RQIA Guideline for Planning to Birth at Home in Northern Ireland (2019)

The Regulation and Quality Improvement Authority

Assurance, Challenge and Improvement in Health and Social Care

Introduction

Place of birth influences not only the type of birth that women experience, but also the number of interventions that the mother and baby are exposed to (Scarf et al. 2018). Women who plan to give birth in a midwife-led unit or at home experience fewer interventions than in an obstetric unit, including: amniotomy, augmentation of labour, episiotomy, instrumental vaginal birth and opiate or regional analgesia (Hutton *et al*. 2016; Halfdensdottir *et al*. 2015; Brocklehurst *et al*. 2011). There is also evidence that, for healthy women, outcomes are better for out of hospital birth and this is also true for the babies of multiparous women born at home (Scarf 2018, NICE 2014, Brocklehurst *et al*. 2011; Hollowell *et al*. 2011). Based on the findings of the England Birthplace Study, the National Institute for Health and Care Excellence (NICE) Intrapartum guideline (CG190) recommend that low-risk nulliparous women should be advised that, if they plan birth at home, there is a *'small increase in the risk of an adverse outcome for the baby'* (p.6). Findings from other cohort home birth studies have identified adverse perinatal outcomes from home birth as low and not significantly different from other places of birth (De Jonge *et al.* 2015, Van der Kooy *et al.* 2011). The Birthplace in England study (Brocklehurst et al 2011) supports a policy of offering women with straightforward pregnancies a choice of all four birth settings (home birth, alongside MLU, free standing MLU or obstetric unit) (NICE 2014).

The NI Maternity Care Strategy (Department of Health and Social Services and Public Safety (DHSSPS), 2012) acknowledges the importance of high quality maternity care and how it contributes to the health and well-being of women, giving babies the best possible start in life. It recognises the need for women to receive 'the right care from the right person at the right time in the right setting' (p 5, DHSSPS 2012) which also includes birthing at home. This is further supported by the Northern Ireland Health and Social Care Maternity Services Core Care Pathway for Antenatal Care (2016).

From an economic perspective, an analysis of the cost of births for women with an uncomplicated pregnancy in a variety of locations in NHS Trusts in England concluded that home birth was the most cost-effective option for women having a second or subsequent baby (Schroeder et al, 2012).

In 2018, there were 22,833 births recorded in Northern Ireland (NI) (Northern Ireland Statistics and Research Agency (NISRA), 2019). However, despite evidence of the health and economic benefits of home birth, and of increasing numbers of women who want to plan a birth at home, there is inconsistency across NI in terms of:

- how the home birth service is provided,
- what information and support is given to women regarding planning a home birth, and
- the approach of different individuals and teams within the Health and Social Care (HSC) Trusts.

An online women's forum (NI Home Birth Facebook Group 22 September, 2016) further highlighted these inconsistencies. Each of the Maternity Services in the Trusts, have developed their own guidelines, this includes the Belfast Health and Social Care Trust (BHSCT) Maternity Services who co-produced a 'Guideline for the Management of Homebirth' (BHSCT, 2017) with their Maternity Services Liaison Group and service users. However, the need for regional evidenced-based guidelines across NI to support women in their decision to plan a home birth is required.

It is clear that there is an expressed need for an evidence based guideline that supports women and maternity healthcare professionals in their decision-making around planning birth at home, and that these should be co-produced between all relevant stakeholders. Importantly, the guideline is needed to reflect the World Health Organisation (WHO) recommendations for a positive pregnancy and birth experience (WHO 2017, 2018) as the basis for improving women's self-esteem and sense of competence and capacity to care for themselves and their family.

Methodology

Who is the guideline intended for?

This guideline is essential for all maternity healthcare professionals who are providing information and supporting women in their choice of birth place; in particular, women planning a home birth. In addition to the guideline, a care pathway for women planning a birth at home was developed. Further resources and evidence-based information to assist with the implementation of the guideline are detailed in the appendices, including: a script for use when requesting an ambulance transfer for a woman (and baby) from home to hospital (or MLU)-*Guide for LIFE THREATENING/ NON LIFE THREATENING Ambulance Transfer Request from MLU/Home birth; the Northern Ireland Midwife-led Care HART Referral and / or Transfer Report (See appendices 2, 3 & 4).* In addition, a woman and partner's information booklet has been developed which incorporates key elements of the guideline but also tips from women who themselves have planned and gave birth at home (See Appendix 8).

Terms of Reference for the Guideline

These were agreed by the Guideline Development Group. The timeline was discussed and used as a guide to progress the work.

Aim and Objectives

The aim was to develop an evidenced-based guideline to assist women and health care professionals in their decision-making when planning birth at home in Northern Ireland.

The objectives were:

1. To critically review local, national and international evidence surrounding home birth;

2. To utilise this evidence to develop a home birth guideline through collaboration with the Guideline Development Group, made up of key maternity services stakeholders including: multidisciplinary maternity care staff with a particular interest and experience of home birth provision along with a number of service users and women's groups representatives in NI;

3. To disseminate the regional home birth guideline to all primary and secondary maternity care staff and service users/groups in NI;

4. To collaborate on the design and dissemination of a user-friendly information leaflet, which will provide service users with evidence based information to assist them in their decision-making when planning a birth at home.

Needs Assessment

During the development of the Regulation and Quality Improvement Authority's (RQIA) Guideline for Admission to MLUs in NI (RQIA, 2016; Healy and Gillen, 2016), the need for consistency of access and response from healthcare professionals to a request for home birth was highlighted as a priority for service users. This highlighted the need for the Planning Birth at home guideline. Women's personal experiences of maternity care matters to them and research commissioned by the PHA NI (2013) highlighted that experience of care is a key component of quality healthcare.

A systematic search strategy was devised with aid of an Ulster University subject librarian which aimed to identify and synthesise the evidence for planning birth at home. Systematic database searches included: Cochrane Central Register of Controlled Trials (CENTRAL), EMBASE, Ovid MEDLINE, PsycINFO, ProQuest Dissertations & Theses, Scopus, and The Cochrane Library (Cochrane Database of Systematic Reviews). The search terms included: home birth, planned home birth, maternal outcomes and home birth, neonatal outcomes and planned home birth, pregnant women and home birth. The search was last updated in August 2018 and used database specific search terms including MeSH terms and free text terms. In addition, back-chaining of reference lists of included papers was undertaken and guideline development group members contributed relevant papers and guideline documents accessed through their networks.

Involvement of Stakeholders

The Guideline Development Group

From the outset, it was intended that the Guideline for Planning to Birth at Home in Northern Ireland would be developed using a co-design and co-production approach (Department of Health (DoH), 2018). The Guideline Development Group (GDG) was recruited from the six Health and Social Care (HSC) Trusts in Northern Ireland, including the Northern Ireland Ambulance Service HSC Trust and women from Maternity Services Liaison Committees across NI. In addition, Service Users from women's and parents groups such as the National Childbirth Trust, Sure Start, and Mother's Voice were members of the GDG.

Throughout the guideline development process, the membership was kept under review to ensure that it reflected those who would make most use of the guideline (see Appendix 1). Some of the Service User members were not able to commit to attending the meetings in person, but were keen to be consulted via email and social media. This ensured that a wide range of members were involved in the development of the guideline throughout the process. Women's partners with an interest in home birth were also included in the membership.

Guideline Development Group Meetings

There were 15 meetings held from April 2017 to September 2018 with regular input from and consultation with home birth social media forums. At the inaugural meeting, a Claims, Concerns, and Issues exercise was facilitated. This is a Fourth Generation Evaluation methodology (Guba and Lincoln, 1989) which gave the GDG members the opportunity to voice their opinion, identify key issues and agree the way forward. The meetings' agenda focused on clinical criteria for planning birth at home and the evidence underpinning their inclusion or exclusion from the guideline. However, from the outset, it was clear that a specific Northern Ireland care pathway for women planning to birth at home was also necessary (see page 18), to ensure consistency of approach across HSC Trusts. Further work was undertaken to develop additional resources that will be key to the implementation of the guideline, and these are included in the appendices of this document. A woman and partner version of the guideline was considered vital in ensuring that the guideline was accessible to women and their families when making decisions about planning their birth at home (See appendix 9).

Maternity Care Service Users and Representatives

Involvement and engagement of Maternity Care Service users and representatives was key to the development of the guideline and the woman and partner's planning a home birth resource in particular. The Chair of the GDG ensured that all members had the opportunity to contribute and that members' views were respected. In addition, at each meeting, a core agenda

item entitled 'Service User's Perspectives' ensured a designated opportunity to contribute their views.

Expert Advisers

The Guideline Development Group members were experts through user experience or professional experience and expertise. Therefore, throughout the guideline development process, the specific expertise of individual members informed particular aspects of the discussion. In addition, members' drew on the expertise of colleagues from within their networks to provide additional insight from experiences of home birth practices elsewhere; for example, a teleconference between the Steering Group and Cate Langley, a Consultant Midwife from Wales, with experience of setting up and managing the provision of a home birth service. These were vital in providing insights into alternative organisation of home birth care provision, decision-making processes and resources needed for an integrated home birth service.

The co-leads of the Guideline Development Group were able to bring learning and shared experiences from other countries gained through Short Term Scientific Missions, funded by Co-operation Science and Technology (COST) Action IS1405 visits to The Netherlands (Healy 2016) https://eubirthresearch.files.wordpress.com/2015/09/dr-maria-healy-stsm_scientific_report_october_2016.pdf and Gillen(2017) https://eubirthresearch.files.wordpress.com/2018/08/stsm-report-september-2017-gillen.pdf.

In particular, differences in organisation of care and perceptions regarding certain aspects of care, including transfers in labour, informed the discussions and set the tone for learning from experiences and practice elsewhere. Guideline Development Group members used their wide global networks to bring information to the table which informed the discussions and provided examples of best practice.

Updating the Guideline

It is anticipated that the guideline will be reviewed in 2022 or sooner, if new evidence emerges.

Funding

The development of the guideline was funded by the Regulation and Quality Improvement Authority (RQIA) subsequent to a successful bid for funding.

RQIA Guideline for Planning to Birth at Home (Maternity Health Care Provider Version)

This guideline* relates to all healthy women with a straightforward singleton pregnancy ((1), see page 9) who plan to birth at home (see ((2), page 10-13) below for NICE recommendations).

Women who meet the following can also plan to birth at home without any additional discussions:

- Are aged ≥ 16 Years & ≤ 40 years at booking appointment
- Had assisted conception with Clomifene
- Have a BMI **at booking** of ≥ 18kg/m^2 & ≤ 35kg/m^2
- Had a previous third degree perineal tear with no significant symptoms
- Had a previous baby with a condition requiring medical assistance, with no evidence of the possibility of reoccurrence
- Had up to 4 previous vaginal births in the absence of a previous C/S uterine scar
- Have experienced mental ill-health and fulfil the criteria for Step 1 & 2 of the Regional Mental Health Care Pathway ((3), see page 14)
- Had a threatened miscarriage, now resolved
- Have a last recorded Hb ≥100g/l prior to labour
- Had a suspected low lying placenta, now resolved
- Have a medical condition that is not impacting on pregnancy
- Have required Social Services support and there is no related impact on the pregnancy
- Have had a threatened preterm labour, now resolved
- Have Serum Antibodies of no clinical significance
- Have had previous cervical treatment, now term
- Have an expected birth weight of a baby with appropriate growth on a customised growth chart
- Have had SROM≤ 24 hours and no signs of infection
- Have meconium stained liquor of no significance ((4), see page 14) in the absence of any other risk

In addition, women who do not meet these criteria but who still wish to plan a home birth after discussion and the development of an individualised care plan should be supported to do so (See Page 15).

Midwives and Maternity Care Providers always aim to build trusting woman-centred relationships. Any queries or difficulties, contact the Head of Midwifery/Consultant Midwife in your Trust. Further multidisciplinary discussion may be necessary, with documentation as appropriate.

These notes ([1-4]) are additional information linked to the text in the grey box above (and the purple box in the women's booklet that may assist maternity care professionals and women with discussion of the evidence).

[(1)] A straight forward singleton pregnancy, is one in which the women does not have any pre-existing condition impacting on her pregnancy, a recurrent complication of pregnancy or a complication in the pregnancy which would require on-going consultant input, has reached 37 weeks gestation and ≤ 2) Term +14 (GAIN, 2016).

[2]Place of Birth; what the evidence says in relation to outcomes from Homebirth (For further information, see NICE CG190, 2017; Hutton 2016; Bolten 2016).

Women at low risk of complications

1.1.1 Explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the mother and her baby. [2014]

1.1.2 Explain to both multiparous and nulliparous women that they may choose any birth setting(home, freestanding midwifery unit, alongside midwifery unit and or obstetric unit) , and 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 their 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 birth in a midwifery – led unit (freestanding or alongside) is particularly suitable for them as 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 adverse outcome for the baby. [2014]

1. 1.3 Using tables 1 and 2 (below) explain to low-risk multiparous women, that:

- Planning birth at home or a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these three settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- Planning birth in an obstetric unit is associated with higher rates of intervention, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings
- There are no differences in outcomes for the baby associated with planning birth in any setting.[2014]

From NICE (2017) Intrapartum care for healthy women and babies
https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth

Table 1 Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low risk multiparous women (sources: Birthplace 2011; Blix et al. 2012).

	Number of incidences per 1,000 multiparous women giving birth			
	Home	**Freestanding midwifery unit**	**Alongside midwifery unit**	**Obstetric unit**
Spontaneous vaginal birth	984*	980	967	927*
Transfer to an obstetric unit	115*	94	125	10**
Regional analgesia (epidural and/or spinal)* **	28*	40	60	121*
Episiotomy	15*	23	35	56*
Caesarean birth	7*	8	10	35*
Instrumental birth (forceps or ventouse)	9*	12	23	38*
Blood transfusion	4	4	5	8

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).

** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.

*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 2 Outcomes for the baby for each planned place of birth: low-risk multiparous women (source: Birthplace 2011)

	Number of babies per 1,000 births			
	Home	**Freestanding midwifery unit**	**Alongside midwifery unit**	**Obstetric unit**
Babies without serious medical problems	997	997	998	997
Babies with serious medical problems*	3	3	2	3

*Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total.

Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes (less than 4% of adverse events).

For the frequency of these events (how often any of them actually occurred), see appendix A (NICE CG190 2017).

Using tables 3 and 4 (below), explain to low-risk nulliparous women

- Planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth in an alongside midwifery unit, and these three settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit.
- Planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings.
- There are no differences in outcomes for the baby associated with planning birth in an alongside midwifery unit, a freestanding midwifery unit or an obstetric unit.
- Planning birth at home is associated with an overall small increase (about 4 per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings. [2014] (see table 4 below for further details re outcomes for babies in relation to place of birth).

From NICE (2017) Intrapartum care for healthy women and babies https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth.

Table 3 Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk nulliparous women (sources: Birthplace 2011; Blix et al. 2012)

	Number of incidences per 1,000 nulliparous women giving birth			
	Home	**Freestanding midwifery unit**	**Alongside midwifery unit**	**Obstetric unit**
Spontaneous vaginal birth	794*	813	765	688*
Transfer to an obstetric unit	450*	363	402	10**
Regional analgesia (epidural and/or spinal)* **	218*	200	240	349*
Episiotomy	165*	165	216	242*
Caesarean birth	80*	69	76	121*
Instrumental birth (forceps or ventouse)	126*	118	159	191*
Blood transfusion	12	8	11	16

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).

** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.

*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 4 Outcomes for the baby for each planned place of birth: low-risk nulliparous women (source: Birthplace 2011)

	Number of babies per 1,000 births			
	Home	**Freestanding midwifery unit**	**Alongside midwifery unit**	**Obstetric unit**
Babies without serious medical problems	991	995	995	995
Babies with serious medical problems*	9	5	5	5

***** Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes – less than 4% of adverse events. For the frequency of these events (how often any of them actually occurred), see appendix A (NICE CG190 2017).

Tables and text from NICE (2017) Intrapartum care for healthy women and babies https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth.

(3) **Regional Mental Health Care Pathway (Revised July 2017):** This relates to (3) in the grey box above. Women who fulfil the criteria for step 1 and 2 of the Regional Mental Health Care Pathway as in the Figure 1 below should be supported to have a homebirth if this is their choice. Individual women may require additional postnatal care and support.

