NHS SCOTLAND

Scottish Perinatal Network

Framework for maternity healthcare professionals to support individualised care for women who choose alternative/non-standard birth choices

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DOCUMENT CONTROL SHEET

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This document has been prepared by NHS National Services Scotland (NSS) on behalf of the Scottish Perinatal Network. Accountable to Scottish Government, NSS works at the heart of the health service providing national strategic services to the rest of NHS Scotland and other public sector organisations to help them deliver their services more efficiently and effectively. Scottish Perinatal Network is a collaboration of stakeholders involved in care of women and babies, who are supported by an NSS Programme Team to drive improvement across the care pathway.

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1.0	17.03.2026	Original version	Amanda Gotch	

Disclaimer

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The recommendations in this guideline represent the view of the Network, arrived at after careful consideration of the evidence available. When exercising their clinical judgement, healthcare professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service.

SCOPE OF THIS FRAMEWORK

This guidance provides a structured framework for all maternity health care professionals (HCPS), to support women who are considering birth choices that are out with local clinical recommendations and wider national and UK guidance e.g. The National Institute for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), Royal College of Obstetrics and Gynaecology (RCOG), Royal College of Midwives (RCM), etc., and is applicable to all women accessing maternity care in Scotland.

It aims to ensure that care remains respectful, safe, and legally and professionally accountable, while upholding the principles of informed choice and supported decision-making.

This framework is intended for:

- Midwives
- Obstetricians
- Maternity support workers
- Nurses
- Allied Health Professionals
- Clinical governance teams
- Scottish Ambulance Service/ScotSTAR teams
- Anaesthetists
- Neonatologists
- Service managers and leaders in maternity care
- Health Boards delivering maternity services

FRAMEWORK AIMS

- To ensure practitioners feel supported, and are supported, by the wider maternity team when caring for women who choose care that falls outside clinical recommendations.
- To acknowledge that the care that midwives can provide may, in some circumstances, be limited or not possible due to safety, environmental, or practical considerations, such as being asked to wait outside the woman's home or having no access to basic facilities including water or toilet facilities. Midwives must work within professional and personal safety boundaries; however, a woman's choice to pursue care out with guidelines or recommendations must not result in the withdrawal of support or

maternity care. Women will always be offered the opportunity to continue discussions at any point during pregnancy as part of personalised care planning.

- To acknowledge the role of all practitioners in the support of women who choose to birth outside local clinical recommendations and wider national and UK guidance or decline aspects of care that is supported by evidence.

FRAMEWORK PRINCIPLES

Legal and regulatory context

1. **It is a woman's legal, ethical and human right to accept or to decline any aspect of maternity care.**

Informed choice is fundamental to person centred care; this requires acknowledging that the fundamental basis of choice is that care can be accepted or declined. As competent adults, women are able to appreciate and weigh up the current evidence alongside their values and preferences. This is not merely a matter of trust and choice but also women's legal, ethical and human right *(NMC 2018, GMC 2020, HRA 1998, Montgomery v. Lanarkshire Health Board 2015).*

Before birth, healthcare professionals must respect the pregnant person's autonomy and decision-making, as the fetus does not have separate legal rights under UK law. This means that care decisions are made in partnership with the pregnant person, and interventions cannot be imposed solely for the benefit of the fetus.

After birth, the newborn is recognised as a legal person with human rights protected by the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. Healthcare professionals then have a legal and ethical duty to act in the best interests of the newborn. This includes providing necessary medical care, safeguarding the baby's welfare, and, where appropriate, escalating concerns to child protection services if a newborn's health or safety is at risk. Refusal of essential care for the newborn may require professionals to override parental wishes to fulfil their duty to protect the child's rights and wellbeing.

(NMC The Code, Prioritise People 2.5: respect and document a person's right to accept or refuse care and treatment and Act in the best interests of people at all times. Prioritise People 4.1: balance the need to act in the best interest of people at all times with the requirement to respect a person's right to accept or refuse treatment. The Human Rights Act | EHRC Article 2, Article 3, Article 8, Article 9, Article 14, and GMC principles)

2. **Midwives and doctors have a duty to offer evidence-based information to support women in decision making**

