The Scottish Government
Children and Families Directorate

Scottish Government
Riaghaltas na h-Alba

Dear Colleagues,

Maternity Services Policy:

- **Racialised Health Inequalities Action Plan, Interpretation Toolkit and Evidence and Data Resource (Annex A – C);**
- **Pathway of Maternity Care clinical guidance and schedule and information leaflet on Birthplace Decisions (Annex D – E); and**
- **Miscarriage Framework and Progesterone Pathway (Annex F – G).**

1. This Circular informs NHS Boards of a suite of new publications for implementation/consideration by Health Boards. Specific asks for each area are given in this letter. All documents are attached and will be published on the Scottish Government website shortly.

2. They have been produced to support the aim of improving maternity and neonatal care in Scotland. A co-development approach has been taken, drawing on expertise of our clinical and third sector partners. Please see the annexes for the full suite of documents.

Racialised Health Inequalities Action Plan and interpretation toolkit

Background

3. Whilst the inequalities in outcomes for pregnant women and babies from black and Asian backgrounds have been improving (5x more maternal deaths of black women in 2019 to 3.8x more in 2023 at a UK level), these inequalities still persist and are present in Scotland. A Short-Life Working Group (SLWG) on Racialised Health Inequalities in Maternity Care was established in January 2023, which met five times during 2023-24. The group developed three key deliverables: an action plan, interpretation toolkit and an evidence and data resource.

DL (2025) 02

6 February 2025

Addressees

For action

NHS Board Chief Executives,
Medical Directors,
Nurse Directors,
Clinical Directors,
Directors and Heads of Midwifery

For information

NHS Directors of Finance

Enquiries to:

Maternal and Infant Health Team,
Children and Families Directorate,
Scottish Government,

MaternalandInfantHealth@gov.scot

Action

4. The action plan and implementation toolkit are for immediate consideration to inform planning and support local activity.

5. The action plan outlines actions identified by the SLWG as priorities over the next 3-5 years, from date of publication. Boards should start now to integrate the toolkit into practice.

6. The evidence and data resource is included with this letter to support NHS Boards focusing on perinatal care as part of their anti-racism planning.

Pathway of Maternity Care clinical guidance and schedule and Information Leaflet on Birthplace Decisions

Background

7. 'The Best Start: Five-Year Forward Plan for Maternity and Neonatal Care', Scotland's plan for improving maternity and neonatal services, recommended that the 2009 Pathways for Maternity Care should be revised at a national level and that national, standardised core information should be made available on the range of safe birth settings to support women's choice. An expert group was convened to develop the resources, and a consultation exercise was carried out in summer 2024 and revised drafts agreed with the Best Start Implementation Programme Board in December 2024.

Action

8. NHS Boards will be required to move over to the new Pathway by April 2025, with full implementation by this date. The leaflet will be available on gov.scot from publication, and shared through clinical networks. It will also be made available on platforms including Badgernet and Ready Steady Baby!. It should be introduced to women linked to antenatal discussions about place of birth.

Delivery Framework for Miscarriage Care and Progesterone Pathway

Background

9. The Scottish Government committed through the Programme for Government 2021/22 and 2023/24 to improving miscarriage care. The Delivery Framework for Miscarriage Care in Scotland was developed by an expert Short Life Working Group, along with a writing group, and outlines a plan for introducing a graded model of miscarriage care in Scotland. Scottish Government officials, professional advisers and expert NHS healthcare professionals developed a Scottish Government/NHS Scotland Progesterone pathway for women who have had at least one previous miscarriage, and early pregnancy bleeding.

Action

10. The framework contains actions for next 6, 12 – 15 and 15 – 24 months. The status given to each action should help NHS Boards prioritise change and move to a One

Scotland approach. The Progesterone Pathway should be implemented within 6 months from publication.

11. We will require action plans on delivery of the Framework and Progesterone Pathway and will provide a template for NHS Boards to complete.

Monitoring Implementation

12. Implementation of each of these new workstreams will be monitored through the Annual Delivery Plan reporting process. A monitoring framework which includes this process and existing maternity services monitoring processes will be developed to coordinate the requests for data from NHS Boards. We expect to share the performance management framework and further information on monitoring requirements by April 2025.

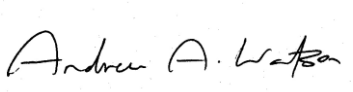
Timescales

Name	Implementation target date
Racialised Health Inequalities Implementation Toolkit	Integrated into practice from date of publication
Information Leaflet on Birthplace Decisions	Integrated into practice from date of publication
Pathway of Maternity Care clinical guidance and schedule	April 2025
Progesterone Pathway	Within 6 months from publication
Delivery Framework for Miscarriage Care	Individual actions: majority between 6 – 15 months from publication with remaining between 15 – 24 months from publication.
Racialised Health Inequalities Action Plan	Individual actions: between 3 – 5 years from publication

Your ongoing commitment to the improvement of maternity and neonatal services is helping to ensure women, babies and their families receive high-quality, safe care and I am grateful for your continued efforts.

If you have any queries please contact MaternalandInfantHealth@gov.scot.

Yours sincerely,



ANDREW WATSON
Director, Children and Families

Annex A: Racialised Health Inequalities Action Plan

Tackling Racialised Health Inequalities in Maternity Care

Action Plan

Deliverable 1
Short-Life Working Group

Version 1, February 2025

Foreword from Minister for Public Health and Women's Health

I hear from stakeholders, researchers and community organisations about the impacts these disparities have on women and families and know there is more to be done.

Across Scotland, we are fortunate to have organisations, like Amma Birth Companions (a Glasgow charity that supports women and birthing people from migrant backgrounds) and KWISA, Women of African Descent in Scotland (an African women-led organisation based in Edinburgh), advocating for and amplifying the voices of women and families from racialised and marginalised communities. I have had the privilege of hearing firsthand about the impact of racism and racialised inequalities, and of seeing the hugely positive work undertaken by third sector organisations across Scotland.

Disparities in outcomes and experiences for women and babies from minority ethnic communities are unacceptable. It is incumbent on us to understand those disparities and identify meaningful action to address them. Maternity services meet women and families at a unique window in their lives and have the opportunity to provide women and their babies with the best possible start in life. That is why our Programme for Government 2024-25 reaffirms our ongoing commitment to the implementation of continuity of carer under *The Best Start*, prioritising those who are most likely to benefit, including women from minority ethnic communities.

I am grateful to the Co-chairs of the Short-Life Working Group on Racialised Health Inequalities in Maternity Care for their leadership in taking forward this work and I would like to extend my thanks to every member of the Short Life Working Group (the SLWG) for their engagement, drive and dedication to tackle racialised health inequalities and the impact of racism on women and families in Scotland's maternity and neonatal services. Its work demonstrates the power of collaborative working and coproduction.

The outputs from the Group will support NHS Boards in developing their anti-racism plans, as well as support frontline staff to deliver the high-quality, equitable service they want to provide for all women and their families.

We recognise that structural racism persists in Scotland, including within our NHS. Tackling racialised health inequalities is a priority for the Scottish Government and our 2024-25 Programme for Government makes clear our commitment to embedding antiracism across the public and third sectors.

To address the ongoing inequalities and injustices experienced by minority ethnic communities in Scotland, we must take a firm anti-racism stance. The Cabinet Secretary for Health and Social Care's anti-racism statement, in September 2024, set out clearly this government's position and expectations on anti-racism.

As we move forward and address the actions highlighted in this plan, we must continue to listen carefully to those with living expertise and create and maintain the conditions for meaningful feedback and participation. The title of the recent report by KWISA Women of African Descent in Scotland – *Nothing About Us Without Us* – is a powerful reminder of this. We will work with national and local partners to respond to and deliver against these actions and look forward to building on the work of the SLWG in partnership with third sector and community organisations.

As Minister for Public Health and Women's Health, I am determined that, where we identify inequalities and inequities in healthcare, we address them. This plan represents an important starting point from which to build momentum.

Jenni Minto MSP

Foreword from the Co-chairs of the Short Life Working Group on Racialised Health Inequalities in Maternity Care

Since March 2023, it has been our privilege to co-chair the Short-Life Working Group (SLWG) on Racialised Health Inequalities in Maternity Care. We know that the existence and impact of racialised inequalities and disparities are well-documented issues across the healthcare system as a whole and that, as part of that wider system, maternity services are also affected by these issues. Immediate action is required to address these inequalities and inequities, to improve outcomes and experiences for women and families from racialised communities.

The SLWG took a coproduction approach, bringing together a wide and diverse membership united in their ambition to tackle racialised health inequalities in maternity care. We are hugely grateful to every member of the SLWG for sharing their expertise, insights and experiences so generously. Your drive, energy and commitment to listening to living expertise, responding to the evidence and delivering positive change is invaluable. At all stages of the group's work, we have been well supported by Secretariat from the Scottish Government's Maternal and Infant Health team, for which we are very grateful.

From the start, the focus of our work has been on taking a positive, constructive approach, focusing on practical action to make a difference for service users now while building momentum and establishing a foundation – and learning – for longer-term progress. This action plan, informed by the group's expertise, the evidence base and reports of lived experience and expertise, is intended to focus attention on these inequalities across all parts of our healthcare system and to accelerate progress.

We all have a part to play in tackling these inequalities and we must ensure that we build in opportunities to share learning and emerging

good practice across the system, to build momentum and accelerate the pace of change.

To build on the work of the SLWG, we will write to the Chairs of established groups and forums to reinforce the need for us all to maintain an ongoing and unrelenting focus on tackling racialised health inequalities in perinatal care.

Members of the SLWG demonstrated to us the importance and value of building networks of colleagues across the system who feel empowered and connected to drive forward the changes we need to tackle racialised health inequalities. The deliverables of the SLWG represent our collective first steps towards this shared aim. We thank you for your work on this so far and look forward to working with our colleagues across the wider system in the months and years to come.

Dr Alastair Campbell
Consultant Obstetrician, NHS Lothian, and Co-chair of Scottish committee of the Royal College of Obstetricians and Gynaecologists (RCOG)

Maree Aldam
Chief Executive Officer of Amma Birth Companions

Introduction

Background

Tackling racialised health inequalities in maternity and neonatal (perinatal) services is a priority. Disparities in experiences and outcomes for women from minority ethnic communities across the UK are well documented in data, audit reports and confidential enquiries, and reports detailing the experiences of women and their families.

We established the Short-Life Working Group (SLWG) on Racialised Health Inequalities in Maternity Care in January 2023. Co-chaired by Maree Aldam, CEO of Amma Birth Companions, and Dr Alastair Campbell, NHS Lothian Consultant Obstetrician and Co-chair of the Scottish Committee at the Royal College of Obstetricians and Gynaecologists (RCOG), the SLWG met five times between September 2023 and May 2024

The SLWG took a coproduction approach, underpinned by data and evidence, and identified three key deliverables:

- Deliverable 1: Action Plan.
- Deliverable 2: Best Practice Toolkit: Working with Interpreters in Maternity and Neonatal Services, and
- Deliverable 3: Scoping of Data and Evidence.

Taken together, these set out the next steps identified by the SLWG towards tackling racialised health inequalities in perinatal care in Scotland. We are committed to working with national and local partners to respond to and deliver against the individual actions in this plan and look forward to building on these first steps in partnership with NHS, third sector and community organisations.

Language and Terminology

This document will use the term women/ woman throughout as this is the way that the majority of those who are pregnant and having a baby will identify. For the purposes of this document, this term includes girls.

However, we recognise that this will not necessarily reflect the identities and experiences of everyone who will access maternity care. For example, some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience pregnancy. All healthcare services should be respectful and

responsive to individual needs and all individuals should be asked how they wish to be addressed throughout their care.

Membership

The group brought together a wide range of expertise that informed its discussions. Lived expertise and experience has informed the group's focus at all stages of its work and has been represented by third sector involvement both in leadership and membership of the group. **Annex A** details the membership of the group.

Timescales

The SLWG defined the timescales assigned to actions in the plan as follows:

Term	Timescale
Immediate	By Spring 2025

Timescale	Within (from date of publication)
Shorter-term	1 year
Medium-term	1-3 years
Longer-term	3-5 years

Progress by end 2024

This group provided an initial forum to bring together emerging conversations about how best to tackle racialised health inequalities in maternity and neonatal care. Through this, it became clear that there were more immediate opportunities to draw together threads of emerging good practice and make connections across the system to accelerate progress, in parallel to the SLWG.

Since the launch of this work in January 2023, we have:

- Written to NHS Boards, advising them to prioritise the implementation of continuity of carer under the *Best Start* for women with known poorer outcomes, including women from minority ethnic communities. The Scottish Government's Programme for Government 2024-25 reaffirms this ongoing commitment.
- Supported the Scottish Perinatal Network, following our commissioning of specific work on local maternity engagement.
- Further developed relationships with undergraduate midwifery higher education institutions (HEIs) through NHS National

Education for Scotland (NES) and the Midwifery Education Group Scotland.

- Deepened connections with Healthcare Improvement Scotland (HIS) and Scottish Patient Safety Programme (SPSP) Perinatal to support NHS Boards to adopt quality improvement activity to respond to locally identified inequalities in experiences and outcomes, including racialised health inequalities.
- Supported key stakeholder meetings bringing together senior leaders in NHS Scotland's maternity services to have racialised health inequalities on the agenda regularly allowing opportunities for sharing good practice.
- Developed a Delivery Framework for Miscarriage Care in Scotland with an expert Short Life Working Group, with wide representation, including from third sector partners. The Framework is being published for NHS Boards to action at the same time as this Action Plan.
- Continued our work to revise the Pathways for Maternity Care in line with recommendation 11 of *The Best Start*. The revised Pathway will support the provision of antenatal care that ensures all aspects of a woman's circumstances are considered and addressed providing individualised care.
- Work continues in parallel to integrate and embed antiracism and intersectionality in tackling inequalities as key strands of the Scottish Government's perinatal safety work from the outset of its development.
- Work is ongoing to establish a process for audit report monitoring and outlier identification to respond in a systematic way to emerging data/ evidence.
- Developed relationships across the Scottish Government to enhance alignment of cross-cutting work on antiracism in Health and Social Care, including ensuring inclusion of perinatal safety as a key area of focus for NHS Boards in their antiracism planning, based on the strength of data and evidence in perinatal services.

NHS National Education for Scotland (NES) has initiated work through the Scottish Multiprofessional Maternity Development Programme (SMMDP) to respond to key themes emerging through the SLWG and wider data and evidence.

Development of simulation scenarios which encompass the care of a woman for whom English is an additional language is ongoing. These

scenarios will form part of existing core mandatory training through the SMMDP.

Public Health Scotland (PHS) has worked with NHS Boards to sustain improvements in the completeness and accuracy of maternal ethnicity data recording and reporting. PHS has considered collecting data on self-identified ethnicity of the father and further work will be required to ascertain if and how this data should be collected.

Healthcare Improvement Scotland (HIS) relaunched the Scottish Patient Safety Programme (SPSP) Perinatal in 2023, renewing the support available for NHS Boards to support locally-identified quality improvement (QI) activity, including in tackling racialised health inequalities in perinatal (maternity and neonatal) services.

The Scottish Perinatal Network (SPN) is progressing various programmes of work to address health inequalities. Their work on pathways and guidance seek to improve consistency in the standard of care and choices available to women.

SPN is also maintaining the national Safeguarding Groups that support professionals whose remits include safeguarding pregnant women and families with complex social needs, for example those affected by poverty, gender-based violence or disabilities.

SPN is also bringing together professionals and families with neonatal care experience to develop an inclusive national Neonatal Family Integrated Care (FICare) approach for Scotland. In parallel, the Scottish Maternity Engagement Framework and toolkit has been coproduced to improve national consistency in how maternity services engage with their service users.

This work, like the work of the SLWG, is informed by and based on robust data and evidence. Feedback from SLWG members indicated that further support and guidance in accessing these sources and resources would be helpful. Led by this demand, the group developed a *Scoping of Data, Evidence and Feedback* resource which provides an overview of the evidence base and resources as a tool for use by NHS Boards.

National Context

The Cabinet Secretary for Health and Social Care's statement on 6 September 2024 identified racism as a significant public health challenge and a key cause of health inequalities. NHS Boards have been asked to make more rapid progress in tackling the impacts of racism on colleagues, service users and on health outcomes. This includes an ask for NHS Boards to develop antiracism plans.

Guidance issued to NHS Boards on 9 September 2024 to support the development of these plans. Perinatal care is a specific area of focus for this, based on the existing evidence of racialised healthcare inequalities in perinatal care. The actions in this plan and the deliverables of the SLWG will provide further support and guidance for NHS Boards in taking forward improvement activity focused on perinatal services.

Review and Monitoring Progress

Action owners will be asked to review and report on their progress towards addressing the actions outlined in this plan. Annual and Local Delivery Plan guidance for NHS Boards from 2025-26 highlights tackling racialised health inequalities in maternity care as a specific planning priority. NHS Boards will therefore be expected to report to the Scottish Government on progress towards both developing and delivering actions in maternity services within their anti-racism plans, in line with this plan and implementation of the deliverables from the SLWG.

The timeframes for actions to be completed from the date of publication of this action plan are outlined in the table below.

Timescale	**Within (from date of publication)**	**For completion by end**
Shorter-term	1 year	March 2026
Medium-term	1-3 years	March 2027-28
Longer-term	3-5 years	March 2028-30

Abbreviations used throughout the text:

HIS – Healthcare Improvement Scotland
NES – NHS Education for Scotland
PHS – Public Health Scotland
SG – Scottish Government
SPN – Scottish Perinatal Network
SPSP Perinatal – Scottish Patient Safety Programme Perinatal

SLWG - Short-Life Working Group on Racialised Health Inequalities in Maternity Care

Recommendations for Action

This action plan contains the 14 actions identified by the SLWG to be addressed in the first instance. These actions were identified during the five meetings of the SLWG, between September 2023 and May 2024. We are committed to embedding an anti-racist approach within our broader policy development and recognise that the actions contained within this plan are the first steps towards this. This action plan will remain dynamic and responsive to emerging evidence, from data, research and living experience.

As we move forward, we are committed to:

- Learning from and building on the work of the SLWG, taking a cocreation approach to develop and embed an antiracist approach to policymaking and delivery across maternity and neonatal care in Scotland, in line with the Cabinet Secretary for Health and Social Care's statement on antiracism of 6 September 2024.

- Working with national and local partners to respond to the actions identified in this action plan, along with emerging evidence and feedback, to take a joined-up, systemic approach to tackle racialised health inequalities.

Clinical Care

1. The Scottish Government will write to all NHS Boards to highlight and share the work undertaken to date by the SLWG and set the following expectations of all perinatal (maternity and neonatal) services by Summer 2025:
    - Data and evidence available, as outlined in Deliverable 3, should be used to inform local work to understand the local population and identify inequalities in experiences or outcomes.
    - Setting expectations regarding the use of local data, in understanding inequalities in experiences and outcomes locally, benchmarking and monitoring progress and outcomes in tackling inequalities at the local level.
    - Targeted action to respond to inequalities identified may include quality improvement activity. The Scottish Patient Safety Programme (SPSP) Perinatal provides information to support local quality improvement work and recognises that work to address inequalities in experiences and outcomes is a legitimate area of focus for Quality Improvement (QI) activity.

    Owner: SG, NHS Boards
    Timescale: Immediate

2. The SPSP Perinatal Advisory Group will consider how best to ensure that work to improve experiences and outcomes for women and babies from minority ethnic communities is considered at each SPSP Perinatal Advisory Group meeting and how the work of the SPSP Perinatal programme can maximise its impact in contributing to tackling racialised health inequalities.
Owner: SG, SPSP Perinatal
Timescale: Immediate

3. The SPN to facilitate the sharing of good practice in an Equality Impact Assessment (EQIA) for clinical guidelines and pathways.

a) NHS Boards, SPN and other national partners responsible for the development of clinical guidelines and pathways to ensure that a programme timeline for the comprehensive review of clinical guidelines and pathways on a rolling basis is in place by March 2026. The needs of Black and Asian women and babies, and impact of racialised health inequalities on those from minority ethnic communities, should be considered throughout the development process of guidelines and their review and reflected in EQIAs.
b) NHS Boards, SPN and other national partners responsible for the development of clinical guidelines and pathways should assure themselves that all meet the needs of all service users, with a particular focus on the needs of women and babies with Black and Brown skin. Development should take account of national guidelines and all local extant and forthcoming maternity and neonatal guidelines.
c) NHS Boards to ensure that they have robust mechanisms in place to ensure that local and national guidelines, their review, and any updates are communicated effectively with all staff working in perinatal services.

Owner: NHS Boards, SPN
Timescale: Medium-term

4. SG will develop the next iteration of the Maternity Care Experience Survey, to be completed by end summer 2026, to provide a national snapshot benchmark of lived experience across Scotland, including by ethnicity as far as possible, to better understand qualitative experience and feedback.
Owner: SG
Timescale: Medium-term

5. NHS Boards and the SPN to explore the current availability and use of bilirubinometers to detect newborn jaundice in darker skin toned neonates and babies, in response to reports of poor visual detection of jaundice in babies with darker skin, by March 2027.
Owner: NHS Boards, SPN
Timescale: Medium-term

6. NHS Boards to ensure that all staff working in perinatal services complete the mandatory TURAS Introduction to equality, diversity and human rights training by March 2026.
a) NHS Boards to recommend completion of the TURAS Cultural Humility training package for all staff working in perinatal services.
Owner: NHS Boards
Timescale: Shorter-term

Communication

7. PHS to work together with NHS Boards and national partners, including PHS and NHS inform to ensure that information in translation is available in the most commonly spoken languages, and that all NHS Boards understand the process by which written public health information in other languages can be sourced.
Owner: PHS
Timescale: Shorter-term

8. NHS Boards to work with the Scottish Government and the SPN to:
a) Explore how audio versions of information in translation can be developed and made available to service users who may require it using existing digital platforms.
b) Work with digital providers (e.g. Badger) to ensure that all national and local information in translation is made available digitally for service users to access equitably. Work with digital providers to ensure that national information translated in one NHS Board area can be shared across Scotland to minimise duplication.
Owner: PHS, NHS inform, NHS Boards
Timescale: Longer-term

9. SPN and HIS to work with third sector organisations to identify ways and methods to involve communities in meaningful, representative and accountable coproduction. NHS Boards, the Scottish Perinatal Network, and other national partners to involve members of seldom heard communities through existing service user groups and structures.
Owner: SPN, HIS, NHS Boards

Timescale: Medium-term

Cultural

10. NHS Boards and national partners such as NES, SPN, HIS and PHS to work together to facilitate the sharing of good practice in providing leaders with equality, diversity and inclusion (EDI) training and providing staff with multidisciplinary cross-cultural workshops.
Owner: NHS Boards, NES, SPN, PHS
Timescale: Medium-term

11. SG to work with members of the SLWG and others with expertise in antiracism, perinatal services and lived experience, to co-produce a video resource package for healthcare staff on the history of racism in healthcare and the specific impact of this legacy on maternity and neonatal experiences and care.
Owner: SG
Timescale: Shorter-term

Data and Evidence

12. NHS Boards to work with the SPSP Perinatal Programme for support in undertaking quality improvement activity to address disparities in experiences or outcomes identified locally for women and babies from minority ethnic communities. Where good practice, improvements and learning is identified, SPSP Perinatal to facilitate learning and information sharing at a national level.
Owner: SPSP Perinatal, NHS Boards
Timescale: Medium-term

13. Work with national partners, NHS Boards and across the Scottish Government to identify appropriate mechanisms to monitor progress in addressing inequalities in experiences and outcomes in perinatal care, to supplement final reporting through Annual Delivery Plans and Local Delivery Plans processes.
Owner: SG, NHS Boards
Timescale: Shorter-term

14. SG will continue working with HIS, SPN and perinatal service leaders to ensure links with adverse event review and Perinatal Mortality Review Tool (PMRT) work to develop a national feedback mechanism to ensure experiences of bereaved parents inform service improvement at both the local and national level in a culturally competent and equitable way.
Owner: SG, HIS, SPN, NHS Boards
Timescale: Longer-term

Annex A

Membership of the Short-Life Working Group

Name	Role	Organisation
Maree Aldam *Co-Chair*	CEO	Amma Birth Companions
Jayne Bekoe	Head of EDI	RCM
Laura Brown	Programme Manager - (Maternity)	Scottish Perinatal (Maternity) Network
Alastair Campbell *Co-Chair*	Consultant Obstetrician and Co-chair of the Scottish committee of the RCOG	RCOG, NHS Lothian
Isla Bumba	Equality & Human Rights Lead Officer	NHS Fife
Sarah Corcoran	Team Leader, Maternal and Infant Health	Scottish Government
Liz Cheung	Lead Midwife	NHS Grampian
Justine Craig	Chief Midwifery Officer	Scottish Government
Iona Duckett	Professional Advisor for Midwifery and Perinatal Care	Scottish Government
Clea Harmer	Chief Executive	Sands
Lesley Jackson	Consultant Neonatologist and Clinical Lead for the Scottish Neonatal Network	Scottish Perinatal (Neonatal) Network, NHS Greater Glasgow and Clyde
Rachel Kearns	Consultant Anaesthetist	NHS Greater Glasgow and Clyde
Jaki Lambert	Director	RCM Scotland
Aileen Lawrie	Director of Midwifery	NHS Fife
Nicola MacKay	Consultant Midwife	NHS Grampian
Shonag Mackenzie	Clinical Director and Consultant, Obstetrics and Gynaecology	NHS Borders

Alison McBride	Head of Midwifery	NHS Forth Valley
Anna Molnar	Policy Officer	Scottish Government
Vongayi Mufara	Expert by lived experience, Advocacy and Community Engagement Manager	Amma Birth Companions
Isioma Okolo	Consultant Obstetrician & Gynaecologist	NHS Forth Valley
Maria Pollard	Deputy Director NMAHP/ Lead Midwife	NHS Education Scotland
Amanda Purdie	Head of Advocacy and Communications	Amma Birth Companions
Stephanie Rodger-Phillips	Senior Policy Adviser	Scottish Government
Sarah Shemery	PhD Candidate in Social Work	University of Edinburgh
Lydia Simpson	Consultant Obstetrician	NHS Lothian
Jo Thomson	Senior Improvement Advisor	HIS SPSP Perinatal
Padma Vanga	Consultant in Obstetrician and Gynaecologist	NHS Greater Glasgow and Clyde
Sarah Zadik	Co-Founder and Head of Services	Amma Birth Companions

Secretariat provided by the Scottish Government Maternal and Infant Health team, Improving Health and Wellbeing Division, Directorate for Children and Families (DCAF).

Annex B: Interpretation Toolkit

Best Practice Toolkit: Working with Interpreters in Maternity and Neonatal Services

Deliverable 2
Short-Life Working Group

Version 1, February 2025

Toolkit: Working with Interpreters in Maternity and Neonatal Care

1. Principles

2. Routine antenatal and postnatal appointments
   - Draft toolkit

3. Remote Interpreting (including triage)
   - Draft toolkit

4. Emergency and/ or unexpected appointments, including presentation during labour
   - Draft toolkit

Toolkit: Working with Interpreters in Maternity and Neonatal Care

1. Principles

Note

All NHS Boards should have their own policy and procedures to ensure access to interpreting services is available for service users who may require it. The Scottish Government public sector procurement Framework for Interpreting, Translation and Transcription Services includes guidance for public sector organisations on how to access and use the procurement framework agreement.

Best practice and further guidance is also available through the NHS Scotland Competency Framework for Interpreting (2020). The NHS Scotland Interpreting, Communication Support and Translation National Policy (2020) also provides guidance on NHS Scotland responsibilities to service users who require support from interpreting and translation services.

The toolkit below is designed to provide practical, 'in the moment' support for health professionals working in **maternity and neonatal services** across Scotland, to help support the consistent application of the principles described by these policies and frameworks.

The first section of the below toolkit gives detailed advice on how to work with interpreters and how to communicate with women whose preferred language is not English during a routine appointment. The other two sections provide additional advice that would need to be taken into consideration on top of the routine communication in cases of remote interpreting and emergencies.

This document will use the term 'women'/'woman' throughout. It is important to highlight that it is not only those who identify as women who require access to maternity (including early pregnancy services) and neonatal services. For example,

some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience pregnancy. It is the intention of this toolkit to contribute to maternity and neonatal services being respectful and responsive to individual needs.

Identify if interpreting services are required

Who might require interpreting services?

- Women and their families whose preferred way of communication is in a spoken language other than English.
- Deaf British Sign Language (BSL) users.
- Deafblind (dual sensory impaired) service users.
- Any service user who requests interpreting support.

Language needs and preferences cannot be inferred or assumed based on, for example, skin colour or cultural background.

Please note, this toolkit only considers spoken language interpreting. For guidance on translating written material, BSL and Deafblind interpreting, please consult your local guidelines.

Proficiency in 'conversational' English should not be taken as a sign of fluency, nor as a sign of understanding and communication in English necessary to make informed choices about care.

Verbal fluency or proficiency in 'conversational' English should not be taken as an indicator of literacy and access to written material, whether in English or in an individual's preferred language/ dialect.

Why work with an interpreter?

Using the services of an interpreter benefits women and their families as well as the maternity staff and services in delivering safe and equitable care. It can be important for:

- Patient safety.
- Ensuring accurate information-sharing.
- Protecting vulnerable women.
- Obtaining informed consent.
- Helping to improve pregnancy and birth experiences and outcomes.

Face-to-face interpreting, with the service user, interpreter and healthcare professional(s) together in one room, is the preferred option for all maternity appointments and episodes of care: antenatal, labour and postnatal. However, while face-to-face appointments are recommended, there might be many factors that influence whether it can be offered.

Appointments which will be supported by an interpreter will take longer. Allow more time for such appointments: if possible, double the standard appointment time would be desirable.

Consider prioritising in-person interpreting for complex appointments, all intrapartum care and booking appointments. For routine antenatal and postnatal care appropriate digital interpreting solutions may be used. Telephone or video interpreting may be used routinely for arranging, changing or cancelling appointments or for calling a patient at home.

For provision of planned care, family members and friends should not be asked to interpret. It is important that family members are able to attend appointments to support and advocate for their friends/ family and giving them another role during appointments hinders their ability to do this.

- They may not have the level of language proficiency required to translate medical terminology.
- Women may feel uncomfortable sharing personal medical information through their family member.
- The involvement of a family member may raise concerns around, for example, safeguarding and domestic abuse.

- It should be avoided at all costs that children are asked to interpret for their family members.

In an emergency, or where care is unplanned, a family member may interpret informally until connection is established with a professional interpreter via telephone or app, or until an interpreter arrives in person.

In circumstances where a woman wishes their family member to interpret, it remains best practice to provide an independent, professional interpreter to support shared understanding of information discussed and to mitigate against any potential inequity.

Public Health Scotland's *NHSScotland Interpreting, Communication Support and Translation National Policy* (2020) notes that *healthcare staff who are bilingual but not registered with an accredited interpretation of translation service should not act as an interpreter or translator.* The policy outlines a number of reasons for this, including risks associated with indemnity insurance and establishing language proficiency for translation. This does not prevent bilingual staff from using their language skills to converse with women and families socially until the interpreter arrives.

> *Women have the right to decline the interpreting services offered. It is important that you take every step possible to make sure the woman is comfortable with the interpreter provided. Make sure the interpreter's role in facilitating communication both ways are clearly emphasised and explained*.

It is important to be curious about the reasons why someone may decline the use of a professional interpreter. Individuals may have concerns about being perceived as "difficult" or "a problem." They may also be concerned about being treated differently if they require the services of an interpreter.

Where a service user declines professional interpreting support, the *NHSScotland Interpreting, Communication Support and Translation National Policy* (2020) advises

that this should be documented in the service user's healthcare record and signed by the patient. Informed consent for this should be obtained in the woman's preferred language and be sought independently.

Toolkit: Working with Interpreters in Maternity and Neonatal Care

2. Routine antenatal and postnatal appointments

Before the appointment

- Familiarise yourself with the principles outlined at the start of this toolkit document.
- Familiarise yourself with your local NHS Board guidance on how to book interpreters. An interpreter should be used for all appointments, including scans and blood tests.
- Make sure to correctly identify the language, dialect and region of the country of origin of the woman before making a booking. Note: preferred language cannot be predicted from country of origin.
- Ensure the correct language and dialect are recorded in the relevant system (e.g. Badger or Trak).
- Determine whether the woman would prefer a male or female interpreter.

If you have no way of determining whether a male or female interpreter would be preferred, consider booking a female interpreter if possible. During the first appointment, you will have the opportunity to confirm if there is any preference.

- Book interpreters as far in advance as possible. Ideally, the same interpreter would be booked to attend in-person for a series of appointments.
- Share all necessary information to enable the interpreter to provide an effective service. This may include:
    - Date, venue and time of appointment, including anticipated duration.
    - Language and dialect requirements.
    - Whether a male or female interpreter is required.
    - Nature of the appointment (e.g. might they be asked to communicate culturally sensitive or difficult news about health or diagnoses).

- Allow more time for appointments which will be supported by an interpreter – double the standard appointment time if possible.
- It is important that women feel safe: make sure the space you will use for appointments with an interpreter can facilitate a three-way conversation, whether digitally or face-to-face, so that everyone is able to see and hear everyone else involved in the appointment.

During the appointment

- Introduce yourself and the interpreter, explain your roles and confidentiality.
- During the booking appointment, consider dedicating time to explaining how the service user can make contact generally and in emergencies, what the processes are and how interpreting needs will be met. Consider repeating the information during following appointments to give assurance and reiterate that when contact is made, interpreters will be accessed, including in emergencies.
- Provide or signpost to information available in the woman's language. Where this is not available, follow your local guidelines to provide written translation or an audio recording in the woman's language. Your local equalities team could also assist.

It is good practice to maintain a list of trusted resources that are specific to the local board, NHS Scotland or applicable to the UK more broadly. Inclusion of multilingual video resources in the list is important.

Examples of such resources:

labourpains.org - This resource from the Obstetric Anaesthetists' Association provides carefully curated, up to date and evidence-based information on analgesia in labour in multiple languages.

Translation patient information | RCOG – Developed by the Royal College of Obstetricians & Gynaecologist, a range of leaflets translated into a variety of languages.

- Service users can decline a specific interpreter if, for example, they are already known to or have a relationship with them.
- Always speak directly to the woman, rather than to the interpreter: i.e. “you” rather than “she.”
- Try not to use jargon or too much medical terminology. Where this is necessary to facilitate informed consent, the interpreter should be asked to confirm understanding with the woman and encourage questions and clarification at regular intervals.
- After every few sentences, pause to allow opportunities for interpreting. If you talk for too long the interpreter may not be able to remember all the information to interpret.
- Allow time for and encourage clarification and questions. The woman or the interpreter may not be familiar with NHS Scotland care and customs.
- Consider providing additional information they may find useful.

The woman or the interpreter may be familiar with different healthcare systems, they may expect services that are not offered or not offered in the same way by NHS Scotland. For example, you may need to explain NHS service users' rights and the way they can participate in decision-making concerning their own care.

- Prioritise keeping the arranged appointment time of women with interpreters, as the interpreter’s availability may be time-limited. If running late, communicate with both the interpreter and the woman about options.
- Ensure the interpreter co-signs consent forms with the woman to document the informed consent has been facilitated by an interpreter in person. Document the interpreter’s ID number and full name.
- Invite feedback from the service user on <u>both</u> the quality of care received and the quality of the interpreting service (e.g. technology and connection issues for telephone and video interpreting).

- Highlight opportunities and mechanisms for providing feedback, including complaints procedures, and how these can be accessed by service users for whom English is not their first language.

<u>After the appointment</u>

- Always record the use of an interpreter and their name and ID number in the woman's notes.
- Sign the interpreter's paperwork.
- Book an interpreter for the next appointment, if required. Try to book the same interpreter for a series of appointments, if possible.

If possible, offer the option of scheduling the outstanding antenatal appointments, so that it is easier to book the same interpreter.

- Offer to debrief the interpreter. Consider asking the interpreter if they have any questions or if they had difficulties with anything throughout the appointment. You may also ask the interpreter to provide you with any advice on what you could have done differently to best optimise working with interpreters.

Offering a debrief is highly advised if the appointment was upsetting or traumatising to ensure the interpreter's wellbeing as well. Consider if the interpreter would benefit from any counselling services available via the local health board if involved in challenging discussions.

Toolkit: Working with Interpreters in Maternity and Neonatal Care

3. Remote interpreting (including triage)

All NHS healthcare staff should:

- Be familiar with the principles outlined at the start of this toolkit document.
- Know how to access remote interpreting, including telephone and video interpreting services in their NHS Board area. They should be familiar with the process of three-way dialling-in of interpreters over the telephone.
- Be familiar with the processes and procedures in place in their ward/ unit.
- Record language, dialect and interpreting requirements clearly in the maternity notes.
- Be familiar with the use of Near Me and how to involve interpreters in an appointment facilitated on Near Me.

<u>Before, during and after the appointment</u>

- You should interact with the woman and the interpreter in the same way as detailed in the routine appointments section of the toolkit above.
- In the case of remote appointments, where either the interpreter or both the interpreter and the woman are joining the appointment online, you should consider additional steps:
    - Familiarise yourself with the technical problems that could arise (for example, call dropping or bad quality connection) and what measures you can take to avoid, as well as what actions you can take to solve the problems quickly when they arise.
    - Consider discussing possible technical problems at the start of the call and detail the steps that will be taken if any of them arise and how connection will be reestablished if lost.
    - Consider regularly confirming with the woman and the interpreter if the technical set-up suits them or if they have any issues.

Triage

- Where face-to-face assessment is indicated, ensure a face-to-face interpreter is booked immediately following the call. If no face-to-face interpreter is available immediately, ensure video or telephone interpreting is available.
- Ensure you are familiar with the process of three-way dialling in of interpreters over the telephone.
- In instances where communication by telephone presents particular challenges or difficulties, you may wish to consider whether it would be to the woman's benefit to present in person. This approach should be clarified with the individual woman and should not be adopted as a blanket approach for all women who require access to an interpreter.

Toolkit: Working with Interpreters in Maternity and Neonatal Care

4. Emergency and/ or unexpected appointments, including presentation during labour

In cases of extreme emergencies, working with interpreters may be challenging. It is crucial that every possible step is taken to ensure that equitable communication is established.

Emergencies require immediate action and urgent, critical care should not be delayed when the most appropriate interpreting is not available immediately. All effort should be made to provide an interpreter as soon as possible.

<u>At first contact</u>

- Check maternity notes for the correct language, dialect and region of the country of origin of the woman. Using language identification cards/ posters, confirm with the woman that the information you obtained from the notes are correct or ask for the information if not recorded.
- Check the maternity notes if any preference for gender of the interpreter has been recorded.
- Book an interpreter immediately. In-person interpreting is preferable and essential for all women in labour or expected to be admitted. In the interim, use of telephone/ video interpreting services should be made available immediately. Communicate any challenges, for example, unavailability of interpreter with preferred gender or delays.
- Delivery of care using an interpreter will likely require more time: this should be reflected in the woman's notes, so that information is accessible to all professionals involved in her care. When booking an interpreter for labour, consider advance booking of interpreters who can take over if labour is taking longer.

<u>Delivering care using an interpreter</u>

- You should interact with the woman and the interpreter in the same way as detailed in the routine appointments section of the toolkit above.
- Introduce yourself and the interpreter, explain your roles and confidentiality.

- Always speak directly to the woman, rather than to the interpreter: i.e. “you” rather than “she.”
- Try not to use jargon or too much medical terminology. Where this is necessary to facilitate informed consent, the interpreter should be asked to confirm understanding with the woman and encourage questions and clarification at regular intervals.
- After every few sentences, pause for interpreting. If you talk for too long the interpreter may not be able to remember all the information to interpret.

<u>After the contact</u>

- Always record the use of an interpreter, including the interpreter's name, in the notes.
- Sign the interpreter's paperwork.
- Book an interpreter for the next appointment, e.g. for next contact on ward or for first postnatal contact in community. Try to book the same interpreter for a series of appointments, if possible.
- Offer to debrief the interpreter.

Annex C: Evidence and Data Resource

Scoping: Data, Evidence and Feedback

Deliverable 3
Short-Life Working Group

Version 1, February 2025

Summary

The Short Life Working Group on Racialised Health Inequalities in Maternity Care recommended that the various sources of data, evidence and information on racialised health inequalities be collated into an easy-access reference document for NHS Boards. Feedback from members of the Group indicated that this would be a helpful resource for NHS Boards and perinatal (maternity and neonatal) services to support their work to identify and tackle racialised health inequalities. The following resource responds to that ask, bringing together key sources of data, evidence, analysis and reporting on racialised health inequalities – both overall and with a specific focus on outcomes and experiences in perinatal care in particular.

These sources reflect available information, data and evidence as at **30 January 2025** and include reports, enquiries, studies, research outputs, data sources and learning resources. While this resource provides a starting point and signposts a wealth of relevant information to support understanding and the development of work to tackle racialised health inequalities in perinatal care, it should not be viewed as an exhaustive list of all possible pertinent resources.

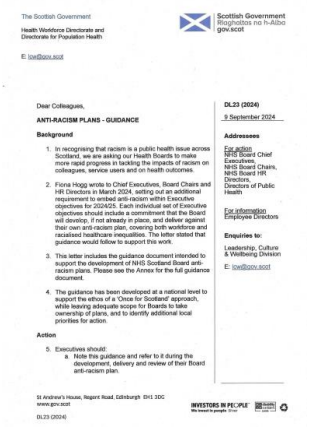
Accessing Resources

For each resource, a thumbnail image of the relevant document or landing page is provided where available. All images are linked to the relevant document online. Additional links or background information (for example, where reports are underpinned by more detailed data, which is available separately) are provided as hyperlinks under the ‘Key Themes’ box alongside the image.

Contents

1. Scotland – Antiracism

Scottish Government – NHS Board Anti-racism Plan Guidance
Published 9 September 2024


The Scottish Government
Health Workforce Directorate and Directorate for Population Health
E: how@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

Dear Colleagues,

ANTI-RACISM PLANS - GUIDANCE

Background

1. In recognising that racism is a public health issue across Scotland, we are asking our Health Boards to make more rapid progress in tackling the impacts of racism on colleagues, service users and on health outcomes.
2. Fiona Hogg wrote to Chief Executives, Board Chairs and HR Directors in March 2024, setting out an additional requirement to embed anti-racism within Executive objectives for 2024/25. Each individual set of Executive objectives should include a commitment that the Board will develop, if not already in place, and deliver against their own anti-racism plan, covering both workforce and racialised healthcare inequalities. The letter stated that guidance would follow to support this work.
3. This letter includes the guidance document intended to support the development of NHS Scotland Board anti-racism plans. Please see the Annex for the full guidance document.
4. The guidance has been developed at a national level to support the ethos of a 'Once for Scotland' approach, while leaving adequate scope for Boards to take ownership of plans, and to identify additional local priorities for action.

Action

5. Executives should:
   a. Note this guidance and refer to it during the development, delivery and review of their Board anti-racism plan.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

DL23 (2024)

DL23 (2024)
9 September 2024

Addressees
For action
NHS Board Chief Executives, NHS Board Chairs, NHS Board HR Directors, Directors of Public Health

For information
Employee Directors

Enquiries to:
Leadership, Culture & Wellbeing Division
E: how@gov.scot

INVESTORS IN PEOPLE

Key Themes

- Letter to NHS Boards on the publication of guidance to support NHS Boards in developing their anti-racism plans.
- Perinatal care is identified as a priority area within the guidance, which includes suggested actions for Boards to focus on within their anti-racism plans.
- These align with those identified by the Short-Life Working Group in its action plan.

Note: The resources detailed in this document may also be useful in supporting NHS Boards and perinatal services in the development of their anti-racism plans.

- Letter to NHS Boards: Anti-Racism Plans - Guidance

Cabinet Secretary for Health and Social Care – Statement: Addressing Racism as a Significant Public Health Issue
Published 6 September 2024


Scottish Government
Riaghaltas na h-Alba

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Home > Publications

Publication - Speech/statement

Anti-racism: Cabinet Secretary's statement

Published: 6 September 2024
From: Cabinet Secretary for Health and Social Care
Topic: Health and social care
Programme for Government
Delivered by: Neil Gray, Cabinet Secretary for Health and Social Care

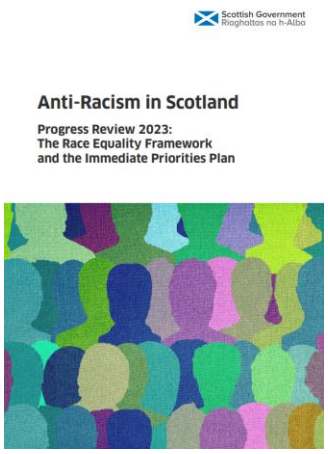
Statement by the Cabinet Secretary for Health and Social Care Neil Gray identifying racism as a significant public health challenge, and a key cause of health inequalities.

Key Themes

- Identifies racism as a significant public health challenge and a key cause of health inequalities.
- Highlights that a firm anti-racism approach should be adopted in service improvement activities. Maternity care is noted as an area of focus.
- Anti-racism means actively standing up against racism; challenging and changing the policies, practices, beliefs and behaviours that unjustly disadvantage people from minority ethnic groups, and being proactive in creating a more inclusive and fair society.

- Full text: Anti-racism: Cabinet Secretary's statement - gov.scot
- Announcement ofof Statement: Addressing racism as a significant public health issue - gov.scot (www.gov.scot)

Scottish Government – Antiracism in Scotland: Progress Review 2023
Published 28 June 2023



Key Themes

- Sets expectations in place at a national level re commitment to antiracism and antiracist practice in Scotland.
- Detailed examination of progress made under the SG Race Equality Framework (published 2016) and the more recent Immediate Priorities Plan.
- Theme 6: Health and home includes focus on pursuing equity of access, experience and outcomes for racialised minorities and addressing structural racism within health and social care.
- Maternal and Infant Health features, including reference to the work underway to develop a programme of improvement activity in Scotland.

Coalition for Racial Equality and Rights (CRER) – Anti-racist policy making: Learning from the first 20 years of Scottish devolution
Published 14 September 2021

Key Themes

- Presents findings of a research programme into Scottish national race equality strategies since 2000.
- Notes importance of data in identifying where disparities exist and in monitoring developments over time.
- Highlights requirements of the Public Sector Equality Duties in Scotland (including Scottish-specific duties)

Scottish Government – Addressing Race Inequality in Scotland: The Way Forward
Published 11 December 2017

Key Themes

- Report from the Scottish Government's independent advisor on race equality in Scotland, Kaliani Lyle.
- Sets out recommendations and actions for inclusion in the Race Equality Delivery Plan 2017-2021. This Plan was the first strand of a 15 year Race Equality Framework, with the overarching vision of a fairer Scotland for people of all ethnicities by 2030.
- Highlights the importance of data collection in providing a baseline from which to measure change.

Scottish Government – Race Equality Framework for Scotland 2016 to 2030
Published 21 March 2016

Key Themes

- Scottish Government publication setting out how the Scottish Government aims to progress its ambition to show leadership in advancing race equality and tackling racism, using its influence to ensure that this approach is embraced across Scotland.
- Sets vision for 2030 that *[m]inority ethnic communities in Scotland have equality in physical and mental health as far as is achievable, have effective healthcare appropriate to their needs and experience fewer inequalities in housing and home life.*

2. Scotland – Racialised Health Inequalities

The Health Foundation – Leave no one behind: The state of health and health inequalities in Scotland
Published January 2023

Note: The focus here is on healthcare inequalities in general, with particular focus on socioeconomic deprivation and disadvantage, which may compound the impacts of existing disparities for some minority ethnic communities.

Key Themes

- Healthcare inequalities as a consequence of unfair differences in people's living conditions and live experiences.
- Historic socioeconomic inequalities and disadvantage.
- Persistence of health inequalities related to three underlying factors: accumulation of severe multiple disadvantage; lack of improvement in living standards, and impact of austerity.
- Highlights health and experiences of infants and children in their early years as a particular area of concern (absolute inequalities widened in low birth weight)

Public Health Scotland (PHS) – Monitoring racialised health inequalities in Scotland: Data and evidence
Published 30 May 2023

Key Themes (re maternity and neonatal):

- Focuses on ongoing work within maternity and early years data.
- Mums Matter project, set up in Fife, aiming to make maternity and health visiting services more accessible to Gypsy/ Traveller women.
- Ethnicity data collection (including in maternity) – data completeness.
- Antenatal booking by ethnicity and deprivation, noting that pregnant African and Caribbean or Black women are more likely to live in the most deprived areas compared to pregnant white women.
- COVID-19 vaccination in pregnancy – uptake by ethnicity.
- Infant feeding – babies born to women from minority ethnic communities more likely to be breastfed.

Public Health Scotland (PHS) – How you can improve the health of Gypsy/ Travellers in Scotland
Published 11 April 2023


Public Health Scotland

How you can improve the health of Gypsy/Travellers in Scotland

In Scotland, people in Gypsy/Traveller communities are dying at least a decade earlier than the rest of the population.

Gypsy/Travellers have poorer experiences of the things that help us live in good health, such as access to services, adequate housing, good education and social inclusion. They can also experience stigma and discrimination.

Gypsy/Travellers experience some of the worst physical and mental health outcomes in the UK. We need to take action to improve this.

Aim

This resource highlights practical solutions that Health Boards and Health and Social Care Partnerships have implemented to try to prevent these premature deaths, improve health and support Gypsy/Traveller communities to thrive.

It is designed for decision-makers and people working in health and care services, and provides some actions you can take to improve the health of Gypsy/Travellers in your area.

Why do Gypsy/Travellers have health inequalities?

Income, wealth and power

Unfair differences in income, wealth and power are important drivers of health and health inequalities in Scotland. These can affect access to services that help us live in good health. For example, they can affect how we access quality housing, stable and well-paid work, social and cultural opportunities, and quality public services. For Gypsy/Traveller communities, access to these is missing in too many cases, meaning they are at greater risk of poorer health and health outcomes.

Use of health services

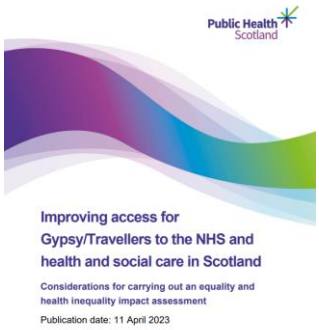
Previous experiences of discrimination when using health services means that some Gypsy/Travellers will be reluctant to access a service when they really need it. This could mean they miss routine screening appointments, or they do not have access to the right medication or use emergency services when their symptoms are much worse, and their health is poorer.

Limiting people's chances of their right to health limits their ability to live a healthy life. But by fixing the gaps in these services, we can create conditions that improve Gypsy/Travellers' health and wellbeing.

Key Themes

- Previous experience of discrimination when using health services means that some Gypsy/ Travellers will be reluctant to access a service when they really need it.
- Suggests practical solutions to make healthcare services more accessible for Gypsy/ Travellers.
- Includes overview of the Mums Matter project in Fife and highlights available e-learning on Turas: 'Raising awareness of Gypsy/ Traveller communities'.

Public Health Scotland (PHS) – Improving access for Gypsy/ Travellers to the NHS and health and social care in Scotland
Published 11 April 2023


Public Health Scotland

Improving access for Gypsy/Travellers to the NHS and health and social care in Scotland

Considerations for carrying out an equality and health inequality impact assessment

Publication date: 11 April 2023

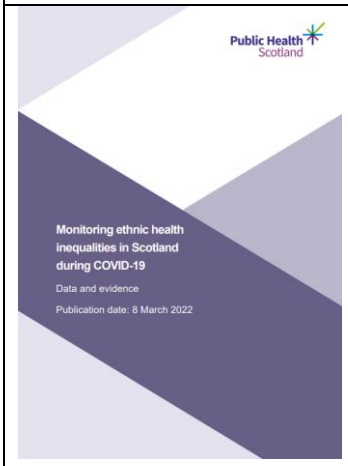
Key Themes

- Inequalities in health outcomes for Gypsy/ Travellers (based on analysis of 2011 Census data).
- Edinburgh Access Practice (EAP) research indicating that the Gypsy/ Traveller community had higher than average levels of obesity, hypertension, risk factors for diabetes, heavy alcohol use and/ or smoking, and risk of cardiovascular disease when compared with the general population.
- Gypsy/ Travellers are at higher risk of poor mental health, mental illness and suicide than the general population.
- Travellers also face challenges in receiving continuity of care, as NHS primary and secondary care are set up to provide services to a static/ settled population.
- Suggests actions to improve Gypsy/ Travellers' experience of health and social care services (p9)

Improving access for Gypsy/ Travellers to the NHS and health and social care in Scotland, Public Health Scotland, published 11 April 2023

- Landing page: Improving access for Gypsy/Travellers to the NHS and health and social care in Scotland - Improving access for Gypsy/Travellers to the NHS and health and social care in Scotland - Publications - Public Health Scotland

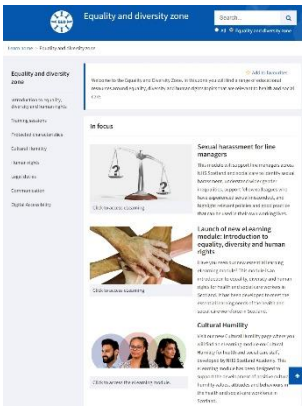
Public Health Scotland (PHS) – Monitoring ethnic health inequalities in Scotland during COVID-19
Published 8 March 2022



Key Themes

- Scottish data have consistently shown an increased risk of serious illness and death from COVID-19 among many minority ethnic groups, mirroring similar trends seen in other countries of the UK.
- COVID-19 vaccination rates have been persistently lower in some minority ethnic groups compared to the rest of the population.
- Hospital data and improving ethnicity data recording.

NHS Education for Scotland – Equality and diversity learning resources



Note: This links to the TURAS Equality and Diversity zone, which includes links to training and topic information on a variety of subjects relevant to tackling racialised health inequalities.

- Includes Cultural Humility | Turas | Learn (nhs.scot) (requires login).

Public Health Scotland – Health Inequalities
Last accessed 13 January 2025

Note: This resource provides information on health inequalities and offers an introduction to:

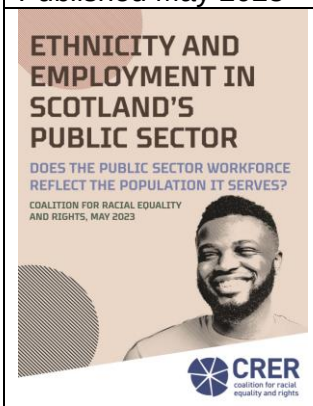
- Health inequalities (including extent and trends)
- Causes of health inequalities
- How we can reduce health inequalities
- Measuring health inequalities

Scotland's Census - Scotland's Census 2022 - Ethnic group, national identity, language and religion
Published 21 May 2024

Key Themes

- In 2022, 12.9% of people in Scotland had a minority ethnic background, an increase from 8.2% in 2011.
- In 2022, 17.8% of Scotland's population aged between 20 and 39 were born outside the UK. The overall percentage of people born outside the UK remains relatively small, however, at 10.2%.
- Includes access to Census data (available for ethnicity at Health Board level for 2019)
  - Search | Scotland's Census - Search by topic - Topic selection

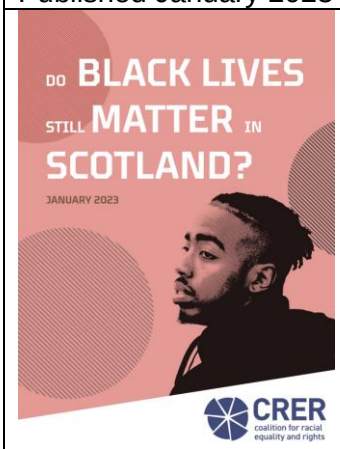
Coalition for Racial Equality and Rights (CRER) – Ethnicity and Employment in Scotland's Public Sector: Does the public sector workforce reflect the population it serves?
Published May 2023



Key Themes

- Makeup of the public sector workforce in Scotland overall does not reflect the ethnic diversity of the communities it serves.
- Links this disparity to employment barriers connected to structural, institutional and interpersonal racism across Scotland and the public sector.
- Found the greatest proportion of Black and minority ethnic workers in the higher education sector and in NHS Boards.
- Found no ethnicity information held for over 20% of workforce in NHS Boards in 2021 reporting period.

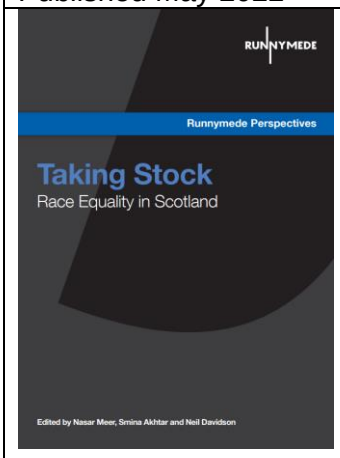
Coalition for Racial Equality and Rights (CRER) – Do Black Lives Still Matter in Scotland?
Published January 2023



Key Themes

- Looks at progress made by organisations since making statements following the Black Lives Matter protests in 2020.
- Organisations were approached at the end of April 2022 and asked about their actions following their statements in 2020, the impact these actions had on Black and minority ethnic staff, service users or others, and any actions planned for the future.
- NHS Greater Glasgow and Clyde only NHS Board to feature, with reference to its One NHS family campaign and BME Staff Network mural development.

Runnymede Perspectives – Taking Stock: Race Equality in Scotland
Published May 2022

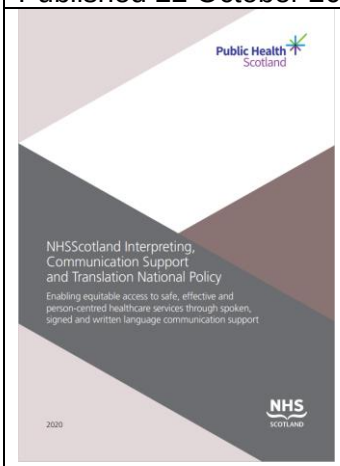


Key Themes

- Explores impacts of COVID-19 on minority ethnic communities in Scotland in "Different but Similar? BAME Groups and the Impacts of COVID-19 in Scotland" (p22).
- Emphasises that ethnic and racial categories are not themselves a causal factor but map on to underlying social determinants of health.
- Identifies language barriers as an issue for some minority ethnic communities.

Note: Runnymede is a UK independent thinktank on race equality and race relations.

Public Health Scotland (PHS) – Interpreting, Communication Support and Translation National Policy
Published 22 October 2020

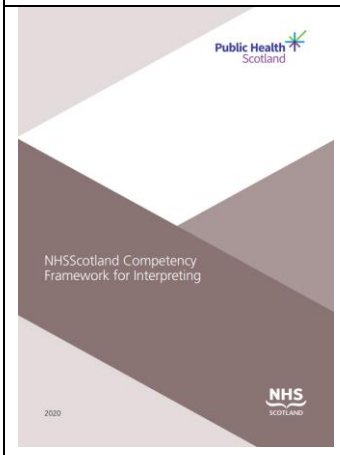


Key Themes

- Provides guidance on NHSScotland responsibilities to patients and carers who require support from interpreting or translation services.
- Includes all interpreting and translation requirements – for example, British Sign Language, Braille, literacy needs and preferred language other than English.
- Outlines benefits to using professional interpreting and translation services and risks of staff, family, friends or carers undertaking the role of interpreter or translator.

Note: Deliverable 2 from the Short-Life Working Group on Racialised Health Inequalities in Maternity Care – *Best Practice Toolkit – Working with Interpreters in Maternity Services* – references this policy.

Public Health Scotland (PHS) – NHSScotland Competency Framework for Interpreting
Published 22 October 2020



Key Themes

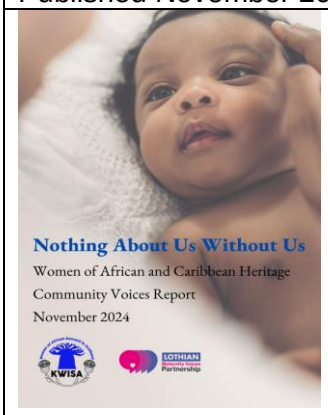
- This document is intended to provide clear, precise and simple guidance for those working with patients with preferred communication other than spoken English. As services and agreements differ between areas, this document may be adapted to reflect relevant local information.
- To be used alongside the NHSScotland Interpreting, Communication Support and Translation National Policy (above).
- Outlines three-way interpreting process between NHS staff, the Public Service Interpreter and the patient/ service user.
- Indicates responsibilities of NHS staff, interpreting service providers and public service interpreters.

Note: Deliverable 2 from the Short-Life Working Group on Racialised Health Inequalities in Maternity Care – *Best Practice Toolkit – Working with Interpreters in Maternity Services* – references this Competency Framework.

3. Scotland – Racialised Health Inequalities in Perinatal Care

i. Reports

KWISA – Nothing About Us Without Us: Women of African and Caribbean Heritage Community Voices Report
Published November 2024



'Nothing About Us Without Us' was a community participatory initiative and innovative collaboration model established between KWISA Women of African Heritage and NHS Lothian's Maternity Voices Partnership. The report offers valuable insights into both service user and staff experiences and makes recommendations for improvement which could be applied across Scotland.

Key Themes

- Women shared a mix of positive and negative experiences of care. Positive experiences were associated with feeling listened to and having concerns valued. Negative experiences were characterised by not being listened to, pain being dismissed, misdiagnosis of conditions on darker skin, poor communication and delays in receiving care.
- Engagement with minoritised groups needs to meaningful – previous experience of engagement as *tokenistic 'tick box' exercise*.
- Detection of conditions in darker skin tones (particularly anaemia and jaundice).
- Importance of healthcare providers showing genuine curiosity and listening.
- Importance of monitoring and evaluation of outcomes and experiences.

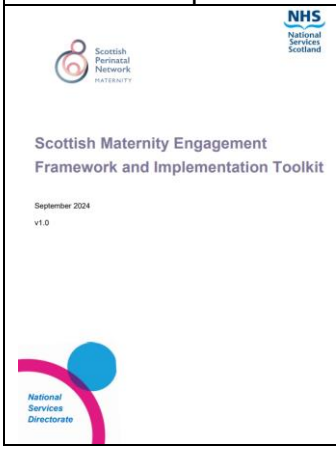
Amma Birth Companions – Birth Outcomes and Experiences Report
Published March 2024

Key Themes

- Report focuses on the experiences of 100 clients of Amma Birth Companions over 2021 and 2022.
- Amplifies experiences of women seeking asylum.
- Highlights issues experienced by women, including practice issues and discrimination (e.g. around birth choices, consent, insensitive and disrespectful behaviour, traumatic experiences and misinformation, and inadequate support and dismissive attitudes.
- Highlights issues with interpreting, including availability of interpreters, quality, of interpreting, access to interpretation in the correct dialect, technical issues (e.g. with phone connection), and staff awareness, willingness and knowledge to support access to interpreting services.
- Raises increased rates of induction for Amma clients, as

	well as observations regarding Caesarean section rates and low rate of spontaneous labour among the client group. • Highlights close working with NHS maternity services. • Makes recommendations for improvement for NHS staff, NHS management, policy makers and statutory bodies, educators and Amma Birth Companions.

Scottish Perinatal Network (SPN) – Scottish Maternity Engagement Framework and Implementation Toolkit
Published September 2024



Key Themes

- The Framework offers key principles to implement goals for effective maternity service user engagement, and a toolkit of suggestions and resources to support implementation.
- Highlights importance of tailoring approaches to include service users from seldom heard communities and on taking an inequalities focus.

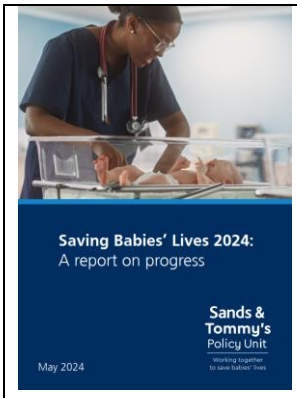
Further background:

- Maternity Engagement - Scottish Perinatal Network

Sands and Tommy's Joint Policy Unit – Saving Babies Lives 2024: A report on progress
May 2024

Key Themes

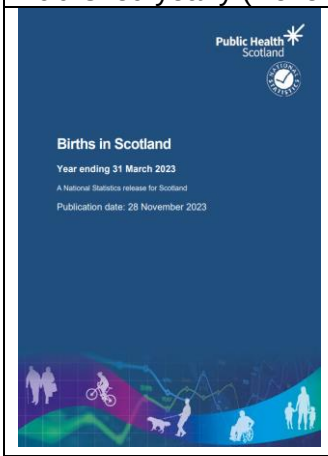
- Highlights importance of ethnicity data collection in identifying inequalities and in monitoring progress towards tackling those inequalities and improvements in outcomes.
- Notes the relationship between deprivation and ethnicity and outlines other drivers of inequalities (linked with the Joint Policy Unit's 2024 Progress Report).



Key Themes

- UK-wide report on progress towards reducing stillbirth and neonatal death rates.
- Outlines differences in pregnancy and baby loss by ethnicity and deprivation.
- Importance of integrating efforts to tackle inequalities as part of work to intended to support improvements in maternity safety.
- Highlights experiences of Black and Asian bereaved parents shared with the Sands Listening Project.
- Figure 17 (page 17) provides the Joint Policy Unit's 'Health Inequalities Framework', adapted from: A Comprehensive Review on Social Inequalities and Pregnancy Outcome-Identification of Relevant Pathways and Mechanisms - PubMed (last accessed 16 January 2025).

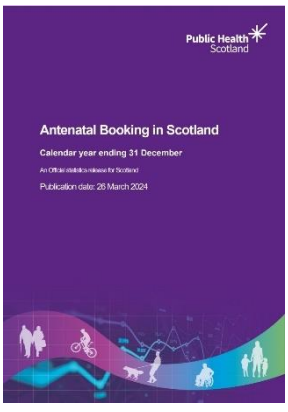
Public Health Scotland (PHS) – Births in Scotland
Published yearly (November)



Key Themes

- Crude numbers and rates including by ethnicity of: pregnant women giving birth, maternal obesity, gestational diabetes, operative delivery, preterm birth, birthweight adjusted for gestational age.
- It is important to note that apparent differences in crude rates may be at least partly explained by differences in the age structure of different ethnic sub-populations.

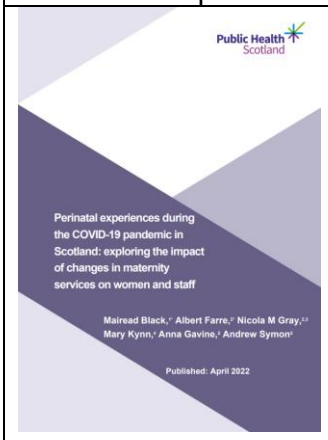
Public Health Scotland (PHS) – Antenatal Booking in Scotland
Published yearly (March)



Key Themes

- Crude numbers and rates including by ethnicity of women booking for antenatal care, average gestation, and smoking status at booking.
- It is important to note that apparent differences in crude rates may be at least partly explained by differences in the age structure of different ethnic sub-populations.

Public Health Scotland (PHS) – Perinatal experiences during the COVID-19 pandemic in Scotland: exploring the impact of changes in maternity services on women and staff
Published 6 April 2022



Key Themes

- Research report, commissioned by PHS and the Scottish Government, undertaken by researchers at the University of Aberdeen and the University of Dundee.
- Outlines learning from the COVID-19 pandemic and makes recommendations to inform planning, policy and approaches for the future.
- Explores a variety of inequalities.

Note: The study acknowledges the generalisability of the study sample as a limitation, reflecting responder bias: *[t]he final sample under-represented women from minority ethnic groups, those who do not speak English as a first language and those from low-income households.*

Public Health Scotland – Ready, Steady, Baby!

Key Themes

- Provides information and guidance on pregnancy, labour and birth, and early parenthood up to 8 weeks' postnatal.
- Information available in translation, Easy Read format and online via the NHS Inform microsite.

Ready, Steady, Baby!: Current Versions

- Easy read - Ready Steady Baby! Easy Read: Guidance for health professionals - Publications - Public Health Scotland
- Polish
- Simplified Chinese
- Arabic
- Ukrainian
- NHS Inform microsite

Note: PDF copies of *Ready, Steady, Baby!* in translation are available from the PHS website (https://www.nhsinform.scot/ready-steady-baby). Hard copies can be requested via the PHS Other Formats mailbox: phs.otherformats@phs.scot.

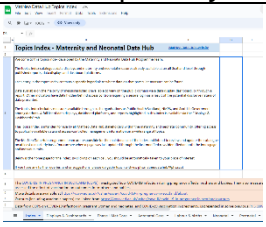
Jeeva Reeba John, Gwenetta Curry, Sarah Cunningham-Burley - Exploring ethnic minority women's experiences of maternity care during the SARS-CoV-2 pandemic: a qualitative study
Published 6 September 2021

Key Themes

- Importance of respectful communication, particularly during times of high maternal stress.
- Those with non-'British' accents identified bias due to accent as a significant concern.
- Participants felt that language barriers were the most common cause of miscommunication between themselves and healthcare professionals.
- Cultural dissonance was identified as a significant barrier to effective communication, including religion and wider cultural context.
- Importance of empathy in interactions with healthcare professionals.
- Institutional racism was highlighted as a significant issue in pregnancy care by most of the participants.
- Impacts of changes in the delivery of care as a result of the pandemic.
- Notes interplay between socioeconomic factors and ethnicity.

ii. Data

Public Health Scotland – MatNeo Data Hub Topics Index – Google Sheets
Reviewed quarterly



Note: The Maternity and Neonatal Data Hub topics index catalogues data displays and maternity and neonatal measures already available at an all-Scotland level through published reports, data displays and dashboard platforms. Each entry in the topics index contains a specific hyperlink to where data on that particular measure can be found.

Public Health Scotland, Scottish Strategic Perinatal Network, Healthcare Improvement Scotland, Scottish Government, National Records of Scotland – MatNeo Data Hub
Last accessed 14 January 2024

Note: Provides background on the development of the MatNeo Data Hub

Scottish Perinatal Network / Public Health Scotland- Data sources rundown

- Web Resources - Scottish Perinatal Network

Scottish pregnancy, births and neonatal data dashboard:

- Landing page
- Dashboard

4. UK-wide – Racialised Health Inequalities in Perinatal Care

Durham Infancy & Sleep Centre, Durham University and Amma Birth Companions – We Don't Ask for a Luxury Life: The Health, Safety and Well-being of Babies and their Mothers in Dispersal Asylum Accommodation in the UK
Published December 2024

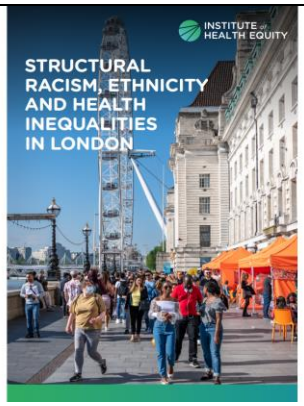
Key Themes

- Investigates the experiences of mothers and babies seeking asylum allocated dispersal accommodation in Glasgow.
- Highlights the multiple and intersecting inequalities facing people seeking asylum and the particular challenges facing pregnant asylum seekers, babies and children.
- Focus on dispersal accommodation but provides useful insight into the challenges experienced by women and families regarding housing.

Summary and Recommendations:

- The Health Safety and Well-being of babies in Asylum Accomodation in the UK

University College London (UCL) Institute of Health Equity – Structural Racism, Ethnicity and Health Inequalities in London
Published 1 October 2024

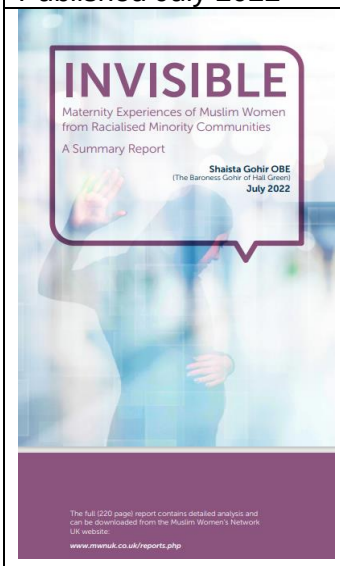


Note: While the report is focused on London, it provides helpful explanations of race and racism (from page 11) and offers valuable examples of good practice, particularly on work taking an actively anti-racist approach (From page 173).

Key Themes

- Explores ethnic inequalities and racism in health and in six areas of social determinants of health (as set out in the 2010 Marmot review as key drivers of health).
- Approach demonstrates the importance of understanding local populations and demography.
- Chapter 3: Racism and Ethnic Inequalities in Health includes specific focus on maternal and infant mortality and health.
- From page 173, the report offers additional information on organisational action on antiracism and highlights examples of good practice.
- Emphasises the importance of community coproduction in developing strategies and interventions to tackle racialised inequalities that are culturally appropriate and designed with the communities that are most affected.

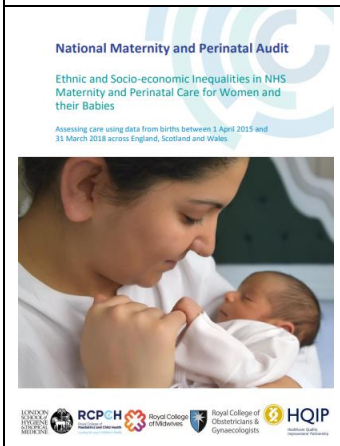
Muslim Women's Network (Secretariat, APPG on Muslim Women) – Invisible: Maternity Experiences of Muslim Women from Racialised Minority Communities
Published July 2022



Key Themes

- Reports on the maternity experiences of Muslim women in the UK, particularly from Black, Asian and other minority ethnic backgrounds.
- Highlights poorer experiences for Muslim women during the antenatal, intrapartum and postnatal periods.
- The report identified six themes as contributory factors to poor maternal outcomes for Muslim women from racialised minority communities:
  - Data gap
  - Maternity information gap
  - Women not feeling listened to
  - Women feeling invisible during maternity care provision
  - Care lacking dignity and respect
  - Feedback not being captured, with services missing opportunities to learn from service user experiences to improve care.
- Identifies a need to improve clinical, interpersonal and cultural staff competency to ensure culturally appropriate care.

National Maternity and Perinatal Audit (NMPA) – Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies
Published 2021



Key Themes

- Describes inequalities in maternity and perinatal care for women and their babies in England, Scotland and Wales during the period from 1 April 2015 to 31 March 2018.
- The results demonstrate differences in outcomes of maternity and perinatal care among women and their babies between those living in the most deprived and least deprived areas, and in those from ethnic minority groups compared with white ethnic groups.
- Women from South Asian and Black ethnic groups, and those from the most deprived areas, had higher rates of hypertension and diabetes.
- Women from Black ethnic groups had a higher rate of experiencing a birth without intervention and had higher rates of major postpartum haemhorrhage when compared with women from white ethnic groups.
- Babies born to women from South Asian ethnic groups were less likely to have an Apgar score of less than 7 at 5 minutes but were more likely to be admitted to a neonatal unit at term when compared with babies born to women from white ethnic groups.
- Makes recommendations regarding training, recording of ethnicity data and local understand of population and demography (page xi).

Hannah Rayment-Jones, James Harris, Angela Harden, Cristina Fernandez

Turienzo, Jane Sandall - Project20: Maternity care mechanisms that improve (or exacerbate) health inequalities. A realist evaluation
Published 26 November 2022

Key Themes

- Evaluation of two UK specialist models of care that provide continuity to women with social risk factors.
- Experiences of stigma, discrimination and paternalistic care were reported when women were not in the presence of a known midwife during care episodes.
- Benefits of continuity of care for women's experience of maternity services.
- Value of accessible, culturally sensitive antenatal education.

Royal College of Midwives (RCM) – Decolonising Practice in Midwifery
Published October 2024

Key Themes

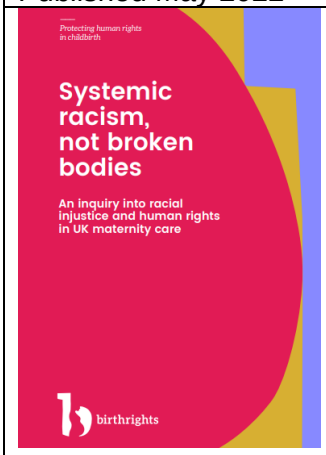
- RCM position statement outlining commitment to addressing racial inequalities in maternity care, including advocating for decolonising practice in midwifery.

Royal College of Midwives (RCM) – Decolonising Midwifery Education Toolkit
Published March 2023

Key Themes

- Developed for midwifery educators and other stakeholders involved in planning and delivering midwifery education.
- Aims to empower midwifery educators to challenge the legacies of colonial perspectives in all aspects of midwifery education.
- Provides definition of 'decolonisation' and how it pertains to midwifery education and practice.
- Highlights importance of language in terms of promoting inclusion and cultural safety.
- Offers reflective questions which can be applied or used more broadly to reflect on practice and culture.

Bliss UK – South Asian families' experiences of neonatal care Published 2022	
	**Key Themes** • Variable experiences of maternity care. Some women reported feeling unsupported physically and emotionally, particularly around support for breastfeeding and pain relief. • Impact of cultural assumptions on fathers' participation in care. • Importance of understanding need for privacy and modesty. • Parents who did not speak English as a first language were more likely to report poor experiences. • Makes recommendations for Bliss and for neonatal service providers.

Birthrights – Systemic Racism, Not Broken Bodies Published May 2022	
	**Key Themes** • Inquiry into racial injustice and human rights in UK maternity care. • Sets out five calls to action to drive forward change, including calling on all parts of the maternity system to commit to being anti-racist organisations; decolonising maternity curriculums and guidance; ensuring Black and Brown women are decision-makers in their care and in the wider maternity system; creating safe, inclusive workforce cultures, and dismantling structural barriers to racialised inequalities. • Shares findings and evidence, including case studies. • Highlights areas of good practice. • Outlines calls to action, with explicit links to human rights and equalities legal bases.

FIVEXMORE – The Black Maternity Experiences Survey Published May 2022	
	**Key Themes** • Shares results of a survey used to gather qualitative and quantitative data from 1340 women from around the UK who either identified as Black or of Black mixed heritage and who had accessed NHS maternity services whilst pregnant between 2016 and 2021. • Negative experiences outweighed the positive, particularly in three key domains: attitudes (e.g. use of discriminatory language by healthcare staff); knowledge (e.g. poor understanding about the anatomy and physiology of Black women and poor understanding of the clinical presentation of conditions in babies of Black women), and assumptions (e.g. racially biased assumptions about pain tolerance). • Highlights lived experience and living expertise of Black women accessing maternity services.

National Neonatal Audit Programme (NNAP) – Summary Report on 2023 Data
Published October 2024

Note: While NNAP measures do not report by ethnicity, individual Boards/ services may find this information helpful to triangulate with other local data sources, including ethnicity data.

Further resources:

- NNAP landing page
- Data dashboard
- 2023 Summary Report and available downloads

MBRRACE-UK - Maternal Mortality and Morbidity – *Saving Lives, Improving Mothers' Care*
Published October 2024

Key Themes

- Inequalities in maternal mortality remain, with Black women at 3x higher risk and Asian women at 2x higher risk of death.
- Provides key messages for the care of recent migrant women with language difficulties:
  - Assess women's language needs at booking and every interaction;
  - Document women's language needs and interpreter use;
  - Use professional interpreter services at every interaction;
  - Provide written information in the woman's preferred language.
- Consider barriers to access re late booking and where appointments are missed.

October 2024: full materials:

- Saving Lives, Improving Mothers' Care 2024

Further resources:

- MBRRACE-UK – Maternal programme of work
- Maternal reports – Saving Lives, Improving Mothers' Care
- Maternal Mortality Data Briefs (Maternal mortality UK 2021-23 published January 2025)

MBRRACE-UK Perinatal Mortality Surveillance
Published July 2024

Key Themes

- Extended perinatal mortality rates decreased across the UK in 2022 after a rise in 2021, although rates remain higher than both 2019 and 2020.
- Compared with rates in 2021, stillbirth rates were lower across all the devolved nations except Scotland, where there was a small increase.
- Deprivation continues to be associated with greater risk of stillbirth and neonatal death.
- Wide ethnic inequalities in stillbirth rates remain, with babies of Black ethnicity still more than twice as likely to be stillborn than babies of white ethnicity.
- Babies of both Asian and Black ethnicity continue to have higher rates of neonatal mortality than babies of white ethnicity.
- The combined effect of deprivation and ethnicity: babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity continue to be disproportionately affected by the higher rates of stillbirth and neonatal mortality associated with socioeconomic deprivation.

July 2024: full materials:

- UK perinatal deaths of babies born in 2022

Further resources (including data and previous reports):

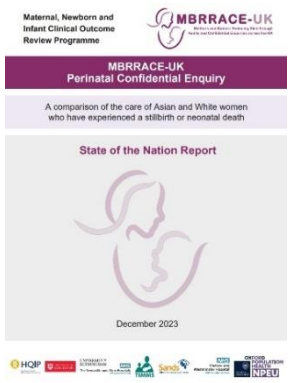
- MBRRACE-UK perinatal mortality
  - Surveillance
  - Data viewer
  - Confidential Enquiries
- Perinatal Mortality and Morbidity Confidential Enquiries
- Perinatal Mortality Surveillance reports

MBRRACE-UK Perinatal Confidential Enquiry – The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death
Published 12 December 2024

Key Themes

- Citizenship was not routinely or accurately recorded for all women.
- Provision of interpretation services needed to be improved, with 73% of contacts taking place without documented professional interpreter provision from either an in-person interpreter or LanguageLine. 50% of all contacts took place with no documented interpreter provision.
- There was variation in the recording of social risk factors.
- One Somalian woman's ethnicity was incorrectly recorded in the notes as Asian rather than Black African, an error also noted for another Somalian woman in the previous perinatal confidential enquiry, suggesting that ethnicity was assumed rather than self-declared by the

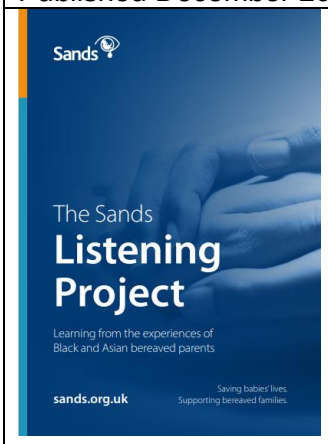
	woman. • Outlines challenges in access to maternity services and in specific areas within the perinatal care pathway, as well as bereavement care and pathology. **December 2024: full materials:** • Perinatal Confidential Enquiry | MBRRACE-UK **Further resources (including data and previous reports):** • MBRRACE-UK perinatal mortality - Surveillance - Data viewer - Confidential Enquiries • Perinatal Mortality and Morbidity Confidential Enquiries • Perinatal Mortality Surveillance reports

MBRRACE-UK Perinatal Confidential Enquiry - A comparison of the care of Asian and White women who have experienced stillbirth or neonatal death, MBRRACE-UK Published December 2023	
	**Overall Findings:** • Identifies where improvements in care may have made a difference for both white and Asian women. • Highlights variation and inconsistency in the recording of ethnicity, nationality and citizenship status, which is likely to lead to a lack of personalised care which is kind and compassionate. • Identification and response to language needs a particular issue across all ethnic groups, which may have impacted on women's ability to make informed choices about their care. • Makes recommendations for improvement.

MBRRACE-UK Perinatal Confidential Enquiry – A comparison of the care of Black and White women who have experiences a stillbirth or neonatal death, MBRRACE-UK Published December 2023	
	**Key Themes** • Investigates any differences in the quality of care provision for mothers of Black and white ethnicity whose pregnancy ends in a stillbirth or neonatal death. • Identified instances where improvements in care may have made a difference to the outcome of the baby (42% of Black women and 49% of white women) and the mother (61% of Black women and 69% of white women). • 33% of Black women and 54% of white women had major or significant issues during postnatal and bereavement care. • 75% of Black parents and 66% of white parents had major or significant issues identified at follow-up or during review of their and their babies' care. • Noted variation and inconsistency in the recording of ethnicity, nationality and citizenship status.

	• Identifying and responding to language needs are inadequate across all ethnic groups, with inconsistent use of independent interpretation services noted for all women who needed it. • Compared with white women, fewer Black women had evidence of routine mental health questions being asked. • Black women were more likely to experience barriers to accessing specific aspects of care or advice that were offered. • Lack of personalised care which was both kind and compassionate. • Makes recommendations for improvement.

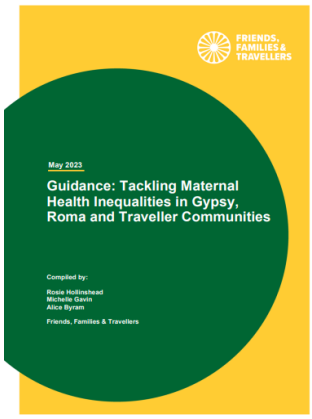
Sands UK – Listening Project: Learning from the experiences of Black and Asian bereaved parents
Published December 2023



Key Themes

- Focus on bereavement care and learning from adverse events.
- Half of participating parents believed they had received worse care or been treated differently by healthcare staff because of their ethnicity.
- Safety issues across four key areas of care:
  - Being listened to and heard
  - Personalised, joined-up care
  - Communication about safety and risk
  - Safety and learning
- Of the participating parents who spoke specifically on whether ethnicity had been a factor in their care or treatment, over half believed that their ethnicity had affected how they were treated, with some sharing examples of racism and bias on the part of healthcare staff.
- Includes examples of positive stories and interactions to illustrate good practice.

Friends, Families and Travellers – Guidance: Tackling Maternal Health Inequalities in Gypsy, Roma and Traveller Communities
Published May 2023



Key Themes

- Cultural norms around infant feeding vary across different Gypsy, Roma and Traveller communities.
- A lack of culturally pertinent and accessible information and support on infant feedback was reported.
- Literacy and language barriers, as well as lack of cultural competency or awareness around structural issues accessing primary care.
- Accommodation and living circumstances have a major impact on feeding experiences and ability to access services.
- Parents described feeling stigma, pressure and judgement around their feeding choices.

	• Experiences of discrimination and prejudice when accessing maternity or infant feeding services, resulting in mistrust or fear of health professionals and institutions for some, including fear of social services involvement. • Makes **recommendations** for maternity and infant feeding services.

5. UK nation other than Scotland – Racialised Health Inequalities (including in Perinatal Care)

BEAMs: Better outcomes postnatally for MumS - Outputs
Published 30 January 2025

Key Themes

- Outlines aims of the study and resulting outputs.
- Example of work to cocreate resources with women.
- Includes resources which may be of use, e.g. animations on postnatal red flags and mental health, information posters and the BEAMs postnatal health report.
- The study team also developed checklists for designing accessible information and on how to reach women, which are available on the website.

NHS England Race and Health Observatory (RHO) – Seven Anti-Racism Principles
Published 17 November 2024

Key Themes

- Anti-Racism Infographic and accompanying explainer video.
- The resources outline practical steps to foster anti-racist practice, raise awareness and address racial inequities in healthcare.

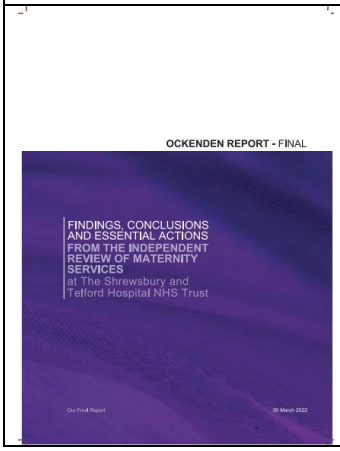
Equality and Human Rights Commission (EHRC) – Policy briefing on using equality data to understand and tackle race inequalities in maternity and antenatal care in England
Published 23 July 2024

Note: This briefing applies to England only but offers an overview of how collecting and using equality data (including on ethnicity) can promote patient safety.

Further information:

- Race discrimination | EHRC

Ockenden Review Team – Final Findings, conclusions and essential actions from the Ockenden review of maternity services at The Shrewsbury and Telford Hospital NHS Trust
Published 30 March 2022



Note: The report focuses on one particular NHS Trust in England and makes limited reference to ethnicity. It is included here given the high profile of the report and its recommendations.

Key Themes

- Completeness and accuracy of ethnicity data collection is important in understanding local populations and in identifying any disparities in experiences and outcomes by ethnicity.

Kirkup Review Team – Reading the Signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation
Published October 2022

Note: The report focuses on one particular NHS Trust in England and makes limited reference to ethnicity. It is included here given the high profile of the report and its recommendations.

Key Themes

- Notes concerns raised around lack of diversity and racial discrimination, with impact on both staff and service users.
- Notes missed opportunities to respond to bullying and inappropriate behaviour (including alleged racism).

Schoenaker, J Stephenson, H Smith, K Thurland, H Duncan, KM Godfrey, M Barker, C Singh, NA Alwan, for the UK Preconception Partnership - Women's preconception health in England: a report card based on cross-sectional analysis of national maternity services data from 2018/2019, DAJM
Published 21 February 2023

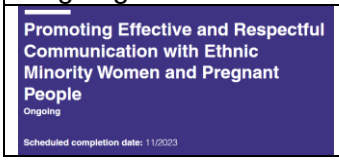

RESEARCH ARTICLE

Women's preconception health in England: a report card based on cross-sectional analysis of national maternity services data from 2018/2019

Key Themes

- Looks at women's preconception health in England.
- Inequalities were observed by age, ethnicity and area-based deprivation level.
- The findings suggest opportunities to improve preconception health and reduce sociodemographic inequalities for women in England.

NHS England Race and Health Observatory (RHO) – Promoting Effective and Respectful Communication with Ethnic Minority Women and Pregnant People
Ongoing

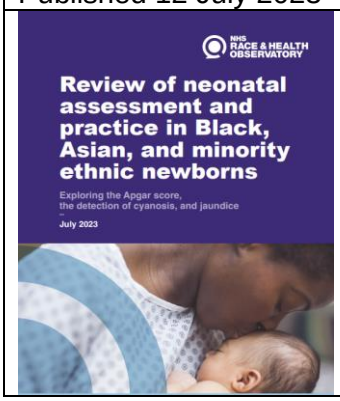


Note: This links to work underway in NHS England's Race and Health Observatory on promoting effective and respectful communication with ethnic minority women. This work is ongoing.

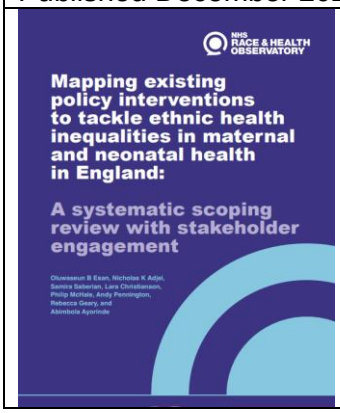
NHS England Race and Health Observatory (RHO) – Trauma-Informed Care in Black, Asian and Ethnic Minority Communities
Ongoing

	**Note:** This links to work underway in NHS England's Race and Health Observatory on trauma-informed care, looking to better understand trauma in the context of race; to assess the effectiveness of trauma-informed care through the lens of race and racism, and to explore best practice in developing race-aware trauma informed care. This work is ongoing.

NHS England Race and Health Observatory (RHO) – Review of neonatal assessment and practice in Black, Asian and minority ethnic newborns: Exploring the Apgar score, the detection of cyanosis and jaundice
Published 12 July 2023

	**Key Themes** • Outlines challenges in neonatal care for Black, Asian and minority ethnic babies, alongside clear recommendations on tackling them. • NHS RHO is in England but recommendations may also be applicable in Scotland. • Impact of current approaches to Apgar, identification of jaundice and cyanosis in neonates and potential mitigations to risk of perpetuating inequalities (e.g. use of bilirubinometer in diagnosis of jaundice).

NHS England Race and Health (RHO) – Mapping existing policy interventions to tackle ethnic health inequalities in maternal and neonatal health in England: A systematic scoping review with stakeholder engagement
Published December 2022

	**Note:** This document relates to England only but provides an insight into the Observatory's recommendations for policy and practice which may be of interest, particularly the consideration of evidence for interventions on reducing ethnic health inequalities.

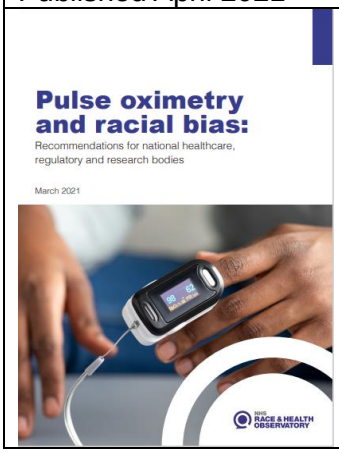
NHS Race & Health Observatory – Policy Briefing: The Ockenden review

Published 22 September 2022

Key Themes

- Ethnicity data collection and importance of understanding local population and demography.
- Importance of workplace culture to support safe delivery of care.
- Barriers to speaking up faced by staff from minority ethnic backgrounds, including fear of referral to professional regulators and fear of harsher sanctions, and experiencing detrimental treatment in response to raising concerns.
- Indicates strong correlations between the experiences of minority ethnic staff at work, and patient satisfaction and safety.
- Notes importance of continuity of carer in combating health inequalities amongst minority ethnic communities.

NHS England Race and Health Observatory (RHO) – Pulse oximetry and racial bias: Recommendations for national healthcare, regulatory and research bodies
Published April 2021



Key Themes

- Notes evidence that pulse oximetry is less accurate in darker skinned patients.
- Highlights need to understand physical signs of hypoxia in service users with Black and Brown skin – e.g. language such as ‘going blue’ may not be appropriate when assessing for cyanosis.

New findings from our national maternity inspection programme, Care Quality Commission
Published 14 July 2023

Blog post outlining findings from the Care Quality Commission (CQC) national maternity inspection programme.

- Update on CQC's national maternity inspection programme 2023 | Medium

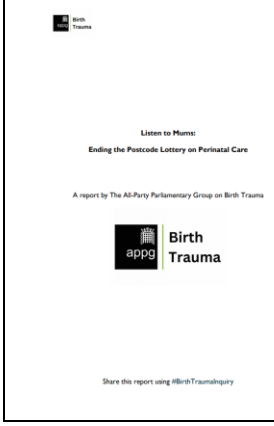
Key Themes

- Translation and interpretation services – areas of good practice.
- Importance of learning from demographic data and feedback (reviewing outcomes by ethnicity) – CQC *Safety, equity and engagement in maternity services report* (May 2022)

6. UK-wide – Racialised Health Inequalities

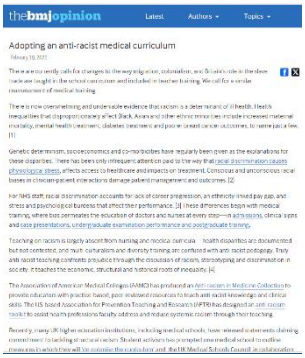
Royal College of Obstetricians and Gynaecologists (RCOG) – The College's ambition for race equality Last accessed 13 January 2025	
	The RCOG has set out its ambition for race equality, including: • Confronting racism and cultural bias in Obstetrics and Gynaecology – for both professionals and women accessing services. Notes workgoing to carry forward the legacy of its Race Equality Taskforce. • **For RCOG members**, the *Levelling the playing field: RCOG differential attainment, race and racism report* (2023) can be accessed via the RCOG website.

Tommy's – Resources for Black and Black Mixed-Heritage pregnant women and birthing people Last accessed 13 January 2025	
	Tommy's, the pregnancy and baby charity, has produced a list of resources, organisations and people who provide support specifically for Black women. Many of the sources are based in England but Tommy's has reach across the UK. • Resources for Black and Black Mixed-Heritage pregnant women and birthing people | Tommy's In addition, Tommy's offers a specialist helpline to support Black and Black mixed-heritage women across the UK. • Tommy's Midwives Helpline for Black and Black Mixed-Heritage women | Tommy's

The All Party Parliamentary Group on Birth Trauma – Listen to Mums: Ending the Postcode Lottery on Perinatal Care Published 13 May 2024	
	**Key Themes** • Variations in maternal outcomes related to ethnicity and deprivation (Chapter 7, p58). • Outlines vignettes and experiences shared by women. • Notes impact of language and access to interpreting services, which will be relevant for some women from minority ethnic communities as well as white women whose first or preferred language is other than English. **Note:** This is a UK APPG report. Given UK-wide call for submissions, some respondents may have given birth in Scotland.

Ispos – Hysterical Health: Unpicking the cultural beliefs that shape women's healthcare Published February 2023

	**Key Themes** • Explains how culturally embedded beliefs about gender might be shaping healthcare practices in the UK. • Perceptions of pain • Intersection of gender and ethnicity (see p12 for consideration of this in relation to pain, childbirth and ethnicity). • Issue of essentialising bodies – *assuming that incorrect social and cultural perceptions have a physical basis in bodies*. • Suggests four areas of focus, with first focused on addressing how women from ethnic minority backgrounds can be treated in the healthcare system, from training to culture and cultural beliefs.

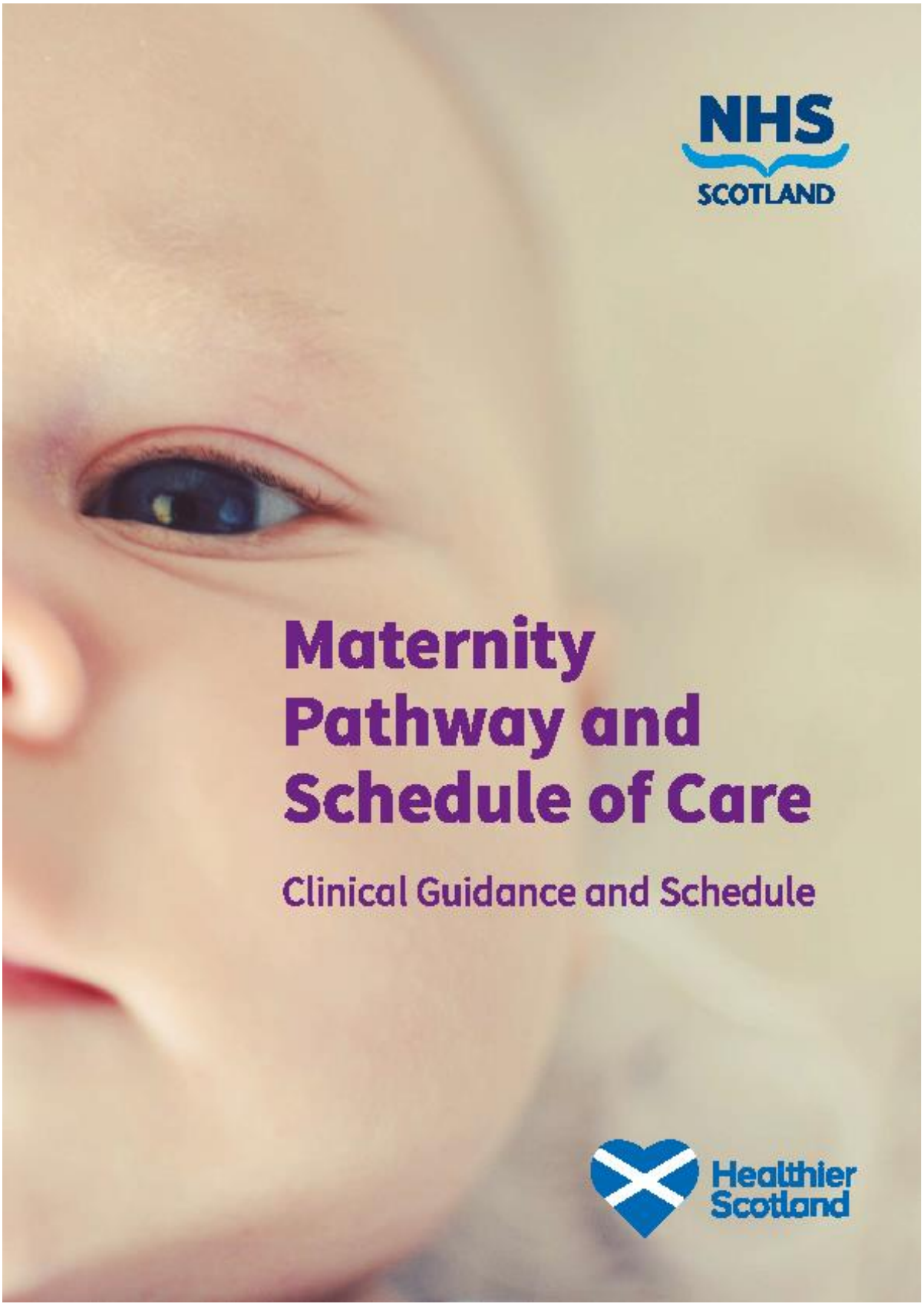
Padmasayee Papineni, Sarah Filson, Tiffanie Harrison, Malachi McIntosh - Adopting an anti-racist medical curriculum Published 19 February 2021	
	**Note:** BMJ opinion piece on the reassessment of medical training. **Key Themes** • Racism as a determinant of ill health. • Need for anti-racist education and suggestions for the creation of an anti-racist medical curriculum. • Notes need for healthcare professionals to be able to recognise, name, understand and talk about racism.

6. International – Racialised Health Inequalities

Glossary and Thesaurus, European Institute for Gender Equality Last accessed 14 January 2025	
	**Note:** The European Institute for Gender Equality provides a glossary and thesaurus of various terms which may be useful, including: • Disadvantaged groups (rather than vulnerable groups) • Intersectionality and intersectional discrimination • Marginalised groups

The O'Neill-Lancet Commission on Racism, Structural Discrimination and Global Health Last accessed 14 January 2025	
	**Note:** The O'Neill-*Lancet* Commission on Racism, Structural Discrimination and Global Health is founded on the recognition that racism, rather than race, creates and maintains unjust and avoidable health inequities in countries around the world. The Commission aims to identify and promote the implementation of anti-racist actions and strategies to reduce structural discrimination. **Key Resource** (free but requires individuals to create an account and log in to access): • Ngozi A Erondu, Tlaleng Mofokeng, Matthew M Kavanagh, Margareta Matache, Sarah L Bosha, published 18 May 2023 - Towards anti-racist policies and strategies to reduce poor health outcomes in racialised communities: introducing the O'Neill–Lancet Commission on Racism, Structural Discrimination, and Global Health - The Lancet **Key Themes:** • Global focus • Explains that racism is embedded in the structures and institutions that drive global health governance and healthcare systems. • Notes impact of previous experiences (including experiences of racism) of healthcare on decision to seek care and treatment in future, with implications for outcomes.

Annex D – Pathway of Maternity Care



Contents

1. Introduction

All women and babies, whatever their circumstances, will have high quality and safe maternity and neonatal care, which takes account of their individual needs and preferences. Women, their partners and families will be aware of the support and choices that are available to them in order that care can be provided in partnership to achieve the best outcomes.

This pathway illustrates the core care that women and their babies should receive. All core contacts antenatally and postnatally (other than 32 weeks antenatal visit for primigravid and parous as required) should be face to face as they include physical examination.

The foundation of care is to offer a strengths based, family-centred, trauma informed, safe and compassionate approach to care that is individualised to each family entering into the maternity setting. This will support pregnant women, and their families, to optimise their birth and parenting potential.

Care provided will be tailored to each individual with continued ongoing assessment of needs throughout pregnancy, birth and the postnatal period to inform the range of birth choices available. This will be enabled by delivery of continuity of carer.

This Pathway includes schedules outlining the core contacts every woman should receive and is intended to cover the majority of care and clinical judgement required. When deciding it is not appropriate to follow the guidance this decision should be discussed with the woman and recorded.

This document will support conversations with women through their maternity journey. It is to be used in conjunction with and complement existing local information and/or guidance.

The information in this document complements the information in the Birth Place Decisions Leaflet, which is available for pregnant women to support informed decision making.

Health professionals should facilitate conversations and encourage questions.

There are different tools available to support quality conversations. The BRAN framework and It's OK to Ask resource can enable women to be more involved and make informed decisions about their own care and treatment.

Care provided should be responsive and adaptable to individual needs circumstances and preferences.

The terms woman/women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity.

All healthcare services should be respectful and responsive to individual needs, and all individuals should be asked how they wish to be addressed throughout their care.

An Equality Impact Assessment has been produced to accompany this publication.

Informed choice/consent:

Clinical practice requires clinicians to have discussions with women and give information regarding risks, benefits and alternatives throughout their maternity journey to enable women to make informed decisions that are right for their own situation.

Each consultation between women and healthcare professionals should be based on the assumption that they may suggest a set of clinical recommendations and care pathways that can be accepted or declined. Decisions about care should be documented, implemented and shared with the multi-disciplinary team as appropriate.

All discussions about decisions regarding maternity care should be clearly documented.

The principles of informed choice and consent must be applied when offering the care described in this Pathway.

Refer to Consent | RCOG

Refer to care_outside_guidance.pdf (rcm.org.uk)

1.1 Best Start Vision and Principles of Care

The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland (2017) outlined a vision for maternity care in Scotland where:

All mothers/birthing parents and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences

Fathers, partners, co-parents and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care

Birthing parents experience real continuity of care and carer, across the whole maternity journey, with families offered additional support tailored to their specific circumstances.

Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary complications

Staff are empathetic, skilled and well supported to deliver high quality safe services, every time

Multi-professional team working is the norm with an open and honest team culture, with everyone's contribution being equally valued

Principles of care:

- Care is supported by evidence
- The impact of inequality is recognised
- Consistently high quality communication is promoted
- Women are supported to take an active central role in their care and that of their baby/babies
- It is recognised that women's situations are dynamic and circumstances may change over time
- All women have the same level of core care regardless of additional need.
- When offering care health professionals should be mindful of the UNICEF UK Baby Friendly Initiative standards.

The foundations of care are to offer every woman, every family, every time care which is:

- strengths based
- family-centred
- trauma informed
- safe
- compassionate

Care will be individualised. This will support women and their families to optimise their birth and parenting potential. Further information about how to support individualising care can be found in this guide on Personalised Care and Support.

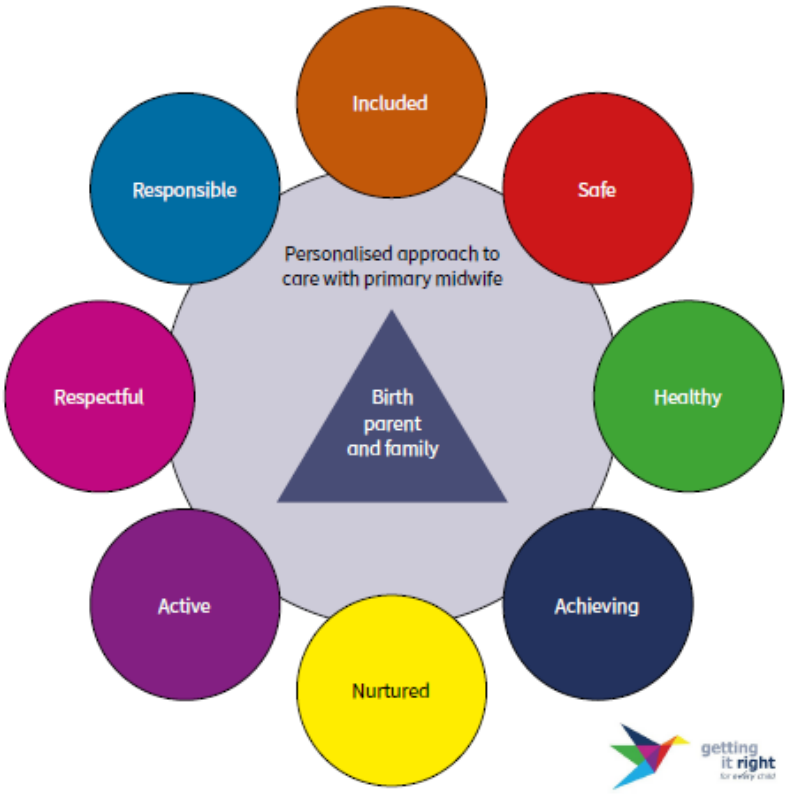
Women are provided with advice and services to promote lifestyle changes during their pregnancy in order to improve their own health and the health of their baby.

1.2 Getting it right for every child (GIRFEC)

The primary midwife is responsible for carrying out the 'Getting it right for every child' (GIRFEC) wellbeing assessment and implementing and revisiting the resulting wellbeing plan. GIRFEC provides Scotland with a consistent framework and shared language for promoting, supporting, and safeguarding the wellbeing of all children and young people. GIRFEC is the key underpinning policy and approach to our collective work across the country to improving outcomes for babies, children and young people. GIRFEC supports families by making sure children and young people can receive the right help, at the right time, from the right people.

GIRFEC and the UNCRC (United Nations Convention on the Rights of the Child) (which Scottish Government has incorporated into Scots law) applies to everyone up to the age of 18. Before birth, midwives and maternity professionals can apply the values and principles of GIRFEC and support to the parents in considering their wellbeing, and that of the unborn baby. Following birth, the UNCRC captures children's rights and articulates them within the context of a child's life and experiences. These rights apply equally to all children either individually, or as a group, and apply in all settings including at home, in the community, at school, or in other protective settings such as in secure primary care facilities. The best interests of the child should be a primary consideration, and the views of the child must be given due weight in accordance with their age and maturity. GIRFEC also continues to apply to all children and young people up to the age of 18, or older if still at school, including young people who have left school but are not yet 18. As such, midwives and maternity professionals should consider that GIRFEC and the duties in the UNCRC (Incorporation) (Scotland) Act will also apply to young parents up to the age of 18.

GIRFEC takes account of the 8 SHANARRI indicators when considering the wellbeing and specific needs of women throughout pregnancy and birth. These indicators are shown in the diagram below.



1.3 Continuity of Carer

The Best Start recommends that every woman will have continuity of carer from a primary midwife working within a continuity of care model who will provide the majority of their antenatal, intrapartum and postnatal care. Relationships are key and it is vital that parents are receiving consistent care from one person. Where appropriate, women will also have continuity of obstetric care.

The woman and her primary midwife will develop a plan of care to ensure all aspects of the woman's clinical, personal, cultural and lifestyle circumstances are considered and addressed. Any additional care offered, clinical and social, will be brought around the woman, with the woman at the centre, coordinated by and in partnership with their primary midwife. Keeping care close to home, where possible, will allow parents and their babies to stay together.

Midwives delivering continuity of care and carer, and the named obstetricians, build strong working relationships, focused around a specific caseload of women. This supports effective team working, enables on-going discussions between women, their primary midwife and their named obstetrician or wider team where required. By embedding a supportive decision making approach across Scotland involving healthcare professionals, women and families working together, the best care possible can be delivered.

Evidence shows that outcomes for both women and babies are improved when they receive continuity of midwifery care, and this should be provided to every woman. Women who need the input of an obstetrician will have continuity of a named obstetrician throughout their antenatal and postnatal care.

1.4 Personalised Care

The principle of personalised or individualised care is that it is always centred around the needs and choices of the woman (and her baby/ies) and not the needs of the service. Choice is supported with unbiased, evidence based and non judgemental information sharing and any plan is co produced with woman and care givers. Further information about how to support individualising care can be found in this guide on Personalised Care and Support.

1.5 Social Complexities

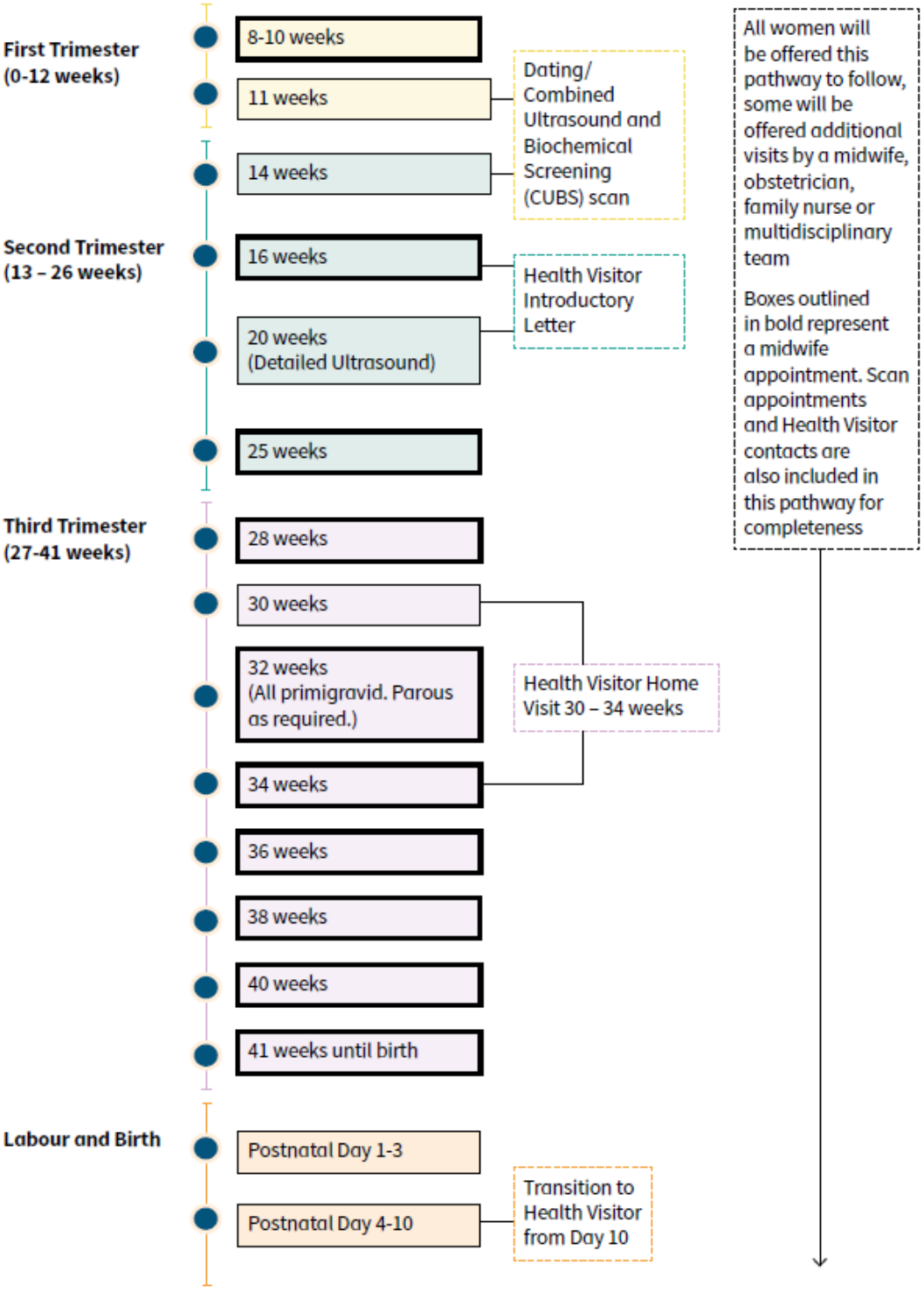
There are degrees to complexities, so it is vital that all midwives are equipped as the first point of contact, to recognise and work with women with social complexities appropriately. The work of the primary midwife is likely to be particularly important for women with social complexities, and caseloads may need to be reviewed to support this position.

Women with more complex needs may be offered referral into specialist, multi-professional and multi-agency teams, but many women can be supported as part of routine care, with extra support from their primary midwife and the wider team.

In all cases it is important to ensure that the team care is constructed around the women's needs, and is accessible.

The National Autism Implementation Team have produced some Key Messages for Perinatal Teams, which can be used by teams to help them support neurodivergent women in their care.

2. Core Health Contacts for All Women and Babies (Conception to Postnatal)



Additional Antenatal and Postnatal Care

All women will receive the core care illustrated above. Some women with medical conditions, comorbidities, or complex social needs may need to be offered multidisciplinary team care. The primary midwife can offer additional appointments if the need is identified.

Primary Midwife

The primary midwife leads and co-ordinates care planning for women with additional needs and will continue to be the lead for midwifery care throughout.

Named Obstetrician

The named obstetrician leads care planning for women with additional clinical needs with input from a range of multidisciplinary partners as required.

Pre-existing medical conditions where referral to an obstetrician for care planning is required. This list is not exhaustive. Any other conditions of concern should be considered for discussion with or referral to an obstetrician.			
Confirmed cardiac disease	Pre-existing type 1 or 2 diabetes	Cystic fibrosis	Asthma with an increase in treatment or hospital admission in current pregnancy
Hypertensive disorders	Non-specific connective tissue disorders and systemic lupus erythematosus, scleroderma	Organ transplant	Epilepsy or other significant neurological conditions such as multiple sclerosis or myasthenia gravis
Hyperthyroid	BMI >40	Haemoglobinopathies, such as sickle cell disease	Rhesus isoimmunisation
Atypical antibodies	Female Genital Mutilation	Past or current Malignancy	Hep B/C or liver disease with abnormal liver function
HIV	Bleeding or platelet disorder such as ITP	Von Wilibrands Disorder	History of thrombolic disorders
Inflammatory Bowel Disease (Crohn's disease or Ulcerative colitis)	Current active Varicella Zoster, rubella, herpes	Abnormal renal function or renal disease requiring supervision by a renal specialist	
Family History of Genetic Conditions	Maternal age 40 or over at booking	Significant substance or alcohol use	
Previous cerebrovascular accident	Psychiatric disorder under current psychiatric care	Previous myomectomy or hysterotomy	
Unstable hypothyroid such that a change in treatment is needed	Spinal abnormalities	Previous significant cervical treatment	
Tuberculosis under current treatment	Previous history of bariatric surgery		

If you are unsure, please ask.

Some conditions, such as perinatal mental health or anaemia, will have an established local pathway that should be followed.

Previous pregnancy, labour and birth complications where referral to an obstetrician for care planning is required. **This list is not exhaustive. Any other conditions of concern should be considered for discussion with or referral to an obstetrician.**			
Previous shoulder dystocia	Eclampsia	Placental abruption	Uterine rupture
Primary postpartum haemorrhage	Previous caesarean birth	Stillbirth or neonatal death	Late miscarriage or recurrent miscarriage
Previous baby with neonatal encephalopathy	Pre-eclampsia requiring preterm birth	Extensive vaginal, cervical, or third- or fourth-degree perineal trauma	
Uterine anomaly such as bicornuate uterus	Previous growth restriction	Preterm birth or Premature Rupture of Membranes < 34 weeks	

If you are unsure, please ask.

Some conditions, such as perinatal mental health or anaemia, will have an established local pathway that should be followed.

Choice of Place of Birth

Birth is generally very safe for women and their babies with low risk of complications.

Each NHS Board will provide the full range of choice of place of birth within their region.

A national Birthplace Decision Leaflet has been designed to support women with their decision on where to give birth and have informed discussions with their midwife and consultant obstetrician (where appropriate).

Additional care – labour and birth

Some women may have complex care needs which mean they will be advised that the optimal place in which to labour and birth should be in an obstetric unit.

In an obstetric unit care should continue to be individualised and options for labour and birth continue to be considered, acknowledging that not all women will be recommended the same package of care. For example, it may not be necessary to offer a women who has had a previous Post Partum haemorrhage (PPH) continuous electronic fetal monitoring (CEFM) in labour.

Obstetric conditions arising in this pregnancy where referral to an obstetrician for care planning is required. Most women with these conditions will be advised to birth in an obstetric unit. **This list is not exhaustive. Any other conditions of concern should be considered for discussion with or referral to an obstetrician.**			
Preeclampsia or pregnancy induced hypertension	Multiple pregnancy	Placenta praevia	Polyhydramnios
Fibroids >5cm	Fetal growth restriction	Oligohydramnios in the absence of ruptured membranes	Haemoglobin less than 85g/dl
Malpresentation – breech or transverse lie	Recurrent antepartum haemorrhage	Gestational Diabetes	Obstetric cholestasis
Fetal abnormality/ anomaly	Ultrasound suspicion of macrosomia	Abnormal fetal heart rate, umbilical or fetal doppler studies	Preterm prelabour rupture of membranes

If you are unsure, please ask.

Some conditions, such as perinatal mental health or anaemia, will have an established local pathway that should be followed.

Vaccines

Vaccines discussed and offered (as per guidance) in antenatal period	
Flu vaccine	In season at any gestation
Whooping cough	From 16 weeks
Respiratory syncytial virus (RSV)	From 28 weeks

3. Antenatal Pathway

The following schedule outlines the antenatal care contacts every woman should receive and is intended to cover the majority of care and clinical judgement required. It is to be used in conjunction with and complement existing local information and/or guidance.

First Trimester

First Trimester (0 – 12 weeks)

Gestation	Content of Care - Prior to this appointment review any previous maternity records. Woman should be given screening information prior to booking appointment
8 – 10 weeks	Introduction to primary midwife and provide information about the continuity team. Introduce role of the midwife (and wider team). Ensure plan of care is co produced with woman and takes into account "what matters to me". Complete obstetric and medical history/family/social. Complete Mental Health Risk Assessment. Complete GIRFEC wellbeing assessment and create plan if required. Initial holistic assessment, BP (Blood Pressure), Height, Weight, BMI. Carbon monoxide testing. Refer to smoking cessation team if reading >4. Perform and record initial Maternity risk assessment category and care provider. Introduction to Health Plan Indicator. Incorporate appropriate private time and private space. Ensure interpreter is provided for scheduled appointments if required/requested. Tests: full blood count, group and screen, booking virology screen, haemoglobinopathy screening, urinalysis and MSSU (Mid-Stream Sample of Urine). Consider further screening following review of previous history (for example previous gestational diabetes). **Discuss and document: (refer to Ready, Steady Baby)** • Financial inclusion and referral to welfare rights • Smoking. CO (Carbon Monoxide) monitoring • Nutrition and exercise. Discuss Best Start Foods if appropriate • Substance and alcohol use • Gender based Violence – routine enquiry • Mental health and well being • Safety and security of accommodation and planning where mother and baby will sleep as per RCM guidance • Discuss vaccination • Discuss pregnancy screening options. Ensure consent obtained. • Folic acid and Healthy Start vitamins/vitamin supplements • Consider prevention of anaemia regarding prophylactic iron therapy • Consider anaesthetic referral as appropriate • Introduction of options of place of birth • Explore what parents already know about infant feeding and provide information about feeding options • Raised BMI: implement additional care plan. Refer to local guideline Discuss the significance of having a raised BMI and managing a raised BMI in pregnancy. Focused discussion on nutrition and exercise including positive health behaviour changes. PHS Weight Stigma hub can support conversations: Course: Challenging weight stigma learning hub | PHS Learning (publichealthscotland.scot) • VTE (Venous thromboembolism) risk assessment • Consider local aspirin in pregnancy guidance

First Trimester

Initiate interaction with all obstetric and social needs providers to establish a care plan for pregnancy and birth.

Identify notes for consultant review and plan if appropriate.

Notify GP and Health Visitor (HV) or Family Nurse

Written information/leaflets provided in appropriate language and format if required.

Contact GP and HV/Family Nurse to share booking information and request relevant history.

Inform about Parentclub website.

Additional Care Needs

Assessment of maternal/family health, wellbeing and early identification of social complexities or additional care needs including those with lived experience of care. Ensure early referral for appropriate support as per local pathways to ensure supportive networks are established. Follow local concern for unborn baby process as appropriate. Consider arranging joint Midwifery / Health Visitor / Family Nurse Partnership appointment. If complex social support to be offered, commence chronology.

Use of Substances: Implement individual care plan. Explain and offer routine bloods and Hepatitis C. Urine toxicology with consent. Refer to drug/alcohol specialist. Explain and offer, with informed consent, information sharing and multiagency working and liaison. Clarify professional responsibility. Consider / discuss with FNP if 24 years or under.

Mental Health: Follow Perinatal Mental Health Pathway: Antenatal: Consider / discuss with FNP if 24 years or under

Learning Disabilities: For women with learning disabilities, give a a copy of My Pregnancy My Choice. Refer to Learning Disabilities Service. Consider / discuss with FNP if 24 years or under. Individualised plan of care.

Teenage Pregnancy: If 19 years or under send notification to the Family Nurse Partnership (FNP).

Young Parents: Where available at local Health Board

- - 20 years or under send notification to FNP
- - 25 years or under, with a history of being looked after as a child, send notification to FNP.

If under 16 years follow local guidelines for child and adult protection.

If currently under 18 and in school or college, with consent, consider notifying relevant school nursing team in line with GIRFEC information sharing guidance.

11 – 14 weeks

Dating Scan

Ultrasound – Calculate EDD (Estimated Due Date) based on Ultrasound Scan. Generate growth chart.

Combined ultrasound and biochemistry screening. Nuchal Translucency Screening.

HV sends out introductory letter and service information leaflet. FNP arranges contact and gives written information at the engagement visit.

Second Trimester

Second Trimester (13 – 26 weeks)

Gestation	Content of Care
16 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Review, discuss and record the results of screening tests the woman has accepted, including BP and urinalysis. Investigate a haemoglobin level below 11g/100ml and consider offering iron supplements if not following prophylactic iron therapy guideline or recommend increasing iron supplements if on prophylactic iron therapy. Give specific information on the detailed fetal anomaly scan offered in the second trimester. Reinforce information re anti-D if RhNeg and document woman's decision regarding this. Consider joint 16 week appointment with HV/FNP as appropriate. **Consider, discuss and document as required:** • financial inclusion and referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • The importance of developing a positive relationship with their growing baby. • Review and update risk assessments • Safer sleep discussion - Safer Sleep for Babies resource • Nutrition and exercise • Gender based violence • Consider introduction to continuity team member/s • Raised BMI: weigh, discuss and document • VTE risk Assessment • Consider local aspirin in pregnancy guidance • Discuss vaccination • Discuss pelvic floor health • Explore what parents already know about infant feeding and provide information about feeding options **Use of Substances:** Prepare and agree care plan and ongoing management of use of substances. Consider joint visit with appropriate professional colleague e.g. Substance use Worker or HV. Continual liaison with appropriate services. **Teenage Pregnancy**: Discuss and agree care plan. Continual liaison with appropriate services. Consider joint FNP visit. **Raised BMI** Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Reminder** Ensure referrals have been received and actioned. **Notification to HV/FNP if not already made.** Contact Health Visitor (HV) and Family Nurse (FN) to share booking information if not already done. Remind/encourage women to take Healthy Start Vitamins/vitamin supplements. Discuss vaccination. Referral to financial inclusion services if not already. **Written Information/leaflets provided:** Baby Box leaflet, Bookbug Antenatal Leaflet: "Sharing songs, rhymes and stories before birth" and webpage: Sharing songs, rhymes and stories before birth - Scottish Book Trust.

Second Trimester

Gestation	Content of Care
20 weeks **(Fetal anomaly scan)**	Detailed Ultrasound Scan. (USS). Any abnormal finding from USS must be escalated appropriately.
25 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigations of: BP, urinalysis, abdominal palpation, measure fundal height - plot on growth chart, record fetal heart in conjunction with maternal pulse and fetal movements. Reassess and discuss planned care for the pregnancy and identify any emerging additional or complex support that should be offered. Start discussion of birth preferences and place of birth. **Use of Substances:** Urine toxicology with consent, monitor substance use & progress of care. Discuss Neonatal Abstinence Scoring System. **Raised BMI:** Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Consider, discuss and document as required** • Financial inclusion/referral to welfare rights if not completed previously. Discuss Best Start Grant if appropriate • Smoking. CO monitoring • Mental health and wellbeing • Safety and security of accommodation and planning where mother and baby will sleep as per RCM guidance • Nutrition and exercise • The importance of developing a positive relationship with baby • Gender based violence • Update any care plans and/or referrals for substance/ alcohol use • Care Pathway • Consider introduction to continuity team member/s • VTE risk Assessment • Review and update risk assessments • Importance of monitoring fetal movements • Link with stillbirth discussed. Use teach back tool • Discuss vaccination • Discuss pelvic floor health

Second Trimester

Gestation	Content of Care
	Reminder: Notification to HV/FNP if not already made. Parent education and infant feeding workshops. Solihull online access. Update GIRFEC Wellbeing Plan as required. Mat B1 certificate. Remind/encourage women to take Healthy Start Vitamins/vitamin supplements. Discuss the value of skin to skin contact for all mothers and babies. Sign Baby Box form. Outcomes of wellbeing assessment discussed – refer to resources and third sector agencies to optimise parenting skills **Mental Health:** individual care plan, discuss with Perinatal Mental Health team **Learning Disabilities:** give a copy of You & Your Baby. One to one parent education should be offered if they do not wish to attend the generic programme. **Teenage Pregnancy:** All young women to be offered specific antenatal education tailored to suit their needs. One to one parent education should be offered if they do not wish to attend the generic programme.

Third Trimester

Third Trimester (27 – 41 weeks)

Gestation	Content of Care
28 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigations: of BP, urinalysis, oedema, abdominal palpation, measurement of fundal height and plot on growth chart, auscultate fetal heart in conjunction with maternal pulse and fetal movements. Offer anti-D if Rh Neg. **Bloods**: full blood count, antibody screen – offer to all women. **Use of Substances:** Urine toxicology. Pre-birth case discussion (single or multiagency as required); reassess social circumstances/risk; discuss infant feeding incl. encourage breast feeding; consider growth scan /fetal monitoring; reiterate Neonatal Abstinence Scoring System; discuss and plan contraception. Communicate update with FNP/HV. **Mental Health:** Request a network meeting if appropriate. Communicate update with FNP/HV. **Teenage Pregnancy:** Re-assess social circumstances. Communicate update with FNP/HV. **Raised BMI:** : Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Consider, discuss and document as required:** • Financial inclusion/referral to welfare rights if not completed previously • Smoking. CO monitoring • Mental health and wellbeing • VTE risk Assessment • PPH (Postpartum Haemorrhage) Risk Assessment • Review and update risk assessments • Nutrition and exercise • Gender based violence • Update any care plans and/or referrals for substance/alcohol use • Care pathway • Consider introduction to continuity team member/s • Importance of monitoring fetal movements. Link with stillbirth. Use teach back tool. Fetal movements leaflet **Reminder:** • Parent education and infant feeding workshops. Solihull online access • Pregnancy Conversation Sheet to be completed by 34 weeks • Update GIRFEC Wellbeing Plan as required • Remind/encourage women to take Healthy Start Vitamins/vitamin supplements

Third Trimester

Gestation	Content of Care
32 weeks **(All primigravid. Parous as required.)**	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigations of: BP, urinalysis, oedema, abdominal palpation, measurement of fundal height and plot on growth chart, auscultate fetal heart in conjunction with maternal pulse and fetal movements. Review, discuss and record the results of screening tests undertaken at 28 weeks. **Consider, discuss and document as required:** • Financial inclusion and referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • Nutrition and exercise • Consider introduction to continuity team member/s • Gender based violence • Update any care plans and/or referrals for substance/alcohol use • Review birth preferences document, discuss anything woman has recorded, update individual plans and make any appropriate referrals • The importance of developing a positive relationship with their growing baby. Reminder about Bookbug resources **Use of Substances, Mental Health, Learning Disabilities:** Consider one to one parent education sessions. Discuss any multi agency reports/child protection case conference as appropriate. **Teenage Pregnancy:** Consider one to one parent education sessions. **Raised BMI**: Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Reminder:** • Update GIRFEC Wellbeing Plan as required • Parent education and infant feeding workshops. Solihull online access • Complete and discuss and child protection birth response plan (if required) by 34 weeks. Allocate Health Plan Indicator if not completed • Remind/encourage women to take Healthy Start Vitamins/ vitamin supplements

Third Trimester

Gestation	Content of Care
34 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Follow anaemia guideline. Offer investigation of: BP, urinalysis, oedema, abdominal palpation, measurement of fundal height and plot on growth chart, presentation, fetal heart in conjunction with maternal pulse and fetal movements, if abnormal presentation at 36 weeks, refer for presentation scan and Consultant review. Weight to be recorded at 35 weeks. Review, discuss and record the results of screening tests undertaken at 28 weeks. All concern for unborn baby referrals should aim to have a birth response plan completed by the midwife by 34 weeks. This plan should be discussed with the parents. **Use of Substances, Mental Health, Learning Disabilities:** Birth plan put in place. Continue one to one parent education sessions. **Use of Substances:** 34 and 36 weeks – monitor drug/alcohol use; discuss and plan contraception. 36 weeks – Urine toxicology. **Mental Health:** – Individualised care plan **Teenage Pregnancy:** Continue one to one parent education sessions as appropriate; contraception information and discussion. **Raised BMI:** Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes discussed. **Consider, discuss and document as appropriate:** • financial inclusion/ referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • Benefits of perineal massage • Nutrition and exercise • Gender based violence • Review birth preferences document, discuss anything woman has recorded, update individual plans and make any appropriate referrals • Review and update risk assessments • Update any care plans and/or referrals for substance/alcohol use • Care of the new baby, vitamin K prophylaxis and newborn screening tests • Consider introduction to continuity team member/s • Discuss vaccination • VTE Risk Assessment • PPH Risk Assessment • Postnatal self-care, • Awareness of baby blues • Contraceptive choices postnatally to be documented in notes • Review infant feeding information, have meaningful conversation, share evidence of benefits of breastfeeding • The importance of developing a positive relationship with their growing baby. Reminder about Bookbug resources • Discuss fetal movements and use teach back tool **Reminder:** Encourage women to have their birth preferences document updated prior to labour Remind/encourage women to take Healthy Start Vitamins/vitamin supplements. All women to be offered a home visit from HV between 30 – 34 weeks.

Annex D – Pathway of Maternity Care

Third Trimester

Gestation	Content of Care
36 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Follow anaemia guideline. Offer investigation of: BP, urinalysis, oedema, abdominal palpation, measurement of fundal height and plot on growth chart, presentation, fetal heart in conjunction with maternal pulse and fetal movements, if abnormal presentation at 36 weeks, refer for presentation scan and Consultant review. Weight to be recorded at 35 weeks. Review, discuss and record the results of screening tests undertaken at 28 weeks. All concern for unborn baby referrals should aim to have a birth response plan completed by the midwife by 34 weeks. This plan should be discussed with the parents. **Use of Substances, Mental Health, Learning Disabilities:** Birth plan put in place. Continue one to one parent education sessions. **Use of Substances:** 34 and 36 weeks – monitor drug/alcohol use; discuss and plan contraception. 36 weeks – Urine toxicology. **Mental Health:** – Individualised care plan. **Teenage Pregnancy:** Continue one to one parent education sessions as appropriate; contraception information and discussion. **Raised BMI:** Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Consider, discuss and document as appropriate:** • financial inclusion/ referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • Safety and security of accommodation and planning where mother and baby will sleep as per RCM guidance • Benefits of perineal massage • Nutrition and exercise • Gender based violence • Consider introduction to continuity team member/s • Review birth preferences document, discuss anything woman has recorded, update individual plans and make any appropriate referral • Update any care plans and/ or referrals for substance/ alcohol use • Care of the new baby, vitamin K prophylaxis and newborn screening tests • Discuss vaccination • Postnatal self-care, • Awareness of baby blues • Contraceptive choices postnatally to be documented in notes • Review infant feeding information, have meaningful conversations, share evidence of benefits of breastfeeding • Antenatal colostrum harvesting can be discussed on an individual basis • The importance of developing a positive relationship with their growing baby • Discuss fetal movements and use teach back tool • Review and update risk assessments • VTE Risk Assessment • PPH Risk Assessment **Reminder:** Encourage women to have their birth preferences document updated prior to labour. Remind/encourage women to take Healthy Start Vitamins/vitamin supplements.

Third Trimester

Gestation	Content of Care
38 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigation of: BP, urinalysis, oedema, fetal heart in conjunction with maternal pulse and fetal movements, abdominal palpation, measure fundal height plot on growth chart, palpate for presentation. **Use of Substances:** Urine toxicology. Liaison with appropriate professional colleague re pregnancy outcome; Neonatal Abstinence Syndrome assessment and care; discharge plan (include prescription arrangements and contraception); follow postnatal care plan/inform HV & GP; discharge information. **Teenage Pregnancy:** Continue individualised birth preparation session. **Raised BMI**: Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. **Consider, discuss and document as required:** • Financial inclusion/ referral to welfare rights • Smoking CO monitoring • Mental health and wellbeing • Review birth preferences document, discuss anything woman had recorded, update individual plans and make any appropriate referrals • Review and update risk assessments • Nutrition and exercise • Gender based violence • Consider introduction to continuity team members • Discuss vaccination • The importance of building a positive relationship with baby • VTE Risk Assessment • PPH Risk Assessment • Update any care plans and/or referrals for substance/alcohol use • Care of the new baby, vitamin K prophylaxis, and newborn screening tests • Postnatal self-care • Awareness of baby blues • Contraceptive choices – document • Review infant feeding information, have meaningful conversations, share evidence of benefits of breastfeeding • Antenatal colostrum harvesting can be discussed on an individual basis • Discuss fetal movements, link with still birth and use teach back tool **Reminder:** Encourage women to have their birth preferences updated prior to labour Update GIRFEC Wellbeing Plan as required.

Third Trimester

Gestation	Content of Care
40 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigations of: BP, urinalysis, oedema, abdominal palpation, measurement of fundal height and plot on growth chart, auscultate fetal heart in conjunction with maternal pulse and fetal movements. Discuss possible induction of labour. Offer to have a discussion regarding the risks and benefits of membrane sweep at this appointment. Raised BMI: Refer to local guideline. Focused discussion on nutrition and exercise including positive health behaviour changes. Update GIRFEC Wellbeing Plan as required. Remind/encourage women to apply for Best Start Foods. Remind/encourage women to take Healthy Start Vitamins/vitamin supplements. **Consider, discuss and document as required:** • Financial inclusion/ referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • Review birth preferences document, discuss anything woman had recorded, update individual plans and make any appropriate referrals • Review and update risk assessments • VTE Risk Assessment • PPH Risk Assessment • Nutrition and exercise • Gender based violence • Consider introduction to continuity team member/s • Benefits of perineal massage • Care of newborn, vitamin K prophylaxis and newborn screening tests • Antenatal colostrum harvesting can be discussed on an individual basis • Update any care plans and/or referrals for substance/alcohol use • Fetal movements, link to still birth and use teach back tool • Discuss vaccination • Postnatal self-care • Awareness of baby blues • Contraceptive choices – document • Review infant feeding information, have meaningful conversations, share evidence of benefits of breastfeeding • Importance of developing a positive relationship with growing baby Discussion of management of prolonged pregnancy. Discuss induction of labour including risks, benefits, procedure and current evidence. Ensure discussion is documented in full. Document woman's choice and plan including ongoing review and care. Update birth preferences document accordingly.

Third Trimester

Gestation	Content of Care
41 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer investigations of: BP, urinalysis, oedema, abdominal palpation, measure fundal height plot on growth chart, presentation, fetal heart in conjunction with maternal pulse and fetal movements. Offer to have a discussion regarding the risks and benefits of membrane sweep at this appointment. Raised BMI: refer to local guideline. Discuss induction of labour including risks, benefits, procedure and current evidence. Ensure discussion is documented in full. Document woman's choice and plan including ongoing review and care. UPDATE birth preferences document accordingly. **Consider, discuss and document as required:** • Financial inclusion/ referral to welfare rights • Smoking. CO monitoring • Mental health and wellbeing • Nutrition and exercise • Gender based violence • Consider introduction to continuity team member/s • VTE Risk Assessment • PPH Risk Assessment • Review and update risk assessment • Update any care plans and/or referrals for substance/alcohol use • Fetal movements, link to still birth and use teach back tool • Discuss vaccination **Ensure any recommended previous discussions have taken place** – care of newborn, baby blues, vitamin K prophylaxis, birth plan discussion etc. **Reminder**: Update GIRFEC Wellbeing Plan as required.
From 42 weeks	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Offer women who decline induction of labour a Consultant Obstetrician appointment, increased monitoring as per local guideline.

4. Intrapartum Pathway

Refer to NICE Guidelines: Overview | Intrapartum care | Guidance | NICE
Overview | Intrapartum care for women with existing medical conditions or obstetric complications and their babies | Guidance | NICE

Principles of Intrapartum Care:

1. **Respectful maternity care:** refers to care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, is trauma informed, and enables informed choice and continuous support during labour and childbirth.
2. **Effective Communication:** between maternity care providers ,women in labour and birth partners, using simple and culturally acceptable methods. This may require the support of interpretation services.
3. **Companionship during labour and childbirth:** A companion(s) of choice is recommended for all women throughout labour and childbirth.
4. **Continuity of care:** Midwife-led continuity-of-care models, in which the primary midwife, buddy midwife or member of the team supports a woman supports a woman throughout the antenatal, intrapartum and postnatal continuum. The buddy midwife supports the primary midwife, providing cover for annual, and other, leave.

Points to consider for intrapartum care in any setting:

- The woman is the expert in her maternity care and should be provided with unbiased information, based on the best available evidence, in order that she can make decisions that are right for her and her baby. Time should always be given, where possible, for women to choose or decline care
- A full assessment will include the pregnancy history and any antenatal factors which relate to intrapartum care, the current situation, stage and progress in labour
- Where the wider perinatal team is involved in care, there is an open and honest team culture and joined-up decision making, with everyone's contribution equally valued
- Discuss birth preferences on admission and review document throughout labour
- Discuss options for fetal monitoring
- Birth environment - relaxed, private, safe, comfortable
- One to one support from a midwife
- Birthing partner(s) present (where desired)
- Facility to eat and drink in labour according to guidelines
- Range of pain-relief
- Any intervention should be carefully considered and discussed and informed maternal consent obtained
- Upright positions that facilitate labour progress should be encouraged
- Women in the expulsive stage of 2nd stage of labour should be encouraged and supported to follow their own urge to push
- Techniques to reduce perineal trauma are recommended, based on a woman's preferences and available options
- All birth choices should be accommodated where possible in all birth settings, including when birth takes place in a theatre setting

The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

Physiological management of the third stage involves a package of care which includes all of these components:

- no routine use of oxytocic drugs
- no clamping of the cord until at least pulsation has ceased (unless clinically indicated)
- birth of the placenta by maternal effort
- offer skin to skin contact
- Assess Maternal Early Warning Score (MEWS) and blood loss
- Inspect placenta and membranes are complete

Active management of the third stage involves a package of care which includes all of these components:

- routine use of oxytocic drugs
- delayed cord clamping and cutting of the cord prior to controlled cord traction (unless clinically indicated)
- controlled cord traction
- offer skin to skin contact
- Assess Maternal Early Warning Score (MEWS) and blood loss
- Inspect placenta and membranes are complete

Woman may choose to accept all or only parts of this package of care.

The third stage of labour is diagnosed as prolonged if not completed within 60 minutes of the birth of the baby with physiological management and 30 minutes with active management.

Continual assessment will take place throughout labour and birth, anticipating potential changes in care that may be recommended.

Birthing women and their partners should be involved in discussions and kept informed throughout. Include information about transfer processes for mother and baby if required.

Labour and birth are dynamic, all care decisions should be made and documented in partnership with the woman.

5. Postnatal Care

The postnatal period, defined here as the period beginning immediately after the birth of the baby and extending up to six weeks (42 days), is a critical time for women, newborns, partners, parents, caregivers and families.[1]

Postnatal care: The number of postnatal visits should be discussed with and tailored to the woman and baby's needs, based on clinical, emotional, infant feeding and social requirements. A wellbeing assessment will have been carried out in the antenatal period, and continually reviewed throughout antenatal care, and this should be reviewed as part of postnatal care. Any additional social and medical support services will be brought in to the postnatal care plan, coordinated by the primary midwife and wider team. Consider Near Me and other technology enabled services where appropriate for keeping in touch and providing support.

Postnatal care should be planned to ensure continuity of carer, with an individualised care plan encompassing the woman, baby and family. The emphasis should be on practical advice and information on pain management, signs and symptoms to look out for, infant feeding, social networks and coping strategies with a seamless handover from midwife to health visitor/FNP keeping the woman informed and involved at all stages. The pathway advises on what should be carried out during the postnatal period, but the actual number of postnatal visits should be individualised to the woman and baby's needs. Prior to discharge women should be given the opportunity to discuss their maternity journey with their midwife and any appropriate referrals to other services should be made at this time.

Mothers of babies who are receiving neonatal care, those whose baby is taken into care at or near birth, and those who have experienced the loss of their baby will still be offered postnatal care appropriate to their individual circumstances.

Early Postnatal Care

Refer to WHO recommendations on maternal and newborn care for a positive postnatal experience and Postnatal care (nice.org.uk) for details on physiological assessment of the mother and baby.

Minimum schedule of appointments

Face to Face – day *1 to day 2 inclusive for ALL women.

Face to Face – 96 to 120 HRS (around day 5) post birth for ALL women.

Telephone - around day 7 for all women (include full physical and emotional assessment).

Face to Face - around day 10 for all women.

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Annex D – Pathway of Maternity Care

Postnatal

Post Natal	Content of Care
First Hour	In the first hour, if mother and baby are together, recognise importance of moment and encourage bonding by minimising separation of baby, mother and birth companion. Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Explain and offer perineum inspection to assess trauma. With informed consent, repair if required. Offer inspection of wound if caesarean birth. Skin to skin contact for ideally at least an hour. Offer women help with first and subsequent feeds, as required. Offer to show all breastfeeding mothers how to hand express their breastmilk. Set of maternal observations: MEWS, fundal palpation and blood loss Ensure nutrition and hydration needs are met. Bladder care. When appropriate, check baby's temperature, undertake initial examination of the newborn, and weigh baby. At a minimum, weigh baby at birth, 5 days and 2 weeks while following local guidelines. For low birth weight babies, follow local guidelines. Discuss findings with parents and make appropriate referral after findings if required. Vitamin K consent and administration Full discussion about crying baby and touchpoint key messages from ICON: Babies Cry, You Can Cope! Where possible this should be in the presence of both parents.
Up to 3 days	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Notify GP and HV/FNP of birth. Ongoing care of mother and baby on ward/in unit. Recording of vital signs. Temperature, pulse, BP and respiratory rate. VTE Risk Assessment. Examination of newborn <72 hours. Newborn hearing consent and test. Vitamin K consent and administration. Sepsis awareness. Offer women help with first and subsequent feeds, as required. Offer to show all breastfeeding mothers how to hand express their breastmilk. Keep mothers and babies together. Parenthood education and support, including feed preparation information for mothers choosing to formula feed, contraception advice, and lifestyle information. Undertake full feeding assessment and develop feeding plan if appropriate Safer sleep discussion - Safer Sleep for Babies resource. Full discussion about crying baby and key messages. Discuss ICON: Babies Cry, You Can Cope! Arrange GP/consultation/PN follow up where required. Consider Long-acting reversible contraception before discharge if appropriate. Discuss pelvic floor health.

Postnatal

Postnatal

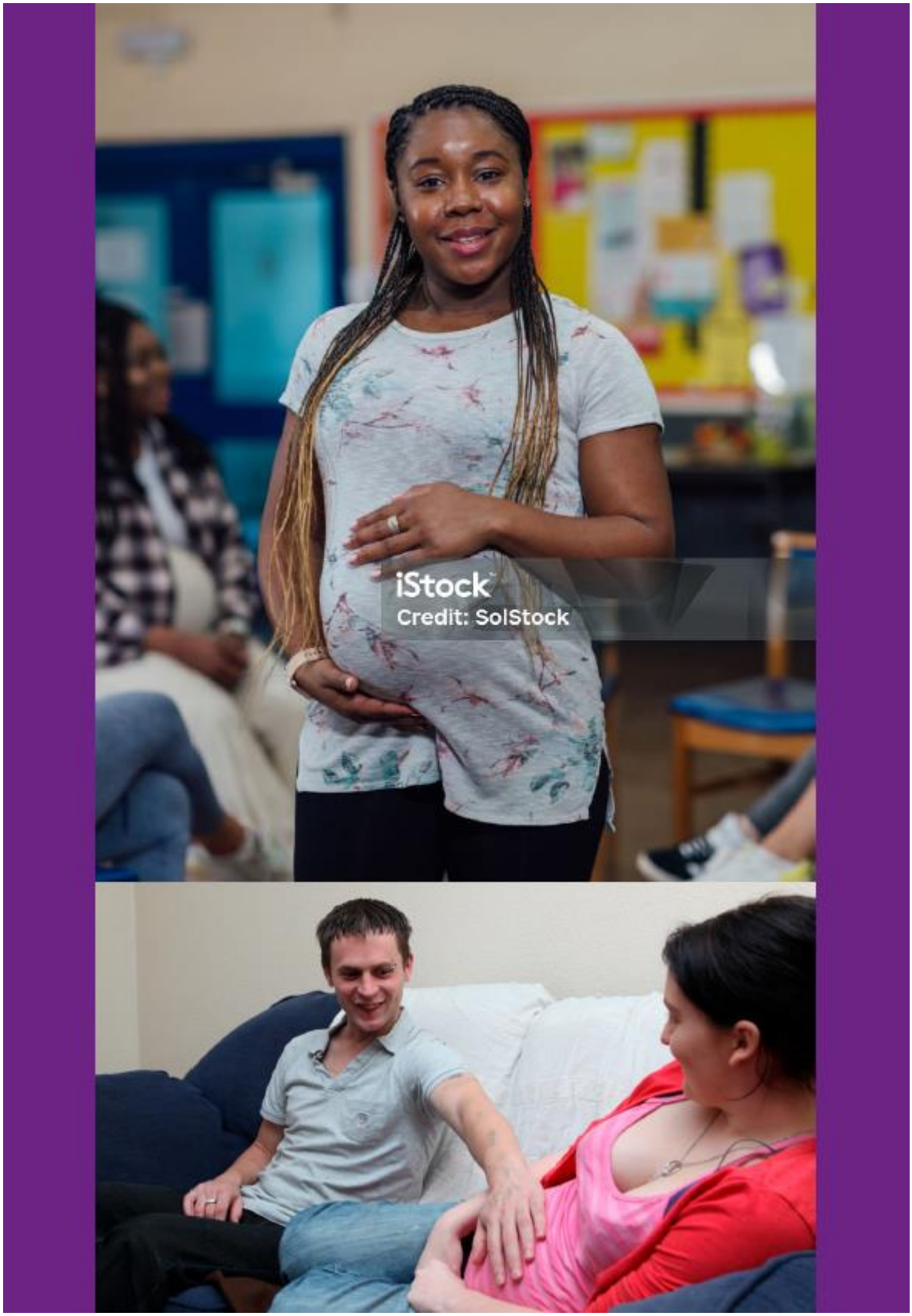
Post Natal	Content of Care
Up to 3 days	**Where appropriate all processes should be aligned and streamlined to support transfer to community care.** **Reminder:** Consider financial inclusion and referral to welfare rights. Update mother and baby care plan regularly. Update GIRFEC Wellbeing Plan as required. Supply Vitamin D supplement to mothers breastfeeding or giving breastmilk Update postnatal conversations sheet. Review and update risk assessment. Full assessment of continence for all Postnatal Women.
Post Natal (Home Visits) **Day 4 – 9**	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Postnatal assessment, emotional assessment, at least 2 breastfeeding assessments in first 10 days. Sepsis awareness. At a minimum, weigh baby at birth, 5 days and 2 weeks while following local guidelines. For low birth weight babies, follow local guidelines. Provide information about access to local support for infant feeding. Newborn blood spot as close to 96 hrs post birth as possible. **Reminder:** Update GIRFEC Wellbeing Assessment as required financial inclusion and referral to welfare rights. Discuss and document safety and security of accommodation and planning where mother and baby will sleep as per RCM guidance. Remind/encourage women to apply for Best Start Foods. Remind/encourage women to take vitamin D supplements if appropriate. Discuss the use of Vitamin D children's vitamin drops at day 5 with all women, this information will be recorded and communicated at the HV and FN handover from midwives (Vitamin D will be provided by the HV/FN on their first visit if mother breastfeeding). Complete postnatal conversation sheet. Full discussion about crying baby and key messages. Discuss ICON: Babies Cry, You Can Cope! Where possible this should be in the presence of both parents.

Postnatal

Post Natal	Content of Care
Postnatal (Home Visits) **Day 10 – 42 as needs required.** **Midwife/ Health Visitor**	Ensure plan of care is updated, co produced with woman and takes into account "what matters to me". Ongoing care of mother and baby in home. Postnatal assessment, infant feeding assessment at first visit by Health Visitor / FNP Health promotion tailored to individual needs. Transition to Health Visitor / FNP after day 10 (Primary Visit) and ensure full information is shared. At a minimum, weigh baby at birth, 5 days and 2 weeks while following local guidelines. For low birth weight babies, follow local guidelines. **Those with additional care needs:** Ongoing care of mother and baby, if baby home with mother. With agreement from management, midwifery services can extend care for women with the most complex additional care needs up to 42 days post birth. Ensure screening tests are recorded including hearing screening and blood spot. **Reminder:** Update GIRFEC Wellbeing Plan as required. Remind/encourage women to take vitamin D supplements if appropriate. Ensure all women are supported to discuss their experience, reflect with their primary (or team) midwife prior to discharge or an appointment is offered. Ensure any postnatal appointment is arranged as required with appropriate professional – obstetrician, neonatologist etc. Full discussion about crying baby and key messages. Discuss ICON: Babies Cry, You Can Cope! Where possible this should be in the presence of both parents.

Annex E – Birthplace Decisions Leaflet

Annex E – Birthplace Decisions Leaflet



What is this guide for?

You have the right to decide where to give birth. The birth setting you choose should feel like the safest place for you.

This leaflet will help you plan where to give birth. You can use the leaflet to support discussions with your midwife or obstetrician and your partner or support person.

This leaflet:

- describes where and how maternity services in Scotland can provide labour and birth care.
- highlights what is important to think about when making this decision and having discussions with your clinician.
- provides information and data, including birth outcomes and complications in different birth settings, and explains how to request your local data.
- provides information about why a certain birth setting may be advised by your clinician and what information you may want to consider before deciding where to give birth.

In this leaflet the term 'clinician' is used to mean your midwife, and if you have one, your obstetrician. It may also include other members of your maternity care team.

The terms woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity.

All healthcare services should be respectful and responsive to individual needs, and you should be asked how you wish to be addressed throughout your care.[1]

There are weblinks to further information in this leaflet. If you are unable to access the links, please let your clinician know so they can print out the information for you.

1 This definition is used as per the Standards for Proficiency for Midwives and the Women's Health Plan

Planning where to labour and birth

Planning where to labour and birth is an important decision that you can make at any time during your pregnancy and in early labour. You can also change your plans at any stage.

Throughout your pregnancy your clinician will talk to you about what they know about your health and your baby's health and will advise you on place of birth. As part of your routine midwifery care your midwife will talk to you about your unique circumstances, provide you with information about labour, birth, and different birth settings, and will encourage you to access resources that will help you make the decision that is right for you. Your clinician will ensure you have all the information you need to make the right decisions for you and your family. During these discussions you can ask questions to help you make your decision.

If there are more complex issues to consider you will also be offered the opportunity to discuss your planned place of birth with members of the team who will support you and your midwife with birth place planning – for example, a senior midwife, your obstetrician if you have one, or a consultant midwife. These discussions will be about supporting your choice, making plans that are as safe as possible using the resources available within the maternity service and ensuring that when your labour starts everyone involved in your care knows the plan and what you have decided.

A wide variety of birth settings are provided in many areas. All birth settings should be comfortable, provide privacy and dignity, and promote active labour and birth, encouraging mobility. All NHS Health Boards should offer you a range of pain relief. More information on pain relief option is provided throughout the leaflet. Please also speak to your clinician about what pain relief options are available locally.

Evidence shows that giving birth is generally very safe.[2] You have choices about where to have your baby and this guide can answer some of the questions you may have about the availability and safety of all the options you may be offered.

Developing your birth plan

Everyone is encouraged to develop a birth and postnatal plan with their clinician. Your plan should be reviewed by you and your clinician together throughout your pregnancy and should clearly detail what matters to you, what has been discussed and what you have chosen for your labour and birth. An important aspect of birth planning is choosing the place that is right for you. It can also be helpful to visualise the birth settings, and many units can support a visit or show you a video of where you will birth, if not at your home.

When developing your birth plan and deciding where to labour and birth you may find it helpful to consider these points:

- what your preferences are – what sort of birth you would like, who you want supporting you and where you will feel safe and supported.
- travel arrangements and time for you and your birth partner(s), and possible transfer time if required.
- whether you or your baby have any pre-existing medical conditions or any factors in pregnancy that make it more likely that you might need medical intervention during your labour or birth.
- birth outcomes in different settings.
- access to care from a doctor.

2 NICE Clinical Guideline on Intrapartum care for healthy women and babies

- what type of pain relief will be available.
- whether you want to use a birthing pool.

The philosophy of maternity care should be the same in all birth settings. In all birth settings maternity care should be kind, compassionate, respectful, and supportive of your choice and your human rights.

In all birth settings you should receive one-to-one supportive care throughout labour and birth, privacy, uninterrupted skin to skin and support with early feeding. Families should be supported to remain together, and you and your partner should be provided with effective support.

All birth settings have different risks and benefits, and your perspective of risk and benefit will be unique to you. You might be considering a birth at home as a safe and comfortable option; however, you will have to balance this with any clinical risk factors which may mean your clinician advises you to birth in a Labour Suite.

In all birth settings **you will always be asked for consent** for any procedure including intimate examination. More information on consent is provided on page 20.

Your decisions will be recorded in your birth plan which will be updated at each routine appointment with your clinician. Remember, you can change your mind at any time, including when you are in labour.

For further information see the Ready Steady Baby! resource on Your Birth Plan.


Image by Freepik

Your right to choose where you birth

You have the right to choose where to give birth. Only when it is determined that you lack mental capacity can someone else, such as a doctor, make decisions about your health care.

Your maternity care will be coordinated by your primary midwife, who will provide the majority of your routine pregnancy care. This helps you and your midwife build a trusting relationship, develop a plan that is right for you together, discuss birthplace throughout your pregnancy, and ensure you feel seen and heard throughout your journey.

If you feel that you need further support to discuss your choice about where to labour and birth, please contact the senior charge midwife, senior midwife, or consultant midwife in your local area. You can ask your primary midwife for their contact information.

Birth Settings

Your clinician will discuss the maternity care that can be offered in different birth settings and where care can be provided in your NHS Health Board area. This could include:

At home

- 'At home' means planned birth at home, with a midwife who comes to your home and cares for you during labour and birth.
- Midwives are trained and equipped to support you to labour and birth at home.
- At home you will be in a familiar place where you will be able to use your own facilities and have the comfort of your own surroundings. You can choose how many people you have around you.
- At a home birth, pain relief options available to you include water, gas and air, and opiate injections. Epidurals can only be provided at a hospital. You will be supported to use any skills you and your partner have learned such as hypnobirthing, relaxation, massage, or aromatherapy.
- Labour progresses well when women are relaxed and feel safe and supported in a familiar own environment. For women with low chances of complications, the chances of needing an intervention are lower for home births than for births in a Labour Suite (also known as an obstetric unit).
- During any labour and birth unexpected complications or emergencies can happen. Midwives are able to carry out some immediate emergency procedures however these are limited by the environment, and you may need immediate access to medical care from a doctor. Or you may need something that can only be provided at a hospital. There are no doctors in home or CMU settings so you would need to be transferred to hospital by ambulance or by car. This can be discussed in more detail with your clinician.

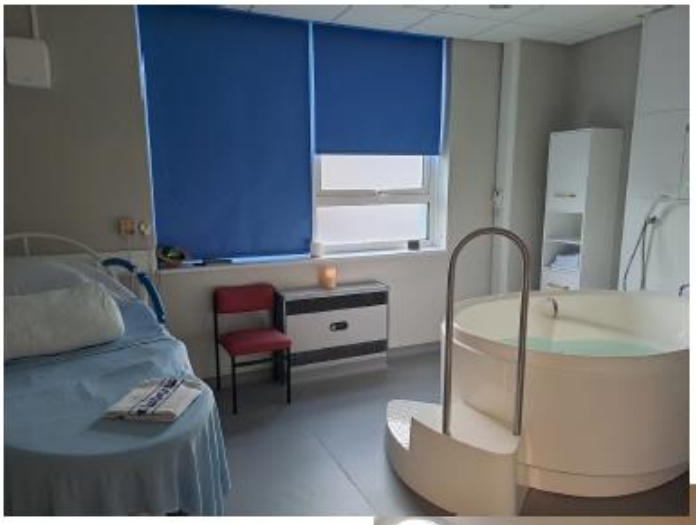
Image by Freepik

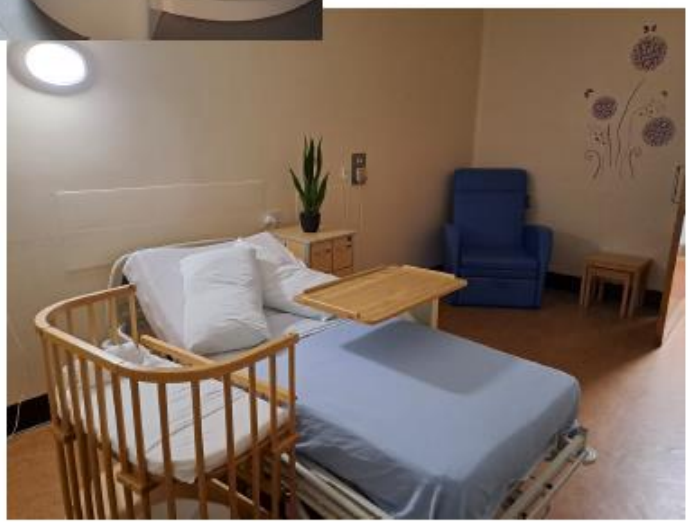
Questions you may want to ask your clinician:

- Is there any reason that birth at home would not be advised for me?
- If it would not be advised, can you discuss the reason and any evidence?
- Can you tell me how midwifery cover will be arranged for me?
- What is the home birth figures for my local area?
- Can I speak to other women who have birthed at home locally?
- How would I arrange to have a birthing pool at my home birth?
- What pain relief will be available?
- Will I be supported and encouraged to be mobile and upright throughout my labour and birth with consideration of the best positions for birthing my baby?
- What if I want an epidural during labour?
- What are the chances of being transferred to the hospital during labour or following birth, for me and for my baby, in my local area?
- How is transfer arranged for me and/or my baby if needed including times?
- If me or my baby need a transfer, how long would it take for an ambulance to arrive, and how long might the journey to hospital be?
- How will my partner get to the hospital if I am transferred?
- Will my primary midwife or member of the team care for me during my home birth?
- How long will my midwife stay at my home following birth?
- Will I be supported to feed and care for my baby following birth?
- What will I do if I need support after my midwife has left?
- Will I have access to an interpreter during my labour and birth at home?

In a community midwifery unit (CMU)

- A CMU is a birth centre on a separate site from the nearest Labour Suite, which may be closer to your home and can provide a comfortable and relaxed setting. Midwives will care for you and support your labour and birth.
- In a CMU, pain relief options available to you include water, gas and air, and opiate injections. Epidurals can only be provided at a hospital. You will be supported to use any skills you and your partner have learned such as hypnobirthing, relaxation, massage, or aromatherapy. Many CMUs have birthing pools for you to use during labour and birth.
- You are more likely to have a birth with fewer interventions in a CMU than in a Labour Suite.
- During any labour and birth unexpected complications or emergencies can happen. Midwives are able to carry out some immediate emergency procedures however these are limited by the environment, and you may need immediate access to medical care from a doctor. Or you may need something that can only be provided at a hospital. There are no doctors in home or CMU settings so you would need to be transferred to hospital by ambulance or by car. This can be discussed in more detail with your clinician.



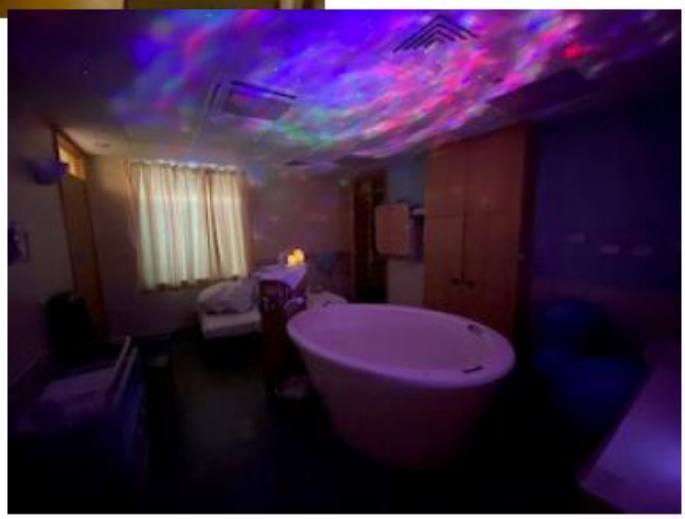


Questions you may want to ask your clinician:

- Is there any reason that birth in a CMU would not be advised for me?
- If it would not be advised, can you discuss the reason and any evidence?
- Can you tell me how midwifery cover will be arranged for me?
- What is the CMU birth figures for my local area?
- Can I speak to other women who have birthed in the CMU?
- Can I visit the CMU prior to my birth?
- Is there a birthing pool? What if another woman is using the birthing pool?
- What pain relief will be available?
- Will I be supported and encouraged to be mobile and upright throughout my labour and birth with consideration of the best positions for birthing my baby?
- What if I want an epidural during labour?
- What is my chance of transferring to the hospital during labour, following birth, for my baby in my local area?
- How is transfer arranged for me/my baby if needed, including times?
- If me or my baby need a transfer, how long would it take for an ambulance to arrive, and how long might the journey to hospital be?
- How will my partner get to the hospital if I am transferred?
- Will my primary midwife or member of the team care for me during my CMU birth?
- How long will I stay in the CMU following birth?
- Will I be supported to feed and care for my baby following birth?
- Will I have access to an interpreter during my labour and birth in a CMU?
- What support will my family have (e.g. access to food and comfortable space) during my labour and birth in the CMU?

In an alongside midwifery unit (AMU)

- An alongside midwifery unit (AMU) is based within hospitals with a Labour Suite but are separate from the Labour Suite. Midwives will care for you and support your labour and birth.
- In an AMU, pain relief options available to you include water, gas and air, and opiate injections. Epidurals can only be provided at a hospital, in a labour suite. You will be supported to use any skills you and your partner have learned such as hypnobirthing, relaxation, massage, or aromatherapy. Many AMUs have birthing pools for you to use during labour and birth.
- You are more likely to have a birth at an AMU with fewer interventions than if you plan to birth in a Labour Suite.
- During any labour and birth unexpected complications or emergencies can happen. Midwives are able to carry out some immediate emergency procedures however these are limited by the environment, and you may need immediate access to medical care from a doctor. Or you may decide that you need something that can only be provided in the Labour Suite. In these circumstances, you will be transferred to a Labour Suite on the same site.



Questions you may want to ask your clinician:

- Is there any reason that birth in an AMU would not be advised for me?
- If it would not be advised, can you discuss the reason and any evidence?
- Can you tell me how midwifery cover will be arranged for me?
- What is the AMU birth figures for my local area?
- Can I speak to other women who have birthed in the AMU?
- Can I visit the AMU prior to my birth?
- Is there a birthing pool? What if another woman is using the birthing pool?
- What pain relief will be available?
- Will I be supported and encouraged to be mobile and upright throughout my labour and birth with consideration of the best positions for birthing my baby?
- What if I want an epidural during labour?
- What is my chance of transferring to the hospital during labour, following birth, for my baby in my local area?
- How is transfer arranged for me I need to go to Labour Suite?
- How is transfer or a review arranged for my baby if needed?
- Will my primary midwife or member of the team care for me during my AMU birth?
- How long will I stay in the AMU following birth?
- Will I be supported to feed and care for my baby following birth?
- Will I have access to an interpreter during my labour and birth in an AMU?
- What support will my family have (e.g. access to food and comfortable space) during my labour and birth in the AMU?

In a Labour Suite (also known as labour ward or obstetric unit)

- A Labour Suite is in a hospital and provides services including obstetric, medical, midwifery, neonatal and anaesthetic care. All mainland NHS Health Boards in Scotland have at least one Labour Suite. You may want to ask whether you have a choice of Labour Suites.
- Midwives will provide your midwifery care before, during and after your birth. If you need additional care or are having a planned Caesarean birth this will be provided a team of people on site, including obstetricians and sometimes anaesthetists and neonatal paediatric staff.
- There is advanced equipment for monitoring you and your baby's health and well-being within the Labour Suite.
- You can usually choose to include up to two birth partners to support you.
- In a Labour Suite, pain relief options available to you include water, gas and air, opiate injections, and epidural analgesia. The Labour Suite is the only birth setting where epidural analgesia can be provided.
- You will be supported to use any skills you and your partner have learned such as hypnobirthing, relaxation, massage, or aromatherapy. Many Labour Suites have birthing pools for you to use during labour and birth.

- If you or your baby have a health or medical concern your clinician may advise that birth is safest for you in Labour Suite. This does not mean that you cannot choose Home, CMU, or AMU, but that there are concerns that birth in one of these places will pose a more significant risk than birth in Labour Suite. This will usually be because in Labour Suite there is access to monitoring equipment, medications, doctors, more midwives and the wider team and hospital services and you are more likely to need that extra care.
- If you still wish to consider giving birth in a CMU, AMU or at home, you can talk to your clinicians about this. They will work with you to support your choices about place of birth, discussing your plans and preferences. Discussing this with your clinicians as early as possible can help them support you to develop your birth plan accordingly.
- The Neonatal Unit is within the same hospital as the Labour Suite and AMU, so any care for your baby is readily available. It is important that you are provided with the information about why birth in Labour Suite is recommended and where possible this will be discussed with you during your pregnancy. Your clinicians will provide you with the evidence to support their recommendation so you can make an informed decision.

Questions you may want to ask your clinician:

- Is there any reason that birth in a Labour Suite would not be advised for me?
- If it would not be advised can you discuss the reason, including evidence and data?
- Can you tell me how midwifery cover will be arranged for me?
- What are the Labour Suite birth figures for my local area?
- Can I speak to other women who have birthed in the Labour Suite?
- Can I visit the Labour Suite prior to my birth?
- Do you have a birthing pool? What if another woman is using the birthing pool?
- What pain relief will be available?
- Will I be supported and encouraged to be mobile and upright throughout my labour and birth with consideration of the best positions for birthing my baby?
- What if I want an epidural during labour?
- What is my chance of my baby transferring for neonatal care following my labour and birth in Labour Suite?
- Will my primary midwife or member of the team care for me during my Labour Suite birth?
- How long will I stay in the Labour Suite following birth?
- Will I be supported to feed and care for my baby following birth?
- Will I have access to an interpreter during my labour and birth in Labour Suite?
- What support will my family have (access to food and comfortable space) during my labour and birth in Labour Suite?

What happens if you are planning to birth in a maternity theatre (planned Caesarean birth)?

You will be given information about where and when to attend prior to your planned Caesarean birth. This will be in the hospital, and you will be cared for by dedicated staff throughout your journey. Midwives will provide your midwifery care before, during and after your birth.

Your midwife and obstetrician will encourage you to complete your birth plan with what matters to you and will explain the procedure and what to expect.

You will be introduced to the staff in the maternity theatre when you arrive. Please speak to your midwife and obstetrician if you would like to discuss the environment in the maternity theatre for your birth.

If your baby needs support from the neonatal doctors they will be in the maternity theatre and will ensure you and your partner are kept up to date about care being provided for your baby.

If you need an unplanned Caesarean birth this will also take place in the maternity theatre.

Questions you may want to ask your clinician:

- Why is a planned Caesarean birth advised for me?
- Can you tell me which midwife/team will support me in the maternity theatre?
- Can you provide me with planned Caesarean birth figures for my local area?
- Can I speak to other women who have had a planned Caesarean birth in the maternity theatre?
- Can I visit the maternity theatre prior to my birth?
- What pain relief would be provided, and can I speak with the anaesthetist about my options for anaesthesia?
- Why might a general anaesthetic be advised?
- Can my partner come into the maternity theatre with me?
- What is my chance of my baby transferring for neonatal care following my planned Caesarean birth?
- Will my named midwife or member of the team provide any care for me in maternity theatre?
- How long will I stay in the maternity theatre and Labour Suite following birth?
- Will I be supported to feed my baby and have skin-to-skin immediately following birth?
- Will I have access to an interpreter during my birth in maternity theatre?

For further information see the Ready Steady Baby! resource on Deciding Where to Give Birth

Why would I be advised to birth in a particular place?

If you are generally healthy with no medical concern for you or your baby (a low chance of complications) your clinicians will advise that, from their perspective, birth is safe at home, in a CMU, or in an AMU. This does not mean that you cannot choose the Labour Suite. A full discussion about risks and benefits of every setting should take place so you can make an informed decision. You will be advised to consider all of these aspects when you make your birthplace decision.

Having a low chance of complications means:

- other than the common discomforts of pregnancy, you are generally healthy and well.
- you have no significant medical or pregnancy conditions affecting you or your baby.
- if you have given birth before, that there were no complications (such as heavy bleeding after birth).
- you are pregnant with one baby (not twins or triplets).
- your baby has grown healthily during pregnancy and is in a 'head down' position.
- you are between 37 and 42 weeks (term), and you have not developed any new conditions or issues just before your labour begins, such as bleeding, your waters breaking more than 24 hours before labour begins, or developed an infection that could be passed to your baby.

It is important to note that low chance of complications does not mean there is no chance of complications in any labour and birth setting.

Image by pch.vector on Freepik

Decision Making

It is helpful to be able to weigh up the potential benefits, harms and limitations of the available options when making your decisions about your care and where to labour and birth.

Thinking BRAN before your appointments will help you to prepare and be more able to actively engage with decision making.

1. What are the Benefits?

2. What are the Risks?

3. What are the Alternatives?

4. What if I do Nothing?

To find out more see It's Okay to Ask! – Publication | NHS inform and Realistic Medicine | NHS inform

What does the evidence show about births in different birth settings?

Birth is generally very safe for women who have a low chance of complications, and their babies.

You may wish to discuss what the evidence shows us about the risks and benefits of birth in different settings with your clinician when thinking about your birth choices. It might be helpful to know information specific to your Health Board, for example:

- birth outcomes for home births, CMU births, AMU births and Labour Suite births.
- the transfer rate from home, CMU, and AMU.
- feedback about experiences of different birth places.
- Caesarean, induction of labour and forceps/ventouse birth rate.
- breastfeeding rates for home, CMU, AMU, and Labour Suite births.

The tables on pages 16-18 show outcomes for women and their babies when birth is planned in different settings. The tables refer to healthy women with low chances of complications. This data is from the 'Birthplace in England' programme of research. The data is based on outcomes of women who gave birth between April 2008 and April 2010 in England. This information has been included to help give an idea about the sorts of outcomes that you may want to discuss with your clinician. Your clinician will be able to provide you with more up to date information from your own NHS Health Board area.

Spontaneous Vaginal Birth

Spontaneous vaginal birth means that you go into labour by yourself (labour is 'spontaneous') and give birth without assistance from instruments (ventouse or 'vacuum' birth, or forceps), without Caesarean and without general, spinal, or epidural anaesthetic before or after birth.

What are the chances I will have a spontaneous vaginal birth in each birth setting?

First Baby		
Planned place of birth	**Women who had a spontaneous vaginal birth (%)**	**Women who have had interventions (%)**
Obstetric unit	46	54
Alongside midwifery unit	62	38
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	70	30
Home	67	33

Second, third or fourth baby		
Planned place of birth	**Women who had a spontaneous vaginal birth (%)**	**Women who have had interventions (%)**
Obstetric unit	70	30
Alongside midwifery unit	91	9
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	95	5
Home	96	4

Birth with Forceps, Venouse/Vacuum, and Caesarean Birth

Birth with forceps and unplanned Caesarean birth, ventouse or 'vacuum', and forceps, are sometimes needed to help you birth your baby.

Like Caesarean births, births with forceps are more common amongst women having their first baby, compared to women having their second or subsequent baby. In some cases, the use of instruments is not successful, and then a Caesarean birth is performed.

What kind of birth can I expect to have?

First Baby			
Planned place of birth	**Women who had a spontaneous vaginal birth (%)**	**Women who had a birth with forceps or ventouse/vacuum (%)**	**Women who had a caesarean birth (%)**
Obstetric unit	61	23	16
Alongside midwifery unit	76	16	8
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	82	11	7
Home	78	13	9

Second, third or fourth baby			
Planned place of birth	**Women who had a spontaneous vaginal birth (%)**	**Women who had a birth with forceps or ventouse/vacuum (%)**	**Women who had a caesarean birth (%)**
Obstetric unit	89	6	5
Alongside midwifery unit	97	2	1
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	98	1	1
Home	98	1	1

Outcomes for babies

Birth is generally very safe for women with low chances of complications and their babies. Poor outcomes for you and your baby are rare but can happen in any setting.

These table show outcomes for babies when birth is planned in different settings.

First Baby		
Planned place of birth	**Without serious medical problems (per 1000)**	**With serious medical problems (per 1000)**
Obstetric unit	995	5
Alongside midwifery unit	995	5
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	995	5
Home	991	9

Second, third or fourth baby		
Planned place of birth	**Without serious medical problems (per 1000)**	**With serious medical problems (per 1000)**
Obstetric unit	997	3
Alongside midwifery unit	998	2
Freestanding midwifery unit (known as a community midwifery unit in Scotland)	997	3
Home	998	2

Whilst your midwife will be able to provide some data on some measures (such as birth type, perineal trauma or clinical emergencies such as heavy bleeding and neonatal resuscitation) there are other outcomes that are more difficult to gather data on, but which should also be considered when choosing what matters to you. This might include:

- support for me and my partner with bonding, attachment and breastfeeding related to place of birth.
- postnatal psychological health linked to birth experience and birthplace.
- previous birth trauma linked to birth experience and birthplace.
- having a birth that aligns with my religious and cultural beliefs.

Some further information can be found here in these links:

Birth & Breastfeeding - La Leche League GB

The Birth Trauma Association

Choice of place of birth - Birthrights

What else would be helpful to know?

Transfer

When people think about 'transfer', they often think this will be an emergency, but in practice, most transfers are for non-emergency reasons (such as a long labour, or 'delay' in labour). CMUs and midwives providing home birth services work closely with hospitals and ambulance services to provide safe, timely and co-ordinated care during transfers. So, while you may be transferred, you may still go on to have an uncomplicated birth in the Labour Suite. Emergency transfers, while less common, will still be coordinated to be as safe as possible by your midwife, the wider team, and the ambulance service.

Transfer from home or CMUs is more likely for women expecting their first baby. Between a third (36%) and half (45%) of women who plan first births at home or in CMUs are likely to require transfer into a Labour Suite. For women expecting their second, third or fourth baby, transfer into hospital is less likely. About 10% of women planning second or subsequent births at home or in CMUs are likely to require transfer into a Labour Suite.

Some women may need to be transferred from the Labour Suite to theatre or to a high dependency unit. Where possible the midwife caring for you will support you during this transfer.

Neonatal Transfer

Neonatal transfer services are in place to provide babies with safe and efficient transfers to and from specialist neonatal care services. This is important as unwell newborns may have difficulty with breathing or keeping warm and require support as they are transferred.

It is important to discuss what the local arrangements are for transfer of your newborn baby from home and CMU. Within the AMU the neonatal team will be able to easily access your baby and start care prior to transfer to the neonatal unit if required, similar to Labour Suite.

What if my baby needs neonatal care?

Most babies are born healthy and without any complications. However, around one-in-ten babies will need some specialist care. Some of these babies will need to be looked after in a neonatal unit, while others can be looked after on the maternity ward.

A baby might need neonatal care if they were born too early (preterm), too small, or if they are unwell. Some babies are born with particular complications that require services such as surgery or help from heart specialists (cardiology). Babies born as part of a twin or multiple pregnancy are more likely to need neonatal care.

There are 15 neonatal units in Scotland. Each of these units provides a particular level of specialised care. Neonatal care is available in most hospitals where babies are born in Scotland, but more specialised treatment for the smallest and sickest babies is limited to fewer, more specialist neonatal units.

You will be advised about the best place to give birth for you and your baby. If your baby is likely to need neonatal care you will be advised to give birth in a unit that can provide that care, rather than your baby being transferred after birth.

It will not always be possible to transfer mothers before they give birth, and in those cases our specialist neonatal transfer service, ScotSTAR will transfer those babies in specialist ambulances equipped to care for neonates. Babies will be transferred back to their local neonatal unit for ongoing care as soon as possible.

For more information please see the Information for Expectant Parents resource on Neonatal Service in Scotland. To find out more about Neonatal Units in Scotland, visit: Neonatal Units - Scottish Perinatal Network

Consent: it's your decision

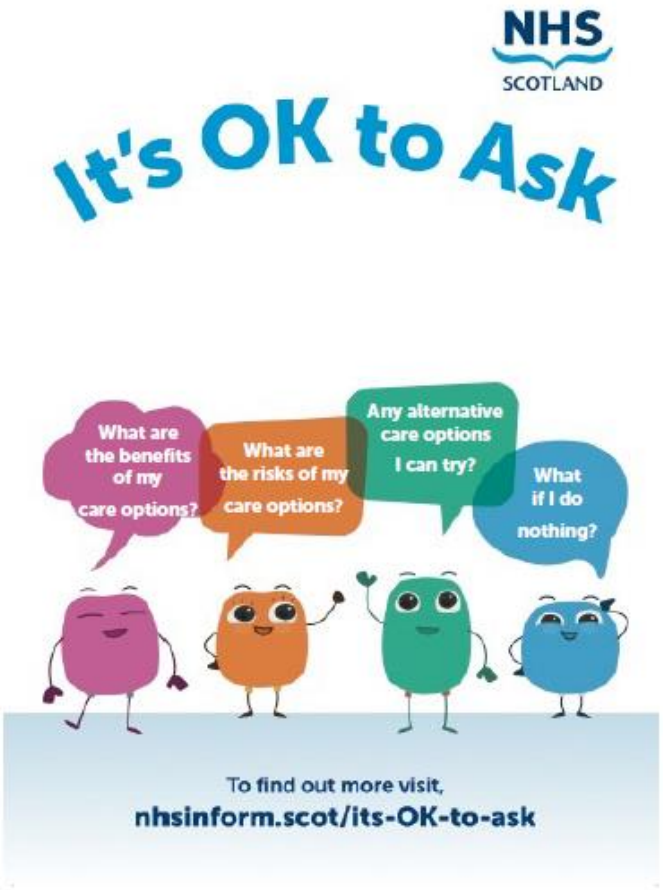
Before a doctor, midwife, nurse, or any other professional can examine or treat you they must have your consent: which means you give your agreement. Unbiased evidence must always be provided to support any conversation about birthplace, treatment, or examination.

You can give consent if you can make decisions for yourself. Being able to make decisions means you can understand what is involved and can think clearly about the advantages and disadvantages of different actions. You must be given enough information, and you should be allowed to make up your own mind without pressure from other people.

You can ask for a second opinion at any time during your care and you can have someone else present at appointments to support you or help you express your views.

Further information on consent is available:

NHS Inform - Communication and involving you


NHS
SCOTLAND
It's OK to Ask
What are the benefits of my care options?
What are the risks of my care options?
Any alternative care options I can try?
What if I do nothing?
To find out more visit,
nhsinform.scot/its-OK-to-ask

Resources

Further information and resources

This guide is intended to help you think about where to give birth. It may have raised new questions for you; please talk to your midwife or obstetrician about these. Below are some additional resources which you may also find useful. There may be other organisations and services operating in your local area, you can ask your midwife about what else is available.

NHS Inform Ready Steady Baby: https://www.nhsinform.scot/ready-steady-baby

Your guide to pregnancy, labour and birth and early parenthood up to 8 weeks.

National Childbirth Trust: www.nct.org.uk

Find out about antenatal classes and about 'the first 1,000 days' of parenthood.

National Perinatal Epidemiology Unit: https://www.npeu.ox.ac.uk/

The National Perinatal Epidemiology Unit's UK Midwifery Study System has produced information resources based on national research to help women make an informed choice about place of birth:

- BMI over 35 and thinking about birth in an Alongside Midwifery Unit?
- Diagnosed with gestational diabetes (GDM) and thinking about birth in a midwifery unit (MU)?
- Previous Postpartum Haemorrhage and Thinking about Birth in a Midwifery Unit?

Birthrights: www.birthrights.org.uk

An organisation which campaigns to support human rights during birth.

If you don't feel they have been listened to, or you haven't had a chance to talk about where to give birth, try talking to your midwife first. If you still have questions, ask to speak to a consultant midwife, the senior charge midwife, your consultant obstetrician if you have one, or to the Head of Midwifery at your NHS Health Board.

Charter of Patient Rights and Responsibilities: https://www.gov.scot/publications/charter-patient-rights-responsibilities-revised-june-2022/documents/

The Charter summarises what you're entitled to when you use NHS service and receive NHS care in Scotland. It also covers what you can do if you feel that your rights have not been respected.

The Birth Trauma Association: https://www.birthtraumaassociation.org/

A charity which supports parents who have experienced birth trauma and aim to improve parents' experience of birth.

La Leche League GB: https://laleche.org.uk/birth-breastfeeding/#Birth

An organisation that provides breastfeeding support, including antenatal education.

Young Patients Family Fund: If you are the parent/primary carer of a hospital inpatient under the age of 18 then you could be entitled to help to cover the cost of hospital visits. https://www.mygov.scot/young-patients-family-fund

Maternity Voices Partnerships act as a voice for the people who use maternity services. Speak to your midwife to find out if your local area has one.

Neonatal Units in Scotland

The Scottish Perinatal Network have a webpage where you can find out more about the different Neonatal Units in Scotland. The webpage has links to all the units, which you can follow to find out more about what is available in your area: Neonatal Units - Scottish Perinatal Network

Sources

This booklet uses findings from the 'Birthplace in England' programme of research. More information including published papers and summaries of findings can be found at: www.npeu.ox.ac.uk/birthplace

The booklet also contains advice found in the revised NICE guideline: 'Intrapartum Care: Care of healthy women and their babies during childbirth Clinical Guideline 235 NICE September 2023'. https://www.nice.org.uk/guidance/ng235

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The Scottish Government
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Delivery Framework for Miscarriage Care in Scotland

Version 1, February 2025

Contents

Foreword

The loss of a baby, no matter at what stage of pregnancy, has a profound and lasting impact on women and their families. To all who have experienced such a tragedy, I offer my deepest sympathy.

The Scottish Government recognises this impact and is clear that women and families who have experienced pregnancy or baby loss, must be provided with the right information, care and support taking into account their individual circumstances.

I understand that not all women and families want to talk about their miscarriage, however, sometimes they choose to remain silent due to the stigma or perceived stigma they feel surrounding their loss. It is vital that as a society we break that stigma and begin normalising conversations about miscarriage and the compassionate care and support women, and their families should expect to receive at this difficult time.

Women and families deserve the best care. That is why we enshrined miscarriage in our Programme for Government and set out our commitment to introducing a graded model of miscarriage care, so that women do not wait until a third miscarriage to receive tailored support, including access to progesterone prescriptions, and ensuring that separate spaces are available in maternity units for women who suffer a miscarriage.

We also committed to the introduction of a Memorial Book and certificate for those who have experienced a pregnancy or baby loss prior to 24 weeks. I am pleased that the Memorial Book and certificate became operational in October 2023. National Records of Scotland administer this service, which is free of charge, completely voluntary and historical applications are welcomed, as are applications for more than one loss.

I know that there is already a lot of work underway within NHS Boards to improve their provision in relation to miscarriage care and I'm delighted that we are now able to publish this Delivery Framework for Miscarriage Care, and a Progesterone Pathway, which will help and support NHS Boards to implement the Programme for Government commitments and deliver sensitive and compassionate care.

I am deeply grateful to the Chairs of the Short-Life Working Group and Writing Group for leading this work and I want to thank the members of both groups for their time, input and dedication on the Delivery

Framework for Miscarriage Care and Progesterone Pathway as well as their support for women and their families following a miscarriage.

Implementation of the Framework and Progesterone Pathway will help ensure that early pregnancy care is equitable so that no women are disadvantaged regardless of where they receive their care.

Jennie Minto, Minister for Public Health and Women's Health

Services which provide care for women with problems in early pregnancy are of fundamental importance. The care received can make a difference for the future of every woman accessing early pregnancy services. It is vital that there is both equity of access and provision across Scotland. Sitting at the interface between gynaecology and obstetrics, the huge numbers of women requiring these services mean that those involved in providing these services and their importance and impact cannot be underestimated. Scotland, as an early adopter of the concept of Early Pregnancy Units, run by nurses and midwives, has a long history in providing dedicated specialist miscarriage care. This document, produced by a committee of experts, stakeholders and patient representatives, is designed to consolidate good practice in miscarriage care throughout Scotland, regardless of location.

Colin Duncan, Professor of Reproductive Medicine and Science at the University of Edinburgh
Professor Justine Craig, Chief Midwifery Officer for Scotland

Co-Chairs of the Short Life Working Group on Miscarriage Care

Inclusivity Statement

This document will use the term ‘women’/‘woman’ throughout. However, it is important to highlight that it is not only those who identify as women who require access to miscarriage care. For example, some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience miscarriage. Miscarriage services and the delivery of care must therefore be appropriate, inclusive and sensitive to individual needs. The term couple is used to describe two individuals of any sexuality or gender.

1. Introduction

The Delivery Framework for Miscarriage Care in Scotland was developed by an Expert Short Life Working Group, along with a writing group, and outlines a plan for introducing a graded model of miscarriage care in Scotland. The groups brought together a wide range of expertise that informed discussions, including wide representation from third sector organisations. **Annex A** details the membership of the groups.

The Framework brings together professional guidance, including guidance from the National Institute for Clinical Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG), with the recommendations in the Lancet series, Miscarriage Matters (thelancet.com). Miscarriage care in Scotland is generally considered to be of high quality and NHS Boards have been further improving miscarriage care as a result of the drivers set out in the above-mentioned guidance and recommendations, and both of the published Scottish Government, Programme for Government commitments on improving miscarriage care.

The group considers that 15 months is a reasonable timeframe for NHS Boards to implement the majority of the key actions/deliverables in this document but recognises that a few of the actions/deliverables listed as “medium” status priority may take longer to put in place in a few areas.

The group suggests the following prioritisation categories of the actions/deliverables. However, it is recognised that miscarriage services in Scotland are at different stages of delivery against the actions/deliverables in the Framework, as many have been following good practice and implementing professional guidance, including offering progesterone treatment where appropriate, for some time. The actions/deliverables have been given the following status:

- N – priority now and implemented within 6 months
- S – should be implemented in the short term within 12 – 15 months
- M – should be implemented in the medium term within 15 – 24 months

The status given to each action will help NHS Boards prioritise change locally and move to a ‘One Scotland’ approach.

Review and Monitoring Progress

NHS Boards will be asked by Scottish Government to assess what their service is delivering now, and report on their progress towards implementing the key actions/deliverables. Annual and Local Delivery Plan guidance for NHS Boards from 2025-26 highlights improving miscarriage care and implementing this Framework as a specific planning priority. NHS Boards will therefore be expected to report to the Scottish Government on progress towards implementation.

2. Summary of Key Actions/Deliverables

1.	Miscarriage can have significant emotional and psychological impacts. At all points of contact, healthcare services should provide compassionate, culturally competent, and high-quality bereavement care, including clear communication and appropriate support.	**N**
2.	All NHS Boards to fully implement all five National Bereavement Care Pathways (NBCP), including the Miscarriage, Ectopic and Molar Pregnancy Pathway. A link to the NBCP can be found here: https://www.nbcpscotland.org.uk/.	**N**
3.	Ensure patients are made aware that clear, easily accessible and translatable information is available on NHS inform about managing concerns in early pregnancy which includes details on accessing care within each NHS Board. Provide patient leaflets for additional support www.nhsinform.scot/early-pregnancy-units and www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby.	**N**
4.	NHS Boards to ensure that information about their early pregnancy service is up-to-date, effectively communicated, and easily available, to women, as highlighted in the Refreshed Framework for Maternity Services in Scotland (2011).	**N**
5.	NHS Boards to ensure that those experiencing complications in early pregnancy are able to self-refer to their nearest Early Pregnancy Unit /Assessment Service (EPU/EPAS) within opening hours.	**N**

6.	Women, who are clinically stable, with pain and/or bleeding and a positive pregnancy test who contact the Scottish Ambulance Service, 111, their GP or the Emergency Department should be directed to their nearest EPU/EPAS within opening hours.	**N**
7.	Outside EPU/EPAS opening hours it is important that women have access to advice to prevent unnecessary attendance at the out of hours service or Emergency Department. Each NHS Board should ensure that women have access to someone who can speak to them over the telephone 24 hours a day, seven days a week, including via an interpreter in their preferred language if required. Clinically stable women should be directed to the EPU/EPAS service when the service opens. In person assessment should be available to those who require to be seen urgently because of clinical concern no matter what time of day or night.	**S**
8.	Wherever possible NHS Boards to build access to a seven-day early pregnancy assessment service with a same day approach. Women with pain or bleeding in early pregnancy should be able to speak to someone with expertise in early pregnancy every day and be triaged for in person assessment in the EPU/EPAS as required. All patients should be managed through EPU/EPAS within 24 hours of initial presentation as per MBRRACE-UK 2024 recommendations. MBRRACE-UK Maternal MAIN Report 2024 V1.0 ONLINE.pdf	**S**
9.	NHS Boards that cannot provide a seven-day EPU/EPAS service within their Board should have agreements in place with neighbouring NHS Boards with clear lines of referral pathways. A networked approach within and between NHS Boards will ensure that patients and local non-specialist providers, including in primary care, are able to speak to someone with expertise in early pregnancy every day who can advise and arrange access to in person assessment as required.	**S**
10.	Those experiencing miscarriage at any stage of pregnancy should be seen in a separate private space appropriate for bereavement, as advised in the NBCP Bereavement Care Standards, and if admitted to hospital, where possible be treated in a single room. Generally, this should be located within maternity services away from other pregnant, labouring or postpartum women, or in an EPU/EPAS, or other clinically appropriate environment that has privacy in spaces sensitive to the	**N**

	needs of all individuals. Rooms should ideally have sound proofing. Women/couples who wish to avoid walking through areas where there are other pregnant women should be given the choice of using a different exit or if not possible, they should if they wish, be compassionately accompanied through the shared area rather than being left to walk alone.	
11.	NHS Boards should ensure that clear local procedures are in place, in line with NICE Guidelines, for the diagnosis of miscarriage using ultrasound scanning by appropriately trained and validated ultrasonography practitioners and conducted in single rooms.	**N**
12.	NHS Boards should facilitate the use of micronised progesterone treatment, as set out in professional guidance, for those with a previous miscarriage who are experiencing bleeding in early pregnancy, NHS Boards must follow the NHS Scotland *National Guidance on the Use of Progesterone in the Management of Threatened Miscarriage and Recurrent Miscarriage*. [Insert link when available]	**N**
13.	Clear written and verbal information on the miscarriage management options should be given to women and available for other care providers. Women need to be supported to choose the management approach that suits their needs and preferences. If required, interpretation services including British Sign Language (BSL) to be available for women, in-person where possible, throughout their assessment and care, ensuring this is delivered compassionately.	**N**
14.	Where medical management is opted for, the use of mifepristone in advance of misoprostol should be standard practice as it increases the chance of success in missed miscarriage.	**N**
15.	Where surgical management of miscarriage is opted for, women are to be offered a choice of anaesthetic options including manual evacuation under local anaesthetic. Provide clear and realistic information, on each option, including intra and post-surgical pain relief, to support fully informed decisions.	**S**
16.	Where NHS Boards do not have all anaesthetic options available, the networked approach should be adopted with clear formal agreements in place to seek care in an	**M**

	adjacent NHS Board to facilitate patient choice.	
17.	After a miscarriage, women are to be provided with written and verbal information about miscarriage and support available, sign-posted to the NHS inform miscarriage and pre-conception health pages, and, where appropriate, contraceptive advice should also be provided. The NHS inform information will be accessible to all and made available in translated and audio versions. www.nhsinform.scot/early-pregnancy-units and www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby.	**N**
18.	After miscarriage, women are to be provided with the Scottish Government/National Records of Scotland leaflet on the memorial book of pregnancy and baby loss prior to 24 weeks and directed to the Scottish Government and National Records of Scotland related webpages Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks and The Memorial Book - National Records of Scotland.	**N**
19.	All NHS Boards to provide a graded model of miscarriage care as recommended in the Lancet series, Miscarriage Matters (thelancet.com) published in 2021.	**S**
20.	After a first miscarriage, women should be given and/or signposted to high quality information to allow them to self-assess modifiable risks at a time appropriate to their individual circumstances.	**N**
21.	After a first miscarriage, women/couples should be able to speak to a nurse/midwife with expertise in early pregnancy complications and care if they have additional questions and require additional support after accessing the above information and self-assessing.	**S**
22.	After a second miscarriage, women should be offered an appointment with an early pregnancy nurse/midwife where personalised care and initial investigations can take place or be organised. Where abnormal investigation results are found, a local pathway should be developed to manage these results including where appropriate, a referral to an appropriate primary or secondary care doctor.	**M**
23.	After two miscarriages, women should be offered full blood count, thyroid function testing and screening for obstetric antiphospholipid syndrome (APS) using anticardiolipin antibodies and lupus anticoagulant tests.	**M**

24.	After two or more previous miscarriages, an early ultrasound scan in a subsequent pregnancy should be offered, at a time most sensitive to the couple's needs but not before 7 weeks' gestation if asymptomatic (no pain or bleeding).	**S**
25.	After three miscarriages, women/couples should be offered the opportunity to attend a specialist recurrent miscarriage clinic. All NHS Boards should provide specialist consultant or equivalent medical staffing within these clinics and ensure dedicated time is allocated, or develop a formal agreement where women can be referred to their preferred NHS Board that can provide such a recurrent miscarriage clinic.	**N**
26.	After three miscarriages, women should be offered uterine imaging for congenital and acquired uterine abnormalities using 3D ultrasound. 3D ultrasound has been shown to improve detection of uterine anomalies therefore NHS Boards should develop access to this service where it is not available.	**S**
27.	Where 3D ultrasound is not available, 2D ultrasound should be offered after a 3rd miscarriage. Where any abnormality is suspected, further imaging with 3D ultrasound, at a different site or with an agreement with another NHS Board, or MRI should be offered.	**N**
28.	Cytogenetic analysis should be offered on pregnancy tissue of the third and subsequent miscarriage(s). This may require a maternal blood sample to check that the fetal genotype has been tested.	**S**
29.	Asymptomatic women with four previous miscarriages should be offered vaginal micronised progesterone from a positive urine pregnancy test until 12 weeks of gestation, where clinically appropriate. They should be provided with written information on available evidence and potential benefits/risks. An ultrasound scan should be provided at 6 weeks gestation, for these women treated with progesterone, in order to confirm intrauterine gestation.	**N**
30.	Couples with five or more previous miscarriages should be offered parental karyotyping where no results of genetic testing of pregnancy tissue are available (including previous maternal cell contamination or where no pregnancy tissue is available for testing). National discussions are ongoing to support this deliverable.	**M**

31.	All NHS Boards should have a nurse or midwife led team with specialist training and expertise in recurrent miscarriage and time allocated commensurate with local service needs to provide support to couples with recurrent miscarriage and work alongside the specialist medical clinic.	**S**
32.	NHS Boards should ensure staff receive training in providing compassionate, culturally competent care after miscarriage and other early pregnancy complications. Training should include supporting bereaved individuals, peer support for staff, and aligning with the NBCP Miscarriage, Ectopic and Molar Pregnancy Pathway.	**N**
33.	NHS Boards should develop their bereavement counselling services towards offering counselling (including online platforms) to women who have experienced a miscarriage.	**M**
34.	NHS Boards should ensure that those who experience miscarriage have access to culturally competent, trauma-informed and responsive services which embed the principles of choice, collaboration, empowerment, safety and trust. This means services which recognise the prevalence of trauma and its impact (including amongst their own staff) and which respond in ways that support recovery. It also means services that follow the key principles of trauma informed care, which do not unintentionally retraumatise, and which allow individuals to easily access the appropriate care and support, including appropriate third sector support, they need.	**M**

3. Background

The Scottish Government committed through the Programme for Government 2021 – 22, published on 7 September 2021 and the Programme for Government 2023 – 24, published on 5 September 2023 to: improving miscarriage care so women do not wait until a third miscarriage to receive tailored support; supporting access to progesterone when indicated; providing separate spaces in hospitals for people who suffer a miscarriage, and launching the Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks. Further information can be found in **Annex B** (Programme for Government) and **Annex C** (Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks).

These Programme for Government commitments built on previous publications and commitments to develop:

- A miscarriage service tailored to the needs of women, taking forward the findings of the Lancet series, Miscarriage matters (thelancet.com), and supporting the development of individualised care plans after a woman's first miscarriage.
- Ensuring that maternity departments have dedicated facilities for women who are experiencing unexpected pregnancy complications.

The Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks was launched by the former First Minister on 4 October 2023 and is now operational. The scheme is administered by National Records of Scotland, working with Scottish Government, to give recognition and comfort to those who want to record their loss. Further information on the Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks can be found at **Annex C**

As part of the work to fulfil the Programme for Government commitments, Scottish Government analysts carried out a scoping exercise across all 14 NHS Boards into the availability of services within Boards for miscarriage and unexpected pregnancy complications. A National report and 14 individual NHS Board reports have been produced with senior board review and sign off, following analysis of responses of the scoping exercise and these will help inform improvements to miscarriage services. The reports were published on 29 November 2023 and the findings were presented at a Scottish Government Miscarriage Event for health professionals and third sector stakeholders on the same day. Links to the National and 14 individual Board Reports can be found at **Annex B**.

The Scottish Government put workstreams in place to inform this Delivery Framework for Miscarriage Care in Scotland, and all workstreams fed into its development. These include:

- Development of an NHS Scotland protocol for progesterone to ensure that women who have had at least one previous miscarriage, and present with early pregnancy bleeding, are offered vaginal micronised progesterone, where it is clinically indicated, in line with relevant Royal College of Obstetricians and

Gynaecologists (RCOG) and National Institute for Health and Care Excellence (NICE) guidelines (**Annex B**):

- Development of comprehensive patient information, in collaboration with Tommy's charity, in addition to updating information for health professionals and the wider public. A working group was established with wide representation from charities and health professionals to help develop these national information resources. This information is available via the NHS inform platform and in digital and physical leaflet format www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby.
- Commissioning Public Health Scotland (PHS) to collect meaningful miscarriage data, which will provide a more accurate picture of the number of miscarriages in Scotland. Initial work is concentrating on establishing data collection for miscarriages presenting to EPU/EPAS settings.
- Ensuring implementation of the National Bereavement Care Pathway (NBCP) https://www.nbcpscotland.org.uk/ in all 14 NHS Boards. Further information on the NBCP can be found at **Annex C.**
- Updating information on NHS inform about preconception care following a loss which links to information on Tommy's website. This information sits on the Women's Health Platform and is contained within a section on planning a pregnancy.
- Exploring, with NHS Education for Scotland (NES), what additional training is necessary and can be developed for health professionals in relation to miscarriage care.
- Initiating work to map mental health services following a pregnancy and baby loss so that, where indicated, women can access appropriate mental health support should they require it in addition to bereavement care. Considering how counselling and psychological services (including third sector organisations) could be expanded/improved so that, where indicated, women can access the appropriate mental health support following a miscarriage.

4. The Importance of Miscarriage

Context

Early pregnancy care represents a large, but often unmeasured, volume of clinical activity. For example, in the Royal Infirmary of Edinburgh, which sees approximately 7000 births each year, around 5000 women contact the early pregnancy unit annually because of concerns in the first 12 weeks of pregnancy. In Aberdeen Maternity the early pregnancy unit has over 1000 calls a month from women under 24 weeks gestation. Women who attend may be experiencing bleeding, pain or issues with nausea and vomiting, or have a past history of early pregnancy problems. Early pregnancy services manage all women with potential or actual early pregnancy problems, including suspected or confirmed miscarriage, ectopic pregnancy and molar pregnancy, and all these losses are recognised in the National

Bereavement Care Pathway https://www.nbcpscotland.org.uk/. Up to 80% of women attending early pregnancy units have an ongoing pregnancy.

The framework acknowledges all of this but **focuses on first trimester miscarriage care.**

Definition

Miscarriage is the spontaneous loss of an intrauterine pregnancy up to the end of the 23rd week of pregnancy. Definitions of when the first trimester ends, and the second trimester starts are varied. Herein, we consider that **first trimester miscarriages** occur in the first 11 weeks and 6 days of pregnancy, while **second trimester miscarriages** occur between 12 weeks and 23 weeks and 6 days of pregnancy. It is thought that miscarriage affects around one in five pregnancies before 12 weeks gestation, though it is likely that very early miscarriages - sometimes called “biochemical pregnancies” - are even more frequent.

The clinical definition of **Recurrent miscarriage** varies. For example, The European Society of Human Reproduction and Embryology (ESHRE) defines recurrent miscarriage as two or more pregnancy losses after 6 weeks, excluding ectopic and molar pregnancies. The 2023 Royal College of Obstetricians and Gynaecologists guidance defines recurrent miscarriage as three or more non-consecutive first trimester miscarriages. The American Society for Reproductive Medicine suggests that three or more losses should be used for epidemiological studies while clinical evaluation may proceed following two first-trimester losses.

The Scottish Government supports the Lancet series Miscarriage Matters graded model of care. This puts in place pathways of care that start after one miscarriage and are linked to the number of previous miscarriages experienced with initial investigation of causes of miscarriage taking place after two miscarriages.

Type

A **Complete miscarriage** is where the pregnancy tissue has all been expelled from the uterus and the bleeding has stopped. An ultrasound scan would clearly show no pregnancy tissue in the uterus. It is important to consider an ectopic pregnancy in all cases where an intrauterine pregnancy has not been confirmed and this would involve additional pregnancy hormone testing**.** This may be referred to as pregnancy of unknown location until hormone tests provide more information.

An **Incomplete miscarriage** is where some, but not all, pregnancy tissue has passed from the uterus. Women will usually have on-going pain and bleeding, and pregnancy tissue would be visible in the uterine cavity on an ultrasound scan.

A **Missed miscarriage** is where the pregnancy tissue remains complete inside the uterus without fetal heart activity or where the pregnancy remains inside the uterus but only a pregnancy sac has developed. The woman may have minimal symptoms, and a missed miscarriage can be discovered at a routine scan appointment.

A **Threatened miscarriage** is where the pregnancy remains viable (ongoing) or potentially viable with a closed cervix, but the woman experiences early pregnancy

bleeding. This is very common: more than 25% of women may experience threatened miscarriage in the first 12 weeks; the majority do not miscarry.

Prevalence

In the UK, an estimated 250,000 miscarriages occur every year, suggesting around 25,000 per year in Scotland. Miscarriage is the commonest complication of pregnancy. The population prevalence of women who have had one miscarriage is 10.8% (10.3–11.4%), two miscarriages is 1.9% (1.8–2.1%), and three or more miscarriages is 0.7% (0.5–0.8%). The prevalence of late miscarriage, defined as being between 12 weeks and 23 weeks and 6 days of pregnancy, is estimated to be 1% of all pregnancies and around 15% of all miscarriages.

However, the exact incidence of miscarriage remains uncertain. Many women do not present to hospital when experiencing a miscarriage and their experiences of miscarriage are not always reported or recorded, with the true impact of miscarriage likely to be underestimated. Miscarriage data have not been published in Scotland since 2016 because data is only collected nationally from inpatient settings, although having a miscarriage will be recorded in a women's medical records if she presents to services. The Scottish Government recognises that data recording and reporting will facilitate data-informed patient centred care and has commissioned Public Health Scotland to collect meaningful miscarriage data. A miscarriage (early pregnancy) data set has been agreed and Public Health Scotland is now testing this data set using data extracted from clinical information systems.

Risk of miscarriage

The risk of miscarriage is lowest in women with no history of miscarriage (11%), and increases by about 10% for each additional miscarriage, reaching 42% in women with three or more previous miscarriages. Risk of miscarriage is lowest in women aged 20–29 years at 12%, increasing to 65% in women aged 45 years and older, and likely to be even higher in women with recurrent miscarriage and age-related risk. Black women, additionally, are reported to have a 40% higher miscarriage risk when compared with women of white ethnicity. Male age older than 40 years is also associated with an increased risk of miscarriage.

Female body-mass index (BMI) is associated with miscarriage risk; the BMI associated with the least risk of miscarriage is 18.5–24.9 kg/m^2. Health-harming products, including tobacco, excessive caffeine and alcohol consumption during pregnancy have been associated with an increased risk of miscarriage, as have persistent stress, exposure to air pollution and exposure to pesticides.

Risks of previous miscarriage

Miscarriage, and especially recurrent miscarriage, is associated with future obstetric complications which can impact on child development. The risk of preterm birth increases stepwise with each previous miscarriage, showing a biological gradient with the highest risk in women with three or more previous miscarriages. The risk of fetal growth restriction, placental abruption, and stillbirth in future pregnancies is also increased. The antenatal care needs of women with recurrent early miscarriage, or late miscarriage in subsequent pregnancies, is largely unknown.

A history of recurrent miscarriage is also a predictor of longer-term health problems and is associated with an increased risk of cardiovascular disease and venous thromboembolism.

There is currently no universally used tool to screen for psychological distress following a pregnancy loss. There is a clear unmet need as women and their partners experiencing recurrent miscarriage are at risk of serious mental health conditions, including depression, anxiety, post-traumatic stress disorder (PTSD) and suicide. The risk of PTSD is 17% at 9 months after miscarriage and suicide risk is increased 4-fold. Women with these conditions often require specialist psychological support to help manage the significant distress and heartbreak of their losses. For some, access to specialist psychological services in addition to recurrent miscarriage and primary care support will be required. There is a need for improved access to specialist counselling or support services for women and their partners experiencing miscarriage.

Cost

The costs of miscarriage affect individuals, health-care systems, and society. The short-term national economic cost of miscarriage is estimated to be at least £471 million per year in the UK and approximately £47 million in Scotland.

Key Actions

1. *Miscarriage can have significant emotional and psychological impacts. At all points of contact, healthcare services should provide compassionate, culturally competent, and high-quality bereavement care, including clear communication and appropriate support.*
2. *All NHS Boards to fully implement all five National Bereavement Care Pathways (NBCP), including the Miscarriage, Ectopic and Molar Pregnancy Pathway. A link to the NBCP can be found here: https://www.nbcpscotland.org.uk/.*

5. Aims of the Framework

In this Delivery Framework for Miscarriage Care in Scotland, a clear clinical pathway is defined for women who experience miscarriage. This includes access to early pregnancy units, miscarriage management, psychological support and a graded model of care for women who have had one or more miscarriages. The Framework also sets out expectations in relation to patient information and high-quality bereavement care.

The overarching aims are to:

- Standardise miscarriage care in a ‘One Scotland’ approach.
- Address inequalities in miscarriage care access, support and care including racialised health inequalities.

- ❖ Ensure that early pregnancy care is equitable so that no women are disadvantaged due to their location, digital connectivity, ethnicity and/or social circumstances.
- ❖ Ensure that NHS Boards have evidence that information about their early pregnancy service is effectively communicated to women and maternity care services.
- ❖ Provide trauma-informed, culturally competent and responsive quality care to women experiencing miscarriage and define a minimum expected standard of care regardless of location.
- ❖ Ensure that miscarriage is an opportunity to promote access to preconception care planning to optimise next-pregnancy outcomes.
- ❖ Introduce a structured, graded model of clinical care pathways including investigation and preconception care.
- ❖ Promote identification of and support for the psychological needs of women/couples experiencing miscarriage.
- ❖ Support evidence-based miscarriage care and the implementation of clinical audit and research into miscarriage.
- ❖ Ensure that NHS Boards provide appropriate staff with the time, training, development and support they require to effectively support bereaved women, their partners and families.

The primary objectives of this framework are as follows:

Optimise pre-conception health

- Provide plain language and evidence-based information about miscarriage and ways to optimise health for future pregnancy.
- Facilitate access to advice on healthy eating, achieving normal BMI, tobacco dependency/smoking cessation, alcohol avoidance, and pre-pregnancy micronutrient supplementation (folic acid, vitamin D).
- Signpost to preconception information on NHS inform and ensure equitable access to care and information for disadvantaged or marginalised groups.
- Identify maternal medical conditions that may impact pregnancy (e.g. diabetes, hypertension, heart disease, and epilepsy) and early referral opportunities for specialist management and optimisation.

Graded model of miscarriage care

- Establish a tailored, graded model of miscarriage care to standardise increased investigation and management based on the number of previous miscarriages (Figure 1).
- Facilitate multi-disciplinary involvement and access to specialist support such as clinical genetics, fertility care, haematology, and endocrinology as indicated by miscarriage investigations.
- Standardise early pregnancy care and support for women with recurrent miscarriage in a ‘One Scotland’ approach.
- Provide access to early pregnancy reassurance scans in subsequent pregnancies after a second miscarriage.

- Enhance specialist nurse/midwife involvement in patient support and investigation.
- Share information and collaborative research for women/couples with recurrent miscarriage.

Obstetric risk prevention

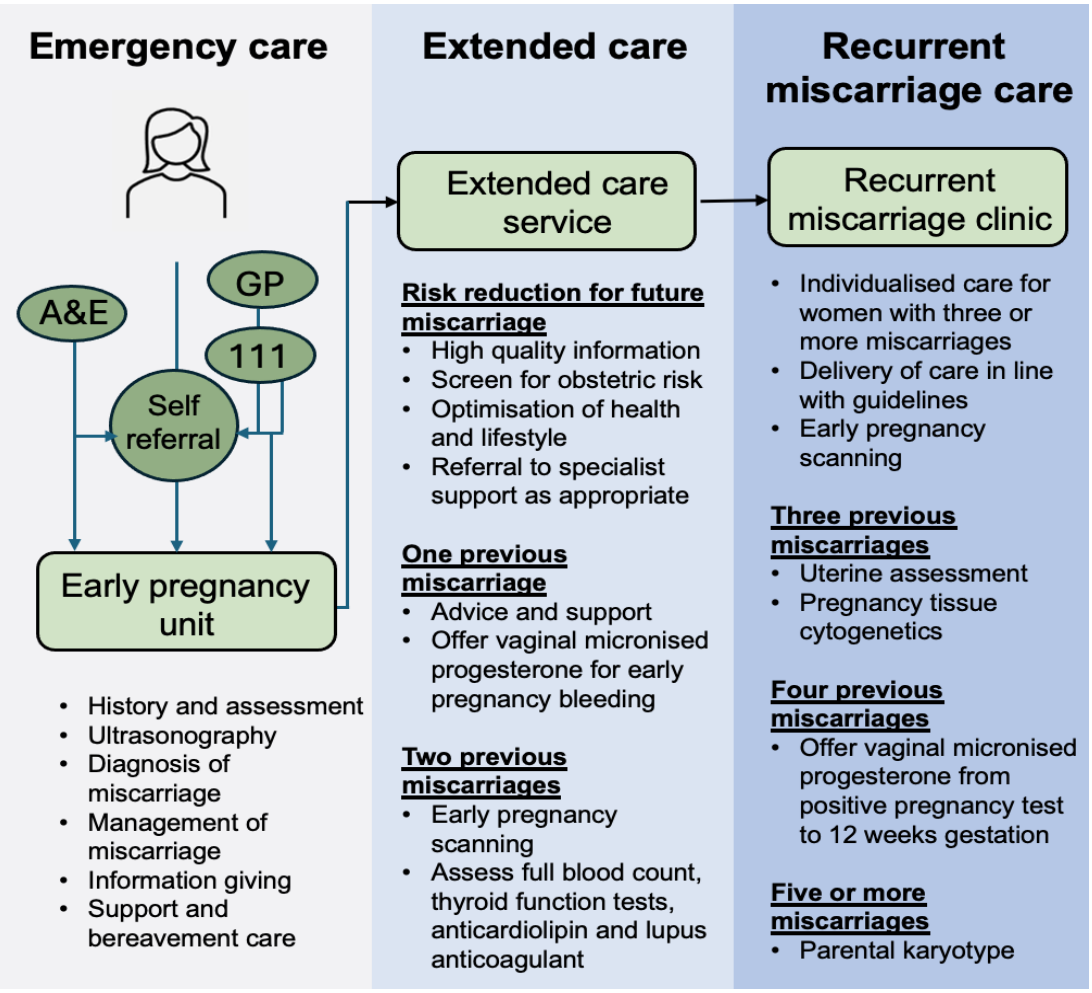
- Ensure timely referral to appropriate pre-conception specialist care services for optimisation of chronic disease such as referral to hypertension or diabetes clinics.
- Ensure obstetric services have access to detailed past miscarriage history and subsequent investigations to tailor obstetric care.
- Promote increased understanding about the obstetric impact of recurrent miscarriage in community midwives who facilitate triage of care.

Bereavement and psychological support

- Provide support in line with the National Bereavement Care Pathway and ensure that all women/couples are provided with information about where to access bereavement support, including after early miscarriage, before they leave hospital.
- Signpost to patient support groups and online self-help strategies.
- Train staff in sensitive communication (e.g. the Sands midwife training session) and trauma skilled practice and give them the tools and information to refer on for further psychological support if the woman's situation is more complex than bereavement support can provide.
- This trauma skilled practice should recognise not just the psychological impact of pregnancy loss but also the impact that pregnancy loss may have on people who have experienced previous trauma.
- Facilitate timely access to specialist tailored care, where appropriate, for complex psychological needs post miscarriage (e.g. post-traumatic stress, moderate or severe anxiety and moderate or severe depression).
- Remember that additional mental health support following a miscarriage may be required by not only the woman or couple but others around them who are impacted by the loss.

Figure 1. Flow diagram for miscarriage care pathway – Although in this diagram all pathways end in the early pregnancy unit it is acknowledged that in some circumstances GPs or community midwives are able to provide appropriate advice without onward referral.

Annex F: DELIVERY FRAMEWORK FOR MISCARRIAGE CARE – FEBRUARY 2025



6. Accessing Early Pregnancy Care

Considerations

Care

Organisation and provision of miscarriage care should be by clinical nurse or midwifery specialists, and medical staff, specifically trained in early pregnancy care within self-contained early pregnancy units, where possible. The model of care within rural and island services will be different but the care should always be patient-centred with support from a regional early pregnancy network. Formal training should be provided for sonographers, specialist nurses/midwives and clinicians responsible for early pregnancy ultrasound to ensure: individualised communication and care; diagnostic accuracy; robust reporting; inclusivity and cultural competency, and consistent and accessible information provision for women/couples. Where possible regional EPU/EPAS should arrange to share training opportunities with smaller NHS Boards and island units.

Referral

Referrals to early pregnancy services are made by self-referral, referral by health care professionals such as a GP, NHS 24, Midwife or via the Emergency Department. Self-referral to the nearest EPU/EPAS is the optimal pathway recommended in this framework; this reduces the burden on all other services, offers the best patient-centred referral pathway and ensures access to specialist advice.

Emergency care

Emergency early pregnancy care should be delivered in line with the latest NICE guideline (NG126) (Figure 2). This framework recommends that a same day emergency care plan is established with 111 and 999 services referring women directly to EPU/EPAS or local obstetrics and gynaecology department rather than to the ambulance and Emergency Department services. This means appropriate information must be available for 111 and 999 call handlers. A clear referral pathway should exist to the EPU/EPAS in the local area that can provide a call back service to women with early pregnancy complications, to arrange any appropriate further management and triage. NICE recommends that this should be within 24 hours.

If the EPU/EPAS is unavailable and urgent care is required, treatment should be managed in the Emergency Department as a last resort. Where possible, women should be able to directly access out of hours care in specialist obstetrics and gynaecology departments and receive telephone advice and face to face review as necessary instead of being referred to the Emergency Department. The exception to this is where a woman is haemodynamically unstable with severe abdominal pain, or major haemorrhage, where local policy may be to attend the Emergency Department directly in those circumstances. Triage within an obstetrics and gynaecology department for all other scenarios would be most appropriate.

Outside of normal working hours, regional teams and integrated care systems could combine to provide a cover service whereby women could access advice and care 24/7 without needing a referral from another healthcare provider. A directory of services that signposts women to the correct EPU/EPAS has been developed www.nhsinform.scot/early-pregnancy-units.

Regional centres

Consideration should be given to the development of regional centres within NHS Board areas to ensure that out of hours provision of early pregnancy care can be established, and smaller units can refer patients and seek second opinions.

Separate spaces

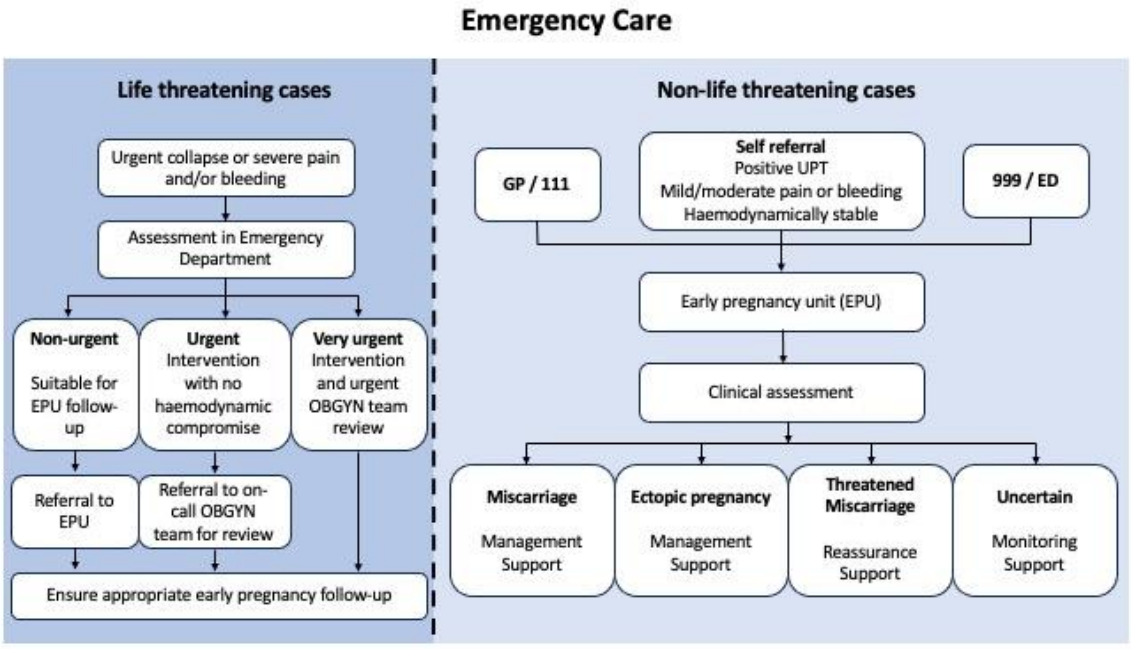
All hospital settings treating those who are experiencing pregnancy complications should provide an appropriate separate private space for breaking bad or unexpected news and managing miscarriage care. All EPU/EPAS and out of hours services should ensure that there are cold storage facilities available to receive or store pregnancy remains. This might be for the investigation of recurrent miscarriage or to access sensitive disposal care pathways with staff trained in bereavement care.

The Scottish Government Programme for Government commitment is clear that NHS Boards should provide separate spaces for people who suffer a miscarriage (or other type of pregnancy and baby loss). This framework recommends that the most appropriate setting should be offered to assess and manage women with pain, bleeding or where risk of fetal loss and miscarriage is very high. This may be within a maternity triage setting where no other option exists, but boards should consider and explore the most appropriate, private and dignified space to assess and manage such women. Appropriate settings include early pregnancy units, bereavement suites or appropriate single room facilities within obstetrics and gynaecology wards.

Bereavement care

Compassionate, culturally competent and high-quality sensitive care, bereavement care and trauma-informed care is fundamental. All staff involved with the care of women in early pregnancy should have bereavement care training specific to early pregnancy, in line with the National Bereavement Care Pathway https://www.nbcpscotland.org.uk/ (**Annex C**).

Figure 2. Flow diagram of early pregnancy emergency care



Key Actions

3. *Ensure patients are made aware that clear, easily accessible and translatable information is available on NHS inform about managing concerns in early pregnancy which includes details on accessing care within each NHS Board. Provide patient leaflets for additional support www.nhsinform.scot/early-pregnancy-units and www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby.*
4. *NHS Boards to ensure that information about their early pregnancy service is up-to-date, effectively communicated, and easily available, to women, as highlighted in the Refreshed Framework for Maternity Services in Scotland (2011).*
5. *NHS Boards to ensure that those experiencing complications in early pregnancy are able to self-refer to their nearest Early Pregnancy Unit /Assessment Service (EPU/EPAS) within opening hours.*
6. *Women, who are clinically stable, with pain and/or bleeding and a positive pregnancy test who contact the Scottish Ambulance Service, 111, their GP or the Emergency Department should be directed to their nearest EPU/EPAS within opening hours.*
7. *Outside EPU/EPAS opening hours it is important that women have access to advice to prevent unnecessary attendance at the out of hours service or Emergency Department. Each NHS Board should ensure that women have access to someone who can speak to them over the telephone 24 hours a day, seven days a week, including via an interpreter in their preferred language if required. Clinically stable women should be directed to the EPU/EPAS service when the service opens. In person assessment should be available to those who require to be seen urgently because of clinical concern no matter what time of day or night.*
8. *Wherever possible NHS Boards to build access to a seven-day early pregnancy assessment service with a same day approach. Women with pain or bleeding in early pregnancy should be able to speak to someone with expertise in early pregnancy every day and be triaged for in person assessment in the EPU/EPAS as required. All patients should be managed through EPU/EPAS within 24 hours of initial presentation as per MBRRACE-UK 2024 recommendations. MBRRACE-UK Maternal MAIN Report 2024 V1.0 ONLINE.pdf*
9. *NHS Boards that cannot provide a seven-day EPU/EPAS service within their Board should have agreements in place with neighbouring NHS Boards with clear lines of referral pathways. A networked approach within and between NHS Boards will ensure that patients and local non-specialist providers, including in primary care, are able to speak to someone with expertise in early pregnancy every day who can advise and arrange access to in person assessment as required.*

7. Diagnosis and Management of Miscarriage

Considerations

Miscarriage diagnosis

Although diagnosis can be achieved by a negative pregnancy test after bleeding, when there has been a positive pregnancy test, often accurate diagnosis of miscarriage relies on high-quality transvaginal ultrasound scanning (TVUS) to identify location and viability of the pregnancy

It is recommended that a second suitably trained practitioner should confirm the diagnosis of miscarriage when the scan is diagnostic of miscarriage, in line with NICE guidelines. Those experiencing miscarriage should be offered a second opinion, including returning on another date to have this second ultrasound opinion where not possible on the same day. Further information on miscarriage diagnosis can be found at **Annex D**.

Miscarriage management

Women should be given written and verbal information on miscarriage management options, including data on success rates, risks and benefits, and be supported to choose the management approach that suits their needs and preferences. If required, interpretation services, including British Sign Language (BSL) should be available for women, in-person where possible, throughout their assessment and care. These services should be delivered compassionately.

There are three recognised management pathways for miscarriage:

Expectant management (also called natural or conservative management) – this means waiting for the natural passage of pregnancy tissue and allows a miscarriage to happen without medical intervention. This method is often recommended in the early part of the first trimester. Expectant management is an effective approach for women with incomplete miscarriage but is less effective than medical or surgical management for women with missed miscarriage. The NICE guidelines state that expectant management should be the first method considered.

Medical management – this means treatment with medication taken orally and/or vaginal tablets (pessaries) to start or assist the process of a missed or incomplete miscarriage. The medications used for the medical management of miscarriage are mifepristone and misoprostol. Misoprostol is a synthetic prostaglandin E1 analogue that induces cervical softening and uterine contractions. Misoprostol alone can complete an incomplete miscarriage. Mifepristone acts as a competitive progesterone and glucocorticoid receptor antagonist that interferes with the nuclear receptor signalling of progesterone, blocking its actions and sensitising the uterus to the effects of misoprostol to facilitate completion of the miscarriage. Among medical management strategies, a combination of mifepristone and misoprostol is more effective than misoprostol alone in completing a missed miscarriage and NICE recommends a combination of mifepristone and misoprostol for the medical management of missed miscarriages.

Surgical management – this means to remove the pregnancy tissue surgically. Surgical methods involve dilation of the cervix and suction aspiration of pregnancy tissue, with or without the preparation of the cervix with misoprostol to minimise the risk of injury from cervical dilation. Surgical management can be carried out under general anaesthetic or regional anaesthetic (such as spinal block) using electric suction aspiration, although it can be safely performed as manual vacuum aspiration (MVA) under local anaesthetic. The range of anaesthetic options should be made available to women so they can make a choice most acceptable to them. This may include travel to a different site within boards, but wherever possible the range of options should be made possible at all EPU/EPAS.

After miscarriage

Women should be counselled on what to expect following a miscarriage (including expectant management). Advice should be given about potential duration (how long things might take to resolve), extent of pain or bleeding and possible side effects. Some women will require

more than one treatment if the initial management fails or if there are worsening symptoms and management needs expediting. Women should be advised when and how to seek help if existing symptoms worsen or new symptoms develop, including giving them a 24-hour contact telephone number with access to specialist early pregnancy or obstetrics and gynaecology staff. Women should be provided with a take home pack including information on support, signposting to NHS inform pages, pain relief, menstrual pads and a urine pregnancy test to take three weeks after management of miscarriage. It is good practice to keep a log of women who are managing miscarriage at home and provide an individualised patient-centred wellbeing call to support those women. Women should be advised to return for individualised care if the post miscarriage pregnancy test is positive. Anti-D should be provided to women following surgical management of miscarriage.

As well as the practical management of miscarriage there is also the emotional impact of the loss of a pregnancy. The way in which people process this loss varies. Written and verbal information about miscarriage should be provided and the woman offered the ability to recontact the EPU/EPAS. The woman should be signposted to the NHS inform miscarriage pages www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby and the Scottish Government Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks and The Memorial Book - National Records of Scotland webpages. A list of resources for support is included in **Annex E.**

Written information about miscarriage should provide information about support for the emotional impact of pregnancy loss. This should include contact numbers to speak to EPU/EPAS staff, and information about support available from the NHS as well as third sector organisations. While it is acknowledged that counselling, bereavement support and psychological support services may be stretched in some areas, there is an unmet need for clear local guidance for EPU/EPAS staff to facilitate onward referral to additional support services, where required.

Key Actions

10. *Those experiencing miscarriage at any stage of pregnancy should be seen in a separate private space appropriate for bereavement, as advised in the NBCP Bereavement Care Standards, and if admitted to hospital, where possible be treated in a single room. Generally, this should be located within maternity services away from other pregnant, labouring or postpartum women, or in an EPU/EPAS, or other clinically appropriate environment that has privacy in spaces sensitive to the needs of all individuals. Rooms should ideally have sound proofing.*

    Women/couples who wish to avoid walking through areas where there are other pregnant women should be given the choice of using a different exit or if not possible, they should if they wish, be compassionately accompanied through the shared area rather than being left to walk alone.
11. *NHS Boards should ensure that clear local procedures are in place, in line with NICE Guidelines, for the diagnosis of miscarriage using ultrasound scanning by appropriately trained and validated ultrasonography practitioners and conducted in single rooms.*
12. *NHS Boards should facilitate the use of micronised progesterone treatment, as set out in professional guidance, for those with a previous miscarriage who are experiencing bleeding in early pregnancy, NHS Boards must follow the NHS Scotland National*

Guidance on the Use of Progesterone in the Management of Threatened Miscarriage and Recurrent Miscarriage. [Insert link when available]

13. *Clear written and verbal information on the miscarriage management options should be given to women and available for other care providers. Women need to be supported to choose the management approach that suits their needs and preferences. If required, interpretation services including British Sign Language (BSL) to be available for women, in-person where possible, throughout their assessment and care, ensuring this is delivered compassionately.*
14. *Where medical management is opted for, the use of mifepristone in advance of misoprostol should be standard practice as it increases the chance of success in missed miscarriage.*
15. *Where surgical management of miscarriage is opted for, women are to be offered a choice of anaesthetic options including manual evacuation under local anaesthetic. Provide clear and realistic information, on each option, including intra and post-surgical pain relief, to support fully informed decisions.*
16. *Where NHS Boards do not have all anaesthetic options available, the networked approach should be adopted with clear formal agreements in place to seek care in an adjacent NHS Board to facilitate patient choice.*
17. *After a miscarriage, women are to be provided with written and verbal information about miscarriage and support available, sign-posted to the NHS inform miscarriage and pre-conception health pages, and, where appropriate, contraceptive advice should also be provided. The NHS inform information will be accessible to all and made available in translated and audio versions. www.nhsinform.scot/early-pregnancy-units and www.nhsinform.scot/losing-a-baby and www.nhsinform.scot/after-losing-a-baby.*
18. *After miscarriage, women are to be provided with the Scottish Government/National Records of Scotland leaflet on the memorial book of pregnancy and baby loss prior to 24 weeks and directed to the Scottish Government and National Records of Scotland related webpages Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks and The Memorial Book - National Records of Scotland.*

8. The Graded Model of Miscarriage Care

Considerations

First miscarriage

After a first miscarriage, information about the effects of body mass index (BMI), diet, micronutrients (Vitamin D and folic acid), and health-harming products (excessive caffeine, alcohol, tobacco smoking) and medical co-morbidities should be highlighted to women/couples at an appropriate time, with the opportunity for appropriate additional contact and referral. An important concern is the psychological effects of miscarriage: women should be given information about how to seek support for psychological distress after miscarriage. This includes signposting to bereavement care, high quality information, third sector support groups, and self-help websites, as well as their primary care team. Miscarriage can highlight some future obstetric risks and as well as preconception health optimisation there are tools available for risk assessment for preterm birth, fetal growth restriction and stillbirth to personalise antenatal care. Further information about counselling can be found in **Annex E**. Further information on BMI, diet and nutrients, and health-harming products can be found at **Annex F.**

Progesterone use

To facilitate the use of micronised progesterone treatment, as set out in professional guidance, for those with a previous miscarriage who are experiencing bleeding in early pregnancy, NHS Boards must follow the NHS Scotland *National Guidance on the Use of Progesterone in the Management of Threatened Miscarriage and Recurrent Miscarriage*. [Insert link when available] Further information on the use of micronised progesterone can be found at **Annex F.**

Two previous miscarriages

In addition to the information and support offered after one miscarriage, the Lancet series Miscarriage Matters graded model of care recommends additional follow-up care, including offering an appointment at a nurse or midwife led miscarriage clinic for full blood count and thyroid function testing. In line with other guidance, screening for acquired thrombophilia with anticardiolipin and lupus anticoagulant testing is also appropriate at this stage. A reassurance scan should also be offered at seven to eight weeks of a subsequent pregnancy, or at a gestation prior to 12 weeks that is preferred by the woman; for example, someone who has always miscarried at 9 or 10 weeks may prefer a slightly later ultrasound scan. Further information on anaemia, thyroid function and acquired thrombophilia can be found at **Annex F**

Three previous miscarriages

After a third miscarriage, women will be offered an appointment at a specialist recurrent miscarriage clinic where additional tests and a full range of treatments can be offered. The consultant/appropriate medical staff should have specialist interest in recurrent miscarriage and be up to date with latest national, international guidance and latest research findings. Each clinic should have dedicated nursing and clerical support. Pregnancy tissue from the third and any subsequent miscarriages will be sent for genetic testing.

A comprehensive medical history should be taken for both partners, where appropriate. A history proforma can be implemented, which collates the details regarding previous miscarriages. The Royal College of Obstetricians and Gynaecologists has produced evidence-based guidelines for the delivery of high-quality recurrent miscarriage care. For some people who experience recurrent miscarriage, a potential cause is an underlying medical problem that may or may not already be identified. Such problems include thyroid disease, anaemia, poorly controlled diabetes and anti-phospholipid syndrome. Women with these conditions often require joint-specialist antenatal surveillance throughout pregnancy and ongoing primary care follow up. Referral pathways to access appropriate specialist clinics (such as clinical genetics, haematology, endocrinology, infertility and obstetric pre-pregnancy) should be in place.

Unexplained recurrent miscarriage itself is associated with adverse antenatal and perinatal outcomes. In addition, co-morbidities associated with recurrent miscarriage, and further information obtained during investigation of miscarriage, can worsen antenatal and perinatal outcomes. That means that clear pathways of communication with the multidisciplinary antenatal team are essential. Support, with health optimisation and clear information, before, during and after pregnancy is also vital.

After three previous miscarriages, women should be offered assessment for congenital uterine abnormalities, ideally with a 3D ultrasound and an early pregnancy reassurance scan in subsequent pregnancies. After four previous miscarriages, the addition of vaginal micronised progesterone (such as uterogestan 400mg BD) from positive urine pregnancy test to 12 weeks of gestation should be offered. This guidance, with regards to when to start and duration for treatment, is based on the PROMISE study and differs from the guidance for threatened miscarriage in those with previous miscarriage(s), which is based on the PRISM study and NICE guidelines. To ensure intrauterine gestation, an ultrasound scan should be offered at 6 weeks gestation for those women treated with progesterone. After five or more miscarriages it is appropriate to perform parental karyotype assessment if no genetic information is available. Follow-up may be with the consultant, specialised nurse/midwife, or the bereavement care team.

Further information on medical management of those with experience of three or more miscarriages can be found at **Annex G**

Delivering the Graded Model of Care

It is recommended that caregivers neither normalise nor over-medicalise recurrent miscarriage care but individualise care according to women's, and their partners', needs and preferences. The Lancet series Miscarriage Matters defines the minimum set of investigations and treatments that should be offered to women/couples who have had repeated miscarriages (Figure 3). Services for couples who have had recurrent miscarriages should not only have their physical support needs at the centre of their care, but also their psychological support needs. Staff working within the EPU/EPAS setting may need additional training to sensitively deliver the Graded Model of miscarriage care.

Current evidence indicates that treatment of tobacco dependency and stress management should be prioritised to improve general health and reduce the risk of miscarriage. Alcohol should be avoided throughout pregnancy, fruit and vegetables should be thoroughly washed to avoid the risk of ingesting pesticides, and the possibility of reducing night shifts should be explored. Further information on BMI, diet and nutrients, reduction in the use of health-

harming products (e.g. tobacco, alcohol), and the use of progesterone after a first miscarriage where the patient is currently bleeding can be found at **Annex F**

Figure 3. Graded model of miscarriage care

1st Miscarriage	Provide information and guidance to optimise preconceptual health Patient assessment and self-assessment for access to additional support Referral to improve diet and reduce use of health-harming products and address medical co-morbidities as required
2nd Miscarriage	Additionally: Offer discussion with early pregnancy health care professional Assessment of preconception health with advice and intervention as required Investigation of full blood count and thyroid function and screening for acquired thrombophilia Offer early reassurance scan in subsequent pregnancy
3rd Miscarriage	Additionally: Offer support at a recurrent miscarriage clinic Assessment of pre-pregnant uterus using ultrasound Offer tissue karyotyping in subsequent pregnancy Appropriate referral for assessment and health optimisation where indicated
4th Miscarriage	Additionally: Recommend vaginal micronised progesterone from positive pregnancy test to 12 weeks
5th Miscarriage	Additionally: Parental karyotyping

Key Actions

19. *All NHS Boards to provide a graded model of miscarriage care as recommended in the Lancet series, Miscarriage Matters (thelancet.com) published in 2021.*
20. *After a first miscarriage, women should be given and/or signposted to high quality information to allow them to self-assess modifiable risks at a time appropriate to their individual circumstances.*
21. *After a first miscarriage, women/couples should be able to speak to a nurse/midwife with expertise in early pregnancy complications and care if they have additional questions and require additional support after accessing the above information and self-assessing.*
22. *After a second miscarriage, women should be offered an appointment with an early pregnancy nurse/midwife where personalised care and initial investigations can take place or be organised. Where abnormal investigation results are found, a local pathway should be developed to manage these results including where appropriate, a referral to an appropriate primary or secondary care doctor.*

23. *After two miscarriages, women should be offered full blood count, thyroid function testing and screening for obstetric antiphospholipid syndrome (APS) using anticardiolipin antibodies and lupus anticoagulant tests.*
24. *After two or more previous miscarriages, an early ultrasound scan in a subsequent pregnancy should be offered, at a time most sensitive to the couple's needs but not before 7 weeks' gestation if asymptomatic (no pain or bleeding).*
25. *After three miscarriages, women/couples should be offered the opportunity to attend a specialist recurrent miscarriage clinic. All NHS Boards should provide specialist consultant or equivalent medical staffing within these clinics and ensure dedicated time is allocated, or develop a formal agreement where women can be referred to their preferred NHS Board that can provide such a recurrent miscarriage clinic.*
26. *After three miscarriages, women should be offered uterine imaging for congenital and acquired uterine abnormalities using 3D ultrasound. 3D ultrasound has been shown to improve detection of uterine anomalies therefore NHS Boards should develop access to this service where it is not available.*
27. *Where 3D ultrasound is not available, 2D ultrasound should be offered after a 3rd miscarriage. Where any abnormality is suspected, further imaging with 3D ultrasound, at a different site or with an agreement with another NHS Board, or MRI should be offered.*
28. *Cytogenetic analysis should be offered on pregnancy tissue of the third and subsequent miscarriage(s). This may require a maternal blood sample to check that the fetal genotype has been tested.*
29. *Asymptomatic women with four previous miscarriages should be offered vaginal micronised progesterone from a positive urine pregnancy test until 12 weeks of gestation, where clinically appropriate. They should be provided with written information on available evidence and potential benefits/risks. An ultrasound scan should be provided at 6 weeks gestation, for these women treated with progesterone, in order to confirm intrauterine gestation.*
30. *Couples with five or more previous miscarriages should be offered parental karyotyping where no results of genetic testing of pregnancy tissue are available (including previous maternal cell contamination or where no pregnancy tissue is available for testing). National discussions are ongoing to support this deliverable.*
31. *All NHS Boards should have a nurse or midwife led team with specialist training and expertise in recurrent miscarriage and time allocated commensurate with local service needs to provide support to couples with recurrent miscarriage and work alongside the specialist medical clinic.*

9. Training

Aim

Appropriate training should be available to all healthcare professionals working in early pregnancy and recurrent miscarriage care. Training should emphasise the importance of compassionate care and, in particular, the central role of good and clear communication. On the job training is provided for nurses/midwives who start within Early Pregnancy Services, and all should follow the National Bereavement Care Pathway including the Miscarriage, Ectopic and Molar Pregnancy pathway.

Training should be provided on bereavement care, trauma care, and all midwives, obstetricians and gynaecologists are trained in pregnancy care at whatever gestation. There

are a number of additional resources on bereavement and trauma informed care. Further links to these resources can be found below at **Annex E.**

Key Actions

32. *NHS Boards should ensure staff receive training in providing compassionate, culturally competent care after miscarriage and other early pregnancy complications. Training should include supporting bereaved individuals, peer support for staff, and aligning with the NBCP Miscarriage, Ectopic and Molar Pregnancy Pathway.*
33. *NHS Boards should develop their bereavement counselling services towards offering counselling (including online platforms) to women who have experienced a miscarriage.*
34. *NHS Boards should ensure that those who experience miscarriage have access to culturally competent, trauma-informed and responsive services which embed the principles of choice, collaboration, empowerment, safety and trust. This means services which recognise the prevalence of trauma and its impact (including amongst their own staff) and which respond in ways that support recovery. It also means services that follow the key principles of trauma informed care, which do not unintentionally retraumatise, and which allow individuals to easily access the appropriate care and support, including appropriate third sector support, they need.*

10. Data Collection

Aim

Meaningful miscarriage data should be collected from all 14 NHS Boards across all settings where patients experiencing miscarriage present.

Guidance

Public Health Scotland has been commissioned to carry out this work. The initial phase will focus on data from early pregnancy services. A miscarriage (early pregnancy) dataset has been agreed and Public Health Scotland is now testing this data set using data extracted from clinical information systems. The availability of high-quality data on incidence of miscarriage is required to understand where and for whom the need for prevention is greatest and to ensure treatment services are resourced proportionate to need (and therefore equitably).

Annex A

Short Life Working Group on Miscarriage Care Members

Name	Organisation
Prof. Colin Duncan, **Co-Chair**	RCOG, Professor of Reproductive Medicine and Science, University of Edinburgh
Prof. Justine Craig **Co-Chair**	Chief Midwifery Officer, Chief Nursing Officer Directorate, Scottish Government
Yvonne Bronsky	Royal College of Nursing, Midwifery Forum, Chair
Dr Alastair Campbell	RCOG, NHS Lothian
Yvonne Carruthers	Team Manager for Infertility/Early Pregnancy/Termination of pregnancy services, NHS Fife
Anne Chien	Fertility Counsellor, NHS Tayside
Sarah Corcoran	Team Leader, Maternal & Infant Health, Scottish Government
Kate Davies	Associate Director, Information and Support, Tommy's
Iona Duckett	Professional Midwifery Adviser, Chief Nursing Officer Directorate, Scottish Government
Dr Evelyn Ferguson	Obstetric Clinical Director, NHS Lanarkshire, CDs Group
Dr Clea Harmer	Chief Executive, Sands
Nicola Harper	Clinical Midwifery Manager, NHS Dumfries and Galloway
Dr Scott Jamieson	General Practitioner, NHS Tayside
Myra Kinnaird	Bereavement Support Midwife, NHS Grampian, Scottish Early Pregnancy Network
Jaki Lambert	Director, RCM Scotland
Dr Corinne Love	Senior Medical Officer, Maternity and Women's Health, Scottish Government (to October 2024)
Prof. Abha Maheshwari	Consultant Reproductive Medicine, Director and Person Responsible, Aberdeen Fertility Centre, NHS Grampian
Ailsa Meldrum	Counsellor, Held In Our Hearts
Louise McCue	Senior Policy Manager, Maternal & Infant Health, Scottish Government
Dr Tom McEwan	Principal Educator: Women, Children, Young People and

	Families, NHS Education Scotland
Sue McKellar	National Bereavement Care Pathway (NBCP) Scotland Manager, Sands
Dr Alastair Philp	Information Consultant, Maternity & Neonatal Data Hub for Scotland, Public Health Scotland
Prof. Siobhan Quenby	Professor of obstetrics and honorary consultant at University Hospitals Coventry and Warwickshire and Deputy Director of Tommy's National Early Miscarriage Research Centre
Dr Mary Ross-Davie	Director of Midwifery, NHS Greater Glasgow and Clyde, Midwifery Directors Group
Vicki Robinson	Chief Executive Officer, Miscarriage Association
Brooke Stirling	Policy Officer, Maternal & Infant Health, Scottish Government (Secretariat)
Anthea Taylor	Policy Manager, Maternal & Infant Health, Scottish Government
Gill Valentine	Associate Director of Midwifery, NHS Highland
Jacqueline Whitaker	Head of Midwifery, NHS Shetland
Dr Andrea Woolner	Consultant Obstetrician and Early Pregnancy Lead, NHS Grampian
Hannah Watson	Unit Head, Health and Care (Scotland) Staffing Act, Strategy and Policy, Chief Nursing Officer Directorate, Scottish Government
Dr Emma Webber	Consultant Clinical Psychologist, NHS Tayside

Delivery Framework for Miscarriage Care Writing Group Members

Name	**Organisation**
Prof. Colin Duncan, **Chair**	RCOG, Professor of Reproductive Medicine and Science, University of Edinburgh
Yvonne Carruthers	Team Manager for Infertility/Early Pregnancy/Termination of pregnancy services, NHS Fife
Sarah Corcoran	Team Leader, Maternal & Infant Health, Scottish Government
Louise McCue	Senior Policy Manager, Maternal & Infant Health, Scottish Government
Brooke Stirling	Policy Officer, Maternal & Infant Health, Scottish Government (Secretariat)

Anthea Taylor	Policy Manager, Maternal & Infant Health, Scottish Government
Jacqueline Whitaker	Head of Midwifery, NHS Shetland
Dr Andrea Woolner	Consultant Obstetrician and Early Pregnancy Lead, NHS Grampian

In addition to the above mentioned groups, the Scottish Government sought input and views from other healthcare professionals. Third Sector representatives ensured that lived experience input was provided.

Annex B

References and Useful Links

Programme for Government 2021 to 2022 – gov.scot (www.gov.scot)

Programme for Government 2023 – 24

https://www.thelancet.com/series/miscarriage

Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks

Miscarriage Care and Facilities in Scotland: Scoping Report National

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Ayrshire and Arran

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Borders

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Dumfries and Galloway

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Fife

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Forth Valley

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Grampian

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Greater Glasgow and Clyde

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Highland

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Lanarkshire

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Lothian –

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Orkney

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Shetland

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Tayside

Miscarriage Care and Facilities in Scotland: Scoping Report NHS Western Isles

https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/recurrent-miscarriage-green-top-guideline-no-17/

https://www.rcog.org.uk/for-the-public/browse-all-patient-information-leaflets/recurrent-miscarriage-patient-information-leaflet/

Overview | Ectopic pregnancy and miscarriage: diagnosis and initial management | Guidance | NICE

https://www.nbcpscotland.org.uk/

Planning for pregnancy | NHS inform.

Miscarriage | NHS inform

www.nhsinform.scot/losing-a-baby

www.nhsinform.scot/after-losing-a-baby

www.nhsinform.scot/early-pregnancy-units

https://www.nhsinform.scot/ready-steady-baby/pregnancy/health-problems-in-pregnancy/when-pregnancy-goes-wrong/

Homepage- National Trauma Transformation Programme

A Refreshed Framework for Maternity Care in Scotland: The Maternity Services Action Group - gov.scot

Annex C

Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks.

The Scottish Government, Programme for Government 2023 – 24, published on 5 September 2023 made a commitment to improve miscarriage care so women do not wait until a third miscarriage to receive tailored support, including access to progesterone prescriptions and separate spaces in hospitals within maternity wards for women who suffer a miscarriage, and the launch of a Certificate and Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks.

The Memorial Book for those who have experienced a pregnancy or baby loss prior to 24 weeks was launched by the former First Minister on 4 October 2023. Along with a physical entry in the book, a commemorative certificate is also provided, this is intended to give recognition and comfort to those who want to record their loss.

The service is free of charge, completely voluntary and historical applications are welcome, as are applications for more than one loss. A link to the memorial book and certificate can be found here Memorial Book of Pregnancy and Baby Loss Prior to 24 Weeks.

National Bereavement Care Pathway

The Scottish Government is committed to supporting families who have experienced pregnancy and baby loss by delivering high-quality, sensitive bereavement care and provide funding to Sands to develop and support NHS Boards to implement, the National Bereavement Care Pathway for pregnancy and baby loss in Scotland (NBCP).

Sands worked with health professionals, bereaved parents, baby loss charities and Royal Colleges to deliver the pathways, putting voices of bereaved parents at the heart of the development of the pathways.

The pathways provide health professionals with evidence-based care and describe best practice for bereavement care following a miscarriage, ectopic and molar pregnancy, termination of pregnancy for fetal anomaly, stillbirth, neonatal death, or the sudden unexpected death of an infant. All 14 NHS Boards in Scotland are now officially signed up to the NBCP and are at different stages of implementation. A link to the NBCP can be found here: https://www.nbcpscotland.org.uk/

The NBCP Parent Advisory Group ensures that bereaved parents voices continue to be heard throughout the implementation and full roll out stages. Sands have also produced Bereavement Care Standards, and these complement the National Bereavement Care Pathway for Scotland. The Scottish Government encourages NHS Boards to use the Bereavement Care Standards wherever possible. More information on the Bereavement Care Standards can be found here: Bereavement Care Standards.

Women and their partners who experience mental health struggles following childbirth, complications or loss, including from previous pregnancies, are also able to access support from their midwife, GP, health visitor, psychological services in primary care and, in some areas, from specialist perinatal mental health services.

Annex D

Miscarriage Diagnosis on Ultrasonography

An empty gestation sac with a mean sac diameter of 25 mm or more, or an embryo with a crown-rump length of 7 mm or more with no visible heart activity is considered to have sufficient accuracy for the diagnosis of miscarriage to justify management as miscarriage on a single scan.

If the diagnosis cannot be made on a single scan, a second ultrasound assessment is required 7-10 days later. At that scan failure to develop appropriately will allow the diagnosis of miscarriage to be made. This is because the exact date of conception is not known. However, in assisted conception the exact date of conception is known, and this can facilitate diagnosis on the first ultrasound scan.

Where the pregnancy is intrauterine, serial hCG assessment has no role in the diagnosis of miscarriage. The use of serial hCG assessment to make diagnostic decisions for miscarriage is not recommended and it is strongly advised to avoid their use for reassurance in the absence of an ultrasound scan for example in primary care.

Annex E

Support Resources

TURAS and NES Resources

Pregnancy Loss, Stillbirth and Neonatal Death | Support Around Death (scot.nhs.uk)
Death, Dying and Bereavement | Turas | Learn (nhs.scot)
Transforming psychological trauma: national trauma transformation programme online resources | Turas | Learn
Embedding Trauma Informed Care within Maternity Services in Scotland | Turas | Learn
Trauma-Informed Maternity Care- My Trauma & Pregnancy 1 | Turas | Learn
Pregnancy and Maternity | Turas | Learn
Perinatal and Infant Mental Health | Turas | Learn (nhs.scot)
Person-centred care zone | Turas | Learn

Third Sector Resources

An overview of the Miscarriage Association health professionals resources: https://www.miscarriageassociation.org.uk/information/for-health-professionals/

ELearning for health professionals caring for women with pregnancy loss: https://www.miscarriageassociation.org.uk/information/for-health-professionals/e-learning/

Professional Pause sessions – a safe online space for health professionals to network and share experiences: https://www.eventbrite.co.uk/cc/professional-pause-3340689

Miscarriage Association patient information leaflets and contact cards, available to health professionals to order for free: https://www.miscarriageassociation.org.uk/information/leaflets/

Health professionals are welcome to get in touch at any time with the Miscarriage Association support team to discuss individual cases or ask for guidance on supporting their patients: helpline number is 01924 200799 and they can also be contacted by emailing info@miscarriageassociation.org.uk and via live chat on their website: www.miscarriageassociation.org.uk

Tommy's Miscarriage Support Tool: https://www.miscarriagetool.tommys.org/

Tommy's Progesterone info leaflet: https://www.tommys.org/sites/default/files/2022-11/Tommys%20Progesterone%20Guide%20FINAL.pdf

More information on progesterone on Tommy's website: Taking progesterone to help prevent pregnancy loss | Tommy's (tommys.org)

The MifeMiso leaflet is the Management decision aid - here Management of missed miscarriage - leaflet | Tommy's (tommys.org)

Tommy's information on Missed Miscarriage: (2) Missed miscarriage: what happens next? | Tommy's - YouTube

PREGNANCY LOSS	
Miscarriage Association The Miscarriage Association provides free support and information to anyone affected by miscarriage, ectopic pregnancy or molar pregnancy. It provides a staffed helpline, live chat and email service and facilitates peer support, both in person and online.	www.miscarriageassociation.org.uk Email: info@miscarriageassociation.org.uk Helpline (0192 420 0799) and live chat available from, 9am - 4pm Mondays, Tuesdays and Thursdays and 9am to 8pm on Wednesdays and Fridays.
Held in our Hearts Held in Our Hearts provides counselling and support to anyone who has experienced pregnancy, baby or infant loss. Counselling is free and other services include one to one peer support, group, telephone and online support. Held In Our Hearts also offers education, training and support to professionals.	Website – www.heldinourhearts.org.uk Email – info@heldinourhearts.org.uk Phone – 0131 622 6263 Referral - Held In Our Hearts Hospital to Home - Held In Our Hearts
Sands Sands supports anyone who has been affected by the death of a baby before, during or shortly after birth.	www.sands.org.uk Helpline: 0808 164 3332
Tommy's	www.tommys.org/pregnancy-

Information and support following pregnancy and baby loss.	information/
The Ectopic Pregnancy Trust Providing dedicated support and information on ectopic pregnancy	Request a Call-back Support line on 0207 733 2653 The Ectopic Pregnancy Trust - Support For You And Your Loved Ones
SIMBA Support families who have lost a baby by providing memory boxes, helping to refurbish bereavement rooms and trees of tranquillity.	Email: enquiries@simbacharity.org.uk Telephone: 0131 353 0055
Twins Trust Provide twins, triplets or more – and their families – with the information needed to make informed decisions. Facilitate a network of community support.	Twins Trust | Twins Trust - We support twins, triplets and more... Monday to Friday from 10am-1pm and from 7pm-10pm on 0800 138 0509
Antenatal Results and Choices (ARC) non-directive information and support before, during and after antenatal screening	www.arc-uk.org Helpline: 020 7713 7486 Monday to Friday, 10.00am-5.30pm.
Child Bereavement UK Help children, young people, parents, and families to rebuild their lives when a child grieves or when a child dies.	Child Bereavement UK Email:helpline@childbereavementuk.org Telephone: 0800 02 888 40
Baby Loss Retreat Provide free of charge retreats to bereaved parents throughout Scotland. The charity also provides counselling, trauma therapy and listening music therapy for siblings affected by loss.	Baby Loss Retreat | Supporting Bereaved Families | Scotland Email: info@babylossretreat.org.uk Telephone: 07555467805 or 0141 248 4200
Fertility Network UK Fertility Network UK offer a wide range of resources and support so that nobody, whether trying to conceive, going through treatment, or	Fertility Network Email: info@fertilitynetworkuk.org Information line: 01424 732361

living without children struggles alone.	Support line: 0121 323 5025
Fertility Alliance The Fertility Alliance is a national fertility charity offering support and accurate information for anyone who wants to know more about their fertility.	The Fertility Alliance Email: thefertilityalliance@outlook.com
MISS Charity providing support for miscarriage and early pregnancy loss based in Aberdeen.	www.miss-support.org.uk Email: advice@miss-support.org.uk Phone: 07597 584253
GENERAL MENTAL HEALTH/EMOTIONAL WELLBEING	
Healthy Working Lives NHS support and referral service for staff absent – or at risk of absence – from work due to health conditions	Healthy Working Lives - Public Health Scotland
LGBT Health and Wellbeing Community initiative that promotes the health, wellbeing and equality of lesbian, gay, bisexual and transgender (LGBT) people in Scotland.	LGBT Health and Wellbeing Telephone: 0131 564 3970 Email: admin@lgbthealth.org.uk LGBT+ helpline 0800 464 7000
IMMEDIATE/CRISIS SUPPORT	
Breathing Space A confidential phone line for anyone in Scotland feeling low, anxious or depressed.	Telephone: 0800 83 85 87 Monday to Thursday, 6pm to 2am Friday 6pm to Monday 6am Breathing Space
Samaritans Offer a safe place for you to talk any time you like, in your own way – about whatever's getting to you	Telephone: 0845 790 9090 or 116 123 Available 24 hours Samaritans | Every life lost to suicide is a tragedy | Here to listen
FOR WOMEN AND FAMILIES FROM MINORITY ETHNIC COMMUNITIES	
Saheliya A specialist mental health and well-being support organisation for black and minority	Telephone: 0131 556 9302 Email: Info@saheliya.co.uk.

ethnic women and girls in Scotland	
Amma Birth Companions Amma Birth Companions is a Glasgow charity that provides vital services to ensure women and birthing people from migrant backgrounds and other underserved groups are supported during pregnancy, childbirth, and early parenthood. Our services include birth and postnatal companionship, peer support, and education.	Home - Amma Birth Companions Telephone: 0141 471 9799 Email: info@ammabirthcompanions.org
TRAUMA AND SEXUAL ABUSE	
Victim Support Scotland For victims of all crime, provides free and confidential independent help	Home - Victim Support Scotland Helpline: 0800 160 1985
Rape Crisis Scotland National office for the rape crisis movement in Scotland	Helpline: 08088 01 03 02 Rape Crisis Scotland | Working to end sexual violence
OCD	
OCD Action Information about and support for obsessive compulsive disorder	OCD Action Email: support@ocdaction.org.uk Helpline: 0300 636 5478
BIPOLAR DISORDER AND SCHIZOPHRENIA	
Bipolar UK MDF Bipolar organisation produces information and advice specifically related to bipolar disorder	Bipolar UK National UK Charity
Change Mental Health Help and support for people affected by mental illness.	We are Change Mental Health Advice and Support: Telephone: 0808 8010 515 Email: advice@changemh.org
EATING DISORDERS	
BEAT Beat is the UK's leading charity supporting anyone affected by eating disorders or difficulties with food or body image	The UK's Eating Disorder Charity - Beat Helpline: 0345 634 1414 Email:

	help@beateatingdisorders.org.uk
FINANCIAL STRESS	
Citizens Advice Scotland Scotland's main independent advice network	Citizens Advice

Annex F

Impacts on Miscarriage Risk

Body mass index (BMI)

There is no clear association between a low BMI (<18.5 kg/m^2) and recurrent miscarriage. Obesity, on the other hand, has been specifically linked to an increased risk of recurrent miscarriage (odds ratio [OR] 1.75, 95% confidence interval [CI] 1.24 to 2.47). Other factors, including ethnicity, play an important role in the evaluation of body weight. For example, in the Caucasian population the evidence shows that reproductive outcomes are worse in those whose BMI is ≥30 kg/m^2, whereas in people of Asian origin keeping a BMI lower than 27 kg/m^2 should be encouraged. Pregnant women in the first trimester, and those trying to conceive, should be advised that a balanced diet, rich in fruit and vegetables, with reduced high fat, sugar or salt (HFSS) food intake, is crucial to maintaining a stable body weight and supporting embryo/fetal development. Women and men with recurrent pregnancy loss (RPL) should strive for a healthy BMI (19-25 kg/m^2).

Micronutrients

Vitamin supplementation is frequently recommended for women planning pregnancy. The benefits of supplementation are to lower the risk of congenital conditions such as neural tube defects and reduce the risk of low birth weight, small for gestational age and preterm births. Data from observational studies advocate vitamin supplementation for the prevention of miscarriage, typically in the form of folate and B vitamins. A Cochrane review on vitamin supplementation for preventing miscarriage found no evidence that taking vitamin A, vitamin C, multivitamins or folic acid prior to or in early pregnancy prevented pregnancy loss. However, the evidence showed that women receiving multivitamins plus iron and folic acid had a lower risk of stillbirth compared to taking iron and folate only (RR 0.92, 95% CI 0.85 to 0.99, 10 trials, 79,851 women; high-quality evidence). Similar results with micronutrient supplementation in addition to iron +/- folic acid or with folate supplementation alone have also demonstrated no benefit in reducing pregnancy loss. Folic acid at a dose of 5 mg once daily should be considered in women with a BMI ≥30 kg/m^2, epilepsy, diabetes types 1 and 2, neural tube defect in a previous pregnancy and sickle cell disease. However, folic acid has not been shown to prevent pregnancy loss in women with unexplained RPL. Supplementation doses of 10 micrograms vitamin D should be considered for all pregnant women.

Caffeine

Caffeine is a widely consumed stimulant, and up to 9 in 10 pregnant women report drinking coffee. International advisory panels have historically adopted a moderate approach to caffeine intake in pregnancy. For example, the European Food Safety Authority advises that ingesting up to 200mg of caffeine per day has not been shown to cause harm to the developing fetus, echoing advice from the American College of Obstetricians and Gynecologists (ACOG) and the UK National Health Service. However, there is growing evidence suggesting that caffeine intake may be detrimental to pregnancy. A recent systematic review of 26 studies showed that the risk of miscarriage increased by 32% in women who consumed caffeine (odds ratio [OR] 1.32, 95% confidence interval [CI] 1.24 to 1.40). Further, for every additional two cups of coffee per day, the risk of miscarriage rose by 8%. While the effect of caffeine intake on miscarriage has been less studied in men, prospective cohort data suggest that the risk of miscarriage may be up to 73% higher in men

who drink 2 cups of coffee per day in the preconception period in comparison to a daily intake of <2 cups (hazard ratio [HR] 1.73, 95% CI 1.10 to 2.72). In women and men who choose to continue consuming caffeine in the pre-conception period and during pregnancy, clinicians should advise couples that the risk of miscarriage has been shown to be higher in those ingesting 2 cups of moderate-strength coffee per day. Women with recurrent miscarriage should be advised to limit caffeine to less than 200 mg (2 cups) per day.

Alcohol

Alcohol is a powerful teratogen, leading to fetal abnormalities that range from low birth weight to severe fetal alcohol syndrome (FAS). Daily alcohol use is nonetheless reported by as many as 1 in 6 pregnant women, making it the most common preventable cause of congenital malformations and intellectual impairment. Furthermore, there is a dose-dependent relationship between maternal alcohol consumption and the severity of fetal abnormalities, with evidence showing that doses as low as 1-2 units per week may be harmful. Although there is a lack of evidence on the impact of alcohol intake specifically upon the incidence of miscarriage, the detrimental effect of alcohol on embryo development and sporadic miscarriage has been well established. A recent systematic review of 24 studies including 231,808 pregnant women showed that those exposed to alcohol during pregnancy were more likely to miscarry (odds ratio [OR] 1.19, 95% confidence interval [CI] 1.12 to 1.28). This review also demonstrated that in women consuming 5 or fewer drinks per week, there was a 6% increase in miscarriage risk for each additional drink (OR 1.06, 95% CI 1.01 to 1.10). Alcohol consumption has also been shown to negatively affect semen volume and sperm morphology. Evidence suggests that male alcohol intake at the time of conception may lead to a fivefold increase in the risk of miscarriage. Clinicians caring for women and men with a history of recurrent pregnancy loss and ongoing issues with alcohol use should signpost patients to alcohol support services or contact their general practitioners for onward referral to an appropriate agency.

Smoking

Tobacco smoking is known to cause harm in pregnancy. It has been found to be associated with miscarriage, ectopic pregnancy, low birthweight, placental abruption and birth defects. Despite widespread campaigns promoting smoking cessation in the preconception period and during pregnancy, up to 14% of pregnant women report smoking tobacco. A recent systematic review showed that the risk of sporadic miscarriage was increased in both active (risk ratio [RR] 1.23, 95% confidence interval [CI] 1.16 to 1.30, n = 50 studies) and passive (RR 1.32, 95% CI 1.21 to 1.44, n = 25 studies) smokers. In addition, a prospective study of 526 men identified an association between heavy paternal smoking and early pregnancy loss. Nicotine replacement therapy, in the form of patches or gum, has not been shown to be harmful in pregnancy and does not increase the risk of miscarriage. In recent years, the use of electronic cigarettes (EC) and vaping among pregnant women has also increased significantly, although it remains unclear whether EC can cause harm to the fetus. Clinicians caring for women and men with a history of miscarriage and ongoing issues with tobacco smoking should signpost patients to smoking cessation services.

Progesterone – Threatened Miscarriage

There is evidence that vaginal micronised progesterone may increase live birth rates in women with early pregnancy bleeding and a history of miscarriage. Results from the PRISM RCT, which included 4153 women, showed that progesterone did not reduce the rate of miscarriage for those with no previous miscarriages as the live birth rate was 74% (824/1111) in the progesterone group and 75% (840/1127) in the placebo group. There was

a small reduction in miscarriage for those with 1-2 previous miscarriages as the live birth rate was 76% (591/777) in the progesterone group and 72% (534/738) in the placebo group. There was a big reduction in miscarriage for those with 3 or more previous miscarriages as the live birth rate was 72% (98/137) in the progesterone group and 57% (85/148) in the placebo group. The overall live birth rate was 75% (1513/2025) in the progesterone group and 72% (1459/2013) in the placebo group. Vaginal micronised progesterone (such as utrogestan 400mg BD) in the form of a vaginal pessary is used although it is not currently licenced for this indication. NICE guidance recommends confirmation of intrauterine pregnancy using a scan to avoid masking an ectopic pregnancy. NICE guidance recommends treatment until 16 weeks of gestation and the following NICE Evidence review provides information on the evidence including duration which is on page 18 NG126 Evidence review C. Progesterone therapy should be discontinued if there is an ultrasound diagnosis of a miscarriage.

Progesterone – Recurrent Miscarriage

Progesterone is produced by the corpus luteum in the ovaries and helps to prepare the endometrium for implantation of the embryo. Progesterone is therefore an essential hormone for a successful pregnancy. The PROMISE trial, which included 836 participants, evaluated the benefit of progesterone supplementation in women with 3 or more unexplained miscarriages. A live birth after 24 weeks of gestation was considered to be a successful outcome.

The trial reported that for those who received progesterone, the live birth rate was 65.8% (262 of 398 pregnancies) and for those who received placebo, it was 63.3% (271 of 428 pregnancies). A post hoc analysis found that progesterone may be of benefit in women with a history of 4 or more miscarriages.

Therefore, in women with a history of four or more previous miscarriages, progesterone should be offered after an informed discussion. Women should ideally be provided with written information on the potential benefits and risks. Women who are being treated with progesterone supplementation should continue to be treated while viability is being determined. Progesterone therapy should be immediately discontinued if there is an ultrasound diagnosis of a miscarriage or ectopic pregnancy.

Anaemia

Iron deficiency is considered the most common nutrient deficiency in pregnant women. Supplementation with iron reduces the risk of maternal anaemia and iron deficiency in pregnancy. Significant blood loss can accompany miscarriage and anaemia should be corrected prior to subsequent pregnancy. Further studies are required to investigate the clinical significance of low ferritin in miscarriage and whether preconception prophylactic iron supplementation would improve live birth rates. However, anaemia due to iron, folate or vitamin B12 deficiency should be corrected in the pre-conception period.

Thyroid function

Thyroid dysfunction is common in women of reproductive age. Normal functioning of the thyroid gland is essential for successful conception and pregnancy. Detection of thyroid disorders prior to pregnancy is of utmost importance due to the adverse effects thyroid abnormalities have on conception and pregnancy. Uncontrolled thyrotoxicosis has been associated with reduced fertility, miscarriage, pre-eclampsia, pre-term birth, placental abruption, and fetal hyperthyroidism. Untreated hypothyroidism has been linked to adverse outcomes including impaired fertility, miscarriage, hypertensive disorders of pregnancy, placental abruption, preterm birth, and higher rates of neonatal intensive care unit admissions as well as lower intelligence scores (IQ) in the offspring.

Subclinical hyperthyroidism and subclinical hypothyroidism (SCH) are biochemical diagnoses defined by an abnormal serum thyroid stimulating hormone (TSH) concentration accompanied by normal concentrations of circulating thyroid hormones. They may represent the earliest stages of thyroid dysfunction and can progress to overt disease in later life. SCH has been linked to adverse outcomes such as subfertility, miscarriage, pre-term birth, pre-eclampsia, gestational hypertension, and perinatal mortality.

Thyroid autoimmunity (TAI) describes the presence of circulating anti-thyroid autoantibodies that are targeted against the thyroid, with or without thyroid dysfunction. Thyroid peroxidase antibodies (TPOAb) are the most common anti-thyroid autoantibody; they are present in approximately 10% of women. The presence of TPO antibodies, even in women with a normal thyroid function, has been shown to be associated with an increase in adverse pregnancy outcomes, such as miscarriage and preterm birth. However, treatment with thyroxine was not effective at reducing pregnancy associated risks.

Overt thyroid disease should be managed jointly with endocrinologists. Overt hypothyroidism or hyperthyroidism should be treated accordingly. If sub-clinical hypothyroidism (TSH >4.0 mU/L with normal free T4) is diagnosed, treatment with levothyroxine, with an aim for TSH <2.5 mU/L, should be commenced. For women already taking levothyroxine, an empirical dose increase should be initiated from point of conception. Women should be advised to start taking double dose on 2 days of the week and require regular TFT monitoring starting at 7-9 weeks gestation. Women should be advised not to become pregnant until TFTs are in normal range.

Antiphospholipid syndrome

Antiphospholipid syndrome (APS) is an acquired systemic autoimmune disease where the body's immune system produces antibodies that affect phospholipids. APS is found in approximately 15-20% of women with recurrent pregnancy loss (RPL), representing the most frequently identifiable risk factor amenable to treatment. APS can be found as a lone

diagnosis but may occur concomitantly with other autoimmune diseases. For example, patients with APS may also have a diagnosis of Systemic Lupus Erythematosus (SLE). APS presents with a range of clinical phenotypes, including poor reproductive outcomes (recurrent pregnancy loss, preeclampsia, preterm birth, fetal growth restriction and stillbirth), venous and arterial thrombosis, and rash.

Women with RPL should be tested for APS by obtaining blood and testing for lupus anticoagulant (LA) and anti-cardiolipin (aCL) (IgM and IgG) antibodies. A long time between taking the blood sample and laboratory processing can quench the lupus anticoagulant and yield a false negative result. The diagnosis is made with the detection of LA or aCL on two separate occasions, 12 weeks apart. Repeat testing is only recommended if an initial APS antibody test is positive or indeterminate. Some women require a third ‘decider’ test. Testing should be postponed 6 weeks following a pregnancy (loss). Women with APS should receive specialist pre-conception counselling and joint obstetric-haematology ‘high-risk’ care. The general practitioner (GP) should be informed due to the long-term increased risk of arterial and vascular disease.

If a first test for APS is negative no further tests are required. If the first test for APS is positive a second test should be performed at least 12 weeks later. If this is negative no further testing or treatment is required. If the second test is indeterminate then a third test would be required after an additional 12 weeks. If that is not negative treatment would be recommended. Those with a confirmed positive APS on the second test also require treatment. Women with APS should receive: Aspirin 75 mg once daily from the time of a positive pregnancy test and low molecular weight heparin (LMWH) at a weight-adjusted prophylactic dose from confirmation of an intrauterine pregnancy on ultrasound scan, to be continued for six weeks postnatally. The dose of aspirin should be reviewed at the woman’s booking appointment and increased to 150 mg once daily for the prevention of preeclampsia where applicable. Those with APS will require signposting to the general practitioner for ongoing post-pregnancy surveillance as this has life-long implications.

Annex G

Assessment and management after three or more miscarriages

Fetal genetic abnormalities

Fetal genetic abnormalities are a recognised cause for both sporadic and recurrent pregnancy loss (RPL). The prevalence of genetic abnormalities is estimated to be at least 45% for a single pregnancy loss and 39% where a pregnancy loss is preceded by RPL history. There is emerging data suggesting that genetic testing of pregnancy tissue may have some prognostic value. The primary reason for determining the genetic status of pregnancy tissue is to identify a possible cause, thus potentially offering women and their partners some closure. Pregnancy tissue should be collected in a dry specimen pot without formalin. The recommended test is array-based comparative genomic hybridisation (array-CGH). Where an unbalanced translocation is identified in the pregnancy tissue, parental karyotyping should be organised. People with abnormal karyotypes should be offered a referral to clinical genetics. Women should be counselled that in some circumstances cytogenetic analysis cannot be performed on the pregnancy tissue that is sent due to contamination with maternal tissue, or lack of fetal tissue. A robust system should be in place for debriefing couples and discussing the results of their cytogenetic analysis. This requires dedicated specialist consultant level staff and nursing support adequate to the service needs of a Board.

Anatomical uterine abnormalities

Anatomical uterine abnormalities can be divided into congenital (CUA) and acquired uterine anomalies (AUA). CUAs refer to Müllerian tract malformations which include septate, unicornuate, bicornuate and didelphic uteri. Their prevalence is higher in women with recurrent pregnancy loss (RPL) (13.3%) compared to the general population (5.5%). CUA are associated with increased risks of adverse outcomes during pregnancy. Women with a uterine septum or bicornuate uterus are at increased risk of first-trimester miscarriage, preterm birth and fetal malpresentation. Women with uterine didelphys have an increased risk of preterm labour and fetal malpresentation. Various hypotheses have been put forward to explain the pathophysiology. It has been suggested that the endometrium overlying a uterine septum is suboptimal for implantation, with an insufficient blood supply to support placentation and embryo growth. Other studies have suggested that there is also reduced uterine capacity and uncoordinated uterine contractions.

AUAs include submucosal fibroids, endometrial polyps and intrauterine adhesions (IUA). Their prevalence is poorly researched amongst the RPL population, however, and can be as high as 12.9%. Risk factors for IUA include recurrent miscarriage and dilatation and curettage procedures, however the clinical relevance of IUA with regards to conception and miscarriage is unclear. Evidence for treatment is confined to a limited number of small observational studies and the rationales for treatment are similar to the hypotheses given for CUA. It is good practice to have a multi-disciplinary team (MDT) to discuss management of anatomical uterine abnormalities in conjunction with specialist fertility or gynaecology teams.

Traditionally, abdominal/laparoscopic metroplasty was performed in order to restore the shape of the uterus in women with bicornuate or didelphic uteri. However, due to significant adverse effects (prolonged hospital stay, intrauterine adhesion formation, uterine rupture during subsequent pregnancy) with no improvement in pregnancy outcome, this is no longer offered. The only congenital uterine anomaly with recognised treatment is uterine septum,

where the treatment is hysteroscopic resection. However, reproductive outcome data is scarce and conflicting. There is no clear evidence suggesting that endometrial polypectomy is associated with a lower risk of future miscarriage in RPL patients. However, as polyps can be removed at the same time as hysteroscopic diagnosis with minimal additional risk, treatment is advised. There is no available trial data on the effect of submucosal fibroid resection or intrauterine adhesiolysis on the miscarriage rate specifically in recurrent miscarriage patients. However, there is limited observational data suggesting a benefit with treatment.

Parental karyotyping

Some couples who have had recurrent pregnancy loss may require parental karyotyping to identify a chromosomal abnormality. The presence of a balanced translocation leads to abnormal chromosomal arrangements in the gametes, and therefore aneuploidy in the embryo.

The prevalence of abnormal parental karyotypes in couples with a history of recurrent pregnancy losses is estimated to be 1.9 – 3.8%. This is a 5-10-fold increase compared to the general population. However, it should be noted that although couples affected with a balanced translocation also have a good chance of having a healthy child from natural conception there is also an increased chance of a severely disabled child as a result of unbalanced genetic material.

The risk of recurrent pregnancy loss depends on the nature of the genetic abnormalities found. There is a higher risk of miscarriage in those with balanced translocations and inversions compared to those with Robertsonian translocations or other types of genetic differences. Some translocations also confer an increased risk of seriously affected stillborn or live born infants, so detailed genetic guidance should always be obtained. Pre-implantation genetic testing for structural rearrangements (PGT-SR) offers a solution for couples with balanced translocations wishing to avoid any risk of a pregnancy with unbalanced genetic material.

The probability of abnormal parental karyotypes in unselected population is estimated to be very low. In particular, parental genetic testing is likely to be of limited value for couples whose age(s) is/are higher. Genetic analysis of parents should be considered following individual assessment of the clinical history or if indicated by the results of genetic analysis of pregnancy tissue from previous losses, or consideration of number of losses. Where an unbalanced translocation is identified in the pregnancy tissue, parental karyotyping should be organised, with onward referral to clinical genetics in the case of abnormal results.

Progesterone supplementation

If someone with recurrent miscarriages presents with a threatened miscarriage and a scan shows a viable or potentially viable intrauterine pregnancy NICE guidelines recommend treatment with vaginal micronised progesterone pessaries (400mg bd) can be continued until 16 weeks of gestation. Progesterone treatment should not be commenced in women who present with symptoms (pain or vaginal bleeding) who are diagnosed as a pregnancy of unknown location (PUL) where there is a risk of ectopic pregnancy. This is based on the PRISM trial that showed that for women with three or more previous miscarriages who presented with early pregnancy bleeding, there were 15% more livebirths in the progesterone group compared to placebo (livebirth rate 72% with progesterone, 57% with placebo, RR 1.28 (95%CI 1.08-1.51), P=0.004).

The PROMISE trial, the largest multicentre Randomised Control Trial to date, which was adequately powered and with a very low risk of bias, showed that routine progesterone

supplementation in women with recurrent miscarriage did not result in a significantly higher rate of live births (progesterone 65.8% vs placebo 63.3% Difference 2.5% (95%CI -4.0 – 9.0)). However, the efficacy seemed to change based on number of previous miscarriages. The livebirth rate was not higher for women with a history of 3 miscarriages (RR 1.01 CI 0.89-1.14, P=0.91). There was a trend to a benefit for women with 4 or more miscarriages (63% vs 58%, P=0.07). NHS Scotland National Guidance on the Use of Progesterone in the Management of Threatened Miscarriage and Recurrent Miscarriage recommends offering progesterone supplementation in women with four or more previous miscarriages.

Asymptomatic women with four or more previous miscarriages should be offered vaginal micronised progesterone (400 mg twice daily) from a positive urine pregnancy test until 12 weeks of gestation, where clinically appropriate. This regimen is based on the PROMISE study protocol that informed this advice. As progesterone could be harmful in the event of an abnormally located (ectopic) pregnancy an ultrasound scan should be provided at 6 weeks gestation for these women, in order to confirm intrauterine gestation and potential viability. Where women are already on progesterone and a diagnosis of PUL is made on ultrasound scan progesterone supplementation should be discontinued and hCG estimations used to inform diagnosis and management.

Common side effects of vaginal micronised progesterone are: breast pain, drowsiness and gastrointestinal discomfort, vaginal offensive discharge and itch. Contraindications to progesterone treatment include acute porphyria, history during pregnancy of idiopathic jaundice, pemphigoid gestationis or severe pruritus, breast cancer, thromboembolism or thrombophlebitis. Caution is required in diabetes, history of depression or migraine. Take care if the woman has a soy and/or peanut allergy as components in some preparations may cause issues due to cross-sensitivity.

Use of Progesterone in the Management of Threatened Miscarriage and Recurrent Miscarriage

National Pathway

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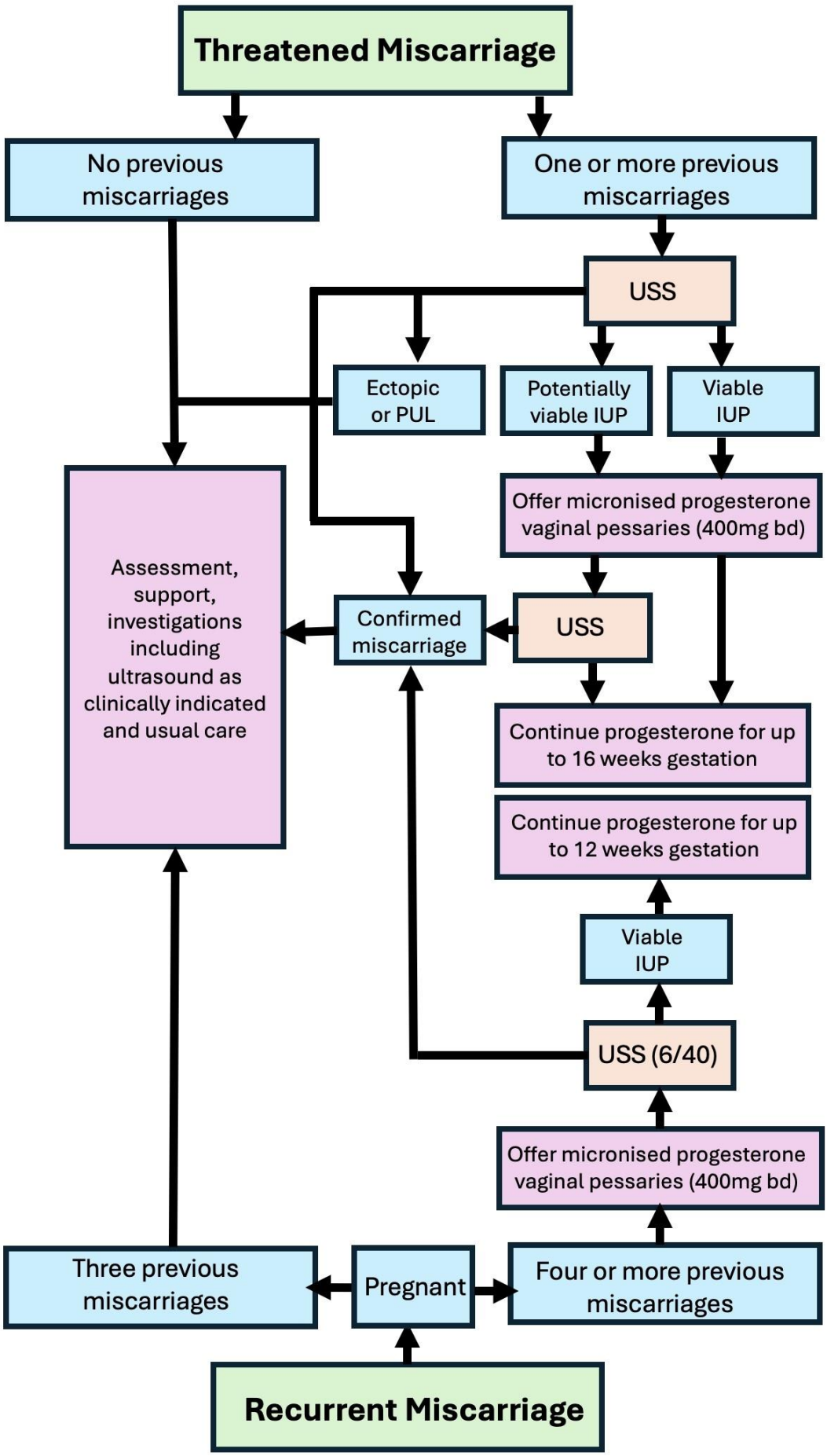
Annex G – Progesterone Pathway



1. Background

For the purposes of this guideline, we refer to early pregnancy bleeding under 12 weeks' gestation as threatened miscarriage. Threatened miscarriage is defined as an episode of vaginal bleeding in early pregnancy, where the cervical os is closed and the pregnancy is normally sited within the uterus and remains potentially viable. It is one of the most common reasons women attend early pregnancy care. In a large study following up couples trying to conceive who became pregnant (n=4539) 27% of women experienced early pregnancy bleeding. In that cohort more than 85% of women were under 34 years of age and the miscarriage rate was 12%. While the incidence of early pregnancy bleeding and miscarriage in more representative older populations is higher than this, it is still true that most women with early pregnancy bleeding will have a continuing pregnancy. Around 60% of women with vaginal bleeding in the first trimester of pregnancy will have a viable pregnancy.

It is important to remember that vaginal bleeding in pregnancy can be a sign of other pathology such as ectopic pregnancy, molar pregnancy, cervical ectopy or rarely, cervical malignancy. Early pregnancy unit protocols are designed to ensure that other pathology is not missed. That means that women presenting at less than 12 weeks gestation with vaginal bleeding should be triaged by staff experienced in early pregnancy care, where possible, to determine the most appropriate management within 24 hours of reporting vaginal bleeding. Assessment usually involves detailed history, ultrasonography +/- speculum examination.

The requirement for a scan before starting treatment with progesterone

The NICE guideline states that progesterone should only be used in women with vaginal bleeding in early pregnancy if they have a confirmed intrauterine pregnancy on ultrasound scan and a history of prior miscarriage. See **Annex A**. This is because progesterone can mask, and potentially worsen, other pathologies such as ectopic pregnancy and molar pregnancy. The requirement for an intrauterine pregnancy to be confirmed before treatment protects women with other pathologies from being prescribed progesterone when it is not clinically appropriate.

Ensuring that a pregnancy is viable or potentially viable

Miscarriage can sometimes be diagnosed on a single ultrasound scan and treatment of a non-viable pregnancy inappropriately with progesterone can unnecessarily delay management of a miscarriage.

This means that only the following scan findings in women with threatened miscarriage and previous miscarriage would be suitable for vaginal micronised progesterone treatment:

- Normally sited pregnancy within the uterus with fetal pole and fetal heart pulsation confirmed.
- Normally sited pregnancy with a fetal pole where the CRL <7mm and no fetal heart pulsation is seen.
- Normally sited pregnancy with a gestational sac and a yolk sac but no fetal pole.
- Where there is a gestation sac (MSD <25mm) but no fetal pole and no yolk sac. However, caution should be exercised because a pseudosac can sometimes be seen in ectopic pregnancy. A gestation sac is eccentrically placed in the uterus with an obvious decidual reaction. Pseudosacs are in the midline with no decidual reaction and may have teardrop rather than smooth edges. If a pseudosac is suspected this is a pregnancy of unknown location and progesterone should not be offered at this stage.

Progesterone should not be offered:

- For women with threatened miscarriage who have no history of previous miscarriage.
- For women with a pregnancy of unknown location (PUL). These women need additional assessment with hCG measurement and repeat scanning.
- For women of previous molar/ectopic pregnancy/PUL alone with no previous miscarriage.
- For women with some clinical conditions and elements of patient history that mean that treatment with progesterone is contraindicated or relatively contraindicated even if they have a history of previous miscarriages, therefore treatment must take individual history into account.

The dose of progesterone

Only vaginal micronised progesterone should be offered. The dose recommended is 400 mg twice a day.

At present there are no licensed preparations in the UK for this indication. This guideline is therefore recommending the use of vaginal micronised progesterone off-label for this patient group. Off-label prescribing means the product licence does not cover the indication or age for which the medicine is being prescribed. It is commonly used in some areas of medicine, such as in paediatrics. The General Medical Council (GMC) has published guidance to support the prescribing of unlicensed medicines and medicines off-label. The guidance states that doctors should usually prescribe licensed medicines in accordance with the terms of their licence but they may prescribe medicines off-label where, on the basis of an assessment of the individual patient, they conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient. In doing so, doctors must be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy and take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring and any follow up treatment. The guidance also advises that if a doctor intends to prescribe a medicine off-label they should

explain this to the patient and give the reasons for doing so. Please see the General Medical Council's "Good practice in prescribing and managing medicines and devices" (Section titled: Prescribing unlicensed medicines) for further information.

The duration of treatment

Vaginal micronised progesterone treatment can be continued until 16 weeks, as per the NICE guideline. See **Annex A**.

Side effects of treatment

Women may experience increased discharge using progesterone pessaries. For information on side effects, cautions, contraindications and interactions please refer to the British National Formulary and Summary of Product Characteristics (SmPC):

- Cyclogest 200mg pessaries - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)
- Cyclogest 400mg pessaries - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)
- Utrogestan Vaginal 200mg Capsules - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)
- Progesterone | Drugs | BNF | NICE

Utrogestan vaginal capsules contains soya lecithin and may cause hypersensitivity reactions (urticarial and anaphylactic shock in hypersensitive patients). As there is a possible relationship between allergy to soya and allergy to peanut, patients with peanut allergy should avoid using Utrogestan vaginal capsules. Cyclogest contains animal ingredients which may not be acceptable to some patients

Contraindications to treatment with progesterone

Therapeutic progesterone may not be suitable for those with a history of liver tumours or severe hepatic dysfunction, current genital or breast cancer, severe arterial disease, previous history of thromboembolism, jaundice relating to

pregnancy, severe itch related to pregnancy, pemphigoid gestationis, acute porphyria and a previous reaction to progesterone.

Follow up after treatment with progesterone is initiated

No extra follow up is required for eligible women who opt to use vaginal micronised progesterone for threatened miscarriage with a history of one or more miscarriages if they are known to have a viable pregnancy at treatment initiation. Their usual antenatal care booking should proceed as normal. Women should be advised to stop vaginal micronised progesterone treatment by 16 weeks' gestation.

For women using vaginal micronised progesterone who commence treatment when viability of the pregnancy is not certain it is good practice to repeat an ultrasound scan for viability 1-2 weeks after commencement of progesterone.

Effects of progesterone on fetal development

Women should be made aware that there are no current concerns for the mother or unborn baby from existing evidence and as per the NICE guidelines. However, there is overall limited evidence available and there is no evidence on the long-term effects on babies of using progesterone supplementation in the first 16 weeks of pregnancy. The discussion should be documented in the Electronic Patient Record (EPR).

2. Use in Recurrent Miscarriage

The PROMISE trial, the largest multicentre Randomised Control Trial to date, which was adequately powered and with a very low risk of bias, showed that routine progesterone supplementation did not result in a significantly higher rate of live births (progesterone 65.8% vs placebo 63.3% Difference 2.5% (95%CI -4.0 – 9.0)). However, the efficacy seemed to change based on number of previous miscarriages. The livebirth rate was not higher for women with a history of 3 miscarriages (RR 1.01 CI 0.89-1.14, P=0.91). However, there was a trend to a benefit for women with 4 or more miscarriages (63% vs 58%, P=0.07).

Therefore, based on the evidence from the PROMISE trial, and as per the recommendations in the Lancet miscarriage series, it is recommended that vaginal micronised progesterone treatment should be offered for asymptomatic women with recurrent miscarriage with 4 or more miscarriages.

Treatment regimen for recurrent miscarriage

Asymptomatic women with four or more previous miscarriages should be offered vaginal micronised progesterone (400 mg twice daily) from a positive urine pregnancy test until 12 weeks of gestation, where clinically appropriate. This regimen is based on the PROMISE study protocol that informed this document. Women considering treatment should be provided with verbal and written information on available evidence and potential risks/benefits, including that there is no conclusive trial evidence that progesterone reduces the risk of miscarriage including after 4 miscarriages.

As progesterone could be harmful in the event of an abnormally located (ectopic) pregnancy an ultrasound scan should be provided at 6 weeks gestation, in order to confirm intrauterine gestation and potential viability. At the time of writing, there is no need to wait for an ultrasound scan prior to commencing vaginal micronised progesterone for asymptomatic women with four or more miscarriages.

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ANNEX A

Evidence Base

Threatened Miscarriage

Progesterone is the naturally occurring hormone that maintains pregnancy. It reduces bleeding, makes the uterus less irritable, lowers inflammation and dampens down the immune system. It was suggested that some women who repeatedly miscarry may have insufficient progesterone or an insufficient response to progesterone. Therefore, the large PRISM randomised controlled trial assessed the efficacy of progesterone treatment in the prevention of miscarriage in those presenting with threatened miscarriage.

The overall findings of the PRISM study showed that progesterone treatment for threatened miscarriage did not result in a statistically significant increase in livebirth. Overall, without progesterone treatment 72% of women in that study had a livebirth (cf 76% with progesterone, P=0.08). However, the study suggested a clinically significant difference with a greater effect seen with increasing number of previous miscarriages. Post-hoc analysis of the PRISM trial found that administrating vaginal micronised progesterone, which is molecularly similar to endogenous progesterone, into the vagina may increase chance of livebirth at 34+ weeks gestation after bleeding in early pregnancy for women with 1 or more previous miscarriages (70% vs 75% RR 1.09 95%CI 1.03-1.15, P=0.003.

Subgroup analyses showed that women with no previous miscarriages had 1% less livebirth if treated with progesterone (74% vs 75%, RR 0.99, 95%CI 0.95-1.04, P=0.71) which was not statistically significant. However, for women with 1-2 previous miscarriages, there was a non-significant trend for 4% more livebirths in the group treated with progesterone compared to placebo (livebirth rate 76% with progesterone, 72% with placebo, RR 1.05 (95%CI 1.00-1.12), P=0.07). For women with three or more previous miscarriages who presented with early pregnancy bleeding, there were 15% more livebirths in the progesterone group compared to placebo (livebirth rate 72% with progesterone, 57% with placebo, RR 1.28 (95%CI 1.08-1.51), P=0.004). A single study has evaluated the cost-effectiveness of

progesterone use in this setting, and suggests progesterone is cost-effective for women with a history of previous miscarriage(s).

As a result of this study NICE changed their guidance in 2021. They recommend that vaginal micronised progesterone (400mg twice daily) should be offered to women with an intrauterine pregnancy confirmed by a scan, if they have vaginal bleeding and have previously had a miscarriage. If a fetal heartbeat is confirmed vaginal micronised progesterone should be continued until 16 completed weeks of pregnancy. The Review of evidence and justification of the recommendation and duration of treatment is available in the NICE guideline (NG126) and can specifically be found NG126 Evidence review C on page 18.

Recurrent Miscarriage

There have been no NICE recommendations on the use of vaginal micronised progesterone without threatened miscarriage. The RCOG Green-Top Guideline on recurrent miscarriage advised that routine supplementation with progesterone should be used with caution in asymptomatic women with unexplained recurrent miscarriage. Meta-analysis have reported a possible benefit from progestogen supplementation. This document is recommending that vaginal micronised progesterone treatment should be offered for asymptomatic women with recurrent miscarriage with 4 or more miscarriages. This is based on the evidence provided from the PROMISE trial. In that study the livebirth rate was not higher for women with a history of 3 miscarriages (RR 1.01 CI 0.89-1.14, P=0.91). However, there was a trend to a benefit for women with 4 or more miscarriages (63% vs 58%, P=0.07).