Oxford University Hospitals NHS
NHS Foundation Trust

Midwife Led Unit (MLU) and Homebirth (HB) Booking and Referral Criteria Guideline

Category:	Guideline
Summary:	This document provides clinical guidance for maternity staff who are involved in caring for pregnant women accessing the Oxford University Hospitals NHS Foundation Trust (OUHFT) who plan to birth at home or in an MLU.
Equality impact assessed:	30/06/2023
Valid from:	22/11/2023
Date of next review:	23/07/2026
Approval date/ via:	Prospective update ahead of noting at Maternity Clinical Governance Committee (MCGC) on 27/11/2023
Related documents:	Maternal Transfer by Ambulance Guideline Antenatal Care guideline Handover of Care Guideline GBS Guideline
Author(s):	Consultant Obstetrician Community Matron Consultant Midwife Spires MLU Lead
Clinical lead:	Consultant Midwife
Further information:	
This document replaces:	MLU and HB Booking and Referral Criteria v4.0 – valid from 26/07/2023

This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.
This document contains many hyperlinks to other related documents.
All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Version valid from	Version number	Reason for review/update
22/11/2023	4.1	Appendix 7: Ambulance Transfer from MLUs and Home to Hospital At a Glance graphic on page 20 updated. Number to be used for Level 1,2,3 and 4 transfers is: **0300 123 9826**

26/07/2023	4.0	3 Yearly review and update (including recent updates in previous v3.2)
29/06/2023	3.2	PROM and meconium updates

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Document Review Group (DRG)	Review and approval ahead of MCGC
Consultant Midwife	Review
Oxford Maternity Voices Partnership	Service User review

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Who should read this document?

1. This document should be read by all maternity staff involved in providing antenatal care for women accessing the OUHFT.

Gender inclusive language in OUH Maternity and Perinatal Services:

- This guideline uses the terms woman, women and mother throughout. These terms should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term parent(s) is used, this should be taken to include anyone who has main responsibility for caring for a baby.
- The term partner refers to the woman's chosen supporter. This could be the baby's father, the woman's partner, a family member or friend, or anyone who the woman feels supported by and wishes to involve in their care.

Key Standards/Messages

- **PROM update to align with Care in Labour Guideline and Intrapartum EFM guideline:** If on Spires, IV antibiotics at 18 hours post confirmed SROM can be commenced, and fetal wellbeing monitored via IA for women progressing in established labour with no other concerns.
- New guidance on meconium liquor added on page 8
- **Escalation of Obstetric or Neonatal Emergency on the Spires** (see page 8).
- If the woman is transferred from an MLU for obstetric concerns, they should have an obstetric review within 1 hour of arrival on Delivery Suite.
- Women on pathway D with normal fetal growth and blood pressure and who have a combined PI (pulsatory index) value of <3 at the 20-week ultrasound scan can birth on the Spires.
- Updated Homebirth and Freestanding Midwifery Led Unit (FMLU) Assessment Forms should be completed during birth setting discussions for women choosing to birth in an FMLU or at home (see Appendix 8 on page 21 and Appendix 9 on page 26). Once completed, the assessment form should be signed and dated by the Midwife and filed in the woman's handheld notes.
- Maternity Ambulance Transfer Times added as Appendix 10 (on page 31).
- For urgent transfers from the Spires, FMLUs and Homebirths – the number for the 'red' phone on Delivery Suite should be used (external: 01865 462 427/internal: 62427) and reason/need for transfer should be discussed with the DS coordinator.

- All women should be given the Birthplace Choices leaflet at booking.

- If a woman requests care that is outside of Trust guidance, they should be referred to Birth Choices Clinic by selecting the 'communicate' function on EPR (select 'pool' then 'mat' – Birth Choices Clinic can then be found in the drop-down list).

- Transfer to hospital for mother and/or baby can be achieved by calling:
  - **(New in v4.1)** 0300 123 9826 for Level 1 Immediately life-threatening conditions
  - 0300 123 9826 for Level 2 emergency transfer
  - 999 for paramedic support.
  - If both mother and baby need medical aid then 2 ambulances will be required.

- Women should be assessed for the risk of PPH at 34 weeks gestation. PPH risk should also be assessed as part of the suitability for an MLU birth/Homebirth (see PPH Guideline).

- If a moderate/major risk of PPH is identified, an ANC clinic appointment should be arranged for discussion of birth planning to take place.

- VTE risk should be assessed antenatally and throughout the intrapartum period. A postnatal intermediate risk/score of ≥ 2 requires thromboprophylaxis to be prescribed and offered to the woman.

- Women from an MLU/home birth setting who require obstetric care/input should be transferred to the appropriate care setting (either delivery Suite or Observation area according to clinical need/situation).

- All women should have place of birth discussed at booking, 28wks and a plan documented in their antenatal record by 36 weeks gestation

Background/ Scope

2. NICE recommended that women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. The Birthplace study (2011) findings support a policy of offering healthy nulliparous and multiparous women with low-risk pregnancies a choice of birth setting. The study found that women with planned births at home or in freestanding or alongside midwifery units were significantly less likely than those with planned births in obstetric units to have an instrumental or operative delivery. They were also less likely to receive medical interventions such as augmentation, epidural or spinal analgesia, general anaesthesia or episiotomy and significantly more likely to have a normal birth.

3. Adverse perinatal outcomes were uncommon in all settings. However, for nulliparous women, there is some evidence that planning birth at home is associated with a higher risk of an adverse perinatal outcome and a substantial proportion of women having their first baby who plan to give birth in a non-obstetric unit setting are transferred to an obstetric unit.

4. This guideline applies to all pregnant women cared for by the Oxford University Hospitals NHS Foundation Trust (OUHFT) who plan to birth at home or in an MLU.

Key Updates

- **(New in v4.1)** Appendix 7: Ambulance Transfer from MLUs and Home to Hospital At a Glance graphic on page 20 updated:

  Number to be used for Level 1,2,3 and 4 transfers is:
  0300 123 9826

- **PROM update to align with Care in Labour Guideline and Intrapartum EFM guideline:** If on Spires, IV antibiotics at 18 hours post confirmed SROM can be commenced, and fetal wellbeing monitored via IA for women progressing in established labour with no other concerns.

- New guidance on meconium liquor added on page 8

Aim(s)

5. This guideline gives advice to midwives and obstetricians on the care and management of women planning to and giving birth at home or in a Midwife Led Unit (MLU).

Full Guideline

Booking and Referral Criteria for Midwife Led Units (excluding spires*) and Homebirth

6. As long as there are no other indication for cEFM:

- Women booked for Midwife Led Care with no medical conditions or previous obstetric complications (see referral criteria appendix 2 in the Antenatal Care guideline)
- Over 16 years and:
  - primiparous women who are less than 40 years old at booking
  - multiparous women who are less than 45 at booking
- Women having 1st to 4th baby (inclusive)
- Pregnancy of 37 – 42+0 weeks (at onset of labour)
- Singleton pregnancy
- Hb ≥ 100 g/l at term *
- Previous third-degree tear with no sequela; recommend birth out of the pool
- IVF pregnancy with no other contraindications
- Women on pathway D with normal fetal growth and blood pressure and a combined PI (pulsatory index) value of <3 at the 20-week ultrasound scan.

BMI: *

- Primiparous women with BMI 18 to 35kg/m^2
- Multiparous women 18 to 40kg/m^2

7. All women wishing to use the birth pool should be individually risk assessed to ensure that they can enter and exit the pool independently; this is particularly important for women with a raised BMI.

*Extended Criteria for Birth on the Spires MLU

- Post-dates women undergoing IOL, with no additional risk factors, who establish in labour and do not require oxytocin infusion to augment contractions
- Previous PPH 1000mls or less with no additional risk factors; to have actively managed 3rd stage out of the birthing pool
- Group B Streptoccoccus Infection – see flowchart for women with GBS wishing to birth on the Spires (appendix 5 in Care of Women in labour).
- BMI 40kg/m^2 or less (primiparous and multiparous women – however active management of 3rd stage is strongly recommended especially in women with BMI less than 18kg/m^2)
- Hb 90g/l or more at term (however active management of 3rd stage is strongly recommended)
- Platelet levels above 100 x10^{9}per litre
- Prolonged rupture of membranes > 24 hours unless any concerns/signs of infection (see Care in Labour Guideline).

Women under consultant care

8. Following an individual risk assessment by their Consultant Obstetrician women under consultant care for additional surveillance during pregnancy but with no additional intrapartum risk factors may birth in one of the community MLUs or the Spires. There needs to be clear documentation of antenatal discussion and plan for place of birth in the woman's health record and on EPR.

Women requesting a MLU birth setting who are outside of the MLU admission criteria

9. The Community Midwife should discuss options of place of birth with the woman.
10. Advice and recommendation for place of birth should be documented in the woman's maternity record and on EPR.
11. The Community midwife should discuss ongoing care planning with line manager, Community Matron or Consultant Midwife (in Birth Choices Clinic).
    If concerns remain unresolved refer to Birth Choices Clinic and/or Consultant Obstetrician if there are obstetric issues
12. Document a clear record of antenatal discussion on recommendation for place of birth and a plan of care and record on EPR in a Birth Planning Note.

Intrapartum Transfer Criteria from an MLU for obstetric opinion or care in labour:

- Maternal choice
- Maternal request for analgesia i.e. an epidural
- Fetal heart rate abnormalities
- Diagnosed delay in the first or second stage of labour
- Pain reported by the woman that differs from the pain normally associated with contractions
- Any vaginal blood loss other than a show
- Malpresentation/ high (4-5/5 palpable) or free-floating head in primiparous woman
- Obstetric emergency
- Maternal haemorrhage > 500mls (consideration symptomatic
- Retained placenta (see care of women in labour guideline)
- Third or fourth degree perineal tear
- Any concerns regarding maternal, fetal or neonatal wellbeing
- A baseline ≥ 150bpm at ≥ 40 weeks gestation is a concerning feature; this may be due to secondary infection or fetal hypoxia – therefore continuous electronic fetal monitoring (CEFM) should be offered (see Intrapartum Electronic fetal monitoring Guideline).

Meconium stained liquor (MSL):

- If meconium-stained liquor is identified, consider the character of the meconium as part of the overall clinical assessment, in conjunction with other antenatal or intrapartum risk factors.

- Fetal hypoxia and acidosis can result in increased peristalsis and relaxation of the fetal anal sphincter, leading to the passage of meconium. If a fetus attempts to breathe or gasp this meconium can then be aspirated into the lungs. Births where meconium-stained liquor is present are associated with increased frequency of operative delivery, birth asphyxia, neonatal sepsis and neonatal intensive care unit admissions compared with clear liquor.

- Prior to 40 weeks gestation, meconium-stained liquor should be treated with extra caution and should trigger a full risk assessment and discussion with the woman.

- The presence of meconium-stained liquor in a labour with a fetus of equal to or more than 40 weeks gestation is not always indicative of fetal compromise and can be a normal physiological event but should still trigger a full risk assessment and discussion with the woman.

- When meconium is identified, inform the woman and discuss:
    - the presence of meconium, which can indicate possible fetal compromise and may lead to complications such as meconium aspiration syndrome and fetal hypoxia. . Meconium-stained liquor can also present an infection risk. While clear liquor has antibacterial properties, in the presence of meconium these properties are restricted.
    - that continuous CTG monitoring is offered (and strongly recommended in the presence of significant meconium)
    - place of birth
    - access to advanced neonatal services

- post birth neonatal observations.

- Document this discussion in the clinical record.

- Recognise that the type of monitoring method used is the woman's choice and support her decision. If the decision is made to monitor the fetal heart rate via intelligent intermittent auscultation (IIA) in labour, then extra vigilance should be undertaken for signs of infection, fetal hypoxia and evolving risk factors.

SROM over 18 hours

- **(New in v4.0)** If on Spires, IV antibiotics at 18 hours post confirmed SROM can be commenced and fetal wellbeing monitored via IA for women progressing in established labour with no other concerns.

