Consultant Midwife Additional Care & Support Plan Clinic / Meetings SOP

Summary statement: How does the document support patient care?	This SOP is to support maternity professionals when care planning for pregnant women and people who wish to make choices which deviate from National/local guidance.
Staff/stakeholders involved in development:	Consultant Midwife, HOM's, Obstetric leads, Midwifery Clinical Governance Managers for UH Sussex.
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Consultant Midwife UH Sussex
For use by:	All midwives, obstetricians & anaesthetists who come into contact with pregnant women and people during the antenatal, intrapartum or postnatal periods.
Purpose:	To ensure clear, individualised care plans are made for women and people who chose to deviate from National/local guidance and that they are provided with accurate evidence-based information to base these choices on.
This document supports:	https://www.nmc.org.uk/standards/code/
Key related documents:	UH Sussex Maternity Guidelines for provision of antenatal, intrapartum and postnatal care.
Approved by & date:	Joint Obstetric Guideline Group (SRH&WH): 15th March 2023 Protocol Steering Group (PRH&RSCH): February 2023
Date uploaded:	16th March 2023
Ratified by Board of Directors/ Committee of the Board of Directors	Not Applicable – Divisional Ratification only required
Ratification Date:	Not Applicable – Divisional Ratification only required
Expiry Date:	March 2026
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	SP23006

Version	Date	Author	Status	Comment
1.0	March 2023	Katie Christie, Consultant Midwife UH Sussex	LIVE	New SOP outline role and responsibilities of Consultant Midwife

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.
If in doubt contact a senior colleague or expert.

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1.0 Key principles

A standard operating procedure (SOP) is a set of step by step instructions ensuring that a potentially complex process can be undertaken in a timely way. Professional judgement may be used in the application of a SOP.

2.0 Scope

This SOP applies to:

- All members of staff who come into contact with the pregnant woman and person, being referred during the antenatal, intrapartum and postpartum periods.
- Pregnant women and people whose care is being transferred from home to hospital, from site to site and from this Trust to another Trust.

3.0 Responsibilities

It is the responsibility of all Midwifery and medical staff to:

- Access, read, understand, and apply this guidance.
- Attend any mandatory training pertaining to this guidance.

It is the responsibility of the division to:

- Review the SOP in line with national recommendations.
- Ensure the SOP is accessible to all relevant staff.
- Monitor outcomes of the SOP.

4.0 Abbreviations used within this SOP

SOP Standard Operating Procedure	**IOL** Induction of Labour
AAR Action After Review	**PCSP** Personalised Care and Support Plan
VBAC Vaginal Birth After Caesarean	**MVP** Maternity Voices Partnership
MDT Multidisciplinary Team	**LGA** Large for Gestational dates
GDM Gestational Diabetes Mellitus	**VE** Vaginal Examination
MROP Manual Removal of Placenta	**CCU** Critical Care Unit
ITU Intensive Care Unit	**IUGR** Intrauterine Growth Restriction
SROM Spontaneous Rupture of Membranes	**HB** Homebirth
GBS Group B Streptococcus	**PROM** Prolonged Rupture of Membranes
SGA Small for Gestational Age	**MLU** Midwifery Led Unit
MIS Maternity Information System	**PPH** Postpartum Haemorrhage

5.0 Definitions

Induction of Labour (IOL) is defined as when a labour is induced artificially as it is considered that the safest course of action is to end the pregnancy. This can be due to the maternal or fetal condition.

Planned Vaginal Breech Birth is defined as when, during the antenatal period, the fetus is presenting in the breech position and the pregnant woman or person, has decided to birth vaginally.

Deviating from protocol/guidelines is defined as when the birthing woman or person, chooses a pathway of care outside of either local or national guidance.

Clinician is defined as any registered practitioner who is responsible for the delivery of care, for example a Midwife or Obstetrician.

High Risk is defined as when the care of a pregnant woman or person requires a referral for obstetric or medical input into their care.

Homebirth is defined as when a pregnant woman or person chooses to birth at their domestic address.

After Action review (AAR) is defined as a supportive conversation between the multi-disciplinary team, led by a maternity professional peer, following an event that requires discussion or resolution.

Personalised Care and Support Plan (PCSP) renamed ‘My choices for pregnancy birth and beyond’ is defined as an individualised care plan available to all pregnant women and people within maternity care to support their choices and individual preferences.

6.0 Aims

- To support maternity professionals when care planning for pregnant women and people who wish to make choices which deviate from National/local guidance.
- To provide an opportunity for pregnant women and people to, with a Consultant Midwife, discuss their individual needs and choices in addition to the routine pathway of care.
- To provide pregnant women and people with accurate and contemporaneous evidence-based information as per national guidance to support an informed decision alongside their personal choices and wishes.
- To ensure multidisciplinary team involvement in care planning and facilitate pregnant women and people with relevant healthcare professionals, where necessary.
- For pregnant women and people to feel listened to, understood and that their choice is respected.

- To provide clear documentation of the care plan.
- To ensure care plans are shared and accessible to maternity staff involved in their care within the Maternity Information System (MIS) eg Badgernet or Medway, or their hospital maternity notes.

7.0 Indications

Midwives and obstetricians at UH Sussex offer evidence based information and choice during women's & people's pregnancy, labour and postnatal period in alignment with local and national guidance. The consultant midwife clinic has been developed in response to the needs of those pregnant women & people who wish to make choices which are not aligned with this guidance, and provide additional support alongside their routine antenatal care.

The consultant midwife clinic has been developed in response to the needs of these pregnant women & people and their need for additional support alongside their routine antenatal care.

7.1 Supporting evidence for the service

The importance of close multi-professional working between clinicians to ensure good outcomes for mothers and babies was highlighted in the Report of the Morecombe Bay Investigation. In addition the recent Ockenden report in 2020 stated that where a complex pregnancy is identified there must be early specialist involvement and management plans agreed between the pregnant woman or person and the multi-disciplinary team.

The Ockenden report in 2020 recommended pregnant women & people must be enabled to participate equally in all decision making processes and make informed choices about their care. The National Maternity Review 'Better Births' identified the need to develop safer and more personalised care through a process of support that empowers pregnant women and people to make decisions about their care through on-going dialogue. As Midwives and Obstetricians we have a responsibility to treat pregnant women and people as individuals, to listen, share the information required in order for them to make a decision, respond to their preferences and concerns and act in the best interest of the woman or person at all times All women and people have the right to make their own decisions as a basic human right, protected by the common law unless they lack the mental capacity to decide.

Regular feedback received from the MVP (Maternity voices Partnership) when undertaking their 'Walk the patches' continues to identified the need for complex care planning. It has also been identified through Datix and AAR's that further complex care planning is required to meet women & people and the named clinicians needs and experiences.

8.0 Pathway

When a pregnant woman or person advises that they are considering a pathway that deviates from guidance or protocol the reviewing clinician should explain current guidelines,

explore the wishes of the pregnant woman or person and discuss any risks of this. All discussions must be clearly documented.

- If there is agreement on the new pathway between the named clinician and the pregnant woman or person, then the named lead clinician can continue delivering the care if they feel that this sits within their remit.
- If the clinician feels that the request from the pregnant woman or person is outside of their sphere of practice, a referral to the Consultant Midwives must be made in a timely way dependent on gestation and urgency.
- Examples of where referrals may be made (but not exclusive to) are:
    - Those women/people wishing to consider a twin birth with midwifery led care or in water
    - Vaginal breech birth
    - VBAC after 2 or more caesareans with midwifery led care
    - Woman/person with significant medical or mental health complexities wishing to give birth with midwifery led care.

9.0 Referral process

9.1 Routine referrals

Should be made as soon as they are identified and ideally prior to 36-weeks.
Please see Appendix 5 (Personalised Place of Birth Assessment Tool for guidance)

Routine referrals for women & people deciding to deviate in pregnancy should be made as soon as they are identified and ideally prior to 36 weeks. Once a routine referral is received the Consultant Midwife will aim to triage it within a working week (Exception made to annual leave when response times could be longer).

Referrals should be made via Badgernet referrals (Brighton and Haywards Heath) (See Appendix 3) or direct email with the woman or person's details and sent to: uhsussex.consultantmidwife@nhs.net (Worthing and Chichester).

Once the referral is received it will be prioritised based on gestation and clinical need. A decision will be made to either:

- Book an appointment for the pregnant woman or person in the Consultant midwife's clinic named the '*Midwifery Additional Care*' Clinic.
- Offer advice for the lead clinician so that they can deliver the support and care planning themselves.

Late referrals may be required for pregnant women or people whose pregnancies are postdates and undecided about induction or there is unexpected complication later in pregnancy such as breech presentation where the named clinician requires additional input.

The consultant Midwife can be contacted via email or telephone. This will usually be office hours and their availability can be learned from the management rota on labour ward.

9.2 Urgent referrals

Urgent referrals may be required for pregnant women or people who are postdates and declining induction or they are in labour with an unexpected complication such as undiagnosed breech presentation. The Consultant Midwife can be contacted directly via telephone. This will usually be office hours and their availability can be learned from the management rota on labour ward.

The Consultant Midwife will discuss with referring clinician via telephone or email and contact the pregnant woman as soon as possible.

NB: If the referral is after 36/40 or urgent and the Consultant Midwife is not available then the labour ward lead or co-ordinator should be contacted for immediate advice and support.

10.0 Consultations and care planning

10.1 Consultant Midwife Clinic

The Consultant Midwife will work across all four UH Sussex sites, across Brighton, Haywards Heath, Worthing and Chichester. The clinics will be running at differing sites each week, dependent on demand.

