidence it is necessary therefore to consider a variety of outcome measures.

**Safety of home births**

In the Cochrane Review ‘Home versus hospital birth’ Olsen and Jewell (2003) assessed the effects of planned home birth compared to hospital birth on the rates of interventions, complications and morbidity as determined in a small randomised trial. They conclude that there is no evidence to discourage planned home birth for selected pregnant women. There is no strong evidence to favour either planned hospital birth or planned home birth for low risk pregnant women where it is possible to establish a home birth service backed up by a modern hospital system in case a transfer proves necessary. The reviewers state that all low risk pregnant women should be offered the possibility of considering a planned home birth.
An earlier meta-analysis of observational studies suggested that planned home birth may be safe and with less interventions than planned hospital birth (Olsen 1997). Included in the meta-analysis are 6 controlled observational studies and the outcomes of 24,092 selected and primarily low risk pregnant women were analysed to measure for morbidity and mortality. The results showed the principal difference was reduced frequency of low Apgar scores and perineal lacerations in the home birth group and fewer medical interventions. The author concludes that home birth is an acceptable alternative to hospital confinement for selected pregnant women. However, the studies varied in terms of eligibility for inclusion, which suggests different assessment of acceptable risk. In some instances home birth midwives were not attached to a maternity unit and outcome definitions varied.

**Continuity of care**

Care during pregnancy, childbirth and the puerperium is often provided by multiple caregivers, many of whom work only in one location, the antenatal clinic, labour ward or postnatal unit. Other models provide continuity of care at all stages by the same caregiver or small group of caregivers. Continuity of care has been associated with a lower rate of interventions and increased satisfaction.

In the Cochrane Review ‘Continuous support for women during childbirth’ (Hodnett et al, 2003) it was found that women who experienced continuous one-to-one support during labour were more likely to give birth without using analgesia or anaesthesia, less likely to have a caesarean or instrumental vaginal birth, and less likely to report dissatisfaction with their childbirth experiences. The authors concluded that this form of care appears to confer important benefits without attendant risks.

Further evidence indicates that the effectiveness of continuous intrapartum support may be enhanced or reduced by policies in the birth setting, type of support provided and timing of onset of support. A major finding in this
review was that the effects of continuous labour support vary by type of provider and was generally more effective when provided by non-staff members (friend, relative or doula) rather than institutional staff. A description is given of the historical attendance of women during labour by other women and of attempts in various countries to re-establish this tradition. Hodnett et al assert that continuous support during labour should be the norm rather than the exception.

Rowley et al (1995) found that continuity of care by a team of midwives was as safe as routine care and resulted in more satisfying birth experience with fewer adverse maternal and infant outcomes. In relation to low risk pregnancy, Villar et al (2003) concluded that antenatal care provided by midwives and general practitioners was associated with clinical effectiveness, similar to that of obstetrician led care, and improved perception by women. Also Waldenstrom and Turnbull (1998) found that continuity of midwifery care was associated with lower intervention rates than standard maternity care and no statistically significant differences were observed in maternal and infant outcomes. However, it was recognised that further research is needed to make definite conclusions about safety for the infant and mother.

In the Cochrane Review of continuity of care during pregnancy, childbirth and the postnatal period, Hodnett (2003a) concluded that while studies of continuity of care show beneficial effects, for example women who had continuity of care with a midwife were less likely to need medication for pain relief during childbirth, it is not clear whether these benefits are due to greater continuity of care or to midwifery care. The review recommends further trials of continuity of care which do not confound continuity of care with the type of caregiver.

Hodnett et al (2003) also note that many labour and birth interventions routinely involve, or increase the likelihood of, co-interventions to monitor, prevent, or treat adverse effects, in a ‘cascade of interventions’. Continuous one-to-one support has the potential to limit this cascade and therefore
have a broad range of different effects in comparison to usual care. For example, if continuous support leads to reduced use of epidural analgesia, it may in turn involve less use of electronic fetal monitoring, intravenous drips, artificial oxytocin, drugs to combat hypotension, bladder catheterisation, vacuum extraction or forceps, episiotomy and less morbidity associated with these, and may increase mobility during labour and spontaneous birth (Caton et al, 2002).

**Continuity and location of care**

In a review of trials which compared a home-like institutional birth environment to conventional hospital care for pregnant women at low risk of obstetric complications, Hodnett (2003b) concluded that there were some benefits from home-like settings for childbirth, but increased support from caregivers may be more important than the setting. Further the review cautioned a need for vigilance in home-like settings for signs of complications. Caregivers and their clients should be alert to the need for detection and prompt action in the event of unforeseen complications. The review concluded that evidence supports the need for changes in caregivers’ behaviour rather than structural changes to labour wards.

*Monitoring and intervention in labour*

Cochrane Reviews have examined the use of amniotomy and electronic fetal monitoring during labour. These reviews concluded that there is no evidence to support high levels of monitoring and intervention for all pregnant women.

Fraser et al (2003) recommend that amniotomy should be used only for labours that are progressing slowly. Routine early amniotomy is associated with both benefits and risks and therefore it is suggested that it should be reserved for women with abnormal labour progress.

Electronic fetal monitoring (EFM) is widely used in clinical practice. In a review of randomised controlled trials addressing the safety and efficacy of continuous electronic fetal heart rate monitoring during labour, the only
significant clinical benefit identified was reduction in neonatal seizures
(Thacker et al, 2003). No significant differences were observed in 1-minute
Apgar scores below four or seven, rate of admissions to neonatal intensive
care units, perinatal deaths or cerebral palsy. It was observed that an
increase in the rate of caesarean section and operative vaginal delivery was
associated with the use of EFM. The review concluded that the benefits
once claimed for EFM are more modest than once believed particularly as
the long term implications of neonatal seizures are less serious than
previously assumed. It is appropriate that the decision to use EFM is made
by the woman and her clinician.

In another Cochrane Review, Neilson (2003) recommends that a technically
satisfactory cardiotocographic (CTG) trace can be obtained by external
ultrasound monitors, which are less invasive than internal scalp electrodes
required for electrocardiographic (ECG) analysis. It is recommended that ST
waveform analysis should be restricted to those fetuses demonstrating
disquieting features on CTG.

The UK NICE Guidelines (2001) recommend that intermittent auscultation
is the appropriate monitoring for an uncomplicated pregnancy in a healthy
woman. Continuous EFM should be offered and recommended where there
is evidence of a baseline less than 110 or greater than 160 BPM, any
decelerations or if any intrapartum risk factors develop. Further it is stated
that current evidence does not support the use of the admission CTG in low
risk pregnancy.

**Early postnatal discharge from hospital for healthy mothers and term
infants**

A review of early discharge (Brown et al, 2003) found no evidence of adverse
outcomes associated with policies of early postnatal discharge but overall
the findings were inconclusive and the importance of midwifery support at
home for the safety and acceptability of early discharge remains unclear. It
was noted that large well-designed trials of early discharge programmes are
needed. The trials should incorporate process evaluation to assess the uptake of co-interventions and use standardised approaches to assess outcome.

**Maternal satisfaction**

Hodnett (2003a) notes that all indicators of maternal satisfaction favoured continuity of care by midwives during pregnancy and childbirth compared with standard care by multiple caregivers. The trials reviewed include hospital births and do not compare home with hospital births. Women were less likely to report dissatisfaction with their childbirth experience when delivered in a home-like setting (Hodnett, 2003b) or if they had continuous intrapartum support (Hodnett et al, 2003).

In a review of patterns of antenatal care it was noted that women appeared slightly more satisfied with midwife/general practitioner managed care compared with obstetrician led shared care (Villar et al, 2003). Elsewhere Goodman et al (2004) found that personal control was a significant predictor of childbirth satisfaction for women and Fleming et al (1988) found that birth satisfaction was higher in home than hospital settings for first time mothers.

**Staff satisfaction**

Hundley et al (1995) found that midwife managed intrapartum care increased continuity of carer and midwife satisfaction compared to a consultant led labour ward. It was observed that midwives caring for women in the midwives’ unit group were significantly more likely to be of a higher grade, more qualified and experienced than those in the labour ward group. Autonomy and continuity of carer were the best predictors of midwife satisfaction.

**Breastfeeding**

There is evidence of an increased chance of successful breastfeeding associated with a midwifery-led model of care. For example, De Koninck et
al (2001) compared midwifery and physician services with regard to humanisation and continuity of care as perceived by the clients. There was a marked difference among women concerning the intent to breastfeed, with 98% of midwifery clients intending to breastfeed compared with 75.9% of physician clients. Following delivery 94.2% of women who received care from midwives started to breastfeed, with 63.8% in the physician group. Of those who had started to breastfeed, 87.5% midwife clients compared with 69.3% physician clients were still breastfeeding a few months after delivery.

Cost-effectiveness/cost benefit
The NHS Centre for Reviews and Dissemination has summarised and commented on several articles concerning the cost effectiveness of births in different settings. The issue of comparability with, and generalisability to, other settings and countries may be a problem in translating findings to local circumstances. However, while models of care may differ the underlying ethos may be applicable. For example, Walker and Stone (1996) comment that in the UK more emphasis has been placed on home birth rather than freestanding birth centres as developed in the US. The birth centre would require capital investment but even so decision makers may be considering the ethos of the birth centre, ie midwife led care in a hospital setting. This type of centre would carry a proportion of the hospital’s overhead but should be cheaper than traditional obstetric wards as it would not need on-site obstetrician and other support. In addition, support would be available nearby if serious complications arose, thereby saving expenditure on transport.

