



Royal College of Obstetricians and Gynaecologists/Royal College of Midwives Joint statement No.2, April 2007

HOME BIRTHS

Summary

The Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) support home birth for women with uncomplicated pregnancies. There is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their families. There is ample evidence showing that labouring at home increases a woman's likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby.¹⁻³

1. Introduction

- 1.1 The rate of home births within the UK remains low at approximately 2%,⁴⁻⁶ but it is believed that if women had true choice the rate would be around 8–10%.⁷
- 1.2 The development of maternity polices over the last four decades, combined with frequent reorganisations of service structure, have impacted on the availability of home birth and have concentrated on births in hospitals.⁸⁻¹⁰ Reasons for this appear to include:
 - financial constraints
 - the values and beliefs of organisations about maternity care
 - lack of staff with the appropriate competencies.¹¹
- 1.3 Throughout this time, women and voluntary organisations have challenged the one-dimensional approach to options for place of birth and have influenced the portfolio of evidence now available to support a return to a more diverse range of childbirth environments.¹²⁻¹⁵

2. Review of the evidence: benefits and harms

- 2.1 The review of the diverse evidence available on home birth practice and service provision demonstrates that home birth is a safe option for many women.^{2,16,17} However, this is not to define safety in its narrow interpretation as physical safety only but also to acknowledge and encompass issues surrounding emotional and psychological wellbeing. Birth for a woman is a rite of passage and a family life event, as well as being the start of a lifelong relationship with her baby. Home births will not be the choice for every woman.⁷
- 2.2 Randomised controlled trials to assess the safety of home births are not currently feasible. The observational data available show lower intervention rates and higher maternal satisfaction with planned home birth compared with hospital birth. Overall, the literature shows that women have less pain at home and use less pharmacological pain relief, have

lower levels of intervention, more autonomy and increased satisfaction.^{1,12,18–20} The studied interventions included induction, augmentation, perineal trauma and episiotomy, instrumental delivery and caesarean section. These are not insignificant interventions and may have considerable impact on a woman's long-term health and emergent relationship with her baby, as well as her satisfaction with her birth experience.

- 2.3 Furthermore, the studies into women's descriptions of home birth experiences have produced qualitative data on increased sense of control, empowerment and self esteem, and an overwhelming preference for home birth.^{3,21–27}
- 2.4 A distinction needs to be made between women who plan for a home birth and those who have an unintended home birth, as unintended home births or women who received no antenatal care are linked to a higher rate of both maternal and perinatal complications.²⁰
- 2.5 A proportion of women who plan a home birth are transferred to hospital,^{9,13,14,19} most commonly for slow progress or needing pain relief not available at home, such as epidural anaesthesia. The most serious reasons for transfer are maternal haemorrhage, concerns about fetal wellbeing and the neonate born in an unexpectedly poor condition. Delay in transfer under these circumstances may have serious consequences. Owing to poor collection of maternity data, the comparative statistics for women being transferred in labour are unclear. Higher transfer rates are associated with nulliparity.^{13,14,19,28} The discussion with women regarding their potential transfer in labour should include consideration of the distance between birth settings and of other local circumstances which may introduce delay in transfer.

3. Achieving best practice

- 3.1 Both the RCM and the RCOG believe that to achieve best practice within home birth services it is necessary that organisations' systems and structures are built to fully support this service. These will include developing a shared philosophy, fostering a service culture of reciprocal valuing of all birth environments.
- 3.2 Comprehensive involvement by local multidisciplinary teams and users to underpin home birth practices within a clinical governance framework results in a quality service which demonstrates commitment to supporting women in their choices.^{4–6} Equally, it supports the development of responsible and responsive practices that are maintained by effective clinical decision making.

4. Provision of information, informed choice and user involvement in planning the services

- 4.1 The key principles include providing unbiased information on birth environment options and being transparent about the potential advantages or disadvantages of home birth.^{14,29–33} Written information regarding place of birth should be available for all women, all women should be encouraged to participate actively in the full range of antenatal care and women can make the choice for a particular place of birth at any stage in pregnancy.¹⁴
- 4.2 The support for women's choices is linked to clinical assessments during pregnancy and labour, to update the care pathway.¹² It is acknowledged that there are no known risk assessment tools which have an effective predictive value concerning outcomes in the antenatal period and labour.^{34,35}
- 4.3 Home birth provision should take into account women's individual needs, especially women from socially excluded, disadvantaged and minority backgrounds,^{4,36–38} as they are less likely to access services or to ask for home births

- 4.4 The involvement of fathers/partners in planning and attending home birth is encouraged as pregnancy and birth are the first major opportunities to engage fathers/partners in the appropriate care and upbringing of their children.⁴

5. Continuity and communication

- 5.1 Continuing communication between health professionals, women and their families is requisite for continuity of care. 'A midwife providing care to women, regardless of the setting, must take care to identify possible risk and pre plan to mitigate those risks through her approach to care, knowledge of local help systems and communication with colleagues and the woman and her family'.¹⁵ Planned referral pathways in pregnancy are designed to facilitate effective communication and feedback at all levels and with any agency involved in providing care.
- 5.2 UK maternity policies recognise that, for the majority of women, pregnancy and childbirth are normal life events and that promoting women's experience of having choice and control in childbirth can have a significant effect on children's healthy development.⁴⁻⁶ The improved relationships built upon continuity of care and carer can lead to considerable advantages in the promotion of breastfeeding, reduction in smoking in pregnancy and improved nutrition for women.
- 5.3 Continuity of care is a complex concept as it can mean continuity of care from a team of midwives or continuity of carer by a single known midwife. Organisations need to explore ways of promoting home births within these care schemes, especially for socially excluded women.³⁶⁻³⁹
- 5.4 Another aspect in ensuring effective communication is clear and detailed documentation of the care plan for home birth.^{32,36}

6. Service structure support

- 6.1 The recent recruitment and retention problems of midwives within the maternity services have led to some NHS trusts withdrawing home birth services or informing women at the last minute that staff are not available. For women to believe throughout their pregnancy that they will have a home birth and for this option to be withdrawn late in pregnancy or in labour is not acceptable and will lead to further pressure on labour wards and midwives, as they have to manage women who are disaffected by the service at the start of their labour. Any possibility of not being able to provide the service should be highlighted in early pregnancy.
- 6.2 It is essential that formal local multidisciplinary arrangements are in place for emergency situations, including transfer in labour and midwives referring directly to the most senior obstetrician on the labour ward and/or to the paediatrician. The midwife is responsible for transfer and must remain to care both for the woman and the baby during transfer and, where possible, continuing on in the transferred unit. These protocols need to encompass the independent practitioners providing home birth service. The use of 'flying squads' is no longer supported and in the event of an emergency, transfer in is the only option.
- 6.3 Other agencies have an integral role in the collaborative management of home birth services, particularly the regional ambulance service. Therefore, developing a service agreement with these agencies will provide an improved risk management framework; for example, in the event of emergency transfer ambulances should take women to the consultant obstetric unit rather than the accident and emergency department. Babies need to be transferred to maternity units where there are appropriate neonatal services.

- 6.4 The clinical and personal safety of the midwife practitioner at home birth requires extra resources. For example, it is the employer's responsibility to set minimum agreed levels of equipment for carrying out the role, including equipment for communication.^{33,40} In addition, midwives working alone in the community should have appropriate lone-worker arrangements provided by their local NHS trust or employer.
- 6.5 Midwifery supervision is integral to any midwifery practice and all organisations must ensure that there are adequate numbers of supervisors of midwives to ensure 24-hour access.⁴¹ Where a woman has a risk factor which may deem her unsuitable for a home birth it is advisable that the midwife involves a manager and supervisor of midwives.

7. Skills and competencies

- 7.1 Midwife practitioners must be competent within the home birth environment and may require enhancement or updating of their existing midwifery skills prior to providing home birth services.¹⁵ Midwives' personal accountability for only undertaking duties for which they have competencies, is governed by *Midwives' Rules and Standards*.⁴¹ The organisation's responsibility is to provide resources for acquiring new or maintaining existing skills associated with home birth practices, both linked to facilitating and observing physiological labour, as well as acting on emergencies. The mandatory 'drills and skills' training must include environments outside labour ward and simulation models should be available to encourage practising of skills. Up-to-date registers should be kept of those participating in skills drills to ensure that all staff participate regularly in a rolling programme.⁴²
- 7.2 The advanced courses in obstetric emergencies and neonatal resuscitation require adequate funding for further training.
- 7.3 Risk assessment must take place with what limited tools are available. Careful selection of low-risk maternities is important to minimise complications. Ideally, this should be by senior midwifery and obstetric staff.

8. Record keeping, audit and user surveys

- 8.1 Contemporary and accurate record keeping is vital; as for all aspects of health care.^{33,41,43} The health records maintained on various sites need to be stored as a complete set and most organisations now require computer input for the birth records and obtaining the baby's NHS number. These computer programmes aid auditing practices, both personal and organisational. Areas of service or practice for audit should include home birth, transfer and intervention rates as a minimum. User satisfaction surveys and focus groups need to be linked with home birth services. There should be robust clinical governance systems for monitoring the quality of home birth services. These should include both qualitative and quantitative audit data. Consideration should be given to women's experiences, stories, transfer rates, ambulance response times and emergency scenarios. In the case of serious adverse outcome a detailed root cause analysis should be undertaken.⁴²

9. Conclusion

- 9.1 The RCM and RCOG support the provision of home birth services for women at low risk of complications. If the service is provided by midwives committed to this type of practice within continuity of care schemes and appropriately supported, outcomes are likely to be optimal. Services need evidence-based guidelines, where possible. Good communications, adequate training and emergency transfer policies are vital.

References

1. Wiegers TA, Keirse MJ, Van der Zee J, Berghs GA. Outcome of planned home birth and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands. *BMJ* 1996;313:1309–13.
2. Olsen O. Meta-analysis of the safety of the home birth. *Birth* 1997;24:4–13.
3. Ogden J, Shaw A, Zander L. Deciding on a home birth: help and hindrances. *Br J Midwifery* 1997;5:212–15.
4. Department of Health. *The National Service Framework for Children and Young People. Maternity Services*. Standard 11. London: Department of Health; 2004 [www.dh.gov.uk/assetRoot/04/09/05/23/04090523.pdf].
5. Welsh Assembly Children's Health and Social Care Directorate. *National Service Framework for Children, Young People and Maternity Services in Wales*. Cardiff: Welsh Assembly Government; 2005 [www.wales.nhs.uk/sites/documents/441/ACFD1F6.pdf].
6. Scottish Executive. *A Framework for Maternity Services in Scotland*. Edinburgh: Scottish Executive; 2001 [www.scotland.gov.uk/library3/health/ffms-00.asp].
7. Department of Health. *Changing Childbirth: Report of the Expert Maternity Group*. London: HMSO; 2003.
8. Department of Health and Social Security. Standing Maternity and Midwifery Advisory Committee (Chairman J. Peel). *Domiciliary midwifery and maternity bed needs*. London: HMSO; 1970.
9. Campbell R, Macfarlane A. *Where to be Born: the Debate and the Evidence*. Oxford: National Perinatal Epidemiology Unit; 1987.
10. Tew M. *Safer Childbirth? A Critical History of Maternity Care*. 2nd ed. London: Chapman and Hall; 1998.
11. Demilew J. Homebirth in urban UK. *MIDIRS Midwifery Digest* 2005;15:4(Suppl 2).
12. Edwards N. *Choosing a Home Birth*. London: Association for Improvements in the Maternity Services; 1994.
13. Chamberlain G, Wraight A, Crowley P. *Home Births: The Report of the 1994 Confidential Enquiry by the National Birthday Trust Fund*. Carnforth: Parthenon; 1997.
14. National Childbirth Trust. *NCT Home Birth In the United Kingdom*. London: NCT; 2001.
15. Nursing and Midwifery Council. *Midwives and Home Birth*. NMC Circular 8–2006. London: NMC;2006 [www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1472].
16. Springer NP, Van Weel C. *Home birth*. *BMJ* 1996;313:1276–7.
17. Olsen O, Jewell MD. Home versus hospital births. *Cochrane Database Syst Rev* 1998;(3):CD000352.
18. Northern Region Perinatal Mortality Survey Coordinating Group. Collaborative survey of perinatal loss in planned and unplanned home births. *BMJ* 1996;3:371–5.
19. Davies J. The Midwife in the Northern Regions Home Birth Study. *Br J Midwifery* 1997;5:219–24.
20. Confidential Enquiry into Stillbirths and Deaths in Infancy. *5th Annual Report. Focus group place of delivery*. London: Maternal and Child Health Research Consortium; 1998.
21. Viisainen K. Negotiating control and meaning: home birth as a self-constructed choice in Finland. *Soc Sci Med* 2002;52:1109–21.
22. Andrews A. Home birth experience 2:births/postnatal reflections. *Br J Midwifery* 2004;12:552–7.
23. Munday R. Women's experience of the postnatal period following a planned home birth; a phenomenological study. *MIDIRS Midwifery Digest* 2004;13:371–5.
24. O'Brien M. Home and hospital: a comparison of the experiences of mothers having home and hospital confinements. *J R Coll Gen Pract* 1978;28:460–6.
25. Goldthorp WO, Richman J. Maternal attitudes to unintended home confinements: a case study of the effects of the hospital strike upon domiciliary confinement. *Practitioner* 1974;212:818–53.

26. Alment EA, Barr A, Reid M, Reid JJ. Normal confinement: home or hospital? The mother's preference. *BMJ* 1967;I:52–53.<<only ref found is: Alment EA, Barr A, Reid M, Reid JJ. Normal confinement: a domiciliary and hospital study. *Br Med J.* 1967 May 27;2(5551):530–5.>>
27. Paddison J. *Home Birth a Family Affair: A Qualitative Research Case Study of Home Birth and Social Boundaries*. Wigtownshire: Impart Publishing; 2005.
28. Campbell R, Macfarlane A. *Where to be Born? The Debate and the Evidence*. 2nd ed. Oxford: National Perinatal Epidemiology Unit, 1994.
29. Emslie MJ, Campbell MK, Walker KA, Robertson S, Campbell A. Developing consumer-led maternity services: a survey of women's views in a local healthcare setting. *Health Expectations* 1999;2:195–207.
30. Hundley V, Rennie AM, Fitzmaurice A, Graham W, Van Teijlingen E, Penney G. A national survey of women's views of their maternity care in Scotland. *Midwifery* 2000;16:303–13.
31. Singh D, Newburn M. *Access to Maternity Information and Support: the needs and experiences of pregnant women and new mothers*. London: National Childbirth Trust; 2000.
32. Royal College of Midwives. *Home Birth Hand Book: Volume 1: Promoting Home Birth*. London: RCM; 2002.
33. Royal College of Midwives. *Home Birth Hand Book: Volume 2: Practising Home Birth*. London: RCM; 2003.
34. Enkin MW, Keirse MJ, Renfrew MJ, Neilson JP. *A Guide to Effective Care in Pregnancy and Childbirth*. 2nd ed. Oxford: Oxford University Press;2000. p. 52.
35. Campbell R. Review and assessment of selection criteria used when booking pregnant women at different places of birth. *Br J Obstet Gynaecol* 1999;550–6.
36. Hutchings J, Henty, D. Caseload practice in partnership with Sure Start: changing the culture of birth. *MIDIRS Midwifery Digest* 2002;(Suppl 1):538–40.
37. Sandall J, Davis J, Warwick C. *Evaluation of the Albany Midwifery Final Report*. London: Florence Nightingale School of Midwifery, King's College; 2001.
38. Royal College of Midwives. *Making Maternity Services Work for Black and Minority Ethnic Women: A Resource Guide for midwives*. London: RCM; 2004.
39. Hodnett ED. Continuity of caregivers for care during pregnancy and childbirth. *Cochrane Database Syst Rev* 2000;(2):CD000062.
40. Royal College of Midwives. *Safety for Midwives Working in Community*. Position Paper 12. London: RCM; 1996.
41. Nursing and Midwifery Council. *Midwives Rules and Standards*. London: NMC; 2004 [www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=169].
42. National Health Service Litigation Authority. *Clinical Negligence Scheme for Trusts, Maternity. Clinical Risk Management Standards*. London: NHSLA; 2007 [www.nhs.uk/NR/rdonlyres/F8184718-3AF9-400E-A3F3-5D9309E2AA72/0/CNSTMaternityClinicalRiskManagementStandardsApril2007website.pdf].
43. Royal College of Midwives. *Litigation: A Risk Management Guide for Midwives*. 2nd ed. London: RCM Trust; 2005

This statement was produced on behalf of the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives by:

Miss JL Cresswell FRCOG, Chesterfield, and Ms E Stephens RM

and peer reviewed by:

Ms J Demilew, Ms C Dowling, Dr MCM Macintosh MRCOG, Ms P McConn, Dr MP Mohajer FRCOG,

Mr RJ Porter FRCOG and Mr PJ Thompson FRCOG.

The final version is the responsibility of the RCM and the RCOG.

Valid until April 2010 unless otherwise indicated.