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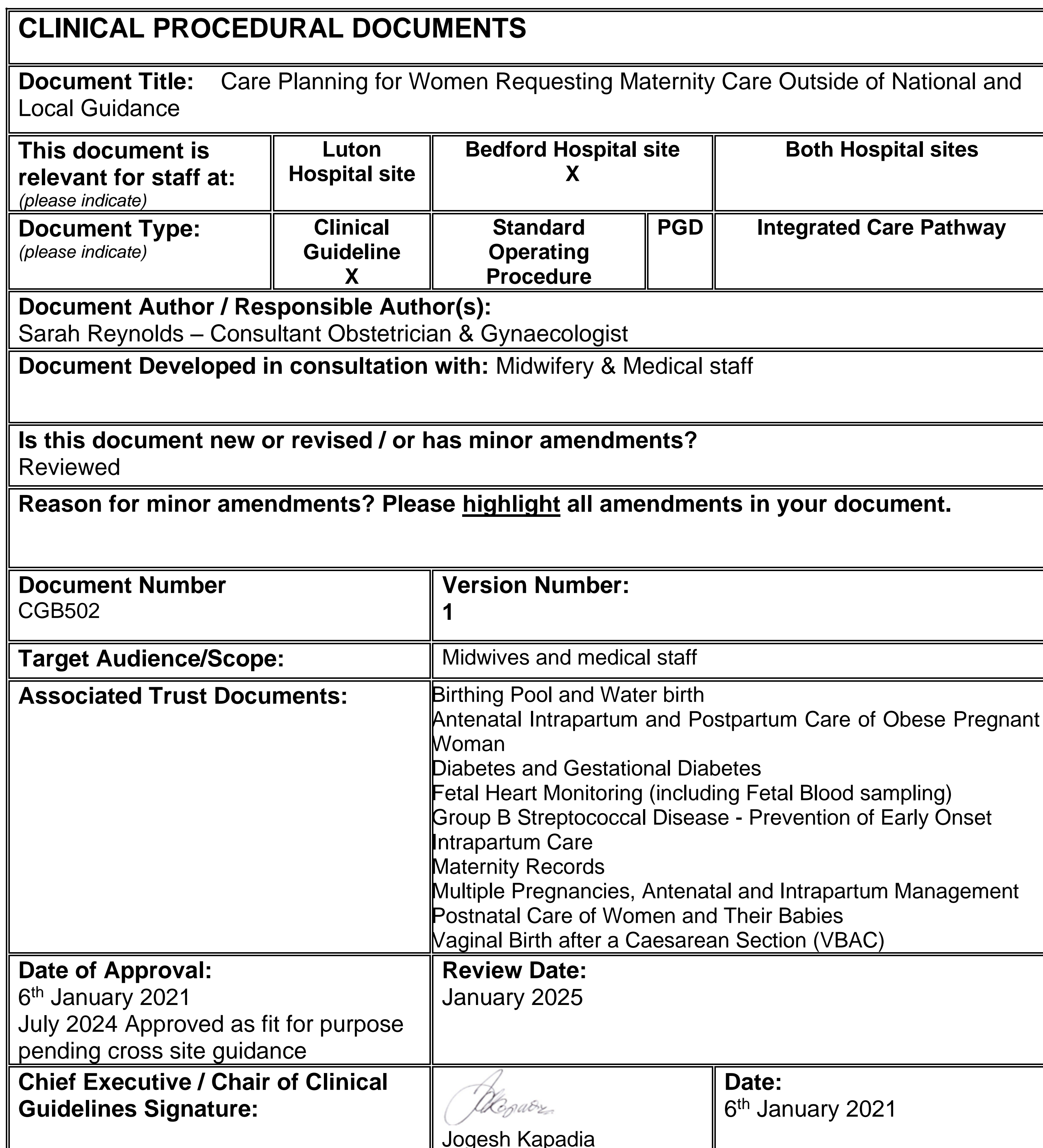

