Sherwood Forest Hospitals
NHS Foundation Trust

Facilitating Choice & Shared Decision-Making Within Maternity Care Guideline

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Evidence Base/ References:	See section 9

Lead Division:	Women & Children's
Lead Specialty:	Maternity
Lead Author:	[redacted] (Professional Midwifery Advocate)
Sponsor:	[redacted] (Head of Midwifery / Head of Nursing)

	Name the documents here or record not applicable
Associated Policy	Not Applicable
Associated Procedure(s)	Not Applicable
Associated Pathway(s)	Not Applicable
Associated Standard Operating Procedure(s)	Not Applicable
Other associated documents e.g. documentation/ forms	Not Applicable

Consultation Undertaken:	Senior Midwifery Team, Specialist Midwives, Obstetric & Paediatric Consultants. Anaesthetics, Trauma-informed care specialist for SFH & NUH. Maternity Parents' Voice Representative.

Template control:	v1.4 November 2019

CONTENTS

1 INTRODUCTION/ BACKGROUND

This guideline has been produced to provide support to all SFH staff in meeting the individual needs of women and their families, through shared and informed care-planning. Where a woman chooses care, or declines care, outside of SFH guidelines, clear guidance is essential to ensure those choices are heard and supported through the process of informed shared decision-making. This document also provides guidance to support the needs of maternity staff providing care in all areas.

Ockenden (2020) highlighted that Maternity Services must ensure women and their families are listened to and their voices heard. Women have the right to choose care that is specific and suitable for them, their family and their circumstances. Additionally, Ockenden (2022) stipulated that all Trusts must ensure every single woman has access to accurate information to enable their informed choice of all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods (including intended place of birth and mode of birth). The essential actions outlined in the report state that women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. The choices made following a shared and informed decision-making process must be respected.

'Shared decision-making' is described by the National Institute of Health and Care Excellence (NICE) (2021) as an approach that is collaborative between the health care professional and the woman; together they reach decisions based on both evidence and the woman's individual preferences. Use of the word 'shared' suggests that the midwife or health care professional is involved in the decision making along with the woman, however it is more accurate to understand that the health professional is involved in supporting the individual to make their own decision by providing them with the information and evidence they need (Royal College of Midwives (RCM), 2022).

The health care professional must provide evidence-based information i.e. risks, benefits, alternatives and likelihood of occurrence to ensure access to an informed choice. It is important to know that women have the right to decline the information you are offering. Individual decisions may also be influenced by personal values, beliefs and culture.

It is well documented that women are more likely to report a positive birth experience (regardless of the outcome) if their care is personalised, if they are treated with respect and kindness, and if they are involved in decision-making (NHS England, 2016). The PMA (Professional Midwifery Advocate) team will support staff to promote and provide this philosophy of care, with the Birth Options service available to refer into where appropriate. The Birth Afterthoughts Service also supports this ethos by listening to a woman's experience and therefore forward-planning for their future care and choices. Often, an understanding of previous birth events can inform the choices and decisions within the current pregnancy.

NB: Pregnant women includes any women who are pregnant as well as transgender or non-binary people who are pregnant. This terminology is used to maintain consistency with NHS documents and websites.

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

- To ensure a collaborative approach between the PMA, Midwives (acute & community), Safeguarding, Specialist Midwives, Obstetricians and Neonatal Teams to work in partnership with women, ensuring they are treated with dignity, compassion and respect.

- To provide guidance and support for all health professionals based on best evidence for personalised care and shared decision-making.

- To provide a clear referral pathway for women who would benefit from referral to the Birth Options Service, Birth Afterthoughts Service and any other situation where PMA referral would be appropriate.

Related Trust Documents

Maternity Services

- Antenatal Care Provision Guideline
- Escalation and Suspension of Acute Maternity Services Policy and Suspesion of Acute Maternity Services SOP
- Home birth management guideline
- Perinatal Mental Health Guideline (SFH & NUH)
- Professional Midwifery Advocate (PMA) Service: Support for Staff SOP.
- Professional Midwifery Advocate (PMA) Service: Birth Afterthoughts Service & Birth Options Service SOP.
- Responsibilities of the on-call Consultant for Obstetrics & Gynaecology SOP

Trustwide

- Consent to Examination, Treatment and Care Policy (Trustwide)
- Mental Health Act (MHA) Policy (Trustwide)
- Privacy & Dignity Policy (including same sex accommodation non-compliance reporting procedure) (Trustwide)
- Safeguarding Children & Young People Policy (Trustwide)

3 SCOPE OF GUIDELINE

This guideline applies to all staff employed by SFH, who provide care to women in the acute maternity setting, in primary care and within their homes. All midwifery and obstetric staff have a responsibility to ensure that they are aware of this guideline and its' essence.

