ANTENATAL CARE PATHWAY

NGH-GU-AN26

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GUIDELINE

CONTENTS

1. INTRODUCTION & AIMS

This Pathway was designed to ensure evidence-based care is provided for all women accessing maternity care at Northampton General Hospital (NGH). The ethos of the Pathway is that pregnancy and childbirth are normal physiological processes and unnecessary intervention should be avoided. Interventions offered should have known benefits and be acceptable to pregnant women (NICE, 2014).

An assessment of a woman's well-being and needs are made at each contact and healthcare professionals should offer consistent information and clear explanations. They should provide pregnant women with the opportunity to discuss issues and ask questions (NICE, 2014). Women's views should be respected, even when this is contrary to the views of the healthcare professional (NICE, 2014).

This Pathway is based on National Institute for Health and Care Excellence (NICE) standards for routine antenatal care (NICE, 2014) which are applicable to all women. , However, some women will require additional care so reference is made to other NGH guidelines and policies which support the needs of women with more complex pregnancies. Healthcare professionals should remain alert to risk factors, signs or symptoms that may affect the health of the mother and baby, such as domestic violence, pre-eclampsia and diabetes and discuss referral for appropriate support (NICE, 2014).

2. SCOPE

The Care Pathway provides an evidence-based framework for the health care professionals involved in the antenatal care of a woman in all settings. This involves predominantly the Midwife, but may also include the obstetrician, Maternity Support Worker, Assistant Practitioner and clerical staff.

The Pathway covers the process of the woman first accessing the maternity services, her booking appointment including history taking and sharing of information, and the care given at all subsequent routine antenatal appointments.

It is to be read in conjunction with trust policies and guidelines, which are cross-referenced within the pathway.

3. DEFINITIONS

Term/Word	Definition
ANC	Antenatal Clinic
BBA	Born Before Arrival
BMI	Body Mass Index
EDD	Estimated Date of Delivery
FBC	Full Blood Count
GTT	Glucose Tolerance Test
Hb	Haemoglobin
ICE	Integrated Clinical Environment
IOL	Induction of Labour
MSW	Maternity Support Worker
Mcg	Micrograms
MDU	Maternity Day Unit
MSU	Midstream Urine Test
NBBS	Newborn Blood Spot Screening
NBH	Newborn Hearing
NICE	National Institute for Health & Clinical Excellence
NIPE	Newborn and Infant Physical Examination Programme
NSC	National Screening Committee
NSF	National Service Framework
SROM	Spontaneous Rupture of Membranes
T21	Trisomy 21
USS	Ultrasound Scan

4. ROLES & RESPONSIBILITES

The Obstetrician

Is responsible for formulating and writing a clear plan of care in the woman's antenatal notes when she has been referred for shared care/consultant opinion.

This plan should also be discussed with the woman. When a woman is referred back to community care it is the doctors responsibility to clearly document this in her hand held antenatal notes, discuss this plan with her and also advise her of when she should next see her midwife.

The Midwife

Midwives are autonomous practitioners in normal pregnancy and birth. They are responsible for taking a detailed history at the booking appointment and then referring the woman to be seen by the obstetrician if any risk factors are identified as part of this assessment. It is their responsibility to ensure that, once women have accessed the maternity services, they are seen promptly and that the booking is completed before twelve weeks of pregnancy, and within two weeks of making contact.

The surgery where (s)he is based should have his/her contact details, the phone number of the community midwives office, and the triage phone number. The midwife is responsible for advising women to see a doctor for a medical history and full clinical assessment if they have not had a full medical examination in the United Kingdom. The antenatal care provided by the midwife will be an ongoing assessment of the woman's needs and instigation of the appropriate care.

Maternity Support Worker/Assistant Practitioner

May be involved in the antenatal care of a woman. They will work under the direction of the midwife. They are responsible for informing the midwife of any care undertaken and documenting any care or discussion with the woman in the hand held records.

Clerical Staff in the Community Midwives Office

Are responsible for passing on the message to the community midwife if a woman has contacted them seeking an urgent booking appointment. If the midwife is unavailable the clerical staff must inform the Team Co-ordinator so that an appointment can be arranged by an alternative midwife.

5. The Maternity Care Pathway for Antenatal Care

(5.1 Detailed Version)

GUIDELINE

CARE	RATIONALE/EVIDENCE	STANDARDS
Woman's first contact with Surgery – When the pregnancy is confirmed, the woman usually makes an appointment at her surgery to seek maternity care. When a woman makes contact with her surgery, the receptionist makes an appointment for the woman to be seen ASAP by the midwife, and within two weeks of the initial contact. Midwives should ensure that the surgeries have contact details in the event of an appointment being unavailable. The midwife may need to contact the woman and arrange an appointment directly. The midwife should ask the receptionist at the surgery to inform her if a woman has communication or language support needs. The midwife can then arrange for the appropriate agency/interpreter to be in place for the booking and all subsequent appointments.		

5.1.1 6-8weeks - 1st Booking appointment. Give relevant information and leaflets. Complete hand held notes, including taking a medical, anaesthetic, obstetric, mental health, family, lifestyle and social history as part of the risk assessment. This will determine the type of antenatal care advised. Complete relevant referral forms. Ensure current contact details are obtained.		1. All women are seen within two weeks of referral to the maternity services. 2. All women will have had their full booking appointment and hand held antenatal notes completed by twelve completed weeks of pregnancy.
Women who have not previously had a full medical examination and history taken in the UK, and clinical assessment made of their overall health will be advised by the midwife to see their GP. If they are not registered with a GP they can access a doctor at 'The Maple Access Centre'.	Pregnant women should be offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This information should include where they will be seen and who will undertake their care. *NICE (2010).* Women who have communication or support needs should have access to the same high quality antenatal care. Information should be given in a form which is easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities and to pregnant women who do not speak or read English *(NICE, 2014)*	3. If an interpreter/support/agency is required this will be clearly documented in her hand held notes**.** 4. There is clear documentation to show that all women who have not previously had a full medical examination and history taken in the UK are advised to see a doctor.

All women to be offered scan for viability, gestation and number of fetus. At this point there is the option to measure the nuchal if screening for T21 has been accepted.	This will ensure consistency of gestational age assessments, improve the performance of screening for Down's Syndrome and reduce the need for induction of labour after 41 weeks. *NICE (2008) Induction of Labour* *NICE (2008) Antenatal care*	1. Every woman to be offered a dating scan and information given about the anomaly scan also shared. This will be booked via ICE.
Discuss scans and screening tests including Screening for sickle cell diseases and thalassaemias, hepatitis B, HIV, Rubella, Syphilis, red cell antibodies, group and FBC and Down's syndrome screening. Discussion to be documented in the records.	Abnormal results can be actioned and, therefore, improve health outcomes in addition to giving parents timely choice.	2. All blood tests and scans are discussed with the woman and the leaflet 'Screening test for you and your baby' given
If the woman consents and feels she has had sufficient information regarding her screening tests, blood can be taken at this appointment. Blood results should be checked by 10 days. Discuss need for MSU	Identification and treatment of asymptomatic bacteriuria reduces the risk of pyelonephritis *NICE (2008) Antenatal care*	3. Discuss the need for MSU with every woman 4. All women under the age of 25 to be offered Chlamydia screening. 5. All women who are at increased risk of developing gestational diabetes are identified and offered screening with glucose tolerance test.
Offer Chlamydia screening in under 25's and give information on the local programme	Chlamydia is the most commonly diagnosed sexually transmitted infection in the UK; affecting both men and women. Chlamydia often has no symptoms and can lead to pelvic inflammatory disease,	6. All women under the age of 25 to be offered Chlamydia screening.

Risk assesses need for screening for gestational diabetes- and explain rationale behind testing. See NGHT 'Diabetes in pregnancy' guideline Women at increased risk of developing gestational diabetes will be offered a glucose tolerance test at 26 weeks gestation. (16 and 26 weeks on MDU if history of gestational diabetes (Appendix 1). Carry out antenatal checks in accordance with National Guidelines (Appendix 2) and woman's choice. Document who is present at each consultation. Antenatal Summary (in yellow folder) to be completed at each contact in surgery/home.	• BMI above 30kg/m2 • Previous gestational diabetes • First degree relative with diabetes (parent, sibling or child) plus grandparents • Family origin with a high prevalence of diabetes: • South Asian (specifically women whose country of origin is India, Pakistan or Bangladesh • Black Caribbean • Middle Eastern (Specifically women whose country of family origin is Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon or Egypt) • Previous baby weighing 4.5kg or above • Unexplained stillbirth • Polycystic ovary Syndrome Plans will be open to change at any point during pregnancy and any risks carefully assessed Shribman (2007) Making it better for Mother and Baby	7. All women who are at increased risk of developing gestational diabetes are identified and offered screening with glucose tolerance test. 8. Blood pressure and urinalysis for proteinuria and glycosuria to be assessed at every visit.

Discuss health/lifestyle issues including food hygiene, diet, alcohol, smoking cessation and recreational drugs (see Substance Misuse in Pregnancy - NGHT 2009)	There are significant risks to the health, and life, of a baby if the mother smokes. These include the risk of miscarriage, premature birth and stillbirth, of placental abnormalities, low birth weight and, after birth, sudden infant deaths. It is estimated that about one third of all perinatal deaths in the UK are caused by smoking. There is also a significant risk to fetal development with women misusing drugs or alcohol *NSF (2004) Standard 11* *NICE (2008) Antenatal care* *RCOG (2008) Standards for Maternity Care* *Shribman (2008) The Child Health programme* *NGHT (2009) Substance Misuse in Pregnancy(NGHT 2009)*	9. All pregnant women who smoke should receive clear information about the risks of alcohol and smoking and the support available to them to stop
	Women should be advised to avoid drinking alcohol in the first three months of pregnancy as it may be associated with an increased risk of miscarriage Those who choose to drink alcohol should be advised no more than 1-2 units per week (NICE 2010).	10. All women to be advised on the benefits of taking folic acid
Discuss rationale behind taking folic acid See Appendix 1 for those requiring high dose folic acid	Ideally women should take 400mcg folic acid before conception until 12 weeks gestation. This is known to reduce the risk of neural tube defects. *NICE (2008) Antenatal Care*	

Discuss importance of maintaining Vitamin D stores, and advise supplementation to those at greatest risk. See Appendix 1 Allergies must be identified as part of the antenatal assessment	All women should be informed of the importance for their own and their baby's health of maintaining adequate Vitamin D stores during pregnancy and whilst breastfeeding. In order to achieve this, women may choose to take 10 micrograms of Vitamin D per day, as found in the Healthy Start multivitamin supplement. Particular care should be taken to enquire as to whether women at greatest risk are following advice to take this daily supplement. These include: − women of South Asian, African, Caribbean or Middle Eastern family origin − women who have limited exposure to sunlight, such as women who are predominantly housebound, or usually remain covered when outdoors − women who eat a diet particularly low in Vitamin D, such as women who consume no oily fish, eggs, meat, Vitamin D-fortified margarine or breakfast cereal − women with a pre-pregnancy body mass index above 30 kg *NICE 2008 (Antenatal Care)*	11. Supplementation of Vitamin D discussed with women at greatest risk. 12. Allergies must be identified as part of the antenatal assessment
Identify and document women who would decline blood or blood products. See guideline for 'Women who decline Blood Products' Measure height and weight and calculate BMI	*'Women who decline Blood Products'* Normal Range:18.50 - 24.99.	12. Ask all women if they give consent to blood/blood products-this will be documented in the hand held antenatal notes 13. BMI to be calculated at booking and

(Refer to guideline for 'The Management of Women Who Present With a High Body Mass Index At Booking)	Women with a low BMI, or who gain inadequate weight in the third trimester, are more likely to give birth preterm Women with a raised BMI have a higher mortality and morbidity rate. There is also evidence that babies of obese women have significantly increased risks of adverse outcomes, including fetal congenital anomaly, prematurity, stillbirth and neonatal death. *WHO (2004)* *CEMACH report (2003-2005) Saving Mothers lives* *NICE (2008) Antenatal Care* If BMI above 35 - unsuitable for midwife-led care *'The Management of Women Who Present With a High Body Mass Index At Booking) NGHT (2009)*	documented in the handheld notes
Discuss choices of care/lead professional/place of birth (See Appendix 3a, 3b & 3c) 'planning place of birth' - tool to aid assessment for home birth suitability. To make a referral for Consultant care a referral form is completed and then faxed to Gynae bureau stating 'routine' or 'urgent' appointment required. An urgent referral is seen within 7 days. (Appendix 4) Where shared care is declined, the midwife must ensure that an individual management	Midwives in partnership with pregnant women and their partner, will discuss all realistic options and draw up a personalised, individual flexible plan for care. *DOH (2007) Maternity Matters* The midwife should promote normality and choice in maternity care *NSF (2004) Standard 11* *NICE (2014) intrapartum care* *Standards for Maternity Care (2008) Standard 11 and Standard 6* For low risk multiparous women, birth at home or in a midwifery led unit is particularly suitable for them because the rate of	14. Antenatal records to clearly show who the lead professional is i.e. midwife or consultant 15. Women with complex medical conditions or any identified risk factors to be offered assessment by consultant obstetrician 16. Where risks are identified, A clear management plan to be documented by the obstetrician, in the antenatal records following discussion with the woman.

plan is identified following discussion with the obstetrician. If at any time during pregnancy the midwife has any concerns; a direct referral to ANC; MDU or Labour Ward should be made as appropriate to needs.	interventions is lower and the outcome for the baby is no different compared with an obstetric unit. For low risk nulliparous women birth in a midwifery led unit is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. A planned birth at home carries a small increase in the risk to an adverse outcome for the baby. *(NICE 2014)* Every woman is able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have. *NSF (2004) Standard 11* *NICE (2008) Antenatal Care*	17. Written and verbal information given on options for place of birth, and documented in the antenatal records.
Assess: • Mental health If mental health issues identified, refer to guideline 'Perinatal Mental Health 2009'	Mental disorders during pregnancy and the postnatal period can have serious consequences for the Mother, her infant and other family members. Ask about: • past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the • postnatal period and severe depression • previous treatment by a psychiatrist/specialist mental health	21. Discussion of mental health issues with all women

• Safeguarding issues • All women who meet criteria on trigger list for safeguarding are referred to appropriate agencies where relevant	team including inpatient care • a family history of perinatal mental illness. • During the past month, have you often been bothered by feeling down, depressed or hopeless? • During the past month, have you often been bothered by having little interest or pleasure in doing things? *(Whooley questions)* A third question should be considered if the woman answers 'yes' to either of the initial questions 1. Is this something you feel you need or want help with? *NICE (2008) Antenatal Care* *NICE (2007) antenatal and postnatal mental health* *NSF-Standard 11 Pre-birth Mental Health* *DOH (2002) Women's Mental Health: Into the mainstream* *CEMACH Report 2003-2005 (2007) Saving Mothers Lives* *NSF (2004) STANDARD 11* *Perinatal mental Health Guideline NGHT 2009* Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. All those who come into contact with children and families in their every day work, including professionals who do not have a specific role in relating to child protection have a duty to safeguard and promote the welfare of children. *Working together to Safeguard Children (2006)* *Childrens Act (2004) Section 11*	

• Domestic violence issues • Midwife to document who woman is accompanied by at all antenatal appointments Complete initial risk assessment as part of the booking appointment. This will be fully reassessed at 28 and 36 weeks. This not only identifies any deviation from the norm and action taken, but also provides an assessment of any antenatal risk factors including personal, medical, anaesthetic, surgical, mental health and obstetric history. Women who do not attend appointments must be actively followed up (See guideline for 'Non attenders to Antenatal/Postnatal Appointments' NGHT 2015	*NSF (2006) Standard 5* *Every Child Matters: Next steps (2004)* *Northampton Child Protection Policy 2007* Almost a third of domestic violence begins with pregnancy. Feedback from pregnant women already in abusive relationships is that existing abuse often intensifies during pregnancy. The effect of violence on the unborn baby can lead to miscarriage, stillbirth, intra-uterine growth restriction and premature birth as well as to long lasting physical disability. For the mother, violence can cause life-threatening complications and sometimes result in her death. *DOH (2000)Domestic Violence* *CEMACH report 2003-2005(2007) Saving Mothers Live* The risk assessment identifies if there is any deviation from the low risk care pathway. Every woman develops and is encouraged to regularly review, her individual care plan in partnership with a health care professional. The plan is based on an assessment of each woman's clinical and other needs and she and her health care professional are able to discuss changing it at any point in her pregnancy *DOH (2004) NSF* Children born to women from more vulnerable groups experience a higher risk of death or morbidity and face problems with pre-term labour, intrauterine growth restriction, low	22. All women are asked, (when not accompanied by partner) if they are affected by domestic violence 23. Complete full risk assessment at booking, 28 and 36 weeks 24. When a woman returns from consultant to midwife led care this is clearly documented in the antenatal records, including the plan of care. The woman will be advised of the plan, and also the timing of her subsequent appointment with her midwife. This will be documented in her hand held antenatal records Women who do not attend appointments are actively followed up

Risk assess for VTE Risk assess for pre eclampsia And consider more frequent BP measurements for women with any of the identified risk factors (Appendix 1) Risk assessments for hypertensive diseases of pregnancy, gestational diabetes, vitamin D insufficiency, need for high dose folic acid supplementation and chlamydia screening are part of a risk assessment sheet which should be attached using the adhesive strip to the antenatal notes. (Appendix 1) The VTE risk assessment is contained within the antenatal notes.	birth weight, low levels of breastfeeding and higher levels of neonatal complications. The findings of the CEMACH report demonstrate that those women who need maternity services most use them the least. *CEMACH (2003-2005) 2007 Saving Mothers Lives* *'Non attenders to antenatal/postnatal clinics ' NGHT (2015)* Thromboprophylaxis in the antenatal, intrapartum and postpartum period (NGHT 2009) *Hypertension in Pregnancy: NICE 2010*	25. Risk assess for VTE - and refer to Antenatal Clinic if indicated 26. Risk assess for pre eclampsia and refer to ANC if indicated.
5.1.2 **8 - 10 weeks** 2nd Booking appointment. Blood Tests obtained and consent documented (results to be followed up within 10 days). If previously obtained, access results and document in records and discuss with the woman. .	Screening for sickle cell diseases and thalassaemia should be offered to all women. *NICE (2008) Antenatal Care* *(2008)* *NSF (2004) Standard 11* *NSF (2004) Standard 11*	27. Where bloods were not taken at the initial booking, a second appt will be made. Ideally this should be by 10 weeks of pregnancy 28. All women to have contact numbers of midwives in team and of the triage phone number
Discuss breastfeeding and options for antenatal classes	Promotion of health and wellbeing includes the discussion of breastfeeding with	29. Breastfeeding to be discussed with all women before 16 weeks of pregnancy.

	prospective parents and the risks of not breastfeeding *Shribman (2008) The Child Health Programme UNICEF 2006*	
Offer to review labour notes of previous birth, if appropriate	*CEMACH Report (2003-2005) Saving Mothers Lives*	30. Send MSU in early pregnancy
Send MSU sample to screen for asymptomatic bacteriuria	*NICE (2008) Antenatal Care*	31. Send MSU in early pregnancy
Discuss importance of pelvic floor exercises	Pelvic floor muscle training should be offered to women in their first pregnancy as a preventive strategy for postnatal urinary incontinence *NICE (2006) Urinary Incontinence*	33. Discussion of pelvic floor exercises with all women
Scan performed at the hospital And 20 week anomaly scan appointment will be made by USS following dating scan.	11-13 +6 week scan. *National Screening Committee (2008)*	34. All women who have requested an ultrasound scan to have had ultrasound scan before 13+6 wks

5.1.3 16 weeks Carry out appropriate checks in accordance with National Guidelines and woman's choice. (Appendix 2) Document blood results in handheld notes. Offer second trimester screening if combined screening has not be offered or previously declined. Information on prophylactic Anti-D for women who are rhesus negative.	*NICE (2008) Antenatal Guidelines* Second trimester Quadruple test can be performed from 14+2 – 20+0 weeks' gestation. To prevent haemolytic disease of the infant and new-born.	3. All women who have missed the nuchal scan to have been offered the Quadruple Test by 20 weeks gestation 4. All women should be offered T21 screening and the results recorded. 5. All booking bloods, and dating scan results will be discussed and documented by 16 weeks gestation

Discuss the health benefits of breastfeeding	Infant Feeding Policy NGH NHST 2015	6. All Women to receive information on the health benefits of breastfeeding
5.1.4 18 – 20+6 weeks If the woman accepts anomaly screening, an ultrasound scan is performed at the scan department. For a woman whose placenta is found to extend across the internal cervical os at this time, a further scan at 32 - 34 weeks is offered	An anomaly scan should be offered to detect structural anomalies to give parents choice in addition to timely appropriate referrals that may include place of delivery. *NICE (2008) Antenatal Care* *National Screening Committee (2008)* *Assessment of Fetal growth*	7. All women to be offered an anomaly scan and it has been undertaken by 20+6 weeks of pregnancy.
5.1.5 25 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice (Appendix 2) *1. All primips should be seen at 25+ weeks to carry out a full antenatal assessment including fundal height measurement* *2. If this appointment occurs when a primip is 24+ weeks, carry out an antenatal assessment but ask the woman to return in two weeks (at 26+ weeks) for a fundal height measurement.* *3. All multips should be seen at 28 weeks for a full antenatal assessment and fundal height measurement.'*	Measuring and plotting symphysis-fundal height at each appointment is good practice. This can help to detect large or small for gestational age infants. *NICE (2008) Antenatal Care* *'Although NICE advise that all primips are seen at 25/40 and have the fundal height measured and plotted at this stage, the Perinatal Institute who provide the growth chart training, advise that this is done at 26/40.* *In order to detect pre eclampsia in early pregnancy it is important that primips are seen prior to 26/40. The disadvantage of measuring fundal height at this stage is an increase in the number who plot below the 10th centile.*	8. Measure and plot symphysis-fundal height at each routine appointment on the customised growth chart. From 25 weeks in all nulliparous women and 28 weeks for parous women. 9. Notification of Pregnancy to health Visitor by 26 weeks gestation

Notification of Pregnancy to health Visitor by 26/40		
5.1.6 28 weeks Carry out antenatal checks in accordance with National guidelines and woman's choice. Screening tests will be dependent on consent of individual. FBC and red cell alloantibodies Administer prophylactic Anti-D to those women who are blood group rhesus negative and who have consented. All bloods should be reoffered if declined previously Previously declined IDPS tests should be reoffered and outcome recorded. If still declines – consider referral to specialist services. Offer and book antenatal classes Repeat 28 week risk assessment Discuss feeding and the value of relationship building in relation to her unborn baby. Discuss options for place of birth	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if needed *NICE (2008) Antenatal Care* *UK National Screening Committee (2008)* *NSF (2004) Standard 11:* *Standards for Maternity Care (2008) Standard 10* Reduced risk of vertical transmission *(NSC, 2010).* Infant Feeding Policy NGH NHST 2015	10. All women are offered repeat blood tests. 11. If rhesus negative, consent completed ensure Anti D is given at 28 weeks 12. All women and their partners to have been offered programme of education for childbirth and parenthood 13. Infant feeding to have been discussed again with all women by 28/40 14. Repeat 28 week risk assessment 15. Give Verbal and written information on infant feeding and relationship building.
5.1.7 31 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 2) Sign Surestart form	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if	

Document 28 week blood results for all nulliparous women	needed. To ensure Health Visitor is kept updated if appropriate *NICE (2008) Antenatal Care* *UK National Screening Committee (2008)* *NSF (2004) Standard 11*	
5.1.8 34 weeks Carry out antenatal checks in accordance to National guidelines and woman's choice (Appendix 2). Discuss breastfeeding. Repeat FBC – if Hb at 28 weeks was below 10.5. if no improvement consider parental supplementation Discuss option of a 36 week home visit to/home assessment in labour for low risk women Discuss choices around place of birth. Referral to the Birth Centre where appropriate. Women who have had a previous BBA /precipitate labour to be referred to the Homebirth team for a risk assessment	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. Infant Feeding Policy NGH NHST 2015 NICE Antenatal Care Update 2014 NICE Intrapartum Care 2014 To reduce the risk of a BBA a midwife from the Homebirth team will offer a home visit at 36 weeks to complete a risk assessment.	. 16. All 28 week screening tests to have been followed up within 10 days and discussed and recorded by 34 weeks. 17. Breastfeeding, responsive feeding and relationship building with the unborn baby to have been discussed by 34 weeks . 18. Low risk women to be given information and choice around home assessment in labour 19. All women to have a further discussion around place of birth. 20. Women who have had a previous BBA /precipitate labour to be referred to the Homebirth team for a risk assessment
5.1.9 36 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice. (Appendix 2) Complete risk assessment form 'women choosing a homebirth Review scans for placental location. Review all screening results.	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if needed. To detect any deviation from norm.	21. Complete risk assessment at home at 36 weeks for women choosing to birth at home 22. Women who have an uncomplicated singleton breech pregnancy from 36 weeks should be offered external cephalic version.

Refer for presentation scan if appropriate. Homebirth team contact details to go in notes of low risk women who are suitable for home assessment in labour. Give specific information on care of the newborn including screening tests, Vit K, postnatal self care, baby blues and postnatal depression. Discuss early labour assessment at home for low risk women irrespective of place of birth. Give specific information on Preparation for labour and birth, including the birth plan, recognising active labour and coping with pain. Place of birth to be re-discussed. Discuss and given information about Newborn Screening, NIPE and NBBS NBH.	*NGHT (2008) Home Birth Policy* *NSF (2004) Standard 11:* *NICE (2008) antenatal Care* Breastfeeding rates are higher in women who receive breastfeeding education *NICE (2008) Antenatal Care* *UNICEF (2006)* *NSF (2004) Standard 11:* *RCOG (2008)Standards for Maternity CARE Standard 15* To ensure women are able to make an informed choice regarding examination and tests for their baby. *(NSC, 2008, 2012).*	. 23. Homebirth team contact details to go in notes of low risk women who are suitable for home assessment in labour 24. Complete 36 week risk assessment 25. Postnatal care to be discussed with all women, including information on Vitamin K 26. All women are given the opportunity to discuss preparation for labour and birth at 36 weeks 27. At least one antenatal visit to be undertaken at home by either a midwife, AP or MSW
5.1.10 38 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 2) Discuss options for management of prolonged pregnancy	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle • using health promotion opportunities • integrated woman and baby centred care • what women want; kindness, support and respect • promotion of normality *NICE (2008) Antenatal Care*	28. Management of prolonged pregnancy to be discussed with all women.

	NSF (2004) Standard 11:	
5.1.11 40 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 2) Date for induction of labour can be offered and arranged	*NICE (2008) Antenatal Care* *NICE (2008) Induction of labour* *NGHT (2007) Induction of Labour*	
5.1.12 41 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice. Date for induction arranged Induction offered and booked T + 12 weeks. This should only be considered when vaginal delivery is felt to be the most appropriate mode of delivery. Due consideration should be given to maternal preferences and priorities prior to commencement of induction. Rhesus Negative women: if a woman decides to prolong her pregnancy to ≥42 weeks offer an additional dose of Anti D and arrange Anti D clinic appointment if accepted.	Membrane sweeping makes spontaneous labour more likely, and so reduces the need for formal induction of labour to prevent prolonged pregnancy *NICE (2008) Induction of Labour* *NICE (2014) Updated Antenatal Care* To prevent Haemolytic Disease of the Newborn (BCSH, 2014, NGH, 2015).	29. All women are offered a stretch and sweep from 41 weeks and / or prior to formal induction of labour 30. All women with uncomplicated pregnancies are offered induction of labour at T + 12

5.1.13 Record keeping **(see bolt on Maternity Records Management NGHT 2009)**	Record keeping is an integral part of nursing midwifery and specialist community public health nursing practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow. Good record keeping helps to protect the welfare of patients and clients by promoting • high standards of clinical care • continuity of care • better communication and dissemination of information between members of the inter-professional health care team • an accurate account of treatment and care planning and delivery • the ability to detect problems such as changes in the patient's or client's condition at an early stage The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner whilst careless or incomplete record keeping often highlights wider problems with the individual's practice. *NMC (2007) Record Keeping*	31. An annual notes audit is carried out

5.2 Maternity Care Pathway for Antenatal Care (Summary)

APPOINTMENT	INFORMATION/ISSUE	COMPLETE	PROCEDURE	DISCUSS
6- 8 weeks First Booking appt with midwife Identify communication needs e.g. interpreter	Pregnancy hand held notes 'Screening tests for you and your baby' available in various languages from: http://www.screening.nhs.uk/searchwebsite.php?searchstring=screening+tests+for+you+and+your+baby Contact numbers of named midwife/team/triage/GP/ other referral agencies FW8 prescription form Bounty pack Healthy Start Leaflet ' NHS Choices website Pregnancy Book available to download from http://www.dh.gov.uk Blood Groups and Red Cell Antibodies in Pregnancy leaflet (NHS Blood and Transplant). Inform pregnant women younger than 25 years about the high prevalence of chlamydia n their age group. Emotional Changes During Pregnancy and Following Childbirth Choices Leaflet	Pregnancy hand held notes-documenting who is present at each consultation Complete electronic booking Antenatal Clinic referral form, if appropriate Smoking referral form and return to community office FW8 Antenatal Summary at each appointment (in yellow folder) Risk Assessments including mental health Assess for PET, VTE and GTT Accept/decline Blood/products identification in the handheld notes Complete referral for obstetric opinion form Blood test forms, Consent, Family Origin Questionnaire Document alone or accompanied at all appointments. Where provided partners details to be recorded in the antenatal records	Previous obstetric history: Review hospital notes if appropriate Venepuncture (results to be followed up within 10 days) Height, weight and BMI BP and urinalysis Confirm contact details are current on IT system or midwives register. Take history performing risk assessments to identify women who need additional care Book scan	Pattern of care/lead professional Choices for place of birth Blood tests including FBC, syphilis, Hep B, HIV, rubella, haemoglobinopathies, group and red cell antibodies. (Can be taken at this appt-if not organise second booking appt by 10/40) Need for GTT if relevant (see Appendix 1) Identify women who have had FGM Health/lifestyle issues-diet, food hygiene, smoking cessation, recreational drug use, alcohol consumption Maternity benefits Benefits of Folic acid (400mcg) Vit D (10mcg) Supplements for those at risk of Vit D deficiency Previous labour/birth if applicable Local Chlamydia Screening Programme Mental health/Safeguarding issues Domestic violence issues (if seen alone-at least one opportunity to be seen alone during the pregnancy) Nuchal scan plus screening bloods, or quadruple test if late booking. Anomaly scan. Benefits and risks of screening/ diagnostic tests. Acceptance/decline Blood/products Offer screening for gestational diabetes and pre-eclampsia
11 - 13^{+6} weeks Ultrasound Scan with Sonographer		Scan report by sonographers	Attend scan – if abnormal, refer to PND, inform Community Midwife	
16 weeks With midwife	Rhesus D Negative women give Antenatal Prophylaxis with Anti D (CSL Behring) 'Off to the Best Start' leaflet	Risk assessment EDD from dating scan Pregnancy hand held notes Blood results documented in notes Record discussions	BP and urinalysis Reassess planned pattern of care – identify any need for additional care Investigate Hb below 110g/100ml. Make appointment in Anti D clinic if Rhesus Negative and consents to Anti-D	Scan report Relevant health/lifestyle issues Individual queries of the woman/partner Blood test results Relevance of rhesus negative blood group-Anti D for antenatal and possible need for postnatal administration. Safety of Anti-D. Health Benefits of Breastfeeding

APPOINTMENT	INFORMATION/ISSUE	COMPLETE	PROCEDURE	DISCUSS
18 - 20 weeks With Ultrasound Department			Anomaly scan	Low lying placenta – Repeat scan at 32 - 34 weeks gestation if placenta covering or reaching internal os
25 weeks With Midwife (nulliparous only)	MATB1 (Eligible from 20/40) Give information, with an opportunity to discuss issues and ask questions. Offer verbal information supported by antenatal classes and written information.	Pregnancy hand held notes MATB1 (eligible from 20/40) Notification of Pregnancy to the Health Visitor	BP and urinalysis Reassess planned pattern of care – identify any need for additional care Measure and plot symphysis-fundal height Offer auscultation of fetal heart	Relevant health/lifestyle issues Individual queries of woman /partner Feedback re: Quadruple Test Scan results Blood results Infant feeding choices Antenatal classes
28 Weeks With Midwife	Continue to offer consistent information and clear explanations about care "Mothers And Others Guide"	Pregnancy hand held notes including risk assessment Full blood count and antibodies form/ICE Document discussions Second risk assessment in antenatal records Electronic Health visitor liaison form by 26/40	BP and urinalysis Weigh if BMI >30 (booking) FBC/Antibodies: investigate Hb level below 10.5g/100 ml and consider iron supplementation if indicated. Measure and plot symphysis-fundal height Offer auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Discuss place of birth Ensure antenatal classes booked if required Verbal and written information on infant feeding and relationship building. Review planned pattern of care to ensure still appropriate
28 – 30 Weeks Anti-D clinic	Advise woman to wait in clinic for 20 mins after administration and to alert staff if becomes unwell.	Anti-D consent in records, batch number, site,date and time given	Administration of prophylactic Anti-D 1500iu for Rhesus Negative women who have consented.	Ensure woman has received and understood information about Anti-D prohylaxis
31 Weeks With Midwife Nulliparous women only	Sign Surestart grant if requested Results of screening tests Identify women who require additional care	Pregnancy hand held notes – blood results documented in notes Document discussions.	BP and urinalysis Measure and plot symphysis-fundal height Offer auscultation of the fetal heart Review to identify if woman has additional needs and refer to obstetrician if appropriate	Relevant health/lifestyle issues Individual queries of woman/partner Blood test results Review planned pattern of care to ensure still appropriate
34 Weeks with Midwife	'Care of women and their babies during labour' (NICE) Preparation for labour and birth: Birth plan, coping with labour pain, Recognition of active labour	Pregnancy hand held notes – blood results documented in notes (multips) Document discussions Document	BP and urinalysis Measure and plot symphysis -fundal height Offer auscultation of the fetal heart Review to identify if	Relevant health/lifestyle issues Individual queries of woman/partner. Early labour assessment at home for low risk women irrespective of place of birth. Refer previous BBA/precipitate labour to

	Results of screening tests undertaken at 28 weeks (if not previously discussed)	blood/screening results in notes if not previously completed	woman has additional needs and refer to obstetrician if appropriate	Homebirth Team Review and discuss planned pattern of care Breastfeeding, responsive feeding and relationship building with the unborn baby to have been discussed by 34 weeks
36 Weeks With Midwife – Clinic or Home visit At least one home visit by 36/40 to be undertaken by a midwife AP or MSW	Home birth notes and ID stickers for woman's notes Homebirth team contact details for women who are suitable for home assessment in labour Breastfeeding information Vitamin K Information leaflet NGHT 'Caesarean Section' 'Your choice of Anaesthesia' Elective CS Pathway enhanced recovery leaflet. 'External Cephalic Version' available from antenatal clinic Discuss newborn screening, NIPE, NBBS, NBH and information in the Screening Tests for You and Your Baby booklet Postnatal self-care Awareness of 'baby blues' and postnatal depression	Pregnancy hand held notes Document discussions Risk assessment of women using birth centre or home birth	BP and urinalysis Measure and plot symphysis – fundal height and check presentation Reassess planned pattern of care/identify need for additional care Offer Auscultation of the fetal heart	Preparation for labour and birth, including the birth plan, recognising active labour and coping with pain. SROM at term. Latent phase of labour Place of birth, Birth plan, vitamin K, third stage, birth partners, postnatal care Reassess health/lifestyle issues Individual queries of woman/partner Contact information for home assessment in labour If breech, offer ECV Postnatal period, 'baby blues' and postnatal depression.
38 Weeks With Midwife		Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis –fundal height and check presentation Offer Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Management of prolonged pregnancy
40 Weeks With Midwife		Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis-fundal height and check presentation Offer auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Management of prolonged pregnancy
41 Weeks With Midwife	Date for IOL can be offered and arranged 41– 42 weeks 'Induction of Labour' (NICE)	Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis-fundal height and check presentation Offer vaginal examination for membrane sweep Book induction of labour, if consented Offer Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Additional Anti-D dose required if Rh Neg if woman not delivered at 42 weeks. Discuss with consultant.

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Northampton General Hospital Guideline for Domestic Violence - draft 2009

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Appendix 1

It is possible to reduce the risk of some conditions developing in pregnancy, reduce their severity or make an early diagnosis by giving particular treatments/supplements or performing additional tests. It is not necessary to do this for every pregnant woman but only those who have risk factors. This sheet will allow the midwife and/or doctor to assess these risk factors.

Risk factors for hypertensive diseases of pregnancy, including pre-eclampsia:

Major risk factors
Hypertensive disease during a previous pregnancy
Chronic kidney disease
Autoimmune disease such as systemic lupus erythematosis or antiphospholipid syndrome
Type 1 or type 2 diabetes
Chronic hypertension

→ Advise women with one of these major risk factors to take 75 mg of aspirin daily from 12 weeks until the birth of the baby. Refer to Consultant-led care.

Minor risk factors
First pregnancy
Age 40 years or older
Pregnancy interval of more than 10 years
Body mass index (BMI) of 35 kg/m2 or more at first visit
Family history of pre-eclampsia
Multiple pregnancy.

→ Advise women with **two or more** of these risk factors to take 75 mg of aspirin daily from 12 weeks until the birth of the baby. Refer to Consultant-led care

Please see British National Formulary for cautions and contraindications to aspirin. Do not prescribe if there is a history of peptic ulceration. Caution is advised in patients with asthma and known hypersensitivity to aspirin and NSAIDs. If in doubt seek medical advice from Obstetrician or GP.

Vitamin D supplementation:

Women at risk of low Vitamin D
South Asian, African, Caribbean or Middle Eastern family origin
Limited exposure to sunlight, such as women who are predominantly housebound, or usually remain covered when outdoors
Diet particularly low in vitamin D, such as women who consume no oily fish,eggs, meat, vitamin D-fortified margarine or breakfast cereal
Pre-pregnancy body mass index above 30 kg/m2

→ All women should be informed at the booking appointment about the importance for their own and their baby's health of maintaining adequate vitamin D stores during pregnancy and whilst breastfeeding. In order to achieve this, women may choose to take 10 micrograms of vitamin D per day, as found in the Healthy Start multivitamin supplement. **Particular care should be taken to recommend women at greatest risk ie women with one of these risk factors to take 10 micrograms of vitamin D per day during pregnancy and whilst breastfeeding.**

High dose folic acid:

Women requiring high dose folic acid
BMI over 30
Pre-existing diabetes
First degree relative of either parent or personal history in either parent of neural tube defect
Epilepsy

→ Advise women with one of these risk factors to take 5mg folic acid per day ideally from 3 months pre-conception to at least 12 weeks.

This sheet does not cover all of the preventative treatments/assessments that can be done in pregnancy but those used most commonly. Risk assessments should be performed in conjunction with clinical judgment.

NGV1767 Updated 11/15

Risk factors requiring a GTT are as follows:

Previous gestational diabetes	Book for GTT on MDU at 16 weeks. If normal, repeat test at 26 weeks
BMI above 30kg/m2	One or more risk factors - organize GTT in community at 26 weeks
First degree relative with diabetes (parent, sibling or child)	
Grandparent with diabetes (parents may be too young to have developed diabetes as yet)	
Family origin with a high prevalence of diabetes: ○ South Asian (specifically women whose country of origin is India, Pakistan or Bangladesh) ○ Black Caribbean ○ Middle Eastern (specifically women whose country of family origin is Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon or Egypt)	
Previous baby weighing over 4.5kg or customised birthweight centile greater than 90th	
Previous unexplained stillbirth	
PCOS (polycystic ovarian syndrome)	

It is the responsibility of the person requesting the GTT to obtain and act upon the result of the GTT within one week.

Abnormal GTT results are (Association of British Clinical Diabetologists):

Fasting – greater than or equal to 5.6 mmol/L
2 hour – greater than or equal to 7.8 mmol/

VTE risk assessment

At booking, the Perinatal Institute VTE risk assessment in the antenatal notes should be used. **However, please note that a BMI of 30-40 is a risk factor but a BMI of over 40 counts as "2 risk factors".** Therefore a woman with a BMI of over 40 and one other risk factor should be considered for antenatal thromboprophylaxis.

Chlamydia screening

All women under the age of 25 should be offered screening for Chlamydia.

This sheet does not cover all of the preventative treatments/assessments that can be done in pregnancy but those used most commonly. Risk assessments should be performed in conjunction with clinical judgment.

Routine Antenatal Assessment

Standard: "Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies."

DH (2004)

Rationale: "Care pathways and managed care networks link maternity and neonatal services with a range of services and professionals to ensure all women and their babies have equal access to high quality care"

DH (2004)

Antenatal Examination/assessment:

- Blood Pressure
- Urinalysis for **proteinuria and glycosuria**
- Measure symphysis/fundal height from 25 weeks and plot
- Check presentation from 36 weeks
- Routine auscultation of the fetal heart is of no benefit and should not be routinely undertaken
- unless specifically requested by the woman.

Risk assessment is a continual process and midwives need to use their professional judgment at each visit. If the woman is referred and seen by a consultant obstetrician, if no problem has been confirmed/present, then the woman is referred back to the community midwife. Good communication and mutual respect between the multidisciplinary team is vital.

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Appendix 3a

Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000 Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Endocrine	Hyperthyroidism Diabetes
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

[1]Appendix 3b

Other factors indicating increased risk - suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia
Current pregnancy Fetal indications	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 85 g/dl at onset of labour Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie Body mass index at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate (FHR)/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

11

Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle-cell trait Thalassaemia trait Anaemia – haemoglobin 85–105 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 4 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) Body mass index at booking of 30–34 kg/m^2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions Clinical or ultrasound suspicion of macrosomia Para 4 or more Recreational drug use Under current outpatient psychiatric care Age over 40 at booking
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

NICE clinical guideline 55 – intrapartum care 15

Appendix 4

DIRECTORATE OF OBSTETRICS & GYNAECOLOGY

Referral for Obstetric Opinion

Mother's Name :	GP: Dr.
Address:	Surgery Address/Stamp:
Date of Birth:	Tel:
NHS. No.:	GP Code:
Gravida Parity	Practice Code:
LMP EDD	Fund Holder Code:
Gestation……..wks……..days	
Allergies:	Interpreter required: Yes / No
SG2 referral: Yes / No	Spoken language:
Appointment: Urgent (less than 7 days) / Routine	

Date……

Dear Colleague

I refer this expectant mother for an obstetric opinion as to the most appropriate plan of care for her pregnancy and would therefore be grateful if you would arrange for an antenatal appointment.

Yours faithfully

Name……Designation…….

Please send completed form to:

Antenatal Clinic Appointments
Gynae Bureau
Northampton General Hospital
NORTHAMPTON
NN1 5BD

Telephone: 01604 545495

Fax: 01604 545906

FOR HOSPITAL USE ONLY	
Appropriate referral or Obstetric opinion	Yes / No
Referral back for Community Led Care	Yes / No
Hospital Number	Consultant
Date & Time of Appointment	

GUIDELINE

Patient's Name & Hospital Number

Indications for referral *Please tick to indicate reason(s)*

Personal History

	✓	Code*
Body Mass Index (BMI) by 12 weeks gestation: greater than 35		A
Body Mass Index by 12 weeks' gestation: less than 18		A
Women aged 40 or older, or 16 and under		
Women declining blood products		
Women at risk of developing VTE/PET		

Medical History

Anaesthetic problems		
Asthma - severe		B
Cardiovascular disease		B
Deep Vein Thrombosis or Pulmonary Embolism		B
Diabetes Mellitus – ***Contact MDU on 01604 545435***		B
Drug / Alcohol / Medication dependency		A
Epilepsy / Neurological factors		A
Essential Hypertension – (BP 140/90 or above)		A
Family history of note		
Haematological disorders		B
Haemoglobinopathies		B
HIV positive		B
Hep B positive		A
Hep C positive		A
Puerpual psychosis or psychiatric disorders being treated with medication		A
Renal Disease		B
Thyroid or any other endocrine disorder		B
Any other medical condition eg autoimmune disorders, malignant disease		

Surgical History

Uterine surgery including CS, myomectomy or cone biopsy/LLETZ		A
Fractured pelvis/pelvic abnormality		

Obstetric History

Preterm delivery – before 34 weeks gestation		A
Recurrent miscarriage (three or more consecutive miscarriages or a Mid-trimester loss)		A
Baby with congenital abnormality (structural or chromosomal)- ***Contact Prenatal Diagnosis on 01604 545899***		A
Previous Stillbirth or Neonatal death		A
A small for gestational age infant (<10 centile as identified on the customised growth chart)		A
A large for gestational age infant (>90th centile as identified on the customised growth chart))		A
3 Baby weighing below 2.5kg or above 4.5kg		A
Rhesus immunisation or other significant blood group antibodies		B
Previous Eclampsia, HELLP syndrome or severe Pre-eclampsia		A
Grand multiparity (more than 6)		
Previous shoulder dystocia		
Previous 3rd degree tear with symptoms/4th degree tear regardless of symptoms		
Previous Antenatal or postpartum haemorrhage on two occasions		
Previous placenta accreta		A

Present Pregnancy

Late booker (>20 weeks gestation)		
Maternal Request		
Multiple pregnancy		B

Additional Information

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*Code: A = intermediate
B = Intensive

GUIDELINE

Submission Documents

7. IMPLEMENTATION AND TRAINING

Prior to implementation, the document will be circulated to the Supervisors of Midwives. The document will be discussed with them at their meeting, including their role in the implementation of compliance to the document.

The care pathway will be implemented through workshops that will be available to all midwives and obstetricians working within the organisation.

Training in how to use the pathway will be part of the Preceptorship/Induction Programme

Workshops in the implementation of the pathway will be facilitated for the teams of community midwives, at their team meetings.

Receptionists at the surgeries and clerical staff will be will be advised of their roles and responsibilities by the Matron for Community and Primary Care Services

All midwives to sign for a copy of the maternity care pathways

8. MONITORING AND REVIEW

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
1	To determine whether women have their full booking visit and hand held notes completed in line with the defined timescales.	Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.	75%	Antenatal notes reviewed against the standards.	Clinical Effectiveness Group	Annually	Directorate Governance Group
2.		Pregnant women are cared for by a named midwife throughout their pregnancy.	**80%**				

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
3.		Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.	100%	antenatal notes of women will be reviewed against the standards.	As Above	As Above	As Above

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
4.		Pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.	100%	.	As Above	Annually	As Above

No	**Purpose of the Audit**	**Auditable Standards**	**Target % Compliance**	**How data will be collected**	**Responsibility for Audit**	**Frequency of Audit, when audit last done and next due**	**Group to which audit will be submitted**
5.		Pregnant women who smoke are offered referral to an evidence-based stop smoking service at the booking appointment	100%	antenatal notes of women will be reviewed against the standards.	As Above	Annually	As Above
6.		Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment	100%				
7.		Pregnant women at increased risk of pre-eclampsia at the booking	100%$				

GUIDELINE

		appointment are offered a prescription of 75 mg of aspirin to take daily from 12 weeks until birth.					
8.		Pregnant women at intermediate risk of venous thromboembolism at the booking appointment have specialist advice provided about their care.	100%				
9.		Pregnant women are offered fetal screening in accordance with current UK National Screening Committee programmes	100%				

10.		Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version.	100%				

Monitoring

An annual audit of the above standards will be co-ordinated by the Maternity Clinical Effectiveness Group. The subsequent audit report will be made available to staff and Supervisors of Midwives via the Maternity Governance Group. If any deficiencies are identified, the Maternity Governance Group will instigate the development of an action plan with clear timescales and responsibilities. The action plan will remain an agenda item until completed.

9. COMPLIANCE STATEMENTS

Equality & Diversity

This policy has been assessed against the Trust's Equality Impact assessment tool as required by the Service Equality Scheme 2006 and Race Relations (Amendment) Act 2000.

General Statement of Intent

This Trust aims to design and implement services, policies and measures that meet the diverse needs of the population it serves and its workforce ensuring that none are placed at a disadvantage over others.

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FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	Antenatal Care Pathway
Is the document new?	Yes / No
If yes a new number will be allocated by Governance	New Number
If No - quote old Document Reference Number	
This Version Number:	**Version: 3**
Date originally ratified:	May 2009
Date reviewed:	November 2015
Date of next review: a 3 year date will be given unless you specify different	**Date:** **Or** **Highlight 1yr: 2yr: 3yr:**
If a Policy has the document been Equality & Diversity Impact Assessed? (please attach the electronic copy)	yes / No
DETAILS OF NOMINATED LEAD	
Full Name:	Anne Richley
Job Title:	Community Matron
Directorate:	Obstetrics & Gynaecology
Email Address:	Anne.richley@nhs.net
Ext No:	
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10 –** to assist a search on intranet	Mother, baby, screening, gestation,

GROUPS WHO THIS DOCUMENT WILL AFFECT?
(please highlight the Directorates below who will need to take note of this updated / new policy)

Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		Trust wide

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who
Launch in Maternity	February 2016	CEG
Stork Talk	March 2016	CEG

Northampton General Hospital NHS
NHS Trust

FORM 2 - RATIFICATION FORM to be completed by the document lead

Please Note: Document will not be uploaded onto the intranet without completion of this form

CONSULTATION PROCESS

NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify

Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments

Existing document only - FOR COMPLETION BY DOCUMENT LEAD

Have there been any significant changes to this document? *if no you do not need to complete a consultation process*		YES / NO
Sections Amended:	YES / NO	**Specific area amended within this section**
Re-formatted into current Trust format	YES / NO	
Summary/ Introduction/Purpose	YES / NO	
Scope	YES / NO	
Definitions	YES / NO	
Roles and responsibilities	YES / NO	
Clinical Content	YES / NO	**P.8 Booking appointments** When a woman makes contact with her surgery, the receptionist makes an appointment for the woman to be seen ASAP by the midwife, and within two weeks of the initial contact. Midwives should ensure that the surgeries have contact details in the event of an appointment being unavailable. The midwife may need to contact the woman and arrange an appointment directly. **P.10 Screening** If the woman consents and feels she has had sufficient information regarding her screening tests, blood can be taken at the first booking appointment- ideally by 10 weeks of pregnancy. Blood results should be checked within 10 days **P.17 Antenatal Visits & Documentation** **Antenatal visits and documentation** Midwife to document who woman is accompanied by at all antenatal appointments

		All women are asked, (when not accompanied by partner) if they are affected by domestic violence At least one antenatal visit to be undertaken at home by either a midwife, AP or MSW All primips should be seen at 25+ weeks to carry out a full antenatal assessment including fundal height measurement. If this appointment occurs when a primip is 24+ weeks, carry out an antenatal assessment but ask the woman to return in two weeks (at 26+ weeks) for a fundal height measurement. All multips should be seen at 28 weeks for a full antenatal assessment and fundal height measurement. **P.21 Notification of Pregnancy to health Visitor** This should be sent to the Community office by 26/40 **P.21 Breast feeding** Discuss the health benefits of breastfeeding Breastfeeding, responsive feeding and relationship building with the unborn baby to have been discussed by 34 weeks **P.22 Place of birth** Place of birth to be discussed at booking, 28 weeks and 34 weeks. Low risk women to be given information and choice around home assessment in labour
Refs & Assoc Docs	YES / NO	**Yes**
Appendices	YES / NO	**Yes**
Implementation and Training	YES / NO	**Yes**
Monitoring and Review	YES / NO	**Yes**

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) **Read in conjunction with FORM 2**			
Document Name:	**Antenatal Care Pathway**		
	YES / NO / NA	**Recommendations**	**Recommendations completed**
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	**YES**		
Title -Is the title clear and unambiguous?	**YES**		
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	**YES**		
Introduction Is it brief and to the point?	**YES**		
Purpose Is the purpose for the development of the document clearly stated?	**YES**		
Scope -Is the target audience clear and unambiguous?	**Yes**		
Definitions –is it clear what definitions have been used in the	**YES**		
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	**YES**		
Substantive Content is the Information presented clear/concise and sufficient ?	**YES**		
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	**YES**	Reviewed Guideline Launch 15/02/16	
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	**YES**		
References & Associated Documentation / **Appendices**- are these up to date and in Harvard Does the information provided provide a clear evidence base? Are the reference provided using Harvard Referencing format?	**YES**		
Are the keywords relevant	**Yes**		

Name of Ratification Group	Ratified Yes:Maternity Clinical Effectiveness Group	Date of Meeting: 28/10/15
	Ratified No:	
	Ratified subject to amendments and chair approval	
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