Talking to women about transfer from home, freestanding midwifery units or alongside midwifery units into obstetric units: a guide for midwives

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About one in every five women who plan for a birth at home or in a midwife-led unit (MLU) will require transfer to an obstetric unit. It is therefore not surprising that the prospect of having to transfer can be a major consideration for women when they are making decisions about where they want to give birth.

Women who are planning a birth at home or in a freestanding midwifery unit (FMU) want realistic information about what a transfer entails. Unfortunately, in the absence of accurate information about transfers, myths develop that can create anxieties for women and their partners and undermine informed discussions about choosing a birth at home or in an MLU.

The purpose of this paper is to set out the facts and summarise recent evidence in order to give a woman accurate information in response to questions that she may have about transfers, such as:

- Why might I be transferred during labour or after birth?
- Where am I likely to be transferred to?
- How long do transfers typically take?

I hope that this paper will also be of help to a midwife when she is going through the options with the women, around place of birth, and the role of transfer within this process, so that she can feel confident about the choices that are best for her.

Acknowledgement

This briefing was written for the Royal College of Midwives by Dr Kirstie Coxon, formerly at King’s College London, currently based at Kingston University/St George’s, University of London.

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Why talking to women about transfer is important.

The Birthplace study (1) found that birth at home or in midwifery units is generally very safe for women with low risk pregnancies and their babies, and that the likelihood of interventions is reduced if women plan to give birth in settings other than hospital obstetric units. The NICE guideline for Intrapartum Care (2) reflects this evidence, advising that low risk multiparous women plan birth at home or in a midwifery unit, and that low risk nulliparous women plan birth in midwifery units. The NICE guideline also makes clear that midwives should explain these recommendations to women, to help them make an informed choice about where to give birth. This briefing is designed to help support such discussions.

One issue that affects women’s decisions about where to plan to give birth is the information they receive about transfer. Around 20% of women who plan to give birth at home or in an MLU will require transfer into an obstetric unit (OU). Women expecting their first baby are more likely to require transfer (36-45%), whilst 9-13% of women expecting their second or subsequent babies require transfer.

This revised and updated briefing draws together recent UK evidence on transfer in labour or just after birth. The primary aim is to provide midwives with sufficient information to enable conversations about transfer with healthy women who have straightforward pregnancies and obstetric histories, and to help women and their partners think about transfer as part of making an informed decision about where to give birth. Here, ‘transfer’ refers to transfer of care during labour or up to 24 hours after birth from any setting other than an OU. This includes transfers to OU from home, from FMUs and from alongside midwifery units (AMUs). This definition is consistent with the Birthplace study operating definition (1), and much of the evidence presented here comes from this research (see https://www.npeu.ox.ac.uk/birthplace).
The Birthplace in England cohort study – key findings

The Birthplace in England prospective cohort study followed 64,500 women with singleton, cephalic babies born at term. The women had no risk factors in their current pregnancy, and no obstetric history that would mean birth in an obstetric unit should be recommended. The study used the previous NICE guideline for Intrapartum Care (CG55) (3) to identify clinical risk factors, and these are consistent with the risk factors in the revised NICE guideline (CG190) (2).

Planning where to give birth: what midwives need to explain to healthy women with low risk pregnancies.

Planned place of birth: healthy multiparous women with low risk pregnancies

The Birthplace cohort study (1) found that planned birth at home and in midwifery units (FMUs and AMUs) was as safe as birth in the OU for babies of healthy multiparous women. The revised NICE guideline for Intrapartum Care (2) reflects this evidence, and advises that healthy multiparous women with low risk pregnancies plan to give birth either at home or in an alongside or freestanding midwifery unit.

Planned place of birth: healthy nulliparous women with low risk pregnancies

Planned birth in an FMU or AMU is safe for babies of women pregnant with their first baby, however there is a small increase in the risk of an adverse outcome for the baby if birth is planned at home, compared with planned birth in an OU. The Birthplace research (1) showed that around 9 babies per 1000 had an adverse outcome if a first birth was planned at home, compared with 5 babies per 1000 for planned OU birth, so about 4 more babies per 1000 were affected, and this finding was statistically significant. Although the number of babies affected is small, the likelihood of adverse outcome approaches 1% for planned home birth of a first baby.

Intervention rates for women are considerably lower when birth is planned in a midwifery unit; the likelihood of requiring a caesarean section in labour is halved, and straightforward birth rates are higher. The revised NICE guideline for Intrapartum Care (2) says that birth is generally very safe and that women may choose any setting for birth, but advises that nulliparous women who are at low risk of complications plan birth in midwifery units, where intervention rates are lower than OU, and there is no difference in outcomes for babies compared with birth in an OU.
Key considerations

Planned place of birth and transfer

The prospect of transfer is a major consideration when women make decisions about place of birth, particularly for first births, and concerns about transfer, or a wish to avoid car or ambulance transfer in labour, are a key reason women plan hospital birth (4, 5). Women who are planning to give birth at home or in an FMU want realistic information about transfers and the amount of time these take (5) although at present there is no evidence to say what an ideal or appropriate transfer time might be.

Whilst this briefing provides national data, transfer rates and times may vary from region to region, and it is useful to provide local data where these are available. However, it is important that local data, if provided, should be consistent with the Birthplace data; for example, data should reflect transfer rates in relation to planned place of birth at the start of care in labour, and it should be routinely collected and reported. It is also important to talk to women about where they are likely to be transferred to; how long transfers typically take, including arranging transfer and journey time; and whether the woman’s midwife usually travels with her and/or may be able to continue looking after the woman after transfer.

Transfer rates by parity

When nulliparous women plan first births at home or in a midwifery unit (AMU or FMU), transfer rates are higher than in second or subsequent births.

<table>
<thead>
<tr>
<th></th>
<th>National transfer rates by parity for planned births:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At home</td>
</tr>
<tr>
<td>Nulliparous</td>
<td>45%</td>
</tr>
<tr>
<td>Multiparous</td>
<td>12%</td>
</tr>
</tbody>
</table>

At what point during labour and birth are women transferred?

Nulliparous women: timing of transfer

In the Birthplace study (1), 36-45% of nulliparous women who planned to give birth at home or in midwifery units required transfer to OU. Of those, about 80% were transferred to OU during labour, and the remainder were transferred following the birth.
Timing of transfer for nulliparous women

<table>
<thead>
<tr>
<th>Planned place of birth</th>
<th>Home</th>
<th>Freestanding Midwifery Unit</th>
<th>Alongside Midwifery Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before birth:</td>
<td>78%</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>After birth:</td>
<td>20%</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Time of transfer not known:</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Multiparous women: timing of transfer

In the Birthplace study, between 9-13% of multiparous women who planned birth at home or in midwifery units required transfer. The timing of transfer depended on the setting, but most required transfer during labour.

<table>
<thead>
<tr>
<th>Planned place of birth</th>
<th>Home</th>
<th>Freestanding Midwifery Unit</th>
<th>Alongside Midwifery Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before birth:</td>
<td>53%</td>
<td>56%</td>
<td>68%</td>
</tr>
<tr>
<td>After birth:</td>
<td>43%</td>
<td>42%</td>
<td>28%</td>
</tr>
<tr>
<td>Time of transfer not known:</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Reasons for transfer

The main reasons for transfer from FMUs and home before and after birth are summarised overleaf. Reasons for transfer from AMU are very similar, although transfer for epidural request is more common in AMU transfers. However, AMU transfers may not be comparable with home and FMU transfers; for example, obstetric care might begin before the transfer takes place, and if the transfer happens after birth, a baby may be transferred to neonatal care whilst the woman remains on the AMU.

Transfers from FMUs and home to OUs also take longer to arrange and complete.

The most common reason for transfer for all births, from home, FMU or AMUs, and in first or second and subsequent births, is delay during the first and second stages of labour. Most transfers, whether they occur before or after birth, are for non-urgent reasons ¹.

¹ Rowe et al [6] classified transfers during labour as ‘non-urgent’ if they included delay in the first stage of labour (without fetal distress), or request for epidural.
Most common reasons for transfer from FMU, AMU and home during labour:

- delay in first or second stage of labour
- fetal distress
- epidural request
- meconium stained liquor.

Most common reasons for transfer following birth:

- retained placenta
- repair of perineal trauma.
- concerns about the baby after birth.

Duration: how long does transfer take?

On average, transfers from home take about 49 minutes, or about 42 minutes when the transfer is for a potentially urgent reason. This includes making the decision, arranging the transfer and journey time (6).

Transfers from FMUs take a little longer; about 60 minutes, or about 50 minutes when the transfer is for a potentially urgent reason. This includes making the decision, arranging the transfer and journey time.

Transfers from AMUs to OU are thought to be much quicker (around 14 minutes on average); most are completed within 30 minutes (7).

Which factors influence transfer?

This information is intended to help midwives individualise the information provided to women and partners.

Parity

Women pregnant with their first babies who plan to give birth at home or in a midwifery unit are more likely to require transfer into OU after the start of care in labour than multiparous women.

