

# Intermediate Homebirth Report

December 2013 to October 2014

**Introduction**

Birmingham Women’s NHS Foundation Trust seeks to provide women with a service that is of highest quality, safe and exceeds the needs and expectations of women and their families. The publication of the “Place of Birth Study” (2011) provided impetus for the development of a long desired dedicated home birth team (HBT) that was planned to meet the aspirations of both women and the Trust. The benefits of taking this approach could potentially produce positive results in three key areas:

* women’s experiences of maternity services,
* financial aspects of Maternity Services: multiparous women require less interventions when they deliver at home
* capacity and resources within the hospital as more elements of care would be undertaken outside the physical environment of the hospital.

**Context**

Previous provision for home birth rested with the four community midwifery teams, who maintained a twenty-four /seven on call service for women. This proved to be unsatisfactory as these staff were part of the hospital escalation policy and therefore had to work in the hospital when activity level was high. The ramifications of this were two fold; neither women nor midwives had the confidence in the homebirth service being available 24/7 and therefore the midwives did not actively promote the service as they were concerned women were likely to be disappointed. Also the midwives did not feel that they had been able to maintain their intrapartum skill base. Historically management of staffing decisions have had to prioritise resources into the hospital. The direct impact of this was that few women had their babies at home, only 23 in 2013, which is less than 0.31%. The publication of Birth Place (2011), the joint RCOG and RCM statement (2011) supported BWH to press for a dedicated to Homebirth Team to be commissioned.  In 2013 the lead CCG approved a funded pilot project to develop a dedicated HB team.

Birmingham Women's hospital is the second largest maternity unit in England, with over 8100 births per year, and serves a rich and diverse demographic with 48% of its population being from a non-white British origin. The birth rate in Birmingham is expected to grow approximately 1% year on year over the next ten years (National Statistics Audit, 2013). The Trust cap bookings and births to ensure a safe high quality service, largely due to a physically restricted environment. It is expected this will be partially ameliorated by BWH VITA project that will involve rebuilding some of the hospital. In addition we will seek to increase our birth by offing home birth to low risk women. This will also significantly impact choice and control for women who meet the criteria.

Strategically the need for reconfiguration of maternity services is clear to move low risk women out of the hospital setting into the community. Health outcomes will be improved and there will be improved use of financial resource to direct to the areas of higher need such as the increase in complexity of deliveries as a direct result of increased public health concerns such as obesity. This predicted redirection of finances from within what is a limiting tariff certainly contributed to Birmingham Women's successful funding bid with Birmingham South Central CCG.  Evidence suggests that by the end of the three year pilot the service would begin generating an income allowing for the redirection of tariff to under resourced areas of maternity.

The homebirth team (HBT) was commissioned in 2013 by the Clinical Commissioning Group and funded by Birmingham South Central commissioning group with an aim of the service of increasing the homebirth rate in Birmingham Women’s Hospital from 0.3% to 3% in 3 years (a total of 240 women pa by the end of year 3). The recruitment of staff for the service started in October 2013. All staff had completed the Trust induction period and underwent compulsory mandatory training, which was accomplished by the end of March 2014.

Active recruitment of women into the service commenced at beginning of April 2014.

**Methods and innovation**

Before the team were in post the consultant midwife and other senior managers reviewed other Homebirth models of care used across the country. As a starting point the best fit was the model that Kings College Hospital NHS Foundation Trust has used successfully for the past 5 years, achieving a homebirth rate of 5.5%.

*Staffing*

It has been reported that midwives suffer from burn out when providing a 24/7 on-call homebirth service with a continuity of care model. Being aware of issues faced by other home birth teams, BWH sort to be innovative in its staffing design it, decided to use Maternity assistants/support workers to be the second on call birth attendant, once they had been through the appropriate training. This would help maintain a service that is sustainable and affordable. This training has resulted in the formation of a bespoke foundation degree in partnership with Birmingham City University. This has been largely funded by Health Education West Midlands LETC. In addition to increasing the academic achievements of the wider maternity workforce we are also providing a sustainable career structure to support staff.

*Rotas*

At the outset the planned structure for the on calls was from 08:00-20:00 (1st and 2nd) and 20:00-08:00 (1st and 2nd) with additional day shifts covering clinics. Although this structure has been followed the model is proving to be unrelenting on staff. The main reason for this has been that there have been delays in training the Maternity Support Workers. It is expected that once these are trained the on call system will work more smoothly. Use of Maternity Support Workers at home birth is a relatively new approach and will be reviewed further.

**Results and evaluation:**

In 2013, the year before the Homebirth Team was set up there were 23 planned homebirths. From the go live date to October 2014 the HBT received 212 referrals of which 173 (82%) were accepted have a home birth. Of these 139 received care until they were in labour and 61 resulted in a homebirth out of a possible 79 attempted. Therefore 18 women had to transfer to hospital during their labour. The remaining women had not delivered by the time of writing the report. Water was the most commonly used analgesia with a 48% water birth rate. 34% of women did not use any analgesia in labour. Data displayed in key findings at the end of the report.

External Evaluation

We are working with The West Midlands CLAHRC delivered by University of Birmingham to formally evaluate the service. There first report is due to be published in January 2015.

**Key learning Points:**

*Planning*

* Have a clear strategic plan, and utilise project methodology to allow for agreement and monitoring of measurable targets in collaboration with the team and managers
* Recruit the right people, from the project lead to each team member, who are committed to the project and are able to embrace change.
* Do not underestimate the degree of flexibility of mind needed when setting up a new service that is trying to change the norm

*Team building*

* Celebrate the regular successes
* Set realistic goals, which can be movable if the situation indicates and therefore not viewed failures in a negative light
* Embrace failure, this has enabled the team to try new, innovative ideas around recruitment, most of which have worked; others have not been so successful and therefore stopped
* Employ an experienced leader
* Do not underestimate the training needs of existing qualified midwives.  As 21st century Midwives we have become deskilled at homebirth because with a national average of 2.46% it is no longer the norm. The skill set required is different and requires midwives to be confident in working alone delivering autonomous intra-partum care. One of the things we have done is to conduct ‘emergency skills and drills training’ in the home environment

*Change management*

* Culture is key! The perception and culture over the last 50 years has been that all mum's and babies do better if they birth in hospital. One of our biggest challenges, therefore, was to win hearts and minds. The team approached this in numerous ways: lots of face to face contact, going to children's centres, homebirth groups and hosting tea parties which are an informal way for families to meet other families who have had or are interested in having a homebirth and to meet other midwives and MSW's. Leaflets have been sent to every GP surgery. The team are active on Social Media and we ensure we are at the forefront of all Trust wide publications.
* One innovation that is currently under review as there are difficulties maintaining sustainability is the approach of sharing the cost of the pools with the families. A very successful marketing strategy has been our pilot birthing pool project. Women booking with the homebirth team are entitled to receive a birth pool voucher which entitles them to ¾ discount off the cost of a birthing pool. This has proved to be popular and the homebirth team water birth rate is 48%

**Planning Ahead**

* Undergo an external evaluation that will lead to further developments and improvements
* This project was a pilot for three years – it is currently at its half way mark and therefore plans to mainstream the service are afoot.
* Develop a domino service that will work in tandem with the home birth service for women who don’t want to give at home.

**Conclusion**

This project, as with all new services has not been without its difficulties however the work outlined above has been well evaluated by the women and the staff, although they have found the way of working very tiring.

There have been teething problems with the development of the MSW training programme, as there is no precedent for this approach. The team are working towards resolving issues as they occur.

The consultant midwife has consulted and chaired Skills for Health Working Party looking at the national Occupational Standards of MSWs. This has now been published . <https://tools.skillsforhealth.org.uk/competence_search/>

<http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards/nos-for-maternity-support-workers/>

**Key Findings**

Referrals

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Month** | **Referrals** | **Decision/Suitability to book with HBT** | **Number of Antenatal Transfers to Cons Led Care** | **Number of women cared for by HBT up until Labour** |
| December | 10 | 10 | 2 | 8 |
| January | 19 | 19 | 8 | 11 |
| February | 16 | 14 | 3 | 11 |
| March | 28 | 17 | 4 | 13 |
| April | 20 | 18 | 3 | 15 |
| May | 16 | 12 | 3 | 9 |
| June | 18 | 16 | 2 | 14 |
| July | 19 | 18 | 5 | 13 |
| August | 20 | 17 | 2 | 15 |
| September | 26 | 19 | 2 | 17 |
| October | 11 | 11 | 0 | 11 |
| Unrecorded | 9 | 2 | 0 | 2 |
| Total | 212 | 173 | 34 | 139 |

## Table 1: *Table demonstrating how many women in the system planning a homebirth at different stages of the process*

## The HBT received 212 referrals for Homebirth of which 173 (82%) planned to have a home birth

## Bookings

**Table 2**: *Main reason for not booking with Homebirth Team (n=39)*

* 13 (33%) women changed their mind about having a HB, most of whom opted to go to the Birth Centre instead

Antenatal Transfer of Care

**Table 3**: *Main reason for transferring in pregnancy to hospital based care (n=34)*

* 26 (76%) women in total were transferred to hospital care for developing obstetric risk factors
* 3 (9%) women were transferred for post-term induction of labour

## Analgesia used at home

**Table 4**: *Analgesia used at home in labour*

* 29 (48%) planned home water-births: 6 to nulliparous and 23 to multiparous mothers
* 21 (34%) women did not use analgesia for labour and birth, the majority of whom were multiparous mothers (n= 19)
* No mothers have utilised pethidine during labour
* 2 (3%) mothers date used TENS machine

**Intrapartum Homebirths**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Month** | **Planned Homebirths** | **Unplanned homebirths****Midwife present for birth** | **Midwife not present for birth but 3rd stage**  | **Total Homebirths with midwifery input** |
| December | 1 | 0 | 0 | 1 |
| January | 3 | 0 | 0 | 3 |
| February | 3 | 0 | 0 | 3 |
| March | 2 | 0 | 0 | 2 |
| April | 2 | 0 | 2 | 4 |
| May | 8 | 0 | 1 | 9 |
| June | 6 | 0 | 0 | 6 |
| July | 7 | 2 | 2 | 9 |
| August | 11 | 2 | 0 | 13 |
| September | 9 | 1 | 2 | 12 |
| October | 9 | 0 | 0 | 9 |
| Total | 61 | 3 | 7 | 71 |

**Table 5**: Demonstrating split between planned and unplanned homebirths

* In addition to the 61 women who were under the care a further ten women received care from the HBT unexpectedly as they found themselves in labour at home. In three cases the midwife arrived in time to provide care for the birth and in seven cases the baby had already been born. Paramedics were also present at some of these births

## Comparison of number of homebirths between 2014-2015

**Table 6:** *Comparison of planned homebirths in 2013 and 2014*

* There were 23 planned homebirths in 2013
* To date the pilot has delivered 61 planned home births

**Birth Against Medical Advise**

|  |  |  |
| --- | --- | --- |
| **Women booked with the HBT against medical advice** | **Number** | **%** |
| Transferred in pregnancy | 1 | 10 |
| Intrapartum transfer | 1 | 10 |
| Birthed at home | 7 | 70 |
| Still pregnant | 1 | 10 |
| **TOTAL** | **10** | **100** |

**Table 7*:*** *Women booked with the HBT against medical advice*

* 10 (7%) out of 139 women receiving HBT care going into labour have booked against medical advice – all have been multiparous women. They have a full care plan written by the consultant midwife in conjunction the obstetrician and Supervisor of Midwives.

**Intrapartum transfers**

|  |  |  |
| --- | --- | --- |
| **Primary reason for intrapartum transfer** | **Women booked with HBT** | **Total** |
| **Nulliparous**  | **Multiparous**  | **Number** | % |
| Fetal distress | 5 | 2 | 7 | 39 |
| Delay in 1st stage | 3 | 1 | 4 | 22 |
| Malpresentation | 1 | 0 | 1 | 5.5 |
| Haemorrhage | 2 | 1 | 3 | 17 |
| Retained placenta | 0 | 1 | 1 | 5.5 |
| Neonatal concern | 0 | 1 | 1 | 5.5 |
| Other | 0 | 1 | 1 | 5.5 |
| **TOTAL** | **11** | **7** | **18** | **100** |

## Table 8: *Primary reason for Intrapartum Transfer*

## Seventy nine hoped to have a homebirth but 18 of these had to transfer to hospital leaving 61 women having successful home birth.

## The most common reason was for intrapartum transfer was fetal distress

* The Waterbirth Rate is 48%, water was most commonly used analgesia

|  |  |  |
| --- | --- | --- |
| **Reason for neonatal admission to hospital** | **Number** | **Total n**=6) |
| Admission to hospital <24 hrs old: |   | 3 |
|  Infection | 1 |   |
|  Generalised neonatal concern | 1 |   |
|  Baby <1st centile & low temperature | 1 |   |
| Admission to hospital >24 hrs old: |   | 3 |
|  Bacterial meningitis | 1 |   |
|  Jaundice | 1 |   |
|  Infection | 1 |   |

 **Table 9**: *Reasons for neonatal admission to hospital from home birth*

* Of the 3 neonatal admissions to hospital within 24 hours, 1 was admitted to the NNU
* The most common cause for neonatal admissions was infection (n=3)
* 2 of the admissions to hospital aged over 24 hours old were to Bimingham Childrens Hospital
* Additionally 10 women declined transfer post-natally, nine of these had babies that plotted below below 10th customised centile with a temperature less than 36.5 degrees Celsius. This is a reason for transfer at Birmingham Women’s hospital. National guidance is < 2.5kg, none of these babies were less than this weight. All these women had prior reason for transferring in labour (e.g. meconium) This will be audited further and notes looked at in detail.