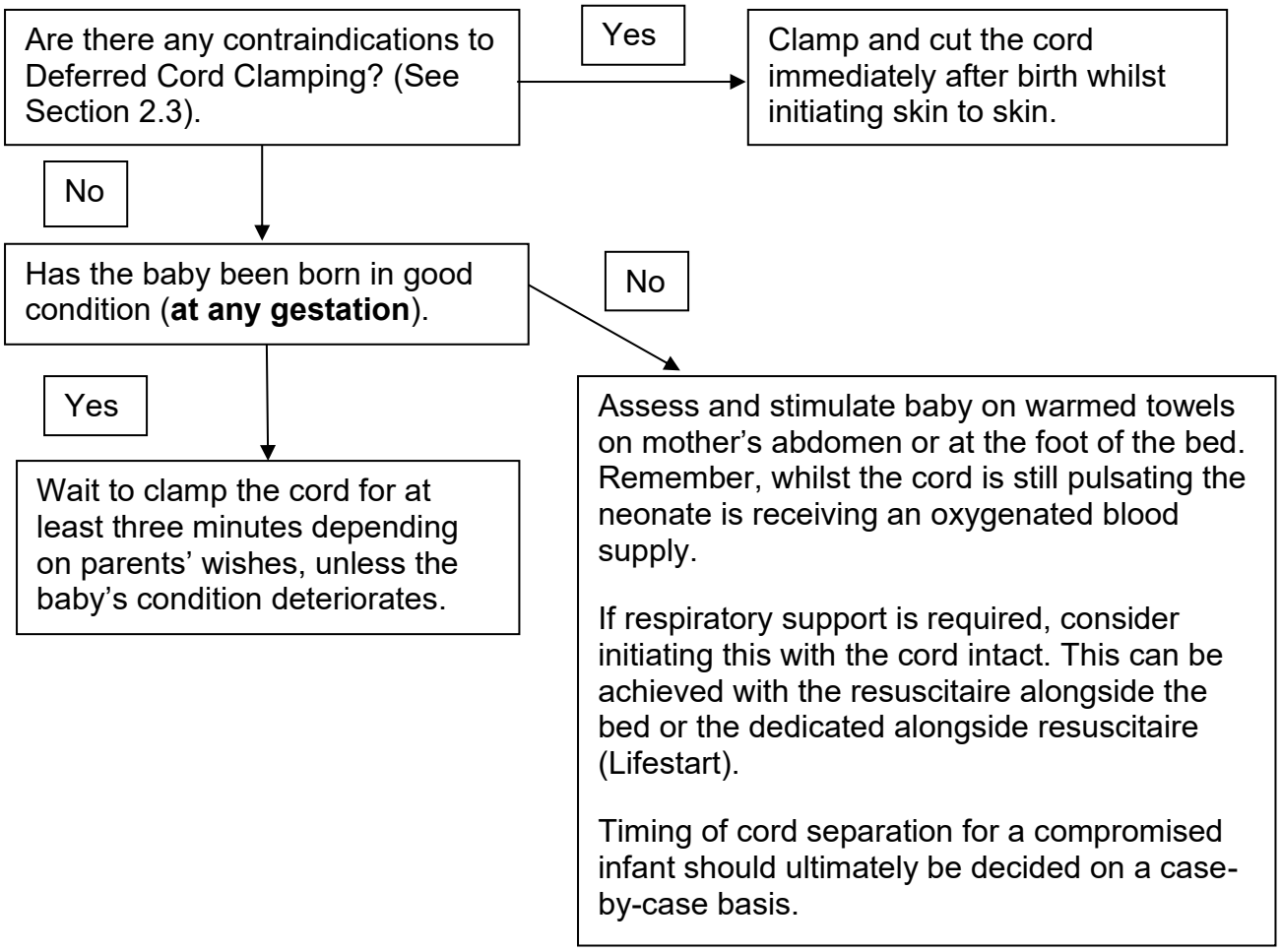
Royal Cornwall Hospitals
NHS Trust

Cord Clamping Clinical Guideline

V4.1

March 2026

Summary: Deferred Cord Clamping



Key Considerations

- **Warmth** – Ensure the baby is kept warm during Deferred Cord Clamping, use warmed towels from the resucitaire or skin to skin to achieve this for infants >34/40.
- **For babies <32/40 use a transwarmer mattress and a neohelp poncho.**
- **For babies 32-34/40 consider the use of a transwarmer mattress.**
- **Maternal Deterioration** – In the event that the condition of the mother deteriorates i.e. Massive acute obstetric haemorrhage, ruptured vasa previa, maternal resuscitation, then Deferred Cord Clamping should be abandoned and emergency measures initiated.
- **Neonatal Deterioration**- In the event where bedside resuscitation equipment is not available any baby that is born unstable with no clear improvement after drying and stimulating then immediate clamping and cutting of the cord should take place to facilitate transfer to a resuscitaire where NLS can be undertaken.
- Deferred Cord Clamping should never be performed at the expense of the health of mother or baby.
- **Third Stage Management** - Syntometrine/Syntocinon or Carbetocin administration does not need to be delayed during Optimal Cord management.

1. Aim/Purpose of this Guideline

1.1. To inform all Midwives and Obstetricians on the topic of Optimal Cord management including rationale, contraindications and guidance on when to implement. Deferred Cord Clamping is a routine part of a physiological third stage. It can also be safely implemented when active management is required. There is a growing body of evidence to support Deferred Cord Clamping and it is recommended by the Royal College of Midwives (RCM), World Health Organisation (WHO) and the UK Resuscitation Council.

1.2. Optimal Cord Clamping has clear benefits to both mum and baby, alongside a discussion on management of the third stage of labour, parents should be informed that Deferred Cord Clamping may:

- Increase their baby's blood volume by up to 40% and subsequently improve iron stores for the first 6 months of life which helps with growth and emotional development. Iron is essential for brain development. The blood has many red cells needed to transfer oxygen from the lungs to the heart and brain (New 2025).
- Ensure baby receives stem-cell rich cord blood which helps to repair damaged tissues, growth and the immune system (New 2025).
- Maximise the amount of oxygenated blood their baby receives and help establish breathing.
- Stabilise blood pressure.

1.3. Although the benefits are present for all babies the findings have more significance for babies that are: premature, have a low birth weight or are born to an anaemic mother. In preterm infants, deferred Cord Clamping has additionally been shown to decrease infant sepsis, intraventricular haemorrhage, rates of neonatal blood transfusion and the incidence of necrotising enterocollitis.

1.4. For the mother deferred Cord Clamping can decrease the volume of the placenta, reduce rates of feto-maternal transfusion (important for rhesus negative mothers) and assist in creating a calm and unhurried environment.

1.5. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

1.6. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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2. The Guidance

2.1. Active Management of Third Stage of an Uncompromised Baby at any Gestation

- Following delivery of the baby give oxytocic.
- Clamp and cut the cord between three – five minutes or until pulsation stops (New 2025).
- Wait for signs of separation before attempting to deliver the placenta.
- The position of the baby during Deferred Cord Clamping is not thought to influence the amount of blood the baby receives.

2.2. Optimal Cord Clamping for Babies Requiring Resuscitation

- Those neonates requiring positive pressure ventilation and resuscitation would especially benefit from Deferred Cord Clamping. A policy of 'wait a minute' may be appropriate unless the baby has a heartbeat below 60bpm which is not getting faster. Consider that neonatal assessment and stimulation usually happens during this first minute which can be carried out on warm towels on the delivery bed or on the mother's abdomen. Remember that while the cord continues to pulsate the baby is still receiving oxygenated blood.
- Consider alongside resuscitation with optimal cord management for all babies, this can be achieved by using the resuscitaires in the room alongside the bed or using the Lifestart alongside resuscitaire in a theatre setting.
- Should transfer to a resuscitaire be deemed necessary the cord should be promptly clamped and cut. In these situations 'cord milking' towards the baby may be performed in babies >28/40.

- Timing of cord clamping for a compromised infant should ultimately be decided on a case-by-case basis by the perinatal team, being mindful of the clinical context and the equipment available.

2.3. Contraindications to Deferred Cord Clamping

- Neonatal resuscitation required with no alongside equipment available.
- Maternal resuscitation required.
- Acute massive Maternal Haemorrhage.
- A ruptured Vasa Praevia, snapped cord or other trauma to the cord vessels which will result in haemorrhage from the baby (New 2025).

2.4. Special Circumstances

2.4.1. Complete placental abruption

Where the placenta is delivered at the same time as the baby, it could be held above the baby, with gentle application of pressure to the placenta, and then clamped at 60 seconds before the placenta is lowered. Umbilical cord milking could also be considered in this situation.

2.4.2. Short Cord length

A short cord length might interfere with the management of the mother or baby but can usually be addressed with optimal positioning. It should not be considered as an automatic indication for early cord clamping, nor a contraindication to optimal cord management.