This clinical guideline applies to:

Staff group(s)

- Midwives
- Obstetricians
- All staff involved in providing antenatal, intrapartum and postnatal care to women and their babies. This includes babies being cared for on NICU and Ward 25

Patient group(s)

- All women and their babies receiving maternity care provided by SFH

Clinical Area(s)

- Community Midwifery
- Antenatal Clinic/Consultant clinics including Sherwood Women's Centre
- Pregnancy Day Care
- Sherwood Birthing Unit
- Maternity Triage Centre
- Maternity Ward
- Homes where maternity care is being provided

Exclusions

- None
- The guideline details circumstances where a woman lacks capacity to make decisions regarding their care

4 GLOSSARY

Birth Afterthoughts Service - A one-off appointment offered to women and their partners to explore and discuss their birth experience. See Standard Operating Procedure.
Birth Options Service - A dedicated antenatal service for women who choose care outside of guidelines and/or other complexities. See Standard Operating Procedure.
Capacity - the ability to use, understand and retain information to make a decision, and communicate that decision.
Consent - Voluntary and informed permission obtained prior to any treatment, test or examination.
IOL - Induction of Labour
Lotus Team - Specialist Maternal Mental Health Services see separate SOP & guideline
MDT - Multi-Disciplinary Team (encompasses a wide range of expertise and specialists)
MTC - Maternity Team Care is a model formerly known as Consultant-led care; encompasses a multi-disciplinary approach to caring for high-risk pregnancies.
PDM - Practice Development Midwife
PMA - Professional Midwifery Advocate (A midwife trained to deploy the A-Equip model).
RCS - Restorative Clinical Supervision (a supportive group or individual session with a PMA).
SBU - Sherwood Birthing Unit
SFH - Sherwood Forest Hospitals
SOP - Standard Operating Procedure

5 ROLES AND RESPONSIBILITIES

The role of the Midwife:

Community midwives are well-placed to facilitate meaningful conversations early in pregnancy and should:

- Offer women the choice of where to have their baby regularly, with any newly-identified risks and preferences being taken into account.
- Identify and refer women who would benefit from the input of the Lotus Team, Birth Options service and/or the Consultant Obstetrician.
- Consider how choice is offered: for example: “What are your thoughts regarding IOL now that you are approaching 41 weeks?” rather than steering choice, assuming choice or removing choice altogether e.g.: “I’ll book you in for IOL at 40+12 if you haven’t had the baby”.
- Consider a Birth Afterthoughts appointment to discuss previous birth, particularly if this will impact or inform the decisions in the current pregnancy.

Midwives in all settings should:

- Provide opportunity and an open dialogue for women a to express their individual needs at each contact.
- Support and facilitate the principles of shared decision-making with women by listening, by providing evidence-based guidance and signposting to reliable sources of information to enable informed decisions. (See Appendix A).
- Take care not to ‘protect’ women from understanding potential implications of their decisions, whilst ensuring the provision of unbiased data.
- Ensure understanding; offer other formats and/or use interpreting services to support these discussions if required. Team Leaders must support community midwives if necessary, for example: longer clinic appointments for women who need them.
- Respect any decisions made by the woman, including their right to decline any aspect of care. Decisions may be made which are considered unwise by the health professional; our role is to ensure the woman has been equipped with balanced information and has been assessed to have the capacity to make this decision.
- Record-keeping: Document any choices made and a summary of dialogue in both the handheld records and digital records.
- Midwives to seek support from their Team Leader/Line Managers, PMA and PDMs for specific areas of support where a woman has made a choice outside of guidelines. The Safeguarding Midwife must be informed of any requests where there is doubt or concern regarding the wellbeing of the baby or requests for home birth with known safeguarding factors.
  N.B: the choice to freebirth (plan an unassisted birth) is not an indication for a MASH referral, however best practice is to share information with the Safeguarding Midwife to ascertain previous known safeguarding concerns, domestic abuse or coercion.

- Provide all families upon discharge from midwifery care with information on how to access the Birth Afterthoughts Service.
- Continue to provide wraparound care where a woman has chosen to employ an Independent Midwife.

Usually, the decisions made by the woman are in accordance with what is considered to be routine practice or 'within guidelines'. Occasionally, plans for labour and birth may be considered to be 'care outside of guidance'. This guideline has been produced to support all maternity staff in these circumstances. See 4.3.

The role of the PMA:

- Provide support to all midwives in the community and acute settings to enable and empower them to facilitate individual choices.
- Support training and development to instil confidence and expertise in all maternity care staff to support individual choice, particularly in the instance of care outside of guidelines.
- Support all maternity staff to follow the principles of shared decision-making (see appendix A)
- Work alongside the MDT including other specialist Teams to ensure women are supported to make fully informed decisions, via the Birth Options service.
- Provide all women (and their partners) with the opportunity to access a Birth Afterthoughts discussion when their community midwife is unable to answer their questions or offer sufficient insight into their birth experience.
- Provide opportunities for midwives to take part in reflective discussions and share learning from practice.
- Ensure all midwives are able to access PMA support and/or RCS (group or individual) to promote an on-going supportive framework.

The role of the Obstetrician:

- Provide guidance and clinical expertise to midwives (both in the community and acute settings) and work in collaboration with midwives to ensure women are supported to make fully informed decisions.
- Follow the principles of shared decision-making (See Appendix A).
- Work collaboratively with the Specialist Teams, with regards to care-planning, where a woman has been assessed to lack capacity in accordance with the TrustConsent & Capacity guideline.
- Provide comprehensive and balanced information regarding risks, benefits and alternatives to women and their partners to support and inform their decision-making. Share and signpost to relevant statistics and safety issues, taking care to adapt language to the individual's understanding. Interpreting services must be used in situations where the woman is non-English speaking or limited English.
- Ensure clear documentation.
- Identify cases where both immediate and follow-up Obstetric Debrief is required and arrange for these to be undertaken.