CLINICAL PROCEDURAL DOCUMENTS				
Document Title: Care Planning for Women Requesting Maternity Care Outside of National and Local Guidance				
This document is relevant for staff at: *(please indicate)*	**Luton Hospital site**	**Bedford Hospital site X**		**Both Hospital sites**
Document Type: *(please indicate)*	**Clinical Guideline X**	**Standard Operating Procedure**	**PGD**	**Integrated Care Pathway**
Document Author / Responsible Author(s): Sarah Reynolds – Consultant Obstetrician & Gynaecologist				
Document Developed in consultation with: Midwifery & Medical staff				
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Reason for minor amendments? Please highlight all amendments in your document.				
Document Number CGB502	**Version Number: 1**			
Target Audience/Scope:	Midwives and medical staff			
Associated Trust Documents:	Birthing Pool and Water birth Antenatal Intrapartum and Postpartum Care of Obese Pregnant Woman Diabetes and Gestational Diabetes Fetal Heart Monitoring (including Fetal Blood sampling) Group B Streptococcal Disease - Prevention of Early Onset Intrapartum Care Maternity Records Multiple Pregnancies, Antenatal and Intrapartum Management Postnatal Care of Women and Their Babies Vaginal Birth after a Caesarean Section (VBAC)			
Date of Approval: 6th January 2021 July 2024 Approved as fit for purpose pending cross site guidance	**Review Date:** January 2025			
Chief Executive / Chair of Clinical Guidelines Signature:	Jogesh Kapadia		**Date:** 6th January 2021	

Contents

CLINICAL PROCEDURAL DOCUMENTS 1
Introduction 3
DUTIES 3
DETAILS OF THE PATHWAY 4
Records 5
TRAINING 5
REFERENCES .... **Error! Bookmark not defined.**
References 6
Staff Involved In Development 6
Appendix 1 - Individualised care planning pathway 7
Appendix 2: Maternity Partnership Referral form 8
Appendix 3: Maternity Partnership Assessment Tool 9
Appendix 4: Maternity Partnership Care Plan 11
Appendix 5: Proforma of letter to patient 12
Appendix 6 - Water birth for women with risk factors management plan 13
Monitoring / Audit Criteria 14

Introduction

It is known that involving women in decisions about their care can contribute to a positive birth experience and improve psychological wellbeing. Making a choice, according to Kings Fund (2008) requires self-knowledge and confidence, awareness of all possibilities, understanding of responsibilities, freedom from pressure, awareness of what is available and confirmation of processes and consequences.

The Better Births strategy (2017) states that women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.

Women who request care options that are outside local or national guidance are those who make an informed choice not to accept care that is routinely offered to all women during pregnancy. When this occurs, it can be a challenging time for midwives. However, the NMC (2016) sets out a requirement for midwives to act in the best interest of people at all times. One way this can be achieved by balancing the need to act in the best interest of people at all times with the requirement to respect a person's right to accept or refuse treatment (2016). Doctors have similar guidance which they should follow.

Factors that support the positive pregnancy and birth experience include continuity of care and good communication skills. This will assist in developing trust between the woman and the doctor or midwife consequently increasing confidence when challenged by supporting maternal choice outside the local and national guidelines. Successful maternity services are those that enable women to choose the most appropriate care through each phase of their maternity experience. Offering a range of options and discussing possibilities provides women with informed choices that best meet their needs (RCOG 2016). Better Births (2017) define personalised care, as centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

Tools that support doctors and midwives include risk assessment, multidisciplinary team planning and documentation. These will be used in the following process which attempts to ensure that women identified as requiring an individualised care plan will receive appropriate care promptly. If required, the Mental Capacity Act (2005) can be utilised to provide clarity around a woman’s capacity to make decisions.

To offer guidance to the midwives and doctors who find themselves caring for women who chose care options that are outside of local or national guidance.

DUTIES

It is the responsibility of whichever midwife to whom the woman discloses that she wishes to choose care options outside local and national policy to start the Maternity Partnership pathway (see appendix 2). In practice this is usually the community midwife (CMW) in the antenatal period.

DETAILS OF THE PATHWAY

Referral to a consultant obstetrician must be made using the maternity partnership referral form (appendix 2). This starts the multi-disciplinary care, even if the woman declines to see a consultant the referral should be made. A named consultant can be a point of contact and support for the wider multidisciplinary team.

The woman is to be made aware of the fact it is our policy to submit a referral but that she has the choice whether to attend or not. The appointment needs to be for consultation meeting not a routine antenatal appointment.

The purpose of this meeting is to provide the woman with evidence-based information and ensures that the woman understands the rationale behind the care offered so she's sure what she's saying yes or no to. Key information, for example notes from previous births, should be available to aid discussion and deliberation in order to reach a decision.

Special arrangements may have to be made in advance such as a translator, advocates, support, leaflets in appropriate formats and attendance of the community midwife. These considerations should be mentioned within the referral from the community midwife.

The woman may at this point agree to follow guidance. If this is the case the consultant devises a plan in partnership with the woman which is documented in the woman's hand-held notes. The plan should be forwarded to the Matrons, Head of Midwifery, Team Leaders, Professional Midwifery Advocates and named community midwife as well as any other relevant professional. Documentation of this meeting should be recorded using the maternity partnership assessment tool (appendix 3).
The plan is then disseminated as needed. Women should be given enough time between receiving information and making choices to reflect upon the information, consider their options and seek additional information and advice where they wish to (RCOG 2016).

If the woman doesn't accept the plan suggested by the consultant the woman should be offered a second opinion from another consultant. (Department of health 2013) The consultant should arrange this appointment before the end of the meeting. If the woman declines medical recommendations the consultant obstetrician should inform the Community Midwifery Manager, Team Leader and Community Midwife. Where women request or decline services or treatment, their decision should be respected (RCOG 2016). A letter should be sent from the consultant to the woman detailing the potential risks to her or her baby where she chooses care options outside of guidelines and should include the woman’s reasons for declining. This ensures her arguments are treated with respect. (Appendix 5)

The Professional Midwifery Advocate (PMA) Midwife is available to meet with the midwife to support him/her to work in partnership with the woman to develop a plan of care which meets her individual needs, to listen to her and to advocate for her as required (A-EQUIP 2017). The community midwife should then offer to meet with the woman. The purpose of this meeting is to ensure that the woman is clear about information so far received, answer any new questions and to clarify what care may be offered. For example, if choosing a home birth against medical advice she will receive routine midwife led care for a home birth, not including elements from high risk policies for example intravenous access. A detailed care plan will be devised to

ensure the safest possible options for the birth using the maternity partnership care plan (appendix 4).

It is essential that the care plan is shared with the multi-disciplinary team in a timely way. Team members include: Obstetric, Paediatric & Anaesthetic consultants, Head of Midwifery, Matrons, Midwifery Team Managers, Professional Midwifery Advocates and specialist midwives. A copy of the care plan should be stored on the Professional Midwifery Advocates (PMA) drive for the purpose of audit and monitoring outcomes.

At every point of contact the pregnancy should be risk assessed to identify any new possible problems that may have arisen and which may impact upon the proposed plan. This should be discussed with the woman and the appropriate referrals made. The on call consultant should be involved if there are any disagreements.

The midwife caring for the woman at the birth needs to ensure outcome feedback via the delivery suite coordinator to the multi-disciplinary team. The rational for this is closure; sharing learning and supporting of all staff involved including the reflection from practice.

The midwife responsible for the care of the woman at the birth also has a duty of care towards the baby. If there is any cause for concern for the baby's health and the parents decline treatment this must be escalated and appropriate safe guarding actions taken in accordance with local national or guidelines.

If the care plan is around a home birth the community midwife caring for the woman must inform the delivery suite coordinator once the initial assessment has been made. The delivery suite coordinator will inform medical staff, Consultant Obstetrician, Matron or senior manager on call and other professional as appropriate. This escalation process will trigger any support or guidance strategies that may be required.

A high standard of robust documentation is crucial that every contact including any evidence discussed e.g. local policy RCOG or NICE guidance, the woman's responses and the next logical steps. Letters or telephone calls may be appropriate as well as entries into the health record.