- **(New in 4.0)** 1-to-1 midwifery care should be provided as usual for women in established labour. This is particularly important in this group of women (with SROM over 18 hours), so that any evolving signs of infection can be detected at the earliest opportunity and transfer to Delivery Suite for obstetric review and cEFM can be arranged.
- Transfer to Delivery Suite is recommended if:
  - MEOWS score ≥ to 1
  - Any clinical signs of infection
  - Any meconium-stained liquor is present
  - Delay in progress of labour
  - Any fetal heart rate concerns

Maternal pyrexia:

- A temperature of 38˚C or more on 1 occasion
- 2 temperature readings of 37.5˚C to 37.9˚C, 1 hour apart

Maternal tachycardia:

- Above 120bpm on two consecutive readings, ½ hr apart

Raised blood pressure:

Diastolic 90 to 99mmHg	On two consecutive readings, ½ hr apart
Diastolic 100mmHg or above	On one occassion
Systolic 140 to 159mmHg	On two consecutive readings, ½ hr apart
Systolic 160mmHg or above	On one occassion
An increase in reading from 1st trimester of at least 20mmHg diastolic or at least 30mmHg systolic	On two consecutive readings, ½ hr apart

Proteinurea

- A reading of 2+ protein on urinalysis

  and

- a single reading of either raised diastolic blood pressure (90mmHg or above) or raised systolic blood pressure (140mmHg or above).

Intrapartum transfer of a woman and/or baby from the Spires MLU to Delivery Suite

13. When transferring a woman from the Spires MLU to Delivery Suite the following procedure should be followed:

- Discuss the need for transfer clearly with the woman, gain consent and document accordingly in the notes
- Use the urgent transfer number for the 'red' phone on Delivery Suite (external: 01865 462 427/ internal: 62427) and discuss the need for transfer with the Delivery Suite Coordinator – ensure a room is clearly allocated to the woman. Inform the bleep holder of the transfer and ensure the Spires is left with adequate and safe cover whilst you are away from the unit
- Inform colleagues of the transfer and arrange any temporary cover of care if necessary
- Arrange handover of the unit keys to an appropriately qualified colleague
- Transfer the woman either on the bed, wheelchair or they may choose to walk– choose whichever mode is most appropriate for the situation
- If a baby is accompanying a woman to Delivery Suite, then it should have two identity name bands attached
- Transfer down via the right hand lift (M4) opposite the refuse collection point
- The lift override key is located on the adult resuscitation trolley on Level 7
- When you arrive on Delivery Suite
    - Hand over care using the SBAR tool, see Handover of Care Guideline
    - Ensure the Coordinator is fully informed of the woman's condition and plan of care
    - Write the woman's details on the Delivery Suite whiteboard, and put the woman's ID sticker in the admissions book with details of her time of arrival, pregnancy and labour details
    - **(New in v3.1)** If the woman is transferred from an MLU for obstetric concerns, they should have an obstetric review within 1 hour of arrival on Delivery Suite.

- All transfers on the incident trigger list will need an incident form (Ulysses) to be completed
- Complete Spires transfer audit form

(New in v3.1) Escalation of Obstetric or Neonatal Emergency on the Spires

14. Upon recognition of obstetric and/or neonatal emergency on the Spires the following procedure should be followed:

- **Pull emergency bell**
    - When extra staff arrive start to delegate clinical tasks to manage the emergency accordingly.

- Request that a member of staff makes appropriate 2222 (or 4444) call (see poster by the phone in Spires office for guidance on the verbal communication needed to inform switchboard):
  - Call 2222 when the Obstetric, Neonatal or Adult Team is required
  - Call 4444 to activate the major obstetric haemorrhage (MOH) protocol, to call Security or to fast bleep a member of staff (4444 should also be called in the event of a fire).

- **When calling be clear about which team is required – Obstetric/Adult and/or Neonatal and include details of the exact location they should attend - room number/name etc)**.
- The staff member making the 2222 (or 4444 call) should report back to lead midwife managing the emergency that call has been actioned.
- If possible, delegate appropriate member of staff to wait at the entrance to Spires to direct attending emergency teams to the correct room
- Request that a member of staff prepares the resuscitaire and brings back the appropriate the emergency equipment into the room

- Follow the emergency protocol as per OUH guidance according to nature of the emergency.
- Ensure appropriate member of staff retains situational awareness/helicopter view of situation.
- Delegate appropriate member of staff to scribe ensuring contemporaneous documentation when possible
- Ensure SBAR handover to relevant professionals on arrival to room.

- **If there is an unanticipated delay in team arriving or lack of staff to help, repeat above steps and in addition phone Delivery Suite to escalate. Continue to provide emergency care to woman and baby until help arrives.**

- If the emergency is downgraded, ensure clear plan of care from relevant clinician is made and documented.

- If transfer of the woman is required follow the procedure below:

Transfer of a Woman and/or Baby from Homebirth or Community MLU to a Consultant Delivery Suite (New Ambulance transfer information)

- inform the Co-coordinator on Delivery Suite of the situation prior to transfer using the urgent transfer number for the 'red' phone on Delivery Suite (external: 01865 462 427 / internal: 62427)

- Transfer to hospital for mother and/or baby can be achieved by calling:
  - **(New in v4.1)** 0300 123 9826 for Level 1 Immediately life-threatening conditions
  - 0300 123 9826 for Level 2 Emergency transfer
  - 999 for paramedic support
  - If both mother and baby need medical aid then 2 ambulances will be required.
    Refer to the Maternity Transfer by Ambulance Guideline for full details.

- A midwife must accompany all transfers in established labour by ambulance into hospital
- If a baby is accompanying a woman to hospital then it should have two identity name bands attached and be transported in a car seat
- The reasons and time for transfer need to be documented in the maternal notes along with any discussions with the couple
- (New 3.0) Complete Ambulance Transfer form (see Maternity Transfer by Ambulance Guideline)
- Enter details of transfer onto transfer spreadsheet located in the Maternity Patient Tracking folder on Microsoft Teams
- If a woman is declining transfer inform the coordinator on Delivery Suite along with the Manager on call. All relevant discussions and the woman's viewpoint should be clearly documented.
- When you arrive on Delivery Suite
  - Hand over care using the SBAR tool, see Handover of Care Guideline
  - Ensure the Coordinator is fully informed of the woman's condition and plan of care
  - Write the woman's details on the Delivery Suite whiteboard, and put the woman's ID sticker in the admissions book with details of her time of arrival, pregnancy and labour details
- Submit an incident report (Ulysses) for any untoward incident eg. BBA, obstetric emergencies
- Take the carbon copy of the completed Ambulance Transfer form back to the MLU/Team Lead.