6 GUIDELINE DETAILS

6.1 Informed choice through the principles of shared decision-making:

This document provides guidance through the shared decision-making process (Toolkit available see appendix A).

The following guidance is taken from NICE Guideline Shared Decision Making (2021) and from NICE Quality Standard QS15 Patient Experience in Adult NHS Services, Quality Statement 6: Decision Making (2019):

1. Shared decision-making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care.
2. Any decisions made are based both on **evidence** and on the person's **individual** preferences, beliefs and values. It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing. Other formats to enable understanding must be used if required.
3. This joint process empowers people to make decisions about the care that is right for them at that time. This includes the option of choosing to have no treatment or refusing care. People have the right to change their mind at any time.
4. The information shared must be relevant, up to date, and from a reputable source. It must be free from jargon and any technical terms explained in a way that can be clearly understood. Share links to NICE-accredited information, NHS website for example or the RCOG https://www.rcog.org.uk/
5. The fundamental premise of shared decision-making is the **accepting of** and **respect** for the decision once it has been made. This is paramount, even if the decision may be considered unwise by health professionals and could lead to the death of the person or the unborn baby. Health professionals may only administer care in the patient's best interests if the patient lacks capacity to make that decision for themselves (for example, is unconscious) see section 4.2.

6.2 Informed consent and capacity within shared decision-making:

It is a legal and ethical principle that valid consent must be obtained before commencing any type of care or treatment, and a healthcare professional who does not respect this principle may be liable both to action by their professional body and legal action by the patient. People have the legal right to:

- Be treated with dignity and respect in accordance with human rights laws.

- Be given information about the proposed treatment in advance, including any significant risks, any alternative treatments which may be available and the option of, including risks involved in, doing nothing.

- Accept or refuse the treatment that is offered and are not to be given any physical examination or treatment unless valid consent has been gained.

(Department of Health, 2021)

The Trust's guideline 'Policy for Consent to Examination, Treatment and Care' details the framework of consent in greater depth, including the structured, formal protocol which must be adhered to when a patient is 'consented' for invasive and/or surgical procedures.

It is important to remember, that under UK Law, the unborn baby does not have a legally enforceable right to life until it is born (The British Institute of Human Rights, 2016). Health professionals cannot override a woman's decision(s) unless they are assessed to be lacking mental capacity to make such decisions.

Under the Mental Capacity Act (2005), a person **must be assumed to have capacity**. If there is any doubt about a patient's capacity, then the healthcare professional should assess the capacity of the patient to make the decision in question. An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. This assessment and the conclusions drawn from it should be documented on the Trust's two stage test proforma (link to guideline) and recorded in the medical notes.

Therefore, in the context of maternity care, when a woman has the mental capacity to make a fully informed decision and has provided (or withdrawn) fully informed consent, we have the legal and professional duty to uphold and respect this, regardless of our own personal views. Please refer to the Trust Safeguarding Policy for support regarding unborn babies and young people; advice can also be sought from the specialist within the SFH safeguarding team.

The Montgomery Vs Lanarkshire Health Board (2015) case is a landmark example of this context of informed consent within Obstetrics in the UK (Appendix C). The ruling highlights the legal and ethical position that a doctor must not withhold information simply because they disagree with the decision the patient is likely to make if given that information. Furthermore, the case redefined the standard test for informed consent and the "Montgomery Test" now places a legal weighting to how much "a reasonable person in the patient's position would be likely to attach significance to the risk".

6.3 Duty of Care

A midwife's 'duty of care' is underpinned by informed decision-making and the principles of consent and capacity (RCM, 2022). Women who therefore, have mental capacity and have made a fully-informed decision, may choose to accept or decline any guidance or care offered by a midwife. Midwives have a legal duty (Nursing and Midwifery Council (NMC), 2018) to respect these decisions whilst still maintaining compassionate and professional care of the woman. An obstetrician's duty of care follows the same structure of exploring, understanding and accepting an informed decision, though they may also refer the patient to a colleague to offer a second opinion (General Medical Council (GMC), 2020).

NHS England (2017) have stipulated that all midwives will be supported by the PMA to advocate for women, including those planning more complex care that may fall outside traditional pathways, recognising that they have a legal right to be informed about the benefits and risks of all available options and to weigh these up for themselves, supported by their midwife and obstetrician where required.

It is inevitable that in some instances, maternity staff may feel conflicted between this duty of care and the woman's decision, whilst having to effectively put aside their own opinions. The RCM (2022) acknowledges this, stating that "midwives may have to negotiate their professional concerns sensitively whilst still providing compassionate care, particularly when attending woman for care outside of guidance".

The NMC (2019) further supports this ethos by stipulating that:

1. Midwives must be able to understand and respect the woman's right to decline consent and demonstrate the ability to provide appropriate care and support in these circumstances.

2. Midwives must be able to advocate for the woman when her decision is outside of clinical guidance, in order to minimise risk and maintain relationship

All health professionals, including midwives, student midwives, health care assistants and the obstetric and anaesthetic teams, will be fully supported to deliver care in accordance with a woman's wishes on the occasion of personal conflict. This support may be clinical, professional, emotional and/or spiritual and will be upheld by members of senior management, coordinators, consultant obstetrician, team leaders, practice development, the PMA team and any other source where applicable.

If a midwife providing care has a genuine conscientious objection to a particular aspect of the individual's choice, it is advised that the midwife informs the coordinator of SBU as soon as possible. Such a scenario will be explored on a case-by-case basis and, where feasible, it will be arranged for a suitably qualified colleague to take over responsibility for that person's care (NMC, 2018).

At any time, if a midwife has concerns regarding the safety of a woman and/or the baby in their care (particularly if the midwife is unable to access the full clinical picture due to the woman's decisions), the midwife must escalate those concerns immediately to the coordinator of SBU (also applies if supporting a home birth). The coordinator may escalate to the Senior Midwifery Team and the on-call Consultant Obstetrician (direct escalation to Consultant if out of hours). If necessary, the Bronze on call may be notified. The out of hours Trust escalation pathway to be followed where applicable.

If the clinical situation has changed, the woman and their partner should be kept fully informed, with choices re-offered and decisions made using the shared decision-making principles, based on the current situation. Sometimes the woman's decisions will change in the context

of new information (for example a heavy PV bleed or meconium-stained liquor) and sometimes it will not.

Usually, particularly where choices fall outside of guidelines, the majority of decisions will have been discussed in advance following the SOP for the Birth Options Service. This guideline will support maternity staff to uphold both those advance decisions or any unexpected/unplanned situations which may occur within our service provision.

It is important to recognise that, when a woman has made their decision, if the midwife has practised according to the Code (NMC, 2018) they are not responsible for that decision, or potential adverse outcomes. Transparent discussion and documentation to evidence informed shared decision-making is essential, and all maternity staff will be supported in this where requested.

6.4 Birth Options Service

The Birth Options Service (see SOP) is a dedicated antenatal service for women who wish to choose care outside of guidelines (or other complexities) to explore all options regarding their birth and plan their care. It is managed by the PMA Team, with support from the Consultant Midwife and Consultant Obstetric Team. Referrals can be made by any member of maternity staff or by the woman via the PMA email address (sfh-tr.pmateam@nhs.net).

A respectful, evidence-based discussion takes place between the PMA and the woman, including their support person, where the choices and values are explored and the principles of shared decision-making are followed. A birth plan is produced by the PMA, following the SBAR framework (see Appendix E) and is shared with appropriate health professionals before being cascaded to the wider maternity teams for their information where appropriate. The woman also has a copy for their records and may also be available within the digital records where applicable.

The following list provides examples of appropriate referrals. Please note this list is not exhaustive:

- Chooses home birth where there are contra-indications present
- Chooses to use the birthing pool on SBU where there are contra-indications present
- Declines IV Antibiotics or other recommended course of treatment
- Maternal request for caesarean birth (in the absence of medical conditions/woman already under MTC)
- Fear (phobia) of labour and/or birth in the absence of severe mental health history
- Previous birth trauma and wishes to explore all options
- History of sexual abuse and/or assault and wishes to explore all options
- Understand and discuss previous birth experience (with the medical notes if requested) and how this may inform or impact on choices in the current pregnancy
- Requests specific to IOL

It is important to remember that many choices and birth preferences can be discussed and agreed during routine antenatal care with the named Community Midwife or in the acute setting. For example, if the woman has requested no vaginal examinations to assess dilatation or wishes to decline fetal heart monitoring in labour, then providing the principles of shared decision-making have been followed there may be no need to refer. The midwife must firstly ensure robust documentation, and secondly should email the PMA team (sfh-tr.pmateam@nhs.net) to enable the information to be cascaded appropriately to SBU coordinators.

It may be considered 'undue influence' if women are repeatedly informed of risks and consequences by several health professionals once her decision has been made (Birthrights, 2021). It is also important to note that some women may decline extensive information-giving by the maternity professional. This is their right to do so and should be respected and documented accordingly (RCM, 2022).

The PMA Team will be happy to answer any queries regarding referral to the Birth Options Service and are available to provide guidance on any aspect of birth planning/advocating for women.

6.5 Maternal Request Elective Caesarean (including Fear of Childbirth & Previous Birth Trauma).

Fear of childbirth (Tocophobia) may frequently present as a maternal request for caesarean birth.

It can develop following a previous birth (secondary tocophobia) particularly if maternal birth injury occurred (The Birth Trauma Association) or may occur in first pregnancies (primary tocophobia). There may be other causes or associated psychological issues such as body-image, fear of pain, anxiety due to perceived lack of control and previous trauma such as sexual assault. It is important to acknowledge the fears disclosed by the woman and provide time and opportunity to explore these with them and their support partner if appropriate.

Women who present at any stage on pregnancy with a fear of childbirth, in any form, should be offered referral to the PMA within the Birth Options Service. This provides an unhurried space to have meaningful and deeper conversations around their options and they will be supported to make a fully-informed decision regarding their preferred mode of birth, taking into consideration what is important to them.

Some women may require additional input from the Lotus Team or the Trauma Informed Service for NUH & SFH, please see PNMH SOP for more guidance. The Trauma Service may be appropriate If you suspect severe birth trauma and/or possible symptoms of PTSD beyond what can be managed within community mental health talking/listening therapy services eg: Insight.

A screening tool to identify fear of birth at booking to support women is currently being developed and will be implemented when ratified.