A cost-effectiveness analysis compared midwifery practice in a free-standing birth centre with traditional obstetric practice in a hospital setting during intrapartum care with midwives providing care in both settings (Walker and Stone, 1996). The study population was low risk pregnant women in New York State USA 1986-1992. It was found that birth centres provided more benefit at less cost than the hospital and concluded that birth centres are a cost-effective model of health care delivery for low risk labour and delivery.
care. However, this study was criticised for using a measure of benefit which was not valid and recommendations have been made for further research to investigate birth centre outcomes and identify the real costs of care.

Also in the USA, Anderson and Anderson (1999) assessed the cost-effectiveness of home births compared with hospital and birth centres for low risk mothers with uncomplicated births from 1987 to 1991 in 29 US states. The study included 11,000 intended home births and the findings support previous research which indicates that planned home birth with qualified care providers is a safe alternative for healthy low risk women. It was found that an average uncomplicated vaginal birth costs 68% less in a home setting than in a hospital and that births initiated in the home have lower rates of intrapartum and neonatal mortality and caesarean section.

In Canada, Reinharz et al (2000) assessed the cost effectiveness of birth centre based midwifery services compared with standard hospital based medical services in terms of costs to the Ministry of Health, regional board and patient. Data was gathered for 1000 low risk pregnant women using midwifery services from 1995 to 1996 who were randomly matched with a hospital control group. Midwifery services proved slightly cheaper but there was overlap in some instances and overall the difference was not substantial. Health outcomes were more favourable in the midwifery group with the exception of one indicator, neonatal ventilation. The authors suggest that an increase in collaboration between midwifery services and standard carer could improve the service outcomes and reduce episodes of under or over utilisation of resources.

In Australia a randomised trial was carried out of more than 800 women (Rowley et al, 1995). A comparison was made between continuous care during pregnancy and birth from a team of midwives and routine care from a variety of midwives and doctors. It was concluded that continuity of care by a small team of midwives resulted in a more satisfying birth experience.
at less cost than routine care and fewer adverse maternal and neonatal outcomes.

**Decision to delivery interval**

When an emergency caesarean section is required for fetal distress, the time interval between the decision to operate and the delivery of the baby should be less than 30 minutes (Association of Anaesthetists of Great Britain and Ireland, 1998; NICE, 2004). The NICE (2001) guideline ‘The use of electronic fetal monitoring’ states that in cases of suspected or confirmed acute fetal compromise, delivery should be accomplished as soon as possible, accounting for the severity of the fetal heart rate abnormality and relevant maternal factors.

There is limited research to support the standard of 30 minutes which is an “arbitrary cut-off” (Schauberger et al, 1994; Dunphy et al, 1991). The association between decision to delivery interval and baby and maternal outcomes was examined by Thomas et al (2001, 2004). The studies concluded that poor outcomes are more likely when the decision to delivery interval is longer than 75 minutes. Thus all emergency caesarean deliveries should occur within this time (Thomas et al, 2004).

The benefits to the baby of rapid delivery are difficult to quantify because the most compromised babies are often delivered with the least delay and are more likely to have a poorer outcome (James, 2001). It has also been suggested that rapid delivery may be an additional fetal risk factor because of the association between shorter decision to delivery intervals and lower umbilical arterial pH values (MacKenzie and Cooke, 2001).

There is concern that rapid delivery increases the risk of maternal mortality. The Confidential Enquiries into Maternal Deaths (2001) reported a 16-fold increase in maternal mortality following grade 1 urgency caesarean section compared to situations where there is no compromise but early delivery is needed (i.e. grade 3 urgency caesarean section). This increase in maternal
mortality may be because these women are already compromised and thus predisposed to a poor outcome. However, aspects of surgical or anaesthetic management may contribute, for example the use of general anaesthesia may be more dangerous for the woman than regional anaesthesia.

Preparing a woman for caesarean section is a complicated multidisciplinary task (Tuffnell et al, 2001). The procedures that need to be carried out between the decision to deliver and delivery involve midwives, nurses, doctors (obstetrician, anaesthetist, paediatrician), laboratory, clerical and porter staff.

**Distance**

If complications arise during labour at home it may be necessary for emergency transfer of mother and/or infant to a hospital setting to ensure optimum care. Distance from and difficulty of getting to the nearest hospital may indicate consideration of a birth site other than the family home. In certain geographic areas, weather conditions may influence the safety and speed of transfer to the hospital. In cities traffic congestion may be a major factor.

Many studies refer to the time taken for transfer. Consideration is given to distance from hospital, as well as road and weather conditions, in determining whether a planned birth at home is appropriate. For example, one report indicates that the client should live within a defined service area (e.g. 30 minutes) of a hospital obstetric unit and must make arrangements for emergency transport (Vedam and Kolodji, 1995). But there is no universal standard.

**Summary of the international evidence**

- There is no evidence to support high levels of monitoring and intervention for all pregnant women
- Continuity of care has been associated with a lower rate of interventions and increased satisfaction
• There is no evidence of adverse outcomes associated with policies of early postnatal discharge
• There is no strong evidence to favour either planned hospital birth or planned home birth for low risk pregnant women where it is possible to establish a home birth service backed up by a modern hospital system in case a transfer proves necessary
• Women are less likely to report dissatisfaction with their childbirth experience when delivered in a home-like setting or if they had continuous intrapartum support

Based on the available evidence it can be argued that there is a need to change the paradigm, to move away from the polarisation of argument on location of birth and towards the reorientation and continuity of care during pregnancy to optimise utilisation of resources and expertise and to optimise the spectrum of outcomes of pregnancy.

**Irish studies**

A randomised trial was undertaken in Dublin (1997-2001) to determine the efficacy of admission cardiotocography for low risk women during labour in terms of neonatal and maternal outcome (Impey et al, 2003). It was found that the routine use of cardiotocography for 20 minutes on admission to the delivery ward did not improve neonatal outcome and was not associated with a significant increase in operative delivery.

A study was carried out in the Rotunda Hospital to ascertain the potential level of demand for home births (O’Donovan et al, 2000). Approximately 10% of a sample of women attending the antenatal clinic indicated that they would consider a home birth. However, most of these women expressed concern about accessing emergency services if needed during pregnancy. Also, it was noted that those who favoured home birth had a high complication and intervention rate in a previous pregnancy.
O’Connell and Cronin (2002) reviewed community midwifery practice and documented the outcomes of home births between 1993 and 1997. They obtained data from 11 independent midwives on 585 women who planned home births. Findings showed high rates of spontaneous vaginal delivery and breastfeeding. There were 500 babies born at home with three perinatal deaths, including one undiagnosed breech delivery, one infant with abnormal lungs on post-mortem and one infant with Potter’s Syndrome who was stillborn.

O’Connor (1992) carried out a national study of home births. The study investigated intentional home births in the Republic of Ireland from 1981 to 1985, in terms of who had home births and why, how the births were organised and the outcomes. Childbirth is considered from the mother’s perspective and the issue of personal autonomy is discussed. Further, the study examined existing statutory services for domiciliary births during this period and made recommendations for future policy relevant to home births.

McKenna and Matthews (2003) compared deaths from intrapartum hypoxia of normally formed babies born at home and those born in hospital 1999-2002. They conclude that the risk of dying at home is much higher than in hospital and note the importance of selection criteria and integration of hospital and home birth systems. However this study has been criticised and the findings questioned. MacFarlane (2004) criticises the methodology and the data. Murray (2004) argues that some of the statements in the paper are not supported by the data presented.

In addition professional attitudes have been documented. There is evidence that some professionals want to offer alternative models of care. However, opinion is divided and concerns have been raised regarding the safety of different models.

Begley and Devane (2003a and b) give an overview of the history of midwifery-led care, with particular reference to Ireland. Reference is made
to a study which shows that midwives act as ‘piggy in the middle’ between the pregnant woman and obstetrician (Murphy-Lawless, 1991). The authors assert that women should receive optimum care from the most appropriate person to ensure the best possible outcome for mother and baby. They argue for midwifery care for women for whom the model is suitable.

A report on the attitudes of 100 GPs in NEHB to home deliveries found that the majority were not in favour of home births because of skill deficits and litigation (O’Connell et al, 1998).

**Reports and Policy Documents from other countries**

**A Framework for Maternity Services in Scotland. (Scottish Executive, 2001)**

This report from the Department of Health and Community Care sets out a framework for the provision of maternity services in Scotland. The services should provide a family centred, locally accessible, essentially midwife managed, comprehensive and clinically effective model of safe care, before, during and after childbirth and reflect a multidisciplinary integrated approach. It is asserted that women should be involved and consulted in the decision making process when choosing how and where to give birth. Further, care should be safe, evidence-based and provided within the community setting when appropriate with risks discussed and agreed by all.

When planning the location for childbirth, the Royal College of Obstetricians and Gynaecologists three tiered model approach to care should be considered, ranging from Level 1a (planned home birth) to Level 3 (consultant-led specialist maternity unit). There should be a minimum of two professionals present at a planned home birth. One of them should be trained in maternal and neonatal resuscitation. An individual action plan, agreed with the supervisor of midwives, must be in place for each home birth. It should outline emergency procedures including avenues of professional support and emergency transfer.
The provision of maternity services in Scotland is considered against a diverse geographical backdrop. The Framework acknowledges that a balance must be achieved between:

- The configuration of maternity services provided
- Local access
- Women’s choice and expectation
- Professional availability
- Quality of care and safety

‘Equity and access to acute services in remote and rural areas is difficult. A realistic approach must be taken to provide, as far as is reasonably practicable, a service that is woman and family-centred and takes account of choice, safety and availability of transport in routine and emergency situations.’

Where there is a geographical imperative community maternity units may be considered for low risk women with a normal pregnancy. In particular this may provide a model of care for remote and rural areas offering a local service choice for women in the absence of other options of care, and following discussions with them on risk and contingency plans for referral if required.

The report asserts that integrated, individualised and involved care is most effectively achieved by making sure that continuity of care permeates the service and that there is

- consistency of service provision across NHS Boards
- different professional groups have shared protocols for service delivery
- all professionals involved in services provision share information about each woman with each other and with the woman herself.
Northern Ireland - Community Midwifery Units, Consultation Paper. (Department of Health, Social Services and Public Safety, 2003)

This consultation document describes a “standalone” midwife-led maternity unit. If developed, pilot units in Northern Ireland would be known as Community Midwifery Units (CMU). The units would provide a homely, safe environment, a greater choice of place of birth and improved continuity of care and carer. The key features of CMU are:

- they are run by midwives who have enhanced skills in decision making, dealing with adult and neonatal resuscitation and obstetric emergencies
- they offer care to ‘low risk’ women
- robust selection and risk assessment criteria are used to assess a woman’s suitability for care in the CMU
- when required specialist advice is obtained from an associated consultant obstetric/neonatal unit
- communication and interaction with GPs will be maintained in the interests of continuity of care
- if complications arise, there are clearly defined criteria for transfer from midwife-led care to consultant care during the antenatal period, during labour and postnatal period
- there is no access to doctors on the site of the unit
- there is no epidural anaesthesia service, but other methods of pain relief are available.


This document recognises that, for the majority of women, pregnancy and childbirth are normal life events requiring minimal medical intervention. These women may choose midwifery-led care, including a home birth. Where appropriate, home births should be offered within a risk management framework and with adequate local infrastructure and support. Care should be provided within a framework that enables easy
and early transfer of women and babies who unexpectedly require specialist care. The outcomes of all types of care should be regularly audited.

For optimum health and well-being women require easy access to services, choice and control regarding the care they receive and continuity of support during their pregnancy, childbirth and the post-natal period. What women want when they are giving birth are

- confidence in staff providing care during the birthing process
- one-to-one care from a named midwife throughout labour and birth, preferably whom they have got to know and trust throughout pregnancy
- personalised care, and to be treated with kindness, support and respect
- a pleasant and safe birth environment
- adequate information and explanations about their choices for childbirth, including pain relief and hospital practices
- access to medical help if complications arise

Also it is noted that women living in disadvantaged or minority groups and communities are less likely to access services early or maintain contact throughout their pregnancies. The standard seeks to improve equity of access to maternity services, which will increase survival rates and life chances of children from disadvantaged backgrounds, and to ensure that all mothers and babies receive high quality clinical services.

*Maternity Services: Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000* *(New Zealand Ministry of Health, 2002)*

This document makes provision for maternity services in New Zealand. Maternity care is provided by a Lead Maternity Carer (LMC) throughout pregnancy. A LMC may be a midwife (self-employed or hospital based), a GP, or an obstetrician and is selected by women to provide their lead maternity care at home or in hospital. This care is free and available to all
women throughout New Zealand. The LMC is available 24 hours a day, 7 days a week to provide phone advice to the woman and attendance if required. The LMC must take into account the limits of his/her own competency and exercise the use of referral guidelines if required. In addition, the LMC must have an access agreement with any maternity facility that he/she wishes to utilise.

During labour and birth the LMC is responsible for ensuring that the following services are provided:

- all primary care from the time of labour including initial assessment of the woman at her home or at a maternity facility and regular monitoring of the progress of the woman and baby
- management of the birth
- all primary care until two hours after delivery of the placenta.

For a home birth, in addition to the above points, the LMC must:

- arrange for a second authorised practitioner to be available to attend the birth
- maintain equipment (including neonatal resuscitation equipment), provide the delivery pack and consumable supplies.

**Obstetrical Manual: Final Report of the Obstetric Working Group of the National Health Insurance Board of the Netherlands** (National Health Insurance Board of the Netherlands, 2000)

Obstetric care in the Netherlands is based on the principle of risk selection and the co-operation between primary and secondary level obstetric caregivers. Low risk pregnant women receive primary level obstetric care provided by (independent) midwives or GPs and may choose to give birth at home or in hospital with their primary care provider. Women with a high-risk obstetric profile receive secondary level care, provided by obstetricians, and deliver in hospital. If obstetric problems occur during pregnancy or birth, the primary level caregiver can consult with the secondary level caregiver and refer when appropriate. The secondary level care provider can
also refer the woman back to primary care at any time if the condition which prompted referral is no longer a risk factor. Collaboration between midwives, GPs and gynaecologists is promoted in order to optimise individualised patient care. This can be achieved by making agreements about the provision of individualised care, about the organisation of obstetric care and about the quality of the care provided.

**Canada - Standards of Practice Policy for Second Birth Attendants.** *(College of Midwives of British Columbia, 1998)*

In British Columbia it is required that two people trained and currently certified in CPR and neonatal resuscitation attend each home birth and it is stated that the ideal assistant to the principal midwife at a birth would be another midwife. But it is noted that the second attendant will depend on many factors, for example geographic area, the availability of appropriate professionals in that area, and the midwife’s and woman’s preferences. Ideally, the second birth attendant will be known to the woman. Where a midwife works with a second attendant, the midwife is responsible for primary care throughout. Sole attendance with a woman in labour is not considered an appropriate responsibility for the second birth attendant who is not a registered midwife or licensed physician.

**Selection criteria**

Selection criteria for home birth vary by country, region, and provider type. In general, the screening process includes the evaluation of medical, obstetric, nutritional, environmental, and psychosocial factors, as well as evaluation of the midwife-client relationship *(Vedam and Kolodji, 1995).* The general consensus is that selection criteria and protocols for care need to be established, ideally by a multidisciplinary group representing all those engaged in the provision of care, in order to promote safe outcomes for the mother and baby *(Zander and Chamberlain, 1999).* Clinical judgement, standards of practice, the evidence to date, and professional ethics will influence the decision about the safe place of birth.
Ireland
Currently there are no national guidelines on selection criteria for domiciliary or domino births in Ireland. Inclusion and exclusion criteria used in the pilot home birth projects were based on best available evidence and agreed by the respective steering committees. See Appendix 3 for an example of guidelines used for domino and home births by the service based in the North Eastern Health Board.

United Kingdom
‘The Confidential Enquiries into Maternal Deaths in the UK’ (CEMD, 2001) stressed the importance of risk and needs assessment at booking and the importance of identification and management of risk throughout pregnancy. Selection criteria and standards should be in accordance with the Royal College of Midwives, which provides guidance for eligibility and exclusion criteria, antenatal referral for consultant advice or transfer, and criteria for consultation or transfer during labour. ‘The Confidential Enquiry into Stillbirths and Deaths in Infancy ‘(CESDI, 1998), also published criteria for assessment of low obstetric risk when booking a home birth. Many trusts have developed criteria for decision making about the suitable place of birth (RCM, 2002). However, Campbell (1999) described the selection criteria at booking in 27 NHS Trusts as poorly focused and recommended a systematic review.

‘A Framework for Maternity Services in Scotland’ (Scottish Executive, 2001) sets out the necessary action to ensure maternity services are appropriate to the needs of people and geography. Guidance is given for the management of maternity care and exclusion criteria are specified for all levels of care. Decisions should be made on an individual patient basis depending on geography, existing services, manpower and morbidity (Scottish Executive, 2002). NHS Trusts are required to develop local guidelines for investigations during pregnancy and specify criteria for identifying women who require specialist advice and referral.
Netherlands
In the Netherlands, national guidelines specify criteria for site selection and need for specialised obstetric care (Vedam, 2003). Planned home births occur with access to consultation and referral and a transfer plan for each birth. The Obstetrical Manual (National Health Insurance Board, 2000) lists the indications which form a decision making tool for obstetric care providers in risk selection. The list includes pre-existing disorders (gynaecological and non-gynaecological), obstetric medical history, disorders developed during pregnancy, birth or the puerperium. Also, an explanation is provided about the obstetric policy related to specific indications, referral policy and the most suitable care provider.

Canada – British Columbia
Since 1998, midwives have provided a full range of antepartum, intrapartum, postpartum and newborn care for women whose pregnancies are considered to be at sufficiently low risk to fall within the scope of midwifery practice (Janssen et al, 2002). The choice to deliver at home or in hospital is made by the client and her midwife, based on standards of practice established by the College of Midwives of British Columbia (CMBC, 1997). The CMBC expects members to use their professional judgement in making decisions to consult or transfer care.

United States
In the United States there are no universal guidelines for midwives, physicians, and hospitals regarding home birth practice (ACNM, 2003). Midwives must devise their own screening guidelines (Vedam and Kolodji, 1995). The client must be “low risk” with an excellent prognosis for a normal, healthy pregnancy, delivery, and postpartum course. Screening is an ongoing process during pregnancy, labour and the postpartum period.

New Zealand
The Lead Maternity Carer (LMC) is responsible for care provided throughout pregnancy, labour, birth and the postpartum period, in accordance with the
Referral Guidelines outlined in Section 88 of the New Zealand Public Health and Disability Act 2000. The LMC must conduct a comprehensive pregnancy assessment of the woman including a physical examination, an assessment of her general health, family and obstetric history. During pregnancy and labour the LMC will monitor progress of the woman and baby including early detection and management of any problems. Where a consultation occurs with a Specialist, any decision regarding ongoing clinical roles and responsibilities will involve a three way process between the Specialist, the LMC and the woman concerned.

**Australia**

The ‘National Midwifery Guidelines for Consultation and Referral’ were developed by the Australian College of Midwives (2004). These guidelines provide specific indications for discussion, consultation and/or transfer of care in response to maternal and infant conditions or abnormalities identified at booking, during pregnancy, labour, birth and post-partum. When an abnormality or complication arises, it is recommended that the primary level maternity care provider, i.e. the midwife, discusses the issue with another midwife, or consults with a medical practitioner or transfers responsibility to a medical specialist. At all times the woman concerned should be informed, consulted and involved in the decision making process.
Chapter 4. Literature review

Findings

• Home birth is a safe option for low risk women. There is no strong evidence to favour either planned hospital birth or planned home birth where it is possible to establish a home birth service backed up by a modern hospital system in case a transfer proves necessary.

• Continuity of care has been associated with a lower rate of interventions and increased satisfaction.

• Evidence does not support high levels of monitoring and intervention for all pregnant women

• Early postnatal discharge is not associated with adverse outcomes

• In New Zealand, British Columbia and Scotland it is a recommendation/requirement that a second authorised practitioner attend a planned home birth

• In Australia, New Zealand and the Netherlands there are national guidelines for selection and transfer criteria

Recommendations

1. There should be national guidelines for the selection criteria used by women and their healthcare providers to determine the appropriate model of care

2. Midwifery-led units should be established by all maternity hospitals

3. A second authorised practitioner (*normally a midwife*) should be in attendance for a planned home birth where feasible.* Both authorised practitioners must be trained in maternal and neonatal resuscitation.

4. In order to ensure continuity of care, the governance structure should determine access agreements between services and self-employed midwives.

*It is not intended that a general practitioner is the second authorised practitioner
Chapter 5. The Role of the Midwife

Irish maternity services are undergoing a period of unprecedented change in response to increasing consumer awareness and in recognition of the need to extend the range of options of care available to women.

Midwives are key providers of care to pregnant women throughout pregnancy, childbirth and the postnatal period. Midwives provide clinical care and emotional support in both community and acute care settings and are usually the lead professional throughout pregnancy and childbirth for low risk pregnancies. Their expertise is in normal pregnancy, childbirth and postnatal care and in making referrals to appropriate medical professionals and others if they detect deviations from the normal. They also have a significant role in health education and in supporting the mother and family in the transition to parenthood (Scottish Executive, 2001).

Studies have shown that women want confidence in staff providing care during the birthing process, to receive personalised care, to be treated with kindness, support and respect and to have access to medical help if complications arise. (Department of Education and Skills and Department of Health, 2004).

The role of the midwife is integral to models of care which promote normality. Maternity service providers can enhance midwifery skills and autonomous practice by providing appropriate practice settings. (Royal College of Midwives, 2004). The scope of midwifery practice in Ireland is the range of roles, functions, responsibilities and activities which a registered midwife is educated, competent and has authority to perform. (An Bord Altranais, 2000a).
**Definition of a Midwife**

“A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She\(^1\) must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child-care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service”. (WHO/ICM/FIGO, 1992)

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**A Philosophy of Midwifery**

An Bord Altranais (2001) has defined the following philosophy for midwifery as:

1. *Childbirth is viewed as part of the life cycle, a normal healthy event.*

2. *The focus of midwifery practice is pregnant women and their families and delivering women-centred maternity services.*

3. *Midwifery care is delivered in a manner that respects the uniqueness and dignity of each person, regardless of culture and religion.*

4. *The concept of partnership between the woman and the midwife is fundamental to midwifery practice. It is based on mutual trust, support and collaboration, which facilitates informed choice and decision-making and the empowerment of both the woman and the midwife.*

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\(^{1}\) The female gender is referred to in this definition of a midwife; it should be interpreted as referring to either gender.
5. Decisions about an individual midwife’s scope of practice should always be made with the woman’s and her family’s best interest foremost and in the interest of promoting and maintaining best quality maternity services for women and their families.

6. Midwifery practice is based on the best available evidence.

7. Midwifery practice involves advocacy for the individual woman and her family.

8. Midwifery practice should always be based on principles of professional conduct as outlined in the latest version of The Code of Professional Conduct for each Nurse and Midwife and the Guidelines for Midwives produced by An Bord Altranais.”

Actuities of a Midwife
The activities of a midwife are stated in the European Directive 80/155/CE Article 4 (Council of European Communities, 1980). The European Directive states:

“Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

- To provide sound family planning information and advice
- To diagnose pregnancies and monitor normal pregnancies, to carry out examinations necessary for the monitoring of the development of normal pregnancies
- To prescribe or advise on the examinations necessary for earliest possible diagnosis of pregnancies at risk
- To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
- To care for and assist the mother during labour and to monitor the condition of the foetus in utero by the appropriate clinical and technical means
- To conduct spontaneous deliveries including, where required, an episiotomy, and in urgent cases, a breech delivery
• To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measure in the doctor’s absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus

• To examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation

• To care for and monitor progress of the mother in the post-natal period

• And to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant

• To carry out the treatment prescribed by a doctor

• To maintain all necessary records”.

The third edition of Guidelines for Midwives was published by An Bord Altranais in September 2001 and states the following aims:

“(i) To inform registered midwives of the legislation that governs or informs their practice and to make them aware of the responsibilities and accountabilities that accrue to them as a result of that legislation.

(ii) To provide guidance to registered midwives and assist their decision making so that the care they provide is based on the best available evidence and has regard for both the safety of mother and baby and the provision of a satisfactory childbirth experience for women. “

The absence of statutory prescribing powers for midwives poses challenges in clinical practice. This area is currently being examined by An Bord Altranais in an ongoing project entitled ‘Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products Project’. The principal objective of this project is to examine the potential future role of nurses and midwives in the prescribing of medications.
Models of Maternity Care – the Irish Context

Medical Model

Currently the most usual model of care in Ireland is the medical-led model. In this model, obstetricians are the lead care providers for antenatal care for all pregnant women attending maternity units. The obstetrician has primary responsibility for the care provided during pregnancy and childbirth, but midwives usually assist the mother in normal childbirth and refer to the obstetric team if complications arise and intervention is required.

Shared Models of Care

Many women opt for shared antenatal care, where responsibility for the pregnancy is shared between professionals including obstetricians, general practitioners and midwives. This model facilitates women who wish to attend their GP or midwives clinic. The ultimate responsibility for decisions regarding care remains with the obstetrician.

Midwifery-Led Care

Midwifery-led care describes services where the midwife is the lead professional in the planning, organisation and control of the care given to a mother from initial booking to the postpartum period. The midwives work in partnership with the mother and the obstetric team, referring to the obstetrician if complications arise. Some schemes are organised to provide antenatal and postnatal care to a selected group of mothers by a team of midwives, with the hospital-based midwives providing care in the intra-partum period.

An example of midwifery-led care, the DOMINO model, has been introduced in a small number of hospitals to provide comprehensive care throughout the pregnancy from booking to postnatal discharge to a designated group of mothers. The DOMINO describes domiciliary care in and out of hospital which allows the midwife and/or the general practitioner to monitor the mother throughout her pregnancy, be with her in hospital and to continue to provide her with care when she returns home.
The first midwifery-led units (MLU) have been established by the North Eastern Health Board. The development of these units offers an alternative model of care to low risk women. Midwives provide care to pregnant women throughout pregnancy, childbirth and the postnatal period. The antenatal component of care is usually shared by midwives and GPs. The mother is cared for during labour in a self contained midwifery-led unit adjacent to, but independent of, the obstetric unit. The midwifery-led units have been designed to provide a home-like setting which are also equipped for emergency situations.

These services in the NEHB have been established within the context of a randomised control trial termed the MidU Study, the results of which will provide evidence to support the organisation and provision of maternity services in the future.

**Domiciliary Births**

A small number of women choose a planned home birth. Some may use one of the services provided by Health Boards or employ a midwife privately. Currently there are a small number of self-employed midwives practising in the Republic of Ireland. The domiciliary birth service offered by self employed midwives is a private arrangement between the midwife and the woman, except in the case of the Southern Health Board where the midwives have a contractual agreement to provide services in counties Cork and Kerry.

Self-employed midwives currently have particular needs and concerns. These include the need the to access laboratory, ultrasonography and pharmacy services and other provisions such as birth packs.

**Structures to support midwifery-led services**

The international literature suggests that a framework is required to support the implementation of midwifery-led services in order to ensure the
quality and safety of services. This framework includes clinical governance, quality, risk management, clinical guidelines and rotation systems.

**Clinical Governance**

Accountability is one of the fundamental principles of recently published strategy documents from the Department of Health and Children. In line with the duty of accountability all professions must continuously monitor their performance and the midwifery profession is no exception. Each profession needs a framework to demonstrate its accountability to the public. Midwifery is a regulated profession under the 1985 Nurses Act and systems of approval of education programmes, guidelines for practice and control of registration exist.

Scally and Donaldson (1998) define clinical governance as a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical governance enables midwifery staff at all levels to influence improvements in practice, leading to an improved experience for clients. Midwives do not work in isolation and clinical governance demands true partnerships between all professional groups, between managers, clinical staff and clients.

Halligan (Royal College of Nursing, 2003) suggests that the development of robust and sustainable clinical governance frameworks, ensures systems through which health service organisations are accountable for continuously improving the quality of service provision and safeguarding high standards of care by creating an environment in which excellence in clinical practice will flourish. Clinical governance places quality firmly on the agenda thus embracing the core concepts of the Health Strategy (2001) and aims to integrate all activities that impact on client care.
Clinical governance

- Requires a client focus at all times.
- Must focus on improving the quality of client care.
- Should apply to all health care, wherever delivered.
- Demands true partnerships between professionals and clients
- Requires that midwives have a key role in its implementation.
- Requires a safe, open and enabling culture, which celebrates success and learns from mistakes.
- Needs to be defined and communicated clearly so that all staff understand its relevance to their work.
- Requires that each individual practitioner is responsible and accountable for the quality of the care (s)he provides
- Does not replace individual clinical judgement or professional self-regulation; clinical governance complements these and provides a framework in which they can operate.

(Adapted from Royal College of Nursing, 2003)

Quality

The development of a quality culture throughout the healthcare system ensures the provision of high-quality, integrated health-care at national, regional and local level. This involves an inter-disciplinary approach and continuous evaluation of the system using techniques such as clinical audit.

Risk Management

Risk management in health care is still relatively new in Ireland. It is a methodology and philosophy used to identify, analyse and treat risk so that the impact of a risk and/or the probability of its recurrence is eliminated or significantly reduced. Risk management involves a specific process which includes risk identification, analysis, treatment and evaluation. All health professionals must have a clear understanding of the concept of risk assessment and management to improve the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents.
**Clinical Guidelines**

The development of evidence-based clinical guidelines, which are subject to regular audit and review, is essential. The development of these guidelines should involve all key stakeholders and be supported by a programme of audit and training. A learning culture must be fostered in all settings where midwifery care is practised and an appraisal system developed.

**Rotation System**

Midwifery-led services provide opportunities for midwives to learn and enhance their skills in supporting women through normal birth. The opportunity for midwives in these services to maintain expertise in emergency care is limited because more complicated births are referred to consultant-led services. To enable staff to maintain competence in emergency care, a policy of rotation for midwives in all maternity services should be considered. This would allow midwives experience delivering babies in different environments. A policy of rotation for midwives was recommended in the report of an independent enquiry following adverse incidents in a UK Birth Centre (Garland et al, 2004).

**A guide for midwives in daily practice**

The Australian College of Midwives (2004) has developed a decision diagram for use by midwives in daily practice. This guide could be adapted for use in different models of maternity services.
A guide for midwives in daily practice

**Booking**

Initial Assessment

Uncomplicated history
Care provided by midwife

Complicated history
Consult Guidelines
Decide A, B or C

**Pregnancy**

Ongoing assessment

Uncomplicated
Care provided by Midwife

Complicated
Consult Guidelines
Decide A, B or C

**Labour and birth**

Ongoing assessment

Uncomplicated
Care provided by midwife

Complicated
Consult Guidelines
Decide A, B or C

**Postnatal time**

Ongoing assessment

Uncomplicated
Care provided by midwife

Complicated
Consult Guidelines
Decide A, B or C

A Discuss with midwife/medical practitioner and care provided by midwife

B Consultation with medical practitioner and care continues with midwife or is transferred to medical practitioner

C Transfer care to medical practitioner

Source: Australian College of Midwives, 2004

**When there is any doubt, consultation is recommended**
Educational Framework

Midwifery education in Ireland is undergoing a period of change. These changes were influenced by a number of factors including the movement of pre-registration nursing education into third level institutions. Since 1995 Schools of Midwifery have been establishing links with third level institutions. Currently all Schools of Midwifery offer a two year post registration midwifery education programme for registered nurses. The Commission on Nursing recommended a pilot direct entry midwifery programme which commenced in June 2000 and was completed in May 2003. Following evaluation and review, this programme will be developed and it is planned to offer a four-year degree programme from 2005. Post registration education programmes will also be provided for registered nurses who wish to undertake midwifery registration programmes.

Specific changes in the provision of maternity services including the setting up of midwife-led units, and the expansion of community based midwifery-led services are providing midwives with new opportunities to develop their role within the Irish health services. Midwives must be educated to meet the challenges of these changes, in particular the need to provide responsive, high quality maternity care which is woman centred, equitable across different parts of the country, accessible to all, safe and accountable (Department of Health and Children, 2001a).

Until the 1960s the maternity hospitals provided a home birth service but this was increasingly marginalized and in most cases the service ceased completely. Responsibility for home births moved from the maternity services to community care. In addition, until the early 1970s community midwifery and home birth was part of the syllabus of training for midwifery registration but the lack of home births nationally meant that experience in community midwifery became increasingly difficult to obtain. Therefore attendance and participation at a home birth ceased to be a requirement for midwifery registration.
To assist midwives in developing competencies for practice in a variety of settings it is proposed that:

- Midwives who opt to work in the community should be supported to identify their education and training needs
- A programme of education should be provided to assist with skills and competency development
- A period of clinical experience in a community setting should be undertaken. Midwives who have prior experience in this area could provide support.

The suggested indicative content for educational programmes should include:

- Community midwifery and professional regulation
- Antenatal care in the community
- Preparing women for birth at home
- Care for women in labour and giving birth at home
- Pain relief in labour
- Positions for labour and birth
- Equipment and documentation
- Postnatal community care
- Community midwife working in hospital
- Quality Assurance
- Risk Management
- Accountability
- Autonomous Practice
- Clinical and theoretical skills development in the following areas:
  - Advanced Life Support in Obstetrics (ALSO)
  - Neonatal Resuscitation Programme (NRP)
  - Cardio Pulmonary Resuscitation (CPR)
  - Intravenous cannulation
  - Performance of episiotomy and perineal suturing
Future Pre-Registration Programmes

- Future programmes should prepare midwives to function with equal level of competency within community and hospital settings
- Placement within community services should be an integral part of future pre-registration programmes

Midwifery is a practice discipline and the integration of theory and practice is essential. Midwifery education must not end at registration and must be seen as a continuum. As with all professions there is a need for continual professional development for all registered midwives. Continued competence is essential for all midwives and The Scope of Nursing and Midwifery Practice Framework (An Bord Altranais, 2000a) and The Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000b) emphasise the need for midwives to be competent and accountable for their practice.

Competence is the ability of the registered midwife to practice safely and effectively fulfilling his/her professional responsibility within his/her scope of practice (An Bord Altranais, 2000).

An Bord Altranais has developed a framework for assessing competencies for midwifery practice. This framework will be used to support the education programmes and will help to ensure that midwives are competent and accountable practitioners in all settings. The third edition of Guidelines for Midwives (An Bord Altranais, 2001) helps inform registered midwives of the legislation that governs and informs their practice and provides guidance to ensure that the care they provide is based on the best available evidence and has regard for the safety of mother and baby.
Chapter 5  The Role of the Midwife

Findings

- Midwives are key providers of care to pregnant women throughout pregnancy, childbirth and the postnatal period. They should be the lead carers for low risk pregnancies
- The provision of choice will enhance the development of midwifery
- An Bord Altranais’ competency framework governs midwifery practice
- Clinical governance ensures accountability and safeguards high standards of care

Recommendations

1. Midwives must provide evidence of continuing professional development and must be supported to gain experience in the community setting
2. Workforce planning is essential to provide for different models of midwifery care.
3. A programme of continuing professional development that includes peer review, reflective groups and audit of records should be developed for all midwives.
4. Networks where best practice can be developed and shared should be supported.
5. In the interest of quality assurance, a clinical governance structure should exist at national, regional and local level.
Chapter 6. Statutory Framework and Indemnity Issues

The legal basis for the provision of maternity and infant care by Health Boards is Section 62 (1) of the 1970 Health Act which states that “A Health Board shall make available without charge medical, surgical and midwifery services for attendance to the health, in respect of motherhood” of eligible women.

Section 62 (2) provides entitlement for a woman to choose a medical practitioner (G.P.) for the provision of services, (the service commonly known as ‘combined care’) and Section 62 (3) provides that, “when a woman avails herself ....for a confinement taking place otherwise than in a hospital or maternity home, the Health Board shall provide, without charge, obstetrical requisites to such an extent as may be specified by regulations made by the Minister. Subsequent Regulations (Health Service Regulations 1971, S.I. 105/1971) set out in Article 9, in detail, the obstetrical requisites to be provided in accordance with Section 62 (3).

Section 57 of the 1985 Nurses Act provides for the general supervision of independent midwives (i.e. those not directly employed by the Board or its agents) by Health Boards in whose areas they are operating subject to “regulations made by the Minister for Health”. However no such regulations have been issued to date, and Health Boards are therefore in an ambiguous position vis-à-vis such midwives, having no regulatory context in which to carry out their supervisory function. New legislation which is pending in regard to nursing and midwifery may address this deficit.

There is no other legislation directly addressing the issue of domiciliary births, and, since 1970, Health Boards have responded to the demand for these services on an ad hoc basis, the response varying, as previous reports have shown, from one Health Board area to another, or even, at times, between Community Care Districts. These service responses were largely
dictated by considerations such as legal advice, available resources (both human and financial) and the perceived level of demand for the service.

After 1988, when a Supreme Court Judgement in relation to the payment of grants for home births (Spruyt V Southern Health Board) interpreted Section 62 (1) as giving a statutory right to eligible women to avail of a Home Birth Service, most Health Boards responded and continued to provide financial assistance to women, of varying amounts, to employ midwives on a private basis.

Following an intervention by the Ombudsman's office, in 1996, in relation to inequity arising from inconsistencies of approach between Health Boards, a short-term arrangement was introduced, with the sanction of the Department of Health, providing for an ex-gratia payment, equivalent to two-thirds of the midwife's fee, up to a prescribed ceiling (then £400) to be refunded to women who opted for a home delivery. The Ombudsman's intervention and the Department of Health's approval were based on an assumption that Health Boards had a statutory obligation to provide home birth services, in accordance with the 1988 Supreme Court Judgement.

