

Midwifery Led Acceptance Criteria

Introduction

The National Service Framework (DOH 2004) states that women should have access to supportive, high quality maternity services, designed around their individual needs and those of their babies. The NHS Plan (DOH 2000) advocates that the service user should be at the centre of care, services should be easily accessible, and staff should develop new ways of working.

Pregnancy is a normal physiological process. We recognise that some women are more at risk of developing complications during their pregnancy than others and may need specialised antenatal care. In a review of the evidence comparing, midwife-managed or midwife and GP-managed antenatal care for women at 'low risk' to consultant led care, NICE 2003 concluded that midwife or GP managed antenatal care did not increase the risk of adverse maternal or perinatal outcomes (NICE 2003). NICE concluded that for low risk healthy pregnant women routine involvement of obstetricians in their care does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise (NICE 2003).

The midwife at booking is responsible for identifying which women are suitable for MLC by performing a comprehensive risk assessment. Risk assessment are subsequently performed at each antenatal visits and on admission in labour as "risk" is a dynamic factor and women can change from low to high risk. The aim of the risk assessment process is to identify women who may have risk factors, which may adversely affect pregnancy outcome. However, risks cannot be reliably and objectively quantified in terms of likely occurrence of specific adverse outcomes. Many women labelled as high risk will not experience the adverse outcome for which they have been assessed to be at risk, conversely many women experiencing adverse outcomes have previously identified as low risk. In the evaluation of the Edgware Birth Centre Saunders et al 2000 wrote:

"The "screening" test at booking at the Birth Centre, using the eligibility criteria, is not a specific or sensitive tool. It rules out from the start many women who could potentially have a normal delivery (specificity) but also includes many women who later develop complications of pregnancy and have their care transferred elsewhere (sensitivity (Saunders et al, 2000, Barnet Health Authority)

Despite these difficulties it is important to have a framework that enables the identification of women suitable for MLC care and for women who may benefit from consultant led care. Therefore women selected for Midwifery Led Care should have general good health and an uncomplicated medical and obstetric history. It is expected that healthy women who are experiencing a problem-free pregnancy will be offered the choice of midwifery led care and may opt to have to their babies at home or at a midwifery led unit. In case of doubt an obstetric/medical opinion should be sought.

The following criteria have been agreed to guide practice within the Trust:

Inclusion Criteria:

Full Term (37th to 40 +12 days pregnant)

Singleton pregnancy

Cephalic presentation

Spontaneous onset of labour

An uncomplicated pregnancy, medical and obstetric history (see exclusion criteria)

Parity

Women having their 1st, 2nd, 3rd, 4th or 5th baby without previous complication or where recurrence of a complication would not be anticipated.

Age - 16 to 42 years

Weight - Body mass index greater than 18.5 or less than 35

Exclusion Criteria:

Women with the following conditions require booking for consultant-led care and delivery in a consultant unit:

<p>Medical history:</p> <p><u>Respiratory</u></p> <ul style="list-style-type: none"> • Asthma: severe attack requiring nebuliser / steroids in previous 12 months • Cystic fibrosis <p><u>Haematological</u></p> <ul style="list-style-type: none"> • Sickle cell disease • Previous P.E. or D.V.T. • Von Willebrands disease / other thrombotic disorders • ITP (current or previous pregnancy) <p><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> • Liver disease • Chron's disease / ulcerative colitis • Severe Hyperemesis • Coeliac disease • Major surgery <p><u>Immune</u></p> <ul style="list-style-type: none"> • Rheumatoid arthritis • Systemic lupus erythematosus • Connective tissue disease e.g Ehlers Danlow and Marfon's syndromes 	<p><u>Neurological</u></p> <ul style="list-style-type: none"> • Epilepsy • Neurological disease • Myasthemia gravis <p><u>Endocrine</u></p> <ul style="list-style-type: none"> • Thyroid disease • Diabetes • Other significant disorders e.g. Cushings disease <p><u>Renal</u></p> <ul style="list-style-type: none"> • Renal disease / renal abnormality • Recurrent UTI infections needing prophylactic antibiotics <p><u>Psychiatric history</u></p> <ul style="list-style-type: none"> • Previous puerperal psychosis • Severe and enduring mental health problems • History of attempted suicide • Past history of substance and alcohol abuse <p>Child protection concerns in vulnerable adults</p>	<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> • Known cardiac disease / Congenital heart abnormality • Hypertensive disorders <p><u>Anaesthetic Risk</u></p> <ul style="list-style-type: none"> • Known airway problem <p><u>Infective</u></p> <ul style="list-style-type: none"> • TB • HIV positive • Toxoplasmosis • Chicken pox • Genital herpes • Hepatitis C and B • Group B Streptococcus
<p>Gynaecological history:</p> <ul style="list-style-type: none"> • Previous major gynaecological i.e. Myomectomy, Hysterotomy, Knife Cone Biopsy, circumcision (Unless NVD has followed since treatment) • Uterine / vaginal abnormality • Recurrent TOP'S (3 or more) 		
<p>Obstetric history:</p> <p>Complications in previous pregnancy:</p> <ul style="list-style-type: none"> • Stillbirth/neonatal death • Previous preterm labour 		

- Previous obstetric cholestasis
- Previous acute fatty liver disease
- Sever early onset pre-eclampsia
- Uterine rupture
- Previous C.S.
- Complicated instrumental delivery: needs obstetric / midwifery review at 36 weeks
- Primary PPH > 500ml: needs obstetric review before decision is made
- Retained placenta
- Previous 3rd/4 degree tear
- Previous shoulder dystocia
- Previous baby of < 2.5kg / > 4.5kg
- 3 or more previous, consecutive, spontaneous abortions and no subsequent NVD
- Previous placental abruption

Current pregnancy:

- Rhesus disease
- Haemoglobin of less than 10.g/dl at term
- APH/placental abruption
- Placenta praevia
- Unstable lie
- Multiple pregnancy
- Treatment with clexane/aspirin
- Suspected thrombo-embolism
- Hypertension >140/90
- Pre-eclampsia
- Gestational diabetes
- Obstetric cholestasis
- Current history of drug/alcohol abuse
- Known haemolytic strep B during this pregnancy
- BMI of less than 18 or 35 or greater
- Women who book late in pregnancy or who miss 2 or more antenatal visits
- History of domestic violence with current partner
- Induction of labour
- Postmaturity (40+12 days)
- Prolonged rupture of membranes (greater than 48 hours)

Labour:

- Hypertension
- Unstable lie
- Pyrexia > 37.8
- Prolonged first stage of labour (see progress in the first stage of labour guidelines)
- Prolonged 2nd stage (see progress in the second stage of labour guidelines)
- Midwife or maternal concern

A report by the National perinatal Epidemiology unit 2005 on birth centre outcomes found considerable variation in criteria used for admission to either freestanding or alongside birth centres/midwifery led units. The report recommended that a standardised system of inclusion and exclusion criteria in relation to birth centre services should be developed and implemented in NHS Trusts. Until standardised evidence-based criteria in terms of likely benefits and harms are developed, the above criteria should inform practice in the Trust. The report also recommended that NHS Trusts should monitor pregnancy and birth outcomes for women booking to give birth in midwifery led units and birth centres. To achieve this the audit tool adapted from the study by Saunders et al (2000) will be used to monitor practice in the midwifery led units as well as information derived from other data systems.

References:

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