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# **Midwife-led care in Calderdale**

## **Report on transfers of care for 2000**

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**Midwife-led care in Calderdale**  
**Report on transfers of care for 2000**

The analysis looks at the data received for both intranatal and antenatal transfers at Calderdale hospital over a one-year period (1<sup>st</sup> January 2000 through to 31<sup>st</sup> December 2000 inclusive). The classifications for transfer are listed below in table 1 also showing the frequency and percentage for each package of care in terms of overall transfers.

Table 1. Classification

	Frequency	Percent
Transfer from GP care to consultant care antenatally	81	17.3
Transfer from consultant care to GP care antenatally	2	.4
Transfer from GP care to consultant care in labour	75	16.0
Transfer from MLC to consultant care antenatally	127	27.1
Transfer from consultant care to MLC antenatally	41	8.7
Transfer from MLC to consultant care in labour	143	30.5
Total	469	100.0

It is apparent that from the data above there were 469 women transferred from one form of care to another. The largest number of transfers were from midwife-led care (MLC) to consultant care in labour (n = 143), and the second largest being from MLC to consultant care in the antenatal period (n = 127). Together these transfers from MLC to consultant care accounted for 57.6% of all women transferred between various packages of care in 2000, and this analysis will concentrate on these transfers. All 270 babies in this group were live born.

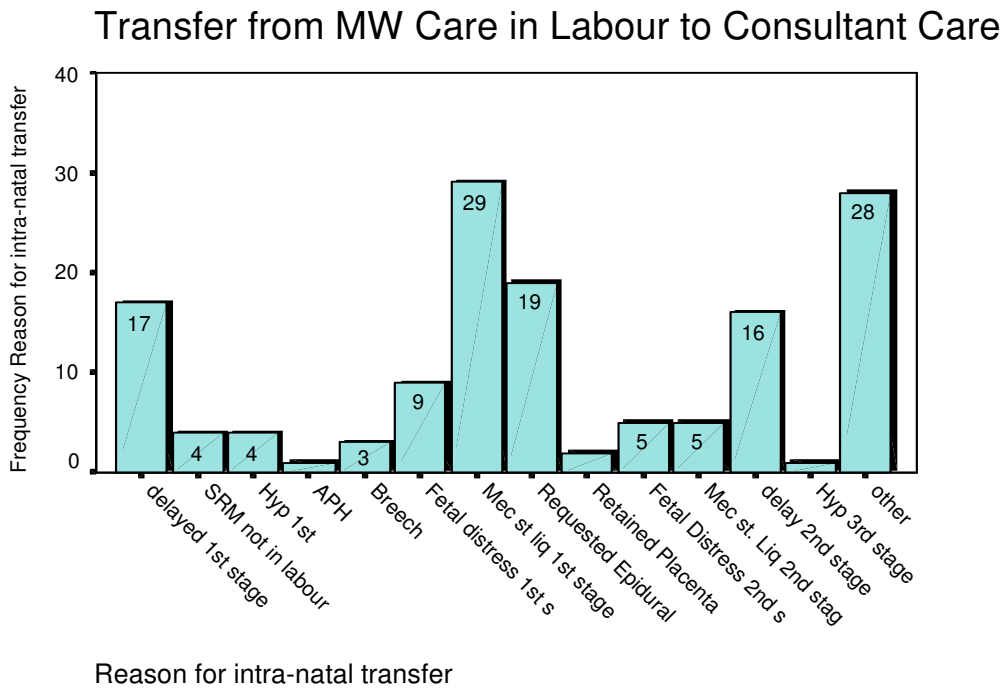
**Transfers from Midwife-led Care in labour**

Chart 1 on page 2 shows that the main reason for transfer from MLC to consultant care intra-natally is meconium stained liquor in the 1<sup>st</sup> stage (29), followed by women requesting an epidural (19). A combination of delays in 1<sup>st</sup> stage (17) and 2<sup>nd</sup> stage (16) form the 3<sup>rd</sup> and 4<sup>th</sup> reasons for transfer. There were also 28 cases for which the reason for transfer was not stated.

Of the women transferred because of meconium stained liquor in the 1<sup>st</sup> stage (n = 29), 51.72% (n = 15) had spontaneous vaginal births. Of the 19 women transferred for an epidural, only one did not have an epidural.

The women transferred because of delay in the first stage (n = 17) can be divided into three groups in terms of augmentation. Of these 17 women, 11 (65%) had oxytocics, 4 (24%) women had ARM only, and 2 (11%) of the 17 women transferred because of delay had no augmentation.

**Chart 1: Reasons for transfer from MLC during labour**



The types of birth experienced by the 16 women transferred due to a delay in the 2<sup>nd</sup> stage are indicated below in chart 2

**Chart 2: Outcomes for women (n = 16) transferred for delay in the 2<sup>nd</sup> stage**

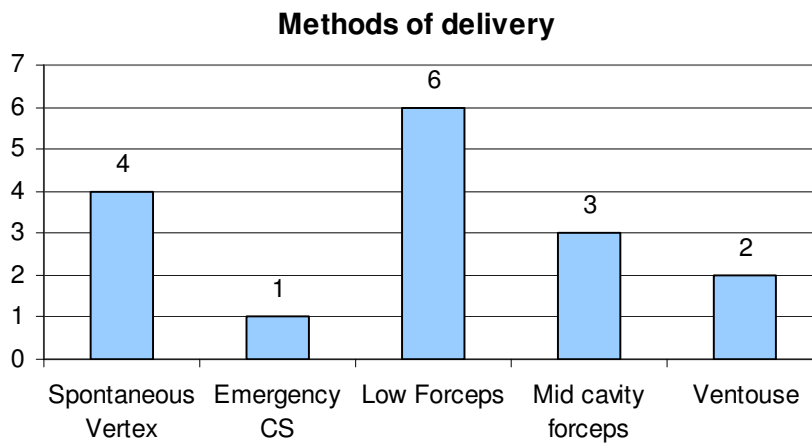


Table 2 below gives a monthly breakdown of the reasons why women were transferred from MLC to consultant care in labour. This table reflects the numbers indicated in graph 1 above, and shows the reasons for transfer by month. The numbers by month are small but there appears to have been an increasing trend for transfer for delay in the 1<sup>st</sup> stage as the year progressed. Also the numbers of women requesting an epidural increased as the year progressed.

Table 2. Monthly breakdown of reasons for transfers from MLC to consultant care in labour.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Delay 1st stage	1	1		1	2		2	1	3	3	1	2
SROM			1	1	1			1				
Hyp 1 <sup>st</sup> stage			1				2				1	
APH										1		
Breech		1						1	1			
Fetal distress 1 <sup>st</sup> Stage	1					1	2		1	2	1	1
Mec st liquor 1 <sup>st</sup> stage	2	1	1	3	1	5	2	2	2	5	3	2
Mec st liquor 2 <sup>nd</sup> stage				1	1		1	1			1	
Requested Epidural	1	1	2		1	1	4	2	2		3	2
Retained placenta			1		1							
Delayed 2 <sup>nd</sup> stage	2			1	2	1	2	3	1	3		1
Hyp 3rd stage												1
Fetal Distress 2nd stage						1				2	1	1
Other		1			6	1	7	2	3	3	3	2
Total	7	5	6	7	15	10	22	13	13	19	14	12

Types of birth experienced by transferred women are listed below in Table 3. Of these 143 births, 66 women (42.2%) had an epidural and 77 (57.6%) did not have an epidural.

Table 3. Types of birth experienced by women transferred from MLC in labour

Outcome	No	%
Spontaneous	66	46.15
Low Forceps	15	10.48
Mid-Cavity Forceps	10	6.99
Rotational Forceps	2	1.39
Vacuum	21	14.68
Assisted Breech	2	1.39
Emergency C S	27	18.88

82 (57.3%) of the women transferred in labour were birthing their 1<sup>st</sup> child, 32 were having their 2<sup>nd</sup> child, 14 their 3<sup>rd</sup>, 12 their 4<sup>th</sup>, 1 her 5<sup>th</sup> and 1 her 7<sup>th</sup>.

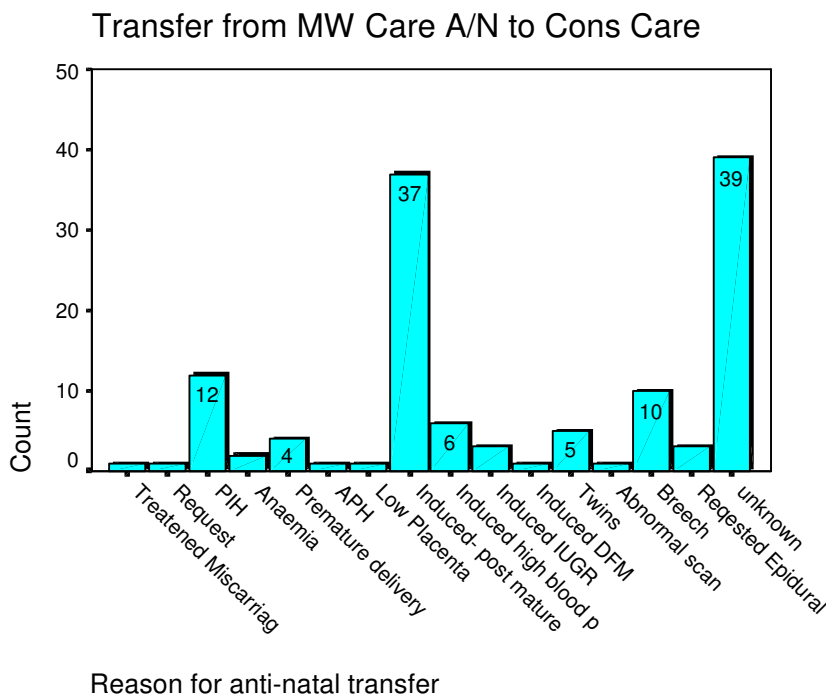
Rates and methods of augmented labour for all women transferred in labour were as follows: of the 143 deliveries 18 (12.58%) had ARM, 46 (32.17%) had augmentation by oxytocic drugs (and, presumably, ARM), and the remaining 79 (55.25%) gave birth with no apparent augmentation. (Rates of augmentation for women transferred specifically for delay in the first stage are given on page 1.)

### Transfers from MLC during pregnancy

The second most common transfer pattern is from MLC to consultant care during pregnancy. There are 127 recorded cases (27.1%) of antenatal transfer during the year.

Chart 3 below indicates that the largest reason for this transfer is unknown (40 cases, 31.5%), followed by 37 cases (29.1%) of induction of labour for postmaturity. Only one woman requested a transfer from MLC to consultant care. Pregnancy Induced Hypertension (PIH) and breech presentation accounted for 11 and 10 transfers (7.1%) respectively.

**Chart 3: Reasons for transfer from MLC during pregnancy**



In chart 3 (page 4) it is clear that the main identified reason for transfer during pregnancy is for women to be induced for post-maturity (37 cases) Of these 37 women 45.94% (n = 17) were indeed induced.

Chart 4 below indicates the types of birth experienced by the 37 women transferred from MLC to consultant care antenatally when the reason was stated as induction for post-maturity. For these 37 women, augmentation rates are as follows: 4 (10.81%) had ARM only, 12 (32.43%) had oxytocic drugs (and, presumably, ARM), and 21 (56.76%) of the

women had no augmentation of labour. The data does not indicate whether or not these women had any prostaglandin.

**Chart 4. Types of birth for women transferred antenatally from MLC to consultant care due to postmaturity**

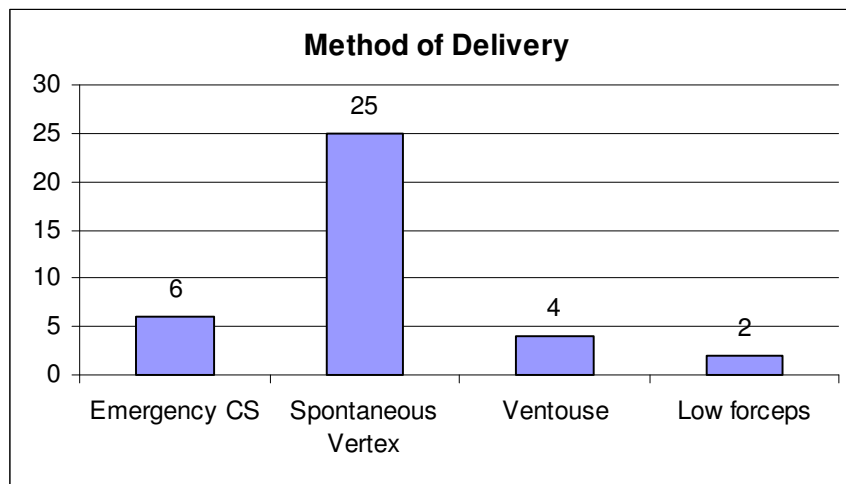


Table 4 on page 6 shows the monthly breakdown of the reasons why women were transferred from MLC to consultant care during pregnancy.

The table does not disclose any trends in the reasons for transfer. Transfers for induction for post-maturity are more frequent nearer either end of the year but are less frequent during April-July.

Of the 127 women transferred from MLC to consultant care in pregnancy, augmentation rates are similar to those of women for transferred in labour, with 14 (11.02%) women having ARM only, 32 (25.21%) being given oxytocic drugs, and a further 81 (63.77%) women having no augmentation. Types of birth are listed below in table 5 on page 6.

Again the majority of women (n = 55, 43.3%) in this transfer category were having their 1st child, 41 (32.3%) their 2<sup>nd</sup>, 21 (16.5%) their 3<sup>rd</sup>, 9 (7.1%) their 4<sup>th</sup>, and 1 (0.8%) her 5<sup>th</sup>.

Table 4: Monthly breakdown of reasons for transfer from MLC to consultant care antenatally.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Prem birth	1		1								1	1
Induced post-maturity	3		4	2	3	2	2	4	5	2	5	5
Induced High BP	1				1		3			1		
Induced DFM			1				1					
Induced IUGR							1					2
Breech	1	2			1	1		1	1	2		1
Requested Epidural	1		1						1			
APH		1										
Abnormal scan				1								
PIH				1	1			1	1	5	1	1
Twins							1	1	1		1	
Low placenta									1			
Anaemia										1		1
Requested								1				
Other	2	3	5	3	7	4	4	1	1	2	5	2
Total	9	6	12	7	13	7	12	9	11	13	13	13

Table 5: Types of birth experienced by women transferred from MLC antenatally

<b>Outcome</b>	<b>No</b>	<b>%</b>
Spontaneous	79	62.20
Low Forceps	4	3.15
Vacuum	11	8.66
Assisted Breech	2	1.57
Elective CS	9	7.09
Emergency CS	22	17.33