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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 06036 Maternity Record Keeping including Documentation in Handheld Records 07040 Management of Pregnant and Postnatal Patients refusing Blood Products 09127A Interpreting and Translation Policy 09044 Roles and responsibilities of staff when arranging an Elective Lower Segment Caesarean Section (EL.LSCS) 09090 Identification and Management of a Patient with Mental ill Health during the Perinatal Period 06040 The Management of Domestic Abuse in Maternity Patients 04266 Diabetes in Pregnancy 08101 Management of a Home Birth 04237 Waterbirth Labour, delivery in water and third stage management 04227 Roles and Responsibilities of Medical and Midwifery Staff Working within the Maternity Services 06031 Receiving and Acting on Test Results in Maternity by Both Hospital and Community 11018 Child Safeguarding Supervision Policy 08056 Management of Human Immunodeficiency Virus (HIV) in maternity

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1.0	Julie Bishop		January 2008
2.0	Amy Wren		December 2009
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4.1	Sarah Moon	Clarification to point 5.6, 6.5, 6.8, 6.12, 7.11, 7.18 and 13.0	March 2016
4.2	Nicky Leslie	Clarification to point 8.0 and Appendix B	3rd July 2016
5.0	Angela Wrobel & Rosie Newman	Full review	14th January 2019

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1.0 Purpose

1.1 To ensure that pregnant patients, their partners and their families are treated with kindness, respect and dignity. Their views, beliefs and values in relation to a patient's care and that of her baby should be sought and respected at all times, enabling them to feel supported throughout their pregnancy and prepared for the birth and subsequent care of their baby.

1.2 To ensure that pregnant patients have the information and opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

1.3 To ensure information is provided in a form that is easy to understand and accessible to pregnant patients with additional needs, such as physical, sensory or learning disabilities, and to pregnant patients who do not speak or read English.

1.4 To ensure that if pregnant patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines (2016).

1.5 To ensure that every pregnant patient should know who the lead professional is, and when and where she will receive her care. The lead professional has a key role in the planning and provision of her care. This may change during her pregnancy, in which case any changes should be clearly documented in the patient's health care records.

1.6 To provide an evidence-based framework of clinical care given by health professionals.

1.7 To recognise uncomplicated pregnancy as a normal physiological process and that, as such, any interventions offered should have known benefits and be acceptable to pregnant patients.

1.8 To ensure that even if the pregnancy is complicated care enables a pregnant patient to make informed decisions based on her needs, having discussed matters fully with the healthcare professionals involved.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix J)

3.0 The Key Professionals who Provide Antenatal Care

(Refer to appendix A)

3.1 **The midwife** works across a variety of settings and is able to be with the pregnant patient when and where needed, ensuring that the pregnant patient is the focus of care.

3.2 When pregnancy is uncomplicated the midwife is responsible for providing and arranging all maternity care that is needed for a patient and her baby.

3.3 If abnormalities occur the midwife is obliged to refer the patient to the relevant professional.

3.4 Patients with complex pregnancies and who receive care from a number of specialists or agencies should continue to receive the support and advocacy of a known midwife throughout their pregnancy.

3.5 **The General Practitioner's** (GP) role is to provide overall health care, not just for the duration of the patient's pregnancy but before and after. The GP and midwife should work in a complementary way, providing low-risk care in the primary health care setting.

3.6 **The obstetrician** is the acknowledged expert in the care of pregnant patients with complicated pregnancies, and is the lead professional for these patients.

3.7 The obstetrician is an advisor on actual and suspected abnormalities, and responsible for the care of pregnant patients who have obstetric emergencies, and a provider of technical skills beyond the expertise of a midwife/GP.

3.8 Obstetricians should be involved when a problem is suspected and not just when it has occurred.

3.9 Every patient, including those with uncomplicated pregnancy can request to meet an obstetrician during her pregnancy.

3.10 **The Antenatal Newborn Screening Co-ordinator** is based in Antenatal Clinic and is responsible for co-ordinating antenatal and newborn screening services for pregnant patients receiving their care within Mid Essex Hospital Services NHS Trust.

3.11 The Antenatal Newborn Screening Co-ordinator is a source of expertise to staff and patients regarding the screening services available.

3.12 For patients who have received an abnormal result (excluding microbiology and full blood count which remain the responsibility of the originator) or whose pregnancy requires additional investigation the screening coordinator provides support and counselling for these patients and their families.

3.13 It is the responsibility of the Antenatal Newborn Screening Co-ordinator to arrange referral to appropriate specialists/centres for further investigations/treatment when required.

3.14 To contact the Antenatal Newborn Screening Co-ordinator phone: 01245 513433 between the hours of 0900-1700 hours; messages can be left on answer-phone if out of office hours.

4.0 Schedule and Content of Antenatal Care

(Refer to Appendix A)

4.1 The recommended number of antenatal care appointments for pregnant patients who are healthy and whose pregnancies remain uncomplicated in the antenatal period are as follows:

- 10 appointments for nulliparous patients

- 7 for parous patients

4.2 Care should be provided by a small group of healthcare workers to enhance continuity of care.

4.3 Frequency of antenatal visits, scans and blood tests are likely to be increased for pregnant patients who require obstetric-led care. These patients will have individual plans of care tailored to their needs.

4.4 These appointments follow the patient's initial contact with a healthcare professional when she first presents with the pregnancy, and from where she is referred into the maternity care system. This initial contact should be used as an opportunity to provide patients with the information they require for pregnancy
(Refer to Appendix A)

4.5 The booking appointment ensures all midwives undertake a complete holistic needs risk assessment of the pregnant patient. This should include identification of the following risk factors relating to:

- General health/medical conditions
- Lifestyles
- Previous obstetric history
- Family history
- Social exclusion, including problems such as learning difficulties
- Anaesthetic history
- Appropriate place of birth
- Identifying patients who decline blood products
- Routine enquiry into Vulnerability and Safeguarding issues including domestic abuse.
- Routine enquiry into Mental Health history. Planning for enquiry at future appointments where appropriate.

4.6 The antenatal booking can be undertaken in either a hospital or community setting but should be completed ideally by **10 weeks gestation** and no later than 12 completed weeks of gestation to ensure the patient has all the relevant information and the opportunity for all antenatal screening to be offered.
(Refer to appendix B)

4.7 This process involves the following:

- Patient **self-referral** can be made via **email** which is located on the **MEHT website**. The email link is as follows:
chelmsfordmidwives@meht.nhs.uk
- The administration team are responsible for arranging the dating scan and informing the patient by letter. The midwife will arrange the patient's booking appointment.
- **Referral** by the general practitioner (**GP**)/ or **Midwife**: the GP completes the MatAd1 form and forwards this to the maternity administration team at Broomfield hospital or the ward clerk/midwives at the midwife-led unit as appropriate. On receipt of the MatAd1 form, the administration team will arrange the dating scan and inform the patient by letter. The administration team will forward the MatAd1 form to the appropriate midwife who is responsible for arranging the patients booking appointment.

4.8 If a patient is referred at more than 12 completed weeks gestation, the process is as for

4.7. These patients should be booked within 2 weeks of the referral date.

4.9 It should be made clear on the patient's health care records who the lead professional is at all times during her pregnancy, labour and puerperium.

4.10 Referrals to the relevant professionals should be discussed with the patient as the need arises and this should be recorded in the patient's health care records i.e. Antenatal and Newborn Screening Co-ordinator, midwife lead for vulnerable women or safeguarding, physiotherapist, anaesthetist.
(Refer to Appendix E, F)

4.11 If the patient is a Jehovah's Witness or declines blood products, refer to the management of pregnant and postnatal patients refusing blood products, register number 07040.

4.12 A consultant appointment should be arranged at booking for 16-18 weeks gestation to set an individual management plan /sign refusal of blood products.

4.13 Pregnant patients who require obstetric-led care should be booked for delivery Broomfield Hospital

4.14 Cases where there are Safeguarding concerns should deliver at Broomfield Hospital

5.0 Appointment Procedures

5.1 At each appointment the patient's address and contact details should be checked and updated as necessary.

5.2 Staff should introduce themselves by name and status and produce their identity badge and explain the purpose of the appointment.

5.3 Low risk patients may request to see an obstetrician at any stage of their care.

5.4 Verbal information should be supported by written documentation in the patient's health care records and an opportunity should be provided to discuss issues and ask questions. All information provided should be easy to understand and accessible to pregnant patients with additional needs, such as physical, sensory or learning disabilities, or to pregnant patients who do not speak or read English.
(Refer to the policy entitled 'Interpreting and Translation Policy' (09127)

5. 5 All information gained and given should be recorded in the patient's health care records including details of written information provided i.e. leaflets. All entries should be timed, dated and signed. The health professionals should also print their name and grade by each entry.
(Refer to the 'Guideline for maternity record keeping including documentation in handheld records.' Register number 06036)

5.6 Patient's decisions should be respected, even when this is contrary to the views of the healthcare professional (unless safeguarding issues arise as a result).

5.7 When discussing the woman's choice of the place of birth with her, do not disclose personal views or judgements about her choices.

5.8 Information on common pregnancy related complaints should be provided.
(Refer to Appendix B, following NICE guidance)

5.9 Risk assessment should be undertaken at booking and at each subsequent antenatal appointment.

5.10 Healthcare providers should remain alert to risk factors, signs or symptoms of conditions that may affect the health of the mother and baby, such as domestic violence, mental illness, pre-eclampsia and diabetes. Identified risks should be documented in the patient's health care records however this is not the case for domestic abuse or other cases where harm may be caused. In these situations documentation should be entered in the hospital medical records (lilac folder). (Refer to the guidelines for the 'Identification and management of a patient with mental ill health during the perinatal period', register number 09090; 'Domestic abuse', register number 06040; 'Management of diabetes in pregnancy' register number 04266)

5.11 Patients admitted antenatally should have the summary of the admission documented to include the risk status in the patient's handheld records.

5.12 Ensure that all healthcare professionals involved in the care of pregnant woman are familiar with the types and frequencies of serious medical problems that can affect babies, in order to provide this information to women if they request it. (Refer to Appendix I)

5.13 If a patient is transferred to consultant-led care, the reason for the transfer should be made clear to the patient and to the referring obstetrician and documented in the patient's health care records. This will also apply to patients who following obstetric review can continue with their low risk care.

5.14 A customised growth chart will be produced at the woman's 16-18 weeks appointment and will be used to plot her baby's growth from 26 weeks gestation until her delivery. If any deviation from the norm occurs in relation to growth the woman will be referred appropriately.

6.0 Women Suitable for Midwife-led Care, Delivery at Home or a Midwife-led Unit

6.1 Consider a face-to-face early assessment of labour for all low-risk nulliparous women, either: at home (regardless of planned place of birth) or in an assessment facility in her planned place of birth (midwifery-led unit or obstetric unit), comprising one-to-one midwifery care for at least 1 hour.

6.2 Patients suitable for midwife-led care, delivery at home or a midwife-led unit should meet the criteria referred to in Appendix C.

6.3 The midwife should explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby

6.4 The midwife should explain to both multiparous and nulliparous women that they may choose any birth setting (home, standalone unit, co-located unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth.

6.5 Midwives should advise multiparous women that planning to give birth at home or 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.

6.6 Midwives should advise low risk nulliparous women that planning to give 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. In addition, the midwife should explain if the woman plans to birth at home that there is a small increase in the risk of an adverse outcome for the baby.

6.7 All women at 28 weeks gestation require a blood test to ascertain haemoglobin levels. If the haemoglobin results are between 85 to 105 g/l, the woman should be treated with the appropriate iron therapy.
(Refer to the guideline entitled 'Iron deficiency anaemia in pregnancy'; register number 08011)

6.8 If anaemia is identified at 28 weeks gestation, the woman's haemoglobin levels should be repeated at 36 weeks gestation to review the bloods levels and ascertain whether the iron therapy has been effective.

6.9 If the haemoglobin level is less than 85 g/l, the woman should be referred to consultant led care.

6.10 Midwives should refer to guidelines for the 'Management of home birth', register number 08101 and the 'Management of waterbirth in labour'; register number 04237.

6.11 Low risk patients may decide to deliver in the obstetric unit at Broomfield Hospital dependant on their personal choice.

6.12 If further discussion is required by either the midwife or the woman about the choice of planned place of birth, an appointment can be arranged to see a consultant obstetrician if there are obstetric issues; or the midwife can discuss with the Supervisor of Midwives Team.

6.13 There is a low risk Co-located Birthing Unit adjacent to the Consultant-led Unit at Broomfield Hospital

6.14 Standalone Midwife-led Units are also located at:

WJC Birth Centre
St Michaels Health Centre,
Rayne Road,
Braintree
CM7 2QU
Tel Number 01376 560010
Ext 60010

St Peters Hospital
Spital Road,
Maldon
CM9 6EG
Tel 01621 725305/725306/725368
Ext 5305

7.0 Indications for Obstetric-led Care / Referral

(Refer to appendix D)

7.1 This list is for guidance only, and is not meant to be exhaustive. Obstetric consultant / registrar advice is available for midwives and general practitioners when issues surrounding appropriate care are not easily identified

7.2 Consultant antenatal clinics are held in the following areas:

- Broomfield antenatal clinic (ANC)
- St Peters Hospital ANC
- William Julian Courtald (WJC) ANC
- South Woodham Ferrers' Surgery

7.3 Obstetric referral - all midwives have the facility to refer directly to a consultant clinic / team. Where the woman is identified as high risk at booking, the midwife will refer the patient to the obstetric registrar/ consultant who will in turn review the relevant documentation. (Refer to the 'roles and responsibilities of medical and midwifery staff working within the maternity services', register number04227)

7.4 Should urgent transfer to obstetric care be necessary the midwife requesting transfer should whenever possible refer directly to the on-call consultant team through the specialist registrar, liaising with the Labour Ward Co-ordinator or midwife in charge of the Day Assessment Unit.

7.5 Patients who have had a colposcopy for an abnormal smear only, should continue to be seen in the colposcopy clinic and not to be referred to the ANC to discuss the management in pregnancy and mode of delivery.

7.6 Patients who have had a LLETZ biopsy or Loop biopsy **once** should not come to the ANC clinic as the management is the same as a patient without a biopsy.

7.7 Patients who have had 2 or more LLETZ should be referred to the ANC in the first trimester so that serial cervical length measurements can be performed.

7.8 For less urgent opinion/transfer, an antenatal appointment should be made for obstetric review.

7.9 Reason for all opinions/ transfers should be clearly documented in the patient's healthcare records.

7.10 A midwife should refer directly to the general practitioner (GP) or to the obstetric registrar/consultant. The midwife does not fully discharge her responsibilities by referring, and should keep in contact with the patient to ensure:

- Continuity/co-ordination of care by known professional
- That the patient did see her GP/obstetrician
- The plan of care has been understood by the pregnant patient
- There has been no deterioration in the patient's condition
- Available to advise the patient of normal aspects of maternity care
- Follow up social care, mental health referrals

7.11 In relation to medical condition, health care professional should discuss these risks and the additional care that can be provided in the obstetric unit with the woman so that she can make an informed choice about the planned place of birth.

7.12 Patients with complex pregnancies and who receive care from a number of specialists or agencies should receive the support and advocacy of a known midwife throughout their pregnancy.

7.13 In some cases investigations may be initiated by the midwife in primary care, to aid assessment of the patient before referral e.g. pre eclampsia bloods, ultrasound scan, glucose tolerance test.

7.14 The midwife must ensure that arrangements are made to follow up the result of any requested investigation, either by referring to the Day Assessment Unit (DAU), Antenatal Clinic or Labour Ward.

7.15 If any abnormality or risk factors develop and are confirmed the patient will be transferred to obstetric-led care. In the absence of any pathological findings, or if the problem resolves, the patient may remain or be transferred back to midwifery/GP-led care. In any event the midwife/obstetrician should make it clear to the patient who her primary carer is.

7.16 The health care records and medical records should clearly indicate when responsibility of care has been transferred or an opinion has been sought between professionals. (Refer to Appendix F)

7.17 Referral for anaesthetic review may be identified at booking or subsequent appointments (Refer to Appendix F)

7.18 In relation to a medical condition, the Senior Midwife for the Maternal Medicines Clinic/ Named Consultant obstetrician should discuss these risks and the additional care that can be provided in the obstetric unit with the woman so that she can make an informed choice about the planned place of birth.

8.0 Summary of Screening Tests

(Following the advice of the NHS National Screening Committee ‘Screening tests for you and your baby’ offered at Mid Essex Hospital services NHS Trust and NICE guidance)
(Refer to Appendix B)
(Refer to the ‘Receiving and acting on test results in Maternity by both hospital and community’. Register number 06031)

8.1 The Maternity Services has a designated lead for antenatal and newborn screening.

8.2 Patients should be booked ideally by 10 weeks and no later than 12 weeks gestation. At this appointment information should be discussed regarding antenatal screening tests and appropriate leaflets given. All discussions and decisions should be documented in the patient’s health care records.

8.3 Any patient presenting over 12 weeks gestation should be offered a booking appointment within 2 weeks as per the process outlined in 4.7.

8.4 The appropriate antenatal screening forms should be completed and given following consent from the patient.
(Refer to Appendix B)

8.5 Following the dating scan, the ultrasound department should automatically book the anomaly scan between 18-20 weeks gestation.

8.6 For patients who book later than 12 weeks information should be discussed regarding antenatal screening tests appropriate to their gestation and leaflets given. Patients should be offered the next available ultrasound scan appointment and this should be made by the midwife responsible for that patient's care. All discussions and decisions should be documented in the patient's health care records. It is the midwife responsibility to follow-up the ultrasound scan result within one week.
(Refer to point 8.3 and 8.4 if appropriate).

8.7 If an antenatal clinic, community midwife or GP receive any of the abnormal results (other than microbiology or full blood count which they will action themselves) they should liaise with the screening coordinator before discussing plans of care with the patient and her family.

8.8 Tests not offered as routine by the Trust but should be discussed with the patient in order that she is able to make an informed choice:

- CVS
- Amniocentesis when all screening results are low risk
- Tay Sachs testing
  (Refer to the guideline for the 'Antenatal Referrals for Tay Sachs disease'. Register number 08093)

8.9 It is the responsibility of the midwife / doctor initiating any screening or diagnostic test to check the results are obtained and entered into the patient's notes. If there are any concerns over abnormal results these can be discussed with the Antenatal Newborn Screening Co-ordinator or on-call obstetrician; and a plan of action should be arranged to inform the patient and discuss further testing if applicable.

8.10 In line with MEHT guidance, patient confidentiality must be adhered to for all women with positive results from infectious diseases screening. Documentation in the handheld records, including printed blood results must be with patient consent. All other documentation must be placed in the hospital records.
(Refer to 'Confidentiality and Data Protection Policy'; register number 07011)

9.0 Non-Attendees

9.1 The sixth report of Confidential enquiries into Maternal Deaths in the United Kingdom identified '20% of the patients who died from direct or indirect causes booked for maternity care after 22 weeks of gestation or had missed over 4 routine antenatal visits.

9.2 For patients who have missed one appointment for all care settings the midwife should complete the missed appointment proforma and file in the lilac medical notes. In addition, the midwife should send the patient a missed appointment letter, indicating a follow up appointment.
(Refer to Appendix G, H)

9.3 If there are known safeguarding/vulnerable patients concerns, the lead midwives for safeguarding/ vulnerable should be informed.

9.4 For patients who have missed a second appointment, the community midwife should undertake a home visit. If there is no contact, the midwife should confirm address details with the GP and undertake a second home visit within 1 week.

9.5 If there is no contact with the patient on the second home visit, this should be documented as described in 9.7. If there are known safeguarding/vulnerable patients concerns, the lead midwives for safeguarding/vulnerable should be informed.

9.6 Any difficulties in giving care should be escalated to the community midwifery manager, having liaised with the general practitioner and colleagues.

9.7 All actions should be documented, dated and signed in the patient's hospital healthcare records or the community midwives diary as appropriate and an electronic risk event form completed.

9.8 If a patient does not attend an ultrasound scan appointment, the scan department should complete an antenatal ultrasound form for the midwife in the antenatal clinic or the Midwife-led Units as appropriate. The midwife should follow the process as for non-attendees for antenatal appointments; (refer to point 9.2 to 9.6).

10.0 Management of Patients who Book Late

10.1 A late booking is considered to be 22 weeks gestation and over.

10.2 As soon as such patients are known to the maternity services, a full risk assessment/ booking should be carried out by the midwife with careful assessment of the woman's social background, such as history of alcohol and drug abuse.

10.3 Referral to an obstetrician should be arranged in order to plan the remainder of the pregnancy.

10.4 An ultrasound scan should be offered and arranged at the earliest opportunity in order to locate the placenta and assess for fetal wellbeing and growth. It is the responsibility of the midwife to arrange the follow-up appointment following the ultrasound scan.

10.5 The following blood tests should be offered and arranged: full blood count, antibodies and blood group, rubella, VDRL, hepatitis, HIV and haemoglobinopathies. Blood tests for infectious diseases should be labelled urgent.

10.6 If a patient presents in labour unbooked, all staff should be mindful that her HIV and hepatitis state are unknown and if through careful history of the patient's health there is a risk of the patient having hepatitis or HIV or that the patient may have a history of drug/alcohol abuse the midwife should discuss further management with the obstetrician and paediatrician.

10.7 For patients presenting in labour, who have not already been booked, then priority should be given to hepatitis B, HIV and Syphilis. Urgent samples can be taken to the laboratory, for testing Monday – Friday 9-5 pm. Maternity staff need to liaise with the

laboratory and take the blood sample directly to the laboratory themselves (without the use of the POD system or porter, to ensure prompt arrival of the sample for testing).

10.8 Patients who have not previously had a full medical examination in the United Kingdom should have a **medical history** taken and **clinical assessment** made of their overall health at this initial contact or arrangements made for it to be undertaken. The patient should be advised to register with/ see her local GP who should perform the examination. If the patient presents as an inpatient, the medical examination should be performed by the senior house officer and documented in the patient's handheld records; using an interpreting service if indicated.
(Refer to the guideline entitled 'interpreting and translation policy'; register number 09127A)

10.9 Women who book late in pregnancy should be considered carefully for ECC999 Children's Social Care referral, with close scrutiny of the reasons given for not having done so. It may be considered as neglectful for a woman not to access antenatal care unless the reasoning is sound and fully explained to the midwife. Late booking is frequently associated with avoidance behaviours, domestic abuse, drug and alcohol abuse and neglect.

11.0 Staffing and Training

11.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

11.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

11.3 All midwifery and obstetric staff must ensure they attend level 3 Safeguarding Training three yearly and access Safeguarding Supervision commensurate with the Trust Safeguarding Supervision Policy.

11.4 Student midwives should be supervised whilst carrying out booking interviews.

12.0 Infection Prevention

12.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

13.0 Audit and Monitoring

13.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

13.2 As a minimum the following specific requirements will be monitored:

- Responsibilities of relevant staff groups

- Process for ensuring that patients have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy
- Process for ensuring that patients who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral
- Process for ensuring that migrant women who have not previously had a full medical examination in the United Kingdom have a medical history taken and clinical assessment made of their overall health, using an interpreter if necessary
- Process for identifying for which patient health records from previous pregnancies are required for review by clinicians
- Process for arranging the availability of health records for patients for which health records from previous pregnancies are required for review by clinicians
- process for ensuring that patients who miss any type of antenatal appointment are followed up
- Documentation of follow up of patients who miss any type of antenatal appointment
- Process for ensuring that patients who miss any type of antenatal appointments are seen
- Process for audit, multidisciplinary review of results and subsequent monitoring of action plans

13.3 A review of a suitable sample will be audited from the health care records of patients who have delivered to evidence process for ensuring that patients:

- who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral
- have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy

13.4 A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

13.5 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

13.6 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

13.7 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

13.8 Key findings and learning points will be disseminated to relevant staff.

14.0 Guideline Management

14.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

14.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

14.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

14.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

15.0 Communication

15.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

15.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

15.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

15.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

16.0 References

National Screening Committee. (2015) Population Screening Programmes www.screening.nhs.uk

**UK National Screening Committee. NHS Fetal Anomaly Programme. Screening for Down`s syndrome : UK NSC Policy recommendations 2011 – 2014 Model of Best Practice.

National Institute for Health and CareExcellence. (2014) Intrapartum Care for healthy women and babies during childbirth. Clinical Guideline (CG190) London: NICE.

National Institute for Health and Care Excellence. (2014) Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. Clinical Guideline (CG192) London: NICE.

National Institute for Health and Care Excellence. (2012) Antenatal Care. Quality Standard (QS22) London: NICE.

National Institute for Health and Care Excellence. (2017) Antenatal Care for uncomplicated pregnancies. Clinical Guideline (CG62). London: NICE. www.nice.org.uk

National Institute for Health and Care Excellence, (2010) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Clinical Guideline (CG110) London:NICE.

**screening standards updated April 2018:
Public Health England (2018) Standard 1: Fetal Anomoly Screening – coverage for Down's, Edward's and Patau's syndromes.
Available at: https://www.gov.uk/government/publications/fetal-anomaly-screening-programme-standards/standards-valid-from-1-april-2018

Appendix A

Antenatal Appointments and Content – Initial Contact

Initial Contact	• The **initial contact** with a healthcare professional when she first presents with the pregnancy and from where she is referred into the maternity care system should be used as an opportunity to provide women with much of the information they need for pregnancy
Information	• Give **information** (supported by written information i.e. NHS Dept of Health 'The Pregnancy Book and NHS National Screening Committee **'Screening Tests for you and your baby' -** the latter available on CD or translated copies held by screening co-ordinator in ANC Broomfield), with an opportunity to discuss issues and ask questions.
Topics	• **Folic acid supplementation** (400mcg per day for up to 12 weeks) • **Lifestyle advice**, including smoking cessation, recreational drug use and alcohol consumption (Refer to NICE guideline 62 Section 1.3) • **Food hygiene**, including how to reduce the risk of a food-acquired infection (Refer to NICE guideline 62 Section 1.3.3) • **All antenatal screening**, including risks and benefits of the screening tests (Refer to NICE guideline 62 Section 1.6-1.8) • **Choice of care provider** - provide contact numbers of carers and details of where and when patient will next be seen for booking appointment. Give the patient information booklets on 'Emma's Diary' and chosen 'Trust's Antenatal booklet' • **Complete** referral documentation (**MAT AD 1**) and send to the NHS Trust where the patient wishes to receive her care. This document should contain the following information: details of any past or present medical, psychiatric, social, and family history (including details of any domestic violence or safeguarding issues) • If a patient is suspected to be twelve or more weeks pregnant the MAT AD 1 should be faxed as well as sent to the Maternity Administration Department at Broomfield. • **Complete FW8** (prescription exemption certificate)

Appendix B

Antenatal appointments Schedule and Content

Booking appointment (all pregnant patients)	**Booking appointment** (ideally by 10 weeks) • At the booking appointment, give the following information (supported by written information) Screening tests for mother and baby. Risks and prevention of deep vein thrombosis. Information about Ultrasound scans. Midwife Led Birth Centres. Exercise During Pregnancy. Healthy eating in pregnancy. • Provide an opportunity to discuss issues and ask questions (Refer to NICE guide 62 – Antenatal Care Sections 1.3 -1.8) and supported by NHS Dept of Health 'The Pregnancy Book and NHS National Screening Committee; **'Screening Tests for you and your baby'** • Ensure all **contact details** for patient are correct, and that partner, next of kin and GP details are recorded and correct • Document the date of the last menstrual period and calculate estimated date of delivery **(EDD)** by dates, informing the patient that this will be adjusted after the dating scan is performed
Topics	• How the **baby develops** during pregnancy • **Pregnancy care pathway** record a written schedule of care and discuss with the professionals involved in the patient's care (ensure contact numbers are also given) (Refer to Appendix F and G) • **Nutrition and diet**, including vitamin D supplementation and provide details of the 'Healthy Start' programme (www.healthystart.nhs.uk) • Advise against **Vitamin A** supplementation and products containing large doses of vitamin A i.e. liver and liver products • **Exercise,** including pelvic floor exercises information on physiotherapist-led sessions within Mid Essex Hospital Services NHS Trust • **Antenatal screening**, including risks and benefits of the screening tests

Topics	(Refer to Trust guideline 'Receiving and and acting on test results in maternity by both Hospital and Community'. Register number 06031) • **Place of birth** (NICE guidance, place of birth patient information leaflet discussed and given, refer to antenatal health care records for documentation) • Breastfeeding, (provide booking details of workshops available) • Participant-led **antenatal classes** for primigravid patients (provide booking details) • **Maternity benefits**.(provide FSA the parents guide to money) • At this appointment identify patients who may need **additional care** (see appendix C) and plan pattern of care for the pregnancy • Offer **screening tests** and organise as detailed below inform pregnant patients younger than 25 years about the high prevalence of chlamydia infection in their age group, and give details of their local National Chlamydia Screening Programme) (https://www.nhs.uk/conditions/chlamydia/diagnosis/ Provide self-screening pack if available in booking location • **Measure height, weight** and **calculate body mass index** • **Measure blood pressure** and **test urine** • Offer **screening for gestational diabetes and pre-eclampsia** using risk factors (refer to NICE guideline 62 Section 1.9) • **Offer Carbon Monoxide monitoring. Any lady who smokes at time of booking should be offered referral to Smoking Cessation support.** • Identify patients who have had **genital mutilation** (NICE guideline 62 Section 1.5.4.) • Ask about any past or present **severe mental illness** or psychiatric treatment (refer to NICE guideline 192 Section 1.5nd to trust guideline for referral) ask about mood to identify possible depression This enquiry must be repeated at each appointment if one or both questions have been answered with yes • Ask about if **domestic violence** is present within any of her relationships and does she feel safe at home ask about the

	woman's occupation to identify potential risks. This must not be asked in presence of others. Every effort must be made to speak to her in confidence. If possible, the Safeguarding screening form should be completed at booking and filed in the main medical records. (See Appendix J) • **Identify any risk factors** and make appropriate referrals to obstetrician or other health professionals as appropriate i.e. screening co-ordinator, midwife for vulnerable women, anaesthetist
Routine Enquiry	• **At every contact with the patient during pregnancy a routine enquiry should be carried out. Refer to appendix J for example questions.**
Screening tests **Screening tests (all pregnant patients)**	• **Screening tests** to be offered at the booking appointment and arranged if consent given • Blood tests (for checking blood group and rhesus D status and screening • For **haemoglobinopathies, anaemia, red-cell alloantibodies, hepatitis B virus, HIV,** and **syphilis**, ideally before 10 weeks • **Urine tests (**to check for proteinuria and screen for asymptomatic bacteriuria) • **Ultrasound scan** to determine gestational age using: • Crown–rump measurement between 11 weeks 2 days and 14 weeks 1 days (head circumference if crown–rump length is above 84 millimetres) • Down's syndrome screening using: 'combined test' at 11 weeks 2 days to 14 weeks 1 days • serum screening test (triple or quadruple) at 14 weeks 2 days to 20 weeks 0 days • Ultrasound screening for structural anomalies, normally between 18 weeks 0 days and 20 weeks 6 days discuss screening available outside NHS i.e. CVS / screening for Tay Sachs if of Jewish descent • A second USS will be offered at 23 weeks gestation if the sonographer was unable to complete the fetal anomaly at the 18 weeks to 20 week scan
16 weeks gestation (all pregnant patients)	• **Review**, discuss and record the results of all **screening tests** undertaken and **document** in the patient's handheld records • **Reassess planned pattern of care** for the pregnancy and identify patients who need additional care

	• **Investigate a haemoglobin level below 11 g/100 ml** and consider iron supplementation if indicated • **Measure blood pressure** and **test urine for proteinuria** • **Give information**, with an opportunity to discuss issues and ask questions, including discussion of the routine anomaly scan; offer verbal information supported by written information. • A customised **growth chart** will be produced at the woman's 16-18 weeks appointment and will be used to plot her baby's growth from 26 weeks gestation until her delivery. If any deviation from the norm occurs in relation to growth the woman will be referred appropriately. • Give verbal and written information to those who require a Glucose Tolerance Test at 28 weeks. (Refer to Ante-natal records. Women should be advised to make this appointment for themselves. The tests may be done at Broomfield, St. Peters or St. Michaels. • All women who are Rhesus negative will be given verbal and written information about the prophylactic administration of Anti-D. The Anti-D appointment should be made for 28 weeks. Women should be given the appropriate blood form to have group and antibody levels checked within 7 days of receiving the prophylactic anti-D. Anti-D appointments are available at Broomfield, St. Peters and St. Michaels. • Discuss the opportunity to book antenatal classes (Breast feeding, hypnobirth). • Discussion regarding Tommy's fetal movement leaflet within the antenatal care record

18 to 20 weeks (all pregnant patients)	• At 18 to 20 weeks, if the patient chooses, an **ultrasound scan** should be performed for the detection of structural anomalies • For a patient whose placenta is found to extend across the internal cervical os at this time, another scan at 36 weeks should be offered
26 weeks (For primips)	• At 26 weeks, another **antenatal appointment** should be scheduled for nulliparous patients • At this appointment **measure and plot symphysis–fundal height** • **Measure blood pressure** and **test urine for proteinuria** • **Enquire about fetal movements**, listen in to fetal heart if decreased or if patient requests • **Give information**, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information • **Mental health repeat enquiry if indicated from booking**
28 weeks (all pregnant patients)	• The **next appointment** for all pregnant patient should occur at **28 weeks** • At this appointment offer a **second screening for anaemia and atypical red-cell alloantibodies** • **Investigate a haemoglobin level below 10.5 g/100 ml** and consider iron supplementation, if indicated • Offer **anti-D prophylaxis to rhesus-negative patients** • **Measure blood pressure and test urine for proteinuria** • **Measure and plot symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements**, listen in to fetal heart if decreased or if woman requests (refer to NICE guideline 62 Section 1.10.7) • **Give information**, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information • **Mental health repeat enquiry if indicated from booking**

31 weeks **(For primips)** **31 weeks** **(For primips)**	• **Nulliparous patients should have an appointment** scheduled at 31 weeks to **measure blood pressure and test urine for proteinuria** • **Measure and plot symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements**, listen in to fetal heart if decreased or if woman requests (refer to NICE guideline 62 Section 1.10.7) • **Give information**, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information • **Review, discuss and record the results of screening tests** undertaken at 28 weeks; reassess planned pattern of care for the pregnancy and identify patients who need additional care • **Mental health repeat enquiry if indicated from booking**
34 weeks **(all pregnant patients)**	• **At 34 weeks, all pregnant patients should attend an antenatal clinic** • **Give information** (supported by written information and antenatal classes), with an opportunity to discuss issues and ask questions • **Topics** covered should include preparation for labour and birth, including information about coping with pain in labour and the birth plan • **Recognition of active labour** • **Measure blood pressure and test urine for proteinuria** • **Measure and plot symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements,** listen in to fetal heart if decreased or if woman requests (refer to NICE guideline 62 Section 1.10.7) • **Review, discuss and record the results of screening tests** undertaken at 28 weeks; reassess planned pattern of care for the pregnancy and identify patients who need additional care • **Mental health repeat enquiry if indicated from booking**

36 weeks (all pregnant patients) **36 weeks (all pregnant patients)**	• At the **36-week appointment, all pregnant women should attend an antenatal clinic appointment** • **Give** the following **information** (supported by written information and antenatal classes), with an opportunity to discuss issues and ask questions • **Topics** covered should include breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF 'Baby Friendly Initiative' (www.babyfriendly.org.uk) • **Care of the new baby** • **Vitamin K prophylaxis** and **newborn screening tests** • **Postnatal self-care** • **Awareness** of 'baby blues' and **postnatal depression** • **At this appointment measure blood pressure and test urine for proteinuria** • **Measure and plot symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements**, listen in to fetal heart if decreased or if patient requests • **Check position of baby** • For patients whose babies are in the breech presentation, offer external cephalic version **(ECV)** (refer to NICE guideline 62 Section 1.11.2) • **Mental health repeat enquiry if indicated from booking** • **MRSA screen** if indicated
38 weeks (all pregnant patients)	• Another **appointment at 38 weeks** will allow for **measurement** of **blood pressure** and **urine testing** for **proteinuria** • **Measurement and plotting of symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements,** listen in to fetal heart if decreased or if woman requests (refer to NICE guideline 62 Section 1.10.7)

	• **Information giving**, including options for management of prolonged pregnancy, with an opportunity to discuss issues and ask questions; verbal information supported by antenatal classes and written information • **Mental health repeat enquiry if indicated from booking**
40 weeks **(For primips)** **40 weeks** **(For primips)**	• For **nulliparous women, an appointment at 40 weeks** should be scheduled to **measure blood pressure and test urine for proteinuria** • **Measure and plot symphysis–fundal height** and **plot** on **grow chart** • **Enquire about fetal movements**, listen in to fetal heart if decreased or if patient requests • **Mental health repeat enquiry if indicated from booking** • **Give information**, including further discussion about the options for prolonged pregnancy, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information • At the **40 and 41 week antenatal visits**, **nulliparous** patients should be offered a vaginal examination for **membrane sweeping**; the midwife should ensure that the 41- 42 week visit page in the Antenatal Care Record is completed
41 weeks **41 weeks** **(all pregnant patients)**	• **41 week antenatal visits**, **nulliparous** patients should be offered a vaginal examination for **membrane sweeping**; the midwife should ensure that the 41- 42 week visit page in the Antenatal Care Record is complete • At the **41 week antenatal visit, parous** patients should be offered a vaginal examination for **membrane sweeping**; the midwife should ensure that the 41- 42 week visit page in the Antenatal Care Record is completed • **Induction of labour** should be offered • **blood pressure** should be **measured and urine tested for proteinuria** • **Symphysis-fundal height should be measured** and **plot** on **grow chart** • **Enquire about fetal movements,** listen in to fetal heart if decreased or if patient requests • **Information** should be given regarding induction of labour,

	with an opportunity to discuss issues and ask questions; verbal information supported by written information • **Mental health repeat enquiry if indicated from booking**

Appendix C

Criteria for Low Risk Antenatal Care and Delivery at Home, Midwife-led Unit or if a Patient wishes to deliver in an Obstetric unit

(Refer to guidelines for the management of a home birth'. Register number 08101)

- More than 37 completed weeks of pregnancy and under 42 weeks of pregnancy
- Low-risk obstetric history – See indications for Obstetric-led care
- Absence of maternal disease that affects childbearing – see indications for Obstetric-led care
- No evidence of Pre-eclampsia / Pregnancy Induced Hypertension
- Haemoglobin 85 to 105 g/l
- Singleton pregnancy
- Cephalic presentation
- Clinically well grown baby (no evidence of IUGR or macrosomia)
- BMI within normal limits
- Placenta outside of lower segment
- Reassuring vaginal loss (absence of bleeding or meconium)
- Advice shared midwife/consultant-led care for women newly arrived in the UK and/or those who are unable to speak English. (Why Mothers Die 2000-2002)
- The midwife/midwifery team will be the lead professional
- If a patient requires transfer to high-risk (consultant care) during labour the lead professional will be the consultant on-call

Appendix D

Indications for Obstetric-led Care / Referral

Indications for Obstetric-led Care / Referral	
	Cardiovascular Confirmed cardiac disease Hypertensive disorders **Respiratory conditions** Asthma requiring an increase in treatment or hospital treatment **Haematological** Haemaglobinopathies Thalassaemia History of thromboembolic Disorders Family history of previous thrombo- embolism Immune thrombocytopenia purpura or other platelet disorder or platelet count below $100x10^9$/litre Von Willebrand's disease Bleeding disorders in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn Identified as high risk for deep vein thrombosis or pulmonary embolism at antenatal booking assessment **Endocrine** Thyroid disease Diabetes or previous history of gestational diabetes **Infective** Tuberculosis under treatment HIV HBV Sexually transmitted disease Hepatitis Toxoplasmosis if occurs when pregnant Current active chicken Pox/rubella/genital herpes in the woman or baby Rubella –if pregnant **Immune** Rheumatoid arthritis SLE (systemic lupus erethromatosis) APS (antiphospholoid antibody syndrome) Scleroderma **Renal disease** Abnormal renal function Renal disease requiring supervision by a renal specialist **Neurological conditions** Epilepsy Myasthenia gravis Previous cerebrovascular accident **Gastro-intestinal** Liver disease Crohns disease Ulcerative colitis **Psychiatric history** Drug/alcohol abuse Psychiatric disorders being treated with medication

Indications for Obstetric-led Care / Referral	**Previous Gynaecological history** Myomectomy Hysterotomy **Anaesthetic risk** Known airway problems History of drug/ latex allergy Other significant disorders e.g. Cushing's disease **Social Factors** Age < 16 > 40 Vulnerable women – who lack social support or experience domestic violence All Safeguarding / Child Protection cases for security of staff and patients Patients whose first language is not English Alcohol abusers or users of recreational drugs BMI > 35 or < 18 at booking interview If BMI > than 35 refer to guideline for patients with raised BMI Recurrent infection Other connective tissue disease Spinal abnormalities Neurological defects Malignant disease
Previous complications:	Unexplained stillbirth /neonatal death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Eclampsia / HELLP syndrome Uterine rupture Placental abruption with adverse outcome Primary postpartum haemorrhage (PPH) requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Shoulder dystocia Caesarean section Obstetric cholestasis Previous puerperal psychosis Prev fetal haemolytic anaemia Rh isoimmunisation or other significant blood group antibodies Baby with congenital abnormality (structural or chromosomal) Babies > 4.5kg or < 2.5kg Previous pre-term delivery <36weeks Previous fourth degree tears or 3rd tear with continence problems (see @ 36wks) Previous perineal trauma of third or fourth degree. These patients should be seen by consultant in the specialist perineal trauma clinic at 28 weeks. These clinics take place at Broomfield (ANC) every alternate week.
Current Pregnancy:	Rhesus disease Atypical antibodies Anaemia – haemoglobin less than 85g/litre at onset of labour Recurrent antepartum haemorrhage

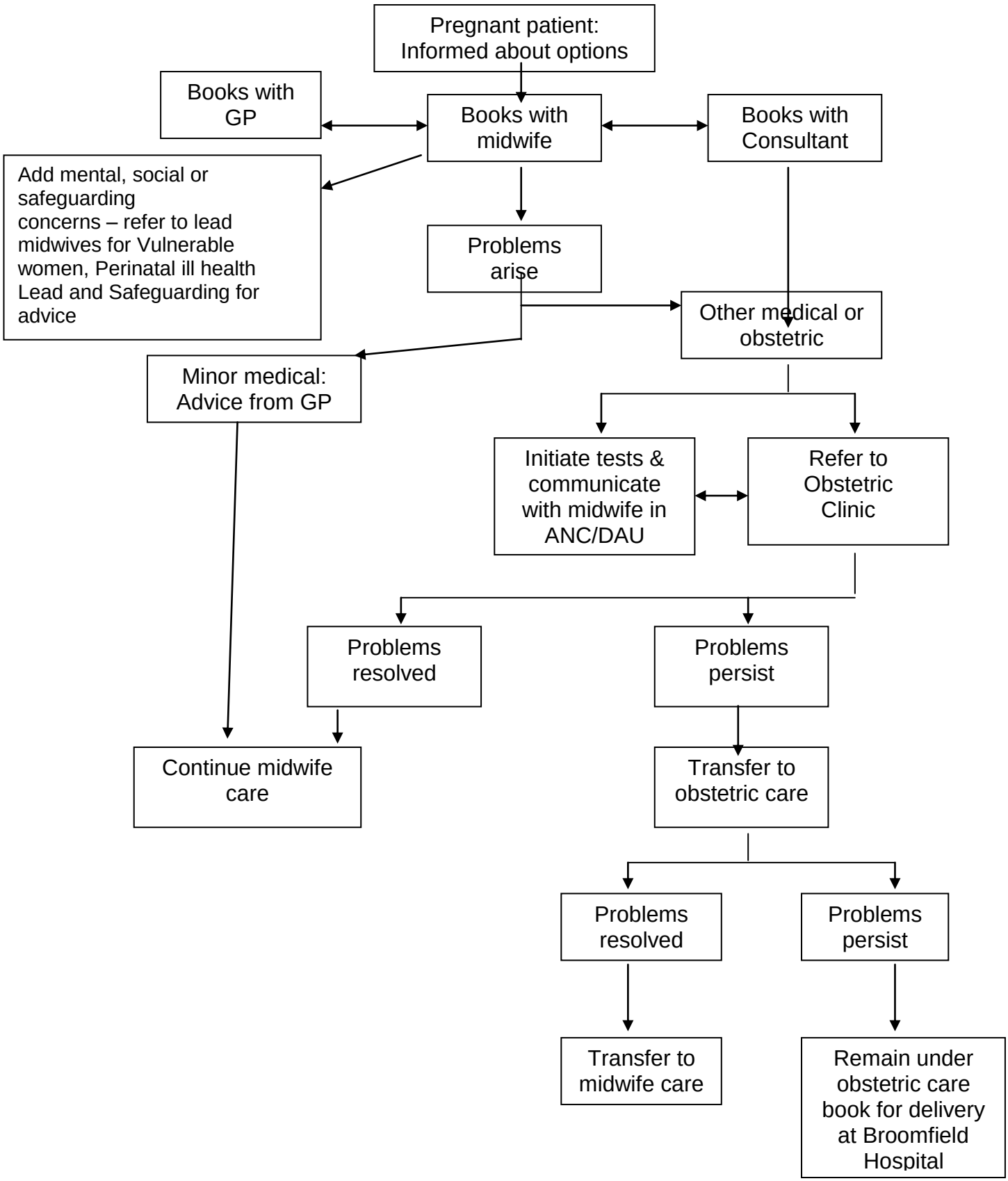
Obstetric Problems: Current Pregnancy	Multiple birth Unstable lie Small for gestational age in this pregnancy (less than 5th centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios Malpresentation – breech or transverse lie Placenta praevia Pre-term labour or preterm prelabour rupture of membranes Pulse over 120 beats/minute on 2 occasions 30 minutes apart Hypertension: single reading of either raised diastolic blood pressure of 110mmgh or more or raised systolic blood pressure 160 or more. Either; raised diastolic blood pressure of 90 mmgh or more; or raised diastolic blood pressure of 140mmgh or more on 2 consecutive readings taken 30 minutes apart Proteinuria: a reading of 2+ protein on urinalysis and a single reading of either raised diastolic blood pressure (90mmgh or more) or raised systolic blood pressure (140mmgh or more) Pre-eclampsia or pregnancy induced hypertension Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment and treatment Epigastric pain Seizures Placenta abruption Pain reported by the woman that differs from the pain normally associated with contractions Suspected thromboembolism / DVT Anaemia – haemoglobin < 85g/l or symptomatic Purities / obstetric cholestasis Pyrexia Onset of gestational diabetes Prolonged rupture of membranes (refer to guideline for management of term rupture of membranes) IVF or infertility / repeated miscarriage (>3) Late booking > 22weeks BMI at booking of greater than 35 kg/m^2
Fetal Indications	SGA baby (current or previous babies) Suspected fetal growth restriction or macrosomia Suspected anhydramnios or polyhydramnios Abnormal presentation, including cord presentation Transverse or oblique Known fetal abnormality Abnormal doppler studies Abnormal fetal heart rate Oligohydramnios Polyhydramnios Meconium-stained liquor Abnormal scan / screening tests Intrapartum indications : Above criteria and including: High presenting part with SRM

	High / free floating head in a nulliparous woman in established labour Reduced fetal movements in the last 24 hours reported by the woman Fetal heart rate below 110 or above 160 beats per minute A deceleration in fetal heart rate on intermittent auscultation Suspicious / pathological CTG Intrapartum haemorrhage Any concern about the progress of labour (See management of labour guideline) Cord prolapse Shoulder dystocia Pyrexia > 38°C or persistent low grade pyrexia Neonatal abstinence syndrome risk
Post Partum / Postnatal	Referral to the woman's GP will be more appropriate in cases where problems are minor and the woman is at home PPH primary / secondary Suspected retained products / incomplete third stage Thrombo embolic disorders Pyrexia temperature > 38°C / persistent low grade pyrexia Complex vaginal/perineal tears including third & fourth degree tears Retained placenta Patients requiring intrapartum prophylaxis for GBS Patients requiring epidural Chronic urinary retention Infected mastitis / symptomatic sub-involution of uterus Mental health problems, enquiry should be made about the severity of the illness, its clinical presentation, treatment required and timing of onset Collapse Severe pre eclampsia / hypertension Seizures: Epilepsy / eclampsia
Other Healthcare Professionals involvement	Anaesthetist Physician Neonatologist / paediatrician Fetal-medical specialists Haematologist Physiotherapist HIV counsellor Lead midwife for vulnerable women Named midwife for safeguarding

	Lead midwife Peri-natal Mental Health Geneticist Psychiatrist Dietician Physiotherapist Screening co-ordinator Smoking Cessation Services Drug and Alcohol Agencies Social services Interpreter Health Visitor Community psychiatric nurse (CPN) Trust counselling service
Additional Midwifery Support & Safeguarding	Patients who may require additional midwifery support as well as obstetric care: • Patients where English is not their first language (requiring an interpreter) • Patients who lack support • Teenagers • Anxiety / psychiatric disorders • Disability • Suspected domestic violence • Drug / alcohol abusers / • Patients who have experienced previous traumatic delivery • Parents who are not suitable or permitted to parent as a result of safeguarding processes • Previous social care involvement • FGM

Appendix E

General Referral System



Appendix F

Referral for Anaesthetic Review

- Anaesthetic review is booked via antenatal clinic on extension 3664 and is usually scheduled for 32 weeks gestation

- If the need for review occurs after 32 weeks gestation an appointment should be booked for the next available session

- If there are no appointments available before the woman is due to deliver, or in the case of imminent delivery the on-call anaesthetist can be requested to review the woman – this should occur within the obstetric department i.e. on Day Assessment Unit or Labour Ward

- The following factors are indications for anaesthetic review:

  - History of adverse reaction to local or general anaesthetic women awaiting an elective LSCS (may not be necessary if women have had an anaesthetic review for a previous LSCS)

  - Multiple births

  - Anti coagulant therapy or with haematalogical disorders

  - History of severe backache, scoliosis, back surgery or significant injury

  - History of cardiac disease, respiratory disease or previous ITU admission

  - History of chronic neurological disease or neurological symptoms

  - Any pregnant mother who, having received obstetric analgesia leaflets, wishes to see an anaesthetist

  - Diagnosed placenta praevia after 32weeks gestation patient with a raised BMI >40

  - Any patient who it is thought by the midwife / GP or obstetrician to need referral

- The following patients can be given the obstetric analgesia leaflets

  Patients planning VBAC delivery
  Patients requesting epidural in labour

Appendix G

Missed Appointment Proforma

NAME:

ADDRESS:

HOSPITAL NO:

GP:

TYPE OF APPOINTMENT: (please tick)

FIRST CONTACT □

BOOKING □

ANTENATAL □

SCREENING BLOOD TEST □

ULTRASOUND SCAN □

ANAESTHETIST □

LOCATION:

PREVIOUS DNA APPOINTMENTS □ **YES** **DATE……**

□ **NO**

ACTION TAKEN:

FURTHER APPOINTMENT ARRANGED?

DATE & TIME

CONTACT METHOD:

LETTER **TELEPHONE** **HOME VISIT**
(second or subsequent DNA)

SIGNED…….. DESIGNATION…….....

PRINT NAME……

DATE……..

Appendix H

Mid Essex Hospital Services NHS Trust

Dear

I am sorry that you were unable to attend your appointment today for (circle appropriate appt):

Booking

Antenatal care

Ultrasound Scan

It is very important that we see you regularly to monitor the health and wellbeing of you and your baby.

I have made you a further appointment (circle appropriate location):

at…….birthing unit / GP surgery / Broomfield Ultrasound Department

on……..

at ……..am / pm

If this is inconvenient please telephone……..to make a further appointment.

I look forward to seeing you.

Kind regards

Appendix I

Numbers and proportions of the individual components of the composite adverse outcomes measure recorded in the Birthplace UK (2011) study

Outcome	**Actual number of babies affected out of [63,955 to 64,535]* (number per 1000)**	**Percentage of all Adverse outcomes measured**
Stillbirth after start of care in labour	14 out of 64,535 (0.22 per 1000)	5%
Death of the baby in the first week after birth	18 out of 64,292 (0.28 per 1000)	7%
Neonatal encephalopathy (disordered brain function caused by oxygen deprivation before or during birth) (clinical diagnosis)	102 out of 63,955 (1.6 per 1000)	40%
Meconium aspiration syndrome (the baby breathes meconium into their lungs)	86 out of 63,955 (1.3 per 1000)	34%
Brachial plexus injury 24 out of 63,955	(0.38 per 1000)	9%
Bone fractures 11 out of 63,955	(0.17 per 1000)	4%
TOTAL (of all outcomes included in the 'adverse outcome' composite measure)	255 out of 63,955 to 64,535) (approx. 4 per 1000)	99%**
Note: Each of the categories above are mutually exclusive and outcomes listed higher in the table take precedence over outcomes listed lower down. For example, if a baby with neonatal encephalopathy died within 7 days the outcome is classified as an early neonatal death. * Denominator varies because of missing values. ** Does not equal 100% because of rounding.		

https://www.npeu.ox.ac.uk/birthplace/results

Appendix J

Date		**Time**			
PATIENT NAME		**PATIENT DoB**		**Hospital number**	
Screening must BE STARTED at initial assessment/ admission. **If not started circle reason:**		**Unconscious / intubated / other (**please specify):			

SECTION 1 – to be completed in all cases		
Visible / disclosed indicators of potential abuse		
Mark / injury		**Location/explanation (record details on patient notes)** **Does the explanation match the injury/mark?**
Bruising	**Y/N**	
Cuts/ grazes / scratches	**Y/N**	
Broken / fractured bones	**Y/N**	
Strangulation/suffocation marks / indicators	**Y/N**	
Burns	**Y/N**	
Sprains / strains	**Y/N**	
Stab / slash wounds	**Y/N**	
Self harm / threats to self harm	**Y/N**	
Other visible / disclosed injury/illness	**Y/N**	

SECTION 2 – Initial screening to be completed with ALL PATIENTS			
Safeguarding screening questions (if 'no' to questions 1-5 sign at section 6 and no further action required)			
	Question	**Y/N**	**If 'Yes': provide additional details here including:** **Who is it and what do they do?** **Is this a safeguarding concern?**
1	Is there any one at home or anywhere else who • hurts you or • makes you scared?	**Y/N**	
2	Is there anyone at home or anywhere else who • Makes you do things you don't want to do? or • Stops you doing things you want to do?	**Y/N** **Y/N**	
3	Is there anyone at home or anywhere else who takes your things or does not let you have your own things? E.g. passport, money, food	**Y/N**	

4	Is there anyone at home or anywhere else who does things to you sexually that you don't like or want but don't have any choice over? **or** Is there anyone at home or anywhere else get other people to do things to you (or you do to them) sexually that you don't have any choice over?	**Y/N** **Y/N**	

5	**FEMALE Patients only** "We are asking all our female patients this question so please do not be offended. There are a lot of communities where cutting a woman or girl down below/ between the tops of their legs is part of tradition and culture. Have you or any of your family or your partner / husband's family ever been cut or stitched down below/ between your legs" (It can be helpful to indicate the relevant area between the top of the legs when asking this question)	**Y/N** **Y/N**	**IF YES – Complete FGM Information gathering sheet.** If other safeguarding concerns also complete Section 3 below. **If girl is under 18 immediate referral to safeguarding on completion of FGM checklist (and section 3 where appropriate)** **DO NOT ASK WHAT TYPE OF FGM OR HOW IT WAS DONE – THIS IS NOT RELEVANT** and may re-traumatise the patient and/or practitioner

SECTION 3 – for completion where any of Q1-5 are answered 'yes' AND there are safeguarding concerns

6	**IMMEDIATE / IMMINENT HIGH RISK IDENTIFICATION FACTORS**		
A	• How frightened are you of X? • How frightened were you during the last event? (when was it) • What are you frightened of X doing and to whom? • Are you scared to go back home/there?	Y/N	
B	• When you leave here what do you think X will do to you if you go back? • If you don't go back when you leave here what do you think X will do?		
G	• What is likely to happen if you do not conform to family, community, gang or X's rules?		
D	• Has X threatened to kill you or him/herself recently? • Do you believe X will do it or try?	Y/N Y/N	Inform the Safeguarding team whatever the final risk level

SECTION 4: For completion where;

	a. any of Q1-4 are answered 'yes' AND there are safeguarding concerns, or **b. Q5 is answered 'yes'**		
7	**WIDER SAFEGUARDING CONSIDERATIONS**		
A	Is anyone in the family / location household pregnant?	Y/N	If **yes** consider referral to Safeguarding Team/ Social Care Who: Relationship: Comments:
B	Are the any children (U18) in the family / location	Y/N	If **yes** consider referral to Safeguarding Team/ Social Care Who: Relationship: Comments:
C	Are the any adults at risk (vulnerable adults) in the family / location	Y/N	If **yes** consider referral to Safeguarding Team/ Social Care Who: Relationship: Comments:

SECTION 5 – Where abuse is identified

Potential abuse identified	**Y/N**	**Abuse type** (Tick all that may apply)	Domestic Abuse		Physical abuse	
			Emotional/ psychological		Forced marriage / HBA	
			Sexual exploitation		Female Genital Mutilation	
			Sexual abuse		Human trafficking / modern slavery	
			Neglect / Omission		Stalking/harassment	
			Self-neglect		Financial / material	
			Discriminatory		Organisational	
			Other abusive behaviour			

Name of potential abuser(s)		**Relationship(s)**	

IMMEDIATE / IMMINENT risk of serious harm or death indicated	**Y/N**
Initial safety planning and /or referrals (all risks):	

Risk assessment trained practitioner or department manager notified	**Y/N**	**Name:**	

Secondary/ confirmatory Risk assessment	**Y/N**	**Name:**	

IMMEDIATE / IMMINENT HIGH risk of serious harm or death confirmed	**Y/N**
Immediate safety planning, referrals and external agency contacts:	

Safeguarding Team / Clinical Ops Manager contacted	**Y/N**	**Name:**	

On-going safety planning, referrals and external agency contacts:

SECTION 6 – Practitioner details

Practitioner carrying out screening		**Signature**	

Date completed	

Appendix J Preliminary Equality Analysis

This assessment relates to: 04272 Maternity Care Guideline

A change in a service to patients		A change to an existing policy	x	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Additions made to the guidance: -Booking appointments following previous perineal trauma (3/4th degree tear) in specialist clinic -CO monitoring at booking for all women (as per saving babies lives care bundle) - GTT and Anti D booked at 16 week appointment -Routine enquiry at every contact
2. Why are you making this change? (What will the change achieve?)	Giving advice to book appointments earlier to avoid delay in patient care. Ensure that routine enquiry is carried out at every patient contact where possible to safeguard women. CO monitoring as per SBL care bundle.
3. Who benefits from this change and how?	Women and families – ensuring appointments are arranged and booked well in advance and PIL are given with time for the information to sink in.
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	To be circulated prior to approval to all maternity staff.

Preliminary analysis completed by:

Name	Rosie Newman	**Job Title**	Midwife	**Date**	21/11/2018