Greater Manchester Integrated Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Unassisted Birth guideline

Final V2
April 2023

Part of Greater Manchester Integrated Care Partnership

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

Document Control

Ownership

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Version control

Title	**GMEC Unassisted Birth guideline**
V1.0	Ratified 14/8/2020
V1.0	Revision due; circulated to maternity steering group for comments 27/1/23. Deadline for comments 10/2/23
V1.1	ES reviewed comments; edits made 28/2/23. Further comments from KW, SKC. ES addressed 11/4/23
V2.0	**Ratified 28/4/2023**

Ratification process

The document received formal ratification by the Greater Manchester and Eastern Cheshire SCN Maternity Steering Group	28/04/2023
Circulation date	May 2023
Review date	April 2025
Responsibility of	GMEC SCN

Contents

1 What is this guideline for?

The guidance has been adapted to reflect the current context of maternity services under pressure, rather than a specific context, eg pandemic. The term 'Unassisted birth' will be used throughout the rest of the document.

Service pressures in maternity and related services (including but not limited to pressures on the ambulance service, maternity unit staffing challenges and other issues) have resulted in some maternity units making the difficult decision to suspend the availability of home birth and/or midwife-led birth in some areas. This means that some women may not be able to access the type or place of birth that they had planned. In these circumstances, women will be supported to adapt their birth plan to birth in the hospital maternity unit, or the alongside midwife led unit.

Some women/people will find the alternative options on offer unacceptable or feel that they do not meet their needs and may choose to have an unassisted birth. Women/people may feel that unassisted birth is the only way that they can retain choice, control and autonomy during the birth process.

The concern from maternity services is that birthing without midwifery assistance brings with it increased risks to both the mother and baby.

This guideline includes measures that maternity services may utilise if they become aware of a woman planning an unassisted birth. In addition, it lays out the legal stance for attending unplanned births at home once the maternity service becomes aware of it. It covers all care settings and is to be used by obstetric and midwifery staff, so that they provide consistent and effective care and minimise harm to mother/parent and baby.

2 Why do I need to know?

It is important to ensure that during pressures on health services (e.g., pandemic or major incident), maternity services can respond and adapt to the changing picture of health care, ensuring that the offer and options for care are acceptable to most women/people and that they and their babies receive the best evidence-based care even in uncharted circumstances. This guidance will ensure that a standardised approach will be implemented across our region, to reduce variation in the quality of care delivered.

3 Establishing a dialogue

When a woman/person indicates that they plan to give birth without assistance, the maternity service should reach out to them to try and build a dialogue.

Arrangements should be put in place as soon as possible, in order to establish a conversation. It is important to listen and understand more fully their concerns and reasons for choosing unassisted birth. This is best done in a face-to-face setting if possible or through virtual means or over the telephone.

Where continuity of care exists, utilise the existing relationship between the named midwife, woman/person and family. The midwife will have knowledge of the woman's /person's circumstances and their needs. Ongoing continuity of care may help with dialogue and assist the consideration of different options.

Where a known midwife is not available, consider using a midwife who is experienced in supporting women/people and their choices, for example a senior midwife, consultant midwife or Professional Midwifery Advocate.

Where English is a second language, it is important that interpreting services are utilised rather than relying on family members for the discussion. The midwife must feel confident that the woman/person and their family fully understand all the information given, including risk factors.

3.1 Content of the discussions

It is important to listen to the individual and to give them the time to share what is important to them in relation to their psychological and physical safety.

Explore why they want to have an unassisted birth.

Spend time explaining the evidence about any individualised risk factors for them and their baby.

During the conversation(s), identify any previous trauma and consider the potential benefit of offering psychological support from an expert in birth trauma.

Identify any misconceptions or misunderstanding about current practice or service provision in the area and provide the woman/person with accurate information. This is likely to include the systems and policies in place in the maternity unit, for example, if the homebirth service has been suspended, when it is likely to resume, if known.

Ask the individual what plan for the birth would feel safe and acceptable and consider options of how to provide an individualised plan of care, while considering and explaining the impact on safety for other women/people and staff. The RCM document '*Supporting women seeking care outside guidance'* may be useful (https://www.rcm.org.uk/news-views/rcm-opinion/2022/supporting-women-seeking-care-outside-guidance/).

Reassure the woman/person that they will continue to be offered usual antenatal and postnatal care even if they decide to have an unassisted birth.

Give the woman/person time to reassess their decision and review the conversation again.

Inform them who they can call and how to access assistance in labour, during the birth or afterwards.

If a woman/person chooses to have an unassisted birth, the maternity service will need to ensure that the individual has been informed that a midwife may not be available to be sent out to them at home during the labour and birth should they change their mind and request attendance. The availability of midwives for homebirth would be dependent on the staffing and safety of the maternity unit at that time, and therefore if professional care during labour and birth is requested, the woman/person may need to attend the maternity unit in order to receive it.

Inform the woman/person that should urgent assistance be required during the birth, an ambulance can be requested via 999. An ambulance will attend in an emergency; however, response times are dependent on service pressures at the time and this should be discussed with the individual.

Request that the woman/person notifies their maternity care provider when the baby has been born.

Advise how the parents can register the baby's birth, if there has been an unassisted birth.

All details surrounding discussion of the risks and benefits together with explicit details of proposed management must be documented contemporaneously, in both the Personal Maternity Record and the main notes as appropriate (NMC 2009).

4 Understanding the law

Midwives should ensure that women/people have an understanding of their own rights in relation to childbirth and about the law in relation to unassisted birth and place of birth.

It is not illegal for a woman/person to give birth unattended by a midwife or healthcare professional.

Women/people are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity to make decisions for themselves (Birthrights, 2017).

It is not appropriate for healthcare professionals to refer a woman/person to social services with concerns about the unborn baby, solely on the basis that they have declined medical support, as they are legally entitled to do (Birthrights, 2017). However, if there are safeguarding concerns, the maternity healthcare professional should still follow protocols for referral. This will be pertinent in particular when baby is born.

It is illegal for anyone present during the labour or birth to be undertaking the roles of a midwife or doctor. According to Article 45 of the Nursing and Midwifery Order (2001), it is a criminal offence for anyone other than a midwife or registered doctor to 'attend' a woman during childbirth, except in an emergency.

Birth partners, including doulas and family members, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.

5 Role and responsibilities of the midwife

A number of key sections of the NMC Code set out the responsibilities of midwives, that can be related to caring for women/people who identify that they wish to give birth without assistance or choosing to give birth at home outside of recommendations for home birth. They include the following:

5.1 Prioritise People

- Treat people as individuals and uphold their dignity; treat people with kindness, respect and compassion
- Listen to people and respond to their preferences and concerns; respect, support and document a person's right to accept or refuse care and treatment
- Act in the best interest of people at all times. To achieve this, you must always balance the need to act in the best interests of people with the requirement to respect a person's right to accept or refuse treatment *(sections 1, 1.1, 2, 2.5, 4 and 4.1 of the NMC Code, NMC, 2018)*

5.2 Preserve Safety

- Recognise and work within the limits of your competence.
- Always offer help if an emergency arises in your practice setting or anywhere else. To achieve this, you must:
  - Only act in an emergency within the limits of your knowledge and competence.
  - Arrange, where possible, for emergency care to be accessed and provided promptly *(Sections 13, 15, 15.1, 15.2, NMC, 2018)*
- It is natural that midwives will feel anxious about the safety of women/people and the families in their care and have a sense of responsibility for outcomes, even if they have no control over them.
- Women/people have the right to choose care that goes against the advice of their midwife. If a woman/person chooses to have an unassisted birth, the midwife has a responsibility to inform them about the risks of that decision.
- If there are safeguarding concerns, midwives should still follow protocol for referral. This may be pertinent in particular when the baby is born.
- The midwife is not responsible for the outcome of the unassisted birth.
- If a midwife is caring for a woman/person planning to have an unassisted birth or wishing to have a homebirth with risk factors that would suggest they would be safer to give birth in a hospital, the midwife should be offered the opportunity to discuss their concerns and plan of care with their manager. The RCM document '*Supporting women seeking care outside guidance'* may be useful (https://www.rcm.org.uk/news-views/rcm-opinion/2022/supporting-women-seeking-care-outside-guidance/).
- Midwives will also benefit from seeking support through professional midwifery advisors (PMA) or other support such as Matron/HOM/DoM/consultant midwife.

6 Provision of assistance at an unplanned home birth

Once a maternity service becomes aware that there is a woman/person in labour at home who wishes to have the attendance of a midwife, the maternity service has a duty of care to provide assistance.

Midwives who are informed of a woman/person planning to have an unassisted birth must escalate to the senior midwifery management team, who will then assess what individualised, flexibility of service provision might be possible to avoid an unassisted birth as far as possible. The type of assistance available during specific maternity service pressures might need to reflect the level of acuity and capacity within the service at that point.

The rights of women/people to choose their preferred place of birth will need to be balanced against the rights of all women/birthing people to receive a safe level of midwifery care.

If a woman/person has indicated in the antenatal period that they wish to have an unassisted birth, the service will have ensured that the individual is aware that a midwife may not be available to be sent out to the home during labour and birth. If that is the case, at the time the maternity service is informed of the labour and attendance requested, the woman/person will be offered the opportunity to receive professional care within the maternity unit.

Where the maternity service is informed after the birth of the baby, a midwife may be requested to attend either by the woman/person directly or via the ambulance service. Care will be provided as per local Born Before Arrival (BBA) guidelines.

NWAS uses the Advanced Medical Priority Dispatch System (AMPDS) triage system. The different response times based on the national Ambulance Response Programme (ARP) are as follows:

6.1 NWAS category response times

C1 – mean - 7 min / 90th Percentile 15 min
C2 – mean -18 min / 90th Percentile 40 min
C3 – mean - 1hr / 90th Percentile 2 hrs
C4 – No mean / 90th Percentile 3 hrs

Mean is the average time of all incidents in that category. 90th Percentile is response target met in 9 out of every 10 incidents in that category. Please note that in times of severe service pressures on NWAS, this average may change. Every effort must be made to inform the woman/person of most recent NWAS response times.

From a maternity perspective, the following points are classified as a Category 1 emergency.

- Breech
- Head visible
- Cord Prolapse
- 3rd trimester haemorrhage
- Baby born, complications with the mother/parent

These conditions remain during increased pressure on the ambulance service (including during a pandemic or during any strike action) as well as during usual service provision.

7 Service provision during increased service pressure (including in a Pandemic)

Midwifery service leads will need to use judgement and seek guidance to provide safe, high quality maternity services during periods of intense service pressure for the women/people in their care and this will, on occasion, require making difficult judgement calls about what services can be safely provided.

Where a service lead is making a decision about temporary suspension of some services including homebirth, as a result of service pressure, they should have mechanisms in place that informs their Trust Board and LMNS that these changes have taken place.

Maternity service leads should ensure that clear information is provided to all women/people booked to give birth in their service about current service configuration that is updated regularly, through the service website, social media and through their local Maternity Voices Partnership (MVP).

Where services have been reconfigured based on judgements around staffing shortages, skill mix and the accessibility of paramedic and ambulance services in an emergency, it is important that any cessation of homebirth or midwife led services is only short-lived and the provision is reassessed continually. Such an approach should reduce the possibility of an increase in unassisted birth.

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