Homebirth Guideline

Reference No.: UHDB/09:24/H5

Contents

1. Introduction

All women should be given evidence-based, unbiased information around birth place options including home, and supported in their decision for place of birth (NICE 2022). NICE guidance states that all women should be given the opportunity to discuss place of birth and for low-risk women this should include homebirth (NICE, 2023).

The National Maternity Review (2016) recognized that;
“Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.”

The Royal College of Midwives (RCM) state that ‘the environment in which a woman labours can have a great effect on the amount of fear and anxiety she experiences. Women are more likely to have an enjoyable birth experience with better outcomes if they are able to choose a birth environment that feels best suited to them and are supported in this decision-making process (RCM, 2012).

In their joint statement on homebirth, RCM & RCOG report that homebirth is a safe option for many women, especially when "safety" is expanded beyond physical safety to encompass psychological safety including sense of control, empowerment and self-esteem.

ONS data indicate that 2.4% of births occurred at home in 2020 which is a slight increase from 2019, despite the impact of COVID19 on the provision of homebirth services throughout the UK.

2. Purpose & Scope

This Guideline should be used in conjunction with the UHDB Homebirth SOP.

The purpose is to support all staff providing care for women & birthing people who are considering homebirth in terms of risk assessment and supportive discussions. In most cases these will be those on the low-risk pathway, however the cohort of women choosing to birth at home is evolving to include those with more obstetric and medical complexities. This guideline provides a framework for planning and attending homebirths for women with both straightforward and more complex care needs.

This guideline & SOP also supports all midwives providing clinical care during and following homebirth including Birth Before Arrival (BBA). Please refer to the Unassisted Birth SOP for women who are choosing or have intentionally undertaken birth without medical support.

3. Abbreviations

ARM	-	Artificial rupture of membranes
BAPM	-	British Association of Perinatal Medicine
BBA	-	Born Before Arrival
CLC	-	Consultant-led Care
CTG	-	Cardiotocography
EFM	-	Electronic Fetal Monitoring
EPR	-	Electronic Patient Records
FHR	-	Fetal Heart Rate
MNSI	-	Maternity & Newborn Safety Investigations
MWLC	-	Midwife Led Care
NEWTT2	-	Newborn Early Warning Track & Trigger Version 2
ONS	-	Office of National Statistics
PPH	-	Post Partum Hemorrhage
QHB	-	Queens Hospital Burton
RAG	-	Red/Amber/Green Risk Assessment
RDH	-	Royal Derby Hospital
SBAR	-	Situation, Background, Assessment, Recommendations
SROM	-	Spontaneous rupture of membranes
TENS	-	Transcutaneous Electrical Nerve Stimulator
VE	-	Vaginal Examination

4. Risk Assessment & RAG Status

Risk assessment is an ongoing process throughout the maternity pathway and MNSI advocates a move away from a dichotomous view of risk in pregnancy, stating this can be restrictive and create a perception that risk status will not change (MNSI 2023). The Ockenden Inquiry (2022) has highlighted risk assessment as one of the key priorities during maternity care. Risk assessment should be dynamic and holistic - avoiding focus on one particular risk factor with the exclusion of awareness of emerging new concerns. This is especially true for homebirth given the time it will take to transfer into an obstetric unit. Ongoing awareness and vigilance for changes in risk status during pregnancy and labour is therefore crucial.

The associated SOP gives clear advice on when to complete risk assessments and actions to take when the RAG status changes as a result.

5. Supporting staff when hospital birth is recommended

Homebirth midwives attending homebirth with known risk factors, following a recommendation for hospital birth, may find this experience challenging and stressful. They should be reassured that they are not responsible for decisions made by the woman or birthing person as long as they have ensured that the woman or birthing person is making a fully informed decision. Staff may require additional support and debrief even when there is a positive outcome due to the difficult nature of such work.

When maternity staff attend a homebirth, following a recommendation for hospital birth, it is important that this is escalated to the flow coordinator/delivery suite coordinator so that they understand the

situation should the homebirth midwives telephone for support. Senior community midwives should be made aware during day time hours, or the manager on call outside working hours, to ensure that additional telephone support is available and to allow for debrief if required. In the case of a poor outcome a professional midwifery advocate should also be made available.

6. Unassisted birth at home (Freebirth)

A woman or birthing person may choose to plan an unassisted birth, unattended professionally by a midwifery or medical team, often referred to as freebirth. The woman or birthing person has the right to choose this route and midwives have no right to be in attendance should the woman choose not to contact or engage in care. The woman or birthing person will assume responsibility for their birth but they may have their partner, relative, friend or doula present in a supportive role.

Every effort should be made to engage with a woman or birthing person to discuss the options available to them in terms of them accessing midwifery or medical care. However it may be that the options of a hospital birth or attended homebirth are unacceptable to the woman. *Please refer to the unassisted birth SOP for information and ensure that they are provided with the Unassisted Birth Patient Information Leaflet.*

7. Babies born before arrival (BBA) or Unplanned Home Birth

Unplanned homebirth, or a baby born before arrival of midwifery staff (at a homebirth) may occur with notification from the ambulance service, from the woman or birthing person or an attendee accompanying them.

In the event that a woman or birthing person has an unplanned birth at home due to a precipitate labour, the homebirth midwives should be called to attend if available. The ambulance service should be contacted to attend as an emergency response, as the midwives will have a longer response time to get to the property. If the midwives are unable to respond, the woman or birthing person and baby should be advised to accept transfer to the maternity unit with the ambulance service.

If it is possible, the ambulance should be called by the person in attendance/partner by dialing 999 for an emergency response. If this is not possible triage staff should call 999 to summon the response. Where possible the midwife should remain on the line to support until the ambulance crew is on scene or the ambulance service are available on another telephone line to those present.

The woman or birthing person and baby should be transferred to the maternity unit booked for care or to a maternity unit if unbooked/concealed pregnancy. Consider and confirm possible concealed pregnancy or safeguarding concerns when a BBA or unplanned homebirth occurs.

7.1 Ongoing Plan of Care following BBA

- If the woman or birthing person has known risk factors or there are known indications for additional neonatal care then they should be transferred to the appropriate maternity unit. If the woman or birthing person was booked for a planned homebirth then the homebirth midwives should be asked to attend to evaluate with the understanding that it may still be necessary to transfer to hospital due to the circumstances e.g perineal trauma, concerns re blood loss, meconium, neonatal cold injury or other concerns. If this is obvious to the paramedics attending then they may choose to transfer straight into the unit.
- If the woman or birthing person was booked for hospital birth but does not have additional risk factors requiring transfer to hospital, and the homebirth midwives are happy with the status of both mother and baby, then the woman or birthing person can be offered the choice to remain at home.
- BAPM guidance states that BBA is associated with increased risk of infection or cold injury. All babies who are born without a midwife in attendance should have NEWTT2 observations completed at 1hour and at 2hours of age. If both sets of observations remain normal then the baby may remain at home. If the baby triggers on any aspect of NEWTT2 then transfer should be arranged and the observations completed for a full 12 hour period as per NEWTT2 guidelines or until it is appropriate to discontinue if the observations are abnormal at any point.

On arrival at hospital the baby should receive a neonatal review in line with NEWTT2 protocols. Any baby with cold injury will require transfer into the maternity unit as per hypoglycaemia policy.

8. Key Responsibilities and Duties

All community midwives should be suitably experienced and confident with home birth risk assessment and birth option discussion. Place of birth should be discussed at booking with continued risk assessment throughout the pregnancy. Community midwives should make every effort to engage with any woman or birthing person with to choose homebirth, regardless of whether they themselves agree with the choice being made. They should facilitate supportive discussions around safety and birth planning with any woman or birthing person who wishes to pursue homebirth when hospital birth is recommended. They may request support from the senior community midwives with this. They should document within the EPR the wishes expressed by the woman or birthing person and inform the obstetric team of preferences expressed.