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Rowe et al (6) defined transfers as ‘potentially urgent’ if the main reason for transfer was one of the following: antepartum haemorrhage, delay in the second stage of labour, fetal distress in the first or second stage of labour (or fetal distress with stage not specified). Transfers following birth were considered potentially urgent if the main reason was post-partum haemorrhage.
Age and parity

Amongst nulliparous women who planned to give birth in AMUs or FMUs, transfer rates increased with increasing maternal age (8), and details of this are provided in the graphs on the next page (Figure 1). Increasing maternal age did not increase transfer rates for nulliparous women who planned a home birth. There was no significant increase in transfer rates with increasing maternal age for multiparous women who plan birth in non-OU settings.

Age and transfer from FMUs: nulliparous women

In the Birthplace study (1), 36% of nulliparous women who planned to give birth in an FMU were transferred into OU. This was an average amongst nulliparous women, but overall, younger women were less likely to be transferred, and women aged 30 or above had a higher likelihood of transfer from FMU to OU.

Age and transfer from AMUs: nulliparous women

In the Birthplace study (1), 40% of nulliparous women who planned to give birth in an AMU were transferred. This was an average amongst nulliparous women, but overall, younger women were less likely to be transferred, and women aged 30 or more had a higher likelihood of transfer. Amongst nulliparous women aged 40 or older, transfer rates were around 50%.

Gestational age

Women are more likely to require transfer from AMUs, FMUs and planned home birth when their labour starts after 40 weeks of pregnancy (9).
Figure 1 – Percentage of women transferred for reasons other than neonatal concerns from midwifery units by age and parity from Rowe et al (2012).³

³ Transfers of women planning birth in midwifery units: data from the Birthplace prospective cohort study. Rowe RE, Fitzpatrick R, Hollowell J, Kurinczuk JJ BJOG 2012 119(9) Copyright (c) [2012] [The Authors]. Reproduced with permission from J Wiley.
Summary: key messages about transfer

- Transfer is a key consideration when women are considering birth at home or in an FMU or AMU. Women may hope to have a straightforward birth in their chosen setting, and may not feel prepared for the likelihood of transfer. Sensitive preparation by midwives may help women if they require transfer from their planned place of birth.
- Between 36–45% of nulliparous women who plan birth in FMU, AMU or at home are transferred to an OU.
- Between 9–13% of multiparous women who plan birth in FMU, AMU or at home are transferred to an OU.
- The main reason for transfer is delay in the first or second stage of labour.
- On average, transfers from home take 49 minutes from decision to start of care in the OU, and about 42 minutes if they are for potentially urgent reasons.
- On average, transfers from FMUs take 60 minutes from decision to start of care in the OU, and about 50 minutes if they are for potentially urgent reasons.
- Transfer rates increased with age amongst nulliparous women planning birth in AMUs and FMUs.
- Transfer rates increased with gestational age beyond 40 weeks for women planning birth in midwifery units.
Transfer is more likely in first births and much less likely in second or subsequent births. For first births, most transfers happen during labour, fewer than 20% happen after birth. In second and subsequent births, more than 50% of transfers happen during labour.
Delay in 1st or 2nd stage of labour
Meconium stained liquor
Epidural request
Fetal distress

Retained placenta
Concerns about the baby after birth
Perineal trauma

During labour
After labour

How long does transfer take?

From Home
From FMU
From AMU

Potentially urgent
Not urgent

What happens to the babies after transfer?

Most babies are born healthy when women plan to give birth at home or in an FMU and transfer to OU; adverse outcomes are rare amongst babies of healthy women with low risk pregnancies.
References


2. NICE (2014) Intrapartum Care: Care of healthy women and their babies during childbirth Clinical Guideline 190 NICE December 2014 https://www.nice.org.uk/guidance/cg190


Scope

The scope of this evidence review is limited to the UK, where the Birthplace in England study was conducted. In the UK, midwives are fully autonomous and accountable for supervising births and are also trained to respond to emergency situations, and must update these skills regularly. Care provided to women at home or in midwifery units is part of a fully integrated NHS maternity service.

With very few exceptions, births at home and in midwifery units are conducted by NHS midwives in a system which is supported by NHS ambulance services and women who labour in settings other than a tertiary hospital obstetric unit can be safely transferred into hospital should the need arise. The evidence presented here may have resonance in other countries where birth in settings other than an OU is supported, and where arrangements for transfer are part of a similarly integrated maternity care system, but variations between UK services and health systems in other countries, as well as demographic differences, could mean that different outcomes are found in other settings. For this reason, we recommend that this information is interpreted with caution in non-UK settings.

Intended audience

UK midwives working in NHS services and the women and families they care for, and independent midwives whose practice includes referral or transfer to NHS services.