WOMEN'S HEALTH AND PAEDIATRICS

MATERNITY UNIT

Antenatal care including booking appointment, maternity care pathway and antenatal clinical risk assessment

Amendments			
Version	**Date**	**Comments**	**Approved by**
1.0	24/11/09	This guideline supersedes the assessing client suitability for midwifery led care in pregnancy and labour the Antenatal non attendance guideline	Women or pregnant people's' Health Guidelines Group
2.0	April 2012	Roles and responsibilities of named midwife and Community Team Leaders Use of Interpreting services Review and update of antenatal risk factors Liaison with Health Visitor	Women or pregnant people's Health Guidelines Group
3.0	Nov 2014	Addition of CNST update detailing process identifying risk factors	Women or pregnant people's Health Guidelines Group
4.0	Jan 2016	Non-attendance to scan appointments	Women or pregnant people's Health Guidelines Group
5.0	Feb 2018	Document review, remove references to Supervisor of Midwives	Head of Midwifery
6.0	October 2018	Addition of Carbon Monoxide Testing	Women or pregnant people's Health Guidelines Group
7.0	August 2019	Addition of referral to consultant at booking when requesting care outside of guidance >37 weeks	Women or pregnant people's

			Health Guidelines Group
8.0	October 2021	Change to reflect current NICE guidelines. Guideline split into three guidelines to incorporate the referral to maternity care process and pathway for non-attendance for maternity care	Women or pregnant people's Health governance and guidelines group
9.0	October 2023	Whole document review, updated with Saving Babies Lives Care Bundle version 3 recommendations	Maternity Guidelines Group
10.0	January 2024	Section added on reduced fetal movements	Maternity Guidelines group

Compiled by: Katie Spiers – Community Matron
Sian McDonnell – Consultant Obstetrician

In consultation with: All consultant obstetricians and senior midwives
Perinatal Governance Group

Ratified by: Perinatal Governance Group

Date ratified: **07/12/2023**

Next review date: **January 2027,** or if legislation, national guidance or lessons learnt indicate an earlier review

Target audience: All health professionals within the maternity services

Equality impact assessment: Perinatal Governance Group

Comments on this document to: Perinatal Governance Guideline Group

Contents

Antenatal care including booking appointment, maternity care pathway and antenatal clinical risk assessment

1.0 Introduction

Routine antenatal care focuses on maintaining and improving health and wellbeing, ensuring that women or pregnant people are equal partners with healthcare professionals in planning their care. Regular antenatal care gives the opportunity to review and update the plan of care to reflect any changes in maternal or fetal health. Women or pregnant people should have the opportunity to make informed decisions about their care and treatment in partnership with health care professionals. Midwives are responsible for women or pregnant people with a low-risk pregnancy and who have identified risk factors referral to an obstetrician may be required recommending an appropriate care pathway.

The 2020 MBRRACE-UK reports on maternal and perinatal mortality, women or pregnant people and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support.

2.0 Role and Responsibilities of the Named Midwife

Women or pregnant people should be allocated a named midwife and team prior to booking. The named midwife is a registered midwife who is responsible for planning and providing all or most of women or pregnant people's antenatal care and coordinating care.

The named midwife will engage and build a relationship with the women or pregnant people and their partner to understand and help meet their needs throughout pregnancy and in the postnatal period. Where possible continuity of care by the named midwife in the antenatal and postnatal periods will support these relationships. The named midwife is responsible for ensuring that women or pregnant people and their families are aware of arrangements for on-going midwifery support and coordination should they not be available. The named midwife and where appropriate the named link or specialist consultant obstetrician will be documented in the 'Circle of Care' on the woman or pregnant person's electronic notes.

A woman or pregnant person can be supported by a partner during her pregnancy so healthcare professionals should involve partners according to the woman or pregnant person's wishes and inform the woman or pregnant person that she is welcome to bring a partner to antenatal appointments and classes.

Furthermore, the named midwife should liaise with the woman or pregnant person's GP and Health Visitor and other health care professionals, when the woman or pregnant person is identified as vulnerable and/or with high risk social factors.

To ensure appropriate liaison and joined up care pathways, there will be a minimum of three contact opportunities during the antenatal and postnatal care pathways.

These are as follows:-

Contact 1 Following the booking, the midwife will confirm and save the clinical antenatal booking summary report that sends an email copy to the GP and HV, notifying them of any risk factors identified at the booking.

Contact 2 At around 28 weeks the women or pregnant people's care pathway should be reviewed and for those with identified social risk factors and refer for additional support if required. If concerns are identified, the midwife should discuss the plan with their team leader and facilitate a telephone or face to face contact with the Health Visitor team.

Contact 3 On discharge from community midwifery care, the midwife must ensure the Health Visitor is aware that the midwifery service is transferring care to the Health Visitor's team. For all women or pregnant people deemed at risk because of social or medical factors the midwife must transfer care through either a meeting with the Health Visitor or through a telephone discussion which then must be documented.

For vulnerable women or pregnant people and families where there is safeguarding and or mental health concerns there will be increased contact and referrals with multi-agency teams.

3.0 Allocation of Midwifery Team

All women and pregnant people will be allocated a named midwife working within a midwifery team at booking. This will usually be a community team based on their postcode, providing care in a location that is easily accessible to the woman or pregnant person and their family.

In complex pregnancies (such as multiples, previous loss or pre-existing medical disorders) women or pregnant people should be referred to the Complex Care (Parks) team. This team provides midwifery care working in conjunction with the Maternal Fetal medicine team.

For women or pregnant people who live out of the geographical area (OOA) they will be referred to the community team closest geographically.

4.0 fThe Booking Appointment

For most women or pregnant people, the booking appointment will be carried out in the community in a location that is easily accessible to the woman or pregnant person and their family.

The booking appointment should take place by 8 to 9 weeks gestation, or earlier, if possible, to allow time for booking bloods to be reviewed and be available to women or pregnant people by 10+0 weeks gestation. If women or pregnant people book after 12+6 gestation, the midwife should ask

about the reasons for the late booking because it may reveal social, psychological or medical issues that need to be addressed. Women or pregnant people who book after 20+0 gestation require a request for support form (RSF) to be completed.

Midwives should offer screening for:

- haemoglobinopathy, anaemia, group & red-cell antibodies, hepatitis B virus, HIV, syphilis, ferritin if meets criteria via a blood sample
- asymptomatic bacteriuria via urine sample.
- HIV, Syphilis and Hepatitis B.
- the NHS sickle cell and thalassaemia screening programme (A family origin questionnaire should be completed as part of as part of this screening)
- NHS fetal anomaly screening programme provided.

The pregnant person's height and weight should be measured, and body mass index calculated.

All blood results taken throughout a pregnant person's pregnancy should be checked within 10 days and recorded on badgernet.

If the MSU is positive, a repeat MSU should be send 2 weeks after completing treatment to ensure clearance. This test of clearance if required after any positive MSU at any stage of pregnancy. If there are more than 2 positive MSUs, the woman should be referred to an obstetric clinic for review.

Midwives should maintain an antenatal attendance record to ensure she does not go unseen in her pregnancy. Midwives should consider reviewing the women or pregnant people's previous medical records and these should be sourced from the previous delivering hospital or if the women or pregnant people had her baby at ASPH these can be found on Evolve or Badgernet.

All information can be found on the women or pregnant person's maternity app and should be given in a form that is easy to understand and accessible to pregnant women or pregnant people with additional needs, such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. All midwives should be aware of the availability of Language Line and interpreting service as per trust guidance.

At booking the midwife should identify women or pregnant people who may need additional care by the obstetric team and make an appropriate referral. Refer to Indications for referral to an Obstetric Antenatal Clinic SOP for more details.

5.0 Antenatal risk assessment

An antenatal risk assessment should be carried out at the initial 'booking appointment'. All findings will be documented in Badgernet and a plan documented for any identified risk factors. Risk assessment is ongoing throughout pregnancy and should be carried out at every antenatal contact.

At every antenatal appointment, carry out a risk assessment as follows:

- ask the woman about her general health and wellbeing including risk factors for venous thromboembolism, gestational diabetes, pre-eclampsia and fetal growth restriction
- ask the woman (and her partner, if present) if there are any concerns they would like to discuss; this could include discussing risks relating to parental genetic conditions, including consanguinity, and factors relevant to the environment in which she lives, at the booking appointment
- provide a safe environment and opportunities for the woman to discuss topics such as concerns at home, domestic abuse, concerns about the birth (for example, previous traumatic birth) or mental health concerns
- review and reassess the plan of care for the pregnancy
- identify women who need additional care.

The assessment should recognise that women's needs can change during pregnancy. It should be broad-based and holistic, aiming to recognise if 1 or more elements of the woman's physical and mental health (taking into account her medical history) and wellbeing represents a risk to her or her baby's health or wellbeing. It is important, after discussion and agreement with the woman, that information about the pregnancy and potential concerns or complications during pregnancy are shared between the maternity unit and the woman's GP

Indications and timeframes for obstetric referral can be found here.

Management plans should be completed and reviewed on Badgernet. They should include a brief summary of relevant history and current issues and be updated as the clinical situation changes.

Example of high quality management plan on BadgerNet:

Midwife's name and date
Mat age 42, previous CS x3
Previous stillbirth (34/40), previous FGR
History of depression – medicated
Current smoker
Tommy's App:
PTB – moderate risk (for cervical length at anomaly USS)
PFA – complete at 14 weeks and update management plan

Plan:
Obstetric pathway – high risk
Intermediate VTE
Referrals made – obstetric consultant, smoking cessation

In addition to ongoing risk assessment there should be a discussion about choice of birthplace. This should be verbally discussed with the woman or pregnant person and documented on BadgerNet. It is essential that birth choices are enabled so women or pregnant people can participate equally in all decision-making processes and to make informed choices about their care.

6.0 Venous Thromboembolism Risk Assessment

Woman or pregnant person's risk factors for venous thromboembolism should be assessed at the first antenatal (booking) appointment and after any hospital admission or significant health event during pregnancy.

Risk assessment should be completed using the 'VTE risk assessment' section within BadgerNet in line with local and national guidance. Follow the ASPH VTE in pregnancy guideline – see Trust Intranet. For women or pregnant people at risk of venous thromboembolism, offer referral to an obstetrician for further management.

7.0 Body Mass Index (BMI)

Each pregnant woman or pregnant person should have their Body Mass Index (BMI) calculated and recorded at their booking appointment to ensure appropriate management of their pregnancy. Pregnant women or pregnant people who are obese are at greater risk of a variety of pregnancy-related complications compared with women or pregnant people of normal BMI, including pre-eclampsia and gestational diabetes (RCOG, 2018).

Pregnant women or pregnant people with a **BMI of 30kg/m2** or more at this appointment should be offered personalised advice on healthy eating and physical activity. A referral should be made for a Glucose Tolerance Test (GTT) between 24-28 weeks.

When a woman or pregnant person has a **BMI of 35-39kg/m2** a obstetric referral should be made and the woman or pregnant person place on the intermediate growth surveillance pathway. In addition these women or pregnant people should have a repeat BMI risk assessment carried out in the third trimester.

A **BMI of 40kg/m2** or more will require an additional anaesthetic referral and be placed on the high risk fetal surveillance pathway, alongside obstetric input.

8.0 Vitamin D supplementation

Pregnant women (including breastfeeding women) should be advised to have 10 µg of vitamin D a day. Vitamin D regulates the amount of calcium and phosphate in the body, which keeps bones, teeth and muscles healthy. Women with BMI >25 have decreased bioavailability of vitamin D which makes these women and their babies at greater risk.

Some women are more likely to need vitamin D than others: those who rarely go outside; always cover their skin; use high-factor sun block; have darker skin; have a BMI above 25.

9.0 Folic Acid supplementation

Pregnant women should be advised to continue to take Folic Acid until the 12th week of pregnancy. Folic acid (also known as vitamin B9) is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida.

Women or pregnant people with a booking BMI of 39kg/m2 should be informed that they should increase their dose of folic acid to 5mg.

10.0 Gestational Diabetes Screening

It is essential that pregnant women or pregnant people are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment. Risk factors are taken from NICE's guideline on diabetes in pregnancy:

- BMI above 30 kg/m^2
- previous macrosomic baby weighing 4.5 kg or more
- previous gestational diabetes
- family history of diabetes (first-degree relative with diabetes)
- an ethnicity with a high prevalence of diabetes.
- PCOS

Women and birthing people who take antipsychotic medication require referral for a GTT.

Testing for gestational diabetes should be carried out in accordance with local guidance aligned with the NICE guideline on diabetes in pregnancy.

11.0 Tommy's Application

The Tommy's App has been developed in conjunction with the Tommy's National Centre for Maternity Improvement and is supported by both the RCOG and RCM. It supports safe and effective delivery of care to women or pregnant people by using validated algorithms to assess a woman or pregnant person's risk of premature birth and placental dysfunction.

This web based application should be used by midwives at the woman or pregnant people's booking appointment to generate a pre term birth (PTB) risk assessment, and then again at between 14-16 weeks gestation to generate a placental function (PFA) risk assessment.

The PFA risk assessment will identify women or pregnant people who may be at additional risk of placental dysfunction and will recommend a fetal growth surveillance pathway and if Aspirin should be advised. The midwife should update the Management Plan box on Badgernet with the outcome of the risk assessment and the relevant management plan.

The Tommy's App can be used to generate a PTB risk assessment for all pregnant people but there are some circumstances where the PFA risk assessment should not be used. In these situations please follow NICE guidance NG133 (section 11.2-11.3) to ascertain if aspirin should be advised.

Additional guidance on the Tommy's App is available here.

Midwives should measure and record the woman or pregnant person's blood pressure at booking and every routine face-to-face antenatal appointment using an electronic device validated for use in pregnancy, and offer a urine dipstick test for proteinuria at every routine face-to-face antenatal appointment.

12.0 Monitoring fetal growth and wellbeing

Women or pregnant people should be offered a risk assessment for fetal growth restriction at the first antenatal (booking) appointment and again using the Tommys App (see above) at the 14-16 week midwifery appointment.

Symphysis fundal height measurement (SFH) should occur at each antenatal appointment after 24+0 weeks (but no more frequently than every 2 weeks) for women or pregnant people with a singleton pregnancy unless the woman or pregnant person is having regular growth scans or is unsuitable for SFH measurements. Plot the measurement onto a growth chart in badgernet and compare previous measurements to ensure consistent fetal growth.

At every appointment/contact after 24+0 women or pregnant people should be asked if they have any concerns about their baby's movements at each antenatal contact after 24+0 weeks. Women or pregnant people should be advised to contact the 'Call the Midwife' line at any time of day or night if they have any concerns about their baby's movements or if they notice reduced fetal movements.

Fetal Auscultation should be discussed with women or pregnant people in line with the NICE guidelines. It is worth noting that NICE does not recommend routine antenatal fetal heart auscultation. However, if fetal heart auscultation is requested the midwife should auscultate the fetal heart with a Pinard stethoscope prior to using a hand held Doppler and should also palpate the maternal pulse to distinguish between the two different heart beats.

Please refer to the Fetal Growth Surveillance Pathway for more information.

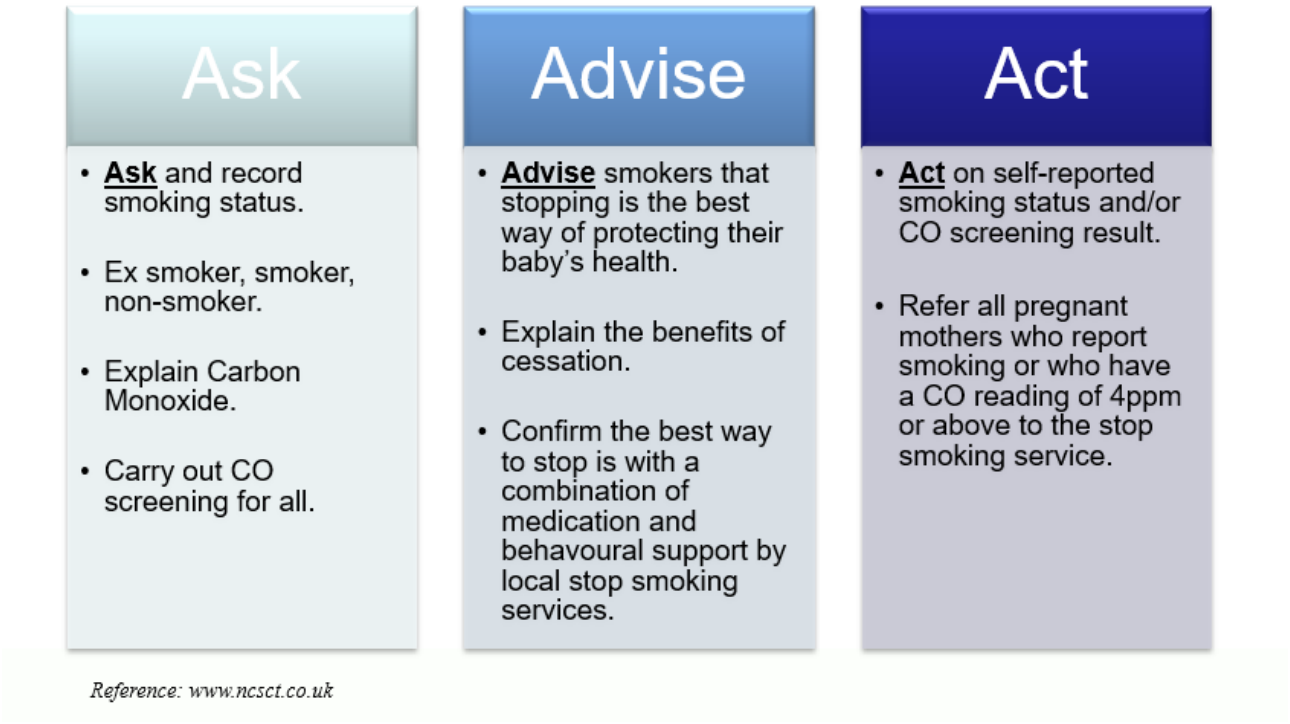
13.0 Carbon Monoxide (CO) Testing

CO testing should be offered to all pregnant women at the antenatal booking and the 36 week antenatal appointments. Whenever CO testing is offered it should be followed up with an enquiry about smoking status with the CO result and smoking status recorded.

Additionally, CO monitoring and a smoking status enquiry should be offered at **every appointment** if the pregnant woman:

- Smokes **or**
- Is quitting **or**
- Used to smoke **or**
- Had a CO reading of 4 parts per million (ppm) or above at the first antenatal appointment

There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth, premature birth, miscarriage, low birth weight, and Sudden Infant Death Syndrome (SIDS). Midwives or clinicians should explain the purpose of the CO screen to the woman or pregnant person and that it is conducted routinely. The midwife or clinician should use a Very Brief Advice (VBA) approach to support a brief conversation about stopping smoking.



13.1 Recording the Carbon Monoxide test reading

The CO reading should be recorded on BadgerNet within the observations section of the antenatal assessment using the **Carbon Monoxide (CO) Level offered** tab. The CO reading **must** be entered in the **Carbon Monoxide (CO) Level** box below.

If the reading is below 4ppm, tell the woman or pregnant person that her recent level of exposure to CO is low.

13.2 Opt out referral to the in house Tobacco Dependency Service

An opt-out referral **must** be made to the in house Tobacco Dependency Service for all pregnant women/people who:

- Say they smoke or have stopped smoking in the past 2 week **or**
- Have a CO reading of 4ppm or above **or**
- Have previously been provided with an opt-out referral but have not yet engaged with stop-smoking support

Referrals to the Tobacco Dependency Service should be made via the referrals form in BadgerNet. The Tobacco Dependency Advisor (TDA) will contact within 24-48 hours to have a fuller discussion and outline all options for help and support. **The TDA will ascertain readiness and willingness to participate** in the supervised cessation programme. If a client rejects all options and prefers not to proceed. This will be recorded as a formal declination. **The TDA will electronically record the NO response in the Smoking in Pregnancy Notes** and send a communication note to the Midwife. The client can be re-referred at any time during either the antenatal or post- natal period.

13.3 High readings in non-smokers

If the pregnant woman does not smoke but has a carbon monoxide level of **4 ppm or more**, help her to identify the source of carbon monoxide and reduce it. (Other sources include household or other second hand smoke, heating appliances or traffic emissions.)

If the pregnant woman has a high carbon monoxide reading (more than 10 ppm) but says she does not smoke:

- Advise her about possible CO poisoning
- Ask her to contact the Gas Emergency Line **(0800 111 999)** for gas safety advice
- Phrase any further questions about smoking sensitively to encourage a frank discussion.

For further information please refer to the Tobacco Dependency SOP linked here

14.0 Schedule of Antenatal Care

The schedule of antenatal care should be explained to all women or pregnant people. NICE (NG201) Antenatal care guideline recommends that the schedule of antenatal appointments is determined by the woman or pregnant person's needs.

For a woman or pregnant person who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate.

For a woman or pregnant person who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate.

Women or pregnant people should be reminded that these are the minimum number of antenatal appointments and those with increased risk factors will receive an individualised care plan of maternity appointments.

15.0 14-16 week Midwife Appointment

At this appointment:

Booking bloods including screening for trisomies should be reviewed

If a woman or pregnant person is found to be RhD negative at booking and has a negative antibody screen, she should be offered a Fetal RhD test. These results will available within 14

days. Women or pregnant people with fetus predicted RhD negative do not require any Anti-D in their pregnancy.

The placental function assessment should be completed on the Tommys App and the results documented within the management plan on Badgernet for the sonographers to view at the time of the woman's anomaly scan. If the woman is high chance PFA on Tommys and is not already taking aspirin, this should be commenced. The midwifery PGD can be used for the first 2 weeks of aspirin and the midwife should send a letter to the GP via Badgernet for the ongoing prescription. Please follow the link to the Aspirin SOP for more information.

16.0 Reduced Fetal Movements

Please refer to the reduced fetal movements SOP for more information on:

- Timing of discussions about reduced fetal movements
- When and where to find written information on reduced fetal movements

Discussions regarding the importance of fetal movements should be undertaken before 28 weeks and at every subsequent antenatal contact.

Women should be signposted to information regarding RFM by 28+0 gestation

17.0 28 Weeks Gestation

Women or pregnant people who fetus is predicted positive require both Anti-D prophylaxis between 28 and 30 weeks and sensitising event prophylaxis should this be required. Where the result is inconclusive please refer to the Blood Transfusion Policy.

In addition a further blood test to check full blood count, Ferritin levels, blood group and antibodies should be taken at 28 weeks gestation.

Advice should be provided to women or pregnant people regarding sleep position and avoiding going to sleep on their back after 28 weeks of pregnancy and to consider using pillows, for example, to maintain their position while sleeping.

After 28 weeks health care professionals should discuss and give information on preparing for labour and birth, including information about coping in labour and creating a birth plan.

- recognising active labour
- the postnatal period, including:
- care of the new baby
- the baby's feeding
- vitamin K prophylaxis
- newborn screening

- postnatal self-care, including pelvic floor exercises
- awareness of mood changes and postnatal mental health.

Abdominal palpation should be offered at all appointments after 36+0 weeks to identify possible breech presentation for women or pregnant people with a singleton pregnancy.

18.0 Responsibilities of the Community Team Leader

All community teams are led and managed by a band seven midwifery team leader. The team leader is responsible for the overall management of the team of midwives and for its organisation and running. This includes the adequate staffing for the workload, enabling continuity of care and for ensuring communication and liaison with GP's, Health Visitors and other relevant agencies.

A key role of the team leader is in providing support, advice and overall responsibility for high risk/vulnerable women or pregnant people within the caseload ensuring there is continuous support for the named midwife to enable them to coordinate, plan the antenatal and postnatal care and continuously monitor the plans.

The team leader will liaise with the team's named consultant, the community matron and safeguarding team as necessary for support and advice.

19.0 Personalised Care Plans

Depending on their circumstances, women or pregnant people and their partners will be able to choose between midwifery led care or care provided by a team of maternity health professionals including midwives and obstetricians. Women or pregnant people should also be offered a choice of place of birth taking into consideration any identified risk factors when making choices. All identified women or pregnant people who are low risk at should be given information about the midwifery led Abbey Birth Centre and will reassessed at 34 -36 weeks gestation about suitability of using the birth centre or for having a home birth.

A Personalised Care and Support Plan is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person. These plans should be proportionate, flexible and coordinated/adaptable to a person's health condition, situation and care and support needs. An individual care management plan will be developed for those women or pregnant people with an identified clinical risk and will be documented in the pregnancy and birth record. Women or pregnant people should be informed at booking of the possible pathways of care which are available to them and where they will be seen and who will undertake their care.

20.0 Homebirth

All low risk women or pregnant people should be offered a planned home birth. At booking, and during the antenatal period, the midwife should discuss the choices available to the woman or pregnant person regarding place of birth including homebirth. This should include an individualised risk based discussion. A home visit should be arranged at 36 weeks to assess the birthing environment, and to discuss plans for the birth and preparation for labour. The midwife should discuss practical arrangements and complete a 'Home Birth Assessment' on badgernet. Refer to the Homebirth Guideline.

If a high risk woman or pregnant person requests to have a home birth, the Consultant Midwife should be referred to for advice via a Badgernet referral. Refer to Birth Choices (Out of Guideline)

21.0 Induction of labour and Membrane Sweeps

At antenatal visits after 39+0 weeks, discuss with women or pregnant person if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them. As per NICE guidance women or pregnant people with uncomplicated pregnancies should be offered induction of labour (IOL) at 41+0. Women from 39-41 weeks can have IOL booked by a midwife, and this does not need to be approved by a Consultant

Please refer to the Induction of Labour guideline

22.0 Infant Feeding discussions and preparation

Midwives should discuss feeding choices and relationship building at least once in each trimester. Conversations regarding infant feeding should be documented in the electronic patient notes as 'conversations in pregnancy'. Breastfeeding/breastmilk should be promoted as the healthiest way to feed a baby and midwives should share the '*term, well baby' feeding leaflet* antenatally to help parents make informed choices and prepare to feed their baby safely.

In the antenatal period women and birthing people should be signposted to the Feeding and Nurturing Padlet

Midwives should signpost parents to the antenatal infant feeding workshops from 32-34 weeks gestation and promote/ facilitate collecting colostrum antenatally for all birth parents from 36 weeks gestation. The *Vulnerable baby feeding leaflet* should be shared if a small, sick or preterm birth is anticipated and the *Milk as Medicine* parent leaflet if it is likely that a baby will be admitted to NICU.

23.0 Safeguarding

Child Protection is the responsibility of all midwives and the Maternity Safeguarding Children Guideline aids health care professionals to recognise any child where there is a safeguarding concern and respond appropriately. Midwives should consider the pregnant persons parenting

capacity and consider family, household and environmental factors. Midwives have a responsibility in the management of a child where a safeguarding concern has been recognised and ensure that all affected children receive appropriate and timely therapeutic and preventative interventions.

Referrals should always be made in any of the following circumstances:

- Children in the household/family currently subject to a child protection plan/child in need plan or previous child protection concerns.
- A sibling (or other child in the household of either parent) has previously been removed from the household either temporarily or by court order.
- There has been a previous unexpected death of a child whilst in the care of either parent.
- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children.
- Severe mental illness, domestic violence, or substance misuse.
- Concerns about parental ability to self-care and/or care for the child e.g. unsupported, young parents, or parents with learning disabilities.
- All teenagers age 16 and under.
- Avoidance of antenatal care, non-compliance with necessary services, non-compliance with treatment with detrimental effects for the unborn baby.
- Booked for maternity care at 20 or more weeks with no previous antenatal care.
- X3 or more DNA of appointments with no legitimate explanation.
- Any other concerns that the baby may be at risk of significant harm.
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Referrals should be made as soon as the midwife is aware of the concerns, using the Request for Support Form (RSF). Parents should be informed of the decision to make a referral to Children's Services.

24.0 Interpreting Services

All health care professionals should ensure that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman or pregnant person rather than using a family member or friend. All use of interpreting services must be documented in the electronic maternity record. The midwife must also ensure that interpreting services are booked for any further antenatal appointments. A labour birth plan should also consider use of an interpreter.

Internal resources such as 'In-House Interpreters' List (which includes staff from a range of clinical and non-clinical backgrounds) can be used when comfort needs are addressed. For accurate clinical interpretation or urgent translation external professional resources such as Language Line, British Sign Language (BSL) or Professional translators especially when gaining consent.

Language Line 0800 028 0073 (Client ID – 270016)

Hounslow Interpreting and Translation Services

Face to Face interpretation or BSL is organised by Hounslow Interpreting Services via on-line link

www.hounslow.gov.uk/translation cost centre 900811

25.0 Associated Guidelines

See also:

Antenatal Care (NG201)

Aspirin in Pregnancy SOP

Homebirth Guidelines

Induction of Labour Guideline

Iron Deficiency Anaemia (IDA) in Pregnancy

Obesity in Pregnancy Guidelines

Tommy's Application SOP

Ultrasound Protocol

VTE in pregnancy guideline

Maternity Safeguarding Children Guideline

Obstetric Referral Indications to Antenatal Clinic (SOP)

Saving Babies' Lives Care Bundle Version 3

26.0 References

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