Birmingham Women's NHS
NHS Foundation Trust

Antenatal Care Guidelines

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NB. Hard copies of this policy are not permitted as they **cannot guarantee** that they contain the most up to date information and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust intranet policies link.

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
1.0	2006	Paula Clarke	Archived	New Policy
2.0	2010	Paula Clarke, Jenny Henry, Pam Salisbury	Archived	Addition of Consultant led women, to Midwifery-led guidelines, so now guidelines for ALL antenatal care
3.0	27th May 2010	Pam Salisbury	Archived	Approved by maternity Services Directorate
4.0	14th Oct 2010	Pam Salisbury	Archived	Updated in line with NHSLA standards
5.0	1st September 2011	Becky Wilson	Archived	Updated following national guidance on MCADD
6.0	29th June	Becky Wilson Audit and Guidelines Midwife	Approved	Amended section 6.5 and appendix G. Put into new trust format.

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1. Introduction

All women should have access to professional care in the antenatal period, which is from conception to the onset of labour.

Routine antenatal care focuses upon maintaining and improving health and well-being, ensuring that women are equal partners with health care professionals in planning their care. (Standards for Maternity Care 2008)

The Changing Childbirth Report (DOH 1993) highlighted the importance of the role of the midwife as the expert of 'normal' and the lead care provider for women who are fit and well. This option for women has been available at Birmingham Women's Hospital (BWH) since 1996.

Our service has since evolved significantly. Now all women receive their initial booking appointment with a midwife. Following a detailed assessment, the woman will either:

- Remain under the care of a midwife (Midwifery-Led Care)
- Remain under the care of a midwife (Midwifery-Led Care) but require an opinion from a consultant midwife and then an obstetrician if necessary.
- Require transfer of care from midwife to obstetrician (Consultant Led Care)

2. Objectives

To provide a guide to antenatal care for all women booked at Birmingham Women's NHS Foundation trust.

3. Policy Scope

This guideline applies to all Trust employees involved in providing antenatal care to patients, including locum and agency staff, students and staff employed on honorary contracts.

4. Document Definitions

4.1 Midwifery Led Care

Midwife led care means a named midwife plans, coordinates and provides care with the women where a normal pregnancy and birth outcome is anticipated. The midwife is the lead care professional who is responsible for providing care, focused on the individual needs of each woman. Care will reflect women's clinical and social requirements which may involve seeking the opinion of additional expertise as necessary. It is the responsibility of the midwife to confirm suitability for midwife led care at each contact.

4.2 Consultant Led Care

Consultant-Led Care means a named consultant team plans, coordinates and provides care for women where a complication has been identified on assessment. This may be medical, and/or obstetric. The members of the medical team are the lead care professionals who are responsible for providing care, together with midwifery input, focused on the individual needs of each woman. Care will reflect

women's clinical and social requirements which may involve seeking the opinion of additional expertise as necessary.

5. Duties and Responsibilities

5.1 Booking Office Staff

Will receive the referral letters and prepare them for the clinic midwife to review Monday-Friday. This will include date and clinic stamping the letters, checking the estimated date of delivery, and ensuring appointments are made and sent to the woman by post. If there are any problems this will be escalated to the Head of Midwifery of a designated person.

5.2 Antenatal Clinic Midwife

Will review all booking letters (Mon–Fri) and allocate to the appropriate clinic, taking into account clinical needs. The aim as far as possible is to book women under the care of a midwife.

5.3 Midwife

- Book and risk assess all women. (Midwife and Consultant Led)
- Refer as appropriate
- Provide total antenatal care for low risk women
- Develop management plans as required for 'low risk' women.
- A review of that plan should be undertaken at each contact.
- Provide shared care following a consultant management plan for high risk women, including post dates membrane sweeps.
- Refer for appropriate investigations and /or opinion to consultant midwife/obstetrician
- Refer for specialist services i.e. Safeguarding, teenage, mental health, Drug & Alcohol, as required.
- Discuss and document in the hand held notes plans for pregnancy and parenthood and preferences for birth
- Review and take into account previous history and management plans at each contact. Also review previous documentation by clinicians. If necessary, request copy of birth records from previous hospitals
- If necessary complete a change of lead professional form, i.e. to consultant or back to Midwifery care and document clearly on the front of the hand held notes.
- Document clearly in the health records the discussions and provision of information to women as clinically indicated.

5.4 Medical Staff

- Medical staff have a duty to provide individual woman-centred care in line with approved guidance, and to document clearly what that care should be.
- Develop management plans in line with specific guidance for high risk care together with consultation with the woman.
- A review of that plan should be undertaken at each contact.
- Receive requests from midwives/ colleagues for an opinion, review the women and decide on future management.

- Review history and management plans at each contact. Also review previous documentation by clinicians.
- If necessary complete a change of lead professional form, i.e. to consultant or back to Midwifery care and document clearly on the front of the hand held notes.
- Document clearly in the health records the discussions and provision of information to women as clinically indicated.

6. Procedures

6.1 General Principles

- Women, their partners and their families should always be treated with kindness, respect and dignity.
- Pregnancy should enable a woman to make informed decisions, based on her needs having discussed matters fully with the healthcare professionals involved.
- Antenatal care should be provided by a small group of healthcare professionals with whom the woman feels comfortable. The aim should be to provide continuity of care throughout the antenatal period.
- Health care professionals should offer consistent information and clear explanations and should provide pregnant women with an opportunity to discuss issues and ask questions.
- All women's decisions should be respected, even when this is contrary to the views of healthcare professionals.
- The environment in which antenatal care appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use.
- In all communications (including initial referral) with maternity services, health care professionals should include information on any relevant history of mental disorder.
- Early in pregnancy, all women should receive appropriate written information about the likely number, timing and content of antenatal appointments.
- Opportunity should be given to discuss this schedule with a midwife of doctor. Routine involvement of obstetricians in the care of women with uncomplicated pregnancy does not appear to improve outcomes compared with involving an obstetrician when complications arise.
- An assessment of the woman's health and history is undertaken by the midwife at the booking appointment to identify suitability for midwife led care and discussion surrounding place of birth. Women, who have identified risk factors, as per NICE guidance, (see Appendix A) will have their care transferred to an appropriate consultant obstetrician.
- There will be a continuous assessment of a woman's suitability to remain under the care of a midwife (See Appendix B for Birth Centre Suitability)
- If there is doubt, it is the responsibility of the midwife providing care at each assessment, to seek advice from a more senior colleague, consultant midwife or obstetrician.
- Some women may present physically well but have significant social/ safeguarding requirements. Liaison with the safeguarding team may be indicated.

6.2 Referral for Maternity Care

Process to ensure women have their first booking visit completed by twelve completed weeks of pregnancy

South Birmingham Community midwives, based at Birmingham Women's hospital, receive referrals for booking from a number of sources, either from GP surgery, the woman contacting the midwife directly, or hospital appointment letters, as detailed in section 7.9.

Once notified, the community midwife will contact the woman by phone and arrange a home visit before twelve completed weeks of pregnancy. This will be documented in either the appointment diary or the GP appointment system. The first booking visit will ensure that a full history / risk assessment is taken and the pregnancy handheld notes are completed.

Out of Area community midwives follow the same process; therefore women arriving at the hospital should have hand held notes completed.

If any woman arrives for their scan/antenatal appointment, or specialist clinic, prior to their community appointment, then core midwives will complete the hand held notes.

Women referred after 12 completed weeks

If women are more than 12 completed weeks pregnant when the hospital receives the referral letter, the letter will be stamped and dated, and an appointment will be made within 2 weeks of this date. This may be a home visit or part of the antenatal / scan appointment at the hospital.

If any woman arrives for their scan/antenatal appointment, or specialist clinic, prior to their community appointment, then core midwives will complete the hand held notes.

If there are no consultant clinic slots available for the antenatal / scan appointment, the woman will be booked into the midwifery antenatal hospital clinic and will be seen by medical staff.

Women referred at 20 weeks or later

This refers to anyone who has their initial booking appointment at 20 weeks gestation or later

- These women must be booked under consultant led care.
- It is well recognized that vulnerable groups of women (domestic abuse, safeguarding issues, substance misuse, low social class, newly arrived migrants/refugees/asylum seekers) are less likely to attend for antenatal care or book late.
- *Savings Mothers Lives* (CEMACH 2007) identifies that around 20% of women who died from direct or indirect causes either booked for maternity care after 20 weeks gestation, missed over four routine appointments, did not seek care at all or actively concealed their pregnancies. This delay denied them the opportunities that early maternity care provides for mother, baby and family.
- Midwives need to consider antenatal screening and any safeguarding issues

6.3 Booking Appointment

The first booking visit will ensure the pregnancy handheld notes are completed and a full history and risk assessment is taken. This will be undertaken before 12 completed weeks and will be documented in the maternity hand held records

- The main risk assessment for the pregnancy will be carried out at booking.
- A further formal risk assessment is carried out in labour, please refer to the Care of Women During Labour and Birth Guideline.
- Depending on individual circumstances and risk factors, the risk assessment may be repeated at any time, and changes to the plan of care documented in the health records.
- At booking the midwife must ensure that the Information Sharing discussion box is completed in the pregnancy hand held records.

Booking history and risk assessment details and summary are completed by a midwife, using the checklists in the pregnancy hand held notes. Any additional information is added as free text. As a minimum the risk assessment will include:

- Relevant family history
- Lifestyle history; smoking, alcohol and drug use, nutrition, exercise. See section 7.18 for further guidance.
- Medical history including anaesthetic and psychiatric history. See separate guideline for Mental Health. (See Appendix A for further details of medical conditions and factors from previous pregnancies to be considered, as per NICE guidance).
- Factors from previous pregnancies.

If at booking the midwife/medical staff identify a significant problem with the woman's obstetric history that may impact on the current pregnancy and details are with another trust/GP surgery, a standard letter (Appendix C) is sent to request the health records from that organisation. As a minimum, this will include history of previous caesarean section where the type is unknown, i.e. query classical incision, previous still birth or neonatal death, recurrent miscarriage (3 or more), previous history of congenital anomalies and previous extreme prematurity (less than 28 weeks gestation). Documentation of the request made, or a copy of this letter will be filed within the maternity hospital notes. The clinician can then review the notes once available. It is also good practise, where possible, to contact the previous clinician involved to ask for any additional information. This will be documented in the health records.

Additional information will be sought for the following:

- Migrant women, i.e. all pregnant women from countries where they may experience poorer overall general health. The booking midwife should ensure that a physical examination is carried out. The midwife will refer the woman to her GP. If the woman has no GP, then the booking midwife will refer the woman to the hospital medical staff. Details of this will be entered on the 'Medical History page' of the hand held records. (CEMACH 2007)
- A Thromboprophylaxis assessment will be documented in the hand held notes. Please refer to Guidelines for the prevention and treatment of venous thromboembolic disease.

- When discussing blood transfusion, if a woman indicates that she has/would decline blood and blood products, documentation must be made in the special features box in the pregnancy hand held records under 'key points'. Refer to Blood Transfusion Policy.

Additional conditions/ history to consider:

- Hypothyroidism – Will initially be referred to a Consultant clinic. If the woman has a normal thyroid function test at 28 weeks and the fetal growth is within normal limits, she will be referred back to midwife led care and have access to the birth centre if she otherwise fulfils the criteria.
- History of confirmed pre-eclampsia – Suggest regular antenatal contacts particularly inlate pregnancy i.e. weekly. Advise woman of symptoms to look for. If no proteinurea and B/P <140/90 can remain midwife led care.
- Fibroids 4cm or less-unlikely to be a problem. If 4cm or more or numerous fibroids – refer to obstetrician for opinion. Observe symphysio-fundal height, exclude polyhydramnios clinically/unstable lie.
- Maternal family history of diabetes – A Glucose Tolerance Test (GTT) should be arranged for 26 weeks. Women can remain under midwife led care, until result is known. Any woman with an impaired or abnormal glucose curve must be referred to Diabetic clinic.
- Family history of Medium-chain acyl-CoA dehydrogenase deficiency MCADD. If both parents are MCADD carriers, there is a one-in-four chance of their child being born with MCADD. If there is a family history of MCADD refer to specialist paediatric inherited metabolic disorder services and specialist genetic counselling services.
    - Refer to specialist genetic counselling services by either sending a letter or fax outlining any relevent history to BWNFT Genetics Unit, Norton Court, fax number 0121 627 2618
    - Refer to specialist paediatric inherited metabolic disorder services by contacting the metabolic screening lab at Birmingham Childrens Hospital
    - If urgent help is needed contact the metabolic disease on call consultant at Birmingham Childrens Hospital via switch (333 9999)

FGM

- Appropriate Women from cultures where it is prevalent, should be asked about female genital mutilation (FGM) routinely at the booking appointment. This should be documented in the hand held records and include a 'plan of care'.
- With the woman's consent, an examination of the external genitalia is required in order to assess the degree of FGM (the woman may not know this herself). This should be done by an appropriately trained member of staff at a suitable time in the pregnancy.
- Consideration needs to be given as to the appropriate place of birth.
- The midwife needs to develop a relationship with the woman so that the woman's views on the procedure are obtained. Consider other female siblings & whether they have had FGM. If the midwife feels that the woman, on giving birth to a female child, would subject the child to this procedure, an interagency referral to Children's Services is required (BSCB procedures, 2009, BWFT Safeguarding Policy, 2010)
- Midwives should provide culturally sensitive health information & advice to women, using an interpreter where required, clearly informing women that the practice of FGM is illegal in the UK (Female Genital Mutilation Act, 2003).

- The midwife should liaise with the health visitor using the Information sharing tool.
- Documentation should be recorded in the FSR of the hospital records.

Home Assessment

- If the booking history is done at the woman's home, a home assessment should also take place by the community midwife. This should take into account the home conditions considering the suitability for a new baby to be transferred home, and preparations made for the arrival of the new baby, including proposed sleeping arrangements. Also:
  - Home Heating
  - Social Support Available
  - Level of Deprivation/ poverty
  - Arrangements for the care of sibling when the women is giving birth at home or in the hospital
  - CONI (Care of Next Infant) Referral
  - Support is available to families who are having a baby and have previously suffered a cot death. The midwife should consider discussing this with the woman and make a referral if requested.
  - A record of the assessment should be made in the hospital/ hand held records, and if there are any concerns these should be discussed with LNMS

  If the woman requests a homebirth, the community team manager should also be informed (see homebirth guideline).

6.4 Outcome of booking appointment

Women will be booked under Midwifery Led Care where possible. Exceptions to this are:

- Women who are 12 completed weeks or above, who need to receive an appointment within 2 weeks
- Medical conditions such as: Diabetes, Epilepsy, Renal Disorders, Immunological Disorders such as SLE and Rheumatoid Arthritis, Endocrine Disorders, Cardiac Disease, Haematological conditions
- Other medical conditions requiring medication e.g. Hypertension
- Genetic disorders
- HIV, or Hepatitis B Positive.
- Substance users
- Confirmed multiple pregnancy
- Previous miscarriages >2
- Previous late pregnancy losses
- Extreme BMI (high or low.)
- Later Bookers >20 weeks who have not had any Antenatal care
- Diagnosed Learning Disability (LD)

These women must be booked under Consultant care.

The Women in categories below may be booked under the care of the midwife but must be transferred to the care of the consultant at an appropriate gestation.

If uncertain book under Core Midwives alongside a consultant or ask advice from the clinic midwife.

These include:

- Previous Caesarean Sections
- SGA babies, Pre-term deliveries
- Perineal trauma
- Pregnancy induced hypertension
- Cholestasis
- Medical condition not requiring medication.

If requested, please book Interpreters to be available for when the woman attends her appointment.

For a more detailed list see Appendix A 'Planning place of birth / Lead Care provider'.

Following the initial risk assessment, the woman will either:

- Remain under the care of a midwife (Midwifery-Led Care)
- Remain under the care of a midwife (Midwifery-Led Care) but require an opinion from an obstetrician/consultant midwife (Appendix A)
- Require transfer of care from midwife to obstetrician (Appendix A) (Consultant Led Care)

The woman may also require referral to specialist services.

6.5 Referral to Consultant Care

6.5.1 Following Initial Risk Assessment

- If a risk is identified, the midwife documents the risk and the need to refer to consultant led care on the management plan page in the pregnancy hand held notes.
- If referral to consultant is identified on the management plan page when the woman attends for her appointment/ dating scan a follow up appointment will be made for the appropriate consultant clinic. This appointment will be documented on the back page of the pregnancy hand held notes.

6.5.2 During Pregnancy

Some women will require transfer of care during pregnancy.

- The midwife should clearly document the reason for referral in the pregnancy hand held records
- A hospital appointment will be made. If in community, a transfer of care will be completed and sent into the outpatient's reception lists who will then make an appointment and send it out to the woman. If in hospital, the tranfer of care will be completed by the midwife in antenatal clinic and the appointment will be generated at point of contact care.
- The transfer should be documented on the front of the green hand held records 'Plan of care' page and a change of lead care professional form completed.
- Ensure the woman understands the reason for referral and document this reason in the health records.

- If scan is required, complete scan form and ensure that woman knows to ask for scan on arrival.
- New labels will be obtained and the old labels destroyed.

NB. Do not change lead care professional labels prior to assessment and decision re on-going management.

If no clinic slots are available women must be booked into the Core antenatal midwife clinic and they will be seen by the medical team.

6.5.3 Urgent Medical Review

If at any point during the antenatal period the woman requires urgent medical review, the midwife must:

- Explain her concern to the woman and document this in the pregnancy hand held records.
- Contact the most appropriate personnel/department e.g. Triage or Day Assessment Unit (DAU) to inform them of the need to review.

NB: The midwife will decide whether to speak to a senior obstetrician. If the woman is in the community, a decision will be made by the midwife whether it is appropriate for the woman to go to hospital via her own transport or whether an ambulance needs to be called.

Following assessment by a suitably experienced clinician, a decision will be made regarding her subsequent management and documented in the pregnancy hand held notes.

Where possible, any follow up appointment(s) must be made at the time and given to the woman. If this is not possible, a request form will be faxed to the appropriate community team. If there are no forms on Delivery Suite / Triage, they can be obtained from antenatal clinic. A note is left with the following shift for Ward Clerk to make appt and contact the woman. If appt is for that day in DAU the woman is asked to contact DAU herself at 9am.

6.6 Referral Back to Midwifery Led Care

If deviation from normal resolves and no further additional management is required, the woman should be referred back to midwifery care.

- The woman should be informed of the transfer
- The transfer should be documented on the front of the green hand held records 'Plan of care' and a change of lead care professional form completed.
- New labels should be obtained and the old labels destroyed

Opinion Clinic

If at any point during the pregnancy a further opinion is required regarding the Lead Care Professional, the next available appointment should be made with the

Consultant Midwife, who can be contacted by phone, and appointment made in the opinion clinic. The urgency will depend on individual circumstances.

NB. Do not refer to the Opinion Clinic if it is clear that a change of lead care professional to obstetrician is required.

6.7 Documentation of Lead Care Provider

The Lead Care Professional will be either a Midwife or Consultant. This may be a Consultant team eg, Fetal Medicine, Diabetic, Renal, Immunology, Neuro, Multiples. The lead care professional must be evident in the following place:

- Front of the pregnancy hand held notes.

If a change occurs at anytime during the pregnancy it should be clearly recorded as above

If further advice is required in order to identify the appropriate Lead care professional, the midwife will discuss this with the Community Team Manager or Senior Antenatal Clinic midwife.

6.8 Individualised Management Plan

An individual management plan will be developed for any woman in whom risks are identified during pregnancy. This will be documented on the management plan page in the pregnancy hand held notes and reviewed at each visit.

At a minimum this must include:

- Risk Factor(s)
- Who to refer to (Consultant / Specialist Team or services)

Further information will be documented as required, to include;

- Additional investigations and tests
- Follow up required

If the woman refuses to follow medical advice this will be discussed with her by the medical team and documented in the health records.

This management plan will vary between patients depending on their risk factors. The management plan can change throughout pregnancy and so clear documentation on the 'Management Plan' page in the pregnancy hand held notes and the hospital case notes is essential.

The Trust 'Alert sheet' located at the front of the hospital case notes must be reviewed for any recommended actions.

Each time the plan of care is reviewed it should be documented.

If, for any reason a woman does not receive care due to failures in the processes:

Incident Form Trigger

6.9 Referral for Initial Antenatal / Scan Appointment

Along with the booking history, the hospital will simultaneously send out a scan and antenatal appointment. Access to this appointment will be via:

- Choose and Book
- Letter from GP/ Community midwife
- Letter from Community Midwife if direct referral by woman

(Appendix D)

Referral by Choose and Book

- After the woman has seen her GP and a request made to be booked at Birmingham Women's Hospital through the on-line Chose and Book System the woman will phone the Booking Office for an appointment.
- When on-line referral letter is received the booking office staff will check with the clinic midwife, to make sure the appointment was for the correct clinic and alter if necessary.
- Referrals are processed (Mon-Fri) by a senior antenatal clinic midwife and stamped with a type of clinic stamp i.e. MLC, consultant, or specialist clinic.
- If women who are accepted for care are more than 12 completed weeks gestation, they will receive an appointment within 2 weeks.
- Women will then receive an appointment by post.

Referral letters from GP /Community Midwife

- All referral letters/faxes are processed through the Medical Records booking office, and are date stamped on arrival.
- Referrals are processed (Mon-Fri) by a senior antenatal clinic midwife and stamped with a type of clinic stamp i.e. MLC, consultant, or specialist clinic.
- If women who are accepted for care are more than 12 completed weeks gestation, they will receive an appointment within 2 weeks
- Women will then receive an appointment by post.

6.10 Initial antenatal / scan appointment

- An USS is offered to all women to determine viability, gestational age and multiple pregnancy. It confirms the EDD and reduces the incidence of induction of labour for prolonged pregnancy. (NICE 2008)
- If dating scan done in community**,** Dating at 14 weeks and over (with CRL greater than 84mm) should be dated by HC now and not BPD. The measurement should be taken on the newer transventricular section rather than the previously used transthalami. (see link below to the relevant page on BMUS showing details.)
- http://www.bmus.org/policies-guides/23-17-3-161_ultBMUS.pdf
- Maternal height and weight should be measured to calculate body mass index (BMI) (weight (Kg) height (M^2). This will be documented in the pregnancy hand held records, the main hospital notes and the electronic records. Refer to the Raised BMI Guideline for further guidance.

- Ethnic origin plus EDD and birth weights of previous babies will be used to produce a customised GROW chart which is inserted into the green hand held notes
- A mid-stream specimen of urine (MSU) is obtained and sent to Microbiology Asymptomatic bacteriuria with treatment reduces the risk of pyleonephritis. (NICE 2008)
- Routine booking bloods should be taken, and the woman advised how she will obtain the results.
- Women will be advised regarding further antenatal clinic appointments for 16, 20 and 28 week appointments.
- Explain frequency and importance of antenatal check-ups using the pregnancy planner in the hand held notes.

6.11 Antenatal Screening

Refer to the Antenatal Screening Guideline for further details.

6.12 Communication of Any Test Results

- All specimens are processed either at Birmingham Women's Hospital, Birmingham Children's hospital or by NBS.
- Results when available are put online on the respective computer systems. Clinicians can access the results on line and print reports.
- Hard copy reports are also generated by the laboratories. For more details on screening for full blood count results see Appendix F.

Process for reporting results to women

For routine antenatal screening results please refer to the Antenatal Screening Guideline.

For any additional tests, the woman will be informed that she will be contacted if the result is abnormal, and normal results will be given at her next appointment.

6.13 Frequency of Antenatal Contacts

Early in pregnancy, all women should receive written information about the likely number, timing and content of antenatal appointments. For women with an uncomplicated pregnancy, the following visits should be adequate If additional visits are required, please document the reason for the extra visit (s):

Nulliparous 10 appointments. (NICE 2008)
Multiparous 7 appointments. (NICE 2008)

Suggested Timings.

Nulliparous: Booking by 12 completed weeks: 15-16wks; 20 weeks; 25; 28; 31; 34; 36, 38, 40.

Multips: Booking by 12 completed weeks: 15-16wks; 20 weeks scan only; 28; 32; 36, 38, 40.

For women with complications, additional visits will be determined on an individual assessment, and an appropriate plan of care made by their lead professional. Refer to appropriate guidelines

16 weeks

- Review, discuss and record results of all booking screening tests undertaken; reassess planned pattern of care for the pregnancy and identify women who need additional care. Review BMI.
- Triple Test offered & taken
- Investigate a haemoglobin below 10.5g/dl and consider iron if indicated.
- Measure blood pressure and test urine When taking blood pressure, consideration should be given to size of cuff and type of machine used. A large cuff should be used where appropriate.
- Encourage attendance at parent education classes

18-20 weeks appointment

- Women booked under the care of a community team will usually have an USS appointment only and will then see their midwife later. If any problems are identified on the scan, they will be referred to ANC for advice. Increased Liquor Volume on USS – Refer for immediate consultant obstetrician opinion.
- Low placenta on USS. If the woman has a low lying placenta identified at 20/40 she can remain under midwifery care if otherwise suitable. A repeat USS will be done at 36 weeks. For the woman to access the birth centre, it should be documented on the USS report that the placenta is upper segment.
- Women booked under a consultant will have an antenatal clinic visit as well as a scan. Booking blood results will be discussed and also their individual plan of care confirmed.
- Mat B1 certificate to be given after 20 weeks.
- Reweigh at 20 weeks

25 weeks (usually nulliparous women only)

- Measure blood pressure and urine
- Review BMI
- Assess fetal well being,
- Health in pregnancy grant form to be completed

28 weeks

- Offer screening for anaemia and antibodies
- Offer anti-D prophylaxis for rhesus-negative women
- Measure blood pressure and test urine
- Reweigh ,
- Review BMI. If BMI 40 or above, need anaesthetic assessment.
- Measure and plot symphysio-fundal height on the customised GROW chart (Appendix E)
- Book post dates appointment
- Health in pregnancy grant form to be completed if not already done.

31 weeks (usually nulliparous women only)

- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the customised GROW chart
- Assess fetal well being
- Review, discuss and record the results of screening tests undertaken at 28 weeks. Review haemoglobin below 10.5 g/dl and consider iron if indicated

32 weeks (usually multiparous)

- If USS at 20/40 identified a low lying placenta, a repeat USS will be done at 32 weeks.
- For Midwifery Led Women: If the placental location is other than 'upper segment', refer to consultant led care for the next available appointment.
- Review, discuss and record the results of screening tests undertaken at 28 weeks. Review haemoglobin below 10.5 g/dl and consider iron if indicated
- Assess fetal well being

34 weeks

- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the customised GROW chart
- Assess fetal well being
- Discuss preparation for labour and birth including coping with pain in labour and birth plan. Recognition of active labour (34-36 weeks)

36 weeks

- Home assessment may be done by community midwife. The midwife should take into account the home conditions considering the suitability for a new baby to be transferred home:
- Preparations made for the arrival of the new baby – including sleeping arrangements for the baby.
- Home heating
- Social support available
- Level of deprivation/ poverty
- Arrangements for the care of siblings whilst the woman is giving birth (home or hospital).
- A record of the assessment should be made in the hospital/ hand held records.
- If there are concerns these should be discussed with LNMSC.
- Discuss: Breastfeeding information, including good technique and good management practices which would help women to succeed (www.babyfriendly.org.uk).Care of the newborn baby, cot death and cot safety, Vitamin K, postnatal self-care, awareness of postnatal blues and depression and document on page 19 & 21 hand held notes.
- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the customised GROW chart
- Assess fetal well being & fetal presentation (suspected malpresentation – refer for USS and consultant clinic appointment). For women with a breech presentation, medical staff may offer external cephalic version .

- Review place of birth again with the woman. (See Appendix B for Birth Centre suitabilility) If Midwifery led care, encourage woman to book tour of the Birth Centre ☎ 0121 627 2748.
- Check contact details for labour have been given.

38 weeks

- Discuss: Options for prolonged pregnancy and risks associated of pregnancy beyond 42 weeks.
- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the customised GROW chart
- Assess fetal well being

40 weeks

- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the customised GROW chart
- Assess fetal well being
- Offer a VE for membrane sweeping.

41 weeks

- Women with uncomplicated pregnancy should be offered induction of labour beyond 42 weeks (T +12)
- A membrane sweep should be offered for all women (repeat sweep recommended for Nullips).
- Measure blood pressure and test urine
- Measure and plot symphysio-fundal height on the recognised GROW chart
- Assess fetal well being

For additional information of the Management of Post Dates women see the Membrane Sweeping Guideline and/or the Induction of Labour Guideline.

Consultant-Led women

In addition to the antenatal visits above, these women will have additional visits depending on clinical need. These may include additional scans, discussion re mode of delivery etc. These must be clearly documented in the hand held notes and the individual management plan of care documented in the antenatal section of the patient notes and reviewed at each visit. It may be helpful to print out a specialist care plan, if available and put into the hand held notes.

NB: Women who are booked under the specialist fetal medicine team, whose babies when delivered may have problems, require an antenatal discussion with the paediatricians, so that a plan of care can be agreed. (See policy for referral when a fetal abnormality is detected.)

6.14 Antenatal / Labour Patient Information

Information should be given in a way that is easy to understand and accessible to pregnant woman with additional needs, such as physical, sensory or learning disabilities and to pregnant women who do not speak or read English. (NICE 2008)

At appropriate times, relevant information should be discussed with women.
It is important for clinical staff, midwives and medical staff, to document clearly the discussion and provision of information to women as clinically indicated in the health records. The 'Preferences for Birth' page in the pregnancy handheld notes must be used to facilitate this where appropriate.

Please refer to Appendix G for a list of patient information topics and schedules for discussion.

6.15 Access to Interpreters and Link Workers

If there are communication or language support needs then the clinical staff should seek additional support as individually required e.g. interpreters, link workers, interpreting phone, use of signers. Please refer to Trust Use of Interpreting Services Policy & Procedures.

6.16 Missed Appointments

If a woman does not attend for antenatal care refer to the trust DNA Policy.

6.17 Specialist Midwifery Services

Safeguarding / social Issues

Emerging themes from Serious Case Reviews have shown that social factors have contributed to poor outcomes for both mother and baby. (Standards for maternity Care 2008) For women identified with social related problems there is a need for a risk assessment to be undertaken at booking, with further ongoing assessment throughout the pregnancy. Consideration needs to be given into implementing a Common Assessment Framework (CAF), with the woman's consent, in order to introduce a supportive package of care. Consideration also needs to be given as to the need to an interagency referral to Children's Social Care.

Examples of risk factors include:

- Previous or current Children's Service involvement
- Learning disabilities
- Domestic abuse
- Substance misuse
- Concealed pregnancy
- Voluntary adoption
- Persons Posing a Risk to Children

This list is not exhaustive & further guidance should be sought from the appropriate professional/ agency (BSCB/ Trust policy entitled 'safeguarding children policy').

Staff must discuss and seek advice & supervision from the Lead Nurse/Midwife for safeguarding. (LNMSC.)

Identified learning disabilities may affect a woman's capacity to consent. A referral should be made to a consultant obstetrician if mental capacity is a concern.

These women should not routinely be excluded from using the Birth Centre. Ssee Appendix B for Birth Centre suitability).

Consideration should be given to the risk factors. Vulnerable women are more likely to fail to attend antenatal appointments regularly (NSF, 2004).

If a midwife has concerns for the welfare of an unborn baby enquiries / referral must be made with Children's Social Care Services (BSCB, 2009)

Working Together – Midwife must share information with appropriate agencies and professionals where there are concerns (Working Together, 2010)

Child Protection

An individualised approach should be used when making an assessment regarding place of birth. This should be in partnership with the woman and include an assessment of risk. A discussion should take place with the LNMSC and social worker. An individualised plan of care should be documented in the Family Supplementary Record (FSR).

Factors to consider:

- Issues of known violence and/or aggression – including domestic violence.
- Past history of childhood sexual abuse.
- Individuals 'Posing a Risk to Children' (PPRC). This will largely depend on who the offender is and current contact with the woman. Case must always be discussed with LNMSC to determine the risk.
- Child Protection Plan – generally, but not exclusively, babies who have a plan that specifies the child will not be discharged home into the care of the parents should not deliver on the Birth Centre. Discuss individual cases with the LNMSC.
- Women who use cannabis should not be excluded from the BC **unless** she appears to be under the influence of drugs at the time of her arrival in labour. Use discretion re appropriateness of the pool for labour and birth, bearing in mind all aspects of her history and pregnancy.
- Teenagers under the age of 16 years are excluded from the Birth Centre.

Drug & Alcohol Users

At first booking all women should be asked about routine drug use, illicit drug and alcohol use and given appropriate advice. Due to the increased risks of complications these women should be transferred to consultant care and also referred to the Specialist Midwife for Drug/Alcohol Misuse and Smoking Cessation. A multi agency clinic is run every Tuesday morning at which the woman may be seen by the specialist midwife, a specialist drug worker and the obstetrician. Women with concerns about previous drug or alcohol use may also be referred to the specialist midwife for advice and assessment. Some women may be fearful of disclosing drug or alcohol use in pregnancy. Appropriate advice and monitoring during pregnancy has been shown to significantly improve the outcome for both mother and baby. The maternal pregnancy notes allow for a minimum of 2 further assessments to be made during the pregnancy and advice referral made as appropriate.

(See Guideline for the Management of Women with Problem Drug Use Attending for Antenatal Care)

Teenage Pregnancy

At booking a Birmingham Teenage Pregnancy Midwives (BTPM) referral form should be completed for all teenagers aged 19 years and under at booking and sent to the Specialist midwife for Teenage Pregnancy. All Teenagers less than 16 years at booking should be transferred to consultant care to be seen at the specialist consultant clinic on a Wednesday afternoon under the care of the Teenage Pregnancy Specialist Midwife and a Consultant. Pregnant Teenagers aged 16-19 years with any social risk factors should also be referred for additional support.

(See Guideline for the Management of Pregnant Teenagers)

Social History relating to Domestic Violence

Health care professionals need to be alert to the symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment in which they feel secure. Midwives should ask the question:

"I am sorry if you have been asked this question before. According to research 1 in 4 women experience domestic violence in their home during their lifetime, and many cases start during pregnancy. It can take many forms, including physical, sexual, emotional, financial control, mental or emotional abuse so we are now routinely asking every woman about domestic violence".

Other suggested examples can be found in Domestic Violence guidelines.

The question should be timely and individualised with the women on her own. If there is sensitive information to record '✓ the box at the top of page 2 in the handheld notes. Also record information on the hospital clinic summary sheet. It is the midwives responsibility to file this sheet in the hospital case notes.

Mental Health

Refer to BWNFT guideline for management of women with mental health concerns attending for maternity care

6.18 Health / Lifestyle Information

The majority of women can be reassured that it is safe to continue working in pregnancy. A woman's occupation during pregnancy should be ascertained to identify those who are at increased risk through occupational exposure.

Pregnant women should be informed of their maternity rights and benefits.

Smoking Cessation Advice

At the first contact with the woman, discuss her smoking status, provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking.

Pregnant women should be informed about the specific risks of smoking during pregnancy (such as the risk of having a baby with low birth weight and preterm birth). The benefits of quitting at any stage should be emphasised. All women who currently smoke or who have quit in the last 2 weeks should be referred to NHS Stop Smoking Services. If a partner or other household member smokes they should also be offered referral to NHS Stop Smoking Services. If a woman declines referral this should be accepted in an impartial manner and the offer of help left open.

Routine CO (carbon monoxide) monitoring is offered at booking to all women and allows a woman to see a physical measure of her smoking and exposure to second hand smoke. Women with a CO reading of 7 ppm or above regardless of smoking status should also be referred to NHS Stop Smoking Services. If a woman has a high CO reading, (above 10ppm) but states they do not smoke, advice should be given about possible CO poisoning and they should be advised to contact the free Health and Safety Executive gas safety advice line on: 0800 300 363.

The woman's smoking status and whether a referral has been accepted or declined should be recorded on page 2 of the hand-held pregnancy notes. Carbon monoxide levels should be recorded on page 19 of the hand-held notes.

At subsequent appointments the midwife should check if the referral was taken up and offer another referral. This again should be recorded in the pregnancy hand-held notes.

Breastfeeding

Every opportunity must be taken to talk positively and encouragingly about breastfeeding and skin to skin, irrespective of identified intended feeding method. It is hoped that if the mother identifies her wish to artificially feed her baby, she may be encouraged to change her mind before or immediately after the baby is born.

There are two strands to these conversations: why breastfeeding is important and how to get started.

NB Skin to skin is recommended for all babies, irrespective of chosen feeding method.

The mother will be informed that she will have an opportunity to discuss feeding later on in the pregnancy. This is for all women, even if they have identified that they currently want to artificially feed, in order that she may make an informed decision about her feeding choices

20 -28 weeks

- The mother will be given the BWH leaflet "Your new baby – off to a good start". This is recorded on the front of the A/N notes with a sticker/stamp bearing the breastfeeding logo.
- The mother will be given the DVD "From Bump to Breastfeeding" either in the community or at BWH ANC. This will be recorded on the front of the AN notes by writing "DVD"

Between 32 and 36 weeks

- The mother will have a discussion with the midwife, wherever this may take place, i.e. in her home, at a community clinic or in ANC/antenatal ward at

BWH. This must include a full discussion of all the points listed on page 19 of the AN notes. This must be fully documented on this page. The mother has to be able to recall the basic elements of this discussion.

Nutrition

All women are given BWNFT Leaflet,' Pregnancy and your weight.'
Referral to Dietician Criteria:

- Low BMI below 18
- High BMI above 35
- History of poor diet
- Underlying medical conditions.
- Complete a dietician referral form.

Vitamin D:

- All women should be informed at the booking appointment about the importance for their own and their baby's health of maintaining adequate vitamin D stores during pregnancy and whilst breastfeeding. In order to achieve this, women may choose to take 10 micrograms of vitamin D per day, as found in the Healthy Start multivitamin supplement. Particular care should be taken to enquire as to whether women at greatest risk are following advice to take this daily supplement. These include:
- women of South Asian, African, Caribbean or Middle Eastern family origin
- women who have limited exposure to sunlight, such as women who are predominantly housebound, or usually remain covered when outdoors
- women who eat a diet particularly low in vitamin D, such as women who consume no oily fish, eggs, meat, vitamin D-fortified margarine or breakfast cereal
- women with a pre-pregnancy body mass index above 30 kg/m^2 (NICE 2007)
- Folic Acid
- Pregnant women should be advised that folic acid prior to conception and throughout the first 12 weeks, reduces the risk of neural tube defect. The recommended dose is 400mcg per day (if previous neural tube defect, diabetic or epilepsy 5mg needs to be prescribed).
- Complete checklist for nutrition.
- Referral to Dietician. (After booking or as required.)

Exercise

- Routine exercise in pregnancy should be encouraged.
- Women should be advised to continue with any exercise as long as they feel well.
- Aqua-natal classes available.

Hygiene

Good hygiene is important in preventing acquisition of infections including group A streptococci, and also in protecting against transferring the bacterium to the genital tract where it is likely to cause serious infection. Women should be advised to:

- Wash their hands carefully before and after going to the toilet or changing pads
- Seek medical advice if they or another household member develops cellulites, or has a sore throat that is unusually severe &/or persists for more than 48 hours.
- Avoid close contact with anyone who has been diagnosed with group A streptococcal infection until they have received antibiotics for at least 24 hours

6.19 Handover of Care and Transfer

Refer to the Handover of Care and Transfer Guideline for details.

7. Review, Monitoring, and Revision Arrangements

All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to	Action Plan Review
• Responsibility of relevant staff groups • Process for ensuring that women have their first full booking visit and hand held notes completed by twelve completed weeks of pregnancy • Process for ensuring that women who on referral to the maternity service are already 12 or more weeks pregnant are offered an appointment to be seen within 2 weeks of the referral • Process for ensuring that migrant women who have not previously had a full medical examination in the UK have a medical history taken and clinical assessment made of their overall health, using an interpreter if necessary • Process for identifying for which women health records from previous pregnancies are required for review by clinicians	Audit	Annual	Jenny Henry, Head of Midwifery	Antenatal Group	Antenatal Group

• Process for arranging the availability of health records for women for which helath records from previous pregnancies are required for review by clinicians					
• Timing of risk assessments • Following to be considered during risk assessment: o Medical/anaesthetic/psychiatric history o Factors from previous pregnancies o Lifestyle history o Those who decline blood products • Risk assessment for appropriate place of birth • Development of an individualised management plan available for woman in whom risks are identified during the clinical risk assessment • Process for referral of women in whom risks are identified during the clinical risk assessment • Process for referral back to midwifery led care if appropriate	Audit	Annual	Jenny Henry, Head of Midwifery	Antenatal Group	Antenatal Group
• Schedule of when the information should be given • Process for providing information to women who have communication or language support needs • Maternity services expectation of staff to document clearly in the health records the information given to women as clinically indicated, in relation to: o Place of birth options o Antenatal screening tests o Induction of labour o Fetal monitoring in labour o Pain management in labour (including	Audit	Annual	Jenny Henry, Head of Midwifery	Antenatal Group	Antenatal Group

regional anaesthesia) ○ General anaesthetic ○ Vaginal birth following caesarean section ○ Caesearean section ○ Perineal repair ○ External cephalic version ○ Vitamin K prophylaxis ○ Women who decline blood and blood products					
Actions resulting from deficiencies identified from any of the above.	Review	As specified in audit report	Jenny Henry, Head of Midwifery	Antenatal Group	Antenatal Group

7.1 Booking Appointments Audit Proforma

Patient ID Number:

Delivery Date:

	Yes	No	N/A
Booking Appointment			
Was it documented in either the community midwife's appointment diary or the GP appointment system that the community midwife contacted the woman by phone to arrange a home visit before twelve completed weeks of pregnancy?			
Were the pregnancy handheld records completed by twelve completed weeks of pregnancy?			
If the woman was more than 12 completed weeks when accepted for care, was the referral letter stamped and dated, an appointment offered and pregnancy handheld records completed within 2 weeks of this date?			
Initial antenatal / Scan Appointment			
Did the Medical Records Booking staff date and stamp the referral letter on arrival?			
Was the EDD estimated and documented?			
Was the letter stamped with a type of clinic by the ANC Midwife?			
Did the woman receive an appointment prior to 12 completed weeks.			
If the woman was more than 12 completed weeks when accepted for care, did she receive an appointment within 2 weeks of referral?			
Migrant Women			
If a migrant mother has not previously had a full physical examination, was a referral to the GP/Medical Staff for a full physical examination documented on the Medical History page of the pregnancy hand held notes?			
Was a Physical Examination documented in the pregnancy hand held records?			
Accessing Notes			
If one of the following problems was identified with the woman's obstetric history and details were with another Trust/GP surgery, was a letter completed to request the records: • Previous Stillbith or Neonatal Death • Previous Caeasarean Section where there is uncertainty re the type, i.e. classical incision. • Recurrent miscarriage (3 or more) • Previous baby with congenital anomalies • Extreme prematurity (less than 28 weeks gestation)			

7.2 Clinical (Antenatal) Risk Assessment Audit Proforma

Patient ID Number

Delivery Date:

	Yes	No	N/A
Risk Assessment			
Was a risk assessment documented in the risk assessment section of the pregnancy hand held notes at booking?			
Were medical conditions as in Appendix A, including anaesthetic and psychiatric history considered and documented in the pregnancy hand held notes?			
Were factors from previous pregnancies considered and documented in the pregnancy hand held notes?			
Was lifestyle history considered and documented in the pregnancy hand held notes?			
Was the woman asked about previous blood transfusions, including declining the use of blood and blood products?			
If the woman declined the use of blood and blood products, was the special features section of the pregnancy hand held notes completed?			
Was the planned place of birth documented on the front of the pregnancy hand held notes?			
Risks identified			
Was an individualised management plan documented in the health records where risks were identified? As a minimum this must include; follow up required and who to refer to (Consultant / Specialist Team or services)			
Was the need for referral to Consultant documented on the management plan page in the pregnancy hand held notes			
At the next antenatal appointment / dating scan was an appointment made for a consultant clinic and recorded on the back page of the pregnancy hand held notes			
Was the Lead Care Professional identified on the front of the pregnancy hand held notes?			
If the woman was referred back to MW Led Care was the Transfer documented on the front of the pregnancy hand held notes?			
Do the printed label sheets within the health records identify the correct Lead Professional?			
Were all routine booking results documented on the results page in the pregnancy handheld notes?			
Were any abnormal results relating to mid stream urine, blood group, antibodies and full blood count reviewed and actioned by the Midwife.			

7.3 Patient Information Audit Proforma

Patient ID Number:

Date of Delivery:

Were any communication needs identified: Yes No

If yes, was the appropriate provision made, i.e. interpreter: Yes No

Were the following topics discussed and documented in the health records if appropriate:

At Booking:

Topic	Yes	No	N/A	Gestation discussed:
Antenatal screening tests-verbal information documented in the pregnancy hand held notes.				
Advanced Directive signed and filed in the Maternity Hospital notes (at initial contact with medical staff)				

28-34 Weeks

Infant Feeding- verbal information and leaflet documented on preference for birth page.				

From 28 weeks gestation

Place of birth options including information on locally provided services – verbal information documented in the pregnancy hand held notes on the preferences for birth page.				
Perineal Repair - verbal information documented in the pregnancy hand held notes on the preferences for birth page.				
Labour Information, including Fetal monitoring - verbal information documented in the pregnancy hand held notes on the preferences for birth page.				
Pain management in labour (including regional anaesthesia) - verbal information provided and documented in the pregnancy hand held notes on the preferences for birth page.				
Vitamin K prophylaxis - Leaflet and/or verbal information provided and documented in the pregnancy hand held notes on the preferences for birth page.				

28 weeks onwards, if clinically indicated.

Caesarean section - leaflet provided and documented in the health records				
Vaginal birth following caesarean section (VBAC) – leaflet provided and documented in the health records				

36 Weeks onwards, if clinically indicated.

General anaesthesia verbal information provided and documented in the health records on the Pre-operative assessment				
External cephalic version (ECV) – leaflet provided and documented in the health records				

40 Weeks onwards

Induction of Labour- leaflet provided (if applicable) and documented on the IOL proforma if available in the maternity the health records				

8. Associated Documents

- Antenatal Screening Guideline
- DNA Policy
- MRSA Screening Policy
- Guidelines for the prevention and treatment of venous thromboembolic disease for referral
- Guideline for management of women with mental health concerns attending for maternity care
- Homebirth guideline
- Induction of labour guideline
- Guidelines for the Management of Pregnant Teenagers
- Use of Interpreting Services Policy & Procedures
- Blood Transfusion Policy
- Fetal Medicine: policy for Referral when a fetal abnormality is detected
- Vulnerable Adults Policy
- Safeguarding Children Policy
- Raised BMI Guideline

9. References

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Appendix A – Planning Place of Birth / Lead Care Provider

Women should be offered the choice of planning birth at home, in a midwife led unit or in an obstetric unit

The following medical conditions indicate increased risk of complication, suggesting planned birth in an obstetric unit. Locally, this means that the woman should be booked under the care of an obstetrician and seen at 20 weeks .

Recommended place of birth: obstetric unit

Disease Area	Medical Condition
Cardiovascular	Confirmed cardiac disease, Hypertensive disorder
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic Fibrosis
Haematological	Haemoglobinopathies-sickle cell disease, beta thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100 Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests HIV positive Toxoplasmosis-women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Endocrine	Unstable hyperthyroidism Diabetes
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia Gravis Previous cerebral Vascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests Inflammatory bowel disease (e.g. crohn's) if previous surgery or on steroids/ASA
Anaesthetic	Any previous problems with general/local anaesthetic
Genetic	Medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
Psychiatric	Psychiatric disorders requiring current inpatient care
Factor	Additional Information
Previous Pregnancy Complications	Unexplained stillbirth/neonatal death of previous death related to Intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine Rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion

	Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia Previous baby less than 10th centile need consultant care and serial growth scans.
Current Pregnancy	Multiple pregnancy (refer to multiples clinic) Placenta previa or low lying placenta less than 5cm from the os Pre-eclampsia or pregnancy induced hypertension Preterm labour or prelabour rupture of membranes Placental abruption Anaemia-Hb less than 8.5 g/dl at onset of labour Confirmed intrauterine death Onset of gestational diabetes Malpresentation-breech or transverse lie Body mass index at booking greater than 35 kg/m^2 Recurrent antepartum haemorrhage Fetal Abnormality (refer to fetal medicine team) Teenager less than 16 years at booking Proteinuria on 2 occasions not associated with UTI
Fetal Indications	Small for gestational age in this pregnancy less than 10th centile or reduced growth velocity/oligo/polyhydramnios on ultrasound Abnormal fetal heart rate
Gynaecological	Hysterotomy

Recommendation: Individual assessment when planning place of birth

NB: Locally the midwife should consider whether the woman can remain under midwife led care or needs transfer to obstetrician)

Disease area	Medical condition
Cardiovascular	Cardiovascular disease without Intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle cell /Thalassaemia trait Anaemia -Hb 8.5-10.5 at onset of labour Thrombo-embolism
Infective	Hepatitis B/C with normal liver function tests
Immune	Non specific connective tissue disorders Autoimmune/antiphospholipid disease
Endocrine	If the woman has a normal thyroid function test at booking and 28 weeks and the fetal growth is within normal limits - refer back to midwife led care and have access to the birth centre if she otherwise fulfils the criteria.
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis
Previous complications	These are usually consultant led until this pregnancy confirmed as ok. Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome Previous baby >4.5 kg Extensive vaginal/cervical or 3rd /4th degree perineal trauma Previous term baby with jaundice requiring exchange transfusion Fetal anomaly

	Mid-trimester loss/stillbirth/neonatal death: Recurrent miscarriage (3 or more) Birth weight <2.5kgs (at term) / > 4.5Kgs Preterm birth Rhesus disease Cholestasis
History of confirmed pre-eclampsia	Suggest regular antenatal contacts particularly late pregnancy i.e weekly. Advise woman of symptoms to look for. If no proteinurea and B/P <140/90 can remain midwife led care.
Raised AFP on triple test	Woman is reviewed by antenatal screening midwife and automatically referred for detailed ultra-sound scan. This is followed up at 24 weeks with uterine Doppler's – If these are abnormal will need transfer to Consultant care.
Malignancy	Individual care planning
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks) Blood pressure 140 mmHg systolic or 90mmHg diastolic on 2 occasions at least four hours apart Clinical ultrasound suspicion of macrosomia Para 6 or more Age over 40 at booking Proteinuria on 2 occasions not associated with UTI
Fetal Indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or loop excision of the transformation zone Fibroids – 4cm or less-unlikely to be a problem. If 4cm or more or numerous fibroids - refer to obstetrician for opinion. Observe symphysio-fundal height, exclude polyhydramnios clinically/unstable lie Or if fibroid appears to be below head at term Cervical/uterine surgery(seek consultant opinion) Current STD (receiving treatment) (seek consultant opinion)
Mental Health	Any major psychosis, major psychiatric drugs, ongoing risk of self-harm should have on-going assessment with mental health team then decide optimal place of birth (see management of women with mental health concerns attending for maternity care guideline)
Substance and or alcohol misuse	Individual plan
Myomectomy	Some myomectomies don't pose a risk of uterine rupture check with gynaecologist
FGM	Sensitive enquiry. A/N examination to enable planning for birth.

This has been adapted from NICE Intrapartum Guideline (2007)

Appendix B – Birth Centre Suitability

In principle: we accept all women who do not require continuous fetal heart rate monitoring during labour with a well grown baby and no history of concern. For women who have additional medical/fetal concerns - should have had an AN opinion or consultant clinic appointment to agree a plan care
Please refer to relevevant guidelines on the intranet for more information

Issue	Comments	We accept
PROM	Antibiotics recommended in labour CEFM & IV antibiotics at 24 hours recommended	PROM in spontaneous labour or labour with Propess up to 72 hours. If woman declines CEFM - accept for BC up to 72 hours (pool still an option) if no sign of infection and all else normal IV antibiotics on BC if woman's choice
Low placenta		Placenta 5cm or more from the os
Fibroids		4cm or less-unlikely to be a problem. If 4cm or more or numerous fibroids - refer to obstetrician for opinion. Observe symphysio-fundal height, exclude polyhydramnios clinically/unstable lie.
Hypothyroidism		Only women who have had consultant agreement for the BC (usually women who are stable at booking & thereafter).
Women over 40 years	Primips Multips	**Only** if they have attended Opinion clinic following an individual assessment If otherwise suitable
GBS	Antibiotics needed ONLY if GBS positive this pregnancy or previously affected child with GBS. BC staff should aim to complete IV drug package and canulate. Otherwise ask triage/DS/medics to canulate and give antibiotics	Women with GBS this pregnancy or previously affected child with GBS. Can use the pool and keep canulae dry (otherwise it will need to be recited). Pink canulae acceptable.
Hepatitis B positive	There is a care pathway for hepatitis positive surface antigen negative women initiated in ANC. All of these	Hepatitis B positive **(surface antigen negative only)** who has attended the opinion clinic

	women are seen in the opinion clinic at 36 weeks (referred by the AN screening midwives).	AN & had the pathway completed
Post dates IOL PROM IOL (see in conjunction with PROM guideline)	IOL for post dates accepted up until 40+14/40	Following Propess - needs to have had a normal CTG once regular contractions. Also needs to be contracting regularly and in labour before BC suitable. Not excluded from birth in the pool
Raised AFP	Is associated with potential growth restriction & abruption.	Unsuitable for the BC as CEFM indicated.
Grande multips (5th baby or more)	Check previous history	If no history of PPH
Jehovah's Witnesses	Usually seen in the opinion clinic Hb 36 weeks to optimise Advance directive to have been signed by medical staff	Inform anaesthetist and obstetrician when in labour Advise active 3rd stage
Large Baby	Only needs USS if polyhydramnios suspected. Advise hospital birth BC suitable if estimated weight 4500kg or less.	In Labour adhere to 1st stage guidelines Be alert to significance of slow progress in 1st & 2nd stage. Please advise out of the pool for the birth. Notify registrar on DS when in 2nd stage
Mental Health Issues	Accept history of depression on medication. Ideally needs mental health links	If on medication suggest out of the pool for birth because of the unknown side effects of the medication on the baby.
Child Protection	Individual approach.	We usually accept women unless the partner is abusive (reduced numbers on BC) or babies who need to be removed at birth.
Cannabis /drug/user	Women who use cannabis should not be excluded from the BC **unless** she appears to be under the influence of drugs at the time of her arrival in labour	Use discression re appropriateness of the pool for labour and birth, bearing in mind all aspects of her history and pregnancy.
Increased liquor volume at any point in the pregnancy	• Needs to have had GTT/TOXO/CMV screen which are negative (old infection is ok for the	Latest liquor volume needs to be 'normal' and not raised i.e. 8cm or below

	BC i.e. IgG positive, IgM negative. If not old infection then unsuitable). • A fetal medicine USS needs to have been done to confirm a structurally normal baby	

We do not accept		
Women beyond 42 weeks	Needs CEFM	Unsuitable for the BC
Child protection Issues that require the baby to be removed at birth		Unsuitable for the BC

If midwife considers woman possibly suitable for the BC but requires medical opinion, please consult with an SPR or above as a minimum. The decision to accept must then be written in the case notes by the SPR.

Appendix C – Standard Letter to Request Notes

Birmingham Women's NHS
NHS Foundation Trust

Antenatal Clinic
Birmingham Women's Foundation Trust
EDGBASTON
Birmingham
B15 2TG

FAO:
Medical Records Manager
(Ask switchboard for the contact number of the trust to obtain address)

Date

To whom it may concern

We are in the process of planning care with *(women's name)* and we are requesting additional information to assist us in the development of that plan.

Please could you provide us with information of her previous pregnancy(s) from your health records, as below:

- ❒ Pregnancy
- ❒ Labour and delivery
- ❒ Postnatal
- ❒ Neonatal

Name: *(when she had her baby at that trust)*
DOB:
NHS Number:
Address of woman *(when she had her baby at that trust)*
Date of Delivery

It would be really helpful if you could send this information before her next antenatal clinic appointment which is planned for …… .

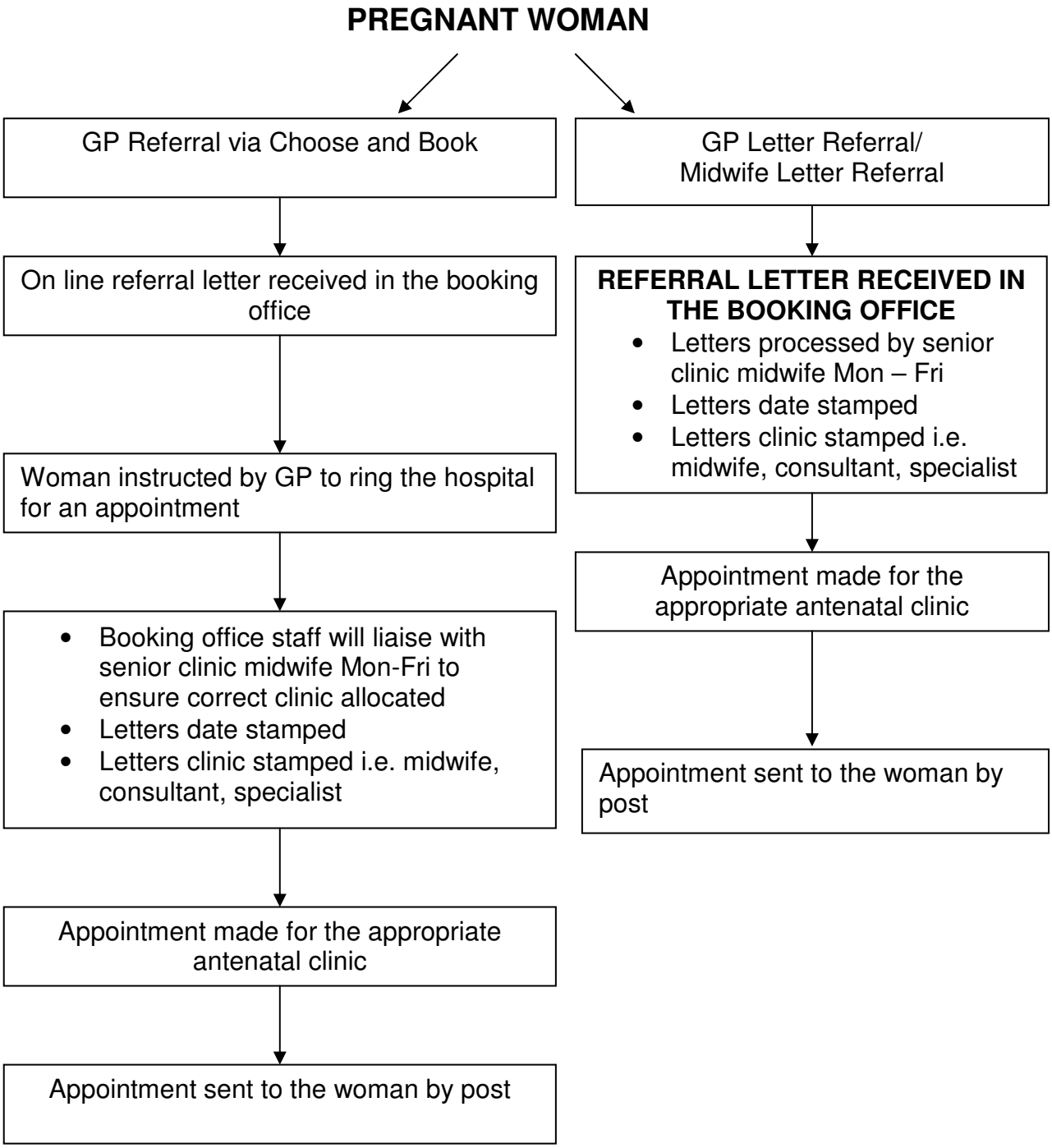
Yours sincerely

Your signature
Print Name

NB: please copy and paste this letter, complete the info in *italics* and delete *italic* prompts before sending!

A copy of the completed letter must be put in the woman's medical records.

Appendix D – Process for referral for antenatal / scan appointments.



NB. IF WOMEN ARE GREATER THAN 12 COMPLETED WEEKS GESTATION THEY WILL RECEIVE AN APPOINTMENT IN THE POST WITHIN 2 WEEKS

Appendix E – GROW Charts, Guidance for Midwives

Please refer to IUGR Detection Guideline for further information.

- The GROW charts should be generated by community team / hospital and be available in the hand held notes before 20 weeks.
- Fundal height measurements from 26 to 28 weeks.
- Mother semi-recumbent and bladder empty.
- Measurements to monitor growth should be every 2-3 weeks, preferably by same person.
- Hold non-elastic tape at top of uterine fundus.
- Measure to top of symphysis pubis.
- Measure along longitudinal axis and plot on chart.
- Referrals for growth scan* should be arranged if:
    - the first fundal height measurement plots below the 10th centile on the customised chart
    - consecutive measurements suggest;
        - NO growth (static or flat curve) or
        - SLOW growth (curve not following slope of any curve on the chart) or
        - EXCESSIVE growth (curve steeper than any curve on the chart)

*ultrasound biometry for estimated fetal weight (EFW) and amniotic fluid assessment (plus Doppler flow if scan suggests growth problems.)

Note: A first measurement above the 90th centile lone does NOT need referral for scan for LGA, unless there are other clinical concerns –e.g. polyhydramnios.

Following Ultrasound, if the assessment is:
1. Normal ….. revert to serial fundal height measurement.
2. Abnormal……refer for urgent obstetric review,

Additional BWNFT guidance
This is additional trust guidance relating to the customised GROW chart
Principles:
- Consider the growth chart as a 'reference range' rather than a 'normal' range.
- Estimated fetal weight above 4500g should be used as a marker of risk, rather than 90th centile.
- There is good evidence for babies below the 10th centile being at higher risk. The evidence is less certain for babies above the 10th centile on a customised growth chart.
- Any test that we offer (such as ultrasound) should lead to a measurable benefit to the woman or her child. Assess the potential benefits and harms of any test (and its consequences) before it is offered, rather than simply react by offering a scan.

Suspected Large baby
- If fundal height measurement plots above the 90thcentile, do not refer for scan (unless there is clinical suspicion of polyhydramnios).
- Fundal height which plots above the 90th centile should be advised to give birth in hospital. Advise of the risks and document.
- The birth centre is an option for women who's fundal height measurement is above the 90th centile (unless the fetus is considered to be **very** large for dates **or** that the estimated fetal weight is 4500kg or above).

If the birth centre is chosen:

- Adhere to 1st stage of labour guidance
- Be alert to the special significance of slow progress in labour
- The pool for labour is acceptable but for the birth is not recommended
- Notify the registrar on MDS when the woman is in 2nd stage

Polyhydramnios confimed on USS - needs medical plan of care that day

- Transfer to consultant care
- Please arrange Parvovirus TORCH screen, GTT, detailed USS
- Consider neonatal naso-gastric tube before feeding after birth (in case of oesophageal atresia)

Appendix F - Midwifery Screening of Full Blood Count Results

HAEMOGLOBIN 9.00 - 10.5 g/dl (or 9.00 – 11.00 g/dl at booking sample) → Generate standard letter to patient and GP re: low HB / iron treatment

If known haemoglobinopathy refer to case notes (and discuss with Will Lester if unsure) before sending letter

HAEMOGLOBIN < 9.0 g/dl → result to Pam Jordan (Specialist Midwife Antenatal Clinic) to co-ordinate treatment / follow up

MCV < 80 (microcytosis) and/or MCH < 25 (hypochromasia) with Hb in normal range → repeat bloods for ferritin at next appointment and check that Antenatal Haemoglobinopathy screen has been done.
(This may be due to a haemoglobinopathy trait without iron deficiency)

MCV > 108 (macrocytosis) → Blood tests for ferritin / B12 / folate / Liver and thyroid function
Appointment with Dr Lester within 4 weeks to review with results (fill in referral form)

PLATELETS

- < 80 at any gestation, refer to Dr Lester (fill in referral form)
- < 100 at booking → refer to Dr Lester, as above
- 600 at any gestation → refer to Dr Lester, as above
- 100-130 → repeat bloods after 4 weeks (2wks after 36/40)

NEUTROPHILIA If neutrophils > 18.0 → for clinical review
EOSINOPHILIA If eosinophils > 1.5 → for clinical review
LYMPHOCYTOSIS If lymphocytes > 6.0 → for clinical review
(Clinical review - Show result and notes to Consultant Obstetrician re: further action)

ALWAYS CHECK FOR CLINICAL COMMENTS AND ADVICE ON FBC REPORTS

Appendix G – Patient Information Topics and schedules for discussion.

Gestation	Topic	Format	Where documented
At Booking	Antenatal Screening tests	Verbal	Investigation page of pregnancy hand held notes
At initial contact with medical staff	Declining of Blood Products (DBP)	Verbal	If DBP consent form indicating what blood products would be acceptable signed and filed in hospital records
28-34 weeks	Infant feeding	Leaflet and/ or Verbal	Preferences for Birth page of the pregnancy hand held notes
From 28 weeks gestation	Place of Birth Options discussed	Verbal	Preferences for Birth page of the pregnancy hand held notes
From 28 weeks gestation	Labour information including: fetal monitoring in labour anaesthesia	Verbal	Preferences for Birth page of the pregnancy hand held notes
From 28 weeks gestation	Pain management in labour (including regional	Verbal	Preferences for Birth page of the pregnancy hand held notes
From 28 weeks gestation	Perineal repair	Verbal	Preferences for Birth page of the pregnancy hand held notes
From 28 weeks gestation	Vitamin K prophylaxis	Leaflet and/ or verbal	Preferences for Birth page of the pregnancy hand held notes
28 weeks onward, if clinically indicated	Vaginal birth following caesarean section	Leaflet	Maternity Health Records- VBAC Proforma if available
28 weeks onward, if clinically indicated	Caesarean section	Leaflet	Maternity Health Records- Pre-operative checklist if available
36 weeks onward, if clinically indicated	General anaesthesia	Verbal	Maternity Health Records- Pre-Operative Assessment form
36 weeks onward, if clinically indicated:	External cephalic version	Leaflet	Maternity Health Records- ECV Proforma if available
40+ weeks	Induction of Labour (IOL)	Leaflet	Maternity Health Records- IOL Proforma if available

This is not an exhaustive list and other topics may be relevant and should also be recorded.

Appendix H – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Antenatal Care Guidelines		
Date finalised:	29th June 2012	**Dissemination lead: Print name and contact details**	Diana Wylie
Previous document already being used?	**Yes**		
If yes, in what format and where?	Electronic copy available on the intranet		
Proposed action to retrieve out-of-date copies of the document:	Archive out of date copy		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
Trust Wide	Via email to all staff	Electronic	

Dissemination Record to be used once document is approved.

Date put on register / library of procedural documents	24th July 2012	**Date due to be reviewed**	29th June 2015

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**
Trust wide to all staff	Electronic	24th July 2012	0	Staff informed that the policy has been updated and added to the intranet

Appendix I – Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy/Function Details	
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Antenatal Care Guidelines
Is this a new policy or function?	Updated ☒
Responsible Manager	Jenny Henry
Date Assessment Completed:	29th June 2012
Sources of Data	NICE

Screening Assessment					
Equality Group	**Impact**		**Status of Impact**		**Brief Detail of impact**
	Yes	**No**	**Positive**	**Negative**	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		**X**			
Gender or Marital Status of Men or Women		**X**			
Gender or Marital Status of Transsexual or Transgender people		**X**			
Religion or belief		**X**			
Physical or Sensory Impairment		**X**			
Mental Health Status		**X**			
Age or perceived age		**X**			
Sexual Orientation (Gay, Lesbian, Bisexual)		**X**			
Offending Past		**X**			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		**X**			
Please provide details of any mitigation you can provide against negative impacts highlighted above					

[1] Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?
N/A
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?
Yes, Midwives, SOM, clinical managers, Obstetricians, Users etc.
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?
N/A
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?
On trust Intranet
How will the impact of the policy/service be monitored and reviewed?
Review as in guideline

Assessor Name:	**Jenny Henry**
Assessor Job Title:	**Head of Midwifery**
Date Completed:	**29th June 2012**

Appendix J – Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Has all the information on the front page been completed?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Maternity Directorate
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	**Format**		
	Does the policy conform to the prescribed policy format?	Yes	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited using Harvard referencing?	Yes	
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
8.	**Document Control**		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11	**Equality Assessment**		
	Has an equality impact assessment been carried out?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Jenny Henry	Date	29th June 2012
Signature			

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Tracey Johnston On behalf Maternity Services Directorate	Date	29th June 2012
Signature			