York Teaching Hospital
NHS Foundation Trust

MATERNITY SERVICES GUIDELINE

HOME BIRTH

Version Authors	Michala Little, Deputy head of Midwifery Community Midwifery Team Leader, Ruth Thompson, Community Midwifery Team Leader; Lynda Fairclough, Community Midwifery Team Leader, Kath Chapman	
Owners	Sarah Ayre- Community midwifery manager	
Date of First issue	August 2018	
Version	10.2	
Date of Version issue	November 2020	
Ratified by	**York:** Clinical Governance and Labour Ward Forum	**Scarborough:** Clinical Governance
Date Ratified	via voting buttons	via voting buttons
Review date	August 2021	
Version information	General information update including stats and NICE recommendations Homebirth agreement updated, specifically around women choosing birth outside of guidance	

Contents

Section	Title	Page
1	**Introduction & Scope**	3
2	**Definitions**	4
3	**Guideline Statement and details**	4
4	Operational details for women who choose Home Birth	5
	4.1 Discussion on place of birth	5
	4.2 Booking a home birth	10
	4.3 Home Visit at 36-37 weeks	11
	4.4 At 40 weeks	12
	4.5 At the onset of labour	13
	4.6 Following delivery	14
	4.7 Before leaving woman's home	15
	4.8 Back at Hospital	16
	4.9 Intrapartum Transfer	16
	4.10 Postpartum Transfer	16
	4.11 Home Birth List	16
	4.12 Local Harmonising oncall arrangement	16
	4.13 Booking Home Confinement flow chart	17
	4.14 Requesting midwifery support at home flowchart	18
5	**Training needs**	19
6	**Monitoring compliance**	19
7	**Links to other Guidelines**	19
8	**References**	19
	Appendices	
	Appendix A: Home Birth Referral for Senior Support	20
	Appendix B: Home Birth Referral Form	21
	Appendix C: Home Birth Agreement	22
	Appendix D: Homebirth box contents	25
	Appendix E: Breech Presentation	28
	Appendix E: VBAC	29
	Appendix E: Twins	30
	Appendix E: Postpartum Haemorrhage	31
	Appendix E: Shoulder Dystocia	32
	Appendix E: Raised BMI	33
	Appendix E: Group B Haemolytic Strep	34
	Appendix E: Low Haemoglobin	35
	Appendix F: Homebirth statement	36
	Appendix G: Birth environment	37
	Appendix H: Version Log	38

1 Introduction and Scope

Both The Royal College of Obstetricians and the Royal College of Midwives support homebirth for women with uncomplicated pregnancies (2007).

696,271 babies were born in the UK in 2016 – 2.1% of which were homebirths. This is a slight reduction on the previous rate of 2.3%. Women aged between 35 – 39 are most likely to birth their babies at home (ONS 2018). York and Scarborough homebirth rates are between 1.5 and 2%.

Better Births (2016) states 'Women need clear unbiased information to help them make decisions about where to give birth, including: the chances of receiving interventions; availability of pain management; on site availability of obstetric and neonatal services; and the frequency and likely duration of transfer. Such information needs to be personalised according to their individual circumstances'. This statement is informed by the Birthplace Study, undertaken by the National Perinatal Epidemiology Unit (NPEU, accessed online and last updated 2017) which found that:

For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother

- For multiparous women, there were no significant differences in adverse perinatal outcomes between planned home births or midwifery unit births and planned births in obstetric units.
- For multiparous women, birth in a non-obstetric unit setting significantly and substantially reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy.

For women having a first baby, a planned home birth increases the risk for the baby

- For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

- For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned Freestanding Midwifery Unit (FMU) births and 40% for planned Alongside Midwifery (AMU) Unit births

For women having a second or subsequent baby, the transfer rate is around 10%

- For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births, 9% for planned FMU births and 13% for planned AMU births.

The Royal College of Midwives (RCM) say 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).

NICE (2017) suggest we explain to both multiparous and nulliparous women that giving birth is generally very safe and that they may choose any birth setting (home, FMU, AMU or obstetric unit) and that we support them in their choice of setting wherever they choose to give birth.

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

Please refer to NICE guidance 'Intrapartum care for healthy women and babies' (latest version 2017) for full detail.

When providing care to women, regardless of setting, midwives must take care to identify possible risk and pre plan to mitigate those risks, through their:

- approach to care,
- knowledge of local help systems
- Communication with colleagues, the woman and her family

This guideline is intended for the use of midwives who will be delivering care in a home setting; supported by medical/midwifery opinion or against medical/midwifery guidance and advice.

This guideline should be read in conjunction and links with York Teaching Hospital NHS Foundation Trust Maternity Services Guidelines (as well as any others relevant to the care of the individual woman).

2 Definitions

Home birth is a birth that has occurs at home rather than in a hospital or birth centre.

YH York Hospital

SH Scarborough Hospital

3 Guideline Details

Women who are booked either midwife led or consultant led care can make the choice for a particular place of birth at any stage in their pregnancy. The presence or absence of risk may change during pregnancy and/or labour and the **midwife must continuously assess the advice she gives to women about the place of birth**.

Women who choose home birth need to be informed that:-

- Giving birth is generally very safe for both the woman and her baby.
- That pharmacological pain relief options in labour are limited.
- That there is a possibility of transfer into hospital during labour or soon after and that this is more likely if it is their first baby

- That if something does go unexpectedly wrong or in the event of an emergency at home during labour, only basic life support is able to be administered to either mother or baby and this may lead to a worse outcome than if an emergency occurred in hospital with advanced life support staff and facilities for mother and baby.
- That in the presence of certain risk factors that puts her in a higher chance group of developing complications; she will be advised to give birth in an obstetric unit.

NB. The feasibility of a supported home birth by midwifery and medical staff in this Trust is based on there being no risk factors present that may put the woman or her baby at significant risk. A Consultant Obstetrician can only inform the woman that there are no contraindications to a home birth, or that there are risk factors present; It is the woman's choice whether she requests a home birth after being informed of the contraindications and risks.

4.0 Operational Details for Women Who Choose Home Birth

4.1 Discussion on Place of Birth

This might take place at any time in the pregnancy but often commences at the booking appointment. Subsequent appointments provide an opportunity to continually risk assess the place of birth as factors may change throughout pregnancy. **Any woman who chooses care outside of any York Teaching Hospitals NHS Trust Guideline will be considered a home birth against guidance/advice.**

Medical conditions and other factors that may affect planned place of birth (NICE 2014)

Use tables 6, 7, 8 and 9 as part of an assessment for a woman choosing her planned place of birth:

- Table 6 and 7 show medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labour, where care in an obstetric unit would be expected to reduce this risk.
- The factors listed in table 8 and 9 are not reasons in themselves for advising birth within an obstetric unit, but indicate that further consideration of birth setting may be required.
- Discuss these risks and the additional care that can be provided in the obstetric unit with the woman so that she can make an informed choice about planned place of birth.