A care pathway to support women who request a caesarean birth and/or identify with fear of birth is provided in Appendix B. In the absence of severe mental health concerns and any additional fetomaternal complexities, any requests for caesarean birth may be referred directly to the PMA team via the Birth Options Service (see appendix B). Following the principles of shared decision-making, if a planned caesarean birth is the choice of mode of birth, the PMA will ensure follow up in ANC with the Consultant Obstetrician who will complete the pathway.

6.6 Birth Afterthoughts Service

The Birth Afterthoughts Service is an opportunity for women (and their partners) to explore and understand their individual experience of birth and ante/postnatal care (see SOP). The main objective of the session is to listen to the woman and their partner. The previous pregnancy and birth records are usually requested for the session, to enable the PMA to answer questions or fill in 'gaps' in the memory of their birthing experience.

The Birth Afterthoughts session may be in addition to, or alongside, an obstetric debrief. It should be noted that the PMA-led Birth Afterthoughts sessions are different to an obstetric debrief and the term 'debrief 'should not be used to describe the PMA-led service. An obstetric debrief is undertaken by a Consultant obstetrician at around 6-8 weeks postnatal, or later if any relevant results are awaited e.g. placental, histology, port-mortem report.
An obstetric debrief should be considered in place of, or in addition to, the Birth Afterthoughts Service in the event of:

- Intrauterine death, stillbirth, neonatal death (usually obstetrician-led in conjunction with the Bereavement Midwife).
- Unexpected ITU admission.
- Baby treated for acute or chronic hypoxia; transferred for cooling/diagnosed with HIE.
- Any serious untoward clinical incident where obstetric-led debrief would be appropriate.

Most often however, the Birth Afterthoughts session is accessed as a stand-alone appointment, with no time limit placed on how much time has passed since the birth.

All families should be provided with details of how to access the service upon discharge from hospital and again on discharge from community midwifery. The PMAs undertake visits to each clinical area and are available to speak with anyone identified by staff who would benefit from an informal discussion during their stay.

How to refer: anyone can email details (patient's name, DoB, telephone number and NHS number if possible) to the PMA team sfh-tr.pmateam@nhs.net and they will be contacted within 10 working days. Alternatively, the PMAs can be contacted on extension 3746 if needed more urgently (during normal office hours, Monday to Friday).

7 EDUCATION AND TRAINING

- Multi-disciplinary training sessions to support the contents of this guideline are planned for development and will be supported by the PMA Team.
- Updates regarding the use of Personalised Care Plans.
- Updates regarding the transition to digital/paperless record-keeping.

8 MONITORING COMPLIANCE AND EFFECTIVENESS

- Feedback obtained from service-users who access both Birth Options & Birth Afterthoughts services and collated.
- Monthly audit of themes and outcomes.
- Bi-monthly reporting to the Maternity Safety Champions board.
- Planned engagement with maternity staff to assess effectiveness

9 EVIDENCE BASE & REFERENCE LIST

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10 EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment (EIA) Form (Please complete all sections)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: [redacted]	**Date of EIA completion:** 2 February 2026
Department: Maternity	**Division:** Women's and Children's
Name of service/policy/procedure being reviewed or created: Facilitating Choice & Shared Decision-Making Within Maternity Care Guideline	
Name of person responsible for service/policy/procedure: Sam Todd, Consultant Midwife	
Brief summary of policy, procedure or service being assessed: Facilitating Choice & Shared Decision-Making Within Maternity Care sets out how maternity staff should support women to make informed, personalised decisions about their care. It emphasises respectful, evidence-based shared decision-making, where healthcare professionals provide clear information on risks, benefits and alternatives, and where individual values, beliefs and preferences are central. The guideline confirms women's legal rights to consent to or refuse care (including care outside clinical guidelines), outlines responsibilities of midwives, obstetricians and Professional Midwifery Advocates (PMAs), and provides clear pathways for support services such as the Birth Options and Birth Afterthoughts services. Its overarching aim is to promote dignity, autonomy, safety, and positive maternity experiences while supporting staff to practise confidently within legal, ethical and professional frameworks.	
Please state who this policy will affect: Staff, Patients	

(Please delete as appropriate)		
Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.** **Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.**
Race and Ethnicity	No	-Mandatory cultural safety training for staff -Interpreting services and CardMedic available -Double community appointments when interpreters are required -Written information and leaflets provided in first language where possible -Inclusive mandatory training materials reflecting different skin tones -16-week personalisation appointment pilot -The guideline explicitly defines "pregnant women" as inclusive of transgender and non-binary people who are pregnant, ensuring clarity and inclusivity while maintaining alignment with NHS documentation -Recognition of partners and carers regardless of gender identity -Guideline promotes individualised discussions without age-based assumptions -Mandatory training on learning disability and neurodiversity -Reasonable adjustments and physical access considerations -Use of health-literacy principles - The inclusive terminology statement supports broader inclusivity and reduces ambiguity
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	
Gender Reassignment	No	

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	No	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4. n/a

What consultation with protected characteristic groups including patient groups have you carried out?

-Service User Voice

-Patient experience data and complaints/compliments

-Local demographic data via BadgerNet

-CQC survey findings

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No new or specific human rights concerns identified. The guideline supports autonomy, informed consent, dignity, and non-discrimination. Ongoing awareness of national concerns regarding racial injustice in maternity care has informed mitigations.

