University Hospitals Sussex
NHS Foundation Trust

Provision and Schedules of Antenatal Care

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Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This protocol applies to:

- All childbearing service users

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

This guidance is for midwives and doctors working in and with Brighton & Sussex University Hospitals Trust Maternity Services. The guidance is not rigid and should be tailored to the individual circumstances of each pregnant person. If the guidance is not being followed, documentation of the reasoning and/or justification is essential, with clear documentation of alternative plans and discussions

Management Team:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure the protocol is available to service users on request

1 Booking and Antenatal:

The process for ensuring that service users have their first full booking visit and Badger Net record completed by 10 completed weeks of pregnancy.

The following points need to be reviewed and discussed at each point of contact in the antenatal period:

- Risk assessment
- Place of Birth
- Personalised care plans

2 Process and responsibilities of staff groups for initial contact and booking:

2.1 Newly pregnant women and people will self-refer via the e-referral system on the UH Sussex website. The GP surgeries sign post them to this process. The Maternity Office will generate a scan appointment and apply the named community midwife who is linked to their GP surgery.

2.2 Pregnant women and people will be informed prior to their booking appointment that they need to download the Badgernet app and to complete the pre booking questionnaire prior to attending their booking appointment. The midwife should ensure women and people have access to the app at their first contact with the woman and pregnant person.

2.3 At the booking appointment a booking questionnaire is completed on BadgerNet by themidwife with the woman and person (demographics, medical, social, psychological, obstetric history). The midwife then needs to refer all women and people to the Antenatal Clinic Lead Midwife via BadgerNet.

2.4 The booking visit and the completion of the BadgerNet records should becompleted by the midwife by the 10th completed week of pregnancy.

3 Late bookers:

A late booking is defined as presenting for maternity services after 20 weeks of pregnancy.

3.1 Pregnant women and people over >12 weeks and un-booked: Midwife to complete a late booking form when online e-referral received and ensure a woman and person has been booked within 2 weeks of initial referral. The process is followed as above withthe community midwife responsible for ensuring referrals are actioned urgently. A pre-booking appointment is not required.

3.2 Scans:

If <20 weeks maternity office at PRH will do a scan referral to scan department, if >20 weeks it is the booking midwife's responsibility to refer for scan.

In relation to fetal anomaly screening please refer to Maternity Protocol: MP002 Antenatal screening: Fetal Anomaly Screening Programme

3.3 Women and people who have received A/N care during this pregnancy, but from anotherTrust should be seen by a community midwife within 2 weeks but will not usually require a scan unless clinically indicated.

3.4 Where a midwife appointment is not available in the midwives own clinic the midwife will make arrangements for the woman and person to be seen for booking at another available clinic as soon as possible.

3.5 The community midwife should undertake a booking appointment and complete the BadgerNet smart booking form. The reason for late booking should be documented on BadgerNet and on the antenatal lead midwife referral.

3.6 Where women and people have booked at another trust and are transferring care to UH SUSSEX, the booking midwife should recommend that all booking bloods [to include blood tests for screening: Infectious diseases and sickle cell and thalassaemia] are repeated. This ensures a result is held within this NHS trust. Where women and people decline to have bloods repeated the booking midwife should ensure the following:

- Advise the woman and person to have FBC and blood group repeated as a minimum
- Scan and upload hard copies of blood results from the previous trust to BadgerNet
- Hand written results from another trust are not acceptable. Where there are no hard copies of previous results attempts should be made to access the results from the previous trust. Where no hard copies are available and the pregnant person continues to decline screening bloods, a
  blood decline form should be sent to the Service users's Health Advisor[See Antenatal Screening policies for HIV, Hep B and Syphilis and sickle cell and thalassaemia for more information].
- The service users's decision to decline repeat screening should be clearlydocumented on BadgerNet

3.7 If booking is late due to a transfer from another area, the midwife transfers previous antenatal information from service users's hand held notes to this Trust's maternity notes. Where risk factors are identified midwife to consider (following discussion with the obstetric team) requesting copies of any previous notes from the relevant Trust. If a pregnant person has had a 20/40 scan in theUK she does not need a repeat, but booking bloods need repeating.

3.8 If the booking falls on or after 20 weeks and there is no history of antenatal care, the pregnant person should be advised to see a Consultant Obstetrician. The referral by the midwife can be made for the next available Consultant appointment in ANC via BadgerNet or by phone/email to the Maternity Office.

3.9 If there are concerns for the pregnant person and her unborn baby's welfare, a *referral to be sent to children's services electronically via the PANDA Portal, copying in community team leaders and safeguarding team.* See Maternity Protocol: MP013 Safeguarding Children and Child Protection for further information.

4 Concealed Pregnancy:

A concealed pregnancy is when a pregnant person knows she is pregnant but does not tellanyone; or a pregnant person appears genuinely not to be aware she is pregnant.

Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought. This can become apparent at any stage of the pregnancy. Concealment of pregnancy may be revealed late in pregnancy; in labour; or following delivery. The birth may be unassisted and may carry additional risks to the child and mother's welfare.

In all cases where a young person/pregnant person arrives at the hospital in labour or following an unassisted delivery, which has been the result of a concealed pregnancy, an immediate referral must be made to Children's Social Care. Please see Maternity Protocol: MP013 Safeguarding Children and Child Protection for further information.

The baby should not be discharged until a Strategy Meeting has been held and relevant assessments undertaken. This Strategy Meeting must consider the initiation of a psychiatric assessment.

Where the referral is received out of hours in relation to a baby born as the result of a concealed pregnancy, the Emergency Out of Hours Service will take steps to prevent the baby being discharged from hospital until Children's Social Care have been informed and given their approval for discharge, in most instances this would be after a Child and Family Assessment has been undertaken. The baby should not be discharged out of hours.

5 For Service users coming in from Outside the UK (Migrant Service users):

If a pregnant person has had no previous full medical examination in the UK the midwife should make an urgent referral for a full medical examination with the GP in order that a full medical history can be undertaken and clinical assessment made of theiroverall health using an interpreter if necessary. The referral date and GP appointment date and time must be documented on the pregnant person's BadgerNet record.

6 Communication and Language Support:

6.1 Service users for whom English is not their first language

6.1.1 The Midwife should assess the need for an interpreter at the first booking appointment and if required make arrangements with the interpreting service for the booking appointment.

6.1.2 It is not acceptable for a family member to act as the interpreter because there can be confusion about medical terminology or the potential for misrepresentation of information.

6.1.3 The use of an interpreter needs to be documented on BadgerNet and a plan made for future antenatal visits, labour and birth and the postnatal period. If referral to the hospital is necessary the interpreting service should be arranged for the time ofthe appointment.

6.1.4 The interpreting service can be arranged by midwives and doctors or delegated to support staff. Reception staff should also be made aware of the importance of the need to plan for future visits.

6.1.5 48 hours 'notice is required to arrange the attendance of an interpreter.

6.1.6 Contact the service either on line at www.sussexinterpreting.org.uk or through the relevant community midwives office stating the language you require. Please give as much detail of the specific language or dialect as possible.

6.1.7 If there needs to be more than one session booked please complete the booking form (available on the UHSUSSEX Intranet).

RSCH & PRH Sussex Interpreter service	
Office hours	Out of office hours & Sat/Sun
01273 702 005	07811 459 315
01273 380013	
Fax 01273 234 787	

6.2 **Service users with other communication difficulties**

BSL: British Sign Language
Non Emergency: 08445 938443
Emergency: 07947 714040
Online booking: www.actiondeafness.org.uk

6.3 For service users with mental health difficulties please see Maternity ProtocolMP014: Service users with Mental Health Problems.

7 Identification of Service users with Risk Factors and Reviewing PreviousNotes:

7.1 **Timing of risk assessments:** Risk assessment should be undertaken at booking by the midwife. At each point of contact with a health professional this initial risk assessment should be reviewed and risk status altered accordingly with appropriate referrals and individual plan of care as required. This should be clearly documented on BadgerNet.

7.2 Following booking the community midwife should complete an Antenatal Clinic Lead Midwife referral on BadgerNet. This referral has details of medical, social, psychiatric and previous and current obstetric history that will have been gathered from communication between the midwife and pregnant person at the booking appointment. A risk assessment will bemade based on the information given. A list of the medical conditions to be considered (including anesthetic and psychiatric history), factors from previous pregnancies, lifestyle history as part of the risk assessment are in Appendix D.

7.3 The referral will be reviewed by the A/N lead midwife who will identify risk factors (see Appendix D for list) and offer service users appointments in antenatal clinic to meet with the obstetric team, or specialist midwife as appropriate (see Appendix D for list of types of referrals). An appointment will be generated by the ward clerks, put on the maternity computer system and sent to service users by post with an appointment time, date and location.

7.4 The process for arranging the availability of health notes from previous pregnancies that are required for review by clinicians: all service users notes from previous pregnancies are requested from the main medical libraryand sent to the maternity unit storage for easy access.

7.4.1 At RSCH the ward clerks input the booking data and request the previous obstetric notes to be sent to L13 RSCH

7.4.2 At PRH the midwife or ward clerk inputs the booking data and request the previous obstetric notes to be sent to the maternity office 2nd Floor PRH

7.5 **Identification which service users's health notes from previous pregnancies are required for review by clinicians:** If service users are referred to ANC (i.e. service users that have been referred to the obstetric antenatal clinic for an obstetric or anaesthetic review due to identified risk factors during the booking process) theprevious obstetric notes will be pulled by the ward clerks ready for their clinical appointment where they will be reviewed by the clinician. Should risk factors occur during pregnancy the notes can be accessed by clinicians or wardclerks internally within the maternity unit.

7.6 If service users have identified neonatal risk factors e.g. family history or inheritedmetabolic disorders such as MCADD, a referral to a Neonatal Consultant should be generated for care planning and discussion regarding the implications of this risk factor (in line with NPSA - rapid response alert NPSA/2011/RRR002)

7.7 If service users have identified Child Protection issues the previous obstetric notes will be reviewed by the Child Protection Lead during the antenatal period (seeMP013: Safeguarding Children and Child protection for more detail on process).

7.8 If service users arrive on labour ward or DAU with complications clinicians can access and review the previous obstetric notes by asking the ward clerk toidentify and pull the notes for review (daytime) or by accessing the notes themselves (night-time).

7.9 If previous pregnancy/birth has occurred in another maternity unit (and there is an indication to review them during the current pregnancy) clinicians should attempt to request a copy of them from the unit where they are held. This attempt should be documented on BadgerNet.

7.10 **Risk assessment for pre-eclampsia**:
A risk assessment relating to pre-eclampsia should be undertaken by midwives at booking. (NICE 2013). Service users will be deemed to be high, moderate or low risk of developing pre-eclampsia. Community midwives will advise the service users on their risk assessment outcome. This will be documented on BadgerNet.

Risk assessment in relation to prevention of developing pre- eclampsia:

Service users at high risk of developing pre-eclampsia		
Risk Factors *(any of the following)*		Plan of care
	Hypertensive disease during a previous pregnancy	If any of these risk factors present: 1. Advise to take 150mg aspirin daily in the evening from 12 weeks gestation until 36 weeks of pregnancy. 2. Advise consultant review in ANC at 16 weeks
	Chronic hypertension	
	Chronic kidney disease	
	Autoimmune disease *(e.g. systemic lupus erythematosis or antiphospholipid syndrome)*	
	Type 1 or 2 Diabetes	

Service users at moderate risk of developing pre-eclampsia		
Risk Factors *(any **2** of the following)*		Plan of care
	First pregnancy	If any **2** of these risk factors present 1. Advise to take 150mg
	Aged 40 or over	
	Pregnancy interval of more than 10 years	

	BMI of 35 kg/m² or more at first visit *(offer referral to Consultant ANC at 34/40 as per protocol)*	aspirin daily in the evening from 12 weeks gestation until 36 weeks of pregnancy. 2. Continue usual care pathways *(refer to ANC should signs / symptoms of pre-eclampsia become apparent)*
	Family history of pre-eclampsia	
	Multiple pregnancy *(offer referral to Consultant ANC at 16/40 as per protocol)*	

Service users who are deemed high risk or with 2 moderate risk factors Community midwives will provide both verbal and written information recommending service users to take 150mg aspirin daily in the evening from 12 weeksgestation until 36 weeks of pregnancy.

7.10.1 Service users will be given 2 choices that will be clearly outlined in theleaflet:

- To buy the aspirin themselves and self-medicate appropriately as instructed (packet of Aspirin costs about 25p)
- Use tear off slip in Aspirin leaflet to be collected from any pharmacy, needs to be signed by community Midwife

7.10.2 Service users at high risk of developing pre eclampsia will also be offered areferral to a consultant ANC by 16 weeks for a review and plan of care.

7.10.3 Service users at moderate risk can continue with the usual care pathway unless there is a deviation from the norm and a referral is indicated.

7.10.4 A plan of care outlining the above will be clearly documented on BadgerNet.

8 Missed Appointments:

Please refer to Maternity protocol MP017: DNA appointments

9 The notes and antenatal booking visit:

9.1 The first antenatal contact or 'booking' visit is the most important and detailed of all visits and gives an opportunity to assess general health and to start making forward-looking plans for pregnancy, birth and parenthood. It is considered to be part of the clinical risk assessment process. The following should be considered and documented as part of the risk assessment:

9.1.1 Medical conditions - see Appendix D for conditions to be considered / referred

9.1.2 Anaesthetic risks - see Appendix D for conditions to be considered / referred

9.1.3 Psychiatric history - see Appendix D for conditions to be considered / referred

9.1.4 Factors from previous pregnancies - see Appendix D for conditions to be considered / referred

9.1.5 Lifestyle factors - see Appendix D for conditions to be considered / referred

9.1.6 Identification of service users who will decline blood / blood products refMP053: Obstetric Haemorrhage)

9.1.7 Appropriateness of place of birth (based on risk assessment)

9.1.8 Following the risk assessment there should be the development of an individual management plan for service users in whom risks are identified.The Midwife should document the risk assessment and individual management plan and make the appropriate referrals, recording dates / times of appointments on the pregnant person's BadgerNet record.

9.2 All maternity care will be documented on the BadgerNet system. All service users will have access to their own maternity record via the badgernotes app. Service users can access their maternity notes via the app on their phones or on a computer via the internet.

9.3 The Maternity BadgerNet records are designed to be multi-disciplinary. All professionals who provide maternity care should document this within the BadgerNet records.

9.4 For service users who do not have access to the internet or a mobile phone, all information entered onto BadgerNet should be printed and given to the pregnant person to carry as a handheld record.

9.5 The BadgerNet maternity records include:

9.4.1 booking data and pre conception details as appropriate

9.4.2 clinical test results including ultrasonic scans, antenatal screening tests

9.4.3 subsequent antenatal visits and examination

9.4.4 antenatal in-patient summaries, blood test report

9.4.5 Documented individualised antenatal risk assessment that is regularly reviewed throughout pregnancy

9.4.6 Development of an individualised management plan for service users inwhom risks are identified during the clinical risk assessment.

10 Calculating the EDD (Estimated Delivery Date)

Refer to Appendix B

11 Responsibilities of relevant staff groups at booking:

11.1 It is the responsibility of the midwife undertaking the booking assessment to ensure that:-

11.1.1 The midwife completes antenatal booking form on BadgerNet. If a pregnant person has completed some of the data on the form prior to the appointment, the midwife must check all details on the form with the pregnant person to ensure full and accurate completion.

11.1.2 An accurate history is taken and documented using the BadgerNet system.

11.1.3 A full risk assessment must be recorded and referrals made appropriately. The risk factors will be reviewed at subsequent antenatal appointments and at the onset of labour.

11.1.4 Give the pregnant person an overview of the antenatal schedule (Appendix A) and how the information & notes are intended to be used.

11.1.5 Ensure the pregnant person knows who their named midwife is and that this is documented on BadgerNet, how to contact a midwife and is aware of the correct urgent/non urgent contact numbers.

11.1.6 Give the leaflets (or information about accessing leaflets) and discuss the information contained therein in line with the schedule of care (below). All discussions should be documented fully on BadgerNet.

11.1.7 Encourage the pregnant person to read the information and guidance information within their BadgerNet records and to consider and document their preferences for labour and birth and to document any questions she wishes to discuss. This should be reviewed and actioned at every subsequent point of contact.

11.1.8 Ensure service users are signposted to Trust website and social media pages for further information.

12 Responsibilities of all Health Professionals:

12.1 Give the leaflets (or information about accessing leaflets) and discuss the information contained therein in line with the schedule of care (below). All discussions should be documented fully in the handheld notes.

12.2 Health professionals who take blood/specimen tests are responsible for full documentation, the follow up of results within 10 days and subsequent action/referrals are made where appropriate. Health professionals who provide care to service users at any point are responsible to ensure all blood/specimen tests are followed up, documented, reviewed and action taken where appropriate.

13 To be completed at booking visit:

Antenatal Booking Assessment	• Completed at the time of booking by the midwife on the pregnant person's BadgerNet record • This includes the pregnant person's social, medical (including anaesthetic), obstetrichistory and an assessment of mental health • This includes documentation of the booking and risk assessment. It also provides a structured approach for ongoing care provision both antenatallyand in labour. • A referral to the Antenatal Clinic Lead Midwife via BadgerNet on completion of the booking assessment which will be reviewed to generate appointments with obstetric and anaesthetic teams.
Maternity Risk Assessment	• The booking documentation on the BadgerNet system offers a thorough risk assessment of a pregnant person's social, lifestyle, medical (including anaesthetic), obstetric andmental health risk factors • If any risk factors are identified an individualised management plan should be formulated and documented clearly on BadgerNet. A referral may be indicated as part of this management plan and this need should be clearly communicated via ANC Lead Midwife referral on completion of the booking assessment. • The risk assessment and management plan should be reviewed at each visit and adjusted if indicated
Appropriate Screening Referral Form	• UHSUSSEX Scan request form • Quadruple Test Form • UHSUSSEX combined screening form
Blood Test Forms	• For all tests obtained with consent • Ensure family origin details are included on antenatal screening booking blood form
Other Referrals that may be required at booking	• Antenatal Screening Coordinator • Smoking Cessation Referral Form • If risk factors identified refer to ANC • Dietician & DAU for GTT (as per Obesity Protocol) • One Stop Clinic (if substance use disclosed) • Young person's pregnancy • Mental Health Team • Claude Nicole Clinic • Social Services Referral Form

14 Schedule of Care:

The schedule of antenatal care should be holistic and encompass the needs and wishes of the pregnant person. It should be stressed that these are the minimum and if service users requireadditional consultations they should be encouraged to make the appointments. (See Appendix A for detail)

14.1 Leaflets, information and discussion

Leaflets can be accessed via the badgernotes app or service users can be advised to access them via the trust Website where they can be downloaded. Service users whodo not have access to the internet should be given paper copies of the leaflets. Thisshould be documented on BadgerNet

14.2 Leaflets (or information about accessing leaflets) should be given routinely at the times identified (see Appendix A) and documented in the maternal notes.

14.2.1 The following leaflets (or information about accessing leaflets) should be given as follows (where clinically indicated) alongside a verbal discussion. This should be documented in the maternal notes: Vaginal Birth After Caesarean (VBAC) Leaflet – to be given post-natally to service users who have has a first LSCS when discharged home. To be givento all service users who have had a previous LSCS when booking for subsequent pregnancies at booking.

14.2.2 Aspirin In Pregnancy leaflet

14.2.3 Fetal Movements leaflet / Information

14.2.4 Homebirth leaflet

14.2.5 Caesarean Section leaflet – to be given to service users at time of booking aplanned LSCS

14.2.6 External Cephalic Version (ECV) leaflet – to be given to service users when abreech presentation is discovered any time after 34 weeks of pregnancy: With a discussion of options

14.2.7 Declining Blood and Blood products leaflet – at the time this issue is identified

14.2.8 General Anaesthetic leaflet:

All service users having a planned LSCS when this is decided andbooked

All service users with known Placenta Praevia as soon as identified

All service users with known factors that will make them at high riskof requiring a general anaesthetic

14.2.9 Care of the Perineum leaflet (perineal repair)– given to all service users who suffer a 3rd and 4th degree tear during the initial postnatal periodprior to discharge home

14.3 Responsibility of staff groups about information giving and leaflets:

14.3.1 Midwife providing care should ensure that all leaflets and information that is required has been given (or directed to via the website) at the appropriate time and format. If this has not occurred the midwife is responsible for providing the information when possible. Any leaflets / information given should be documented by the midwife in the BadgerNet notes.

14.3.2 Other health professionals such as obstetricians, phlebotomists and physiotherapists are responsible for giving leaflets relevant to the specific care they are providing at the time. Any leaflets / information given should be documented by the health professional in the BadgerNet notes.

14.4 Process for providing information to service users who have communication orlanguage support needs:

14.4.1 Leaflets in other languages are available viaTrust website ".

14.4.2 Leaflet can also be explained using an interpreter at an appointment.

14.4.3 Service users with other communication difficulties: midwives should makean individual assessment of their requirements and provideinformation in a format that is acceptable for the pregnant person. A Team leader can provide support and advice for midwives and service usersabout information giving and care planning.

14.4.4 Health professionals should document fully all discussions and information given, including any leaflets, in the BadgerNet notes.

15 Named Midwife, choice of care and continuity of care:

15.1 It is the midwife's responsibility, at initial contact, to inform the pregnant person of thename of the midwife who will have overall responsibility for her community based care. The name of the midwife and the community team should be documented on BadgerNet at this first contact. The service users will be able to view this on the badgernotes app.

15.2 Midwives in GP surgeries can only see service users registered to that practice.

15.3 If a pregnant person requests to be transferred to another named midwife she can contact the community manager via the community midwives office (each site) for discussion.

15.4 Continuity of care is what we ideally want to provide at UHSUSSEX NHS Trust. In order to achieve this each community midwife is attached to a GP surgery andwill be the named midwife there. This midwife will, with the exception of annual leave, sickness or mandatory training, provide regular antenatal care for the service users linked to that GP surgery. Cover will be provided by another community midwife in the same team when required. Where service users request more flexibility with antenatal appointments in the community, continuity of the named midwife will be affected, and service users may be seen by a number of different midwives in that community team.

16 Notes:

The schedule is a guide for the minimum standard of care in an uncomplicated pregnancy. The recommended number of appointments is between 6 and 11 and multiparous service users are likely to need less than primiparous service users. A function foreach appointment should be identified.

17 Symphysis Fundal Height (SFH) measurement:

From 24 weeks gestation the Symphysis Fundal Height (SFH) measurement (See Appendix E) should be used to assess fetal growth. The SFH measurement should be entered into BadgerNet during documentation of the antenatal assessment. The measurement will be automatically plotted on the intergrowth chart which is available to view on BadgerNet.

17.1 Service users with a single SFH which plots BELOW the 10th centile or serial measurements which demonstrate slow or static growth by crossing lower centiles (a distance of approx. 3cms) should be referred ultrasound(USS) measurement of fetal growth via the PANDA Portal (RCOG, 2013).

17.2 Service users with a SFH measurement of ≥ 3cm MORE than gestation in weeks should NOT be referred for an USS providing there are no other risk factors (NICE, 2008). The midwife is to check for glycosuria: If positive refer for GTT.If negative continue with normal A/N care pathway.

17.3 Service users in whom measurement of SFH is inaccurate (for example: BMI > 35,large fibroids, hydramnios) should be referred for serial assessment of fetal size using ultrasound (RCOG, 2013).

17.4 If polyhydramnios is suspected from clinical review and abdominal palpation service users should be referred in to DAU for an urgent obstetric review and ultrasound scan (ideally the scan should be performed within 48hours of referral being received).

17.5 Routine listening in or auscultation is unlikely to have any predictive value and is not recommended. However, it is acknowledged that many service users will
request FH auscultation and this should be discussed and service users's informedchoice supported and documented.

18 Referral of service users for additional care

18.1 Service users should have the opportunity to discuss any screening tests and theirconsent must be documented. All service users should be offered a dating scan before 13 weeks. See Maternity Protocol: MP002 Antenatal screening: Fetal Anomaly Screening Programme

18.2 If service users have identified neonatal risk factors e.g. family history or inheritedmetabolic disorders such as MCADD, a referral to a Neonatal Consultant should be generated by the midwife providing care for care planning and discussion regarding the implications of this risk factor (in line with NPSA - rapid response alert NPSA/2011/RRR002).

18.3 Service users who have had previous gastric band surgery should be referred in to see a Consultant Obstetrician in Antenatal Clinic to discuss the implications andplan pregnancy and delivery care.

18.4 Service users who have IVF pregnancies should be offered a referral to be seen at aConsultant led antenatal clinic by 16 weeks gestation. The referral should be made by the midwife with the pregnant person's consent.

18.5 All service users to be weighed again, using calibrated scales, at 34-36/40 gestation to enable correct weight for drug calculation around the time of birth should itbe thought necessary. This should be documented in the maternity notes.

18.6 CO monitoring should be offered at booking and at 36/40 for non smokers and at every appointment for smokers (appendix G).

18.7 Mental health issues should be discussed using the recognised guidelines. See Maternity Protocol: MP014 Service users with Mental Health problems.

18.8 Domestic violence should be sensitively discussed with all service users during anunaccompanied visit. See Domestic Abuse UHSUSSEX Trust policy.

18.9 From 42 weeks, service users who decline IOL should be offered increased antenatalmonitoring consisting of at least twice weekly CTGs and ultrasound examination of maximum amniotic pool depth. See Maternity Protocol: MP033 Induction of Labour.

18.10 All service users who have an uncomplicated singleton breech pregnancy at 36 weeks in primigravida and 37 weeks in a multiparous should be offered ECV.See Maternity Protocol: MP046 Breech & ECV.

18.11 If service users with risk factors make informed choice to plan labour and birth at home the community midwife should inform the Maternity Care Choices Midwife maternity.care.choices@UHSussex.nhs.net who will make contact with theservice users and offer a meeting/discussion to plan care.

19 Process of referral of service users in whom risks are identified duringthe clinical risk assessment:

19.1 A referral should be made for an obstetric review if risk factors (Appendix D) are identified at booking or at any point during pregnancy. The reason for the referral and the appointment time/date should be documented clearly in the maternal notes.

19.2 This can be done via the BadgerNet Antenatal Clinic Lead Midwife referral on completion of the booking assessment. Ifreferral is urgent telephone ANC directly and ask to speak to the AN lead midwife to prioritise appointment.

19.3 The Antenatal Clinic lead midwife referral should be reviewed by the A/N lead midwife who will arrange for an appropriate appointment to be made for the service users in an obstetric clinic. A letter will be sent with the ANC appointment details to thepregnant person at her home address in the post.

19.4 During antenatal period (after booking)
This can be done by the midwife or GP telephoning the Antenatal clinic to make an appointment at the next available appropriate consultant led clinic. The reason for the referral and the appointment time/date should be documented clearly on BadgerNet.

20 Reasons for Referral:

20.1 If a risk factor is detected during completion of the risk assessment or at any review of that assessment, a referral should be offered if appropriate; the risk factor should also be discussed in relation to her antenatal care, intrapartum care planning (including place of birth) and potentially postnatal care planning to produce an individualised care plan.

20.2 All referrals, risk assessment and individualised management plans should be clearly documented on BadgerNet by the health professional making the plan with the pregnant person.

20.3 Please ensure these service users are booked prior to their hospital appointment.Some of the reasons for referral are listed in the Appendix D.

21 Process for referral back to Midwifery Led Care:

21.1 Service users who are reviewed by the obstetric team and then deemed to be lowrisk should be referred back to MLC.

21.2 The obstetric review should be documented on BadgerNet with an individualised plan of care in to include written instructions that the pregnant person should receive midwifery led care.

21.3 Service users should be asked to make an appointment with her community midwife within a specified period of time and documented in the maternalnotes.

22 References:

Nursing and midwifery council (2004) *Midwives rules and standards.* NMC, London Department of Health 2007 Choice*, access and continuity of care in a safe service.*

Maternity Matters DoH, London

NICE (2008) *Antenatal Care – routine care for the healthy pregnant pregnant person.* RCOG:London

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Appendix A - Antenatal Care Schedule in Uncomplicated Pregnancy

1 *Timings of risk assessments*
2 *Development of individualised management plan*
3 *Appropriate and process of referral*
4 *All discussions & leaflets provided should be documented by the person giving them in the maternal hand held notes*

All service users
 	
Booking By 10 weeks following e-referral
	• Establish relationship with pregnant person through effective, sensitive and opencommunication
	• Discuss diet and lifestyle – folic acid, food hygiene etc.
	• Smoking cessation referral if necessary
	• Record weight, height, BMI
	• Give booking form to complete before next appointment
	• Give Maternity Services Guide
	• **Discuss, document and enable access to information and leaflets on:**
	  ○ **NSC 'Screening Tests For You and Your Baby' (antenatal screening tests)** booklet
	  ○ **Combined screening in pregnancy**
	• Risk assessment:
	  ○ Medical history/conditions (including anaesthetic & psychiatric history)
	  ○ Previous pregnancies
	  ○ Lifestyle history
	  ○ Identification of service users who will decline blood & blood products
	• Identify service users that may need referral to specialist midwife, obstetric orother care – See Appendix D
	• **Complete risk assessment & action/refer for further care as required**
	• NB at PRH there is no 8 week appointment – all information is given at booking appointment around 10 weeks
	• **Complete BadgerNet notes & action/refer for further care as required ifnot already undertaken**
	• Ascertain gestation and estimated due date (EDD) by last menstrual period (LMP)
	• Highlight any communication barriers and ensure appropriate measures are taken to ensure accurate communications can take place at all appointments
	• Identify service users who will decline blood and blood products. Documentclearly and offer referral to obstetrician in ANC
	• Booking blood tests should be taken by ten weeks – blood group, Rh status, screening for anaemia, haemoglobinopathies (according to Family Origin Questionnaire), red-cell alloantibodies, hepatitis B, HIV, syphilis
	• **Hepatitis C Screening for the following service users**:
	  • Recreational drug use which includes snorting and declines referral to One Stop

	• IVDU / Ex – IVDU (including steroids) and declines referral to One Stop • Contact of Hepatitis C (partner or sharing home with) • Sex worker • Ex-prisoner • Sexual assault • **Booking Midwife to check ALL results within 10 days and action abnormal findings OR repeat samples. Results to be promptly documented on BadgerNet and published to maternity notes** • GTT for high risk service users (refer MP018 Diabetes in Pregnancy) • Offer MSU • Offer Chlamydia screening if pregnant person <25 • Discuss: ➢ Issues surrounding depression and mental health issues in pregnancy (see UHSUSSEXmental health guidance) ➢ Domestic abuse if alone (see UHSUSSEX guidance). Give leaflet ➢ Antenatal care schedule ➢ Place of birth options ➢ Maternity benefits ➢ Medications in pregnancy – provide with Prescription Exemption form if not already provided by GP ➢ Risk assessment for service users at risk of pre-eclampsia and appropriateinformation and advice give and documented ➢ Nutrition including Vit D, Healthy Start vitamins ➢ A/N Screening ▪ Offer and arrange screening for Downs syndrome, Adwards & Pataus ▪ Offer and document consent and arrange 20 week structural anomaly scan • Consider social or CP issues • Risk assessment of VTE documented • Calculate BMI and offer referrals where required (see MP011 Obesity) • Offer Carbon Monoxide screening to all service users. Offer smoking cessation referral to all service users with reading of >3ppm. Direct all service users to UHSUSSEX maternity website formore information about smoking in pregnancy • **Discuss, risk assess, document and enable access to information/ leaflets on:** ➢ **Where the baby will be born (place of birth options)** Inform service users that we are a cross site and she may be asked to attend anotherunit at busy times ➢ **Types of delivery (how the baby will be born)** • **Develop Individual care plan with the pregnant person and document in BadgerNet records**
16 weeks All	• Review risk assessment & action/refer if required • Review individual care plan • Fetal Movement Leaflet and advise • A/N Screening: • If Quad test required – make an appointment with the AN screening team / DAU. Test to be carried out in DAU • If undertaken, check the service users has received her combined screening result – follow up if not received • Review and document booking blood results

	• If Hb <11 investigate and consider iron supplement. (Haematology Protocol TBC) • If Rh –ve, discuss implications. Give forms for 28 week blood tests • Discuss and enable access to information and leaflets on: ➢ Anti D in pregnancy (ensure appointment has been booked) • BP & proteinuria check.
25 weeks Primips only	• Review risk assessment & action/refer if required • Review individual care plan • BP & proteinuria check • Measure Symphysis-Fundal Height • Discuss: Fetal Movements Birth options • Review Diabetic Screening for high risk service users
28 weeks All	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Offer screening for: ➢ Anaemia and antibodies • Ensure appointment made if necessary for anti-D • GTT for high risk service users refer to (MP018 Diabetes in Pregnancy) • Give Mat B1 form (from 20 weeks onwards) • Follow up Safeguarding referral if appropriate/required • Consider Place of Birth (offer Home Birth option for low risk service users) • Discuss and enable access to information and leaflets on: ➢ Home birth (as appropriate) ➢ Water birth (as appropriate) • Give information about parentcraft classes • Follow up any Safeguarding referral's if appropriate/indicated

31 weeks Primips only (MW)	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Discuss and document 28 week blood results – if Hb <110g investigate and consider iron supplement (refer to Haematology Protocol TBC) • Has Anti D appointment happened if rhesus negative?
34 weeks All	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Document blood results for multips • Discuss labour, birth plan, coping with pain • Follow up Safeguarding referral if appropriate/required • Discuss, document and enable access to information and leaflets on: ➢ Fetal heart monitoring in labour ➢ Coping with pain / labour (pain management in labour including regional anaesthesia) ➢ Perineal massage/ care in preparation for birth

	➢ Breastfeeding • Follow up any Safeguarding referral's if appropriate/indicated • If the pregnant person is wanting a homebirth a chat/risk assessment to be bookedpreferably by named midwife ➢ Complete home birth form on BadgerNet ➢ For service users with risk factors planning a home birth: send summary of home Birth risk assessment to PMA
36 weeks All	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Palpate for presentation and refer if suspected malpresentation • Re-weigh using calibrated scales and document in maternal notes • Discuss: o Breastfeeding o care of the newborn o vitamin k o postnatal depression o newborn screening o postnatal self-care o baby-blues • If CP issues, check care plan in notes • Offer Carbon Monoxide screening to all service users. Offer smoking cessationreferral to all service users with reading of >3ppm. Direct all service users to UHSUSSEX maternity website for more information about smoking in pregnancy
38 weeks All	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Discuss options for management of prolonged pregnancy
40 weeks **Primips only**	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Further discussion of management of prolonged pregnancy • Discuss, document and enable access to information and leaflets on: o Induction of Labour • Offer membrane sweep for low risk service users and VBAC service users with noadditional risk factors
41 All not yet delivered	• Review risk assessment & action/refer if required • Review individual care plan • Check BP, proteinuria, SFH, FM • Offer membrane sweep • Offer and arrange IOL

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Appendix B - Calculating the EDD:

1. EDD should be calculated by USS performed at UHSUSSEX (CRL is the gold standard [up to14+1 weeks]) rather than LMP[1,6]. This is for all pregnancies including IVF / ICSI pregnancies.

2. However where service users conceived by IVF/ICSI and there is a discrepancy between thescan date and IVF date, the pregnant person should be referred to a consultant obstetrician fora final decision about EDD. The agreed EDD should be clearly documented in the pregnant person's notes by the consultant.

3. Service users who decline all scans should have the EDD calculated by LMP. In these casesthe potential problems of using an EDD calculated by LMP should be discussed. Usingan EDD calculated by LMP increases the likelihood of induction for post maturity. In addition it creates difficulties when advising on management / prognosis where labour occurs prematurely, especially around the limits of viability

4. The optimal time for calculating EDD by scan is between 10+0 and 14+1 weeks. EDD calculated by scan between these gestational limits supersedes EDD calculated from LMP and scans before 10+0 weeks. In practice the dating scan is usually performed between 11+2 and 14+1 weeks [i.e. at the time of the NT scan]

5. If a pregnant person has two scans between 10 and 14 weeks, the scan at the time of the NTshould be used

6. If a pregnant person has a scan before 10+0 weeks, an EDD is given but this is recalculated atthe NT/dating scan [11+2 to 14+1 weeks]

7. If a pregnant person declines combined screening, a dating scan is offered ideally at 12 weeks, although a scan at any gestation between 10+0 and 14+1 will provide an accurate EDD

8. Service users booking later than 14 weeks or who are found to be over 14 weeks at thetime of the first scan will have their EDD calculated by head circumference [HC] attheir first scan

9. NB In expected peri-viable deliveries EDD should be agreed between obstetric, midwifery and neonatal teams. This discussion and plan should be clearly documented in the maternity notes and signed by the lead professionals present for the discussion

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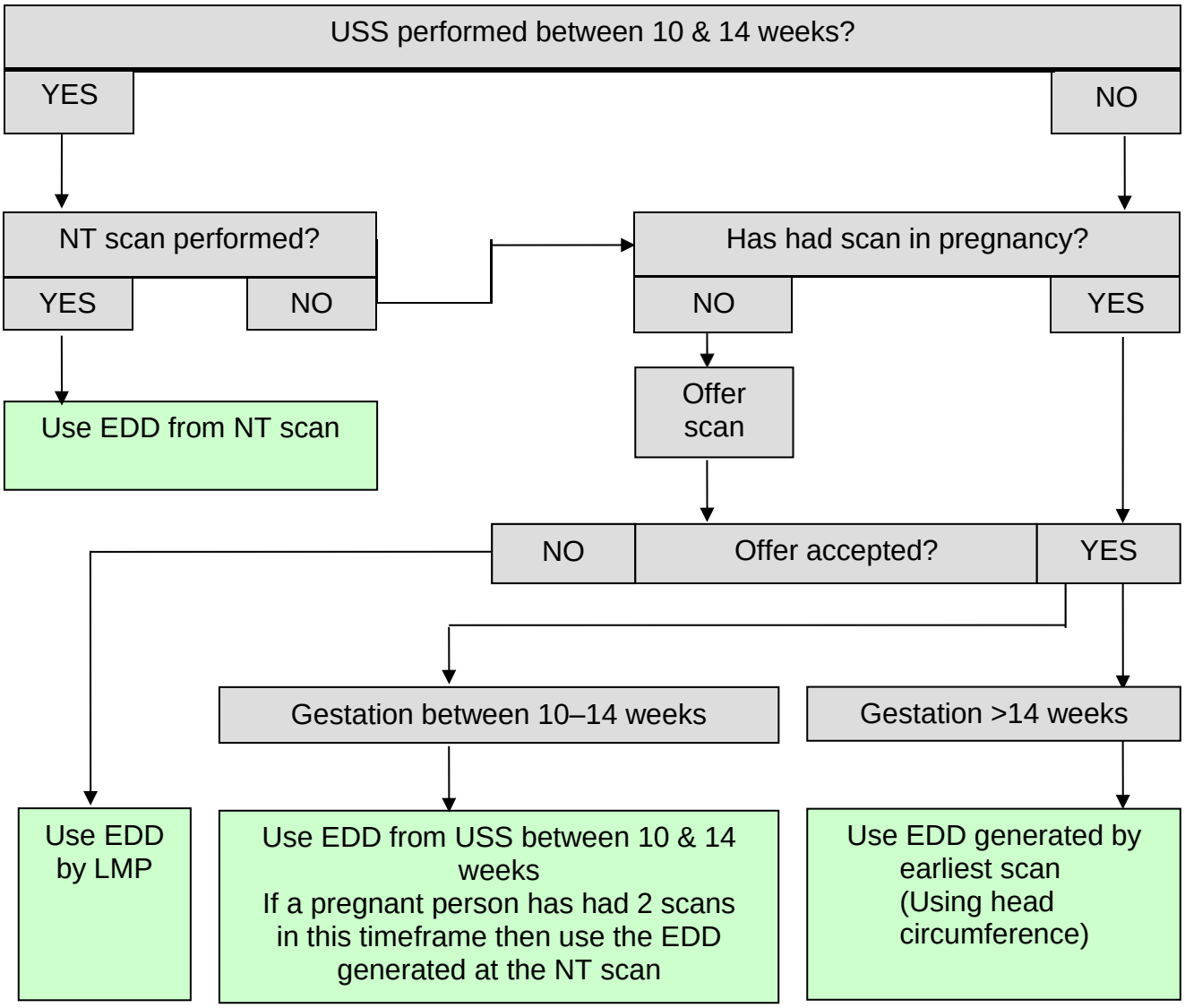
Appendix C - Calculating the EDD flow chart



NB If delivery is likely around 22-25 weeks

- Discussion may be indicated between maternity / neonatal services and family regarding action plan and agreed EDD
- This discussion must be clearly documented in the records and signed by the lead professional

References

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- NHS England 2019 Saving Babies' Lives v.2

Appendix D - Types of Referrals:

Medical – refer to obstetric clinic and relevant specialist midwife (MW)

- Diabetes & endocrine disorders
- Epilepsy
- Cystic fibrosis
- Severe asthma
- Transplant
- Kidney disease
- Cardiac conditions
- Autoimmune disorders inc lupus
- Haemoglobinopathies
- Chronic hypertension
- Antiphospholipid syndrome
- Metabolic disorders
- Previous thrombo-embolic disease / high or intermediate risk of VTE at booking or at any stage risks are identified or changed during pregnancy (via the VTE risk assessment form)
- Psychiatric disorders (see MP014 Mental Health Protocol for further guidance)
- HIV/Hepatitis B/Hepatitis C
- Female Genital Mutilation
- Obesity (BMI of 30 or above) or low weight (BMI of 17 or below)
- Previous malignant disease
- Adverse or allergic reactions to anaesthesia
- Spinal problems (eg scoliosis)
- Service users who have made an informed decision to decline blood products
- Anaesthetic issues / any problems that may affect the ability to administer general or regional anaesthetic
- Service users at high risk of pre-eclampsia

Pregnancy-related (previous or current) – refer to obstetric clinic and relevant specialist MW

- IVF pregnancy (refer to be seen by 16 weeks)
- PIH
- Oligohydramnios / Polyhydramnios
- IUGR (below 5th centile or below 2.5kg)
- Previous large baby (above 95th centile or above 4.5kg)
- Previous uterine surgery including caesarean section
- Previous shoulder dystocia
- Previous LSCS
- Previous PPH (see MP53 Obstetric Haemorrhage for detail)
- Multiple gestation
- Previous stillbirth or neonatal death
- Malpresentation from 36 weeks
- Previous preterm birth
- Severe pre-eclampsia, HELLP or eclampsia

- Three or more recurrent miscarriages
- Puerperal psychosis
- Rhesus immunisation or other blood group antibodies
- Grandmultiparity (more than 6 pregnancies)
- Baby with congenital or structural abnormality

Social / lifestyle related – refer to appropriate specialist midwives

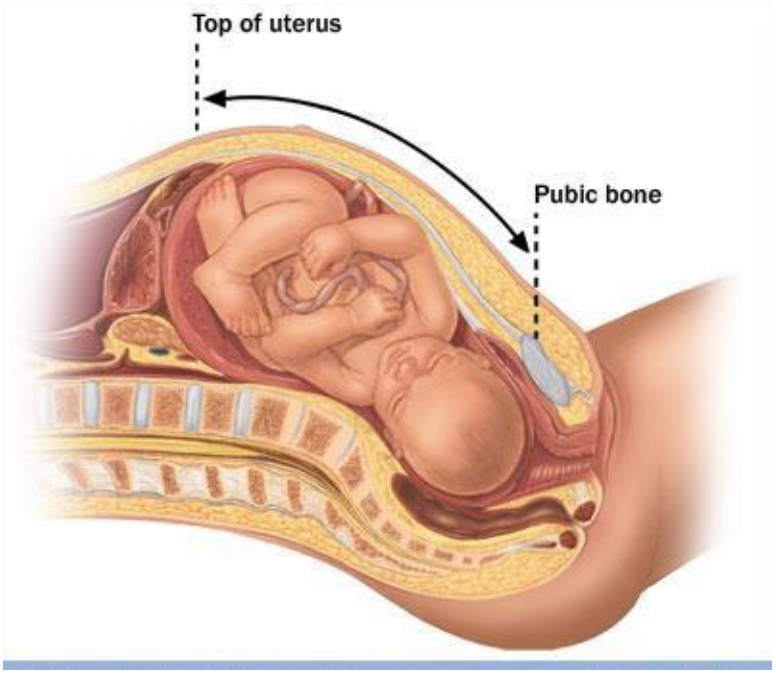
- Substance misuse
- Homelessness
- Teenage pregnancy
- Domestic violence
- Mental health or Learning difficulties
- Disability

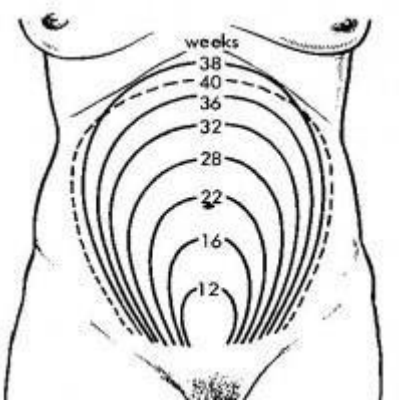
Referral to Anaesthetic Clinic:

A past medical history of any anaesthetic problems	Have had previous difficulties with, or complications of, spinal/epidural anaesthesia or general anaesthesia Allergy to suxamethonium; Known suxamethonium apnoea. History or family history of malignant hyperpyrexia
Respiratory Problems	Severe asthma; cystic fibrosis; pulmonary embolus on anticoagulants; history of pneumothoraxes
Neurological Problems	Any neuromuscular disease e.g. muscular dystrophy; multiple sclerosis; focal neurological signs; Poorly controlled epilepsy; Spina Bifida
Muscular-skeletal Problems	Scoliosis; Harrington rods; Rheumatoid arthritis / Still's Disease. Connective tissue disorders associated with cardiac abnormalities eg Marfans, Ehlors Danlos
Endocrine problems	Unstable thyroid disease
Haematological problems	Idiopathic thrombocytopaenia purpura (ITP); sickle cell disease; congenital spherocytosis; Von Willibrand's Disease
Renal Disease	Renal transplant
Allergies/ Drug sensitivities / Drug abuse	Multiple allergy syndromes; allergies to local anaesthetics; Known scoline apnoea, history of intravenous drug abuse
Airway Problems	Known difficult intubation; obvious anatomical features suggestive of a difficult intubation e.g. bucked teeth, receding jaw; reduced neck movement
Rare But Serious Medical Conditions	Malignant disease

Known Obstetric Conditions That Pose An Increased Risk	Placenta praevia Raised BMI above 50

Appendix E: Calculating Symphysis Fundal Height Measurement:





Definition:

Symphysis-fundal height (SFH) measurement refers to the distance (measured in centimetres) over the abdominal wall from the top of the uterus (fundus) to the upper border of the symphysis pubis. This measurement is taken along the longitudinal axis of the uterus without any correction of the tape measure to the midline of the abdomen, using a non-stretch tape measure which remains in continuous contact with the skin surface of the abdomen.

Process for SFH measurement:

1. Ensure pregnant person has an empty bladder
2. Ensure that the pregnant person has given her consent, is comfortable and lying in a semi-recumbent position
3. Prior to SFH measurement, the midwife should palpate the pregnant person's pregnant abdomento check the baby's size, its position and presentation, the volume of amniotic fluid around the fetus, and to identify the uterine fundus
4. The (metric) measurement scale on the tape measure should always be placed face downwards against the pregnant person's abdomen to prevent the practitioner from making asubjective or biased assessment.

Appendix F – Criteria for Booking Growth Scans

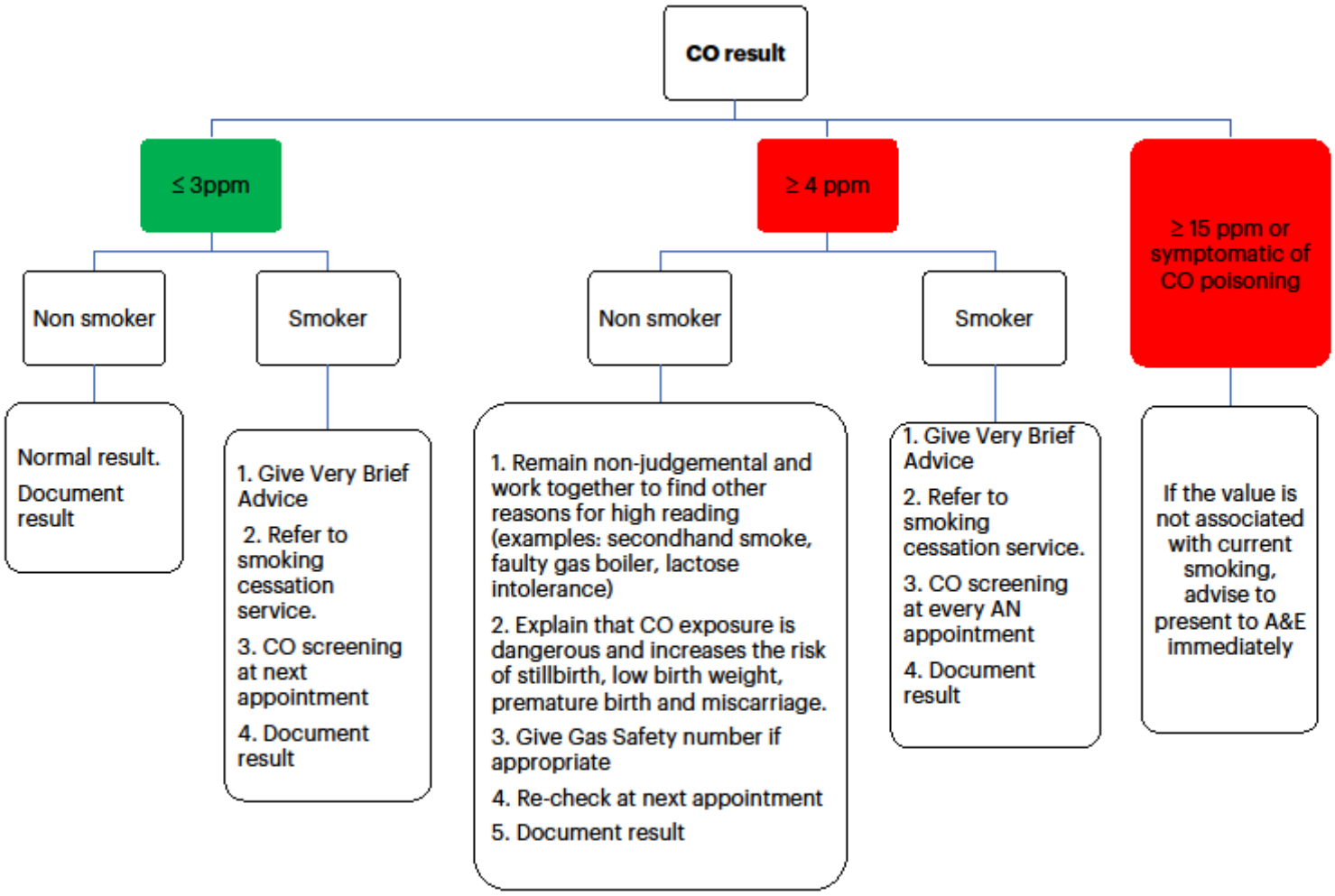
General growth scans at 30 and 34 weeks.Previous IUGR
Previous Stillbirth Uterine anomalies
Anti-phospholipid syndrome/ ThrombophiliaMaternal age over 40 years at booking Service users on anti-epileptic medication

Conditions with different schedule of care
Parvovirus B19 infection – 2-3 weekly from 10 weeks until 10 weeks post infection. After 18weeks gestation, refer for MCA velocities
Pre-existing Diabetic – 24, 28, 32, 36 weeksEssential Hypertension - 28 and 32 weeks
Substance misuses - Growth scan and review at 30 weeks gestationBMI ≥35 - single scan with clinic appointment at 34 weeks gestation
Mild fetal hydronephrosis at the anomaly scan – Repeat scan at 34 weeks gestation Mild/moderate PIH diagnosed before 34/40 - single growth scan, AFI and UA at 34 weeks. Noneed to repeat if normal
Severe PIH – Growth scan, AFI and UA repeated not less than fortnightlySROM – Only if evidence on speculum
Post Dates – AFI only
Reduced Fetal movements – After 2nd episode
Maternal Medical conditions – as requested by consultantGestational Diabetes – as requested by Consultant Suspected polyhydramnios

Multiple pregnancies:
Monochorionic twins: 16, 18, 20, 22, 24, 28, 32, 36 weeks
Dichorionic twins: 24, 28, 32, 36 weeks
Trichorionic triplets: 24, 28, 32, 34
Triplets with monochorionicity: 2 weekly from 16 weeks to 34 weeks.

Growth scans **NOT** indicated routinely.IVF
Single episode of PV bleedingObstetric cholestasis
Mild/moderate PIH diagnosed after 34/40Previous large baby/ traumatic delivery Larges for dates
Anxiety/ maternal reassurance
Fibroids unless close to cervix then single follow-up scan at 36 weeksIncreased NT in early pregnancy
Unexplained recurrent miscarriage Presentation – refer to DAU for scan2 vessel cord
Previous premature labour where the size was normal for gestation

APPENDIX G



Adapted from: Greater Manchester SmokeFree Pregnancy Guideline and Care Pathway. February 2020.