REGIONAL FRAMEWORK

for midwives and obstetricians who support women requesting care outside of guidance in Northern Ireland

HSC Public Health Agency

APRIL 2023

Contents

01 Scope of Guidance

02 Introduction and Background

03 Understanding the Law

04 Pathway for Health Professionals

05 Discussing the Personalised Care Plan and Effective Decision Making

06 Discussing Risk

07 Education

08 What should women expect from a conversation about risks and benefits?

09 Dissemination

10 Conclusion

11 References

12 Appendices

HSC Public Health Agency

Associated Documents

NICE Guidance

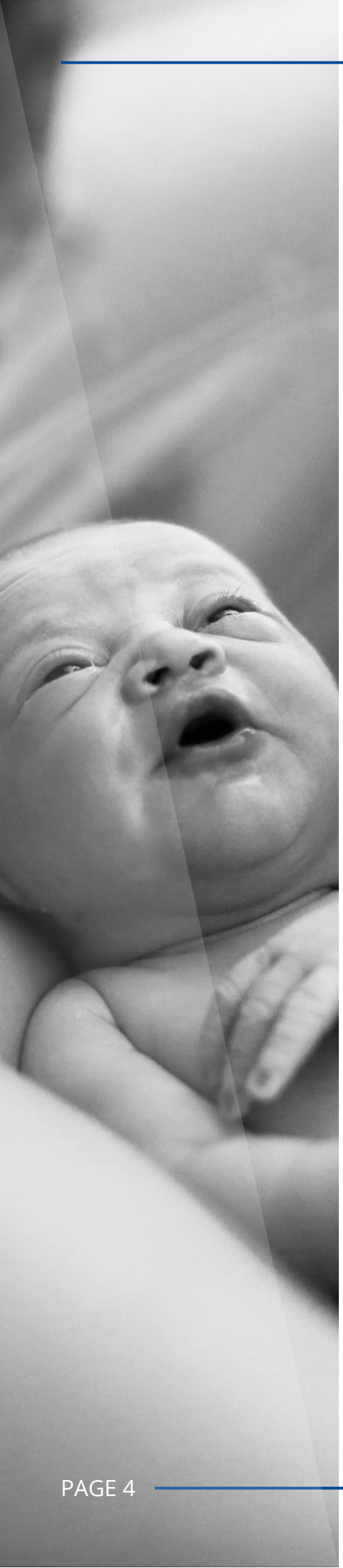
Click here to view

RCM Freebirth Guidance

Click here to view

RCM Care Outside of Guidance

Click here to view



01 Scope of Guidance

The purpose of this regional guidance is to support midwives and obstetricians when a woman declines certain aspects of maternity care at home, in an alongside or freestanding midwifery led unit, or an obstetric led unit.

It is recognised by maternity professionals that all women have the right to receive personalised care that meets their needs. This should also include having a real choice of where to give birth. Women are free and encouraged to make informed choices about the care that they wish to accept and decline.

Informed decision making is a key ethical principle within healthcare. This guidance will provide women, midwives and obstetricians with a framework to undertake discussions and plan personalised care when women choose to birth in a low-risk environment when they have a complex obstetric or medical history. The key concern for health professionals is upholding their professional obligations whilst recognising and responding to the human rights of women within maternity services. This framework aims to ensure that these responsibilities can be met in a meaningful way.

This guidance is intended for use in each Northern Ireland Maternity service when;

- A woman requests a place of birth or aspects of maternity care at any time that is considered outside of guidance.
- A midwife or obstetrician is concerned that a woman's decision or intention to decline recommended care may limit their capacity to provide safe clinical care and may potentially contribute to poor outcomes for the woman and/or her baby.
- A midwife or obstetrician is concerned that a woman's decision or intention to decline recommended care may require them to provide care that is outside their current competencies and confidence.

The Consultation Process

In order to inform the recommendations, a consultation process was completed with various stakeholders across Northern Ireland.

01 Engagement with mothers who had experienced or requested homebirth care outside of guidance

- A questionnaire was distributed to women asking for their feedback and to share their experience of requesting homebirths outside of guidance. This was publicised using social media and a range of forums. In total, 78 women responded to the survey.
- Participants were asked if they would be willing to share their experience further as part of a focus group. For those who wished to discuss their experience privately, this was completed via an informal interview with a Consultant Midwife. 18 of the survey respondents participated in the focus groups/interviews.

02 Engagement with midwifery teams across Northern Ireland

- A questionnaire was distributed to the Heads of Midwifery across 5 HSC Trusts to understand the current process for requesting homebirths, developing care plans and supporting midwives with education and training.
- In addition to this, a series of focus groups with midwives in hospital and community settings were completed to provide direct feedback and suggestions in relation to what further support and guidance is needed for midwifery colleagues.

03 Engagement with other key stakeholders

- Other health care professionals and support networks are a critical part of supporting women who request care outside of guidance, so it was important to hear their views and ideas as well. Therefore, further focus groups were conducted with obstetricians and Practice Education Teams within HSCNI and the Doula network.
- All of this information and feedback was then used to inform the recommendations and framework for women who birth outside of guidance in Northern Ireland.

02 Introduction and Background

Some women for whom it would be recommended that they follow the high-risk obstetric led pathway may choose to plan a midwifery led birth, be that at home, in a freestanding midwifery led unit or birth in an alongside midwifery led unit.

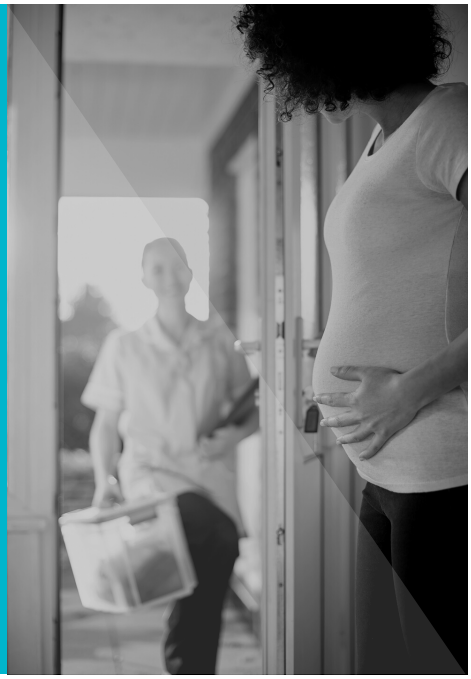
This would usually be deemed as care against medical advice on account of the increased risk of perinatal mortality and morbidity associated with birthing in midwifery led areas in high-risk pregnancies (NICE, 2022).

In keeping with regional and national guidance the ideal situation would be that women who choose to plan a homebirth or birth in a freestanding or alongside midwifery led unit would be experiencing a low-risk pregnancy and be following a midwifery led care pathway (NICE, 2022).

NICE (2022) guidance and the birthplace study provides women with an evidence base to assist them in their decision making in relation to place of birth. This guideline focuses on women who meet the current criteria i.e. a low-risk pathway. Women who require care outside of that criteria are directed to discuss an individualised plan of care, however this planning is not consistent across each maternity service within Northern Ireland.

Thus, this framework was developed to provide maternity professionals with a framework to facilitate discussions and a consistent approach to documenting a personalised care plan with women. It also outlines best practice in relation to communication within the multidisciplinary team.

One of the key principles of ensuring safe and effective care is placing the woman, her baby and her family at the centre of care and centring her needs on the concept of unbiased information and informed choice. In some situations, such as that place of birth, women and health professionals are not discussing consent, but rather exploring informed decisions and alternative plans whilst maintaining autonomy. This is re-iterated by the NMC (2018) stating that a midwife should work in partnership with women and their families, facilitating informed decision making. (NMC, 2018a; NMC, 2018b).



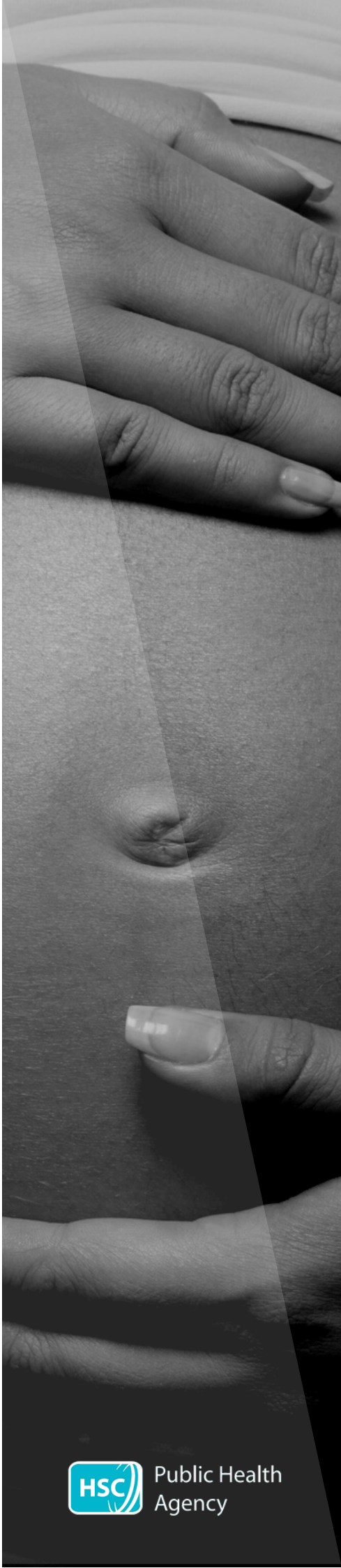
General Medical Council (GMC)

The General Medical Council (GMC) published updated recommendations in 2020 in relation to decision making and consent.

The GMC highlight seven key principles within this guidance:

- All individuals have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
- Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
- All individuals have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
- Doctors must try to find out what matters to individuals so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
- Doctors must start from the presumption that all adults have capacity to make decisions about their treatment and care. An individual can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.
- The choice of treatment or care for individuals who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.
- Individuals whose right to consent is affected by law should be supported to be involved in the decision making process, and to exercise choice if possible.

Click here to view the document



03 Understanding the Law

Informed choice is fundamental to woman centred care, even if local guidelines are contravened. Midwifery standards (NMC, 2018) promote autonomous decision making and informed choice, and it is recognised that this may result in women choosing to birth outside of local and regional guidance. Ensuring women are at the centre of their care is of paramount importance and healthcare professionals need to support women in their decisions. As competent adults, women are able to appreciate and weigh up the current evidence alongside their values and preferences. This is not merely a matter of trust and choice but also women's legal, ethical and human right.

