WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Ante-natal Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal and scan appointments

Amendments			
Date	Page(s)	Comments	Approved by
24/11/09	Various	This guideline supersedes the assessing client suitability for midwifery led care in pregnancy and labour the Antenatal non attendance guideline	Women's' Health Guidelines Group
April 2012		Addition of CNST update detailing process identifying risk factors	Women's Health Guidelines Group
Nov 2014		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's Health Guidelines Group
Jan 2016		Non-attendance to scan appointments	
Feb 2018		Document review, remove references to Supervisor of Midwives	Head of Midwifery
October 2018	5	Addition of Carbon Monoxide Testing	Women's Health Guidelines Group
August 2019	4	Addition of referral to consultant at booking when requesting care outside of guidance >37 weeks	Women's Health governance and guidelines group
November 2019	5/6	CO screening updated to reflect change from SBLCBv2	

Compiled By:	Theresa Spink, Clinical Manager, Community & Outpatients
In Consultation with:	All consultant obstetricians and senior midwives, Supervisors of Midwives
Ratified by:	Women's Health Guidelines Group
Date Ratified:	November 2014
Date Issued	October 2018
Next Review Date:	October 2018
Target Audience:	All staff working within the Maternity Services
Impact Assessment Carried Out By:	Theresa Spink

Comments on this document to: Theresa Spink Clinical Midwifery Manager

See also: Maternal Antenatal Screening Tests
Ultrasound screening guidance
Home birth guideline
Mental Health Guideline
Obesity Guideline

Introduction

Routine antenatal care focuses on maintaining and improving health and wellbeing, ensuring that women 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 should have the opportunity to make informed decisions about their care and treatment in partnership with health care professionals. Midwives and General Practitioners are usually responsible for low risk pregnancy and for those women who have identified risk factors the obstetrician is responsible for recommending an appropriate care pathway. The Confidential Enquiry into Maternity and Child Health 2007 (CEMACH) *Saving Mother's Lives* identified that around 20% of women who died from direct or indirect causes either booked for maternity care after 20 weeks gestation, missed over four routine appointments, did not seek care at all or actively concealed their pregnancies.

Role and Responsibilities of the Named Midwife

The named midwife is a named registered midwife who is responsible for planning and providing all or most of women's antenatal care and coordinating care should they not be available.

In complex pregnancies where the women receives the majority of her antenatal care within the obstetric antenatal clinic the named midwife will be a registered midwife working within this service and where possible the same named midwife will attend the named obstetrician's clinic each week. Postnatal care will revert back to the named community midwife who carried out the booking appointment.

Continuity of care from the named midwife will include responsibility to engage and build a relationship with the women and their partner to understand and help meet their needs throughout pregnancy and in the postnatal period. The named midwife is responsible for ensuring that women 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 consultant obstetrician will be clearly documented on the front of the maternity hand held notes.

Responsibilities of the Community Midwife
There are five community teams each led and managed by a band 7 midwifery team leader.
The team leader is responsible for the overall management of the team of midwives and for organisation of the team. This includes the adequate staffing for the workload, ensuring continuity of care for each woman by their named midwife and for ensuring excellent 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 women 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 Community Manager and safeguarding team as necessary for support and advice.

Responsibility of the Named Midwife / Team Leader
Liaise with GP and Health Visitor and other health care professionals, for women identified as vulnerable and 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 are pathways. These are as follows:-

Contact 1 - Following the booking the named midwife will send the completed GP/HV Notification of Risks Form giving the GP and Health Visitor team's details of the women and any risk factors identified at the booking.

Contact 2 - At around 28 weeks the women's are pathway should be reviewed for women with identified social risk factors and identifies requiring additional support. 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 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.

See postnatal care guidelines

For vulnerable women and families where there is safeguarding and or mental health concerns there will be increased contact with multi-agency teams. The midwife and team leader will be the key professional responsible for the antenatal and postnatal care pathway, and will be responsible for coordinating a multi-agency approach.

Documentation required for all women See appendix 1; Referral pathway to maternity services

See appendix 1; Referral pathway to maternity services
Midwives and GP's should care for women with an uncomplicated pregnancy, providing continuous care throughout the pregnancy. Antenatal care should take place in a location that is easily assessable for the women and where possible in their local community. Local GP surgeries, Health Centres and Children's Centres provide good facilities and enable women to access other health information and advice.

Women should be encouraged to seek the advice and support of the midwife/ GP early in pregnancy usually between 6-8 weeks gestation. When they first learn that they are pregnant, women and their partners will be able to refer direct to a midwife if they wish, or to their GP. Self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services Women should have their first full booking visit and be given their hand held maternity record ideally by 10 weeks gestation and no later than 12 completed weeks of pregnancy.
Those that are referred for maternity care who are already 12 or more weeks pregnant should be seen within 2 weeks of referral.

