Suspension of Home birth Briefing Paper for Health Care and Wellbeing Scrutiny Committee April 2026

Following an inquest held for the death of a mother and baby in Manchester during a homebirth; the coroner identified several failings with note that there is currently no national guidance resulting in different models and no clear expectation around practice, training or competence. In response to this the coroner issued a Prevention of Future Deaths Report. Jennifer Cahill and Agnes Cahill - Prevention of future deaths report - 2025-0559.

In addition to this NHSE contacted all maternity services and requested that each service review their provision for providing a homebirth service identifying several key areas:

1. The operational running of the service –particular focus on being able to provide a 24-hour service supporting appropriate rest periods for staff.

2. Care planning and risk assessment – a pathway in place that ensures MDT working and good oversight to support dynamic risk assessment

3. Governance and oversight – oversight of whole organisation with audit programme and a review of outcomes

On the 5th February, following an initial review of the service, the Board made the difficult decision to temporarily suspend the homebirth service because of the reducing number of homebirths and the difficulty for staff to maintain their intrapartum skills. In addition, changes to the neonatal life support (NLS) guidance for pre - hospital resuscitation indicated that the procurement of equipment was indicated and further training of staff recommended.

In addition, the suspension provided an opportunity to review all areas of the homebirth service and to address the issues identified to ensure that the future of the service was safe and sustainable.

In response to the above the following actions have been undertaken

- Following the announcement of the suspension all women who were booked for the homebirth service were contacted either by telephone or letter to inform them of the service change and the alternatives that were available to them. The Trust website was updated regarding service change and FAQs were posted. It was unfortunate that some women heard about the change via social media and have contacted the Trust to raise their concern alongside local birth workers, councillors

and the local MP. All enquiries have been responded to either via meetings or letter addressing their specific individual concerns.

- A review of the traditional midwifery on call service has previously been undertaken at WVT recognising that community midwives who are on call and providing the homebirth service were at risk of working excessive hours – a change to the rota was agreed and has successfully ensured that regular rest periods from work have been achieved.

- In addition, it was recognised that as the home birth rate is declining (n=11 in 2025) and community midwife exposure to intrapartum care was becoming more infrequent and therefore maintenance of competence/confidence was becoming more challenging. There were significant numbers (70%) of the team who had not provided intrapartum care for over a year. To address this risk the maternity service has recommended that all current community staff are released to attend delivery suite to provide them with an opportunity to have exposure to intrapartum care and upskill where needed. A training needs analysis has been agreed, and each midwife has a skills passport to complete. Given the small number of homebirths, it is acknowledged that ongoing opportunity to update skills will be undertaken on an annual basis to ensure sustainability of the service in the future.

- Care planning and risk assessment – there is currently a Foundation Group wide personalisation framework in development which is in the final stages however a local Standard Operating Procedure is now in place at wye valley trust which reflects the recommendation of the framework.

- NHS England has recently announced that there are plans to produce a national set of standards for homebirth services in England. Several colleagues have shared an expression of interest to join the working group, and the service will be benchmarked against these standards when they are published.

- Currently there is not a regular audit programme to review outcomes specifically from homebirths however all incidents that occur during homebirths are reported via the incident reporting system. These incidents are then reviewed by the multidisciplinary team at the local Quality and Safety meeting and escalated to Patient Safety Panel should the threshold be met. These incidents are reported to Board via the quarterly Incident report that is presented in Private Board. Birth data is reported on the maternity dashboard.

- In addition to the recommendations above, a review of the most recent Newborn Life Support Guidance (Oct 2023 - implementation date 1st Jan 2026) has been completed. The guideline outlines the resus equipment that should be available in an out of hospital setting. This has previously been considered as an ambulance service requirement by many services however considering recent events it would be prudent to ensure that midwives attending homebirths have the skills and equipment to resuscitate the newborn in accordance with the neonatal life support algorithm whilst awaiting the arrival of a paramedic crew. Procurement of the equipment is underway and once arrived 3 training sessions are planned to ensure that all community midwives can provide resuscitation in accordance with the national guidance.

- The suspension of the homebirth risk is recorded on the risk register – Inphase #2290 and a quality impact assessment has been completed and shared with the ICB and regional NHSE colleagues.

- Monthly meetings are in place to enable oversight of progress against the agreed action with the Chief Nursing Officer and the Non-Executive Director Maternity Safety Champions and the Director of Midwifery.

Once the following actions have been completed a recommendation to restart the service will be made to the Trust Board for consideration:

1. Immediate upskilling of staff
2. Procurement of equipment and required resuscitation training
3. Standard operating Procedure for Homebirth/Personalisation of Care
4. Development of skills passport for midwives providing a homebirth service

Report Ends