Responsibility for Care Throughout All Stages of Pregnancy Guideline

The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identify does not align with the sex that they were assigned at birth

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Brief Summary of Document:	Responsibility for care throughout all stages of pregnancy
Scope	The guideline is aimed at all healthcare professionals who provide care for women and birthing people throughout all stages of pregnancy. The vast majority of midwifery service users are women and we already have language in place to reflect this, however as a healthboard we recognise that not all people who give birth will identify as being female and therefore aim to use gender inclusive language wherever possible. 'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.

To be read in conjunction with:	• NICE guideline (NG201) Antenatal Care: August 2021. Available at www.nice.org.uk/guidance/ng201. • NICE Clinical guideline (CG110): Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. September 2010 reviewed Aug 2018. Available at www.nice.org.uk/guidance/cg110 • NICE guideline (NG194) Postnatal care. 20 April 2021. Available at www.nice.org.uk/guidance/ng194

Owning group	Obstetric Written Documentation Group

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	14.9.17
2	Guideline update: Inclusion of proformas for consultant led care and criteria for consultant led care.	15.10.21

	The inclusion of an obstetric review at 36-37 weeks' gestation for women booked under consultant led care which includes an assessment for suitability to return to midwife led care; intrapartum management plan; recommended place of birth; discussion and informed choice regarding mode of birth and associated risks, plan for postnatal care.	

Keywords	Responsibility for care throughout all stages of pregnancy

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1. Introduction

Antenatal services should be accessible and welcoming so that women can access care easily and early on in their pregnancy. Having a baby is a joyous and fulfilling experience and nowadays a safe one for the majority of women. Some women will have more complex health issues and will require obstetric care, alongside midwifery care, to ensure an appropriate plan is in place to maximise the best outcomes for the woman her baby.

2. Antenatal

2.1 The woman will be invited to booking appointment with a midwife at around or prior to 9 weeks of pregnancy. If any complex social or health factors are identified, as outlined in the criteria for Consultant-Led care (see appendix1), then the midwife will discuss reasons why Consultant-Led care is recommended. The woman will then make an informed decision regarding whom she wishes to be her named lead professional. The woman may choose a Consultant-Led pathway as a personal preference in the absence of any complexities.

2.2 The responsible person will be named on the front cover of the pregnancy hand-held records. Care will be either:

- Consultant Led Care
- Midwifery Led Care

2.3 If a referral is necessary following Midwifery-Led Care, then the policy for routes of referral within maternity services multidisciplinary team should be followed.

2.4 A clear plan of care must be included within the pregnancy held records. Any special instructions must be written plainly and communicated to those involved. For women having a named consultant as the lead professional then the consultant will complete the antenatal proforma with a detailed plan of care. The woman must be kept informed of this plan and of any changes throughout all stages of her pregnancy.

2.5 Women who are under consultant-led care should have their care pathway re-evaluated by their consultant (or Senior Obstetrician) at 36-37 weeks' gestation, appropriately referring for midwife-led care in the absence of any ongoing complex factors. This review should incorporate a discussion with the woman regarding birth choices including: The preferred mode of birth; place of birth and a rationale for any recommendations; any specific plan for intrapartum care agreed (such as intravenous access etc); and postpartum care required (such as follow up appointments etc). This should be clearly documented in the All-Wales antenatal hand-held record, in the relevant intrapartum and postpartum considerations page. Patient information leaflets should be given as appropriate.

3. Intrapartum

The midwife has the responsibility to recognise the warning signs of abnormality in the mother and infant which necessitates referral to the obstetric team in accordance with the NMC's Standards of proficiency for midwives (2019).

When a referral has been made to the obstetric team the consultant on call becomes the responsible professional for care.

4. Postnatal

4.1 Unless there are ongoing issues care will be transferred back to the named midwife following the delivery who will be responsible for referral if necessary.

4.2 Formal handover of care to the Health Visiting Services must take place and be clearly documented in the hand-held records.

5. References

GMC. Ethical Guidance for Doctors: Good Medical Practice available at https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

NICE guideline [NG201] Antenatal Care: August 2021. Available at www.nice.org.uk/guidance/ng201.

NICE quality standard (QS192) Intrapartum care: existing medical conditions and obstetric complications Quality standard Published: 28 February 2020 www.nice.org.uk/guidance/qs192

NICE guideline (NG190) Intrapartum care for healthy women and babies Clinical guideline Published: 3 December 2014 available at: www.nice.org.uk/guidance/cg190

NICE Clinical guideline [CG110]: Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. September 2010 reviewed Aug 2018. Available at www.nice.org.uk/guidance/cg110

NICE guideline (NG 194) Postnatal care Published: 20 April 2021. Available at www.nice.org.uk/guidance/ng194

NMC Standards of proficiency for midwives Published 18 November 2019 https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf

NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2020). Available at https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

6. Appendices

Criteria for referral for consultant led care

Appendix 1.

Hywel Dda University Health Board Consultant-Led Criteria (CLC)

The following are medical conditions and situations where there is an increased risk for mother and baby.