At the **first meeting** (usually between 6-8 weeks of pregnancy) the midwife/ GP will give the woman specific information on:

- folic acid and vitamin D supplements
- food hygiene, including how to reduce the risk of a food-acquired infection
- lifestyle including smoking cessation, recreational drug use and alcohol consumption
- all antenatal screening, including risks, benefits and limitations of the screening tests
- discuss options for place of birth

A referral will be made to the chosen hospital. If the woman chooses Ashford and St Peter's Hospitals NHS Trust then a '**Pink'** referral form must be completed highlighting any known risk factors and returned immediately to the antenatal clinic reception. The woman will also be given information on how to arrange her 'booking' appointment with her named midwife.

The antenatal clinic team leader will review all referrals to maternity services and will advise community midwives on appropriate investigations and referral pathway to consultant. On receipt of the referral the receptionist will enter details onto the maternity Evolution System and will make an ultrasound appointment. The woman will be sent a copy of the NHS screening booklet with a date and time for the first ultrasound scan. If the woman is more than 12 weeks pregnant the reception staff will notify the appropriate community team by documenting in their team diary (email *Ashford antenatal clinic* for Topaz team) to ensure that a prompt booking appointment can be made, within 2 weeks of receiving the referral.

Referral should be made to a Consultant obstetrician when booking for pregnancy care at ≥ 37 weeks gestation when requesting care outside of clinical guidance and/or risk factors are present.

The Booking Appointment
For most women the booking appointment will be carried out in the community in a location that is easily assessable to the woman and her family. This will normally be in the GP surgery or a local children's centre. For women who live out of the geographical area for Ashford and St Peter's Hospitals trust (OOA) or known to be high risk women (e.g. insulin dependent diabetics), the booking will take place in antenatal clinic at St Peter's hospital or in the Topaz suite at Ashford Hospital.

At booking the midwife will give evidence based information on:

- how the baby develops during pregnancy
- nutrition and diet, including vitamin D supplementation for women at risk of vitamin D deficiency, and details of the 'Healthy Start' programme (www.healthystart.nhs.uk)
- exercise, including pelvic floor exercises
- place of birth (refer to 'Intrapartum care' [NICE clinical guideline 55], available from www.nice.org.uk/CG055)
- the pregnancy care pathway (NICE clinical guideline 62)
- breastfeeding, including how to refer for breast feeding workshops
- details for access to local antenatal classes

- further discussion of all antenatal screening
- discussion of mental health issues (refer to 'Antenatal and postnatal mental health' [NICE clinical guideline 45], available from www.nice.org.uk/CG045)

All booking summary sheets are reviewed by the appropriate community team leader to ensure that all risks are actioned 'Fresh Eyes'.

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

CO Testing at Booking and 36 weeks

Booking

All women should be offered Carbon monoxide (CO) testing at the booking appointment, as determined by the Saving Babies' Lives Version 2. There is strong evidence that reducing smoking in pregnancy reduced the likelihood of stillbirth, premature birth, miscarriage, low birth weight, and Sudden Infant Death Syndrome (SIDS).

Explain the purpose of the CO screen to the woman and that it is conducted routinely. Ask the woman to take a big deep breath, and hold it for a 15 second countdown, and then exhale completely into the monitor. Document the reading within the electronic maternity record.

If the reading is below 4ppm, tell the woman that her recent level of exposure to CO is low. Check whether the woman has recently given up smoking, and refer to Smoking Cessation Programme Quit51 if smoked within 3 months of pregnancy.

If the reading is 4ppm or above, tell the woman that the reading is at a level consistent with someone who smokes or who has been exposed to CO. Ask her if she, or anyone else in her household, smokes. If she uses tobacco, explain your concerns and the risks of continuing to smoke. Outline the effects of CO on the placenta and the fetus. Explain that quitting is the best thing she can do to improve her health and the health of their baby. Refer to Smoking Cessation Programme Quit51, unless she decides to opt out. If her partner or others in her household smoke, advise them to contact Quit51 directly.

If the reading is 4ppm or above, and the woman insists she is a non-smoker, has stopped smoking, or has not been exposed to second-hand smoke, remain non-judgemental in your approach and give evidence base information. A high CO reading could also be due to a faulty gas appliance or a faulty car exhaust for example. A woman who is lactose intolerant may also have a high reading if she has been consuming dairy products. Discuss possible causes with the woman and try to find an explanation together. Ask her to call the Gas Safety Advice Line on 0800 300 363 for expert help.

Where a referral has been sent, this should be followed up by the midwife at the next antenatal appointment to check if the referral was taken up by the woman. Offer to re-refer if necessary. CO testing can be repeated as required at any subsequent antenatal appointment.

36 week CO testing

CO testing should be offered, and the result recorded in the electronic maternity record, if the woman attends this appointment in her 35th or 36th week of pregnancy. If at any subsequent appointment it is apparent that CO testing at the 36 week appointment has been missed the midwife should offer CO testing then.

Explain the purpose of the CO screen as detailed above. Ask the woman to take a big deep breath, and hold it for a 15 second countdown, and then exhale completely into the monitor.