In some situations, such as place of birth, women and healthcare professionals are not discussing consent, but exploring informed decisions and alternative plans. HCPs have a duty to take reasonable care to make sure that the woman is aware of all material risks and benefits involved in any recommended treatment, and of material risks and benefits any reasonable alternative or variant treatments. The multi professional maternity team has a duty as per law and professional codes to offer a discussion on all these points. However, a woman can decide that she does not wish to have such a discussion. In that case, consistent with the Montgomery ruling, HCPs should respectfully explore and clarify any areas a woman does not wish to discuss, to ensure their wishes are upheld while fulfilling the duty to discuss material risks and reasonable alternatives relevant to that individual. HCPs can satisfy their professional and legal obligations by respecting and documenting the woman's decision, and no HCP should insist upon a discussion taking place. (GMC 2020, HRA 1998, Montgomery v Lanarkshire Health Board 2015, NMC 2018).

3. **Employers must ensure there are systems in place for individual HCPs and teams of maternity care professionals to be supported in developing personalised care plans and delivering care in all circumstances.**

Employees have a right to feel safe in their practice and to be supported by their employer. All employers have a legal duty to protect the health and safety of employees (Health and Safety at Work, 1974).

Employers have a responsibility to ensure all maternity staff can access multi professional training and development to enhance collaborative working when supporting women planning alternative/non-standard birth choices.

Where a significant risk to the employed health care professional is identified, it may not be possible to facilitate specific care requests. Care provision must comply with professional regulatory codes and employer policies, including health and safety and lone-working requirements. Decisions will be made in line with the human rights law framework, balancing the rights and preferences of the woman with the duty to protect the health, safety, and wellbeing of staff.

Introduction and Background

Scotland's maternity services are committed to providing woman family-centred care, improving health outcomes, and reducing inequalities. This will be achieved by providing continuity of care that is trauma informed, relationship based and is in keeping with national strategies such as The Best Start, A Refreshed Framework for Maternity Care in Scotland and Healthcare Improvement Scotland's Perinatal Scottish Patient Safety Programme (SPSP). Throughout this document, the terms woman and women are used to refer to people who are pregnant or have recently been pregnant, this includes transgender, non-binary and intersex people.

Principles of Care

This guide recognises that the following principles are universal factors that contribute to safe, effective, and personalised maternity care:

- A woman's right to choose what care she accepts or declines, as supported by the Human Rights framework.
- As a person with decision-making capacity, women are able to appreciate and weigh up the current evidence alongside their values and preferences. This is not merely a matter of trust and choice but also women's legal, ethical and human right.
- Supporting the healthcare provider is essential to safe care. A woman's choice to decline care can be particularly challenging for those providing care when decisions fall outside recommended practice, especially in settings where access to the wider multidisciplinary team is limited.

Safeguarding of women and babies should be considered for all women accessing care in Scotland, and any concerns escalated appropriately according to local pathways:

- Declining maternal care does not, in and of itself, warrant any referrals to Social Work, Maternity and Neonatal Psychological Interventions (MNPI) Team or Public Protection.
- Declining essential newborn care may meet thresholds for child protection and should follow local newborn safeguarding pathways with early neonatal team involvement.

Plan of care is made following a full assessment of the woman's medical, psychological and social needs and circumstances and in partnership with her.

- A trauma informed approach should be adopted for all women accessing care.

Effective, open and honest communication between maternity care providers and service users:

- To enable fully informed decision making, ensure communication is in an accessible format for each woman and family, using interpreters or visual aids as required. Keeping lines of communication open and inclusive helps foster a positive relationship between women and maternity healthcare professionals.

Relationship based continuity of carer, both from a primary midwife and, if indicated, an obstetrician:

- Women may request to change their primary midwife or named obstetrician. Efforts should be made to support this request, including redeployment of HCPs from other areas if required, and opportunity given for the woman to discuss any concerns with her care if she wishes. There should always be open and honest discussions between women and service providers of what can practically be accommodated in the context of smaller and/or remote and rural maternity teams. Support for HCPs should also be offered and acknowledgement of the difficult emotions which can arise if a relationship with a service user breaks down. All HCPs should have regular access to clinical supervision as well as case supervision with their line manager.

HCPs safety at work:

- When a woman's choice or request may place HCPs at risk of physical harm or compromise personal safety (for example, being asked to remain outside the home for prolonged periods or being denied access to basic facilities), careful consideration must be given to whether it is reasonable, safe, or appropriate to fulfil the request. HCPs are not expected to provide care in circumstances that compromise their physical safety.

