The Shrewsbury and Telford Hospital NHS Trust

Women Seeking Midwife Led Birth Choices That Fall Outside Guidance.

(Previously Birth Against Professional Advice Guideline, previously Place or Mode of Birth outside of Local or National Guidance)

Version 7.2

Lead Person	**:**	Consultant Midwife
Care Group	**:**	Women and Children's
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Version	Implementation Date	History	Ratified By	Full Review Date
1	2004	New Guideline		December 2006
2	December 2006	Minor revisions		December 2008
3	12th Sept 2008	Supervisory input and LSA guidance	MG & MGG	September 2010
4	24th May 2011	Minor changes	MGG	May 2014
4.1	28th September 2012	NMC and legal guidance and definition of free birthing and lotus birth	MGG	May 2014
5	18th September 2014	Full Version Revision	MGG Maternity Governance	September 2017
6	26th June 2017	Full Version Revision Change to title from Birth Against Professional Advise) Removal of Supervisor of Midwives. New Midwifery Advocate role defined	MGG Maternity Governance	June 2022
6.1	18th September 2018	Detail to section 5.5 birth plan discussions at maternity governance	MGG Maternity Governance	June 2022
6.2	November 2022	Audit & Monitoring paragraph updated to reflect new process		June 2022
7.0	27th June 2023	Full Version Review, guideline renamed	Maternity Governance	May 2026

7.1	11th August 2023	Auditable Standards added- Appendix 3		May 2026
7.2	20th December 2024	Incorrect numbering corrected. Wording adjusted for accuracy in Appendix 1		May 2026

To read in conjunction with
Clinical Risk Assessment (Antenatal) guideline (025)
Consent to Examination or Treatment (CG11)
Mental Capacity and Best Interest Policy and Procedures (CG14)
Homebirth Standard Operating Procedure (SOP 043)
Care in Labour on A Midwife Led Unit or Homebirth guideline.
Maternity Personalised Care and Support Planning Group (SOP 097)
Women Choosing Unassisted birth or Freebirth Guidance
Fetal Monitoring for labour & birth (Electronic fetal monitoring & Intermittent Auscultation (076 (2))

Definitions/abbreviations

Outside of Local Guidance - In the context of this guideline, 'outside of local guidance' is taken to mean a woman who chooses not to accept advice from her named professional regarding her place or mode of birth, after taking into consideration the potential risks to the safety and wellbeing of herself and her baby.

MLU – midwife led unit providing intrapartum care.

Personalised care - a series of facilitated conversations in which the person actively participates to explore the management of their health and wellbeing within the context of their whole life and family situation so that all considerations that may impact on safe care are accounted for.

Badgernet – the electronic maternity patient records system used at SaTH.

Informed decision making - Individuals being supported to understand the care, management, and support options available to them as well as well as the potential associated risks, benefits, and alternatives of those options.

Lack of Mental Capacity (Incapacity) - A person lacks capacity if they have an impairment or disturbance in their mind or brain, and the impairment or disturbance means that they are unable to make a specific decision or take a particular action for themselves at the time the decision or action needs to be taken.

Professional Midwifery Advocate (PMA) - PMAs act as role models, promoting safe and effective evidence-based care for women, babies, and their families. This is achieved by supporting midwives to identify how personal actions can improve the quality of care provided to women and families, and by using a process known as restorative clinical supervision.

In this guideline we use the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

1.0 Introduction

1.1 The concept of woman-centred care is at the core of midwifery care and midwives have a key role as advocates and facilitators of women's choices. Personalised care accounts for individuals' values and preferences and is based on choice and control through genuine partnership with health professionals to improve care outcomes. The NHS Long Term plan (NHS England 2019) sets out a vision for universal personalised care an ambitious target for the implementation of the comprehensive model for personalised care across health and care system. This includes the implementation of Personalised Care and Support Plans (PCSP) in maternity (NHS England 2021)

1.2 The best available evidence should be presented in an accessible way, including a personalised and holistic risk assessment which takes into consideration what the individual wants to know, rather than what clinicians think the individual should be

aware of. It is also important to note that some women may decline extensive information giving by maternity professionals. This is their right to do so and should be respected and documented accordingly in their Badgernet records.

