Guideline for Managing Antenatal Care

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Section Headings

1.0 Introduction

This guideline is designed to provide a framework to enable consistent provision of high quality, evidence based holistic care to pregnant women when Barnsley District General Hospital is their chosen place to birth.

2.0 Objective

To ensure that women book in the appropriate timescales and receive antenatal care which is appropriate to their individual circumstances.

The guideline supports the philosophy that women are treated as individuals with care tailored to their specific needs, circumstances and preferences. Women will be empowered and enabled to make informed choices regarding the care they receive.

3.0 Scope

This guideline applies to all medical midwifery and support staff working within maternity services.

4.0 Main body of the document

Women will be booked for either midwifery led care (MLC) or shared care (SC) following risk assessment and discussion. SC is when risks are identified that require extra surveillance and obstetric expertise. Women who are booked under SC will continue to have care shared with their community midwife and the maternity unit.
See attached pathway (Appendix 1) to determine high risk factors for women - this list is not exhaustive. These women should be booked under SC. The woman may choose to be booked under MLC even if SC is recommended.

4.1 Referral process for women wishing to birth at Barnsley Hospital

Women are encouraged to access a Midwife as early as possible, to ensure a risk assessment and appropriate planning of care is undertaken. NICE Antenatal Care Guidance (2008), states that women should ideally be booked by 10 weeks.

- Women can inform their General Practitioner (GP), who will complete a paper referral to their link community midwife. The referral will be collected by a community midwife/maternity support worker (MSW) when they attend the weekly GP antenatal clinic
- Women can self refer by contacting a community midwife or the Community Admin Team on 01226 43 5369

Out of Area women will book initially with their community midwife, who will send an email referral into the Antenatal Admin Team (Barnsleymaternity.referrals@nhs.net).
A Midwife in Antenatal Clinic will check the referral for suitability of MLC or SC.
The Antenatal admin team will input the referral into the electronic patient record (EPR).

4.2 Continuity of Care

Teams of up to 8 midwives, with a link Consultant have been set up in Barnsley, to offer women antenatal, intrapartum and postnatal continuity of care as recommended by Better Births (2016). The Teams are linked to certain GP surgeries across Barnsley.

4.3. MSW pre booking clinic

A pre booking appointment with an MSW is beneficial to offer screening tests and health promotion advice.

Please see Appendix 3 for what is undertaken at this appointment

The appointment will ideally be between 6 – 8 weeks gestation, where possible.

4.3.1 Booking bloods

Antenatal booking bloods should be offered as per the following guideline:

https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Antenatal%20screening%20including%20diagnosis%20and%20referral%20of%20women%20with%20suspected%20fetal%20abnormality

It is the responsibility of the midwife undertaking the booking appointment to check the results of the booking bloods, action any abnormal results, and inform the women of these.

4.3.2 Screening for asymptomatic bacteriuria

A mid-stream urine (MSU) culture will be offered as routine screening.

It is the responsibility of the midwife undertaking the booking appointment to check the results of the MSU, action any positive result, and inform the woman of this. If positive, the women should be treated with antibiotics. The midwife will contact the GP to arrange this. The woman will be advised that a second culture is required 7 days after the completion of the antibiotics.

4.4 GP health records check

In order to gain a full picture of the woman's previous history it is essential for the midwife to access the full medical records that are held by the GP. The review will be undertaken prior to the community midwife booking appointment, via the GP electronic record

This should include: -

- Medical / surgical conditions
- Review of medication
- Previous Obstetric history
- Mental health
- Social / lifestyle issues (including any interactions with social care)

4.5 Community Midwife Booking appointment

The link midwife for the GP surgery will aim to book all of their women. When this is not possible, another community midwife from the same team will complete the booking.

The booking appointment is essential to ensure a thorough risk assessment is undertaken. The appointment may either be in person, or virtual using AccuRx/Microsoft Teams/Telephone.

The Community midwife will undertake a full booking assessment within the EPR. Risk assessment should include:

- Medical history
- Obstetric history
- Anesthetic issues
- Mental Health factors
- Social factors including safeguarding, FGM (Female Genital Mutilation) and lifestyle choices such as smoking, alcohol consumption, substance misuse
- Identification of women who refuse blood and blood products
- Assessment of appropriate place to deliver
- Aspirin requirements
- Thromboembolic disease risk assessment
- Risk of a Small for Gestational Age (SGA) baby or Fetal Growth Restriction (FGR)
- Risk of preterm birth
- Risk of gestational diabetes

Consideration will always be given to the woman's understanding of the English language and Big Word will be used if necessary to aid the conversation between the woman and the health care professional.

The community midwife should request on ICE both the dating and Anomaly USS. Extra narrative should be added to include BMI, any relevant previous obstetric history e.g., previous lower segment caesarean section (LSCS) or pregnancy loss.

Once the EPR (Electronic Patient Record) booking workflow has been completed, the referral into Antenatal Admin Team is made, within the EPR. The referral must include if the woman requires MLC or SC, and state within the narrative what her current risks are. If the women require an early obstetric consultation, this must also be requested here. (See 4.8)

Supplementary to the booking assessment within the EPR, an email referral for the Maternity Exemption form is to be sent

4.6 Early referral for Consultant appointment.

The following women must be seen at the earliest opportunity by an Obstetrician, following the midwife booking appointment:

- LMWH required in early pregnancy - TRAF ≥ 3 at booking
- Women requiring an obstetric plan following previous pregnancy
- Women with uncontrolled epilepsy or women with epilepsy who are not known to epilepsy services
- Migrants with history of cardiac disease, and not known to UK services
- Any patient with an uncontrolled medical condition e.g., uncontrolled diabetes

This list is not exhaustive, if the community midwife is unsure if early referral is required, they should speak to the Antenatal Clinic team, for them to liaise with a Consultant for a decision.

4.7 Screening for Domestic Abuse

Women who present to maternity services should be asked routine enquiry questions around domestic abuse as part of standard clinic practice within a safe environment. These should be asked when the woman is alone, and staff should know and have access to information about services to support a victim of domestic abuse. https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Domestic%20Abuse

It must be documented within the EPR whether the questions have been asked or not. If the questions have not been asked, it must be recorded why this was not possible. If the questions have not been asked on three consecutive occasions, this must be escalated to senior staff.

4.8 MLC

Women with low-risk pregnancies will have a midwife as their lead professional. The midwife will be responsible for all aspects of care, and when any deviation from normal is identified at any part of the pregnancy, they will refer to the hospital.

Routine antenatal care should be scheduled as per Appendix 3

4.9 Shared Care

When risks are identified, as per appendix 1, the woman will be referred to the appropriate clinician for review. The woman will be given an appointment to attend antenatal clinic under the care of the allocated Obstetric Consultant, alongside her dating scan.

Any changes in lead professional will be recorded electronically on the EPR. If the woman was previously under MLC the Consultant will be informed using the designated referral form.

4.10 Maternal request for Caesarean Section

NICE (2020) states:

When a woman requests a Caesarean Section because she has anxiety about childbirth, referral to a healthcare professional with expertise in providing perinatal mental health support should be offered to help her address her anxiety in a supportive manner.

For women requesting a Caesarean Section, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned Caesarean Section.

An obstetrician unwilling to perform a Caesarean Section should refer the woman to an obstetrician who is prepared to offer this.

Consideration will be given to support from the Mental Wellbeing midwife, to aid decision making.

If the woman is under MLC, a referral will be made to a consultant of the woman's choice, if after discussion she wishes to have a normal birth, she can return to MLC.

4.11 Planning Place of Birth

Women will be offered a choice of birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit) and will be supported in their choice.

At Barnsley we have an obstetric unit with the facilities to care for midwifery led women. We do not have a freestanding midwifery led care unit. Women who wish to pursue this option will be referred to a unit of their choice. Women who wish to birth at home, will be supported in their decision making.

The following advice should be offered to guide women in their choice:

- Delivery in an obstetric unit is recommended for women with risk factors as identified in appendix 1.

- The obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia, and birthing pools
- The circumstances in which transfer from home to the Maternity unit would be advocated; the process for arranging the transfer and the risks to the mother and the baby if the transfer does not happen
- Regardless of the birth setting, one to one care will be provided but this may not necessarily be by a familiar midwife or the same midwife for the duration of the labour

Ultimately the choice of birth setting lies with the woman. Women who choose to opt for a home birth where a hospital birth is deemed to be the safest option will be offered an appointment with an Obstetrician to discuss risks and benefits. Ideally the woman will be supported at this meeting by a Community Midwife. If the woman still wishes to birth at home, the named Community Midwife and the Community Lead Midwife will offer a home visit to discuss her birth plan, and support her wishes.

All further information regarding home birth can be found on the Trust Approved Documents (TAD) section of the intranet:

https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Planned%20home%20birth

4.12 First Consultant hospital appointment following dating scan

A thorough risk assessment should be undertaken at this appointment. All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision-making processes and make informed choices about their care. Women's choices following a shared decision-making process must be respected. (Ockenden 2020).

A midwife will review a woman, prior to the obstetrician where there are safeguarding concerns (such as drug and alcohol misuse or domestic violence) or additional support is required (such as learning difficulties). The midwife will ensure that all appropriate referrals to specialist midwives have been made.

Women from out of area will also require additional support from midwives in antenatal clinic, to ensure the booking information within the EPR is accurate, the TRAF is completed and any referrals to specialist midwives have been made.

The obstetrician will review any risks identified by the community midwife, the dating scan report and any new identifiable risks e.g. previous SGA on customised growth chart, abnormal booking bloods.

A clear plan for the antenatal, intrapartum and postnatal period should be documented within the EPR by the obstetrician, for all members of the maternity team to see.

4.13 Review of hospital medical/obstetric records

At the first hospital appointment, the woman's medical/previous obstetric records will be obtained and are reviewed by the midwife and obstetrician, including:

- Previous obstetric records
- Birth weights of previous children
- Previous safeguarding history
    - Any previous safeguarding documentation should be read and reviewed and there must be clear documentation that this has been undertaken
- Medical history

If the woman is under the care of a medical team or specialist pharmacist the obstetrician must write to the relevant team to request medical history and an ongoing plan of antenatal care. A plan for intrapartum care must be made including management of medications and this must be documented within the electronic patient record.

If the previous records are not available e.g. if the woman birthed at another hospital, a written request for the information will be made by the Obstetrician.

A further appointment for the woman is generated to review the information and discuss any recommended changes to her plan of care. This appointment can be offered virtually.

If the information is not received within the requested timeframe a further request for information is made by the obstetrician.

The obstetrician will inform the GP by letter of all women receiving shared care.

4.14 Aspirin

Assessment for aspirin use in pregnancy should commence at booking.
NICE (2019) recommend aspirin in pregnancy to reduce the risk of pregnancy complications relating to placental dysfunction and preeclampsia

Aspirin requirements will be assessed by the obstetric team at the first hospital appointment, and a prescription given to the woman, if required. The GP will be asked to continue this medication throughout pregnancy.

150mg from 12 weeks gestation should be offered. Women are advised to take this at night as it may be more effective (Saving Babies Lives 2019). The obstetrician should document how long the women should take the prescribed medication.

Women with previous SGA babies should have the need for aspirin assessed in line with reviewing the previous placental histology report.

This table is for the use of aspirin to prevent pre-eclampsia (Saving Babies Lives 2019)

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

4.15 Customised Growth Chart (CGC)

The customised growth chart is now held within the GROW APP 2.0 software, online. An email link will be sent to the mother once the chart is produced in Antenatal Clinic, following dating scan.

If the woman is out of area, a copy of the growth chart will be printed, and used during the antenatal period. Women will be advised to take the CGC to all community midwife and hospital appointments.

4.16 Process for referral back to MLC

Women can be referred back to MLC following a specific event if warranted following risk assessment. This decision is taken by the most senior obstetrician involved in the care at the time. The change in lead professional will be recorded on the EPR

4.17 Pregnant people < 18 years of age at booking

Care should be individualised, and the needs of the young family met. This may require adaption to where antenatal care takes place, liaising with schools and colleges etc with the aim of trying not to impact on education. It is essential that parental education is tailored and ideally held on a one to one basis.

Supplemental to routine antenatal care, the following is required:

- Option to be given for care to be provided by the Young Families Midwife or GP attached Community Midwife
- Bookings and antenatal care will always take place face to face
- Gillick Competency is to be recorded at every contact for under 16 year olds
- Child Sexual Exploitation screening tool to be completed and attached to the EPR Careflow
- Following Anatomy and Physiology ultrasound scan refer those applicable to the 0-19 service (Appendix 4)
- Consider MDT approach and reasonable adjustments for the young family
- Discuss options for contraception following birth in the antenatal period, and ensure prior to discharge from community midwifery all options have been considered and the woman supported in her choice
-
    - Offer referral to SPECTRUM in the antenatal period, using the referral form in Appendix 5

4.18 Antenatal Appointments

Antenatal Appointments should take place in a location that women can easily access. The location should be appropriate to the needs of the woman. Each antenatal appointment should have structure and focus on incorporating routine investigations and providing an opportunity for discussion, enabling women to make informed choices. Women should feel able to discuss sensitive issues and disclose problems.

In an uncomplicated pregnancy there should be 10 appointments for nulliparous women and 7 appointments for parous women.

See the Low risk antenatal pathway (Appendix 3) for information regarding when women should attend for routine antenatal care and the suggested criteria for of each visit.

4.19 SFH (Symphysis Fundal Height) measurements

Please refer to the following guideline for criteria and timing of SFH (Symphysis Fundal Height) measurements.

Fetal growth guideline
https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Fetal%20Growth

4.20 Failure to attend

Please refer to the following guideline for non-attendance in maternity care
https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Non-attendance%20in%20maternity%20care

5.0 Roles and responsibilities

Role of the MSW

The MSW will routinely perform: BP, urinalysis for protein, CO monitoring and any required bloods, with consent.

MSWs will escalate immediately to a midwife any deviation from normal or any concerns/questions from the women which she is not trained to advise on.

Role of the Midwife

To provide the best evidence-based care for women in accordance with appropriate guidance throughout the antenatal, intrapartum and postnatal period.

Obstetrician

To provide the best evidence-based care for women in accordance with appropriate guidance throughout the antenatal, intrapartum and postnatal period.

6.0 Associated documents and references

Better Births Improving Outcomes of Maternity Services in England (2016) . 1 st ed. [pdf] London: NHS England https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

National Institute for Health and Clinical Excellence. (2008) Antenatal Care: Routine care for the healthy pregnant woman. [Online] https://www.nice.org.uk/guidance/cg62/resources/routine-antenatal-care-for-healthy-pregnant-women-254938789573

National Institute for Health and Care Excellence (2014). Clinical guideline 190. Intrapartum care: Care of healthy women and their babies during childbirth [online] https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-pdf-35109866447557

National Institute of Health and Care Excellence (2011) (updated 2019), Caesarean Section. https://www.nice.org.uk/guidance/cg132

National Institute of Health and Care Excellence (2019) Hypertension in pregnancy: diagnosis and management https://www.nice.org.uk/guidance/ng133/resources/hypertension-in-pregnancy-diagnosis-and-management-pdf-66141717671365

Ockenden Report (2020) https://www.donnaockenden.com/the-ockenden-review-sath/

Royal College of Obstetricians and Gynaecologists, Guidance for Antenatal and Postnatal Services in the evolving Coronavirus (Covid 19) Pandemic. https://www.rcog.org.uk/globalassets/documents/guidelines/2020-10-21-guidance-for-antenatal-and-postnatal-services-in-the-evolving-coronavirus-covid-19-pandemic-v3.pdf

Saving Babies Lives (2019) https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf

National Institute of Health and Care Excellence (2016) Domestic violence and abuse. https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

7.0 Training and resources

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to the guideline for the management of antenatal care will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the management of antenatal care will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Antenatal High-Risk Inclusion Criteria

Women will be individually assessed by their own obstetric consultant regarding the complexity of their medical condition and whether they need referral to a specialised centre.

Disease area	Identified Problem	Consultant clinic
Cardiovascular	• **Confirmed** Cardiac Disease • Women undergoing investigation/ surveillance of any cardiac disease	Place of care will be dependent upon condition as classified in Table 1 of the Guideline for the Management of Women with Cardiac Disease in pregnancy:
Endocrine	• Hyperthyroidism/ hypothyroidism • Diabetes/ gestational diabetes	Consultant led care at BHNFT – medical disorders clinic
Gastrointestinal	• Crohn's disease • Ulcerative colitis	Shared care at BHNFT
General medical	• BMI < 18 or > 35 at booking • Women with malignant disease • Cystic fibrosis	Shared care at BHNFT Continue care with Cystic Fibrosis Centre in a tertiary unit. Centre for obstetric care at patient request
Gynaecological	• Uterine surgery including: Myomectomy, and Hysterotomy or any other major gynaecological surgery • Gynaecological problems such as: fibroids, cone biopsy, large loop excision, known as LLETZ • History of recurrent miscarriage (3 or more) • IUCD in situ • Awaiting treatment for CIN	Shared care at BHNFT
Gynaecological/Social	• Women with female genital mutilation	Shared care at BHNFT

Haematological	• Haemoglobinopathies (sickle cell disease, beta-thalassemia) • Thrombo-embolic disorders • Thromboprophylaxis risk assessment: ○ Antenatally score of more than 3 needs early first trimester appointment to commence treatment • Immune thrombocytopenia purpura, platelet disorders or a platelet count below 150 000 • Von Willebrand's disease • Bleeding disorders in the woman or fetus • Rhesus iso-immunisation or any atypical antibodies • Haemoglobin <85g/L and/or significant symptoms of anaemia, late gestation >36weeks, poor response to oral iron or abnormal ferritin or B12 levels • Haemoglobin < 85g/L at the onset of labour	Shared care at BHNFT
Infective	• Group B streptococcal infection in this pregnancy or a previous infant with GBS disease • Genital herpes • Hepatitis B/C • Carrier of or infected with HIV • Toxoplasmosis • Active infection with chicken pox or rubella • Tuberculosis	Shared care at BHNFT HIV
Immune	• Systemic lupus erythematosus • Scleroderma • Non- specific connective tissue disorders	Shared care at BHNFT
Liver	• Liver disease	Shared care at BHNFT
Neurological/skeletal	• Epilepsy • Myasthenia gravis • Previous cerebrovascular accident • Spinal abnormalities • Previous fractured pelvis • Neurological deficits	Shared care at BHNFT
Obstetric	• Previous caesarean section • Para 4 or more • Previous shoulder dystocia	Shared care at BHNFT

	• Previous extensive vaginal or cervical tears or 3rd/4th degree perineal trauma
	• Previous postpartum haemorrhage (over 500ml) requiring:
	  ○ More than normal third stage management
	  ○ Treatment other than oral iron
	  ○ Blood transfusion
	• Previous retained placenta requiring manual removal
	• Previous placenta accreta
	• Previous uterine rupture
	• Multiple pregnancy
	• Antepartum haemorrhage in this pregnancy
	• Preterm pre-labour rupture of membranes in this pregnancy
	• Ultra sound diagnosis of oligo-/polyhydramnios in this pregnancy
	• Malpresentation/transverse lie in this pregnancy
	• Induction of labour in this pregnancy
	• Preterm labour in this or previous pregnancies
	• Placenta praevia in this or previous pregnancies
	• Placental abruption in this or previous pregnancies
	• Previous cholestasis
	• Primigravida with a high head at term in the current pregnancy	

Psychiatric	• Women with current mental health issues, who have suffered with a previous mental illness antenatally or postnatally or who have stopped their medication less than 1 year ago are booked for shared care • Women with a previous history of depression who are no longer on treatment can be booked under MLC	Shared care at BHNFT
Renal	• Renal disease or abnormal renal function	Shared care at BHNFT
Respiratory	• Uncontrolled Asthma requiring an increase in treatment or hospital treatment	Shared care at BHNFT
Social	• Young people under the age of 18 or women who are aged 35 or over at booking • Smoker	Shared care at BHNFT

	• Substance misuse, alcohol dependency • Women with safeguarding issues or domestic violence • Women who refuse booking bloods • Women who refuse blood products • Late bookers >20 weeks • Asylum seekers	
Baby	• Abnormal fetal heart rate in this pregnancy • Fetal abnormality in this or previous pregnancies including chromosomal abnormalities • History of pregnancy loss after 14 weeks • Still birth in this or previous pregnancies • Previous intra-partum death/neonatal death • Previous baby with encephalopathy • Previous baby with jaundice requiring an exchange transfusion • Previous or current small for gestational age or growth restricted baby using customised GROW chart • Previous baby weighing > 4.5kgs or suspected macrosomia in this pregnancy	Shared care at BHNFT

Appendix 2

Antenatal Clinic Timetable (correct as of March 2021)

	AM	PM
Monday	**Sarkar** **Ruby Team**	**Chen** **Young Families**
Tuesday	**Srinivas** **Mental Health**	**Khanem** **Sapphire Team** **MC/MA Twins** **MC/DA Twins** **Cardiac Disease**
Wednesday	**Fawzy** **MC/MA and MC/DA Twins** **Epilepsy, HIV,** **Cardiac Disease**	**Sharma** **Substance Misuse**
Thursday	**Diabetes Midwife** **Dietician** **MLC bookings**	**Medical Disorders** **(diabetes/endocrine)** **(NK & MF)**
Friday	**Sankar -** **Emerald Team** **Fetal Clinic** **(NK & MF)**	**Newly diagnosed Diabetic** **Diabetes Midwife**

Appendix 3

Low Risk Antenatal Pathway

At every routine antenatal appointment, in any setting, i.e. community or hospital appointment the following will be undertaken:

- BP & Urinalysis
- Abdominal palpation and SFH if applicable
- Carbon monoxide (CO) reading and refer to Smoke stop service if required. If unable to undertake CO monitoring, document smoking status and refer if appropriate
- Review TRAF form
- Mental health assessment
- From 24 weeks discuss fetal movements
- Review management plan and intended place of birth
- Consider domestic abuse - ask Routine Enquiry questions
- Read any safeguarding records
- Ensure woman is aware of where and when she can receive any seasonal flu vaccination/pertussis vaccination
- Ensure the woman has maternity contact numbers

All of the above must be recorded within the EPR.

NB. This low risk antenatal pathway is the minimum care that will be provided. High risk pregnancies will have an individual pathway devised through their management plan and will involve appointments at the Consultant Antenatal Clinic.

P = Primigravida
M = Multigravida

Midwife apts	**Gestation**	**Minimum care and advice given (this does not take away from professional judgement)**

P & M	1st Trimester
	
	As soon as referral received to birth at Barnsley
	
	Pre-Booking clinic (Midwifery Support Worker (MSW))
		Investigations to be taken with consent:
		• FBC
		• Haemoglobinopathy screen with Family Origin Questionnaire, Blood Group & Antibody screen Treponema
		• Hepatitis B
		• HIV- Ensure consent obtained
		• MSU testing for asymptomatic bacteriuria
		• Weight/Height and calculate BMI
		• Routine observations
		• Provide Screening booklet and advise to read prior to midwife booking appointment
		• Direct to website and Personalised Care Plan
		• Discussion of folic acid and vitamin supplementation
		  ○ BMI >30 will need 5mg folic acid
		  ○ Emphasise the importance of vitamin D supplementation

		○ Provide Healthy Start Vitamins and advise where to obtain further supply ○ Provide Healthy Start Leaflet if eligible • Give Screening Letter regarding (Pregnancy Associated Plasma Protein -A) PAPP-A test • If < 25 years offer chlamydia testing • Update EPR following assessment
1 **P & M**	**Booking Appointment – Midwife**	• Obtain history and complete full booking workflow on (EPR) • Review investigation results and record on EPR– ensure any abnormal results are acted upon • Discuss rhesus sensitisation, offer fetal DNA test to rhesus negative women when attending for dating scan • Complete thromboprophylaxis risk assessment on EPR ○ If TRAF score >3 refer for early ANC appointment with Consultant ○ Identify appropriate risk criteria and care pathway • If positive screen to metal health questions, complete PHQ9 and GAD 7 – refer as per mental health pathway • Discuss options for care and place of birth with woman • Discuss screening programme ○ refer to antenatal screening pathway and ensure they understand 1st trimester screening prior to dating scan • Give a brief introduction to the benefits of breastfeeding including workshops • Give information including where women will be seen and who will undertake care • Re-discuss website and Personalised Care Plan • Discuss maternity benefits • Document professional lead, agreed plan of care and place of care
2 **P & M**	**11+2 – 13+6 weeks** Dating scan appointment (Optimum time 12 weeks)	• Confirmation of gestation by ultrasound • Update ultrasound confirmed EDD on EPR • Complete Antenatal Assessment on EPR including TRAF • Offer first trimester screening (11+2 – 14+1 weeks gestation) ○ Obtain with consent, reweigh and complete form in full • Book Glucose Tolerance Test for 28 weeks if required • For Out of Area women book 28 and 36 week blood clinic appointment • Follow SOP to generate a customised growth chart • For Rhesus negative women obtain fetal DNA test with consent up to 23+6 weeks gestation
3 **P & M**	**14-20 weeks** Optimum time 15 weeks	• Offer quadruple test second trimester screening (14+2 – 20 weeks) if first trimester screening is not performed or declined • Review and record first trimester screening test results • Discuss vaccinations: seasonal flu and pertussis • Check customised growth chart correct • Inform of fetal DNA result
	18- 20+6 weeks A+ P Scan appointment	• Offer pertussis vaccination

4 **P**	**24 - 25 weeks**	• If Rh negative - discuss Anti-D if required, complete blood bank request and arrange appointment for administration in ANC • Discussion regarding arrangements for the preparation of parenthood • Discussion regarding symptoms of pre-eclampsia • Discussion regarding fetal movements and wristband given if available • Give Mothers and Others guide if available • Review management plan and mental health pathway • Offer MAT B1 form if required • Check placental localisation ○ If low lying signpost to RCOG leaflet on the website and document on maternity computer system • Check OGTT Appointment has been arranged and venue appropriate

5
 	
P & M
	28 weeks	• Repeat Blood Group and Antibody screen & FBC
		• Document on request form if Anti D has been given
		• Discuss Vitamin K, Labour & 'Skin to Skin'
		• Discuss antenatal classes, personalised care plan and website
		• Re offer infectious diseases screening if declined at booking
		• Complete Sure Start maternity grant form if applicable
		• Refer to nearest infant feeding group
		• Discuss greeting your baby for the first time - infant feeding
		• If having serial USS at 32 weeks, arrange next community midwife appointment as an in person or virtual appointment at 36 weeks to discuss birth plan
		• Out of area women
		  ○ Will attend ANC for routine bloods/OGTT
		  ○ Ensure antenatal assessment is performed by their CMW
		  ○ If not, a midwife in ANC should undertake this

6 **P & M**	**31 weeks**	• Review infant feeding plans • Discuss preparation for parenthood classes • Discuss antenatal health promotion contact by health visitor • Revisit place of birth - discuss home birth
7 **P & M**	**34 weeks**	• Provide information on recognition of: active labour, coping with contractions, SROM, vaginal loss • Review birth plan and formulate plan of care for delivery and place of delivery • If GBS positive in previous pregnancy discuss pathway - arrange for GBS appointment at 36 weeks in ANC for swab
8 **P & M**	**36 weeks**	• FBC • MRSA swabs, nasal and groin. • Abnormal presentations or planned home birth refer for presentation scan in ANDU after 36+6 weeks • Reinforce breast feeding information as detailed in the UNICEF 'Baby friendly initiative' • If not discussed before provide information on Vitamin K, newborn screening tests, care of new baby, postnatal self-care and awareness of baby blues and postnatal depression

		• Discuss signs of labour and when to phone the hospital • Discuss birth plan • Home birth - arrange for delivery of birth equipment
9 **P & M**	**38 weeks**	• Discuss options for the management of prolonged pregnancy ○ Give induction of labour leaflet/signpost to website • Arrange appointment for membrane sweep (multiparous) • Discuss enhanced recovery for Elective LSCS if applicable • Discuss healthy start vitamins to continue if breastfeeding • Give information on baby vitamins • Discuss induction of labour (IOL), including methods and expectations regarding length of stay, signpost to website for leaflet
10 **P**	**40 weeks**	• Offer membrane sweep to primigravida's • Primigravida with free high head – refer to ANDU for obstetric review.
11 **P & M**	**41 weeks**	• Offer membrane sweep • Discuss and arrange a date for induction of labour • Discuss low risk outpatient induction (if applicable) • Arrange CTG monitoring if IOL cannot be done until after T+12 • Arrange CTG for women who decline IOL and refer to ANDU
12 **P & M**	**42 weeks**	• Offer increased antenatal monitoring for women who decline induction of labour. Liaise with medical team/ANDU.

Appendix 4 – Referral to 0-19 Services

0-19 PHNS IHSP Referral Form.docx

Appendix 5 – Antenatal Referral to Spectrum

Referral from Midwife AUG22.doc

Appendix 6
Equality Impact Assessment – required for policy only

Appendix 7
Glossary of terms

BMI Body Mass Index
CASH Contraceptive and Sexual Health
CGC (Customised Growth Chart)
EPR (Electronic Patient Record)
FGM (Female Genital Mutilation)
FGR (Fetal Growth Restriction)
GP (General Practitioner)
LSCS (Lower Segment Caesarean Section)
LMWH (Low Molecular Weight Heparin)
MLC (Midwife Led Care)
MSU (Mid Stream Urine)
MSW (Maternity Support Worker)
NICE (National Institute of Clinical Excellence)
PAPPA (Pregnancy Associated Plasma Protein -A)
SFH (Symphysis Fundal Height)
SGA (Small for Gestational Age)
SROM (Spontaneous Rupture of Membranes)
TAD (Trust Approved Documents)
TRAF (Thromboembolic Risk Assessment Form)

Appendix 8 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
1	25/01/2023	Minor amendments made to review process in the MAU	Governance Midwife

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	04/03/2021
Reviewed at Women's Business and Governance meeting	19/03/2021
Approved by CBU 3 Overarching Governance Meeting	25/01/2023
Approved at Trust Clinical Guidelines Group	13/05/2021
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	**Guideline for Managing Antenatal Care**
Document author (Job title and team)	**Matron for Community Midwifery and Antenatal Day Services**
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	**Senior midwives, consultant obstetricians**
Approval recommended by (meeting and dates):	Reviewed at Women's Business and Governance meeting 21/10/2022 Approved by CBU 3 Overarching Governance Meeting 02/11/2022 Approved by CBU 3 Overarching Governance Meeting 02/01/2023
Date of next review (maximum 3 years)	02/11/2025
Key words for search criteria on intranet (max 10 words)	Antenatal care
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Jade Carritt** **Designation: Governance Midwife**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Overarching Governance
Date approved: 02/01/2023
Date Clinical Governance Administrator informed of approval: 23/02/2023
Date uploaded to Trust Approved Documents page: 27/02/2023