15 July 2025

Shared Insights

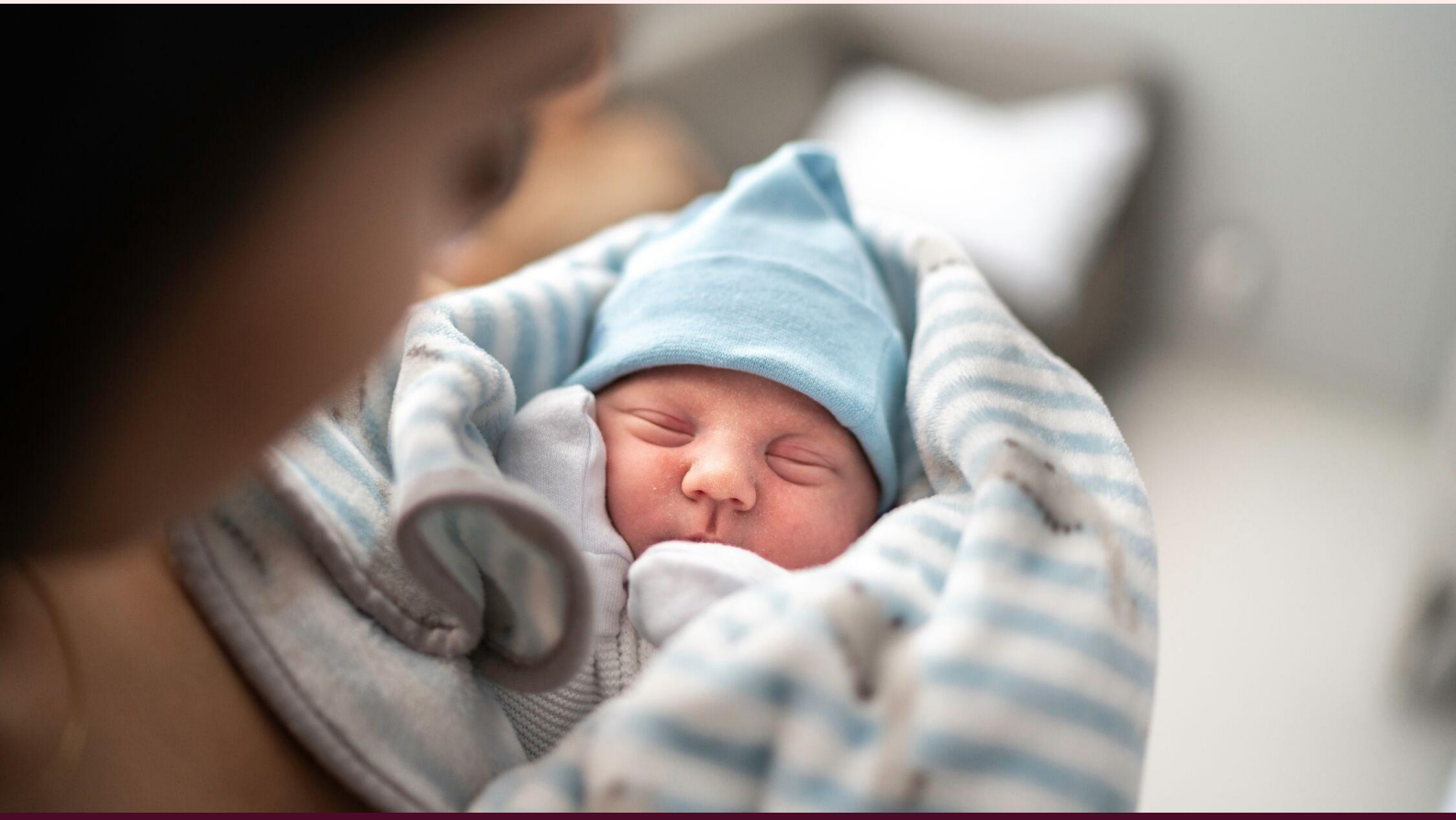
Maternity Forum: Birthing outside of guidance

Panel of Speakers

Kelly Buckley – Partner, Browne Jacobson (Chair)
Rachael Bose – Senior Associate, Browne Jacobson
Heather Simmonds-Copete – Research Officer and Peer Supporter, Birth Trauma Association
Floretta Cox – Consultant Midwife, University Hospital of Leicester NHS Trust
Elizabeth Swift – Consultant Obstetrician, University Hospital of Leicester NHS Trust

BIRTH TRAUMA ASSOCIATION

NHS University Hospitals of Leicester NHS Trust



Browne Jacobson

Introduction

This session focused on how to support staff to provide safe clinical care to birthing people who choose 'birthing outside of guidance', (sometimes also described as birthing off pathway' or 'birthing choices'), meaning that they opt for a birth that falls outside of the current recommendations or clinical guidelines. This includes 'free birthing'.

We appreciate that however described, 'birthing outside of guidance' can be a highly emotive topic for both birthing individuals and healthcare providers. We know birthing people may have strong preferences for how they want to give birth, sometimes diverging from recommended guidelines or care pathways. We acknowledge the challenges, which can lead to tension between the desire for patient autonomy and healthcare professionals' responsibilities to ensure safety according to established protocols.

Contents

In this session, we heard legal, patient and clinician perspectives and discussed a range of issues including:

- The legal risks associated with 'birthing outside of guidance'.
- Common pitfalls.
- Best practices during planning and supported decision-making processes.

The session was chaired by Browne Jacobson's Kelly Buckley. Rachael Bose of Browne Jacobson covered the legal framework and potential issues arising from decisions to 'birth outside guidance'.

We were delighted to be joined by Heather Simmonds-Copete, who shared her powerful personal story of birth trauma and the work she now does to support others through the Birth Trauma Association and Floretta Cox and Elizabeth Swift of University Hospitals of Leicester NHS Trust who gave an account of their tailored support for patients in these circumstances. They shared their practical experience of providing a dedicated service for these patients and how to keep communication open to support achieving the best outcome for all.

Given the time limitations, our session did not deal with emergency situations when 'birthing outside of guidance' or the issue of capacity.

We would like to thank our speakers for enriching our understanding with their diverse experiences and knowledge.

How we can help

This session highlighted the importance of clear communication and facilitating supported decision making through informed consent.

We provide practical training to support organisations and clinicians to improve consent and supported decision-making processes and have developed a virtual training bundle, delivered by Browne Jacobson's risk management and maternity experts, to empower healthcare organisations and clinicians with the knowledge to handle consent more effectively, reducing legal risks and improving patient care.

This paid for on-demand webinar includes insights, lectures and case studies. If you would like more information about the training package you can find it here

Alternatively, please contact:

Rebecca Coe or Amelia Newbold

The legal perspective

Rachael Bose – Senior Associate,
Browne Jacobson

Overview

From a claim's perspective, nationally, obstetric claims made up 12.8% of the number of new claims received in 2023/2024, but this accounted for 57% of the total estimated value of claims against NHS Trusts in 2023/2024 (approximately £6.6 billion). Annual report and accounts 2023/24.

Whilst every case is different, the following clinical themes are often present:

- Failures/delays in escalating concerns leading to delays in delivery.
- Errors in fetal heart monitoring (CTG).
- Documented plans for review not being actioned.
- Lack of situational awareness.
- Shortcomings in the process to obtain consent.
- Shortcomings in communication and record keeping.

The issues most likely to arise in 'birthing outside of guidance' and the main focus for today relate to consent, communication and record keeping.

'Birthing outside of guidance'

The phrase 'birthing outside of guidance' typically refers to situations where a birthing person opts for treatment that falls outside standard medical recommendations or clinical guidelines. This covers a broad range of circumstances from reducing the amount of fetal monitoring to maternal requests for Caesarean section to planning for a VBAC delivery at home.

The most common themes identified by the recent MNSI Briefing: Birthing outside of guidance are refusing an induction of labour and requests for VBAC at home.

Asking 'why?'

It is important to understand why the birthing person chooses to 'birth outside of guidance' and how healthcare professionals can support them to improve outcomes and the experience of birthing persons and babies.

There are many reasons why people choose to 'birth outside of guidance'. This includes a desire for autonomy, tokophobia (extreme fear of childbirth), a previous traumatic birth experience, perceived control / safety concerns, personal or cultural preferences or mistrust of the medical system.

'Birthing outside of guidance' can also encompass a wide range of situations from free birthing without the assistance of any registered health professional to maternal requests for a caesarean section when one is not 'medically indicated'.

Current themes in 'birthing outside of guidance' include reducing the amount of fetal monitoring, declining examinations during the intrapartum period, opting not to have an induction of labour against advice, maternal requests for caesarean section and the use of a Doula or other traditional / non-licenced birth attendant in place of a licenced midwife or obstetrician.

The legal framework

Of particular relevance to these scenarios is the law around informed consent. Rachael discussed the case of Montgomery v Lanarkshire which aligned the law with guidance towards a patient-centred standard.

This is also covered in detail in our recent Shared Insights session on Consent click here to read that note.

