Booking Process (including Late Bookers) and Risk Assessment in Pregnancy and the Postnatal Period

University Hospitals of Leicester NHS
NHS Trust

C16/2011

Introduction and who the guideline applies to:

This guideline is based upon recommendations from NICE Antenatal Care Guidelines (2008). Women may present at a variety of health care and local authority settings when they first receive a confirmed diagnosis of pregnancy. Booking with the maternity service prior to 10 weeks of pregnancy is recommended.

This guideline is intended for the use of all Midwifery, Primary Care and Clerical staff involved in the care of pregnant women.
It is to inform midwives and other health professionals about the booking process and risk assessment of women in the antenatal period and the postnatal period.

If a woman presents at the maternity service beyond 24 weeks of pregnancy the midwife needs to ascertain from the mother the reason why this is the case and what the barriers were to her accessing timely care.
A pregnancy presenting to services on or after 24 weeks gestation is defined as a concealed or denied pregnancy as per LSCB guidelines and procedures, therefore An A form needs to be completed and sent to the safeguarding midwives alerting them to the late booking and the reasons for this. Please refer to the concealed/denied pregnancy guideline in conjunction with this guideline in these circumstances

Contents

Related Documents

Aspirin in Pregnancy UHL Obstetric Guideline
Booking Bloods and Urine Test Guideline
Concealed or Denied Pregnancy UHL Obstetric Guideline
Downs Pataus and Edwards Syndrome Screening UHL Obstetric Guideline
Safeguarding in Maternity UHL Obstetric Guideline

Recommendations:

1. All pregnant women should have their first full booking visit and personal maternity record completed by 10 weeks of pregnancy

2. If the woman is presenting at 8 weeks or beyond she should be seen within 2 weeks for booking and a timely and appropriate appointment should be made for screening and a hospital appointment should it be required once the notes have been reviewed by the antenatal services.

3. The Midwife will discuss the pathway of antenatal care and provide the woman with the relevant information ensuring accurate documentation. Where possible the relevant leaflet should be given and explained.

4. The Midwife will discuss the booking bloods and explain the maternal and neonatal screening that is available.

5. The Community Midwife will send the booking information electronically to the clinic coordinators at the hospital.

6. The Midwife will obtain a full history at booking and this will be reviewed by the Antenatal Core Midwives once the electronic personal maternity record has been received and printed off by the Hospital. This is the basis upon which the risk assessment is performed.

7. All care will be fully recorded in the personal maternity record and hospital notes where appropriate (NMC 2015).

8. After the initial risk assessment by the Antenatal Core Midwives, the Community Midwife or relevant health care professional will review the woman's risk status and intended place of birth at every contact and document any relevant changes where appropriate.

9. Women who require postnatal Obstetric input should be identified in the Antenatal Period where possible.

Recommendation One:

All pregnant women should have their first full booking visit and personal maternity record completed by 10 weeks of pregnancy.

- **Booking for UHL Maternity Care can occur via the following routes:**

  a) **Woman presents to GP surgery**
  b) **Woman presents to Children's Centre**
  c) **Woman contacts her Community Midwife directly**
  d) **Woman contacts Community Office**
  e) **Woman requests booking via Maternity Website**
  f) **Woman contacts Antenatal Core Midwives at UHL directly (e.g. women with previous obstetric complications)**
  g) **Woman contacts Consultant's secretary directly (as above)**
  h) **Pregnancy notification via other agency eg social care, police**

- For a) Information should be available within GP's surgeries, which will signpost women to their Community Midwife. Receptionists within these centres should forward messages to the Midwives at the surgery when they present. Rarely, the GP may send a referral letter directly to the Antenatal Services; this is directed to the Antenatal Core Midwives who then send a copy to the Community Office requesting a booking appointment with the Community Midwife. The Antenatal Core Midwives retain a copy to monitor progression of the process.

- For b) information should be available at Children's Centres which will signpost women to their Community Midwife. The Receptionist will then arrange an appointment directly with the Midwife for booking if there is a booking clinic held within the Children's Centre. If there is not a clinic held within the Childrens Centre the Receptionist will pass the details to the Community Midwife either directly by telephone or to the Community Office.

- For c) The Community Midwife will arrange an appointment directly with the woman. The midwife should contact the woman prior to the booking appointment to recommend that the woman watches the antenatal screening video: https://www.youtube.com/watch?v=_afr5ollpTM

- For d) The Community Office staff will document the contact on a message sheet, and then contact the Community Midwife by telephone within 24 hours. This will be documented on the message sheet. The Community Midwife will then contact the woman directly to arrange an appointment.

- For e) The Community office staff will receive the message via the website and then contact the Community Midwife by telephone within 24 hours. This will be documented on the message sheet. The Community Midwife will then contact the woman directly to arrange an appointment.

- For f) and g) Women who have had complications in their previous pregnancies will sometimes contact the Hospital Antenatal Core Midwives or the

Consultant's secretary (who will notify the Antenatal Core Midwives) directly as soon as they have confirmation of pregnancy. For these women the previous pregnancy health care records are obtained by the Core Midwives from the maternity records department and if a management plan had been made following delivery this will be followed. If there is not a plan in place the Core Midwives will discuss the case with the Consultant and obtain a plan and document it in the health record. The woman is then contacted and directed to her Midwife for booking or given an appointment to attend the Hospital. Ideally the booking history should be performed before the hospital appointment.

- For h) safeguarding midwives / specialist midwives to arrange to contact the woman to arrange confirmation of pregnancy and subsequent booking appointment

- Vulnerable groups such as teenagers, the homeless and asylum seekers, substance misusers may need access to a specialist team of Midwives. Referral form (see appendix) should be sent to vulnerable midwifery mailbox. An A form safeguarding referral should be sent if there are additional safeguarding concerns. The specialist midwives will review the referrals on a weekly basis and ascertain whether they should be case held in the specialist midwifery team or with the community midwife and have access to specialist clinics.

- The Community Midwife or Specialist Midwife will undertake the antenatal booking and risk assessment to determine the antenatal care pathway and the booking category. All Community, Specialist and Hospital Antenatal Core Midwives have access to the referral criteria. (Appendix 1)

- Confidentiality and dignity will be maintained at all times in accordance with trust policy.

Recommendation Two:

<u>If the woman is presenting at 8 weeks or beyond she should be seen within 2 weeks for booking and a timely and appropriate appointment should be made for screening and a hospital appointment should it be required.</u>

- If the woman is 10+6 weeks or beyond at presentation to the initial point of contact the following should take place:

a) Woman presents to GP surgery
b) Woman presents to Children's Centre/Connexions
c) Woman contacts her Community Midwife directly
d) Woman contacts Community Office
d) Woman requests booking via Maternity Website
f) Woman contacts Antenatal Core Midwives at UHL directly (e.g. women with previous obstetric complications)
g) Woman contacts Consultant's secretary directly (as above)
h) Pregnancy identified via other agency eg police, social care

- For a) The receptionist forwards messages from the women to the Community Midwife at the GP's surgery. If this is not possible it is communicated by the Receptionist to the Community Office at the hospital. The Community Office staff contact the Community Midwife within 24 hours. This is documented on the message sheet and stored. An urgent booking appointment is then be made by the Community Midwife receiving the request.

- For b) The Receptionist will then arrange an urgent appointment directly with the Midwife for booking if there is a booking clinic held within the Children's Centre. If there is not a clinic held within the Children's Centre or the woman has presented to Connexions the Receptionist will pass the details to the Community Midwife straight away either directly by telephone or to the Community Office.

- For c) The Community Midwife will arrange an appointment directly with the woman.

- For d and e) The Community Office staff contact the Community Midwife immediately. This is documented on the message sheet and stored. An urgent booking appointment is then be made by the Community Midwife receiving the request.

- For f and g) Women who have had complications in their previous pregnancies will sometimes contact the Hospital Antenatal Core Midwives or the Consultant's secretary (who will notify the Antenatal Core Midwives) directly. For these women the previous pregnancy health care records are obtained by the Core Midwives from the maternity records department within 3 working days (this may take longer if the notes are in storafile) and reviewed for any specific management plans. If a management plan had been made following delivery this will be followed. If there is not a plan in place the Core Midwives will discuss the case with the Consultant and obtain a plan and document it in the health record. The Antenatal Core Midwife will contact the Community Office and request that an urgent appointment with the Community Midwife is made within 2 weeks of initial contact. The booking should not be delayed if the notes are initially unavailable.

- For h) safeguarding midwives / specialist midwives to arrange to contact the woman to arrange confirmation of pregnancy and subsequent booking appointment

- Vulnerable groups such as teenagers, the homeless and asylum seekers, substance misusers may need access to a specialist team of Midwives. Referral form (see appendix) should be sent to vulnerable midwifery mailbox. An A form safeguarding referral should be sent if there are additional safeguarding concerns. The specialist midwives will review the referrals on a weekly basis and ascertain whether they should be case held in the specialist midwifery team or with the community midwife and have access to specialist clinics.

- The gestation that the woman presented to the maternity services should be documented and also the gestation that the woman was seen for her booking appointment by the Midwife. The midwife should document whether the woman has been booked elsewhere in early pregnancy in the UK or overseas, if so document confirmed EDD on the E3 booking notes.

- Consider if the woman can be booked on the low risk pathway if EDD is confirmed. Does she require an individualised care plan if so refer to consultant clinic for a plan of care which should include details of type of growth surveillance required, timing of delivery, and mode of delivery.

- If the booking appointment is not within 2 weeks a reason should be documented in the health record.

- Should the woman fail to attend for the booking appointment the Community Midwife will follow the missed appointments management guideline.

- The personal maternity record is then sent as soon as possible by the booking Midwife to the chosen hospital of birth. It is reviewed by the Antenatal Core Midwife and an urgent dating scan appointment arranged.

- Appointment for a fetal anomaly scan should be made based on the dating scan gestation. It should be made clear to the woman that the accuracy of the anomaly scan will decline with increasing gestation.

Recommendation Three:

The Midwife will discuss the pathway of antenatal care and provide the woman with the relevant information ensuring accurate documentation. Women will be signposted to the relevant electronic leaflets, and a discussion about these will take place during the booking appointment

- At the booking visit the Community Midwife will discuss the pathway of antenatal care including the proposed schedule of visits as set out in “Antenatal care for uncomplicated pregnancies” (NICE 2008).

- Appropriate place of care/birth is discussed and documented. This should take into account risk assessment for suitability of low or high risk care as per risk assessment criteria below.

