

Working Together To Facilitate Birth Choices:

Our experiences of setting up and running an MDT ‘birth outside of guidance’ service at a busy, acute Trust in East London

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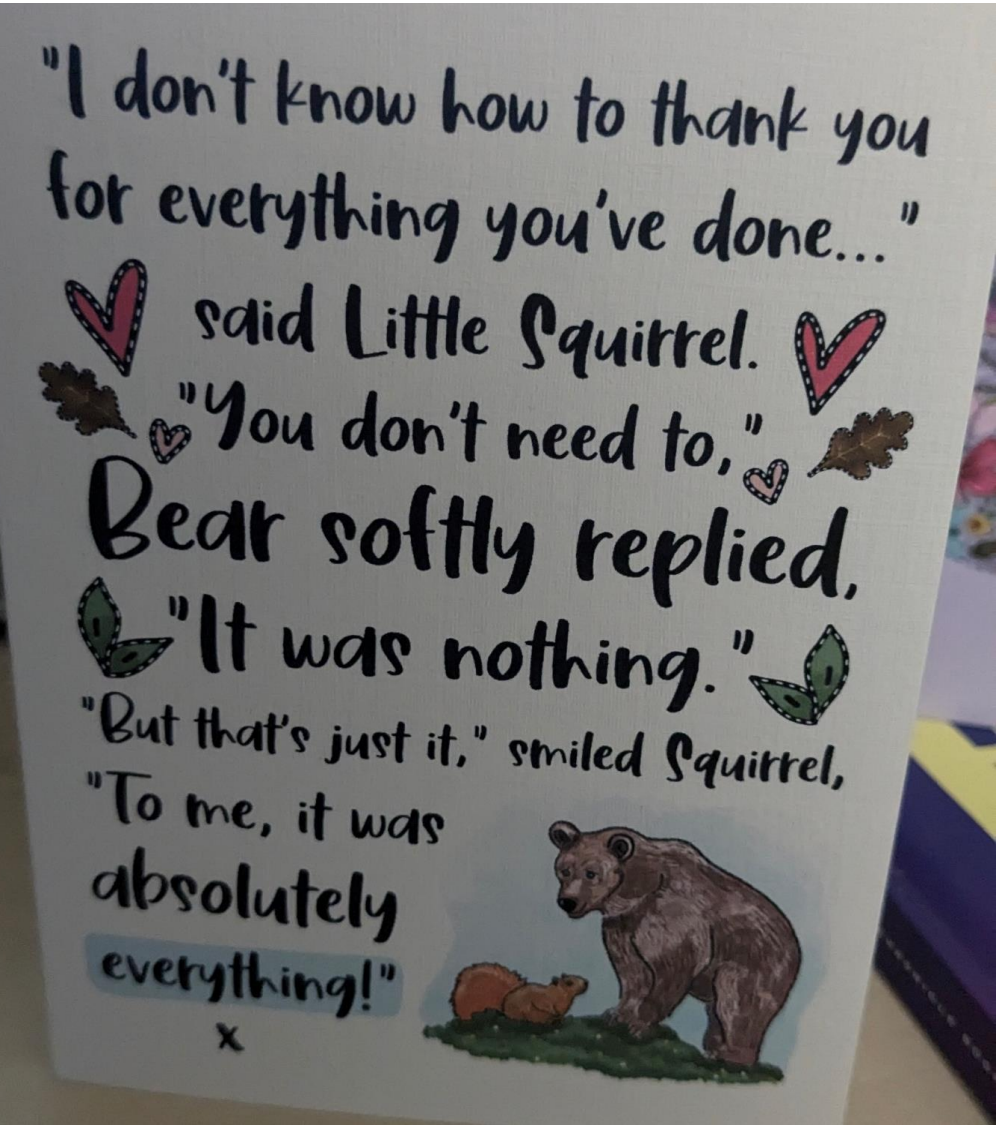
1 Barking, Havering and Redbridge University NHS Trust 2 The Princess Alexandra NHS Trust 3 West Hertfordshire Hospitals NHS Trust



Introduction

Barking, Havering and Redbridge Trust provides care for the residents of three diverse London boroughs; as well as providing healthcare services to people in south-west Essex. We offer antenatal care from two main sites – King George Hospital in Goodmayes and Queen’s Hospital in Romford. Inpatient services including the Consultant Led Unit and Midwifery Led Birth Centre are based on the Romford site. We provide maternity care to above 7,000 women and birthing people each year, making our service one of the largest in the country and the largest single site maternity service in London.

As with many other services, we have seen an increase in requests for care outside of standard guidance, particularly from those who birthed during the covid pandemic. In early 2023, a new Obstetric Consultant joined the Trust, with an interest in provision of care to women and birthing people requesting care outside of standard guidance. The existing pathway was led by the Consultant Midwife for Midwifery-Led Care, with ad hoc input from Obstetricians.



Methodology

An MDT antenatal clinic was established in 2023 to provide care for women and birthing people requesting care outside of standard national and local guidance, run jointly by the Consultant Obstetrician and Consultant Midwife.

Appointments are arranged to be double the usual length and run predominantly in person, with remote video or telephone options available to those who requested them for reasons of convenience or hospital-based trauma.

Referrals are triaged by the Consultant Midwife to assess appropriateness for the MDT service. Inclusion criteria is anyone seeking care with two predominant exclusions:

- Women or birthing people seeking birth in a low risk setting whose only risk factor is high BMI, are risk assessed through using a structured proforma by any Midwife or Obstetrician.
- Women or birthing people requesting a Caesarean section with no clinical indication can be seen by any Obstetrician and counselled using the RCOG information.

We use the BRAIN acronym to structure conversations and focus on building relationships and avoiding coercive language or behaviour.

A written birth preferences document is co-produced with the service use, circulated to all relevant staff and attached to the electronic record.

Once seen in the clinic, women and birthing people remain under the care of the same MDT team for the remainder of their pregnancy, unless there is a clinical reason why this is not appropriate (eg requiring diabetes specialist input). Where members of the MDT are available, they will also attend during the labour and birth, in addition to staff providing routine care. The MDT are also available to provide telephone advice and support to teams providing care.

Results

In the first 15 months of the service, 93 women and birthing people were cared for by the Birth Choices MDT. The most common reason for referral was seeking a VBAC in a low risk setting (MLU or at home). Other common reasons for falling outside of current guidance were raised BMI, maternal age, declining IOL, previous PPH, large/multiple fibroids, diabetes and other maternal medical conditions.

Ages ranged from 20-49 years old. Reasons for seeking care outside of guidance included birth trauma, previous sexual assault, neurodivergence, and positive experience of family or friends.

Ethnicity of service users choosing birth outside guidance was generally representative of the ethnicities of all users of our maternity services. However, only two service users required the use of interpreting services, considerably lower than the average across our maternity services.

38 women and birthing people chose to attempt VBAC in a low risk setting. 20 achieved vaginal birth, 10 had a CS for maternal choice and 8 had a CS for obstetric indications. There were no cases of uterine rupture.

Perinatal morbidity and mortality – there were no IUDs or NNDs. There were no NICU admissions.

Feedback from service users was universally positive. This was the case even when birth outcomes were not in alignment with the original preferences. Service users reported feeling listened to and their choices respected.

Feedback from staff was also positive. Some Community Midwives felt that the current format for birth plans is too lengthy as it currently includes documentation of antenatal counselling as well as final preferences.

Conclusions

- Most common request is VBAC at home/MLU
- Multiple successful ‘out of guidance’ births supported with no adverse outcomes since the service was set up
- Even where birth ended up different to the plan, women and birthing people report that they hugely valued being listened to and their choices respected
- Feedback has been extremely positive

Further & ongoing work

- Publicising service more widely amongst all staff and service users from all backgrounds
- Structured referral proforma
- Dedicated clinic code to improve data collection
- RAG rating for referrals
- Dedicated neurodivergent specialist clinic commenced October 2024
- Improving written birth plans alongside community midwives
- Wider work around informed consent and preventing birth trauma and unnecessary interventions
- Stickers on notes to quickly identify those seen in clinic for triage MWs