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Health Board

Informed Choice, Personalised Care And The Care Of Women Making Choice Outside Of Recommended Guidelines

Document Reference No:	PTHB / MAT 079	
Version No:	2	
Publication Date:	14 May 2026	
Review Date:	20 October 2028	
Expiry Date:	20 January 2029	
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Document Owner:	Head of Midwifery, Sexual and Women's Health	
Accountable Executive:	Executive Director of Nursing, Quality Women and Family Health	
Approved By:	Women and Childrens Policies & Procedures Governance Group	
Approval Date:	20 January 2026	
Document Type:	Guideline	Women and Children's
Parent Policy		
Scope:	Maternity	

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

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1.0 Scope

This guideline is to outline the process of supporting choice and personalized care for women who use the maternity services in Powys and details the process for managing cases where women choose care 'outside of guidance' or 'against medical advice'.

2.0 Introduction

Midwives are obliged by the Nursing and Midwifery Council (NMC) Code (2018) to 'put the interest of people needing or using midwifery services first'. Midwives must therefore prioritise care and safety whilst ensuring women are treated with kindness whilst preserving dignity and human rights.

To provide personalised care, there needs to be a relationship of trust, continuity of care, as well as multidisciplinary involvement centered around the woman; care options should take into consideration the individual values, preferences and perceptions of risk (Royal College of Midwives [RCM], 2022a, NMC, 2025).

Guidelines include sets of recommendations based on the trade-off between benefits and harm; some are made with more certainty than others based on the quality of the underpinning evidence and moreover, guidelines do not supersede women's human rights over bodily autonomy (RCM, 2022a).

Midwives must provide women with the information and support they need to make decisions about their care and must respect the decisions that women make (RCM, 2022b). In providing informed choice women will choose to either give or decline consent for that care.

3.0 Objective

This document sets out the guidance for ensuring informed choice and personalised care for all pregnant women and new mothers (hereafter referred to as women). Whilst its focus is to provide guidance for supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, the principles within this document should be used for all aspects of care.

This guideline should be used in conjunction with
Human Rights Act (HRA) (1998)
Nursing and Midwifery Council (NMC) Code (2018)
National Institute of Health and Care Excellence (NICE) (2021) ECD8
Standards Framework for shared decision-making support tools,
including patient aids
RCM 2022 Royal College of Midwives (RCM) (2022a) – Caring for those
women seeking choices that fall outside of guidance. London: RCM

Royal College of Midwives (RCM) (2022b) – Informed decision making.
London: RCM

MAT 030 – All Wales Midwife Led Care Guidelines

NMC (2025) Principles for supporting women's choice in maternity care
[Principles for supporting women's choices in maternity care](#)

Equality statement:

Powys Teaching Health Board Maternity Services are committed to:

- The elimination of unlawful and unfair discrimination
- The active promotion of equal opportunities for women and their families and our workforce
- The protection of the human rights of women and their families and our workforce
- The promotion of inclusive relationships between groups who share protected characteristics and those who don't
- The valuing of the diversity inherent in the communities we serve and in our workforce.

The words 'woman' and 'women' have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby. It is recognised that there are many different family arrangements.

When translation services are required, there is the expectation that a face-to-face translator or digital interpretation services will be provided.

The Language Line App is available to all maternity staff to use for this purpose. Consideration is required with written documents and leaflets to be provided in a woman's preferred or 1st language.

For further support and advice contact PTHB Equality Team:
powys.equalityandwelsh@wales.nhs.uk

4.0 Definitions

- **AWCPNL** – All Wales Clinical Pathway for Normal Labour
- **CIS** – Clinical Information Sharing
- **CSfM** – Clinical Supervisor for Midwives
- **DGH** – District General Hospital
- **MARF** – Multiagency referral form
- **NICE** – National Institute of Health and Care Excellence
- **OTL** – Operational Team Lead
- **PTHB** – Powys Teaching Health Board
- **RCM** – Royal College of Midwives
- **SBAR** – Situation, Background, Assessment, Recommendation
- **WAST** – Welsh Ambulance Service NHS Trust
- **WPAS** – Welsh Patient Administration System

5.0 Roles and Responsibilities

Responsibilities in relation to this guideline are:

Head of Midwifery and Sexual Health Services

The Head of Midwifery and Sexual Health Services must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

Assistant Head of Midwifery and Sexual Health Services

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff
- Ensuring there is adequate Bronze cover across the roster to support care planning and guidance.

Team lead

The Team Lead has responsibility for:

- Working to the requirements of their role within the scope of this guideline
- Ensuring compliance with this document by the teams that they manage
- Discussion about management of women with medical conditions, supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, during PADR process

Consultant Midwife

The consultant midwife has responsibility for:

- Supporting implementation of this document
- Reviewing any new evidence or guidance that is produced that may influence the service
- Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration.
- Being available in an advisory capacity related to care outside of guidance
- Working to the requirements of their role within the scope of this guideline

Clinical Supervisor for Midwives (CSfM)

The CSfM has responsibility for:

- Supporting implementation of this document through group supervision sessions
- Offering opportunity for discussion of management of medical conditions supporting care planning and provision for those making choice outside of recommended guidance in relation to place of birth, in relation to content of this guideline through group and individual supervision
- Leading record keeping audits with discussion about women with medical conditions and ensuring cases have been managed appropriately
- Working to the requirements of their role within the scope of this guideline

Women and Children's Risk and Governance Lead

The Women and Children's Risk and Governance Lead has responsibility for:

- Monitoring review of incidents in relation to content of this document
- Liaising with District General Hospitals (DGH) to feedback where care has fallen outside of this guideline

All Staff working within maternity services

All staff working the maternity services have responsibility for:

- Reading and being familiar with contents of this document
- Referring women appropriately for additional care where required
- Working to the requirements of their role within the scope of this guideline.

6.0 Informed choice and personalised care

All women should be provided with information to make decisions and choices about their care. Personalised care is achieved by ensuring facilitated discussions, in which the woman participates and considers the management of their health and well-being in the context of their whole life and family situation.

Midwives should assess all pregnant women at booking from an obstetric, mental health, medical and social perspective and in discussion with them should make a recommendation and plan for care during the pregnancy and beyond. This should be revisited throughout pregnancy and amended in response to any changes that occur.

The provision of informed decision-making means that the woman is supported to;

- Understand the care, management and support options available and the risks, benefits and consequences of those options
- Make a decision about a preferred course of action, based on evidence-based, good quality, timely information and their personal preferences (NHS E/I, 2021)

In supporting informed choice midwives should ensure the following recommendations (RCM, 2022b)

- Provide balanced, transparent and reliable information
- Ensure understanding
- Facilitate the decision-making process
- Be an advocate for women and families
- Act on the decision
- Ensure accurate record keeping

Women are encouraged to use a recognised framework, for example [BRAN](#), (Welsh Government, 2021) to help navigate the choices during maternity care. Within maternity services this has been adapted to also include 'intuition';

- **B**enefits – what difference will it make? What will happen and how?
- **R**isks – side effects, challenges or potential for adverse outcomes?
- **A**lternatives – consider, benefits and risks
- **I**ntuition – explore feelings, values and past experiences
- **N**othing – consequences of doing nothing, waiting, what could happen? Consider benefits and risks

Duty of care is underpinned by informed decision-making and the principles of authentic and legal consent. Midwives need to counsel

women using the very best and up to date evidence or options available to them in accessible format and document such conversations. Women can accept or decline such recommendations and develop personalised care and support plans, which are facilitated by continuity of care (RCM, 2022a)

Even when there may be strong evidence in favour of a course of action or treatment, information giving should not unduly persuade or coerce and maternal decisions should be respected (RCM, 2022b).

7.0 Human Rights

The Human Rights Act (1998) protects individuals' basic rights and freedoms. It protects women's choices regarding how and where they give birth as well as their rights to decline recommended care based on medical advice.

Articles 2, 3 and 8 provide particularly relevant guidance in relation to the provision of personalised care.

- Article 2 – The Right to Life – Women should never be denied access to maternity services and potential impediments in accessing care (such as a lack of personalised care) should be removed.
- Article 3 – Right to be free from inhuman or degrading treatment – Women should not be subjected to medical procedures they do not consent to, nor should they be denied pain relief.
- Article 8 – Right to respect for private and family life, home and correspondence – Women should be supported in any choice they make during pregnancy and childbirth; this includes care against medical recommendations.

In relation to the unborn baby; in UK law, a fetus does not have rights. An unborn baby doesn't become a separate person with legal rights until they are born.

Midwives can access further information through the Birth Rights organisation, which supports the protection of human rights in relation to childbirth.

8.0 Process when women choose intrapartum care outside of recommended guidelines

Women who are planning care outside of local/national guidance should be encouraged to;

- have a full evidence-based discussion explaining the best available and up to date research information and information around professional opinion in the absence of research.
- understand why their health care provider is recommending care models, including place of birth.
- have a clear description and understanding of the available packages of care, limitations of these in relation to specific care settings.
- be aware of the care recommendations in relevant clinical scenarios in each birth setting.
- be supported to birth in accordance with their wishes where the principles of [informed decision making](#) (NICE, 2021) have been achieved

Discussions about models and packages of care should include fetal surveillance, maternal monitoring and investigation, analgesia, availability and skills set of the team, transfer and birth environment. All conversations should be clearly documented in clinical records.

Following the provision of information if the woman is making a choice that is outside of recommended guidance the midwife must ensure that the woman understands that the choice is outside of recommendation, but that they will be supported in their personal choice and preferences. Adequate time should be planned and allocated for care planning discussions with the woman and to compile the appropriate documentation.

Midwives will take responsibility for identifying the relevant guidance and evidence to support care planning. Advice should be sought from the Consultant Midwife. Support can also be sought from the team lead, CSfM and bronze on call during the drafting stage.

Care planning in these cases should occur as early as possible in pregnancy and by 34 weeks at the latest. Urgent, unexpected cases should be escalated to the consultant midwife or bronze on call for a discussion as soon as possible.

Weekly CIS Clinic/drop ins will be available, and midwives should attend these when they have cases for discussion. Appointments with the consultant midwife should be made outside of the CIS clinic when required for care planning support.

Midwives will bring detail about the case ready for discussion and a draft CIS.

Midwives are encouraged to provide some summary details ahead of the clinic or meeting to enable the consultant midwife or bronze on call to prepare and review available evidence to support the discussion.

The midwife will draft the CIS and the consultant midwife or bronze on call will support review of the CIS and clarify any additional detail that is required.

Documentation must align with local and national guidance, consider risk assessment and informed decision making and Human Right's principles and accurately reflect the discussions with the woman.

Appendix A (from PTHB MAT 030) supports with care planning discussions and guides on risk assessment at 36 weeks of pregnancy to assess suitable place of birth. Appendix A suggests cases that should be discussed with the consultant midwife or bronze on call. This list is not exhaustive, and professional judgment must be used. If risks are identified early in pregnancy and the woman has expressed her wishes for a local birth outside of guidance, then the clinical information sharing process should begin as soon as possible. The care pathway should be reviewed at each antenatal contact to assess for emerging risk factors.

A Clinical Information Sharing (CIS) document will be drafted by the named midwife for all cases of birth planned in Powys outside of recommended guidance [MASTER COPY - CIS Paperwork - May 2026.docx](#) (Appendix B) and saved on SharePoint in the relevant month and year that the woman's estimated due date (EDD) falls. In addition, the details will be added to the 'clinical information sharing outcome' database on SharePoint. This enables live tracking of active cases to occur.

The CIS follows an SBAR (Situation, Background, Assessment and Recommendation) format to support clear communication. This will be first shared with the person (Consultant midwife or Bronze on call) with whom the care plan was discussed for final review prior to circulation.

The consultant midwife or bronze on call will review the CIS to ensure it reflects the discussion held and will then circulate it, accordingly, also ensuring it is saved on SharePoint.

The CIS will be circulated to all Powys Midwives to ensure that anyone who may care for the client knows about the case. The CIS should also be filed/uploaded in the client's pregnancy record. A copy of the CIS should also be emailed to the woman's obstetric team so that a copy

can be retained on her file in case of the need for transfer. The information from the CIS plan will be added to the current annual CIS database by the named midwife.

Any updates must be added to the CIS document, discussed with the consultant midwife or bronze on call to ensure emerging risk factors have been considered and it must be recirculated to the same group (Powys midwives and obstetric team where relevant) following any changes.

The CIS database is reviewed at the weekly safety meeting to ensure there is oversight on open cases and assessment of cases that may require further escalation within the Health Board.

Responsibility of the Midwife

- Ensure care planning discussions take place throughout pregnancy
- When a woman indicates that they intend to give birth in Powys despite having additional risk factors commence care planning by 34/40 for birth.
- For any changes in decision making about place of birth or urgent changes (for example declining induction of labour) beyond this the CIS process must be commenced urgently.
- Ensure adequate time is set aside to support the discussion by attending CIS clinic/drop in or arranging an appointment (with a minimum of 48-72 hours' notice) with the consultant midwife or bronze on call in the absence of the consultant midwife.
- Ensure up-to-date situation is presented
- Ensure a background and history is provided
- Seek any additional requirements or detail where needed
- Escalate any new concerns to the consultant midwife or Bronze on call for review of emerging risk factors
- Liaise with obstetric and neonatal colleagues to ensure MDT care planning
- Follow up for responses and action any feedback from the obstetric/neonatal teams
- Handover to a buddy midwife to follow up during any periods of planned absence
- Previous records should be requested if a previous birth did not take place in Powys

Responsibility of the consultant midwife

- Review all CIS documents and support midwives to draft
- Provide written feedback to the midwife on each case
- Ensure provision of support and guidance to the OTL and bronze on call

- Lead escalation of cases to the Director of Midwifery and the Quality and Safety team when required.
- Join MDT meetings for cases with multiple complexities
- To facilitate and support care planning discussions with the client and the named midwife when required through the provision of remote or face to face consultations for complex cases.
- Discuss cases at the weekly safety meeting to ensure sharing of complex cases with the senior team

Responsibility of bronze on call/OTL and senior midwifery team

To support care planning as per the consultant midwife in the absence of availability of the consultant midwife and for urgent cases.

9.0 Process when women choose antenatal or postnatal care outside of recommended guidelines

At any stage of maternity care women may choose to decline aspects of care. Midwives must ensure that the maternity record is updated and the plan of care is documented accordingly during the antenatal period. During the postnatal period the maternal and/or postnatal pathway should be updated if care is being chosen outside of guidance. This should include documented discussion of advice sought from the obstetric and/or neonatal team. The woman should also be informed of indications to contact the midwifery team for advice and support.

A CIS does not need to be circulated in respect of antenatal and postnatal plans unless particularly complex and these will be assessed on an individual basis. The named midwife should seek advice from the bronze on call or consultant midwife in these cases.

10.0 Communication with the obstetric and/or neonatal team

Multidisciplinary team working is essential in maternity care when a woman is assessed to have additional risk factors. If the woman has received obstetric input during the pregnancy and is choosing to birth in Powys outside of recommended guidance, then they should be encouraged to share their preferences with their obstetric team as early as possible. The named midwife should also update the obstetric team of their woman's wishes.

Attempts should be made to facilitate a joint obstetric review with the named midwife present to support collaborative working, shared decision making and to support care planning. This can be done remotely or in-person. If a joint meeting is not possible then the named midwife should liaise with the obstetric team by phone or email to ensure the woman's wishes are known. The named midwife should

be clear about what care the woman would be offered if they received intrapartum care within the obstetric unit so that the woman can be clear about their options and what they are declining to receive. To do this accurately, input is required with the appropriate clinician. A copy of the CIS should be shared with the obstetric and/or neonatal team.

There may be circumstances when a woman does not wish to be referred for obstetric care despite professional advice. In this case, ensure that the woman understands the reason for recommending the referral and document the discussion. Explore the woman's reasoning for declining an obstetric review. If the woman has declined to receive any obstetric input during the pregnancy and plans to birth in Powys outside of guidance, a referral should be re-offered to support care planning. If this is declined, then the midwife should seek obstetric opinion to seek clarity of the care that would be offered to support informed decision making. The woman must be informed that this is happening.

If a woman is insistent that they decline any obstetric discussion they should be informed that:

Declining an obstetric review or discussion restricts the advice and plan of care that we can recommend as midwives and the risk therefore is that she is not informed of something that might have been of importance to her had she known about it.

A draft template to use to request obstetric or neonatal input can be found in [Draft Obs letter - CIS.docx](#) Appendix C.

The impact of the care choices that the woman makes should also be considered in terms of potential impact on the neonate. Women should be clear about any recommendations of care for the neonate after birth and advice can be sought from a neonatologist if required. If there are concerns about the neonate based on any recommended observations, then immediate transfer to the nearest obstetric unit should be arranged.

If the woman is requesting to birth in an alongside midwifery-led unit in an obstetric unit outside of midwifery-led care guidance then it may be necessary to liaise with the consultant midwife in the relevant Health Board/NHS Trust.

11.0 Communication with the ambulance service

There may be occasions where communication with the ambulance service is required during the antenatal period prior to labour. Individual cases will be escalated by the senior midwifery team to the relevant ambulance service using a 'patient specific directive' which

will summarise any key information required as detailed in [updated 2025 WAST Safeguarding - Blank Midwifery Alert.docx](#) Appendix D. This will be saved in the clinical information sharing file within maternity and circulated to the safeguarding team in the ambulance service.

12.0 Safeguarding considerations

In the absence of concerns relating to a family with additional vulnerabilities or safeguarding concerns, choices around antenatal care and birth alone are not grounds for referrals to be made in relation to safeguarding.

If there are concerns that the child will be at significant risk of harm once they are born, then a multiagency referral form (MARF) should be completed.

If the midwife suspects that the parents may not, or they do not follow professional advice post birth or in the postnatal period, such as declining to take the baby to a hospital for review when there are clinical concerns, there should be a documented discussion about the risk of declining to follow the advice and consider making a report to local authority.

A telephone discussion with the neonatal registrar or consultant at the relevant DGH should be had to obtain advice on a plan of care.

If the baby is considered to be at risk, contact PTHB safeguarding team on 01686 252806 or PowysTHB.Safeguarding@wales.nhs.uk for advice and support (for urgent out of hours safeguarding advice, contact Powys Front Door on 0345 054 4847

13.0 Intrapartum care provision

When the woman goes into labour, depending on the clinical presentation they may require early assessment in labour.

Skill mix should be considered in all cases, with more junior staff being supported by more senior staff. Two midwives must be present for birth and timing of calling the second midwife will be dependent on skill mix, geography, complexity of the case and clinical presentation.

The bronze on call should be contacted and informed that the woman is in labour, and this should be documented.

Depending on the clinical presentation it may be necessary to inform the nearest obstetric unit and this detail documented.

Long hand documentation should be used in CIS cases. The All-Wales Clinical Pathway for Normal Labour (AWCPNL) can be used for record keeping purposes, but long hand notes should be used in addition within the pathway and then on continuation sheets if required. The

partogram should be used in all cases to support assessment of progress and maternal and fetal well-being.

A variance should be noted on each part (parts 1,2 and 3) of the AWCPNL to identify that a CIS is in place. At each initial assessment a plan should be made based on the CIS.

An SBAR should be documented and reviewed at least hourly, and more frequently where clinically indicated, and as part of the hourly holistic assessment in labour. This ensures focus remains on the evolving clinical picture and presentation. When 2 midwives are present, the hourly holistic assessment should be undertaken by the 2nd midwife to support a fresh eyes review.

Contact should be maintained with the bronze on call as agreed at onset of care so that they can have an overview of the case and offer support on a regular basis. In rare cases where the bronze on call is providing care as the 1st midwife, fresh ears on the case can be sought from an alternative midwifery colleague who is not providing care.

The obstetric unit can also be contacted for guidance related to CIS cases. The discussion should take place with the labour ward coordinator and/or obstetrician on call. Any contact should be documented within the records.

14.0 When a woman declines all aspects of care in labour

A discussion should happen with all women antenatally about what they will be offered in terms of intrapartum care and to explore their preferences and wishes. In most cases this will take place at the 34-36-week birth preferences appointment.

On the rare occasion that a woman intends to, or calls for midwifery support when in labour, but then declines the care on offer there should be:

- Exploration of the reason for declining care and attempts to develop a trusting relationship with the woman and her birth partner
- Confirmation to the woman that she will be supported in her decision making
- Documentation of the woman's choices and intentions
- A documented discussion about the risks and benefits of both the recommended care and the woman's intended course of action
- Exploration with the woman about her expectations of the midwife and documentation of this in the handheld record or AWCPNL

- Ongoing offer of the recommended care during labour, documented within the records each time this happens and whether it is accepted or declined
- A discussion with a senior colleague and escalation to bronze and 'silver' on call for the Health Board if required at onset of care in labour
- At least hourly discussion with the bronze on call for support and review of the clinical situation when intrapartum care is being provided
- Discussion with the obstetric unit in cases where the woman is not assessed as being midwifery-led care
- Assessment for the need for 2 midwives to be present for support
- Accurate record keeping throughout the care noting any limitations in ongoing assessment
- Following of the CIS process when the woman's intentions are known antenatally

Care should not be withdrawn unless the woman is assessed to not be in established labour. In this case the woman should be clear about when to call for midwifery support if needed and this should be documented in the records.

15.0 Support for staff

Team meeting and/or group supervision sessions will be facilitated for cases that are particularly complex to enable the opportunity to discuss any elements of the care plan as required. Specific skills and drills practice will be made available as required and midwives can access any member of the PROMPT Faculty to discuss obstetric emergency practice if they feel they would benefit from this. Individual midwives should seek support through the CSfM or consultant midwife if required at any point. Debrief through individual or group supervision or for specific cases will be available.

16.0 Freebirth

In making informed choice some women may choose to give birth without medical or professional help. For some women, they feel the only way to retain choice, control and autonomy over their bodies during the birth process (Feeley & Thomson, 2016). In the absence of concerns relating to a family with additional vulnerabilities or safeguarding concerns, choices around freebirth alone are not grounds for referrals to be made in relation to safeguarding.

The woman assumes responsibility for her birth, but she may and can have her partner, relative, friend or doula present in a supportive role. A midwife has no right to be at a baby's birth and if a woman chooses not to contact or engage a midwife it is her right to do so. It is legal if the birth is not attended or the responsibility for care is assumed or undertaken by an unqualified individual, (an unqualified individual is a person who is not a registered Doctor or Midwife but acts in that capacity during birth) (NMC 2018).

If a woman states her intention to free birth then the midwife should seek to explore the woman's reasons and motivation for this. Consideration should be given to any additional support that can be put in place. If the woman chooses not to access further antenatal care, attempts should be made to contact them as per the recommended Schedule of antenatal care and care offered with an explanation of what would be offered at each appointment. Records should be maintained to reflect these discussions. It should be made clear that the woman can access midwifery care at any stage should they wish to, and they should be informed of indicators for accessing advice and care.

The woman's wishes should be documented within the handheld record and a CIS formulated and circulated. The woman should be advised that the detail will be shared with the nearest obstetric unit to ensure safe care should there be any concerns.

Birth Notification & Registration

The Notification of Births Act [1907] creates a duty upon the woman and her family to notify their birth within 36 hours. The National Health Service Act (2006), Section 269 provides further information around those relevant bodies to notify is either (a) NHS England, (b) Integrated Care Boards or (c) Local Authorities
<https://www.legislation.gov.uk/ukpga/2006/41/section/269>

There is a legal requirement to notify a birth within 36 hours, and advice will need to be sought with the Child Health Department for individual cases. There should be advanced planning undertaken during the antenatal period when a woman is known to be opting to freebirth.

Advise the woman in advance of the birth, the provisions in the individual Health Board of notifying birth before the situation becomes time critical as mothers are obliged to manage this legal requirement alongside caring for a newborn baby.

If the woman or a member of her family informs you of a freebirth and is requesting post-birth care from the maternity service, it is appropriate to complete the digital maternity system which can be completed if this is within 6 hours of birth.

If there is no midwife or other health professional present within 6 hours of the birth, but the woman/family engage with the maternity service and would like to accept post-birth care from the maternity service, then it may be appropriate to complete the digital maternity system.

Midwives should seek advice from the bronze on call. It is highly likely that many fields within the digital maternity system will need to be estimated, as would be undertaken when a "BBA" has occurred. Detail may need to be added within the notes section to state that it was a freebirth and therefore some information may not be known. Where free text can be inserted it is important to note that the woman has had an unassisted birth and therefore all entries are made in good faith with advice and support from the family.

If there is no midwife or other health professional present within 6 hours of the birth, and the woman/family decide not to engage with the maternity service and decline post-birth care from the maternity service, it would be inappropriate to complete the digital maternity system. The woman or any other person who was present at the birth, or who arrived within 6 hours of the birth, should be advised of the legal duty which exists to notify the birth.

Notification of birth is different to registering birth, the woman must firstly notify the birth in writing within 36 hours of her baby being born. The woman can be advised to attend to notify her GP. The woman can register her baby via the GP and obtain an NHS number. This will enable her to proceed to fulfil her legal duty to register her baby.

Once the birth has been notified, the mother will be given an NHS number for their baby, and they can proceed with registering the birth as normal through the local registry office (within 42 days) as per legal requirements [Register a birth: Overview - GOV.UK](#).

Following freebirth/unassisted birth; if there is no midwife or other health professional present within six hours of the birth, the mother or any other person who was present at the birth, or who arrived within 6 hours of the birth, must notify the birth in writing within 36 hours of the baby being born. If a midwife is present within 6 hours of the birth

then the birth should be entered into the digital maternity system with as much detail as possible.

Postnatal care should be offered to the woman and her family and the registered GP and named Health Visitor should be informed and safeguarding advice considered.

Midwives may find it helpful to access the RCM Guidance on Freebirth (2020) for further detail and support.

17.0 Monitoring Compliance, Audit & Review

An annual Clinical Information Sharing database is maintained within maternity services which records all cases where care is planned outside of guidance. This database is reviewed weekly at the midwifery leadership and management meeting to ensure monitoring of active cases. Clinical Information sharing cases for escalation are considered as part of the PTHB Weekend / out of hours planning and highlighted to Assistant Director for W&C services and Executive Director for Nursing and Midwifery.

The database includes the clinical reason/presentation and the outcomes for each case. This allows data and themes and trends to be monitored. The place of birth, type of birth, transfer in labour or postnatally plus any relevant extra information (PPH, failed IOL, MROP, reasons for transfer) all help with evaluating and auditing the CIS process. This enables an annual report to be written.

The named midwife is responsible for ensuring that the outcomes of all cases on their caseload are circulated so that the database can be updated.

If there is an adverse outcome or transfer for CIS cases, then a Datix must be submitted. Datix submissions are reviewed as part of the weekly maternity Datix meetings and will form part of the monthly midwifery management meeting with Governance theme to discuss any issues in more depth.

Where there is specific learning that may require urgent sharing to avoid recurrence this will be shared with the central Quality and Safety team for wider sharing. If it is an urgent or significant case a Patient Safety Huddle will be arranged and terms of reference for the incident will be agreed.

This guideline will be audited one year after implementation to ensure adherence to it. Peer review through record keeping audit of all CIS cases will also take place.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

18.0 References / Bibliography

Feeley C & Thomson G (2016) Why do some women choose to freebirth in the UK? An interpretative phenomenological study. BMC Pregnancy and Childbirth. Available at [Why do some women choose to freebirth in the UK? An interpretative phenomenological study | BMC Pregnancy and Childbirth | Full Text \(biomedcentral.com\)](#)

NHS England and NHS Improvement (2021) Personalised care and support planning guidance.

NHS (Wales) 2006 Special notices of birth and death section 200

NICE (2021) ECD8 – Standards Framework for shared decision-making support tools, including patient aids

Nursing and Midwifery Council [NMC] (2025) Principles for supporting women’s choice in maternity care. London:NMC
[Principles for supporting women’s choices in maternity care](#)

PTHB MAT 030 – All Wales Midwifery-Led Care Guideline

Royal College of Midwives (RCM) (2020) Clinical briefing sheet: ‘Freebirth’ or ‘unassisted childbirth’ during COVID-19 pandemic

Royal College of Midwives (RCM) (2022a) – Caring for those women seeking choices that fall outside of guidance. London: RCM

Royal College of Midwives (RCM) (2022b) – Informed decision making. London: RCM

Welsh Government (2021) National Clinical Framework: A Learning Health and Care System

Version Control:

Version	Summary of Changes/Amendments	Publication Date
1	Initial issue	Nov 2022
2	Review Amendment to process for review to ensure consultant midwife oversight and adequate care planning time	14/05/2026

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

(remove those not applicable)

Directorate	Date	Job Title
Women and Children's - Maternity	03/12/25	Consultant Midwife
Women and Children's - Maternity	10/12/25	Senior Midwifery Team

Task & Finish Group Members

(complete where applicable)

Name	Job Title

Impact Assessment Reviews

Has an Equality Impact Assessment (EIA) been completed	No	
Name of the person giving this response	Shelly Higgins	
If NO:	Not currently as update to current guideline (not policy) and awaiting full all-Wales guideline	
If YES:		

Procedure Approval Route

(include all stages of approval remove those not applicable)

Name	When	Outcome
PTHB Midwifery team Link Obstetric Teams in ABUHB, CTMUHB, SBUHB, HDUHB, BCUHB, SaTH, WVT PTHB Women & Children's Policy Group members Safeguarding team Health Board Clinical Lead – Welsh Ambulance Service University NHS Trust	16-12-2025	Consultation document circulated: No comments received
Maternity guidelines group	06/01/2025	
Women and Children's Policies and Procedures Governance Group	20/1/2026	<i>Approval Group</i>

Appendix A

Guidance on clinical presentation and process for 'fresh eyes/ears'

	Pathway A	Pathway B
1 – 2 risk factors	Discuss with consultant midwife or bronze on call	Named midwife completed individual assessment CIS not required
3 or more risk factors	Discuss with consultant Midwife or bronze on call	Discuss with consultant midwife or bronze for fresh eyes/ears and assess on individual basis if CIS required

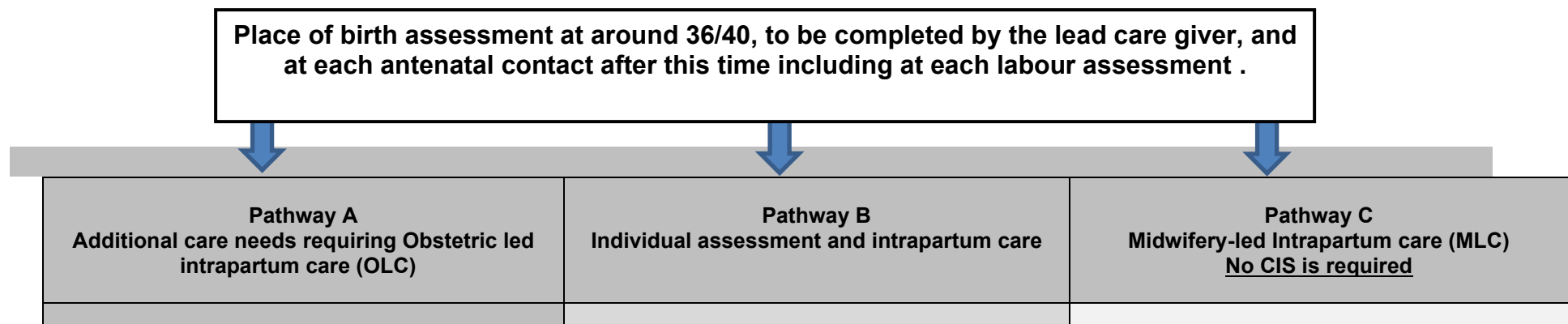
Cases in **Pathway C** can be treated as midwife-led care and a CIS is **not** required.

Cases to be considered for escalation to the Director of Midwifery, women and Families, Executive Director of Nursing and Quality and Safety Team

- Freebirth is known to be planned
- Following review by the Midwifery Leadership and Management team, there is consideration of a significant level of risk for the organisation

This list is NOT exhaustive and professional judgement must be used. If there are concerns always escalate.

All Wales Place of Birth Assessment Criteria




<p><u>Cardiovascular/other medical conditions</u></p> <ul style="list-style-type: none"> • Confirmed cardiac disease • Hypertension • Malignant Disease 	<p><u>Cardiovascular/other medical conditions</u></p> <ul style="list-style-type: none"> • Cardiac disease without intrapartum implications. 	
<p><u>Haematological</u></p> <ul style="list-style-type: none"> • Autoimmune disorders e.g. Systemic Lupus, • Antiphospholipid syndrome • Haematological – History of sickle-cell, beta thalassemia Major • History of thromboembolic disorders • Hb less than 85g/l • Immune thrombocytopenia purpura or platelet count below 100 10/litre. • Von Willebrand’s disease • Bleeding disorder in the women/fetus • Atypical antibodies known to cause HDN • Jehovah’s witness with additional care needs • Women scoring 3 or 4 on VTE assessment and on prophylactic or therapeutic antenatal anticoagulants. 	<p><u>Haematological</u></p> <ul style="list-style-type: none"> • Atypical antibodies not known to cause HDN • Platelets >100 <150 10/litre. • Hb between 85-105 g/l and asymptomatic of anaemia. 	<p><u>Haematological</u></p> <ul style="list-style-type: none"> • Hb of <110g/l at booking and <105g/l after 28 weeks, require iron therapy and recheck Hb at 34/40 OR 4 weeks after commencing iron therapy. • • Women scoring 2 on VTE assessment where postnatal thrombo-prophylaxis has been prescribed or declined.
<p><u>Endocrine</u></p> <ul style="list-style-type: none"> • Hyperthyroidism (any history of hyper, may present as hypo) • Women on oral steroids • Type 1 and type 2 diabetes • Gestational diabetes 	<p><u>Endocrine</u></p> <ul style="list-style-type: none"> • 	<p><u>Endocrine</u></p> <ul style="list-style-type: none"> • Adequately treated primary hypothyroidism
<p><u>Auto-immune</u></p> <ul style="list-style-type: none"> • Systemic lupus erythematosus, Scleroderma • Connective tissue disorders 	<p><u>Auto-immune</u></p> <ul style="list-style-type: none"> • Connective tissue disorders (non-specific) 	<p><u>Auto-immune</u></p>
<p><u>Infective</u></p> <ul style="list-style-type: none"> • Hepatitis B or C Carriers of, or infected 	<p><u>Infective</u></p>	<p><u>Infective</u></p>


<ul style="list-style-type: none"> • HIV • Toxoplasmosis in pregnancy • Active infection or chicken pox/rubella • Primary infection of genital herpes (First lesion) diagnosed in pregnancy or recurrent active lesions after 36/40. • Tuberculous under treatment 	<ul style="list-style-type: none"> • Covid 19-symptoms or positive test within 10 days of onset of labour or previous hospital admission due to Covid-19 during pregnancy. • Previous baby affected by GBS, diagnosed with GBS this pregnancy, or opting for Intrapartum Antibiotic Prophylaxis (IAP). 	<ul style="list-style-type: none"> • History of genital herpes, and lesion free throughout pregnancy, offer prophylactic acyclovir from 36/40. • Reoccurrence of genital herpes in this pregnancy but lesion free prior to 36/40, offer prophylactic acyclovir from 36/40. • Group B streptococcus in current pregnancy, declining Intrapartum Antibiotic prophylaxis (recommend neonatal observation as per EOS calculator). • GBS in last pregnancy; Offer Vaginal/rectal swab 35-37/40. If negative IAP not required, can be MLC for birth unless mother wishes IAP in which case this should be supported.
<p><u>Neurological</u></p> <ul style="list-style-type: none"> • Epilepsy • Myasthenia gravis • Multiple sclerosis • Previous cerebrovascular accident 	<p><u>Neurological</u></p> <ul style="list-style-type: none"> • Previous epilepsy not medicated and no seizures for 3 years. 	<p><u>Neurological</u></p>
<p><u>Gastro-intestinal/Renal</u></p> <ul style="list-style-type: none"> • Liver disease (not obstetric-cholestasis) • Abnormal renal functions/known renal disease 	<p><u>Gastro-intestinal/Renal</u></p> <ul style="list-style-type: none"> • Crohn's disease or ulcerative colitis 	<p><u>Gastro-intestinal/Renal</u></p>
<p><u>Previous pregnancies</u></p> <ul style="list-style-type: none"> • Previous Molar pregnancy • Previous HELLP syndrome • Severe pre- eclampsia/eclampsia • Pre-eclampsia requiring preterm birth, • Baby with neonatal encephalopathy • Uterine rupture • Placental abruption • Previous PPH 500-999mls requiring treatment or blood transfusion. 	<p><u>Previous pregnancies</u></p> <ul style="list-style-type: none"> • Pre-eclampsia at term and asymptomatic this pregnancy. • 3rd/4th degree tears with no ongoing issues. 	<p><u>Previous pregnancies</u></p> <ul style="list-style-type: none"> • 3 or more consecutive miscarriage • Mid trimester miscarriage (12-22 weeks). • Previous SGA below 10th centile (Suitable for Midwifery-led birth where USS's are Normal) • Previous pre-term birth now >37/40. • Previous PPH 500-999mls with no treatment or evidence of bleeding due to uterine atony, previous birth record to be reviewed to confirm clinical picture.

<ul style="list-style-type: none"> • Primary PPH >1000 mls or any amount causing symptoms of hypovolaemia. • Retained placenta • Caesarean section. • Shoulder dystocia • Cervical tears • 3rd /4th degree tears with ongoing concern or continence issues 		
<p><u>Current pregnancy</u></p> <ul style="list-style-type: none"> • Multiple pregnancy • Low PAPP-A and concerns around fetal growth. • Gestational diabetes • Placenta praevia • Pre-eclampsia /pregnancy induced hypertension • Pre-term pre-labour rupture of membranes • APH of placental origin or > 1 episode after 24 weeks • Alcohol dependency • Maternal age ≥40 at booking (SBAR-10). • Nulliparous BMI ≥35-39.9 with normal GDM screen and USS's. • All parity BMI>40 • Grand multiparity P6 >. • Concerns with fetal growth or placental function. • Concerns around fetal movement within 24 hours of the onset of labour. • EFW ≥97th with any other additional care needs • Polyhydramnios/oligohydramnios • Gestation >41+6 • Therapeutic or prophylactic thromboprophylaxis • Wt. <50kg with anaemia • Persistent breech/mal presentation. 	<p><u>Current pregnancy</u></p> <ul style="list-style-type: none"> • Women declining booking/anomaly USS • APH of unknown origin, 1 episode after 24/40 • Substance misuse • Para 5 • EFW via USS > 97th centile with normal GDM screen and otherwise uncomplicated pregnancy. • 2 episodes of raised blood pressure antenatally, taken more than 4 hours apart. • Recurrent¹ episodes of AFM (2 or more within 21 days) with reassuring outcomes of investigations and where fetal movements have been normal in the last 24 hours. • Booking WT<50kg , no concerns around fetal growth and normal haemoglobin. • Low PAPP-A with normal fetal growth on serial USS 	<p><u>Current pregnancy</u></p> <ul style="list-style-type: none"> • BMI at booking of 30 to 34.9kg/m • Multiparous BMI 35-39.9 with previous vaginal birth who are otherwise suitable for Midwifery-led birth with normal GDM screen and normal routine USS's. • Maternal age 35-39 inclusive at booking. • Smoker (Suitable for Midwifery-led birth where USS's are normal). • P4 or < • EFW >90th <97th centile on USS at 36/40 with otherwise uncomplicated pregnancy. • Assisted conception • A single episode or >1 episode of AFM (occurring > 21 days apart), with reassuring investigation and normal fetal movement in the last 24 hours.


<p><u>Previous gynaecological history</u></p> <ul style="list-style-type: none"> • Myomectomy • Hysterotomy • Cone biopsy • Any uterine perforation resulting from previous STOP or surgery. 	<p><u>Previous gynaecological history</u></p> <ul style="list-style-type: none"> • Extensive vaginal repair/re fashioning • LLETZ x2 laparoscopy/laparotomy 	<p><u>Previous gynaecological history</u></p> <ul style="list-style-type: none"> • LLETZ x 1
<p><u>Respiratory</u></p> <ul style="list-style-type: none"> • Severe asthma requiring increase in treatment of hospital admission during pregnancy • Cystic fibrosis 	<p><u>Respiratory</u></p>	<p><u>Respiratory</u></p> <ul style="list-style-type: none"> • Mild asthma women only using inhalers prescribed by GP. Steroid inhalers where asthma has been stable during pregnancy
<p><u>Mental Health</u></p> <ul style="list-style-type: none"> • Where intensive maternal or neonatal monitoring is required during labour and/or postnatally. 	<p><u>Mental Health</u></p> <ul style="list-style-type: none"> • Stable mental health illness on various psychotropic medication, including antipsychotics. (Plan neonatal care as per maternal psychotropic drug pathway) 	<p><u>Mental Health</u></p> <ul style="list-style-type: none"> • Women on SSRIs and stable (neonatal care as per All Wales maternal psychotropic drug pathway).



Advise to give birth in an obstetric unit. Any women who are planning birth outside of the OU will be planning birth 'outside of guidance' and will require detailed care plans as per local pathways.



After an individual discussion and assessment may be suitable to give birth in a midwifery-led setting.



Advise to give birth in a midwifery-led setting.

At every antenatal assessment, by midwives and the medical team, review of the antenatal care pathway should occur and the lead professional and place of birth recommendation changed where required.

1 =Definition of recurrent altered fetal movement =is where at least 2 episodes of altered fetal movements are reported within a 21-day period.

*It is noted that the above is not exhaustive and clinicians should exercise clinical judgment.

*Midwives should be aware of the impact of multiple complexity, even where these are in care pathway B, multiple factors in any pathways may move the care need to pathway A

Appendix B - CIS PAPERWORK

Midwifery Clinical Information Sharing – SAMPLE Access at [MASTER COPY - CIS Paperwork - May 2026.docx](#)

Named Midwife:		
Alert Compiled by:		Date compiled:
Discussed with:		Date discussed:

CLIENT DETAILS			
Name:			
P number:		DOB	
NHS number:		Age	
Address:			
Phone number:			
EDD:		Gravida:	Para:
Situation: <i>To be stated clearly, bullet points</i>			
Background: <i>Key points related to the case history</i>	Obstetric history Medical History Mental health and social history Current Pregnancy		
Assessment <i>Summary of key discussions and care including possible risks and summary of obstetric review if applicable</i>			
Recommendation/Plan: <i>Clear plan outlining care</i>			
Directions <i>Directions if required</i>			

Has the management plan been updated in records:	Yes	No
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Details added antenatally to 'CIS outcomes' database on SharePoint by named midwife <u>and</u> CIS saved by month EDD on SharePoint – maternity templates	Yes	No
CIS copied to:		
Consultant Midwife:	Yes	No
Midwifery Team:	Yes	No
Clinical Supervisor for Midwives; if relevant	Yes	No
DGH: Name:	Yes	No
WAST Ambulance:	Yes	No
Complex Multiple factors escalated to HoM & Out of Hours Senior Operational On Call / Executive level; if relevant	Yes	no

Health Board/ NHS Trust	Relevant Contact email	Process ANC = antenatal clinic
SaTH	For MDT email sath.PMA@nhs.net For sharing of CIS email: sath.prh-maternity-anc@nhs.net	Email copy to them and can be discussed at monthly MDT to support care planning if particularly complex. Named midwife can attend. Ideally 32/40. Also share to ANC
CTMUHB	CTM.ANCmidwivesPCH@wales.nhs.uk Consultant midwife requests: Brynany.tweedale@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review. Consultant midwife review should be requested for all requests for AMU birth in CTMUHB
ABUHB	ABB.ANCBookingsNHH@wales.nhs.uk Consultant midwife requests: Emma.mills@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review. Consultant midwife review should be requested for all requests for AMU birth in ABUHB
Hywel Dda	Bronglais.antenatalclinic@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review
Swansea Bay	SBU.ANCNPT@wales.nhs.uk Consultant midwife requests: SBU.consultantmidwife@wales.nhs.uk	Email copy to ANC and can request consultant midwife or obstetric review.
Wye Valley	hhn-tr.anreferrals@nhs.net	Email copy to ANC and can request obstetric review.
BCU	BCU.MOAUBlairbell@wales.nhs.uk and copy to Karen.Roberts12@wales.nhs.uk Emma.adamson2@wales.nhs.uk and Jane.Jones16@wales.nhs.uk	Email copy to ANC and can request obstetric review.

Appendix C – SAMPLE - Draft letter/email/wording for phone call for obstetric/neonatal review

Available at: [Draft Obs letter - CIS.docx](#)

Subject: *Request for Individualised Plan – Clinical detail*

Dear Dr XXXXX,

Regarding: Name, NHS number, EDD

I am writing regarding name at gestation with the following relevant history:

- *Detail high level clinical summary of situation*

She is planning a *home birth or midwifery-led unit birth*. Given her obstetric history, we believe consultant oversight and an individualised plan are essential for safe care.

We would be grateful if you could:

1. Review her history and provide an individualised care plan outlining recommended place of birth, risk mitigation, monitoring, and escalation guidance.
2. Advise on contingency planning should complications arise.
3. If she declines a face-to-face appointment, consider a telephone or virtual review to provide the plan.

If you are unavailable, it would be appreciated if another consultant could provide support and review to ensure a plan is in place.

We aim to document the plan in the Clinical Information Sharing (CIS) document and share it with both the midwifery team and the woman to support informed decision-making. Your guidance will ensure that our team is fully supported and care is delivered safely.

This approach ensures we mitigate risk for the woman, our organisation and the midwifery team, and provides appropriate support for staff managing this high-risk situation.

Please let me know if you require any further information to facilitate this.

Kind regards,

Appendix D – SAMPLE - WAST PSD



Available at: [updated 2025 WAST Safeguarding - Blank Midwifery Alert.docx](#)

Child's Name: Unborn Mother's Name: Address: Mother's DOB: EDD:	Contact details for Professionals involved with family: Named Midwife: Midwifery Team: Social Worker: Emergency Duty Team:
Child Protection Concerns, and/or relevant medical background details:	
Safeguarding actions, and/or treatment to be taken in an emergency that would differ from the normal process for WAST: (WAST will dispatch as per dispatch protocol) *If completing for a flag to be added to an address, please include the time frame this will be needed for	
Police Incident Number(if applicable)	Is it safe to visit the home alone?
Name of professional requesting Safeguarding Children Alert: Agency:	
Has parental consent been obtained:	Date:

Midwifery Alert Notification Proforma

[Welsh Ambulance Services NHS Trust / Amb_wastsafeguarding@wales.nhs.uk](#)

Name of professional raising alert on behalf of WAST: Signed :	Date:
*****End of Document*****	