Frimley Health
NHS Foundation Trust

Assessment for the use of the Mulberry and Juniper Birth Centre guideline (including colour-coded system for assessment)

Key Points

- All women should receive evidence-based information about place of birth throughout their pregnancy.
- The Mulberry Birth Centre (Frimley Park hospital) and Juniper Birth Centre (Wexham Park hospital) are midwifery-led birthing environments.
- Low risk women, without obstetric risk factors, medical conditions, or complex social circumstances (green criteria) have less intervention during labour if they choose to birth on the Birth Centre.
- Some women who receive obstetric led care in pregnancy (red criteria) are expected to have reduced risk birthing on the Labour Ward.
- Some women who receive obstetric led care in pregnancy (amber criteria) may express a preference for using the Birth Centre and then should receive an individualised discussion assessing their safety and suitability.

Version: 1.1
Date Issued: 18/07/2025
Review Date: 01/04/2028
Key words: Birth centre, Mulberry, Juniper, midwifery led care, physiological birth

This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition. Printed copies must be destroyed after use.

Abbreviations

BMI	Body mass index
CTG	Cardio tocography
ERPC	Evacuation of retained products of conception
GAP	Growth assessment protocol
ICSI	Intracytoplasmic sperm injection
IVF	In vitro fertilisation
LLETZ	Large loop excision of transformation zone
MROP	Manual removal of placenta
PAPP-A	Pregnancy associated plasma protein-A
PPH	Postpartum haemorrhage
SMM	Surgical management of miscarriage
SROM	Spontaneous rupture of membranes
USS	Ultrasound scan

Purpose

This guideline outlines the assessment criteria and process for women who wish to birth in the Mulberry and Juniper Birth Centres.

Background

Low-risk women without obstetric risk factors, medical conditions, or complex social circumstances should be advised that planning to give birth in a midwifery-led unit is associated with a lower rate of interventions and the outcome for the baby is no different compared with an obstetric unit. (NPEU 2011)

Women on obstetric led care pathways should be advised that care on an obstetric led unit is expected to reduce associated risks.

Deciding on place of birth should be a continuous process throughout pregnancy taking into consideration maternal preference, previous obstetric history, clinical circumstances, medical conditions, and social factors.

Place of birth should continue to be assessed and may change for an individual based on a developing clinical picture throughout pregnancy, on admission in labour, throughout labour and a transfer of care to another labour environment may be required even in the postnatal period.

Information about place of birth should be provided to women in an accessible format at the earliest opportunity.

The following colour-coded system of assessment should be used to support place of birth planning.

Colour-coded System of Assessment: Definitions

The following table outlines and defines the colour-coded system of assessment to support with place of birth planning. This system is to promote the safety of mother and baby.

GREEN	**Birth centre use should be routinely offered to all women.** Criteria listed within the green section indicates that admission to the Birth Centre is recommended.
AMBER	**Birth centre use should not be routinely offered to all women.** Criteria listed within the amber section indicates that if the woman requests the Birth Centre as her place of birth, an individual assessment should take place and a discussion with the birth centre lead, senior midwife, consultant midwife or an obstetrician is required. Where there is more than one amber risk factor present, it is important to consider cumulative risk. The discussion and decision must be documented in the electronic records.
RED	**Birth centre use should not be offered to women.** Conditions listed within the red section are contraindications to the use of the Birth Centre and the woman should be advised to give birth on the Labour Ward with a consultant obstetrician as the lead professional.

Amber Criteria

Those with criteria in the amber section and have expressed a preference to birth on the Birth Centre should have an individualised discussion with the Birth Centre lead, a senior midwife, consultant midwife or an obstetrician to include the following:

- Exploration of what is relevant or important to the individual,
- Benefits of using of the Birth Centre,
- Risks of using the Birth Centre (including realistic transfer times and implications of this),
- Alternative options for place of birth.

Where available, evidence, research and data should be used to inform these discussions.

Women should be informed where there is a lack and/or absence of evidence, as well as the implications and limitations of this evidence gap on their decision making in regard to place of birth.

These discussions and any decisions must be clearly documented in the electronic records.

(See Maternity Personalisation and Informed Decision-Making SOP for further support with discussions)

Colour-coded System of Assessment

GREEN	
• Midwifery led care • Gestation ≥ 37+0 weeks ≤42+0 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 • Low PAPP-A with normal growth on USS	
AMBER	
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 labour onset)
Infective	• Group B Streptococcal • 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 (must avoid prolonged labour)
Gastrointestinal	• Liver disease with normal liver function tests • Crohn's disease/Ulcerative colitis with no flare during the current pregnancy
Complications in a Previous Pregnancy	• PPH ≤1000ml (advise an active 3rd stage and consider IV access) • Extensive perineal trauma (previous 3rd or 4th degree, clitoral, urethral, or cervical tear)
Current Pregnancy	• IVF/ICSI • Antepartum bleeding after 24 weeks • Under current outpatient psychiatric care • Women with safeguarding concerns • Women who miss 2 antenatal appointments in the third trimester • BMI between ≥36-39 kg/m2 at booking in a multiparous woman only • Age 40-44 at booking • Gestational diabetes on diet control with stable and documented blood sugar values ***(see note 1)*** • Two episodes or more of reduced fetal movements after 34 weeks ***(see note 2)*** • Reduced fetal movements in the last 24 hours (even if it is the first episode during this pregnancy) ***(see note 2)***
Fetal Indications	• Fetal abnormality with intrapartum or immediate neonatal implications
Previous gynaecological history	• Major gynaecological surgery including cone biopsy/LLETZ • Bicornuate uterus • Fibroids ***(see note 3)*** • Surgical termination of pregnancy (e.g. Not tablets) or surgical management of miscarriage (SMM) or ERPC x 3
RED	
Current Pregnancy	• Multiple birth • Placenta praevia • Declining of blood products • Para 6 or more • Pre-eclampsia or pregnancy induced hypertension • Preterm labour or preterm prelabour rupture of membranes • Induction of labour for reason other than postdates or maternal request **(See Appendix 1)** • Placental abruption • Presence of meconium • Prolonged SROM >24 hours ***(see note 4)*** • Anaemia (haemoglobin less than ≤85 g/litre at labour onset) • Confirmed intrauterine death • Substance misuse/recreational drug use in pregnancy • Extensive alcohol use in pregnancy • Gestational diabetes requiring medication or insulin, or gestational diabetes on diet control with unstable/undocumented blood sugars • Malpresentation (breech, unstable or transverse lie) • BMI of 40 kg/m2 or more at booking if multiparous • BMI of >35 kg/m2 at booking if a primigravida • Recurrent antepartum haemorrhage

	• Small for gestational age in this pregnancy (estimated fetal weight <10th centile on GAP/GROW chart) • Large for gestational age in this pregnancy (estimated fetal weight >90th centile on GAP/GROW chart) • Any concerns in relation to fetal growth where USS has NOT taken place (i.e. SFH plotting <10th or >90th, accelerated, static or slow growth as per SFH on GAP/GROW chart) • 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 Blood pressure >140mmHg systolic or >90mmHg diastolic or other abnormal maternal observations
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 $100x10^9$/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) • Pre-existing diabetes (Type 1 or Type 2)
Infective	• Hepatitis B or 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

Additional notes:

1. a) Place of birth should be discussed and documented with the diabetes specialist team from 36 weeks onwards at each contact. If there has been a need for additional review or input from the diabetes specialist team since the last documented place of birth discussion, this would equate to a move to the red criteria.
   b) Once labour is established, capillary blood glucose monitoring should be performed hourly and maintained between 4-7.8mmol/L. Any values outside of this range will warrant transfer to Labour Ward
   c) Neonatal and maternal observations in line with guidance will also be required in the postnatal period.

2. 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 24 hours prior to admission, a CTG must be performed. If there are no ongoing concerns and the CTG is normal, the woman may transfer to the Birth Centre after an individualised risk assessment.
3. The appropriateness of the Birth Centre as a place of birth should be considered carefully regarding fibroids. A discussion with the obstetrician on Labour Ward (if no documented antenatal birth plan in place) should take place regarding size and location of fibroid(s) and the relevance to labour.
4. 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.
5. The following factors should also be considered when discussing and planning place of birth:
   a. Previous stillbirth or neonatal death with a known non-recurrent cause
   b. Pre-eclampsia developing at term
   c. History of previous baby more than 4.5 kg
   d. Previous term baby with jaundice requiring exchange transfusion

Useful links

Recommendations | Intrapartum care | Guidance | NICE
Personalisation and Informed Decision-Making in Maternity SOP
Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study | The BMJ

Reference

The National Perinatal Epidemiology Unit (NPEU), Birthplace in England Research Programme. (2011) *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study.*

Appendix 1: Admission to Birth Centre after Induction of Labour (IOL) for postdates or maternal request

IOL rationale

- IOL for postdates alone (40+0 – 41+6) can be considered for Birth Centre admission

- IOL for maternal request alone (39+0 – 41+6) can be considered for Birth Centre admission.

- Those who have received midwifery-led care antenatally, who are otherwise in the green colour-coded System of Assessment, and are without any other risks, or indications for IOL should be considered for Birth Centre admission.

IOL process

- Low risk nulliparous and multiparous women in established labour (see Care in Labour guideline for definition) may be admitted to the Birth Centre:
    - following a **single** dose of prostaglandin **OR**
    - following an artificial rupture of membranes (ARM) **without** any dose of prostaglandin.

- Prior to admission to the Birth Centre, all women require a full risk assessment including maternal observations, CTG and VE (with removal of Propess). There should also be a discussion about what may warrant recommended transfer to Labour Ward (i.e., slow progress, need for oxytocin infusion and other routine transfer reasons).

- Once in established labour, if ARM is required (i.e. for slow progress or outside of the initial process of IOL), this should take place following transfer to Labour Ward.

- Women should be advised to have an active 3rd stage when prostaglandins have been administered.

Full version control record

Version:	1.1
Guidelines Lead(s):	Rebecca Edwards, Nicola Rose Stone (consultant midwives)
Contributor(s):	Naomi Amero, Valerie Gunawardena (senior sisters, Mulberry birth centre), Fearne Meehan (Juniper birth centre senior sister, community matron WPH)
Lead Director / Chief of Service:	Balvinder Sagoo
Professional midwifery advocate:	Joanna Hedges
Library check completed:	10.02.2025
Ratified at:	Cross site obstetric clinical governance meeting, 22 April 2025
Date Issued:	18/07/2025
Review Date:	01/04/2028
Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Birth centre, Mulberry, Juniper, midwifery led care, physiological birth

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.
This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	April 2025	Rebecca Edwards, Nicola Rose Stone (consultant midwives)	Final	Previously included in the operational policy for Mulberry and Juniper Birth Centres. Separated and updated from policy and ratified at Cross site Obstetrics Clinical Governance meeting, 22 April 2025
1.1	May 2025	Rebecca Edwards, Nicola Rose Stone (consultant midwives)	Interim	Clarification of amber and red criteria as contradiction in relation to fetal growth parameters noted. Signed off as chair's action by CoS B. Sagoo on 16.7.2025

Related Documents

Document Type	Document Name
SOP	Operational Policy for Mulberry and Juniper Birth Centres
SOP	Personalisation and Informed Decision-Making