York Teaching Hospital
NHS Foundation Trust

MATERNITY SERVICES GUIDELINE

ANTENATAL APPOINTMENTS GUIDELINE

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Contents

1 Introduction & Scope

This guideline is designed to provide a framework to enable the consistent provision of high quality, evidence based holistic care to pregnant women when they access services provided by York Teaching Hospital NHS Foundation Trust.

This guideline is for the use of any health care professional working within maternity services. It will be mainly used by those working in the community, ante-natal clinic, ante-natal day assessment unit and ante-natal wards, but will also be a valuable point of reference for a variety of additional groups involved in the provision of ante-natal care or related services (for example GP's Dr's rotating into obstetrics, radiographers, ultra-sonographers, physiotherapists, nurses working on gynaecology wards etc).

All professionals caring for pregnant women are responsible for their own professional practice and for working within the guidelines detailed in this document. Furthermore, each professional involved in an individual's care is accountable for ensuring they communicate any relevant information with other professionals or agencies as deemed appropriate.

2 Management

2.1 The Booking Process

Once the woman has presented in pregnancy it is the responsibility of the midwifery services to offer antenatal care by providing an initial booking appointment. This should take place as early as possible, ideally around 8 weeks, and be no later than 12 completed weeks of pregnancy - sooner if the woman has complex medical needs

Women who present at any gestation after 12 weeks of pregnancy should be booked within 2 weeks as far as is practicably possible

Women should receive a 'pre-booking' pack (usually given out by GP's receptionists or can be collected by the woman or her representative from GP surgeries) containing the following leaflets:

- 'Screening Tests for you and your baby' (PHE 2017)
- 'Congratulations on your pregnancy' (Trust PIL) - which includes details on the purpose of the booking process and how to contact a midwife
- Emotional Support in Pregnancy (Trust PIL)

Document in the hand held notes the date that the woman made the first contact regarding this pregnancy

The booking appointment is the 1st in a series of risk assessments undertaken at every appointment in the antenatal period to ensure care is provided by the appropriate health professional(s).

2.2 Criteria For Midwife Led Care (See Appendix 1 for referral details)

Women with low risk pregnancies will have a midwife as their lead professional. The midwife, as the lead professional, must be responsible for all aspects of the pregnancy and will make referral to appropriate professionals as required or as requested by the woman.

At each antenatal contact the risk assessment must be reviewed to ensure women remain within the correct care pathway.

If the woman becomes high risk at any stage during the pregnancy, she must be referred for a Consultant appointment and update management plan in the handheld notes.

2.3 Referral Criteria for Consultant Review

All women with 'high-risk' pregnancies must be booked for consultant led care and a pregnancy management plan formulated and documented in the handheld notes. Previous pregnancy notes will be available for ANC appointments for all women who have previously delivered in the Trust. For women who have previously delivered outside York Trust and whose consultant requests the notes e.g. previous complicated delivery, the consultant's secretary will contact the previous Trust by letter and request a record of the previous pregnancy(ies).

Options for antenatal care will be discussed with the woman and any women appropriate for midwife led care will be referred back to the midwife. This will be documented in the management plan.

Medical indicators:

- Cardiac disease including hypertension
- Renal disease
- Endocrine disorders
- Liver disorders
- A diagnosis of psychiatric illness or any history of severe mental illness (requiring psychiatric or CMHT involvement – current or historical) – refer to perinatal mental health guideline
- Medicated for depression/anxiety in current pregnancy
- Previous puerperal psychosis
- High risk VTE assessment
- Autoimmune disorders
- Genetic disorders
- Epilepsy requiring anticonvulsant drugs
- Malignant disease
- Severe asthma (not well controlled or ongoing respiratory team input)
- Drug misuse including alcohol
- HIV, syphilis, HBV or Hep C positive (also inform screening team)
- Genital herpes simplex (whether primary or recurrent)
- Obesity (BMI ≥ 35 at 1st contact)
- Previous anaesthetic difficulties

Obstetric indicators: h/o any of the following

- Recurrent miscarriage (3 or more consecutive pregnancy losses with the same partner or a mid-trimester loss)
- IVF/clomid induced pregnancy
- Age 40 or above
- Grand multiparity - more than 4 deliveries (definition from NICE, RCOG)
- More than 6 pregnancies (regardless of parity)
- Previous pre-term birth (<37weeks)
- Severe pre-eclampsia, HELLP syndrome or eclampsia
- Rhesus iso-immunisation or other significant blood group antibodies. Please also refer to antibody care plan in 'Pathway of care for women having blood taken for grouping and Antibody Screening' guideline (Appendix 11).
- Uterine surgery, including LSCS, myomectomy, (cone biopsy and LLETZ if this is the 1st pregnancy following this procedure)
- Previous retained placenta on two or more occasions
- Previous postpartum haemorrhage
- Previous stillbirth or neonatal death
- Previous baby small for gestational age (less than 5th centile)
- A previous baby with congenital anomaly (structural or chromosomal)
- Previous impaired GTT
- Previous 3rd/4th degree tear
- Any positive GBS screening in any pregnancy must be screened by midwife
- Requesting homebirth against guidance or advice (at any point of pregnancy)
- Women who decline blood products

Social indicators (more at risk of complications developing):

- Teenagers (<18)
- Safeguarding issues

2.4 Criteria for Planned Home Birth

Better Births (2016) states 'Women need clear unbiased information to help them make decisions about where to give birth, including: the chances of receiving interventions; availability of pain management; on site availability of obstetric and neonatal services; and the frequency and likely duration of transfer. Such information needs to be personalised according to their individual circumstances'. This statement is informed by the Birthplace Study, undertaken by the National Perinatal Epidemiology Unit (NPEU, accessed online and last updated 2017) which found that:

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

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

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

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

- For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units

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

- For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned Freestanding Midwifery Unit (FMU) births and 40% for planned Alongside Midwifery (AMU) Unit births

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

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

Women can make an informed choice to birth outside of guidance (this refers to any and all maternity guidelines) at home or in hospital. All discussions will be recorded in the management plan in the handheld notes or where a homebirth is requested, in the homebirth agreement - refer to homebirth guideline

2.5 Booking Risk Assessment

Antenatal care should include continued risk assessments at every contact. Refer to all/any other appropriate guidelines for any complicating factor/s. Ensure non English speaking women or women requiring BSL interpretation have interpreting services present/ available. The booking appointment is the first antenatal visit and its purpose is to determine the appropriate care pathway as per the referral criteria and provide women with information around their choices:

- Record personal details, medical, family, social, lifestyle and obstetric history
- Identify past and current medical, obstetric, mental health and anaesthetic history and refer as needed**.**
- Pregnant women who have had female genital mutilation should be identified early in antenatal care through sensitive enquiry and referred for consultant clinic review. The safeguarding team require notifying. Please see FGM guideline
- Discuss information around VTE risk factors
- Identify any potential safeguarding issues and refer as necessary as per safeguarding guidance. Discuss that we will request the sharing of safeguarding information with their GP and gain consent for this (women to sign sticker on front of green hospital ante natal summary sheet)
- Identify those women who will be offered a GTT
- Identify those women with a past history of Group B Haemolytic Streptococcal infection

- Identify whether the woman has had chicken pox or shingles and advise to be 'rash aware'. If a women is uncertain if she has had chicken pox in the past then offer to test for immunity (VZVIgG) and request this on the booking bloods form (no extra blood is required). If a woman is certain she has had a h/o chicken pox then reassure her that she will be immune. Please note also that women originating from the tropics or sub tropics should have chicken pox immunity checked regardless of chicken pox history
- Discuss PHE leaflet on flu, whooping cough and german measles and advise uptake of flu vaccination during flu season and the whooping cough vaccination after the 20 week scan and also rubella vaccination post natally if there is no known history of having had MMR vaccination twice in the past
- Inform women that they need to enquire re their vaccination history for MMR. To be protected against rubella they should have evidence of having had 2 documented MMR vaccinations in the past. If they have not had at least 2 MMR vaccines in the past they should be advised to attend their GP postnatally for MMR vaccine.

  NB Midwives should advise women to be '**rash aware'** at booking. Women should be advised to contact their GP if they develop any rashes **or** are in close contact (face to face/same room) with anyone with a rash type illness. It is the GP's responsibility to investigate and action any referral for Consultant opinion as regards the pregnancy**.** All women should be advised to avoid people with rash type illnesses wherever possible and also regarding good hygiene particularly if they have contact with children under 6.
- Identify women who will decline blood and blood products and refer for consultant review
- Record any known allergies
- Complete family origin questionnaire (FOQ) form (inform screening team of any history of donor egg, donor sperm or bone marrow transplant in either parent and ensure this is detailed on the FOQ form)
- Identify eligibility for BCG for Neonates and document in handheld record https://www.gov.uk/government/publications/tuberculosis-tb-by-country-rates-per-100000-people
- Complete request forms for scans/screening as required and after discussion – refer to screening booklet and obtain informed consent for screening (women to sign sticker on the back of the green hospital ante natal summary sheet)
- Complete VTE risk assessment and refer as appropriate
- Identify women who should take low dose aspirin from 12 wks of pregnancy - **please see appendix 8 for further information**. Women should be advised to obtain aspirin from their GP.
- Complete maternity payment pathway (PBR) (Appendix 9)
- Ensure at least two occasions during the antenatal period where you can speak with the woman alone around any issues of violence within the home (See appendix 10) and refer as appropriate
- Discuss preferred place of birth and give options around this
- Identify preferred lead professional and plan pattern of care for pregnancy

Also include:

- Provide information regarding diet, exercise, healthy relationships, folic acid and Vitamin D supplementation, as detailed below:
- Folic acid -all women should be advised to take a daily supplement of 400 micrograms of folic acid until at least 12 weeks of pregnancy.
- Some women should be advised to take a higher dose of 5 milligrams of folic acid daily until after 12 completed weeks of pregnancy This is only available on prescription. The following women should take this higher dose of folic acid:
  - Women on certain medications for epilepsy
  - Women with pre-existing Type 1 diabetes
  - Women with a BMI of > 30
  - Women with coeliac disease
  - Any woman who has a neural tube defect, whose partner has a neural tube defect or who has had a previous baby with a neural tube defect
- All women should be advised to take a daily supplement of vitamin D (10 micrograms) throughout pregnancy to aid the absorption of calcium. This is particularly important in teenage mums, those with a raised BMI, those with darker skin tones and those who are not exposed to natural sunlight.
- Provide information on smoking cessation and record CO reading on ALL women and document in handheld record. Refer to smoking cessation services where appropriate (this is an opt-out process)
- Refer to 'emotional support in pregnancy leaflet' and discuss mental health and wellbeing. Complete mental health assessment in handheld notes.
- Refer to 'congratulation on your pregnancy' leaflet and discuss dental care, antenatal classes and online support, exercise in pregnancy, diet and foods to avoid, travel safety and state maternity benefits. Provide FW8 to claim free prescriptions and dental treatment and for those women who are eligible sign and provide Healthy start Vouchers application form
- Discuss importance of antenatal care and obstetric observations and offer to:
  - Measure and record blood pressure and urinalysis
  - Measure and record height and weight and calculate and record BMI
  - Obtain clean catch MSU for screening for asymptomatic bacteriuria (see management of proteinurea below)
  - Take blood for routine booking investigations including: FBC, group and antibody screen, syphilis screen, HIV, Hepatitis B, haemoglobinopathies, thalassaemia and depending on ethnicity, sickle cell . Complete family origin questionnaire. Discuss with any woman declining blood tests the possible implications for the pregnancy and document the discussion has taken place. Inform the screening team and ensure to re-offer at every future appointment
  - Refer to Anaemia in pregnancy guideline to determine management of HB <110
- Inform pregnant women younger than 25 years about the high prevalence of chlamydia infection in their age group and advise to access screening (a pack can be offered where available)
- Offer 'baby buddy' app and information

- Offer Mothers & Others Guide
- Issue disposable tourniquet
- Check woman's understanding of the information that has been given and provide the opportunity to further discuss any issues, questions or concerns
- Provide contact telephone numbers and make 16/40 appointment

Document all findings on the appropriate pages in the hand held notes. The management plan in the hand held notes must be commenced and the special features section completed. If the booking visit takes place close to EDD (≥ 37 weeks) the bloods should be sent as URGENT.

Any confidential or sensitive information e.g. regarding domestic abuse or child protection processes, should **not** be documented in the maternity hand held notes but should be captured on the maternity x-drive.

Management of Proteinurea

- **Do not use first morning urine void to quantify proteinuria in pregnant women**
- In pregnant women with hypertensive disease, if dipstick screening is positive (1+ or more), send urine for protein:creatinine ratio (PCR) and microscopy, culture and sensitivity (MSU).
- use 30 mg/mmol as a threshold for significant proteinuria
- if the result is 30 mg/mmol or above and there is still uncertainty about the diagnosis of pre-eclampsia, consider re-testing on a new sample, alongside clinical review.
- **If dipstick screening is 2+ or more in the community, these women need to be referred to ANDU for review and follow-up. A PCR should not be sent in the community for these women as results may be delayed.**

In women with no hypertensive disorders, persistent proteinuria (1+ or more) a PCR should still need to be sent to rule out renal disease.

All booking blood and MSU results need to be checked by the booking midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, it needs to be followed up within 24-48 hours

The midwife should recommend all primigravida women have a medical examination to be carried out by their GP, ideally before 16 weeks gestation or for migrant women entering the country who have not previously been examined by a GP

Screening

Following the screening discussion at the booking appointment the woman will be offered either a 10-14 week visit for a dating scan or a 11+2 – 14+1 week visit for nuchal combined test, depending on choice of screening – refer to Antenatal Screening Guideline.

Women can choose:

- not to have screening
- to have screening for T21 and T18 / T13
- to have screening for T21 only

- to have screening for T18 / T13 only

They will receive 2 separate risks: one for T21 and the other for T18 / T13.

2.6 Frequency of Antenatal Visits for Low Risk Women

The following are based on NICE Guidelines (2019) and follow the pregnancy planner in the hand held records but differ slightly to reflect local Consultant opinion and Trust requirements. Patient choice also needs to be considered when discussing frequency of appointments with women.

Women with a new partner **do not** need to be seen as per the nulliparous regime; neither do multiparous women who have had a previous LSCS at term unless it has been as a result of medical complications e.g. pre-eclampsia. Pre-eclampsia is defined as new hypertension and significant proteinurea at or after 20 weeks of pregnancy. NICE recommends that all women are given warnings about preeclampsia.

In general, a 24 and 31 week appointment for a multiparous lady with no **current** medical or obstetric complications is unnecessary, however this is a guide and should be based upon individual need and clinical judgement; The main exception to this would be women who are vulnerable or have a history of mental health concerns. Where there have been past medical or obstetric problems, individualised patterns of care and frequency of visits will be decided by the MDT in conjunction with the woman.

NULLIPAROUS		MULTIPS
Booking visit asap and prior to 12w		Booking visit asap and prior to 12w
Dating scan 10 - 14 weeks Nuchal Scan (if applicable) approx. 11w+2d – 14w+1d (depending on CRL result at time of scan Quad Test (if applicable) 15w – 19w+ 6d		Dating scan 10 - 14 Nuchal Scan (if applicable) approx. 11w+2d – 14w+1d (depending on CRL result at time of scan Quad Test (if applicable) 15w – 20w+0d
16 weeks		16 weeks
18 - 21 weeks mid trimester scan		18 - 21 weeks mid trimester scan
24 - 25 weeks		
28 weeks		28 weeks
31 weeks		
34 weeks		34 weeks
36-37 weeks (for presentation check)		36-37 weeks (for presentation check)
38-39 weeks		38-39 weeks
40-41 weeks (for membrane sweep if required)		40-41 weeks (for membrane sweep if required)

All return appointments are a continuation of the risk assessment process commenced at booking. The risk assessments must be documented at booking and a second assessment as stated in the hand-held notes, in the 3rd trimester. A review of the management plan should be made at each visit, acknowledged in the tick box, and any changes clearly documented.

Ensure that women who do not speak English or that require BSL interpretation have access to the interpreting service at every contact. Friends or relatives should not be used to interpret

If any woman presents at a returns appointment without her hand held notes, refer to **Appendix 2**

If any woman does not attend (DNA's) for any appointment in the antenatal period, please refer to **Appendix 3**

16 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Record all previously reviewed specimen results from antenatal booking appointment, discuss this with the woman and record any actions taken in the hand held notes. If low level PAPP-A result has been identified, discuss letter from screening team and ensure consultant clinic review has been arranged. Document in management plan.
- Encourage woman to read through handheld notes and refer to pregnancy symptoms and complications.
- women should be advised to seek immediate advice from a healthcare professional if they experience symptoms of pre-eclampsia:
  - severe headache
  - problems with vision, such as blurring or flashing before the eyes
  - severe pain just below the ribs
  - vomiting
  - sudden swelling of the face, hands or feet.
- Discuss aspirin use
- Discuss rhesus negative blood groups if applicable and prophylactic anti D and possible sensitizing incidents in pregnancy. Arrange anti D appointment and ensure that bloods for FBC and Rh antibodies are offered prior to the appointment.
- Arrange GTT where applicable for 26 weeks. At this 26 week appointment, a FBC will be obtained but rhesus antibodies should not be taken due to the integrity of the sample and the risk of not identifying sensitizing incidents
- Reassess planned pattern of care for the pregnancy and identify women who need additional care (including multiparous women who may require an appointment at 24-25 weeks)
- Offer BP & urine testing. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Offer chance to discuss any information (written or verbal) that has been received
- If smoker and not previously referred or support not taken up – refer to smoking cessation, repeat brief interventions and offer repeat CO testing
- Check and sign customised growth chart using NIBBE proforma. Refer for consultant led care any previous babies below the 5th centile or above the 95th centile and update management plan

- Discuss fetal movements (FM). Advise women of the importance of being aware of their baby's movement pattern and of the importance of contacting and attending the maternity unit if there are any changes in their baby's normal movement pattern.
- Offer meaningful conversation regarding feelings about the pregnancy and discuss developing a relationship with the baby in pregnancy (sign and date under 'connecting with your baby' in the handheld notes). Encourage women to bring magazine to subsequent appointments
- Reiterate the importance of uptaking vaccinations in pregnancy for flu and whooping cough; advise women to make an appointment with their GP/Practice Nurse to have this done
- Check anomaly scan is arranged

18 – 21 week visit:

This is a hospital appointment for anomaly ultrasound scan and to determine placental site. Midwife led women will not routinely see a midwife for an antenatal check.

N.B: If placenta is found to be low lying or covering the os, a rescan will be arranged for 32 weeks. At this point, the woman will require referral to consultant clinic.

Some women will attend the midwife to request Mat B1 which can be issued from 20 completed weeks and is needed to apply for SMP and SMA. If women do attend and have face to face contact, information regarding FM pattern and breastfeeding can be given (see 24-25 week visit information below)

24 – 25 week visit: (for nulliparous women only or vulnerable women/ women with mental health needs. Consider that midwife led multiparous women will not routinely see a midwife between 16 and 28 weeks unless clinically or socially appropriate – bring back at this point for review if indicated)

- Ask about mental health and wellbeing and document
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Encourage women to access antenatal class options – information around online sessions should be given
- Check if woman has had anomaly scan completed if consented to this at booking
- If smoker – re offer smoking cessation, brief interventions and offer repeat CO testing
- Give mat B1 form

- Discuss fetal movements (FM). Advise women of the importance of being aware of their baby's movement pattern and of the importance of contacting and attending the maternity unit if there are any changes in their baby's normal movement pattern (discuss at 28 weeks if not seen ie.multip)
- Have a meaningful conversation around breastfeeding and connecting with your baby including talking and responding to baby while pregnant and how this helps baby's brain development. Information should be given around the health benefits and value of breast milk for nutrition, comfort and protection (discuss at 28 weeks if not seen)

28 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Offer FBC and antibodies for all women and advise that we will contact them if the result requires action (remember that women seen at 26/40 for GTT may not have already had rh bloods obtained) Ensure anti D is arranged for rhesus negative women who consent to receive this prophylactically. Please refer to anaemia guideline for further guidance
- Reiterate the importance of uptaking vaccinations in pregnancy for flu and whooping cough; advise women to make an appointment with their GP/Practice Nurse to have this done if not already done
- Check if woman has had anomaly scan completed if consented to this at booking (multip)
- Measure symphysis – fundal height in cm (**appendix 5**) and plot on customised growth chart. Review growth chart. Refer for scan if indicated
- If smoker~~s~~ - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Offer chance to discuss any information (written or verbal) that has been received
- Offer antenatal classes and inform about online information
- Discuss all abnormal pregnancy symptoms as per the handheld notes and advise women of the contact numbers should they develop any abnormal symptoms
- Complete second social assessment and mental health assessment as per the handheld record, date and sign this assessment and make any referral needed –completing a managing plan where appropriate

- Discuss FM (if not seen at 24-25 weeks). Advise women of the importance of being aware of their baby's movement pattern and of the importance of contacting and attending the maternity unit if there are any changes in their baby's normal movement pattern.
- If not seen at 24-25 weeks have a meaningful conversation around breastfeeding and connecting with your baby as above.

31 week visit

Multiparous women are not usually seen at this gestation. Perinatal Institute guidance recommends that we do not arrange to see women out of our usual pattern of care to ensure that the CGC is plotted as per their recommended regime; however, if a multiparous woman **is** seen then the fundal height measurement would need to be plotted if greater than 2 weeks since the last plotting.

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Measure symphysis – fundal height in centimetres and plot on customised growth chart. Review growth chart. Refer for scan if indicated.
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Offer chance to discuss any information (written or verbal) that has been received
- If smokers - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing
- Verbal and written (or online) information on Vitamin K, information for admission into hospital, pain relief, coping strategies, use of pool for labour, monitoring the baby's heartbeat in labour, positions in labour & a reminder to read the information in the screening booklet regarding screening test when your baby is born can be given at 28, 31 or 34 week appointment.
- Discuss FM

34 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours

- Complete VTE risk assessment and document on proforma - refer as appropriate
- Measure symphysis – fundal height in centimetres plot on customised growth chart. Review growth chart. Refer for scan if indicated.
- Review, discuss and record the results of screening tests undertaken at 28 weeks
- Check FBC if iron therapy commenced at 28 weeks
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Offer chance to discuss any information (written or verbal) that has been received
- If smokers - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing
- Offer meaningful conversation around the importance of skin to skin contact, keeping baby close after delivery including 'keeping baby calm and warm' & of the benefits & links to brain development. Discuss breast feeding positioning & attachment & prevention of SIDS. Complete p 27 of the hand held records.
- Discuss 4 points of ICON around infant crying as part of a wider conversation regarding soothing and bonding
- Discuss FM

- Offer LVS to all women with a history of GBS in current or previous pregnancy 3-5 weeks prior to anticipated delivery date (for multiple pregnancies)

36-37 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Measure symphysis – fundal height in centimetres plot on customised growth chart. Review growth chart. Refer for scan if indicated
- Rh antibody check for those women who declined prophylactic anti-D at 28 weeks
- Check presentation. For women whose babies are in the breech presentation, refer for an ultrasound scan so that an appointment to discuss ECV can be arranged if breech presentation is confirmed.
- Reassess planned pattern of care for the pregnancy and identify women who need additional care
- Record maternal weight and document clearly

- Discuss birth preferences and mode of delivery and ensure all information has now been discussed as per the birth plan section of the hand held record
- Offer chance to discuss any information (written or verbal) that has been received.
- If smokers - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing. Record CO reading of ALL women and record in 2nd assessment
- Discuss FM
- Offer LVS to all women with a history of GBS in current or previous pregnancy 3-5 weeks prior to anticipated delivery date (for singleton pregnancies)

38-39 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate
- Measure symphysis – fundal height in centimetres plot on customised growth chart. Review growth chart. Refer for scan if indicated
- Review, discuss and record the results of any Rh antibody blood tests undertaken at 36 weeks if applicable. Implement any treatment as necessary. Please refer to antibody care plan in 'Pathway of care for women having blood taken for grouping and Antibody Screening' guideline (**Appendix 11**).
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Offer chance to discuss any information (written or verbal) that has been received
- If smokers - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing
- Discuss FM

40-41 week visit:

- Ask about mental health and wellbeing and document
- Consider Routine Enquiry of Domestic Abuse (see **Appendix 10**)
- Enquire about PET symptoms and action appropriately, where necessary
- Offer blood pressure and urinalysis. All test results need to be checked by the midwife and acted upon within 10 days, unless an ALT or a urine protein: creatinine ratio (PCR) in which case, this needs to be followed up within 24-48 hours
- Complete VTE risk assessment and document on proforma - refer as appropriate

- Measure symphysis – fundal height in centimetres and plot on customised growth chart and record in handheld notes if not been measured or results plotted within the last 2 weeks, making referral for scan if indicated
- Reassess planned pattern of care for the pregnancy and identify women who need additional care.
- Discuss management of prolonged pregnancy
- Offer membrane sweep.
- Give IOL information leaflet and commence IOL checklist. Low Risk Women who are post mature without any medical / obstetric problems should be offered IOL between 41and 42 weeks. High Risk Women who are booked for Consultant Led Care will have the decision for IOL made by the Obstetric team
- Offer chance to discuss any information (written or verbal) that has been received
- If smokers - offer smoking cessation advice, repeat brief interventions and offer repeat CO testing
- Discuss FM

3 Links with

All current Maternity Guidelines, including:

Aneuploidy Screening for Down's, Edward's and Patau's Syndromes (trisomy's 21, 18 and 13) Guideline

Infectious Diseases of Pregnancy

Ante natal infections and Skin disorders in pregnancy
Antenatal Infections of Pregnancy Guideline

Infant Feeding Policy

Perinatal mental health guideline

Refusal of Blood & Blood Products guideline

VBAC guideline

Induction of Labour Guideline

Carbon monoxide testing during pregnancy guideline

Assessment of fetal growth guideline

Newborn examination guideline

Group B Haemolytic Strep

Anaemia in Pregnancy

Hypertension in Pregnancy guideline

All safeguarding processes

Obesity Guideline

4 References

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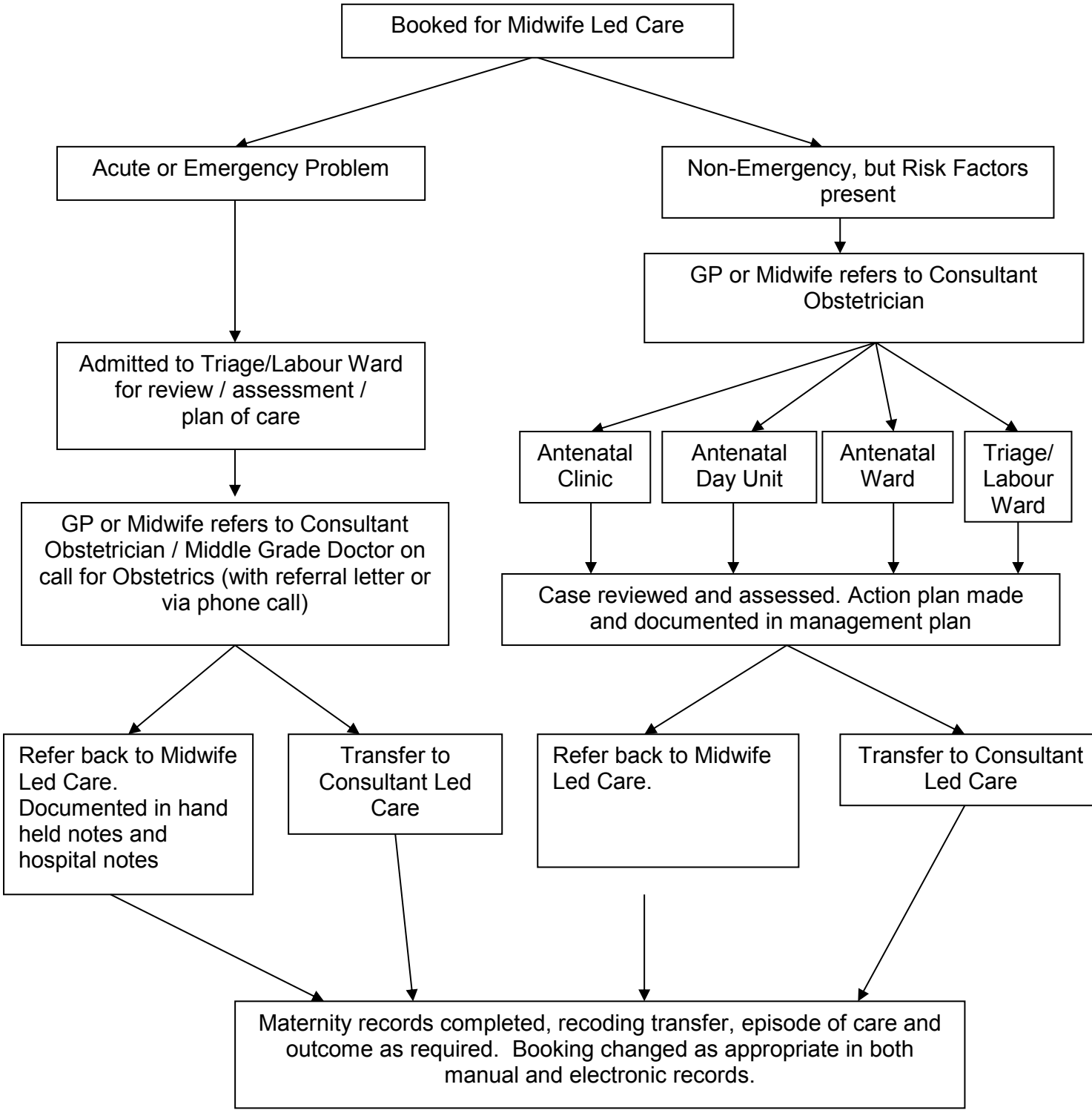
Public Health England (PHE) Screening Tests for you and your baby (2018). Accessed online March 2019 https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Appendix 1: Referral Flowchart from Midwife Led Care to Consultant Led Care



Appendix 2: Procedure for Women Who Attend Antenatal or A Community Clinic Without Handheld Pregnancy Records

Aim

- To maintain accurate record of consultation.
- To reduce incidence of miscommunication between Hospital Antenatal Clinic, Community Midwife and G.P.
- To provide a structured pathway of care.
- Reduce the risk of overlooking relevant medical and obstetric issues.

Action

An attempt to retrieve the pregnancy notes in time for the appointment should be made. If notes are unable to be retrieved in time for appointment, the Midwife/Consultant will decide if the woman is to be reviewed. If the consultation does not take place, the reason & date of next appointment must be recorded on the clinic-held summary sheet in the hospital notes, in a timely manner. From 28 weeks, if the customised growth chart is not available, consider re-appointing or asking the woman to return with her notes, explaining the importance of the accurate monitoring of the fundal height.

Antenatal Clinic

If consultation occurs: reception will label a separate continuation record sheet (page 15) with addressograph. Following consultation, the record sheet will be photocopied; one copy to hospital notes and one copy given to woman for the hand-held notes, to be secured behind the original page 15 at the next appointment.

If consultation unable to occur: further appointment negotiated when woman can attend with hand-held record.

If woman has a scan and review appointment, woman will attend scan appointment.

(a) If non-urgent report, the woman may be reviewed following discussion with the Doctor/ANC Co-ordinator, A further appointment may be when the woman can attend with the hand-held record.

(b) If urgent report, woman for medical consultation to review scan report.

Community Clinic

If consultation occurs: commence a separate continuation record sheet from hand-held notes (if available), completing patient's name & hospital D number. Following consultation give to the woman to put into her hand-held pregnancy notes. At the next appointment place this page behind the original page 15 and document its existence following on from the previous appointment.

If consultation unable to occur: further appointment negotiated as soon as practicable when woman can attend with hand-held record.

Appendix 3: Maternity DNA Process

Hospital

Woman fails to attend appointment in Day Services. It is the responsibility of the Day services Midwife to:

1st DNA
Check CPD/computer system for Safeguarding Alerts.
If alerts exist, contact professionals involved as required.

Contact woman to confirm address and reason for non-attendance and arrange new appointment

2nd DNA
Check CPD/computer system for Safeguarding Alerts. If no contact made Day Services to inform CMW who will make a home visit/s. Contact GP for information, consider TOP. Miscarriage, Independent MW or free birth

Check to see if an inpatient? If yes: document on CPD and inform GP. No further action needed

Community

Woman fails to attend appointment in CMW clinic. It is the responsibility of the CMW to:

1st DNA
Check CPD/computer system for Safeguarding Alerts.
If alerts exist, contact professionals involved as required.

Contact woman to confirm address and reason for non-attendance and arrange new appointment

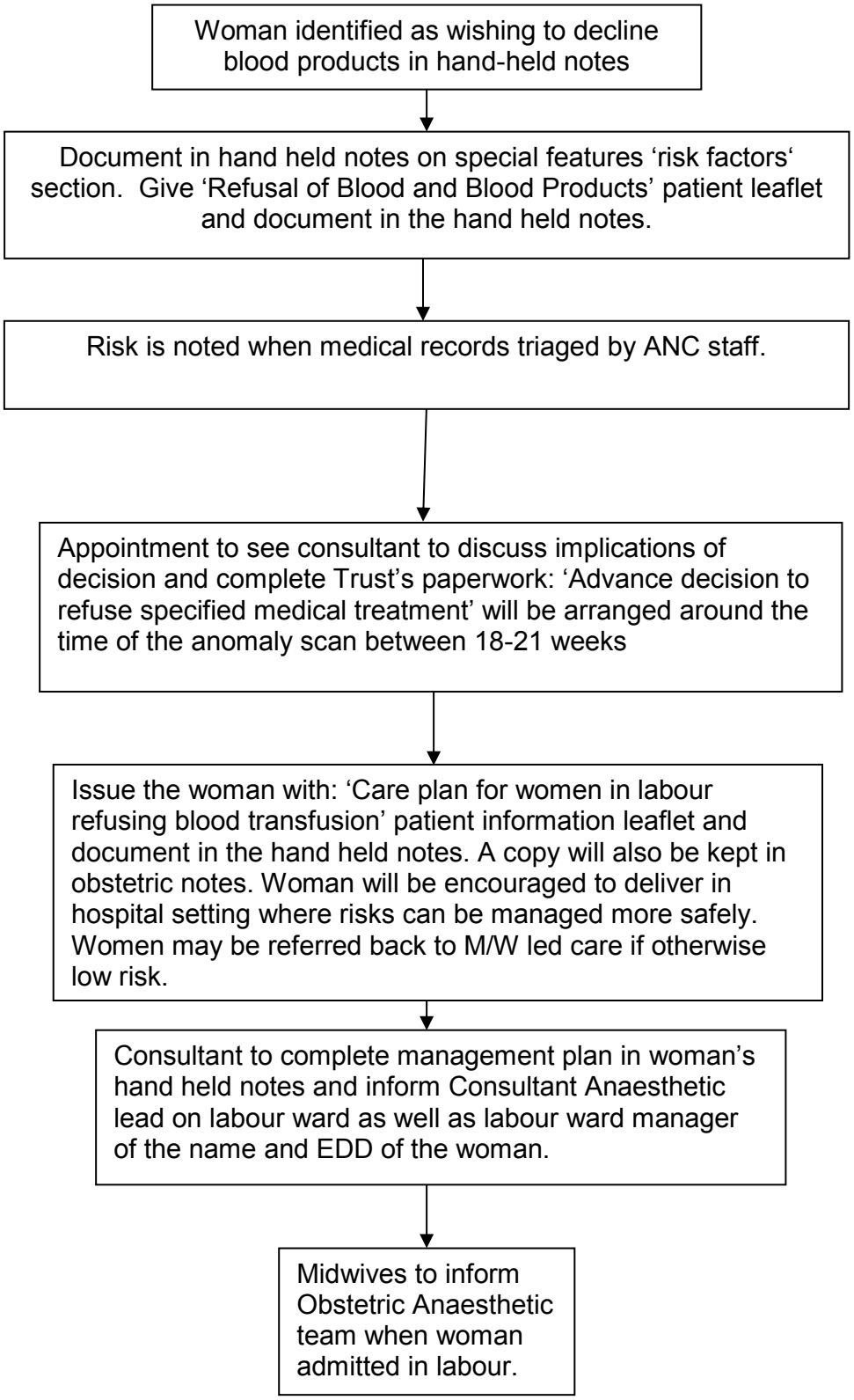
2nd DNA
Check CPD/computer system for Safeguarding Alerts. If no contact made; CMW to make a home visit. If contact not successful (2 attempts), leave contact details. Contact GP for information, consider TOP, Miscarriage, Independent MW or free birth

Non-Engagement
Attempt to contact woman and inform her it will be escalated as a Safeguarding concern.
If contact still unsuccessful, or woman declines antenatal care; document & update hospital and community systems. Inform GP

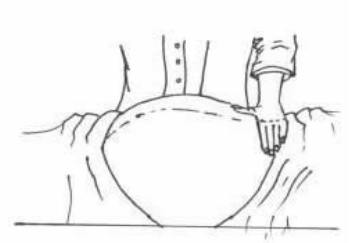
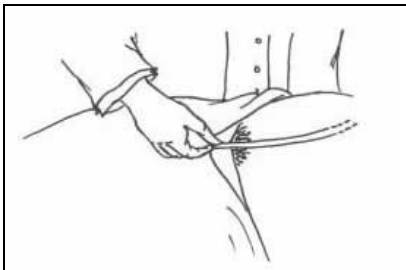
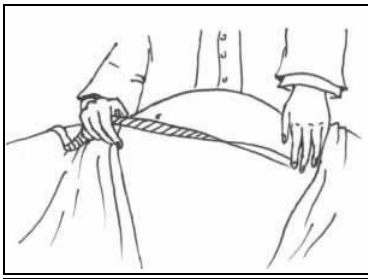
Contact relevant Health Visitor within 0-19 Services by single point of contact and inform GP:
York – HCSSafeguarding@york.gcsx.gov.uk
East Riding – HNF-TR.safeguardinghumber@nhs.net
North Yorkshire – hdft.0-19referrals@nhs.net

Contact Safeguarding Childrens Team at York Teaching Hospital (01904 726647) for advice and Children and Family Services (NYCC) or Children Social Care (CoY / ER) if a referral is required

Appendix 4: Procedure to Follow for Women Who Decline Blood Products



Appendix 5

	• Explain the procedure to the mother and gain verbal consent • Wash hands • Have a non-elastic tape measure to hand • Ensure the mother is comfortable in a semi-recumbent position, with an empty bladder • Expose enough of the abdomen to allow a thorough examination
1. Mother semi-recumbent, with bladder empty.	
	• Ensure the abdomen is soft (not contracting) • Perform abdominal palpation to enable accurate identification of the uterine fundus.
2. Palpate to determine fundus with two hands.	
	• Use the tape measure with the centimetres on the underside to reduce bias • Secure the tape measure at the fundus with one hand
3. Secure tape with hand at top of fundus.	
	• Measure from the top of the fundus to the top of the symphysis pubis • The tape measure should stay in contact with the skin
4. Measure to top of symphysis pubis.	
	• Measure along the longitudinal axis without correcting to the abdominal midline • Measure only once
5. Measure along longitudinal axis of uterus, note metric measurement.	

Appendix 6: High Incidence countries (estimated incidence of 40 per 100,000 or greater)
A current member of the household includes individuals that are currently living in the same household at the time of the booking assessment and that are expected to remain a member of the household by the time the child is born

Afghanistan
Algeria
Angola
Azerbaijan
Bangladesh
Benin
Bhutan
Bolivia (Plurinational State of)
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guinea
Guinea-Bissau
Guyana
Haiti
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Mali
Marshall Islands
Mauritania
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Tajikistan
Thailand
Timor-Leste
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

*** For information PHE (Health Protection) are responsible for updating and dissemination of information regarding eligibility with reference to country of birth of parents and grandparents on an annual basis**

**** A current member of the household includes individuals that are currently living in the same household at the time of the booking assessment and that are expected to remain a member of the household by the time the child is born**

Appendix 7

NORTHERN AND YORKSHIRE CLEFT LIP AND PALATE SERVICE

Please refer all babies with a cleft lip and/or palate within 24 hours of birth / diagnosis by contacting:

The Cleft Co-ordinator on a Wednesday, Thursday or a Friday
on: **0113 3925115** (24 hour answer phone)

OR

The Cleft Lip Palate Nurse
on: **0113 3923788**
or: **07881 824505**

Cleft Co-ordinator: Regional cleft & Palate Service
F Floor
Martin Wing
The General Infirmary at Leeds
Great George Street
Leeds LS1 3EX

Fax: 0113 3925116

Appendix 8: Women who should be advised to take low dose (150 milligrams) of aspirin from 12 weeks of pregnancy onwards. From NICE guidance Hypertension in pregnancy 2019 and Saving Babies Lives V2 2019

There is evidence that the dose of aspirin should be 150mg from 12 weeks' gestation, and may be more effective if taken at night. In some circumstances this may not be appropriate and lower doses (60-75mg) may be used (for example, women with hepatic or renal disease). Aspirin for use in pregnancy needs to be prescribed.

Table 1: Clinical risk assessment for preeclampsia as indications for aspirin in pregnancy

Risk level	Risk factors	Recommendation
High	• Hypertensive disease during a previous pregnancy • Chronic kidney disease • Autoimmune disease such as systemic lupus erythematosus or antiphospholipid syndrome • Type 1 or type 2 diabetes • Chronic hypertension • Placental histology confirming placental dysfunction in a previous pregnancy	Recommend low dosage aspirin if the woman has ≥1 of these high risk factors
Moderate	• First pregnancy • Are 40 years or older at booking • Pregnancy interval of more than 10 years • Body mass index (BMI) of 35kg/m² or more at first visit • Family history of preeclampsia in a first degree relative • Multiple pregnancy	Consider aspirin if the woman has two or more

Appendix 9: Ante natal payments pathway (PBR)

Intermediate

Current Factors

1. Complex Social factors
2. BMI >35 and <= 49
3. Sensory or physical disabilities
4. BMI <18
5. Substance/alcohol misuse
6. Under 20

Medical Factors

7. Mental Health
8. Hepatitis B or C
9. Genetic/Inherited disorder
10. Epilepsy requiring anti-convulsants
11. Previous uterine surgery (excluding previous caesarean section)
12. Hypertension
13. Respiratory disease
14. Gastrointestinal disorder
15. PAPP-A <0.415 MoM

Previous Obstetric History

16. Eclampsia, pre-eclampsia, HELLP
17. Puerperal psychosis
18. Early pre-term birth (<34 weeks)
19. Intrauterine growth restriction
20. Placenta accreta
21. Previous gestational diabetes
22. Fetal loss (12-24 weeks)
23. Neonatal death or stillbirth
24. 3 or more consecutive miscarriages
25. Low weight term baby < 2.5kg
26. High weight term baby > 4.5kg
27. Fetal congenital anomaly

Intensive

Current Factors

28. Multiple pregnancy

Medical Factors

29. Central Nervous System disorder
30. Cardiac disease
31. HIV

32. Thromboembolic Disorder
33. Diabetes/ other endocrine disorder
34. Renal Disease
35. Rhesus isoimmunisation/other significant blood group antibodies
36. Cystic Fibrosis
37. Previous Organ Transplant
38. Cancer
39. Autoimmune disease or anti-TNF or similar drug treatment
40. Haemoglobinopathy
41. Sickle Cell disease/ Thalassaemia
42. Thrombophillia/ clotting disorder
43. BMI > 49

Previous Obstetric History

44. Previous fetal congenital anomaly that required specialist fetal medicine

Appendix 10: Screening for Domestic Abuse in Pregnancy

A woman must be seen alone and routine questions regarding Domestic Abuse asked on a minimum of two occasions in pregnancy. This must be documented in the handheld notes as per local guidance.

All women are to be given information & contact details regarding support services for domestic abuse at booking

In line with Local Safeguarding Children's Board Good Practice Guidance an incident of domestic abuse where a woman is pregnant a referral to Children's Social Care & Multi Agency Risk Assessment Conference (MARAC) must be submitted as this is automatically considered to be high risk (Level 4).

Questions
Consider asking women what their understanding is of violence within the home/their relationships and whether they have found themselves in a situation of feeling frightened or intimidated in any way - Do you feel safe at home?

Follow up questions
In the last year have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act

No Yes

Have you ever felt controlled/abused by someone you have or have had a close relationship with? This could include any of the following: physical, sexual, psychological, verbal or financial?

No Yes

Consider controlling & coercive behaviours
Have you experienced a repeated pattern of abuse which has taken place over time?

TYPES OF BEHAVIOUR

- **Isolating** a person from their friends and family.
- **Monitoring** a person via online communications tools or using spyware.
- Taking **control** over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep.
- **Depriving** them access to support, such as specialist or medical services.
- Repeatedly putting them down.
- **Excessive** control of finances.
- **Threats** to hurt or kills the victim, their children, family pet or their family or friends.
- Criminal damage.

Appendix 11: ‘Pathway of care for women having blood taken for grouping and Antibody Screening’ guideline

http://staffroom.ydh.yha.com/clinical-Directorate-Information/master-clinical-document-library/maternity-guidelines/ante-natal/pathway-of-care-for-woman-haing-blood-taken-for-grouping-and-antibody-screening