From 1996 onwards, a degree of uniformity was maintained by Health Boards in regard to payment of the “home birth grant”, although, where circumstances dictated, some Health Boards varied their approach, either by paying an amount greater than the agreed “ceiling” amount, or by providing direct services for individual home births.

As the fees payable to independent midwives increased, there were increased demands placed on Health Boards to pay the full fee and associated costs, and a number of legal actions were instigated by individuals seeking to have this approach enforced through the courts. An example of such litigation in 2001 was J.T. V East Coast Area Health Board. In this case, the plaintiff had been refused grant assistance for a home birth, as it was considered that she lived at too great a distance from a
maternity unit, and would therefore be at risk in the event of an emergency arising in the course of labour. The plaintiff (unsuccessfully) sought an order that;

- The Health Board was in breach of its statutory duty in refusing to pay reasonable costs to engage the services of an experienced and qualified midwife, contravening section 62 of the Health Act 1970.
- A mandatory order to pay the plaintiff the costs of obtaining such services
- Damages for breach of duty

In the course of conducting the various litigations, legal advice was received by Area Health Boards in the Eastern Region which indicated that payment of “home birth grants” without prior risk assessment, created vicarious liability on the part of the Boards in the event of a poor outcome arising from such a home birth. Boards in the Eastern Region were advised by their law agents to suspend the payment of such grants in the absence of a system of medical assessment of women as to their suitability to have a home birth. Typically, this legal advice indicated that Health Boards, on receiving an application for assistance with the cost of a home birth, should arrange an assessment of that person’s suitability for a home birth. This assessment should take into account both medical circumstances and issues such as the distance of the applicant’s dwelling from a fully staffed maternity unit, and the physical suitability of the dwelling for a home birth. Issues such as social supports available to the mother were also to form part of the assessment.

The question of assessing applicants threw up a number of practical difficulties for Health Boards. Public Health Nurses and General Practitioners have been reluctant to become involved in the issue for professional reasons. Insurance cover for General Practitioners involved in the care of women who opt for a home birth appears non-existent. Some clients, and their midwives, have also expressed reluctance to have an ‘external’ evaluation of their decision to have a home birth, and it has
become clear that the process of assessment would have to be an ongoing matter during the confinement rather than a “one-off” evaluation. Nonetheless, some Health Boards have commenced to carry out some form of assessment on applicants for ‘home birth grants’, and in some cases, are refusing such grants on the basis of factors such as the distance of the applicant’s dwelling place from fully staffed maternity unit.

While Health Boards were considering this issue, a further High Court decision subsequently confirmed by a Supreme Court decision in November 2003, declared that there was no statutory obligation on Health Boards to provide a domiciliary birth service. As the Domiciliary Births Group had already commenced its deliberations, they were asked to advise on the immediate response to this development. Their advice was to maintain the status quo pending issue of their report. In practice, as some Health Boards had suspended the “grant” scheme on the basis of legal advice, this meant that different arrangements again pertain in different Health Board areas, some paying grants based on prior assessment, some paying without assessment, some paying no grant and others opting for direct service provision. An analysis of the practice/arrangements pertaining in each Health Board relating to the payment of “Home Births Grant” was undertaken by the Northern Area Health Board (see Appendix 4).

**Summary of Legal and Indemnity Issues**

While it is obviously outside the powers of the CEOs to alter legislation, a number of issues will continue to cause difficulties in the area of home birth until public policy is clarified through legislation and regulation;

- Public policy in relation to support for home births needs to be clarified, and stated in legislation. Currently, where Health Boards do provide home birth services, it is on the basis of ‘providing choice’ rather than in carrying out clearly enunciated public policy
- Legal liability in relation to litigation arising from home births needs to be clarified for the protection and reassurance of GPs, Public
Health Nurses, Midwives, Consultant Obstetricians and other health workers and service providers

- The legal obligations of Health Boards in respect of supervision of ‘independent midwives’ practicing in their functional areas need to be stated explicitly, whether through regulations under the 1985 Nurses Act or in new legislation governing Nursing and Midwifery practice.

- The continuation of the ‘Grant’ system of support, to women who opt for a home birth and employ a midwife directly, should be critically assessed, and liability and indemnity issues arising from its use should be clarified and addressed if it is to be continued.

- The insurance cover for General Practitioners involved in the care of women who opt for home birth appears non existent.
Chapter 6 – Statutory Framework and Indemnity Issues

Findings

- The statutory obligation for the provision of domiciliary births remains uncertain with further legal considerations pending.
- The 1985 Nurses’ Act requires Health Boards to supervise midwives who practice outside health care institutions. There are no regulations to implement this provision.
- Varying arrangements concerning payment of grants for domiciliary births continue.
- Insurance cover for general practitioners involved in the care of women who opt for a home birth appears non existent.

Recommendations

1. Sections 62 (1), (2) and (3) of the 1970 Health Act and the subsequent regulations should be reviewed to reflect changes in maternity care delivery and particularly the development of midwifery-led services.
2. The new Nurses and Midwives Act currently being drafted should reflect the diversity of midwifery settings and be underpinned by the competency framework developed by An Bord Altranais.
3. The grant system should be critically assessed and liability and indemnity issues clarified.
4. The ambiguity in relation to insurance cover for all practitioners involved in domiciliary care (including general practitioners) must be addressed to support shared care.
5. Legislation should be enacted in the longer term to facilitate the provision of midwifery-led services as achieved in New Zealand.
Chapter 7. Progress Report

The first term of reference for the Domiciliary Birth Group was:

- Prepare an up to date progress report on the implementation of the recommendations from the Expert Group on Domiciliary Births (1997)

The Group set out to identify the current procedures and policies that were adopted by each Health Board following recommendations from the Expert Group in 1997. The recommendations were

1. Procedures and protocols for existing services should be standardized and should include advice on initial contact, advice to expectant mothers, support for expectant mothers, list of midwives and a named officer in each Health Board. A template was sent out to all Health Boards. The findings are summarized below.
2. The suggested pilot schemes and locations as recommended in the report should be approved and funded.
3. There should be standardisation of fee arrangements and any increase in fees should be implemented on a consistent basis across all Health Boards. A local project team should be set up in each area.
4. Ongoing review and evaluation of each project should be carried out. A national group to oversee this evaluation should also be established.

Findings
1. Eight out of the ten Health Boards have standard written procedures/protocols in place to deal with applications for home births. In eight Health Boards the applicant is supplied with the name and contact details of the Director of Public Health Nursing. However, only in four Health Board areas measures taken to ensure that the applicant is met by a Public Health Nurse to discuss options and facilitate an informed decision.
   • Detailed information on maternity services is available in eight Health Board areas.
• In seven Health Board areas mothers who indicate a preference for home delivery are advised regarding services for antenatal and postnatal care.
• Five Health Boards request the name and background of the midwife contracted to provide home birth services.
• Six Health Boards facilitate consultation between the midwife and the Director of Public Health Nursing.
• Four Health Boards areas advise of the contribution available towards the cost of a home birth
• Nine Health Boards provide a list of registered midwives who practice domiciliary midwifery in the area.
• Three Health Boards provide refresher/continual professional development courses for registered midwives as required in conjunction with local maternity hospital.
• Six Health Boards have a named officer who is responsible for domiciliary midwifery service.

2. The three pilot schemes were approved for funding by the Department of Health and Children.

3. Fees for home birth service vary (see Appendix 4). There is no consistency. Local projects teams were established to oversee the projects.

4. The projects were evaluated.
Chapter 8. Recommendations

The Domiciliary Births Group recommends that women have a greater choice of maternity services. This recommendation is based on evaluation of the projects, the literature review, a review of strategy documents, information sessions and written submissions. More choice can be offered to women by the effective utilisation of midwifery skills.

The Group recommends the establishment of a National Implementation Committee to progress the recommendations of this report under the auspices of the Health Service Executive.

National guidelines should be developed for the selection criteria used by women and their health care providers to determine the appropriate models of care.

Detailed findings and recommendations are summarised below.
Chapter 2. Summary of External Evaluation

Findings

- Home birth is a safe option for low risk women where adequately resourced and supported
- Various models of maternity care are successful, where adequately resourced and supported

Recommendations

1. Models of maternity care, which integrate hospital and community services, should be developed and adequately resourced nationally.

2. The National Maternity Hospital Domino and Hospital Outreach Home Birth Service has been established as a service. We recommend
   (i) the continuation and development of the South Eastern Health Board Integrated Hospital and Community Midwifery Service
   (ii) the continuation and development of The Southern Health Board Home Birth Service which has already expanded to include County Kerry
   (iii) the re-establishment and development of The Western Health Board Integrated Home Birth Project with adequate human and financial resources as a priority.

3. New services should have evidence-based guidelines, protocols and standards, which are subject to ongoing audit and review.

4. A steering group involving all relevant stakeholders should be established at local level to provide support for staff and clients and consider applications which do not meet inclusion criteria.
Chapter 3. Report of the Information Sessions and Written Submissions

Findings

- Women expressed high levels of satisfaction with the pilot projects
- People want a woman-centred maternity system which offers
  - continuity of care,
  - choice in how care is delivered
  - options for home birth and midwifery-led care.
- Women want to be supported in their choices
- The recruitment and retention of experienced, confident and competent midwives is essential.
- Some women receiving care from self-employed midwives experience difficulty accessing hospital and laboratory services
- Self-employed midwives highlighted current structural difficulties in combining and integrating care

Recommendations

1. Low risk pregnant women should be offered choices in maternity care, including home birth where feasible.
2. Continuity of care should be a feature of all models of maternity care
3. Integrated hospital and community midwifery services should be developed and extended nationally.
4. The clinical governance structure should determine:
   (i) access to hospital and laboratory services
   (ii) access agreements between services and self-employed midwives
5. In the absence of a structured, funded domiciliary service, a standard grant should be paid, which should take cognisance of the presence of a second authorized practitioner
Chapter 4. Literature review

Findings

- Home birth is a safe option for low risk women. There is no strong evidence to favour either planned hospital birth or planned home birth where it is possible to establish a home birth service backed up by a modern hospital system in case a transfer proves necessary.
- Continuity of care has been associated with a lower rate of interventions and increased satisfaction.
- Evidence does not support high levels of monitoring and intervention for all pregnant women.
- Early postnatal discharge is not associated with adverse outcomes.
- In New Zealand, British Columbia and Scotland it is a recommendation/requirement that a second authorised practitioner attend a planned home birth.
- In Australia, New Zealand and the Netherlands there are national guidelines for selection and transfer criteria.

Recommendations

1. There should be national guidelines for the selection criteria used by women and their healthcare providers to determine the appropriate model of care.
2. Midwifery-led units should be established by all maternity hospitals.
3. A second authorised practitioner (normally a midwife) should be in attendance for a planned home birth where feasible.* Both authorised practitioners must be trained in maternal and neonatal resuscitation.
4. In order to ensure continuity of care, the governance structure should determine access agreements between services and self-employed midwives.

*It is not intended that a general practitioner is the second authorised practitioner.
Chapter 5. The Role of the Midwife

Findings

- Midwives are key providers of care to pregnant women throughout pregnancy, childbirth and the postnatal period. They should be the lead carers for low risk pregnancies
- The provision of choice will enhance the development of midwifery
- An Bord Altranais’ competency framework governs midwifery practice
- Clinical governance ensures accountability and safeguards high standards of care

Recommendations
1. Midwives must provide evidence of continuing professional development and must be supported to gain experience in the community setting
2. Workforce planning is essential to provide for different models of midwifery care.
3. A programme of continuing professional development that includes peer review, reflective groups and audit of records should be developed for all midwives.
4. Networks where best practice can be developed and shared should be supported.
5. In the interest of quality assurance, a clinical governance structure should exist at national, regional and local level.
Chapter 6. Statutory Framework and Indemnity Issues

Findings

- The statutory obligation for the provision of domiciliary births remains uncertain with further legal considerations pending.
- The 1985 Nurses’ Act requires Health Boards to supervise midwives who practice outside health care institutions. There are no regulations to implement this provision.
- Varying arrangements concerning payment of grants for domiciliary births continue.
- Insurance cover for general practitioners involved in the care of women who opt for a home birth appears non-existent.

Recommendations

1. Sections 62 (1), (2) and (3) of the 1970 Health Act and the subsequent regulations should be reviewed to reflect changes in maternity care delivery and particularly the development of midwifery-led services.
2. The new Nurses and Midwives Act currently being drafted should reflect the diversity of midwifery settings and be underpinned by the competency framework developed by An Bord Altranais.
3. The grant system should be critically assessed and liability and indemnity issues clarified.
4. The ambiguity in relation to insurance cover for all practitioners involved in domiciliary care (including general practitioners) must be addressed to support shared care.
5. Legislation should be enacted in the longer term to facilitate the provision of midwifery-led services as achieved in New Zealand.
References


College of Midwives of British Columbia. (1997). Standards of Practice: Indications for discussion, consultation and transfer of care. Vancouver, BC.


Northern Area Health Board. *Domiciliary home births, analysis of the practice/arrangements pertaining in each health board relating to the payment of “Home Births Grant”.*


Appendix 1. List of individuals and organisations who made written submissions

1. Catherine McBride. Assistant Director of PHN. Submission from Donegal Group Area.

2. Sylvia Murphy, RGN, RM, PHN, MSc Student (Women’s Health)


5. Aoife O’Donovan. Birth Choice Cork

6. Kathy Cleere. Independent

7. The National Birth Alliance


9. Home Birth Association of Ireland

10. National Midwifery Forum

11. The Steering Group Community midwifery pilot project. SHB.
Appendix 2. Search Strategy for Literature Review

**Databases searched:** PubMed, CINAHL, Cochrane Library, Evidence-Based Health Care

**PubMed**
The electronic database PubMed (including MEDLINE) was searched excluding foreign-language publications. In addition, the PubMed ‘related articles’ link was used for those articles considered relevant to the search topic.

**CINAHL**
The electronic database CINAHL was searched excluding foreign-language publications.

**Cochrane Library**
The Cochrane Library was searched to identify systematic reviews of randomised controlled clinical trials and randomised controlled trials.

**Evidence-Based Websites**
Search the evidence-based websites that contain publications of guidelines, systematic reviews and abstracts on pregnancy.

- National Guideline Clearinghouse: www.guideline.gov
- NHS National Institute for Clinical Excellence (NICE): www.nice.org.uk
- Scottish Intercollegiate Guidelines Network (SIGN): www.show.scot.nhs.uk/sign
- NHS Centre for Reviews and Dissemination: www.york.ac.uk/inst/crd
- Centre for Evidence-Based Medicine: www.cebm.net
- Bandolier: www.jr2.ox.ac.uk/bandolier
- NHS National Electronic Library for Health: www.nelh.nhs.uk
- SUMsearch: www.nelh.nhs.uk/management/sumsearch.htm
- TRIP: www.tripdatabase.com
**Search Terms:**
domiciliary birth
domino birth
home birth
models of care
continuity of care
midwifery led care
mortality/morbidity of mother/child
safety and birth
postnatal discharge
risk assessment criteria and pregnancy
low intrapartum risk
low obstetrical risk
selection criteria and home birth
selection criteria and low risk pregnancy
selection criteria and low obstetrical risk
electronic fetal monitoring
fetal distress and distance
fetal distress and caesarean section
decision to incision
decision to delivery
time and caesarean section
breastfeeding
Appendix 3. Criteria for Midwifery Led Services in the North Eastern Health Board

Supporting Information
The midwifery-led unit (MLU) offers midwifery-led care for healthy women who are likely to have a normal pregnancy and labour throughout the antenatal, intranatal and postnatal periods.

Eligibility for inclusion for care in the midwifery-led unit will be based on an individual assessment of the woman’s health and well-being. Women may be excluded based on the following criteria (women may be transferred back to midwifery-led care following obstetric/paediatric/neonatology consultation.

Exclusion Criteria
Maternal

>40 years of age and < 16 years age at delivery

- Grand multiparity (>5)
- Height: <152 cms (5 feet); BMI <18 or > 29
- Medical History
  - Respiratory, renal, infective, immune, neurological, cardiovascular, gastrointestinal, haematological, endocrine, mental health, muscoskeletal.
- Social
  - Current history of drug misuse
  - Smoking >20 cigarettes per day
- Latex Allergy
- Previous obstetric history
  - Recurrent history of preterm birth, recurrent miscarriage, caesarean section, previous stillbirth, eclampsia, uterine rupture, placental abruption, PUPP, obstetric cholestasis, PPH (>500 mls or symptomatic), manual removal of placenta, neonatal death, shoulder dystocia, midtrimester miscarriage, neonatal death
- Previous gynaecological history
  - Uterine surgery, Myomectomy, Hysterotomy, Cone biopsy (unless subsequent vaginal delivery), two previous Letz procedures, Uterine fibroids, Cervical cerclage, Infertility, (see detailed guidelines) Uterine anomaly, Perineal reconstruction (more than 24hrs post birth) or 4th degree tear

Detailed Exclusion Criteria
Age

>40 years of age and <16 years age at delivery
(Blum & Goldhagen, 1981; Ezra et al., 1995; Prysak et al., 1995; Gilbert et al., 1999; Cunnington, 2001)
**Parity**

Grand multiparity (>5)

**Stature**

Height: <152cms (5 feet)

Weight: Use BMI (body mass index) at booking to assess for care

Body Mass Index = \( \frac{\text{weight in kilograms}}{(\text{height in metres})^2} \)

**Underweight = BMI <18**

Obesity = BMI >30

(C.A. Lindsay et al., 1997; Cnattingius et al., 1998; Confidential Enquiry into Maternal Deaths, 2001)

**Medical History**

Respiratory
- Asthma requiring daily preventative and/or curative medication
- Other respiratory disease

Renal
- Recurrent pyelonephritis
- Other renal disease

Infective
- History of:
  - Hepatitis B
  - Hepatitis C
  - Tuberculosis
  - Human immunodeficiency virus
  - Toxoplasmosis
  - Genital herpes
  - Group B Streptococci carrier/previous Group B streptococci (in mother or baby)
- Sexually transmitted diseases (including genital warts)
- Varicella Zoster (active)
- Rubella (active)
- Herpes gestations & pemphigoid gestations

Immune
- Rheumatoid arthritis
- SLE
- Antiphospholipid syndrome
- Scleroderma
- Other connective tissue disorders

Neurological
- Epilepsy
- Myaesthenia gravis
- Multiple sclerosis
- Chronic Fatigue Syndrome (CFS)
- Bells Palsy
- Persistent migraine with focal symptoms

**Cardiovascular**
• Cardiac disease (including murmurs requiring antibiotics for surgical procedures)
• Cardiac surgery
• Hypertensive disorders

Gastro-intestinal
• Liver disease
• Crohn’s disease
• Ulcerative colitis

Haematological
• Haemoglobinopathies
• History of previous thromboembolism
• Family history of thromboembolism (Confidential Enquiry into Maternal Deaths, 2001)
• Booking Hb <11g/dL
• Thrombocytopenia (<150)