2.4.3. Multiple pregnancies

Multiple births should not be routinely excluded from Optimal Cord Management. The plan for delivery should be considered on an individual basis with a decision made by an experienced perinatal team ahead of birth. Due to uncertainties with monochorionic twins it is reasonable to clamp twin 1's cord at 1 min and twin 2 can be assessed as per any other infant (New 2025).

2.5. Operative Vaginal Delivery

Optimal Cord Clamping **should be performed at instrumental delivery as for spontaneous vaginal birth.** Good communication with the neonatal team is crucial during this time and if at any point they feel that deferred Cord Clamping should be abandoned this should be respected. Consideration should be given to use alongside resuscitation.

2.6. Caesarean Section (CS)

- Upon delivery of the baby Carbetocin/Oxytocin should be given.
- Cord clamping should be deferred for at least 60 seconds.

- A short delay in cord clamping at CS may reduce maternal bleeding by allowing more time for separation before the surgeon removes the placenta. Heavy bleeding not controlled by Green Armitage clamps should prompt immediate cord clamping and placenta removal.

- The Life start should be used for all LSCS < 36 weeks with consideration to thermal control. If aiming for >1 minute to consider neonatal thermal control and have baby either skin to skin or wrapped in a sterile warm blanket to facilitate OCM with alongside respiratory support if required. If intact cord resuscitation is commenced – good communication with the whole team is necessary if no response after 5 inflation breaths (New 2025).

2.7. Cord Blood Sampling

A delay of three minutes does not appear to adversely affect the validity of umbilical cord blood gas analysis. The cord should be double clamped and samples taken from the section between the two clamps within 15 minutes of delivery (New 2025).

2.8. Documentation

The timing of Cord Clamping must be documented in the maternal and neonatal delivery notes.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Correct management of Deferred Cord Clamping.
Lead	Audit Midwife.
Tool	• Was Deferred Cord Clamping performed when contraindicated? • Was Deferred Cord Clamping offered to women having a CS? • At CS was Deferred Cord Clamping performed for 45 seconds?
Frequency	1% or 10 sets, whichever is the greater, of all health records of women who have delivered will be audited once over the 3 year lifetime of the guideline or sooner if indicated.
Reporting arrangements	• Audit review team (ART). • During the process if the audit compliance is below 75% or other deficiencies identified, this will be identified by the Audit Midwife and an action plan agreed.
Acting on recommendations and Lead(s)	• The Audit midwife will set a time frame for the action to be completed. • The action plan will be monitored by the Audit midwife.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within an agreed time frame. • The Audit Midwife will lead to take each change forward where appropriate. • Maternity Perinatal Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Cord Clamping Clinical Guideline V4.1
This document replaces (exact title of previous version):	Optimal Cord Clamping Clinical Guideline V4.0
Date Issued/Approved:	March 2026
Date Valid From:	March 2026
Date Valid To:	November 2028
Directorate/Department responsible (author/owner):	Charlotte Boswell and Holly Connolly, Fetal Monitoring Midwives
Contact details:	01872 255019
Brief summary of contents:	This guideline gives guidance to Midwives and Obstetricians in the management of Optimal Cord clamping of the baby's umbilical cord at delivery.
Suggested Keywords:	Delayed, deferred, cord, clamping, DCC, new-born, physiological, placenta, 3rd, third, stage.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required.
Related Documents:	• Farrar D, Airey R, Law G, Tuffnell D, Cattle B, Duley L. (2011). Measuring placental transfusion for term births: weighing babies with cord intact. BJOG: An International Journal of Obstetrics & Gynaecology. 118 (1), 70-75.

Information Category	Detailed Information
	• McDonald S, Middleton P, Dowswell T, Morris P. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database of Systematic Reviews (2013) Issue 7. Art. No.: CD004074. • Rabe H et al. Early versus delayed umbilical cord clamping in preterm infants. Cochrane Database of Systematic Reviews (2004) Issue 4. Art. No.: CD003248. • Mercer J, Vohr B, McGrath M, Padbury J, Wallach M, Oh W. (2006). Delayed cord clamping in very preterm infants reduces the incidence of intraventricular haemorrhage and late-onset sepsis: a randomized, controlled trial. Pediatrics. 117 (4), 1235-42. • Airey R, Farrar D, Duley L. Alternative positions for the baby at birth before clamping the umbilical cord. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD007555. • World Health Organisation. (2012). Guidelines on Basic Newborn Resuscitation. WHO. Geneva. • Rabe H, Diaz-Rossello J, Duley L, Dowswell T. Effect of timing of umbilical cord clamping and other strategies to influence placental transfusion at preterm birth on maternal and infant outcomes. Cochrane Database of Systematic Reviews 2012, Issue 8. Art. No.: CD003248. • UK Resuscitation Council. (2010). Guidelines on Newborn Life Support. Resuscitation Council (UK). London. • Erickson-Owens D, Mercer J. (2012). Rethinking placental transfusion and cord clamping issues. The Journal of Perinatal and Neonatal Nursing. 26 (3), 202-17. • Andersson O et al. (2013). Effects of delayed compared with early umbilical cord clamping on maternal postpartum haemorrhage and cord gas analysis: a randomized trial. Acta Obstet Gynecol Scand. 92, 567-74. • RCOG. (2015) Clamping of the Umbilical Cord and Placental Transfusion. • Andersson O, Hellström-Westas L, Domellöf M. Elective caesarean: does delay in cord clamping for 30 s ensure sufficient iron stores at 4 months of age? A historical cohort control study. BMJ Open 2016.