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive						
Low						
If you identified positive impact, please outline the details here: No negative impacts identified, and this volunteer policy promotes good practise around all equality aspects. Only positive impacts identified. No requirement for stage 2 EIA.						

Signature: [redacted] *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 2 February 2026

11 APPENDICES

Appendix A Shared Decision-Making Toolkit
Appendix B Flowchart Maternal Request Caesarean Birth
Appendix C Montgomery Vs Lanarkshire Health Board Judgement 2015
Appendix D FAQs
Appendix E SBAR Proforma / Individualised Plan for Labour & Birth

Appendix A – Shared Decision-Making Toolkit

- Encourage the woman to talk about what is important to them.
- Use a Model to aid your discussion-see below for 2 examples.
- Ask if they want to involve a key family member in any discussions to support them eg: their birth partner.
- Offer help to understand and explore the resources provided or signposted eg: RCOG website.
- Explain the aims/outcomes of each option and together discuss how they align with the patient's preferences.
- Openly discuss the risks, benefits and consequences of each option.
- When discussing risks, use numerical data if available as people interpret terms such as 'rare', 'unusual' and 'common' differently.
- Use both positive and negative framing. For example: "treatment will be successful for 97 out of 100 people and it will be unsuccessful for 3 out of 100 people".
- Deliver information in manageable 'chunks'.
- Check the information has been understood before moving on.
- Clarify what they hope to gain from their preferred option and discuss any myths or misconceptions.
- Set aside enough time to answer any questions.
- Discuss what matters to them considering the information provided and check that their choice is consistent with this.
- When a decision has been reached, check there is a shared understanding to avoid any misinterpretation and document the decision clearly. Ensure the birthing person knows that these discussions can be reviewed throughout their pregnancy.
- Consider referral to other specialists (eg: Birth Options Service) for further opportunity to discuss and explore.

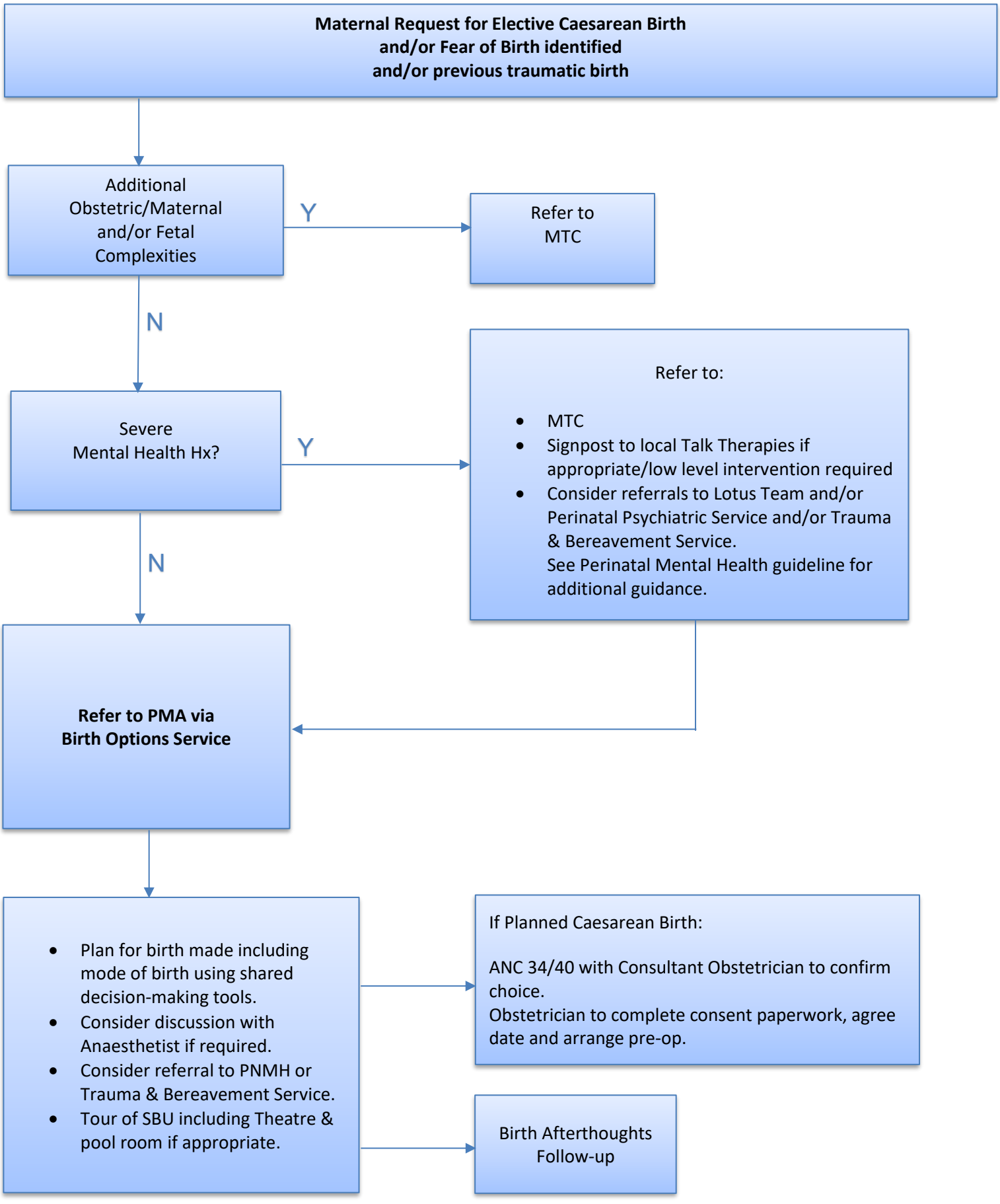
Model 1

AQUA 3 Questions Model (recommended by NICE & RCOG)

Model 2

BRAIN acronym (widely taught in NHS & independent antenatal classes)

Appendix B


Maternal Request for Elective Caesarean Birth
and/or Fear of Birth identified
and/or previous traumatic birth
Additional Obstetric/Maternal and/or Fetal Complexities
Y
Refer to MTC
N
Severe Mental Health Hx?
Y
Refer to:
MTC
Signpost to local Talk Therapies if appropriate/low level intervention required
Consider referrals to Lotus Team and/or Perinatal Psychiatric Service and/or Trauma & Bereavement Service.
See Perinatal Mental Health guideline for additional guidance.
N
Refer to PMA via Birth Options Service
Plan for birth made including mode of birth using shared decision-making tools.
Consider discussion with Anaesthetist if required.
Consider referral to PNMH or Trauma & Bereavement Service.
Tour of SBU including Theatre & pool room if appropriate.
If Planned Caesarean Birth:
ANC 34/40 with Consultant Obstetrician to confirm choice.
Obstetrician to complete consent paperwork, agree date and arrange pre-op.
Birth Afterthoughts Follow-up

Appendix C – Montgomery Vs Lanarkshire Health Board Judgement 2015

Nadine Montgomery raised concerns regarding her baby's size and her ability to birth vaginally during her antenatal period. Montgomery had type 1 diabetes mellitus, was of small stature and felt that her baby was large. However, her obstetrician felt that disclosure of any increased risk would have made her opt for a caesarean, which she believed was not in her best interest. Montgomery gave birth vaginally but experienced a shoulder dysotocia that resulted in her baby suffering hypoxic insult and consequent cerebral palsy.

The Supreme Court of the UK announced judgment in her favour in March 2015. The ruling overturned a previous decision by the House of Lords, which had been law since at the 1980s. It established that, rather than being a matter for clinical judgment to be assessed by professional medical opinion, a patient should be told whatever they want to know, not what the doctor thinks they should be told.

The ruling states that women have a right to information about any material risk to make an autonomous decision about their birth. Montgomery stated that she would have chosen to birth via caesarean if she had known of the potential risk in advance

Following the case, the legal standard for informed consent became defined by the "Montgomery Test" and superseded the previous "Bolan Test".

The Montgomery Test assesses the weighting placed on material risks; The test of materiality defined in the Montgomery ruling was whether "a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is (or should reasonably be) aware that the particular patient would be likely to attach significance to it."

There are two exceptions to the duty to provide the patient with material risks:

(I) Therapeutic Privilege - in cases in which the doctor is excused from disclosing information to a patient if they believe it would be "seriously detrimental to the patient's health."

(II) Emergency Situation - when there is not time to inform the patient of the material risks.

You can read the full case transcript below, and how the law has influenced practice:
https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf
https://www.bmj.com/content/357/bmj.j2224.full

Appendix D – FAQs

"Can a high-risk woman choose a home birth?"

Women and birthing people have the legal right to choose their place of birth, with the only exemption being if they have been assessed to lack capacity (Birthrights, 2021). NICE (2017) advise that all women are risk assessed (high or low) and the birth settings available to her should be discussed. For women and birthing people accessing care through SFH, the available options locally are birth at home or birth within an Obstetric-led Unit. The NICE guideline 'Intrapartum Care for Healthy Women & Babies' (NICE, 2017) provides a comprehensive list of medical conditions where birth in the acute setting reduces the level of risk for both woman and baby. The Guideline advises: "If further discussion is wanted by either the midwife or the woman about the choice of planned place of birth, arrange this with a specialist/consultant midwife [PMA}, and/or a consultant obstetrician if there are obstetric issues present". All factors and conditions must be discussed with the woman/birthing person, including the additional care available to them in an obstetric Unit, so that they may make a fully informed choice regarding the planned place of birth. Referral to the Birth Options Service (see SOP) is likely to be appropriate to support this.

Women and birthing people who choose to birth at home against the recommendation of health care professionals have the right to remain at home, and midwives have a duty of care to support them. Community Midwives will be fully supported with regards to clinical guidance and additional training where necessary in the event of home births outside of guidance (for example, twin pregnancy) in conjunction with PDM team, Senior Management, PMAs and Obstetric input via the Birth Options Service. The Trust has the right to suspend the home birth service (for example: in cases of staff shortages) and women/birthing people will be supported to attend the hospital via ambulance if required. Birthing people also have the right to choose an unassisted birth (see below). All women or birthing person who wishes to discuss choices outside of SFH guidelines are to be offered referral to the Birth Options Service (See SOP & associated discussion proformas).

"I have a surrogate family on my caseload. Who will be able to attend the birth?"