Endocrine
• Thyroid disease
• Diabetes (Including gestational diabetes diagnosed by Glucose Tolerance Test (GTT))
• Other significant disorders e.g. Cushing’s disease

Mental health
• Previous mental health diagnosis of schizophrenia, manic depressive psychosis, puerperal psychosis

Anaesthetic
• Known anaesthetic risk (discuss with consultant anesthetist prior to randomisation)

Musculoskeletal
• Spinal abnormalities (scoliosis, spinal fractures and spinal surgery)

Social
• Current history of drug misuse (prescribed or non-prescribed) including alcohol abuse
• Smoking ≥20 cigarettes per day

Universal risks
• Latex allergy

Previous obstetric history
• Recurrent history of pre-term birth (i.e. more than 1 previous pre-term birth or where preceeding birth was pre-term)
• Recurrent miscarriage (3 or more)
• Caesarean Section
• Previous stillbirth
• Eclampsia
• Uterine rupture
• Placental abruption
• PUPP (pruritic urticarial papules and plaques or pregnancy)
• Obstetric cholestasis
• Postpartum haemorrhage (>500 mls or symptomatic)
• Manual removal of placenta
• Previous should dystocia
• Previous midtrimester miscarriage (14-24 weeks)
• Neonatal death (May be eligible for MLU care after discussion with Neonatologist/Paediatrician)

Previous gynaecological history

• Uterine surgery
  o Myomectomy
  o Hysterotomy
  o Cone biopsy (unless subsequent term vaginal delivery)
  o Two previous Loop Excision of the Transformation Zone (Letz) procedures
• Uterine fibroids
• Cervical cerclage
• Infertility i.e. conceived current pregnancy on infertility treatment and/or greater than 2 years of infertility
• Uterine anomaly
• Perineal reconstruction (more than 24 hrs post birth) or 4th degree tear

If any other condition that may affect the eligibility of the mother to be care for in the MLU is/are present, then this should be discussed with the Team Leader of the Midwifery-led Unit who will refer to the Obstetrician if necessary.

Standard

• All births planned for within the MLU are in accordance to the above criteria

Section II: Antenatal Care

Criteria for antepartum transfer/referral to medical-led/GP care

Aim

To ensure the highest possible standard of care to all women who develop obstetric or medical problems during pregnancy.

Recommendations

Transfer Criteria During Pregnancy

Maternal
• Rhesus disease
• Atypical antibodies
• Antepartum haemorrhage
- Multiple pregnancy
- Request for prenatal screening
- Placental abruption
- Unstable lie
- Malpresentation after 37 completed weeks
- Placenta praevia
- Preterm labour before 37 completed weeks
- Prolonged pregnancy i.e. > 40+10
- Pre-term spontaneous rupture of the membranes (SROM)
- Gestational Hypertension (>140/90mmHg)
- Eclampsia
- Pre-eclampsia
- Proteinuria >1+ on repeat specimen at same visit
- Suspected thromboembolism
- Any itch rash
- Gb<10g/dL
- Gestational diabetes
- Pre-labour rupture of membranes at term for >48hrs
- Induction of labour
- Symptomatic vaginal discharge
- Unbooked pregnancy
- Group B Strep
- More than 2 admissions in ≥ 48hrs at term and not in established labour

Fetal
- Clinically suspected small for gestational age baby
- Known fetal anomaly
- Oligiohydramnious
- Polyhydramnious
- Reduced fetal movement

Where a woman is transferred from midwifery-led care to consultant-led care during pregnancy and the consultant team are of the opinion that the woman may be transferred back to midwifery-led care, such a transfer may occur i.e. reciprocal transfer. The woman will receive care from the consultant-led service while under consultant-led care and midwifery-led care while within the midwifery-led services. If a woman requires transfer to consultant-led care more than twice during pregnancy she will remain under consultant-led care for the remainder of her care.

Where a woman is transferred to consultant-led care during pregnancy and remains under consultant-led care for the remainder of her pregnancy, care will be provided by the consultant-led services from point of transfer for the remainder of her care (including postnatal care).
Supporting information:

Transfer/referrals fall into two main categories.

1. **Referrals for conditions that will or potentially will affect the woman’s suitability for continuing with midwifery-led care.**
   Referrals for this category will be made by the midwife and/or the General Practitioner to a Consultant Obstetrician.

2. **Referrals for conditions that have no bearing on eligibility for continuation with midwifery-led care e.g. women presenting with symptoms incidental to pregnancy, for example, upper respiratory tract infection and women who need review/medication in light of results of investigative procedures.**

Referrals in this category will be made by the midwife based on the easiest pathway of referral for the woman. This will be decided by where the woman is being seen and/or where the woman is when she presents with problems or when the results of investigative procedures become available e.g. if a medical review is required and the woman is already in clinics of the midwifery-led unit then review by hospital obstetrical staff may be the most appropriate whereas if, for example, results become available and the woman is in the community setting then referral to the general practitioner may be the most appropriate means of referral.

The following guidelines contain detailed criteria for conditions requiring midwifery referral for medical opinion and possible transfer of care based on medical opinion.

Though all women will have been screened for any medical or obstetric problems at booking and during admission to the MLU, changes to the original plan may occur. The midwife must remain vigilant at all times in her physical and psychological observations during pregnancy and keep the woman informed of any untoward changes that may result in referral to an obstetric registrar or consultant and transfer to the CLU where appropriate.

Transfer criteria

**Current pregnancy**

Maternal
- Rhesus disease
- Atypical antibodies
- All antepartum haemorrhage (> 20 weeks gestation)
- Threatened miscarriage
- Multiple pregnancy
- Request for prenatal screening
- Placental abruption
Unstable lie \(^2\)
- Malpresentation \(^3\) after 37 completed weeks
- Placenta pravia
- Preterm labour before 37 completed weeks
- Prolonged pregnancy
  - Referral to consultant-led unit will occur at 40\(^{+7}\) so that the woman will be seen between 40\(^{+7}\) and 40\(^{+10}\)
- Pre-term spontaneous rupture of the membranes (SROM)
- Gestation Hypertension (\(\geq 140/90\) mmHg) (Confidential Enquiry into Maternal Deaths, 2001)
  - diastolic blood pressure of 90 mmHg or above on two consecutive occasions at least four hours apart, or a single diastolic blood pressure of 110 mmHg or more (Davey & MacGilvray, 1988; Confidential Enquiry into Maternal Deaths, 2001)
  - or if the initial diastolic blood pressure was <90 mmHg, an increase of at least 25 mmHg, to 90 mmHg or more (Redman & Jefferies, 1988)
- Eclampsia
- Pre-eclampsia (defined as same criteria for ‘Gestational Hypertension’ (as above), but with the addition of significant proteinuria i.e. 1+ on dipsticks on repeat specimen at same visit (Davey & MacGilivray, 1988)
  - Proteinuria \(\geq 1+\) on repeat specimen at same visit
  - Suspected thromboembolism
  - Any itch/rash
  - Hb<10g/dL
  - Gestational diabetes (as diagnosed by GTT)
  - Pre-labour rupture of membranes at term for>Induction of labour
  - Symptomatic vaginal discharge
  - Unbooked pregnancy
  - Group B Strep
  - More than two admissions in \(\geq 48\) hrs at term and not in established labour

Fetal
- Clinically suspected small for gestational age baby
- Known fetal anomaly
- Oligiohydramnious
- Polyhydramnious
- Reduced fetal movements

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\(^2\) Lie defined as unstable when after 37 weeks’ gestation, instead of remaining longitudinal, it varies from one examination to another between longitudinal and oblique or transverse

\(^3\) Any presentation other than the vertex is termed a malpresentation. The malpresentations are therefore breech, face, brow and shoulder. However, an intrapartum diagnosis of a mento-anterior face presentation in the presence of maternal and fetal wellbeing will not require transfer to consultant-led care.
If any of the above or any other condition that may affect the eligibility of the mother to be cared for in the MLU is/are present, referral to the MLU Clinical Manager and a senior obstetrician must be made and plans for transfer/referral undertaken

**Standard**

- All women who experience obstetric or medical problems during pregnancy are referred and/or transferred to medical-led care

**Source:** Midwifery-led Unit (Cavan General Hospital). *Guidelines for Practitioners*. 23rd November 2004. North Eastern Health Board.
Appendix 4 Survey of Home Birth Services by Northern Area Health Board

Northern Area Health Board. Domiciliary Home Births, Analysis of the practice/arrangements pertaining in each health board relating to the payment of “Home Births Grant”.

This document details the operation of the Home Birth Scheme for each Health Board area for the years 2002 and 2003. A description of the application process for a home birth is provided, which is slightly different for each area. The number of home births for the years 2002 and 2003 are listed for both the pilot projects and other Health Board schemes, with the Southern Health Board having the highest number of home births (pilot project). The document also includes the number of home birth grant applications, the amount of grant paid per birth/confinement, the number of midwives providing a service in each board indicating whether employed by Health Board or self-employed, and the nature and extent of supervision of midwives. The following table provides a summary of the data for each Health Board.
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<th>SHB*</th>
<th>SEHB*</th>
<th>MWHB</th>
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<th>MHB</th>
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**Home Birth Grant Applications**

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**Grant per Birth (€)**

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<td></td>
<td></td>
<td></td>
<td></td>
<td>1,270-2,000 N/A</td>
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<td>1,300 + €380 expenses</td>
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**Midwives Providing Services**

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**Supervision-of Self Employed Midwives**

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- Pilot Projects
- N/A = Not Applicable
- DPHN = Director of Public Health Nursing