These women will need to be booked under Consultant-Led Care and a plan of care documented at Booking.

The midwife must tick the appropriate box and insert the completed form into antenatal clinic notes.

NB: * means women are NOT suitable for delivery at Bronglais General Hospital but can receive antenatal care at BGH

MEDICAL CONDITIONS	ADDITIONAL INFORMATION	TICK
Cardiovascular	**Confirmed cardiac disease – *assessment by Consultant for mode & place of delivery***	*
	Hypertensive disorders	
Respiratory	**Asthma requiring oral steroids within last six months**	
	Under care of respiratory physician e.g. cystic fibrosis	
Haematological	**Haemoglobinopathies – sickle cell disease / Beta – thalassaemia major.**	
	History of Thromboembolic disorders DVT /	
	Previous thromboembolism in patient	
	Von Willebrands disease - *assessment by Consultant for mode & place of delivery by 32/40*	*
	Atypical antibodies which carry a risk of haemolytic disease of the newborn	
	Haemoglobin ≤ than 85g/dl	
Infective	**Known GBs carrier or identified in urine**	
	Known Hepatitis B,C ,D etc.	
	HIV positive status - *Consultant to discuss with paediatricians*	*
	Current active chicken pox /rubella/genital herpes/toxoplasmosis/parvo virus – *Consultant to discuss with paediatricians*	
	Tuberculosis under treatment	
Immune	**Systemic Lupus erythematosus - *assessment by Consultant for mode & place of delivery***	*
	Rheumatoid/ inflammatory conditions	
	Scleroderma	
Endocrine	**Hyperthyroidism / Hypothyroidism**	
	Type 1 diabetes – *to be booked at GGH*	
	Type 2 diabetes on insulin at booking/ in pregnancy - *transfer care to GGH by 32/40*	*
	Previous history of Gestational Diabetes/ Diabetes in first degree relative	
Renal	**Renal disease requiring care by a renal specialist - *assessment by Consultant for mode & place of delivery by 32/40***	*
	Bladder surgery / injury	
Neurological	**Epilepsy**	
	Myasthenia gravis	
	Multiple sclerosis	
	Previous CVA/ TIA	
Skeletal	**History of spinal surgery / pelvic fracture resulting in paraplegia**	

Gastrointestinal	**Liver disease/ Hepatitis - *assessment by Consultant for mode & place of delivery by 32/40***	*
	Bariatric surgery	
	Inflammatory bowel disease /ulcerative colitis / crohns	
Psychiatric	**Psychiatric disorder requiring inpatient care**	
	Bipolar disease	
	Previous post -partum psychosis/ depression requiring treatment	
Ophthalmology	**Eye abnormality under care of ophthalmologist e.g. detached retina**	
	Glaucoma	
Previous pregnancy complications	**Pre-eclampsia or PET/ Eclampsia in first degree relative**	
	Previous preterm delivery	
	Placental abruption with adverse outcomes	
	Eclampsia/ HELLP syndrome	
	Late miscarriage	
	Recurrent miscarriage> 3 consecutive pregnancies	
	Uterine rupture	
	Primary postpartum haemorrhage requiring blood transfusions	
	Caesarean section	
	Shoulder dystocia	
	Extensive vaginal tear / cervical tear. 3rd or 4th degree tear	
	Previous IUGR with birth weight less that 2500grms at term or BWC < 10th centile	
	Previous baby weight >4500grms	
	Previous baby with significant neonatal complications / encephalopathy	
	Previous baby requiring an exchange blood transfusion	
Current pregnancy	**Age over 40 at booking**	
	Known multiple pregnancy: • **MCMA – *transfer care to GGH by 28/40*** • **MCDA – *transfer care to GGH by 32/40*** • **DCDA - *transfer care to GGH by 32/40*** **Triplets – *transfer to tertiary unit from viability***	*
	Confirmed/ suspected placenta accreta – *MDT discussion. Transfer care to GGH*	
	Pregnancy resulting from assisted reproduction e.g. IVF (not Clomid)	
	Age under 16 at booking	
	BMI <18 or >35 at Booking - *assessment by Consultant for mode & place of delivery* **BMI>45 at Booking - *assessment by Consultant for place of delivery***	*
	Para 5 or more	
	Smoker >10 cigarettes per day	
	Alcohol consumption > 14 units per week	
	Recreational drug use/ known drug abuse	
	Previous Anaesthetic complication	
	Late booker >20 weeks gestation	
	Suspected IUGR *OR* EFW ≤1.5kg at 36/40 – *consider delivery at GGH*	*
Previous Gynaecological history	**Major Gynaecology surgery/myomectomy/hysterotomy**	
	Known fibroids	
	Surgery to cervix e.g. ≥ 2 LLETZ or **Cone biopsy**	
	Female Genital Mutilation	

This list is not exhaustive and if the midwife has any concerns regarding a condition that is not mentioned above this should be discussed with the consultant obstetrician.