Review

15. This guideline will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents.*

16. *N.B.Policies may need to be revised before this date, particularly if national guidance or local arrangements change, where implementation is unsuccessful or where audits necessitate a policy review.*

17. If the approving committee of the policy has delegated the authority to approve supporting documents to another group, this should be documented here. E.g. The Trust Management Executive has delegated authority to the Health & Safety Committee for the approval of any further supporting or associated documents.

EPR Considerations – this section will become obsolete when BadgerNet goes Live

18. All documentation regarding specific, individualised birth plans should be recorded on EPR as a Note/Birth Plan to aid communication between members of the MDT.

Implementation Plan

No.	Recommendation for Implementation	Action to be taken	Evidence of Action	Responsible Person	Date Action to be completed by	R.A.G. Action completion status[2]
1	Raise awareness of updates to guideline	Include in Monthly Guidelines Updates Table	- Email Circulating Monthly Guidelines Updates Table to all maternity Staff	Quality Team	Within 1 month of guideline being uploaded to the maternity intranet	
2	Raise awareness of updates to guideline	Mention in Maternity News	Publication and circulation of Maternity News	Quality Team	Within 1 month of guideline live date	

References

Birth Place in England Collaborative Group (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;343:d7400
http://www.bmj.com/content/343/bmj.d7400.pdf%2Bhtml (accessed 04/07/2023)

National Institute for Clinical Excellence (2014) Intrapartum care of healthy women and their babies during childbirth. (Updated 14/12/2022)
www.nice.org.uk/guidance/cg190 (accessed 04/07/2023)

Appendix 1: Responsibilities

1. It is the responsibility of all maternity clinical staff involved in providing intrapartum care to for women in an MLU or home birth setting to familiarise themselves with the location and content of this guideline.

Appendix 2: Definitions

Term	Definition
BBA	Born before arrival
BMI	Body Mass Index
cEFM	Continuous Electronic fetal heart monitoring
HB	Homebirth
IA	Intermittent Auscultation
MLU / FMLU	Midwife Led Unit / Free Standing Midwife Led Unit
MoB	Mode of Birth
MSL	Meconium-stained liquor
PPH	Post-partum haemorrhage
SROM/PROM	Spontaneous rupture of membranes/Prolonged rupture of membranes
VBAC	Vaginal birth after Caesarean Section

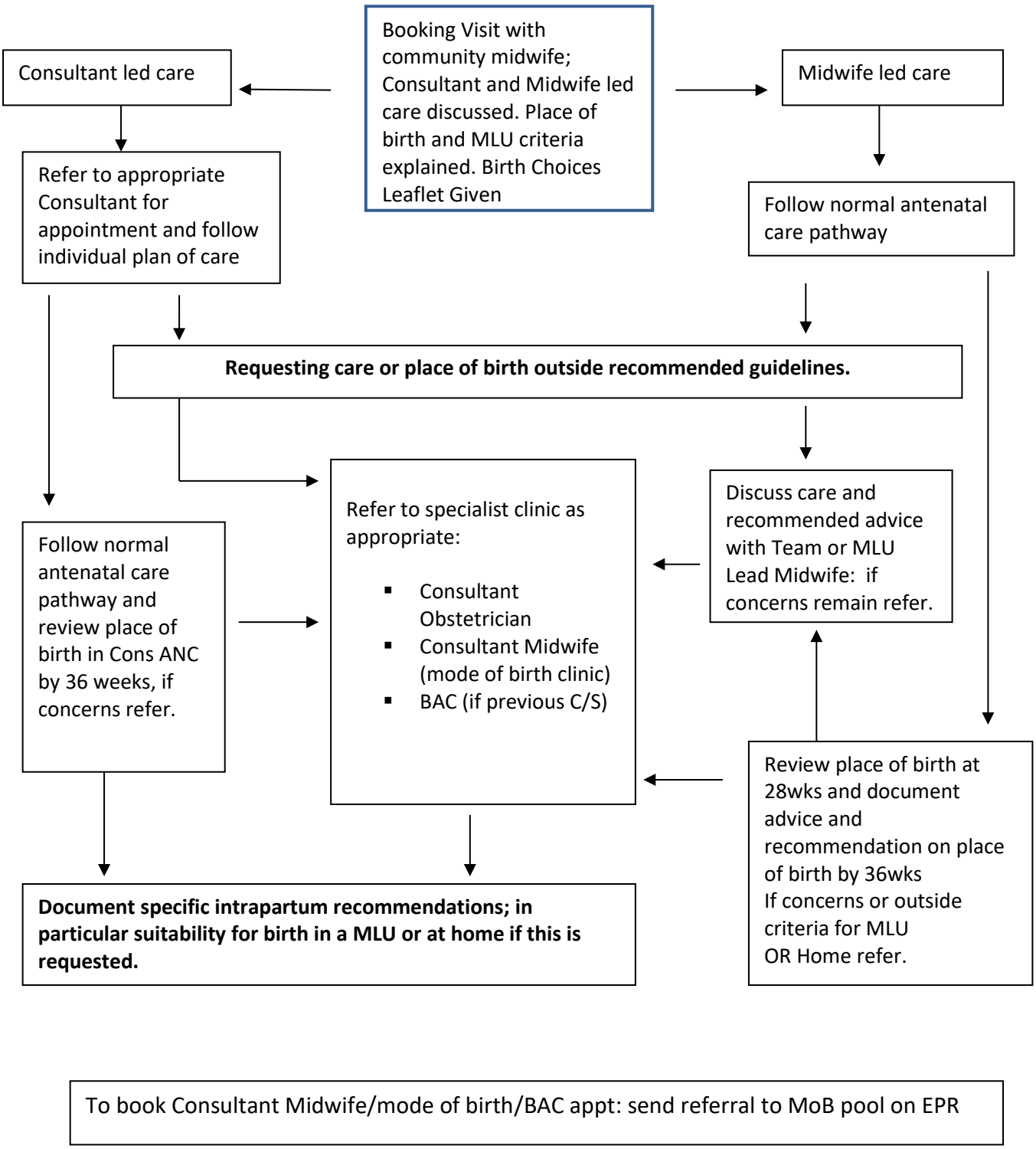
Appendix 3: Education and Training

1.1. 1. There is no mandatory training associated with this policy. Individual training needs will be identified through annual appraisal and supervision.

