Royal Cornwall Hospitals
NHS Trust

Midwifery Led Pregnancy Care and Community Birth Clinical Guideline

V3.0

November 2023

1. Aim/Purpose of this Guideline

1.1. This guideline gives guidance to midwives on how to provide midwifery led care and a community birth to women with an uncomplicated pregnancy.

1.2. Midwife led care should be offered to women with an uncomplicated pregnancy.

1.3. Women should receive clear, unbiased advice to be able to choose where to give birth this should include a discussion regarding the choice of a home or community birth or alongside birth unit (Birthplace study Hollowell, J. et al, 2011) Women who are at low risk of complications are suitable to giving birth in community settings (NICE 2014 CG190). Woman should feel that they can alter their decision about place of birth during pregnancy or early labour. They should be risk assessed at every appointment, leaving each appointment knowing what the recommendations are for their place of birth.

1.4. Inclusion/exclusion criteria should be used in conjunction with this guideline (Appendix 3).

1.5. **This guideline is to:**

- Assist midwives to provide evidence-based information so that women are well informed to be able to make choices for care.
- Support women to consider the benefits and any risks to give birth in their chosen environment.
- Support pregnant people to achieve optimum outcomes for themselves and their babies.
- Support midwives to accurately risk assess pregnant people in order for them to make an individualised recommendation about the safest place to birth.

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

1.7. 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.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Scope

This guideline is to be used by all midwives caring for women in the home/community setting.

2.2. Roles and Responsibilities

2.2.1. All midwives must ensure competence at managing obstetric emergencies and have attended the Trust mandatory training and obstetric emergency training within the last 12 months (PROMPT, Fetal wellbeing study day, Maternity Update Day and NLS (4 yearly).

2.2.2. All midwives attending a homebirth must ensure they have all the equipment required as stated in the Community Midwives Equipment guideline.

2.2.3. Midwives will be called out in pairs by the triage midwife.

2.3. Clinical Content

2.3.1. Choice of Lead Professional

- To be discussed at booking.
- Low risk women should have midwife led care unless they request Obstetrician led pregnancy care.
- Inclusion and exclusion criteria for midwife led care are to be found in appendix 3.

2.3.2. Choice discussion

- Throughout pregnancy, choice of birthplace will be discussed, and recommendations can be made on suitability, pregnant people will be supported to make informed choices and provided with information and evidence to be able to do so.

- Women with risk factors identified during ongoing antenatal risk assessments will be recommended to have their babies at the Obstetric led unit (as per appendix 3).

- Discussion should include the following (NICE 2014 CG190):

2.3.2.1. **For low-risk nulliparous women:** birth in a midwife led unit is suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Planned birth at home is associated with a small increase of an adverse outcome for the baby. The rate of transfer to the obstetric unit is 36-45%.

2.3.2.2. **For low-risk multiparous women:** birth at home or in a midwife led unit is suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. The rate of transfer to the obstetric unit is 9-13%.

2.3.3. Antenatal Care

Refer to Antenatal Booking and Risk Assessment Clinical Guideline.

2.3.4. Home Birth Risk Assessment

- All pregnant people planning to birth at home should have a home visit at 34-36 weeks to undertake a risk assessment.

- The Homebirth Risk assessment form, available on the shared drive, should be used to document any risk factors and a management plan. This should include directions to the property and a 'What3Words' code to support community midwives to find the address when called.

- If the home is deemed unsuitable the pregnant person should be advised against a home birth or recommendations for changes to improve the environment could be made.

- The completed Homebirth risk assessment should be attached to the electronic record and emailed to the team leader for the area to circulate and a home birth alert added to the electronic record.

2.3.5. Intrapartum Care

Women in labour will contact triage to speak to a midwife. If required, the triage midwife will contact the on-call pair closest to the person's address.

The triage midwife should access the home birth risk assessment to check for any risk factors and send a copy of this to the attending midwives as directions/special considerations are recorded here.

The on-call midwife can also access this via the women's electronic record.

2.3.6. **Risk assessment on arrival**

2.3.6.1. The midwife must perform a detailed examination and history to ascertain risk factors which may suggest that transfer to the obstetric led unit is advised. All findings must be documented in the patient records and discussed with the birthing person and partner.

2.3.6.2. A Modified Early Obstetric Warning Score (MEOWS) score should be performed.

2.3.6.3. If the midwife leaves the house after initial assessment has been carried out, she must inform triage and reiterate urgent contact numbers with the family.

2.3.6.4. However, once labour is established the midwife should not leave the house.

NB: If the woman is labouring at home against medical / midwifery advice - the midwife must ensure that:

- A second midwife is in attendance.
- The midwife co-ordinating labour ward is aware of the labour so that advice will be available if required.
- The midwifery manager is informed.

2.3.6.5. The following Maternity Services guidelines should be followed:

- First and Second Stage and Delay in Labour Clinical Guideline
- Intermittent Auscultation of the Fetal Heart
- Meconium Stained Liquor (MSL) in Labour and Management of the Newborn Clinical Guideline
- Maternal Transfer by Ambulance Clinical Guideline (cornwall.nhs.uk)
- ThirdStageofLabourClinicalGuideline.pdf (cornwall.nhs.uk)
- Perineal or Genital Tract Injury Following Childbirth Identification and Management (cornwall.nhs.uk)

2.3.7. **Postnatal Care**

2.3.7.1. The midwife should stay with the mother and baby for a minimum of 2 hours following completion of third stage and until she is confident of their safety and well-being.

2.3.7.2. At one hour postnatal and neonatal observations should be documented on the MEOWS and Neonatal Early Warning Track and Trigger (NEWTT) chart.

2.3.7.3. The birthing person should be asked to contact the on-call midwife if she hasn't passed urine within the 6 hours of the birth if the on-call midwives leave before this time, please refer to the Bladder Care for the Obstetric Patient Clinical Guideline (cornwall.nhs.uk).

2.3.7.4. When the midwife leaves, they must ensure that the family has appropriate contact telephone numbers.

2.3.7.5. Ensure all equipment and other items are returned to the midwife base and disposed of correctly. The placenta should be placed in a yellow placenta bucket.

2.3.7.6. The 'transfer to community' questionnaire must be completed in the electronic record to send the discharge paperwork to the relevant community team and trigger ongoing postnatal care.

2.3.7.7. The community team will receive the discharge via email and telephone the mother the next day or sooner if appropriate. Individualised post-natal care can be planned with the woman.

2.3.7.8. Arrange for the examination of the newborn to be undertaken by an appropriately trained person within 72 hours of birth (Refer to Care of the Newborn (cornwall.nhs.uk)).

2.3.8. **Reasons for transfer to Hospital**

2.3.8.1. Any deviation from the normal should be assessed and a management plan documented.

2.3.8.2. All observations should be recorded on a MEOWS chart a score of ≥ 5 or a score of 3 in one parameter should indicate a need for transfer at any stage in labour.

2.3.8.3. If transfer to hospital is deemed necessary, the midwife should discuss reasons with the person and ensure prompt and safe transfer.

2.3.8.4. When a decision is made to transfer a woman in from a homebirth to the hospital maternity unit, the following procedures should be followed (Maternal Transfer by Ambulance Clinical Guideline (cornwall.nhs.uk).

2.3.8.5. Call 999 and ask for an ambulance for a transfer from home to hospital.

2.3.8.6. If the woman is declining to transfer as advised, the Delivery Suite co-ordinator should be informed and can provide advice, along with the manager on call.

2.3.8.7. Document the time of decision, time of calls and discussions made with the woman, labour ward and ambulance service and reasons for transfer on the maternal transfer sheet Maternal Transfer by Ambulance Clinical Guideline (cornwall.nhs.uk) including SBARD sticker.

2.3.8.8. Review the patient within 30 minutes of admission to delivery Suite. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The co-ordinator should review the patient to assess the urgency. If a doctor is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the co-ordinator should be kept up to date with any changes.

2.3.8.9. The following are reasons for transfer to hospital. Other potential reasons for transfer may occur and where there is any uncertainty the midwife should discuss with team leader/delivery suite co-ordinator:

- Abnormality of FH detected: Abnormal baseline, rising baseline, presence of decelerations.
- Meconium-Stained Liquor: consideration should be given to the woman's parity and stage of labour, and the fetal heart rate and transfer time.
- Delay in labour necessitating augmentation. Refer to First and Second Stage and Delay in Labour Clinical Guideline Consideration must be given to transfer time.
- Temperature: A maternal pyrexia of 38° centigrade, once, or 37.5° centigrade on 2 occasions, 1 hours apart.
- Hypertension: Developing maternal hypertension (hypertension: either systolic blood pressure of 140 mmHg or more or diastolic blood pressure of 90 mmHg or more on 2 consecutive readings taken 30 minutes apart; measured between contractions. (NICE 2014 CG190 2014 last up dated February 2017).
- Maternal request for additional analgesia.
- Obstetric emergency e.g., antepartum haemorrhage, postpartum haemorrhage, hypertension, eclampsia.
- Cord presentation, cord prolapse, shoulder dystocia.

- Malpresentation / malposition.
- Retained placenta.
- Neonatal complications e.g., grunting, low Apgar's, consistent hypothermia, need for any resuscitation, abnormal NEWS, or for review following a shoulder dystocia.
- Third / Fourth degree tear / complicated perineal trauma for suturing.
- Any other concern over maternal or fetal wellbeing.

  This list is not exhaustive.

2.3.8.10. The transferring midwife should give a verbal handover to the hospital midwife receiving the woman. The handover must be documented using the relevant handover tool in the maternal records.

2.3.9. **Documentation following transfer to hospital**

2.3.9.1. The accompanying midwife is responsible for ensuring that the antenatal, intrapartum and postnatal notes accompany the woman and are completed accurately. In an emergency situation, it is not always possible to complete them contemporaneously, however, the community midwife must ensure that they are completed prior to leaving the woman.

2.3.9.2. The community midwife is also responsible for completing a Datix entry as transfer to hospital from home or birthing unit birth is a trigger for a reportable incident.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance of guideline.
Lead	Community Matron.
Tool	**Audit Questions** 1. If choosing a home birth against medical advice was their care escalated to a line manager? 2. Was a 36-week risk assessment of the property performed? 3. Was a full risk assessment of the pregnancy and labour done on arrival? (Were there any risk factors prompting transfer?) 4. Was a full MEOWS performed?

Information Category	Detail of process and methodology for monitoring compliance
	5. If a high-risk labour at home was the second midwife, midwifery coordinator and midwifery manager informed? 6. Did the midwife stay for a minimum of 2 hours following completion of the third stage? 7. Was the MEOWS chart completed 1hour post-delivery? 8. Was the NEWS chart completed 1 hour post-delivery? 9. Was telephone contact made within 24 hours? 10. Was a NIPE check organised for <72hours after birth? **Audit Questions if transfer required.** 1. If MEOWS ≥ 5 or a score of 3 in any parameter was the woman advised to transfer to delivery suite? 2. Were any other indicators to transfer in noted? (abnormality in FH, Meconium stained liquor, delay in progression, developing maternal hypertension, maternal request, obstetric emergency, retained placenta, neonatal complications etc.) 3. Was time and reason for transfer noted? 4. SBARD sticker used for handover of care? 5. Co-ordinator aware of transfer and reasons? 6. Was the Datix completed by the community midwife transferring the woman/ neonate in? 7. If the woman was transferred in from the community, were they assessed on delivery suite within 30 minutes of arrival?
Frequency	Once in the lifetime of the guideline. Earlier if indicated through Patient Safety.
Reporting arrangements	Maternity forum.
Acting on recommendations and Lead(s)	Any deficiencies identified on the annual report will be discussed at the Maternity Patient Safety Forum and/or Clinical Audit Forum and an action plan developed. • Action leads will be identified and a time frame for the action to be completed. • The action plan will be monitored by the Maternity Patient Safety 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 a time frame agreed on the action plan. • A lead member of the forum will be identified to take each change forward where appropriate. • The results of the audits will be distributed to all staff through the Patient Safety Newsletter/Audit Forum as per the action plan.