In Montgomery, the Supreme Court held that doctors must disclose all "material risks" defined by reference to what a reasonable patient in that person's position would find significant. In particular:

It highlights the importance of patient autonomy: A Clinicians' duty is to *inform and respect* the competent birthing person's decisions. Under Montgomery, they should be told of reasonable alternative treatment options and the material risks. The consent process must centre on what matters to the patient.

There is a duty to share information: GMC guidance on Decision making and consent states clinicians must "find out what matters to patients so they can share relevant information" about benefits/harms of options and reasonable alternatives". Discussions should be patient-tailored, explaining recognised risks and how individual factors affect ***them***.

It defined legal responsibilities: A competent birthing person has the right to accept or refuse treatment including their mode and location of delivery. Practitioners must respect these rights and must not coerce. If harm occurs, focus may turn to what information had been provided that prompted them to come to their decision.

It leaves us with the need to balance safeguarding against autonomy: Both UK law and professional codes distinguish between lawful refusal and situations warranting safeguarding. In general, an adult's informed choice to birth outside of guidance, including free birthing, does not itself trigger mandatory safeguarding action, unless there are signs of incapacity or risk to the child after birth. There should not be any threats of legal action solely arising out of the birthing person's choice nor should a Trust refuse all aspects of care.

Emphasis is on supporting women: Even when a decision such as free birthing is made, clinicians should maintain engagement. Midwives and doctors should "unravel the complex reasons" behind that choice and offer continued antenatal and postnatal care. The NMC Code requires treating women with kindness, respect and dignity, even if their choices differ from staff preferences. The RCOG and NMC acknowledge birthing choices such as free birth occur and must be responded to respectfully.

Clinical guidance

All authoritative guidelines recognise maternal autonomy. NICE Caesarean Section Guidelines (NG192) recommend clinicians should discuss the request in detail including the birthing person's reasons for the request, benefits/risks, alternative options and importantly – to document these discussions fully.

If, after informed discussion, the birthing person still makes their request to birth outside of guidance, that choice should be respected and supported.

If the request is driven by severe fear (tokophobia) or other severe anxiety, then offering a referral to the perinatal mental health team is advised.

There is already specific guidance for circumstances that fall outside the standard guidelines such as the RCOG's Planned Caesarean Birth (Consent Advice No. 14) | on what to do should a birthing person request a Caesarean section even when not medically indicated.

These guidelines have a focus on shared decision making with the birthing person ensuring discussions are tailored to that individual and the importance of recording the consent process.

Practitioner and Trust responsibilities

It is important to actively listen to women's concerns and essential to understand their fears, preferences, and past experiences to provide tailored support. This should be followed up with unbiased, comprehensive information on all birth options. This includes detailed explanations of the benefits and risks associated with each, ensuring women can make informed decisions.

Respecting Autonomy: Respecting each birthing person's right to choose their mode of birth is fundamental. Whether it's supporting a request for a Caesarean section or facilitating a freebirth, the guidance is clear that the approach should be without judgement, legal threats, or denial of care.

Supporting Women: Engagement doesn't end with the decision. There must be an offer of continuous care and support throughout all stages—antenatal, perinatal, and postnatal."

Treating all women with kindness and respect, regardless of their birth choices, is essential. This approach fosters trust and supports a positive birthing experience which might mitigate the risks of a complaint or litigation.

Risk Awareness: Trusts should educate staff to ensure they understand the legal position: no policy may unlawfully deny a request without medical justification. However, Trusts also have a duty to ensure safe practice. This means offering timely Caesarean to those who request it, and conversely, making clear the risks of a delayed induction or unassisted birth.

Clinicians must balance respect for choice with their responsibility to patient safety.

Team Roles: One way to do this is by involving senior staff early in the process when a complex birth choice is made, as advised by NICE guidelines. This ensures that adequate resources and expertise are available.

Documentation and risk management requirements

In some scenarios competing clinical demands can make detailed record keeping difficult, but thorough record-keeping and following guidance can mitigate both clinical and litigation risk.

When faced with scenarios such as these, it is vital to document every discussion in detail – why choices were offered or declined, information given, and the patient's questions and decisions. Include that the birthing person was informed of the material risks of their choice and alternatives. The GMC explicitly requires accurate recording of the information exchange and decisions.

Use of leaflets and other resources: It is often useful to have information provided in leaflet form to take away and consider which may prompt questions enabling more informed discussion at any follow-up appointments. There are also other resources available to ensure understanding such as translation apps. There is little to be gained by having a detailed and complex discussion with a patient in a language that they might not understand.

Consent Forms: You can use consent/refusal forms where appropriate as an aide-memoire, but do not rely on them alone. A signed form is not a substitute for meaningful dialogue. Ensure the record makes clear that consent was informed (or refusal documented) and include time, date, names of staff present.

Incident Reporting: If a birthing person departs from Trust plans (e.g. stops attending appointments or explicitly plans a freebirth), consider whether to flag this through internal risk registers so senior staff can review. Any adverse outcome should be promptly reported via Trust incident processes.

E**scalation Logs:** Document referrals to mental health or safeguarding services, even if not pursued. Note any signposts to support services and objections raised by the patient.

Communication and consent strategies

Patient-Centred Discussion: Adopt an empathetic, non-judgemental approach, encouraging the patient to share their fears and values. Listen actively and validate feelings, regardless of personal views.

Tailored Information: Use clear language and visual aids (e.g., risk charts, procedure diagrams) to aid understanding. Verify understanding by asking the patient to repeat the information; correct any misunderstandings. Use translation services and apps to tailor not just the contents of the information provided but the way in which it is communicated.

Balanced Explanation: Outline both maternal and fetal risks for vaginal vs. Caesarean delivery, tailored to their specific situation. Discuss both common and rare but serious risks and explain emergency procedures for freebirth. Information is intended to inform, not scare or coerce. Explain rarer but serious risks such as uterine rupture in VBAC and how management in a home setting will differ from that in a hospital. Explain scenarios when an emergency could occur and how it would be handled (ambulance, hospital transfer).

Offer Alternatives. Studies show that a lot of decisions outside guidance stem from a place of anxiety or a drive for autonomy. Discuss anxiety-reducing options such as psychological support or alternative birthing locations if safe. Highlight that choosing support options does not compromise overall decision-making autonomy.

Reinforce Autonomy: Remind them of their ultimate decision-making power and that there is no universally "right" medical decision. Ensure they are aware of the support available for any chosen option. Emphasise that accepting some support or having alternative arrangements in place should things not go to plan does not negate their overall choice. Most importantly, emphasis should be placed on respect and understanding with the goal of shared decision-making and safer outcomes.

Final Confirmation: Confirm the final decision in writing using a consent form and make detailed notes to document informed choice. Communicate any plan changes to all relevant team members (obstetric, anaesthetic, paediatrics).

Rachael Bose
Senior Associate
+44 (0)330 045 2436
rachael.bose@brownejacobson.com

The patient perspective

Heather Simmonds-Copete –
Research Officer and Peer Supporter,
Birth Trauma Association

Heather bravely shared her own traumatic birthing experience and how this has shaped her journey. She became a peer supporter then a research officer for the Birth Trauma Association, a charity providing free empathy-based peer support to birthing people (and partners) who have suffered birth trauma.

Heather reflected that 'birthing outside of guidance' might conjure up images of free birthing with no medical assistance, but in her experience, it is much wider than that, including refusal of vaginal examinations (VEs) and fetal monitoring. Critically, she highlights that birthing people often decide to 'birth outside of guidance' because they are scared and confused and/or have suffered birth trauma in the past. Maternity services across the country are in crisis and the negative press coverage also affects birthing peoples' decisions and choices. It is not only a physical choice to 'birth outside of guidance' but a psychological and emotional one too.

There are a multitude of reasons why women choose to decline certain procedures which may include that they would trigger memories of traumatic personal experiences such as sexual assault, previous traumatic birth, fear of hospitals and a fear or labour itself (tokophobia).

It is so important that clinical staff supporting birthing people explore the 'why' and offer an opportunity to discuss the available options.

Heather gave some real-life examples of the effects of support (or lack of) for birthing people who ask about 'birthing outside of guidance' both of which highlight the importance of finding ways to achieve supporting women in having safe and better births.

The first example related to a woman who wanted to birth at home because of a previous avoidable traumatic experience in labour. The hospital concerned stood firm on the decision that a home birth was not safe because of risk factors such as a raised BMI. The woman ended up giving birth in hospital which was re-traumatising.

The second is a positive example of a woman who was anxious about having vaginal examinations (VEs). The hospital worked with the woman to make a supportive and effective care plan which enabled her to undertake her own VEs to determine dilation; and also made a plan as to what to do if labour did not progress. The woman felt listened to and cared for and had a good outcome, with the baby delivered safely.

In Heather's experience, taking the time to explore with empathy the underlying reasons for decisions to 'birth outside of guidance' will help women make the best informed decisions for them and help staff find safe ways of respecting those decisions.

