Clinical Guideline

BOOKING APPOINTMENT AND CLINICAL RISK ASSESSMENTS IN PREGNANCY, LABOUR AND POSTNATAL PERIOD (SELECTION OF LEAD PROFESSIONAL)

SETTING	Division of Women's and Children's Services
FOR STAFF	Staff within this service
PATIENTS	All pregnant women

Guidance

This guideline offers evidence based information on the best practice for baseline clinical care at the point of early contact in pregnancy and comprehensive information on the booking process, to enable clinicians and pregnant women to make decisions about appropriate care. All pregnant women will have a clinical risk assessment in the antenatal period and an individual management plan developed. The initial risk assessment will be done at the booking visit, but every subsequent antenatal appointment should also include a risk assessment aiming to identify new risk factors. Furthermore, another clinical risk assessment will be performed when labour commences and throughout labour

It is essential that there is clear documentation regarding which professional is responsible for a woman's care at all times.

Booking Appointment

Midwives should care for women with an uncomplicated pregnancy. Obstetricians and specialist teams should be involved where additional care is needed, with a free flow of information between the specialist team, the patient's GP and the community midwifery team providing care to aid communication.

The booking appointment should ideally be completed by 10 weeks, with a full booking history, risk assessment and needs analysis being undertaken. The woman must also be given her hand-held maternity records at this visit. Some surgeries offer early Pregnancy sessions where woman can receive screening information, early referral if required or an early booking if the history warrants it. If an early pregnancy session isn't offered them women should be advised to collect information leaflets or access the leaflet App for information required prior to the booking appointment.

Lead professional refers to the healthcare professional taking overall responsibility for planning and managing a woman's care and should clearly be documented in the notes. The electronic computer systems used both have a designated field which must be completed at the time of booking. The name of the professional is clearly displayed on the computer generated documentation and it is written on the front of the woman's hand held notes at booking.

Process for ensuring that women have their first full booking visit and hand-held records ideally by ten weeks.

The woman can approach the midwifery team via single point access by contacting the Antenatal

Booking Service who will arrange the booking appointment with the relevant midwifery team. They are given the telephone number by the reception staff or GP at their local surgery. For women accessing care in the Weston area, the booking appointment is currently made by contacting appropriate community hub.

Process for ensuring that women who on referral are already ten weeks or more are seen within three weeks

When the Antenatal Booking Service clerk takes the call, she asks the women how many weeks she is; if already over 10 weeks she makes an urgent appointment for the woman to be seen within 3 weeks. If there aren't any appointments available she will contact the appropriate midwifery team and ask them to arrange an appropriate date and time.

The assessment of women who may or may not need additional clinical care during pregnancy is based on identifying those in whom there are any maternal or fetal conditions associated with an increased risk of maternal complications or perinatal death or morbidity (NICE 2019)

Identification of women who require a full medical examination

A suggested component of the booking process is to identify women who may not have previously had a full medical examination in the UK and to enable referral to a GP or Consultant if applicable for clinical assessment of their general health including a cardiovascular examination. In most cases the GP will be able to complete the examination, however if a woman has a Consultant appointment at an early gestation the Consultant will be able to complete it.

The midwifery team can access the GP records for each woman by accessing Connecting Care or contacting the GP surgery and asking for a summary to be sent prior to the booking appointment date.

A copy of the booking documentation will be sent to the named GP after booking to notify them of the pregnancy. A copy will also be sent electronically to the Health Visitor team via a central administration point.

Booking assessments

Enter in hand held record on" Special Considerations for Pregnancy "page any risk factors. This page will alert the Obstetric team of the need to review the health records of any previous pregnancies held in the hospital at the time of the appointment or write to the hospital that provided care to get copies of the pregnancy details as required to ensure a full review is undertaken.

Discuss early pregnancy information and ensure that the woman has accessed the leaflet app or has received the relevant leaflets prior to the booking appointment; Giving Patient Information In The Antental And Postnatal Period

Assess for risk of hypertension: Community Management Of Hypertension In Pregnancy

Measure height and weight and add to the electronic hospital system. Calculate BMI. If BMI >30 follow: Obesity In Pregnancy

Assess for risk of pre term labour follow: Management Of Women At High-Risk Of Preterm Birth

Screen for risk of Fetal Growth Restriction follow: Small for Gestational Age (SGA) Fetus Risk Assessment at Pregnancy Booking

Offer blood tests - blood group and rhesus D status, anaemia (Full Blood Count), Haemoglobinopathy screening, Hepatitis B,HIV, Syphillis. Follow: Screening in Pregnancy – Antenatal and Newborn Ensure UK National Screening Committee leaflet has been given and understood with discussion

Document if blood tests taken or declined on relevant page of hand held record and ensure the sample tracker is completed and Specialist screening midwife is informed if bloods are declined.

Discuss screening for anomalies using the appropriate screening leaflet that the woman has been given, as a basis for the discussion, to include dating scan, First Trimester Combined Screening and anomaly scans. See Routine Scans In Pregnancy.

Assess risk factors for Venous thromboembolism (VTE) and refer for consultant care as per guideline. The IT system will calculate a VTE risk assessment score. Any woman scoring more than 3 must be referred to an Obstetrician follow: Thromboembolic Disease In Pregnancy And The Puerperium Acute Management

Assess risk factors for gestational diabetes. Follow: Diabetes In Pregnancy Gestational

Women with pre-existing diabetes should be booked as early as possible and referred to the Diabetic Specialist Midwife. Follow: Pre-existing Type 1 and 2 Diabetes In Pregnancy

Ask about previous or present mental illness or psychiatric treatment and ask about present mood to identify potential risk of depression (Wholly Questions). Document in the hand held records in the appropriate box. Complete referral to specialist mental health services if indicated and mother has consented. Follow: Process For Identifying Pregnant/Postnatal Women At Risk Of Mental Health Disorders

This list is not exhaustive and for each assessment of risk ensure appropriate corresponding guideline is used

Inform women under 25 of the high prevalence of Chlamydia infection in their age group and give details of local National Chlamydia screening programmes they may wish to participate in.

Identify women who may have experienced anything that means they may require extra support, such as domestic violence, sexual abuse or female genital mutilation. Complete referral to specialist services if indicated and mother has consented. A referral to social care may be indicated, check local guidelines

Ensure father of the baby/partner details are documented in hand held notes and electronically. To include name, date of birth and address. It is also important to establish if the father of the baby has other children and if he has contact with his children.

Clinical Risk Assessment (Selection of lead Professional)

Timing of clinical risk assessment

Initial (booking) visit

At each subsequent antenatal appointment

Antenatal admissions

On commencement and throughout labour

Risk assessment for appropriate place of birth

The risk assessment for appropriate place of birth is initially undertaken at the booking appointment and subsequently at each antenatal contact and at commencement of labour.

All women who have had no risk factors identified are able to choose to deliver in either a midwifery led unit or at home. Any woman requiring consultant led care will be advised to deliver in a consultant led unit. For details on criteria for suitability of birth on midwifery led unit, refer to St Micheal's Hospital Co Located Midwife Led Unit – Eligibility For Labour And Birth guideline. Place of birth is recorded on the computer printout in the handheld records and the Trust computer system at booking, if any risk assessment requires change of place of birth this is documented in the handheld maternity records and on the IT system.

Decision regarding Lead Professional and timing of referral Process

If risk factors are identified during the antenatal period, referral will be made to an Obstetric Consultant Clinic.

The risk factors will be recorded in the antenatal "special considerations" box in the Maternity hand held notes or on the antenatal pages. If care is then to remain consultant led the lead professional will be changed on the Trust computer system and recorded in the hand held notes. Following the antenatal clinic visit, an individual management plan will be recorded in the notes and further hospital appointments will be arranged as necessary.

When a woman requires referral to medical clinic the GP will write a referral letter to the relevant obstetrician and an appointment will be sent. The community midwife will discuss the referral with the GP of the woman.

If risk factors are identified during or after labour, referral for consultant led care will be made. The risk factors will be recorded in the labour or postnatal "special considerations" box in the maternity hand held notes. For admissions in labour, the risk assessment will be documented on the partogram pages of the handheld records. The Lead Midwife coordinator and the Obstetric Registrar will be informed. The Obstetric Anaesthetist will also be informed, if appropriate. The change should be recorded in the handheld notes and on the Trust computer system. If risk factors are identified during a home birth, the referral process is outlined in the Home Birth guideline.

Process for referral back to midwifery led care

It is possible that many women will be seen in the Obstetric Consultant Clinic and may be eligible for referral back to midwifery led care. In that case, the decision should be recorded clearly in the notes along with any advice/triggers for referral back to consultant-led care, if appropriate.

Risk factors for referral to consultant led care at booking

The midwife can refer at any stage to a consultant obstetrician for advice. The midwife will clearly document the reason for this referral on the antenatal visit page or in the appropriate section of the hand held notes. The obstetrician will either:

A. Give advice and the woman will remain under Midwifery Led Care
B. Recommend change of lead professional to Consultant Led Care. In either instance a clear individual management plan will be written.

Referring a woman for consultant-led antenatal care at St. Michael's Hospital

Please see the table below for risk factors that would warrant consultant-led care and guidance on when women would need to be seen and in which clinic. Please note this table also shows you the woman's gestational age at which the consultant wishes to see the woman for the first time. The risk factors are numbered to allow the consultant identify why the woman is under consultant led antenatal care: please ensure you state the risk factor number to the booking team.

If a woman has been under a consultant in a previous pregnancy and still requires consultant care they should be booked under the same consultant again (continuity of carer model), with their first appointment timed as per the guidance below.

NB: Women with a known medical condition need a GP referral to the maternal medicine team.

If you believe your patient needs a consultant clinic but the reason is not described on this table, you will be asked to send an email referral query to ubh-tr.st.michaels_antenatal_clinic@nhs.net. This email account is checked daily so you will receive a prompt response. Referral queries can also be raised via the antenatal clinic midwife bleep 2733.Healthcare professionals may contact directly either the named consultant for the woman, the Consultant on call if there is any concern regarding the management of care. In the first instance a discussion should take place between the multidisciplinary team involved in the direct care of the woman. If the situation is not resolved, then a more senior healthcare professional should be called for an opinion. If this occurs on delivery suite the co- ordinating midwife should be involved and may call a consultant.

RF	Risk Factor (RF)	Gestational Age at which to be seen in General Antenatal Clinic (ANC)	Comments
	Past History		
1	Previous Pre-eclampsia (PET)/HELLP Syndrome	After 12 week scan and before 16 weeks	Start aspirin 150mg nocte from 12 weeks
2	Previous preterm birth <37weeks	After 12 week scan and before 16 weeks	General consultant clinic who will consider referral to Pre-term Birth clinic
3	Hepatitis B or C	After 12 week scan	Check viral load bloods, clotting and LFT
4	Female Genital Mutilation (FGM) **not reversed**	After 12 week scan and before 20 weeks	
5	Previous puerperal psychosis or Psychiatric disorder requiring treatment or requesting support in pregnancy	After 12 week scan	Wellbeing triage form – booked via maternal mental health team
6	Previous cone biopsy of cervix/ Large loop excision of the transformation zone of cervix (LLETZ)	After 12 week scan and before 16 weeks	General consultant clinic who will consider referral to Pre-term Birth clinic
7	Previous mid trimester loss (miscarriage) after 16 weeks	After 12 week scan, look up previous PN counselling letter on Clinical Document System	General consultant clinic who will consider referral to Pre-term Birth clinic
8	Multiple pregnancy	Multiple pregnancy clinic – follow twin guideline re aspirin and folic acid	Fetal Medicine referral form – booked via FMU

