All Wales Place of Birth Assessment Criteria

Place of birth assessment at around 36/40, to be completed by the lead carer giver, and at each antenatal contact after this time including at each labour assessment.

Pathway A Additional care needs requiring Obstetric led intrapartum care (OLC)	Pathway B Individual assessment and intrapartum care planning	Pathway C Midwifery led intrapartum care (MLC)
Cardiovascular/other medical conditions • Confirmed cardiac disease • Hypertension • Malignant Disease	Cardiovascular/other medical conditions • Cardiac disease without intrapartum implications	Cardiovascular/other medical conditions
Haematological • Autoimmune disorders e.g. Systemic Lupus • Antiphospholipid syndrome • Haematological – History of sickle-cell, beta thalassemia Major • History of thromboembolic disorders • Hb less than 85g/L • Immune thrombocytopenia purpura or platelet count below 100 μ/L • Von Willebrand's disease • Bleeding disorder in the woman/fetus • Atypical antibodies known to cause HDN • Jehovah's witness with additional care needs • Women scoring 3 or 4 on VE assessment and on prophylactic or therapeutic antenatal anticoagulants	Haematological • Atypical antibodies not known to cause HDN • Platelets >100 <150 μ/L • Hb between 85-105g/L and asymptomatic of anaemia	Haematological • Hb of <110g/L at booking and <105g/L after 28 weeks, require iron therapy and recheck Hb at 34/40 OR 4 weeks after commencing iron therapy • Women scoring 2 on VTE assessment where postnatal thrombo-prophylaxis has been prescribed or declined
Endocrine • Hyperthyroidism (any history of hyper, may present as hypo) • Women on oral steroids • Type 1 and type 2 diabetes • Gestational diabetes	Endocrine	Endocrine • Adequately treated primary hypothyroidism
Auto-immune • Systemic lupus erythematosus, Scleroderma • Connective tissue disorders	Auto-immune • Connective tissue disorders (non-specific)	Auto-immune
Infective • Hepatitis B or C carriers of, or infected • HIV • Toxoplasmosis in pregnancy • Active infection or chicken pox/rubella • Primary infection of genital herpes (First lesion) diagnosed in pregnancy or recurrent active lesions after 36/40. • Tuberculous under treatment	Infective • Covid 19-symptoms or positive test within 10 days of onset of labour or previous hospital admission due to Covid-19 during pregnancy. • Previous baby affected by GBS, diagnosed with GBS this pregnancy, or opting for Intrapartum Antibiotic Prophylaxis (IAP).	Infective • History of genital herpes, and lesion free throughout pregnancy, offer prophylactic acyclovir from 36/40. • Reoccurrence of genital herpes in this pregnancy but lesion free prior to 36/40, offer prophylactic acyclovir from36/40. • Group B streptococcus in current pregnancy, declining Intrapartum Antibiotic prophylaxis (recommend neonatal observation as per EOS calculator). • GBS in last pregnancy; Offer Vaginal/rectal swab 35-37/40. If negative IAP not required, can be MLC for birth unless mother wishes . IAP in which case this should be supported.
Neurological • Epilepsy • Myasthenia gravis • Multiple sclerosis • Previous cerebrovascular accident	Neurological • Previous epilepsy not medicated and no seizures for 3 years.	Neurological
Gastro-intestinal/Renal • Liver disease (not obstetric-cholestasis) • Abnormal renal functions/known renal disease	Gastro-intestinal/Renal • Crohn's disease or ulcerative colitis	Gastro-intestinal/Renal
Previous pregnancies • Previous Molar pregnancy • Previous HELLP syndrome • Severe pre- eclampsia/eclampsia • Pre-eclampsia requiring preterm birth • Baby with neonatal encephalopathy • Uterine rupture • Placental abruption • Previous PPH 500-999mls requiring treatment or blood transfusion. • Primary PPH >1000mls or any amount causing symptoms of hypovolaemia. • Retained placenta • Caesarean section • Shoulder dystocia • Cervical tears • 3rd/4th degree tears with ongoing concern or continence issues	Previous pregnancies • Pre-eclampsia at term and asymptomatic this pregnancy. • 3rd/4th degree tears with no ongoing issues.	Previous pregnancies • 3 or more consecutive miscarriage • Mid trimester miscarriage (12-22 weeks). • Previous SGA below 10th centile (Suitable for Midwifery-led birth where USS's are Normal) • Previous pre-term birth now >37/40. • Previous PPH 500-999mls with no treatment or evidence of bleeding due to uterine atony, previous birth record to be reviewed to confirm clinical picture.
Current pregnancy • Multiple pregnancy • Low PAPP-A and concerns around fetal growth. • Gestational diabetes • Placenta praevia • Pre-eclampsia /pregnancy induced hypertension • Pre-term pre-labour rupture of membranes • APH of placental origin or > 1 episode after 24 weeks • Alcohol dependency • Maternal age ≥40 at booking. • Nulliparous BMI ≥35-39.9 with normal GDM screen and USS's. • All parity BMI>40 • Grand multiparity P6 >. • Concerns with fetal growth or placental function. • Concerns around fetal movement within 24 hours of the onset of labour. • EFW ≥97th with any other additional care needs • Polyhydramnios/oligohydramnios • Gestation >41+6 • Therapeutic or prophylactic thromboprophylaxis • Wt. <50kg with anaemia • Persistent breech/mal presentation.	Current pregnancy • Women declining booking/anomaly USS • APH of unknown origin,1 episode after 24/40 • Substance misuse • Para 5 • EFW via USS > 97th centile with normal GDM screen and otherwise uncomplicated pregnancy. • 2 episodes of raised blood pressure antenatally, taken more than 4 hours apart. • Recurrent[1] episodes of AFM (2 or more within 21 days) with reassuring outcomes of investigations and where fetal movements have been normal in the last 24 hours. • Booking WT<50kg , no concerns around fetal growth and normal haemoglobin. • Low PAPP-A with normal fetal growth on serial USS	Current pregnancy • BMI at booking of 30 to 34.9kg/m • Multiparous BMI 35-39.9 with previous vaginal birth who are otherwise suitable for Midwifery-led birth with normal GDM screen and normal routine USS's. • Maternal age 35-39 inclusive at booking. • Smoker (Suitable for Midwifery-led birth where USS's are normal). • P4 or < • EFW >90th <97th centile on USS at 36/40 with otherwise uncomplicated pregnancy. • Assisted conception • A single episode or >1 episode of AFM (occurring > 21 days apart), with reassuring investigation and normal fetal movement in the last 24 hours.
Previous gynaecological history • Myomectomy • Hysterectomy • Cone biopsy • Any uterine perforation resulting from previous STOP or surgery.	Previous gynaecological history • Extensive vaginal repair/re fashioning • LLETZ x2 laparoscopy/laparotomy	Previous gynaecological history • LLETZ x 1
Respiratory • Severe asthma requiring increase in treatment of hospital admission during pregnancy • Cystic fibrosis	Respiratory	Respiratory • Mild asthma women only using inhalers prescribed by GP. Steroid inhalers where asthma has been stable during pregnancy
Mental Health • Where intensive maternal or neonatal monitoring is required during labour and/or postnatally.	Mental Health • Stable mental health illness on various psychotropic medication, including antipsychotics. (Plan neonatal care as per maternal psychotropic drug pathway)	Mental Health • Women on SSRIs and stable (Plan neonatal care as per All Wales maternal psychotropic drug pathway).
Advise to give birth in an obstetric unit. Any women who are planning birth outside of the OU will be planning birth 'outside of guidance' and will require detailed care plans as per local pathways.	After an individual discussion and assessment may be suitable to give birth in a midwifery-led setting.	Advise to give birth in a midwifery led setting.

At every antenatal assessment, by midwives and the medical team, review of the antenatal care pathway should occur and the lead professional and place of birth recommendation changed where required.
1 =Definition of recurrent altered fetal movement =is where at least 2 episodes of altered fetal movements are reported within a 21-day period.
*It is noted that the above is not exhaustive and clinicians should exercise clinical judgment.
*Midwives should be aware of the impact of multiple complexity, even where these are in care pathway B, multiple factors in any pathways may move the care need to pathway A.