The clinician perspective

Floretta Cox – Consultant Midwife, University Hospitals of Leicester NHS Trust

Elizabeth Swift – Consultant Obstetrician University Hospitals of Leicester NHS Trust

Floretta Cox and Elizabeth Swift work together at the University Hospitals of Leicester NHS Trust to provide a dedicated service for birthing people choosing to 'birth outside of guidance'. They began by saying experiences like the one Heather shared are the reason behind the change in guidance at their Trust.

The area they cover includes Leicester, Leicestershire, and Rutland and there are 10,000 births a year, 2 acute sites and 2 alongside birth centres. There is also a dedicated home birthing team which has been in existence since 2017.

The homebirth team consists of midwives who specifically want to work supporting birthing people to give birth at home. They have extensive training including skills drills with the ambulance service.

Floretta explained 22% of women who choose to birth at home in their area would not normally be low risk. Over the last year they had 133 women who chose to 'birth outside of guidance' and of those 133 who were seen and counselled, 35% had a successful home birth, including some VBACs.

Critical to their success are guidelines for supporting birthing people and also the staff providing the service. They have proforma birth plans, which also incorporate the NICE guidelines. For example, there are proformas for women with a BMI of over 40, women taking SSRI (antidepressants), maternal age over 40 and so on. This is done to empower staff and to cover all material concerns and help birthing people make an informed choice.

The Trust has kindly agreed to share its Guideline with basic proformas. This is attached. However, they have asked us to point out that the birthing people Floretta and Elizabeth see have individualised plans.

Floretta explained any birthing person who has two or more risk factors and wants a home birth is referred to the 'birthing outside of guidance' clinic (read more about these clinics overleaf).

Elizabeth Swift became involved when she became a link consultant for the home birth team. It became clear to Liz and Flo there was a lack of consistency of counselling in the context of 'birthing outside of guidance' and they realised they needed more of a focus on shared decision making as people were given different advice depending on who they saw.

Elizabeth explained the need to ensure individual care plans were completed was paramount. This included when to escalate and preparing the women in advance for what might happen if things start deviating from their plans. It was recognised more time was needed for 'birthing outside of guidance' discussions and Elizabeth now runs a once-weekly clinic with three patients at a time who each get a 30-minute appointment.

At this dedicated clinic birthing people have the opportunity for detailed discussions regarding home birthing. There is an emphasis on the woman having a voice and it is made clear that their decisions will be supported.

There is time to try to explore the reasons why birthing people are choosing to 'birth outside of guidance'. This might result in referrals to the birth reflection service or the maternal mental health team. There might also be an offer to use the birth centre which might be an acceptable lower risk option for some people.

Central to the offering is making sure birthing people understand they can access care if they want to at any stage and that they will be supported; specifically they can change their mind at any time and still receive the same level of support.

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There is an MDT meeting once a month (including e.g. consultant midwife, ambulance service, safeguarding team) reviewing all the birthing people due to give birth that month.

Care plans are put in place by about 36 weeks. Importantly, discussions cover the reasons why someone has made a request to 'birth outside guidance', how their decision making can be supported, capacity, who would be best to communicate with the birthing person and to set individualised care plans.

The care plans inform the birthing person of all the risks e.g. limitations of having a home birth, delays in getting to hospital. This allows them to make an informed choice.

The Trust supports its staff by providing empathy training and offer 'Trauma Informed care' study days. If there are issues, they have a dedicated Professional Midwifery Advocacy (PMA) service and the Trust has also launched 'Connect and Reflect', a service where staff who have been involved in any traumatic care experience can contact an advisor straight away to reflect on what happened.

Under the Patient Safety Incident Response Framework (PSIRF) staff have an opportunity to huddle and de-brief if there is a poor outcome.

The Trust also offers a birth reflection service antenatally for women disclosing previous unpacked trauma.

There are occasions where a birth will not be in accordance with the care plan but by having a model which facilitates more detailed discussion about birth choices birthing people feel valued, listened to and supported.

Discussion

What happens when birthing people refuse to engage and have any discussions about birthing choices?

Floretta and Elizabeth advised they would try, if possible, to explore the reasons behind the refusal to engage in discussions. There might, for example, be a specific midwife or other member of staff the birthing person will speak to, and they can then explain that, without exception, they will be supportive of birthing decisions.

If the birthing person still does not want to speak to them, they would write a letter confirming that although the birthing person has declined to discuss the options, the Trust will be supportive and reiterate that the birthing person can come back at any point for support; the door is always open.

At Leicester, they also have 'touch-points' at 28, 32 and 36 weeks when they will seek to make contact with the birthing person again.

Is there is anything staff can do to protect themselves from litigation if things go wrong?

Kelly confirmed that from a legal perspective, each case will need to be taken on its merits. There is no specific pathway to follow in terms of communication with patients. If staff have concerns, we advise clinicians to seek advice from colleagues and/or a Trust's legal team at an early stage.

In terms of the approach taken at Leicester, care plans developed with birthing people will identify when escalation is needed e.g. if labour deviates from the plan and when it would be advisable to transfer to hospital. Having these discussions antenatally is key, so birthing people know in advance what different scenarios may present and what the options are.

In higher risk situations, the advice given in clinic is backed up with a letter to the birthing person setting out what has been agreed including the risks of the option chosen by the birthing person and the support available.

Good, clear, contemporaneous documentation of the discussions throughout the planning stages is key to evidence informed consent throughout. In particular:

- Try and keep dialogue open between clinicians and patients choosing to 'birth outside guidance'.
- Discuss and document all material risks.
- Follow up by sending the patient detailed individualised care plans and/or, where appropriate, a record of discussions in writing.

Is it necessary to have a signature section on the birth plan to acknowledge the information and agreement or is it sufficient to say birth plan agreed and sent

Ideally, it would be good to have the patient's signature on the birth plan, but the notes should also document the ongoing discussions about material risks and reasonable alternatives, and these should be re-visited and discussed at all the antenatal clinic appointments, again documenting these discussions.

Language barriers can sometimes present challenges. Some birthing people who do not speak English prefer using partners/ family members instead of language line whereas local policy recommends using language line. Any advice to address this?

There are a number of antenatal Apps and information leaflets which are available in a variety of different languages and can be very useful when caring for birthing people who do not speak English. When having discussions with someone whose first language is not English, use of an interpreter is the gold standard.

Using family members to translate is not recommended. Medical terminology may not be easily translatable on an ad hoc basis.

What do you do if you are not permitted access to the room/house in which the delivery is taking place during a home birth?

At Leicester a home birth can be facilitated where midwives are requested to be in a different room in the house,. If they are at a home birth but not allowed into the room where a birthing person is delivering the baby, they will recommend they are permitted access. However, if the birthing person refuses, they will respect that decision and wait outside. They are still on hand to provide support and emergency care, if needed, and ensure everything is documented contemporaneously. However, they do require access into the house and cannot be left outside.

How do you include Doulas in your guidance?

At Leicester, there is guidance about the number of people who can attend a labour (this was developed during Covid-19). However, they do try and facilitate the use of Doulas if requested and ensure this is included in the care plan and shared with the MDT.

What do you do if a home birth cannot be safely accommodated because there are not enough staff?

There is not an absolute duty to provide care at home for all women who request a home birth. The legal duty is for the Secretary of State to provide a reasonable system of provision of NHS services, i.e. there is no absolute right of any individual patient to demand a particular service is provided to them in a particular way on a particular day, provided the overall system of NHS care made available to them is reasonable.

Practically, however, communication is again key. Birthing people need to be aware in advance of the possibility that if the home birth team is not available, safe care will need to be provided at the hospital. If this is refused, this needs to be documented in detail and the option for the birthing person to change their mind and access care in hospital at any time reinforced.

Can you recommend any training we can go on to help guide us on how to have these sensitive discussions.

The informed decision making training through the Personalised Care Institute is really good and only takes about 30 minutes.

Birthrights offer training to Trusts/MDT.

The Birth Trauma Association has some videos on its website and also provides training to teams – please email Heather if you would like to discuss what is available: heather@birthtraumaassociation.org

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Kelly Buckley
Partner

+44 (0)115 908 4867
kelly.buckley
@brownejacobson.com

Rachael Bose
Senior Associate

+44 (0)330 045 2436
rachael.bose
@brownejacobson.com

Amelia Newbold
Risk Management lead

+44 (0)115 908 4856
amelia.newbold
@brownejacobson.com

Rebecca Coe
Partner

+44 (0)115 948 5606
rebecca.coe
@brownejacobson.com

Supporting birthing women and birthing people who choose to birth outside of guidance in midwife-led birth settings

NHS University Hospitals of Leicester NHS Trust

Trust ref:C55/2021

Contents

1. Introduction and who Guideline applies to

This guideline sets out the guidance for the planning of care for birthing women and birthing people who make requests outside of recommended Trust guidance to birth in a low-risk environment. The steps required in this process are detailed together with flowcharts and care plans for use by community midwives in the appendices.

In this organisation we, as a multidisciplinary team of clinicians within the maternity service, believe that the safest way for birthing women and birthing people to labour and give birth is to follow the Trust's agreed guidance. We also acknowledge the importance of close multi-professional working between clinicians to ensure good outcomes for parents and babies. This is particularly important within maternity services when it involves complex decision making surrounding the planning of care with birthing women and birthing people who wish to understand their birth options in greater detail, explore the risks and benefits of these choices and make decisions about their care even if outside of Trust guidance. All birthing women and birthing people have the right to make their own decisions as a basic human right protected by the common law unless they lack the legal capacity to decide (Montgomery V Lanarkshire Health Board 2015). This document aims to set out the process to be followed for birthing women and birthing people who have requested care outside of Trust guidance.

University Hospitals Leicester (UHL) currently offers birthing women and birthing people four choices of birth setting across its sites at the Leicester Royal Infirmary, Leicester General Hospital and St Mary's: two obstetric delivery suites; two alongside birth centres; homebirth; and a freestanding birth centre in Melton Mowbray.

Birthing women and birthing people are considered to be 'higher risk' if they do not meet the 'low risk' criteria outlined below:

Low risk criteria -

- Do not have a history of medical diseases.
- Are experiencing an uncomplicated pregnancy.
- Are under the age of 40 years.
- Do not have a drug or alcohol addiction.
- Are carrying a singleton pregnancy.
- Are carrying a baby in a cephalic presentation.
- Are having their 1st – 4th baby without previous complications.
- Have a body mass index (BMI) greater than 18.5 or less than 35 at booking.
- No Safeguarding concerns at 36-week risk assessment

For a comprehensive list of considerations to take into account when assessing birthing women and birthing people for low-risk maternity care please see - Intrapartum Care: Healthy Women and their Babies

Where a birthing woman or birthing person falls outside of the low-risk criteria and requests to birth at home or in one of the birth centres, they must have a documented, evidenced-based discussion and involvement from the multidisciplinary team to ensure they make an informed decision and an individualised plan of care made.

Birthing women and birthing people that have multiple risk factors or risks not detailed below will be reviewed at a monthly Multidisciplinary team (MDT) meeting. Birthing women and birthing people are not included in the MDT meeting unless required on an individualised basis.
Members of the team include the named Consultant for the Home Birth team and when required the named Consultant for St Mary's Birth Centre, Consultant Midwife, Community Matron, Team Lead for the Home Birth team/St Mary's, the named midwife if available and Safeguarding midwife.
Minutes will be taken of the meeting and the discussion should be clearly documented and recorded on the personal maternity electronic record.
Following the meeting a birth choices consultation will be arranged with the Consultant Midwife.
A letter detailing the discussion will be sent to the birthing woman or birthing person and a plan of care attached to EPR.

Birthing women and birthing people requiring an obstetric review/counselling will be offered an appointment in the birth outside of guidance clinic with the Consultant lead. The clinic is held weekly every Tuesday afternoon at the LRI, book via clinic coordinators. Birthing women and birthing people not wishing to attend the birth outside of guidance clinic should be offered an appointment with their linked Consultant to discuss mode of delivery/plan of care. The Consultant Midwife should be contacted to review the requests and make a plan of care with the birthing woman or birthing person.

The role of the consultant midwife is to be a role model and an expert practitioner in midwifery. They will empower midwives and obstetricians to promote better births, informed choice and a positive experience throughout the maternity services. The consultant midwife will support the community, home birth, birth centre and hospital midwives, and obstetricians, in supporting birthing women and birthing people to make informed decisions about their care and individualising care plans where required. Where the consultant midwife is not available, senior midwifery support may be sought from the matron for the area.

During the birth choices consultation, the consultant midwife/matron/consultant obstetrician will take a full history and gain an understanding of the person holistically and the reasons for the requests they are making. A full discussion will take place clearly outlining what the agreed Trust guidance recommends and the benefits and risks associated with the decision they wish to consider. The birthing woman or birthing person should be offered the opportunity of birth reflections or

psychological therapy, if appropriate, to address any psychological trauma or phobias. The discussion should be clearly documented and recorded on their personal maternity electronic record.

Related UHL documents:

- Intrapartum Care: Healthy Women and their Babies
- Home Birth Operational Guideline including management and risk assessment
- Induction and Augmentation of labour UHL Obstetric Guideline
- Referrals to the Maternal Mental Health Service (MMHS), Birth Reflections and Consultant Midwife

2. Guideline Standards and Procedures

Where birthing women or birthing people have existing medical conditions or obstetric complications, a multidisciplinary team led by a named healthcare professional should involve the birthing woman or birthing person and prepare an individualised plan for intrapartum care (NICE 2019).

Birthing women and birthing people who request birth in a midwife-led setting outside of the recommended guidelines must have an individualised plan of care and a documented evidence-based discussion. Examples of where a birthing woman or birthing person may request care outside of guidance include:

- History of a previous postpartum haemorrhage (PPH).
- History of Group B Streptococcus (GBS) in previous or current pregnancy.
- Raised BMI ≥ 35 at booking.
- Maternal use of antidepressants.
- Gestational diabetes in pregnancy.
- History of antepartum haemorrhage (APH) in current pregnancy.
- Maternal age ≥ 40 years at booking.
- History of a previous caesarean section (CS).

(NB. This is not an exhaustive list).

Homebirth

Where a birthing woman or birthing person requests a home birth and they do not meet the criteria, they must have an evidenced-based discussion and individualised plan of care made, following the pathway in appendix one.

An individualised care plan is agreed with the birthing woman or birthing person and obstetric team and the discussion must be recorded on the electronic record. The birthing woman or birthing person is added to a “live” high risk home birth booking register on the high-risk home birth Teams channel. This will be updated with birth outcomes and dates of birth by the home birth team. If the homebirth team attend a high-risk home birth labourer, the labour ward coordinator at LRI is informed. If normal birth achieved at home, the labour ward coordinator is informed.

Where a ‘higher risk’ birthing woman or birthing person requests a homebirth and subsequently requires an induction of labour, they should be advised that the induction cannot be supported at home. An individualised plan of care can be made highlighting the birth choices for the birthing woman or birthing person in the hospital setting.

St Mary's Birth Centre (freestanding)

Birthing women or birthing people requesting to birth outside of guidance at St Mary's Birth Centre (SMBC) should be advised this is not usually supported at St Mary's. If the birthing woman or birthing person wishes to continue to plan birth in a midwife-led setting, they should be referred for discussion and individualised planning for either a homebirth or one of the alongside midwifery units or at times birth at SMBC may be supported on an individualised basis.

Examples of where a birthing woman or birthing person may request care outside of guidance include:

- History of Group B Streptococcus (GBS) in previous or current pregnancy.
- Raised BMI ≥ 35-40 at booking.
- Maternal use of antidepressants.
- Maternal age ≥ 40 years at booking.

Alongside Birth Centres

In some clinical situations a birthing woman or birthing person may not meet the criteria for homebirth or St Mary's birth centre but may have the option to use one of the alongside birth centres. These include:

- BMI ≥ 40.
- Induction of labour requiring one intervention to labour (Foley catheter, single Propess®, or artificial rupture of the membranes), providing an initial labour CTG of the fetal heart rate is normal. The birthing woman or birthing person must have otherwise met the criteria for intermittent auscultation of the fetal heart rate or have an individualised care plan in place that has been agreed by the consultant midwife or consultant obstetrician.
- History of GBS requiring antibiotic prophylaxis in labour.

Where a birthing woman or birthing person requests to use one of the alongside Birth Centres and they do not meet the criteria, they must have an evidenced-based discussion and individualised plan of care made, following the pathway in appendix three.

An individualised care plan is agreed with the birthing woman or birthing person and obstetric team and the discussion must be recorded on the electronic record.

The Birth Centre Managers/Deputies will upload the care plan to the birthing woman or birthing person's electronic record. Complex care plans will be emailed out to the relevant birth centre manager and labour ward coordinators for dissemination with the wider team.

The birthing woman or birthing person will be added to a 'live' birth outside criteria register in the high-risk homebirth Teams channel in the birth centre folder.

All birthing women and birthing people should have their risk status and intended place of birth reviewed at every contact in line with the UHL Trust guideline 'Booking Process and Risk Assessment in Pregnancy and the Postnatal Period'. If there has been a change in risk status or additional risks have developed in the pregnancy or labour/birth, this needs full discussion with the birthing woman or birthing person and documentation on the electronic record (or handheld notes if intrapartum). If the birthing woman or birthing person is still in the antenatal period, further referral and review by the Birth centre manager in the first instance, consultant midwife, matron or obstetrician is advised to review the individualised care plan.
Where an antenatal discussion has not occurred and a birthing woman or birthing person decides to decline recommended interventions in labour/birth, wherever the setting, midwives may use the

proforma's in appendix four to support documented, informed discussions which are then kept in the labour and birth record.

3. Education and Training

- Midwifery training – NMC standards
- Midwifery registration – NMC standards.
- Post registration education and practice – NMC

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Standards against guideline	Audit	Birth Centre Team Leads	Yearly	Maternity Governance
Standards against guideline	Audit	Home Birth Team Lead	Yearly	Maternity Governance

5. Supporting References

Montgomery V Lanarkshire Health Board (2015) UKSC 11

NICE (2022) **Intrapartum care for healthy women and babies**, Clinical guideline (CG190) NICE: London.

NICE (2019) **Intrapartum care for women with existing medical conditions or obstetric complications and their babies**, NICE guideline (NG121), NICE: London.

6. Key Words:

Homebirth; Birth Centre, Birth Centres; outside guidelines

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) F Cox Consultant Midwife		**Executive Lead** Chief Nurse	
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**

December 2021	1	Maternity guidelines group Maternity Governance Committee	New Document
April 2022	1.1	Maternity guidelines group Maternity Governance Committee	Added Maternal age care plan (full review not undertaken)
Oct 2022	1.2	Maternity Governance Committee	Added templates to appendix four for declining of IV access in labour, decline continuous electronic fetal movements, declining active management 3rd stage of labour (full review not undertaken)
August 2023	2	Maternity guidelines group and Maternity governance group	Removed reference to E3 and changed to electronic record. Included Matron as appropriate person for individualised care plan support. Updated individualised care plan templates PPH Risk in line with new PPH guidance. GBS neonatal care in line with neonatal sepsis guidance, BMI recommendation for advising CEFM updated
October 2024	3	F Cox – Consultant Midwife	Added guidance regarding MDT meetings for those with multiple risk factors. Added guidance on actions to be taken if offer to attend birth outside of clinic appointment is declined. Added reference to high-risk home birth TEAMs channel Added a new 'specific requirements' section to each com/mw pro forma

Appendix 1: **High Risk Homebirth Pathway**

Home birth team midwife visits birthing woman or birthing person at home to discuss individual risks for birth at home, including discussion in relation to considering birth in an alongside birth centre as an alternative option.

Birthing woman or birthing person with risk factors requesting to birth in a setting outside of local and national guidance, specifically at home.

Birthing women or birthing people presenting with a history of PPH, GBS, high BMI, Maternal age over 40, antidepressant use, or recurrent episodes RFMs , as a single risk factor, may be seen by the home birth midwife and the associated pro-forma completed. Birthing women and birthing people presenting with risks other than these, or with multiple risk factors, will be reviewed at the monthly MDT meeting, prior to birth choices consultation. The Consultant Midwife/Matron will review previous maternity notes, meet with the birthing woman or birthing person. An individualised care plan is agreed with the birthing woman or birthing person and obstetric team. *When the Consultant Midwife/Matron is not available (e.g. A/L) the midwife should liaise with the named/link Obstetric Consultant or MAU Consultant for urgent referrals*.

Individualised care plan discussed with birthing woman or birthing person and signed. Care plan then uploaded to patient's electronic record.

Weekly list saved to high risk home birth Teams Channel. Contact recorded on each birthing woman's or birthing person's electronic record.

Birthing woman or birthing person's details added to a "live" high risk home birth booking register on the high risk home birth Teams Channel. This will be updated with birth outcomes and dates of birth by the home birth team.

If the homebirth team attend a high risk home birth labourer, labour ward co-ordinator at LRI informed. If normal birth achieved at home, labour ward co-ordinator informed.

Appendix 2: **High Risk St Mary's Birth Centre Pathway**

Birthing woman or birthing person with risk factors requesting to birth in a setting outside of local and national guidance, specifically at St Mary's Birth Centre

Birthing women or birthing people presenting with a history of;

- **GBS, declining antibiotics in labour**
- **High BMI 35-40**
- **Maternal age over 40**
- **Antidepressant use**

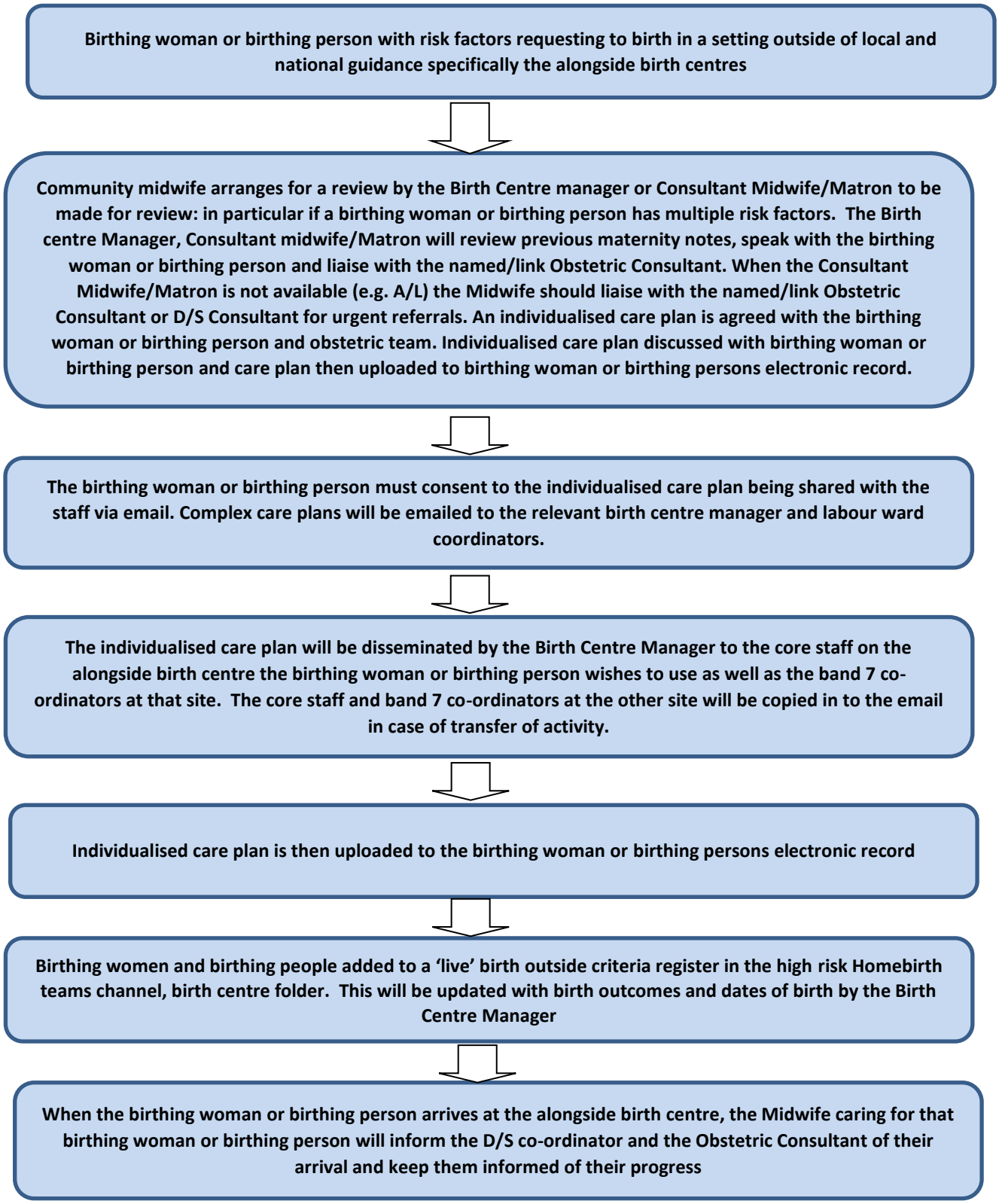
May be seen by the St Mary's midwife and the associated pro-forma completed. Birthing women and birthing people presenting with risks other than these or with multiple risk factors, will be reviewed at the monthly MDT meeting, prior to birth choices consultation. The Consultant Midwife/Matron will review previous maternity notes, meet with the birthing woman and birthing person an individualised care plan is agreed with the birthing woman or birthing person and obstetric team. *When the Consultant Midwife/Matron is not available (e.g. A/L) the midwife should liaise with the named/link Obstetric Consultant or MAU Consultant for urgent referrals*.

Individualised care plan discussed with birthing woman or birthing person and signed. Care plan then uploaded to patient's electronic record.

Weekly list saved to high risk to St Mary's Teams Channel. Contact recorded on each birthing woman or birthing person's electronic record.

Birthing woman or birthing person's details added to a "live" high risk home birth booking register on the high risk St Mary's Teams Channel. This will be updated with birth outcomes and dates of birth by the St Mary's team.

Appendix 3: High Risk Alongside Birth Centre Pathway



Appendix 4 – Community Midwife Proformas

Hospital Copy
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PLAN OF CARE – AT RISK OF Postpartum Haemorrhage (PPH)

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**
OBSTETRIC HISTORY:	

REASON FOR PLAN

The named woman/birthing person is at increased risk of postpartum haemorrhage and as such should be advised to birth in an obstetric unit.