9	Age 18 or under	After 20 week anomaly scan	Vulnerable women antenatal clinic
10	Illicit Drug use: heroin, cocaine, ecstasy	ASAP after booking	Vulnerable women antenatal clinic
11	Previous traumatic delivery	After 12 week scan and before 24 weeks	General consultant clinic, ideally book under same consultant as previous delivery
12	Grand multiparity (≥para 5)	After 20 week anomaly scan and before 28 weeks	General consultant clinic, ideally book under same consultant as previous delivery
13	Previous caesarean section (**not at** full dilatation)	1st appointment: After 20 week anomaly scan and before 24 weeks	Second appointment 36 weeks to finalise mode of delivery
14	Previous caesarean section: **at fully dilated**	1st appointment: after 12 week scan, before 20 week anomaly scan	Any general consultant clinic, where risk of PTB can be assessed
15	Maternal spina bifida	After 20 week anomaly scan and before 28 weeks	And anaesthetic review at the same appointment, no further follow-up
16	Previous myomectomy	After 20 week anomaly scan and before 28 weeks	
17	Significant perineal trauma, including 3rd/4th degree tear, requiring corrective surgery, urinary/bowel dysfunction	After 20 week anomaly scan and before 28 weeks	If required, 1 further appointment in third trimester to finalise mode of delivery
18	Previous stillbirth/neonatal death	After 12 week scan and before 16 weeks, look up previous PN counselling letter on Clinical Document System	General consultant ANC, consider Fetal Medicine Unit for serial scans if FGR, ensure on aspirin
19	Women declining blood products	After 20 week anomaly scan and before 28 weeks	No further follow-up once paperwork complete. If anaemic at 28 weeks refer back to ANC
20	Previous PPH >1000ml or requiring blood products	After 20 week anomaly scan and before 28 weeks	General consultant clinic, ideally book under same consultant as previous delivery
21	Previous documented shoulder dystocia	After 20 week anomaly scan and before 24 weeks	
22	BMI >35 kg/m^2	At 28 weeks with growth scan	Follow SGA/FGR guideline
23	Age ≥ 40	At 28 weeks with growth scan	Follow SGA/FGR guideline
24	Previous baby <2.5kg after 37weeks	At 28 weeks with growth scan	Follow SGA/FGR guideline
25	High risk on small for gestational age (SGA) pathway	1st appointment at 28 weeks with growth scan	Follow SGA/FGR guideline

	Risk factors occurring during this pregnancy:		
26	Pre-eclampsia	As soon as diagnosed	Needs Day Assessment Unit (DAU) or Central Delivery Suite review when diagnosed
27	Low lying placenta after 32 weeks	As soon as diagnosed	
28	DVT	As soon as diagnosed	
29	Obstetric cholestasis	Keep under DAU care, then ANC 37 weeks to make a delivery plan	If severe OC, DAU midwives will ensure patient is under consultant in ANC
30	Antepartum haemorrhage (APH) >50ml after 24 weeks		3 weeks after last hospital admission with growth scan
31	Heavy bleeding in 1st trimester	28 weeks with growth scan	Follow SGA/FGR guideline
32	Abnormal Glucose Tolerance Test (GTT)	As soon as diagnosed	GDM clinic
33	Pre-term Pre-Labour Rupture of Membranes (PPROM)	2 weeks after discharged from hospital with growth scan or 37 weeks, whichever sooner	DAU as per Pre-term Pre-Labour Rupture of Membranes (PPROM) guideline
34	Oligohydramnios	DAU on day of diagnosis and ANC 1 week after diagnosis with repeat scan	
35	Polyhydramnios	Follow polyhydramnios guideline	Glucose Tolerance Test (GTT) (if under 34/40) before ANC referral. CMV if AFI>25
36	Scan diagnosis of intrauterine growth restriction	Follow SGA/FGR guideline	FMU referral if EFW<10th centile with abnormal UA Dopplers
37	Primary genital herpes	At diagnosis	Ensure patient has been referred to Sexual Health Clinic
38	Flare of recurrent genital herpes in pregnancy	By 36 weeks	
39	Malpresentation after 36 weeks	Day Assessment Unit	
40	Rhesus isoimmunisation or other blood group antibodies		Fetal Medicine referral form – booked via FMU
41	Previous Obstetric Cholestasis	50% recurrence: if itch take bloods for urgent liver function tests/bile acids before ANC referral	No need for routine ANC unless diagnosed in current pregnancy
42	Previous congenital anomaly (structural or chromosomal)		Fetal Medicine referral form – booked via FMU
43	Previous GDM		Arrange glucose tolerance test 16 weeks

			and repeat 28 weeks rather than ANC
44	Fetal macrosomia		Follow Large for Dates (LFD) guideline
45	BMI <18	Isolated BMI<18 in otherwise healthy woman may remain as a low risk pregnancy	If eating disorder refer to Wellbeing ANC.
46	Family history of genetic disorders		Send email to ubh-tr.st.michaels_antenatal_clinic@nhs.net with as much clinical detail as possible
47	Previous baby > 4500g	36 weeks with growth scan	GTT at 28 weeks and then ANC at 36 weeks with growth scan
48	2 or more admissions for reduced fetal movements in a 3 week period after 28 weeks		General consultant ANC
49	Maternal Group B Streptococcus	See around 36 weeks	If suitable for Midwife-led Unit intrapartum antibiotics need to be prescribed in ANC
50	Maternal chlamydia		Recommend GP or self-referral to Sexual Health clinic
51	Maternal parvovirus	At diagnosis	Fetal Medicine referral form – booked via FMU
52	Hb <90 g/dl	Check ferritin/B12/folate before referral	See anaemia guideline
54	Ovarian cyst in pregnancy >5cm after 14 weeks	1st appointment 14-18 weeks	Ensure cyst is still present after 14 weeks (by organising rescan >14w) before referral to consultant ANC as most cysts are physiological and disappear by 14 weeks
53	IVF pregnancy	Remain under CMW care if no risk factors	In an otherwise healthy woman with no risk factors: may remain as a low risk pregnancy

Monitoring statement:

Process	Tool	Responsibility of:	Frequency of review	Responsibility for: (plus timescales)			
				Review of results	Development of action plan and recommendations	Monitoring of action plan and implementation	Making improvement lessons to be shared
Audit to ensure risk assessments are completed at the appropriate times during he clinical pathway Audit to ensure documentation of referral when risks are iden ified in a woman's care	Audit tool based upon current CNST standards and National and local drivers	Ante-natal working party	3 yearly aduit	Ante-natal working party Table at audit mee ing Community midwife meeting Close Encounters	Author will formulate an action plan Actions will be based upon result of the audit	Dates incorporated into ac ion plan at time of audit Follow up by Matron to ensure actions completed via Ante-natal working party	1. Improve above present percentages 2. Share learning 3. Share good practice new ways of working Discuss with all staff at meetings, via Newsletters, Re-audit as required

The above table outlines the minimum requirements to be audited; additional audits will be commissioned in response to deficiencies identified within the service through morbidity and mortality reviews/benchmark data provided by CHKS or in response to national initiatives e.g. NICE, RCOG guidelines, CNST standards

Authors of original
[redacted] Community Matron
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Table A

REFERENCES	National Institute for Health and Clinical Excellence. (2019). Antenatal care: Routine care for the healthy pregnant woman. London: NICE. Available at: www.nice.org.uk
RELATED DOCUMENTS AND PAGES	Giving Patient Information In The Antental And Postnatal Period Community Management Of Hypertension In Pregnancy Obesity In Pregnancy Management Of Women At High-Risk Of Preterm Birth Small for Gestational Age (SGA) Fetus Risk Assessment at Pregnancy Booking Screening in Pregnancy – Antenatal and Newborn Routine Scans In Pregnancy. Thromboembolic Disease In Pregnancy And The Puerperium Acute Management Diabetes In Pregnancy Gestational Pre-existing Type 1 and 2 Diabetes In Pregnancy Process For Identifying Pregnant/Postnatal Women At Risk Of Mental Health Disorders St Micheal's Hospital Co Located Midwife Led Unit – Eligibility For Labour And Birth
AUTHORISING BODY	Antenatal Working Party
SAFETY	There are no known safety concerns
QUERIES AND CONTACT	[redacted]

Risk Factor	Gestational Age at which to be seen in General Antenatal Clinic (ANC)	Comments
Past History		
Previous Pre-eclampsia (PET)/HELLP Syndrome	After 12 week scan and before 16 weeks	Start aspirin 150mg nocte from 12 weeks
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IVF pregnancy	In an otherwise healthy woman with no risk factors: may remain as a low risk pregnancy	
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