1.3 Assumptions must be avoided, and safety considered through a holistic lens including physical, mental, emotional, spiritual and cultural considerations.

1.4 The Midwife must explain to the woman and her partner the inclusion criteria for intrapartum care in a midwife-led setting in Shropshire and ascertain that they are fully aware and understand any risks related to their choice of place of birth (Mayberry and Mayberry 2005). Conversations with the woman and partner will be documented in Badgernet.

1.5 The Midwife will inform their manager and request professional support, if required, for advice and guidance. A referral should also be made to the Consultant Midwife via Badgernet if further support is necessary.

1.6 The woman or Midwife can request further discussion with the Consultant Midwife or named Consultant Obstetrician where there are medical or obstetric issues (NICE 2017)

2.0 Aims

2.1 To provide women with the information to enable them to make an informed choice with respect to their chosen place of birth, mode of birth, care and management.

2.2 To provide a care pathway for women who choose a place or mode of birth outside of local guidance to ensure the safest possible care in the circumstances.

2.3 To provide support for staff who will be providing care for women who choose a place or mode of birth outside local guidance and enable measures to be put in place to mitigate the risks.

3.0 Objectives

3.1 To risk assess woman choosing a place of birth outside of local or national guidance.

3.2 To devise a plan of care with the woman and her partner, to promote the safest possible outcomes for mother and baby.

3.3 To demonstrate key events in the care and management of women who have chosen to have a place of birth outside of local guidance.

3.4 To ensure that staff are trained and supported to provide safe care to those choosing a place of birth outside of local guidance.

4.0 Process

4.1 As a Midwife you have a professional duty to report any concerns from your workplace, which put the safety of the people in your care or the public at risk (NMC, 2019a)

4.2 It must always be considered that a person other than a Registered Midwife or a Registered Medical practitioner shall not attend women in Childbirth (The Nursing and Midwifery Order, 2001). However, the exception to this would be in an emergency or when a medical student or a Student Midwife is being supervised by the above.

4.3 In addition, midwives optimise normal physiological processes, and support safe physical, psychological, social, cultural, and spiritual situations, working to promote positive outcomes and to anticipate and prevent complications. (NMC, 2019b).

5.0 Women who request a birth outside of local guidance.

5.1 See appendix 1 -This process is designed for women who have a medical or previous pregnancy related issue that would suggest she is not suitable to birth at home or an MLU and has expressed her choice at the initial consultation in pregnancy (refer to section 6.0 for women who were initially suitable for MLU/home birth but a medical or pregnancy related issue has arisen).

NB It is the responsibility of the Community or Named Midwife to facilitate this process.

5.2 The woman will be offered an antenatal appointment at a mutually convenient time where she can discuss her wishes with her named Midwife. See appendix 2 for a list of risks for the most common conditions when women have a preference to attend a midwife led setting in labour. This meeting should take place by 28 weeks gestation to facilitate further consultation and discussion with Consultant Obstetricians or Neonatologists. The community or named Midwife will refer the woman to the Consultant Midwife via Badgernet with the woman's consent for further discussion.

5.3 The role of the Consultant Midwife is to be a role model and an expert practitioner in midwifery. He/she will empower Midwives and Obstetricians to promote a safe and positive birth experience, informed choice, and personalised care. The Consultant Midwife will support all staff in supporting women to make informed decisions about their care and individualising care plans where required.

5.4 During the birth choices consultation, the Consultant Midwife will review the woman's history and gain an understanding of the reasons for the requests they are making. A full discussion will take place clearly outlining what the local and national guidance recommends and the benefits, risks and alternatives associated with their birth preferences. The discussion should be clearly documented and recorded within the specialist review workflow on Badgernet.