Testing of all women at the 36 week appointment can be used to reassure women with a low CO level regarding their exposure, to congratulate and encourage those who have stopped smoking, and to refer women with a CO measurement of 4ppm or above for specialist support (as detailed above), highlighting the importance of a smoke-free home for their baby.

Considerations for frequency of additional testing: Additional testing of all women at the 16 or 25 week appointment to identify smokers who have not engaged with specialist support or those who may have relapsed. Additional monitoring should also be considered at each antenatal appointment for women who smoke or were recorded as recent/ex-smoker at booking.

Interpreting Services
Internal resource's 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

All use of interpreting services must be documented in the handheld 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.

Antenatal risk assessment

By using structured questions supported by the 'The Pregnancy and Birth Record' an antenatal risk assessment should be carried out at the initial 'booking appointment'. All findings will be documented in the handheld record and any identified risk factors will also be noted on the antenatal summary sheet which is returned to the hospital records. A further risk assessment will be carried out at any antenatal contact. The following list should guide professionals to refer women for an obstetric opinion if any of the following factors occur:
Any women who presents with a history of the following risks will be referred to an obstetrician

Complex social factors
Substance misuse
Asylum seekers
Teenage pregnancy
Migrants
Homelessness
Domestic Abuse
Difficulty reading or speaking English
Prisoners

Psychiatric history

Puerperal psychosis
Bi polar disorder
Currently taking any medication for mental illness
Has extreme anxiety about the birth process

Drug/alcohol abuse

Current obstetric pregnancy / labour;
More than six pregnancies
Rhesus disease
Atypical antibodies
Antepartum haemorrhage
Multiple pregnancy
Unstable lie
Malpresentation
Placenta praevia
Less than 37 completed weeks (or suspicion of incorrect EDD)
Baby with known structural or chromosomal anomaly
Hypertension > 140/90
Or > 15mmHg above 1st trimester diastolic
Or >30mmHg above 1st trimester systolic
Pre-eclampsia
Proteinuria > +1
Epigastric pain
Seizures
Placental abruption
Suspected thromboembolism
Anaemia < 9g/dl
Pruritis/ obstetric choleostasis
Maternal Pyrexia in Labour 38°C once or 37.5°C on two occasions 2 hours apart
Dysfunctional labour eg delay in first or second stage of labour
Not received any antenatal care
Gestational diabetes
3rd or 4th degree tear or complicated perineal trauma requiring suture by a doctor
Massive Haemorrhage
Previous stillbirth/ neonatal death
3 previous miscarriages
Mid-trimester pregnancy loss
Pre-eclampsia/Eclampsia/HELLP
Uterine rupture
Placental abruption
Primary postpartum haemorrhage on two occasions
Retained placenta on two occasions
Preterm birth
Infant birth weight <2500g or >4500g

Anaesthetic risk factors;
History of drug or latex allergy
Known airway problems
BMI greater than 35

Gynaecological factors;
Previous uterine or cervical surgery (includes cone biopsy)
Previous Myomectomy

Fetal factors;
Confirmed Small for Gestational Age (IUGR)
Abnormal presentation
Known fetal abnormality
Abnormal Doppler studies
Abnormal fetal heart on auscultation
Oligohydramnios
Polyhydramnios
Fetus suspected weight more than 4500g by clinical or ultrasound estimation.
Expected need for advanced neonatal resuscitation

Medical Risk Factors
Respiratory disease;
Cystic fibrosis
Asthma requiring step up in treatment/hospital in last 12 months.

Cardiovascular;
Cardiac disease
Hypertensive disorders

Gastro-intestinal;
Liver disease
Crohn's Disease
Ulcerative colitis

Endocrine;
Thyroid disease eg hyperthyroidism
Diabetes
Disorders; eg Cushing's disease

Immune;
Systemic Lupus Erythmatosis (SLE)
Antiphospholipid syndrome (APS)
Rheumatoid arthritis
Scleroderma
Other connective tissue disease

Infective;
Tuberculosis
HIV positive status
Sexually transmitted infection
Hepatitis B or C
Toxoplasmosis
Chicken pox (this pregnancy)
Rubella (this pregnancy)
Genital Herpes
Group B Streptococcus (any pregnancy)

Neurological;
Epilepsy
Myasthenia gravis
Spinal abnormalities
Neurological defects

Haematological;
Haemoglobinopathies such as sickle cell disease (not traits)
Family history of or previous thrombo-embolism
Immune thrombocytopenic purpura
Von Willibrands disease
Bleeding disorders
Rhesus isoimmunisation
Blood group antibodies
Autoimmune disorders
Women who decline blood products

Depending on the urgency of the need for referral for obstetric opinion and the stage of pregnancy, opinion can be gained through obstetric clinics, day assessment unit or labour ward review documenting the need for review in the pregnancy birth record.

Following attendance at an obstetric referral appointment the named consultant team care will decide when/if care can go back to the named midwife/GP pathway. This should be documented in the antenatal record. If the women remains under the care of the consultant and is receiving the majority of her antenatal care at the Named Consultant clinic the Named Midwife will change to a hospital Named Antenatal Clinic Midwife. This must be discussed with the women and clearly documented on the front of her maternity notes.

If a woman has a complex medical or surgical history and was cared for by another hospital, the consultant/ midwife in charge of antenatal clinic will write to the other unit for the details of the medical/ surgical history. (see letter 1)

At the booking the named midwife will also ensure that the woman has previously had a full medical examination in the United Kingdom and if not then organise for the woman to attend GP for this examination.
(See Flow chart- Additional recommendations for specific groups with complex social factors)

The risk assessment tool identifies women who:
• can remain within or return to the routine antenatal pathway of care (Midwifery led care with or without GP input).
• may need additional obstetric care for medical reasons (Team care including consultant obstetrician).
• may need social support and/or medical care for a variety of socially complex reasons (Team care including social services or other disciplines as appropriate).
An individual care management plan will be developed for those women with an identified clinical risk and will be documented in the pregnancy and birth record.
Women 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. Depending on their circumstances, women 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. For some women, team care will be the safest option.
Women should also be offered a choice of place of birth taking into consideration any identified risk factors when making choices such as home birth. All identified women 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 and given contact details.

The midwife will also complete the Antenatal Pathway form and bring back the form and the carbonised risk assessments to the community midwives office within 48 hours of completing the

booking and leave in tray for data entry clerk to add to the pathway data base. Once this has been completed the data entry clerk will give risk assessment to Team Leader for 'fresh eyes' before filing in outside cover.

The booking midwife will also complete the Growth Assessment Protocol (GAP) risk assessment form and return to community office within 48 hours. Any women who have increased risk identified will have her first consultant appointment linked to the first serial scan unless they require an earlier appointment.

Complex Social Factors

- General recommendations on enhancing care delivery for all pregnant women with complex social factors work with: social care professionals
- substance misuse services (Windmill Team 01932-722096)
- domestic abuse support worker (Your Sanctuary 01483 -776822)
- sexual health services (Blanche Herriott Unit 01932-722669)
- Hounslow Interpreters Services (www.hounslow.gov.uk/translation)
- Asian link workers (07824-896987)
- GPs
- Teenage pregnancy support team including Family Nurse Partnership services (see Young Person's Proforma appendix 4)
- Targeted visits with midwife/ health visitors during pregnancy including joint visits at 28 weeks gestation
- All women with previous psychosis, bi-polar disorder, tocophobia and anxiety disorders to be referred Birth Reflections / Counselling Support Midwife

Records from previous pregnancies

Following referral to an obstetrician if a woman has had previous pregnancy or health problems at another hospital and the clinician requires further details and information, the antenatal clinic will write a letter requesting the appropriate information/ records. This information will be filed in the ASPH hospital maternity records once received.

All records from previous pregnancies at ASPH are automatically made available for review on receipt of the 'pink booking form'. Any medical records required for review are requested by the consultant clinic doctors via PAS as these are stored onsite. They are filed with the obstetric records for the duration of the pregnancy and birth. All relevant clinicians have 24hour access to these records held in the antenatal clinic.

The schedule of antenatal care for Healthy Pregnant Women as recommended by NICE 2008 should be explained to all women.

WEEK	Routine appt for healthy pregnant women who are low risk	1st baby	2nd baby
8-10	Booking in the community with screening information given	✓	✓
12-14	Dating ultrasound scan with combined screening	✓	✓
16	Antenatal check with community midwife	✓	✓
22	Anomaly ultrasound scan request MatB1	✓	✓
25	Antenatal check with midwife/ GP	✓	x
28	Antenatal check with midwife / GP	✓	✓
31	Antenatal check with midwife/GP	✓	✓
34	Antenatal check with midwife/GP	✓	✓
36	Antenatal check with midwife/GP	✓	✓

38	Antenatal check with midwife/GP	✓	✓
40	Antenatal check with midwife/GP	✓	x
41	Antenatal check with midwife/ GP Induction assessment discussed as per trust guidance	✓	✓

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

Non- attendance of antenatal appointments
The maternity service has a responsibility to follow up any woman who does not attend for antenatal appointments. The midwife is the named professional who follows up pregnant woman who miss any type of antenatal appointment. The midwife should be aware of social circumstances such as other reasons for non-attendance (women who are particularly vulnerable or who lack social support e.g. teenagers, women with mental health problems or who are suffering from domestic abuse, asylum seekers, travellers, and woman who book late in pregnancy). Women within these groups may require a more flexible approach to antenatal care e.g. home visits or support with transport.