Following discussion with the obstetric team if the woman is not happy with the recommendations that have been made then the community midwife should ensure that referral has been made to the consultant midwives for ongoing MDT birth planning discussions.

Any homebirth midwife who has been unable to attend a birth for a period longer than 6 months should liaise with the senior community midwifes to arrange time working within the birth centre to refresh their care in labour skills including familiarization with all required documentation.

All care should be clearly documented using the EPR.

When attending a homebirth, discussion of roles and responsibilities for both midwives should take place with regards to:

- Which midwife is leading the care for this woman and birthing the baby
- Who will be responsible for leading neonatal resuscitation?

Midwives are individually accountable for their actions and omissions when delivering care, both share responsibility for the safe delivery of care given to women during homebirth. Both midwives must professionally challenge decision-making when in attendance at a homebirth if they believe it is not in the best interests of the woman or birthing person and her baby. In situations where both midwives are unable to agree on a safe plan of care, advice should be sought from a senior midwife, matron, obstetrician or manager on call.

The SBAR tool should be used at handover of care between homebirth midwives or at handover from the homebirth staff to the hospital team.

9. The On-call Service

The homebirth response from UHDB will be from the 2 identified midwives allocated to the shift(s) which cover shifts within any 24 hour period. The Midwives on duty for the shift should have the homebirth equipment and 2 entonox cylinders available to them to allow immediate response to a birth at home.

These shifts are:
RDH Community
A Shift 08:00-16:00
B Shift 16:00 – 22:00
Night Shift 21:45 – 08:15

QHB Community
Day shift 09:00 – 17:00
Overnight on call 17:00- 09:00

Midwives attending homebirth outside of day shift hours should follow the local policy for their site (QHB/RDH) for lone working and ensure their location is known when attending and returning from a call. For RDH this is Maternity Triage - RDH. For QHB this is via Maternity Triage - QHB.

The midwives will respond to the women who are choosing homebirth or in response to unplanned home births when requested or Born Before Arrival (BBA) as requested by the ambulance service as per local agreement. If the homebirth midwives for one area are already attending a homebirth, it should be reviewed on a case by case basis whether it is suitable for the team from the other site to attend. This will depend on the location of the homebirth, expected activity and human factors. If it is not suitable to attend then the woman or birthing person should be advised to attend the unit.

10. Suspension of home birth service

Suspension of the home birth service may occur in accordance with the UHDB Escalation policy:

- Due to Ambulance Service delays
- Should service capacity be reached due to activity and/or safe and appropriately skilled available staff.
- Due to adverse weather conditions
- The service is suspended due to the Midwives already attending a home birth

Suspension will occur on the decision of the Manager on Call, Community Senior Midwives or Midwifery Matrons based on activation of the pathways within the Escalation policy.

If suspension occurs it is the responsibility of the decision maker to coordinate the communication to areas and staff potentially impacted.

- Home Birth shift Midwives
- Birth Centre / Labour Ward / Maternity Triage
- Manager on Call if applicable
- Ambulance Service

Completion of the Homebirth Service Suspension spreadsheet should record the event. Datix should be completed outlining reason for suspension.

The Director of Midwifery, Associate Director & Head of Midwifery should be informed of any women affected by a suspension in order that they may communicate an apology.

In the event the UHDB homebirth service is unable to provide a response due to service suspension or because the Midwives are at another homebirth and a woman or birthing person requests attendance at home:

- An apology should be made and advise that care can be provided in the hospital or Birth Centre at UHDB sites.
- If the woman or birthing person is booked with a cross border hospital they will be advised to contact them to attend at their unit.
- If the woman or birthing person declines to attend, explain that we are able to provide care at the hospital and encourage them to attend. Should they choose to remain at home, acknowledge this is their choice, but at their own risk. Refer to Unassisted Birth SOP.
- Document the conversation and advice given. Ensure the woman or birthing person is aware of emergency contact numbers, how to access an ambulance and that they are welcome to attend the maternity unit at any time.
- It is not advisable to suggest when the homebirth service will next be available as the availability and response cannot be guaranteed until the time the homebirth midwives have completed their ongoing care event or the period of suspension has come to an end.
- Acknowledge that midwives have a professional duty of care to women & birthing people but there is no duty to provide the care in the environment that is their preferred choice when resources do not allow this.
- Inform the Senior Community Midwife or Manager on Call out of hours if a woman or birthing person chooses to remain at home when the service is suspended. The flow coordinator at

RDH/ delivery suite coordinator at QHB should also be updated.

11. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme.

12. References

Birthrights (April 2017) Unassisted Birth Factsheet. Available at https://www.birthrights.org.uk/factsheets/unassisted-birth/

Birthrights (April 2017) Information about consenting to treatment and assessment of mental capacity: https://www.birthrights.org.uk/factsheets/consenting-to-treatment/

National Institute for Health and Care Excellence (2014) Intrapartum care: care of healthy women and their babies during childbirth.

National Perinatal Epidemiology Unit (2016) Birthplace in England research programme. Final report part 1. HMSO. https://www.npeu.ox.ac.uk/birthplace

National Maternity Review (2016) BETTER BIRTHS. Improving outcomes of maternity services in England A Five Year Forward View for maternity care

Nursing and Midwifery Council (2012) Midwives Rules and Standards

Royal College of Midwives (2012). Evidence Based Guidelines for Midwifery-Led Care in Labour. Rupturing Membranes

Royal College of Midwives Clinical Briefing Sheet (2020) 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic

Homebirth RAG assessment Appendix A

This RAG assessment is based on 3 key principles:

1) We should not classify women & birthing people as suitable or not-suitable for homebirth. Dichotomy is not helpful and suggests that they will not be supported if "not suitable". In some cases although a woman or birthing person may be booked under consultant care, the obstetric team may still support the plan for homebirth. Risk status may also change during the pregnancy.
2) Risk assessment is ongoing throughout pregnancy and labour and risk assessment aims to support the escalation process should risk status change or should the woman or birthing person decline the recommended actions based on their status.
3) Health professionals should advise women and make recommendations regarding place of birth in the context of risk factors. However women may or may not accept this recommendation. Midwives continue to have a duty of care to support the woman or birthing person's choices. The risk assessment guides midwives regarding pathways for continued birth planning when the woman or birthing person makes choices other than those recommended by the health professionals providing care.

Is the woman or birthing person suitable for MWLC? If yes will be green
Is the woman or birthing person booked under CLC? If yes will red

Status	Criteria
Green	Low risk pathway - offer homebirth
Red	CLC. May recommend hospital birth rather than homebirth due to risk factors but requires further MDT discussion or further information (e.g completion of growth scan pathway). This classification relates to our RECOMMENDATION around place of birth only. Women and birthing people may still make an informed decision to choose homebirth.

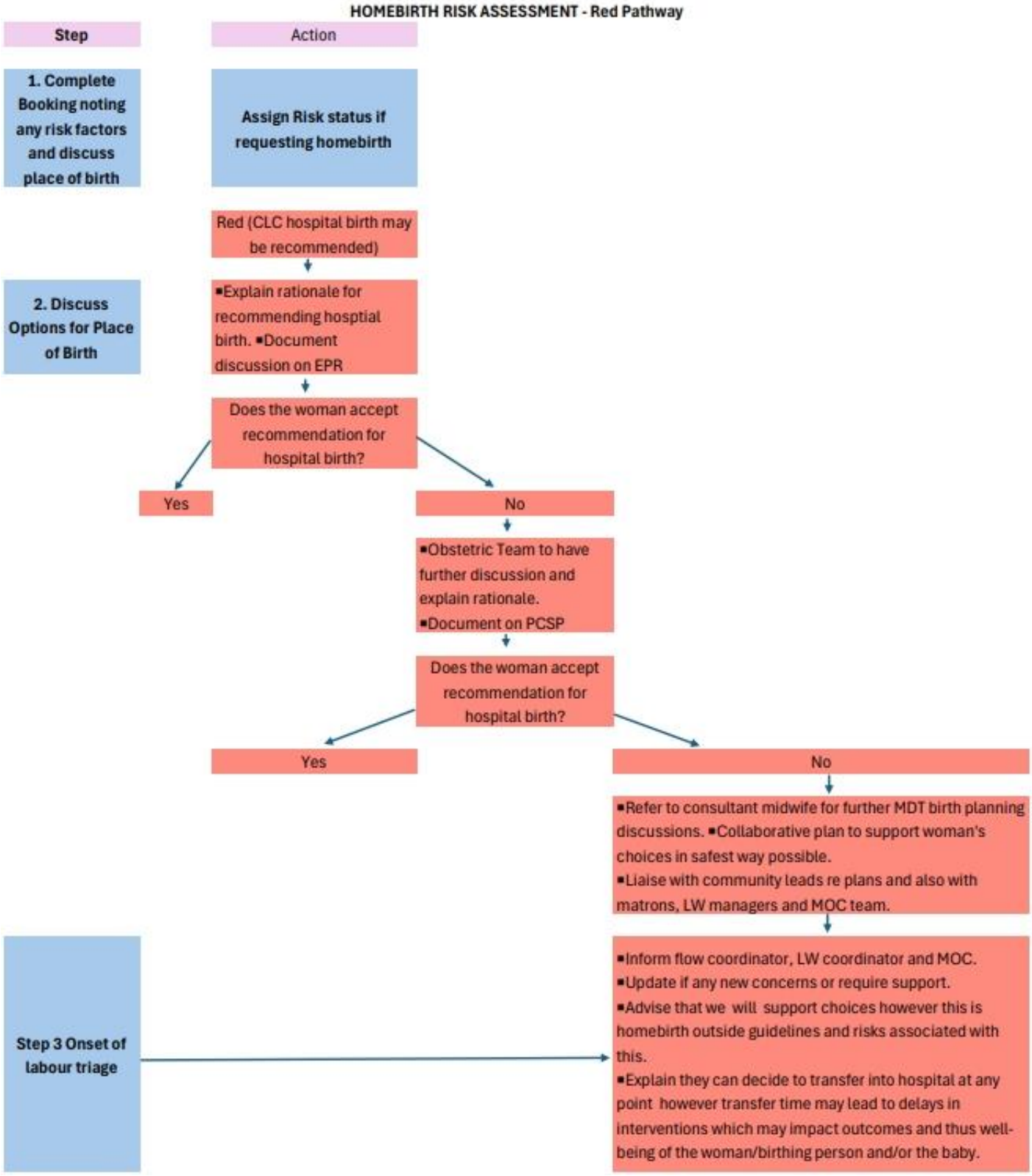
Any woman or birthing person who does not meet green criteria should be referred to their obstetric team to discuss their wish for homebirth and all discussions clearly documented on the EPR. The obstetric team may support the plan for homebirth or may recommend hospital birth. If the woman or birthing person still requests homebirth following obstetric discussion, then they should be referred to the consultant midwives for further discussion and planning. It is important that these conversations start as early as possible in the pregnancy to allow for adequate discussion and planning.

Note in some cases it may not be possible to make a recommendation for place of birth until later in pregnancy (e.g growth scan pathway, initial low-lying placenta, previous preterm birth) and women and birthing people should be advised that their risk status may change. Equally someone who is low risk at the beginning of pregnancy and planning homebirth may develop new risk factors during the pregnancy which will change our recommendation about place of birth. Again, the woman or birthing person may accept or decline this recommendation.

The risk assessment should be reviewed at each contact to ensure women and birthing people remain on the correct pathway. Risk assessment should continue with every contact until the end of pregnancy and throughout labour and birth and may change at any point. See Fig 1 & 2 for pathways.

HOMEBIRTH RISK ASSESSMENT - Green Pathway

Step	Action		
1. Complete Booking noting any risk factors and discuss place of birth	Assign risk status if requesting homebirth		
	Green (Low Risk at booking)		
2. Discuss Options for Place of Birth	Advise all options for place of birth available		
Step 3. 36 week risk assessment.	Has anything changed in terms of risk assessment that might now change recommendation around place of birth?	If yes	▪Revisit place of birth discussion. ▪Regrade risk status. ▪Arrange urgent obstetric review ▪Arrange urgent consultant midwife discussion.
Step 4 Onset of labour triage	Complete BSOTS risk assessment. Is homebirth still a safe option ?	If no	▪Explain why hospital birth recommended e.g mec ▪If declines to attend unit inform flow coordinator & MOC. ▪Advise we will still support choices however now homebirth outside guidelines and risks associated with this. ▪Explain they can decide to transfer into hospital at any point however transfer time may lead to delays in interventions which may impact outcomes and thus well-being of the woman/birthing person and/or the baby.
Step 5 Labour Risk Assessment	Complete labour risk assessment. Is homebirth still a safe option ?	If no	
Step 6 Ongoing Assessment during labour and initial postnatal care	Review risk assessment each hour. Complete 4 hrly holistic review. Is homebirth still a safe option?	If no	


HOMEBIRTH RISK ASSESSMENT - Red Pathway
Step
Action
1. Complete Booking noting any risk factors and discuss place of birth
Assign Risk status if requesting homebirth
Red (CLC hospital birth may be recommended)
2. Discuss Options for Place of Birth
▪Explain rationale for recommending hosptial birth. ▪Document discussion on EPR
Does the woman accept recommendation for hospital birth?
Yes
No
▪Obstetric Team to have further discussion and explain rationale.
▪Document on PCSP
Does the woman accept recommendation for hospital birth?
Yes
No
▪Refer to consultant midwife for further MDT birth planning discussions. ▪Collaborative plan to support woman's choices in safest way possible.
▪Liaise with community leads re plans and also with matrons, LW managers and MOC team.
Step 3 Onset of labour triage
▪Inform flow coordinator, LW coordinator and MOC.
▪Update if any new concerns or require support.
▪Advise that we will support choices however this is homebirth outside guidelines and risks associated with this.
▪Explain they can decide to transfer into hospital at any point however transfer time may lead to delays in interventions which may impact outcomes and thus well-being of the woman/birthing person and/or the baby.

Documentation Control

Reference Number: UHDB/09:24/H5	**Version: 4**	**Status: FINAL**	
Version control for UHDB merged document:			
1	June 2020	Cindy Meijer – Risk Support Midwife	Amendments for COVID-19 and merge
2	June 2021	Eileen Morris – Senior midwife Community	Update – full review, include Freebirth
3	March 2022	Claire Brackenbury - Lead Midwife Continuity of Care	Update
3.1	June 2024	Lauren Wilkinson - Risk Support Midwife	To remove reference to MHHR due to the implementation of BadgerNet
4	September 2024	Katherine Mabey Consultant Midwife	Update – full review and separation into guideline and SOP. Separate freebirth SOP.
Intended Recipients:			
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;			
To be read in conjunction with: Labour care and risk assessment; Neonatal Resuscitation; Newborn Care; Obstetric Emergencies			
Consultation with:	Ambulance services, community midwives		
Business unit sign off:	/ /2024: Maternity Guidelines Group: Miss A Banerjee – Chair / /2024: Tier 4 Maternity Quality & Safety Assurance - Miss J Heslop		
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: V4: ratified on 4th October 2024 by exceptional ratification, all tiers represented			
Implementation date:	04/10//2024		
Review Date:	September 2027		
Key Contact:	Joanna Harrison-Engwell		