GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

Informed Choice, Personalised Care And The Care Of Women Making Choice Outside Of Recommended Guidelines

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

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Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Nov 2022

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Consultant Midwife
Head of Midwifery and Sexual Health
Assistant Head of Midwifery
Women and Children's Governance Lead
Clinical Supervisor for Midwives

Circulated to the following for Consultation

Date	Role / Designation
31/08/2022	PTHB Midwifery team
31/08/2022	PTHB Midwifery Leadership and Management team
31/08/2022	Consultant Midwives Cymru
31/08/2022	Link Obstetric Teams in ABUHB, CTMUHB, SBUHB, HDUHB, BCUHB, SaTH, WVT
31/08/2022	PTHB Women & Children's Policy Group members
31/08/2022	Safeguarding team
31/08/2022	Clinical Lead – Welsh Ambulance Service NHS Trust
31/08/2022	Quality & Safety Team
31/08/2022	Director of Nursing and Midwifery

Groups approved at

Date	Group
3/10/2022	Maternity guidelines group
17/10/2022	Women and Children's policies and guidelines group

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? Human Rights Act (HRA) (1998) Nursing and Midwifery Council (NMC) Code (2018) National Institute of Health and Care Excellence (NICE) (2021) ECD8 Standards Framework for shared decision-making support tools, including patient aids RCM 2022 Royal College of Midwives (RCM) (2022a) – Caring for those women seeking choices that fall outside of guidance. London: RCM Royal College of Midwives (RCM) (2022b) – Informed decision making. London: RCM

Impact Assessments

Equality Impact Assessment Summary

	No impact	Adverse	Differential	Positive	Statement
					Statement Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Age	X				
Disability	X				
Gender reassignment	X				
Pregnancy and maternity				X	
Race	X				
Religion/ Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and civil partnership	X				
Welsh Language	X				

Human Rights	X				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any training and / or resource implications as a result of implementing this? No issues identified

1 Policy Statement / Introduction

Midwives are obliged by the Nursing and Midwifery Council (NMC) Code (2018) to 'put the interest of people needing or using midwifery services first'. Midwives must therefore prioritise care and safety whilst ensuring women are treated with kindness whilst preserving dignity and human rights.
To provide personalised care, there needs to be a relationship of trust, continuity of care, as well as multidisciplinary involvement centered around the woman; care options should take into consideration the individual values, preferences and perceptions of risk (Royal College of Midwives [RCM], 2022a). Guidelines include sets of recommendations based on the trade-off between benefits and harm; some are made with more certainty than others based on the quality of the underpinning evidence and moreover, guidelines do not supersede women's human rights over bodily autonomy (RCM, 2022a).
Midwives must provide women with the information and support they need to make decisions about their care and must respect the decisions that women make (RCM. 2022b). In providing informed choice women will choose to either give or decline consent for that care.

2 Objective

This document sets out the guidance for ensuring informed choice and personalised care for all pregnant women and new mothers (hereafter referred to as women). Whilst its focus is to provide guidance for supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, the principles within this document should be used for all aspects of care.

3 Definitions

- **AWCPNL –** All Wales Clinical Pathway for Normal Labour
- **CIS** – Clinical Information Sharing
- **CSfM** – Clinical Supervisor for Midwives
- **DGH** – District General Hospital
- **MARF** – Multiagency referral form
- **NICE** – National Institute of Health and Care Excellence
- **OTL** – Operational Team Lead
- **PTHB** – Powys Teaching Health Board
- **RCM** – Royal College of Midwives
- **SBAR** – Situation, Background, Assessment, Recommendation
- **WAST** – Welsh Ambulance Service NHS Trust
- **WPAS** – Welsh Patient Administration System

4 Responsibilities

Responsibilities in relation to this guideline are:

4.1 Head of Midwifery and Sexual Health Services

The Head of Midwifery and Sexual Health Services must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

4.2 Assistant Head of Midwifery and Sexual Health Services

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff
- Liaising with District General Hospitals (DGH) to feedback where care has fallen outside of this guideline

4.3 Band 7 operational team lead (OTL)

The OTL has responsibility for:

- Working to the requirements of their role within the scope of this guideline
- Ensuring compliance with this document by the teams that they manage
- Discussion about management of women with medical conditions, supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, during PADR process
- Ensuring there is adequate OTL cover across the roster to support care planning and guidance.
- Providing 24-hour 7 day a week objective clinical case discussion where required

4.4 Consultant Midwife

The consultant midwife has responsibility for:

- Supporting implementation of this document
- Reviewing any new evidence or guidance that is produced that may influence the service
- Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration.
- Being available in an advisory capacity related to care outside of guidance
- Working to the requirements of their role within the scope of this guideline

	4.5 Clinical Supervisor for Midwives (CSfM) The CSfM has responsibility for: • Supporting implementation of this document through group supervision sessions • Offering opportunity for discussion of management of medical conditions supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, in relation to content of this guideline through group and individual supervision • Leading record keeping audits with discussion about women with medical conditions and ensuring cases have been managed appropriately • Working to the requirements of their role within the scope of this guideline
	4.6 Women and Children's Risk and Governance Lead The Women and Children's Risk and Governance Lead has responsibility for: • Monitoring review of incidents in relation to content of this document
	4.7 All Staff working within maternity services All staff working the maternity services have responsibility for: • Reading and being familiar with contents of this document • Referring women appropriately for additional care where required • Working to the requirements of their role within the scope of this guideline