Procedures for follow up of community antenatal appointments

Non-Attendance of booking appointment

- The midwife will check the demographic details for the woman identifying any discrepancies
- The midwife will review the patient administration system (PAS) to see if there have been any attendances to the accident and emergency department (A&E) or early pregnancy unit (EPU)
- The midwife should also contact the GP to ensure that the woman is still pregnant
- The midwife then contacts the woman to find the reason for not attending and arranges for another appointment
- If unable to make contact a home visit may be required. The midwife should ensure that she is able to speak to the woman herself before revealing his/her professional identity
- The midwife should advise about the importance of continuing antenatal care
- A record of the actions taken should be documented in the hospital antenatal record

Non-Attendance of scheduled antenatal appointments
The midwife will enter the details of all women booked for antenatal care on the Antenatal Attendance Record (appendix 2) located in all community antenatal clinics and hospital midwives clinic. This will enable the midwife to identify any women who are not attending regular community antenatal care.

When a woman does not attend for a scheduled appointment with a midwife or consultant, the midwife expecting to see her should:

First Appointment

- Check that the demographic details are correct
- Check the PAS to see if the women has been admitted or recently attended the maternity day assessment (DAU), labour ward, antenatal ward or midwifery led triage
- Check the hospital antenatal record for any reason for non-attendance
- Contact the woman initially by telephone and arrange for another appointment. If contact is made, document reason for non-attendance in the antenatal attendance record or hospital antenatal record.
- If unable to contact by telephone send alternative appointment by post and document in records.

Second Appointment

- If the woman does not attend the second appointment the community midwife will carry out a home visit. If the midwife is still unable to make contact she will contact GP/ Health visitor to ascertain if the woman has moved away or lives out of area.
- If out of area midwife, to contact community services for that area notifying lack of antenatal care. These actions are to be documented in the hospital antenatal record.

- If the midwife is unable to make contact with the woman at all she **must** inform her team leader and it should be reported using the trust's incident reporting system (Datix). The community team leader will ensure the specialist midwife for safeguarding is informed and necessary referrals to social services are made (to include a MARF).

Non- attendance of ultrasound screening appointments

First screening scan (11-12 weeks)

- If a woman does not attend her first screening scan the clerk will check view point to see if she has attended the Early Pregnancy Unit and has had a miscarriage. If there is no evidence of miscarriage the clerk will bring the details to the community midwives office and leave in tray.
- The midwife will check patient centre to see if woman has attended A&E and then check with GP surgery if there is any evidence of miscarriage or termination of pregnancy.
- If the is no evidence of pregnancy loss then the named midwife will try and make contact with the woman as to why she did not attend and make further appointment if appropriate.
- The named midwife will inform ultrasound of their findings so it can be closed on viewpoint.

Anomaly scan (20-21 weeks)

- If a woman does not attend her anomaly scan the clerk will check viewpoint to see if there are any other attendances. They will try and contact woman by telephone to rearrange appointment.
- If the ultrasound department cannot make contact with the woman they will put details in the tray in the community midwives office.
- The named community midwife or team member in her absence will check her details on patient centre. The midwife will also check with GP surgery to see if she has moved away.
- The midwife will try and telephone the woman and rearrange appointment. If she cannot make contact by telephone she will attend the home and leave a letter if no one is at home asking her to make contact.
- If the midwife is unable to make contact with the woman she should consider a referral to Children's Services (MARF).
- The midwife will inform Ultrasound of her findings so that it can be updated on view point.

Monitoring

Compliance with this guideline will be monitored as detailed in the table below. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Women have their first full booking visit and hand held record completed in line with appropriate timescales, which as a minimum must include: a. responsibilities of relevant staff groups b. **process for ensuring that women have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy** c. **process for ensuring that women 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** d. 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 e. process for identifying for which women health records from previous pregnancies are required for review by clinicians f. process for arranging the availability of health records for women for which health records from previous pregnancies are required for review by clinicians 4.2 women who miss antenatal	**Standard lead** Arash Bahmaie-Consultant Obstetrician	Access to the maternity services are monitored using Community Kalamazoo audit tool attached in appendix 2 Review 1% of health records of women who on referral are already 12 weeks or more 1% health records of all women who have delivered	Monthly Non-attendance is monitored via Datix yearly	Reported via the maternity dashboard	**Criterion lead** Theresa Spink -Community and Outpatient services Manager Sarah Legg- Antenatal clinic team leader	• Communication bulletin • Bonus days • MDT Educational half days • staff meetings • any other meeting as appropriate • Individual feedback as appropriate One or all of the above

