



# Primary Care in Maternity. Does It Matter?



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The Primary Care Show  
15th May 2025

# Who am I?



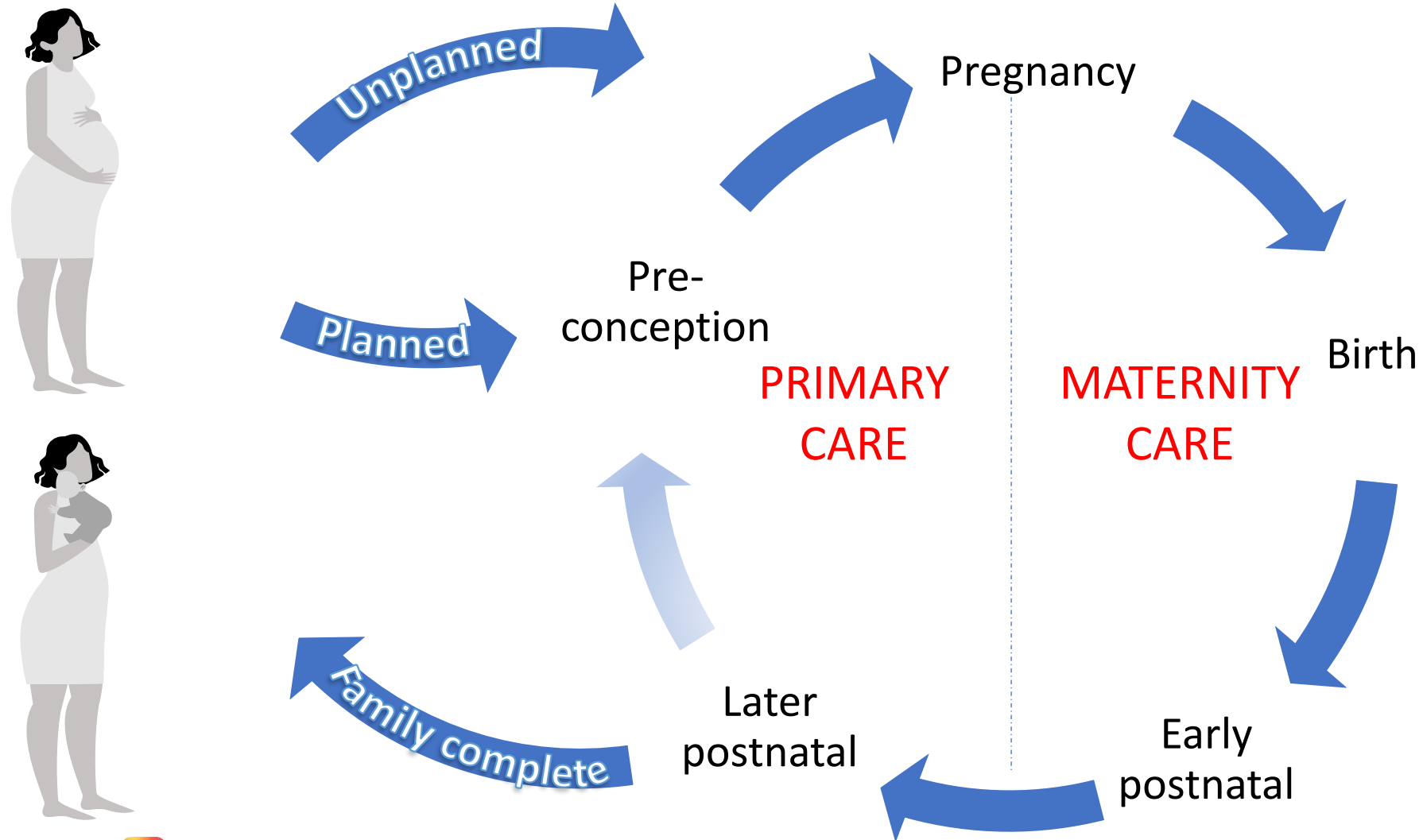


# Who are you?

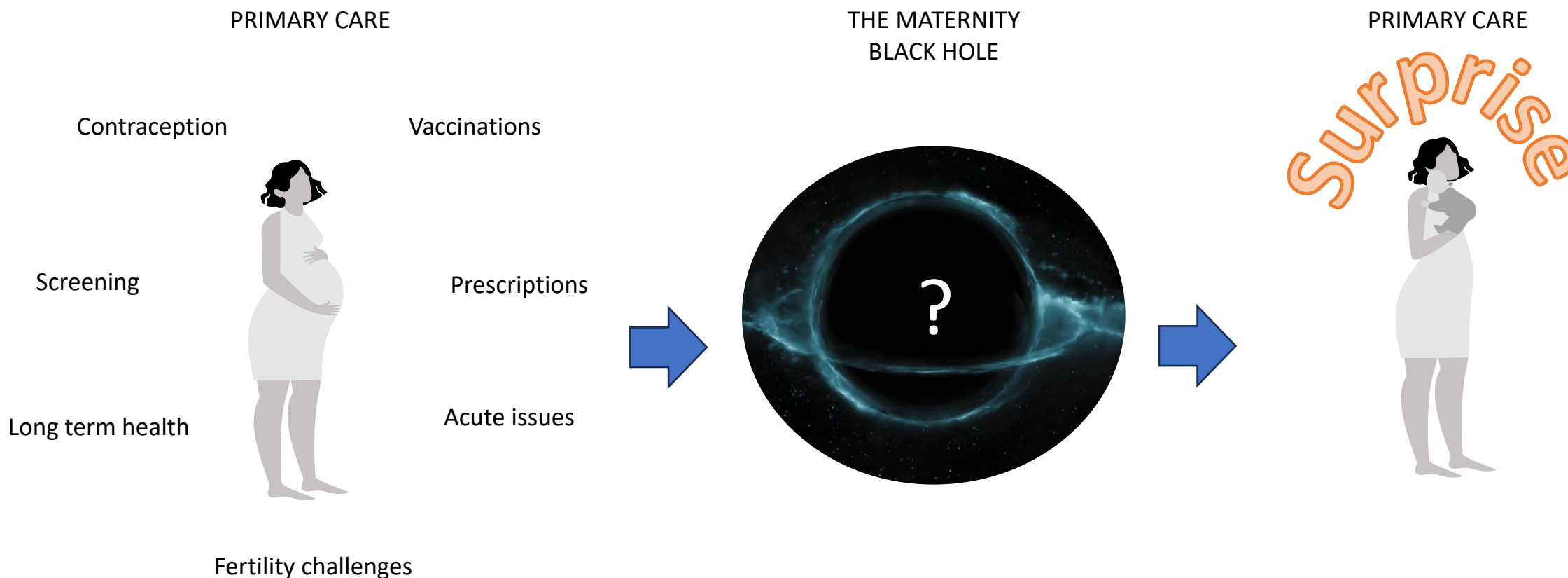


# 'The System'

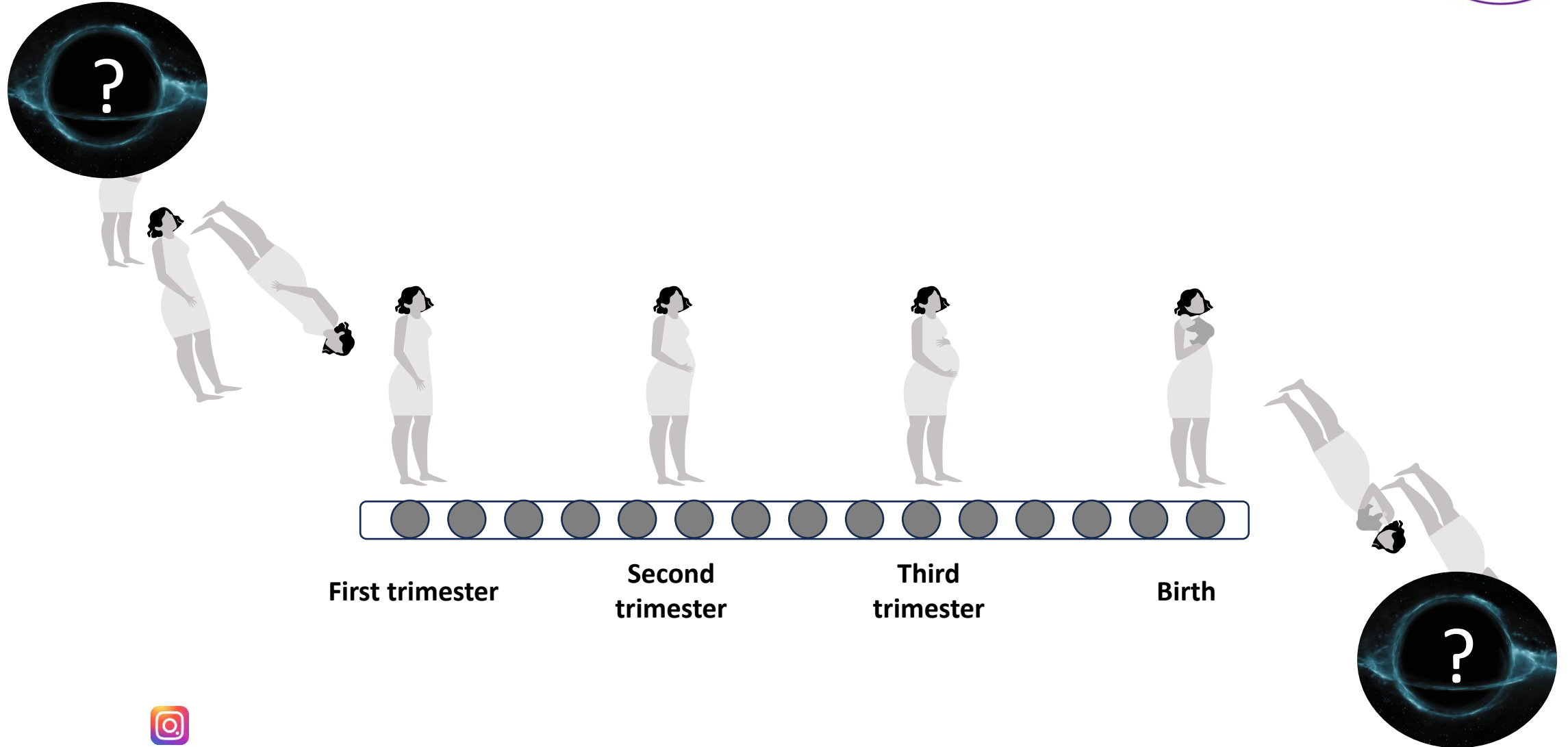
# In theory



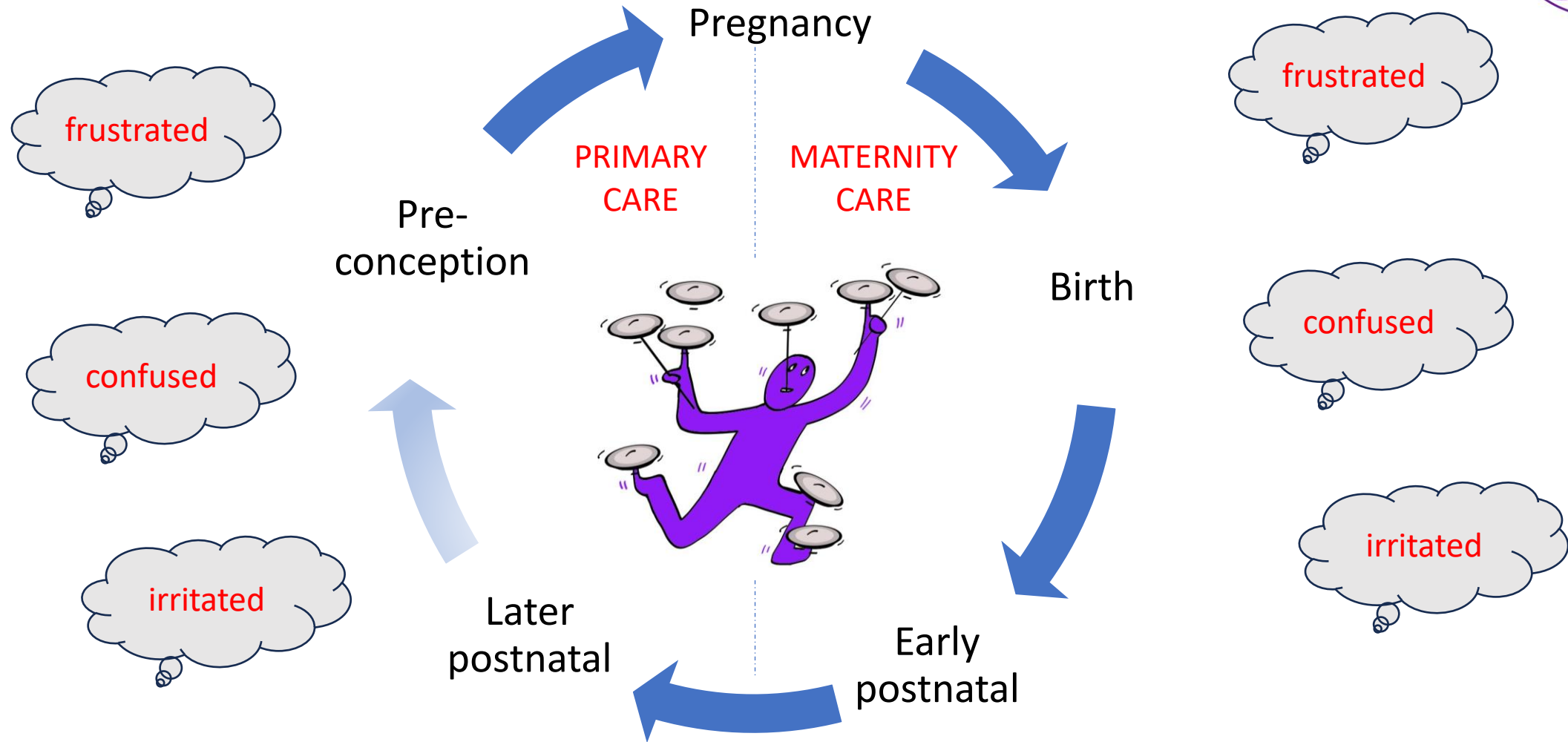
# In practice – primary care view



# In practice – maternity view



# How it feels: the professionals





# How it feels: the woman



## Failure!



I hated it when the midwife kept using the word “failed”. I started with a “failed induction” and then she wrote down “failure to dilate”.

That word had a real impact on me and I just wanted to cry.



You choose ?

BMAT13

Google



Google Search

I'm Feeling Lucky

# Primary care, maternity and the woman working together



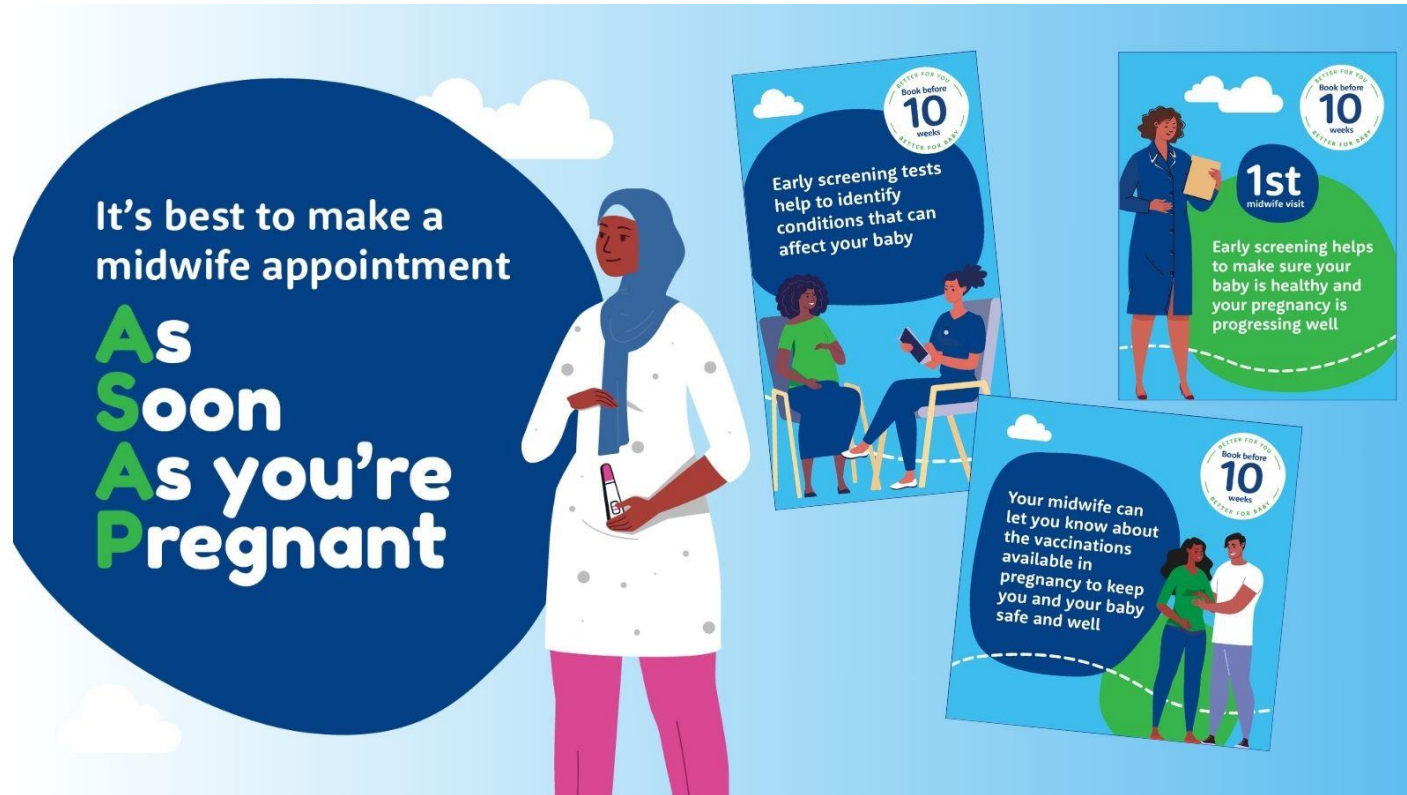


# Barriers



**How often on average do GPs see a woman during pregnancy?**

# Early self referral





# Digital notes

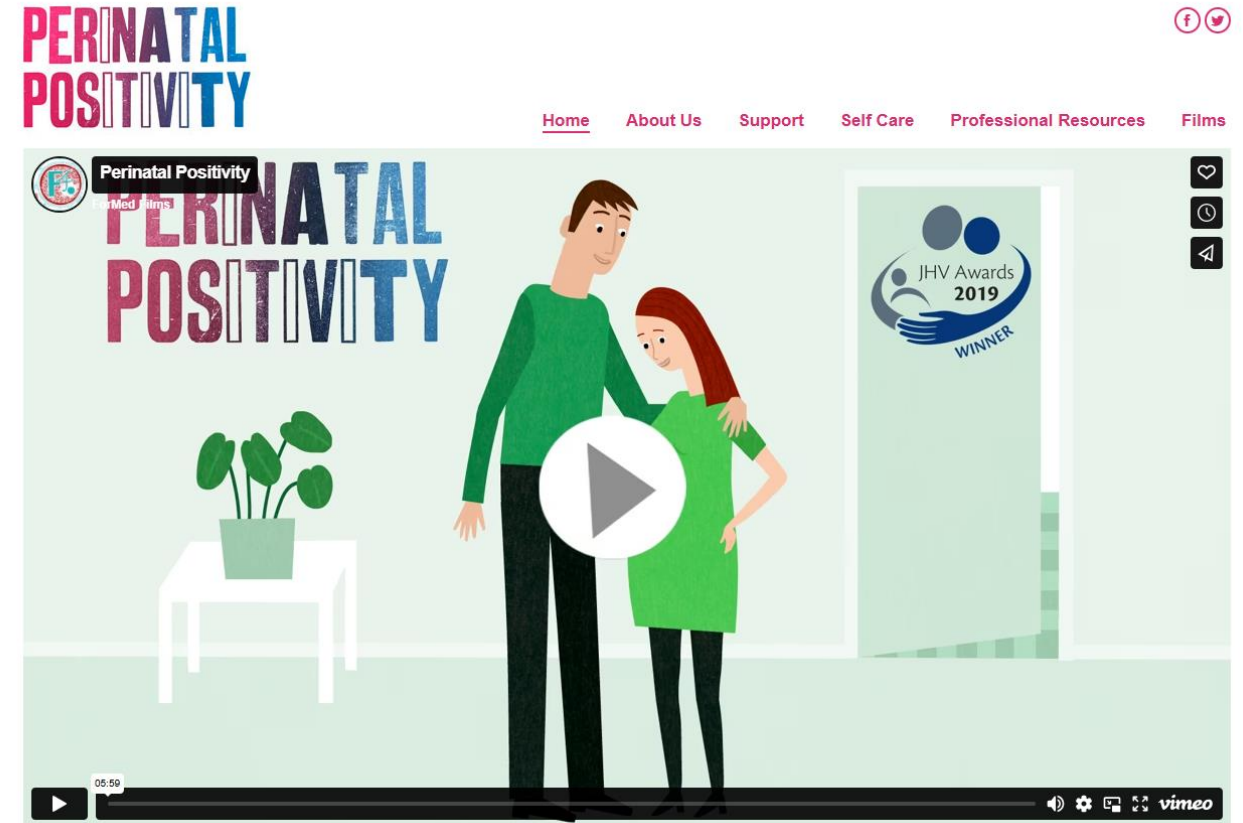




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# Mental health

- Approximately 20% of women will have some form of mental health history at booking.
- Pregnancy and transition to parenthood can precipitate new mental health problems.
- Perinatal mental health services are a separate secondary care service





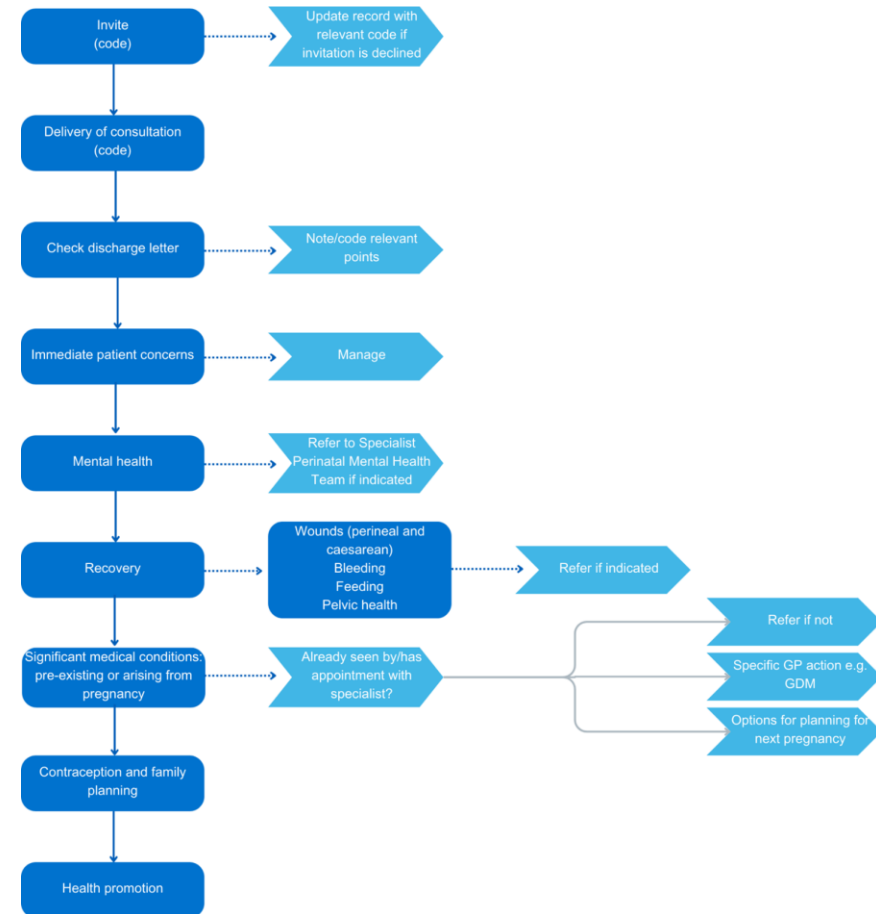


# Postnatal care

## *Limited maternity service support*

- Minimal length of stay: 46% of women one day
- Post-natal clinics replacing home visits
- Variation in practice beyond 28 days

## *Unrealistic expectations on GPs at 8 week check*





# Solutions

# Providing continuity



Obstetrician

Community  
midwife

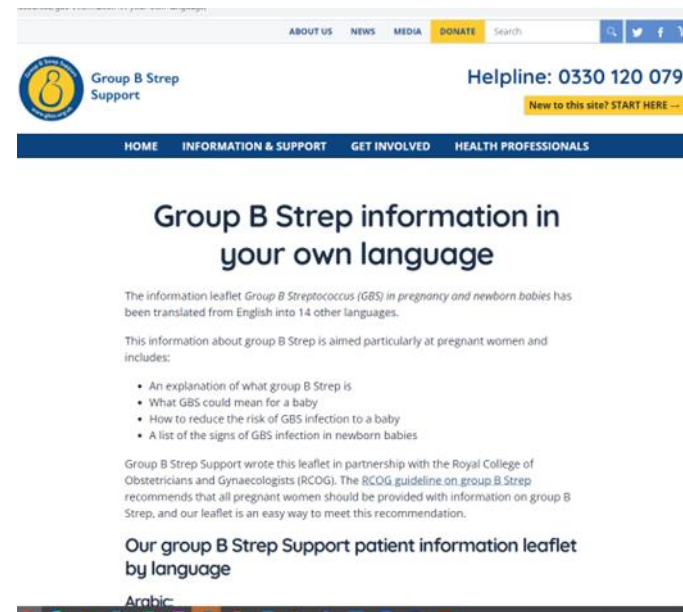
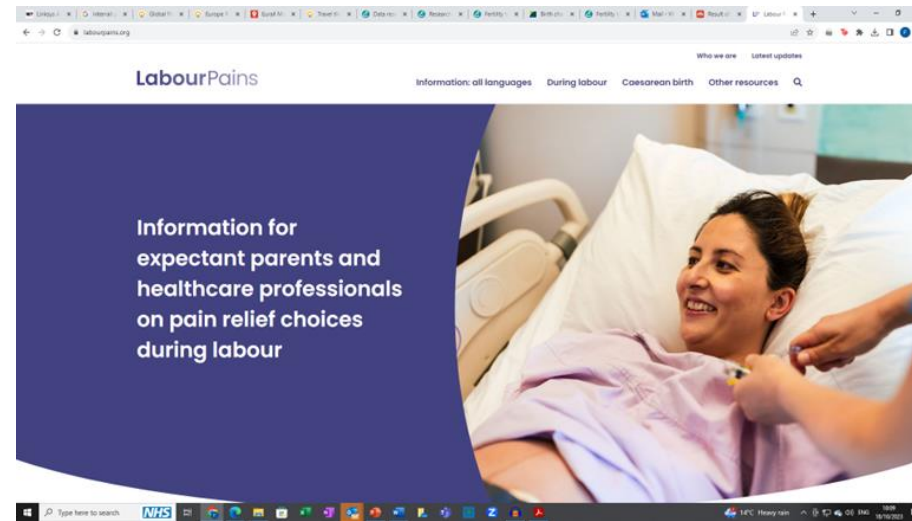
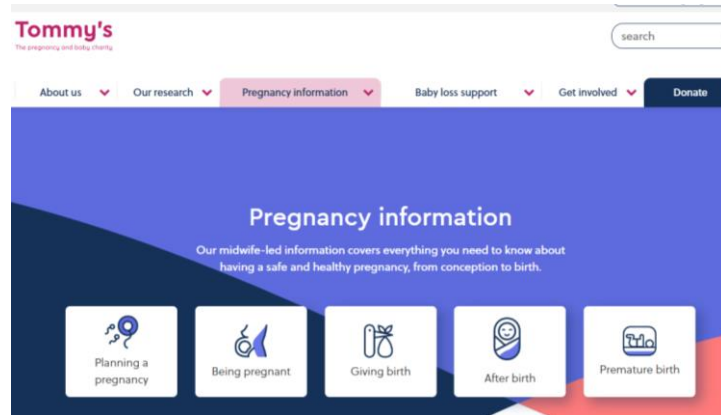
Perinatal mental  
health services

Health  
visitor

General  
Practitioner

Increasing continuity

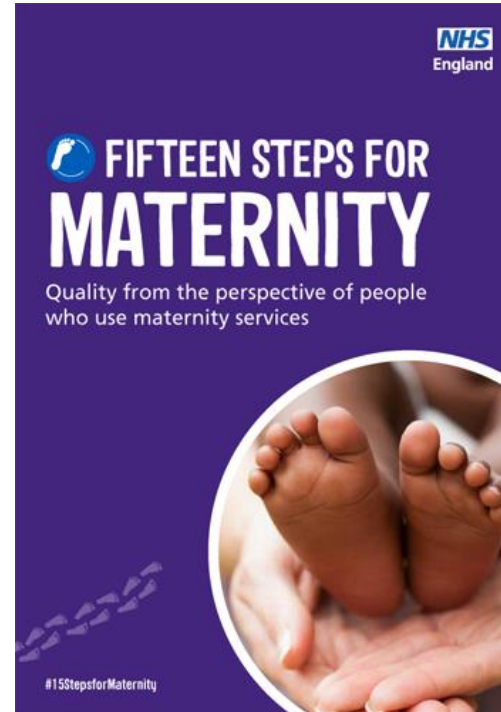
# Sharing resources





# Building relationships

- Reciprocal visits
- Formal networks
- Informal networking
- Job shadowing or swaps
- Using existing integration

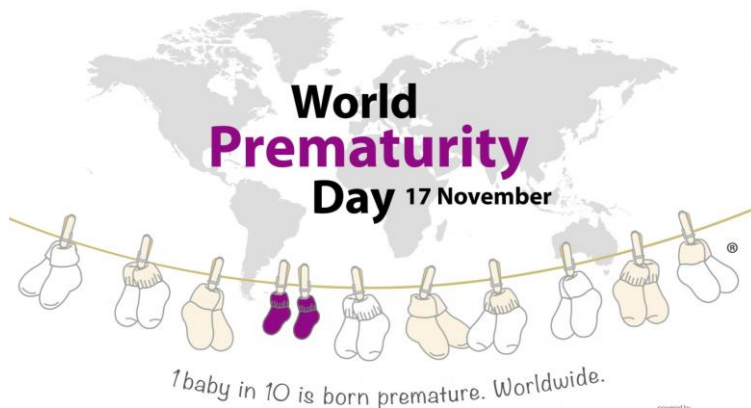




# Leveraging common opportunities

## THE PRIMARY CARE SHOW

14th – 15th May 2025 • The NEC, Birmingham





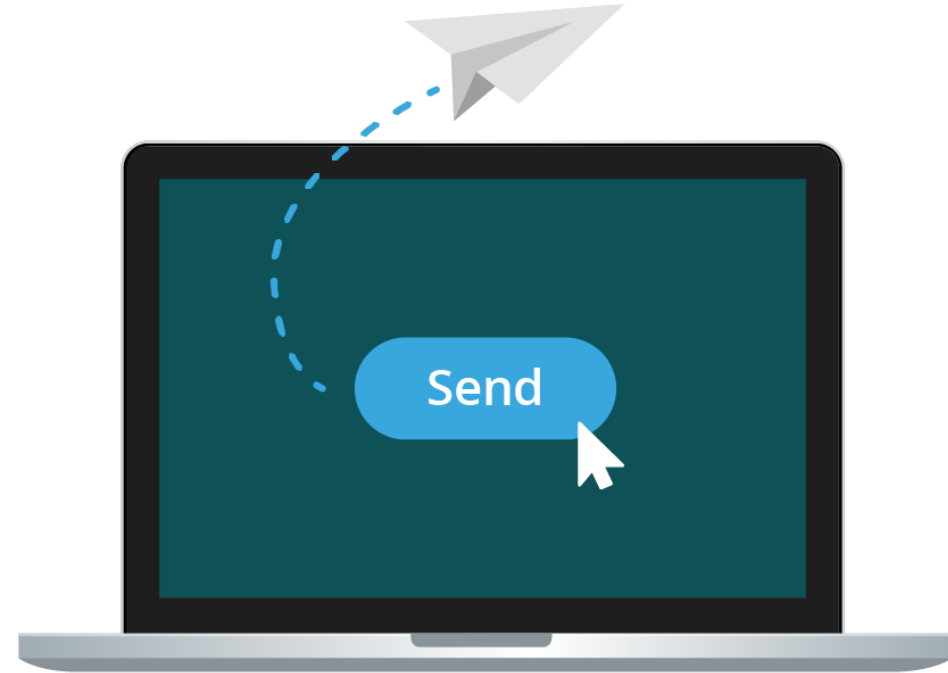
# Using consistent language





# Asking for advice

- Advice & Guidance email
- Maternity Helplines
- Perinatal mental health services







# Working together: pre-conception

# Unplanned conception



**1/3 of births in Britain are unplanned or ambivalent**



## **Impact on women:**

- obstetric complications
- later for antenatal care
- antenatal and postnatal depression



## **Impact on children:**

- birthweight
- mental and physical health
- do less well in cognitive tests



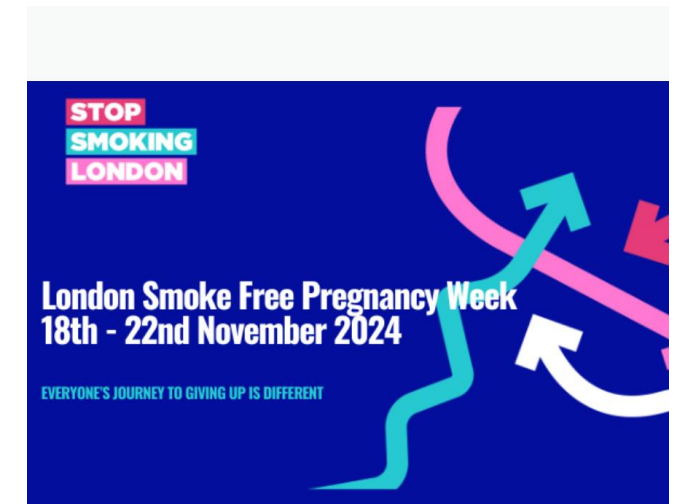
# Healthy lifestyle



Basic nutritional safety net for pregnant women or families with a child under 4yr



Free online training on how to have effective conversations with women about alcohol intake in pregnancy



Stopping smoking single most important action a woman can take to improve the health of her baby

# Medication review



Evidence-based safety information about medication, vaccine, chemical and radiological exposures in pregnancy




[Medicines and exposures information](#)



[Patient information](#)



[Report a Pregnancy](#)



**NHS**  
South East London

## Antidepressant in pregnancy and breastfeeding

Guidance for GPs




Recommendations for antidepressant use in women who are pregnant or are planning a pregnancy

### Women currently prescribed an antidepressant

- If the woman is currently prescribed an antidepressant and it is effective and well-tolerated continue it unless it is either contraindicated in pregnancy or the woman wishes to stop the antidepressant. Before stopping the antidepressant consider the risk of relapse of maternal mental illness and the risk of untreated maternal depression on the foetus or infant.
- It is not usually advisable to abruptly stop antidepressants. Contact South London and Maudsley (SLaM) Medicines Information service or Oxleas Medicines Information service for advice on how to stop antidepressants.
- If the woman is currently prescribed an antidepressant and it is not effective or not well-tolerated they can contact perinatal services, SLaM Medicines Information service or the Oxleas Medicines Information service, for advice on choice of antidepressant. If an antidepressant is not effective it should not be continued.

### Women not currently prescribed an antidepressant

- For a new episode of mild depression non-pharmacological options may be considered. But consider also the risk of untreated maternal depression on the foetus or infant.
- For a new episode of depression which is moderate to severe, prescribe the antidepressant which was previously effective. If no previous antidepressant has been tried, then sertraline may be considered. Other options are available. Please refer to the Maudsley Prescribing Guidelines, BUMPS leaflets, discuss with SLaM Medicines Information service, the National Teratology Service or Oxleas Medicines Information service. Leaflets and resources can be found on page 4.





# Working together: 1<sup>st</sup> trimester

# Pregnancy sickness



- Effective prescribing
- Rehydration
- Mental health support



## Are anti-emetics safe to prescribe in pregnancy?

The most important feature of any treatment for nausea and vomiting in pregnancy are:-

1. Does it work (efficacy)?
2. Does it do any harm to the developing foetus (safety)?
3. Does it have significant side effects on the mother to be?

The [RCOG Guidelines](#) provide information about the

## What medications and treatments can be prescribed?

Hyperemesis Gravidarum is a serious complication of pregnancy and it is essential that sufferers are offered timely and effective treatment. The [RCOG Greentop Guidelines](#) include a treatment ladder that outlines the various medications that are recommended for use in HG pregnancies alongside intravenous fluid therapy and PPIs.

### Medication information

Currently, there is only one anti-emetic licenced for use in pregnancy in the UK which is called Xonvea. It is not available everywhere and as it's only available in oral form, it is a first-line medication and may not be sufficient alone to treat HG in all patients.

PSS are campaigning for Xonvea to be included on all formulary to avoid the current postcode lottery. If you want support to add this to your formulary please [contact us](#).

Alongside IV Fluids, 3 lines of anti-emetic medications are outlined in the RCOG Guidelines for use during an HG pregnancy. They are often most effective when used in combination and can vary from patient to patient in terms of effectiveness.

# IVF



- 77,000 IVF cycles per year UK
- 83% non-NHS
- Inconsistent approaches to medication with limited evidence







# Early pregnancy bleeding

- 10-20% first trimester miscarriage
- Pathway differs depending on gestation
- Confusing for women







# Working together: 2<sup>nd</sup> and 3<sup>rd</sup> trimesters



# Treat and investigate as if not pregnant

## THREE P's IN A POD

Every other day a pregnant or recently pregnant woman dies in the UK.

$\frac{2}{3}$  of maternal mortality is due to a medical or mental health condition, not pregnancy itself.

Remember it's ok to ask...

Working as a team will improve women's care and save lives.

Pick up the phone, pick up the problem and let's prevent maternal morbidity and mortality.

**PREGNANCY "THINK CHEST"**

**23% maternal mortality caused by CARDIAC conditions**  
Cardiac output increases by 50% in pregnancy and there is an increased risk of cardiac failure. Search for cardiac causes of persistent breathlessness.

**14% maternal mortality caused by PNEUMONIA or INFLUENZA**  
CXR should not be withheld. Prompt treatment with antibiotics or antivirals advised. Be aware of a pre-existing medical condition e.g. asthma or obesity as this can increase severity.

**11% maternal mortality caused by VENOUS THROMBO-EMBOLISM**  
Risk evolves. Assess at every encounter and consider LMWH. Treat promptly with high dose LMWH if suspicion of VTE. Pregnancy is not a contraindication to thrombolysis if massive PE.

**POST NATAL "THINK HEAD"**

**11% maternal mortality caused by NEUROLOGICAL conditions**  
Never stop anti-epileptics unless discussed with an expert. First fit in pregnancy or worsening epilepsy is an urgent situation and phone referral to neurology is necessary.

**9% maternal mortality caused by MENTAL HEALTH disorders**  
Urgent care and follow up is necessary for women who report new thoughts of self harm, sudden onset or rapidly deteriorating mental health symptoms or persistent feelings of strangeness from their baby.

**PICK IT UP "THINK HIGH RISK"**  
**Pick up the phone**  
**Pick up the problem**  
Pregnant women are different and you won't always know what to do. Improvement in communication and team working with appropriate escalation to seniors, alongside prompt treatment and management is necessary if we are to reduce maternal morbidity and mortality together.

For further information:  
@TheObsPod  
http://theobs.org.uk  
www.nhs.uk/whatyouneedtoknowaboutpregnancy

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@TheObsPod  
http://theobs.org.uk  
www.nhs.uk/whatyouneedtoknowaboutpregnancy

Royal College of Physicians  
Royal College of Physicians of Edinburgh  
NHS Education for Scotland  
MBRRACE-UK  
Royal College of Obstetricians & Gynaecologists

## Key messages

from the themed mortality enquiry report 2023

**MBRRACE-UK**  
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

**Treat pregnant, recently pregnant, and breastfeeding women the same as a non-pregnant person unless there is a very clear reason not to.**

**Prepare a route for rapid delivery of advice and data on new vaccines and treatments**

**Include in medicine and vaccine research**

**Tailor care after pregnancy to a woman's individual needs**

**Equity for pregnant and breastfeeding women**

**Include in guidance for admission to ECMO\* services**

**Ensure staff in maternal medicine networks have the skills to care for complex physical, mental and social care needs**

**Develop training resources to promote shared decision making and counselling on medication use**

\*ECMO = Extracorporeal membrane oxygenation





# Need pregnancy specific triage



Airway compromise  
Respiration rate  $\geq 30$  or oxygen saturation  $< 92\%$   
Shock: BP  $< 80$  systolic, HR  $> 130$  bpm  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain  
Fetal bradycardia

1. Transfer immediately to DS or HDU or obstetric theatre
2. Inform DS Shift Leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding  
Abnormal MEWS (1x red value or 2x yellow values)  
Fetal heart rate  $< 110$  bpm or  $> 160$  bpm  
No fetal movements

1. Remain in triage room until medical assessment or room on DS available
2. Complete and categorise CTG (if gestation  $\geq 26/40$ )
3. Consider IV access
4. Obtain blood for FBC
5. If bleeding PV take blood for GandS and if Rhesus Negative for Kleihauer. Consider bloods for PET profile/CRP/glucose/clotting
6. Obtain urine sample for urinalysis +/- MSU
7. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
8. Keep nil by mouth
9. Repeat baseline observations every 15 minutes

Mild pain  
Mild bleed (not currently active)  
Altered MEWS (1x yellow value)  
Normal fetal heart rate  
Reduced fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation  $\geq 26/40$ )
3. Obtain urine sample for urinalysis +/- MSU
4. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
5. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

Minimal or no pain  
No bleeding  
Normal MEWS  
Normal fetal heart rate  
No contractions  
Normal fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation  $\geq 26/40$ )
3. Obtain urine sample for urinalysis +/- MSU
4. If after examination and discussion, pain is identified as musculoskeletal/pelvic girdle pain, MW can offer discharge home (at any gestation) and written advice with appropriate follow-up with CMW or ANC
5. Or inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)



**Where would you recommend that a  
multip with uncomplicated pregnancy  
gives birth?**



# Evidence



## Women who received continuity of midwifery care



**7 X MORE LIKELY TO BE  
ATTENDED AT BIRTH BY  
A KNOWN MIDWIFE**



**16% LESS LIKELY  
TO LOSE  
THEIR BABY**



**19% LESS LIKELY  
TO LOSE THEIR BABY  
BEFORE 24 WEEKS**



**15% LESS LIKELY  
TO HAVE  
REGIONAL ANALGESIA**



**24% LESS LIKELY  
TO EXPERIENCE  
PRE-TERM BIRTH**



**16% LESS LIKELY  
TO HAVE  
AN EPISIOTOMY**

### First Baby

#### Birth planned in Obstetric Unit

**995**  
per 1000  
babies are  
born healthy

**5** per 1000  
babies have a  
poor outcome

#### Birth planned in Alongside midwifery unit (AMU)

**995**  
per 1000  
babies are  
born healthy

**5** per 1000  
babies have a  
poor outcome

#### Birth planned in Freestanding midwifery unit (FMU)

**995**  
per 1000  
babies are  
born healthy

**5** per 1000  
babies have a  
poor outcome

#### Birth planned at home

**991**  
per 1000  
babies are  
born healthy

**9** per 1000  
babies have a  
poor outcome

The orange outline shows that 4 more babies per 1000 have a poor outcome, compared to planned first birth in an obstetric unit.

### Second, third or fourth baby

#### Birth planned in Obstetric Unit

**997**  
per 1000  
babies are  
born healthy

**3** per 1000  
babies have a  
poor outcome

#### Birth planned in Alongside midwifery unit (AMU)

**998**  
per 1000  
babies are  
born healthy

**2** per 1000  
babies have a  
poor outcome

#### Birth planned in Freestanding midwifery unit (FMU)

**997**  
per 1000  
babies are  
born healthy

**3** per 1000  
babies have a  
poor outcome

#### Birth planned at home

**998**  
per 1000  
babies are  
born healthy

**2** per 1000  
babies have a  
poor outcome



# Birthing options



**Tommy's**

The pregnancy and baby charity

## B.R.A.I.N.S

### **B – Benefits**

What are the benefits of having this procedure/intervention?

### **R – Risks**

What are the risks of this process for me, my baby and how will it affect my labour and birth?

### **A – Alternatives**

What are the alternatives to this procedure? Can it be carried out differently or can a different process be used?

### **I – Instinct**

What do I feel is right and safe for me? What's my gut instinct?

### **N – Nothing**

What happens if I do nothing? I don't want to do anything right now/ I need time.

### **S - Second opinion**

Can I get a second opinion? Who else could I talk to about this?



# Working together: postnatal

# Long-term health impact



TYPE 2 DIABETES  
KNOW YOUR RISK

NHS

## Gestational diabetes

Up to 50% of women diagnosed with gestational diabetes develop type 2 diabetes within 5 years.

TYPE 2  
**DIABETES PREVENTION WEEK**


NHS

## Pelvic health and wellbeing during pregnancy and after birth

Online tips, advice and information in multiple languages about:

- Pelvic floor exercises
- Posture and positioning
- Constipation and bladder care
- Back and pelvic pain
- Perineal massage
- Pain management and wound care
- Looking after your stomach muscles
- Returning to exercise

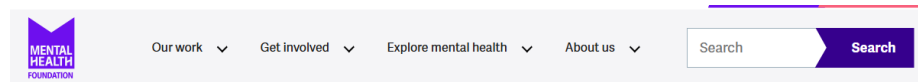


Search 'NHS pelvic health and wellbeing' or scan the QR code to find out more. 





# Role of rest of the family



[Home](#) / [Explore mental health](#) / [Publications](#)

## Becoming Dad: A guide for new fathers

This focus of this guide is to help you make sense of what it can be like to be a Dad, to look after yourself and the others around you, and do the best possible job of becoming a confident father.

We've created this guide to try and answer the questions and concerns you're most likely to have as you set off on your fatherhood journey. We've also included information to signpost you towards whatever help and advice you might need along the way, and to hopefully help you do one of the most important and best jobs in the world – becoming a Dad!

This guide is based on the best, most up-to-date research, and draws on the experiences of thousands of Dads who've travelled this road before you.



### MY DETAILS:

Medical/NHS Number: \_\_\_\_\_ Previous NHS Number: \_\_\_\_\_

Name (On system): \_\_\_\_\_ Age: \_\_\_\_\_

Preferred name: \_\_\_\_\_

My chosen parent name: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

My pronouns are: \_\_\_\_\_ Sexuality: \_\_\_\_\_

### MY FAMILY:

My Family Unit comprises of: \_\_\_\_\_ who is my \_\_\_\_\_

Their preferred name is: \_\_\_\_\_

Their chosen name is: \_\_\_\_\_ Their pronouns are: \_\_\_\_\_

Their chosen parent name is: \_\_\_\_\_ Other children: \_\_\_\_\_

My Family Unit comprises of: \_\_\_\_\_ who is my \_\_\_\_\_

Their preferred name is: \_\_\_\_\_

Their chosen name is: \_\_\_\_\_ Their pronouns are: \_\_\_\_\_

Their chosen parent name is: \_\_\_\_\_ Other children: \_\_\_\_\_

My Family Unit comprises of: \_\_\_\_\_ who is my \_\_\_\_\_

Their preferred name is: \_\_\_\_\_

Their chosen name is: \_\_\_\_\_ Their pronouns are: \_\_\_\_\_

Their chosen parent name is: \_\_\_\_\_ Other children: \_\_\_\_\_

### FAMILY CREATION:

Family creation Pathway:

Home AI / IUI / IVF / RECIPROCAL IVF / ICSI / Sexual Intercourse (please circle)



# Jenny and Sophie

WHOSE  
SHOES?®





## Breast is best?

Breast is best  
I used to agree  
But it wasn't best for my baby  
And it wasn't best for me

My baby wasn't getting enough  
Her blood sugar was low  
My milk just didn't seem to flow  
She was fidgety and distressed  
Clearly desperate for more  
Or too sleepy to care  
It was too much to bear

"Breast is best for your baby"  
An important message for those who  
don't know  
But it made me feel really low  
To hear it over and over again.  
"Click here to confirm"  
... that you're a bad mum  
It made me feel numb  
It's not what it said  
But that's what I read.

At 8 weeks I saw a lovely GP



# Questions ?



- Thank you to the midwives, obstetricians and woman and families at Kingston Hospital with whom I work



- Thank you to Anna & Carrie <https://www.newpossibilities.co.uk/> for many of the images.



- Thank you to Gill Phillips of Whose Shoes **WHOSE SHOES?**



# Contact details



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