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AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services N/a

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√

Women who are at low risk of complications

Explain to all women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby and that they may choose any birth setting (home, freestanding birth centre, alongside birth centre or consultant unit), and support them in their choice of setting wherever they choose to give birth.

Using tables 1 and 2, advise low risk parous women that:

- Planning to give birth at home or in a birth centre (freestanding or alongside) is particularly suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit
- Planning birth at home or in a freestanding birth centre is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside birth centre, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- Planning birth in an obstetric unit is associated with higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings
- There are no differences in outcomes for the baby associated with planning birth in any setting.

Table 1 - Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: *low risk parous women*	**Number of incidences per 1000 parous women giving birth**			
	Home	**Freestanding Birth Centre**	**Alongside Birth Centre**	**Obstetric Unit**
Spontaneous Vaginal birth	984*	980	967	927*
Transfer to a consultant unit	115*	94	125	10**
Regional analgesia(epidural and/or spinal) * **	28*	40	60	121*
Episiotomy	15*	23	35	56*
Caesarean birth	7*	8	10	35*
Instrumental birth (forceps or ventouse	9*	12	23	38*
Blood Transfusion	4	4	5	8

*Figures from *Birthplace 2011* and *Blix et.al 2012*
** Estimated transfer rate from a consultant unit to a different consultant unit owing to lack of capacity or expertise.
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 2 -Outcomes for the baby for each planned place of birth: *low risk parous women*	Number of babies per 1000 births			
	Home	**Freestanding Birth Centre**	**Alongside Birth Centre**	**Obstetric Unit**
Babies without serious medical problems	997	997	998	997
Babies with serious medical problems*	3	3	2	3
*Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes (less than 4% of adverse events).				

Using tables 3 and 4, advise low-risk nulliparous women that:

- Planning to give birth in a birth centre (freestanding or alongside) is particularly suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Planning birth at home or in a freestanding birth centre is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside birth centre, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- Planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings
- There are no differences in outcomes for the baby associated with planning birth in an alongside birth centre, a freestanding birth centre or an obstetric unit
- Planning birth at home is associated with an overall small increase (about 4 more per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings.

Table 3 - Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth*: low risk nulliparous women*	**Number of incidences per 1000 nulliparous women giving birth**			
	Home	**Freestanding Birth Centre**	**Alongside Birth Centre**	**Obstetric Unit**
Spontaneous vaginal birth	**794***	**813**	**765**	**688***
Transfer to a consultant unit	**450***	**363**	**402**	**10****
Regional analgesia(epidural and/or spinal)***	**218***	**200**	**240**	**349***
Episiotomy	**165***	**165**	**216**	**242***

Caesarean Birth	**80***	**69**	**76**	**121***
Instrumental birth (forceps or ventouse)	**126***	**118**	**159**	**191***
Blood transfusion	**12**	**8**	**11**	**16**
*Figures from *Birthplace 2011* and *Blix et.al 2012* ** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise. *** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia**.**				

Table 4 - Outcomes for the baby for each planned place of birth: *low risk nulliparous women*	**Number of babies per 1000 births**			
	Home	**Freestanding Birth Centre**	**Alongside Birth Centre**	**Obstetric Unit**
Babies without serious medical problems	991	995	995	995
Babies with serious medical problems *	9	5	5	5
*Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes – less than 4% of adverse events.				

This table details medical/surgical conditions and obstetric/gynaecological factors that indicate:

- Planned place of birth should be within an obstetric unit
- Individual assessment by an obstetrician is required, when planning place of birth.

