APPENDIX 1

BIRTH CENTRE ADMISSION CRITERIA

GREEN	Criteria listed within the green section indicates that admission to the Birth Centre (BC) is an appropriate and available option.
AMBER	Criteria listed within the amber section indicates that if the woman requests the BC as her place of birth, an individual assessment should take place and a discussion with the BC lead/senior midwife and an obstetrician is required. **This option should not be routinely offered to all women.**
RED	Conditions listed within the red section are contraindications to the use of the BC and the woman should be advised to give birth on the labour ward with a consultant obstetrician as the lead professional. **This option should not be offered to women.**

GREEN - Cases listed below indicate that admission to the Birth Centre is an appropriate and available option.

CRITERIA
• **Midwifery led care**
• **Gestation ≥ 37 weeks <42 weeks**
• **Singleton pregnancy**
• **Cephalic presentation**
• **BMI ≥18 or ≤35 (at the time of booking)**
• **Age ≥16 or <40 (at the time of booking)**
• **Spontaneous labour**
• **Membranes intact or ruptured for less than 24 hours at the onset of labour**

AMBER - Cases presenting with any of the conditions below may be considered appropriate admissions to the Birth Centre subject to discussion with the BC lead midwife, or the labour ward co-ordinator and obstetric team. If an obstetrician considers a woman with any of the conditions below to be suitable for the BC, the decision should be reviewed by the BC lead, for example by copying the antenatal clinic letter to the labour ward matron.

FACTOR	ADDITIONAL INFORMATION
Cardiovascular	• Cardiac disease without intrapartum implications.
Haematological	• Atypical antibodies with no risk to baby • Sickle cell trait • Thalassaemia trait • Anaemia - haemoglobin 8.5-104 g/litre at onset of labour • Declining of blood products **(Advise an active 3rd stage & consider iv access)**
Infective	• Group B Strep • Hepatitis B/ C with normal liver function tests
Endocrine	• All endocrine conditions including hypothyroidism not requiring a change in treatment in the third trimester
Skeletal/ Neurological	• Spinal abnormalities • Previous fractured pelvis • Neurological deficits • Rheumatoid arthritis with no flare in the current pregnancy • Multiple Sclerosis (but must avoid prolonged labour)
Gastrointestinal	• Liver disease with no implications for intrapartum care • Crohn's disease/Ulcerative colitis with no flare during the current pregnancy
COMPLICATIONS IN A PREVIOUS PREGNANCY	• PPH ≤1000ml – **(Advise an active 3rd stage & consider iv access)** • Stillbirth / neonatal death with a known non-recurrent cause, e.g., a fetal abnormality • Pre-eclampsia with the birth occurring at term in a previous pregnancy • Previous baby >4.5kg • Extensive perineal trauma, prev 3rd/4th degree/clitoral/urethral tear • Previous obstetric cholestasis • Previous baby requiring exchange transfusion
CURRENT PREGNANCY	• Consultant-led care for reasons not affecting intrapartum care • Presence of insignificant meconium *this should be confirmed, agreed and documented at regular intervals as insignificant by two midwives. • Antepartum bleeding after 24 weeks • Blood pressure >140mmHg systolic or >90mmHg diastolic • Clinical suspicion of macrosomia (if there has been no opportunity to do an USS under the GAP) • Under current outpatient psychiatric care • Women with safeguarding concerns • Women who book late, e.g., after 20 weeks or who miss x2 antenatal appointments • BMI between ≥36-39 kg/m2 at booking in a **multiparous** woman **only** • *Two episodes or more of reduced fetal movements after 34 weeks

	• *Reduced fetal movements in the last 24 hours, (even if it's the first episode during the pregnancy). • *If two or more episodes of reduced fetal movements have been experienced after 34 weeks **or** if reduced fetal movements have been reported in the last 24 hours from admission - a CTG **must** be performed on the labour ward. Then if there are no concerns and the CTG is normal the woman may transfer to the Birth Centre.
Fetal Indications	• Fetal abnormality with intrapartum or immediate neonatal implications
Previous gynaecological history	• Major gynaecological surgery including cone biopsy/LLETZ • Fibroids ***see note 2** (after RED table)* • Surgical TOP (e.g., a TOP *procedure*, not tablets) **or** surgical management of miscarriage (SMM) or ERPC x 3

RED - These factors indicate increased risk and are **contraindications** to the use of the birth centre.

FACTOR	Additional Information
CURRENT PREGNANCY	• Multiple birth • IVF/ICSI • Placenta praevia • Para 6 or more • Pre-eclampsia or pregnancy induced hypertension • Preterm labour or preterm prelabour rupture of membranes • Induction of labour • Placental abruption • Presence of significant meconium • Prolonged SROM >24 hours ***see note 1*** • Anaemia – haemoglobin less than ≤85 g/litre at onset of labour • Confirmed intrauterine death • Substance misuse/recreational drug use in pregnancy • Extensive alcohol use in pregnancy • Gestational diabetes • Malpresentation – breech or transverse lie • BMI of 40 kg/m2 or more at booking • BMI of >35 kg/m2 at booking if a **primigravida** • Recurrent antepartum haemorrhage • Small for gestational age in this pregnancy (less than 10th centile on GAP/GROW chart) • If the GAP/GROW chart indicates potential slow or static fetal growth that has not been recognised and managed **OR** if the woman is awaiting a growth scan but is admitted in labour before she has had the scan - a CTG and obstetric assessment should be advised on the LW. If all is normal consideration can be given to transferring the woman back to the birth centre. • Large for gestational age (estimated fetal weight greater than 90th centile by USS) • Abnormal fetal heart rate/Doppler studies • Ultrasound diagnosis of oligo-/polyhydramnios • Previous gynaecological history with intrapartum implications including

	myomectomy, hysterotomy, endometrial ablation, e.g., Novasure, extensive endometriosis • Concealed pregnancy • Bicornuate uterus
Cardiovascular	• Confirmed cardiac diseases with intrapartum implications, e.g., Marfan's syndrome • Hypertensive disorders
Respiratory	• Asthma requiring an increase in treatment or hospital admission • Cystic fibrosis
Haematological	• Haemoglobinopathies: sickle cell disease, beta thalassaemia major • History of thromboembolic disorders • Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100x109/litre • Von Willebrand's disease • Bleeding disorder in woman or unborn baby • Atypical antibodies which carry risk of haemolytic disease of the newborn
Endocrine	• Hyperthyroidism • Unstable hypothyroidism (requiring an increase in treatment in the 3rd trimester) • Diabetes – Type 1 or Type 2 (and gestational)
Infective	• Hepatitis B/C with abnormal liver function tests • HIV positive • Toxoplasmosis – women receiving treatment • Current active infection of chickenpox/chlamydia/ rubella/ genital herpes/genital warts • Tuberculosis under treatment
Renal	• Abnormal renal function • Renal disease requiring supervision by a renal specialist
Neurological	• Epilepsy • Myasthenia gravis • Previous cerebrovascular accident
Gastrointestinal	• Liver disease associated with current abnormal liver function tests • Obstetric cholestasis
Psychiatric	• Psychiatric disorder requiring inpatient care
Auto-immune	• Rheumatoid arthritis requiring treatment • Ehlers-Danlos syndrome • Immune Systemic Lupus Erythematosus • Scleroderma
COMPLICATIONS IN A PREVIOUS PREGNANCY	• Unexplained stillbirth/neonatal death • Previous fetal death related to intrapartum difficulty • Placental abruption • Previous baby with neonatal encephalopathy • Pre-eclampsia requiring preterm birth • Eclampsia

	• Uterine rupture • Uterine inversion • PPH **>1000ml** • Caesarean section • Shoulder dystocia • MROP • Acute fatty liver disease in pregnancy

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Additional notes:

1. If SROM >24 hours but in active labour the Birth Centre is a safe option, however, any delay in progress or clinical signs of infection should necessitate a prompt transfer to labour ward. Neonatal observations should be performed postnatally for 12 hours as per the 'prelabour rupture of membranes at term' guideline.
2. The appropriateness of the Birth Centre as a place of birth should be considered carefully with regard to fibroids. A discussion with the obstetrician on labour ward (if no documented birth plan in place) should take place regarding size and location of fibroid and the relevance to labour.