Information Category	Detailed Information
	• Al-Wassia H, Shah PS. Efficacy and Safety of Umbilical Cord Milking at Birth: A Systematic Review and Meta-analysis. JAMA Pediatr. 2015;169(1):18–25.
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
June 2015	V1.0	Initial Issue.	Elizabeth Cowan, Midwife.
September 2018	V2.0	Reviewed, 'deferred' changed to 'optimal', some points clarified, cord milking recommended when Optimal Cord Clamping cannot be facilitated.	Lizzie Anstey, Midwife.
August 2022	V3.0	Reviewed and updated, contraindications to Optimal Cord Clamping updated, lifestart resuscitaire included in guideline.	Jane Pascoe, Fetal Monitoring Midwife.
November 2025	V4.0	Changed to 2-3minute time frame for delayed cord clamping in line with NICE guidance.	Charlotte Boswell and Holly Connolly, Fetal Monitoring Lead midwives.
March 2026	V4.1	Updated to change 'optimal' to 'deferred' throughout document	Chris Bell, Neonatal Consultant.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

For guidance, please contact the Equality, Diversity and Inclusion Team at rcht.inclusion@nhs.net

1. About the Policy / Service Change:

Information Category	Detailed Information
Individual completing QEIA: (Name, Role, Email)	Catherine Wills, Guidelines Midwife. 01872 255019
Service Area: (Department, Care Group)	Obstetrics and Gynaecology
Name of document:	Cord Clamping Clinical Guideline V4.1
Type of document: (Policy, Strategy, Service Change)	Clinical Guideline
Policy / Service Change Objective(s): (What should it achieve, and for whom?)	To maximise the amount of oxygenated blood the baby receives through the cord at delivery.
Does this Policy / Service Change: (Select all that apply)	Eliminate Discrimination? Yes Advance Equal Opportunity? Yes Foster Good Relations? Yes
Which Groups are impacted by this policy? (Select all that apply)	Yes – Workforce. Yes – Patients. No – Visitors. No - System Partners. No - External Organisations. No – Contractors.

2. About the impact:

For each characteristic, please indicate whether you think the impact will be positive, negative or unknown, and provide a brief explanation:

Note: Stating 'This document has no impact on this group' for all characteristics will result in the document not being approved.

Characteristic	Impact	Explanation
Age	Positive	
Sex	Positive	
Gender Reassignment	Positive	
Race, Ethnicity, Culture	Positive	
Disability or Long-term Health Condition	Positive	
Religion or Belief	Positive	
Marriage and Civil Partnership	Positive	
Pregnancy and Maternity	Positive	
Sexual Orientation	Positive	
Armed Forces Community	Positive	
Low Income Households	Positive	

A consultation must take place with appropriate groups to clarify unknown impacts and recommend mitigation of negative impacts.

3. About the Consultation

Information Category	Detailed Information
Which bodies have been consulted? (Not all will be required)	Yes Service Employees. No Employee Network Groups. No Union Representatives. No EDI Team. No Patient / Service Users. No Patient Advisory Group. Yes Patient Representatives. No Local / National Charities. No System Partners. No External Organisations. No Other.

Information Category	Detailed Information
Please list the individuals / groups who have been consulted: (Role, Organisation, Email. Avoid using individual names)	Maternity Guidelines Group
Consultation Outcomes: (Positive feedback, new negative impacts, recommendations)	Guideline agreed
What action will you now take?	Continue without Amendments
Provide Details:	Agreed
Do any negative impacts remain?	No
Explain rationale for proceeding with negative impacts:	None

I am confident that this QEIA is an honest reflection of my efforts to comply with the Public Sector Equality Duty, and that all appropriate, necessary actions have been taken to mitigate any negative impacts as far as practicable.

Name:	Catherine Wills	Role:	Guidelines Midwife.