Risk factor	**If the woman has one of the following conditions she should be advised that the safest place for birth is the obstetric unit**	**If the woman has one of the following conditions she should have a multidisciplinary individualised assessment regarding place of birth (* in the absence of other risk factors this assessment may be undertaken by the midwife)**
Cardiovascular	• Confirmed cardiac disease • Hypertensive disorders	• Cardiac disease without intrapartum implications
Respiratory	• Asthma requiring hospital/increase in treatment • Cystic fibrosis	

Haematological	• Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major history of thromboembolic disorders • Immune thrombocytopenia purpura or other platelet disorder or platelet count <100 x10^9/litre • Von Willebrand's disease • Bleeding disorder in the woman or unborn baby • Atypical antibodies which carry a risk of haemolytic disease of the newborn	• Atypical antibodies not putting the baby at risk of haemolytic disease • Sickle-cell trait • Thalassaemia trait • *Anaemia – haemoglobin 85-105 g/l at onset of labour
Infective	• Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended • Hepatitis B/C with abnormal liver function tests • Carrier of/infected with HIV • Toxoplasmosis – women receiving treatment • Current active infection of chicken pox/rubella/genital herpes in woman or baby • Tuberculosis under treatment	• Hepatitis B/C with normal liver function tests
Immune	• Systemic lupus erythematosus • Scleroderma	• Non-specific connective tissue disorders
Endocrine	• Hyperthyroidism • Diabetes	• Unstable hypothyroidism such that a change in treatment is required
Renal	• Abnormal renal function • Renal disease requiring supervision by a renal specialist	
Neurological	• Epilepsy • Myasthenia gravis • Previous cerebrovascular accident	
Gastrointestinal	• Liver disease associated with current abnormal liver function tests	• Liver disease without current abnormal liver function • Crohn's disease • Ulcerative colitis
Skeletal/ neurological		• Spinal abnormalities • Previous fractured pelvis • Neurological deficits
Mental health	• Psychiatric disorder requiring current inpatient care	
Previous complications	• Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty • Previous baby with neonatal encephalopathy • Pre-eclampsia requiring preterm birth • Placental abruption with adverse outcome • Eclampsia • Uterine rupture • Primary postpartum haemorrhage requiring additional treatment or blood transfusion • Retained placenta requiring manual removal in theatre • Caesearean section • Shoulder Dystocia	• Stillbirth/neonatal death with a known non-recurrent cause • Pre-eclampsia developing at term • Placental abruption with good outcome • History of previous baby more than 4.5 kg • Extensive vaginal, cervical or 3rd or 4th degree perineal trauma • Previous term baby with jaundice requiring exchange transfusion

Current Pregnancy	• Multiple Birth • Placenta Praevia • Pre-eclampsia or pregnancy- induced hypertension • Preterm labour or preterm rupture of membranes • Placental abruption • Anaemia – haemoglobin less than 85g/litre at onset of labour • Confirmed intrauterine death • Substance Misuse • Alcohol dependency requiring assessment of treatment • Onset of gestational diabetes • Malpresentation – breech or transverse lie • BMI at booking of ≥40 • Recurrent antepartum haemorrhage • Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) • Abnormal fetal heart rate/Doppler studies • Ultrasound diagnosis of oligo-/polyhydramnios	• Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) • * BMI Booking of ≤39.9 • Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on two occasions • Clinical or ultrasound suspicion of macrosomia • *Para 5 or more • Recreational drug use • Under current outpatient psychiatric care • *Age over 39 at booking • Fetal abnormality
Previous gynaecological history	Myomectomy Hysterotomy	• Major gynaecological surgery • Cone biopsy or large loop excision of the transformation zone • Fibroids

References:

- National Institute for Health and Clinical Excellence. (2014). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE
- *Birthplace 2011* and *Blix et.al 2012. Cited in* NICE (2014) *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE *Outcomes of planned home births and planned hospital births in low-risk women in Norway between 1990 and 2007: A retrospective cohort study.*

Appendix 1

Lancashire Teaching Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Women's Health			
Lead Assessor	Emma Ashton			
What is being assessed?	Planning Place of Birth			
Date of assessment	03/08/2018			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☐
	Pharmacy, Medicine, Anaesthetics, Scanning, NICE Guidelines and RCOG			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil	Neutral		

Partnership		
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale