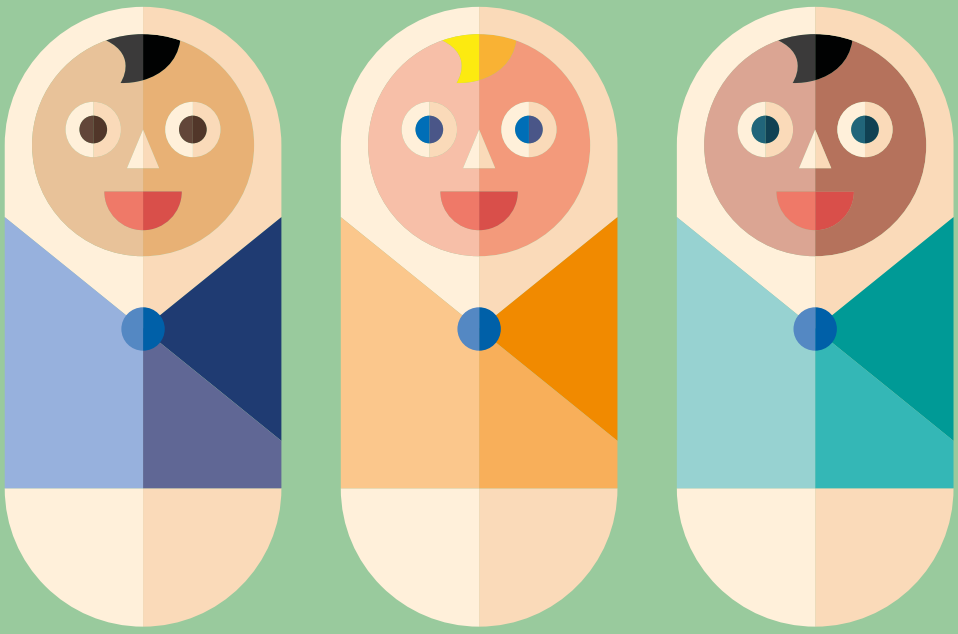
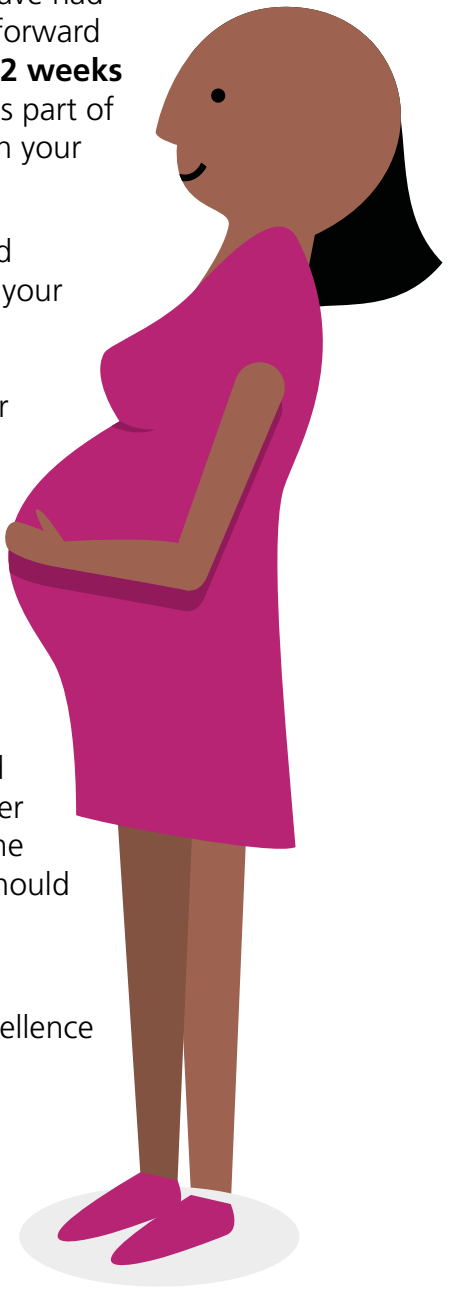
Your choice
Where to have your baby...



Information for healthy, low-risk women who have had a baby before

Who is this information for?

This information is for healthy women who have had a baby before, who expect to have a straightforward pregnancy and give birth **between 37 and 42 weeks of pregnancy.** This booklet should be used as part of a comprehensive, personalised discussion with your midwife.



During your antenatal care, your midwife, and sometimes a doctor (obstetrician) will discuss your health with you. With information from you, they will assess your health and the health of your baby. You can decide what feels right for you. You can change your plans about where to have your baby at any stage if your pregnancy changes or you change your mind.

Planning where to have your baby is an important decision. Evidence shows that giving birth in the UK is generally very safe.

You can choose where to have your baby and this information has been developed to answer some of the questions you may have about the availability and safety of all the options you should be offered.

The information in this leaflet is based on the National Institute for Health and Care Excellence (NICE) clinical guideline **Intrapartum care for healthy women and babies** (CG 190; 2014 updated 2017).

Please note that NICE and all other terms are explained at the end of the leaflet.

What choices do I have about where to give birth?

Your midwife should explain that you can choose to give birth at home, in a midwifery unit (either freestanding or alongside a hospital with an obstetric unit) or in a hospital obstetric unit. There is more information about each on option on pages 6-9, and your midwife will explain which of the options are available to you. All four options (including the different types of midwifery unit) should be available to you. Your midwife will explain which of the options are available in your area.

Wherever you choose to have your baby, you should be supported in your choice. There is more information on this on page 14 of this leaflet.

Midwifery units (sometimes called birth centres) are run by midwives. They can be in or next to a hospital with an obstetric unit (alongside) or in a different place (freestanding). They provide a comfortable environment which is more like being at home. They do not have the same medical facilities as a hospital obstetric unit, but have clear processes for dealing with an emergency for you or your baby.

This will include transfer to an obstetric unit if necessary. Obstetric units (also called labour wards) have more medical facilities. Planning to have obstetric unit care is associated with an increase in the chance you will have an intervention.

If you have had a baby before, your midwife should advise you that planning birth in a midwifery unit is particularly suitable. Wherever you choose to have your baby, a small number of babies will have unexpected medical problems during or after birth.

You can change your plan and make a different choice at any stage. For example, you can come in to a midwifery or obstetric unit once labour starts even if your original plan was for a home birth.

You can discuss your individual circumstances and choices with your midwife at any time including, for example what would happen if you needed a transfer to an obstetric unit and the time it would take.

What does the research say?

The research evidence used in developing NICE guidance about choosing where to have your baby found the following for women who are healthy with a straightforward pregnancy, and without additional risk factors at the start of their care in labour:

- Women planning birth at home or in a freestanding midwifery unit were more likely to have a straightforward vaginal birth than women planning birth in an alongside midwifery unit. Women planning birth in any of these three places were more likely to have a straightforward vaginal birth than women planning birth in an obstetric unit. For more information see Appendix 1.
- The chances of a baby having a serious medical problem were the same for women planning birth at home, in a freestanding midwifery unit, in an alongside midwifery unit, or in an obstetric unit. For more information see Appendix 2 & 3.
- Women planning birth in an obstetric unit were more likely to have interventions, such as ventouse or forceps birth, caesarean section and episiotomy (term explained on page 26), than women planning birth in other places. For more information see Appendix 4.
- Planning to give birth at home or in a midwifery unit (freestanding or alongside) was a particularly suitable option because the rate of interventions was lower and there was no evidence that the outcome for the baby is different compared with an obstetric unit.

Wherever you choose to have your baby, if you and your baby are healthy, you will be cared for by a midwife, and doctors (obstetricians) will not normally be present during your labour or birth. NICE guidance for healthy women says that in some circumstances, birth in an obstetric unit should be considered **(www.nice.org.uk/guidance/cg190)**. For example, you may have a health condition, a clear preference for birthing in an obstetric unit or your health or pregnancy may change.

Some risk factors are more likely to affect your health or your baby's health than others, and if any of these conditions arise, your midwife or doctor should talk to you about what they mean for you and your baby. You can decide what feels right for you. NICE publishes separate guidance on care for particular groups of women, such as women with diabetes or who are pregnant with twins.

Wherever your baby is born, ongoing care will be provided by midwives and maternity support workers on an individual basis following the birth. For further information, you can read the NICE guidelines on postnatal care up to eight weeks after birth. **(www.nice.org.uk/guidance/cg37)**.

Where can I choose to give birth:

At home

- At home you will be in a familiar place where you will be able to use your own facilities and feel comfortable in your own surroundings.
- A midwife will be with you for your labour and a maternity support worker or second midwife will be there for the birth of your baby.
- You are more likely to see the same person throughout your care.
- If you or your baby need to see a doctor, your midwife will call an ambulance and you will be transferred to a hospital obstetric unit.
- Pain relief options may include a bath or birthing pool which you provide, gas and air (Entonox), or an opiate injection of pain relief.
- You will be able to use your own facilities, including toilet and bathroom.

In a free standing midwifery unit (birth centre)

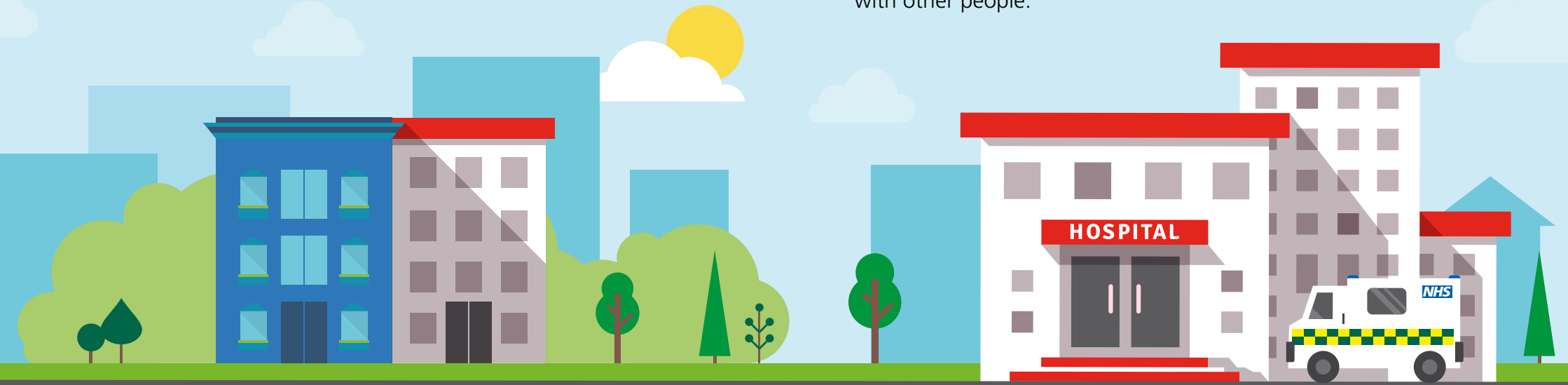
- A freestanding midwifery unit is usually 'home-like', and is in a different place from the hospital obstetric unit.
- A midwife will be with you for most of your labour and a maternity support worker or second midwife may also be there.
- You are more likely to see the same person throughout your care than you would in an obstetric unit.
- If you or your baby need to see a doctor, your midwife will call an ambulance and you will be transferred to a hospital obstetric unit.
- Pain relief options may include a birthing pool (if available), gas and air (Entonox), or an opiate injection of pain relief.
- It is less likely that you will have to share toilet and bathroom facilities with other people.

In an alongside midwifery unit (birth centre)

- An alongside midwifery unit, which is usually 'home-like', is in a main hospital, but separate from the obstetric unit.
- A midwife will be with you for most of your labour and a maternity support worker or second midwife may also be there.
- You are more likely to see the same person throughout your care than you would in an obstetric unit.
- If you or your baby need to see a doctor, you will be transferred to an obstetric unit on the same site. A neonatal unit is also available on site; however these differ in levels of care provided.
- Pain relief options may include a birthing pool (if available), gas and air (Entonox), or an opiate injection of pain relief.
- It is less likely that you will have to share toilet and bathroom facilities with other people.

In a hospital obstetric unit

- An obstetric unit is a hospital environment with a medical team (obstetricians, anaesthetists, neonatologist/paediatricians) and medical equipment.
- A midwife will be with you for most of your labour and a maternity support worker or second midwife may also be there.
- In many hospital settings, you are less likely to see the same person throughout your care.
- If you or your baby need to see a doctor your midwife will call a doctor who is available on site who will come to your room to see you. A neonatal unit is also available on site; these will differ in levels of care provided.
- Pain relief options include a birthing pool (if available), gas and air (Entonox), an opiate injection of pain relief e.g. an opiate, and an epidural. Note: An epidural is only available in an obstetric unit.
- You are more likely to have to share toilet and bathroom facilities with other people.



What else do I need to know?

Some women like to have more detail about the benefits and risks of the choices they are making.

Very few mothers die or are injured as a result of birth, wherever they have their baby.

Few babies die or are injured as a result of the birth itself, wherever the baby is born.

Additional information on national statistics is provided in the appendices. These are about your chances of having a straightforward vaginal birth, transfer to a hospital obstetric unit (how often these are needed and for what reason) and what is meant by serious medical problems for your baby.

It is intended to help answer questions you may have about the research evidence that the recommendations are based on.

Your midwife or doctor can discuss this additional information with you, if you wish.

Local statistics about all local birth settings should be available to you and you can discuss with your midwife the local information on:

- Access to midwives, including:
  - the likelihood of being cared for in labour by a familiar midwife.
  - the likelihood of receiving one-to-one care throughout labour (not necessarily being cared for by the same midwife for the whole of labour).
- Access to medical staff (obstetric, anaesthetic and neonatal).
- Access to pain relief, including birthing pools, Entonox, other drugs and regional analgesia.
- The likelihood of being transferred to an obstetric unit (if this is not the woman's chosen place of birth), the reasons why this might happen and the time it may take.

Appendix 1

What are the chances that I will have a straightforward vaginal birth?

The chances vary depending on your individual circumstances, but the best available research evidence is shown in the table below.

The evidence in the tables below (on pages 12 and 14):

- Is about women who have had a baby before who were considered to be at low risk of complications prior to the start of labour. It relates to where women planned to have their baby, even if the birth eventually happened somewhere else. For example, if a woman planned to give birth out of hospital but transferred to hospital during labour and her baby was born by caesarean section, then that caesarean birth was recorded as being from wherever she had planned to give birth.

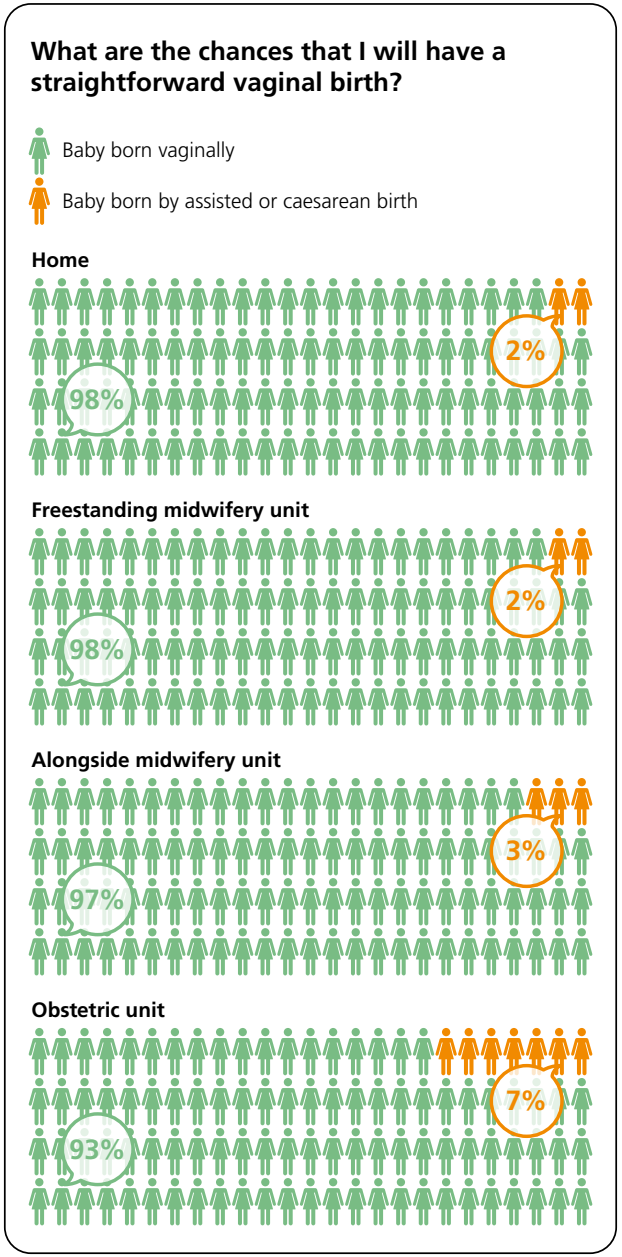
- Please note that there may be additional local information available to you about how many healthy women in your area have their baby in the place where they plan to, and how many transfer to the obstetric unit if not already there. Local information may also be available on rates of spontaneous vaginal birth and obstetric intervention.

Table 1

Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth	Proportion of incidences with women who have had a baby before			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Spontaneous vaginal birth	98.4%*	98.0%	96.7%	92.7%*
Transfer to an obstetric unit	11.5%*	9.4%	12.5%	1.0%**
Regional analgesia (epidural and/or spinal)***	2.8%*	4.0%	6.0%	12.1%*
Episiotomy	1.5%*	2.3%	3.5%	5.6%*
Caesarean birth	0.7%*	0.8%	1.0%	3.5%*
Instrumental birth (forceps or ventouse)	0.9%*	1.2%	2.3%	3.8%*
Blood transfusion	0.4%	0.4%	0.5%	0.8%

This information comes from recommendation 1.1.4 in NICE CG190 Intrapartum Care (2014)
* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).
** 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.

This is the same information presented in a different way (rounded to the nearest percentage point) – see also infographics on pages 21 to 25



Appendix 2

What are the chances my baby will be well or have serious medical problems, including stillbirth, during or after birth?

Wherever you choose to have your baby, a small number of babies will have unexpected medical problems during or after birth. Some problems are less serious and are not permanent, and some are more serious and long term, but still rare. The chances of a problem vary depending on your individual circumstances, but the best available evidence for healthy women who have had a baby before, and are at low risk of complications, is shown in the table below.

NB these are the numbers out of 1000.

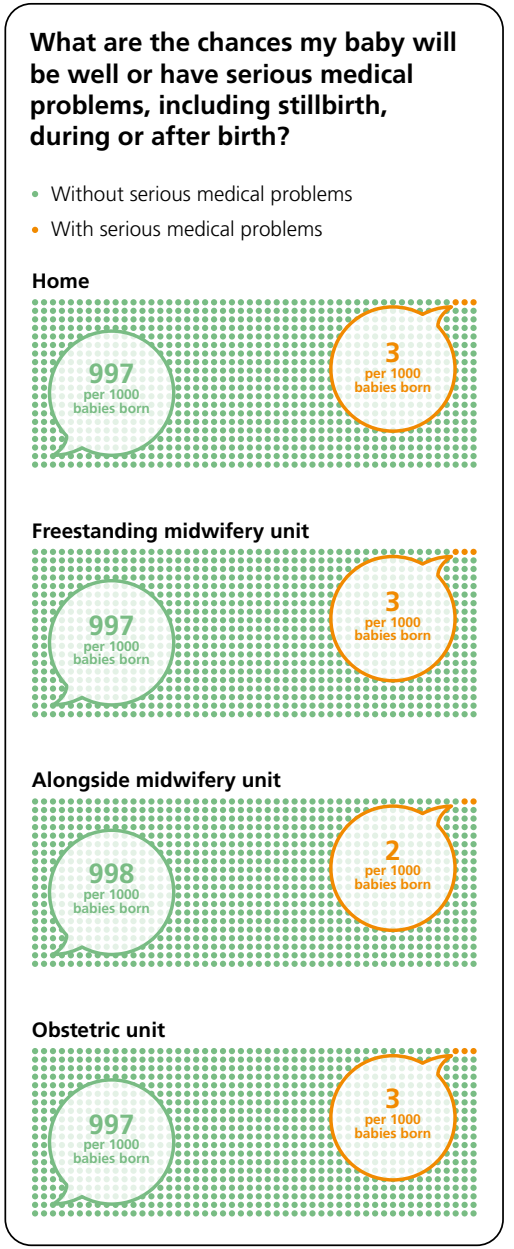
Table 2

Outcomes for the baby for each planned place of birth	Number of babies per 1000 births			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Babies without serious medical problems	997	997	998	997
Babies with serious medical problems*	3	3	2	3

This table is from recommendation 1.1.3 of NICE CG190 Intrapartum Care (2014)

*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 (fractured upper arm bone) and fractured clavicle (fractured collar bone) – less than 4% of adverse events.

This is the same information presented in a different way.



Appendix 3

Serious medical problems

The large UK study that is the source for most of this information (Birthplace 2011) used a definition of serious medical problems or 'adverse outcome' that includes the outcomes listed below. These were chosen because they are all serious at birth.

Some babies get better and recover fully. Some things lead to long-term problems for the baby. Differences in how often these events occurred might reflect differences in the quality of care received during the birth.

Neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for three-quarters of the total.

Stillbirths after the start of care in labour and death of the baby in the first week of life together accounted for 13% (or 1 in 7) of the events.

Fractured humerus (fractured upper arm bone) and fractured clavicle (fractured collar bone) were uncommon outcomes, accounting for fewer than 4% of adverse events. For the combined frequency of these events, see the following tables.

Serious medical problems

Table 3

Outcome	Number of babies affected in each 1000 births	Percentage of all the adverse outcomes measured
Stillbirth after start of care in labour	14 out of 64,535 (0.22 per 1000)	**5%**
Death of the baby in the first week after birth	18 out of 64,292 (0.28 per 1000)	**7%**
Neonatal encephalopathy (disordered brain function caused by lack of oxygen before or during birth that may get better but can lead to permanent brain damage or death)	102 out of 63,955 (1.6 per 1000)	**40%**
Meconium aspiration syndrome (the baby breathes meconium into the lungs)	86 out of 63,955 (1.3 per 1000)	**34%**
Brachial plexus injury (a nerve injury leading to arm weakness in the baby)	24 out of 63,955 (0.38 per 1000)	**9%**
Bone fractures caused by delivering the baby quickly in an emergency	11 out of 63,955 (0.17 per 1000)	**4%**
TOTAL (of all outcomes included in the 'adverse outcome' measure)	255 out of 63,955 to 64,535 (approx. 4 per 1000)	**99%****

This table is derived from table 5 of the NICE CG 190 2014 choosing place of birth resource for midwives. This data is the same for both women who have had a baby before and those who are having their first baby.

Note: Each of the categories are mutually exclusive, and outcomes listed higher in the table take precedence over outcomes listed lower down. For example, if a baby with neonatal encephalopathy died within 7 days, the outcome is classified as an early neonatal death.

* Denominator varies because of missing values.
** Does not equal 100% because of rounding.

Appendix 4

Transfers to the obstetric unit

How likely is it that I would need to transfer to an obstetric unit?

If you are giving birth at home or in a freestanding midwifery unit, and if you or your baby need to see a doctor, your midwife will call an ambulance and take you to an obstetric unit. If you are in an alongside midwifery unit you will be taken to an obstetric unit on the same site.

Table 4 shows rates and timing, of transfer to an obstetric unit during labour or immediately after birth among healthy women without complications in their pregnancy, who have had a baby before, recorded by their planned place of birth at the start of care in labour:

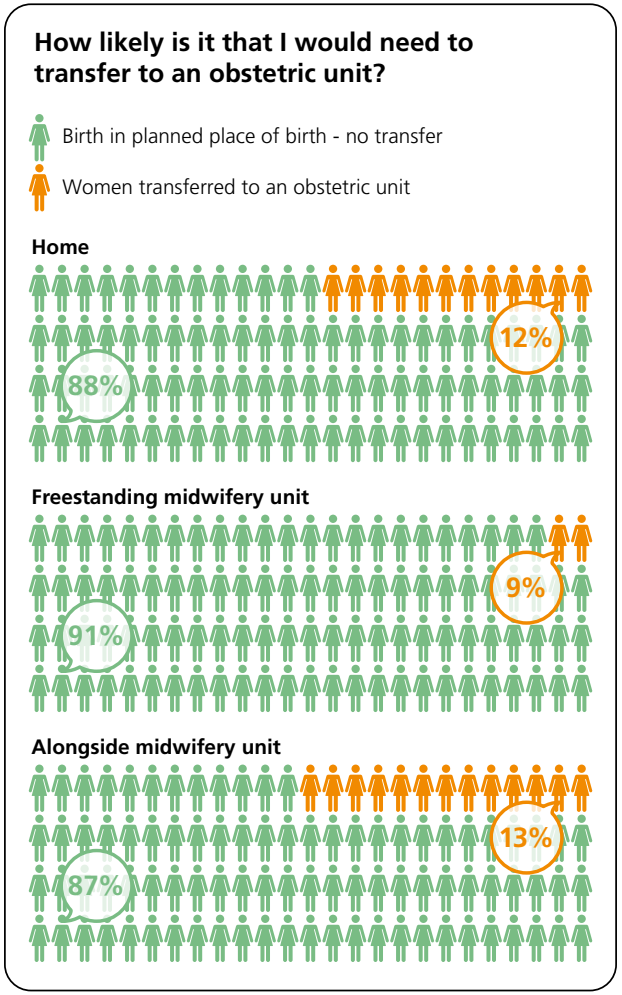
Table 4

Rates of transfer for each planned place of birth	From home	From a freestanding midwifery unit	From an alongside midwifery unit
Transferred during labour	6.4%	5.3%	8.5%
Transferred after the birth	5.2%	3.9%	3.5%
Timing of transfer not known	0.4%	0.2%	0.5%
All transferred	**12.0%**	**9.4%**	**12.5%**

This table is derived from table 6 of the NICE CG 190 2014 choosing place of birth resource for midwives.

A small proportion of births planned in an obstetric unit also involved a transfer to another obstetric unit (1%).

This is the same information presented in a different way (rounded to the nearest percentage point).



What are the most common reasons for transfer to an obstetric unit during labour or birth?

Sometimes women are transferred to an obstetric unit from home or a midwifery unit. The most common reasons for and likelihood of these transfers are shown in Table 5:

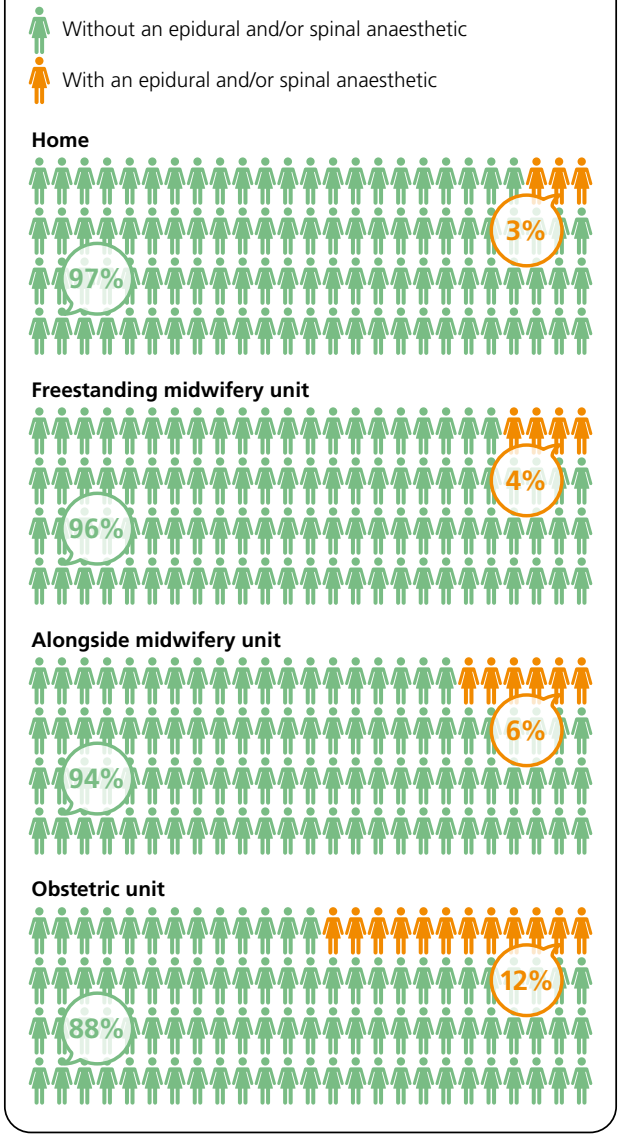
Table 5

Main reason for transfer from planned place of birth to an obstetric unit	From home	From a freestanding midwifery unit	From an alongside midwifery unit
Delay in labour (any stage)	32.4%	37.1%	35.2%
Concerns about fetal heart rate	7.0%	10.5%	10.8%
Request for epidural	5.1%	6.6%	13.3%
Meconium	12.2%	12.2%	12.2%
Retained placenta	7.0%	7.3%	4.6%
For stitches	10.9%	7.5%	8.4%
Neonatal concerns (after birth)	5.2%	2.6%	(less than 0.1%)
Other	20.1%	16.2%	16.3%

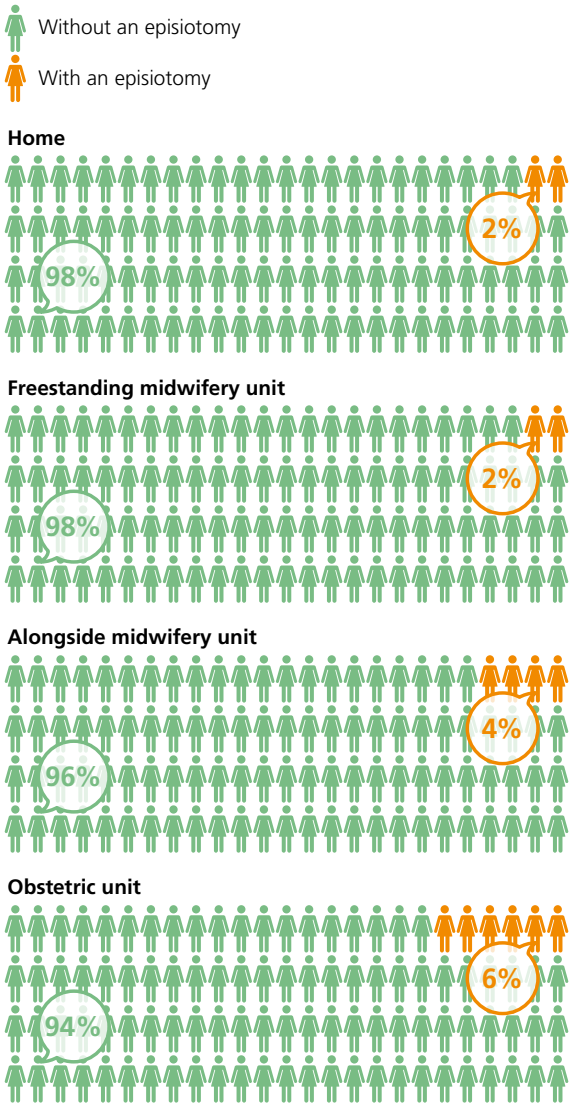
This table is derived from recommendation 1.1.7 of NICE CG190 (2014) figures for all healthy women(those having their first baby and those who have had a baby before)and is taken from the Birthplace Study.

The infographics on pages 21 to 25 are information from Table 1 on page 12 presented in a different way. The numbers have been rounded to the neatest percentage point.

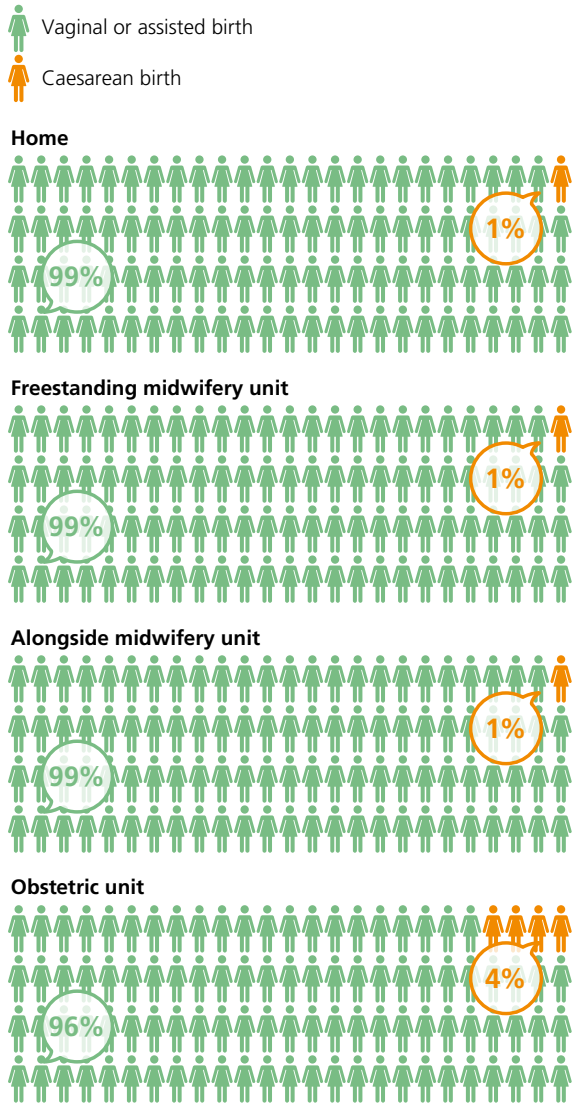
How likely is it that I will not have/ will choose or need an epidural/spinal anaesthetic for pain during labour?



How likely is it that my birth will not/will involve an episiotomy?



How likely is it that my baby will not/will be born by caesarean?



How likely is it that my baby will not/will be born by assisted birth (forceps or ventouse)?

Vaginal birth or caesarean birth

Assisted birth

Home

Freestanding midwifery unit

Alongside midwifery unit

Obstetric unit

How likely is it that I will not/will need a blood transfusion?

No blood transfusion

With blood transfusion

Home

Freestanding midwifery unit

Alongside midwifery unit

Obstetric unit

Terms explained

Anaesthetist
A doctor who specialises in pain relief and anaesthetics (usually epidurals in labour and birth).

Episiotomy
An episiotomy is a cut in a woman's perineum (the area between the vagina and the anus).

Established labour
Established labour is when the woman's cervix is at least 4 cm dilated and she is having regular painful contractions.

Forceps birth
In this type of birth, forceps (smooth metal instruments that look like large spoons or tongs) are placed around the baby's head to pull him or her out of the vagina while you push. An episiotomy is almost always needed for a forceps birth. A spinal block or epidural is usually given beforehand.

Low Risk
A woman is considered at 'low risk' of complications if she and her baby are healthy, there is one baby, she is between 37 and 42 weeks of pregnancy and there's nothing to indicate that labour and birth won't go smoothly. Your midwife or obstetrician will be able to talk to you about whether you are 'low risk'.

Maternity support workers
Maternity support workers assist midwives in caring for women and their babies through pregnancy, birth and the first few days after birth.

Midwife
Specialist in straightforward pregnancy and birth. Their role is to look after a pregnant woman and her baby throughout antenatal care, during labour and birth and up to 28 days after the baby is born. They work with doctors and other healthcare professionals when necessary.

Midwifery unit
Midwifery units (sometimes called birth centres) are run by midwives. They can be inside or next to a main hospital obstetric unit (called 'alongside') or in a different place (called 'freestanding'). They provide a comfortable environment which is more like being at home. They do not have the same medical facilities as a hospital obstetric unit, but have medical equipment to deal with an emergency for you or your baby.

Neonatologist (or paediatrician)
A doctor who specialises in looking after newborn babies who are unwell.

NICE (The National Institute for Health and Care Excellence)
NICE provides national guidance and advice to improve health and social care. The NICE clinical guidelines are based on the best available evidence and help people make informed decisions about their care. The guidelines also help healthcare professionals in their work, but they do not replace their knowledge and skills. All NICE guidance and advice is available on the NICE website at www.nice.org.uk.

Obstetrician
A doctor who specialises in the care of pregnant women and their unborn babies, particularly those who have health problems, or develop problems during pregnancy and labour.

Obstetric unit
A hospital unit where women give birth. It is sometimes called a labour ward.

Opioid
A type of painkiller that can be used by women in labour, such as diamorphine or pethidine. It is given by injection.

Serious medical problem
Serious medical problems that affected babies in the Birthplace study included neonatal encephalopathy (disordered brain function caused by lack of oxygen before or during birth that may get better but can lead to permanent brain damage or death), problems caused by the baby inhaling meconium into the lungs, a fractured arm or collarbone, stillbirth, and death in the first week of life.

Ventouse birth
Ventouse birth (sometimes called vacuum birth) is when the baby is pulled out while you push using a cup that is fitted to the baby's head by suction. An episiotomy is often needed for a ventouse birth. A spinal block or epidural is usually given beforehand.

Sources

Blix et al. (2012) Outcomes of planned home births and planned hospital births in low-risk women in Norway between 1990 and 2007: A retrospective cohort study Sexual & Reproductive. Healthcare Volume. 3(4), Pages 147–153.

Brocklehurst P. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. BMJ 2011; 343:d7400
www.bmj.com/content/343/bmj.d7400

NICE CG190 Intrapartum Care (2014) (Updated 2017)
https://www.nice.org.uk/guidance/cg190

For more information on your choices, please visit NHS Choices at www.nhs.uk

For more information on your choices locally, please visit www.which.co.uk/birth-choice

Prepare your questions for your midwife here

These booklets support the implementation of recommendations in the NICE guideline on intrapartum care for healthy women and babies. They support statement 1 in the NICE quality standard for intrapartum care.

National Institute for Health and Care Excellence
May 2018

Royal College of Obstetricians & Gynaecologists