Appendix 4: Monitoring Compliance

Compliance Standard	Monitoring method	Frequency of monitoring	Group or committee that will review the findings and monitor completion of any resulting action plan
All homebirth and MLU intra-partum transfers to be audited/reviewed	MLU and community audit	3 yearly	Intrapartum Group

Appendix 5: Antenatal Pathway for Choice of Place of Birth



To book Consultant Midwife/mode of birth/BAC appt: send referral to MoB pool on EPR

Appendix 6: Level 1 and Level 2 Transfer Criteria (To be used in conjunction with clinical assessment and current stage of labour)

Level 1 – Immediately life-threatening (Expected response time 7 minutes) *Next available ambulance, will divert from cardiac arrest*	**Level 2 – Emergency transfer** (Expected response time 18 minutes)	**Own Car**
• Obstetric emergency- including APH, PPH, cord prolapse, maternal seizure or collapse, shoulder dystocia, breech presentation or the need for resuscitation • Delay in second stage of labour with fetal distress • Moderate/severe Pain reported by the woman that differs from pain normally associated with labour (signs of abruption) • Concerns regarding fetal wellbeing including; ↑FHR baseline, decelerations heard on IA, inability to monitor FH adequately • Any presentation other than cephalic, including cord presentation • A single reading of either raised diastolic BP ≥100mmHg or systolic BP ≥160 mmHG.	• Pulse ≥ 120bpm on 2 occasions 30 minutes apart • Either raised diastolic BP ≥90mmHg or raised systolic ≥140mmHg on 2 consecutive readings taken 30 minutes apart • A Single BP reading of raised diastolic ≥90mmHg or raised systolic ≥140mmHg and 2+ proteinurea • Temperature ≥38°C on one occasion or ≥37.5°C on 2 consecutive readings at least 30 minutes apart • Retained placenta with no concerns for maternal compromise • Delay in 2nd stage without fetal compromise • The presence of significant meconium • Epidural request in established labour • Transfer for suturing where there are no concerns of PPH or maternal compromise (but not for transfer in own car.) • FHR not appropriate for gestation	**Mum and baby must be clinically well.** • Request by the woman for additional pain relief including an epidural prior to established labour • Slow progress during the first stage with no concerns relating to maternal or fetal wellbeing • Maternal request to transfer • Rupture of membranes ≥ 24 hours prior to established labour • Suspected fetal growth restriction or macrosomia • Suspected anhydramnious or polyhydramnious • Any risk factors recorded in the woman's notes that indicate the need for obstetric care • Either raised diastolic BP ≥90mmHg or raised systolic ≥140mmHg on 2 consecutive readings taken 30 minutes apart and asymptomatic • High (4/5- 5/5ths palpable) or free-floating head in a nulliparous woman • Reduced fetal movements reported in past 24 hours

- If there are multiple factors present from the 'Level 2' or 'own car' columns then consider undertaking a 'Level 1' transfer following a discussion with delivery suite co-ordinator. These criteria are not exhaustive; the midwife in attendance should use their own clinical judgement.

- If any of the above factors are present but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss this with the co-ordinating midwife.

- If transfer from a midwifery led unit or home is required in the 1st or 2nd stage of labour, normal labour care and IA should continue as per guidelines until transfer is in progress. If a woman is transferring by her own means of transport (as per transfer guidance) then a midwife does not need to accompany her. If transfer is via ambulance, then IA should not be undertaken during the journey as the midwife must remain seated and wear the seat belt during transfer. Upon arrival on Delivery Suite, a CTG should be commenced as soon as possible.

Appendix 7: Ambulance Transfer Contact Numbers

Ver 1.2 - November 2023

Oxford University Hospitals NHS
NHS Foundation Trust

Ambulance Transfer from MLUs and Home to Hospital

At a Glance …

LEVEL **1**

Immediately life-threatening
Obstetric emergency including APH and ongoing PPH, concerns for fetal wellbeing, presentation other than cephalic, severe hypertension, seizures, delay in 2nd stage with fetal distress, ongoing newborn resuscitation.

RESPONSE TIME WITHIN **7** Minutes

Call the Thames Valley healthcare professional line on

0300 123 9826

When ringing clearly state:
- Your name and job title
- That you require a Level 1 ambulance transfer stating situation e.g. This is an obstetric emergency for fetal distress

Cotswold	OX7 5FA	Wallingford	OX10 9LT
Horton	OX16 9AL	Wantage	OX12 7AS

LEVEL **2**

Emergency Transfers
Observations triggering on MEOWS chart, significant meconium, epidural request, delay in 2nd stage without fetal compromise, retained placenta, transfer for 3/4th degree tear repair with no maternal concerns.

RESPONSE TIME WITHIN **18** Minutes

Call the Thames Valley healthcare professional line on

0300 123 9826

For all transfers:
1. Document in the maternity notes the time calling for an ambulance and the call reference number
2. Inform the DS Co-Ordinator 01865 221987/8
3. Inform the Neonatal unit if required on SONet line 01865 223344 (manned 24 hrs)
4. Complete the SBAR ambulance transfer form recording the response times and transfer travel times.
5. Submit an incident report (Ulysses) for any untoward incident eg. BBA, Obsteric emergencies.

Appendix 8: Freestanding Midwifery Led Unit Assessment Form

Freestanding Midwifery Led Unit Assessment Form

Name: **MRN:** **Address:**

Landline/Mobile:
Primary Midwife:
Midwifery Team:
Birthing partner:
Case loading ST MW name and contact details:

Background	
Date of assessment	
Parity	
EDD	
Current gestation	
Happy for Student MW?	Yes ☐ / No ☐

Risk of PPH assessment minor/moderate/major	
Routine Enquiry	

Ultrasound	
Pathway	
Placenta	
Growth/Dopplers	
Other relevant findings	

Blood results	
Group (maternal & fetal)	
Antibodies	
Recent Hb /date taken	
Platelets	
Other relevant findings	

Booked MLC or CLC? If CLC - risk factors(s):	
Previous obstetric history including any previous poor outcome	

Special arrangements or requests	
Birth Choices review	Not required ☐ Completed ☐ To be organised ☐
Recommendation/plan	

Signature _____ Name _____ Status_____

Preparing for a birth in a Freestanding Midwife Led Unit (FMLU)

There are a few things that you will need to be aware of if you are planning a birth in a FMLU. Your Midwife will discuss these with you:

	Notes
What to pack in your hospital bag and need to bring car seat discussed	
Understanding the midwives' role (on-call rota and who might attend your birth)	
How baby's wellbeing is monitored during labour and birth (intermittent heart rate monitoring. Continuous monitoring only used on delivery suite)	
The maternal observations routinely offered in a FMLU	
Analgesia options available in labour (for example; TENs, pool, massage and aromatherapy oils, entonox and meptid). Epidurals are available on delivery suite	
Covid guidance for example the PPE midwives will be wearing	
Reasons for ambulance transfer discussed and information sheet (page 4) given to woman containing further information	
Average times given for an ambulance response and transfer into hospital (page 4)	

Preparing for a birth in a FMLU

In view of your request to birth at a FMLU, you have been booked for a 36-week appointment at the FMLU of your choice with your Midwife.

During the appointment your Midwife will discuss:

- **How to prepare for a birth in a FMLU**
- **What to do when you go into labour**
- **Reasons you might be transferred to hospital**
- **There is a possibility that due to staffing we may not be able to safely provide a FMLU birth**

NHS advice on preparing for your birth can be found at:
https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/

This webpage includes links to other useful websites and two 'Your Choice' guides explaining the current research (one for women having their first baby and one for women who have given birth before).

What to do when you go into labour

You should call the relevant Community Team if:

- You feel that you have progressed from being in early labour to being in established labour. This is usually when your contractions are:
  - Every 3 minutes - for women having their first baby.
  - Every 5 minutes - for women who have birthed before.
- Your waters break (also known as 'spontaneous rupture of membranes').
- You are not having regular contractions but feel you would benefit from an assessment and plan.
- You're unsure and need advice

Telephone numbers

Community Midwifery Team Details and telephone number (to be added below by the Midwife completing the assessment)	Daytime 9am to 4pm	Evenings and night-time (from 4pm to 9am) or if there is no answer from the daytime number
	If there is no answer please do not leave a message – call the evening/night time number (opposite)	01491 826037

A Midwife will speak to you on the telephone for you to make a plan together. If you are in early labour, the Midwife might suggest that you allow more time for your contractions to strengthen and advise that you call back.

You should call the Maternity Assessment Unit (01865 220221) if you have:

- **Concerns regarding your baby's movements**
- **Strong, constant pain anywhere in your body (e.g. head, abdomen, chest)**
- **Vaginal bleeding**
- **Symptoms that suggest you are unwell (fever, significant vomiting, etc.)**
- **Started labouring before 37 weeks**
- **If your waters have broken and you think the waters look green in colour**
- **Any other concerns**

Ambulance response times

We are given the highest level (category 1) of response for obstetric emergencies which is reserved for immediately life-threatening cases such as cardiac arrest (target response time is 7 minutes). For other emergency transfers we receive the second highest level of priority where the standard response target time is within 18 minutes from the time of the call.

Transfers from FMLU to the John Radcliffe Hospital for the period October 21 to September 22 (78% category 1 transfers)	Count of Incidents	Average Response Duration	Average Duration of Leave Scene to Arrive at John Radcliffe
Wallingford Birthing Centre	19	0:16:23	0:33:32
Horton General Hospital	7	0:04:07	0:33:55
Cotswold Birth Centre	2	0:19:31	0:33:08
Wantage Community Hospital	1	0:15:05	0:44:06
Grand Total	**47**	**0:10:56**	**0:37:17**

Reasons you might be transferred to hospital

Stage of labour	Reason
Any stage	Concerns that you or your baby are unwell (i.e. abnormal observations or possible Covid-related symptoms)
	Maternal request
	Significant bleeding
	Significant meconium (baby poo) in the waters
	Request for additional pain relief
	Waters broken over 18 hours (as per SROM guideline)
	Staff unavailability
First and second stage (dilation and pushing)	Fetal heartbeat abnormal or difficult to monitor
	Breech or other malpresentation
	Delay (e.g. cervix not opening as we would expect in labour or cervix fully dilated but baby not moving down birth canal)
	Cord prolapse
	Shoulder dystocia (dependent on severity)
Third stage (delivery of the placenta)	Retained placenta
	Postpartum haemorrhage
Fourth stage (early postnatal period)	Suturing significant or complicated tears
	Neonatal resuscitation Neonatal observations

Further discussions	

Signed: Print name: Date:

Appendix 9: Homebirth Assessment Form

Homebirth Assessment Form

Name: **MRN:** **Address:**	Landline/Mobile: Primary Midwife: Midwifery Team: Birthing partner: Case loading ST MW name and contact details:

Background	
Date of assessment	
Parity	
EDD	
Current gestation	
Happy for Student MW?	Yes ☐ / No ☐

Risk of PPH assessment minor/moderate/major	
RE	

Ultrasound	
Pathway	
Placenta	
Growth/Dopplers	
Other relevant findings	

Blood results	
Group (maternal & fetal)	
Antibodies	
Recent Hb /date taken	
Platelets	
Other relevant findings	

Booked MLC or CLC? If CLC - risk factors(s):	
Previous obstetric history including any previous poor outcome High risk of BBA Yes/No?	

Special arrangements or requests	
Birth Choices review	Not required ☐ Completed ☐ To be organised ☐
Recommendation/plan	

Signature _____ Name _____ Status_____

Preparing for a homebirth

There are a few things that you will need to prepare if you are planning a homebirth. Your Midwife will discuss these with you:

	Notes
Adequate parking and access (Midwives and ambulance)	
Adequate mobile phone signal or landline	
Hot water supply	
Childcare arrangements (for example if require transfer into hospital)	
Health and safety assessment of the home environment. Is there adequate space for equipment? Are there pets? Pool arrangements? Suitable access & space to facilitate transfer if required	
What to pack in your hospital bag and having a car seat discussed	
Understanding the midwives' role (on-call rota and who might attend your birth)	
How baby's wellbeing is monitored during labour and birth (intermittent heart rate monitoring. Continuous monitoring only used on Delivery Suite)	
Preparing the home environment: warmth (minimum 20°C), clean towels, access around bed/pool, protective coverings (incontinence sheets/heavy duty polythene), lighting	
Analgesia options available in labour (for example; TENs, pool, massage and aromatherapy oils, entonox). Epidurals are available on Delivery Suite	
What to do if labouring quickly (calling 999, staying calm, breathing through contractions/not pushing, drying baby and keeping them warm)	
Covid guidance for example the PPE midwives will be wearing	
Reasons for ambulance transfer discussed and information sheet (page 4) given to woman containing further information	

Average times given for an ambulance response and transfer into hospital (page 4)	

Preparing for a Homebirth

In view of your request to birth at home, you have been booked for a homebirth assessment with your Midwife. This assessment may have also been scheduled because you want to be prepared in the event that you may labour quickly.

During the home visit your Midwife will discuss:

- **How to prepare a homebirth**
- **What to do when you go into labour**
- **Reasons you might be transferred to hospital**
- **There is a possibility that due to staffing we may not be able to safely provide a home birth service**

NHS advice on preparing for your home birth can be found at:
https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/

This webpage includes links to other useful websites and two 'Your Choice' guides explaining the current research (one for women having their first baby and one for women who have given birth before).

What to do when you go into labour

You should call the relevant Community Team if:

- You feel that you have progressed from being in early labour to being in established labour. This is usually when your contractions are:
  - Every 3 minutes - for women having their first baby.
  - Every 5 minutes - for women who have birthed before.
- Your waters break (also known as 'spontaneous rupture of membranes').
- You are not having regular contractions but feel you would benefit from an assessment and plan.
- You're unsure and need advice

Telephone numbers

Community Midwifery Team Details and telephone number (to be added below by the Midwife completing the assessment)	**Daytime 9am to 4pm**	**Evenings and night-time (from 4pm to 9am) or if there is no answer from the daytime number**
	If there is no answer please do not leave a message – call the evening/night time number (opposite)	**01491 826037**

A Midwife will speak to you on the telephone for you to make a plan together. If you are in early labour, the Midwife might suggest that you allow more time for your contractions to strengthen and advise that you call back. When the midwives are coming to your home, please help them find it; if you have one, put a balloon on the door and turn the lights on at the front of the house.

You should call the Maternity Assessment Unit (01865 220221) if you have:

- **Concerns regarding your baby's movements**
- **Strong, constant pain anywhere in your body (e.g. head, abdomen, chest)**
- **Vaginal bleeding**
- **Symptoms that suggest you are unwell (fever, significant vomiting, etc.)**
- **Started labouring before 37 weeks**
- **If your waters have broken and you think the waters look green in colour**
- **Any other concerns**

Ambulance response times

We are given the highest level (category 1) of response for obstetric emergencies which is reserved for immediately life-threatening cases such as cardiac arrest (target response time is 7 minutes). For other emergency transfers we receive the second highest level of priority where the standard response target time is within 18 minutes from the time of the call.

Transfers from home to the John Radcliffe Hospital for the period October 21 to September 22 (78% category 1 transfers)	Count of Incidents	Average Response Duration	Average Duration of Leave Scene to Arrive at John Radcliffe
Vale of White Horse	13	0:24:30	0:33:16
Cherwell	10	0:17:35	0:26:55
Oxford	10	0:13:49	0:13:01
West Oxfordshire	7	0:30:09	0:29:34
South Oxfordshire	5	0:18:13	0:31:12
Grand Total	**45**	**0:20:46**	**0:26:19**

Reasons you might be transferred to hospital

Stage of labour	Reason
Any stage	Concerns that you or your baby are unwell (i.e. abnormal observations or possible Covid-related symptoms)
	Maternal request
	Significant bleeding
	Significant meconium (baby poo) in the waters
	Request for additional pain relief
	Waters broken over 18 hours (as per SROM guideline)
	Staff unavailability
First and second stage (dilation and pushing)	Fetal heartbeat abnormal or difficult to monitor
	Breech or other malpresentation
	Delay (e.g. cervix not opening as we would expect in labour or cervix fully dilated but baby not moving down birth canal)
	Cord prolapse
	Shoulder dystocia (dependent on severity)
Third stage (delivery of the placenta)	Retained placenta
	Postpartum haemorrhage

Fourth stage (early postnatal period)	Suturing significant or complicated tears
	Neonatal resuscitation Neonatal observations

Further discussions	

Signed: Print Name: Date:

Appendix 10: Maternity Ambulance Transfer Times

This data has been supplied by South Central Ambulance Service (SCAS) for the period October 2021 to September 2022.

Performance Category	% of Incidents
Cat 1 T	78%
Cat 2	19%
Cat 3	3%

78% of the below transfers were category 1.