Table 6 Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100×10^9/litre Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	Hyperthyroidism/ poorly controlled hypothyroidism Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Table 7 Other factors indicating increased risk suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia
Current pregnancy	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 90 g/litre at onset of labour (Trust guidance differs from this in that it would be less than 105 g/litre) Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie BMI at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate/doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Table 8 Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle-cell trait Thalassaemia trait Anaemia – haemoglobin 85–105 g/litre at onset of labour (Trust guidance differs from this in that it would be less than 100 g/litre)
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 9 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) BMI at booking of 30–35 kg/m (Trust guidance differs from this in that it would be BMI 35 or over at booking) Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on 2 occasions Clinical or ultrasound suspicion of macrosomia Para 4 or more Recreational drug use Under current outpatient psychiatric care Age over 35 at booking (Trust guidance differs from this in that it would be age 40 or more as a primigravida)
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

a) Discuss the appropriateness for home birth with the woman and her partner (if available), offering the York Teaching Hospitals NHS Trust Patient Information Leaflet 'Home Birth' which includes details of various useful websites and explain the leaflet is accessible online. Explain that planned home birth is supported and suitable for low risk women after commencement of the 37th week of pregnancy and up until 40 weeks+14 days. The pregnancy would be classed as high risk before or after these gestational periods. Induction of labour will be offered after 41 weeks

b) In the presence of identified risks that may affect the woman's suitability for home birth and the woman wishes to continue in her choice for home birth, discussion in the Consultant clinic should be offered.

Whether the consultation with an obstetrician is declined or accepted, if the woman decides to pursue her request for a home birth, then this should be fully discussed with benefits and risks outlined. Following consideration of this, where the woman makes an informed decision to proceed, this is then considered to be a home birth against midwifery and/ or medical guidance and advice, and should be documented on the homebirth agreement accordingly. Additionally, a 'Home Birth Referral for Senior Midwifery Support' form (Appendix A) should be commenced. This should then be submitted to a Community Midwifery Team Leader, who will arrange to accompany the midwife to undertake the homebirth agreement. The referral form with plan should be placed in the hospital notes and a copy kept on labour ward in the Home Birth folder. A copy of the homebirth agreement should also be given to the woman. The named midwife must continue providing routine antenatal care throughout the pregnancy.

4.2 Booking a Home Birth

a) Once the decision to choose a home birth has been made, complete 1 copy of the 'Home Birth Referral form (Appendix B). This should be reviewed at the appointment following the mid trimester scan and documented in the handheld notes. The completed copy should be forwarded as soon as possible to the Community Midwifery Team Leader, who will ensure the labour ward homebirth file is updated. **The midwife/clinician must continuously assess the advice given to women about their chosen place of birth at every antenatal appointment so that if her homebirth becomes against guidance or advice at any point, this can be discussed appropriately.**

b) Midwives should ensure that women have the following information:

- Explain the midwifery on call rota both day and night
- Ensure that the women and her family are aware how to contact a midwife and have emergency contact numbers including triage and labour ward
- Discuss that we will do our best to arrive in a timely manner, however geographical restrictions may mean it will take us longer than they anticipate for us to arrive. We will advise the woman of our expected time frame when we ring to talk to her when she has contacted for support in labour.
- Discuss the options available for coping with contractions in the home environment
- The woman should be informed that labour prior to 37 weeks is considered pre term and hospital birth would be advised
- Women should be made aware that there is a chance that they may be asked to change their place of birth from home to hospital due to labour ward acuity, the implementation of the escalation policy or if midwives are already out with another labouring woman. In this instance, we will offer a safe place of delivery at the hospital. Where a woman declines to attend hospital, she will be re-advised of this option and informed that we do not have a midwife available to attend her at home.

- For women on antidepressant medication, discuss that certain antidepressants may mean neonatal observations postnatally would be advised
- Discuss that we will undertake a homebirth agreement at around 36 weeks to talk about specifics for the birth and we invite all birth attenders to be present. If against guidance, a senior midwife will also attend

c) If a late request is submitted, the named midwife needs to ensure that the woman's details (name, maternity number, full postal address, telephone number, EDD, parity) are circulated to all community midwives and labour ward clerks by email in order to update their home birth list.

d) During pregnancy where a woman changes from low risk to high risk the referral form should be updated. The Community Midwives should be informed by email so that the woman can be removed from the home birth list where the woman agrees to birth in hospital. Where she chooses to continue to birth at home then send a copy of the amended request form and complete a copy of Appendix A detailing the risks and send a copy to labour ward admin to update the folder. The woman's name will still appear on the home birth list for information purposes **but** with the words "against medical/midwifery advice" and the reasons, next to her name.

e) Advise the women of the dates and venues of the 'Home birth' support group

4.3 Home Visit at 36 – 37 weeks (or as soon as possible if a late request)

The purpose of this visit is to review the home environment, complete the home birth agreement form and deliver the prepared homebirth box – instructing the woman to keep the box in a suitable, accessible place, out of the reach of any pets or other children. It is best practice if the woman's birth partner and any additional birth supporters are present (see Appendix G). This visit should still occur where the woman has chosen to give birth at home against midwifery/medical advice, after further discussion, a suitable plan of care can be put in place; It is appropriate for a Community Team Leader to attend alongside the named midwife in these instances. All booked home births and any care plans that have been drawn up for those women who are choosing to birth at home against midwifery guidance/advice will be kept in a folder on Labour Ward for reference and copies given to the women.

a) Complete a 'home birth agreement' (Appendix C) allowing discussion to take place to enable the woman, her partner and the midwife to prepare for the birth. Document the main points of the discussion on the checklist form. Please make women, partners and other birth attendants aware that if a midwife is called to attend their homebirth the expectation is that the midwife will be able to provide midwifery care and have access to the woman. If you arrive at the home of a woman and she refuses to allow you to access her home or to provide any care for her, you must explain that you will need to leave and explain this decision to her. **This does not include declining certain aspects of care such as vaginal examinations or auscultation of the fetal heart, which remains the woman's informed choice; but in situations where a request that no communication between you and the woman be made, no clinical care is to be given and/or the request that you sit in another room or outside the home as she labours with no access to her, providing no care. The conversation should be fully documented. You should inform**

the woman that you will be happy to return to provide care should she want you to do so.

b) Complete two copies of this form in the home setting, one copy should be retained with the woman's hand held notes, the second copy put in the hospital notes. Where the home birth is against guidance/advice, a copy is given to the Community Team Leader who will ensure a copy is placed in the home birth folder on Labour Ward. Identified risk information checklists (Appendix F) should be discussed as appropriate to the case.

c) Assess the home environment: Ask to see the room the woman intends to birth in. The room should be of sufficient size and clutter free to allow the midwife easy access to her from 3 sides in case of an emergency situation arising. Identify any hazards and suggest how these hazards should be dealt with prior to the home birth actually taking place. Document both the hazards and suggestions made for removal of these on the home birth agreement. If appropriate, arrange to re-visit the home to ensure care can be safely given and hazards have been removed. Check the woman has provided all the equipment requested in the Trust Leaflet on home births

d) Women requesting a pool birth should be advised of the suitability of birthing pools (refer to information in the Trust Leaflet on home births). Risk assessment of the area to be used for pool births should be documented

- Access on 3 sides
- Location of the pool (consider 'weight' if not on ground floor)
- Hazards – electric plug sockets, route of hoses
- Evacuation of the pool
- Flooding

e) Ensure the woman and her partner know how to contact a midwife at the onset of labour (refer to the Trust leaflet on Home Births which they should have received at completion of the home birth referral form).

f) Discuss fully the methods and options of pain relief in labour and that pharmaceutical methods are restricted in the home setting.