- The following information will be given and explained when available:

  Community maternity care booklet
  Tests for you and your baby (NSC) (electronic versions)

Recommendation Four:

The Midwife will discuss the booking blood and urine tests and explain the maternal and neonatal screening that is available within Leicestershire.

- The booking bloods will be taken at this point following discussion and consent. If this is not possible they should be taken at the earliest opportunity. Refer to Booking Blood and Urine Tests Guideline.

- Screening tests will be explained and consent obtained if possible

- The National Screening Committee information explaining the screening tests "Tests for you and your baby" will be discussed at this point.

- Routine booking tests that are not gestation dependant should be performed by the Community Midwife as usual.

- If Trisomy screening is requested and the woman is eligible (less than 20 weeks gestation at the dating scan) screening will be offered and performed at the scan. (Refer to Down's, Patau's and Edward Syndrome Screening in Pregnancy guideline). If the woman is more than 20 weeks gestation screening for Down's Syndrome will be based on an age related risk alone. This will be explained by the Community Midwife and the woman will be referred to the Antenatal Core Midwives should a further discussion about pre natal diagnosis be required.
  In the case of migrant women, the Midwife will determine if the woman has undergone a full medical examination in the United Kingdom. If she has not the Midwife will refer the women to her General Practitioner in order that a full medical history may be taken and a clinical assessment made of the woman's overall health. The Midwife will check during a subsequent appointment that this has been carried out.

Recommendation Five:

The Community Midwife will send the booking information electronically to the clinic coordinators at the hospital

- Complete the booking on E3 and send electronically to the hospital at which the woman has chosen to deliver by the Midwife performing the booking.

- On receipt of the records, the Antenatal Clinic Coordinator will print it off on the next working day.

- The records are passed by the Coordinator to the Antenatal Core Midwives on a daily basis.

Recommendation Six:

The Midwife will obtain a full history at booking and this will be reviewed by the Antenatal Core Midwives once the personal maternity record has been received by the Hospital. This is the basis upon which the risk assessment is performed.

- Antenatal care for women who following risk assessment have been identified as having an uncomplicated pregnancy will be identified as Midwife Led and care should be shared between the Midwife and the General Practitioner.

- The Antenatal Core Midwives will review the history and documentation that has been made by the Community Midwife. They will identify if the woman can have Midwife led care and document this on the front of the personal maternity record.

- The Antenatal Core Midwives will review the records and determine which Growth assessment Pathway the woman will initially be allocated to and record this on the front of the notes.

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- For those high risk women who present with unusual co-morbidities a discussion with a consultant should be initiated as soon as possible and an appropriate appointment identified at that point. (See flow chart)

- A decision is made at this point if a routine appointment will be suitable or if a more urgent one is necessary to meet Antenatal Screening timescale requirements. (NSC Standards 2004). This should be documented on the front of the personal maternity record. If an urgent appointment is required this is specified as such on the front page of the personal maternity record so that the clinic coordinator is aware.

- If there are any queries about or gaps in the obstetric history and the woman has previously delivered at UHL her previous obstetric record will be used to complete the assessment. In women with a history of complicated pregnancies who delivered outside the UHL, the lead clinician will request former records in writing from the place of delivery.

- All women should be risk assessed at every visit to ensure their risks have not changed and the intended place of birth remains appropriate. This is to be recorded electronically

- An intrapartum risk assessment is completed at the onset of labour as per 'Intrapartum Care: Healthy Women and their Babies Guideline'. The obstetrician plans care of the high-risk woman in labour with the woman during the antenatal period and a record is made in the health care record so that staff caring for her will be guided by the specialist's advice. The obstetric team on call will consult the woman's obstetrician where necessary.

Recommendation Seven:

All care will be fully recorded in the personal maternity record, hospital notes and electronic system where appropriate (NMC 2018).

- To ensure there is continuity of care and involvement of the woman and her family, each aspect of her care will be explained and communicated among those involved in the provision of her care including clear and concise documentation at every stage (NMC 2018)

Recommendation Eight:

After the initial risk assessment by the Antenatal Core Midwives, the Community Midwife or relevant health care professional will review the woman's risk status and intended place of birth at every contact and document any relevant changes where appropriate.

- As the pregnancy progresses it will be necessary to identify continually any risk factors at each antenatal assessment. The woman's risk status and intended place of birth should be reviewed at every contact. If any risk factors are identified referral to a Consultant led clinic should be considered or discussed with the Obstetric team.

- Where the woman has been referred for Consultant led care for review as a result of the risk assessment, if she is assessed as low risk by the Obstetrician in the Consultant led clinic following her review, she may be referred back for midwifery care and this should be documented in the personal maternity record.

- Should the identified lead professional change at any point in the pregnancy this will be documented in the health care records.

- Advice on appropriate place of birth should be revised accordingly where the woman moves from low to high risk.

The Postnatal Period

Recommendation Nine:

Women who require postnatal Obstetric input should be identified in the Antenatal Period where possible.

- As the woman herself carries the personal maternity record throughout pregnancy, it is important that the hospital held notes carry a record of the woman's risk status and that this is documented on E3.

- Women requiring postnatal obstetric input may be identified using the postnatal referral criteria and a management plan will have been completed in the antenatal period and will be filed within the personal maternity record, hospital notes and on E3.