5.5 The Consultant Midwife will ensure the named Consultant Obstetrician is aware of the woman's birth preferences and refer the woman to antenatal clinic for further discussion if required.

5.6 The final plan will be discussed at the monthly Multi-disciplinary Care Planning and Complex Needs meeting. The Consultant Midwife will present an overview of all women seen since the previous monthly meeting for information sharing and MDT input (see section 8.0).

5.7 Any woman who has an Obstetrician led pregnancy but chooses a place of birth outside of local guidance, will have two Midwives present during her labour and the birth of her baby.

6.0 Women who were initially suitable for MLU/home birth

6.1 In circumstances where medical or pregnancy related health issues develop that would require the place of birth to change from home/MLU to the Consultant Unit Delivery suite (e.g. reduced fetal movements/large for dates) and the woman chooses not to accept this recommendation, the Community or Named Midwife can facilitate the process in section 5.1 of this guideline and refer the woman to the Consultant Midwife with the woman's consent.

6.2 Documentation will be updated throughout the pregnancy, to include discussions, advice given, when any relevant decisions are made or plans of care change. If the woman decides not to engage in the process, Badgernet will be updated and the MLU and relevant community ward manager will be informed to escalate to the Matron. A full risk assessment should be completed at every antenatal contact and documented on Badgernet. See appendix 2 for a list of risks for the most common conditions when women have a preference to attend a midwife led setting in labour The plan of care will be updated on the Pregnancy Summary page as necessary.

7.0 Mental Capacity

7.1 All women have the right to make their own decisions as a basic human right protected by common law, unless they lack the legal capacity to decide (Montgomery v Lanarkshire Health Board 2015).

7.2 A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision. People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

7.3 Refer to the Trust Mental Capacity and Best Interest Policy and Procedures guideline (CG14) for information on how to assess mental capacity.

8.0 Multidisciplinary discussion and information sharing

8.1 The woman's birth choice will be discussed and documented within the monthly multidisciplinary care planning and complex needs meeting.

8.2 Women will be discussed by the Consultant Midwife, if involved in their care. For those who have not consented for the Consultant Midwife to contact them, the named Community Midwife will refer to the care planning meeting via Badgernet. The referrer (or a designated representative) will attend the care planning and complex needs meeting to provide further information about the woman's history and birth choices.

8.3 In addition to the monthly care planning and complex needs meeting, the Consultant Midwife will meet fortnightly with the intrapartum and community/MLU matron and update them with all pregnant women opting for birth in a Midwife led setting outside of local guidance. Information and birth choices will be disseminated to the MLU, community and delivery suite staff by the relevant Matron.

9.0 Training

Staff will maintain compliance with mandatory training in emergency drills (PROMPT), fetal monitoring in labour and adult and neonatal resuscitation, so that they are clinically competent to manage emergencies. Additional refresher training can be provided in the event of staff requests. This will be arranged by the area ward manager or Matron.

10.0 Monitoring and audit

Compliance with this guideline will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out against the auditable standards and the results of the audit will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

11.0 References

DH (2007) Mental Capacity Act. Department of Health, London.

Mayberry, M. and Mayberry, J (2003) Consent in Clinical Practice. Radcliffe Publishing. ISBN: 1857758048.
Montgomery v Lanarkshire Health Board (2015) UKSC 11

NHS England (2019) The NHS Long Term plan

NHS England (2021) Personalised care and support planning guidance: Guidance for local maternity systems

NICE (2017) Intrapartum care for healthy women and babies, CG190

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

NMC (2015) The Code – Professional Standards of practice and behaviour for Nurses and Midwives

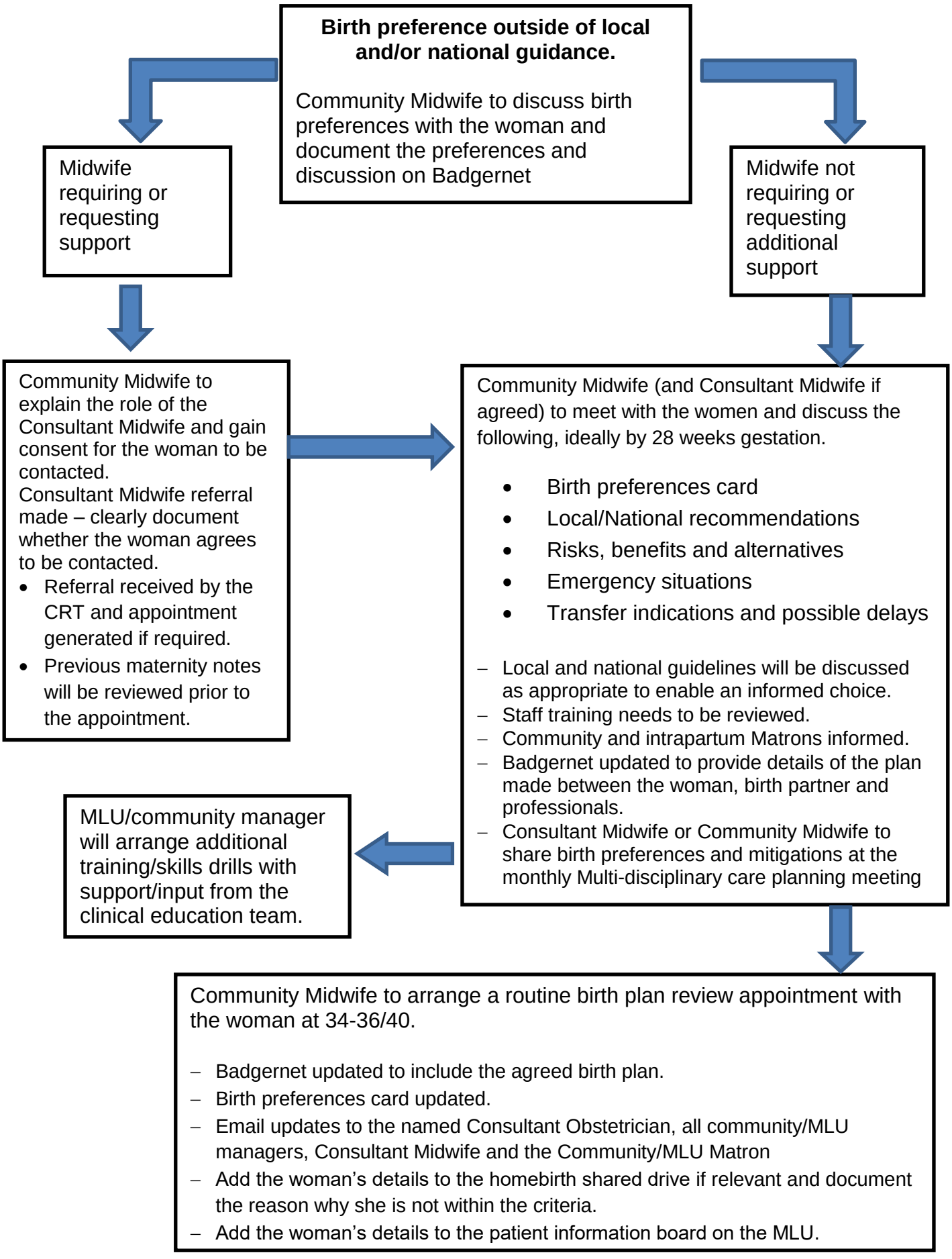
NMC (2019a) Raising concerns: Guidance for nurses, midwives, and nursing associates.

NMC (2019b) Standards of proficiency for midwives

Nursing and Midwifery Order (2001) www.legislation.gov.uk/uksi/2002/253/contents/made (accessed 11.05.2023)

Oberg AS, Hernandez-Diaz S, Palmsten K, Almqvist C, Bateman BT. Patterns of recurrence of postpartum hemorrhage in a large population-based cohort. Am J Obstet Gynecol. 2014 Mar;210(3):229.

Appendix 1


Birth preference outside of local and/or national guidance.
Community Midwife to discuss birth preferences with the woman and document the preferences and discussion on Badgernet
Midwife requiring or requesting support
Midwife not requiring or requesting additional support
Community Midwife to explain the role of the Consultant Midwife and gain consent for the woman to be contacted.
Consultant Midwife referral made – clearly document whether the woman agrees to be contacted.
• Referral received by the CRT and appointment generated if required.
• Previous maternity notes will be reviewed prior to the appointment.
Community Midwife (and Consultant Midwife if agreed) to meet with the women and discuss the following, ideally by 28 weeks gestation.
• Birth preferences card
• Local/National recommendations
• Risks, benefits and alternatives
• Emergency situations
• Transfer indications and possible delays
– Local and national guidelines will be discussed as appropriate to enable an informed choice.
– Staff training needs to be reviewed.
– Community and intrapartum Matrons informed.
– Badgernet updated to provide details of the plan made between the woman, birth partner and professionals.
– Consultant Midwife or Community Midwife to share birth preferences and mitigations at the monthly Multi-disciplinary care planning meeting
MLU/community manager will arrange additional training/skills drills with support/input from the clinical education team.
Community Midwife to arrange a routine birth plan review appointment with the woman at 34-36/40.
– Badgernet updated to include the agreed birth plan.
– Birth preferences card updated.
– Email updates to the named Consultant Obstetrician, all community/MLU managers, Consultant Midwife and the Community/MLU Matron
– Add the woman's details to the homebirth shared drive if relevant and document the reason why she is not within the criteria.
– Add the woman's details to the patient information board on the MLU.

Appendix 2

An overview of risks and statistics for birth in a midwife led setting outside of guidance.

All risks will be discussed within the context of the limitations of resources within the midwife led setting.

All labour and birth emergencies are time critical and the longer the delay in accessing the most appropriate care, the greater the impact on the safety and wellbeing of the woman and/or her baby.

Refer to the WMAS response times available on the Y drive (WomenAndChildrens>CommunityMidwives>WMAS Transfer Figures).

This is in addition to the routine information provided about managing emergency situations at home or on the MLU.

1. Being overweight in pregnancy and after birth RCOG patient information leaflet

www.rcog.org.uk/media/aggdhd3g/being-overweight-in-pregnancy-patient-information-leaflet.pdf

- Some of the risks with raised BMI include increased risk of thrombosis, gestational diabetes, high blood pressure, pre-eclampsia, induction of labour, caesarean birth, anaesthetic complications and wound infections.
- If you are overweight, you are more likely to have a baby weighing more than 4 kg, which increases the risk of complications for you and your baby during birth. If your BMI is 30 or above, your risk is doubled from 7 in 100 to 14 in 100 compared with women with a BMI of between 20 and 30.
- The overall likelihood of stillbirth in the UK is 1 in every 200 births. If you have a BMI of 30 or above, this risk increases to 1 in every 100 births.

Being overweight increases your risk of developing high blood pressure and pre- eclampsia. If you have a BMI of 30 or above, your risk of pre-eclampsia is 2–4 times higher compared with those with a BMI under 25.

2. Birth options after previous caesarean section RCOG patient information leaflet

www.rcog.org.uk/media/na3nigfb/pi-birth-options-after-previous-caesarean-section.pdf

After one caesarean, about three out of four women with a straightforward pregnancy who go into labour naturally give birth vaginally. A number of factors make a successful vaginal birth more likely, including:
• previous vaginal birth, particularly if you have had previous successful VBAC; if you have had a vaginal birth, either before or after your caesarean, about 8–9 out of 10 women can have another vaginal Birth
• your labour starting naturally
• your body mass index (BMI) at booking being less than 30.

- You may need to have an emergency caesarean during labour. This happens in 25 out of 100 women. This is only slightly higher than if you were labouring for the first time, when the chance of an emergency caesarean is 20 in 100 women. An emergency caesarean (cat 3) carries more risks than a planned caesarean. The most common reasons for an emergency caesarean are if your labour slows or if there is a concern for the wellbeing of your baby.
- You have a slightly higher chance of needing a blood transfusion compared with women who choose a planned second caesarean.
- The scar on your uterus may separate and/or tear (rupture). This can occur in 1 in 200 women. This risk increases by 2 to 3 times if your labour is induced. If there are warning signs of these complications, your baby will be delivered by emergency caesarean. Serious consequences for you and your baby are rare.
- Serious risk to your baby such as brain injury or stillbirth is higher than for a planned caesarean,

but is the same as if you were labouring for the first time.
- You may need an assisted vaginal birth using ventouse or forceps.
- You may experience a tear involving the muscle that controls the anus or rectum (third or fourth degree tear).

3. Gestational diabetes RCOG patient information leaflet
www.rcog.org.uk/media/b10mqyfw/pi-gestational-diabetes.pdf

It is important that your blood glucose level is controlled during labour and birth and it should be monitored to ensure it is not too high. You may be advised to have an insulin drip to help control your blood glucose level.

The risks to your baby are:
- being bigger than average
- shoulder dystocia (where your baby's shoulder gets stuck during birth)
- stillbirth or the baby dying at or around the time of birth. This is uncommon.
- needing additional care once they have been born, possibly in a neonatal unit • being at greater risk of developing obesity and developing type 2 diabetes in later life.
- Your baby will stay with you unless they need extra care. You can usually have skin-to-skin contact with your baby straight away if you choose this. Occasionally they may need to be looked after in a neonatal unit if they are unwell or need extra support.

Your baby should have their blood glucose level tested a few hours after birth to make sure that it is not too low.

Controlling your levels of blood glucose during pregnancy and labour reduces the chances of these complications for you and your baby.

4. Group B Streptococcus (GBS) in pregnancy and newborn babies RCOG patient information leaflet
www.rcog.org.uk/media/xtmfktbh/pi-gbs-pregnancy-newbornnewlogo21.pdf

- If you carry GBS, there is a small chance that your baby will develop GBS infection and become seriously ill, or even die.
- Around 1 in every 1750 newborn babies in the UK and Ireland is diagnosed with early-onset GBS infection. The infections that GBS most commonly causes in newborn babies are sepsis (infection of the blood), pneumonia (infection in the lungs) and meningitis (infection of the fluid and lining around the brain).
- Although GBS infection can make your baby very unwell, with prompt treatment most babies will recover fully. However, of the babies who develop early-onset GBS infection, 1 in 19 (5.2%) will die and, of the survivors, 1 in 14 (7.4%) will have a long-term disability.
- If GBS was found in a previous pregnancy and your baby was unaffected, then there is a 1 in 2 (50%) chance that you will be carrying it again in this pregnancy.
- If you are still carrying GBS at 36 weeks of pregnancy, then the risk of your baby developing early-onset GBS infection is increased to around 1 in 400 and you will be offered antibiotics in labour. These antibiotics reduce the risk of your baby developing a GBS infection in their first week of life from around 1 in 400 to 1 in 4000. This is only available on the consultant led delivery suite at present.
- If you are not carrying GBS at this stage of pregnancy, then the risk of your baby developing early-onset GBS infection is much lower (1 in 5000) and you may choose not to have antibiotics.
- If your baby is felt to be at higher risk of GBS infection and you did not get antibiotics through a drip at least 4 hours before giving birth then your baby will be monitored closely for signs of infection for at least 12 hours. This will include assessing your baby's general wellbeing, heart rate, temperature, breathing and feeding.

Most babies who develop GBS infection become unwell in the first week of life (which is known as early onset GBS infection), usually within 12–24 hours of birth. Although less common, late-onset GBS infection can affect your baby up until they are 3 months old. Having antibiotics during labour does not prevent late onset GBS.

Babies with early-onset GBS infection may show the following signs:
• grunting, noisy breathing, moaning, seeming to be working hard to breathe when you look at their chest or tummy, 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)
• have an abnormally fast or slow heart rate or breathing rate
• have low blood pressure*
• have low blood sugar. *
*Identified by tests done in hospital

5. Heavy bleeding after birth (postpartum haemorrhage) RCOG patient information leaflet
www.rcog.org.uk/media/k0shhdb4/pi-heavy-bleeding-after-birth-postpartum-haemorrhage.pdf

Increased risk of PPH when:
• known placenta praevia – when the placenta is located lower down near the neck of the womb
• suspected or proven placental abruption – when the placenta separates from the womb early
• carrying twins or triplets
• pre-eclampsia and/or high blood pressure
• having had a PPH in a previous pregnancy
• having a BMI (body mass index) of more than 35
• anaemia
• fibroids
• blood clotting problems
• taking blood-thinning medication
• having a long labour (more than 12 hours)
• having a large baby (more than 4kg or 9lb)
• having your first baby if you are more than 40 years old

Studies show a PPH recurrence risk of 15% (1 in 7) in women with one previously affected pregnancy and 27% (1 in 4) in those with two prior affected pregnancies (Oberg et al 2014)

Appendix 3

Point	Auditable Standard
5.2	The woman will be offered an antenatal appointment at a mutually convenient time where she can discuss her wishes with her named Midwife
5.2	The community or named Midwife will refer the woman to the Consultant Midwife via Badgernet with the woman's consent for further discussion
5.2	This meeting should take place by 28 weeks gestation to facilitate further consultation and discussion with Consultant Obstetricians or Neonatologists
5.4	A full discussion will take place clearly outlining what the local and national guidance recommends and the benefits, risks and alternatives associated with their birth preferences. The discussion should be clearly documented and recorded within the specialist review workflow on Badgernet.
5.5	The Consultant Midwife will ensure the named Consultant Obstetrician is aware of the woman's birth preferences and refer the woman to antenatal clinic for further discussion if required.
5.5	The final plan will be discussed at the monthly Multi-disciplinary Care Planning and Complex Needs meeting.
5.6	Any woman who has an Obstetrician led pregnancy but chooses a place of birth outside of local guidance, will have two Midwives present during her labour and the birth of her baby.
6.1	In circumstances where medical or pregnancy related health issues develop that would require the place of birth to change from home/MLU to the Consultant Unit Delivery suite (e.g. reduced fetal movements/large for dates) and the woman chooses not to accept this recommendation, the Community or Named Midwife can facilitate the process in section 5.1 of this guideline and refer the woman to the Consultant Midwife with the woman's consent.
6.2	If the woman decides not to engage in the process, Badgernet will be updated and the MLU and relevant community ward manager will be informed to escalate to the Matron. A full risk assessment should be completed at every antenatal contact and documented on Badgernet.
8.1	The woman's birth choice will be discussed and documented within the monthly multidisciplinary care planning and complex needs meeting.
8.2	Women will be discussed by the Consultant Midwife, if involved in their care. For those who have not consented for the Consultant Midwife to contact them, the named Community Midwife will refer to the care planning meeting via Badgernet.
8.3	In addition to the monthly care planning and complex needs meeting, the Consultant Midwife will meet fortnightly with the intrapartum and community/MLU matron and update them with all pregnant women opting for birth in a Midwife led setting outside of local guidance
Flowchart	Community Midwife to arrange a routine birth plan review appointment with the woman at 34-36/40 1, Badgernet updated to include the agreed birth plan. 2, Birth preferences card updated. 3, Email updates to the named Consultant Obstetrician, all community/MLU managers, 4, Consultant Midwife and the Community/MLU Matron 4, Add the woman's details to the homebirth shared drive if relevant and document the reason why she is not within the criteria. 5, Add the woman's details to the patient information board on the MLU.