Once the referral has been triaged, the consultant midwife will respond to the named clinician and offer either supportive discussions or detail about a plan to attend the clinic. The lead clinician for the woman or person can develop the birth plan if they feel comfortable and competent in having discussions when birthing out of guidance for ‘green’ and ‘yellow’ level clients (See Appendix 5). Referrals should still be made for ‘info only’ to the Consultant Midwife.

For ‘Amber’ and ‘Red’ level clients, referrals should be made to the Consultant Midwife and Consultant Obstetrician for review.

People can attend the clinics face to face, virtually via Microsoft teams or via telephone. Appointments will include an opportunity for the pregnant woman or person to discuss their individual preferences to ensure a shared understanding. Information will be provided in line with current evidence, local guidance and trust protocols. Risks and benefits will be discussed to assist in decision making.

An agreement will be made together and documented on the care plan. All discussions should be clearly documented and shared with the woman or person.

Any care planning deviating from guidance, will include the Multi-disciplinary team. It is the responsibility of the consultant midwife to lead on shared planning and refer appropriately to all specialists, obstetric, neonatal, anaesthetic and medical teams for input as necessary. The Consultant Midwife will refer directly to the Obstetrician or refer to the ‘Complex Care Meeting’ (See Appendix 1) for additional guidance from the wider MDT.

The pregnant woman or person will be offered a multi-disciplinary meeting to discuss their care plan where required or requested following the Obstetric input or Complex Care Meeting.

For Brighton and Haywards Heath Service Users:

An agreed plan of care will be made together and all discussions will be clearly documented on Badgernet in the Antenatal Management plan section. It is also recorded in the Antenatal attendance section and an alert identifying that the person has been seen in the consultant Midwife clinic is added on.

For Worthing and Chichester Services Users:

Once the final care plan has been agreed and finalised, it is the Consultant Midwife's responsibility to disseminate this care plan to the named clinician, the pregnant woman or person, the lead Midwives and the Midwifery Matrons via email. A copy will also be kept in the Consultant Midwife T-Drive. The format will use Appendix 3.

An agreed plan of care will be made together and all discussions will be clearly documented in their hand held notes if available and the hospital maternity notes and on MIS.

10.2 Late gestations and urgent referrals

Late and urgent referrals will be discussed directly with the referring clinician via telephone or email.

Pregnant women & people will be seen in the clinical setting or contacted directly via telephone.

The Consultant Midwife will provide an opportunity for the pregnant woman or person to discuss their individual preferences to ensure a shared understanding. Information will be provided in line with current evidence, local guidance and trust protocols. Risks and benefits will be discussed to assist in decision making. An agreed plan of care will be made together and all discussions will be clearly documented on Badgernet (Brighton and Hayward Heath) or in their hand held notes if available and the hospital maternity notes and MIS (Worthing and Chichester).

Any care planning deviating from guidance, will include the Multi-disciplinary team and any other specialists that require input.

11.0 Review, monitoring and compliance

11.1 Data collection

The Consultant Midwives will have access to a database to input and store relevant data when pregnant women & people have been referred to the clinic.

A dashboard has been designed that will collect a measureable list of clinical outcomes for pregnant women & people.

11.2 Review

This Standard Operating Procedure will be reviewed and updated in 6 months to ensure it aligns with the on-going development of the Consultant Midwife clinic for routine referrals and personalised care and support planning for late/urgent referrals.

11.3 Monitoring and compliance

Annual audit and presentation to Quality and Safety meeting will be undertaken against the standards within the document to consider:

- Number of referrals
- Timing of referrals
- Appropriateness of referrals
- Outcomes of women/people compared with care plans
- Staff access and understanding of the Consultant Midwives Personalised Care and Support Plan Meetings and the clinic.

12.0 References

Kirkup B. (2015) The Report of the Morecombe Bay Investigation. The Stationary Office Ockenden Report (2020) Maternity services at the Shrewsbury and Telford Hospital NHS Trust. Emerging Findings and Recommendations from the Independent Review. 10 December

National Maternity Review. (2016) Better Births: Improving outcomes of maternity services in England, London

Nursing and Midwifery Council. (2015) Code. Nursing and Midwifery Council, London. General Medical Council. (2008) Consent: patients and doctors making decisions together, General Medical Council, London.

Montgomery v Lanarkshire Health Board (2015) UKSC 11

12.1 Further reading

Hall J, Collins B, Ireland J, and Hundley V. (2016) *Interim report: The Human Rights & Dignity Experience of Disabled Women during Pregnancy, Childbirth and Early Parenting*. Centre for Midwifery Maternal and Perinatal Health, Bournemouth University: Bournemouth.