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:	Midwifery Led Pregnancy Care and Community Birth Clinical Guideline V3.0
This document replaces (exact title of previous version):	Midwifery Led Pregnancy Care and Community Birth Clinical Guideline V2.0
Date Issued/Approved:	November 2023
Date Valid From:	November 2023
Date Valid To:	November 2026
Directorate / Department responsible (author/owner):	Samantha Gale, Community Matron
Contact details:	01872 252684
Brief summary of contents:	Guidance to midwives on how to book a pregnant woman/person; instigate the appropriate Antenatal Care Pathway and the information needed to be given to pregnant women/people throughout their pregnancy.
Suggested Keywords:	Pregnancy, booking, antenatal, care, leaflets, information, Vitamin, induction, IOL, notes, primigravida, multigravida, multip, primip, screening, bloods, scan, nuchal, Edward's, Patau's, PCP, Wren.
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:	Mel Gilbert
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	Department of Health (2007) Maternity Matters, DH, London. Department of Health (2004) National Service Framework for Children, Young People and Maternity Services. DH, London National Perinatal Epidemiology Unit. NICE (2014) Intrapartum Care: care of healthy women and their babies during childbirth NICE, London. NICE (2015) Antenatal Care – Routine care for the healthy pregnant woman. Clinical Guideline 6. [Online]. London. Nursing and Midwifery Council (2006) NMC Circular 8-2006 Midwives and Home Birth. Nursing and Midwifery Council (2004) Midwives Rules and Standards. NMC, London. Nursing and Midwifery Council (2004) Code of Professional Conduct. NMC, London. Nursing and Midwifery Council (2002) Guidelines for Records and Record Keeping. London, NMC. Office for National Statistics (2001) Birth Statistics. Series FM1 London. HMSO Royal College of Midwives (RCM) (2002) Position Paper 25: Home Birth. Royal College of Midwives (2002) Home Birth Handbook Vol. 1. Promoting Home Birth. London, RCM Trust. Royal College of Midwives (2002) Home Birth Handbook Vol. 2. Practising Home Birth. London, RCM Trust. Royal College of Midwives (1996) Safety for Midwives working in the Community. Position Paper 12. RCM: London. Birthplace Study (2011).
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet

Information Category	Detailed Information
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
August 2016	1.0	New Guideline	Angela Whittaker, Community team Leader and Teresa Phillips, Community Matron
September 2017	1.1	Addition of Birth Place Study reference. Change of training requirements. Triage change. Removal of the supervisor of Midwives role. Addition of born before arrival response. Review by community team leaders.	Trudie Roberts, Matron- community
November 2017	1.2	Contact Community Matron changed to Team Leader. Addition of alongside birth unit.	Trudie Roberts, Matron- community
January 2018	1.3	BBA advice removed as new guideline for BBA uploaded.	Sarah-Jane Pedler, Practice Development Midwife
August 2019	1.4	Addition to section 2.3.11.4 following recommendations from the Health Safety Investigation ranch (HSIB) regarding escalation.	Sarah-Jane Pedler, Practice Development Midwife
May 2020	2.0	Exclusion criteria updated. Inclusion and equality statement added.	Laura Hamblin, Birth Centre Manager
November 2023	V3.0	Full Update, removal of out-of-date advice.	Lizzie Anstey, Community Team Leader

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 6 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. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Midwifery Led Pregnancy Care and Community Birth Clinical Guideline V3.0
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Samantha Gale, Community Matron
Contact details:	01872 252684

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To ensure safe, appropriate care of women with low-risk pregnancy.
2. Policy Objectives	To support midwives when booking low risk women in pregnancy and caring for those women in labour in the community setting.
3. Policy Intended Outcomes	Safe risk assessment of women suitable for midwife only.
4. How will you measure each outcome?	Compliance monitoring tool.
5. Who is intended to benefit from the policy?	All women in low-risk pregnancy.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Guideline Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, DS Coordinator / Maternity Guidelines Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Referrals

The following criteria have been agreed to guide practice within the Trust:

Inclusion Criteria:

Pathway 1 – Low risk and suitable for care in Community

- Pregnancy Full term (37 to 42 weeks pregnant).
- Singleton pregnancy.
- Cephalic presentation.
- Spontaneous onset of labour.
- Haemoglobin at or more than 100g/dl.
- An uncomplicated pregnancy, medical and obstetric history (see exclusion criteria).
- Women/people who are having their 1st, 2nd, 3rd, 4th or 5th baby without previous complications or where recurrence of a complication would not be anticipated.
- Age – ≥16 to ≤40 years.
- Age ≥ 40 and < 40+3 weeks.
- Weight – Body mass index ≥18 – ≤34.9.
- Women/people whose waters have broken who are in established labour within 24 hours.

Pathway 2 – Women/people requiring individualised management plan and discussion with team leader +/- consultant before agreeing community birth.

Pathway 3 – High risk, advised against community birth

Women/people with the following conditions should be recommended booking for consultant-led care and delivery in a consultant unit. Please note this is not an exhaustive list and if you have concerns liaise with consultant obstetrician.

Respiratory:

- Asthma: severe attack requiring nebuliser/steroids in previous 12 months.
- Cystic Fibrosis.

Haematological:

- Haemoglobinopathies.

- Previous P.E. or DVT.

Gastro-intestinal:

- Liver disease.
- Major gastrointestinal surgery.

Immune:

- Systemic lupus erythematous.
- Connective tissue disease e.g., Marfan's syndrome.

Neurological

- Epilepsy.
- Myasthenia gravis.
- Previous CVA.

Endocrine:

- Diabetes.
- Other significant disorders e.g., Cushing's disease.

Renal:

- Renal disease/renal abnormality.

Psychiatric history:

- Current severe mental health concerns.
- Current substance and alcohol abuse.

Cardiovascular:

- Known cardiac disease/congenital heart abnormality.
- Hypertensive disorders.

Anaesthetic Risk:

Known or suspected airway problem.

Current Infective:

- TB.
- HIV positive.

- Toxoplasmosis.
- Chickenpox.
- Genital Herpes.
- Hepatitis C and B.
- Group B streptococcus.

Exclusions- Gynaecological history:

- Previous major gynaecological i.e., Myomectomy.
- Uterine/vaginal abnormality.
- Fibroids.

Exclusions- Obstetric history:

Complications in previous pregnancy:

- Uterine rupture.
- Previous CS.
- Previous abruption.
- Previous acute fatty liver disease.
- Severe early onset pre-eclampsia.
- Primary PPH > 500ml.
- Retained placenta.
- Previous 4th degree tear.

Previous shoulder dystocia.

Exclusions- Current Pregnancy:

- Atypical antibodies that risk haemolytic disease of newborn.
- Haemoglobin of less than 100g/l at term.
- APH/placental abruption.
- Placenta praevia.
- Unstable lie.
- Multiple pregnancy.

- SGA (<10th customised centile).
- Ultrasound diagnosed oligo- or polyhydramnios.
- Treatment dose with low molecular weight heparin.
- Suspected thrombo-embolism.
- Hypertension >140/90.
- Pre-eclampsia.
- Gestational diabetes.
- Obstetric cholestasis.
- Current drug/alcohol abuse.
- BMI greater than 35.
- Domestic violence with current partner.
- Induction of labour.
- Post maturity over 42 weeks.
- Prolonged rupture of membranes (greater than 24 hours) prior to established labour.

Those under obstetric led care should have an individualised plan and a discussion regarding their suitability for community birth.