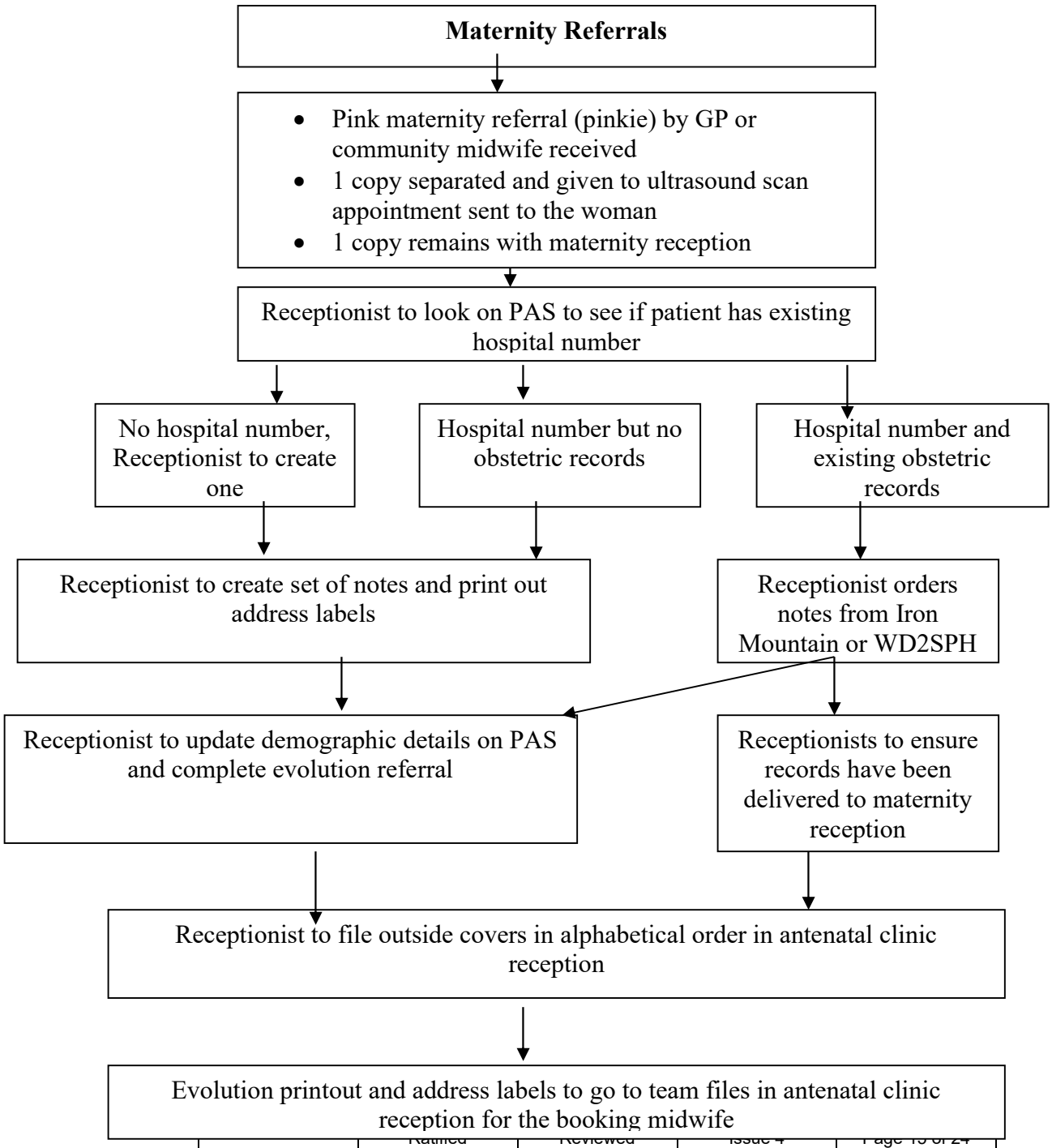
appointments are followed up appropriately and seen, which as a minimum must include: a. **process for ensuring that women who miss any type of antenatal appointment are followed up** b. **documentation of follow up of women who miss any type of antenatal appointment** c. process for ensuring that women who miss any type of antenatal appointments are seen Clinical risk assessment during the antenatal period, which as a minimum must include: a. ***timing of risk assessments*** b. medical conditions to be considered, including anaesthetic and psychiatric history c. factors from previous pregnancies d. lifestyle history to be considered e. identification of women who will decline blood and blood products f. risk assessment for appropriate place of birth g. development of an individual management plan for women in whom risks are identified during the clinical risk assessment h. ***process for referral of women in whom risks are identified during the clinical risk assessment*** i. process for referral back to midwifery led care if appropriate j. ***documentation of all the above, where clinically relevant***		1% or 10 sets of Health records of women who delivered & miss any type of antenatal appt 1% of all health records or 10 sets of records of Women who have delivered in whom risks are identified during the clinical risk assessment		As above As above	As above As above	As above As above

References

Antenatal Care: Routine antenatal care for healthy pregnant women NICE clinical guideline 62 March 2008
Confidential Enquiry into maternity care and child health 2007 Saving Mother's Lives: reviewing maternal deaths to make motherhood safe.
NHS England 2016 Saving Babies' Lives: A care bundle for reducing stillbirth

Appendix I

Maternity Reception Referral Pathway



Appendix 2

Antenatal Record Forms Guidelines

- Each practice/case load will have a folder containing the antenatal attendance records.
- Separate pages for each month.
- The form to be commenced at booking.
- The folder is to be left securely, in GP surgery where possible.
- If not, it must be taken on day of clinic.
- Please let community clerk know where your folder is kept (and/or your team).
- The midwife must record all women's antenatal visits. The date of subsequent appointment should be written on form, and ticked when woman has attended.
- If woman DNA's her appoint follow actions in guideline
- There is space to space to write comments if necessary .

The object of this form

1. To highlight non-attendees so they may be followed up.
2. To provide a communication between other midwives covering midwifery clinics.
3. To allow midwife to have easier access on information regarding case loads.
4. To formalise recording for community antenatal case loads.

Ashford and St Peter's Attendance Month ………………………………………

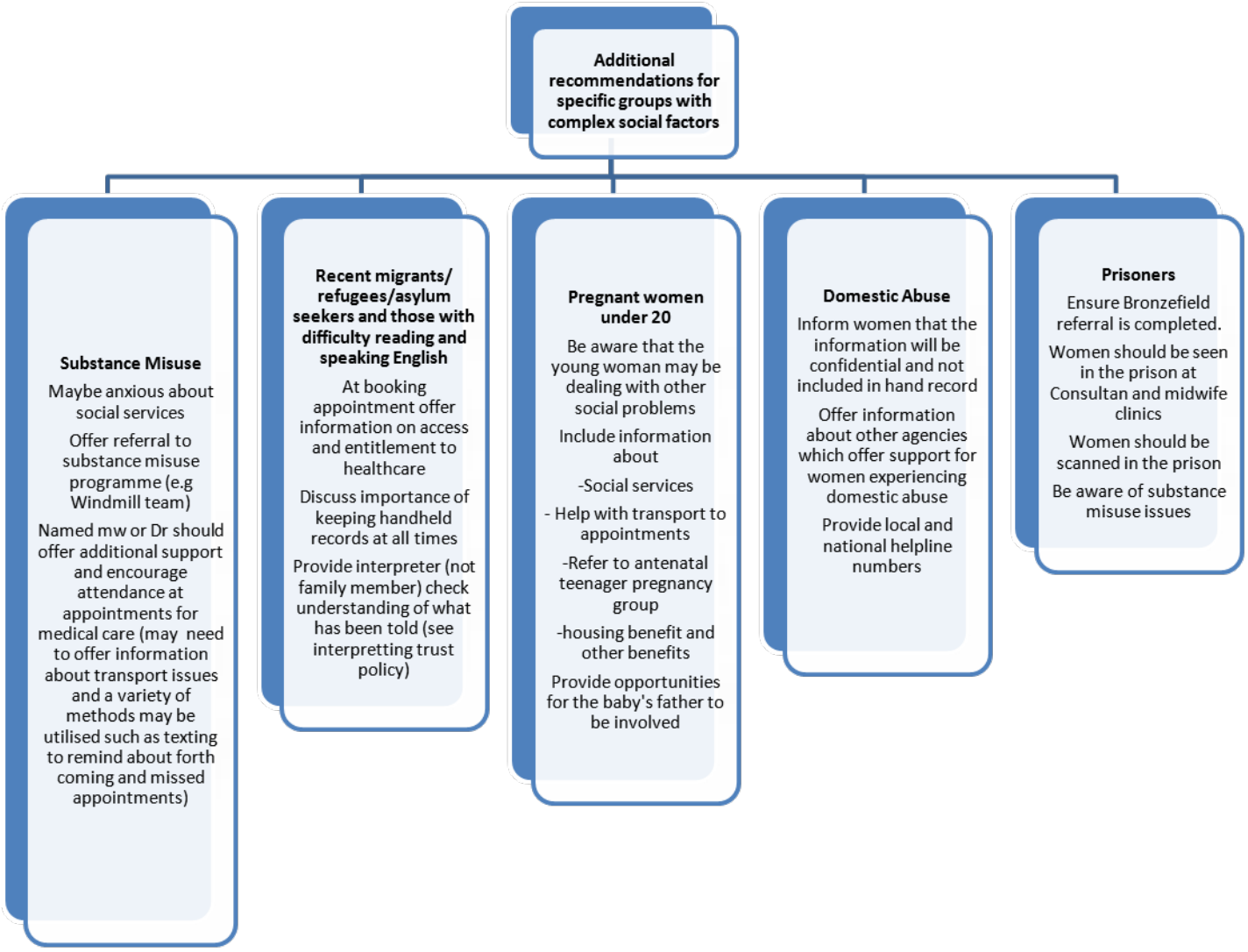
Name Address Tel: Hospital Number GP	Booking	12wk uss	16wks	20wk uss	25wks	28wks
	31wks	34wks	36wks	38wks	40wks	41wks
	NOTES					
EDD Parity						

Name Address Tel: Hospital Number GP	Booking	12wk uss	16wks	20wk uss	25wks	28wks
	31wks	34wks	36wks	38wks	40wks	41wks
	NOTES					
EDD Parity						

Name Address Tel: Hospital Number GP	Booking	12wk uss	16wks	20wk uss	25wks	28wks
	31wks	34wks	36wks	38wks	40wks	41wks
	NOTES					
EDD Parity						

Name Address Tel: Hospital Number GP	Booking	12wk uss	16wks	20wk uss	25wks	28wks
	31wks	34wks	36wks	38wks	40wks	41wks
	NOTES					
EDD Parity						

Appendix
3


Additional recommendations for specific groups with complex social factors
Substance Misuse
Maybe anxious about social services
Offer referral to substance misuse programme (e.g Windmill team)
Named mw or Dr should offer additional support and encourage attendance at appointments for medical care (may need to offer information about transport issues and a variety of methods may be utilised such as texting to remind about forth coming and missed appointments)
Recent migrants/ refugees/asylum seekers and those with difficulty reading and speaking English
At booking appointment offer information on access and entitlement to healthcare
Discuss importance of keeping handheld records at all times
Provide interpreter (not family member) check understanding of what has been told (see interpretting trust policy)
Pregnant women under 20
Be aware that the young woman may be dealing with other social problems
Include information about
-Social services
- Help with transport to appointments
-Refer to antenatal teenager pregnancy group
-housing benefit and other benefits
Provide opportunities for the baby's father to be involved
Domestic Abuse
Inform women that the information will be confidential and not included in hand record
Offer information about other agencies which offer support for women experiencing domestic abuse
Provide local and national helpline numbers
Prisoners
Ensure Bronzefield referral is completed.
Women should be seen in the prison at Consultan and midwife clinics
Women should be scanned in the prison
Be aware of substance misuse issues

Appendix 4

Young Parent Pregnancy Proforma

This Proforma to be sued for all young expectant mother age 19 years or under at booking

Booking appointment	Date and signature	Comments
1.Young parent to be booked within 2 weeks of referral by named midwife preferably at home Notification of risk form completed and sent to FNP if appropriate (ensure continuity of care through pregnancy)		
Contact details for named community midwife to be given to young parent including midwifes work mobile telephone number (remember teenagers like to communicate through text messaging)		
15 years and under **MARF** referral must be completed Date sent to contact centre		
16 to 18 years consider **MARF** referral if other concerns are raised (any history of domestic abuse **MARF** automatic)		
Health Visitor Liaison completed for all young parents highlighting all concerns and referrals		
Develop an individualised care plan including enhanced antenatal pathway Ensure at least one home visit		
Refer for Young Parents pregnancy parent education		

Appendix 5

Referral to maternity services, booking appointments and maternity care pathway including antenatal risk assessment and missed appointment Audit tool.

Booking

a) Documentation of named Midwife		☐ Yes	☐ No
b) Documentation of type of care	☐ Midwife led	☐ Shared	☐ Consultant
c) Booking before 12 completed weeks		☐ Yes	☐ No
If NO, was booked within 2 weeks of referral		☐ Yes	☐ No
d) Is the women a migrant		☐ Yes	☐ No
If YES, has she had medical examination by GP		☐ Yes	☐ No
e) Have previous obstetric records been obtained		☐ Yes	☐ No

Missed Appointment

a) Has women had all appropriate scheduled antenatal appointments ☐ Yes ☐ No

If NO, has she been followed up ☐ Yes ☐ No

b) What is documented _____

c) If she has missed an appointment have arrangements been made for her to be seen ☐ Yes ☐ No

P.T.O.

Risk Assessment

a) Risk assessment completed at booking	☐ Yes	☐ No
And at ALL antenatal contacts	☐ Yes	☐ No
b) Are the following documented in the notes:		
• Assessment for medical conditions	☐ Yes	☐ No
• Previous pregnancies described	☐ Yes	☐ No
• Life style history	☐ Yes	☐ No
• If she declines blood products	☐ Yes	☐ No
c) Risk assessment for place of birth	☐ Yes	☐ No
If risk identified is there an individual management plan	☐ Yes	☐ No
d) Has the she been referred appropriately	☐ Yes	☐ No
e) If risk resolved has she been referred back to midwifery led care	☐ Yes	☐ No
f) Did consultant request details of previous pregnancy / health issues from another hospital	☐ Yes	☐ No
g) If YES, was the information successfully obtained	☐ Yes	☐ No

EQUALITY IMPACT ASSESSMENT TOOL

Name: Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal appointments

Policy/Service: Maternity Service

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
This guideline provides the maternity services with a structured approach to providing access to antenatal care in a timely manner for all women using the maternity services at ASPH
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
This guidance enables equal access to maternity services for vulnerable and disadvantaged groups. This guidance adheres to NICE recommendations for antenatal care and Maternity Matters national DOH standards.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No impact identified
Conclusion • Provide a summary of the overall conclusions
No impact identified
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
None

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal appointments
Name of Person completing form:	Theresa Spink
Date:	April 2012

Author(s) *(Principle contact)*	Theresa Spink
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Theresa Spink
Date of final draft	April 2012
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants, Supervisors of Midwives
Who is the policy/guideline primarily for?
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters, educational half day, training sessions
Describe the process by which adherence to this policy/guideline will be monitored.
See *monitoring section of policy*
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment
All obstetric Consultants, Women's Health Guidelines Group, Labour Ward Forum, Paediatricians, Supervisors of Midwives
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes