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Antenatal Care Pathway

Classification:	Guideline
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Departments/Group this Document applies to:	Maternity

Approval Group: Maternity Guidelines Meeting	**Date of Approval:**	06/2020
	Last Review:	10/2023
	Review Date:	10/2026

Unique Identifier MIDW/GL/137	**Status:** Approved	**Version No:** 10.1

Guideline to be followed by (target staff): All Maternity Staff

To be read in conjunction with the following documents:
- BCG Immunisation Neonates and Paediatrics (MIDW/GL/147)
- Breech Presentation at Term and External Cephalic Version Guideline (MIDW/GL/128)
- Diabetes in Pregnancy Guideline (MIDW-GL-122)
- Fetal Anomalies Guideline (MIDW/GL/146)
- Induction of Labour Guideline (MIDW/GL/11)
- Interpretation, Translation and Accessing Information to meet individual needs (DOC215)
- Maternity Multidisciplinary Confidential Communiqué Guideline (MIDW-GL-116)
- Non-Attendance/No Access for Planned Antenatal and Postnatal Care Guideline (MIDW/GL/104)
- Perinatal Mental Health Guideline (MIDW/GL/103)
- Prophylactic Anti-D Immunoglobulin Guideline (MIDW/GL/67)
- Safeguarding Adults Policy (ORG/GL/51)
- Screening in Pregnancy Guideline (MIDW-GL-145)
- Thromboprophylaxis in Pregnancy and Puerperium Guideline (MIDW/GL/152)
- Vulnerable Team Operational Guidelines (MIDW/GL/159)

Are there any eCARE implications? Yes

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CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 18 – Staffing

Disclaimer -

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This guideline has been developed in line with current NICE Guidance to provide a standardised care pathway for the provision of routine antenatal care to maternity service users.

All patient information leaflets referenced within the guideline can be found Trust documentation> Maternity > Maternity Information Leaflets

All patient information leaflets referenced within the guideline can be found Trust documentation> Maternity > Maternity Forms

Executive Summary

To provide high quality antenatal care for maternity service users in Milton Keynes, which is consistent and in line with current national guidance. (NICE, 2019).

To provide a standardised care pathway, for all health professionals involved with providing antenatal care including Community Midwives, Obstetricians, and allied maternity staff (Department of Health, Department for Education and Skills, 2004).

Key Priorities

Maternity Service User Centred care
Maternity service users, their partners and their families should always be treated with kindness, respect, and dignity. The views, beliefs and values of the maternity service user, their partner, and their family in relation to their care and that of their baby should always be sought and respected, even when their views are contrary to your own. Maternity service users should be provided with the opportunity to discuss concerns and ask questions; ensure that she understands the information provided and given enough time to make decisions (NICE, 2019; Better Births, 2016).

Access to antenatal care
Any maternity service user in Milton Keynes and the surrounding areas can access care at the Milton Keynes Maternity Unit by completing a self-referral on Milton Keynes Hospital website.

Personalised Care
Every service user is entitled to personalised care formed on the foundations of informed decision making and enabling choice. It is a series of facilitated conversations in which the person actively participates to explore the management of their health and wellbeing within the context of their whole life and family situation so that all considerations that may impact on safe care are accounted for (NHSE, 2021). This includes choice of access to maternity services, care provider, place of birth and screening (NICE, 2019).

Communication
Good communication between healthcare professionals and service users is essential for safe and effective maternity care. Information provided should be unbiased, balanced and evidence based. All information should be accessible to service user with additional needs such as physical, sensory, or learning disabilities, and to maternity service users who do not speak or read English.
Refer to Interpreting, Translation and Accessing information to meet individual needs DOC215

Continuity of Carer

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Better Births, the report of the National Maternity Review (2016), set out a vision for maternity services in England which are safe and personalised; that put the needs of the maternity service user, baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At Milton Keynes University Hospital we are committed to keeping the service user at the heart of our care, ensuring each service has a named midwife and consultant where relevant.

1.0 Roles and Responsibilities:

It is the responsibility of the midwife to ensure that all maternity service users requiring maternity services can access their care via a self-referral form. An antenatal booking appointment should be completed by 9+6 weeks of pregnancy, for haematological screening, and subsequent care planned as recommended by NICE (2019). Locally, booking appointments should be arranged before 9+2 weeks of pregnancy to support time frames for haematological screening.

If the service user does not self-refer until 9 weeks gestation, a booking appointment should be completed within 2 weeks (NICE 2019).

Obstetricians – to plan and provide care for maternity service users that are referred to Consultant Care at any point during their pregnancy in collaboration with multidisciplinary team.

GP surgeries and Children Centres should promote early access to maternity care and advise the midwives of maternity service users who are unable to access the self-referral for maternity care form.

All practitioners accessing this document should ensure they are conversant with the details contained within and use it within their sphere of professional responsibility and code of practice.

2.0 Implementation and dissemination of document

This guideline will be available on the Trust Intranet.

3.0 Processes and procedures

- Referral for maternity care
- Booking appointment
- Breakdown of antenatal appointments as recommended by NICE (2019)
- Missed appointments
- Access to Antenatal Day Assessment Unit (ADAU)/ Triage
- Antenatal admission for non-obstetric emergency care

3.1 Referral for Maternity Care

- Maternity service users are encouraged to access antenatal care early via self-referral on Milton Keynes Hospital website.

Link to self-referral form: Self-referral for pregnancy/maternity care - Milton Keynes University Hospital (mkuh.nhs.uk)

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This process is advertised via posters in GP surgeries and Children Centres, as well as staff verbally promoting 'early access' to care.

3.2 Booking appointment

An antenatal booking appointment should be completed by 9+6 weeks of pregnancy, for haematological screening, and subsequent care planned as recommended by NICE (2019). Locally, booking appointments should be arranged before 9+2 weeks of pregnancy to support time frames for haematological screening.

If the service user does not self-refer until 9 weeks gestation, a booking appointment should be completed within 2 weeks (NICE 2019).

- Complete eCare maternity antenatal booking assessment form. This includes a risk assessment of medical, obstetric, mental health, and social history, VTE assessment, smoking/alcohol/substance misuse status, routine enquiry and parental family origin. (NICE, 2019, MBBRACE 2018, Saving babies lives care bundle version 3).
- If recommending aspirin to service users, give patient information leaflet ''Reducing the risk of pre- eclampsia''
- Commence Confidential Communique (CC) and make referrals as indication as per the Maternity safeguarding policy. If not required at booking, a CC can be commenced at any time during pregnancy and the postnatal period.

- Complete paper antenatal risk assessment tool to assess for:
    - SBL care bundle
    - preterm birth risk assessment
    - vitamin D
    - folic acid
    - aspirin recommendations –
    - risk factors for diabetes in pregnancy screening.

(NICE, 2019, MBBRACE 2018, Saving babies lives care bundle version 3, Trust 'Diabetes in pregnancy' guideline). See appendix 1.

- Request serial ultrasound scans at booking, according to their risk, following completion of risk assessment (Refer to fetal growth assessment guideline and the SBL care bundle).

- If a service user has a history of preterm birth, discuss history to determine whether this was associated with placental disease. If associated with placental disease, discuss and document recommendation for aspirin with service user on the booking form.

- Discuss lifestyle and dietary advice as indicated, including vaccinations in pregnancy, and promote the healthy start scheme. All service users should be given dietary information to maximise iron intake and absorption This information can be accessed via the NHS choices website Keeping well in pregnancy - NHS (www.nhs.uk)

- Discuss smoking in pregnancy and offer Carbon Monoxide (CO) monitoring to all service users. Explain the opt out smoking cessation service offer referral to all household smokers. If CO >10pppm and service user does not smoke, advise service user to contact Gas Emergency Line (0800 111 999) and advise of possible carbon monoxide poisoning.

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- Service users should be advised of the risks associated with smoking in pregnancy: Miscarriage, stillbirth, cleft lip & cleft palate, growth restriction, placental abruption and preterm birth. The risk to babies and children born to people who smoke: SIDS, asthma, chest infections pneumonia, ADHD and performing poorly at school.

- Refer to the smoking cessation SOP for further guidance on care for service users who smoke in pregnancy.

- All maternity service users should be recommended to take 10 µg of Vitamin D throughout pregnancy and400 micrograms Folic Acid until the 12th week of pregnancy. Please refer to the maternity risk assessment tool (appendix 1) to assess if higher dosages are recommended.

- Discuss choice of place of birth. Give Birthplace and you 'Birthplace decision support' leaflet.

- Discuss and give FW8 maternity exemption certificate. You can register online via Apply for a maternity exemption certificate - NHSBSA

- Generate and explain GROW 2.0 growth chart and offer access to the service user to view. Give service user the GROW 2.0 patient information leaflet.

- Recommend and offer to measure blood pressure.

- Offer blood tests to determine blood group and Rhesus D status; screen for anaemia, haemoglobinopathies, red-cell antibodies, hepatitis B virus, HIV, and syphilis in line with National Screening Guidance. Identify maternity service users who decline blood and blood products and ensure they are referred for Consultant led care for care as per the 'Treatment and Management of people who decline Blood and Blood Products' guideline.

- Offer and recommend that urinalysis test is performed and send Mid-Stream Urine (sample if the woman/birthing person consents (Saving babies lives care bundle, version 3). Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.

- Discuss screening in pregnancy and the postnatal period as per the trust 'Screening in pregnancy guideline' (MID/GL/145).

- A referral must be made at booking, when a first degree relative of the unborn baby (current pregnancy) is affected by a congenital heart problem.

- Offer ultrasound scan for gestational age assessment, explain, and offer screening for Down's syndrome, Edwards' syndrome and Patau's syndrome. Following discussion, document whether consent for screening has been given.

- Ask about the maternity service user's occupation and advise them of their maternity rights and benefits. This information can be accessed via Pregnant employees' rights - GOV.UK (www.gov.uk)

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- Inform maternity service users younger than 25 years about the high prevalence of Chlamydia infection in their age group and give details of their local National Chlamydia Screening Programme.

- Discuss personalised pattern of care for pregnancy care appointments (NICE 2019), explaining the importance of antenatal care and who to contact with any concerns or in an emergency.

3.2.1 Out of area bookings

For maternity service users living out of area but intending to give birth at Milton Keynes maternity unit the out of area booking appointment should be completed, using the checklist of activities identified above in section 3.2.

Service users should be advised that routine community midwife care should be arranged via the community midwife linked with their GP surgery. If at booking, the service user requests full pathway of care with Milton Keynes maternity unit, the booking midwife should refer to the Maternity Outpatient Matron for support in facilitating the care.

3.2.2 Transfer of care to other hospitals

For maternity service users wishing to transfer their care to another hospital, they should be advised to self-refer to their chosen hospital.

3.2.3 Transfer of care from other hospitals

If a maternity service user transfers their care at any point during their pregnancy, a booking appointment needs to be completed as per section 3.2, offering screening as appropriate to their gestation. Document results from screening completed with previous care provider, including the gestation of the screening, the screening test and the name of the care provider.

3.3 Breakdown of Antenatal Appointments

For all antenatal appointments

- Measure blood pressure and perform urinalysis.
- Discuss whether the service user smokes or has recently stopped smoking. Perform CO measurement and discuss opt out smoking cessation as indicated
- Discuss fetal movements (supported by written information – the Tommys leaflet on reduced fetal movements can be given)
- Provide opportunity for maternity service users to discuss any issues and ask questions
- Undertake routine enquiry at every opportunity when the service user is alone (if concerns, refer to safeguarding pathway)
- For all pregnancies identified as low risk of FGR measure symphysis-fundal height as per the guidance in appendix 1 and document on customised GROW chart
- Complete agreed autotext for each antenatal appointment, as per Appendix 6, this includes the risk assessment that must be completed every antenatal contact so that they service user has continued access to care provision by the most appropriately trained professional.

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3.3.1 16-week appointment for all maternity service users

- Community midwife to discuss and record the results of tests e.g. blood or urine tests as per review of samples SOP. Where results are incomplete, check with the lab and repeat outstanding tests as appropriate. Refer to appendix 8 for management of anaemia.

- The community midwife should check that any maternity service user who has a Rhesus D negative blood group has received a letter and information leaflet from the blood blank about Rhesus D Negative blood groups. The midwife should clarify that the maternity service user understands the letter and information leaflet and should use the translation service to clarify and explain the information in the letter and information as needed.

- Complete request for Anti D where required in eCare (See Prophylactic Anti D Immunoglobulin Guideline).

- Ensure combined screening has been offered. If not obtained at scan, check appointment has been made with the screening bloods clinic for a quadruple test to be completed.

- Offer ultrasound screening for structural anomalies at 18+0 – 20+6 weeks gestation. Following discussion, document whether consent for screening has been given.

- Give pelvic floor exercise leaflet

- For maternity service users who have had a previous caesarean section, the midwife will provide the patient information leaflet and discuss the vaginal birth after caesarean section (VBAC) as per the VBAC auto text (see appendix 7). If further discussion is required, refer to Consultant Midwife using the referral form (appendix 5)

- Ensure consultant appointment has been arranged if required.

- Discuss onset of fetal movements, i.e., can commence from 16 to 24 weeks, with the number of movements increasing up to 32 weeks. A pattern of movements can be expected from 28 weeks, if this changes to contact maternity unit**. Refer to Fetal Movement Guideline and Tommy's Leaflet.**
- Complete pelvic health risk assessment as included in the appointment auto text.
- Give postnatal contraception leaflet

3.3.3 25 weeks – for nulliparous maternity service users

- Full antenatal assessment

- Give Mat B1 form.

3.3.4 28 weeks – for all maternity service users

- Full antenatal assessment

- Offer a second screening for anaemia – refer to appendix 8 for management of Hb below

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105g/l.

- Offer anti-D prophylaxis to maternity service users who are rhesus D-negative after taking blood for antibodies. Please refer to **Prophylactic Anti-D Immunoglobulin Guideline.** Documentation of administration of Anti D prophylaxis should be recorded within Assessments/Fluid Balance Anti D management in eCare. This documentation

- should include the product label for the Anti D; the blood product administration notification to be returned to Pathology

- Recommend, offer, and commence, if accepted, fundal height measurements from 26-28 weeks gestation
- Re-assess VTE

- Give Mat B1 form to multiparous service user

- Provide birth preferences QR code to multiparous service user

- "Fit to Fly" letter (see Appendix 4) can be issued, as required, to low-risk service user due to travel from 28 weeks.

- Complete Antenatal classes and advise the service user to self-refer via the hospital website to be allocated to classes

- Begin to discuss "Meaningful Conversations" such as:
  - Connecting with baby
  - Responding to baby's needs
  - Feeding your baby
  - Birth preferences.

- Discuss postnatal contraception

Full antenatal assessment

Community midwife to discuss and record the results of tests e.g. blood or urine tests as per ''Review of samples SOP''.

Check if antenatal classes have been booked and offer further information as appropriate.

Provide birth preferences QR code/leaflet pack.

3.3.6 34 weeks – all maternity service users

- Full antenatal assessment

- Discuss the results of screening tests undertaken at 28 weeks for multiparous maternity service users.

- Discuss benefits of perineal massage in preparation for birth
- .
- If Hb was below 105g/l at 28-week appointment, then offer a third screening for anaemia and

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manage as per appendix 8.

- Offer nasal MRSA screening.

- Discuss birth preferences and complete birth preferences form on eCare. The birth preferences form can be accessed in eCare via 'Ad Hoc' and then selecting 'Maternity Birth Preferences'. A clinical note using the 'Maternal Birth Preferences' should then be created and a copy to be printed and given to the service user if they do not have MYCARE.

- Confirm planned contraception and document in notes

- Book homebirth assessment for those maternity service users requesting to give birth at home. **Refer to homebirth SOP**

3.3.7 36 weeks – all maternity service users

- Full antenatal assessment

- Recommend and offer carbon monoxide testing and document results in eCare

- Review and discuss the results of any screening tests including MRSA swab undertaken at 34 weeks. Ensure any treatment for MRSA has been recommended and commenced.

- Offer GBS screening or intrapartum antibiotics to service users who have tested positive for GBS in previous pregnancies as per the GBS prevention and management guideline.

- Check the position of the baby. If thought to be breech, arrange a presentation scan. **Refer to Breech Presentation at Term and External Cephalic Version Guideline.**

- Give and discuss specific information (at or before 36 weeks) on breastfeeding: technique and good management practices, such as detailed in the UNICEF Baby Friendly Initiative (https://www.unicef.org.uk/babyfriendly/)

- Discuss care of the new baby, newborn screening tests, postnatal self-care, awareness of 'baby blues' and postnatal depression.

3.3.8 38 weeks – all maternity service users

- Full antenatal assessment.

3.3.9 40 weeks – for nulliparous maternity service users & services users planning for a VBAC

- Full antenatal assessment.

- Give specific written information on options for management of pregnancies post due date.

- Discuss and offer a membrane sweep. If a 40-week appointment falls within the 39th week of pregnancy, a membrane sweep can be offered.

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3.3.10 41 weeks – all maternity service users

- For maternity service users who have not given birth by 41 weeks:
- Full antenatal assessment.
- Discuss and offer a membrane sweep. Refer to Induction of Labour guideline.
- For maternity service users under MLC and requiring induction for postdates, this can be booked by the Community Midwife, outpatient induction should be offered to all maternity
- service users who fulfil the criteria. The Induction of labour patient information leaflet should be given and documented. Refer to Induction of Labour guideline

3.3.1142 weeks

- From 42 weeks, offer maternity service users who decline induction of labour should be offered and advised increased monitoring (at least twice weekly cardiotocography in ADAU and ultrasound examination of maximum amniotic pool depth). They should be offered a consultant review in ADAU when attending for CTG.

3.4 Missed Appointment

Refer to Non-Attendance/No Access for Planned Antenatal and Postnatal Care Guideline.

3.5 Referral to Consultant Midwife Clinic

These clinics are dedicated to supporting and empowering maternity service users in their birth choices by providing evidence-based information to facilitate informed decision making for their birth. Access to the clinics is via the individual referral forms from their Community Midwives or Obstetrician. See Appendix 5 for referral form and criteria, please note this criterion is not exhaustive.

3.6 Patient Group Directive medications

When providing midwifery care, there may be some medications recommended to service users. Midwives may, legally, supply specified medicines within the course of their professional practice to patients registered with MKUH. Some of these can be administered as midwifery exemptions policy which can be accessed via the Midwives Exemption Management guideline (MIDW/GL/187). Midwives can also act within Patient Group Directions (PGDs) to supply or administer medicines. At MKUH, there are several PGDs in place for frequently used medications that are not included within midwifery exemptions.

Full information of patient group directive protocols for use in maternity can be accessed via the intranet –

Clinical documentation> Medicines Management > Patient Group Direction (PGD) & Medicine Administration Protocols (MAP) > Maternity

Each protocol provides additional information on risk assessments for the medications and

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inclusion and exclusion criteria.

For information on transporting PGD medications in the community setting, refer to the ''Transporting Medicines for community Midwives clinics'' SOP. (SOP NUMBER!)

3.6 Access to Antenatal Day Assessment Unit (ADAU) and Maternity Triage

The Antenatal Day Assessment Unit and Maternity Triage is dedicated to the monitoring of maternal and fetal health and wellbeing from 18 weeks gestation. Access to these departments is is via a self-referral via telephone or referral from any other health care professional. **Refer to Antenatal Day Assessment Unit SOP/ Maternity Triage SOP.**

3.7 Access to Labour ward

All maternity service users will be asked to attend Maternity Triage for initial care. They will be transferred to Labour Ward as required for ongoing care.

3.8 Admission to antenatal ward

All service users should have a full antenatal check as per section 3.3 daily or as indicated. If a service user misses a community midwife appointment due to admission, the care that would be offered in the missed appointment e.g. 34 week birth preferences appointment, should be offered whilst on the ward.

3.9 Antenatal Admission for non-obstetric emergency care

For the assessment and management of pregnancy and non-pregnancy related problems all antenatal maternity service users attending the hospital should be managed according to the flow chart, see Appendix 3. Refer to Maternity Outliers SOP for documentation of management plan from obstetricians.

- Service users who are over 18 weeks' gestation should be reviewed in the ward they are admitted to for any specific medical/ surgical concerns. They must be seen by the Obstetric Registrar prior to leaving the hospital.

- Service users who are under 18 weeks' gestation should be reviewed in the ward they are admitted to and be referred to the Early Pregnancy Assessment Unit (EPAU) where appropriate. Ward admission should be specific to any medical/surgical problem.

4.0 Statement of evidence/references

British Committee for Standards in Haematology. (2011) UK guidelines on the management of iron deficiency in pregnancy. [Online]. Available from: http://www.bcshguidelines.com/documents/UK_Guidelines_iron_deficiency_in_pregnancy.pdf [Accessed 12/09/2023]

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5.0 Governance

5.1 Document review history

Version number:	Review date	Reviewed by	Changes made
10	10/2023	Natalie Lucas / Lauren Mitchell	Complete review and update
10.1	12/2023	Alex Fry / Lila Ravel	Addition to include referral to FMU at booking in event of service user / partner / first degree relatives affected by congenital heart condition Addition of risks of smoking in pregnancy to be discussed at booking.

5.2 Consultation History

Include staff in consultation who will be required to ensure the Guideline is embedded. This table should be completed in full even if no comments are received

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Maternity staff	Women's Health	31/12/2019 & 05/03/2020			
Rebecca Daniels	Consultant Midwife	31/12/2019 & 05/03/2020	22/01/2020	Appendices for VBAC and consultant Midwife Clinic	Yes
Julie Cooper	Head of Midwifery	31/12/2019 & 05/03/2020	10/01/2020	Comments about recommendations from SBL2 and Flu & Smoking	Yes
Janice Styles	Matron	31/12/2019 & 05/03/2020	03/02/2020	Answers about risk assessment and CoC teams	Yes
Olivia Albaradura	Community Midwife	31/12/2019 & 05/03/2020	02/01/2020	Direct referral service to be included. Vitamin D and folic acid Change in aspirin dosage, flu, and whooping cough vaccines	Yes
Mr Mulki	Obstetrician	31/12/2019 & 05/03/2020	05/03/2020	Suggestion about completing VTE at each antenatal appointment	

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Guidelines Meeting discussion	Maternity staff	28/05/2020	28/05/2020	Include MSU at Yes booking as per SBL2 Include information on out of area bookings Amend audit criteria as induvial conditions are monitored in their own guidelines	Yes
Guidelines Meeting discussion	Maternity Staff	24/06/2020	24/06/2020	Section 3.3.1 Yes amended to include discussion of VBAC at 16 week appointment	Yes
Maternity and Obstetric team	Maternity Staff	21/02/2022	24/01/2022	Removal of teenage MW referral	
Women's Health Guideline Review Group	Maternity staff	04/10/2023		Version 10 approved	Yes
Women's Health Guideline Review Group	Maternity staff	06/12/2023		Version 10.1 approved as chairman's action	Yes

5.3 Audit and monitoring

The following conditions within this guideline will be audited through their own specific guidelines and therefore, this guideline does not need an additional audit criterion.

10 sets of notes or 1% (whichever is higher) will be audited quarterly to show how service user are enabled to participate equally in all decision-making processes and to make informed choices about their care. Evidence would be recorded documentation of this within the woman/birthing person's notes.

Audit Criteria for smoking in pregnancy in line with
SBLCBv3: Process indicators:

i. Recording of CO reading for each pregnant woman/birthing person on eCare and inclusion of this data in our local MSDA and LMS Dashboard.
ii. Percentage of service user where CO measurement at booking is recorded
iii. Percentage of service user where CO measurement at 36 weeks is recorded

Outcome indicators:

i. Percentage of service user with a CO measurement ≥4ppm at booking
ii. Percentage of service user with a CO measurement ≥4ppm at 36 weeks
iii. Percentage of service user who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment.

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5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	**Women &Children's**	**Department**	**Maternity**
Person completing the EqIA	**Mary Plummer**	**Contact No.**	**85130**
Others involved:		**Date of assessment:**	**15/10/2023**
Existing policy/service	**Yes**	**New Policy / service**	**No**

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be effected?	Midwives, Obstetricians, all staff

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	Yes	
Race	NO	
Religion or belief	NO	
Sex	Yes	
Sexual orientation	NO	

What consultation method(s) have you carried out?	*Emailed to all midwives and obstetricians, EPAU*
How are the changes/amendments to the policies/services communicated?	*email, meetings, intranet, newsletters*
Review date of EqIA	

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Appendix 1: Antenatal risk assessment tool

Full size versions can be found on the intranet – Trust documentation> Maternity > Maternity Forms

Patient Label
Patient name:
MRN:
Date of Birth:

Risk assessment (Perform at booking and mid-trimester anomaly scan)		Prevention	Identification of early onset FGR and triage to pathway	Identification/surveillance pathway for FGR/SGA	Reassess at 28 weeks and after any antenatal admission
Low risk	No risk factors	Nil	Anomaly scan and EFW ≥10th centile‡	Serial measurement of SFH	Assess for complications developing in pregnancy, e.g. hypertensive disorders or significant bleeding → Serial USS from diagnosis until delivery*
Moderate risk	**Moderate risk factors** Obstetric history Previous SGA Previous stillbirth, AGA birthweight Current risk factor Smoker Drug misuse Women ≥40 years of age at booking BMI <18.5 kg/m² & other features (e.g. eating disorder, bowel disorder causing weight loss) Gastric Bypass surgery Previous PTB/ Second T misc (placental mediated)	Assess for history of placental dysfunction and consider aspirin 150mg at night <16 weeks as appropriate.	Anomaly scan and EFW ≥10th centile‡	Serial USS from **32** weeks every 4 weeks* until delivery	
High risk	**High risk factors** Medical history Maternal medical conditions [chronic kidney disease, hypertension, autoimmune disease (SLE, APLS), post Fontan Obstetric history Previous FGR Hypertensive disease in previous pregnancy Previous SGA stillbirth Current pregnancy PAPPA <5th centile Echogenic bowel Significant bleeding EFW <10th centile Single Umbilical Artery	Assess for history of placental dysfunction and consider aspirin 150mg at night <16 weeks as appropriate.	**Additional uterine artery Doppler** Normal uterine artery Doppler	Serial USS from **32** weeks every **2-4** weeks* until delivery	
			Abnormal uterine artery Doppler and EFW ≥10th centile	Serial USS from **28** weeks every **2-4** weeks* until delivery	
			Abnormal uterine artery Doppler and AC or EFW <10th centile	Discussion with fetal medicine	
Other	Significant Uterine Anomalies (e.g. septate, bicorporeal)		Anomaly scan and EFW ≥10th centile‡	Serial USS from **28** weeks for uterine anomalies and **32** weeks for BMI and fibroids every 4 weeks* until delivery	
Other	Not suitable for SFH measurement (e.g., BMI ≥35kg/m²) Significant Fibroids	Nil	Anomaly scan and EFW ≥10th centile‡		

The risk factors listed here constitute those routinely assessed at booking, other risk factors exist and risk assessment must always be individualised taking into account previous medical and obstetric history and current pregnancy history. For women with maternal medical conditions and individuals with disease progression or institution of medical therapies may increase an individual's risk and necessitate monitoring with serial scanning. For women with a previous stillbirth, management must be tailored to the previous history i.e. evidence of placental dysfunction or maternal medical conditions. Serial measurement should be performed as per NICE antenatal care guideline.

V4 07/23

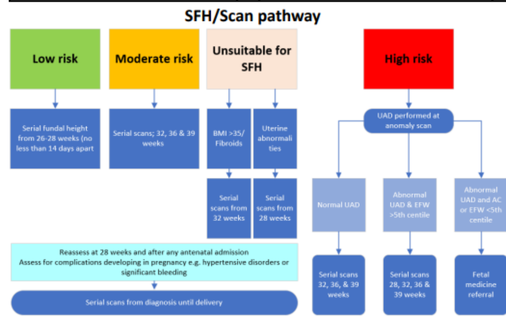
Saving Babies' Lives

Serial scan/SBL care bundle

When booking serial scans either write **High risk SBL** or **Moderate risk SBL**

High risk SBL pathway (dopplers at 20 weeks)		Moderate risk SBL pathway	
Chronic kidney disease		Previous SGA (< 10th centile)	
Chronic hypertension		Previous stillbirth (AGA birthweight)	
Congenital cardiac disease, post Fontan		Smoker (includes CO ≥4)	
Auto immune disease: e.g. systemic lupus erythematosus (SLE) or antiphospholipid syndrome (APLS)		BMI <18.5kg/m² & other features e.g. eating disorder, bowel disorder causing weight loss	
Hypertensive disease (PET/PIH) in previous or current		Gastric bypass surgery	
Previous FGR (<3rd centile)		Drug misuse	
Previous stillbirth (SGA/FGR birthweight)		Age ≥ 40 years old at booking	
EFW <10th In this pregnancy		Previous pre term birth/second trimester miscarriage (placental mediated)	
Low PAPPA in this pregnancy		IVF pregnancy	
Significant bleeding		Hyperemesis with weight loss >5% with dehydration and electrolyte imbalance (persisting > 14 /40 gest)	
Echogenic bowel		BMI ≥ 35kg/m² at booking	
Diabetes - any (no doppler, serial scans from 28/40)		Large(>5cm)/multiple fibroids	
Single umbilical artery		Uterine abnormalities (serial scans from 28 weeks)	

SFH/Scan pathway



(Please tick boxes below to demonstrate risk factors)

Preterm Birth Risk Assessment

Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation).		Previous preterm prelabour rupture of membranes under 34 weeks	
Previous use of cervical cerclage		Known uterine variant (e.g. unicornuate, bicornuate uterus or uterine septum)	
Intrauterine adhesions (Ashermann's syndrome)		Previous delivery by Caesarean section at full dilatation	
History of trachelectomy (for cervical cancer)		History of significant cervical excisional event (e.g. LLETZ where more than 10mm depth removed or more than 1 LLETZ procedure carried out or cone biopsy (knife or laser, typically carried out under general anaesthetic))	
2 or more surgical managements of miscarriage/ termination of pregnancy >12 weeks gestation			

(Please tick boxes below to demonstrate risk factors)

Folic acid and vitamin D

Increased folic acid (5mg)		Increased vitamin D (800-1000units)	
Diabetes		Booking BMI ≥ 30	
Epilepsy/Anti epileptic drugs		High risk family origin	
Family history of fetal anomalies		Diabetes	
Booking BMI ≥ 30		Limited sunlight exposure	
Sickle cell/Beta Thalassemia trait			
Coeliac			
Previous baby with neural tube defect			
HIV			

All women should have 400mcg folic acid and 10mcg (400 units) Vitamin D

(Please tick boxes below to demonstrate risk factors)

Checklist criteria for aspirin from 12 weeks

≥ 1 of the high risk factors listed below = 150mg once a day aspirin to be recommended at bedtime		≥ 2 of the moderate risk factors listed below = 150mg once a day aspirin to be recommended at bedtime	
Hypertensive disorder in a previous pregnancy		Age ≥ 40 years old at booking	
Chronic hypertension		Pregnancy interval ≥ 10 years	
Previous SGA/FGR (< 10th centile)		Booking BMI ≥ 35	
Type 1 or type 2 diabetes		Multiple pregnancy	
low PAPPA		IVF	
Autoimmune disease (e.g. systemic lupus erythematosus or antiphospholipid)		Family history of pre-eclampsia (1st degree relative e.g. mother or sister)	
Histology confirmed placental dysfunction in previous pregnancy		Primigravida	
Chronic kidney disease (If latest creatinine result is >150 mg/dl low dose aspirin 75mg only)			

Those with a booking weight below 50kg should have low dose aspirin (75mg) *only* ☐

V4 07/23

If one risk factor is ticked - routine OGTT

Booking BMI ≥ 30		Minority ethnic family origin (e.g. Black African, Black Caribbean, Middle Eastern, Asian)	
Age ≥ 40 years old at booking		Cystic Fibrosis	
Polycystic Ovarian Syndrome confirmed		Family History of pre-existing diabetes or GDM in immediate family only	
Previous baby ≥ 4.5kgs		Antipsychotic medications (e.g. Risperidone, Quetiapine, Olanzapine)	

ANY service user who has had bariatric surgery should be directly referred to ANC, as they CANNOT have OGTT due to the risk of dumping syndrome.

☐ **Pre-existing Type 1/Type 2 Diabetes** immediate referral to Diabetes Midwife via email to -diabetesmidwife@mkuh.nhs.uk

☐ **Previous GDM** needs urgent OGTT between 14—16 weeks, to be booked via the hub

Patient Label
Patient name:
MRN:
Date of Birth:

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Appendix 2: Antenatal booking form

Full size versions can be found on the intranet – Trust documentation> Maternity > Maternity Forms

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Antenatal Booking Risk Assessment
Referral for Maternity Care

Client Details	
Patient label	Preferred telephone .... E-mail address..................
	Interpreter required ☐ Yes ☐ No Country of Birth..................... Language ....
	Named community midwife ....

Next of Kin Details		Pregnancy Status	
Name + Relationship	Telephone	Gravida.............	Parity.....................
		LMP.........................	Gestation..................
Address		Final EDD from scan ☐ / estimated ☐	
Next of Kin Details to be completed on paper if no e-Care access only.		CO level@ booking .... ppm	

Maternity care			
Has the patient always lived in the UK?	yes	no	Year of entry in the UK :
During this pregnancy has the patient received maternity care abroad?	yes	no	Country: Hospital Name:
During this pregnancy has the patient received care within the UK?	yes	no	Town:
Planning to deliver at MKUH If no refer to appropriate hospital.	yes	no	If entry in the UK<12 months, please send a copy of this form to Rachel Parry, Ext 86267 For any transfer in please retake full booking bloods

Consent	Signature of Client	Print Name	Date
I give my consent for any relevant information to be released by my GP to the Maternity Service.			
I give consent for my contact details to be shared with agencies that may offer me help. Agree to text messages ☐ Yes ☐ No Agree to e-mails ☐ Yes ☐ No			

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Maternal medicine (12 - 16 weeks appointment)	
Previous subarachnoid hemorrhage/ cerebral aneurysms/ VP shunt/ idiopathic intracranial hypertension	
Central nervous system disorder (MS, stroke, spina bifida/occulta)	
Cardiac disease (congenital or acquired) Cyanotic congenital heart disease for SBL	
Cancer (active / previous treated)	
Service user had an organ transplant	
HIV	
Hepatitis B and C	
Epilepsy / anti-epileptic drugs for folic acid 5mg	
Pre-existing hypertension – SBL pathway	
Crohn's / Ulcerative disease	
Intrahepatic cholestasis of pregnancy (previous or this pregnancy) Bile acids > 10	
Liver Cirrhosis	
Ehlers-Danlos, Marfan, or connective tissue disorder	
Cystic Fibrosis	
Autoimmune disease (rheumatoid arthritis, myasthenia gravis)	
BMI>40- for folic acid 5mg & vitamin D 800-1000 units and SBL pathway	
Severe asthma	
Renal disease – For SBL pathway	
Other autoimmune conditions on treatment	
Complex medical conditions	

Joint Haematology / Obstetrics clinic – Please also tick details in categories	
Severe anaemia (Hb < 80 g/l at booking, or later if no response to oral iron supplements)	
Thromboembolic disorder (previous/current VTE, thrombophilia)	
Personal history of inherited or acquired thrombophilia Anti-phospholipid syndrome ☐- Factor V Leiden ☐ - Anti-thrombin III deficiency ☐ - Protein C or S deficiency ☐	
Platelets < 100 or > 600	
History of ITP or TTP	
Thalassemia requiring blood transfusions. For 5mg folic acid	
Personal or significant family history of Haemophilia or Von Willebrand's disease	
Women with significant red cell antibodies	
Sickle cell anaemia For 5mg folic acid	

Fetal medicine (16 weeks appointment)	
Inherited disorder, family history of genetic disorder-Parents with neural tube defect for folic acid 5mg	
Previous neonatal death or stillbirth – SBL pathway	
Previous fetal congenital anomaly- if neural tube defect for folic acid 5mg	
Multiple pregnancies	
Previous cardiac anomalies	
Previous/Current antibodies affecting the pregnancy	

Prenatal screening	
Sickle cell / thalassemia carrier – to take biological father screening if present	
Any infectious disease (HIV, Hepatitis B/C) or congenital anomalies - inform PNS	
Non – immune to chicken pox (request VZV IgG on booking bloods) - inform PNS	

Consultant Led Care, community midwife delivered – BMI between 30 and 35	
no antenatal clinic appointment required For Folic acid 5mg& vitamin D 800-1000 units	

Midwife Led Care	

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Joint Endocrine clinic (16 weeks) - Please also tick details in categories	
Diabetes type 1 – for folic acid 5mg&vitamin D 800-1000units – SBL pathway	
Diabetes type 2 – for folic acid 5mg &vitamin D 800-1000 units – SBL pathway	
Current GDM on insulin or diagnosed in 1st trimester for folic acid 5mg&vitamin D 800-1000 units	
Endocrine disease (eg, Addison's, Cushing)	
Grave's disease or hyperthyroidism ☐ Hashimoto's Thyroiditis ☐	
Previous/ current thyroid cancer or thyroidectomy	
Thyroid problems on high dosage medication (> 75 mcg per day)	
Prolactinoma/ pituitary / adrenal abnormalities	

Pre-term clinic (14 weeks)	
Previous cervical surgery (LLETZ>10 mm, colposcopy…)	
Previous preterm birth	
Previous preterm SROM	
Previous second trimester miscarriage	
Previous LSCS at full dilatation	
Previous/Current uterine anomalies	
Short cervical length	

General Obstetric clinic (22 weeks) – Please also tick details in categories	
Previous anaesthetic complications	
BMI<18	
Antenatal VTE high risk	
Antenatal VTE intermediate risk	
Grand Multiparity Para 5 +	
Previous PPH -MOH	
Genital infections	
Service user who declines blood products	
Previous placenta accreta/percreta	
Previous uterine surgery (caesarean, myomectomy)	
Ovarian cysts ☐ - PCOS ☐	
Previous PET ☐ - PIH ☐	
Hypothyroidism on low dose replacement	
Respiratory disease (asthma controlled)	
Previous shoulder dystocia ☐ - traumatic birth ☐ – 3rd degree tear ☐ – 4th degree tear ☐	
IVF: Harvest date………. Transfer date………… SBL pathway if donor egg only	
CO> 4 ppm / current smoker / vaping SBL pathway	
Age 40 or over at booking SBL pathway	
Low PAPP-A SBL pathway	
BMI >35 and <40 – for folic acid 5mg & vitamin D 800-1000 units - SBL pathway	
Substance misuse SBL pathway	
Previous SGA /FGR(<10th centile) ☐ - Previous LGA / baby above 4.5kg ☐ - SBL pathway	
Unexplained APH - SBL pathway	
Large fibroids >5 cm SBL pathway	
Hyperemesis with weight loss>5% with dehydration and electrolyte imbalance SBL pathway	
Age 18 or under at the start of pregnancy	
FGM	
Sensory ☐ - Physical ☐ - Learning disability ☐ – clarification :	
Moderate mental health (anxiety, depression) refer to mental health criteria forms	
Safeguarding – complete CC & safeguarding form	

Joint Perinatal clinic – severe mental health disorder	

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OGTT (24-28 weeks routine or urgent)	
Risk factors for diabetes	
Previous GDM (booking community midwife to arrange urgent OGTT)	

Current medication and dosage:

Further information/ other risks:

Relevant e-mails sent	YES	N/A
maternalmedicine@mkuh.nhs.uk		
fetalmedicine.preterm@mkuh.nhs.uk		
annbscreeningmidwives@mkuh.nhs.uk		
DiabetesMidwife@mkuh.nhs.uk		
Lucy.Naphtine@mkuh.nhs.uk		
Elizabeth.Payne@mkuh.nhs.uk		

Name of booking midwife:………………………………………………….Date:……………

ANC Triage:

	Weeks of pregnancy	Calendar Week commencing
Any Consultant	22 weeks	
Maternal Medicine	12-16 weeks – Consultant triage	
Fetal Medicine	16 weeks	
Joint Haematology Clinic	12-16 weeks	
Joint Endocrine Clinic	Specialist request	
Preterm Clinic	14 weeks	
Perinatal joint Clinic	Specialist request	
Prenatal screening	Specialist request	
OGTT Early /late OGTT	24-28 weeks Specialist request	
Midwife Led Care	No appointment required	Please tick ☐

ANC midwife triage name:…………………………………………… Date :………..

Hub triage:

	Appointment Date	Name and signature:
Any Consultant		
Maternal Medicine		
Fetal Medicine		
Joint Endocrine Clinic		
Preterm Clinic		
Perinatal joint Clinic		
Prenatal screening		
OGTT		

Named consultant:……………………………………………

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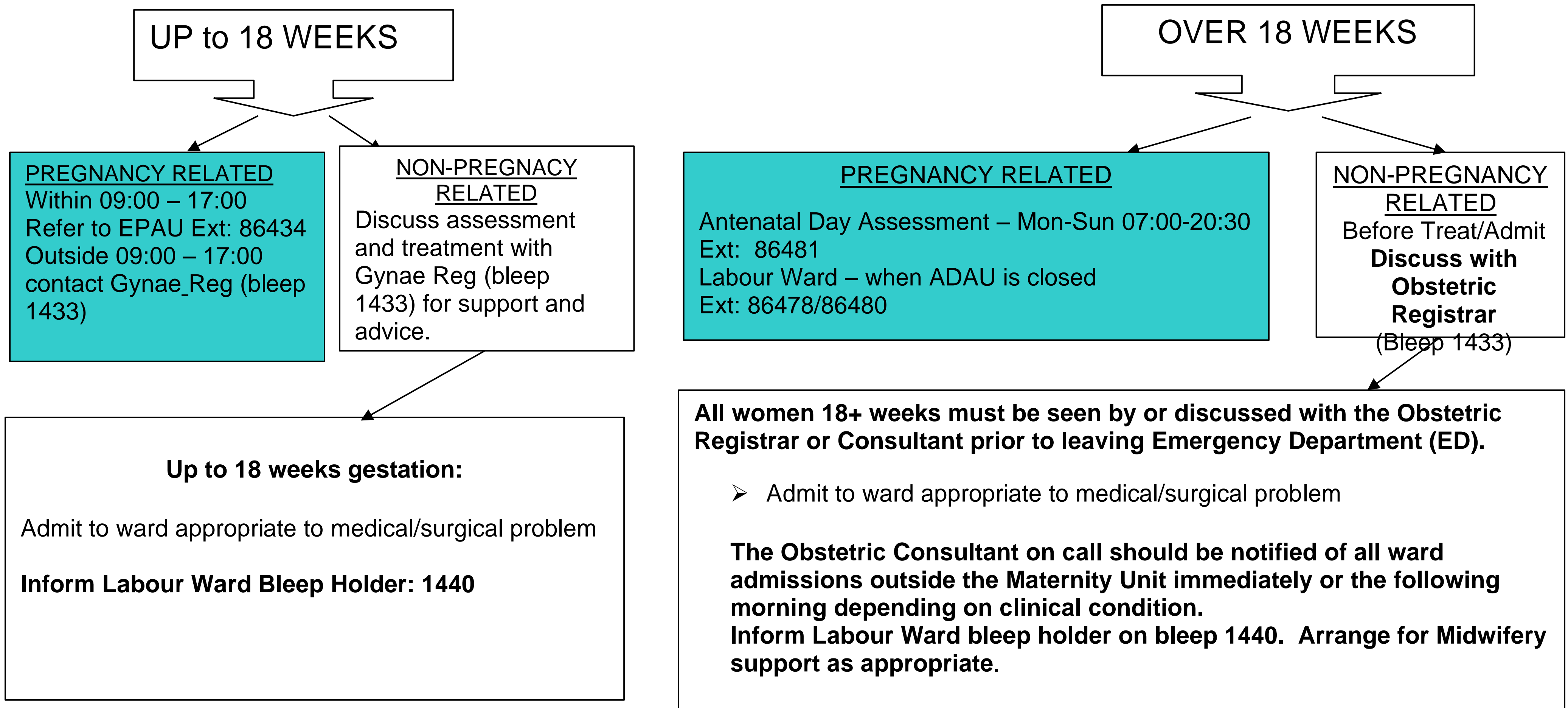
Appendix 3: Flowchart – Process for Managing Pregnant Service user attending for non-obstetric emergencies



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Appendix 4: Fit to Fly Letter

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Milton Keynes
University Hospital
NHS Foundation Trust

Standing Way
Eaglestone
Milton Keynes
MK6 5LD
01908 660033
www.mkuh.nhs.uk

Patient Addressograph

GP Surgery:

Reference: Fit to Fly

Date:

I am the named Midwife for ………………………………. who is currently ….. weeks pregnant at the time of travel with an expected due date of ……………..
The departure date for travel is …………….. with a return date of …………...

I have assessed the pregnancy to be safe to travel within the dates given.
The risk of developing a DVT has been explained with advice to drink plenty of fluids and mobilise when safe to do so.

Yours sincerely,

Pin:

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Appendix 5: Referral for consultation with Consultant Midwife

Consultant Midwife Referral Form

Clinic Times:

Monday 0900-1300

Tuesday 0900-1300 -

Thursday 0930-1300

Please complete the referral form and email to MKConsultantmidwives@mkuh.nhs.uk

Name		Named MW	
MRN		Named Consultant	
NHS no.		Name of referrer	
D.O.B		Date of referral	
Telephone number:			
EDD		Gestation	
Medical/obstetric history			
Reason for referral	o ELCS for maternal request o Severe fear or anxiety of birth o Homebirth outside of guidelines o Requesting care outside of guidelines o VBAC • Other		

For Consultant Midwife use:

Date referral received	
Phone call/Appointment Date	
Outcome of appointment	

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Appendix 5: Antenatal appointment autotexts

/matbooking

Routine booking leaflets given ▼Yes/No
PCP given ▼Yes/No
Tommy's leaflet provided ▼Yes/No
Booking bloods and MSU taken with consent ▼Yes/No
FW8 given ▼Yes/No
BP_/_
GROW chart generated ▼ Yes/No

Care pathway: _▼ Consultant Led Care/Midwife Led Care
Indication for care pathway:

SBL▼ prev PET, SGA, PIH/BMI>35/ current smoker/ prev stillbirthhyperemesis/ large fibroids/ chronic hypertension/ fetal echogenic bowel/ low pappa <0.415/ unexplained APH/ chronic kidney disease/ antiphospholipid syndrome/ not required, for fundal height
OGTT▼ not indicated at present/ for BMI >30/ for family hx of diabetes 1st degree relative/ prev baby >4.5kg/ PCOS / for ethnicity/ for mat age >40/ for prev GDM/ urgent referral to diabetes midwife for type 1/type 2 diabetes)
Dating scan▼ requested/ already has appointment/ declined- referred to screening
Vitamin D▼ 10mcg/to commence higtheir dose 800-1000IU
Aspirin ▼ not required/ 150mg from 12 weeks
Routine Enquiry ▼ not done/ NAD
Mental Health▼ feeling mentally well / reports not feeling mentally well/ offered and accepted IAPT
Social Matrix ▼ Red/ Amber/ Green
CC▼commenced for_/ no SG concerns at present
VTE Score:
VTE risk factors:
Smoking: _▼Current smoker/Non-smoker
Smoking Referral: _▼Accepted/Declined
Preterm Birth Risk: _▼ High risk/Low risk
VBAC ▼Yes/No
If yes, VBAC leaflet provided ▼Yes/No

/mat16weeks

Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined

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Mental health ▼ feeling mentally well / not feeling mentally well.

(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

Booking bloods reviewed

Hb: ▼ Iron medication not required/ Iron medication commenced

Platelets:

Blood Group

Serology ▼ Negative / abnormal - referred

Infectious diseases ▼ Negative / abnormal - referred

Anti D ▼ ordered / not required

Dating scan ▼ Had dating scan and combined result- low risk screening/ Had dating scan- declined combined screening/ Had scan – for quad clinic/ Declined dating scan- screening aware

Anomaly scan ▼ booked / not booked – requested today

OGTT ▼ Booked / Not required

Consultant apt booked ▼ Yes / No/ Not required

Antenatal pelvic floor risk assessment screening		
	16/40	
Presence of current symptoms of PFD (please tick)	**YES**	**NO**
Urinary Incontinence		
Faecal Incontinence		
Pelvic organ prolapse		
Persistent Pelvic pain (not PGP)		
Identified diastasis recti		
Vaginismus		
If yes to any of the above then refer for 1:1 physio		
Presence of risk factors for pelvic floor dysfunction		
	Yes	**No**
BMI >30		
Smoker		
Constipation		
Diabetes		
First degree relative with UI/FI/ Prolapse		
Previous OASI		
Chronic respiratory disease		

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>30yrs for 1st baby		
Previous assisted delivery		
Multiparity		
Longer than 2hrs second stage		
Large baby >4kg		
Baby OP presentation		
If answered YES to 3 or more risk factors refer to physio - will be offered group/webinar **If answered NO or less than 3 YES to all risk factors direct to website for further support/resources**		

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat25weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

Anomaly scan▼ completed – NAD / completed – abnormal and referred / not yet completed – referral made
OGTT▼ result / booked / not yet booked- arranged today
MATB1▼issued / already has / declined

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New risk factors Identified –

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Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat28weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

28 week bloods▼ FBC & Group and Antibodies taken with consent / FBC, Group and Antibodies and Ferritin, Folate and B12 taken with consent / declined
Anti – D ▼ Required - Given with consent / Required – declined / Not Required
OGTT▼ Not required / normal result / GDM diagnosed
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referral for growth scan
Pelvic floor leaflets given ▼ Yes/No
VTE risk assessment completed – Antenatal Dalteparin required ▼ Yes/No Antenatal classes ▼ Accepted – referral made / declined

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified:
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat31weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

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Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

28 week bloods reviewed ▼ NAD / antibodies – referral made / low Hb, tasked GP to prescribe iron tablets
Hb:
Platelets:
Birth preferences pack provided ▼ Yes/No
Antenatal classes ▼ Booked / not booked – referral made / declined

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat34weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

MRSA swab ▼taken with consent / declined
Last Hb:
Bloods ▼ Not required / FBC with consent /FBC with Ferritin, folate and B12 taken with consent / declined
Birth preferences discussion completed ▼ Yes / No
Homebirth Assessment ▼ Completed / not required

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat36weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend

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Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

Weight today: _
CO level:
Bloods ▼Results discussed / Not checked at 34 weeks
MRSA result:
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/Home

/mat38weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

GBS results ▼ Negative / Positive – baby alert completed, and implications discussed

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No

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Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat40weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: bpm
FH after S&S: bpm No decelerations audible.
IOL▼ Post-dates IOL offered and accepted. Discussed inpatient/outpatient IOL. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined at present - will rediscuss at 41 weeks / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat41weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No

Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent

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growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: bpm
FH after S&S: bpm No decelerations audible.
IOL▼ Post-dates IOL offered and accepted. Discussed inpatient/outpatient IOL. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined at present - will rediscuss at 42 weeks / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No Intended
Place of Birth_▼ Obstetric Led unit/ Home

/mat42weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today / completed NAD / see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: _bpm
FH after S&S: _bpm. No decelerations audible.
IOL▼ Post-dates IOL offered and accepted. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Fetal Monitoring and plan >42 weeks organised ▼ Yes / No

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No

Personalised Care Plan Reviewed ▼ Yes/No Intended

Place of Birth_▼ Obstetric Led unit/ Home

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Appendix 6: VBAC discussion auto text

Discussion

The following has been discussed as per RCOG 'Birth Options After Previous Caesarean Section' leaflet and RCOG green top guideline no.45.

Chances of successful VBAC increased if;

- You have laboured previously
- Had a previous VBAC
- Labour spontaneously
- BMI<30
- <40 weeks
- <40 years old
- EFW<4kg or similar to previous baby

Chances of successful VBAC decreased if;

- IOL
- BMI>30
- <1 year between CS

Advantages of VBAC;

- greater chance of VBAC in future
- quicker recovery
- shorter hospital stay
- increased likelihood of immediate skin-to-skin and successful breastfeeding
- less chance of baby having breathing problems (2-3:100)

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Disadvantages of VBAC;

- 1:4 may still need EMCS (slightly higher if you have never laboured before, 1:20)

- increased likelihood of required blood transfusion compared with ELCS

- risk of uterine rupture 1:200 (2-3:200 if IOL)
    - No previous labour/birth 0.02%
    - 1 previous CS 0.5%
    - 2 previous CS 0.92%
    - IOL with prostaglandins 0.87%
    - IOL with ARM/balloon 0.29
    - Use of oxytocin 0.87%

- slightly higher chance of stillbirth or brain injury for baby than ELCS, equivalent to a first labour

- increased likelihood of assisted vaginal birth

- possibility of OASI

- Risk of HIE 0.08%

- Risk of intrapartum stillbirth 0.04%

Statistics;
Successful VBAC – 72-75% or 85-90% if previous VBAC
Previous labour dystocia (64%)
Previous failed operative birth (64%)
Previous EMCS for fetal distress (74%)
Previous EMCS for malpresentation (84%)

Advantages of ELCS;

- reduced chance of scar rupture (0.02%)

- reduced risk of serious complications for baby (2:1000)

- Planned procedure date (however, 1:10 will labour prior to this)

- Risk of intrapartum stillbirth is lowered 0.01%

Disadvantages of ELCS;

- repeat CS can take longer due to scar tissue

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- increased likelihood of wound infection that may take weeks to heal

- Increased likelihood of blood clots in your legs or lungs

- Increased likelihood of PPH/MOH

- longer recovery time

- increased likelihood of CS in future which can increase likelihood of placental site and bleeding issues

- 1-2:100 babies sustain an injury during the procedure

- Baby more likely to have breathing difficulties and go to NNU (4-5:100 vs. 2-3:100 VBAC, 6:100 if less than 38 weeks)

The above risks for both VBAC and ELCS will be minimised as far as possible. Explained that you are able to change your mind if you wish.

Care in labour;

- Close monitoring of contractions and scar pain

- Continuous electronic fetal monitoring recommended

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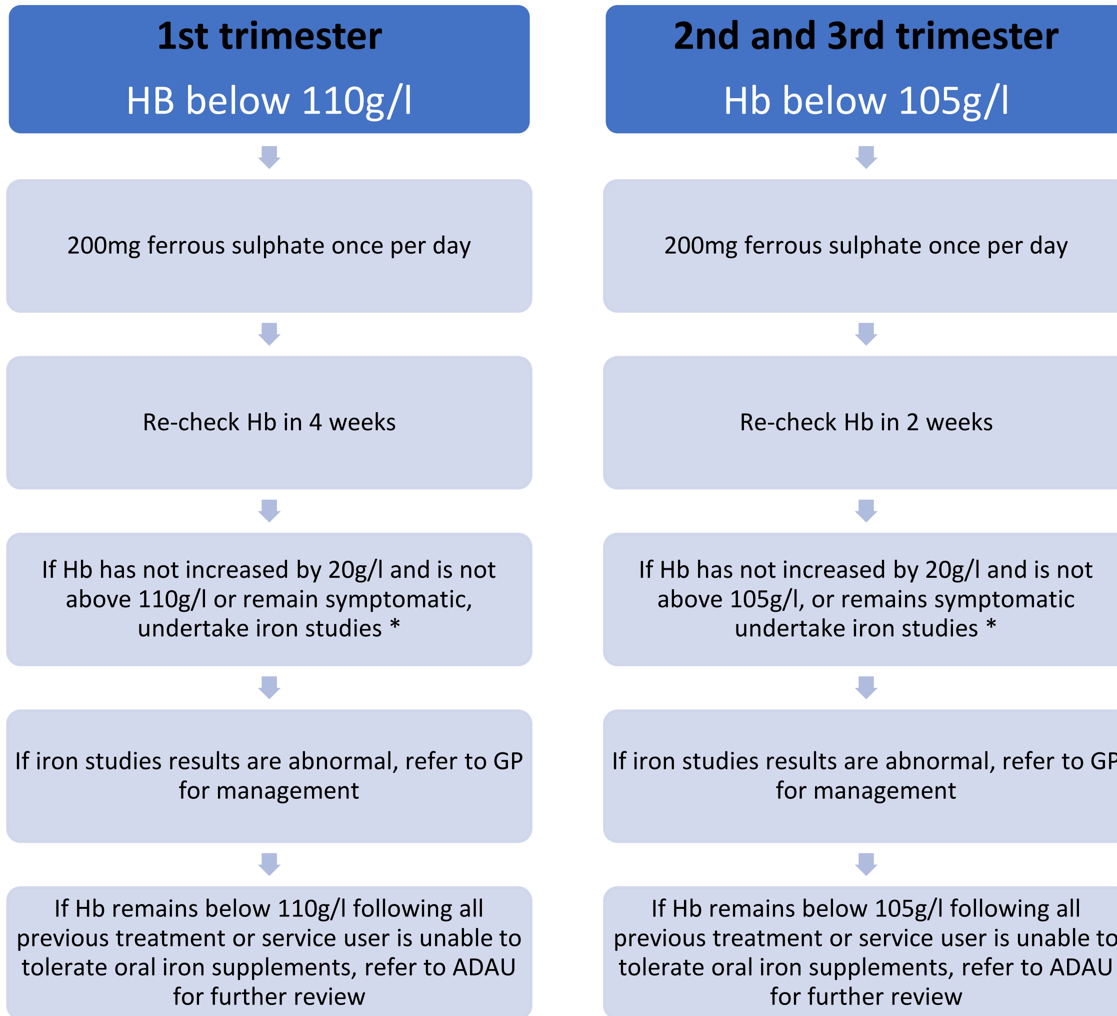
Appendix 7: Management of anaemia in pregnancy flow chart



*iron studies – B12, folate and ferritin