Morad S, Parry-Smith W and McSherry W. (2013) Dignity in maternity care. *Evidence Based Midwifery: June 2013* Department of Health. Final report on the review of the Department of Health Dignity in Care Campaign. November 2009

Why Human Rights in Childbirth Matter (2017) Rebecca Schiller, Printer & Martin.

Appendix 1: Complex Care Planning MDT Meeting: TOR's

1. This group will meet to discuss pregnant women/people with complex care needs.
2. The aims of the meeting are:
    a) To facilitate an MDT approach and timely discussion with the relevant health care professionals where women & people are choosing care outside of guidance or a complex pregnancy is identified requiring specialist input.
    b) To ensure all clinicians are supported by the MDT team within pregnant women & people's plan of care for complex pregnancies or choices outside of guidance.
    c) To respect all pregnant women & people's individual choices and understand their needs alongside MDT input and discussion of local and evidence based recommendation.
    d) To agree a recommended management plan with the MDT to discuss with pregnant women & people alongside their own individual choice and need.
3. The meeting will run monthly as a minimum on Thursday afternoons
4. The core members of the group are the Obstetric team and Consultant Midwife. Other team members required to attend are the Antenatal/community, Labour ward and postnatal Midwifery leads. Additional expertise for specific cases that may wish to attend or be invited are Inpatient and community Maternity Matrons, Anaesthetic/Obstetric leads, Neonatal teams, PNMH professionals, named Midwives, specialist Midwives including safeguarding, mental health, teenage and substance use leads.
5. All referrals for complex care planning from named Midwives will initially be referred to the Obstetric team or the Consultant Midwife.
6. Following referral individual cases will be triaged by the Obstetric team and Consultant Midwives. Cases requiring additional MDT discussion and planning will be taken to the monthly complex care planning meeting.
7. The meeting currently will be held via Microsoft teams and recorded.
8. Women's/people's complex pregnancies will be shared at the meeting where possible prior to meeting with the woman/person to gather information and support a shared understanding of their needs. Referrals later in pregnancy that have required immediate management plans with the pregnant woman or person from the Obstetrician or Consultant Midwife may be discussed at the meeting for any additional input required from the MDT.
9. Following the meeting a consultation will be arranged with the pregnant woman or person and relevant professionals to discuss their wishes/choices, provide the evidence from the MDT recommendation and implement a collaborative plan of care.
10. Individual management plans and care choices will be recorded on the MDT care plan form and should be distributed to the relevant teams in preparation for admission and care.
11. All shared information will remain within the healthcare setting and data protection guidance and disseminated only to those care givers who will be involved and the pregnant person.

Appendix 2: Consultant Midwife Clinic Care Planning – Agreement Worthing/St Richard's

Consultant Midwife Clinic: Care Planning Agreement form

Any correspondence please email: uhsussex.consultantmidwife@nhs.net

Personal details:			
Name:		DOB:	
Hospital No:		EDD:	
NHS No:		Parity:	
Tel no:		Appointment date:	
Email:		Gestation at appointment:	

Key Professionals		
Name	Role/organisation	Contact Number
	Community Midwife	
	Consultant Obstetrician	
	GP	
	Social Worker	
	Neonatologist	
	Interpreter & Language	
	Other:	

Reason for Referral

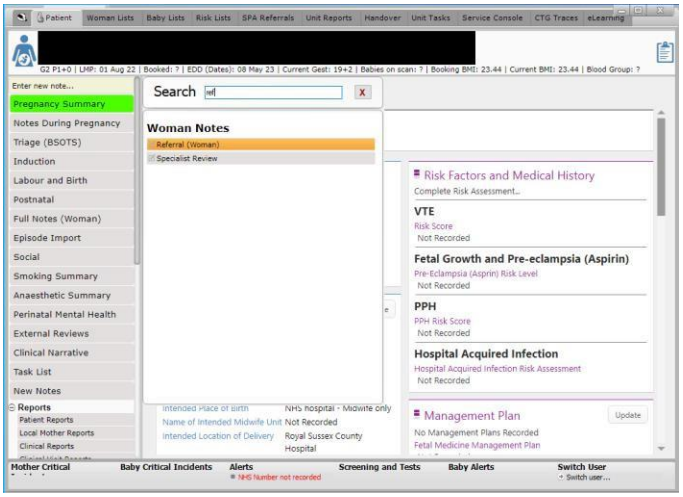
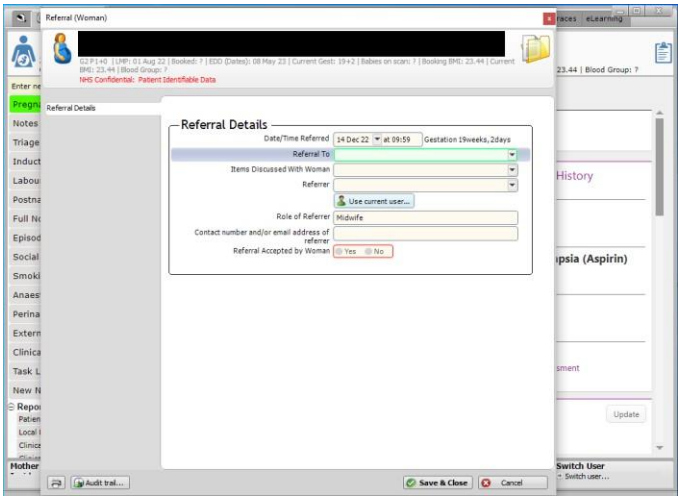
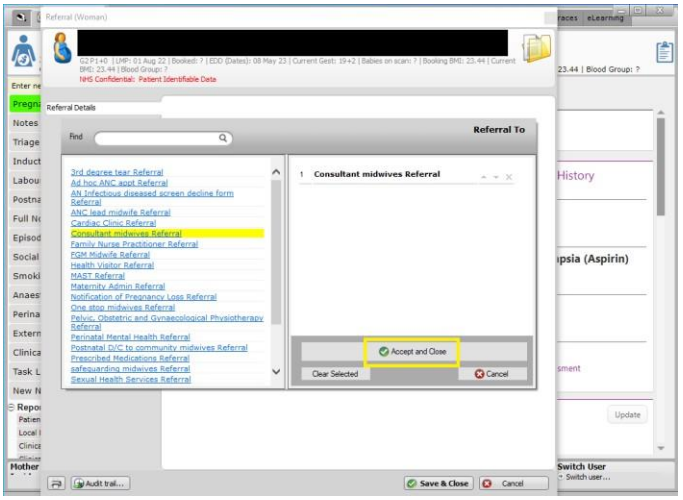
Previous Births/ Relevant obstetric & medical history

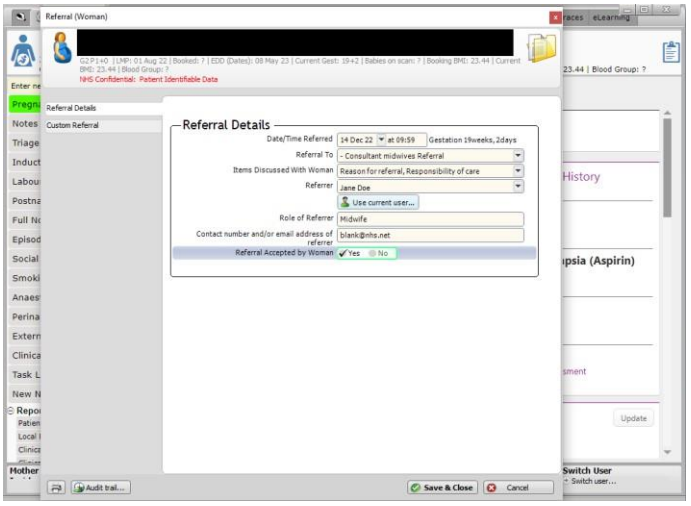
Birth wishes including risks and benefits already discussed (please attach birth plan or any other supporting evidence already discussed outside of this clinic)

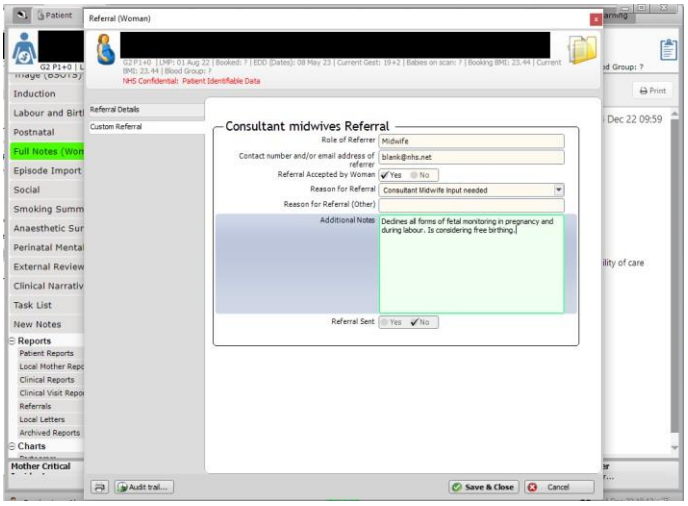
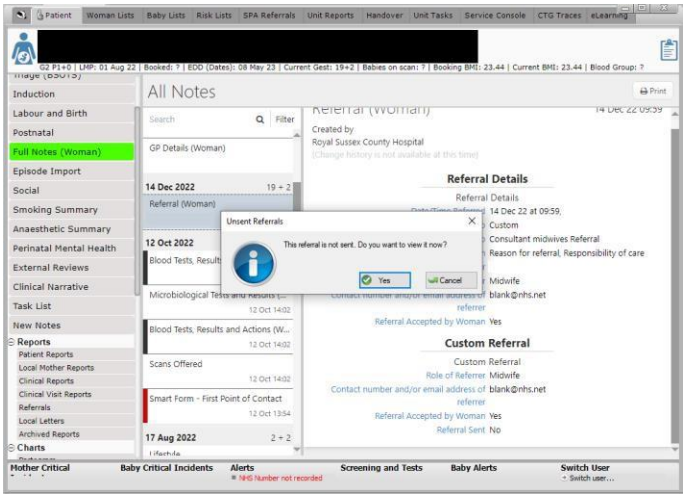
Protocols/ Evidence Provided