Records

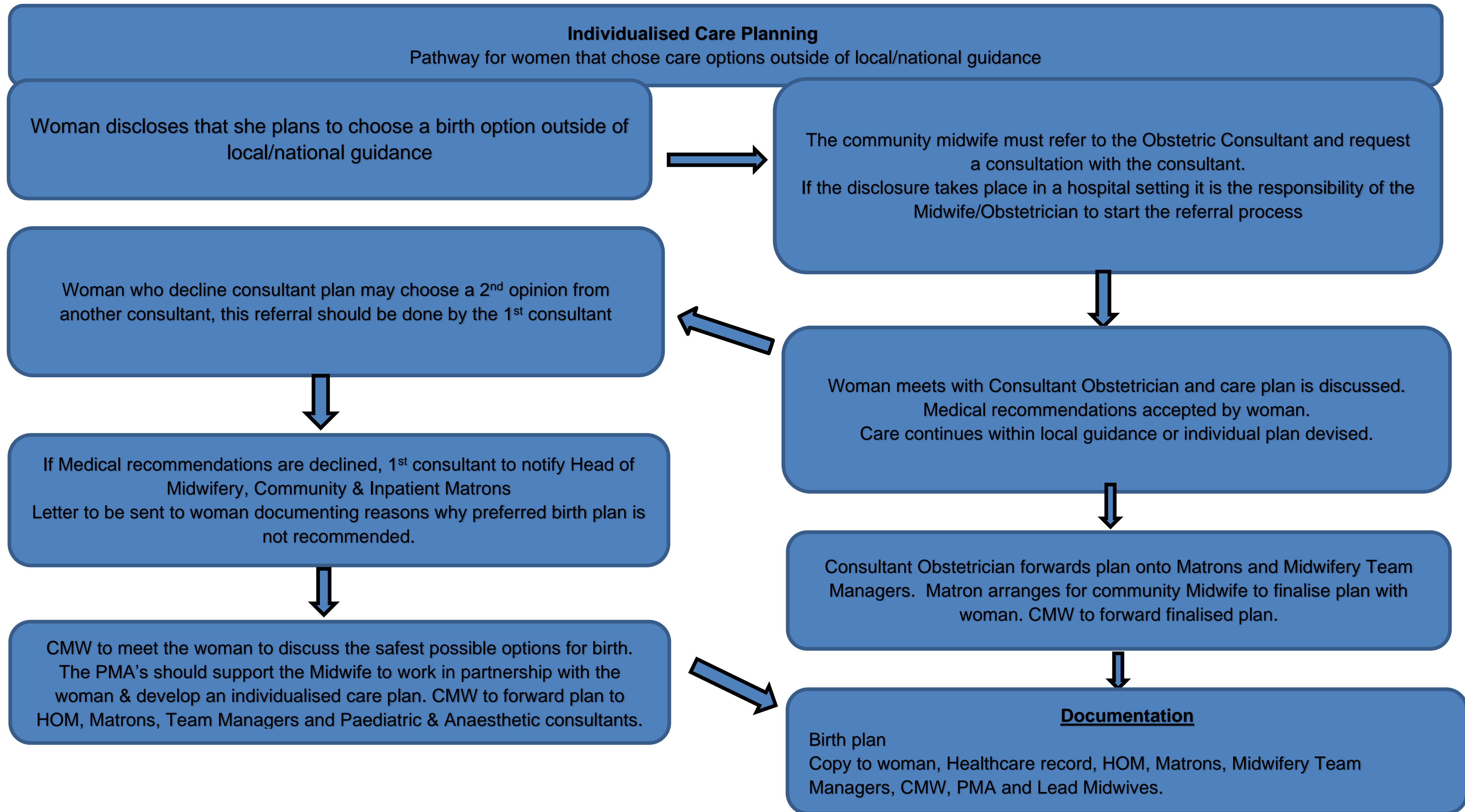
All care provided should be recorded in accordance with the Maternity records guideline.

TRAINING

There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual’s training needs as defined within their annual appraisal or job plan.

References	Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2017) West Suffolk NHS Foundation Trust (2016) Care Planning for Women Requesting Maternity Care Outside of National and Local Guidance. The Newcastle upon Tyne Hospitals NHS Foundation Trust (2016) Maternity Partnership Pathway for women requesting unconventional care. Royal College of Obstetricians & Gynaecologists (2016) Providing Quality Care for Women. A framework for Maternity Service Standards.
Staff Involved In Development	**Version 1** Helen Leonard Midwifery Team Manager/Professional Midwifery Advocate

Appendix 1 - Individualised care planning pathway



Appendix 2: Maternity Partnership Referral form

Patient details:

- Name
- DOB
- Hospital No
- Address
- Contact number

Date of referral

Referred by:

- Name
- Professional Role
- Contact number

Pregnancy details

- EDD Parity

Referral indication

Please inform the woman that she has been referred to the obstetric team and that she will be contacted within 14 days.

This form should be faxed to 01234 795782 for the attention of Labour Ward Lead consultant.

Appendix 3: Maternity Partnership Assessment Tool

Date

Persons present at consultation

Name	Role
	Expectant Mother
	Consultant Obstetrician
	Professional Midwifery Advocate
	Community Midwife

Pregnancy details:

EDD:

Parity:

Previous pregnancy details:

Maternal request/s:

Benefit of requested plan from maternal perspective

Maternal plan if request/s not able to be met:

Professional recommendation/s:

Reason/s:

Outcome:

Plan acceptable to woman agreed Y N

Details

Capacity assessment:

I / we confirm that (insert name)

Understands the information relevant to the discussion above

Has demonstrated that she has retained that information

Has included that information as part of her decision making

Has clearly communicated her decision to me/us.

Signed:

1.
2.

Follow up plan:

Appendix 4: Maternity Partnership Care Plan

Date

Patient details

EDD:

Plan of care:

Staff to be informed in labour:

1. On Call Consultant Obstetrician

2. Labour ward co-ordinator

3.

4.

5.

The above plan has been made in consultation with the woman and is believed by the Maternity Partnership team to be the safest care plan which is acceptable to her in view of her choice. She understands that the recommended care options will remain open to her at all times.

Appendix 5: Proforma of letter to patient

Dear (*insert patient name*),

Thank you for attending the antenatal clinic today to discuss your current pregnancy and plans for delivery. This letter is aimed to document our discussion to make sure we are in agreement with what was discussed.

(summary of past obstetric history and deliveries)

In this pregnancy you have requested (*insert description of non-conventional plan*). The care plan recommended by your midwife and obstetric team is (*insert recommendations*) because (*insert reasons*). This plan would be in line with national (NICE / RCOG / RCM) and local Bedford Hospital guidelines. We accept, however, that some women wish to have alternative birth plans for various reasons, against the recommendations of doctors and midwives.

In your case, you wish to (insert birth plan) because of the following reasons (….)

We <u>do not believe that your preferred plan is the safest for you and / or your baby</u> but we have worked with you today to agree the safest plan which is acceptable to you at the present time. (*details of agreed plan*). We will inform your Community Midwife (*name*), your GP (*name*), Obstetrician (*name*), and (*insert others where appropriate*) of the plan.

As your pregnancy progress, your situation or preferences may change and we will continue to discuss with you how the safest delivery for you and your baby can be achieved. We recognise that women also change their minds and opt for the recommended course of action. We want to reassure you that you will face no criticism for this, but will be supported if this occurs.

Please do not hesitate to contact us if there are any further issues you wish to discuss.

Consultant name and contact details

Matron name and contact details

Appendix 6 - Water birth for women with risk factors management plan

Water birth for women with risk factors pathway **Date:**	Consultant
Risk factors in pregnancy	
Risk factors in labour	
Fetal monitoring in labour	Telemetry CTG Yes/No Intermittent auscultation Yes/NO
Labour in Pool	Yes/No
Birth in pool	Yes/No
Venflon required	Yes/No
Syntocinon in pool	Yes/No
3rd stage	Active/ Physiological
Reasons for exiting pool discussed	Yes/No
Signature of Reviewing Snr Midwife/Dr	

Monitoring / Audit Criteria

Aspect	Method	Frequency	Responsibility	Reporting Arrangements
Number of women who choose care options that are outside local or national guidance.	Professional Midwifery Advocate (PMA) drive	Annual as part of the Professional Midwifery Advocates report to the Head of Midwifery	Professional Midwifery Advocates	Obstetrics and Gynaecology Quality board.

The Maternity Service measures compliance with the guideline through annual audit. Results from the annual audit will be presented and discussed at the multidisciplinary Clinical Audit Meeting and the CBU Maternity, Gynaecology and Sexual Health Quality Committee. Where audit has identified any non-compliance an action plan will be developed to address this, a lead person identified to ensure the actions are carried out and all action plans will be monitored by the Consultant Obstetrician – Audit Lead.