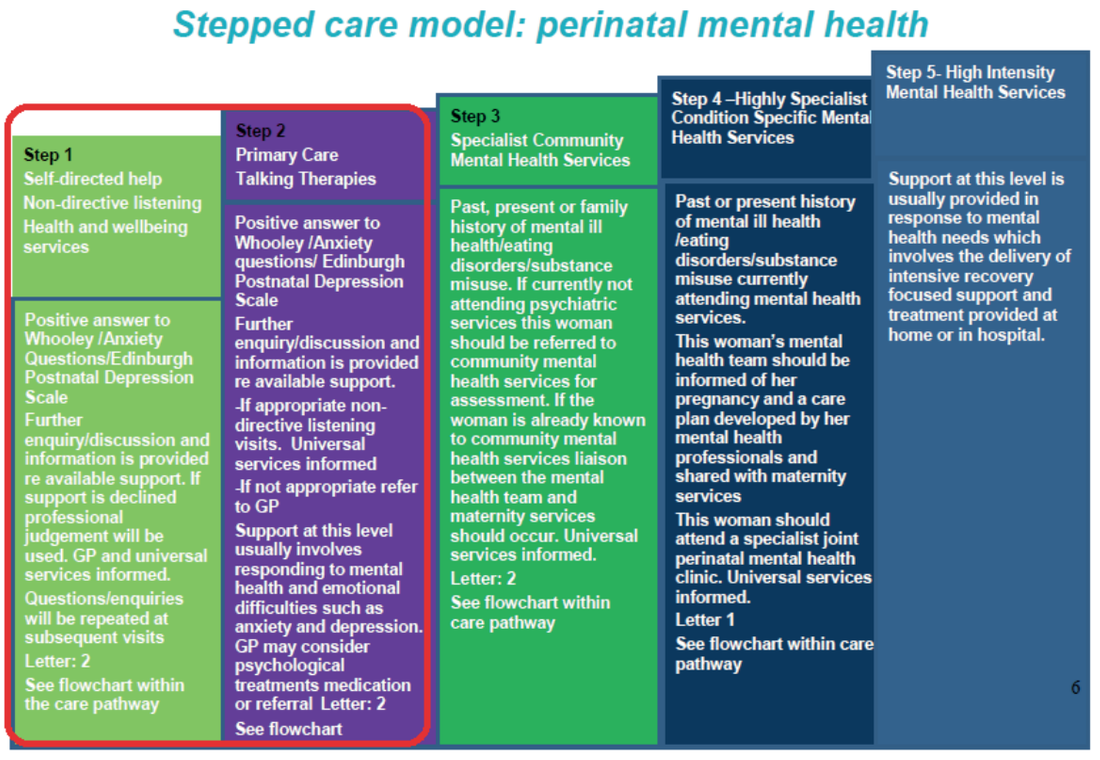


Figure 1 HSC Regional Mental Health Care Pathway (revised 2017, p6) http://www.publichealth.hscni.net/sites/default/files/July%202017%20PNMHP_1.pdf.

(4) Definition of Significant Meconium: 'Dark green or black amniotic fluid that is thick or tenacious or any meconium-stained amniotic fluid containing lumps of meconium' (NICE Intrapartum Care Guideline, p. 32 www.nice.org.uk/guidance/cg 190/)

*Based on the RQIA (2016) Guideline for Admission to Midwife-Led Units in Northern Ireland & Northern Ireland Normal labour and Birth Care Pathway- Planned birth in any MLU (FMU and AMU).

Thanks and Acknowledgments

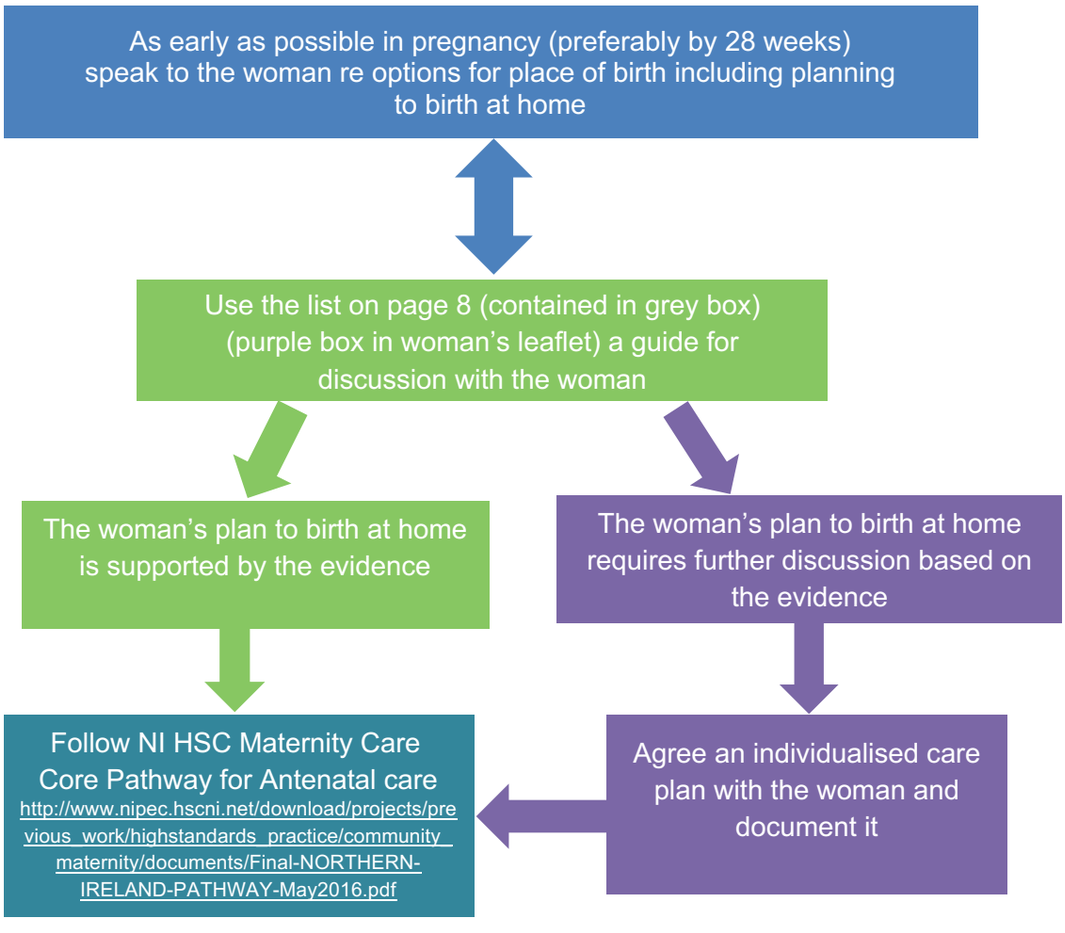
Special thanks to colleagues and service users from the BHSCT Maternity Services who shared their 'Guideline for the Management of Homebirth SG125/08' (2017) with the Guideline Development Group to inform discussion and the content of this guideline. Thanks to the South Eastern Health and Social Care Trust for sharing their 'HOME BIRTH - When a transfer to hospital for ongoing care may be needed (2017)' document.

Northern Ireland Care Pathway for Women Planning Birth at Home (Maternity Care Provider version)

To promote partnership and positive relationships between women, their partner's and maternity health care providers (HCP), discussions should:

- Be individualised & relevant
- Be evidence based and balanced, particularly when discussing uncommon events and complications
- Use absolute numbers rather than percentages and present the information 'both ways' (e.g. 3 babies per 1000 (0.3%) will have a serious medical problem compared to 2 babies per 1000 (0.2%) born in an alongside midwifery unit (AMU) and 3 babies per 1000 (0.3%) born in a freestanding midwifery led unit (FMU) or an obstetric unit. What this means is 2 or 3 babies per 1000 will have a serious medical problem regardless of place of birth).
- Avoid unnecessary repetition and document discussions clearly.

Use the resources in Appendices 5, 6 & 7 to assist you in your discussions of the evidence



Any queries or difficulties, contact the Head of Midwifery/Consultant Midwife in your Trust. Further multidisciplinary discussion may be necessary, with documentation as appropriate.

References:

Belfast Health and Social Care Trust (BHSCT) (2017) *Guideline for Management of Homebirth* SG125/08 Belfast: BHSCT.

Belfast Health and Social Care Trust (2017)*Maternal and Neonatal Transfer/ Referral from Mater Midwifery Led Unit (SG 11/17) Belfast:* Belfast HSC Trust

Blix, E., Huitfeldt, A.S., Øian, P., Straume, B., Kumle, M. (2012) Outcomes of planned home births and planned hospital births in low-risk women in Norway between 1990 and 2007: A retrospective cohort study. *Sexual and Reproductive Health* 3 (4), 147–53. DOI: 10.1016/j.srhc.2012.10.001.

Bolten, N., de Jonge, A., Zwagerman, E., Zwagerman, P., Klomp, T., Zwart, JJ., Geerts, CC.(2016) Effect of planned place of birth on obstetric interventions and maternal outcomes among low-risk women: a cohort study in the Netherlands *BMC Pregnancy and Childbirth* 16:329 DOI 10.1186/s12884-016-1130-6.

Brocklehurst, P., Hardy, P., Hollowell, J., Linsell, L., Macfarlane, A., McCourt, C., Marlow, N., Miller, A., Newburn, M., Petrou, S., Puddicombe, D., Redshaw, M., Rowe, R., Sandall, J., Silverton, L., Stewart, M. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011 23 343:d7400. doi: 10.1136/bmj.d7400.

Davis, D., Baddock, S., Pairman, S., Hunter, M., Benn, C., Wilson, D., Dixon, L., Herbison, P. (2011) Planned place of birth in New Zealand: does it affect mode of birth and intervention rates among low-risk women? *Birth* 38 (2): 111–119.

de Jonge, A. Geerts, C.C., van der Goes, B.Y., Mol, B.W., Buitendijk, S.E., Nijhuis, J.G. (2015) Perinatal mortality and morbidity up to 28 days after birth among 743 070 low-risk planned home and hospital births: a cohort study based on three merged national perinatal databases.*BJOG* 122:720–728.

DHSSPS (2012) *A Strategy for Maternity Care in Northern Ireland* Belfast: DHSSPS.

DoH (2018) *Co-Production Guide Connecting and Realising Value Through People Belfast*: DoH.

GAIN/RQIA (2016). *Guideline for admission to midwife-led units in Northern Ireland and Northern Ireland normal labour and birth care pathway, Belfast*: RQIA. https://www.rqia.org.uk/RQIA/files/3a/3a7a37bb-d601-4daf-a902-6b60e5fa58c2.pdf.

Gillen, P. (2017)*Home birth in Denmark: knowledge translation and research to inform Home birth guidelines in Northern Ireland* https://eubirthresearch.files.wordpress.com/2018/08/stsm-report-september-2017-gillen.pdf.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Publications

Halfdansdottir, B., Smarason, A. Kr., Olafsdittir O. A., Hildingsson, I. and Sveinsdottir, H. (2015) Outcome of planned home and hospital births among low-risk women in Iceland in 2005–2009: A retrospective cohort study. *Birth* 42 (1), pp. 16–26.

Healy, M., (2016) *A detailed exploration of the organisation of home birth services in The Netherlands, towards knowledge transition and development of home birth services in Ireland* COST Action IS1405 Short Term Scientific Report https://eubirthresearch.files.wordpress.com/2015/09/dr-maria-healy-stsm_scientific_report_october_2016.pdf.

Healy, M. and Gillen, P. (2016). 'Planning birth in and admission to a midwife-led unit: development of a GAIN evidence-based guideline' *Evidence Based Midwifery*, 14(3): 82-86.

Hodnett, E.D., Downe S , Walsh D, Weston J. A lternative versus conventional institutional settings for birth. *Cochrane Database of Systematic Reviews* 2010, Issue 9. Art. No.: CD000012. DOI: 10.1002/14651858. CD000012.pub3.

Hutton, E.K., Cappelletti, A., Reitsma, A.H., Simioni, J., Horne, J., McGregor, C., Ahmed, R.J., (2016) Outcomes associated with planned place of birth among women with low-risk pregnancies. *Canadian Medical Association Journal* 188(5):E80-90. doi: 10.1503/cmaj.150564.

KNOV (The Royal Dutch Organisation of Midwives) (2014) *Midwifery in the Netherlands* Netherlands: KNOV.

Lawrence, A. , Lewis. L, Hofmeyr, G.J. , Styles, C. Maternal positions and mobility during first stage labour. *Cochrane Database of Systematic Reviews* 2013, Issue 10. Art. No.: CD003934. DOI: 10.1002/14651858. CD003934.pub4 National Institute of Clinical Excellence (NICE) (2010a) Public Health Guidance 27, July 2010, *Weight management before, during and after pregnancy,* London, http://www.nice.org.uk/guidance/PH27.

National Institute of Clinical Excellence (2010b), CG 110 *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* *https://www.nice.org.uk/guidance/cg110/chapter/1-Guidance.*

National Institute of Clinical Excellence (NICE) (2012) CG 149 *Antibiotics for early-onset neonatal infection: antibiotics for the prevention and treatment of early- onset neonatal infection London*: NICE https://www.nice.org.uk/guidance/cg149/chapter/research-recommendations.

National Institute for Health and Care Excellence (2012) (Updated Aug 2016) *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services CG138* https://www.nice.org.uk/guidance/cg138 [accessed 21 October 2019]

National Institute of Clinical Excellence (NICE) (2014a) *Clinical Guideline 190 Intrapartum care: care of the healthy woman and their babies during childbirth* http://www.nice.org.uk/guidance/cg190/resources/guidance-intrapartum-care-care-of-healthy-women-and-their-babies-during-childbirth-pdf.

National Institute for Health and Care Excellence (NICE) (2014b) Clinical guideline 192, December 2014 Antenatal and postnatal mental health: clinical management and service guidance London https://www.nice.org.uk/guidance/cg192.

National Institute for Health and Care Excellence (NICE) (2008, last updated March 2016) Clinical Guideline 62, *Antenatal Care,* London: NICE http://www.nice.org.uk/guidance/cg62/resources/guidance-antenatal-care-pdf

Northern Ireland Statistics and Research Agency (2017) *Monthly births* Published: 28 September 2018 https://www.nisra.gov.uk/publications/monthly-births.

Offerhaus, P., Rijnders, M., De Jonge, A., De Miranda, E. (2012) Planned home compared with planned hospital births in the Netherlands: intrapartum and early neonatal death in low-risk pregnancies. *Obstetrics & Gynaecology*,119 (2 Pt 1):387-8.

Scarf, V.L., Rossiter, C. Vedam, S., Dahlen, H., Ellwood, D., Forster, D. Foureur, M.D., Mclachlan, H., Oats, J., Sibbritt, D., Thornton, C., Homer, S.E. (2018) Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis *Midwifery* 62, 240-255.

Schroeder, E., Petrou, S., Patel, N., Hollowell, J., Puddicombe, D., Redshaw, M., Brocklehurst, P. (2012) Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study *British Medical Journal* 344: e2292.

South Eastern Health and Social Care Trust (2017) *'HOME BIRTH – When a transfer to hospital for ongoing care may be needed' Lisburn*: South eastern Health and Social Care Trust

Southern Health and Social Care Trust (2008) *HART Referral and /or Transfer Report Form Craigavon*: Southern HSC Trust

Van der Kooy, J., Poeran, J., De Graaf, J.P., Birnie, E., Denktass, S., Steegers, E.A., Bonsel, G.J. (2011) Planned home compared with planned hospital births in the Netherlands: intrapartum and early neonatal death in low-risk pregnancies *Obstetrics & Gynaecology*, 118:1037-46.

World Health Organisation (2017) *WHO recommendations on antenatal care for a positive pregnancy experience* Geneva: WHO.

World Health Organisation (2018) *WHO recommendations: intrapartum care for a positive childbirth experience* Geneva: WHO.

Appendix 1: Guideline Development Group Membership

Name	Designation	Organisation
Gillen Patricia Dr, Chair of GDG, Co-Lead, Main Author	**Head of R & D for Nurses, Midwives and AHPs, SHSCT/ Reader, Ulster**	**Southern HSC Trust/Ulster University**
Healy Maria Dr, Co-Lead, Main Author	**Lecturer in Midwifery (Education), School of Nursing and Midwifery**	**Queen's University Belfast**
Biggerstaff Frances	Team Leader Community Midwifery	Southern HSC Trust
Boreland Zoe	Head of Midwifery (Retired 2018)	South Eastern HSC Trust
Boulter Denise	Midwife Consultant	Public Health Agency
Bradley Fiona	Senior Education Manager	Clinical Education Centre
Branagan Martine	Maternity Care Service User	
Branagan Niall	Maternity Care Service User (Father/partner)	
Bull Elaine	Maternity Care Service User	
Caddell Mary	Regional Officer	Royal College of Midwives
Chesnel Mary Jo	Midwife Education Consultant	Clinical Education Centre
Clarke Wendy	Lead Midwife/ Head of Midwifery (Aug 2018)	Southern HSC Trust
Collins Grainne	Team Leader Community	Western HSC Trust
Cosgrove Roisin	Lead Midwife	Belfast HSC Trust
Crilly Siobhan	Audit Team	Regulation and Quality Improvement Authority
Donnelly Mary Dr	Medical Adviser Primary Care	Newcastle
Doolan Martina	Community Midwifery Team Leader (Alternate for Caroline Keown)	Northern HSC Trust
Duffy Sandra	Community MW Northern Trust	Northern HSC Trust
Farmer Una	Lead Midwife	Western HSC Trust
Fannin Shauna Dr	General Practitioner	RCGP
Firinne Louise	Maternity Care Service User	
Fraser Emma	Maternity Care Service User	
Garvey Maria	Community Team Leader	Southern HSC Trust
Graham Claire	CMW	Northern HSC Trust
Graham David Dr	Consultant Paediatrician	Southern HSC Trust
Hamilton Shona	Consultant Midwife	Northern HSC Trust
Herron Maria Dr	Advocate for Improvements in Maternity Care / Family Support Co-ordinator with Parenting NI	Mother's Voice
Hill Penny Dr	Consultant Obstetrician	South Eastern HSC Trust
Hughes Breedagh	Director RCM NI	Royal College of Midwives
Hylands Esther	Team Leader Community	South Eastern HSC Trust
Kelly Brenda	HOM	Belfast HSC Trust
Keown Caroline	HOM	Northern HSC Trust

Kingsnorth Patricia	Lead Midwife	Southern HSC Trust
Laird Richard Dr	Consultant Anaesthetist	Western HSC Trust
McCabe Brenda	Team Leader Community MW	Western HSC Trust
McCabe Niamh Dr	Consultant Obstetrician	Belfast HSC Trust
McCluskey Fionnuala	Head of Midwifery	South Eastern HSC Trust
McCormack Mary	Team Leader Community Midwife	Belfast HSC Trust
McCusker Cathy	Maternity Care Service User	
McDowell Teresa	Team Leader MLU Downpatrick	South Eastern HSC Trust
McIlwee Judith	Midwife Education Consultant	Clinical Education Centre
McKenna Lorraine	Maternity Care Service User	
McKeown Bid	Lead Midwife for Community Midwifery and Public Health	Northern HSC Trust
McStay Patricia	HOM (Retired 2018)	Southern HSC Trust
Menage Christina	Lead Midwife	Belfast HSC Trust
Miller, Maureen	HOM - A Sayers (Alternate)	Western HSC Trust
Morrow Gillian	MW Educator	Belfast HSC Trust
Murray Karen	Senior Prof Officer	Northern Ireland Practice and Education Council (NIPEC)
O'Byrne Ann	Designated Midwifery Officer (Community)	Health Service Executive
O'Kane Aideen	Lead Pharmacist Controlled Drugs	Belfast HSC Trust
O'Neill Jackie	Midwife Education Consultant	Clinical Education Centre
Porter Nicola	RQIA Manager	Regulation and Quality Improvement Authority
Quiery Pamela	Maternity Care Service User	
Ritchie Maureen	Practice Development Midwife	South Eastern HSC Trust
Robinson Jacqueline	Community MW Team lead	Northern HSC Trust
Rogan Margaret	Consultant Midwife,	Belfast HSC Trust
Ruddell Nigel Dr	Assistant Medical Director NIAS	NIAS
Sayers Amanda	Lead MW (Alternate for Maureen Miller)	WHSCT
Talbot Seana	Surestart Coordinator/Chair of SHSCT MSLC/President of NCT	Surestart
Wallace Verena	Midwifery Advisor DOH	DEPT of HEALTH NI
Wilson Anne	Regional Officer	Royal College of Midwives

External reviewers:

Professor Soo Downe, University of Central Lancaster, UK

Associate Professor Ank de Jonge, University of Amsterdam, The Netherlands

Dr Leanne Morgan, ADEPT Fellow, RQIA

Appendix 2: Guide for LIFE THREATENING Ambulance Transfer Request from MLU/Home birth

LIFE THREATENING AMBULANCE TRANSFERS
FROM MLUs/ PLANNED HOME BIRTH
Contact the Ambulance Service (NIAS) VIA 999

State you are a midwife or family member calling from either a MLU or a woman's Home

(You may need to give the postcode for the location you are at)
Request a Life Threatening transfer for mother/baby

When asked if life of woman and/or baby in danger, Reply **'YES'**

If on-going resuscitation is in place,
State: That this is for a New-born Baby or Woman
State: If baby/woman is UNRESPONSIVE, PULSELESS & NOT BREATHING,
'***CPR is taking place'***.

The Ambulance control operator has a protocol to follow and must ask certain questions. Please be patient as these are required for the NIAS. Following this, dispatch of an ambulance will be expedited. The questions will vary depending on whether the call is made from an MLU facility or a home birth.

Inform the receiving unit that an ambulance has been requested

The HART tool should be completed by the midwife prior to transfer to ensure all important information is communicated

Appendix 3: Guide for NON LIFE THREATENING Ambulance Transfer Request from MLU/Home birth

NON-LIFE THREATENING AMBULANCE TRANSFERS FROM MLUs/ PLANNED HOME BIRTH

Contact NIAS on 999, state you are a midwife (or family member) calling from either a MLU or the woman's Home and request a non-life threatening transfer.
(You may need to give the postcode for the location you are at)

Inform the receiving unit that an ambulance has been requested

(Some examples of non-life threatening conditions: Woman's request for analgesia, 3rd degree tear or retained placenta & not bleeding).

Should the woman/baby's condition change whilst waiting on the ambulance and the situation is now assessed as being life threatening; make another call to NIAS and ask for the original call to be escalated to a '**life-threatening'** transfer to expedite the dispatch of the ambulance

The HART tool should be completed by the midwife prior to transfer to ensure all important information is communicated

Appendix 4: Northern Ireland Midwife-led Care HART Referral and / or Transfer Report Form

AFFIX ADDRESSOGRAPH

Northern Ireland Midwife-led Care

HART Referral and / or Transfer Report Form

For use: between midwife-led care settings, including home birth or from midwifery led units to Obstetric unit

H	**History** Antenatal ☐ Intrapartum ☐ Postnatal ☐ Parity _____ Gestation (if applicable) ___ A/N / Intrapartum / P/N History (as applicable) _____ _____ _____ _____ ___
A	**Assessment of Current Situation** Temp____ Pulse ____ Blood Pressure (BP) ____/____ Resps ____ OEWS score _____ FH_____ (as applicable) Assessment of current situation and reason for referral/transfer _____ _____ _____ _____ _____
R If Obstetric Emergency proceed directly to **T**ransfer	**Referral** Referred to Dr/MW _____ (name) on _____ (date) at _____ (time) Reviewed by Dr/MW _____ Date _____ Time _____ Suitable to remain Midwife Led Care ☐ Yes ☐ No (if **no** please complete transfer section below) Arrangements for next review (if applicable) Date _____ Time _____ Department _____
T	**Transfer** Is transfer agreed Yes ☐ No ☐

	Obstetric Consultant informed of transfer Yes ☐ No ☐ N/A ☐ Date _____ Time _____ Consultant/MW _____ (name) **agrees / disagrees** to assume on-going responsibility for the care of this woman Time _____am/pm ambulance called, Time ambulance arrived at MLU/home _____am/pm, Length of time for ambulance transfer _____hrs/mins Time _____ am/pm ambulance arrived at MLU/obstetric unit Time of hand over & transfer of care _____ am/pm **Plan for on-going management should be documented in Maternity Hand Held Record** Arrangements for next review (if applicable) Date _____ Time _____ Department _____

Midwife Name (Printed) _____

Signature_____

Date _____

Time _____

Doctor Name (Printed) _____

Signature _____

Date _____

Time _____

Adapted from original HART tool Kelly 2008 SHSCT ©

Appendix 5: Possible Reasons for Referral and/or Transfer from a Planned Home Birth

Sometimes there are reasons why a woman who has planned a home birth may need to be transferred to hospital (or a midwife-led unit) during labour for further care. It is important to remember that all women who go into labour at home, and who are not planning a home birth transfer to their planned place of birth. A transfer from a planned home birth is part of a robust decision-making process and transfer normally takes place by ambulance or the woman's own transport (if it is safe to do so). Possible reasons for transfer should be discussed with the woman during the antenatal period and documented accordingly.

Below is a table with the common reasons for transfer, which is not exhaustive.

Transfer can ONLY take place with the woman's consent unless she is unconscious and cannot give consent.

Table 1 Possible reason for referral and/or transfer from a planned home birth

Intra-natal (During labour)	Postnatal (Post birth)
Maternal: Signs of Maternal Infection Raised Blood Pressure Haemorrhage Maternal request for transfer Maternal request for additional systemic analgesia Delay in either 1st , 2nd or 3rd stage of labour Retained Placenta Any deviation from normal birth care pathway	**Maternal:** Signs of Maternal Infection Raised Blood Pressure Haemorrhage Complex perineal tear
Baby: Presence of significant meconium- (' Dark green or black amniotic fluid that is thick or tenacious or any meconium-stained amniotic fluid containing lumps of meconium' NICE 2014:32) Abnormal fetal heart rate Shoulder Dystocia Cord Prolapse Unexpected breech	**Baby:** Shoulder dystocia at delivery (internal manoeuvres required) Baby has required active resuscitation/ low Apgar scores Baby is born who is less than expected growth on a customised growth chart (appears to be small for dates) Any suspected congenital abnormality detected on the baby's examination Signs of neonatal infection or maternal intrauterine infection

Adapted from South Eastern Health and Social Care Trust– 'HOME BIRTH – When a transfer to hospital for ongoing care may be needed' (2017).

Appendix 6: Discussing and understanding the evidence

When discussing preferences for place of birth with a woman and her partner, you may find it useful to use the following 'ASK' mnemonic (based on the National Institute of Health and Care Excellence, CG 138, NICE 2012) to help you decide what format is the best to aid discussion and decision-making re planning a Home Birth.

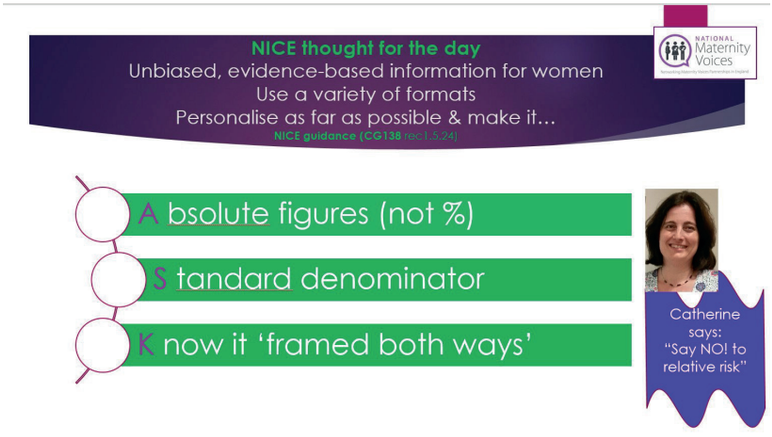


Figure 4 ASK mnemonic (Slide used courtesy of Catherine Williams, NICE Fellow 2016-19)

The following figure includes an example of how the ASK approach can be used to explain the evidence for babies at each place of birth.

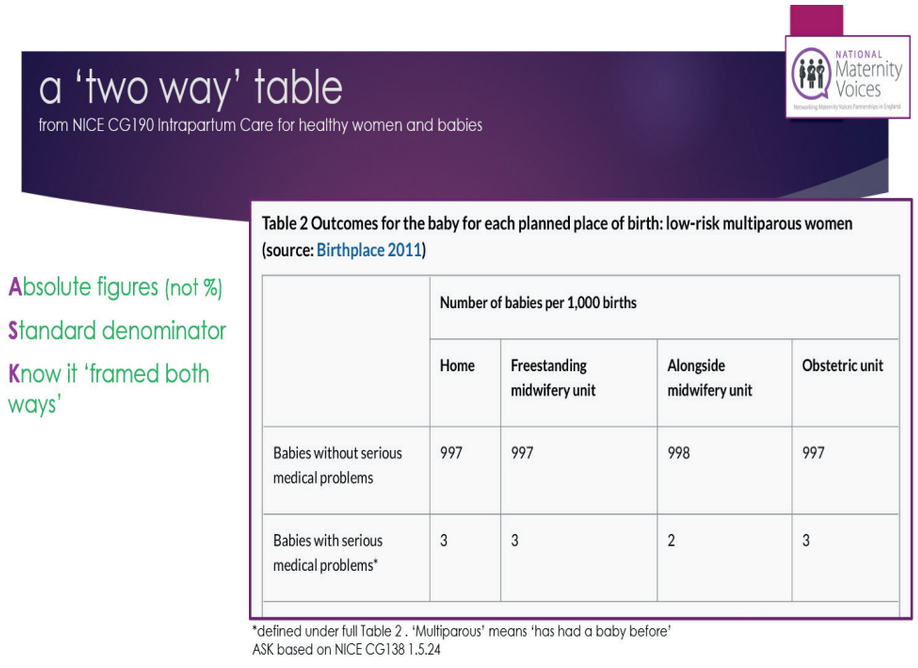


Figure 5 Two-way table (Slide used courtesy of Catherine Williams, NICE Fellow 2016-19)

Appendix 7: Recommended principles to use when discussing benefits and risks with a woman

Use the following principles when discussing risks and benefits with a patient:

- personalise risks and benefits as far as possible
- use absolute risk rather than relative risk (for example, the risk of an event increases from 1 in 1000 to 2 in 1000, rather than the risk of the event doubles)
- use natural frequency (for example, 10 in 100) rather than a percentage (10%)
- be consistent in the use of data (for example, use the same denominator when comparing risk: 7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5)
- present a risk over a defined period of time (months or years) if appropriate (for example, if 100 people are treated for 1 year, 10 will experience a given side effect)
- include both positive and negative framing (for example, treatment will be successful for 97 out of 100 patients and unsuccessful for 3 out of 100 patients)
- be aware that different people interpret terms such as rare, unusual and common in different ways, and use numerical data if available
- think about using a mixture of numerical and pictorial formats (for example, numerical rates and pictograms)

From NICE (2012) Patient experience in adult NHS services: improving the experience of care for people using adult NHS services Clinical Guideline 138; pg31 https://www.nice.org.uk/guidance/cg138/evidence/full-guideline-pdf-185142637.

Appendix 8:

Information for women and their partners on the RQIA guideline

Planning to birth at home in Northern Ireland (2019)

The Regulation and Quality Improvement Authority

Assurance, Challenge and Improvement in Health and Social Care

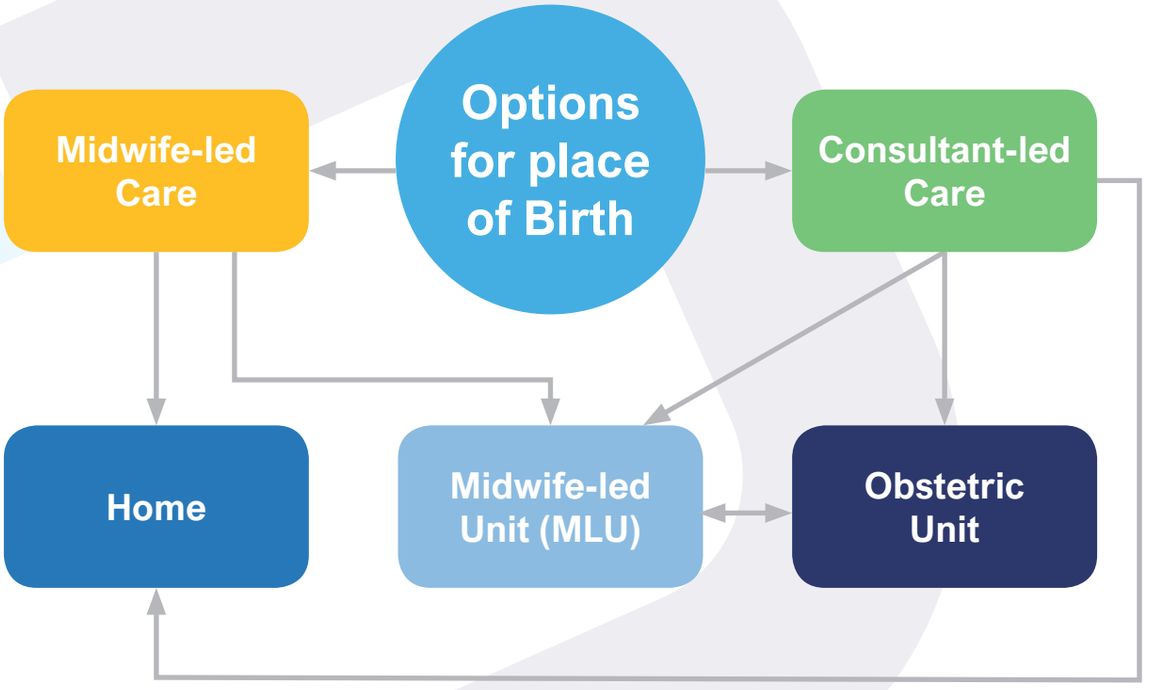
Maternity Care in Northern Ireland

There are two main types of maternity care for women in Northern Ireland:

a) Midwife-led care with the woman birthing at home or in a midwife-led unit.

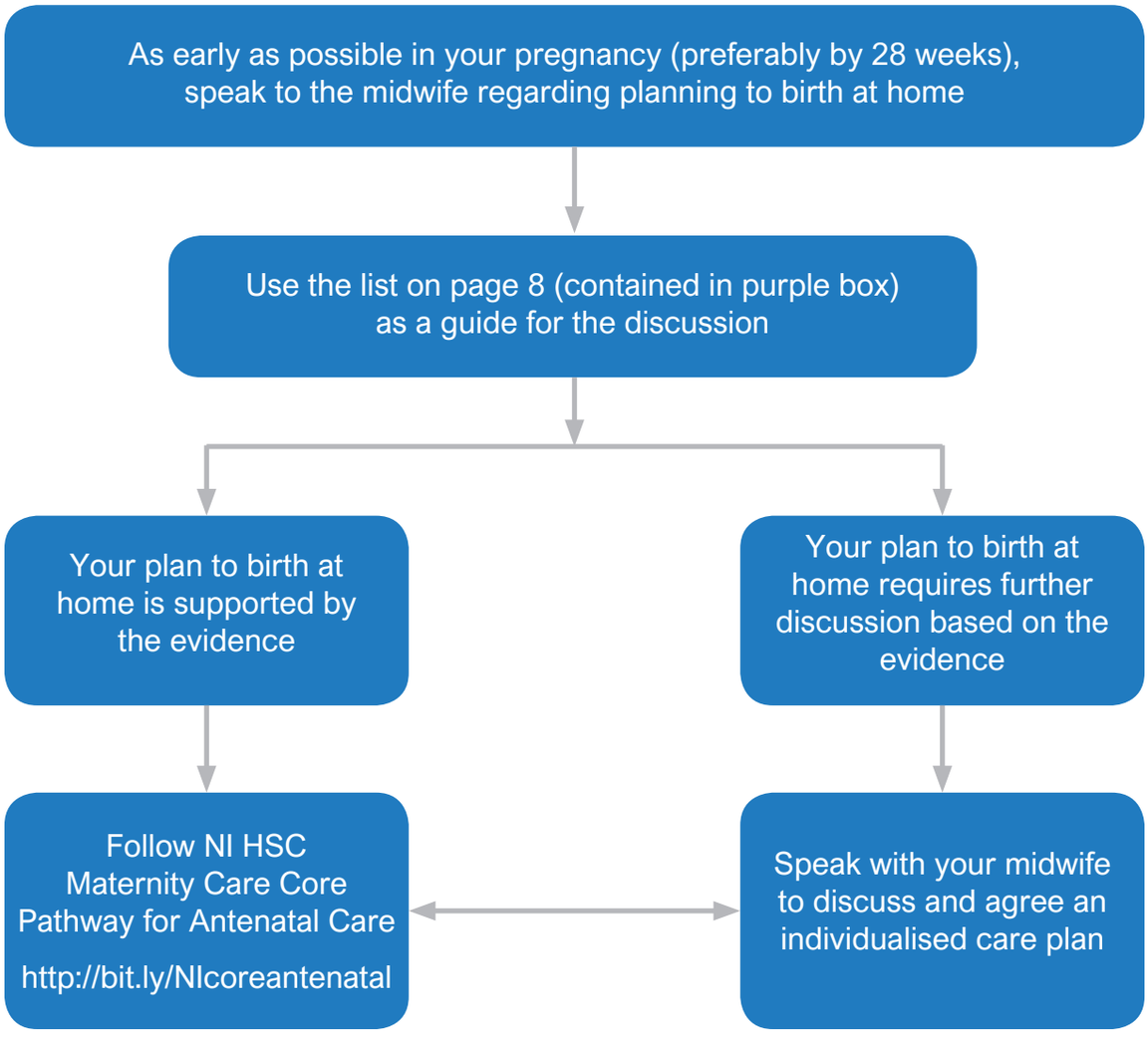
b) Consultant-led with the woman birthing in an obstetric unit (hospital).

If you have had consultant appointments during your pregnancy, depending on your individual circumstances, you can still consider giving birth at home (or in a midwife-led unit). If you choose home birth, your care will be provided by skilled and experienced midwives. They will bring the essential equipment to your home.



Antenatal Care

Your midwives and doctors will follow the pathway below when supporting you through your pregnancy. Apart from additional discussions, if needed, to create an individualised care plan, your antenatal care will follow the usual pattern.



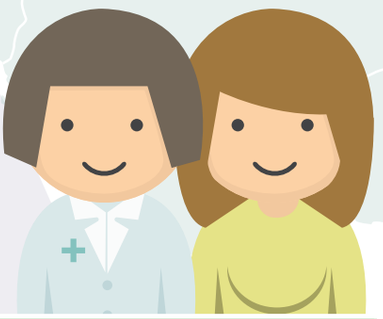
Choosing your Place of Birth

It is important that you make an informed decision about where you would like to give birth. It is up to you where you have your baby, and even after you have decided, you can change your mind. Midwives and doctors will support you in your informed choice of birth setting.

At the booking appointment and throughout your pregnancy, your midwife will discuss birthplace options with you, using evidence-based information.

For access to the RQIA Planning Birth at Home guideline and this leaflet (search **rqia.org.uk/planningbirthathome** for 'Planning birth at home'). Please ask the midwife for this information, if it is not provided.

- Home birth is safe for most women
- Home birth is offered in all parts of Northern Ireland
- Midwives will bring the essential equipment to your home



Giving birth for the first time	If you have had a baby before
79% chance of having a normal vaginal birth	**98%** chance of a normal vaginal birth
45% chance of transfer to obstetric unit (see pages 10 & 11 for more information)	**12%** chance of transfer to obstetric unit (See pages 10 & 11 for more information)

There is a **less than 1%** chance of your baby having a serious medical problem at birth regardless of place of birth.

The Regulation and Quality Improvement Authority

For women giving birth for the first time

Evidence shows that a healthy woman having a straightforward pregnancy is likely to have fewer interventions and better outcomes if they give birth at home or in a midwife-led unit, compared with an obstetric unit (NICE 2014).

For women having their first baby, there is a slightly increased chance of the baby experiencing a serious medical problem at birth - See Place of Birth Tables in your Maternal Hand Held Record (green notes).

Vaginal birth (women giving birth for the first time):

794 women per 1000 (79%) women planning to give birth at home have a spontaneous vaginal birth, as compared to 813 (81%) in a freestanding midwife-led unit (FMU), 765 (77%) in an alongside midwife-led unit (AMU) and 688 (69%) in an obstetric unit.

Transfer rate (women giving birth for the first time):

450 women per 1000 (45%) may transfer to an obstetric unit.
Common reasons for transfer are:

- Request for stronger pain relief
- Slow progress in labour

Caesarean Section rate (women giving birth for the first time):

80 per 1000 women (8%) transfer from their planned home birth and go on to have a caesarean section, as opposed to 121 per 1000 (12%) in an obstetric unit.

Outcomes for the baby (women giving birth for the first time):

9 babies per 1000 (0.9%) will have a serious medical problem, compared to 5 babies (0.5%) born in a midwifery-led unit or an obstetric unit.

Place of birth - the evidence

For women who have given birth before

Vaginal birth (for women who have given birth before):

984 women per 1000 (98%) women planning to give birth at home have a spontaneous vaginal birth, as compared to 980 (98%) in a freestanding midwifery unit (FMU), 967 (97%) in an alongside midwifery unit (AMU) and 927 (93%) in an obstetric unit.

Transfer rate (for women who have given birth before):

115 women per 1000 (12%) may transfer to an obstetric unit.
Common reasons for transfer are:

- Slow progress
- Request for stronger pain relief

Caesarean Section rate (for women who have given birth before):

7 women per 1000 (0.7%) who plan to birth at home will have a caesarean section as compared to 35 per 1000 (3.5%) in an obstetric unit.

Outcomes for the baby (for women who have given birth before):

3 babies per 1000 (0.3%) will have a serious medical problem compared to 2 babies per 1000 (0.2%) born in an alongside midwifery unit (AMU) and 3 babies per 1000 (0.3%) born in a freestanding midwifery led unit (FMU) or an obstetric unit). What this means is 2 or 3 babies per 1000 will have a serious medical problem regardless of place of birth.

The Regulation and Quality Improvement Authority

Pros and Cons of Home Birth

Advantages

- You are more likely to feel relaxed in your own home.
- You are more likely to be looked after by a midwife whom you have got to know during your pregnancy.
- You are more likely to have a normal labour and birth.
- You are less likely to experience interventions such as having your waters broken or having a drip to speed up your labour.
- You are less likely to require a diamorphine injection or an epidural for pain relief.
- You are less likely to need a caesarean section, ventouse (vacuum) or forceps to assist with the birth of your baby.
- You are less likely to need a blood transfusion.
- You are more likely to breastfeed successfully (if this is your choice).
- You and your partner will be able to stay together during and after the birth.

Disadvantages

- You may transfer to a MLU/ obstetric unit during labour or after baby is born. An emergency (blue light) transfer is rare. Further details on pages 10 & 11.
- You can access gas and air and medication such as a diamorphine injection at home. However, if you would like stronger pain relief, such as an epidural, you will need to transfer to obstetric unit.

Suitability for home birth

Home birth is particularly suitable for women who are having a straightforward pregnancy, and have therefore not experienced any complications. This means that you are pregnant with one baby, that both you and the baby are healthy, and that you go into labour between 37- 42 weeks of pregnancy.

However, home birth may also be suitable for other women, such as those described in the box below (from the RQIA Planning Birth at Home Guideline).

Home birth is suitable for you if you:

- Are aged between 16 and 40 years at your booking appointment
- Are pregnant following assisted conception with Clomifene
- Had a Body Mass Index (BMI) at booking that is greater than or equal to 18kg/m2 and less than or equal to 35 kg/m2
- Had a previous third degree tear with no significant symptoms
- Had a previous baby with a condition requiring medical assistance, and in this pregnancy there is no evidence of the same condition recurring
- Have had up to 4 previous vaginal births in the absence of a uterine scar
- Have experienced mental ill-health and fulfil the criteria for Step 1 & 2 of the Regional Perinatal Mental Health Care Pathway (http://bit.ly/PMHcarepathway)
- Have had a threatened miscarriage but pregnancy continued normally
- Have a last recorded blood count (iron/haemoglobin) of at least 100g/l prior to labour
- Have a placenta that was previously low lying but is now in a better position
- Have a medical condition that does not affect your pregnancy
- Are receiving support from Social Services with no impact on your pregnancy
- Have had a threatened early labour, and have reached 37 weeks
- Have blood results showing serum antibodies with no clinical significance (i.e. this has no effect on your baby)
- Have had previous cervical treatment and have reached 37 weeks
- Are having a baby which is growing normally as recorded on your customised growth chart
- Are in labour, your waters broke on their own less than 24 hours ago, you have no signs of infection, you are feeling well and a midwife has confirmed that your baby is well
- Have had your waters break on their own, they are slightly green in colour, and a midwife has confirmed that your baby is well

Individualised Care Plan

Women with other health and well-being considerations not included in the list in the purple box on page 8, may want to consider a home birth for a variety of reasons. If this is the case, your midwife will discuss in detail the pros and cons of planning a birth at home and you will be supported with an individualised care plan for your birth.

The individualised care plan will be revisited if the situation changes, and it will focus on issues specific to you, rather than on the general issues of childbirth.

Your midwife will want to check that you understand the pros and cons of all options, and any issues relating specifically to you and/or your baby.

All discussions about the 'risk' or 'chance' of complications with your birth will follow best practice.

This means that discussions will be

- Individualised and relevant to you and your pregnancy
- Evidence based and balanced (particularly when discussing uncommon events and complications)

If you still have any questions after you have talked with your midwife, or if you want more support for your choice of birthplace, you can get in touch with the Head of Midwifery/Consultant Midwife from your local Health and Social Care (HSC) Trust (contact details available on your local HSC Trust website).

Transfer to Hospital

Maternity care providers aim to keep to your birth preferences and provide safe care for you and your baby at home. However, sometimes there are reasons why your midwife may suggest to you that it would be better for you and/or your baby if you travel to hospital (or a midwife-led unit) for further care.

It is important to remember that all women who go into labour at home, and who are not planning a home birth, transfer in labour to their planned place of birth.

Transfer from a planned homebirth normally takes place by ambulance or your own transport (if it is safe to do so). Emergency (blue-light) transfer is rare. Most transfers are slow, calm, and peaceful.

The table on page 11 outlines some common reasons for transfer.

Midwives are skilled and experienced in dealing with emergencies such as those listed, but may recommend transfer to hospital for further treatment or monitoring. Transfer will only take place with your consent unless you cannot give consent, e.g. if you are unconscious.

As part of planning for birth at home, feel free to ask your midwife about the possibility of a transfer.

Possible reasons for transfer

During labour

Women:

- Signs of infection
- Raised blood pressure
- Significant bleeding
- Woman requests transfer
- Woman requests epidural (only available in hospital)
- Delay in either 1st, 2nd or 3rd stage of labour

Baby:

- There is significant meconium (this means the baby's bowels have opened in the womb)
- Abnormal heart rate
- Shoulder dystocia (baby's shoulders were slow to come out and internal manoeuvres were needed)
- Cord prolapse
- Unexpected breech

After the birth

Women:

- Signs of infection
- Raised blood pressure
- Significant bleeding
- Complex perineal tear (the perineum is the area between the vagina and the anus)
- Retained placenta (neck of the womb closes before the placenta comes out)

Baby:

- Baby has required active resuscitation
- Baby is born who is less than expected weight on a customised growth chart
- Any congenital abnormality detected
- Signs of infection

Adapted from South Eastern Health and Social Care Trust
'HOME BIRTH - When a transfer to hospital for ongoing care may be needed (2017)' document.

Helpful tips

Women who have had (or are planning) a home birth in Northern Ireland have suggested the following tips for you to consider:

- Hire or borrow a birthing pool – water birth is amazing!
- Think about your older children. You can arrange a babysitter, or they can be there for the birth.
- Do you want your pets to be there? If not, you'll need to arrange for them to be looked after.
- Have the right food available – for you, your birth partner/s, (and for the midwives, if you want to).
- You don't need a huge room, especially if you're not hiring a pool.
- Nobody will inspect your house for cleanliness! All homes are suitable for home birth (unless your home is unsafe in some way).
- Make your birth room special by putting up fairy lights and printing out affirmations, if you want to.
- Cleaning up isn't a big deal – there's much less 'mess' than you would think. Buy a cheap plastic sheet or shower curtain and throw it out afterwards.

The Regulation and Quality Improvement Authority

Useful links

Planning Birth at Home
www.rqia.org.uk/planningbirthathome

Place of Birth
http://bit.ly/PlaceofBirth

NICE Guideline CG190 – Intrapartum Care for Healthy Women and Babies
http://bit.ly/cg190

BirthWise
www.Birthwise.org.uk

NICE Guideline CG138 – Patient Experience in Adult NHS Services
http://bit.ly/nicecg138

RQIA Guideline for MLU
http://bit.ly/MLUwomen

HSC Trusts in Northern Ireland
http://bit.ly/HSCTrustsNI

Thanks and acknowledgements

Thanks to the maternity care professionals and service users from the BHSCT Maternity Services who shared their 'Guideline for the Management of Homebirth SG125/08' (2017) with the Guideline Development Group to inform discussion and the content of the 'RQIA Planning a Homebirth' guideline. Thanks to the South Eastern Health and Social Care Trust for sharing their 'HOME BIRTH - When a transfer to hospital for ongoing care may be needed (2017)'.

Also, thanks to all the members of the Guideline Development Group who shared their resources, evidence, ideas and experiences to inform and shape the guideline.

Special thanks to all of the women who provided tips, quotes, and photos, and those who worked on the design of this leaflet.

Quotes from women who have given birth at home

"The best thing about being at home is everything you might need is readily available - a few towels to protect the furniture, bath/shower for comfort. I just love the idea that you can have your baby in familiar surroundings with whomever you choose, and when it's over you can have a shower, get into your pjs, have a cup of tea in your own mug and into your own bed with your partner. If you wish to get a CUB or birth pool these can be hired."

(NI Mum currently planning a home birth)

"I think that the biggest thing was safety for me. Knowing that the midwife brings the equipment well in advance and should you change your mind or issues arise, it is easy to transfer to hospital."

"You feel more in control of what's happening"

"There was minimal mess, plus you have all your home comforts about you"

"I transferred to hospital after a slow second stage, and ended up getting a ventouse birth. The transfer was fine, and needed, but it wasn't an emergency and I didn't feel scared. I am so glad that I had so long at home though, and I'll definitely choose home birth next time again."

"You get to sleep in your bed afterward. Your partner is with you, and your children are less disturbed."

"Having a home birth meant feeling safe and totally comfortable in my own environment. It was wonderful to be surrounded by my own family in the immediate postpartum hours, rather than on a hospital ward, and it was absolutely priceless for my two young daughters to witness the birth of their brother."

The Regulation and Quality Improvement Authority

Photos of births at home

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority,
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast BT1 3BT.
Telephone: (028) 9536 1111
info@rqia.org.uk | www.rqia.org.uk | @RQIANews

www.rqia.org.uk