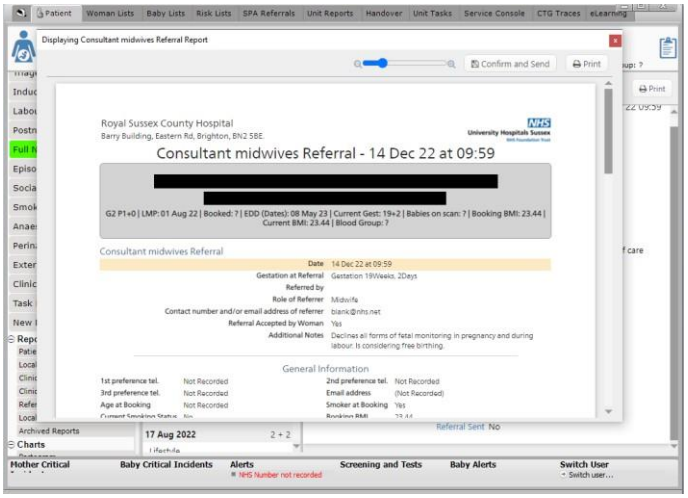
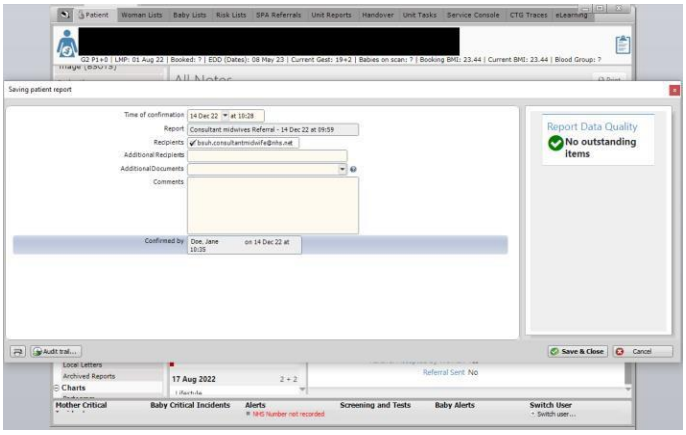
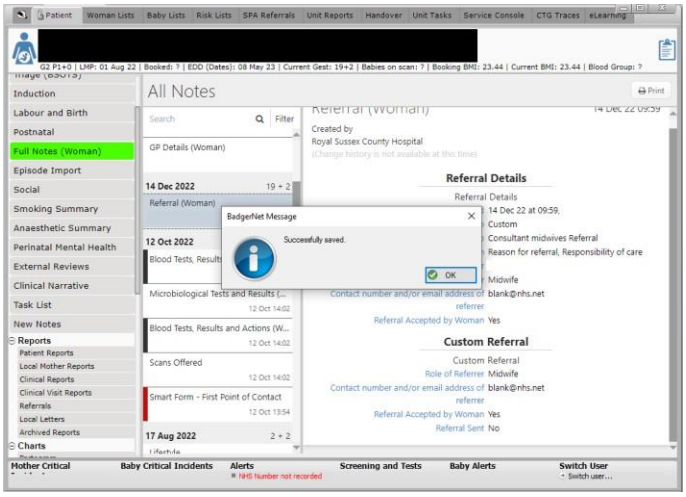
Discussion and finalised care plan made	
Consultant Midwife signature and Date:	I confirm that I have provided up to date information and guidance and discussed any risks which may be associated with the above request. I also believe that this person has the capacity to make decisions that are documented above:

Appendix 3: Badgernet Referral Process

Step	Action	Badgernet Image
1	Using 'Enter new note…' function, search for Referral. Click "Referral (Woman)" to open.	
2	There will then be a pop up box that opens. Ensure that the date and time are correct. In the second drop down box, titled 'Referral To', click in the box or on the downwards arrow open more options.	
3	From the list select 'Consultant midwives Referral'. Then click the button titled 'Accept and Close'.	

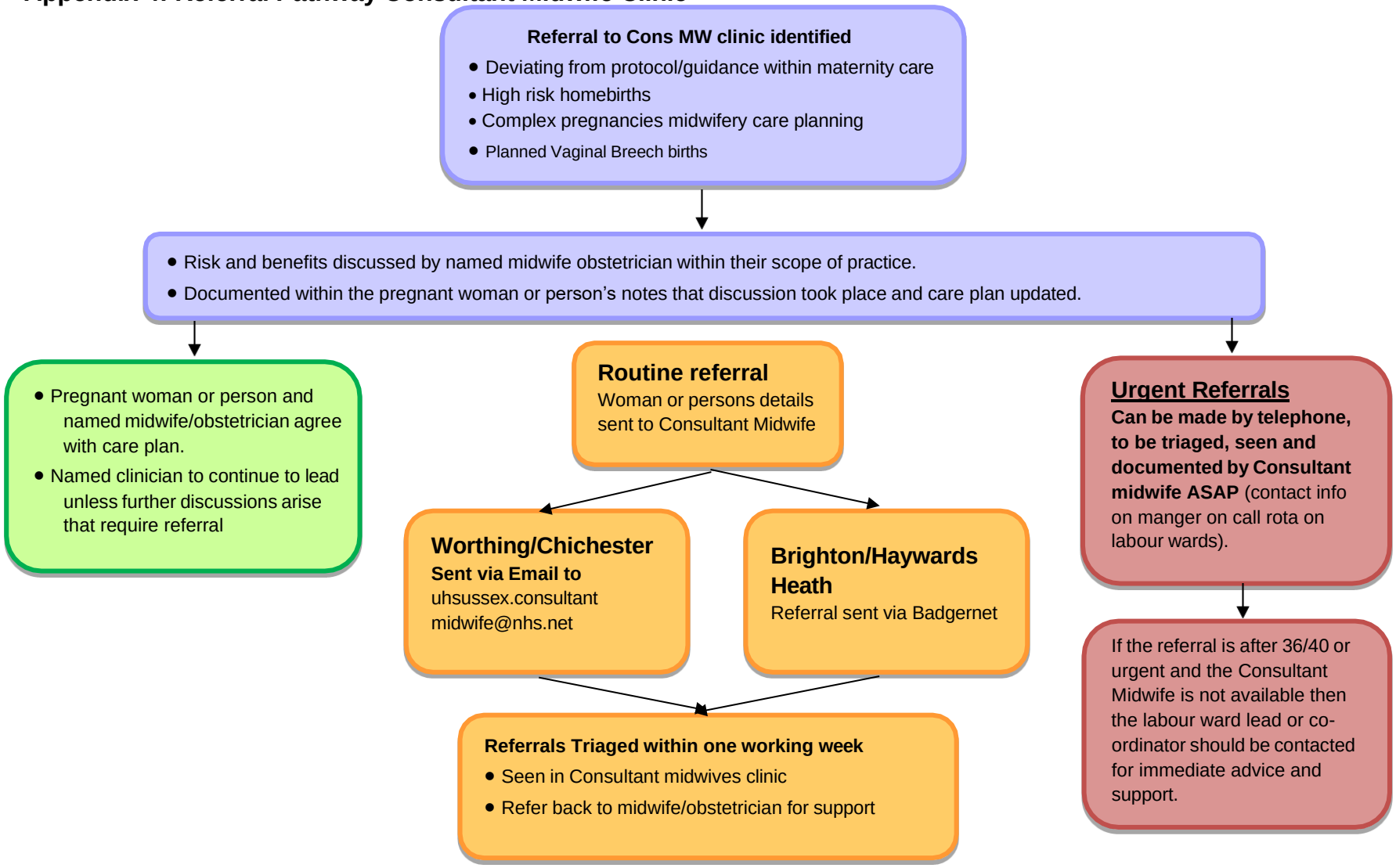
Step	Action	Badgernet Image
4	Then please complete the rest of the 'Referral (Woman)'. • Please select all that has been discussed in the box 'Items Discussed With Woman'. • In 'Referrer', click the 'Use current user..' button or if referring on behalf of someone else, click in the box and search for the user using the find function. • Role of Referrer will automatically fill with ' Midwife' unless deleted and changed manually. • Manually type a contact telephone number or email address in 'Contact number and/or email address of referrer', this streamlines the process of the Consultant Midwife being able to action the referral. • Select either 'Yes' or 'No' to advise the Consultant Midwife that aware whether the Woman or person is aware of the referral to the service or not. This question is mandatory.	

Step	Action	Badgernet Image
5	Click the custom referral tab, on left side of 'Referral (Woman)' box. • If Boxes 1, 2 and 3 have been completed in the 'Referral details' section, these boxes do not need to be filled in again. • Click in the 'Reason for Referral' box or click the downward arrow. A new pop up will appear. Select 'Consultant Midwife input needed' and then click the 'Accept and close' button to save the answer. This question is mandatory. • Complete the box named 'Additional notes', with free text and add as much information as possible. This allows Consultant Midwife to know the reason for the referral. When form is complete click 'Save and Close'.	
6	The referral is not yet sent. The next pop up box enables you to preview the referral prior to sending. When the box pops up select 'Yes' to view it now.	

Step	Action	Badgernet Image
7	Check over the referral information. When happy click button in top right of the box 'Confirm and Send'	
8	Addition comments can be added that will be added to the text of the email but this box does not necessarily need to be filled in. To add digital signature, click 'Authorise' and enter Badgernet Login and password. Click 'Save and Close'	
9	The referral has now been sent.	

Note: Badgernet does not use inclusive language and when forms refer to 'Women' this is inclusive of all birthing people. Also, for this table, a test patient was used to demonstrate the process but all names were removed in case of any coincidences with real patients or staff.

Appendix 4: Referral Pathway Consultant Midwife Clinic



If seen in Consultant Midwife clinic, a birth care planning agreement will be formulated and shared with the appropriate MDT. Additional Obstetric input may be requested for complex cases or referral to the complex care

Appendix 5: Personalised Place of Birth Assessment TOOL

Risk assessment begins in the antenatal period at the booking visit. Every further contact with a woman or person is an opportunity to reassess and identify any individual factors during the antenatal, intrapartum and postnatal period. All midwives are expected to identify deviations from the norm in a timely fashion and act on these findings appropriately, ensuring effective communication with the woman or person, their birthing partners and the multidisciplinary team (MDT). This is specifically around 'place of birth' discussions and a lot of these women and people will be under the care of the MDT already.

Recommend midwifery led care in labour	**Recommend MDT care in labour** – individual assessment		**Recommend Obstetric led care in labour**
Green – minimal individual factors Suggested place of birth at home, MLU (Chichester) or Hospital	Yellow – individual factors Suggested place of birth planning on discussion with clinician/midwife competent in complex care discussions. (If planning a homebirth then to make referral to Consultant Midwife for information only or for further support)	Amber – individual factors Suggested place of birth labour ward. (To contact Consultant MW if wanting a homebirth)	Red – significant individual factors Suggested place of birth labour ward, with birth planning support led by obstetric team
• Uncomplicated pregnancy, medical and obstetric history • Singleton pregnancy • Gestation 37-41+6 weeks • Para 4 and below • Spontaneous onset of labour • Cephalic presentation • Booking BMI with uncomplicated pregnancy: - BMI 18-35 • GBS positive (treatment dependant) • Labour within 24 hours of SROM • Established labour following postdates induction. (excluding HB and MLU) • Haemoglobin >100g/l	• Previous PPH up to 1000mls, or MROP • Previous third or fourth degree tear • Primiparous with BMI up to 35 • Women/people aged <16 or 40 & over at booking • Recurrent HSV (genital herpes) • Haemoglobin 95-105g/l • LGA without other medical/ obstetric factors • Previous reduced fetal movements (RFM) with reassuring assessment of fetal wellbeing • Significant social, safeguarding or mental health factors • Grand multiparity • Low BMI =/<18.5 • Declining IOL for Postdates (joint management with MAU) • Declining VE's in labour • VBAC-1 with no extra risks	• Previous shoulder dystocia • BMI>/= 40 • Previous PPH >1000mls or requiring blood transfusion • VBAC-1 (following 1 previous caesarean birth) • Fibroids • Moderate-severe asthma • SGA =/< 10th centile • Well controlled GDM on diet • Refusal of blood products • GBS • Vaginal Breech	• VBAC-2 (following 2 or more previous caesarean births) • Primary HSV (genital herpes) • Pre-existing diabetes or medicated GDM • Current substance misuse • Maternal medical conditions e.g. hypertension, epilepsy, neurological, cardiac disease, abnormal liver function, previous ITU/CCU admission Pregnancy specific factors: • Oligo/ polyhydramnios • Multiple pregnancy • Malpresentation • Preterm =/42 weeks gestation • Abnormal fetal growth. Eg IUGR • Placenta Previa • Congential abnormality • Any vaginal blood loss other than a show • PROM, augmentation for SROM • Unbooked pregnancy • Abnormal fetal heart rate in labour
The following are not possible at Home: • Continuous monitoring of fetal heart rate • Oxytocin augmentation in labour • Epidural • Instrumental Birth • Planned neonatal attendance at birth • IV antibiotics	Choices surrounding place of birth: We offer personalised care and choice of place of birth; if a woman or person would like to explore a place of birth that is not consistent with the recommendations that have been made, then they should be referred in a timely manner to the Consultant Midwife (amber) and/or Consultant Obstetrician (red) during the antenatal period to fully discuss birth preferences, explore benefits and risks, alternative options and individual factors, and develop and document an individualised plan of care. If a midwife feels uncertain about their scope of professional practice and is not comfortable in taking responsibility for a woman whose care planning falls outside of recommendations, they should refer to the Consultant Midwife and/or Consultant Obstetrician.		