Montgomery v. Lanarkshire Health Board (2015) Supreme Court case

One of the key findings from the Montgomery v Lanarkshire Health Board (2015) case was the duty to ensure that all women are aware of any material risks associated with treatment and any reasonable alternative treatment options.

The Supreme Court held the following:

- An adult with capacity is entitled to decide which, if any, of the available forms of treatment to undergo.
- Doctors have a duty to take reasonable care to make sure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.
- The test for materiality was whether, in the circumstances, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor was or should have been reasonably aware that the particular patient would be likely to attach significance to it.
- A doctor's advisory role involves making sure that the patient understands the seriousness of their condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that they can make an informed decision.
- Doctors are entitled to withhold information about risk from a patient if they reasonably consider that its disclosure would be seriously detrimental to the patient's health. This is a limited exception and doctors must not withhold information because they think it might cause the patient to opt for treatment that the doctor does not consider is in the patient's best interests.

The Mental Capacity Act (2016) states that mental capacity is presumed under the law therefore it should not be assumed that a woman lacks capacity to make a decision solely on the basis that she declines care.

On the rare occasion when it is deemed that a woman lacks sufficient mental capacity to make specific decisions in relation to any aspect of her maternity care, a decision specific mental capacity assessment should be undertaken by an appropriately qualified health professional.

04 Pathway for Health Professionals

Step 1

All women who are referred for discussion and decision making regarding their choices will be seen by a Consultant Midwife or Lead midwife and their named obstetrician where applicable.

There will be women with certain complexities where joint midwifery and obstetric counselling would be preferred. These have included women requesting a twin birth at home or in a midwifery led setting, vaginal breech birth, birth at home after one or more caesarean sections, woman with a previous history of shoulder dystocia, woman with gestational diabetes or current group B streptococcus, small baby with concerns around growth or other significant medical or obstetric complexities.

Step 2

At the initial appointment a full history will be taken, the team will seek to understand the rationale for the care the woman is requesting. A full discussion will take place clearly outlining what the agreed Trust/Regional guidance recommends and the benefits and risks associated with the decision she wishes to consider. This discussion should be clearly documented with the use of the proforma (appendix 2*) and placed in the maternity record, thus ensuring awareness within the multidisciplinary team.

Step 3

The woman will have a follow up appointment with the Consultant Midwife and will make a decision either to follow recommended care, or proceed with her choice outside of guidance. Any discussion/advice via phone will also be documented in the proforma.

Step 4

The Consultant Midwife will present the outcome of this discussion to the Head of Midwifery (HOM) and the multidisciplinary team. Ideally this will be during a multidisciplinary complex case review meeting.

Step 5

The Consultant Midwife will inform the woman of the recommendations discussed with the multidisciplinary team and will consult with the woman as to the next steps in her birth plan.

Step 6

The outcome will be communicated with the multidisciplinary team. Whilst the midwives will continue to risk assess as the woman's pregnancy progresses, there will be no necessity for them to revisit the woman's initial decision making. However, should the obstetric or medical circumstances change, the midwife will escalate as appropriate and discuss this with the woman.

Step 7

The Consultant Midwife will liaise with the Lead Midwife to identify any additional education requirements for the on-call team in the community or in the midwifery led unit. This may be provided by the Practice Education Team in conjunction with the Obstetric team.

Step 8

On admission to the maternity unit or when a community midwifery team attend the homebirth, they will inform the Labour Ward Coordinator, On-Call Obstetrician and Senior Midwife on call. The personalised plan of care will be available in the woman's maternity record.

05 Discussing the Personalised Care and Support Plan (PCSP) and Effective Decision Making

Women have the right to make informed decisions about their care and place of birth. It is essential that women are given clear, unbiased and accurate information in relation to risks when they choose to give birth outside of current guidance. Some women will have medical or obstetric risk factors that require detailed information to ensure they feel supported in making choices for pregnancy, birth and into the postnatal period. The following information can be utilised to undertake a guided conversation that is relevant to the woman and her personal circumstances that includes her previous experience and personal values and beliefs.

The guided conversation should include:

- What is important to the woman and her family for this birth?
- Previous obstetric history
- Previous labour/birth experience
- What is the woman's choice in relation to place of birth?
- Discussion around relevant risk factors
- Discussion to document a personalised care and support plan
- Information for women around this discussion can be found in appendix *********

Supporting the Woman

It is essential that midwives and obstetricians listen to women and give them the time to share what is important in relation not only to her pregnancy but also to her psychological and physical safety. It is essential that these conversations are supportive, non-judgemental and evidence based. The risk and benefits articulated and shared should be presented in a meaningful way and relevant to the individual woman.

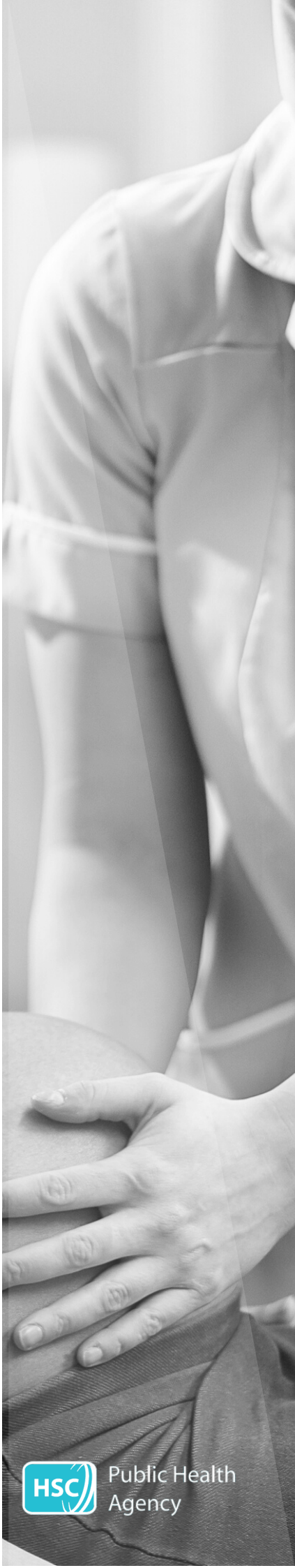
- **During the conversation(s), it is important to identify any previous trauma and consider the potential benefit of offering psychological support.**

It is also important to identify any misconceptions or misunderstandings about current practice or service provision in the area and provide the woman with accurate information. This is likely to include the systems and policies in place in the maternity unit and homebirth service.

- **Ask the woman what plan for the birth of her baby would feel safe and how the maternity team can support a personalised plan of care for her, while considering and explaining the impact on safety for her and her baby.**

- **When women with a complex history chooses to birth outside of guidance, midwives have a duty to place women first and prioritise their safety. Midwives may identify training needs in relation to their own practice and experience. The Health Trust will therefore provide reasonable training, simulation and/or clinical placements to address any identified skill gaps.**

- **Conversations with women should be open and honest and highlight the scope of midwifery practice in respect of a complex birth.**



06 Discussing Risk

It is essential that women are given clear, concise and accurate information in relation to risks when they choose to give birth outside of current guidance. Some women will have medical or obstetric risk factors that require detailed information to ensure they are supported in making choices for pregnancy, labour and birth.

The Northern Ireland Ambulance Service (NIAS) provide support and access to trained paramedics when they attend homebirths with community midwifery teams. However, their ability to attend can at times be challenged by workloads, staffing difficulties and delays. Thus, it is often difficult to accurately predict transfer times to hospital and it is essential that women are aware that a delay may occur that could impact on the care that she and her baby receive in an emergency situation.

Find out more about outside of guidance statistics for discussion with women in Appendix 1.

Effective Decision Making

Supporting a woman's autonomy can be particularly challenging in midwifery and obstetric care when women decline recommended interventions or treatments. This requires the maternity team to utilise respectful communication as a key component of the clinical relationship. This communication should be based on the best available evidence that recognises real or perceived individual risk factors, preferences and personal goals.

The **BRAIN** acronym is a helpful aid when making decisions (NHS Lothian, 2019);

Benefits

- What are the benefits of the suggested course of action? Consider benefits to both you and your baby.

Risks

- Consider the risks associated with this decision? Any side effects? Remember that different people will weigh the advantages and disadvantages differently. Remember what's important to you might not be to someone else.

Alternatives

- Are there other options available?

Intuition

- How do I feel about the suggested course of action? Our subconscious quietly analyses the information in a way that our conscious brain can't. If nothing else, acknowledging your feelings makes them easier to process.

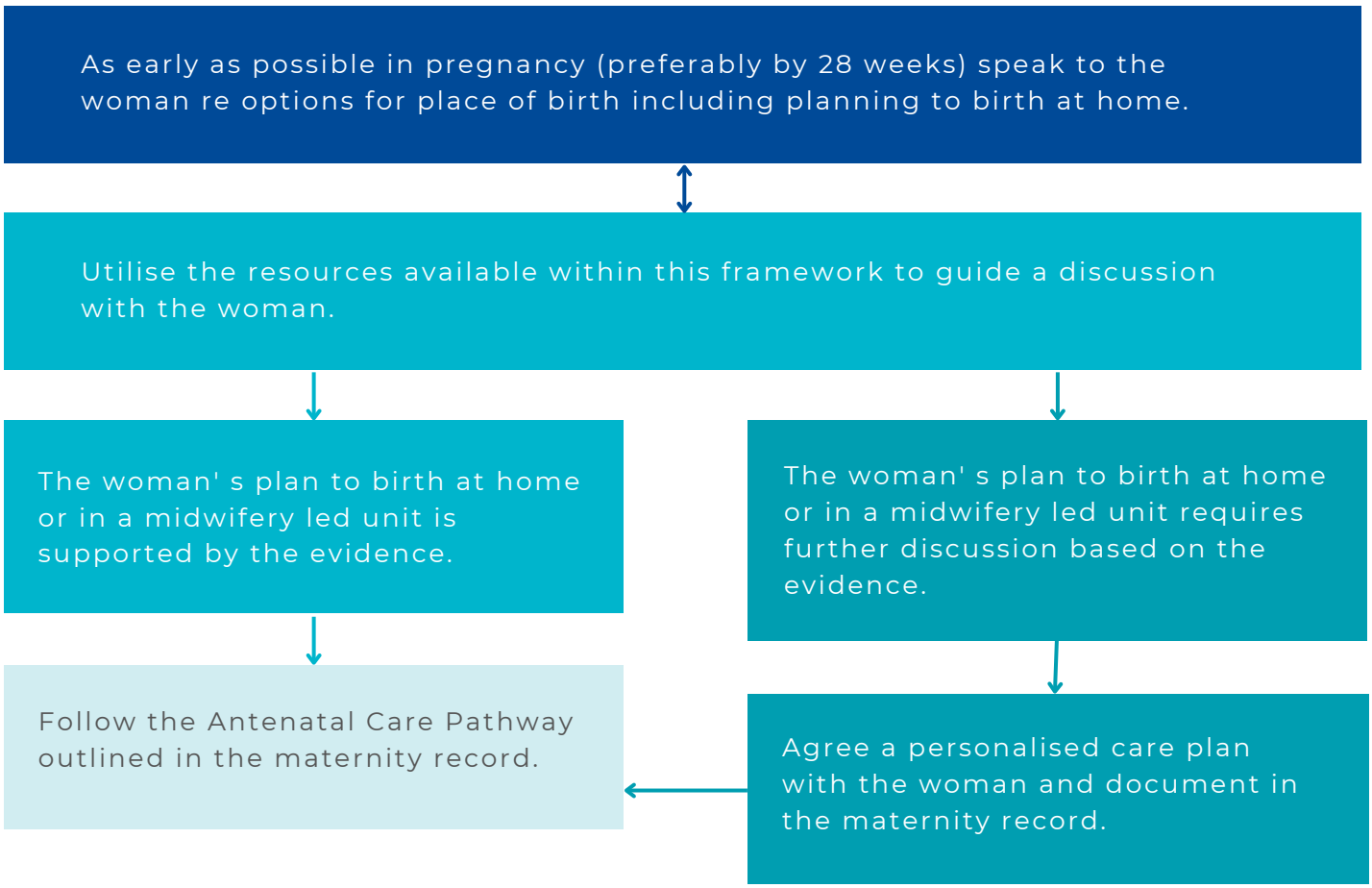
Nothing

- Consider the implications if I do nothing? What if we wait for an hour, a day, or a week?

Articulating Risks and Benefits Effectively

To promote partnership and positive relationships between women, their partners and maternity health care providers (HCPs), discussions should:

- Be personalised & relevant.
- Be evidence based and balanced, particularly when discussing uncommon events and complications.
- Use absolute numbers rather than percentages and present the information 'both ways' (e.g. 3 babies per 1000 (0.3%) will have a serious medical problem compared to 2 babies per 1000 (0.2%) born in an alongside midwifery unit (AMU) and 3 babies per 1000 (0.3%) born in a freestanding midwifery led unit (FMU) or an obstetric unit. What this means is 2 or 3 babies per 1000 will have a serious medical problem regardless of place of birth).
- Avoid unnecessary repetition and document discussions clearly.
- Utilise the principles of informed decision making as outlined in NICE guidance (2021).



07 Education

One of the key findings from the consultation process was the need for ongoing training and education to support community midwives to further develop skill levels and confidence in relation to births outside of guidance.

Feedback received was that midwives valued input from senior midwifery clinicians and members of the multi-disciplinary team particularly when developing Personalised Care and Support Plans (PCSP) for women with complexities.

It is recognised that management have a duty of care to provide the support required and that midwives also need to take accountability for personal development and building competencies where required.

Therefore, the following steps are recommended:

Each midwife should have an annual appraisal, at which their individual learning needs are identified and bespoke training requirements are documented and facilitated.

When the midwifery team are facilitating a complex birth outside of guidance senior midwives should assess the skills and competencies of the midwifery team and provide additional support where required.

Senior midwifery staff in collaboration with the multi-disciplinary team should identify and provide access to bespoke training and develop appropriate escalation plans.

In addition, the following options are available to further midwifery education and skills:

Midwives who are new to community teams freestanding midwifery led units or alongside midwifery led units should be offered a period of preceptorship to gain confidence in their new role.

Additionally, an experienced community midwife should be on call alongside any midwife who may not have attended or recently attended a homebirth until such time that she feels confident to be able to undertake the role without additional support.

All midwives who contribute to an on-call rota for homebirths should evidence basic competencies in intelligent intermittent auscultation, perineal repair, water birth and neonatal resuscitation as a minimum.

All midwives who contribute to an on-call rota for homebirths or working in midwifery led units should be able to avail of skills and drills training specific to their setting at least annually. This training should be at least one day and include:

- Intelligent intermittent auscultation
- Intravenous cannulation
- Appropriate escalation communication e.g. SBAR to NIAS and other health professionals
- Risk assessment management of postpartum haemorrhage
- Shoulder dystocia
- Cord prolapse
- Neonatal resuscitation

All midwives who contribute to an on-call rota for homebirths and work in a midwifery led unit should identify their individual learning needs and spend a minimum of 37.5 hours in the intrapartum setting annually.

08 What should women expect from a conversation about risks and benefits?

Good communication between you and your midwife or obstetrician promotes a trusting relationship and brings greater satisfaction to you both. On your part when discussing your individual care, it is helpful if you:

- Ask plenty of questions to ensure you fully understand the information provided.
- Say if you don't understand the information provided.
- Ask if you want information presented in a different way.
- Say if you need more time to discuss your reason for choosing certain care, whilst being mindful of midwives' and obstetricians' professional accountability to be frank and honest about the care they are recommending for you and your baby.

When you are considering having an intervention, operation or screening test during your pregnancy and childbirth journey you need to know about the benefits and risks or any uncertainties to help you to make an informed decision. Each individual will view risk differently and it will probably depend on some of the following factors:

- The chance of the event occurring (frequency).
- The chance of a condition being detected by a screening test (detection rate).
- The benefits of the treatment or screening
- How much harm may be caused by the treatment or intervention.
- If it is a life-threatening situation.
- How much you feel in control of the decision.
- How much you trust the person discussing the information with you.
- Whether you feel you understand the situation sufficiently.

When explaining risk you should expect midwives and obstetricians to:

- Involve you fully and have empathy whilst exploring your personal views and opinions.
- Give you the opportunity to have someone with you (such as a friend, partner or relative).
- Know and understand your circumstances and how this could affect you and your baby.
- Describe the risk in different ways with correct and up-to-date and evidence based information.
- Give you information that is relevant to you.
- Be honest, frank and open and listen to your concerns.
- Give you an opportunity to ask questions.
- Provide sources of further information e.g. leaflets or websites.
- Check that you have fully understood.

09 Dissemination

This document will be disseminated to the following health professionals:

- Midwives – both hospital and community midwives
- Obstetricians
- Women via Trust websites and the PHA website

Dissemination methods

- **Existing communication channels including:**
  - SPPG/Trust email/intranets
  - PHA website - Welcome | HSC Public Health Agency (hscni.net)
  - DoH website - Home | Department of Health (health-ni.gov.uk)
  - NI Direct website - Home (nidirect.gov.uk)
  - Consultant Midwife Forum which will provide educations sessions for midwifery staff across the region

Dissemination methods for messages to women of choosing to birth outside of current guidance:

- Public-facing websites - as above
- Social media – PHA and DoH Facebook or Twitter
- Encourage links with existing services used e.g. links to web info from GP surgery Facebook page, websites.
- Doulas NI - Doulas of Northern Ireland (doulasni.co.uk)

How do we know it is working?

- We will continue to regularly monitor feedback from women and maternity professionals and update guidance and recommended pathways accordingly.

11 Conclusion

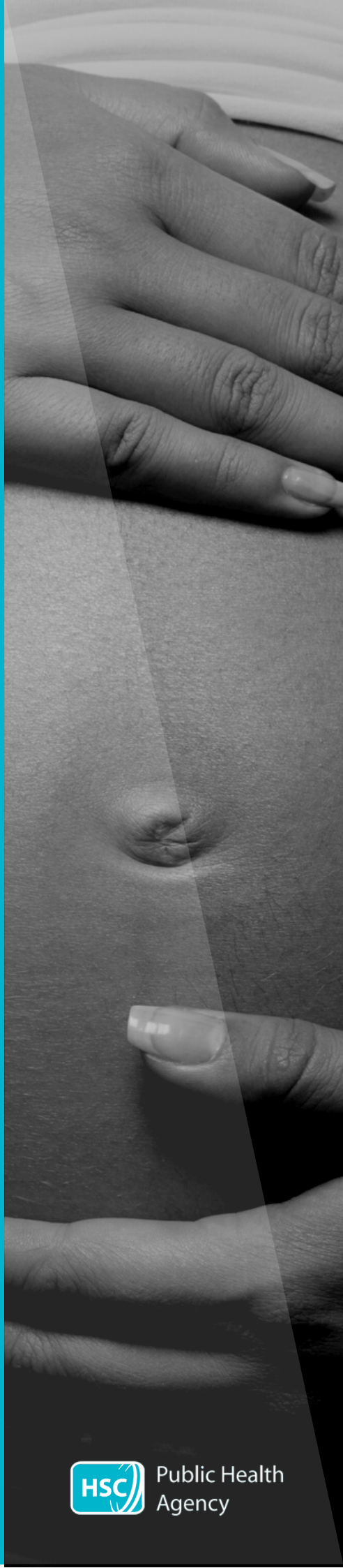
Maternity standards promote autonomous decision making and informed choice, resulting in maternal birth choices which may contravene guidelines. There is a lack of evidence exploring midwives' experiences of managing these choices.

Recent influences on current service provision include the expansion of Birth Choices clinics, implementation of dedicated homebirth teams, guideline criteria for midwife led birthing units, implementation of a structured debriefing service and further research looking at women's choices.

Midwives during the development of this guidance reported a degree of confidence in supporting maternal choices. However midwives expressed that perceived levels of risk, lack of understanding of the law, previous experience and safety concerns have impacted their confidence.

Organisational culture, midwifery leadership and effective multi-disciplinary team working all influence the successful provision of personalised care.

Women are more likely to access and engage with services when their physical, emotional, psychological, and social needs are met and when cultural safety is respected.
Collaboration with local Maternity Services Liaison Committees is key to developing locally appropriate pathways of care that enable women’s views and attitudes to inform maternity care provision.



11 References

National Institute for Health and Care Excellence (2022) *Intrapartum care for healthy women and babies: clinical guideline*. London: NICE.

NHS Lothian (2019) *Informed Consent*. Edinburgh: NHS Lothian. Available from: https://services.nhslothian.scot/maternity/informed-consent/

Nursing & Midwifery Council. (2018). The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Appendices

01 Appendix 1: Outside of guidance statistics to aid guided discussion with women

02 Appendix 2: Guided discussions documentation

12 Appendices

Appendix 1: Outside of guidance statistics to aid guided discussion with women

Women who have had a previous caesarean birth

- The success rate of having a vaginal birth if in spontaneous labour is 72-75 per 100 births.
- If a woman has had a previous vaginal birth as well as c/section, the success rate is 85-90 per 100 births.
- It is important to note that vaginal birth includes birth with forceps and vacuum (ventouse) cup.
- If a woman has a BMI>30 kg/m2 and a previous c/section for slow progress with induction of labour and augmentation the success rate decreases.

The risk of uterine scar

Spontaneous labour: 5 in 1000 (0.5%) therefore 995 in 1000 not	Induced labour with hormones (oxytocin): 10 in 1000 (1%) therefore 990 in 1000 not
Induced labour with balloon catheter: 7 in 1000 (0.7%) therefore 993 in 1000 not	Augmented labour with oxytocin: 8 in 1000 (0.8%) therefore 992 in 1000 not

What care would be provided for you in hospital?

- We would recommend continuous monitoring of your baby using an electronic heart rate trace (CTG) as often the first sign of scar rupture is changes to your baby's heart rate.
- You would have direct access to an emergency caesarean section should complications arise.
- You would have direct access to doctors and anaesthetists should complications arise.

What care would/can we provide for you at home or in an alongside or freestanding midwifery led units?

- Midwives can listen to the baby's heart rate with their handheld doppler every 15 minutes during labour and every 5 minutes when you are birthing your baby.
- Midwives can arrange transfer to Delivery Suite if complications arise but there may be a delay if interventions are required.

What care would we provide for your baby in hospital?

- If complications arise your baby would have direct access to the Paediatric team.

What care can we provide for your baby at home?

- If complications, such as a scar rupture arise, your baby will be given immediate care by the midwives at home and then transferred to hospital via ambulance.
- Implications for baby and woman – Not all babies or women die with a scar rupture BUT survival rates for women and babies relate to obstetric units NOT home or midwife led units.

The midwives will monitor for other signs of scar rupture such as;

- Abdominal pain that does not disappear between uterine contractions
- Bleeding vaginally
- Blood in urine
- or your contractions stop completely

Group B Strep (GBS) identified previously or during this pregnancy

The incidence of early onset GBS infection is 1 in every 1750 new-born babies.

The majority of babies born to women who have GBS will not develop GBS.

- Potential implications for babies who become infected with GBS: prompt treatment with antibiotics is effective and treatment is commenced if a baby shows signs of infection.
- Women who have GBS identified in this pregnancy or in a previous pregnancy with an unaffected baby may choose to have a swab later in pregnancy at 35-37 weeks, to help make the decision regarding the need for prophylactic antibiotics in labour.
- If the swab result shows a positive result, there is a 1 in 400 chance of baby becoming infected.
- If the swab result shows a negative result, there is a 1 in 5000 chance of baby becoming infected.

Every month in the UK:	Babies that are most at risk are those who are:
43 babies develop early-onset GBS infection 38 babies make a full recovery. 3 babies survive with long-term physical or mental disabilities. 2 babies die from their early-onset GBS infection.	Premature - born before 37 weeks where a woman's waters have broken and she had not gone into labour, woman has a high temperature in labour. Previously affected baby 50 in 100 chance.

What care would we provide for you in hospital

- We would offer you antibiotics during labour as research suggests that antibiotics reduce the risk of transmission of infection to the baby to 1 in 4000.
- To be effective the antibiotics need to be given 4 hours before birth.
- Women identified in this pregnancy or in a previous pregnancy with an unaffected baby may choose to have swabs taken later in pregnancy at 35-37 weeks, to help make the decision regarding antibiotics in labour.

What care can we provide for you at home?

- Antibiotics are not available at home or in a midwifery led unit.

What care would we provide for your baby in hospital?

- If complications arise your baby would have direct access to the Paediatric team.
- The midwives would continue to monitor your baby's observations on the postnatal ward using an early warning score to identify any infection early.

What care can we provide for your baby at home?

- If complications arise your baby will be transferred to hospital via ambulance.
- Due to the nature of homebirth rotas, the midwives would not be able to provide ongoing observations at home.
- However midwives in an alongside of free standing midwifery led unit could provide ongoing observations

Previous 3rd / 4th degree perineal tear

If you have had a pervious third degree perineal tear the chances of a reoccurrence are 5 to 7 per 100 births.

Research indicates that 3rd and 4th degree tears are more likely with;

- birth with forceps or vacuum (ventouse) cup
- episiotomy
- back-to-back baby
- a baby over 4kg (8.8lb)

Factors that may help reduce the likelihood of reoccurrence;

- Antenatal perineal massage
- Not giving birth lying on your back
- No directed pushing in order to slow the birth of the baby's head
- Use of a warm compress on perineum during pushing stage
- Manual protection of the perineum by the midwife
- Episiotomy as a preventative action has not been proven to prevent the reoccurrence of a third-degree tear.

A previous third-degree tear is not a reason not to give birth at home or in an MLU, however, if it reoccurs, the tear will need to be repaired in an operating theatre and therefore will require you to be transferred to an obstetric unit for this to be carried out.

Previous Postpartum Haemorrhage (PPH)

If you are choosing to birth outside an obstetric unit, the midwife or obstetrician will review your records to identify some of the following information;

- the amount of blood loss
- when the blood loss occurred
- what actions were undertaken and if a blood transfusion was required

Current recommendations are that women who have had a blood transfusion following a post-partum haemorrhage are advised to give birth in an obstetric led unit.

If you've had a previous PPH the chances of it reoccurring is 1 in 10.

There are other risk factors that may increase your chances of having a PPH again;	There are other labour and birth-related risk factors that increase your chances of having a PPH;
• BMI under 18 or over 30 kg/m2 • Baby predicted to weigh over 4.5 kg • Pre-eclampsia • Para 6+ • Polyhydramnios • APH or abruption this pregnancy • Abnormal placental implantation • Low haemoglobin/Anaemia	• Slow progress in 2nd or 3rd stage • Episiotomy • Instrumental birth • Sepsis • Augmented labour • Active and physiological management

What care would we provide for you in hospital (obstetric led unit or Alongside Midwifery led Unit) ?

- You would be offered intravenous (IV) access in your arm, have your bloods taken to establish your current iron levels, and undertake active management of the third stage of labour.
- You would have access to medical care if required.
- You would have access to additional medication to treat your bleeding if required.
- You would have access to theatre should you require a further intervention.

What care can we provide for you at home or in a free standing midwifery led unit ?

- Midwives will have access to the initial drugs required to treat a PPH in your home.
- Midwives can undertake emergency measures in your home such as inserting a urinary catheter, helping your womb contract more effectively and commencing IV cannulation/fluids.
- Midwives will also arrange your transfer to hospital via ambulance if required.

Women who have been diagnosed with gestational diabetes

Research suggests that gestational diabetes occurs in 4-5 per 100 pregnancies.

Women with Gestational Diabetes are at an increased risk of some obstetric emergencies;

- Shoulder dystocia 14-21 per 1000 – women with BMI <30 and no risk factors 6 per 1000
- Postpartum haemorrhage 5 in 100
- Problems with blood sugars during labour and birth
- Babies also require extra monitoring in the postnatal period

What care would we provide for you in hospital?

- We would provide you with continuous monitoring of the baby's heart rate with a CTG.
- You would have direct access to a emergency caesarean section should you require one.
- You would have direct access to medical care if required.
- You would access to a medical doctor with specialist knowledge of diabetes should complications arise.
- Midwives would monitor your bloods sugars frequently in labour and liaise with the medical team to ensure your blood sugars remain stable.

What care can we provide for you at home or in a midwifery led unit?

- Midwives can listen to your baby with their doppler device every 15 minutes during labour and every 5 minutes when you are birthing your baby.
- Midwives can arrange transfer via ambulance if complications arise at home, but this may delay interventions.
- Midwives can monitor your blood sugars regularly at home but if interventions are required you would need to be transferred to hospital.

What care would we provide for your baby in hospital?

- Midwives can encourage early feeding, skin-to-skin contact, maintenance of body temperature and feeding 3 hourly.
- If complications arise, your baby will have direct access to the Paediatric team and emergency treatment for low blood sugars.
- Midwives will be able to undertake the recommended level of blood sugar monitoring.

What care can we provide for your baby at home or free standing midwifery led unit

- If complications arise, your baby will be transferred to hospital via ambulance.
- Midwives can encourage early feeding, skin-to-skin contact, maintenance of body temperature and feeding 3 hourly.
- Midwives may be unable to undertake the desired level of blood sugar monitoring at home .

Previous Shoulder Dystocia

If you are choosing to birth outside an obstetric-led unit, the midwife or obstetrician will review your records to identify some of the following information;

- If your labour was spontaneous or induced
- What position your baby was in at birth
- What interventions or manoeuvres were required
- What condition your baby was in at birth

It is not recommended for women who have had a previous shoulder dystocia that required internal maneuvers to resolve it, to birth at home or in a midwifery led unit

In every labour there is a reoccurrence chance of 6 in 1000, and that risk increases if you have a BMI ≥30 kg/m2 (to 14-21 in 1000).

The evidence suggests that you have a 6 in 10 chance of a shoulder dystocia happening again.

Other factors that may increase the chances of shoulder dystocia are if;	The evidence suggests that some interventions may reduce your chances;
• You have diabetes • Your body mass index (BMI) is 30 or more • Your labour is induced • You have a long labour • You have a vaginal birth (with forceps or vacuum (ventouse) cup)	• Upright position • Remaining mobile and active during labour and birth

If you have a shoulder dystocia at home or in a freestanding midwifery led unit the midwives will undertake emergency procedures and contact ambulance services to transfer you to hospital. However, that transfer time can have a significant impact on the baby's wellbeing.

Appendix 2: Guided discussions documentation

Guided discussions documentation	
History & Reason for referral	Parity: Gestation: Medical History: Previous Pregnancy History:
Personal thoughts and influencing factors for choice	
What are the benefits identified and discussed?	
What are the risks identified and discussed?	
Are there any alternatives that can be discussed and/or offered?	
Plan of care and mitigation	Place of birth: Monitoring maternal and fetal well-being: Coping strategies: 3rd stage of labour:
Discussion in relation to transfer	
Signature Profession / Grade	
MDT referral and outcome	

REGIONAL FRAMEWORK

for midwives and obstetricians who support women requesting care outside of guidance in Northern Ireland

HSC Public Health Agency

APRIL 2023