Transfers from FMLU to the John Radcliffe Hospital for the period October 21 to September 22	Count of Incidents	Average Response Duration	Average Duration of Leave Scene to Arrive at John Radcliffe
Wallingford Birthing Centre	19	0:16:23	0:33:32
Horton General Hospital	7	0:04:07	0:33:55
Cotswold Birth Centre	2	0:19:31	0:33:08
Wantage Community Hospital	1	0:15:05	0:44:06
Grand Total	**47**	**0:10:56**	**0:37:17**
Average Duration on Scene		**0:19:19**	

Transfers from home to the John Radcliffe Hospital for the period October 21 to September 22	Count of Incidents	Average Response Duration	Average Duration of Leave Scene to Arrive at John Radcliffe
Vale of White Horse	13	0:24:30	0:33:16
Cherwell	10	0:17:35	0:26:55
Oxford	10	0:13:49	0:13:01
West Oxfordshire	7	0:30:09	0:29:34
South Oxfordshire	5	0:18:13	0:31:12
Grand Total	**45**	**0:20:46**	**0:26:19**
Average Duration on Scene		**0:24:27**	

Inclusion Criteria -

NHS Pathway Symptom Discriminator is one of the following:

- **AMB Cord Prolapse**
- **AMB Imminent birth**
- **AMB labour**
- **AMB obstetric emergency**
- **AMB post delivery**

• AMB pre term

AND / OR
NHS Pathways Symptom Group is
• Labour and Childbirth

AND OR
Final Disposition Code is one of the following:
• DX01012 - Emergency Ambulance Response for Obstetric Complications
• Dx0102 - Emergency Ambulance Response for Potential Cardiac Arrest Post Delivery
• Dx0115 - Emergency Ambulance for Labour Complications

AND
Patient conveyed to John Radcliffe Hospital by South Central Ambulance Service

Appendix 11: Equality Impact Assessment

1. Information about the policy, service or function

What is being assessed?			
New Policy/Procedure	[ ]	New Service/Function	[ ]
Existing guideline/Procedure	[x]	Existing Service/Function	[ ]

Staff member completing assessment:
Marie Barnard

Name of policy/service/function:
Midwifery Led Unit (MLU) and Home birth Booking and Referral Criteria Guideline

Details about the policy/service/function:

This document provides clinical guidance for maternity staff who are involved in caring for pregnant women accessing the Oxford University Hospitals NHS Foundation Trust (OUHFT) who plan to birth at home or in an MLU.

Review Date: 04/07/2023	**Date assessment completed:**
Signature of staff member completing assessment: **Marie Barnard**	**Signature of staff member approving assessment:**

2. Screening Stage

Who benefits from this guideline, service or function? Who is the target audience? (*tick all that apply*)					
Patients	[x]	Family/Carers	[ ]	Not applicable	[ ]
Staff	[x]	Other (*specify*):			

Does the policy, service or function involve direct engagement with the target audience?		
Yes	[x]	Continue with full equality impact assessment
No	[ ]	Full equality impact assessment not required

3. Research Stage

Notes:

If there is no impact for a particular group or characteristic, mention this in the Reasoning column and refer to evidence where applicable.

[1]Race categories follow those used in the National Census by the Office for National Statistics. Consideration should be given to the specific communities within broad categories such as Bangladeshi people.

[2]Please select age groups which may be impacted by the policy, service or function and complete as appropriate.

[3]Religion or Belief covers a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus; it also covers people who do not have a faith. Consider these individually and collectively when determining impacts.

Characteristic		Positive Impact	Negative Impact	Neutral Impact	Not Enough Information	Reasoning
Sex and Gender Reassignment	Men (incl. trans men)			x		All genders of pregnant people will have equal access to the care detailed in this guideline
	Women (incl. trans women)			x		
	Non-binary people			x		
Race[1]	Asian or Asian British			x		Consideration should be taken if the pregnant person is not able to read written English. Pictorial explanations may need to be used. If the pregnant person is not able to communicate using English, then language line should be used for consultations.
	Black or Black British			x		
	Mixed Race			x		
	White British			x		
	White Other			x		
	Other:			x		

Disability	Disabled people			x		If the pregnant person has a learning disability an advocate should be in attendance. If the pregnant person has a hearing loss they should be asked if she wishes to have a British Sign Language interpreter in attendance
	Carers			x		
Age[2]				x		This guideline is relevant to pregnant people of all ages
				x		
				x		
Sexual Orientation				x		This guideline does not discriminate with regards to sexual orientation, as all people will have equal access to the care described in this guideline.
Religion or Belief[3]				x		This guideline does not discriminate with regards to belief or religion, as all people will have equal access to the care described in this guideline.
Pregnancy and Maternity		x				The advice in this guideline is for pregnant people so will have a positive impact on this group.
Marriage or Civil Partnership				x		This guideline does not discriminate with regards to marriage or civil partnership, as all people will have

						equal access to the care described in this guideline.
Other Groups /Characteristics	For example: homeless people, sex workers, rural isolation.			**x**		This guideline does not discriminate with regards to social situations, as all people will have equal access to the care described in this guideline.

List the sources of information used in the table below
OUH trust Equality impact assessment procedure guideline – available via trust intranet **Annual Equality and Diversity Report, Workforce Race Equality Standard Data or the Equality Delivery System 2 report**

Using the table below, list any protected groups you will target during the consultation process, and give a summary of those consultations.	
Group	**Summary of consultation**

List any other individuals/groups that have been or will be consulted on this policy, service or function.
This guideline will be reviewed prior to publication by relevant Midwives, Obstetricians, Consultant Obstetricians and Pharmacy if medications are involved.

4. Summary Stage

Outcome Measures List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.
The benefit of this guideline is that it will help clinical maternity staff safeguard women during the intrapartum period by ensuring their care setting is individualised and meets personal preference wherever possible. It also helps to ensure that intrapartum care is risk managed appropriately. Consideration should be taken in those pregnant people who may not be able to read written English. Pictorial explanations may need to be used. If the pregnant person is not able to communicate using English, then language line should be used for consultations. If the pregnant person has any learning difficulties an advocate should be in attendance. If they have a hearing loss – a British Sign Language Interpreter should be offered which can be done via language line.
Positive Impact List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.
As above
Unjustifiable Adverse Effects List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

There are no unjustifiable adverse effects predicted.
Justifiable Adverse Effects List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.
There are no justifiable adverse effects predicted.

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified Risk	Recommended Actions	Lead	Resource Implications	Review Date	Completion Date