- The criteria for referral have been developed to support staff in the provision of safe and appropriate care to mothers and babies. The referral criteria should not be viewed as exhaustive lists but prompts for referral.

- Midwives must, of course, refer to the medical staff any condition that is outside the midwives' sphere of responsibility. Both medical and midwifery staff must recognise the limitations of their skills and expertise and refer to an appropriate senior where necessary.

Postnatal referral criteria:

- Raised blood pressure in labour -systolic BP >140, diastolic >90
- Postpartum haemorrhage
- Urinary retention
- Vulval haematoma
- Pyrexia
- Subinvolution of the uterus
- Any abnormalities in mental state
- Suspected Urinary tract infection
- Suspected DVT
- Any deviation from the normal postnatal course

- Referral is by direct contact from the Midwife to the Obstetrician or if readmission following discharge is made to the Maternity Assessment Unit at either LGH or LRI.

- The Hospital and Community Midwives will provide the woman's postpartum care for up to 28 days postpartum. Handover to the Primary Health Care Team takes place in the community.

- If required the Obstetrician will manage any specialist postnatal care and follow up for high-risk women.

References:

NICE, (2008) Antenatal Care for uncomplicated pregnancies NICE. (last updated 2019).

NMC, (2018) Code of Professional Conduct, NMC. London

NMC, (2019) Standards of proficiency for midwives, NMC. London

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
A formal risk assessment should be made at around 36 weeks gestation and documented in the personal maternity record	Audit	Guideline Lead	Yearly	Audit Group
All notes for women who are high risk and have unusual comorbidities should be discussed with a consultant as soon as possible so that an appropriate appointment can be made.	Audit	Guideline Lead	Yearly	Audit Group
If risks are identified at booking a hospital clinic appointment should be made	Audit	Guideline Lead	Yearly	Audit Group

risk assessment should be documented on the front page of the personal maternity record by the antenatal core midwives	Audit	Guideline Lead	Yearly	Audit Group

5. Key Words

Booking, maternity, screening, virtual clinic

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	L Payne	**Job Title:** – Matron for Community Services
Reviewed by:	M Bodley	
Approved by:	Maternity Service Governance Group	**Date Approved**:

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
4.04.16	2	L Payne	General update of processes and contact numbers. Update of referral criteria. Risk assessment at 36 weeks and not 28 weeks as well.
May 2017	3	As above	All notes for women who are high risk and present with unusual co morbidities should be discussed with a consultant as soon as possible so that an appropriate appointment can be made. Flow chart added. Screening information updated. Childrens centre arrangements amended Referral criteria list updated New Virtual clinic pathway added
March 2021	4	M Bodley	General update. Screening video – advise women to watch before booking. Bookings to be sent electronically. Virtual clinic pathway added in. Late bookings added in.
August 2021	4.1	Mat Governance	Amend anaemia contact referral from specialist Nurse/Midwife to Haem Ob's specialist doctor

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**
4.16	All Midwives and Medical staff	Maternity	
May 2017	All Midwives and Medical staff	Maternity	
March 2021	All Midwives and Medical staff	Maternity	

Appendix 1 - Referral Guide - Consultant Clinics at Booking

Anaesthetic Clinic	• Previous anaphylaxis to an anaesthetic drug (referral not required for women with antibiotic or latex allergies) • Previous spinal surgery and / or scoliosis • Previous difficulty with intubation or general anaesthesia • Previous difficulty with spinal or epidural where the woman is concerned • BMI >≥ 40 Medical conditions that cause concern in pregnancy (e.g. cardiac disease, haematological disease, respiratory disease, neurological conditions etc.) will usually be referred via the relevant maternal medicine team. However, the duty anaesthetist is happy to discuss individual cases and advise on the need for an outpatient clinic appointment. Telephone ext. 6453 (LRI) and 4815 (LGH)
Birth Choices Clinic	One previous uncomplicated LSCS **This clinic is no longer done due to a change in the guideline which meant that all women had to be seen in ANC by a medical practitioner**
Breech/ECV clinic LRI Monday morning	• Women seen in the community (Primi >36 and Multips >37) with a pregnancy that palpates breech (that are not already been seen in another clinic) • Women with confirmed breech pregnancies for discussion about whether ECV is appropriate
Diabetic (LRI & LGH)	**Type 1 or Type 2 Diabetes mellitus –** please check HBA1c at booking immediate referral to ANC **Diabetes insipidus Please refer to ENDOCRINE ANC** **Indications for GTT:** BMI >30, Ethnic origin : Indo Asian, Afro-Caribbean, Middle Eastern, Eastern European !st degree relative with diabetes, Previous large baby >4.5kg, Previous gestational diabetes. NB. Women with previous gastric bypass or gastric sleeve **should not have a GTT**- refer to Specialist Midwife. *PCOS / Lipodystrophy - no need to refer to Specialist Consultant Clinic but **please arrange a GTT at 26 weeks**
Endocrine disorders	Thyroid, Parathyroid, Pituitary, Adrenal) Midwife/Nurse led clinic monthly – **please take TFT's at booking if thyroid disorder.**
Fetal Diagnostic Clinic	• Current or previous fetal abnormality • Increased genetic risk • Monochorionic twins • Triplets or higher order multiple pregnancy • Red cell antibodies **(+ Haematology appointment)** • Increased risk of aneuploidy • Suspected or confirmed fetal anomaly on ultrasound screening • Previous stillbirth or neonatal death due to a fetal anomaly or if seen by FDC in that pregnancy (LGH)
FGM (LRI CLINIC for all women)	All primips and multips who have not previously delivered at UHL

General Obstetric	• Previous shoulder dystocia • Previous 3rd / 4th degree tear or perineal morbidity • Previous post partum haemorrhage (≥ 1000 mls) • Previous difficult or traumatic labour / vaginal delivery • Late bookers (>24 weeks and not referred to other clinic) • Previous gynaecological surgery (including myomectomy – NOT ectopic pregnancy) • Abnormal presentation after 36 weeks (unless breech and considering ECV) • One or more previous LSCS any other clinic • Dichorionic twin pregnancy • IVF pregnancies • Women aged over 40 at the EDD • Previous stillbirth **(follow plan from postnatal debrief. If no plan and does not meet criteria requiring referral to another clinic see in General Obs)** • Previous abruption **(not related to hypertension or medical disorder)**
Haematology	• Low platelets (<100 x 10^9/l) • Known ITP or history of previously treated ITP • Von Willebrands disease or partner of VWD patient • Haemophilia carriers or partners of haemophiliac men • Personal or family history of thrombosis **(See Specialist Midwife/Nurse section)** • Hereditary thrombophilia • Major haemoglobinopathy (not carrier / trait) • Women on long term warfarin • Current or previous haematological malignancy or myeloproliferative disease • Red cell antibodies **(+ Fetal Assessment appointment)** • History of fetal or neonatal thrombocytopenia/ bleeding, unexplained hydrocephalus
	• **Anaemia discuss with Haematolgy/Obstetric specialist doctor**– please also see specialist Midwife/Nurse section for further contact details • AT deficiency • Protein C deficiency • Protein S deficiency • Factor V Leiden • Prothrombin gene variant • Antiphospholipid syndrome (lupus anticoagulant, anticardiolipin antibodies)
Health and Wellbeing Clinic	BMI ≥ 40 with no other risk issues and not referred to any other Obstetric Clinic (will be seen by an Anaesthetist)
Hypertension	• Booking BP ≥140/90 on 2 readings within the same consultation **NB: If BP on 2 readings is 140-150/100 the GP should also be requested to review as a matter of urgency** • Renal disorder **(if booking at LGH refer to Renal clinic)** • Patient hypertensive outside of pregnancy • Multips: Past obstetric history of raised BP requiring treatment **(unless has had a subsequent pregnancy with no BP problems)** **Women with one of the following should be commenced on 150 mg Aspirin and referred to the appropriate clinic (this may not necessarily hypertension i.e. Diabetic** -high blood pressure in a previous pregnancy (requiring medication) - chronic kidney disease - type 1 or type 2 diabetes - auto immune disorder such as Systemic Lupus Erythematosis, or anti Phospholipid Syndrome - taking medication for high blood pressure before or from the beginning of your pregnancy Women with more than one of the following risk factors for pre-eclampsia should be referred to their GP in order to be prescribed 150 mg of aspirin* daily from 12 weeks until the birth of the baby. • first pregnancy • age 40 years or older • pregnancy interval of more than 10 years • body mass index (BMI) of 35 or more at first visit

	• family history of pre-eclampsia • multiple pregnancy
Maternal Medicine (LGH now has mat med clinic)	• **Neurological disorders**: Epilepsy, Multiple Sclerosis, Myasthenia Gravis, Myotonic dystrophy **(+ FAU referral)** • **Cardiac disease** (confirmed) Ensure woman is booked to see cardiologist in maternal medicine clinic. • **Respiratory disease**: Asthma (unstable / repeated admissions / steroids) cystic fibrosis, bronchiectasis • **Inflammatory bowel disease** (not irritable bowel syndrome) • **Severe kyphoscholiosis**, **previous back surgery** • **Liver and pancreatic disease** (including cholestasis) • **Malignancy** (current or previous) • **Rheumatological disease** • ***Previous / ongoing major psychiatric disorder*. I think this should be mint)** • **Blood borne infections** • **(please advise all women with maternal conditions to take a list of current medications, doses, name of consultant they are under, and any relevant letters for first visit)**
PMHT (known as MINT)	• Any woman on any SSRI / Tricyclic or antipsychotic medication • Any woman with a diagnosed mental health condition ie bipolar / schizoaffective disorder or severe enduring condition • Any woman under the care of the City or County Mental Health Team • Any woman with a previous psychosis or admission to mental health services in the last 12 months • Any woman with a family history of bipolar on the maternal side • New onset in pregnancy • Previous severe postnatal depression requiring treatment / medical intervention
Prematurity Prevention	• Last pregnancy a pre-term birth or PPROM (34+6 weeks) • Still birth/Neonatal death due to preterm labour/PPROM (Referral to Prem prevention a priority, discuss with Rainbow clinic if delivery was after 20weeks) • Last pregnancy was a mid-trimester miscarriage • Last pregnancy managed with a cervical cerclage • Known uterine malformations • First pregnancy after LLETZ or cone biopsy – for notes review and appointment if appropriate (over 11 mm) • Women who had Caesarean section at full dilation in a previous pregnancy
Psychiatric Liaison Clinic	**Women suffering a new episode of moderate to severe mental illness, who are not already under the care of a Consultant Psychiatrist,. E.g. Self harm or psychosis**
Rainbow Clinic J Dickens at LRI **S Narain and K Snutch at LGH** **Friday mornings at LRI** **Alternate Wednesday mornings at LGH from August 2019**	• Any woman with previous stillbirth, previous neonatal death or previous fetal death from 20 weeks should be booked an appointment for 16 weeks **NB: Women with stillbirth / neonatal death due to congenital anomaly should be referred to the Fetal Medicine Team and women with stillbirth / neonatal death due to pre term labour / PPROM should be referred to the Prematurity Prevention Clinic.** Contact details: Dr. Sumana Narain - secretary Jo Ayres- 7770. Email - sumana.narain@uhl-tr.nhs.uk Dr Penny McParland – secretary Claire Richards – 5923. E mail penelope.mcparland@uhl-tr.nhs.uk
Substance Misuse (including alcoholics)	Tuesday afternoons at LRI - Weeks 1, 3 and 5 - Consultant led
Specialist Midwife and Nurse Information and Clinics	
Obstetric haematology – Specialist Nurse: Saija Hayes on 07983 057833 or Midwife: Aasimah Alibhai Saija holds a Nurse Led Clinic.	
Antenatal and Newborn Screening Coordinator: Helen Ulyett 07966 558281 / Louise Payne 07833 652574	
Asylum seekers, homeless women and travellers : Midwife: Trudy Russell 07500 959280	
BBI's: Midwives Louise Boon 07775995268,	
Bereavement midwife: Jo Dickens Katy Snutch 07747 475441	
Diabetes and endocrine disorders: Midwives: Di Todd 07966 558333, Tina Evans 07765 827827	

Endocrine disorders (Thyroid, Parathyroid, Pituitary, Adrenal) – **please take TFT's at booking if thyroid disorder.** Midwife/Nurse led clinic monthly Also midwife/nurse led new referral clinic for gestational diabetics on a Tuesday morning at LGH.
Hypertension midwives: Claire Dodd 07966 558325, Andrea Goodlife 07833611697.
Infant Feeding coordinators: Ann Raja – 07765787279.
Mental Health: Gina Twist 07717694373
Safeguarding midwife: Clare Robinson 07876 475318 / Katy Saunders
Substance misuse: Midwife: Angela Geraghty 07966 558286 or Sarah Stone Weekly clinic Tuesday afternoons at LRI for heroin / cocaine use, heavy cannabis use or any other illicit drugs/alcohol use - supported by S Agarwal (Consultant) on weeks 1, 3 and 5. Weeks 2 and 4 are midwife led.
Teenage pregnancy - Age 18 and under **Paula Mortimer 07717 694420**

Algorithm and Risk Assessment Tool: Screening and Surveillance of Fetal Growth in Singleton Pregnancies

Low Risk

☐ No known risk factors

Increased Risk: one or more of the following:

Maternal Risk Factors

☐ Maternal Age 40 years
☐ Ongoing smoker (at booking)
☐ Drug misuse

Previous Pregnancy History

☐ Previous SGA baby (<10th centile)
☐ Previous stillbirth

Maternal Medical History

☐ Chronic hypertension
☐ Diabetes
☐ Renal impairment
☐ Antiphospholipid syndrome

Unsuitable for monitoring by fundal height e.g.

☐ Large fibroids
☐ BMI 35

Current Pregnancy complications

Early Pregnancy

☐ PAPP-a .415 MoM
☐ Fetal echogenic bowel

Late Pregnancy

☐ Severe pregnancy induced hypertension or pre-eclampsia (=PIH and proteinuria)
☐ Unexplained antepartum haemorrhage

No risk factors →

Low Risk Care

Serial assessment (2-3 weekly) of symphysis fundal height (SFH) from 26-28 weeks until delivery
SFH measurements plotted on chart

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Suspected abnormal growth (SFH <10th centile or serial measurements which demonstrate slow or static growth)

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Direct referral for assessment (as soon as practically possible and should be within 72 hours) for estimated fetal weight (EFW), liquor volume and umbilical artery Doppler

→ **Normal** → ↑

↓

Abnormal growth or abnormal umbilical artery pulsatility index (PI)

→ Refer to RCOG guidance on management of the SGA fetus

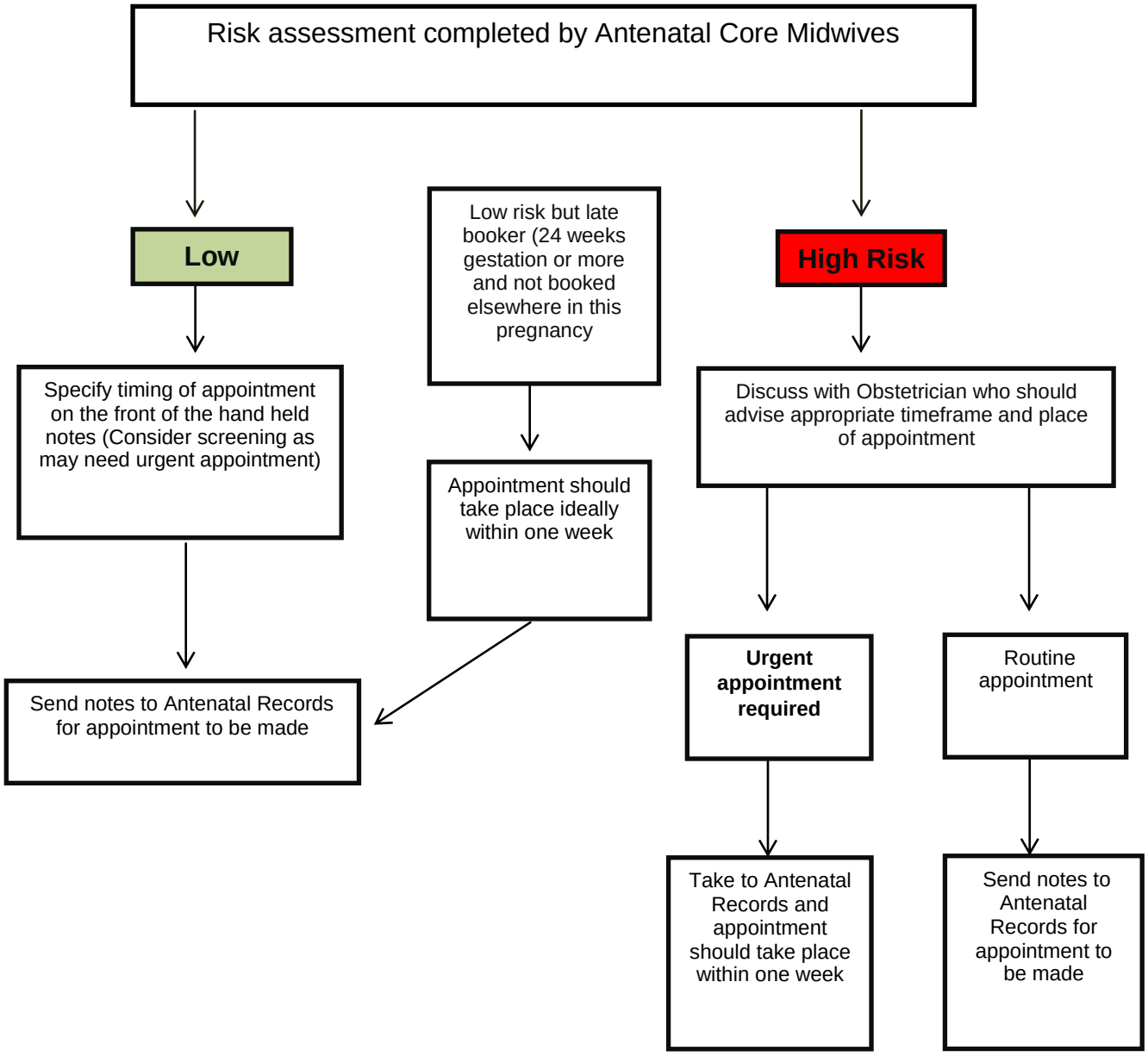
↑

One or more risk factors →

High Risk Care

Serial assessment (no more than 3 weekly) of fetal weight and umbilical Doppler using PI from 26-28 weeks until delivery. EFWs plotted on chart

Appendix 2 - Antenatal Risk Assessment at Booking



Appendix 3 - Obstetric Virtual Clinic Pathway

Step 1: Booking by MW at LGH / Identify women with the following:

1. Previous third / fourth degree tear with no other risk factors
2. Previous PPH (more than 1000 ml blood loss) with no other complications
3. As the clinic establishes more women will be added on the list.

Step 2: Keep booking notes with hospital notes in the labelled box in PAS.

Step 3: Dr. Ansar to look at the notes, fill the proforma and attach the related leaflet to pt handheld notes.

Step 4: Once established pt suitable for virtual clinic then appointment to be sent for 22 – 24 weeks gestation after the NT scan.

Step 5: On the appointment day Telephone Consultation. Notes available with NT scan and anomaly scan.

Step 6: Documentation on Proforma and care plan in the hospital notes.

Step 7: Send Care plan and feedback proforma to the patient

Step 8: If needs Caesarean section then send Tues am LGH clinic appointment at 32 – 34 weeks (Tue am LGH Clinic).

Step 9: Collect Feedback proforma and summarise.

Note: Community midwives to be aware to inform women about the possibility of telephone appointment.

Appendix 4 – Specialist Midwife Referral Form

SPECIALIST MIDWIFE REFERRAL

Substance Misuse / Homeless & Asylum / Teenagers
(Please circle/delete as applicable)

CLIENT DETAILS

Name:
DOB: **NHS/Hospital No:**
Address:

Postcode:
Telephone:
LMP: / / Gravida Para EDD: / /
GP:
Surgery:
Community Midwife:

REFERRERS'S DETAILS

Name & Position:
Address:

Telephone:

Date Of Next follow up appt:

Referral discussed with client: YES/NO
Domestic Abuse: YES/NO

REASON FOR REFERRAL

Please provide as much information as possible on referral

Date referred:

Email to: Vulnerablemidwifery@uhl-tr.nhs.uk
Substance Misuse: 07966 558286 Teenagers: 07717694420 / 07717694373

Homeless & Asylum: 07500 959280

Guidance on for referral to Specialist Midwives

Substance Misuse:

- Anyone with a current significant alcohol intake (>14units/wk / binge drinking
- Anyone on Methadone or Subutex
- Anyone taking illicit substances regularly
- Anyone with a recent drug or alcohol issue within the last year prior to pregnancy
- Anyone or a drug rehabilitation order
- Anyone with a drug or alcohol history that are involved with Social Care or on a Child in Need or Child Protection Plan

* **Take Toxicology Screen at Booking**

Homeless:

- Women and their partners who are homeless
- Women and their partners who are living in hostels/ Bed and breakfast
- Women and their partners who are living on the streets
- Women and their partners who are sofa surfing
- Women living in a refuge
- Women living in supported accommodation
- Women who have recently been liberated from prison
- Women registered with Homeless Health Care at the Dawn Centre Conduit Street Leicester

* **NO MEMBERS OF THE TRAVELLING COMMUNITY**

Asylum:

- Women and their partners who are seeking Asylum in the U.K.
- Women and their partners who are destitute and have been refused asylum in the U.K.

* **NO EUROPEAN NATIONALS**

Teenagers:

- Teenagers with complex needs and/or safeguarding concerns

If you are unsure whether to refer a patient to a particular specialist midwife please contact them on the appropriate mobile number overleaf to discuss the case. Please note completion of a referral form MUST be sent.

Appendix 5 – LSCB agency referral form to Children's Social Care

LSCB AGENCY REFERRAL FORM TO CHILDREN'S SOCIAL CARE [v5 July 2012]

Page 1 SUBJECT DETAILS: Child/Young Person or Adult causing concern (e.g. an Adult where their behaviour is affecting a child)	
1. Your Agency Numbers for Subject (e.g. NHS number, incident number)	
2.Name of Subject	
3. Current Address Postcode	
4.Telephone Numbers	
5. Date of Birth	
6. Gender (delete as applicable)	Male / Female
7. EDD and place of booking: (maternity only)	
8. Religion	
9. Disability (Is the subject disabled)	
10. Ethnicity (tick/ circle the appropriate box)	

a) White	**b) Mixed**	**c) Asian or Asian British**	**d) Black or Black British**	**e) Other Ethnic Group**
English/Welsh/Scottish/Northern Irish/British	White and Black Caribbean	Indian	Caribbean	Arab
Other British	White and Black African	Pakistani	African	Any Other
Irish	White and Asian	Bangladeshi	Any other Black Background	
Gypsy or Irish Traveler	Any Other Mixed Background	Chinese		
Any other White Background		Any other Asian background		

11. First Language	
12. Details of interpreter used/required	
13. What is your reason for contact with the subject? For example, police call out with details, health contact with clinical reasons and actions, maternity booking with EDD and place of booking, neighbour / family member/ school teacher (Please continue in box 25 if required)	
14. Details of most recent contact Please give name and role, date, time, location, who subject was accompanied by, actions/ interventions taken, discharge	

arrangements (Please continue in box 25 if required) Are you likely to have ongoing contact with the subject? Delete as applicable	Yes/ No
15. What is your **safeguarding concern** leading to this referral? (Please give as much detail as possible and continue in box 25 if required)	
16. Is the subject of the concern: (delete as applicable and give details in box 25 where known):	Already known to social care? Yes / No/ Don't Know Subject to a child protection plan? Yes/ No / Don't Know Looked After/ in Local Authority Care? Yes / No/ Don't Know Known to have a CAF referral? Yes / No/ Don't Know Aware of this referral? Yes / No/ Don't Know
17. Is the person with parental responsibility ("PR") aware of this referral? (If possible they should be informed)	No/ Yes (give details of the person) / Don't Know – give details for all answers
18. Has the person with PR given consent for other agencies to be contacted give details for all answers (if yes, please state agencies consented to and how consent was obtained)	No/ Yes/ Don't Know
19. Are you aware of any of the following within the household (please delete as applicable and give details in box 25):	Domestic Abuse Yes / No/ Don't Know Substance Misuse Yes / No/ Don't Know Disabilities Yes / No/ Don't Know Learning Difficulties Yes / No/ Don't Know Mental Illness Yes / No/ Don't Know Missing (MFH) Yes / No/ Don't Know Sexual Exploitation (CSE) Yes / No/ Don't Know Other: (give details)
Page 2. Subject Name:.....Date of Birth:.....	

20. Significant Others in Subject's Life/ Household				
	Date of	Relationship		

Name	Birth	to Subject	Address & Telephone Numbers	Occupation/ School

21. Key Agencies Involved with the Child/ Young Person/ Family

Agency	Name	Base	Telephone Number
GP			
Health Visitor			
School Nurse			
Midwife			
Mental Health			
Social Care			
Police			
School/College/Nursery			
Other (give details)			
Other (give details)			

22. Referrer (Your Details):
For members of the public only , please tick here if you would prefer to remain anonymous: ☐

Name			
Address/ Agency/ Work Base			
Occupation/ Relationship to Subject			
Telephone Number Fax Number			
23. Communication with Social Care			
Name of Person you spoke to		Team/ Base	
Telephone Number/ Fax Number		Date and Time of contact (by telephone or fax)	
Agreed Actions with Social Worker:			
24. For Social Care Use Only:			
Social care Action			
Details of Decisions Taken:			
Feedback to Referrer	*Date/Time*	*To*	*By*
Team Manager	*Name*	*Date*	*Signature*

Page 3 Subject Name:.....Date of Birth:.....

25. Continuation Page Please use this page to add to any details from sections 1 – 22. Please note the section number for which you are providing the additional information

Section Number	