- Organisations must also actively promote psychological safety by ensuring equitable access for all HCPs to clinical supervision, reflective practice, and, where required, timely psychological support resources.

- Organisation will promote a just culture in which staff feel supported to raise concerns, report adverse events, and engage in learning, with a clear focus on improvement rather than blame.

High quality, contemporaneous documentation of all conversations with women should be maintained.

INFORMATION FOR MATERNITY HEALTHCARE PROFESSIONALS

1. Partnership and Informed Choice

Maternity HCPs are encouraged to work collaboratively with women requesting care outside current recommended guidance to co-produce an individualised plan of care. Discussions should be clearly documented to demonstrate that decisions are informed, values-led, and evidence-based.

Shared responsibility:

- Supporting informed choice is the collective responsibility of midwives, obstetricians, the MDT, and NHS Boards.
- In Scotland, the Patient Rights (Scotland) Act 2011, the Charter of Patient Rights and Responsibilities, and national maternity policy guide NHS HCPs to support women in participating fully in decisions about their care.
- Obstetricians are accountable under GMC guidance (Decision Making and Consent), and midwives under the NMC Code. Both frameworks encourage clinicians to provide balanced information, support understanding, and respect decisions, even when they differ from recommended care.

Board responsibilities:

- Boards are expected to provide safe systems, clear pathways, supportive cultures, and access to senior support, including consultant midwives where available.
- Organisational structures should enable shared accountability and safe practice.

Midwives can be reassured that when they discharge their role with integrity, providing evidence, supporting understanding, documenting discussions, and advocating respectfully, they will be supported by colleagues, senior leaders, and the Board.

2. Escalation and Formal MDT Support

Where a woman chooses care outside recommended guidance, Boards are encouraged to have a formal mechanism to escalate the case for multidisciplinary team (MDT) review and collaborative birth planning. This ensures collective professional oversight, facilitates shared decision-making, and provides support for the midwifery team. Depending on local resources, the MDT may include consultant midwives, obstetricians, anaesthetists, neonatal teams, and other relevant specialists. In Boards without consultant midwives or home birth teams, the MDT composition should be adapted while maintaining the principles of collaboration, professional support, and shared accountability. The escalation process should

clearly document the agreed plan, specify responsibilities, and outline proportionate risk management strategies.

3. Building Trust and Continuity

A trusting relationship between the woman and her care team is central to safe, person-centred care:

- Continuity of carer (midwifery and obstetric) should be maximised where possible.
- Advocacy for informed choice is essential.
- Women should be informed that they can request a different primary midwife or obstetrician if the relationship is not developing safely.

4. Holistic Support for Women

Women are entitled to:

- Trauma-informed care
- Perinatal mental health support and referrals
- Evidence-based information in accessible formats and languages
- Appropriate interpreting or translation support
- Facilitated conversations with their support network
- Liaison with the MDT to explore options and share proportionate information
- Accompanied attendance at MDT appointments with advocacy
- Consideration of public protection concerns, with referrals if indicated
- Co-production and sharing of a detailed birth plan
- Planning, Documentation, and MDT Involvement
- Birth choice discussions are within the primary midwife's remit as part of universal midwifery care.
- MDT review and escalation are recommended for any care outside guidance.
- Early, extended, or additional appointments may be needed to explore options and build trust.
- All discussions and co-produced care plans should be documented in the Electronic Patient Record for visibility to the MDT and the woman.

5. Professional Confidence and Accessing Support

- Midwives are encouraged to discuss evidence, risks, and benefits confidently.
- Support can be accessed through line managers, clinical supervisors, senior charge midwives, consultant midwives (where available), home birth teams (where available), obstetric and specialist colleagues, and evidence resources.
- Where a woman chooses a birth option for which midwives may have limited experience or exposure, for example a physiological breech birth or birth of twins at home, Boards and senior maternity leadership teams should provide structured

support, access to training opportunities, and clinical mentorship to enable midwives to develop confidence, competence, and safe practice.
- Consultant and senior midwives are expected to provide leadership, facilitate complex decision-making, and support professional accountability.

6. Organisational Support and Wellbeing for HCPs

Midwives providing clinical care, particularly in community or home settings, should have access to:

- Clear escalation pathways and MDT review for care outside guidance
- Flexible caseload management to allow for additional appointments and collaborative planning
- Full clinical supervision, reflective practice, and access to psychological support
- Peer and MDT support, including visibility of plans and decisions

Wellbeing considerations:

- Midwives may experience emotional or moral distress when supporting non-standard care in the absence of organisational systems and support structures that enable personalised, woman-centred care.
- Boards should proactively support staff wellbeing, recognising that intensity and type of support may differ locally.
- Ensuring midwives feel supported is critical to safe, confident practice and positive outcomes.

7. Summary

Supporting informed choice is everyone's responsibility: midwives, obstetricians, MDT colleagues, and NHS Boards. Where women make choices outside recommended pathways, formal escalation to an MDT provides professional oversight, collaborative planning, and protection for the midwifery team. Midwives practising with integrity providing evidence, advocating for women, and documenting care will be supported by colleagues, senior leaders, and the Board. Collective responsibility, governance, and organisational oversight ensure that care outside guidance is safe, person-centred, and aligned with Scottish statutory and professional standards

Public Protection Considerations

As has already been noted, if a woman declines care this should not automatically warrant or trigger public protection reporting. However, HCPs should be reflective regarding the possibility of public protection concerns and risks, as in all care that is provided. These can include:

- There are concerns about the potential impact on the individual's wellbeing following their decision to decline care AND they meet the '3 point criteria' as an *adult at risk* (as below) under the terms of the Adult Support and Protection (Scotland) Act 2007.
    - they are unable to safeguard their own well-being, property, rights or other interests;
    - they are at risk of harm; and
    - because they are affected by disability, mental disorder, illness or physical or mental infirmity they are more vulnerable to being harmed than adults who are not so affected.
- Concerns where the possible motive for declining care relates to possible Gender Based Violence (GBV) and the possibility of coercive control being a factor.
- Concerns where the motive for declining care may be linked to their immigration and/or employment status due to being a victim of Human Trafficking.
- The existence of current or historic public protection concerns.
- Child protection considerations may apply also when newborn care is declined. HCPs should assess harm/neglect risk to the newborn, seek neonatology input, and follow child protection pathways where thresholds are met.

HCPs should be aware that more than one 'type/element' of public protection concern can exist for the same situation and circumstance. For example, it is entirely possible for an individual to be an 'adult at risk' under the 2007 adult protection legislation whilst also being recognised as a victim of human trafficking.

If HCPs do have concerns regarding public protection risks for women declining care for themselves or their baby, they must seek appropriate guidance and support from:

- Their own clinical/line management;
- Specialist Health Board Public Protection Teams/Leads
- Multiagency colleagues who lead on public protection matters (social work/police)

This will be as per local health board and interagency procedures and processes for public protection.

Discussing the Personalised Care Plan and Effective Decision Making

When women engage in a conversation about the risks and benefits of care planning in maternity services, they should expect a personalised, evidence-based, and respectful dialogue that supports informed decision-making.

All women should be able to access and discuss current reliable evidence-based information with their primary midwife and obstetrician. Midwives and obstetricians should signpost women to reliable sources of information including:

- Local resources
  - Guidelines platforms such as Right Decisions
  - Health Board Website
  - BadgerNet app
  - Local data and information including transfer times, local services available, mode of birth data and outcomes
- NHS Scotland resources such as NHS Inform and Ready Steady Baby!
- Scottish Government's Maternity Pathway guidance
- Scottish Government's Birthplace decisions resource
- NMC Principles for supporting women's choices in maternity care
- NICE guidelines
- Association for Improvements in the Maternity Services (AIMS)
- Birthrights

Colleagues should ensure that they access reliable sources of information to support them in providing care to women asking for care outside guidance, including:

- RCM Care Outside Guidance
- RCM Informed Decision Making
- NMC Standards of Proficiency for Midwives
- NMC The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associates
- NMC Principles for supporting women's choices in maternity care
- RCOG Green-top Guidelines and Patient Information Leaflets
- GMC The dialogue leading to a decision

Doulas and Community Groups

Doulas and community groups may offer valuable support to women and families throughout pregnancy and childbirth. The midwife remains the principal registered healthcare professional with responsibility for the coordination and delivery of maternity care. Collaboration can improve quality of care by enhancing woman's experience and supports the provision of safe, high-quality care, while maintaining the professional standards and accountability of the midwifery team.

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Scottish Government (2025) Birthplace decisions: information for pregnant women and partners on planning where to give birth

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