There are certain circumstances where the restrictions on the number of birthing partners permitted on Sherwood Birthing Unit may be adapted, and this will be assessed on a case-by-case basis. Examples include: surrogate parents, the presence of a Doula or Independent Midwife as a supportive companion, severe anxiety and/or mental illness, learning disability or the requirement of a sign language/spoken interpreter. The home as a birth setting may also be exempt from hospital guidance regarding the number of birth partners within reason. Birthing people and their families should be made aware of the hospital's policies for example: siblings/children not currently permitted on site, zero-tolerance of aggression towards staff or safeguarding policies where an adult is not permitted to be present.

"Can a woman/birthing person choose to have a caesarean section, or decline one when it is indicated?"

Women should be given the opportunity to discuss mode of birth early in their pregnancy (NICE, 2021). The benefits and potential risks of caesarean birth compared to giving birth vaginally should be discussed whenever appropriate, taking into account the individual's circumstances, concerns, priorities and plans for future pregnancies. Where a caesarean birth is identified to be medically indicated during the pregnancy, this will be discussed with the woman/birthing person in the obstetric/antenatal clinic following referral for Maternity Team Care. The birthing person does not have to agree to a caesarean birth, and this decision must be respected. This also applies to

decisions made when an emergency caesarean is indicated. Please follow the escalation policy for support in this instance.
Women and birthing people have the right to request a caesarean birth where there is no medical indication. This is not a legal right in itself, however all birthing people have the legal right to make decisions about the circumstances of their baby's birth under Article 8 of the European Convention on Human Rights (RCM, 2022) which includes the manner in which the baby is born (Schiller, 2016). Women and birthing people who request a caesarean birth in the absence of medical need should be referred to the Birth Options Service (see SOP) where they will have opportunity to plan their care with a PMA, and Obstetric input where required. Women/birthing people who request a caesarean birth and who also identify with a fear or phobia of childbirth (Tocophobia) may also require referral to the Lotus Team and/or the Trauma Service (see appendix B).

"What if the family chooses an Independent Midwife during the pregnancy?"
Families may choose to receive antenatal, postnatal and/or Intrapartum care from a self-employed or independent midwife (IM). This does not mean that the birthing person has 'opted out' of NHS care, and therefore they can access NHS scans, blood tests, and specialist services (including emergency care) in addition to the care they are paying for (Birthrights, 2019).
Usually, an IM will write to the Head of Midwifery of the Trust local to the individual in her care, outlining what care they are providing and may request an honorary contract to provide Intrapartum care in an NHS setting. It is the current position of SFH to not allocate such contracts, however some circumstances may be negotiated at the discretion of the Head of Midwifery. The RCM (2018) does support such contracts and encourages fostering good relationships between NHS midwives and independent midwives to facilitate personalised choice; however it must be noted that unless an honorary contract is in place, the Independent Midwife must have arranged their own indemnity and liability insurance (RCM 2018).
The Independent Midwife will be able to accompany the woman/birthing person, if they require admission for Intrapartum care, as a birth supporter or doula. The IM should be considered part of the team caring for the birthing person, however they will not take clinical responsibility for the labour or birth.

"One of my patients has expressed an interest in freebirthing"
A woman/birthing person has the right to make an advance decision to not seek midwifery care during labour, and therefore chooses an unassisted birth (also known as 'freebirthing'). Unassisted birth is not the same as a BBA (born before arrival) and is not the same as choosing to not access any midwifery care antenatally (a concealed pregnancy).
Freebirthing is not against the law, however it is unlawful for someone to act as a midwife (NMC, 2018) who is not a qualified and registered midwife. For example, a doula acting as a midwife with no intention of seeking midwifery care would be unlawful; a doula supporting a woman who coincidentally gives birth before the arrival of the midwife or arrival at hospital is not unlawful.
A birthing person may occasionally disclose to their midwife that they are planning to freebirth. It may be that the individual feels their decisions or choices would not be supported by NHS midwives either at home or in hospital. It would be appropriate to refer the woman/birthing person to the Birth Options service, where all choices are explored.
Choosing an unassisted birth is not criteria for a MASH referral, unless there are other concerns regarding a concealed pregnancy or the safety of the child following birth.

Sherwood Forest Hospitals
NHS Foundation Trust

Birth Options Service: SBAR Proforma / Individualised Plan for Labour & Birth

Name: NHS ID: Date of Birth:	Birth Partner(s):
Gr P EDD: BMI:	Named MW: Named Consultant: Other Professionals:

Reason for Referral: Seen by: Date:
Situation: *Current pregnancy, description of complexities, type of birth requested, place of birth requested, care outside of guidelines, care/treatment declined or requested.*
Background: *Previous pregnancies and births, medical history, PNMH history.*
Assessment: *Summary of discussion. Include evidence base and Trust Guidelines where applicable. Include what is important to the birthing person.*
Recommendations:
Agreed Plan: **Obstetric Discussion:** *where applicable*

Paediatric Discussion: *where applicable*
Other Specialist Discussion: *where applicable*
Actions: Copy for parent(s) in handheld records Copy for hospital records Inform Intrapartum Matron/Ward Leaders/Community Team Leaders where appropriate Circulate to SBU Coordinators and other teams where applicable Document any changes to plan & ensure updated proforma available asap
Notify when in labour: *please state if N/A* SBU Coordinator Obstetric Consultant Neonatal Consultant Anaesthetist Haematologist Other
Signed: **Print:** **Date:**