Entonox will be provided by the community midwife if requested. Unless you hold a qualification in complimentary therapies do not give advice on this subject. If a woman chooses to use any alternative therapies, this should be documented 'Under the direction of third party' or 'self administered' – see 'Coping strategies in labour'.

g) Email directions to woman's house to community team midwives

4.4 At 40 weeks

a) Prior to formal induction of labour, women should be offered a vaginal examination for membrane sweeping. Women should be informed that membrane sweeping makes spontaneous labour more likely, and so reduces the need for formal induction of labour, but that discomfort and vaginal bleeding are possible from the procedure. Induction of Labour will be offered after 41 weeks. For further information and methods of IOL, see guideline titled 'Induction of Labour'. Homebirth will be supported up to T+14 and after this point will be considered against guidance.

b) From 40 weeks and 14 days, women who decline induction of labour should be referred to antenatal clinic for increased antenatal monitoring. The woman should be made aware of the potential harm and becomes home birth against medical/maternity advice.

4.5 At the onset of Labour

a) The woman should be advised to ring labour ward when she feels she needs midwifery support. The midwife taking the call on labour ward should inform triage as per labour ward proforma, check that the service is not suspended and that the woman is on the home birth list and whether there is any safeguarding documentation.

Where the woman is **not** on the home birth list then she should be advised to come into hospital for her care as a home assessment will not have been carried out. If the woman refuses to have her care in the hospital, then the hospital notes need to be checked to see if there is Safeguarding documentation and a senior midwife should be contacted. (A senior midwife should be contacted whether or not there is Safeguarding documentation if a woman that is not on the home birth list is refusing to come into hospital.) **The community midwife on call should not be expected to attend in this instance, care will be offered in the hospital**.

If the woman is on the home birth list, but pursuing a home birth against guidance/advice, then the arrangements that have been agreed and documented within the care plan of the home birth checklist should be followed.

(See also section 4.2.14 – Flowchart for when women request midwifery support at home)

b) The labour ward co-ordinator must inform the community team leader to organise attendance during the day. Out of hours, the on call midwife for the appropriate area will be contacted.

c) Once informed that a woman is requesting support at a home birth, a community midwife collects Entonox and drug box from labour ward at Hospital or local units as appropriate.

NB. When transporting Entonox please display “Hazardous Gases” sign. This is so your car insurance is not invalidated if there is an accident. Entonox must **NOT** be left in woman’s home. A maximum of 2 cylinders can be taken at any one time and must be adequately separated during transport to prevent contact between them.

d) Inform Labour ward of your arrival at the woman’s home, assess whether labour is established. If so the midwife will remain in attendance and notify:

- Labour Ward if any concerns or at least 4 hourly
- A Senior Midwife if choosing to birth at home against advice
- Second midwife (via labour ward) to assist when appropriate. This informs LW of the woman’s progress and that the 2nd midwife is now out.

All Trust guidelines in intrapartum care must be followed.

If labour is not established, the midwife should leave the woman giving her advice on coping strategies. Inform labour ward that you are leaving the

woman's home and ensure that the woman and her partner know that they need to ring labour ward again when they would like the midwife to return.

If a woman is found to be fully dilated at the first vaginal assessment, a full risk assessment with the history of labour and progress should be made and if the second stage is not progressing well and birth does not appear imminent, transfer into hospital should be advised and a CTG commenced on arrival to hospital as per the 'Care of women in labour' guideline.

NB: The community midwives provide a team approach to women who choose to labour at home. However, if the woman's own midwife wishes to attend for a specific reason, she may do so within her normal working hours. This may mean negotiating changes with 'on-call' or other work commitments.

e) The 1st midwife attending the woman should ensure she brings her own equipment which should be checked weekly and following use (See Appendix D)

f) If there is a rising baseline fetal heart rate or decelerations are suspected on intermittent auscultation, actions should include:

- **carrying out intermittent auscultation more frequently, for example, after 3 consecutive contractions initially**
- **thinking about the whole clinical picture, including the woman's position and hydration, the strength and frequency of contractions and maternal observations.**

If a rising baseline or decelerations are confirmed, further actions should include:

- **summoning help**
- **advising continuous cardiotocography, and explaining to the woman and her birth companion(s) why it is needed**
- **transferring the woman to obstetric-led care, provided that it is safe and appropriate to do so (follow the general principles for transfer of care) NICE 2017**

g) For those women who choose to give birth at home against midwifery/medical guidance and advice, the specific plan of care that has been devised in the antenatal period should be followed.

(See also section 4.2.14 Flow chart for when women request midwifery support at home)

4.6 Following delivery

The midwife will:

a) Inform Labour Ward of birth outcome and ask for minimum data set (sex, date and time of birth) to be completed on the computer. This is to comply with registration of baby within 1 hour of birth and to obtain baby's NHS number. Check whether the mother needs suturing. If she does and the attending midwife feels she can perform this confidently at home, then suture according to Trust guidelines. **N.B. The maximum dose of local anaesthetic used for**

suturing purposes is 0.3mls/kg body weight of 1% lignocaine. The normal dose given is 10mls of 1% lignocaine for any woman weighing more than 33kg.

b) If the midwife feels the suturing needs to be done under better lighting/anaesthetic conditions, then arrange for transfer into hospital (see section 3.2.10)This transfer is to York/Scarborough Hospital regardless of which unit the woman was booked to birth in (other units for example).

c) Check temperature, weigh and perform baby's 1st newborn physical check. Document all findings in relevant sections of baby's red book, care plan and obstetric records.

d) Administer first dose of Vitamin K with parental consent.

e) Check mother's temperature, pulse, blood pressure, fundal height and lochia. Perform VTE assessment. Record all findings in relevant sections of care plan and obstetric records.

f) Take bloods for Kliehaur test with consent, then any other cord bloods samples that are required.

g) Undertake postnatal mental health assessment and action accordingly. Ensure you have access to the written plan of care for any women with a current or history of a significant mental health issue. Please refer to the 'Perinatal Mental Health Guideline' for further information.

h) Ask parents' permission to dispose of placenta at hospital

i) Return any unused drugs that have been obtained via Labour Ward to them. Any unused drugs obtained via a community prescription (woman's GP) must be returned by woman or her partner to the Community Pharmacy. Alternatively they may be destroyed at home by the woman or her partner, witnessed by the midwife and recorded in the woman's notes. **N.B**. Community Midwives must not remove drugs prescribed to an individual woman from her home.

j) Return all equipment to Maternity Unit at Hospital or local units as appropriate.

r) Perform oxygen saturation monitoring on the newborn. Paediatric opinion is that most babies sats should be above 95% within an hour of birth, therefore please perform the test just prior to leaving the woman's home (NB: you no longer need to wait for two hours after birth to perform the first test)

4.7 Before leaving the woman's home

The midwife will:

a) Complete all written records accurately.

b) Ensure the baby has fed. If breastfeeding, ensure the mum knows how to hold and position her baby and that she is aware of the signs of good attachment as outlined in the purple baby notes. If formula fed, ensure the parents know how to sterilise and make up feeds according to Department of Health guidelines and how to responsively bottle feed as outlined in the purple baby notes.

c) Ensure the mother has emptied her bladder and record time and amount of first void in postnatal notes. If she has not, discuss what to do if she hasn't done so within 6 hours of giving birth.(See Bladder Care following Delivery Guideline)

d) Advise the mother on how to contact a midwife if she has any concerns and inform her when to expect her next contact from a midwife.

e) Ensure that the parents are aware of the 'Important Symptoms' of the ill baby and the advice around 'Reducing the risk of cot death' as outlined on the back of the baby purple notes.

4.8 Back at Hospital/Maternity Unit

The midwife will:

a) Inform Community midwives via email that the lady has birthed. This is to ensure an up to date home birth list is available to all.

b) Arrange a postnatal visit with appropriate midwifery team.

c) Arrange a referral to newborn hearing screening service and neonatal examination

d) Arrange Anti-D; MMR; BCG as and if appropriate

e) Compute delivery details at Hospital and sign birth notification.

f) Inform GP

4.9 Intrapartum transfer into hospital

a) In the 1st stage of labour transfer into hospital may be by private means if the assessing midwife is confident there are no maternal or fetal risks. Document the reasons for choice of transport on the referral form.

b) Intrapartum transfer in the 2nd and 3rd stages of labour **must** be by ambulance and one attending midwife should accompany the woman in the ambulance. (See Maternal transfer via Ambulance Guideline.) **An ambulance should always be called, even if you suspect the woman will decline transfer.**

c) An ambulance should be obtained by phoning 999 (in an emergency) stating priority 1 with paramedic support and document the 'call number'. **An ambulance should always be called, even if you suspect the woman will decline transfer.**

4.10 Postpartum transfer into hospital

This may be for either the mother or the baby. In either instance the transfer should take place via ambulance. **An ambulance should always be called, even if you suspect the woman will decline transfer.**

4.11 Home Birth Lists

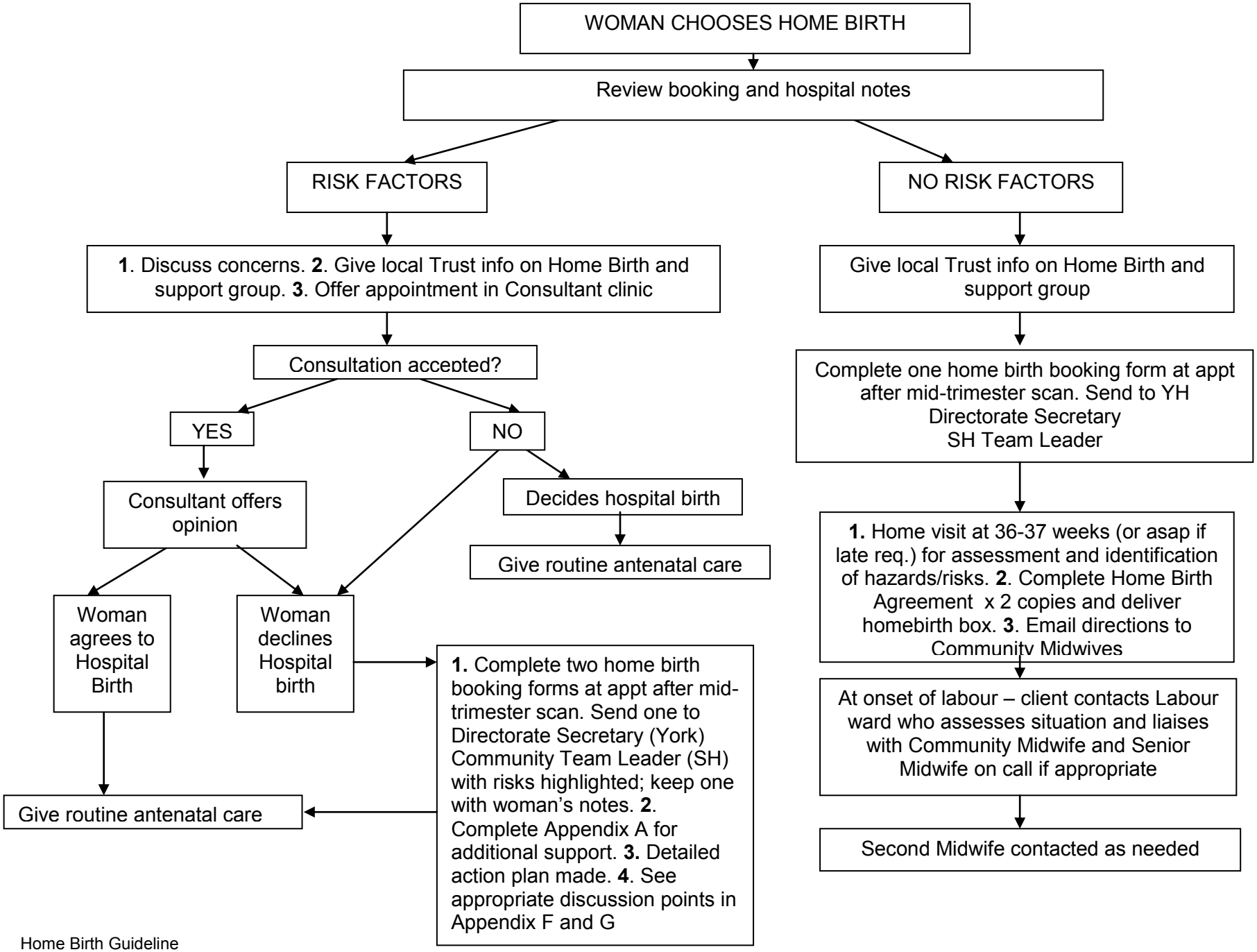
The home birth list will be recorded electronically and made available 2 calendar months ahead. It will contain details of low risk women who are booked for home deliveries and also, information about high risk women who are choosing to proceed with a home birth against midwifery/medical advice. A copy of this list will be kept by all community midwives and on labour ward as a reference for both the Senior Midwives and the labour ward coordinators.

4.12 Local Harmonising Agreement

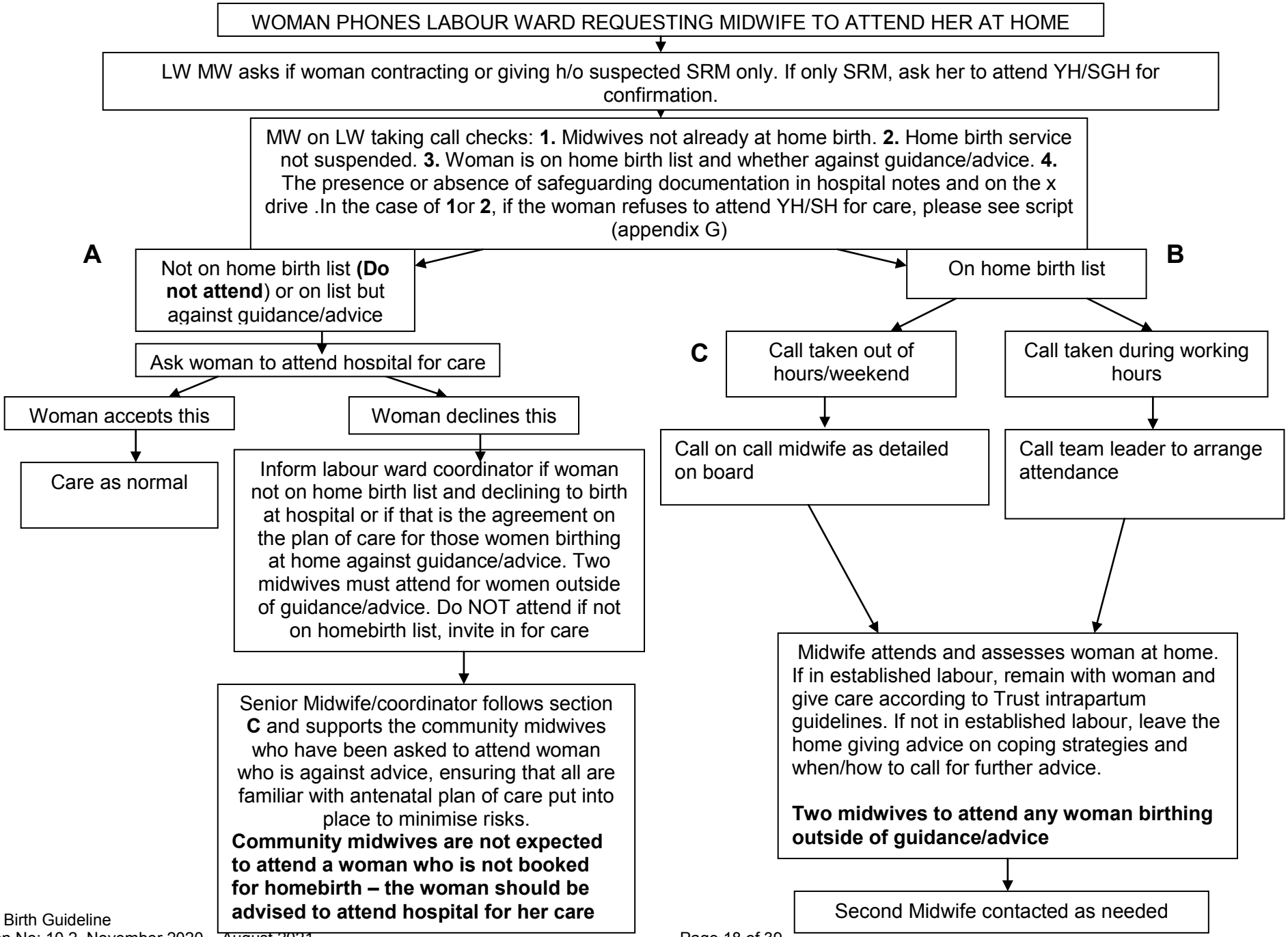
Information on the local harmonising agreement can be found on staffroom:

http://staffroom.ydh.yha.com/HR-and-Recruitment/on-call-guidance/on-call-documents/terms-and-conditions/at_download/file

4.13 BOOKING HOME CONFINEMENT FLOW CHART



4.14 REQUESTING MIDWIFERY SUPPORT AT HOME FLOW CHART



5 Training Needs

Midwives new into the community will be offered a preceptorship period to gain confidence in their new role. Additionally an experienced community midwife will be on call alongside any midwife who may not have conducted a home birth until such time that she feels confident to be able to undertake the role without this additional support.

6 Monitoring Compliance

This guideline will be monitored as part of the Annual Audit Programme.

7 This guideline links with the following guidelines

- Induction of Labour
- Care of a woman in labour
- Perinatal Mental Health
- Water birth
- Bladder Care following delivery
- Maternal Transfer by Ambulance
- Shoulder Dystocia
- Resuscitation of the Newborn
- Immediate care of the Newborn
- Hypoglycaemia in the newborn
- Postnatal care
- Administration of vitamin k to newborn infants

8 References

National Institute for Health and Care Excellence (NICE) (2017), Intrapartum care for healthy women and babies, London. (Accessed online August 2018)

National Institute for Health Clinical Excellence (NICE) 2008: Clinical Guideline 70: *Induction of labour*. London

National Institute for Health Clinical Excellence (NICE) 2014: http://www.nice.org.uk/guidance/cg190/chapter/1-recommendations#place-of-birth

Royal College of Obstetricians and Gynaecologists /Royal College of Midwives (2007): Joint Statement Number 2, April 2007 (accessed online August 2018)

http://rcmnormalbirth.org.uk/

Appendix A

York Teaching Hospital
NHS Foundation Trust

HOME BIRTH REFERRAL FOR SENIOR MIDWIFERY SUPPORT

ID Label or hospital number: Name & Full Postal Address: Tel Number: D Number: D.O.B: EDD (by scan):

Named Midwife _____

Name of Senior Midwife Contacted: _____

Reason for referral: _____

_____

_____

Outcome of Initial Discussion: _____

_____

_____

Home Visit Discussion _____

_____

_____

_____

Plan of Care (continue overleaf if necessary) _____

_____

_____

_____

Birth Outcome: _____

Name & signature of senior midwife: _____

Name & signature of midwife: _____

Senior Midwife to copy: return one copy to midwife, one copy to folder on labour ward

Appendix B

York Teaching Hospital NHS Foundation Trust

HOME BIRTH REFERRAL FORM
To be submitted after mid trimester scan

ID Label or hospital number:
Name & Full Postal Address:

Post Code:
Tel Number:
Mobile Number:
D.O.B:
EDD (by scan):

Date of request:
Date received
Date delivered:

Against guidance? Yes ☐ No ☐

Planned water labour/birth? Yes ☐ No ☐

Past Obstetric History					
Place	Year	Gest	Weight	Delivery Details	Complications

Risks/reasons why against guidance (if applicable):_____

_____

_____

_____

_____

GP_____ Telephone number _____

Consultant_____ Telephone number _____

Midwife _____ Telephone number _____

Review of Case notes: Yes ☐ No ☐
Referral for senior midwifery support completed? Yes ☐ No ☐
Discussed with Senior Midwife Yes ☐ No ☐

Name of Senior Midwife: _____

File a copy in the hospital notes

Appendix C

York Teaching Hospital NHS Foundation Trust

HOME BIRTH AGREEMENT

1. MOTHER'S DETAILS					
Name:			Parity:		
Address:			Telephone Number:		
			Hospital Number:		
			USS EDD:		
			Named CMW:		
2 WHO HAS BEEN INFORMED?					
GP:	Yes ☐	No ☐	Consultant	Yes ☐	No ☐
Community Tam Leader	Yes ☐	No ☐	Community Manager	Yes ☐	No ☐
Community Team Members	Yes ☐	No ☐	Homebirth box delivered	Yes ☐	No ☐
Blood Group:	Previous Hb		Past Obstetric Notes Checked	Yes ☐	No ☐
Past & present medical history checked	Yes ☐	No ☐			

3. PREPARATION & DISCUSSION POINTS		
Trust Home Birth Patient Information Leaflet (PIL) received?	Yes ☐	No ☐
Student welcome?	Yes ☐	No ☐
How to contact a midwife and on call rota discussed?	Yes ☐	No ☐
Home birth available from (date when will be 37 wks):		
Intended birth supporters present at the meeting	Yes/No	
Name of Birth Partners/Birth supporters:		

Neonatal resuscitation and equipment	Yes ☐	No ☐
10 cm at first contact (see guidance around offer to transfer in for CTG)	Yes ☐	No ☐
Fetal distress (meconium liquor/cord round neck/bradycardia or tachycardia)	Yes ☐	No ☐
Shoulder dystocia & management	Yes ☐	No ☐
Cord Prolapse	Yes ☐	No ☐
Prolonged labour	Yes ☐	No ☐
Maternal haemorrhage (ante/postnatal)	Yes ☐	No ☐
PROM (18-24hrs post SROM and NIEL – advised to transfer in)	Yes ☐	No ☐
Raised blood pressure	Yes ☐	No ☐
Post maturity	Yes ☐	No ☐
Emergency Transfer (including postnatal problems e.g. suturing)	Yes ☐	No ☐
Ambulance Delay	Yes ☐	No ☐

3a. DISCUSSION ON HOME ENVIRONMENT (SEE APPENDIX G)		
Heating and good lighting (Angle poised lamp/torch available or use of headlamp)	Yes ☐	No ☐
Child care arrangements specified	Yes ☐	No ☐
Protective bedding/flooring	Yes ☐	No ☐
Planned room to birth in seen? (Access available to woman from 3 sides? Clutter free? Ensure area for documentation and neonatal resuscitation)	Yes ☐	No ☐
Pets (safe provision/containment)	Yes ☐	No ☐
Pool (if to be used) is seen and checked for suitability – fit for purpose. Birthing pool is fully equipped (pump, liner, sieve, 2 foam woggles/noodles, thermometer) Manual handling assessment (Maternal BMI, access to three sides of the pool, suitable flooring, Insurance, ceiling appropriate for weight bearing load) Pools filled in advance of labour are not to be used for labour or birth within the home setting until definitive advice on disinfection/safety is available. Evacuation from pool risk assessment has been undertaken, discussed and documented below	Yes ☐	No ☐
Any unprotected electric sockets near to pool?	Yes ☐	No ☐
Is there a large distance from sink to pool for hose pipe to travel?	Yes ☐	No ☐

No naked flames (once Entonox) in use	Yes ☐	No ☐
Working telephone? Yes/No Mobile signal	Yes ☐	No ☐
Access for midwives and Ambulance (electric Gates, clutter-free, dogs)	Yes ☐	No ☐
Vitamin K	Yes ☐	No ☐
Anti D (available at the hospital)	Yes ☐	No ☐
Syntometrine	Yes ☐	No ☐
Paediatric check (May need to attend Hospital)	Yes ☐	No ☐

3b. HOME HAZARDS

Identified hazards (if any):

Property type ie Flat Smoking
Availability of parking Clutter

Record of recommendations made to remove any identified hazards (before birth). Please explain and document the reasons for this request and any follow up required (another visit may be necessary to check identified hazards have been removed):

Discuss necessary space for paed resus/emergency interventions

****Ensure woman is advised that we will collect the HB box following delivery for disposal****

4. MATERNAL EXPECTATIONS

Discuss the following and document plan for each:

Maternal Observations: BP, Pulse, Temperature Accepted/Declined

Vaginal Examinations Accepted/Declined

Abdominal Palpation Accepted/Declined

Fetal Auscultation Accepted/Declined

External Birth Partners - discuss role

NB: Contract with mother to provide maternity care, External birth supporters are not regarded as midwifery care providers Appendix G

Record of discussion re management plan including emergency evacuation from pool. Discuss that in the event of an emergency, an ambulance will be called and advice given to transfer in to hospital:

Record of discussion that in the event of an emergency at home, only basic life support is able to be administered to mother or baby and that this may lead to a worse outcome than if an emergency occurred in hospital with advanced life support, staff and facilities for mother and baby.

Record of discussion when homebirth is against guidance; Against guidance refers to decisions made by the woman to decline care or advice offered within any York Teaching Hospitals antenatal, intrapartum or postnatal guidelines. Please ensure that the woman is aware of any identified risks and that you have discussed and documented the reasons for this homebirth being against guidance/advice. Please discuss and document what the risk/s posed are and that she wishes to continue with her homebirth:

Referral to Consultant clinic should be offered to all women wishing to birth outside of guidance/advice. Please document detail of this discussion:

Appendix F (homebirth availability) Discussed	Yes ☐	No ☐
Appendix G (the birth environment) Discussed	Yes ☐	No ☐
Identified risk - Appropriate Appendix Completed	Yes ☐	No ☐
5. PLANNED ANALGESIA		
TENS	Yes ☐	No ☐
Water	Yes ☐	No ☐
Entonox/	Yes ☐	No ☐
Other – alternative therapies	Yes ☐	No ☐

7. CONSENT

I confirm that the above information has been discussed with me. I have been made aware that I can further discuss my homebirth with my midwife at any point.

Signed: _____ (Mother) Print: _____

Signed: _____ (Midwife) Print: _____

Date: _____

Appendix D Homebirth Boxes

Homebirth boxes

Please initial and leave in the home birth box

Equipment box	
1x yellow stripe rubbish bag (large)	
1x yellow tie	
1x yellow placenta bags	
Placenta bucket and lid	
2x green aprons	
1x sterile urine pot	
2x in/out catheter	
10x inco pads	
Vomit bowl for measuring loss	
Small sharps bin	
Gel	
1x mucus extractor	
1x hat	
10x VE stickers	
Postnatal notes	
delivery yellow notes	
obstetric drug chart	
unisex red book	
Blood form	
needles	
steret	
tourniquet	
pink and blue bottles x2 each	
Alcohol wipes	
Breastfeeding Log leaflet	
Bottlefeeding leaflet	

In clear plastic bag	
1x Delivery pack	
1x VE pack	
1x amnihook	
2x cord clamps	
2x x-ray vaginal swab pack of 5	
Entonox mouthpiece	
1x pair of protective eye goggles	
Small, medium and large sterile gloves	
Gel	
Non sterile gloves	
Perineal pad x2	

Emergency Suitcase

Please initial and leave in the suitcase for restocking

Suture bag				
1x Suture pack				
1x Tampon				
Gel				
2x 2-0 Vicryl rapide				
2x 3-0 Vicryl rapide				
2x X-ray detectable swabs				
Drape				
1x 1ml, 2ml, 5ml, 10ml, 20ml syringes				
2x Sterile gloves (small, medium and large)				

PPH bag				
2x in/out catheters				
1x Foley catheter (size 12)				
Catheter bag				
Instila gel				
Gel				
2x Sterile gloves (small, medium and large)				
Blood forms yellow/red				
Blood bottles (Blue, brown, red, green)				
Cannuals x2 Grey				
Cannual dressings				
Cannula adaptor				
Tournique				
10ml saline flush				
5 pack gauze swabs				
Micropore tape				

Cord prolapse bag				
1x Foley catheter (size 12)				
1x 500ml bag of IV normal saline				
1x IV giving set				
2x Sterile gloves (small, medium and large)				
Small spencer wells (to clean and reuse)				
Instila gel				

Pink drug box				
2x Vit K				
2x 1ml syringes				
4x 2ml syringes				
2x 5ml syringes				
2x 10ml syringes				
5x Red needles				
3x Orange needles				
4x Green needles				
4x Alcohol wipes				

Inside the Purple Suitcase				
Oral vit k box				
Episiotomy scissors				
Batteries AAx4-SATS Squarex1-sonicaid				
SATS monitor				
Aqua sonicaid				
Scrubs				
Emergency proformas/paperwork folder				
I-Gel neonatal				

Midwives should carry cord clamp, scissors, paediatric ambu bag and face mask. It is the expectation that the Midwife will have with them as part of their clinical bag a stethoscope, sphygmomanometer (inc large cuff), sonicaid, scales and sharps box

Discussion points in the presence of a Breech presentation

Following our discussions regarding your request for homebirth, I confirm we have discussed:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.
    - Current guidelines recommend discussion around the suitability for vaginal delivery in hospital of a baby in the breech position. Women should be informed that planned caesarean section leads to a small reduction in perinatal mortality compared with planned vaginal breech delivery. Women should be informed that the reduced risk is due to three factors: the avoidance of stillbirth after 39 weeks of gestation, the avoidance of intrapartum risks and the risks of vaginal breech birth, and that only the last is unique to a breech baby. (NICE 2017)
- Research has shown that there is an increased risk of baby dying or suffering an injury if born in the breech position.
- There is an increased risk of poor inco-ordinated contractions (not efficient or effective), which could lead to delay in the first or second stage of labour.
- There is an increased risk of cord prolapse (the cord being delivered before the birth of the baby, cutting off its oxygen supply) – this is an obstetric emergency and would require immediate delivery. This would be significantly delayed if labour was taking place at home.
- There is an increased risk of baby dying/being severely ill when a cord prolapse occurs.
- It would be recommended that you had a venflon (needle in your arm) in place for IV (into the vein) access in case of an emergency. As it is not usual practice to have a venflon in the community setting, you may need to go to hospital to have this sited.
- There could be an emergency situation for either mum or baby at any stage and immediate transfer into hospital via ambulance would be necessary.
- Most midwives will have had very little or no experience in delivering a baby in a breech position.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Discussion points for vaginal Home Birth after Caesarean Section (VBAC)

Following our discussions regarding your request for home birth, I confirm that we have discussed:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.

- There is an increased risk of uterine rupture (the womb tearing) during birth if a woman has had a previous Caesarean Section.

- The signs of uterine rupture are:
  - Early vaginal bleeding
  - Severe lower abdominal pain, especially between contractions
  - Poor inco-ordinate contractions (not efficient or effective)
  - Abnormal fetal heart trace (baby's heart beat is too fast or too slow)
  - Maternal tachycardia (pulse rate is very high)

- In hospital it would be normal practice to continually monitor the heartbeat using a CTG (Cardio tocograph) machine, so that signs of problems could be identified early.

- Uterine rupture can cause sudden and unpredictable collapse and in this event immediate transfer into hospital via ambulance would be necessary.

- It would be recommended that you had a venflon (needle in your arm) in place for IV (into the vein) access in case of an emergency. As it is not usual practice to have a venflon in the community setting, you may need to go to hospital to have this sited.

- There could be an emergency situation for either mum or baby at any stage and immediate transfer into hospital via ambulance would be necessary.

- There is an increased risk of mother and baby death/serious illness when a scar rupture occurs.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Appendix E – Twins

York Teaching Hospital NHS Foundation Trust

Discussion points for Home Birth of Twins

Following our discussions regarding your request for home birth, I confirm that we have discussed:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.
- There is an increased risk of cord prolapse (cord being delivered before the babies are born, cutting off their oxygen supply) – this is an obstetric emergency and would require immediate delivery. This would be significantly delayed if labour was taking place at home.
- There is an increased risk of baby dying/being severely ill when a cord prolapse occurs.
- There is an increased risk of poor inco-ordinated (not efficient or effective) contractions, which could lead to delay in the first or second stage of labour.
- There is an increased risk of postpartum haemorrhage (excessive bleeding after the birth) when there is a twin pregnancy.
- You have an actively managed 3rd stage (an injection into your leg to help the placenta (afterbirth) to be delivered) to reduce risk of postpartum haemorrhage.
- Even in an actively managed 3rd stage there is an increased risk of postpartum haemorrhage and it would be recommended that you have a venflon in situ (needle in your arm) so that fluids can be given straight into the vein in an emergency, to try and counter balance the blood loss. As it is not usual practice to have a venflon in the community setting, you may need to go to hospital to have this sited.
- Both babies need to be cephalic (head down) and that you must have reached 37 completed weeks of pregnancy to prevent any further risks.
- Most midwives will have had very little or no experience in delivering a baby in a breech position.
- You will need to be transferred into hospital as an emergency via ambulance if 2nd twin adopts a transverse/oblique or breech presentation.
- There is an increased risk of baby dying/suffering an injury when a baby presents as transverse/oblique/breech in 2nd stage.
- You will need to be transferred into hospital as an emergency via ambulance if there is concern about the heart rate of either twin.
- There could be an emergency situation for either mum or babies at any stage and immediate transfer into hospital via ambulance would be necessary.

That you have also received the following information:

- Discussion points – postpartum haemorrhage.
- Discussion points – breech presentation.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Discussion points for Home Birth with the increased risk of postpartum haemorrhage (excessive bleeding after delivery)

Following our discussions regarding your request for home birth, we have discussed:

- To effectively reduce your risk, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) input.
- There is an increased chance of a postpartum haemorrhage occurring when there is:
    - A multiple pregnancy (twins or more)
    - A large baby
    - Polyhydramnios present (excessive fluid within the womb, diagnosed on scan)
    - A history of previous postpartum haemorrhage
- As you have one or more of the identified risks it is recommended that you have an actively managed 3rd stage (an injection into your leg to help the placenta (afterbirth) to be delivered).
- Even in an actively managed 3rd stage there is an increased risk of postpartum haemorrhage and it would be recommended that you have a venflon in situ (needle in your arm) so that fluids can be given straight into the vein in an emergency, to try and counter balance the blood loss. As it is not usual practice to have a venflon in the community setting, you may need to go to hospital to have this sited.
- This condition can cause sudden and unpredictable collapse and in this event immediate transfer into hospital via ambulance would be necessary.
- There is an increased risk of maternal death/ illness when a postpartum haemorrhage occurs.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Discussion points for Home Birth in the presence of increased Risk of Shoulder Dystocia (severe difficulty with delivery of the baby's shoulders)

Following our discussions regarding your request for home birth, I confirm that we have discussed:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.

- There is an increased risk of shoulder dystocia when there is:

    - Maternal Diabetes – either Insulin Dependent or Gestational Diabetes
    - A predicted birth weight of 4.5kgs or more
    - A BMI (body mass index) of 35 or more
    - A multiple pregnancy (twins or more)
    - A history of previously large baby (4.5kgs or more)
    - A history of previous shoulder dystocia
    - Post maturity (42 weeks or more)
    - Maternal short stature (height)

- The signs that a shoulder dystocia is more likely are:

    - Delay in the descent of the baby's head through the pelvis
    - A Malpresentation of the baby's head
    - No desire to push when second stage is reached
    - A long second stage

- There is an increased risk of Erb's Palsy (paralysis of baby's shoulder/arm) when attempting to deliver a baby with a shoulder dystocia.

- Successful delivery of a baby with a shoulder dystocia is more likely with plenty of staff around to assist you to adopt certain positions that aim to release the trapped shoulder.

- This condition can cause sudden and unpredictable collapse and in this event immediate transfer into hospital via ambulance would be necessary.

- There is an increased risk of baby dying /suffering an injury when a shoulder dystocia occurs.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Discussion points for Home Birth in the presence of a raised BMI (Body Mass Index) ≥35

Following our discussions regarding your request for home birth, I confirm that we have discussed:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.

- Due to your BMI there is an increased chance of :

    - Shoulder dystocia (severe difficulty with delivery of the baby's shoulders)
    - Postpartum haemorrhage (excessive blood loss)
    - Undiagnosed breech in labour
    - Difficulty in monitoring the baby's heartbeat

- In the event of an emergency situation, specialist equipment to assist in moving and handling you safely is available for staff to use within a hospital setting. As this equipment is not available in your home, the midwives caring for you may be put at risk of injury if they were to try and move you. As it is unacceptable for them to take that risk, they may be unable to assist you to achieve the best position for delivery, which may then cause problems for you or your baby.

- You have also received the following information:

    - Discussion points for home birth in the presence if identified risks – shoulder dystocia
    - Discussion points for home birth in the presence of identified risks – postpartum haemorrhage
    - Discussion points for home birth in the presence of identified risks – breech presentation

Signature of Midwife_____ Print_____

Date_____

Discussion points for Home Birth as a Carrier of Group B Haemolytic Streptococcus

Following our discussions regarding your choice for homebirth, I am writing to confirm that we have discussed that:

- To effectively reduce risk to you and your baby, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) & Paediatric doctors' (who specialise in caring for babies and children) input.
- Current recommendations are that you regularly receive IV (into a vein) antibiotics in labour and at least one dose 4 hours prior to the delivery.
- There is an increased risk to the baby of Group B strep infection if
    - There has been a prolonged rupture of membranes (18 hours or more)
    - there is a maternal pyrexia (temperature) in labour
- This condition can cause sudden and unpredictable collapse of the baby and in this event immediate transfer into hospital via ambulance would be necessary.
- Following delivery it is recommended that the baby has its temperature recorded for a minimum of 48 hours and if there is any increase or cause for concern, immediate medical attention must be sought.

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

Discussion points for Home Birth in the presence of a Current haemoglobin ≤ 100g/litre

Following our discussions regarding your choice for home birth, I am writing to confirm that we have discussed that:

- To effectively reduce risk to you, it would be advisable to birth in a hospital with Obstetric doctors' (who specialise in caring for pregnant women) input.
- The risk associated with a low haemoglobin is that should you bleed heavily following your birth, you will be less likely to be able to cope with the effect of the blood loss as your iron levels are already low, causing you to feel faint, dizzy, unwell and with a reduced ability to fight infections.
- To reduce your risk of bleeding heavily following your birth, it is recommended that you have an actively managed 3rd stage.
- Even in an actively managed 3rd stage there is no guarantee that a postpartum haemorrhage (excessive blood loss) will not occur.
- A postpartum haemorrhage can cause sudden and unpredictable collapse and in this event immediate transfer into hospital via ambulance would be necessary.
- There is an increased risk of maternal death/ illness when a postpartum haemorrhage occurs

If during your birth the midwife caring for you becomes concerned, you will be advised to transfer to hospital.

Signature of Midwife_____ Print_____

Date_____

York Teaching Hospital
NHS Foundation Trust

Homebirth Script

York Teaching Hospital Midwives actively support homebirths and aim to provide you with your choice of place of birth. There are Midwives on call to support homebirths in York and Scarborough area every day, but we can only support one labouring woman in each area at any one time.

As already mentioned in the Patient Information Leaflet and at your homebirth assessment there may be occasions when we are unable to provide a homebirth service. This may be because the Midwives are at another homebirth or because of an unexpected period of high activity within the hospital which is beyond our control.

If this is the case you will be told when you telephone that we cannot attend your home at this time, but that we can offer you midwifery care in the hospital or midwife led unit.

Co-ordinator Script

I am sorry but at the moment we cannot support your homebirth due to

High activity in the hospital

or

The on call midwives are already at another homebirth

We can provide you with Midwifery Care on Labour Ward at York or Scarborough

Optional statement if the woman or birth partner says we will be held responsible.

If you chose not to come to the Hospital it is your choice at your own risk. We are offering Midwifery care in the Hospital and advise you to attend for your labour and birth.

Discussion points for home births to ensure the birth environment is safe and to discuss care when external birth partners will be present

Following our discussion regarding your choice of birth partner/s and the home environment, I confirm that we have discussed:

- The recommendation that all birth partners are present when completing the home birth agreement.

- When the midwife attends your home birth that she assumes the role as your main midwifery care provider and will act in accordance with the Trust guidance and her professional code of conduct.

- If in your home birth agreement, you have chosen care which is outside of York Trust guidance, we will provide full information to ensure you are making an informed choice. We may request you have a further discussion with one of our Consultants or senior Midwives around the risks and benefits in relation to your choice.

- The midwife will, wherever possible, act in accordance with your wishes as documented. If the Midwife has concerns at any point for your or your baby she will discuss this with you and give you professional advice to best preserve the safety of you and your baby.

- The expectation that the midwife be invited to provide midwifery care and will be given full access to you in order to provide it. Should you request attendance at home and then not allow the midwife access to care for you in labour or request that the midwife stay in another room while you are labouring or birthing, the midwife will document this as your choice and will leave your home with the assurance that she will happily return if you decide you would like midwifery input/care. This does not include informed decisions that you make around individual aspects of your care in labour such as auscultating the fetal heart or vaginal examinations – your choices around this will be respected and documented.

- The importance of ensuring that the birth environment is free from hazard and that the midwife is able to work safely. That you will ensure safe access to your property i.e electric gates being open, dogs being safely contained away from the birthing area, stairways and birth rooms are free from hazard

- The importance of having sufficient space to safely perform resuscitation or respond to obstetric emergencies where necessary, and we have agreement from you to provide this. For example, switching lights on to give better vision or assisting you to evacuate the birthing pool.

Signature of Midwife_____

Print_____

Date_____

Appendix H: Version History Log

Version	Date approved	Significant changes
1	September 2000	
2	September 2002	**1.** Reformatted to comply with Trust Policy for Guideline writing. **2.** Addition of 'Referral for Supervisory Support' sheet for those women who request Home Birth but who do so against medical advice.
3	September 2004	**1.** Change in title of 'Home Birth Booking request' form to include 'Risk Assessment'. **2.** Change in the 'Home birth Checklist' sheet to remove 'safe storage of blue box' as equipment no longer left in women's houses and removal of section 7 of this form.
4	January 2006	**1.** Change in the booking criteria for home births based on Guidelines from RCOG and NICE. **2.** Reformatting of front page to include New Trust Logo. **3.** Information re use of water as a pain relief at home added.
5	January 2010	**1.** New formatting of whole document to comply with the Maternity Services 'Development of a Guideline' document. **2.** Review and update of booking criteria for home births to reflect current guidance from NICE and RCOG and to tie in with York Trust antenatal guidelines. **3.** Review and extension of operation details for women who choose home births. **4.** New 'booking home birth confinement' flow chart. **5.** New 'requesting midwifery support at home' flow chart. **6.** Change in layout of the 'Home Birth Referral for Supervisory Support' **7.** Change in structure of Home Birth Booking request form. **8.** Reformatting and overhaul of Home Birth Checklist Sheet. **9.** Amendments to Delivery Bag contents list. **10**. Rewording and reformatting of 'Home Birth Labour Summary' form. **11**. Reformatting of 'Audit of Midwife Led Intrapartum Care' form **12**. Creation of letters that will be issued by a Supervisor of Midwives to women who choose to birth at home in the presence of identified risks. **13.** New Patient Information Leaflet – home birth. **14.** Summary pages of all new and updated recommendations within these guidelines
6	February 2016	**1.** Additional wording related to introduction of homebirth boxes **2.** Amendment to Appendix D **3.** Harmonising agreement details **4.** Actions for women who decline midwifery care

Version	Date approved	Significant changes
7	June 2017	**1.** Removal of role of 'Supervisor of Midwives' **2.** Revision of homebirth checklist – now 'agreement' **3.** Addition of Appendix G **4**. Addition of guidance around transfer in if 10cm on first contact **5**. Clarity around community midwives not being expected to attend women at home who are not booked for homebirth
8	August 2018	**1. Updated homebirth agreement including clearer documentation for women choosing homebirth outside of guidance** **2. Updated IOL information** **3. Updated general data around homebirth** **4. Updated NICE guidance recommendations** **5. Updated PMH assessments** **6. Addition of advice to continuously risk assess suitability for homebirth at every AN appointment** **7. Updated homebirth box ticklist**