5 Informed choice and personalised care

All women should be provided with information to make decisions and choices about their care. Personalised care is achieved by ensuring facilitated discussions, in which the woman participates and considers the management of their health and well-being in the context of their whole life and family situation.
Midwives should assess all pregnant women at booking from an obstetric, mental health, medical and social perspective and in discussion with them should make a recommendation and plan for care during the pregnancy and beyond. This should be revisited throughout pregnancy and amended in response to any changes that occur.

The provision of informed decision-making means that the woman is supported to;

- Understand the care, management and support options available and the risks, benefits and consequences of those options
- Make a decision about a preferred course of action, based on evidence-based, good quality, timely information and their personal preferences (NHS E/I, 2021)

In supporting informed choice midwives should ensure the following recommendations (RCM, 2022b)

- Provide balanced, transparent and reliable information
- Ensure understanding
- Facilitate the decision-making process
- Be an advocate for women and families
- Act on the decision
- Ensure accurate record keeping

Women are encouraged to use a recognised framework, for example BRAN, (Welsh Government, 2021) to help navigate the choices during maternity care. Within maternity services this has been adapted to also include 'intuition';

- **B**enefits – what difference will it make? What will happen and how?
- **R**isks – side effects, challenges or potential for adverse outcomes?
- **A**lternatives – consider, benefits and risks
- **I**ntuition – explore feelings, values and past experiences
- **N**othing – consequences of doing nothing, waiting, what could happen? Consider benefits and risks

Duty of care is underpinned by informed decision-making and the principles of authentic and legal consent. Midwives need to counsel women using the very best evidence or options available to them in accessible format and document such conversations. Women can accept or decline such recommendations and

develop personalised care and support plans, which are facilitated by continuity of care (RCM, 2022a)

Even when there may be strong evidence in favour of a course of action or treatment, information giving should not unduly persuade or coerce and maternal decisions should be respected (RCM, 2022b).

6 Human Rights

The Human Rights Act (1998) protects individuals' basic rights and freedoms. It protects women's choices regarding how and where they give birth as well as their rights to decline recommended care based on medical advice. Articles 2, 3 and 8 provide particularly relevant guidance in relation to the provision of personalised care.

- Article 2 – The Right to Life – Women should never be denied access to maternity services and potential impediments in accessing care (such as a lack of personalised care) should be removed.

- Article 3 – Right to be free from inhuman or degrading treatment – Women should not be subjected to medical procedures they do not consent to, nor should they be denied pain relief.

- Article 8 – Right to respect for private and family life, home and correspondence – Women should be supported in any choice they make during pregnancy and childbirth; this includes care against medical recommendations.

In relation to the unborn baby; in UK law, a fetus does not have rights. An unborn baby doesn't become a separate person with legal rights until they are born.

Midwives can access further information through the Birth Rights organisation, which supports the protection of human rights in relation to childbirth.

7 Process when women choose intrapartum care outside of recommended guidelines

Women who are planning care outside of local/national guidance should be encouraged to;

- have a full evidence-based discussion explaining the best available research information and information around professional opinion in the absence of research.
- understand why their health care provider is recommending care models, including place of birth.
- have a clear description and understanding of the available packages of care, limitations and of care packages in relevant clinical scenarios in each birth setting.
- be supported to birth in accordance with their wishes where the principles of informed decision making (NICE, 2021) have been achieved

Discussions about models and packages of care should include fetal surveillance, maternal monitoring and investigation, analgesia, availability and skills set of the team, transfer and birth environment. All conversations should be clearly documented in clinical records including the All-Wales Maternity Handheld Record.

Following the provision of information if the woman is making a choice that is outside of recommended guidance the midwife must ensure that the woman understands that the choice is outside of recommendation, but that they will be supported in their personal choice and preferences. Adequate time should be planned for care planning discussions with the client.
Midwives will take responsibility for identifying the relevant guidance and evidence to support care planning. Advice can be sought from the Consultant Midwife when required.

When the preference is for birth outside of guidance in a Powys birth centre or at home then the case should be discussed with the Operational Team Lead (OTL) who is rostered that day, Clinical Supervisor for Midwives (CSfM) or Consultant Midwife or member of the management team who will provide 'fresh ears and/or eyes'. This should be sought at the earliest opportunity when the client's intentions are known and agreement made between the named midwife and senior colleague about when the CIS will be ready for review, considering days off and other commitments. Any concerns during the week can be escalated to the consultant midwife.

Appendix A supports with care planning discussions and guides on assessment at 36 weeks of pregnancy to assess suitable place of birth. Appendix A suggests cases that should be discussed with the OTL/CSfM or consultant midwife. This list is not exhaustive and professional judgment must be used.

If risks are identified early in pregnancy and the woman has expressed her wishes for a local birth outside of guidance, then the clinical information sharing process should begin as soon as possible.

Following discussion with the senior midwifery colleague a Clinical Information Sharing (CIS) document will be drafted for all cases of birth planned in Powys outside of recommended guidance (Appendix B) and saved on SharePoint in the relevant month and year that the woman's estimated due date (EDD) falls. In addition, the details should be added to the 'clinical information sharing outcome' database on SharePoint. This enables live tracking of active cases to occur.

The CIS follows an SBAR (Situation, Background, Assessment and Recommendation) format to support clear communication.
This will be first shared with the person with whom the care plan was discussed. The OTL, CSfM or consultant midwife will review the CIS to ensure it reflects the discussion held and will then circulate it, accordingly, also ensuring it is saved on SharePoint.

The CIS will be circulated to Powys Midwives to ensure that anyone who may care for the client knows about the case. The CIS should also be filed in the client's pregnancy hand-held notes and within the midwifery tracer in the office. A copy of the CIS should also be emailed to the woman's obstetric team so that a copy can be retained on her file in case of the need for transfer. The information from the CIS plan will be added to the current annual CIS database by the named midwife.

Any updates must be added to the CIS document, and it must be recirculated to the same group following any changes.

The CIS database is to be reviewed at the weekly midwifery leadership and management meeting to ensure there is oversight on open cases and assessment of cases that may require further escalation within the Health Board.

7.1 Responsibility of the OTL and CSfM 'fresh ears/eyes'

- Ensure adequate time is set aside to support the discussion. This may need to be planned for a specific time to support attention, concentration and minimise distraction
- Ensure an up-to-date situation is presented
- Ensure a background and history is taken
- Ensure the care plan is adequate
- Seek any additional requirements or detail where needed
- Escalate any concerns to the consultant midwife
- Escalate complex cases to the consultant midwife

	• Review the CIS when complete and updated and then circulate accordingly • Ensure handover to a different OTL or consultant midwife where workings days will impact on being able to review the finalised CIS.
	7.2 Responsibility of the consultant midwife 'fresh ears/eye' • Review circulated CIS documents • Ensure provision of support and guidance to the OTL and/or CSfM when required • Ensure the same requirements for the OTL and CSfM 'fresh ears/eyes' are followed when care planning involves the consultant midwife • To facilitate and support care planning discussions with the client and the named midwife when required through the provision of remote or face to face consultations

8 Process when women choose antenatal or postnatal care outside of recommended guidelines

At any stage of care women may choose to decline aspects of care. Midwives must ensure that All-Wales Maternity handheld record is updated and the plan of care is documented accordingly during the antenatal period. During the postnatal period the maternal and/or postnatal pathway should be updated if care is being chosen outside of guidance. This should include documented discussion of advice sought from the obstetric and/or neonatal team. The woman should also be informed of indications to contact the midwifery team for advice and support.

A CIS does not need to be circulated in respect of antenatal and postnatal plans unless particularly complex and these will be assessed on an individual basis. The named midwife should seek advice from the OTL, CSfM or consultant midwife in these cases.

9 Communication with the obstetric and/or neonatal team

Multidisciplinary team working is essential in maternity care when a woman is assessed to have additional risk factors.
If the woman has received obstetric input during the pregnancy and is choosing to birth in Powys outside of recommended guidance, then they should be encouraged to share their preferences with their obstetric team as early as possible.
Attempts should be made to facilitate a joint obstetric review with the named midwife present to support collaborative working, shared decision making and to support care planning. This can be done remotely or in-person and counts towards midwifery 'DGH/high risk' hours. If a joint meeting is not possible then the named midwife should liaise with the obstetric team by phone or email to ensure the woman's wishes are known. The named midwife should be clear about what care the woman would be offered if they received intrapartum care within the obstetric unit so that the woman can be clear about their options and what they are declining to receive. A copy of the CIS should be shared with the obstetric team.

There may be circumstances when a woman does not wish to be referred for obstetric care despite professional advice. In this case ensure that the woman understands the reason for recommending the referral and document the discussion. If the woman has declined to receive any obstetric input during the pregnancy and plans to birth in Powys outside of guidance, a referral should be re-offered to support care planning. If this is declined then the midwife can seek obstetric opinion to seek clarity of the care that would be offered to support informed decision making.

The impact of the care choices that the woman makes should also be considered in terms of potential impact on the neonate. Women should be clear about any recommendations for care for the neonate after birth and advice can be sought from a neonatologist if required. If there are concerns about the neonate based on any recommended observations, then immediate transfer to the nearest obstetric unit should be arranged.

If the woman is requesting to birth in an alongside midwifery-led unit in a DGH outside of midwifery-led care then it may be necessary to liaise with the consultant midwife in the relevant Health Board/NHS Trust. See Appendix B for details.

10 Communication with the ambulance service

There may be occasion where communication with the ambulance service is required during the antenatal period prior to labour. Individual cases will be escalated by the senior midwifery team to the relevant ambulance service using a 'patient specific directive' which will summarise any key information required as detailed in Appendix C.
This will be saved in the clinical information sharing file within maternity and circulated to the relevant Health Board Clinical Lead for the ambulance service.

11 Safeguarding considerations

In the absence of concerns relating to a family with additional vulnerabilities or safeguarding concerns, choices around antenatal care and birth alone are not grounds for referrals to be made in relation to safeguarding.
If there are concerns that the child will be at significant risk of harm once they are born, then a multiagency referral form (MARF) should be completed.
If the midwife suspects that the parents may not, or they do not follow professional advice post birth or in the postnatal period, such as declining to take the baby to a hospital for review when there are clinical concerns, there should be a documented discussion about the risk of declining to follow the advice and consider making a report to local authority.
A telephone discussion with the neonatal registrar or consultant at the relevant DGH should be had to obtain advice on a plan of care.
If the baby is considered to be at risk, contact PTHB safeguarding team on 01686 252806 or PowysTHB.Safeguarding@wales.nhs.uk for advice and support (for urgent out of hours safeguarding advice, contact Powys Front Door on 0345 054 4847

12 Intrapartum care provision

When the woman goes into labour, depending on the clinical presentation they may require early assessment in labour.
In most cases, particularly where the clinical presentation is one that might impact prior to birth, two midwives should attend once labour is established. Skill mix should be considered in all cases, with more junior staff being supported by more senior staff.

The OTL should be contacted and informed that the woman is in labour, and this should be documented.
The nearest obstetric unit should also be informed that the woman is in labour, and this detail documented.

Long hand documentation should be used in CIS cases. The All-Wales Clinical Pathway for Normal Labour (AWCPNL) can be used for record keeping purposes, but long hand notes should be used in addition within the pathway and then on continuation sheets if required. The partogram should be used in all cases to support assessment of progress and maternal and fetal well-being.

A variance should be noted on each part (parts 1,2 and 3) of the AWCPNL to identify that a CIS is in place. At each initial assessment a plan should be made based on the CIS.
An SBAR should be documented at least hourly, and more frequently where clinically indicated, and as part of the hourly holistic assessment in labour. This ensures focus remains on the evolving clinical picture and presentation.

Contact should be maintained with the OTL so that they can have an overview of the case and offer support on a regular basis. In cases where the OTL is providing care as the 1st midwife, fresh ears on the case can be sought from an alternative midwifery colleague who is not providing care.

The obstetric unit can also be contacted for guidance related to CIS cases. The discussion should take place with the labour ward coordinator and/or obstetrician on call. Any contact should be documented within the records.

13 When a woman declines all aspects of care in labour

A discussion should happen with all women antenatally about what they will be offered in terms of intrapartum care and to explore their preferences and wishes. In most cases this will take place at the 36-week birth preferences appointment.
On the rare occasion that a woman intends to, or calls for midwifery support when in labour, but then declines the care on offer there should be:

- Exploration of the reason for declining care and attempts to develop a trusting relationship with the woman and her birth partner
- Confirmation to the woman that she will be supported in her decision making
- Documentation of the woman’s choices and intentions
- A documented discussion about the risks and benefits of both the recommended care and the woman’s intended course of action
- Exploration with the woman about her expectations of the midwife and documentation of this in the handheld record or AWCPNL
- Ongoing offer of the recommended care during labour, documented within the records each time this happens and whether it is accepted or declined
- A discussion with a senior colleague and escalation to OTL and ‘silver’ on call for the Health Board if required at onset of care in labour
- At least hourly discussion with the OTL for support and review of the clinical situation when intrapartum care in being provided
- Discussion with the obstetric unit in cases where the woman is not assessed as being midwifery-led care
- Assessment for the need for 2 midwives to be present for support
- Accurate record keeping throughout the care noting any limitations in ongoing assessment
- Following of the CIS process when the woman’s intentions are known antenatally

Care should not be withdrawn unless the woman is assessed to not be in established labour. In this case the woman should be clear about when to call for midwifery support if needed and this should be documented in the records.

14 Support for staff

Team meeting and/or group supervision sessions will be facilitated for cases that are particularly complex to enable the opportunity to discuss any elements of the care plan as required. Specific skills and drills practice will be made available as required and midwives can access any member of the PROMPT Faculty to discuss obstetric emergency practice if they feel they would benefit from this.
Individual midwives should seek support through the CSfM or consultant midwife if required at any point.
Debrief through individual or group supervision or for specific cases will be available.

15 Freebirth

In making informed choice some women may choose to give birth without medical or professional help. For some women, they feel the only way to retain choice, control and autonomy over their bodies during the birth process (Feeley & Thomson, 2016). In the absence of concerns relating to a family with additional vulnerabilities or safeguarding concerns, choices around freebirth alone are not grounds for referrals to be made in relation to safeguarding.

The woman assumes responsibility for her birth, but she may and can have her partner, relative, friend or doula present in a supportive role. A midwife has no right to be at a baby's birth and if a woman chooses not to contact or engage a midwife it is her right to do so. It is legal if the birth is not attended or the responsibility for care is assumed or undertaken by an unqualified individual, (an unqualified individual is a person who is not a registered Doctor or Midwife but acts in that capacity during birth) (NMC 2018).

If a woman states her intention to free birth then the midwife should seek to explore the woman's reasons and motivation for this. Consideration should be given to any additional support that can be put in place. If the woman chooses not to access further antenatal care, attempts should be made to contact them as per the recommended Schedule of antenatal care (PTHB MAT 069) and care offered with an explanation of what would be offered at each appointment. Records should be maintained to reflect these discussions. It should be made clear that the woman can access midwifery care at any stage should they wish to, and they should be informed of indicators for accessing advice and care.

The woman's wishes should be documented within the handheld record and a CIS formulated and circulated. The woman should be advised that the detail will be shared with the nearest obstetric unit and the ambulance service to ensure safe care should there be any concerns.

If there is no midwife or other health professional present within six hours of the birth, the mother or any other person who was present at the birth, or who arrived within 6 hours of the birth, must notify the birth in writing within 36 hours of the baby being born. If a midwife is present within 6 hours of the birth then the birth should be entered onto the Welsh Patient Administration System (WPAS) with as much detail as possible (NHS Wales 2006). Detail may need to be added within the notes section to state that it was a freebirth and therefore some information may not be known. There is a legal requirement to notify a birth within 36 hours and advice will need to be sought with the Child Health Department for individual cases. This should be planned for antenatally when a free birth is known to be planned.

Postnatally, care should be offered to the family and the GP and health visitor should be informed. If no care is accepted, then advice should be sought from the Safeguarding team.

Midwives may find it helpful to access the RCM Guidance on Freebirth (2020) for further detail and support.

16 Monitoring Compliance, Audit & Review

An annual Clinical Information Sharing database is maintained within maternity services which records all cases where care is planned outside of guidance. This database is reviewed weekly at the midwifery leadership and management meeting to ensure monitoring of active cases. Clinical Information sharing cases for escalation are considered as part of the PTHB Weekend / out of hours planning and highlighted to Assistant Director for W&C services and Executive Director for Nursing and Midwifery

The database includes the clinical reason/presentation and the outcomes for each case. This allows data and themes and trends to be monitored. The place of birth, type of birth, transfer in labour or postnatally plus any relevant extra information (PPH, failed IOL, MROP, reasons for transfer) all help with evaluating and auditing the CIS process. This enables an annual report to be written by the Clinical Supervisor for Midwives.

The named midwife is responsible for ensuring that the outcomes of all cases on their caseload are circulated so that the database can be updated.

If there is an adverse outcome or transfer for CIS cases, then a Datix must be submitted. Datix submissions are reviewed as part of the weekly maternity Datix meetings and will form part of the monthly midwifery management meeting with Governance theme to discuss any issues in more depth.

Where there is specific learning that may require urgent sharing to avoid recurrence this will be shared with the central Quality and Safety team for wider sharing. If it is an urgent or significant case a Patient Safety Huddle will be arranged and terms of reference for the incident will be agreed.

This guideline will be audited one year after implementation to ensure adherence to it. Peer review through record keeping audit of all CIS cases will also take place.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

17 References / Bibliography

Feeley C & Thomson G (2016) Why do some women choose to freebirth in the UK? An interpretative phenomenological study. BMC Pregnancy and Childbirth. Available at Why do some women choose to freebirth in the UK? An interpretative phenomenological study | BMC Pregnancy and Childbirth | Full Text (biomedcentral.com)

NHS England and NHS Improvement (2021) Personalised care and support planning guidance.

NHS (Wales) 2006 Special notices of birth and death section 200

NICE (2021) ECD8 – Standards Framework for shared decision-making support tools, including patient aids

PTHB MAT 069 – Maternity Operational SOP during COVID-19 pandemic

Royal College of Midwives (RCM) (2020) Clinical briefing sheet: 'Freebirth' or 'unassisted childbirth' during COVID-19 pandemic

Royal College of Midwives (RCM) (2022a) – Caring for those women seeking choices that fall outside of guidance. London: RCM

Royal College of Midwives (RCM) (2022b) – Informed decision making. London: RCM

Welsh Government (2021) National Clinical Framework: A Learning Health and Care System

Appendix A

Guidance on clinical presentation and process for 'fresh eyes/ears'

	Pathway A	Pathway B
1 – 2 risk factors	Discuss with OTL, CSfM or consultant midwife	Named midwife completed individual assessment CIS not required
3 or more risk factors	Discuss with Consultant Midwife	Discuss with OTL, CSfM or Consultant midwife for fresh eyes/ears and assess on individual basis if CIS required

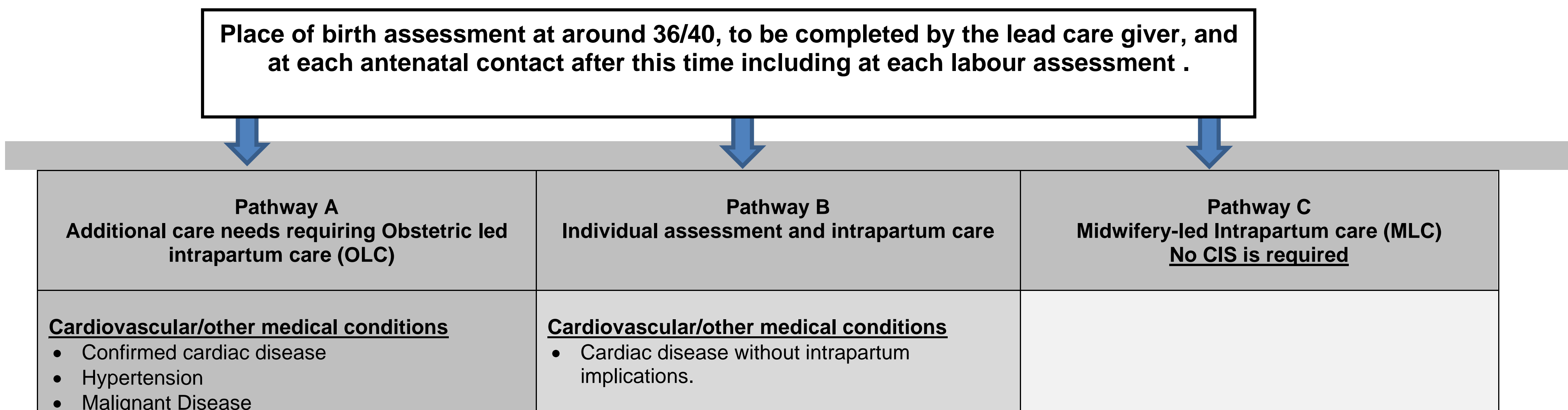
Cases in **Pathway C** can be treated as midwife-led care and a CIS is **not** required.

Cases to be considered for escalation to the Director of Nursing and Quality and Safety Team

- Freebirth is known to be planned
- Following review by the Midwifery Leadership and Management team, there is consideration of a significant level of risk for the organisation

This list is NOT exhaustive and professional judgement must be used. If there are concerns always escalate.

All Wales Place of Birth Assessment Criteria



Place of birth assessment at around 36/40, to be completed by the lead care giver, and at each antenatal contact after this time including at each labour assessment .

Pathway A **Additional care needs requiring Obstetric led intrapartum care (OLC)**	**Pathway B** **Individual assessment and intrapartum care**	**Pathway C** **Midwifery-led Intrapartum care (MLC)** **No CIS is required**
Cardiovascular/other medical conditions • Confirmed cardiac disease • Hypertension • Malignant Disease	**Cardiovascular/other medical conditions** • Cardiac disease without intrapartum implications.	

<u>Haematological</u> • Autoimmune disorders e.g. Systemic Lupus, • Antiphospholipid syndrome • Haematological – History of sickle-cell, beta thalassemia Major • History of thromboembolic disorders • Hb less than 85g/l • Immune thrombocytopenia purpura or platelet count below 100 10/litre. • Von Willebrand's disease • Bleeding disorder in the women/fetus • Atypical antibodies known to cause HDN • Jehovah's witness with additional care needs • Women scoring 3 or 4 on VTE assessment and on prophylactic or therapeutic antenatal anticoagulants.	**<u>Haematological</u>** • Atypical antibodies not known to cause HDN • Platelets >100 <150 10/litre. • Hb between 85-105 g/l and asymptomatic of anaemia.	**<u>Haematological</u>** • Hb of <110g/l at booking and <105g/l after 28 weeks, require iron therapy and recheck Hb at 34/40 OR 4 weeks after commencing iron therapy. • • Women scoring 2 on VTE assessment where postnatal thrombo-prophylaxis has been prescribed or declined.
<u>Endocrine</u> • Hyperthyroidism (any history of hyper, may present as hypo) • Women on oral steroids • Type 1 and type 2 diabetes • Gestational diabetes	**<u>Endocrine</u>** •	**<u>Endocrine</u>** • Adequately treated primary hypothyroidism
<u>Auto-immune</u> • Systemic lupus erythematosus, Scleroderma • Connective tissue disorders	**<u>Auto-immune</u>** • Connective tissue disorders (non-specific)	**<u>Auto-immune</u>**
<u>Infective</u> • Hepatitis B or C Carriers of, or infected • HIV • Toxoplasmosis in pregnancy • Active infection or chicken pox/rubella • Primary infection of genital herpes (First lesion) diagnosed in pregnancy or recurrent active lesions after 36/40. • Tuberculous under treatment	**<u>Infective</u>** • Covid 19-symptoms or positive test within 10 days of onset of labour or previous hospital admission due to Covid-19 during pregnancy. • Previous baby affected by GBS, diagnosed with GBS this pregnancy, or opting for Intrapartum Antibiotic Prophylaxis (IAP).	**<u>Infective</u>** • History of genital herpes, and lesion free throughout pregnancy, offer prophylactic acyclovir from 36/40. • Reoccurrence of genital herpes in this pregnancy but lesion free prior to 36/40, offer prophylactic acyclovir from36/40. • Group B streptococcus in current pregnancy, declining Intrapartum Antibiotic prophylaxis (recommend neonatal observation as per EOS calculator).

		• GBS in last pregnancy; Offer Vaginal/rectal swab 35-37/40. If negative IAP not required, can be MLC for birth unless mother wishes IAP in which case this should be supported.
Neurological • Epilepsy • Myasthenia gravis • Multiple sclerosis • Previous cerebrovascular accident	**Neurological** • Previous epilepsy not medicated and no seizures for 3 years.	**Neurological**
Gastro-intestinal/Renal • Liver disease (not obstetric-cholestasis) • Abnormal renal functions/known renal disease	**Gastro-intestinal/Renal** • Crohn's disease or ulcerative colitis	**Gastro-intestinal/Renal**
Previous pregnancies • Previous Molar pregnancy • Previous HELLP syndrome • Severe pre- eclampsia/eclampsia • Pre-eclampsia requiring preterm birth, • Baby with neonatal encephalopathy • Uterine rupture • Placental abruption • Previous PPH 500-999mls requiring treatment or blood transfusion. • Primary PPH >1000 mls or any amount causing symptoms of hypovolaemia. • Retained placenta • Caesarean section. • Shoulder dystocia • Cervical tears • 3rd /4th degree tears with ongoing concern or continence issues	**Previous pregnancies** • Pre-eclampsia at term and asymptomatic this pregnancy. • 3rd/4th degree tears with no ongoing issues.	**Previous pregnancies** • 3 or more consecutive miscarriage • Mid trimester miscarriage (12-22 weeks). • Previous SGA below 10th centile (Suitable for Midwifery-led birth where USS's are Normal) • Previous pre-term birth now >37/40. • Previous PPH 500-999mls with no treatment or evidence of bleeding due to uterine atony, previous birth record to be reviewed to confirm clinical picture.
Current pregnancy • Multiple pregnancy • Low PAPP-A and concerns around fetal growth. • Gestational diabetes • Placenta praevia • Pre-eclampsia /pregnancy induced hypertension	**Current pregnancy** • Women declining booking/anomaly USS • APH of unknown origin,1 episode after 24/40 • Substance misuse • Para 5	**Current pregnancy** • BMI at booking of 30 to 34.9kg/m • Multiparous BMI 35-39.9 with previous vaginal birth who are otherwise suitable for Midwifery-led birth with normal GDM screen and normal routine USS's.

• Pre-term pre-labour rupture of membranes • APH of placental origin or > 1 episode after 24 weeks • Alcohol dependency • Maternal age ≥40 at booking (SBAR-10). • Nulliparous BMI ≥35-39.9 with normal GDM screen and USS's. • All parity BMI>40 • Grand multiparity P6 >. • Concerns with fetal growth or placental function. • Concerns around fetal movement within 24 hours of the onset of labour. • EFW ≥97th with any other additional care needs • Polyhydramnios/oligohydramnios • Gestation >41+6 • Therapeutic or prophylactic thromboprophylaxis • Wt. <50kg with anaemia • Persistent breech/mal presentation.	• EFW via USS > 97th centile with normal GDM screen and otherwise uncomplicated pregnancy. • 2 episodes of raised blood pressure antenatally, taken more than 4 hours apart. • Recurrent[1] episodes of AFM (2 or more within 21 days) with reassuring outcomes of investigations and where fetal movements have been normal in the last 24 hours. • Booking WT<50kg , no concerns around fetal growth and normal haemoglobin. • Low PAPP-A with normal fetal growth on serial USS	• Maternal age 35-39 inclusive at booking. • Smoker (Suitable for Midwifery-led birth where USS's are normal). • P4 or < • EFW >90th <97th centile on USS at 36/40 with otherwise uncomplicated pregnancy. • Assisted conception • A single episode or >1 episode of AFM (occurring > 21 days apart), with reassuring investigation and normal fetal movement in the last 24 hours.
<u>Previous gynaecological history</u> • Myomectomy • Hysterotomy • Cone biopsy • Any uterine perforation resulting from previous STOP or surgery.	**<u>Previous gynaecological history</u>** • Extensive vaginal repair/re fashioning • LLETZ x2 laparoscopy/laparotomy	**<u>Previous gynaecological history</u>** • LLETZ x 1
<u>Respiratory</u> • Severe asthma requiring increase in treatment of hospital admission during pregnancy • Cystic fibrosis	**<u>Respiratory</u>**	**<u>Respiratory</u>** • Mild asthma women only using inhalers prescribed by GP. Steroid inhalers where asthma has been stable during pregnancy
<u>Mental Health</u> • Where intensive maternal or neonatal monitoring is required during labour and/or postnatally.	**<u>Mental Health</u>** • Stable mental health illness on various psychotropic medication, including antipsychotics. (Plan neonatal care as per maternal psychotropic drug pathway)	**<u>Mental Health</u>** • Women on SSRIs and stable (neonatal care as per All Wales maternal psychotropic drug pathway).

Advise to give birth in an obstetric unit. Any women who are planning birth outside of the OU will be planning birth 'outside of guidance' and will require detailed care plans as per local pathways.

After an individual discussion and assessment may be suitable to give birth in a midwifery-led setting.

Advise to give birth in a midwifery-led setting.

At every antenatal assessment, by midwives and the medical team, review of the antenatal care pathway should occur and the lead professional and place of birth recommendation changed where required.
1 =Definition of recurrent altered fetal movement =is where at least 2 episodes of altered fetal movements are reported within a 21-day period.
*It is noted that the above is not exhaustive and clinicians should exercise clinical judgment.
*Midwives should be aware of the impact of multiple complexity, even where these are in care pathway B, multiple factors in any pathways may move the care need to pathway A

Appendix B - CIS PAPERWORK

Midwifery Clinical Information Sharing

Named Midwife:		
Alert Compiled by:		**Date compiled:**
Discussed with:		**Date discussed:**

CLIENT DETAILS					
Name:					
P number:			**DOB**		
NHS number:			**Age**		
Address:					
Phone number:					
EDD:		**Gravida:**		**Para:**	
Situation: *To be stated clearly, bullet points*					
Background: *Key points related to the case history*	**Obstetric history** **Medical History** **Mental health and social history** **Current Pregnancy**				
Assessment *Summary of key discussions and care including possible risks and summary of obstetric review if applicable*					
Recommendation/Plan: *Clear plan outlining care*					
Directions *Directions if required*					

Has the management plan been updated in records:	**Yes**	**No**
Details added antenatally to 'CIS outcomes' database on SharePoint by named midwife <u>and</u> CIS saved by month EDD on SharePoint – maternity templates	**Yes**	**No**
CIS copied to:		
Consultant Midwife:	**Yes**	**No**
Midwifery Team:	**Yes**	**No**

Clinical Supervisor for Midwives; if relevant	**Yes**	**No**
DGH: Name:	**Yes**	**No**
WAST Ambulance:	**Yes**	**No**
Complex Multiple factors escalated to HoM & Out of Hours Senior Operational On Call / Executive level; if relevant	**Yes**	**no**

Health Board/ NHS Trust	Relevant Contact email	Process ANC = antenatal clinic
SaTH	For MDT email sath.PMA@nhs.net For sharing of CIS email: sath.prh-maternity-anc@nhs.net	Email copy to them and can be discussed at monthly MDT to support care planning if particularly complex. Named midwife can attend. Ideally 32/40. Also share to ANC
CTMUHB	CTM.ANCmidwivesPCH@wales.nhs.uk Consultant midwife requests: Brynany.tweedale@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review. Consultant midwife review should be requested for all requests for AMU birth in CTMUHB
ABUHB	ABB.ANCBookingsNHH@wales.nhs.uk Consultant midwife requests: Emma.mills@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review. Consultant midwife review should be requested for all requests for AMU birth in ABUHB
Hywel Dda	Bronglais.antenatalclinic@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review
Swansea Bay	SBU.ANCNPT@wales.nhs.uk Consultant midwife requests: SBU.consultantmidwife@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review.
Wye Valley	hhn-tr.anreferrals@nhs.net	Email copy to ANC and can request obstetric review.
BCU	BCU.MOAUBlairbell@wales.nhs.uk and copy to Karen.Roberts12@wales.nhs.uk	Email copy to ANC and can request obstetric review.

Outcome of Case – Please complete in as much detail as possible and return to CSfM

Where Birthed	Transfer in Labour - reason	Transfer post birth - reason	Type of birth
DGH -			SVB /circle if waterbirth
Powys			Homebirth
			Forceps/Ventouse
Further helpful information			Emergency C/S
IOL, PPH, MROP, failed IOL etc.			Elective C/S

Appendix C – WAST PSD

YMDDIRIEDOLAETH GIG GWASANAETHAU AMBIWLANS CYMRU
WELSH AMBULANCE SERVICES NHS TRUST

NHS Direct Wales
Galw IECHYD Cymru

Specific Actions for Ambulance Clinicians in relation to an

Advanced Care Plan or a Special Health / Care need.

PATIENT SPECIFIC DIRECTIVE

Confidential once completed.

To be completed by the Lead Clinician in charge of patient care

<table>
<tr><td>Start Date</td><td></td><td>Review Date</td><td></td></tr>
<tr><td>Name of Patient & Identification Number (e.g NHS no.)</td><td></td><td>Date of Birth</td><td></td></tr>
<tr><td>1. Home (Resident) Address

2. Secondary Address

3. Contact Number</td><td colspan="3"></td></tr>
<tr><td colspan="4">Previous Medical History:</td></tr>
<tr><td colspan="4">Social History:
.</td></tr>
<tr><td colspan="4">Details of Medical Condition & Medications:
Medications

Treatment and Actions Required in an Emergency</td></tr>
<tr><td colspan="4">WAST will respond as per Dispatch Protocol.

When an ambulance resource is engaged by [Patient Name] the following treatments & actions are advised:</td></tr>
</table>

Name of Patients Lead Clinician: **GP:** **Contact Details** Signed: Date:
Welsh Ambulance Services NHS Trust Medical Director Dr Brendan Lloyd Signed: Date:

**********End of Document**********

Any Supportive Documentation: