Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: ANTENATAL CARE PROVISION GUIDELINE

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Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
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Amendments from previous version(s)

Version	Issue Date	Section(s) involved	Amendment
V9.0	06-11-2024	• Planned review undertaken	• Language updated to promote equality, diversity and inclusivity • Introduction updated • New guidance updated to include Badgernet maternity electronic patient records system. • References updated
V 9.2	26/08/2025	• Minor amendment	Content updated in line with update to Saving Babies Lives Care Bundle V3.2 .

CONTENTS

1 INTRODUCTION/ BACKGROUND

Maternity care is delivered through multi-professional teams working together to support all women, requiring a wide range of skills, knowledge and expertise, and a supportive context in which these can be applied. By implementing the evidence-based, best practice elements of the Saving Babies' Lives Care Bundle V3 (SBLv3.2), local maternity teams can ensure pregnant women/birthing people receive personalised care that will continue to reduce perinatal mortality [1].

Every day, maternity services support thousands of pregnant women/birthing people and their families through pregnancy and childbirth. The majority of those using maternity services have good outcomes and report a positive experience of care but maternity care is complex and, unfortunately, adverse events occur [1].

The recent MBRRACE-UK (Mothers and babies: Reducing risk through audits and confidential enquiries across the UK) report 'Saving Lives, Improving Mothers' Care' (2023) [2] cited maternal complications such as cardiac disease, thromboembolism, mental health conditions, haemorrhage and pre-eclampsia, contributed to a United Kingdom maternal mortality rate of around 11.7 percent per 100,000, of which died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

There was a statistically non-significant increase in the overall maternal death rate in the UK between 2016-18 and 2019-21, although the report highlights nearly four-fold difference in maternal mortality rates amongst pregnant women/birthing people from Black ethnic backgrounds and an almost two-fold difference amongst pregnant women/birthing people from Asian ethnic backgrounds compared to the White population. Pregnant women/birthing people living in the most deprived areas continue to have the highest maternal mortality rates, emphasising the need for a continued focus on action to address these disparities [2].

Adverse outcomes of pregnancy are sometimes unpredictable events but can be associated with risk factors such as tobacco use, diabetes, obesity, hypertension, substance use or domestic abuse. The aims of antenatal care are to optimise maternal and fetal health, to offer pregnant women/birthing people maternal and fetal screening, for medical or social interventions available where indicated [1, 3, 4, 5, 6, 7].

It is with this philosophy that the Growth Assessment Protocol (GAP) was developed as a co-ordinated program for evidence-based surveillance of fetal growth and prevention of stillbirth [8].

According to Office for National Statics (ONS) figures, stillbirth rates in England have fallen consistently for 9 years to their lowest point of 3.80/1000 in 2020. There was a flattening of the

downward trend during the pandemic in 2020 and a sharp increase in 2021. In 2022, stillbirth rates started to fall again and returned to pre-pandemic levels at 3.93/1000 [9].

Trusts that fully implemented the GAP programme achieved a larger reduction; and the steepest drop was observed in GAP units with the highest small for gestational age detection rates and an overall decline, associated with better protocols and awareness [9].

The provision of antenatal care needs to encompass the vision outlined in the National Maternity Review report 'Better Births' report (2016) [10] that outlines:

"a vision for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where everyone during pregnancy has access to information to enable them to make decisions about their care; and where they and their baby can access support that is centred around their individual needs and circumstances. For all staff to be supported to deliver care which is person centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries".

NB Language in the above statement has been altered to reflect an inclusive maternity service values.

The following guideline summarises the practical information necessary for planning care for pregnant women/birthing people at Sherwood Forest Hospitals NHS Foundation Trust.

2 SCOPE OF DOCUMENT (including Related Trust Documents)

This clinical guideline applies to:

Staff group(s)

- Midwives
- Obstetricians
- Anaesthetists
- Health care support workers
- Receptionist/administrators within maternity services
- Ultrasonographers
- Extended multidisciplinary team who provide specialist care to pregnant women/birthing people

Clinical area(s)

- Community midwifery
- GP surgeries
- Other local buildings e.g. Children's Centres
- Antenatal Clinic
- Pregnancy Day Care
- Sherwood Women's Centre
- Maternity Ward
- Triage

- Sherwood Birthing Unit

Patient group(s)

Pregnant women/birthing people

Related Trust Documents:

- Maternity Guidelines as appropriate
- Consent to Examination, Treatment and Care Policy (v11.2, Feb 2024)
- Chaperone Policy (v6.0, Nov 2021)
- Lone Worker Risk Assessment Form
- Smoking/ Tobacco Dependence/ NRT
- Female Genital Mutilation - recognition, reporting and safeguarding guideline (v3.0, Jan 2023)
- Home Birth Management Guideline (v9.0, Feb 2024)
- Client Choice and Shared Decision Making
- Maternity Triage Operational Policy (v2.2, Jan 2024)
- Maternity Records Guideline
- Lone Worker Risk Assessment Form
- Smoking/ Tobacco Dependence/ NRT
- Management of Pregnant Women who use Substances Guideline (v6.1, September 2021)
- Home Birth Management Guideline (v9.0, Feb 2024)
- Client Choice and Shared Decision Making

3 DEFINITIONS AND/ OR ABBREVIATIONS

SFHFT	Sherwood Forest Hospitals NHS Foundation Trust
MBRRACE-UK	Mothers and babies: Reducing risk through audits and confidential enquiries across the UK
CNF	Case note file

SWC	Sherwood Women's Centre
oGTT	Oral Glucose Tolerance Test
CO	Carbon Monoxide
VBA	Very Brief Advice
AUDIT	Alcohol Use Disorders Identification Test
UTI	Urinary tract Infection
FGM	Female Genital Mutilation
APH	Antepartum Haemorrhage
SFH	Symphysis fundal height
BMI	Body Mass Index
CPD	Cephalopelvic disproportion
PPH	Post-partum haemorrhage
IUCD	Intra uterine contraceptive device
MTC	Maternity Team Care
Named consultant	The named consultant allocated at time of referral for MTC care
GP	General Practitioner
MLC	Midwifery Lead Care
M EPR	Maternity Electronic Patient Record
GAP	Growth Assessment Protocol
SBLV3.2	Saving Babies' Lives: version 3.2
USS	Ultrasound Sonography

4 ROLES AND RESPONSIBILITIES

It is the responsibility of the **General Practitioner (GP) practice** to refer pregnant women/birthing people to maternity services / Community Midwife. Community midwives are geographically based and work within named GP practices or other local buildings. The midwife identified for this location will be the 'named midwife' and their name should be recorded in the Maternity Electronic Patient Record (M EPR).

It is the responsibility of the **named midwife** to:

- Ensure that all pregnant women/birthing people are offered a booking appointment by 10 weeks of pregnancy. Ideally prior to 10 weeks so that the screening test results are available by 10 weeks to ensure prompt treatment or to facilitate urgent risk assessment and arrange dating scan.[3]
- If referral is received after 12 weeks of pregnancy, the community midwife to complete booking within 2 weeks.
- Complete the M EPR.
- Perform a risk assessment to decide on the appropriate type of Maternity Care (see below).
- Refer to the multi professional team in accordance with Trust clinical guidelines.

It is the responsibility of the **Obstetric team** to set the parameters for Maternity Team Care (MTC) referrals and indicate when an appointment should be made for the appointment in Antenatal Clinic (ANC) at either King's Mill Hospital (KMH) or at Sherwood Women's Centre (SWC). Pregnant women/birthing people are allocated a named consultant at the point of

referral and consideration will be given for continuity if the pregnant woman/birthing person has previously received MTC from an existing consultant obstetrician. If the care pathway changes during the pregnancy a different named consultant may be more appropriate for ongoing care.

It is the responsibility of the **Antenatal Clinic administration team** to send an appointment for hospital antenatal care to the pregnant person/woman in a timely manner, ensuring the named consultant is allocated appropriately, especially if this changes during the pregnancy journey with the advice from a midwife or obstetrician.

It is the responsibility of **all health care professionals** conducting antenatal appointments to ensure the pregnant woman/birthing person is informed of their next follow-up appointment and the details are documented on the M EPR and/or a letter is sent with the appointment details. The reasons for the appointment need to be explained to the pregnant woman/birthing person to enable them to understand the importance of the assessment and plan for their next appointment.

Prior to undertaking any examinations, treatment and care, clinicians must ensure that the appropriate consent has been gained. Where relevant the associated documentation must be completed, or the information documented in the records. For further information and policies, please see local guidance: Consent to Examination, Treatment and Care Policy (v11.2, Feb 2024) and Chaperone Policy (v6.0, Nov 2021)

Lone working policy for all staff providing care for pregnant women/birthing people

- Make sure that the risk of working alone is assessed (complete the trusts 'Lone Worker Risk Assessment Form') to reduce the risk so far as is reasonably practicable. This applies to all clinical settings.
- Make sure that appropriate training and advice is available to staff in all areas, and provides practical advice on safety when working alone.
- Encourage full reporting and recording of all adverse incidents relating to lone working. This should be recorded in the alerts section of the M EPR.

5 GUIDELINE DETAILS (including Flowcharts)

5.1 Booking appointment

As a general rule pregnant women/birthing people access Maternity Services through their GP practice. They contact their GP practice and arrange to make an appointment with the community midwife. Pregnant people can self-refer to a community midwife through the maternity service at King's Mill Hospital or Sherwood Women's Centre (SWC).

5.2 Types of Care Available

1. **Midwifery Led Care (MLC)** – Pregnant women/birthing people should have a minimum risk of predictable problems in pregnancy, labour and the puerperium [3, 4]. The community midwife is

the lead professional. Antenatal visiting should be according to individual need with reference to the guidance on MINIMUM recommended antenatal visiting for pregnant women/birthing people considered low risk. (See Appendix A)

2. **Maternity Team Care (MTC)** – The lead professional may be either the named Obstetrician or the named Midwife. For pregnant women/birthing people with risk factors which can impact on the care plan for pregnancy or labour the obstetrician is the lead professional. For those who need review by other members of the maternity team other than the Obstetrician, the named Midwife is the lead professional.

The pregnant woman/birthing person's care may transfer from one lead professional to another at any stage in the pregnancy. Pregnant women/birthing people referred to the named obstetrician may have their care referred back to the community midwife at any point in the pregnancy. The referral and changes will be recorded in the M EPR and other relevant electronic pathways.

At **each visit** the pregnant woman/birthing person pregnancy risk assessment and place of birth is re-evaluated and referral to appropriate care made at the time and recorded in the M EPR **[11]**.

At every routine antenatal appointment, a full antenatal assessment should be undertaken **[3]**, to include:

- Blood Pressure
- Pulse
- Urinalysis (for asymptomatic bacteriuria, proteinuria, glycosuria using dipstick testing at every appointment; and midstream specimen of urine (MSU) for intermediate and high-risk birthing person at booking or if an indirect test is positive)
- CO monitoring for every pregnant woman / birthing person
- Recording of smoking status
- Commence Symphysis Fundal Height measurements (SFH) between 26+0 - 28+6 weeks gestation **[1]**. Further SFH measurements and investigations to be performed according to the Trust guideline 'Use of the customised growth chart' (2024)
- Those pregnant women/birthing people who require serial growth scans follow the SBLV3.2 algorithm[1]. Perform a SFH measurement between 26+0 - 28+6 weeks if the first scan is planned for 32 weeks of pregnancy. If the first serial growth scan is around the 28th week an SFH measurement is not required.

After 36 weeks, palpate the abdomen for possible malpresentation and confirm with an ultrasound scan if suspected.

5.3 Process for identifying which pregnant people/women's health records from previous pregnancies are required for review by clinicians.

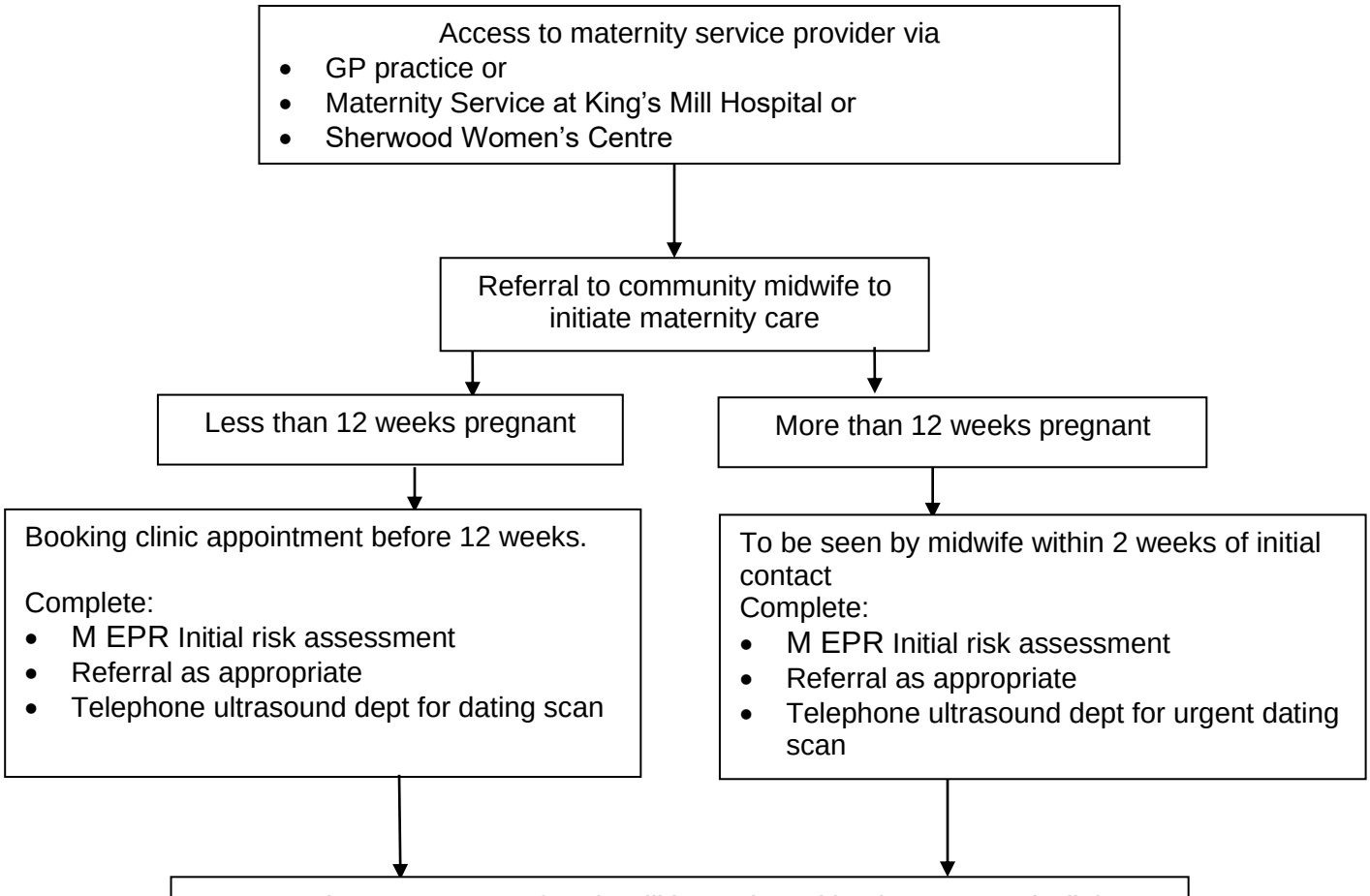
- Pregnant woman/birthing person with previous pregnancy problems are referred for MTC.
- When a pregnant woman/birthing person is referred for a maternity team appointment, the full medical notes (including details of previous pregnancies at Sherwood Forest NHS Foundation Trust are made available at the appointment by the medical records department i.e. all relevant volumes of medical records)

- At the first clinic appointment the obstetrician makes a clinical decision whether to request case notes from another unit.
- When a pregnant woman/birthing person presents in labour, the full case notes are obtained by the acute maternity department staff.
- Medical records for pregnant woman/birthing person are transferred from Case Note File (CNF) to the secure antenatal case note record storeroom, situated in the Antenatal Suite. Medical records for MTC Newark residents are stored securely at the Newark Hospital records store.
- All movements of medical case note records must be tracked out and into departments using the Trust recognised process using the appropriate electronic pathway.

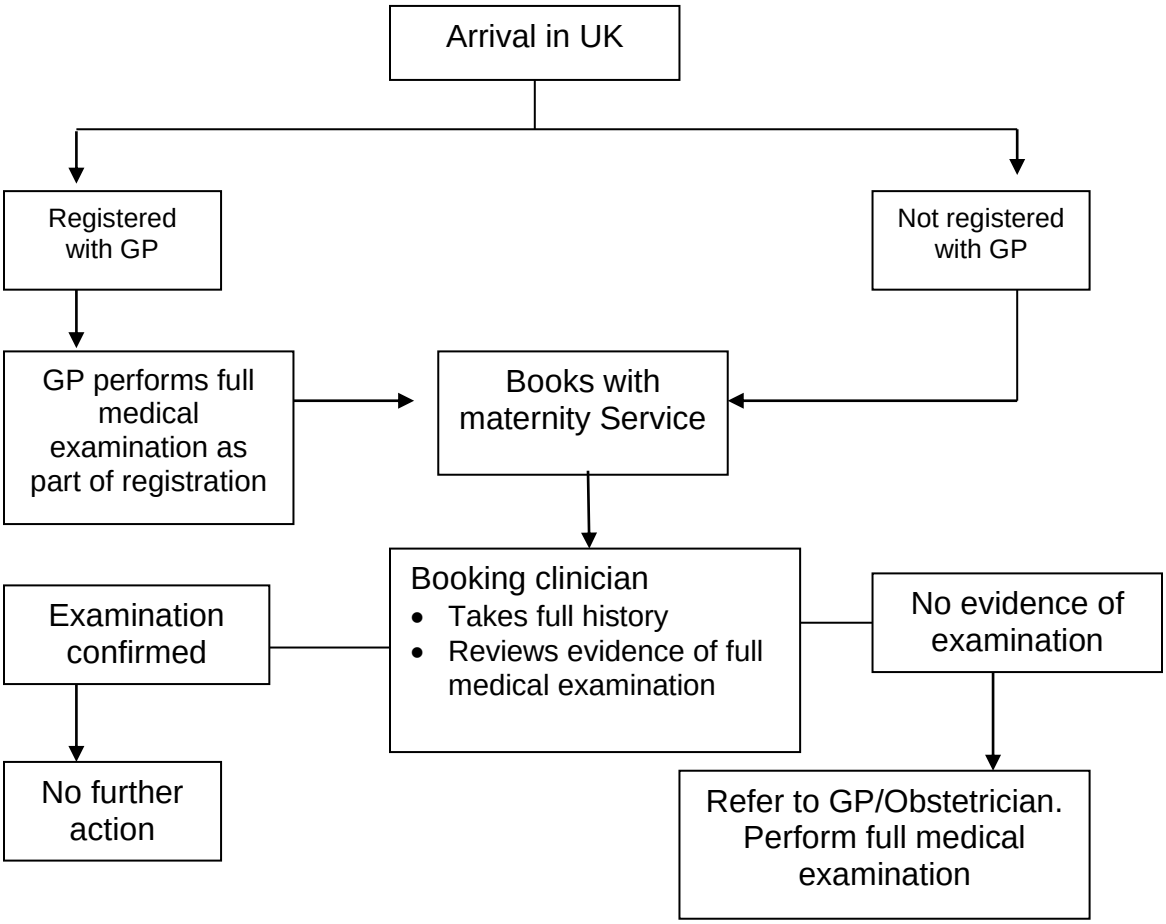
5.4 Process for arranging the availability of health records for pregnant woman/birthing person with previous pregnancies which are required for review by clinicians

- For pregnant woman/birthing person who had previous pregnancies elsewhere a request for case notes/information from previous health service providers can be requested through the relevant Patient Pathway Coordinator.

5.5 Process for ensuring pregnant women/birthing people have their antenatal booking visit by 12 weeks gestation.



5.6 Process for ensuring that migrant pregnant women/birthing people 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



5.7. Risk Assessment in Pregnancy.

Every pregnant woman/birthing person will have their first formal risk assessment at booking. At every contact their future care pathway is reassessed to be appropriate for any risk identified. This should be recorded in the M EPR.

At booking, every pregnant person/woman should also have an assessment of whether she needs to be prescribed aspirin due to her risk of developing pre-eclampsia or her risk of severe fetal growth restriction using the screening tool in the M EPR.

Urinary tract infection (UTI): As indicated in NICE and SBL guidance[1,3], midstream urine sample (MSU) should be taken and sent for culture and sensitivity in all pregnant woman/birthing person at booking. Make arrangements for those who don't provide an MSU at the booking appointment to bring one to their GP surgery within 7 days for prompt assessment. Culture positive samples, even in symptom-free pregnant woman/birthing person (asymptomatic bacteriuria), should be promptly treated. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended. Those who have a recurrent episode require review in secondary care.

A clinical risk assessment is completed at every antenatal contact on her M EPR and this includes place of birth [3,11]. Pregnant women/birthing people for whom risks are identified during the clinical risk assessment will be referred to Maternity Team Care and have an individual management plan made by a named consultant.

Specific risk assessments are performed at certain points of pregnancy eg Re-weigh at 28 weeks to assess Body Mass Index (BMI) as a component for the third trimester VTE assessment.

5.8 Smoking tobacco products in pregnancy.

Smoking tobacco in pregnancy causes harm to both parents and their fetus. Perform carbon monoxide (CO) breath test to identify tobacco use and use Very Brief Advice (VBA) to ask about tobacco use, advise about specific information on the risks of smoking for both the pregnant woman/birthing person and the fetus and advise the pregnant person/woman they should stop smoking. Stopping smoking at any time during pregnancy is beneficial [1, 7] but stopping smoking in first trimester brings the most health benefit. Act by referring them to the Phoenix team via E EPR or email.

For care pathway and referral details please see local guidance:
Smoking/ Tobacco Dependence/ NRT

5.9 Routine Domestic Abuse Enquiry

At each antenatal contact all staff in all clinical areas have a role to make a routine enquiry about domestic abuse when it is appropriate, that is, if the pregnant woman/birthing person is unaccompanied. Midwives should make every effort to ensure that they have had at least one antenatal contact with a pregnant woman/birthing person 'on her own' to discuss this.

For pregnant woman/birthing person who do not speak English the midwife will need to use telephone-based translation service to interpret or the '*cardMedic' app*, not a family member.

Staff are to bring to the attention of the pregnant woman/birthing person the helpline number in the M EPR. At each antenatal contact staff should record who accompanies the pregnant woman/birthing person on the M EPR.

If a pregnant woman/birthing person discloses domestic abuse this should be documented on the Alert section of the M EPR and consideration given to making a safeguarding referral. If

necessary the safeguarding alert tab is to be completed so an alert can be placed in the medical notes. The pregnant woman/birthing person should also be provided with appropriate support following the disclosure.

This information should be shared appropriately with other health professionals. With appropriate consideration may need a Social Care referral.

5.10 Female Genital Mutilation Enquiry

All pregnant women/birthing people are to be asked about if they have female genital mutilation (FGM) at booking. If FGM is disclosed, please follow the care pathway and referral details please see local guidance: Female Genital Mutilation - recognition, reporting and safeguarding guideline (v3.0, Jan 2023)

5.11 Unbooked Pregnancy

Some pregnant women/birthing people attending Maternity Services for care may not have declared their pregnancy to family and may have avoided contact with Maternity Services for a number of reasons (unbooked). Other pregnant women/birthing people will present having booked to give birth elsewhere, they may have been visiting the area.

Some pregnant woman/birthing person will also deliberately avoid antenatal care or attend a unit where they are not booked in an attempt to conceal their pregnancy or the birth of their baby from Children's Social Care. Due to this possibility, it is essential to establish as quickly as possible if there are safeguarding concerns for the unborn child.

This will be eased by maternity units using shared M EPR such as BadgerNet.

Management

a) Pregnant woman/birthing person booked at another unit.

If pregnant woman/birthing person presents with her records review the records as part of the admission assessment and liaise with midwifery teams in area where booked.

For a pregnant woman/birthing person who is booked in another Unit and does not present with their records:-

Ascertain and record details of their medical, social and obstetric history, perform a full medical, obstetric, social and mental health risk assessment including taking 'booking bloods'. Document presenting history, observations, tests/performed declined and assessment of fetal wellbeing.

Contact the Maternity Unit the pregnant woman/birthing person is booked at as soon as possible after admission to find out if there are any safeguarding concerns about the baby.

Ensure all safeguarding concerns and plans are documented on the M EPR as per the Maternity Records Policy

Where safeguarding concerns are identified ensure, all professionals are appropriately informed of plans prior to discharge of the postnatal woman/birthed person and baby from hospital.

b) Unbooked pregnancy in any unit

Ascertain and record details of their medical, social and obstetric history, perform a full medical, obstetric, social and mental health risk assessment including taking 'booking bloods'. Document presenting history, observations and assessment of fetal wellbeing.

Contact Children's Social Care in the area the pregnant woman/birthing person resides immediately to identify any safeguarding concerns / alerts, child protection plans and individuals who may pose a risk. If necessary, make a referral to Children's Social Care. Ensure the pregnant woman/birthing person is kept up to date with information gathered and referrals made as appropriate.

Ensure all safeguarding concerns and plans are documented on the M EPR as per the Maternity Records Policy

Where safeguarding concerns are identified ensure all professionals are appropriately informed of plans prior to discharge of the postnatal woman/birthed person from hospital.

Child Protection Information Sharing Project
https://digital.nhs.uk/services/child-protection-information-sharing-project

The Child Protection Information Sharing (CP-IS) programme is an NHS England sponsored nationwide initiative that helps clinicians in unscheduled care settings identify vulnerable children.

National data relating to children (including unborn children) with a Child Protection Plan, or with Looked After Status is securely transmitted to and stored in CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child.

The aim of the programme is that where a child is subject to a Child Protection Plan, is a Looked After Child, or is a mother of an unborn baby on a pre-birth protection plan and attends an unscheduled health care setting the CP-IS alert is visible, and a notification is sent to the social worker within the Local Authority that the young person / unborn baby originates from. This enables an open dialogue earlier between parents/carers, children's social care and health leading to an earlier intervention (where needed) for the most vulnerable children and young people.

All pregnant women/birthing people who attend unbooked to the Maternity Unit will need to be checked by the midwife caring for the birthing person on the M EPR and allocate the reason booked more than 12 weeks and 6 days. In addition to the management of the unbooked pregnant woman/birthing person described in section above, a Multi-Agency Safeguarding Hub (MASH) MASH referral is to be made and an alert created on the M EPR.

If further advice is required contact a senior member of staff or Named Midwife for Safeguarding Children or Children's Social Care. Children's Social Care telephone numbers are available on the Trust's Safeguarding Children intranet site.

5.12 Indications for referral to Maternity Team Care [1, 2, 3, 4, 5, 6,7,8,9]

Please see Appendix B for referral pathways for the specialist clinics

Medical history

Skeletal problem (spinal/pelvis)	Cardiac disease *
Epilepsy (requiring medication)	Renal disease*
Hypertension *	Thromboembolic disorders* ****
Propranolol medication treatment	Haemoglobinopathies*
Drug/alcohol dependency/abuse***	Autoimmune disease*
Severe psychiatric illness	Genital herpes infection in pregnancy
Previous anaesthetic problems	Severe asthma
Endocrine disorders/diabetes * **	Malignant disease
HIV/Hepatitis B/ Hepatitis C	
Any chronic medical condition with a risk of affecting well-being during pregnancy, childbirth or during the puerperium	
Any medical condition requiring regular medication	

Previous obstetric history

Caesarean section/hysterotomy	Puerperal psychosis[5]
Preterm birth<34/52*	Family history congenital abnormality (structural or chromosomal)
3 or more consecutive miscarriages*	Previous congenital abnormality*
EM LSCS at full cervical dilation *	Intrauterine growth restriction- term baby ≤10th birth weight centile
History trachelectomy (cervical malignancy)*	Eclampsia / HELLP syndrome
Previous cervical suture*	Previous stillbirth/neonatal death
Mid trimester miscarriage *	Rhesus and other significant blood group antibodies*
Previous severe pre eclampsia	Previous baby with neonatal Group B streptococcal infection

Proven CPD	PPH >1000ml
Previous shoulder dystocia	Previous baby >4500gm
Previous 3rd/4th degree tear	Grand multiparity ≥6

Gynae/surgical history

3 or more surgical terminations of pregnancy*	Pelvic eg orthopaedic (inc trauma)
Cervical surgery eg cone biopsy, Lletz *	Refashioning episiotomy/perineal problems
Known uterine variants eg bicornuate uterus*	Intrauterine adhesions
Myomectomy	Female genital mutilation

Current pregnancy

≤16 years old at EDB	BMI <18 or >30 kg/m^2 NB 30-34.9 consultant appointment not needed unless other risk factors. Appointment for GTT only.
≥40 yrs multiparous unless had a baby in previous 10yrs at EDB	Recurrent vaginal bleeding*
≥40 yrs nulliparous at EDB	Multiple pregnancy*
Alcohol score of >15 on AUDIT ***	IUCD in situ*
Teratogenic drugs*	Late booking >20 weeks
APH on x2 occasions	Ovarian cyst/fibroid/pelvic mass (>5cm)
Booking CO reading ≥4ppm and/or self disclosed smoker	PAPP-A MoM below 0.415.
Refusal of blood and blood products eg Jehovah's Witness	Suspected or confirmed exposure to Zika Virus
Abnormal liver function test or Bile Acids >18	Psychological fear of childbirth

Lifestyle

Non prescription drugs*** and regular analgesics eg codeine and opioid based	Methadone or buprenorphine programme

*Requires early referral (ASAP) for consultant opinion

** Pregnant woman/birthing person with pre-existing diabetes, hyperthyroidism, Addison's disease, prolactinoma, poorly controlled hypothyroidism, refer to obstetric/endocrine clinic. Pregnant woman/birthing person with other stable endocrine problems should be referred to the general obstetric clinic.

***__Alcohol Use Disorders Identification Test (AUDIT)__[13] See maternity drug and alcohol guideline Management of Pregnant Women who use Substances Guideline (v6.1, September 2021)

Link to AUDIT assessment
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684823/Alcohol_use_disorders_identification_test__AUDIT_.pdf Badgernet provides the a score from the questions asked and this link provides a pathway for other support networks, plus a handy alcohol unit calculator.

**** See VTE guideline Ref: New updated VTE guideline 2024, not on intranet at time of submission

This list of indications for referral is drawn from evidence of best practice. Individual guidelines to support this can be viewed on the Trust intranet site.

5.13 Place of Birth

All pregnant women/birthing people should be given information by their community midwife about choices for place of birth and reassessed at every contact. Pregnant women/birthing people requesting a Home Birth should have a minimum risk of predictable problems in labour. Those with risk factors identified during the clinical risk assessment may be considered suitable for a home birth and this should be considered on an individual basis.

Pregnant women/birthing people considered unsuitable for home birth due to the nature of risk factors identified, should be discussed with the obstetrician and Professional Midwifery Advocate if required. An individual management plan to be agreed with the pregnant woman/birthing person. For care pathway and referral details please see local guidance [12.]

Home Birth Management Guideline (v9.0, Feb 2024)
Ensure throughout the pregnancy pathway a risk assessment at each contact is undertaken and must include ongoing review of the intended place of birth, based on the developing clinical picture [3, 11].

New or resolved risks should be recognised and documented as part of the on-going plan and discussed with the pregnant person/woman and their birth partner. All pregnant women/birthing people have options regarding their pregnancy journey facilitating choice and shared decision making as per current SFHFT guidance Client Choice and Shared Decision Making.

5.14 Indications for referral to Pregnancy Day Care (PDC)

All referrals to PDC should be for on-going care and not for urgent non-scheduled obstetric assessment. Urgent care is to be provided by the obstetric/maternity triage team using The Birmingham Symptom-specific Obstetric Triage System (BSOTS©) system. This aims to standardise and clinically prioritise care, reduce time to initial assessment and reduce need for inappropriate tests and treatment. See local trust guidance:
Maternity Triage Operational Policy (v2.2, Jan 2024)

This list is not exhaustive for referrals to PDC and referral may be needed in other situations.

- Referral for testing for gestational diabetes mellitus (oGTT). The test is performed within the Antenatal Clinic or Pregnancy Day Care
- On going raised blood pressure
- Clinical polyhydramnios
- Assessment and monitoring of small for gestational age babies or babies with fetal growth restriction.
- Ultrasound assessment of fetal growth as indicated by the Growth Assessment Protocol of the Perinatal Institute [9] https://www.perinatal.org.uk/GAP/Programme
- Pre-operative assessment
- Non-urgent procedures that arise from Antenatal Clinic assessment eg Dexamethasone injections.
- Administration of IV Monofer
- Obstetric cholestasis management

5.15 Indications for referral of Midwifery Led Care during pregnancy for Maternity Team Care/opinion in the antenatal period

(This list is not exhaustive, and referral may be needed in other situations)

- Recurrent haematuria in the absence of infection
- Any abnormal scan findings
- Abnormal GTT (to obstetric/endocrine clinic)
- Recurrent proven UTIs
- Non-specific pruritus, without rash (consider Obstetric Cholestasis)
- Persistent anaemia
- Raised BP/proteinuria
- APH
- Preterm spontaneous rupture of membranes
- Premature labour
- Known Group B streptococcus on any swab or MSU in current pregnancy
- Chickenpox (to clinic post infective phase)
- Parvovirus (slapped cheek)
- Unstable lie >36/52
- For a high fetal head in a nulliparous non-labouring pregnant person/woman at 40 weeks gestation eg 5/5 palpable
- Post mature (T+12) Induction of labour of pregnant woman/birthing person booked for MLC
- Primary genital herpes

5.16 Documentation.

Results of risk assessments and decisions regarding type of care should be documented within the M EPR, completing appropriate M EPR referrals and any other relevant proforma as indicated by specific Trust guidance.

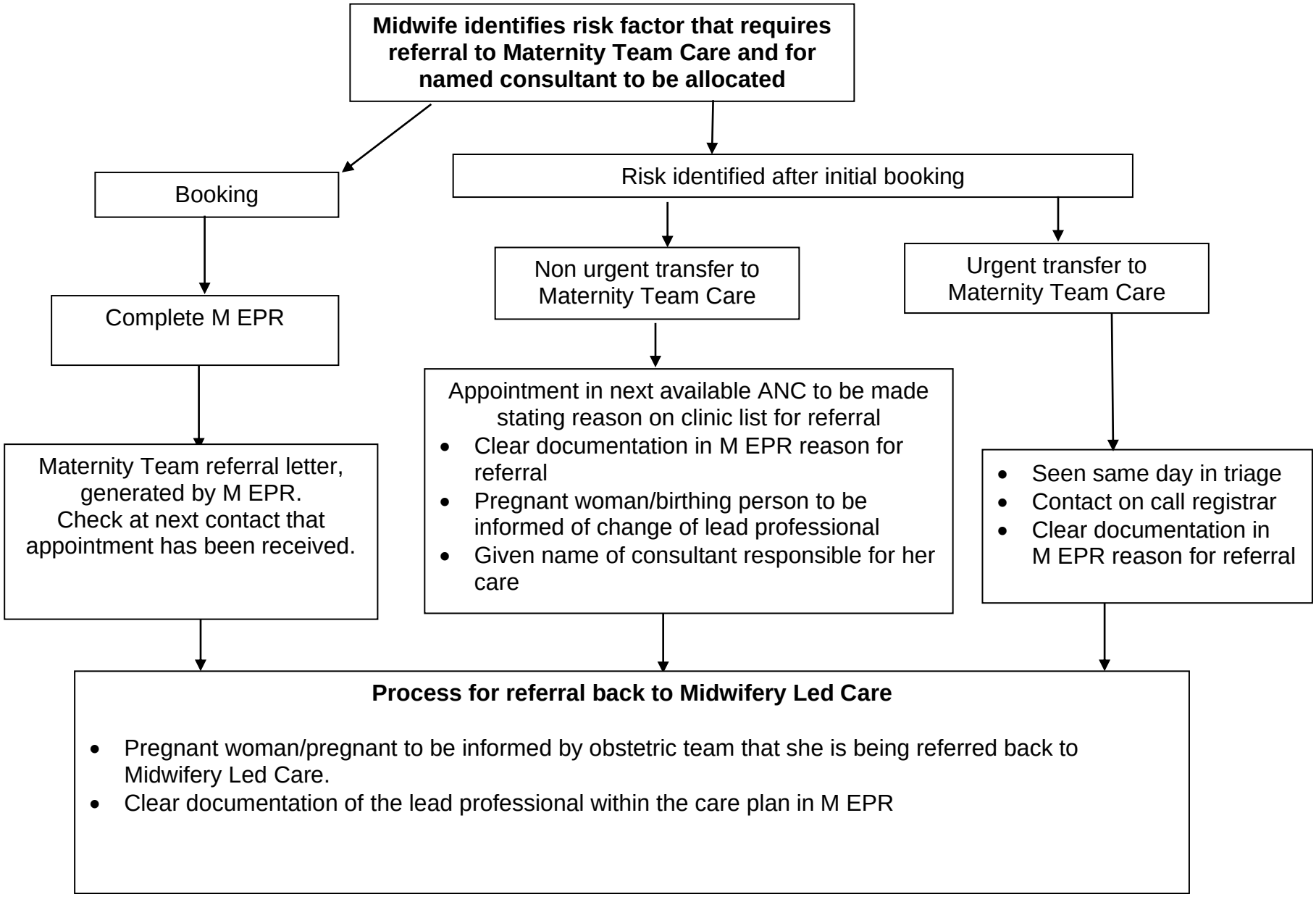
5.17 Action following self-discharge from maternity care

The Community Midwife (and anyone else involved in the pregnant woman/birthing person's care such as Specialist teams) should be informed if a pregnant woman/birthing person self-discharges.

If a pregnant woman/birthing person is taking their own discharge prior to review, a plan of care should still be made and appropriate follow up arranged or appointments amended as necessary. This needs to be communicated out to the pregnant woman/birthing person via letter.

The proposed plan of ongoing care documented on the M EPR needs to be clearly communicated to staff by completing the M EPR and if applicable an antenatal communication form should be completed to alert relevant professionals.

5.18 Process for referral to Maternity Team care: All midwives have the facility to refer pregnant women/birthing people directly to the maternity team through the M EPR.



5.19 Recommended minimum antenatal contacts

The 'pregnancy plan' at Appendix A offers recommendations for minimum contacts for pregnant woman/birthing person in pregnancy [1, 2, 3, 4, 5, 7, 11,]

5.20 Process for providing information to pregnant women/birthing people whose first language is not English

An initial assessment should be made by the community midwife at booking and recorded in the M EPR.

The community midwife should utilise the telephone translation service at the initial antenatal appointment to ensure appropriate translation is provided.

'Big Word' **033 3344 9473** and *Women and Children's unique code:***76546794**
Or '*cardMedic'* app can also be utilised

Interpreters should not be children and should only be family members if the pregnant woman/birthing person is happy for them to interpret and once this has been ascertained through an independent interpreter.

6 EVIDENCE BASE/ REFERENCES

1. NHS England (2025) Saving Babies' Lives: version 3.2. NHS England » Saving babies' lives: version 3 [accessed 23/5/24]

2. MBRRACE-UK (Mothers and babies: Reducing risk through audits and confidential enquiries across the UK) report 'Saving Lives, Improving Mothers' Care' (2023). https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf [accessed 23/5/24]

3. N.I.C.E. Antenatal care (2021) https://www.nice.org.uk/guidance/ng201/resources/antenatal-care-pdf-66143709695941 [accessed 23.5.24]

4. N.I.C.E Antenatal care Quality Standard (2023) https://www.nice.org.uk/guidance/qs22/resources/antenatal-care-2098542418117 [accessed 23.5.24]

5. N.I.C.E Antenatal and Postnatal Mental Health: clinical management and service guidance (2020) https://www.nice.org.uk/guidance/cg192 [accessed 23.5.24]

6. N.I.C.E Maternal and Child Nutrition (2014) https://www.nice.org.uk/guidance/ph11/resources/maternal-and-child-nutrition-1996171502533 [accessed 23.5.24]

7. N.I.C.E. NG209 Tobacco: preventing uptake, promoting quitting and treating dependence
(2023) https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-treating-tobacco-dependence-in-pregnant-women#identifying-pregnant-women-who-smoke-and-referring-them-for-stop-smoking-support [accessed 23.5.24]

8. Evaluating the Growth Assessment Protocol for stillbirth prevention: progress and challenges
J Perinatal Med. 2022;50(6): 737-47.
https://www.degruyter.com/document/doi/10.1515/jpm-2022-0209/html

9. Perinatal Institute (2024) https://www.perinatal.org.uk/GAP/Programme [accessed 23.5.24]

10. National Maternity Review: Better Births (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf [accessed 23.5.24]

11. Ockenden Report Final: Findings, conclusions, and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospitals NHS Trust (2022)
https://assets.publishing.service.gov.uk/media/624332fe8fa8f527744f0615/Final-Ockenden-Report-web-accessible.pdf [accessed 23.5.24]

12. Sherwood Forest Hospitals (2022) Facilitating Choice & Shared Decision-Making Within Maternity Care Guideline V2
https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=17727

7 EDUCATION AND TRAINING

There is no additional training required for the application of this guideline.
All maternity staff to attend mandatory annual training and to keep up to date with learning from incidents.
The senior maternity team to cascade any change in national practice and the maternity pathways updated to reflect national guidance.

8 MONITORING COMPLIANCE AND EFFECTIVENESS

Maternity care pathways are reviewed at the Antenatal Clinical Governance sub group.
Practice will be monitored through incidents and Saving Babies Lives auditing for NHS Resolution maternity incentive scheme compliance.

9 EQUALITY IMPACT ASSESSMENT

Name of service/policy/procedure being reviewed: Antenatal care provision guideline
New or existing service/policy/procedure: Existing
Date of Assessment: 04.09.24

For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	No		
Gender:	Pregnant women/birthing people only service		
Age:	No		
Religion:	No		
Disability:	No		
Sexuality:	No		
Pregnancy and Maternity:	This service is for pregnant women / birthing people		
Gender Reassignment:	No		
Marriage and Civil Partnership:	No		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	No		

What consultation with protected characteristic groups including patient groups have you carried out?

- Consulted with guideline review

What data or information did you use in support of this EqIA?

- Information within this guideline

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Claire Allison
Date: 04.09.24

10 APPENDICES

Appendix A – Provision of care, discussion and information
Appendix B – Maternity referral pathway

Appendix A Provision of care, discussion and information

Recommended contact	All pregnant women/birthing people: care and discussion	Written information	Pregnant women/birthing people requiring additional care
First contact/booking apointment	Commence M EPR. Initial risk assessment [medical, obstetric, social and mental health] Early referral if required. Perform baseline observations including smoking status and CO reading to assess smoking status Discussion re ○ Folic acid ○ Vitamin D ○ 'Healthy Start' ○ Food hygiene ○ Brief intervention smoking & obesity using VBA structured conversation ○ Antenatal Screening including dating/anomaly scans ○ Domestic abuse (DA) ○ Place of birth ○ Maternity vaccination programme	• M EPR Antenatal screening and diagnosis • General information leaflets on M EPR (BadgerNet) • 'Screening Tests for you and your baby'	Pregnant women/birthing people newly arrived in the UK who have not had a medical examination –refer to GP for medical history and clinical assessment of overall health Assess the need for approved translator Consider possibility of FGM Ensure pregnant women/birthing people with a BMI >30, are diabetic or have epilepsy are on higher dose of folic acid. (5mg) If continuing to use tobacco discuss use using VBA and refer to the Phoenix team
Booking appointment (By 12 weeks; if books later than12 weeks this must be within 2 weeks)	Routine booking investigations including booking blood tests and MSU. Review these results, document them in the blood tests tab and publish to badgernet within 2 weeks. Ensure FW8 has been issued Send antenatal summary to GP Send required referrals eg ANC, weight management, GTT, Phoenix team, Lotus team etc Complete topics discussed in pregnancy tab on M EPR Information and discussion re • Work and benefits • Exercise • Hygiene • Travel safety • Vaccines in pregnancy: flu if pregnant during Winter season, Pertussis from 16 weeks and RSV from 28 weeks of pregnancy • Place of Birth • Infant feeding	• M EPR Antenatal screening and diagnosis • General information leaflets on M EPR • Raised BMI leaflet if appropriate. DA information	Arrange GTT appointment if meets criteria for early GTT screening 12-16/52 Commence obesity pathway if BMI >30 If continuing to use tobacco discuss use using VBA and refer to the Phoenix team

Recommended contact	All pregnant women/birthing people: care and discussion	Written information	Pregnant women/birthing people requiring additional care
	• Smoking: Record smoking status and CO monitoring in ANC/SWC at time of dating scan for pregnant women/birthing people continuing to smoke • Mood including Mental Health screening questions (M EPR) • VTE risk assessment (M EPR) • Risk assessment for Aspirin 150mgs (M EPR) Domestic Abuse enquiry		
16 weeks	Discuss all results with the pregnant person. Offer NIPT for fetal genotype to Rh Neg pregnant women/birthing people Risk assessment for Small for Gestational Age (SGA): review PAPP-A MoM result and 12 week CO reading with current smoking status and place of birth Full antenatal assessment Infant feeding, health benefits. If referred for consultant appointment check appt has been received. Arrange GTT appointment if required. Vaccines in pregnancy: flu if pregnant during Winter season, Pertussis from 16 weeks and RSV from 28 weeks of pregnancy	Discuss and record results M EPR supportive conversations toolkit for discussion	Review 'antenatal support conversations' (P&C) Revisit 'topics' discussed in pregnancy and complete appropriate signs and symptoms Review GROW tab and review Aspirin risk assessment
25 weeks	Full antenatal assessment and risk assessment to include place of birth Discuss • skin to skin contact • Antenatal classes • Offer pertussis vaccine if not received vaccine in this pregnancy • Remind about RSV vaccine available from 28 – 36 weeks • Fetal movements Sure Start Maternity Grant Mat B1 for maternity allowance recipients Review CGC – ensure correct EDB and review growth centile of previous babies. Refer if required. Oral GTT to pregnant women/birthing people in at risk categories Reassess smoking status and record on M EPR	M EPR supportive conversations toolkit for discussion	Order Anti-D if needed GTT if required Review care plan Update 'conversations in pregnancy' and 'topics discussed in pregnancy'
28 weeks	Full antenatal assessment Maternal weight and recalculate BMI- use result for VTE assessment and referral if required record on M EPR Commence SFH measurement and plot on CGC Reassess smoking status and record on M EPR for all people FBC and red cell antibody screen, (Administer Anti D if required)	M EPR supportive conversations toolkit for discussion	Routine antenatal anti-D prophylaxis if appropriate Refer to Lime Green team classes if required

Recommended contact	All pregnant women/birthing people: care and discussion	Written information	Pregnant women/birthing people requiring additional care
	Risk assessment [VTE, medical, obstetric, social, mental health and place of birth] Referral if required		Complete lifestyle form
31 weeks	Full antenatal assessment Review results of 28 week investigations, chase any outstanding results. Discuss with pregnant woman/birthing person and record in M EPR Ensure risk assessment [VTE, medical, obstetric, social, mental health and place of birth], mental health screening questions have been completed Referral if required		Revisit and update conversations in pregnancy tab
34 – 36 weeks	Full antenatal assessment and risk assessment to include place of birth Discuss infant feeding	Laminated infant feeding information	Consider birth preferences discussion Complete 'birth plan' tab
36 weeks	Full antenatal assessment and risk assessment to include place of birth including smoking status and repeat CO reading and weight for all pregnant women/birthing people & record on M EPR Measure and plot SFH Discuss • Preparation for labour • Latent phase of labour • Labour and Birth • Infant feeding • Vitamin K • Postnatal experience • Safe sleeping • Reassess smoking status record on M EPR • Smokefree site at KMH for birth	M EPR	If not cephalic presentation offer ultrasound scan to confirm prior to referral. If having a home birth – complete 'smart home birth assessment' Update care plan Revisit 'topics discussed in pregnancy' Complete OASI section
38 weeks	Full antenatal assessment and risk assessment to include place of birth. If re weight hasn't been completed at 36 weeks, complete at this assessment.		
40 weeks	Full antenatal assessment and risk assessment to include place of birth Discuss care for pregnancy beyond 40weeks i.e. normal for pregnancies to be beyond 40 weeks and to monitor fetal movements. Offer membrane sweep to low risk nulliparous pregnant woman/birthing person [10] and consider aromatherapy	M EPR Complete IOL referral on M EPR - BadgerNet	

Recommended contact	All pregnant women/birthing people: care and discussion	Written information	Pregnant women/birthing people requiring additional care
41 weeks	Full antenatal assessment and risk assessment to include place of birth Offer a membrane sweep to nulliparous and parous pregnant people/women[10] For pregnant women/birthing people under midwifery led care book induction of labour at T+12	M EPR Induction of labour information leaflet.	

Appendix B - Maternity Team Care Pathway

Maternity Service Referral Pathway
For Antenatal Clinic receptionists

1. Endocrinology referrals to Ms Rajeswary: known Type 1 and 2 diabetes urgent referral ASAP
2. Methadone or buprenorphine programme to PANDA clinic
3. VTE score ≥4 by 12 weeks
4. TWINS MCDA and at 16 weeks for scan.
5. Smokers with CO ≥4: growth scan at 32 weeks
6. PAPP-A MoM below 0.415: growth scan at 32 weeks
7. Cardiac disease
8. Renal disease

Thromboembolic disorders to discuss with consultant prior to sending out appt.

Early appt at 12 weeks with dating scan for:

1. Previous cervical suture
2. History of cervical excision eg Lletz procedure
3. Mid trimester loss between 16-34 weeks
4. Intrauterine adhesions
5. History of trachelectomy
6. Uterine variant eg bicornuate uterus
7. Early appt at 14 weeks for:
8. Previous preterm birth <34/52
9. Previous pre-term, pre -labour rupture of membranes
10. Previous EM LSCS at full cervical dilation

Medical history

Cardiac disease to discuss with consultant prior to sending out appt.
Renal disease to discuss with consultant prior to sending out appt.
Thromboembolic disorders to discuss with consultant prior to sending out appt.
Skeletal problem (spinal/pelvis)
Epilepsy (requiring medication)
Hypertension
Propranolol medication treatment
HIV / Hepatitis B / Hepatitis C
Drug/alcohol dependency/abuse
Severe psychiatric illness
Previous anaesthetic problems
Endocrine disorders/diabetes
Malignant disease
Haemoglobinopathies
Autoimmune disease
Genital herpes- in pregnancy any episode?
Severe asthma
Any chronic medical condition with a risk of affecting well-being during pregnancy, childbirth or the puerperium.

Current Pregnancy

Methadone or buprenorphine programme to PANDA clinic AHH
≤16 years old
≥40 years multiparous unless had a baby in the previous 10 years;
Multiple pregnancies
≥40 year's old nulliparous
Recurrent vaginal bleeding
IUCD in situ
Score of >15 on AUDIT (Alcohol Use Disorders Identification Test)
Late booking, >20 weeks
Non-prescription drugs and regular Teratogenic drugs
Analgesics e.g. codeine and opioid based
APH on 2 occasions
Refusal of blood and blood products e.g. Jehovah's Witness
BMI <18 or >35 kg/m2
Smoker >16weeks
PAPP A MoM below 0.415.
Ovarian cyst/ Ovarian cyst/Fibroid/Pelvic mass (>5cm)

Previous obstetric history

Previous cervical suture: early apt
Mid trimester miscarriage: early apt
Previous cervical suture: early apt
Emergency LSCS at full cervical dilation: early apt
Caesarean section/hysterotomy
Preterm birth <34/52
Proven CPD
Gestational Diabetes
PPH of >1000mls
Previous severe pre eclampsia/ Eclampsia / HELLP syndrome
Previous shoulder dystocia
Previous baby > 4.5kg
Term baby birth weight ≤ 10th centile
Previous SGA/FGR baby (Please review customised growth chart)
Grand multiparity (≥ 6)
Previous stillbirth/neonatal death
Previous 3rd/4th degree tear
Puerperal psychosis
Family history of congenital abnormality (structural or chromosomal)
Previous congenital abnormality
3 or more consecutive spontaneous miscarriages
Rhesus and other significant blood group antibodies
History of previous baby with neonatal group B streptococcal infection.

Gynae/Surgical History

x3 or more terminations of pregnancy e.g 3 or more surgical terminations of pregnancy
Uterine surgery eg cone biopsy, Lletz procedure
Known uterine adhesions Ashermann's syndrome
History of trachelectomy
Refashioning episiotomy/perineal problems
Myomectomy
Pelvic eg orthopaedic (inc trauma)
FGM

If any doubt ask for consultant opinion on any condition that is not listed above.