WOMEN'S HEALTH AND PAEDIATRICS

MATERNITY UNIT

Indications for referral to Obstetric Antenatal Clinic

Standard Operating Procedure

Amendments			
Version	Date	Comments	Approved by
V1	April 2020	Implemented as part Covid response	Rapid ratification process
V2	June 2021	SOP / Guideline adopted as business as usual	Perinatal Guidelines group
V3	Oct 2022	Updates: Named Link Consultant process and midwifery teams in line with Ockenden Change to email referral process Return to default of in person reviews Updated referral indications	Perinatal Guidelines group

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Date ratified: **December 2022**

Next review date: **October 2025**

Target audience: This document is to be used by midwives, sonographers and obstetricians.

Equality impact assessment: Perinatal Guidelines Group

Comments on this document to: Perinatal Guidelines Group

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Abbreviations

OD – Daily
MW – Midwife
FBC – Full Blood Count
USS – Ultrasound Scan
LLETZ – Large Loop Excision of the Transformation Zone
SOP – Standard Operating Procedure

Indications for Obstetric Review

1.0 Introduction

The tables below outline the criteria to be used when referring a woman for an Obstetric review.

The information within this document is not exhaustive. If uncertainty exists about the need for review please seek further advice from your team leader, maternity matron or maternity bleep holder.

This document is to be used by midwives, sonographers and obstetricians.

SOP to be used in conjunction with other relevant guidelines – antenatal care, anaesthetic, preterm birth, fetal growth surveillance, Tommy's pathway etc.

2.0 Responsibility for referral

This will usually be the Booking or Named midwife at the time the risk is identified.

On occasion risks may arise in the pregnancy. The obstetric referral will be the responsibility of the clinical team who identify the risk and the need for referral. A structured review of risk should be undertaken and documented at each antenatal contact.

3.0 How to refer

Non-Urgent Referrals:

- Refer via Badgernet – 'obstetric referral'
- Women should be referred **at the earliest opportunity**.
- Maternity admin staff to book appointment and send letter confirming appointment
- The maternity service has now returned to the usual model of care with reviews in person (face to face) and in line with national guidance
- Women may request to have their appointment by telephone if they are deemed suitable

Urgent Obstetric Referrals:

Complete a Badgernet – 'obstetric referral'

Telephone Maternity Reception – 01932 722366 or discuss with team leader / MOC

For complex women refer via Badgernet as follows:

- Perinatal mental health (follow pathway) Asp-tr.pmh@nhs.net
- Preterm birth risk (see table): asp-tr.ptbclinicreferral@nhs.net
- Screening abnormalities Asp-tr.anscreening@nhs.net
- Anaesthetic review Asp-tr.labour.wardreferrals@nhs.net
- Birth Reflections (wellbeing referral) Asp-tr.birthreflections@nhs.net
- Diabetes midwives asp-tr.diabetes.midwives@nhs.net

4.0 Process for Named Consultant

Women who fulfil the criteria for Consultant led care will have their 'named Consultant' clearly identified in the relevant field on Badgernet.

Women may be low risk at booking and develop a complication requiring referral to obstetric led care – these women will also have a named obstetric Consultant.

Women who remain suitable for midwifery led care will be discharged with a clear plan from the Antenatal Clinic to their midwifery team.

4.1 Specialist Antenatal Clinics

Women who fulfil the criteria for specialist ANC – link Consultant as per that service

Specialist Clinic	Named Consultant
Diabetes and Endocrine	Temp cover SMcD and KL (pending substantive appt)
Fetal medicine	SMcD
Maternal Medicine	KL
Multiple pregnancy and Cardiac	JH
Perinatal mental Health	SH
Pelvic Floor	GT
Preterm Birth	LU

4.2 General Antenatal Clinics

Women requiring review in a general ANC – geographical post code based link Consultant

Team (Community Hub)	Postcode	**Named Consultant**
Ashford Hub	GU25	ALB
	TW15	
	TW16	
	TW17	
	TW18	DW
	TW19	
	TW20	
St Peter's Hub	KT12	JAP
	KT14	
	KT13	JC
	Part KT15	
	KT16	
Woking Hub	GU21	NIN
	GU22	
	Part KT15	
Out of Area	All postcodes outside above	SMcD

5.0 Previous Obstetric History

Previous Obstetric History	Details	Obstetric Review Timing
Stillbirth		Within 2-3 weeks of booking and by 16 weeks
Pre-eclampsia	Tommy's Placental dysfunction assessment (or refer to SOP if late booker) If PET leading to delivery less than 34 weeks, then refer to maternal medicine	14-20 weeks
Previous Caesarean section		28-30 weeks
2 or more Caesarean sections		28-30 weeks
3rd- 4th degree tear (OASI)	Refer to pelvic floor clinic	14-28 weeks
Previous preterm birth secondary to likely uteroplacental insufficiency (<34 weeks)	Refer to fetal medicine	14-20 weeks
Previous baby > 5kg	Refer for GTT if previous baby >4.5kg	32-36 weeks
Shoulder dystocia		32-36 weeks
Postpartum haemorrhage >1 litre		32-36 weeks
Retained placenta on 2 occasions **(Not RPOC following miscarriage)**		32-36 weeks
Delivery complicated by HDU /ITU admission		14-20 weeks
Previous neonatal death		Within 2-3 weeks of booking and by 16 weeks

Previous neonatal GBS sepsis **(Not prev GBS positive)**		14-20 weeks

6.0 Previous Gynaecological Complications

Previous Gynaecological Complications	Details	Obstetric Review Timing
Myomectomy or other uterine surgery **(Hysteroscopy or surgical management of miscarriage do NOT require a review)**		14-20 weeks
Fibroids (>5cm or cervical / lower segment) – Small fibroids do NOT require a review.		32-36 weeks
Uterine malformation		14-20 weeks
Recurrent miscarriage WITH thrombophilia identified and on aspirin/LWMH		14-20 weeks

7.0 Preterm Birth Pathway

Preterm Birth Pathway	Details	Obstetric Review Timing
Previous treatment to cervix **(Abnormal smears, colposcopy or cervical biopsy do NOT need a preterm birth review).**	LLETZ Cone biopsy Booking MW to highlight need for cervical length at anomaly scan within management plan on Badgernet.	Cervix< 20 mm same day review in DAU Cervix 20-25mm sonographer to refer to next preterm birth clinic via maternity reception
	Trachelectomy	12-14 weeks Preterm Birth Clinic (Ideally after nuchal scan)
Uterine anomaly	Known uterine variant (unicornuate uterus, uterine didelphys etc)	
Previous caesarean section at full dilation	Booking MW to highlight need for cervical length at anomaly scan within management plan on Badgernet.	Cervix< 20 mm same day review in DAU Cervix 20-25mm sonographer to email Preterm birth clinic via BadgerNet
Preterm birth (spontaneous onset) or SROM <34 weeks or miscarriage 14-24 weeks	Preterm birth team to review referrals	Individual plan for cervical lengths and infection screen
Previous cervical cerclage or current short cervix (<25mm)	Preterm birth team to review referrals	Individual plan for cervical lengths and infection screen

6.0 Other Risk Factors

Other Risk Factors	Details	Obstetric Review Timing
Multiple pregnancy	Multiple pregnancy Clinic and Complex care team	Within 1-2 weeks of booking or diagnosis (follow NICE guideline)
Maternal age yo at booking	Follow Tommy SOP / pathway Refer if on moderate or high pathway	16-24 weeks
Maternal age 45yo or more at booking	Refer to link consultant clinic	14-20 weeks
Low BMI <18 WITH eating disorders identified		14-20 weeks
High BMI >35	If BMI >40 may also need anaesthetic referral (see guideline)	14-20 weeks
Women declining blood products	Only women who would refuse lifesaving blood products (not those who would prefer to avoid but would accept)	14-20 weeks
Women with mental health disorder	Refer to PMHT – follow guideline	14-20 weeks
Women using illegal drugs or alcohol more than 5 units per week	Complete RSF as per guideline	Within 1-2 weeks of booking
Maternal choice Caesarean section request - no medical reason	Offer referral to Birth Reflections if suspected tokophobia / previous birth experience Offer Consultant midwife for all others These are offers and are not to be mandated.	14-20 weeks Do NOT need a 2nd Consultant review Unless clinical concern about informed choice and balance risks and benefits
Previous Anaesthetic complications or 1st degree relative serious anaesthetic complications	Obstetric Anaesthetic referral via Badgernet See anaesthetic referral guideline	20-32 weeks

Other Risk Factors	Details	Obstetric Review Timing
Migrant / Refugee woman	Consider RSF referral	14-20 weeks – or if additional concerns later in pregnancy

7.0 Referrals Arising During Pregnancy

Referrals arising during pregnancy	Details	Obstetric Review Timing
Fetal abnormalities	Sonographer / screening: As per ultrasound / FASP guideline	Individualised plan
Fetal growth concerns - small for gestational age	Sonographer: Follow growth scan flowchart	Individual plan, check BP and urine
Tommy's Placental Dysfunction - High or Moderate risk pathway	Follow SOP for scans and aspirin	Named Consultant ANC at 37 weeks to plan timing of birth – refer at time of running the placental function assessment
Large for gestational age (EFW>95th centile)	If <36 weeks – arrange GTT Sonographer Follow growth scan flowchart If >36 weeks – refer to fetal surveillance pathway	Link Consultant ANC at 36 weeks if GTT normal Refer to Fetal Surveillance Pathways Offer IOL 38-39 weeks
Atypical antibodies	Community midwife to Refer to screening team when diagnosed	From diagnosis
Low placenta after 36 weeks (no previous uterine surgery)	If placenta more than 20mm from the os discharge and continue care pathway	If placenta less than 20mm from os - Sonographer to refer via Badgernet to AN Team Leader ANC within 1 week of scan at 36 weeks
Abnormal fetal lie after 36 weeks (breech/transverse lie)	Confirm on scan first (community midwife to refer for scan on x2665)	After 36 weeks
Follow up after antenatal admission	Ward clerk to book appointment or Ward MW	Only if clinically indicated

Gestational hypertension	Follow hypertension pathway Arrange named cons ANC Ongoing surveillance in DAU with Consultant ANC oversight	General ANC Within 1-2 weeks of diagnosis
Gestational Diabetes – new diagnosis	Refer to Diabetes team via Badgernet Follow diabetes guideline	Within 1-2 weeks of diagnosis
Genital Herpes • **Recurrent episodes secondary** **(primary managed acutely)**		General ANC 28-32 weeks
Palpitations **(where 24hr tape arranged and follow-up felt needed)**	Arrange 24hr tape if needed Check FBC and TFT Triage / Community Midwife to refer via BadgerNet	General ANC within 2-4 weeks to review result (only maternal medicine pathway if new arrhythmia identified)
Low Hb (<100) at 34 weeks or more	Manage as per anaemia in pregnancy guideline	General ANC
Recurrent and ongoing RFM – no cause found on scan		General ANC within 1-2 weeks
Recurrent APH	Community midwife or ward team to refer	General ANC within 1-2 weeks
Requesting 'Birth Outside Guidelines'	Refer to Consultant Midwife or ABC lead Individual plan for obstetric referral after personalised birth planning	General ANC 28-34 weeks – Consultant review
Woman requests obstetric review in ANC	Discuss concerns and indications for referral Support referral in line with personalised care if wished	General ANC within 4-8 weeks of referral

8.0 Medical Risk Factors

Medical Risk Factors	Details	Obstetric Review Timing
Hyperthyroidism **Adrenal or Pituitary disorders**	Diabetic endocrine clinic	14-20 weeks
Hypothyroidism • **Known and managed by GP**	Follow guideline and check TFT booking, 28 and 34 weeks	Only if TSH>10 or thyroxine dose more than 200mcg
Hypothyroidism • **New diagnosis in current pregnancy**	Follow guideline and check TFT booking, 28 and 34 weeks	General ANC within 2-3 weeks of referral
Hypothyroidism • **TSH >10 or thyroxine 200mcg or more**	Diabetic endocrine clinic	DiabANC or Maternal medicine within 2-3 weeks referral
Pre-existing Diabetes • **Type 1 or 2**	Diabetic endocrine clinic	Within 1-2 weeks of self-referral / booking
Respiratory disease • **Asthma requiring hospital admission in last year or prior ITU admission** • **Cystic fibrosis** • **Pulmonary fibrosis**	Maternal medicine pathway	14-20 weeks
Hypertension • **On medication at booking or started prior to 20 weeks** • **Preeclampsia less than 34 weeks**	Maternal medicine pathway	Within 2-3 weeks of booking and by 16 weeks
Cardiac disease • **Not previous murmur and normal ECHO** • **Not prev palpitations with no ongoing cardiology input**	Maternal medicine Pathway	Within 2-3 weeks of booking and by 16 weeks
Gastro-intestinal • **Liver disease**	Maternal medicine pathway	14-20 weeks

Medical Risk Factors	Details	Obstetric Review Timing
• Inflammatory bowel disease (Crohn's or Ulcerative colitis) • Not IBS		
Infection • Hepatitis B and C • Other (CMV, toxoplasmosis etc)	Screening team – follow Infectious Diseases pathway	From screening result 14-20 weeks
• HIV diagnosis • Tuberculosis	Maternal medicine	14-20 weeks
Autoimmune disease • SLE, rheumatoid arthritis, scleroderma etc • NOT hypermobile joints, fibromyalgia or chronic fatigue / ME	Maternal medicine pathway	Within 2-3 weeks of booking and by 16 weeks
Haematological • Haemoglobinopathies (not traits) • ITP • Von Willebrands disease • Bleeding disorders	Maternal medicine pathway	Within 2-3 weeks of booking and by 16 weeks
Neurological • Epilepsy • Myasthenia gravis • Previous CVA • NOT migraines	Maternal medicine pathway	Within 2-3 weeks of booking and by 16 weeks
VTE: DVT or PE – not superficial thrombophlebitis • Personal previous history • New diagnosis in current	Follow VTE pathway – start LMWH as appropriate	Within 2-3 weeks of booking and by 20 weeks
VTE - FHx 1st degree relative	Follow VTE guideline to assess need to screen or refer	
Malignant disease	Maternal medicine pathway	Within 2-3 weeks of booking and by 16 weeks

*If uncertainty exists about the need for review please email the antenatal clinic team leader or named link consultant and seek advice.

9.0 Patients Not Requiring Obstetric Referral

The following **DO NOT** need to be referred for obstetric review unless other risk factors identified, but may need a personalised care plan:

• Previous Postpartum haemorrhage 500-1000 mL
• Verbal history of fibroids not reported on the ultrasounds
• IVF pregnancy (even if on progesterone) – this is included within the Tommy's placental dysfunction risk assessment
• Recurrent miscarriage unless thrombophilia identified and on aspirin/LWMH
• Past history of asthma not currently medicated *or* managed by GP and stable
• Gynaecological history of colposcopy, abnormal smear tests now normal, cervical biopsy
• Previous GBS positive but no neonatal sepsis or preterm birth
• Previous obstetric cholestasis – refer to DAU if symptoms develop
• PCOS or previous GDM – arrange GTT and follow pathway if abnormal
• Hypothyroidism – known, TFT normal and managed by GP. Follow guideline.
• Previous baby >4.5kg – arrange GTT, if normal midwifery led care. See SOP if >5.0kg
• Complex social vulnerability – refer to safeguarding team, individual case by case if obstetric input required
• Teenage pregnancy less than 19yo – Fetal growth surveillance pathway