The Shrewsbury and Telford Hospital NHS Trust

Clinical Risk Assessment

(including schedule of antenatal care and referral for obstetric clinics)

Version 14

Lead Persons: Matron for MLU and Community Services
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Revised by: Jen Abbott, Maternity Matron. Steph Chatham, Guideline Midwife, Dr S Rutter, Consultant Obstetrician & Dr Charlesworth, Consultant Obstetrician
Consultation: Jacqui Bolton, Deputy Head of Midwifery. Mei-See Hon, Consultant Obstetrician, Dr S Kidwai, Consultant Obstetrician.

Comments: References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version

Version	Implementation Date	History	Ratified By	Full Review Date
1	1st Nov 2003	Original document		Nov 2004
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3	August 2005	Revised	L/W Forum & MGG	Aug 2006
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10-10.5	8th September 2011-12th October 2014	History page amalgamated see version 11.3 for full history	MGG	September 2014
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Version	Implementation Date	History	Ratified By	Full Review Date
		clinic appointments.		
12.3	November 2022	Audit & Monitoring paragraph update to reflect new process		October 2024
12.4	November 2022	Initial consultation risk assessment document included as appendix	Maternity Governance	October 2024
13	14th December 2022	Full revision in line with NICE guidance	Maternity Governance	December 2025
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13.3	23rd August 2024	Additional guidance on fibroids added	Maternity Governance	December 2025
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1.0 Introduction

In this guideline we use the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

1.1 For most women and pregnant people, birth is a safe experience without complications. For some however, there are risks that may be present prior to pregnancy or become apparent during the pregnancy. Midwives and medical staff need to carry out continuous clinical risk assessments on all women and communicate those women at risk to the correct health care professional.

1.2 The risk and needs assessment will include obstetric, medical, and social history and must be carried out to ensure that each woman has a flexible and personalised plan of care which sets out her decision about her care reflecting her wider health needs (Better Births 2016)

1.3 There must be effective systems of communication between all team members and each discipline, as well as with the women and pregnant people and their family (Better Births 2016, RCOG 2016).

1.4 This guideline should not be read alone. Refer to the Maternity Guideline Intranet Page to locate the guideline related to a specific risk factor/condition.

2.0 Aim

A thorough assessment of risk will be performed by the midwife at the booking appointment. The risk assessment will include discussion with the woman or pregnant person regarding the options in relation to maternity care; including the plan of antenatal care, named lead professional and appropriate place of birth and plan of care postnatally. A risk assessment will be carried out at each point of contact, adapted if necessary and documented within the MIS.

3.0 Objectives

3.1 To assess the risks for each woman or pregnant person using a risk assessment framework based on the respective antenatal care pathway (NICE 2021)

3.2 To follow a clear referral pathway to enable those who require additional care to be managed appropriately, and by a specialist team if indicated (RCOG 2016, NICE 2021)

3.3 To provide midwives with guidance for:

- Conducting thorough risk assessment at initial contact (booking appointment) and continue risk assessments throughout pregnancy.
- Identifying risks and commencing appropriate care pathways
- Completing indicated referrals and if required, identifying a named consultant from booking
- Recognising and discussing factors that may affect the recommended place of birth
- Scheduling antenatal follow up appointment in line with national recommendations
- Arranging appropriate follow up should women’s choices fall outside of guidance
- Providing relevant and unbiased information to women to help them with the decision-making process.

4.0 Definitions

4.1 **Antenatal Care** is the professional care provided to a woman or pregnant person and their partner to support them and their baby through the pathway of pregnancy and to help achieve the best possible health, psychological and social outcomes for the mother, baby and family.

4.2 **Uncomplicated Pathway (NICE 2021)** following the risk assessment carried out by the Midwife

4.3 **Complicated Pathway** following the risk assessment carried out by the Midwife

4.4 **Initial Consultation** is the initial risk assessment carried out by a Midwife on all women and pregnant people utilising the NICE Care Pathways and then categorisation during the initial consultation, taking into consideration previous obstetric, medical, surgical, psychological, and social history.

4.5 **Individual Risk Assessment** is an assessment carried out on all women and pregnant people at each antenatal visit following the uncomplicated pathway or complicated pathway

4.6 **Individual Management Plan** is a written record of planned care based on risk assessment (considering their preferences for care during pregnancy, labour and childbirth). This is reviewed at each antenatal appointment and revised if necessary. It is documented in the MIS.

4.7 **MIS** is the electronic Maternity Information System.

4.8 **Midwife Led Maternity Care (MLC)** is identified as a community-based service providing antenatal, intrapartum, and postnatal care to women considered to have an uncomplicated pregnancy and be at low risk of developing complications during labour (NICE 2021)

4.9 **Consultant/Obstetric Led Care (CLC)** Although every woman and pregnant person has care by a Midwife, for those requiring additional care (NICE 2021) care is provided by a Maternity Team comprising of Midwives, Obstetricians, Anaesthetists, Neonatologists, and other specialists working in partnership.

4.10 **CO reading** Carbon Monoxide reading recorded by exhaling into a carbon monoxide monitor. This records both maternal and fetal CO levels.

4.11 **SFH** – Standardised Fundal Height

5.0 Process

5.1 Pre-conception counselling:

The trust is not currently commissioned for a preconception service, however, women referred by their GP for preconception counselling will be referred to the relevant Mat Med clinic following discussion with the relevant consultant.

5.2 Antenatal risk assessments:

- At the first face-to-face contact with the midwife, a detailed antenatal booking history will be taken. This will include, consideration of medical conditions, including anaesthetics and psychiatric history, previous pregnancies, lifestyle, and those who decline blood products.
- Pregnancy is a normal physiological process and that, as such, any interventions offered should have known benefits and be acceptable to women and pregnant people.
- Care during pregnancy should enable everyone to make informed decisions, based on individual needs, having discussed matters fully with the healthcare professionals involved
- There are two pathways that women and pregnant people will follow; these are Uncomplicated or Complicated (those who require additional support).
- **Complicated pregnancies can require further consideration and individual risk assessment and management plan. Community midwives/ any clinician identifying risks will arrange an initial antenatal clinic appointment where required and identify the named consultant. Refer to Appendix 4**
- Information recorded will be based on the Maternity Notes and/or case notes, information from the GP, medical records and from the woman.
- Individual risk assessments will be undertaken at each antenatal visit throughout pregnancy.
- All women will discuss all birth settings and be advised which is the more appropriate for place of birth and this will be documented on the MIS (NICE 2021).
- Community Midwives will undertake the risk assessment at each point of contact considering place of birth at the initial consultation or during pregnancy. Signpost all women and pregnant people to the patient information on the SaTH website. Appendix 1 and 2 will support these considerations.

5.3 Risk assessment for place of birth

Information will be provided about their chosen place of birth, to include staffing and facilities available and travel distance to the consultant unit if birth in a midwife led setting is preferred. Details of the informed decision making will be documented in the MIS.

My Birth Choice Leaflet will be provided at the initial booking appointment and be referred to during each discussion about preferred place of birth – **refer to appendix 3 for information provision process**

Uncomplicated pregnancy (low risk) also refer to "Care in Labour on n MLU/Homebirth" guideline

- Explain to both multiparous and nulliparous women and pregnant people who are at low risk of complications that giving birth is generally very safe for both the woman and her baby. (NICE 2021)

- Explain to both multiparous and nulliparous women and pregnant people that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth. There is currently no freestanding midwifery unit available at SaTH.

- Advise low-risk multiparous women and pregnant people that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Advise low-risk nulliparous women and pregnant people that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby. (NICE 2021)

- The Birthplace Study (2012) concluded that for 'low risk' women the incidence of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth related injuries including brachial plexus injury) was low (4.3 events per 1000 births).

Midwifery units appear to be safe for the baby and offer benefits for the mother

- For planned births in freestanding midwifery units and alongside midwifery there were no significant difference in adverse perinatal outcomes compared with planned birth in an obstetric unit.

- Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit.

For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother

- For multiparous women, there were no significant differences in adverse perinatal outcomes between planned home births or midwifery unit births and planned births in obstetric units.

- For multiparous women, birth in a non-obstetric unit setting significantly and substantially reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy.

For women having a first baby, a planned home birth increases the risk for the baby

For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units, and this finding was statistically significant.

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

- For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned FMU births and 40% for planned AMU births

For women having a second or subsequent baby, the transfer rate is around 10%

- For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births, 9% for planned FMU births and 13% for planned AMU births.

Those who require additional care- (complicated pregnancy) refer to Appendix 1 and 2

Suggest planning a birth at a consultant led unit for those with existing medical conditions or obstetric complications in their current or previous pregnancies (NICE 2021)

Further consideration of birth setting (refer to Appendix 2)

- The factors listed are not reasons in themselves for advising birth within an obstetric unit but indicate that further consideration of birth setting may be required (NICE 2019)

Planned place of birth outside of local or national guidance
Complete a referral via the MIS to the Consultant Midwife Clinic for further discussion in conjunction with the Ward Manger/Matron for MLU and Community

5.4 Referral where risks identified (see Appendix 4)

The Obstetrician or midwife who identifies a risk during the pregnancy is responsible for arranging a referral to the appropriate clinician or clinical area. A named obstetrician will be allocated to those requiring antenatal consultant clinic appointments, and serial growth scans. Individual management plans may require amendment, or a new plan made by the obstetrician for those previously following an uncomplicated pathway.

Wherever possible, a consultant clinic appointment will be made in the locality closest to the registered home address.

A Neonatal Alert Form will be raised by a doctor or midwife if any concerns are raised during the pregnancy about the fetal / neonatal condition.

5.5 Antenatal appointments

Midwives will aim to conduct at least one antenatal assessment in the home during the pregnancy, **see table 1** for Antenatal Appointments (schedule and content). This will be documented in the MIS.

In addition, at the times specified in the schedule (set out in **table 1**), additional care, advice, and tests will be undertaken by the Midwife. Documentation related to these appointments will be made in the MIS.

5.5.1 Initial Consultation appointment

The following physical assessments and tests will be undertaken:

- Height, weight, and calculation of BMI
- Test urine for proteinuria

5.5.2 Investigations

The following screening tests will be offered (refer to screening guideline):

- Maternal blood group and rhesus factor
- Screening for haemoglobinopathies

- Full blood count
- Red cell alloantibodies
- Hepatitis B
- HIV
- Syphilis
- Screening for asymptomatic bacteriuria
- National Chlamydia Screening Programme – women aged 16-24.
- Nuchal translucency or Quadruple blood screening test
- Dating scan 11+2 – 14+1 weeks' gestation
- Anomaly scan at 18+0 – 20+6 weeks' gestation
- CO reading and referral to smoking cessation providers if indicated
- Glucose tolerance test where applicable

Women and pregnant people will be advised to follow the antenatal pattern of care dependent on their pathway and any additional contacts recommended by an Obstetrician (**see Table 1**). Although the following schedule of care are the 'ideal weeks' it is recognised that there may be a slight alteration to the scheduled appointment due to GP community clinics/ other appointments or maternal choice.

Those who are current smokers at the booking appointment will be advised to have serial growth ultrasound scans from 32 weeks until birth (this does not exclude them from birth on MLU/home). (NHS England 2019)

5.5.3 Table 1- Routine Antenatal Appointments (schedule and content)

Those women meeting criteria in Appendix 4 will require additional AN appointments

Weeks of Pregnancy	Core Antenatal Care	Nulliparous pregnancy	Multiparous pregnancy
6 – 10	Initial consultation appointment with a midwife Emotional and general wellbeing Antenatal care and place of birth discussed (refer to pathways) **Identify risk factors and make appropriate referrals and clinic appointments** Folic acid and Vitamin D supplementation Aspirin review Lifestyle advice to include smoking cessation, recreational drug use and alcohol consumption, exercise Antenatal screening tests offered, including risks and benefits, and samples taken following consent Blood pressure and urinalysis Routine bloods Measure height, weight and calculate body mass index Discuss maternity benefits Antenatal education including Infant Feeding information CO reading Offer screening for gestational diabetes and pre-eclampsia if risk factors present Offer women younger than 25 years, chlamydia screening Offer ultrasound scan for dating and screening for Down's, Edward's and Patau's and screening for structural abnormalities Routine enquiry for domestic abuse if attends alone Discuss all recommended maternal vaccinations and how to access these	✓	✓

11+2 – 14+1	Ultrasound scan for dating and screening for Down's, Edward's and Patau's Syndromes if accepted CO reading Routine enquiry for domestic abuse if attends alone	✓	✓
15 - 16	Screening blood test (Quad) if combined test not done at dating scan Ensure all blood and urine tests taken, results reviewed and recorded Investigate a haemoglobin level < 110g/L and consider iron supplementation if indicated Reassess planned schedule of care for the pregnancy and identify those who need additional care Blood pressure and urinalysis for proteinurea CO reading Routine enquiry for domestic abuse if attends alone Discuss all recommended maternal vaccinations and how to access these if required	✓	✓
18+0 – 20+6	Ultrasound mid pregnancy fetal anomaly and placental location	✓	✓
25	Emotional and general wellbeing Blood pressure and urinalysis for proteinurea Auscultation MATB1 if not already received CO reading Routine enquiry for domestic abuse if attends alone	✓	✗
28	Emotional and general wellbeing Routine bloods Investigate a haemoglobin level < 105g/L and consider iron supplementation, if indicated Offer Anti-D for RhD negative women Palpation, Measure, and plot SFH; Auscultation Blood pressure and urinalysis for proteinurea MATB1 if not already received Offer mood assessment Discuss Mother's Guide to Breastfeeding Discuss antenatal classes and provide verbal and written information CO reading Routine enquiry for domestic abuse if attends alone Discuss all recommended maternal vaccinations and how to access these if required Provide birth preferences leaflet Re-weigh if booking BMI greater than or equal to 30	✓	✓
31	Emotional and general wellbeing Blood pressure and urinalysis for proteinurea Palpation, Measure and plot SFH, Auscultation Discuss antenatal classes and provide verbal and written information review, discuss and record the results of screening tests undertaken at 28 weeks; reassess planned pattern of care for the pregnancy and identify women who need additional care.	✓	✗

	CO reading Routine enquiry for domestic abuse if attends alone Discuss all recommended maternal vaccinations and how to access these if required		
34	Emotional and General wellbeing Discuss preparation for labour and birth, including information about coping with pain in labour and birth preferences (to include choice for place of birth) Palpation, Measure and plot SFH, Auscultation Blood pressure and urinalysis for proteinurea Reassess planned care pathway and identify any additional needs Complete infant feeding checklist CO reading Routine enquiry for domestic abuse if attends alone Discuss all recommended maternal vaccinations and how to access these if required	✓	✓
36	Emotional and General wellbeing Provide information and opportunity to discuss care of the newborn, postnatal self-care, awareness of 'baby blues' and postnatal depression Palpation, Measure, and plot SFH, Auscultation Blood pressure and urinalysis for proteinuria Discuss risks and benefits of neonatal vitamin K CO reading Routine enquiry for domestic abuse if attends alone Review birth preferences leaflet and birth plan	✓	✓
38	Emotional and General wellbeing Palpation, Measure, and plot SFH, Auscultation Give information and opportunity to discuss options for a prolonged pregnancy Blood pressure and urinalysis for proteinurea CO reading Routine enquiry for domestic abuse if attends alone	✓	✓
40	Emotional and General wellbeing Give information and opportunity to discuss options for a prolonged pregnancy Palpation, Measure, and plot SFH, Auscultation Blood pressure and urinalysis for proteinurea Offer membrane sweep CO reading Routine enquiry for domestic abuse if attends alone	✓	✗
41	Emotional and General wellbeing Provide information and discuss and offer a membrane sweep and date for induction of labour Palpation, Measure, and plot SFH, Auscultation Blood pressure and urinalysis for proteinurea Offer membrane sweep CO reading Routine enquiry for domestic abuse if attends alone	✓	✓

5.6 Assessment for those who decline induction of labour after 42 weeks

Refer to the Induction of Labour guideline and Women Seeking Midwife Led Birth Choices That Fall Outside Guidance guideline.

5.7 Documentation

A record of all care given will be documented on the MIS.

Documentation of the clinical risk assessment carried out at booking and during the antenatal period must include:

- Timing of the risk assessment
- Details of any risks identified during the risk assessment
- The referral process when appropriate – which clinic and when
- The individual management plan when appropriate, including named consultant
- Any change in place of birth.

6.0 Training

Refer to Maternity Training Guideline

7.0 Monitoring and audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using the auditable standards and the results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

8.0 References and Resources

Better Births (2016): improving outcomes of maternity services in England — the report of the National Maternity Review (NHS England)

Birthplace Study (2012) - Hollowell J, Puddicombe D, Rowe R, Linsell L, Hardy P, Stewart, M, et al. The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth. Birthplace in England research programme.

Department of Health (2004) National Service Framework for Children, Young People and Maternity Services - Every Child Matter's. DFSE Department of Health. London

Department of Health (2007) Maternity Matters: Choice, access, and continuity of care in a safe service. HMSO. London

MBRRACE-UK (2023) Saving Lives, Improving Mothers' Care. National Perinatal Epidemiology Unit, Oxford.

NHS England (2023) Saving Babies' Lives Care Bundle version 3.1 NHS England » Saving babies' lives: version 3

NICE (2023) Intrapartum Care [NG235] National Institute for Health and Clinical Excellence (updated 2017)

NICE (2021) Antenatal Care (NG201), National Institute for Health and Clinical Excellence

NICE (2021) Antenatal Care: Quality standard [QS22] Risk assessment National Institute for Health and Clinical Excellence

NICE (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies (NG121), National Institute for Health and Clinical Excellence

Nursing & Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates. NMC, London

RCOG (2016) Providing Quality Care for Women: A Framework for Maternity Services Standards. RCOG, London

Appendix 1

Risk factors suggesting planned birth at consultant unit

Disease area	Medical Condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100×109/litre Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	Hyperthyroidism Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care
Gynaecological	Fibroids with a diameter greater than 3 cm, or located adjacent to the placental site or cervix Myomectomy Hysterotomy

Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty. Previous baby with neonatal encephalopathy. Pre-eclampsia requiring preterm birth. Placental abruption with adverse outcome. Eclampsia. Uterine rupture. Primary postpartum haemorrhage requiring additional treatment or blood transfusion. Retained placenta requiring manual removal in theatre Caesarean birth. Shoulder dystocia.
Current pregnancy	Multiple birth. Placenta praevia. Pre-eclampsia or pregnancy-induced hypertension. Preterm labour or preterm prelabour rupture of membranes. Placental abruption. Anaemia – haemoglobin less than 85 g/litre at onset of labour. Confirmed intrauterine death. Induction of labour Substance misuse. Alcohol dependency requiring assessment or treatment. Onset of gestational diabetes. Malpresentation – breech or transverse lie. BMI at booking of 35 kg/m2 and above Recurrent antepartum haemorrhage. Small for gestational age in this pregnancy (less than 3rd centile or reduced growth velocity on ultrasound). Abnormal fetal heart rate/doppler studies. Ultrasound diagnosis of oligo-/polyhydramnios.

Appendix 2

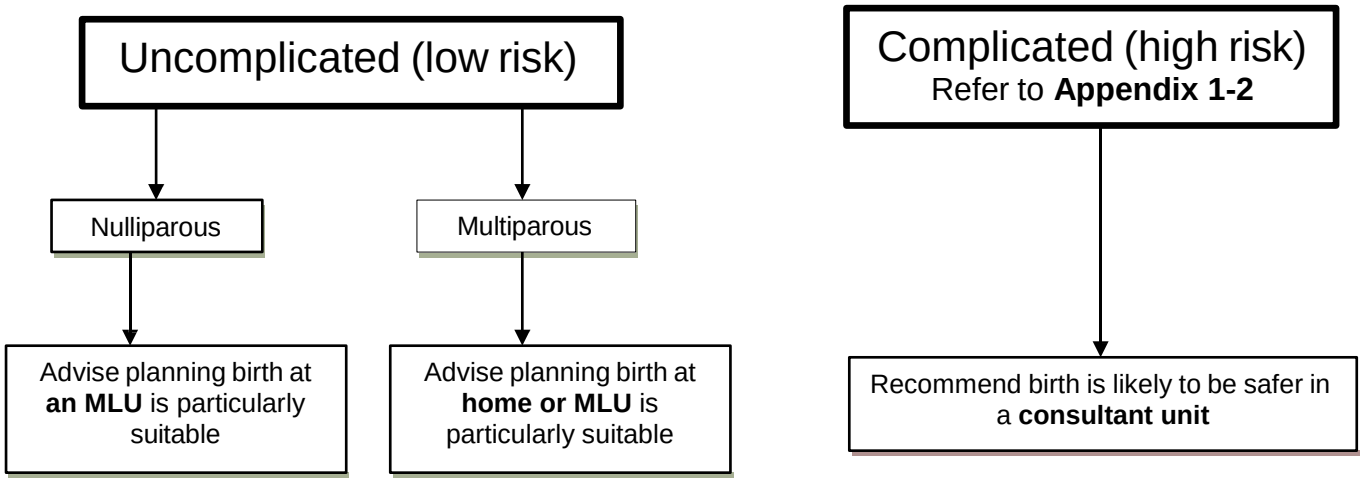
Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease. Sickle-cell trait. Thalassaemia trait. Anaemia – haemoglobin 85–104 g/litre at onset of labour.
Infective	Hepatitis B/C with normal liver function tests.
Immune	Non-specific connective tissue disorders.
Endocrine	Unstable hypothyroidism such that a change in treatment is required.
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits.
Gastrointestinal	Liver disease without current abnormal liver function. Crohn's disease. Ulcerative colitis.
Previous complications	Stillbirth/neonataldeathwith anunknown or recurrent cause Pre-eclampsia developing at term. Placental abruption with good outcome. History of previous baby more than 4.5 kg. Extensive vaginal, cervical, or third- or fourth-degree perineal trauma. Previous term baby with jaundice requiring exchange transfusion.
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation). BMI at booking of 30–34.9 kg/$m^{2.}$ Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on 2 occasions. Clinical or ultrasound suspicion of macrosomia. Para 4 or more. Recreational drug use. Under current outpatient psychiatric care. Age over 35 at booking.
Fetal indications	Fetal abnormality.
Previous gynaecological history	Major gynaecological surgery. Cone biopsy or large loop excision of the transformation zone. Fibroids- determine size and location.

Appendix 3

Flowchart for planning place of birth – for use with Clinical Risk Assessment Guideline and the 'My Birth Place Choices' Booklet

Booking history, risk assessment and 'My birth place choices' booklet given to women and discussed



- All women and pregnant people have the right to receive personalised care that meets their needs as individuals. As a minimum, these discussions should take place **at booking appointment and again at 34-36 weeks gestation which are then documented in the MIS**. Risk assessment is an ongoing process and the **opportunity to complete at each routine antenatal appointment;** this should include revisiting the conversation around choice of where to give birth.
- If initially assessed as complicated (high risk) and then later assessed as uncomplicated (low risk) women and pregnant people will be informed that their birthplace options have also changed.
- If initially assessed as uncomplicated (low risk) and then later assessed as complicated (high risk) women and pregnant people will be informed their recommended birthplace options may also change.

Documented discussions

- To facilitate discussion, completion of the relevant section within the MIS for recording birth plan decisions.
- A further discussion can take place in early labour and a clinical assessment will be carried out by a midwife.

Appendix 4

Community Booking Risk Assessment and Care Plan Guide

Midwives completing the risk assessment, either at booking or during an antenatal follow up, are responsible for completing referrals to obstetric clinics.
The table below details the standard care plan for risk factors (including medical or obstetric conditions) and advises which clinic referrals are indicated, if any.
Referrals are completed via Badgernet. See appendix 5
For most risk factors, a recommended management plan will be created on Badgernet. This will be reviewed by the community midwife and condensed for clarification, allowing the woman to see the plan for her pregnancy.
In situations where there is multiple risk factors present, an appointment should be made for each specialist clinic (where indicated), and the plan will be reviewed at the earliest appointment. Women will be advised that the care plan may develop and change during the pregnancy following obstetric reviews.

If required, midwives can use a dedicated email address (sath.ANCMidwives@nhs.net) to seek further advice on appropriate clinic appointment.

Please be aware specialist clinics have 30-minute slots per patient, whereas general clinics have 15-minute slots. It is therefore essential that when women are booked, they are booked into the appropriate slots. The table below will highlight cases where this applies. Consultants can ask women to reattend if an inappropriate slot is booked either of incorrect length or in the incorrect clinic to prevent disruption to the service for other women and to ensure the woman is given enough time and the appropriate skill set to be seen safely – this will unfortunately cause delay in the woman's journey, and 'waste' an appointment, but appropriate assessment to ensure a woman's safety is paramount.

Women who do not speak English and require an interpreter, require a double slot appointment in whichever clinic they are attending. It takes considerable time to interpret information between clinicians and patients and women should not feel information is incomplete or rushed. This will be specified when completing the Badgernet referral

All ANC referrals are either:	
Urgent	Within 1 – 2 weeks
Early	Between 12 – 20 weeks of gestation
Routine	Between 20 – 24 weeks of gestation
Bespoke	Depends on history and associated guideline

Exceptional Referrals
The trust is not currently commissioned for a preconception service, however, women referred by their GP for preconception counselling will be referred to the relevant Mat Med clinic following discussion with the relevant consultant.

Table 1: Risk Factors and Advised Clinics

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
General				
Age ≥ 40 years at booking	Referral to Diabetic Team for GDM screen Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Aspirin review Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.	Aspirin GDM SGA	
Age ≤ 19 years at booking	Refer all women aged ≤ 17 years old to TIMS (Telford & Wrekin only). Otherwise, for continuity of care with named CMW. Perform safeguarding screen as per safeguarding guideline and refer as indicated for co-ordinated antenatal care with relevant agencies. Refer women **≤ 16** years of age to the JPMHT ANC. **ROUTINE: 20- 24 weeks gestation.**	Signpost to GP/ Sexual health services as required	Safeguarding	
A history of anaphylaxis **A woman with multiple allergies** **A history of adverse reaction to commonly used medications in labour or anaesthetics**	Refer to any consultant antenatal clinic to: • Ascertain nature of anaphylaxis • Assess need for onward referral to anaesthetic consultant clinic • Determine advice for place of birth. Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**			
BMI below 18.5 secondary to medical or mental health pathology	**BESPOKE:** Refer to appropriate antenatal clinic based on suspected cause	Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.	BMI SGA	
BMI 30-34.9	Referral to Diabetic Team for GDM screen Refer to HPSS	Advise 5mg Folic acid until 12 weeks. Reweigh at 28 weeks	BMI GDM screening SGA	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
BMI 35-39.9	Referral to Diabetic Team for GDM screen Refer to HPSS Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Advise 5mg Folic acid until 12 weeks. Aspirin review Reweigh at 28 weeks Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.	BMI Aspirin GDM screening SGA	
BMI ≥ 40	Referral to Diabetic Team for GDM screen Refer to HPSS Refer to Comp Obs ANC. **ROUTINE:** 20-24 weeks Refer to anaesthetic clinic **for next available appointment** May need referral to tissue viability depending on assessment outcome	Advise 5mg Folic acid until 12 weeks. Aspirin review Reweigh at 28 weeks Perform tissue viability assessment at booking and after reweighing Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer. BMI >40 form at 36/40	BMI GDM screening Aspirin SGA	
Previous Bariatric Surgery +/- Raised BMI	Refer to MatMed 2. **EARLY**: **12-20 weeks.**	If aspirin is required, some of these women will need to have a reduced dose or PPI cover – either discuss with the lead for MatMed 2, or a bariatric nurse specialist Perform Bariatric Bloods at booking - found on review in “test group” > Bariatric requesting	BMI	
Smoker (any current smoker or any woman who has quit within the last two weeks prior to their	Refer to HPSS ANC referral not required but needs to be under the named consultant for either the RSH or PRH Comp	Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.	Smoking in Pregnancy SGA	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
booking appointment)	Obs ANC.			
High Carbon Monoxide Reading in Non-Smoker (Reading of ≥ 4 ppm)	Refer to HPSS	Provide 'Test your breath' cards to all non-smokers and advise re gas safety and gas safety advice number (0800 300 363)	Smoking in Pregnancy	
Declining Blood Products	Refer to CompObs ANC. **EARLY: 12-20 weeks.** Refer to anaesthetic clinic. **ROUTINE**	Ensure Jehovah's Witnesses have contacted their hospital liaison/elders to discuss their wishes	Women Declining Blood Products	
FGM Determine subtype where possible. Type 4 (piercings etc) will not require ANC review	Refer to safeguarding team Refer subtypes 1-3 to the CompObs ANC. **EARLY**: **12-20 weeks** (de-infibulation may be required)	Mandated FGM-IS database completed by safeguarding team.	Safeguarding	
Complex Fibroids Diameter greater than 3cm or located adjacent to the placental site/cervix/ multiple	CompObs ANC **ROUTINE: 20-24 weeks**	Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.		
Obstetric – Previous Pregnancy				
Acute Fatty Liver	Refer to MatMed 2 ANC **EARLY**: **12-20 weeks**			
Preeclampsia leading to delivery at < 34 weeks of gestation	Refer to BPObs ANC **EARLY**: **12 -20 weeks**	Requires Aspirin unless contraindicated Referral for serial scans will be determined at the time of the mid-	Aspirin SGA HTN	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
HELLP		trimester scan by the midwifery sonographer.		
Preeclampsia leading to delivery ≥ 34 weeks of gestation **Gestational Hypertension**	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Requires Aspirin unless contraindicated Referral for serial scans will be determined at the time of the mid-trimester scan by the midwifery sonographer.	Aspirin SGA HTN	
PPH **(any volume)**	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Check FBC, at booking, and 28 weeks. Be mindful of maintaining Hb pre delivery i.e. watch for rate of dropping Hb between booking and 28 weeks and consider if further Hb check at 32-34 weeks indicated.	PPH	
Shoulder Dystocia	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**		Shoulder Dystocia	
3rd/4th Degree Perineal Tear	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**		OASI	
Caesarean Section	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation** **BESPOKE:** If previous CS performed at full dilatation will also need referral to Preterm Birth antenatal clinic unless has had two term deliveries since **– see Preterm Birth Guideline for timing of referral (Tables 1+2).**	Request information from previous trust if previous CS in a different trust Provide information on birth after caesarean section Provide Leaflet on Preterm Birth Prevention Clinic via Badgernet where indicated.	Preterm Birth Guideline CS IOL	
Uterine Rupture	Appointment in Comp Obs ANC. **EARLY: 12-20 weeks.**	Check letters on Clinical Portal as may have individualised plan following previous pregnancy.		

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
Uterine Inversion	Appointment in Comp Obs ANC. **ROUTINE: 20-24 weeks.**		PPH	
MROP	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**		PPH Intrapartum Care: On CU On MLU/HB	
Postnatal Psychosis	See medical section on mental health.		Mental Health	
Gestational Diabetes	See medical section on endocrine disorders.		Diabetes	
Stillbirth or Neonatal Death	Refer to Rainbow ANC. **BESPOKE: 16 weeks of gestation.**		Loss of a Baby	
Premature Birth <34 weeks **PPROM <34 weeks** Includes spontaneous onset of labour, and second trimester miscarriage Excludes preterm delivery or PPROM ≥ 34 weeks, unexplained antenatal stillbirth, iatrogenic preterm birth due to obstetric events (e.g. abruption, PET, FGR, etc.) Circumstances leading to the preterm birth, including any interventions, should be ascertained at booking to ensure appropriate referral.	Refer to PTB ANC. **BESPOKE: as per PTB guideline (Tables 1+2)**	Provide Leaflet on Preterm Birth Prevention Clinic via Badgernet	Preterm Birth Preterm PROM	
FGR/SGA • **BW ≤ 10th centile** • **Normal BW but evidence**	Refer to Comp Obs clinic. **ROUTINE**: 20-24 weeks. If uncertainty around FGR status:	Requires Aspirin unless contraindicated Referral for serial scans will be determined at the time of the mid-	Aspirin SGA	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
of FGR in record It is important to determine if a woman is SGA or FGR – aspirin is indicated from 12 weeks of gestation if FGR. Not all women with FGR will deliver with a baby who is < 3rd centile. Please check the previous obstetric notes thoroughly. NB: Women who have had a preterm baby weighing < 2.5Kg with no evidence of FGR in the notes and where the BW is within the normal centiles for gestation are **NOT** considered SGA – the 2.5Kg cut off applies to **TERM** (≥ 37 weeks of gestation) babies.	URGENT: refer to any available obstetric antenatal clinic slot so as not to delay aspirin prescription.	trimester scan by the midwifery sonographer.		
Placental Abruption	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**			
Obstetric – Current pregnancy				
Birth anxiety **Maternal request for CS for those meeting the lighthouse criteria OR due to previous birth experience / primary tokophobia** **Women birthing against medical advice** **Women who have**	Refer to BirDis ANC. **ROUTINE**: earliest available appointment. If urgent referral is required but not possible (i.e. late stages of pregnancy), use either EmANC or CompObs ANC **and request a 30 minute slot**. Refer to PMHT **or** Lighthouse Service were applicable (do not refer to both for same woman) For women birthing against medical advice please refer to consultant midwife who will triage to BirDis		Birth Against Medical Advice	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
anxiety/tokophobia around birth and birth options **Women declining instrumental delivery** **Maternal perception of previous traumatic birth experience requiring additional support in this pregnancy**	ANC appropriately .			
Maternal request LSCS	Consultant antenatal clinic slot (suitable for any). **ROUTINE:** 20- 24 weeks gestation / as soon as possible after identification **(Will need a double slot in clinic)**			
Subchorionic Bleed, Recurrent APH, APH > 50mls in current pregnancy	Appointment in Comp Obs ANC **ROUTINE**: 20-24 weeks. **BESPOKE**: If bleeding/diagnosis after 24 weeks refer with scan 2 weeks from bleed to Comp Obs ANC or Em ANC. Comp Obs clinic to organise appropriate referral for serial growth scans.	In women with active bleeding, these referrals do not replace assessment in EPAS or Triage. Please ensure all women are aware of the need to attend for acute assessment if they have any APH.	APH	
ICP (Obstetric Cholestasis)	Em ANC for appropriate IOL plan. **ROUTINE**	Refer to DAU for assessment as per guideline within 24 hrs	ICP	
Hypertension	Women diagnosed with hypertension at < 20 weeks of gestation should follow the pathway set out for Essential/Chronic Hypertensives **BESPOKE**: All other women should be referred to Triage and have follow up in DAU and either the CompObs ANC (if diagnosed with GH or late onset	Requires Aspirin unless contraindicated	Hypertension in Pregnancy Aspirin	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	PET≥ 32 weeks) or the BPOBS or RENAL ANC (PET diagnosed at < 32 weeks) within a week. Please ensure DAU follow up is at the correct frequency for the diagnosis as per the Hypertension in Pregnancy Guidelines.			
VTE Score ≥ 4 (NB: A CVT/CVST is a type of VTE)	If there is a personal history of a previous VTE, APS, or thrombophilia, then refer to the SpecHaem ANC as per Haematology Section. **URGENT: within 1 week** If SpecHaem ANC not possible within 1-2 weeks, book next available SpecHaem ANC and use GenHaem or EmANC for review in mean time. Otherwise, refer to EmANC as **URGENT**	Where a history of VTE is given, please check clinical records to ascertain if this was a true VTE or the woman was investigated and then subsequently found to have no VTE. In the absence of any notes, a history of prolonged anticoagulation (> 6 weeks) is a good indicator.	Venous Thromboprophylaxis	
VTE Score 3 (NB: A CVT/CVST is a type of VTE)	If there is a personal history of a previous VTE, APS, or thrombophilia, then refer to the **SpecHaem ANC URGENT.** Otherwise, Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Where a history of VTE is given, please check clinical records to ascertain if this was a true VTE or the woman was investigated and then subsequently found to have no VTE. In the absence of any notes, a history of prolonged anticoagulation (> 6 weeks) is a good indicator.	Venous Thromboprophylaxis	
Multiple Pregnancy	**DCDA Twins** Refer to TwinsANC at **BESPOKE:16 weeks of gestation** **MonoChorionic/Higher Order Multiples** Refer to Fetal Medicine	Referrals will be completed by ultrasonographers on diagnosis Aspirin review	Twin & Triplet Pregnancy Aspirin	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	BESPOKE:12-16 weeks of gestation			
Gestational Diabetes	See medical endocrine section.		Diabetes in pregnancy	
LGA (Baby predicted at ≥ 95th centile on Hadlock or ≥ 4kg at term, by USS performed at term)	Refer to EmANC **URGENT.**	Check if needs GDM screen	Macrosomia GDM	
SGA/FGR **Abnormal umbilical artery doppler findings**	**BESPOKE:** For SGA, women < 34 weeks of gestation will be referred either to fetal medicine or a general ANC slot by the ultrasound sonographer, whilst women ≥ 34 weeks of gestation will be referred to the Em ANC. For FGR the woman will be referred to Triage for cCTG and review by the sonographer.		SGA/FGR	
Oligohydramnios **Polyhydramnios**	For oligohydramnios the woman will be referred to Triage for review by the sonographer. **BESPOKE**: For polyhydramnios the woman will be referred to either the Fetal Medicine or any available consultant ANC slot as per the Polyhydramnios guideline	Sonographer to perform TORCH/GDM screen if indicated	Polyhydramnios	
Grandmultiparity (≥ Para 4)	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**	Check FBC, at booking, and 28 weeks. Be mindful of maintaining Hb pre delivery i.e. watch for rate of dropping Hb between booking and 28 weeks and consider if further Hb check at 32-34 weeks indicated.		

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
Group B Streptococcus (GBS) with penicillin allergy	Do not need to be seen unless do not want to birth on CLU or wish to discuss further. Refer to consultant midwife who will refer appropriately **ROUTINE.** If birth discussions clinic not available can be booked into EmANC or CompObs ANC in a **30 minute** slot.		Birthing Against Medical Advice	
Medical – Cardiovascular System				
Cardiac conditions, including: • **Congenital Heart Disease (including any previously treated with surgery)** • **Systematic right ventricle** • **Repaired aortic coarctation** • **Hypertrophic cardiomyopathy** • **Previous peripartum cardiomyopathy** • **Reduced left ventricular ejection fraction** • **CCF (Heart Failure)** • **Cardiac Arrhythmias (including treated cardiac electrophysiology conditions** • **Cardiac Valve Disorders (including valve replacements, bicuspid aortic valve)** • **Ischaemic heart disease (angina, myocardial infarction)** • **Pulmonary Hypertension**	Referral to MatMed1 **URGENT.** If admitted to hospital under cardiology, obstetric consultant on call may need to liaise urgently with maternal medicine network – see guideline.		Complex Medical Conditions in Pregnancy Cardiac Disease in pregnancy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
• **Myocarditis** • **Heart transplant** • **VSD /ASD/ AVSD/ PFO** • **Previous cardiac surgery**				
Marfan's Syndrome **Turner's Syndrome**	Referral to MatMed1 **URGENT**. If not possible, use MatMed 2		Complex Medical Conditions in Pregnancy	
Essential/Chronic Hypertension • **Well controlled – BP ≤ 140/90** • **Poorly controlled – BP 140-159/90-109** • **Severe – BP ≥ 160/110, symptomatic/unwell**	**Well controlled:** Refer to BPObs ANC **EARLY**: 12-20 weeks **Poorly controlled:** Refer to BPObs **URGENT** (Use EmANC if not able.) **Severe:** **BESPOKE**: Refer to Triage	Requires Aspirin unless contraindicated Please obtain urine for a PCR prior to ANC Please obtain blood for FBC, UE's, LFT's prior to ANC Check that they are on "safe" pregnancy drugs	Aspirin Hypertension in Pregnancy	
Medical – Renal				
Existing renal disease - including a single kidney (excludes recurrent UTI and urinary tract reconstructive surgery/ urogynae issues)	Refer to the RenalObs ANC **URGENT: asap**	Chronic Kidney disease - Requires Aspirin unless contraindicated Please take blood for UE's and send a urine sample for a PCR.	Aspirin Complex Medical Conditions in Pregnancy Also follow management in NICE guidance NG121	
Recurrent UTI's	Refer to Em ANC **EARLY: 12-20weeks**		Complex Medical Conditions in Pregnancy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
Renal malignancy	**If current:** RenalObs ANC **URGENT.** **If previous:** See in RenalObs ANC **EARLY: 12-20 weeks.**		Complex Medical Conditions in Pregnancy	
Previous Ureteric Reconstructive Surgery	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**		Complex Medical Conditions in Pregnancy	
Medical – Haematology				
Antiphospholipid syndrome	Referral to SpecHaem ANC **URGENT.** If SpecHaem ANC not possible within 1-2 weeks, book next available SpecHaem ANC and use GenHaem or EmANC for review in mean time.	Requires Aspirin unless contraindicated	Aspirin Complex Medical Conditions in Pregnancy	
Red Cell Alloantibodies **Previous Baby Affected by HDFN** (screening will refer on to fetal medicine as required)	Screening team referral if not already done by pathology **URGENT**. Referral to General Haematology Clinic **ROUTINE: 20-24 weeks.**	Perform red cell alloantibody screenings as per plan from screening team / guideline	The Management of Women with Red Cell Alloantibodies	
Unexplained Thrombocytosis (i.e. without a clear reactive cause such as iron deficiency / acute infection)	Refer to SpecHaem ANC **URGENT**. Use GenHaem ANC if not possible.		Complex Medical Conditions in Pregnancy	
Thrombocytopaenia **Platelet Disorders**	Thrombocytopaenia that develops during pregnancy should be referred to the GenHaem clinic. **URGENT**.		Complex Medical Conditions in Pregnancy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	A prior history of a platelet disorder or a thrombocytopaenia which predates pregnancy should be referred to the SpecHaem ANC **URGENT**. Use GenHaem ANC if not possible.		Thrombocytopaenia	
Complex Haemoglobinopathies (includes sickle cell disease, beta thalassaemia major, haemoglobinopathies leading to iron overload/pulmonary hypertension)	Refer to SpecHaem ANC **URGENT**. Use GenHaem ANC if not possible. Refer to screening team.		Complex Medical Conditions in Pregnancy	
Sickle Cell or Thalassaemia Trait	Refer to screening team. **BESPOKE**: Refer to next available GenHaem ANC if anaemic and ferritin levels are not low		Complex Medical Conditions in Pregnancy	
Current or Previous VTE (A CVT/CVST is a type of VTE) **Inherited Thrombophilia**	Refer to SpecHaem ANC **URGENT**. as urgent Use GenHaem ANC if not possible.		Complex Medical Conditions in Pregnancy VTE Thromboprophylaxis	
Personal or Family History of Bleeding Disorders **Previous Baby Affected by a Bleeding Disorder** (include haemophilia, von Willebrand's, clotting factor deficiencies)	Refer to SpecHaem ANC **URGENT**. Use GenHaem ANC if not possible.		Complex Medical Conditions in Pregnancy	
Previous/Current Haematological Malignancy	If currently active: Refer to SpecHaem ANC **URGENT**.		Complex Medical Conditions in	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	Use GenHaem ANC if not possible. If prior history: SpecHaem ANC **EARLY**: **12-20 weeks**		Pregnancy	
B12/Folate Deficiency **Iron Deficiency Unresponsive to Oral Replacement / Diagnosed at ≥ 36 weeks of Gestation** (NB: oral medication for iron deficiency should be given for a minimum of 4 weeks before rechecking haematinics and compliance should be verified. Women who are unable to tolerate Ferrous Sulphate should be offered Ferrous Fumarate Syrup)	Refer to EmANC **URGENT**		Complex Medical Conditions in Pregnancy Anaemia	
Transfusion Dependent Disease	Refer to SpecHaem ANC **URGENT**. Use GenHaem ANC if not possible.		Complex Medical Conditions in Pregnancy	
Medical – Neurology				
Multiple Sclerosis	Refer to Mat Med 1 ANC: • Stable disease and unmedicated: **ROUTINE**: 20-24 weeks • Disease modifying drugs/unstable disease: **URGENT**: within 1-2 weeks. Use MatMed 2 if unable to use MatMed 1.	Ensure the patient has notified their MS nurse specialist regarding their pregnancy	Complex Medical Conditions in Pregnancy	
Epilepsy	Refer to MatMed 1 **URGENT**.	Ensure receiving folic acid 5mg	Epilepsy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	BESPOKE: If women have discontinued their medication or their epilepsy is unstable, they should be referred to the rapid review service as detailed in the epilepsy guideline as well as the below.			
Migraine **Idiopathic intracranial hypertension Raised intracranial pressure** **Cerebrovascular malformation (CVM/AVM/cavernoma)** **Intracerebral bleed** **Brain tumour** **Cerebral venous thrombosis (CVT)** **Acute stroke/CVA** **Meningitis** **Guillain Barre Syndrome** **Encephalitis** **Myasthenia gravis** **Myotonic dystrophy** **Mononeuropathy e.g.: Bell's palsy, carpal tunnel, peroneal nerve compression** **Reversible Cerebral Vasoconstriction Syndrome (RCVS)** **Posterior Reversible Encephalopathy Syndrome (PRES)** **Spinal cord injury** **Neurofibromatosis** **Neuromuscular dystrophy** **Spinal muscular atrophy**	Refer to Mat Med 1 **EARLY: 12-20 weeks** CVT see VTE section Acute Stroke - see **URGENT.**	ENSURE Screening Team aware and obtain genetics referral	CVM Refer to NICE guidance NG121 1.7.1 – 1.7.8	
Medical – Respiratory				

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
Complicated Asthma • Any medications > one preventor and one reliever (e.g. biologics) • Medicated with oral steroids in last 12 months • Any ITU or inpatient treatment • Anyone under secondary care • Any brittle/uncontrolled asthmatic • Repeated presentations of asthma (≥3) in pregnancy	Refer to Mat Med 1 ANC **EARLY: 12-20 weeks** If not possible referral to Mat Med 2 ANC as urgent.	For all women with asthma enquire about sensitivities with NSAIDS before prescribing any NSAID. Women with uncomplicated asthma should be referred if any of the criteria in column one develop. Uncomplicated asthma: • On one preventor and one reliever • Managed in primary care only • No repeated presentations of asthma	Complex Medical Conditions in Pregnancy	
Pneumonia **Restrictive lung disease (e.g. ILD, kyphoscoliosis)** **TB** **Any respiratory condition receiving immunotherapy / biologics** **Chronic Obstructive Airways Disease Bronchiectasis** **Cystic fibrosis** **Pneumothorax** **Obstructive sleep apnoea/obesity hypoventilation in pregnancy** **Lung transplant** **Sarcoidosis** **COVID pneumonitis** **Pulmonary vasculitis** **Lung cancer**	Refer to Mat Med 1 ANC **EARLY: 12-20weeks**			
Medical – Rheumatology				
Systemic Lupus Erythematosus (SLE)	Refer to Rheum Obs ANC **URGENT**.	Requires Aspirin unless contraindicated	Aspirin Complex Medical	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	If not possible, refer to Mat Med 2 or BP Obs ANC as urgent.	Take bloods for: • FBC • UE • LFT • CRP • ENA antibodies • ds DNA antibodies • C3 + C4 • Autoimmune antibodies – vasculitis	Conditions in Pregnancy	
Inflammatory arthritis (inc. Rheumatoid arthritis, Psoriatic arthritis, spondyloarthropathy)	Refer to Rheum Obs ANC **URGENT**. If not possible, refer to MatMed 1 or 2 for assessment			
Sjogren's syndrome				
Systemic sclerosis				
Inflammatory myopathies				
Vasculitis				
Behcet's disease or autoinflammatory disorders				
Hereditary disorders of connective tissue				
Osteoarthritis	Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**			
Fibromyalgia				
Chronic pain syndromes				
Ehlers Danlos				
Medical - GIT				
Inflammatory Bowel Disease (IBD)	Refer to IBDObs ANC **URGENT**.		Complex Medical Conditions in Pregnancy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
This does not include irritable bowel syndrome (IBS) which does not require ANC referral.				
Biliary Tract Disorders: • **Chronic and Current Pancreatitis** • **Primary Biliary Cirrhosis** • **Primary Sclerosing Cholangitis**	Refer to MatMed 2 ANC **EARLY: 12-20 weeks**		Complex Medical Conditions in Pregnancy	
Liver disorders: • **Liver Transplant** • **Wilson's Disease** • **Autoimmune Hepatitis** • **Liver Cirrhosis** • **Liver Infarction** • **Liver Haematoma/ adenoma**	Stable disease: refer to MatMed 2 ANC **EARLY: 12-20 weeks** Decompensated liver disease/liver failure: admission under medical team and obstetric consultant on call to liaise with maternal medicine network.		Complex Medical Conditions in Pregnancy	
GI Malignancy	**Active:** Refer to MatMed 2 ANC **URGENT**. **Previous:** Refer to MatMed 2 ANC **EARLY**: 12-20 weeks		Complex Medical Conditions in Pregnancy	
Previous Acute Fatty Liver	Refer to MatMed 2 ANC **EARLY**:12-20 weeks		Complex Medical Conditions in Pregnancy	
Medical – Infectious Diseases				
HIV **HEP B/C** **Syphilis**	Refer to screening. Refer to MatMed 1 ANC **EARLY**: 12-20 weeks.		Complex Medical Conditions in Pregnancy	

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
			Infectious Diseases	
HSV	Refer to sexual health clinic if symptomatic: 0300 123 0994 or https://www.mpft.nhs.uk/services/sexual-health/shropshire-telford-wrekin Consultant antenatal clinic slot (suitable for any). **ROUTINE: 20- 24 weeks gestation**		Complex Medical Conditions in Pregnancy Infectious Diseases	
Medical – Malignant Disease				
Any	Refer any malignant disease which falls under one of the joint clinics, to that clinic (e.g. endocrine to endocrine, GIT to gastro, renal to renal, haem to haem, etc.) Any other current or previous history of malignant disease should be referred to MatMed 2 ANC. Timings: **URGENT**: Any active malignancy **EARLY**: **12- 20 weeks** Any previous malignancy (aim early for endocrine as may have coexisting hormone imbalance)			
Medical – Mental Health/Substance Misuse				
Women with a learning disability where there is a suspected mental illness **Women with current substance misuse** **Bipolar disorder** **Schizophrenia**	**BESPOKE**: Refer to the PMHT If there are concurrent general obstetric concerns (i.e. not ones which fall into another specialist clinic) refer to the ObsMH ANC **ROUTINE: 20-24 weeks** If uncertain, please discuss with IWH midwife or the lead obstetricians for ObsMH. Safeguarding referral and referral to allied services	Women with mild depression/anxiety should be signposted to their GP and IAPT A NNA form is required for any substance misuse and those women who are medicated for their mental health. Referral to the IWH midwife – see Mental Health- Antenatal & Postnatal		

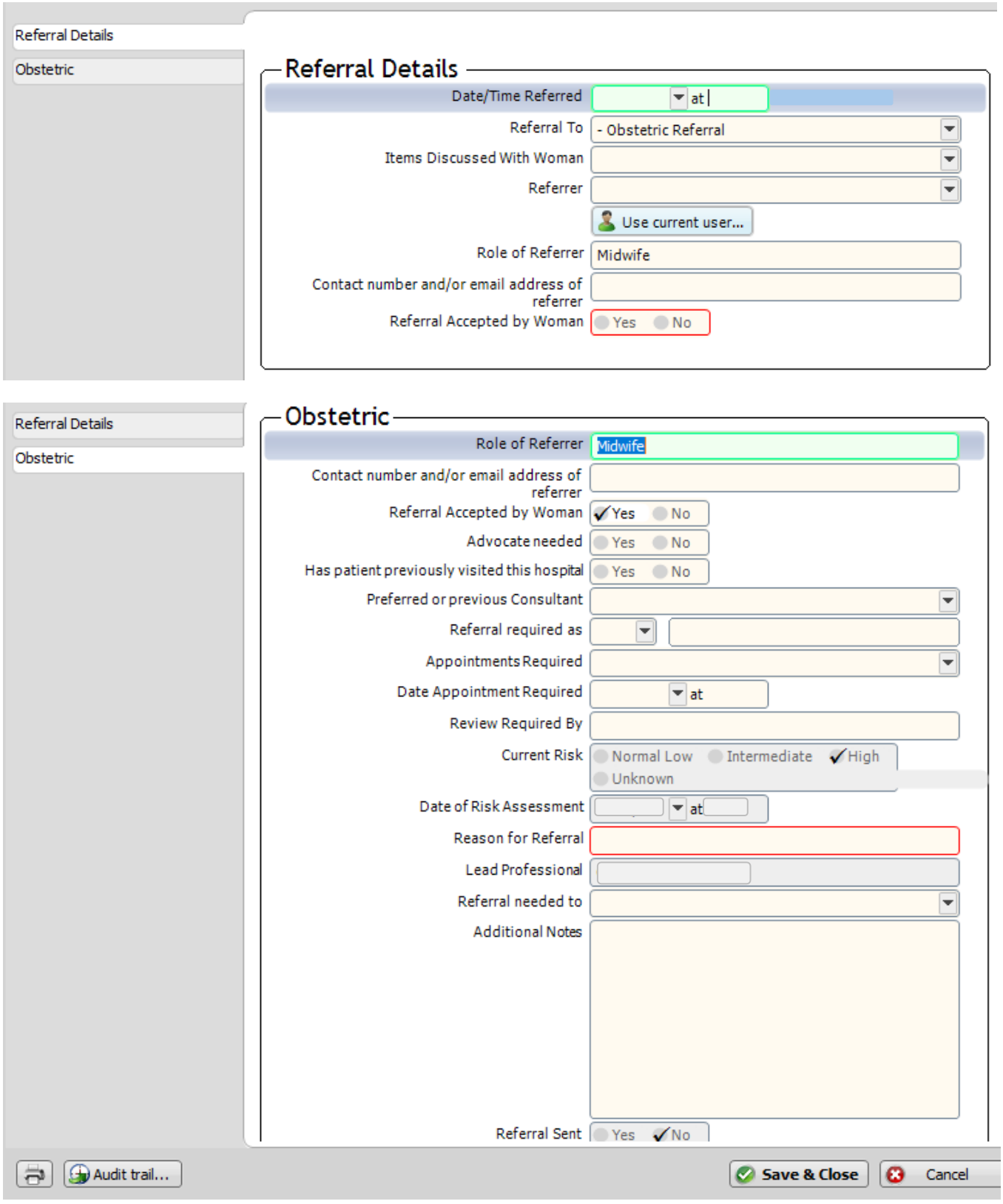
Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
Prior history of post-partum psychosis **Women suffering with moderate to severe anxiety and / or depression** **Family history of severe mental illness e.g. bipolar**	should be made in line with guidance.	Guideline for referral criteria. Where indicated identify current substance misuse community team (STARS T&W or Shropshire Services) and any treatment plan		
Medical – Learning Difficulty/Disability				
Any learning difficulty or disability which could impact a woman's ability to access care, understand procedures, provide informed consent, etc.	Refer to the ObsMH ANC **EARLY: 12-20 weeks.** Hospital liaison nurses can aid with support.	Complete a care passport.		
Medical – Endocrine				
Pre-existing Diabetes	Referral to the diabetic team. **URGENT**. Diabetic team will ensure appropriate clinic appointments are made.	Requires Aspirin unless contraindicated Ensure receiving folic acid 5mg	Aspirin	
Gestational Diabetes – Current and Previous	**Previous:** Refer to the diabetic team. **URGENT**. **Current:** Ensure the diabetic team are aware of the patient and appropriate follow up has been made (should occur automatically as arrange diabetic screening themselves).		Pre-existing and Gestational Diabetes – Antenatal, Intrapartum and Postnatal	
Hypothyroidism	No appointment is required if not on thyroid replacement unless the booking TSH > 4.6 mu/L	Take TFTs at booking for all women with thyroid disorders		

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
	Otherwise, refer to Endocrine ANC **BESPOKE: 12-16 weeks**	Advise all women on treatment to increase their thyroxine dose by 25micrograms if not already done so (send standard GP letter request) – **See Appendix 6a & 6b**		
Hyperthyroidism (Either current or previous)	Refer to Endocrine ANC **BESPOKE:12-16 weeks**	Take TFTs at booking for all women with thyroid disorders Generate neonatal alert		
Thyroid Malignancy	**Current:** Refer to Endocrine ANC **URGENT.** **Previous:** Refer to Endocrine ANC **BESPOKE: 12-16 weeks**	Take TFTs at booking for all women with thyroid disorders		
Thyroid Nodules/Goitre	Please discuss with the endocrine lead to see if ANC is required.	Take TFTs at booking for all women with thyroid disorders		
Rarer endocrine disorders: • **Macroprolactinoma** • **Microprolactinoma** • **Cushing's syndrome** • **Primary and secondary hyperaldosteronism** • **Phaeochromocytoma or paraganglioma** • **Acromegaly** • **Metabolic disorders such as glycogen storage disorder** • **Pituitary disease on hormone replacement**	Refer to Endocrine ANC **URGENT**. If unable to obtain endocrine appointment, please discuss with lead for endocrine clinic.			

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
therapy • **Hyperparathyroidsm**				
Surgical – Previous Cervical Surgery				
LLETZ • **Single procedure depths 15mm and over** • **Multiple procedures** • **Any performed under GA** **Knife cone biopsy**	If a woman has had two term deliveries since her procedure(s), referral to the ANC is not required. **BESPOKE**: Refer to PTB ANC as per guideline (Tables 1+2)	Provide Leaflet on Preterm Birth Prevention Clinic via Badgernet Depth of LLETZ should be stated on the histology report - can be located on Clinical Portal/Review (depth is the 3rd number eg 12X10X15mm)	Preterm Labour	
Surgical – Previous Uterine Surgery				
Uterine Septum Resection **Surgery for Uterine Anomalies** **Cornual Resection for Interstitial Ectopic.** **Previous Uterine Perforation.** **Uterine Reconstructive Surgery (following uterine rupture, myomectomy, etc.)** Please do not refer surgeries performed on structures outside the uterus (endometriosis surgery/ablation, tubal surgery, ovarian surgery, etc.) – see section below for these.	**BESPOKE**: Refer to PTB ANC as per guidance (Tables 1+2)	Provide Leaflet on Preterm Birth Prevention Clinic via Badgernet		
Surgical – Previous Pelvic Surgery				
Previous Complex Surgery for IBD (Hemicolectomy, small bowel	Refer to IBD section in medical disorders	Request previous surgical notes via Antenatal Midwives		

Risk Factor	Referral	Additional Actions	Guideline Link	Clinic Code
resection, etc.)				
Surgery Related to a Specific Organ	Refer to the relevant section in medical disorders e.g. lung to respiratory, Urological – gen ANC covered by urogynae consultant	Request previous surgical notes via Antenatal Midwives		
All Other Complex Pelvic Surgery or Diagnostic Procedures Revealing Complex Pathology	Any surgery which could reasonably be considered to lead to difficulties with performing an emergency caesarean section within 30 minutes. Straight forward removal of an **unruptured** appendix, ovarian cyst, gallbladder, etc. would not fall within this category, but ruptured viscera, laser/resection for severe endometriosis, ureteric surgery, etc. may as it could be anticipated that: • The anatomy within the pelvis may have been altered to the extent that CS delivery will be difficult • The formation of adhesions within the pelvis could be such that CS delivery will be difficult Discussion with any obstetric consultant prior to 20 weeks of gestation to determine if review in any ANC is required at 20-24 weeks and which clinic is most suitable.			

Appendix 5- Process for completing referral on BadgerNet



Appendix 6a – GP letter

The Shrewsbury and Telford Hospital NHS Trust

FAO Duty Doctor

Maternity Outpatients and Scan department
Princess Royal Hospital
Telford
TF1 6TF

Date

Dear Doctor

Name

DOB

NHS No

Your patient has been referred to the Combined Endocrine Antenatal clinic because she is taking thyroxine replacement and is now pregnant.

She will have an appointment with the endocrinology team early in pregnancy to discuss management of her thyroid problem.

In the meantime, we are advising an increase of her thyroxine prescription by 25mcg daily starting as soon as possible. However, if she has had a TSH result of below 0.2 mU/l in the past 6 weeks, please do not increase the thyroxine dose and continue with the current dose.

Please note, the target TSH range is 0.2 – 2.0 mu/l in early pregnancy.

If you need any further information, please contact:

Princess Royal Hospital 01952 641222 ext 5646

Thank you.

Yours sincerely,

Dictated but not signed

Dr David Barton, Consultant Endocrinologist
Dr Anna Green Consultant Diabetes, Endocrinology and Acute Medicine
Mr Guy Calcott Consultant Obstetrician

Appendix 6b – Patient Letter

The Shrewsbury and Telford Hospital NHS Trust

Maternity Outpatients and Scan department
Princess Royal Hospital
Telford
TF1 6TF

Date

Dear

Congratulations on your pregnancy.

At your booking appointment you reported that you have hypothyroidism and take daily thyroxine.

Now that you are pregnant it is recommended that you increase your daily thyroxine dose.

A letter has been sent to your GP to update your regular prescription and advising you to increase your dose by 25 mcgs unless you have had a recent low TSH (below 0.2 mU/l). Please contact your GP for the updated prescription.

If there are delays in updating your prescription, we recommend that you double the dose of the levothyroxine on two days each week and have your usual levothyroxine dose on the other 5 days of the week. You can then start the higher levothyroxine dose as soon as it becomes available.

You will have a consultation to discuss the plan for managing your thyroid problem during your pregnancy.

This appointment will be sent to you shortly and may be before or just after your dating scan.

If you need any further information, please contact
Tel: 01952 641222 Ext 5646

Yours sincerely,

On behalf of:
Dr David Barton, Consultant Endocrinologist
Dr Anna Green Consultant Diabetes, Endocrinology and Acute Medicine
Mr Guy Calcott Consultant Obstetrician