Identified Risk Factor (please circle as appropriate)

- Previous PPH >1000ml, or requiring treatment or blood transfusion
- Previous retained placenta
- History of antepartum haemorrhage (APH) in current pregnancy
- Placenta Praevia/Placenta Accreta
- Para 5 or more
- BMI >40
- Booking weight <40kg
- Haemoglobin <95g/dl
- Uterine anomalies or fibroids
- Multiple pregnancy
- Polyhydramnios
- Macrosomia >90th centile on ultrasound
- Female Genital Mutilation
- Known blood clotting problems including platelets <100 x10^{9}/L

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Primary Postpartum Haemorrhage (PPH) is the most common form of obstetric haemorrhage. It is defined as >500ml blood loss within the first 24 hours after birth.
- PPH can be minor 500-1000mls, major 1000-2000mls or massive >2000mls (NICE, 2017).
- The chance of repeat PPH in a subsequent birth is 15 women in 100.
- The chance of repeat retained placenta in women/birthing people with previous retained placenta is 25 women/birthing people in 100.
- In the majority of cases bleeding can be controlled with simple measures and may only cause minor problems such as feeling faint, nauseous and tired.
- Following a PPH it is not uncommon to become anaemic and require iron replacement therapy. Occasionally a blood transfusion may be recommended.
- In extreme cases, a hysterectomy may be required to treat a massive PPH. (RCOG (1) 2016)
- The risk of death as a result of obstetric haemorrhage is very small 0.56 women per 100, 000 births (MBRRACE, 2020).
- Only basic maternal resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies), the actual travel time, on the roads could mean that emergency and potentially lifesaving care will be delayed.
- 999 will dispatch the closest vehicle; no guarantee staff have midwifery training. If first on scene is a technician crew, they can't cannulate. HBT do not cannulate or carry IV fluids.
- For the above reasons UHL guidelines recommend that women/birthing people should be screened for predisposing risk factors and advised to birth in an obstetric unit where appropriate (UHL, 2017)

SPECIFIC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Information leaflet regarding PPH provided (RCOG (2)2016)

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

MBRRACE-UK (2020) Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. Oxford: National Perinatal Epidemiology Unit, University of Oxford;

NICE: National Institute for Health and Care Excellence (2017) Intrapartum Care for Healthy Women and Babies. Clinical Guideline. [ONLINE]

Nikolajsen S1, Løkkegaard EC, Bergholt T. (2013). Reoccurrence of retained placenta at vaginal delivery: an observational study. Acta Obstet Gynecol Scand 92(4):421-5 {ONLINE}

RCOG: (1) Royal College of Obstetrics and Gynaecology) (2016) Postpartum Haemorrhage, Prevention and Management. (Green-top Guideline No. 52) {ONLINE}

RCOG: (2) Royal College of Obstetrics and Gynaecology (2016) Information for you – Heavy Bleeding after birth (postpartum haemorrhage) {ONLINE}

©UHL (2011) (Reviewed 2020) Postpartum Haemorrhage in a Midwife Led Unit/Low Risk Setting.

Hospital Copy
HBT copy
St Mary's Birth Centre
Handheld notes copy

PLAN OF CARE – GBS

Name	**EDD**
DOB	**ADDRESS :**
Booking Hospital:	
NHS	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has been identified as a carrier of GBS, which increases the risk of GBS infection in the newborn and as such should be advised to birth in an obstetric unit.

Identified risk factor (Please circle as appropriate)

- Previous baby affected by GBS
- Positive GBS culture identified in this pregnancy
- Positive GBS culture in a previous pregnancy

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- GBS is a normal bacterium found in the bowel flora of approximately 20 - 40% of Adults (RCOG, 2017)
- GBS is not harmful to adults but if transmitted to the baby during labour can cause infection in the newborn
- Approximately 1 in 1750 babies are diagnosed with early-onset GBS in the first week of life. No screening test is entirely accurate. Between 17% and 25% of women/birthing people who have a positive swab at 35–37 weeks of gestation will be GBS negative at the time of birth. Between 5% and 7% of women/birthing people who are GBS negative at 35–37 weeks of gestation will be GBS positive at the time of birth.
- Babies with early-onset GBS infection may show the following signs:
    - grunting, noisy breathing, or not breathing at all
    - be very sleepy and/or unresponsive
    - be crying inconsolably
    - be unusually floppy

- not feeding well or not keeping milk down
- have a high or low temperature and/or their skin feels too hot or cold
- have changes in their skin colour (including blotchy skin)

- With suitable and timely treatment over 80% of affected babies will fully recover
- 1 in 14 affected babies will recover but with some form of disability
- 1 in 19 affected babies will die (RCOG, patient leaflet 2017)
- In women/birthing people who carry GBS, the risk of newborn infection is significantly increased when there has been prolonged rupture of membranes (>18hrs) or a maternal temperature >38.0c during labour
- If a woman/birthing person who carries GBS is given prophylactic intravenous antibiotics during labour, the baby's risk of developing infection is significantly reduced from 1:400 to 1:4000. However, it is pertinent to understand that with or without treatment the overall risk remains low
- Only basic newborn resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies), the actual travel time, on the roads could mean that emergency and potentially lifesaving care will be delayed.

- For the above reasons UHL guidelines recommend that women/birthing people identified as a GBS carrier should be advised to birth in an obstetric unit in order to receive prophylactic intrapartum antibiotics and receive a paediatric assessment at birth if indicated (UHL, 2024)
- A paediatric assessment in hospital and Newborn Early warning Track and Trigger NEWTT 2 observations at 0 hours, 1 hour, 2 hours and the 2 hourly until 12 hours (national guidance) is indicated for <u>all</u> babies born to GBS colonised mothers who have not received intrapartum antibiotics at least 4 hours before birth. Where intrapartum antibiotics have been received at least 4 hours before birth, and the baby is >37 weeks with no additional risk factors, the baby does not need a paediatric assessment or NEWTT2 observations.

SPECIFIC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth/St Mary's at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home/St Mary's according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- Should membranes rupture prior to labour onset or should you develop a temperature in labour, the midwife will recommend a transfer into hospital for induction.
- Basic neonatal resuscitation equipment will be available at the birth.
- A full set of newborn observations including a pulse oximetry screen will be performed at home following the birth. Should the baby display any signs of early onset GBS the midwife in attendance will recommend transfer to hospital so that the baby can be reviewed by a neonatologist.

- On the primary home visit a further set of newborn observations will be performed to assess for early onset GBS. Should any of these observations deviate from the norm, the midwife in attendance will recommend an urgent assessment in hospital.
- Information leaflet regarding GBS infection provided (RCOG, 2017) Further information can be found online at http://www.gbss.org.uk/

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

NICE (2017) Clinical Guideline - Neonatal infection early onset: antibiotics for prevention and treatment [ONLINE]

O'Sullivan C, Lamagni T, Efstratiou A, Patel D, Cunney R, Meehan M et al (2016) Group B Streptococcal (GBS) disease In UK and Irish infants younger than 90 days, 2014–2015. Arch Dis Child

UHL (2020) Group B Streptococcus – Management in pregnancy and the newborn obstetic guidelines

RCOG: Royal College of Obstetrics and Gynaecology (2017) Group B streptococcus infection in pregnancy and newborn babies, Patient information leaflet [ONLINE]

RCOG: Royal College of Obstetrics and Gynaecology (2017) Green Top Guideline: Prevention of Early onset Neonatal Group B Streptococcal Disease. [ONLINE]

http://www.gbss.org.uk/ Management .

Hospital Copy
HBT copy
St Mary's Birth Centre
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PLAN OF CARE – BMI of ≥35-40 kg/m2

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY:

REASON FOR PLAN

The named woman/birthing person has been identified as having a BMI of ≥35-40 kg/m2 at booking and as such should be recommended to birth in an obstetric unit.

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- BMI is your body mass index which is a measure of your weight in relation to your height.
- A woman/birthing person is considered to be obese if they have a BMI ≥30 at booking (WHO, 2017). However, UHL's upper limit for low risk midwifery care is a BMI ≥35.
- Most women/birthing people who are overweight have a straightforward pregnancy and birth and deliver healthy babies.
- However, being overweight increases the risk of complications for pregnant women /birthing people and their babies. With increasing BMI, the additional risks become gradually more likely, the risks being much higher for women/birthing people with a BMI of 40 or above.
- **Antenatal risks** associated with maternal obesity include; miscarriage, gestational diabetes, hypertension, preeclampsia, thromboembolism, IUGR, macrosomia & stillbirth (CEMACRCOG, 2010)
- **Intrapartum risks** associated with maternal obesity include; premature birth, shoulder dystocia, increased risk of instrumental delivery, increased risk of caesarean section and failed VBAC (where applicable), prolonged labour, anaesthetic complications, difficulties monitoring the fetal heart and stillbirth (CEMACRCOG, 2010).
- **Postnatal risks** associated with maternal obesity include; PPH, thromboembolism, wound complications, sleep apnoea, baby admitted to NNU & neonatal death (CEMACRCOG, 2010).

Information for consideration

- Women/birthing people booking with a BMI ranging from 35 to 40 who are otherwise low risk can now have the choice of an alongside birthing centre as place of birth (NICE 2019, Rowe 2018 and UHL, 2021). Here they will be offered intermittent auscultation. If there is difficulty with this they can then be offered electronic fetal monitoring in the consultant unit
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies), the actual travel time, on the roads could mean that emergency and potentially lifesaving care will be delayed.

Use of Water for Pain Relief and Labour:

- There is no maternal weight restriction for the fixed pool in hospital/ St Mary's Birth Centre, but the inflatable 'birth pool in a box' has a manufacturing weight limit of 113Kg with a maximum weight for sitting on the side of the pool of 100Kg (Edel Immersys 2019).
- It must be possible for the midwife to auscultate the fetal heart and for the woman/birthing person to enter and exit the pool unaided.
- If there are concerns with the condition of the mother or the baby, there should be a lower threshold for asking the mother to get out of the pool due to difficulties with evacuation from the pool in an emergency.

In view of the numerous and potentially serious complications associated with obesity UHL guidelines recommend that women/birthing people with a BMI ≥35 kg/m2 are advised to birth in an obstetric unit in case of the need for obstetric or neonatal assistance (UHL, 2021).

SPECIFC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home/St Mary's according to the following plan of care:

- Midwives will provide routine intrapartum care at home/St Mary's according to UHL guidance.
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance rather than CEFM as recommended.
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital.
- Is aware that labouring and birthing in a birth pool would not be recommended due to the risk of shoulder dystocia and the health & safety aspects of assisting evacuation from the pool in the event of collapse.
- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Patient leaflet regarding raised BMI provided (RCOG, 2018)
- Is aware to remain well hydrated and mobile to reduce the risks of thromboembolism & to seek urgent medical attention should any symptoms of DVT/PE present following birth.

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron **Discussed with …….. on ……by ……** **Patient signature……..Date……** **Midwife signature……Date…….**

UHL (2021) Clinical Guideline – Obesity in Pregnancy, labour and the Puerperium

CEMACRCOG: Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists (2010) Joint guideline – Management of women with obesity in pregnancy [ONLINE]

Edel Immersys (2019) The Good Birth Company, http://www.edelimmersys.com/uk/

NICE (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies . Evidence reviews for obesity NH121 March 2019

Rowe R Knight M et al (2018) Outcomes for women with BMI >35kg/m2 admitted for labour care to alongside midwifery units in the UK. A national prospective cohort study using the UK Midwifery Study System (UKMisSS)

Royal College of Obstetricians and Gynaecologists (2018) Green top Guidelines No. 72 – Care of women with obesity in pregnancy [ONLINE]

RCOG: Royal College of Obstetrics and Gynaecology (2018) Being overweight in pregnancy and after birth [ONLINE]

WHO: World Health organisation (2017) Recommendations on maternal health (Online)

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE – BMI of ≥40 kg/m2

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY:

REASON FOR PLAN

The named woman/birthing person has been identified as having a BMI of ≥40 kg/m2 at booking and as such should be recommended to birth in an obstetric unit.

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- BMI is your body mass index, which is a measure of your weight in relation to your height.
- A woman/birthing person is considered to be obese if they have a BMI ≥30 at booking (WHO, 2017). However, UHL's upper limit for low-risk midwifery care is a BMI ≥35.
- Most women/birthing people who are overweight have a straightforward pregnancy and birth and deliver healthy babies.
- However, being overweight increases the risk of complications for pregnant women/birthing people and their babies. With increasing BMI, the additional risks become gradually more likely, the risks being much higher for women with a BMI of 40 or above.
- **Antenatal risks** associated with maternal obesity include; miscarriage, gestational diabetes, hypertension, preeclampsia, thromboembolism, IUGR, macrosomia & stillbirth (CEMACRCOG, 2010)
- **Intrapartum risks** associated with maternal obesity include; premature birth, shoulder dystocia, increased risk of instrumental delivery, increased risk of caesarean section and failed VBAC (where applicable), prolonged labour, anaesthetic complications, difficulties monitoring the fetal heart and stillbirth (CEMACRCOG, 2010) .
- **Postnatal risks** associated with maternal obesity include; PPH, thromboembolism, wound

complications, baby admitted to NNU & neonatal death (CEMACRCOG, 2010)

Recommendations and care:

- Women/birthing people with a BMI of >40 would have a medical review on delivery suite, early intravenous access for medication to control possible haemorrhage and offered an early epidural. This is not available in the home birth setting.
- Women/birthing people with a BMI ≥40 kg/m2 are recommended continuous electronic fetal monitoring (CEFM) throughout labour (UHL, 2021), which is unavailable at home.
- All women/birthing people with a BMI ≥40 are recommended to commence 7 days of thromboprophylaxis (UHL, 2021) provided by the hospital at discharge.
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies and then the actual travel on the roads - this time means that emergency, potentially lifesaving care will be delayed.

Use of Water for Pain Relief and Labour:

- There is no maternal weight restriction for the fixed pool in hospital but the inflatable 'birth pool in a box' has a manufacturing weight limit of 113Kg with a maximum weight for sitting on the side of the pool of 100Kg (Edel Immersys 2019).
- It must be possible for the midwife to auscultate the fetal heart and for the woman to enter and exit the pool unaided.
- If there are concerns with the condition of the mother or the baby, there should be a lower threshold for asking the mother to get out of the pool due to difficulties with evacuation from the pool in an emergency.
- Advise the woman/birthing person against labouring or birthing in water and involve senior staff in any discussions where there is a strong maternal request for water birth against medical advice.

In view of the numerous and potentially serious complications associated with obesity, UHL guidelines recommend that women/birthingh people with a BMI ≥40 kg/m2 are advised to birth in a consultant led unit in case of the need for obstetric or neonatal assistance (UHL, 2021).

SPECIFIC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance.
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance rather than CEFM.
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital.
- Is aware that labouring and birthing in a birth pool would not be recommended due to the risk of shoulder dystocia and the health & safety aspects of assisting evacuation from the pool in the event of collapse.

- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Patient leaflet regarding raised BMI provided (RCOG, 2011).
- If your baby weighs <2kg or >4.5kg at birth the midwife will recommend a transfer to hospital for a period of newborn blood glucose monitoring to assess for signs of hypoglycaemia.
- Is aware to remain well hydrated and mobilise early after birth to reduce the risks of thromboembolism & to seek urgent medical attention should any symptoms of DVT/PE present following birth.

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

UHL (2021) Clinical Guideline – Obesity in Pregnancy, labour and the Puerperium

CEMACRCOG: Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists (2010) Joint guideline – Management of women with obesity in pregnancy [ONLINE]

Edel Immersys (2019) The Good Birth Company, http://www.edelimmersys.com/uk/

RCOG: Royal College of Obstetrics and Gynaecology (2011) Information for you – Why your weight matters during pregnancy and after birth [ONLINE]

WHO: World Health organisation (2017) Recommendations on maternal health [Online]

PLAN OF CARE

– Selective Seretonin Reuptake Inhibitors (SSRI's) Medication

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booked Hospital:	
NHS:	**TEL NO:**
OBSTETRIC HISTORY	
REASON FOR PLAN The named woman/birthing person is currently taking SSRI's medication, which may lead to persistent pulmonary hypertension of the newborn (PPHN) and as such should be advised to birth in an obstetric unit.	
CURRENT PREGNANCY:	
SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE • There is evidence that taking SSRIS early in pregnancy slightly increases the risk of your baby developing cardiac abnormalities • Taking SSRIs in pregnancy can cause persistent pulmonary hypertension of the newborn (PPHN). Symptoms of this include rapid or slow breathing, grunting, recession, blue colour to the skin or lips, low blood pressure and low blood oxygen levels. • Infants of mothers who have taken SSRIs in pregnancy should be observed for signs of PPHN. While usually mild and self-limiting, if they occur the infant should receive neonatal assessment (RCOG, 2011). • Therefore, UHL advises that women/birthing people taking any SSRIs should birth in an obstetric unit to allow the baby to be observed for signs of withdrawal for the first 12-24 hours of life and commencement of Newborn Early Warning Track and Trigger (NEWTT2) observations 4 hourly for 24 hours. • This also allows for general observation of the mothers' emotional wellbeing in the early post birth period. • Sertraline is the preferred drug of choice in breastfeeding with a transmission rate of 0.2% into the breastmilk. Citalopram transmission is dose dependent with a transmission rate of 10-15%, and Fluoxetine a transmission rate of 20%.	

- New evidence has identified there is a risk related increase of PPH associated with SSRIs (Grzeskowiak, LE et al (2015)). **Active management of the third stage should be advised.**
- If a woman/birthing person is taking psychotropic medication other than SSRIs, she should be seen in consultant clinic for an individualised care plan.

SPECIFIC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home/St Mary's Birth centre according to the following plan of care:

- Midwives will provide routine intrapartum care at home/St Mary's according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum and immediate postnatal period should the midwife recognise any signs of deteriorating mental health she will recommend a transfer to hospital
- Basic neonatal resuscitation equipment will be available at the birth.
- Following delivery the midwife in attendance will recommend transfer to hospital should she observe any congenital abnormalities or possible symptoms of PPHN.
- As per UHL guidelines Pulse oximetry to be performed after birth.
- The named woman/birthing person has been advised of the signs of PPHN and will contact a midwife should she have any concerns with her baby.
- On the primary home visit within the first 24 hours of life should the midwife identify any symptoms of PPHN she will recommend a transfer to hospital for further newborn assessment.

Reviewed and agreed by

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

Grzeskowiak, LE et al (2015) Antidepressant use in late gestation and risk of postpartum haemorrhage: a retrospective cohort study, BJOG, https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.13612

NICE: National Institute for Health and Care Excellence (2014) Antenatal and Postnatal Mental Health: Clinical management and service guideline.

RCOG: Royal College of Obstetrics and Gynaecology (2011) Management of Women with Mental Health Problems during Pregnancy and the Postnatal Period.

Hospital Copy
HBT copy
St Mary's Birth Centre
Handheld notes copy

PLAN OF CARE –
MATERNAL AGE

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has been identified being over 40 years of age at booking and as such should be advised to birth in an obstetric unit.

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Most women/birthing people, including those over 40 years of age, will have a normal pregnancy and a healthy baby.
- However, maternal age is found to be associated with an increase in antenatal and intrapartum stillbirth. The reason for this remains unknown.
- At 41 weeks of gestation the risk of stillbirth is 0.75 in 1000 women under the age of 35 years old, and 2.5 in 1000 women/birthing people aged ≥ 40 years old (Reddy et al, 2006)
- Due to the above, UHL guidelines recommend offering IOL from 39+4 weeks or around the woman's/birthing persons EDD (UHL, 2019). This service is not available in the home or St Mary's environment.
- The guidance also states that since the overall risk is small, in the absence of other risk factors, women/birthing people should be supported to avoid IOL if this is their wish (UHL, 2019)
- Due to the increased risk of stillbirth electronic fetal monitoring is advised in labour. This type of fetal monitoring is not available in the home/St Mary's birth centre environment.

- **Other antenatal complications** including placenta praevia, preeclampsia, gestational diabetes, thromboembolism, placental abruption, malpresentation & IUGR occur more frequently in older mothers (RCOG, 2013)
- **Intrapartum complications** including premature labour, labour dystocia, instrumental delivery, caesarean and PPH occur more frequently in older mothers (RCOG, 2013)
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies and then the actual travel on the roads - this time means that emergency, potentially lifesaving care will be delayed.
- For the above reasons UHL guidelines recommend that women/birthing people OVER 40 years at the time of booking should be advised to birth in an obstetric unit (UHL, 2019)

SPECIFIC REQUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Consents to active management of third stage due to increased risk of PPH
- Basic maternal & neonatal resuscitation equipment will be available at the birth.

The midwife should discuss with the woman/birthing person when she may accept induction of labour and also offer monitoring via the MAU twice per week if the woman/birthing person wants this. CTG and USS do not have any predictive value but can ascertain the baby's wellbeing at the time of the monitoring. It is the midwife's responsibility to book the induction. The woman's/birthing persons preference in relation to this is:

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……

Reviewed and agreed by consultant obstetrician or consultant midwife/Matron

Discussed with…… on……by……..

Patient signature…….…… Date ……..

Midwife signature……. Date ……

Reddy UM, Ko CW, Willinger M (2006) Maternal age and the risk of stillbirth throughout pregnancy in the United States. American Journal of Obstetrics & Gynecology 195:764–70.

RCOG: Royal College of Obstetrics & Gynaecology (2013) Induction of Labour at Term in Older Mothers – Scientific Paper [ONLINE}

UHL (2019) Clinical Guideline – Induction of Labour

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE REDUCED FETAL MOVEMENTS

NAME:	**EDD**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has experienced 2 or more episodes of reduced fetal movements within a 21-day period in the third trimester **OR** reports reduced fetal movements in the 24 hours preceding labour and as such should be advised to birth in an obstetric unit (UHL, 2017)

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Fetal movements can be described as the maternal sensation of any discrete kick, flutter, swish or roll. Such fetal activity provides an indication of the integrity of the central nervous and musculoskeletal systems (RCOG, 2011)
- A significant reduction or sudden alteration in fetal movement is a potentially important clinical sign.
- Fetal physiology studies utilising ultrasound technology have shown an association between reduced fetal movements and poor perinatal outcome (Harrington, 1998)
- More than 50% of women/birthing people who have experienced a stillbirth perceived a reduction in fetal movements prior to diagnosis (Efkarpidis et al, 2004)
- UHL guidelines recommend women/birthing people who have experienced reduced fetal movements fetal movements in the 24 hours preceding labour should be advised to have electronic fetal monitoring in labour. This facility is not available in the home environment (UHL, 2017)
- That being said the Cochrane review of continuous electronic fetal monitoring found that it is not more effective at picking up distress in babies than intermittent monitoring and does not reduce the number of babies that die or have brain damage (Alfirevic et al 2015)

- For the above reasons, following an antenatal risk assessment should a woman/birthing person be considered at increased risk due to her history of fetal movements, UHL guidelines recommend they be advised to birth in an obstetric unit (UHL, 2017)
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Transfer time varies as it involves the clinical care required before the transfer, the extraction time (which can be more challenging during obstetric emergencies and then the actual travel on the roads - this time means that emergency, potentially lifesaving care will be delayed.

SPECIFIC REQUUIREMENTS;

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine low risk intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Basic maternal & neonatal resuscitation equipment will be available at the birth.

Reviewed and agreed by

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

UHL (2017) Reduced Fetal Movements – Guideline for assessment of risk and management

Alfirevic Z, Devane D, Gyte GML, Cuthbert A (2017) Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. Cochrane Database of Systematic Reviews 2017 [ONLINE]

Harrington, K. Thompson, O. Jordan, L. Page, J. Carpenter, R. Campbell, S (1998) *Obstetric Outcome in Women who present with a reduction in fetal movements in the third trimester of pregnancy.* Journal of Perinatal Medicine, 26: 77-82.

Efkarpidis, S. Alexopoulous Elkin, L. Liu, D. Fay, T (2004) *Case Control Study of Factors associated with Intrauterine Fetal Deaths.* MedGenMed, 6:53.

RCOG: Royal College of Obstetrics and Gynaecology (2011) Green Top Guideline – Reduced Fetal Movements (ONLINE)

Appendix 5 – Proformas for women declining intravenous access, continuous electronic fetal monitoring and active management of 3rd stage of labour

Care plan for persons declining intravenous (IV) access in labour	
Reason IV access recommended	IV access is recommended as you have a higher chance of postpartum haemorrhage (PPH) or need for operative intervention. The reason for IV access in your case is:
Person's reason for declining	
Benefits of IV access	IV access sited during labour allow for the rapid administration of drugs and fluids in the event of an emergency situation. If an emergency event happens it may delay the progress of further care/intervention whilst IV access is secured. In the case of PPH, where there is heavy blood loss, it can be more difficult to secure IV access if the maternal veins have constricted.
Risks	Some people will feel pain at the insertion site and may feel their movement is restricted. There is a small risk of infection at the insertion site.
Alternatives	Not to have a routine insertion and have an IV inserted when clinically needed.
Intuition	What does the person feel about the above information?
Nothing	If no IV cannula is sited then IV drugs and fluids cannot be given.

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:
……...

Date signed: ……..

Care plan for persons declining continuous electronic fetal monitoring (CEFM)	
CEFM is recommended as your pregnancy is 'higher risk' and there is a greater chance of hypoxia and adverse outcome for your baby.	The reason for CEFM is:
Person's reason for declining	
Benefits	CEFM is able to identify changes in baseline rate, variability, presence of accelerations and decelerations. IIA can only identify changes in baseline rate and decelerations that occur after a contraction or those that tale a long time to recover. It cannot identify all types of changes. In women/birthing people with a history of previous caesarean section, an abnormal fetal heart rate pattern will be identified in 60-70% of cases of uterine scar rupture
Risks	Increased chance of intervention such as instrumental birth or caesarean section CEFM has not been shown to reduce the number of babies born with acute brain injury or cerebral palsy. Perceived reduction in mobility of the birthing person during labour and birth
Alternatives	To have IIA in line with UHL and national guidelines.
Intuition	What does the person feel about the above information?
Nothing	Fetal monitoring is the only clinically accurate way of ascertaining wellbeing throughout labour and birth.

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:

……...

Date signed: ……..

Care plan for persons declining active management 3rd stage	
Reason active management is recommended	Active management of the 3rd stage of labour is where an oxytocic injection is given to assist with the birth of the placenta & membranes. It helps to reduce the amount of blood loss post-birth and minimises the chance of postpartum haemorrhage (PPH) Sometimes a doctor will also recommend a drip with an oxytocin infusion to help reduce the chance of PPH The reason for active management of the 3rd stage is recommended in your case is:
Person's reason for declining	
Benefits	Reduction in chance of PPH Early administration of oxytocic drugs may help reduce the amount of PPH
Risks	Pain at insertion site Nausea and vomiting
Alternatives	Not to have a routine insertion and have an IV inserted when clinically needed.
Intuition	What does the person feel about the above information?
Nothing	There may be an increased chance of PPH

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:
……...

Date signed: ……..

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