	DIVISIONAL DOCUMENT
Delete as appropriate:	Clinical Guideline
DOCUMENT TITLE:	**Booking and Referral**
DOCUMENT NUMBER:	**G41 v4**
DOCUMENT REPLACES Which Version	G41 v3
LEAD EXECUTIVE DIRECTOR DGM	Divisional General Manager
AUTHOR(S): Note should not include names	Consultant Obstetrician and Gynaecologist Safeguarding Practitioner

TARGET AUDIENCE:	Midwives, Obstetricians, Anaesthetists & Neonatologists
DOCUMENT PURPOSE:	To describe the process for booking and referring women who are pregnant within ELHT for care by the appropriate team

To be read in conjunction with	Maternity Services Clinical Guideline: Guideline 39: Obesity Guideline 71: Care in the First Stage of Labour Guideline 72 Care in the Second Stage of Established Labour Guideline 73 Care in the Third Stage of Labour
SUPPORTING REFERENCES	

CONSULTATION		
	Committee/Group	Date
Consultation	Midwives, Consultants	
Approval Committee	Women and Newborn QSB	July 2021
Ratification date at WNQSB	8th July 2021	
NEXT REVIEW DATE:	July 2024	

AMENDMENTS:	August 2018 – Full review JUNE – 2021, Change in Practice: All women to be seen alone initially at the Booking and 28 week antenatal appointment. Appendix 4– Flow chart to support staff.

41.1 Booking and referral

41.1.1 Responsibilities of Relevant Staff Groups

STAFF GROUP	RESPONSIBILITIES
GP **Primary Care response not ELHT**	Directs pregnant woman to central midwife booking line: Telephone 01282 804512 Open between 9am and 12pm. The woman makes her own booking appointment with a Midwife for 8-12 weeks gestation, or arranges urgent appointment, within two weeks, for women greater than 12 weeks gestation. ELHT provides appointment slots and clinic cover to enable booking appointments to take place
GP **Primary Care response not ELHT**	Ensures that 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. If there is a need for early referral for urgent CLC e.g. diabetes or medical co-morbidities then a referral letter is sent directly to the ANC who will arrange an early review.
ELHT Maternity Service	Ensures midwifery availability for the booking clinics and attendance at clinics
Midwife	Carries out antenatal risk assessment, completes hand held notes (documenting the date and gestation at time of booking), offers a Dating Scan / Anomaly Scan (depending on gestation, if known) appointment, and sends booking referral information (3-part set) to Antenatal Records Department, requesting either Midwifery led or Consultant led care, as determined by both the assessment and maternal preference. Completes coding sheet and social needs assessment

Obstetrician	Reviews all relevant information available on woman in whom risks have been identified and referred, makes a clinical assessment, and develops an individual management plan with the woman accordingly, documenting this in the notes.
Antenatal Health Records Staff	Generate / retrieve hospital health records, including those from all previous pregnancies (see section 41.1.3 below).
Consultant Obstetric Anaesthetist	See 41.1.5 below and Appendix 1

41.1.2 Flow Chart 1

Process for ensuring women have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy

Confirmation of pregnancy and gestation identified as less 12/40 from LMP
Women are directed to central midwife booking line and make their own appointment with a midwife for 8-12 weeks
GP's can refer directly for consultant opinion if women need an urgent review in the first trimester

ELHT pathway commences

First Full booking appointment with midwife (Midwife attends booking clinic)
Handheld maternity booking records completed (sheets 1,2 &3) and antenatal book commenced
Evidence of booking appointment taking place is documented in antenatal book 1
Risk assessment includes as minimum:

- Medical conditions, including anaesthetic history
- Factors from previous pregnancies
- Lifestyle factors (smoking, alcohol, recreational or opioid drug use)
- Women who decline blood or blood products
- Mental health assessment

Risks identified on antenatal risk assessment – process for referral
Referral is made for consultant opinion (see table) by sending the first 2 copies of the 3 page assessment to antenatal clinic
The hospital health records will be generated and retrieved including the main medical notes
An appointment will be made for obstetric ANC

No risks identified on antenatal risk assessment
Referral is made for midwifery led care by sending the top 2 copies of the 3 page assessment to antenatal clinic annotating MLC
Hospital health records generated and retrieved.

Dating scan appointment
Medical notes available and risk assessment reviewed – referral for obstetric review as necessary or confirm suitable for MLC
Anomaly scan arranged

Dating scan clinic and obstetric antenatal clinic attended
Development of individual management plan written in the antenatal health record by the obstetrician
Anomaly scan arranged
Referral for anaesthetic review, specialist midwifery support or other specialists as appropriate

Midwife- led clinic
Antenatal contact documented
Ongoing risk assessment e.g. palpation, monitoring etc
Referral for obstetric review / specialist midwifery support as necessary
Telephone the antenatal records department to arrange a clinic appointment.
For urgent cases referral may occur via the ANDU, CBS or triage

HIGH RISK

LOW RISK

Obstetric Antenatal Clinic (CLC)
or
Shared care with midwife

Notes:

1. Booking dating scan: midwife calls the ultrasound booking line at time of booking to arrange
2. Maternal preference may determine clinical lead regardless of risk status
3. **Out of area referrals** GP writes or telephones ANC directly who will direct to the booking line to make the appropriate dating scan and booking

It is ELHT policy that ALL women are seen alone initially at both their booking and 28 week appointments. This enables the woman to make any disclosures in a safe space, including any information she might not want her partner to be aware of. This time should also be used to ask about domestic and sexual violence within the home. Follow Appendix 4, if you have any disclosures. Routine Enquiry should also be completed at any antenatal appointment where the woman is alone and also in the postnatal period.

41.1.3 Process for ensuring that women already 12 or more weeks pregnant are seen within two weeks of referral

In such circumstances, a booking appointment is arranged by the GP/practice staff or GP / Children's Centre staff informing the relevant Midwifery Team, either directly or by phoning/faxing the Community Midwives' Office in the Maternity Unit, or by them contacting the Antenatal Records Department at the hospital. A visit will be arranged within 2 weeks from time of contact by referrer. Midwives will enter booking in their diary schedule or clinic slots via the system in each GP practice or clinic which may include appointment books /electronic register systems in Primary Care if available. If the booking visit cannot be done by a Team Midwife because there is no-one available or able to see the woman soon enough, Antenatal Records staff will arrange for the woman to be seen at the hospital, where she will have the appropriate scan appointment made and subsequently be reviewed by an Obstetrician if clinically indicated

41.1.4 Process for ensuring that migrant women who have not previously had a full medical examination in the UK have a medical history taken and clinical assessment made of their overall health

If there is no documented evidence that a woman has undergone a full medical examination in the UK, a hospital antenatal appointment will be necessary, and this examination will be done, along with a clinical assessment of her overall health, at her first hospital antenatal appointment, by a doctor. The assessment must be documented in the antenatal health records.

41.1.5 Process for arranging availability of health records from all previous pregnancies for review by clinicians

On receipt of booking referral information (copy of '3-part set'), Antenatal Health Records staff will request health records from previous pregnancies held by the Trust, so that they will be available when the woman attends her first hospital appointment. The general medical records will also be requested and available for the first hospital appointment.

If the woman has given birth in another Trust and the obstetrician requires further details of the birth, it is the responsibility of the obstetrician, or a member of their team, to write to the relevant Trust to formally request a copy of the health records.

41.1.6 Process for ensuring early consultant review (1st trimester)

Women with pre-existing medical conditions such as diabetes, poorly controlled thyroid disease, hypertension or previous VTE may require an early review. This may occur before they undergo the formal booking process.

A GP can request an urgent obstetric opinion by contacting the antenatal clinic either in writing by faxing a referral or telephoning. An urgent appointment to be seen in the next available consultant ANC will be arranged.

41.2.1 Risk assessment criteria for home / birth centre birth during pregnancy

- Women with no medical conditions or previous obstetric complications (see referral criteria, section 41.2.3 and 41.2.4)
- Women whose conditions have been agreed are unlikely to affect labour
- Over Age 16 yrs
- Women having 1st to 5th baby inclusive (excluding women with a history of PPH at last birth)
- Pregnancy of 37-42 weeks
- Singleton pregnancy
- Weight BMI between 18.5 and 35
- Women who do not meet the eligibility criteria, but who make an informed choice to have a Home Birth (referral to team leader indicated)

It is essential that the primary midwife gives the parents information highlighting transport to the hospital and the time required, before labour starts.

41.2.2 Criteria for midwife led care

Midwife led care should be offered to all healthy pregnant women aged over 16yrs who do not have significant past or current medical, gynaecological or obstetric problems (as listed in the tables in section …..)

Primigravid women, without additional risk factors, do not require a referral for consultant care.

41.3 Indications for referral for consultant opinion

Referrals should be made, as soon as any of the "indicators" listed in the table below are identified by the main care giver involved at the time.

Medical problems past or present	**General**	**Obstetric History**
Cardiac Disease • Currently or previously on treatment • Previous surgery • Known cardiac abnormality or arrythmia Respiratory disease • Asthma – moderate or severe (oral steroids within the last 12 months, poor control, hospital admissions or worsening asthma in pregnancy) • Cystic Fibrosis Renal disease Autoimmune disease Pre-existing diabetes Hyperthyroidism or hypothyroidism (currently treated or not) Ulcerative colitis or Crohns disease Previous VTE or VTE risk score 3 or more Haemoglobinopathies (sickle cells disease or thalassaemia) Bleeding disorder in baby or mother Atypical antibodies Essential Hypertension: on treatment or BP >150/90 at booking Epilepsy HIV, Hep B/C or VDRL	Age: <16yrs or >40yrs at booking Late booker (22/40) BMI >35 (For those with a BMI 30-34.9 please follow BMI care pathway) Women who decline blood products Known significant feature of domestic violence **Gynaecological History** LLETZ or Cone treatment IVF or assisted conception Pelvic floor repair or surgery for incontinence Hysterotomy Myomectomy Fibroids >5cm or located in the lower segment of the uterus Uterine perforation History of fractured pelvis Uterine abnormalities	All 3rd or 4th degree tears Caesarean section Pre-term birth <34 weeks or previous PPROM 16-34/40 3 consecutive miscarriage Previous mid trimester loss Stillbirth or neonatal death PET/HELLP/Eclampsia/PIH needing treatment or early delivery Previous SGA <10th centile PPH > 1L Neonate affected by GBS Para 6 or more History of baby >4.5kg (book GTT don't need reviewing) Gestational diabetes Uterine malformations Cervical trauma Cholestasis of pregnancy Abruption Previous fetal/neonatal abnormality Previous term baby with jaundice requiring treatment

Neurological disorder Spinal abnormalities Current drug or alcohol use Smoker >10/day Mental health issues (refer to guideline for referral)		
Maternal indications during pregnancy	**Fetal indications during pregnancy**	**Physiotherapy referral**
Hyperemesis requiring admission or medication review BP >150/100 on 2 consecutive readings and / or significant proteinuria 1+ (NICE 2017) Suspected or confirmed DVT Confirmed obstetric cholestasis UTI (3 or more confirmed cases) Recurrent APH / known persistent haematoma on early USS Antibodies Anaemia Hb<90 not responding to oral iron therapy Active infection (chicken pox, rubella, genital herpes) Placenta praevia Pre-term rupture of membranes Abnormal GTT Prelabour rupture of membranes >24hrs	Multiple pregnancy Breech >36/40 Fetal abnormality Suspected growth restrictions – follow suspected SGA pathway Reduced fetal movements CTG or doppler request No audible FH Irregular or tachycardiac FH Accelerated fetal growth or suspected polyhydramnios Prolonged pregnancy >Term +12 Unstable lie or abnormal presentation >37/40	Symphysis pubis dysfunction Pelvic floor problems Carpel tunnel syndrome Other MSK problems

41.3.1 Family History

All Women who have a family history as listed below must be referred to the Antenatal and Newborn Screening Team or Senior Midwife in the hospital Antenatal Clinics at the time of booking. Midwives can telephone the Clerical Officers within the hospital clinics who will record the relevant details and alert the screening team. The woman will then be contacted and offered an early appointment This is to ensure the offer of early referral to Genetics and management of the current pregnancy.

Couple / woman already have a child with a Genetic disorder.
Couple / woman have had any children who have died or who have health problems.
Couple / woman have had pregnancy losses associated with multiple congenital anomalies.
Woman / partner are known carriers for an autosomal recessive disorder.
There is a child with a known recessive disorder within the extended family.
A sibling / first degree relative of either parent is affected with an autosomal recessive disorder
Family history is indicative of an autosomal recessive and needs further explanation.
Couple have been found to be a carrier, through a screening programme/ extended genetic service.

41.4 Transfer from Consultant to Midwifery care in antenatal period

If referred for consultant opinion and the decision is that the condition/problem has resolved, not serious or is unlikely to affect the pregnancy or labour referral can be made back to midwifery care

Referral back to MLC must be clearly documented in the woman's hospital maternity notes and in her hand held notes, and the woman advised when to make her next appointment with the community midwife. Ongoing appointments will continue in the community.

Following consultant clinic review it may be appropriate to offer shared care. The individualised management plan should clearly state when the antenatal clinic appointments are required at the hospital so that additional appointments can be arranged with the community midwives.

41.5 Referrals for anaesthetic review (See appendix 1)

Referrals should be made, as soon as any of the 'indications' listed in section 41.5.1 below are identified, by the main care giver involved at the time.

Review may be by case notes review in the first instance, followed by interview if necessary.
The outcome of the referral should be documented by the Obstetric Anaesthetist in the maternity notes or through correspondence filed in the notes, e.g. letter

41.5.1 Indications for referral for anaesthetic review

Guidelines for Anaesthetic Referral

We will see any mothers that request an Anaesthetic Review
We would like to know about and will consider seeing patients with the following conditions:

- Previous anaesthetic problem of any kind (e.g. difficult intubation)
- Previous family history of specific anaesthetic problem (e.g. Malignant Hyperthermia, abnormal plasma cholinesterases)
- Extreme anxiety, extreme needle phobia
- Obesity: BMI≥40 at booking or >35 with other potential cause for concern (see Guideline 39: Obesity) Note: Obese patients having a planned LSCS can be seen at anaesthetic antenatal clinic the week before

Pre-existing medical problems:

- Cardiac
  - affecting activities of daily living
  - obstructive disease, e.g. HOCM, valvular stenotic disease
  - known pulmonary hypertension
  - multiple drug therapy
  - paroxysmal or inadequately controlled dysrhythmia
- Respiratory
  - affecting activities of daily living
  - requirement for multiple hospital admissions
  - deteriorating disease
  - bronchiectasis, cystic fibrosis
- Endocrine
  - poorly controlled disease, e.g. clinical hyperthyroidism
  - pan-hypopituitarism
  - diabetes mellitus with known autonomic neuropathy
- Haematological
  - coagulopathy – inherited/therapeutic
  - thrombocytopenia
  - sickle cell disease (not trait)
  - Jehovah's Witness (only if they wish to have a discussion of the options available)
- Hepato-renal
  - urea>8, creatinine>130
  - pre-existing significant hepatic impairment
- Neurological
  - affecting activities of daily living
  - poorly controlled epilepsy

- known other significant disease (may or may not be intracranial)
- known/suspected raised intracranial pressure

- Musculoskeletal
  - **significant** spinal pathology e.g. significant scoliosis, patients who have had spinal surgery, patients requiring opioid or neuropathic analgesia
  - obvious facial/oral anatomical abnormality
- Miscellaneous
  - known/suspected significant allergies, e.g., local anaesthetic, latex
  - known/suspected history of porphyria
  - history of organ transplantation
  - drug abuse/addiction

This is not an exclusive list. If in doubt ask (bleep 007) or refer.
Please include as much information about the underlying condition as possible in the referral. If the patient has been seen by us during previous pregnancies please include this too.

41.6 Referral for specialist midwifery support

East Lancashire Women's Health Team - Includes Mental Health and substance misuse specialist midwives:

For referral criteria:-

- Severe diagnosed mental health problems. Recent psychotic episodes, schizophrenia, acute mental health, bipolar. History of attempted suicide or self-harm, depression diagnosed and treated by a health professional, under core of CMHT, not GP.
- Asylum seeker with complex health and social care issues
- Sexual Exploitation
- Trafficking
- Safeguarding; Current children's social care involvement for complex issues, such as women in a refuge – family on a CP plan.
- Teenager with complex issues
- Diagnosed Learning Disabilities.
- Problem Drug/Alcohol use.

Referral form see appendix 3

Diabetes midwife – pre-existing or gestational diabetes

Team leaders – birth choices beyond usual care

41.6 Process for Clinical Risk Assessment when Labour commences (all care settings):

Timing:
when commencement of labour confirmed

Risk Assessment (RA)

To be undertaken and documented on RA in labour form (see appendix 2).
RA to include consideration of:

- Medical conditions, including anaesthetic history
- Factors from previous pregnancy
- Lifestyle history
- RA for appropriate place of birth

Any management plan developed following risk assessment at booking or during pregnancy must also be considered

Individual Management Plan:

Develop an individual management plan when risks are identified during the RA, documenting the plan on the RA in labour form or partogram (appendix 2)

Process for referral of women when risks are identified during the clinical risk assessment:

If in hospital setting – liaise with and involve appropriate colleagues from multidisciplinary team in planning and implementing care
If in Home setting – liaise with appropriate colleagues from multidisciplinary team and arrange transfer to hospital as per Guideline 27: Maternal Transfer, where appropriate

41.6.2 Criteria for referral for consultant opinion or care in labour

The timing of subsequent clinical risk assessments in labour must be individually tailored to suit the needs of the women and her fetus (See also table below, and guideline 27: Transfer of care, for referral process)

1. Maternal request for epidural pain relief
2. Fetal heart rate abnormalities (audible decelerations, FH <110 or >160)
3. Delay in progress in labour in presence of good contractions (need to allow for physiological plateaus and latent periods – use action lines – see also ELHT Maternity Clinical Guidelines: Guideline 71, Care in the First Stage of Established Labour, Guideline 72 Care in the Second Stage of Established Labour and Guideline 73 Care in the Third Stage of Labour.
   Maternal temperature
   >38 once (NICE)
   <36 (sepsis)

4. Maternal heart rate
   >120 bpm
   <40 bpm
5. Blood pressure (NICE)
   Single diastolic >110
   Any systolic > 160
   Diastolic >90 or systolic >140 on 2 readings 30minutes apart
   Proteinuria (2+ on a clean catch) with normal blood pressure
6. Maternal respiration
   >25
7. MOEWS 2 or more
8. Meconium stained liquor: fresh thick meconium always referred: thin old meconium judged individually regarding the stage of labour
9. Malpresentation (transverse or oblique lie or a free floating head in a primigravida)
10. Prolonged rupture of membranes (>24hrs)
11. Third stage haemorrhage >1000mls or symptomatic
12. Cord presentation or prolapse
13. Retained placenta over 1 hour following birth and actively managed. All case of retained products
14. Third or fourth degree perineal tear
15. Any concerns regarding maternal, fetal or neonatal wellbeing
16. Vaginal bleeding (other than a show)
17. Anhydramnios or polyhydramnios

An individual management plan must be developed collaboratively for those women in whom risks are identified

Discuss PROM guidelines with women before this point. IV antibiotic prophylaxis is not needed unless any signs of infection develop, but observation of baby for 12hours in hospital is recommended
The level of urgency in relation to transfer will be influenced by the timing and number of risk factors present

41.7 – Monitoring Compliance with the guideline

The guideline will be reviewed and audited when.

I. Clinical Risk Management dictates.
II. National guidance is updated and implemented

If cases, which are reviewed as a result of incident reporting where there is an issue with the identification of clinical risk factors in labour or any failures are identified with the clinical risk assessment process, recommendations will be made and the Central Birth Suite Forum will develop an action plan.

Appendix 1: Referrals for Anaesthetic Consultation

Introduction

There is an increasing need for multidisciplinary input into the care of pregnant women. There has to be a robust system of referral and communication to ensure timely review and feedback.

The process of referral must ensure that

- Referrals are triaged promptly
- Appointments are arranged at a suitable time
- Patients are notified in a timely manner
- Patients who fail to attend are either reappointed or alternative arrangements made to safeguard their care

Who should be referred?

Any patient who has a condition that can affect or be affected by the anaesthetic management for her delivery must be referred for anaesthetic consultation. A number of relevant conditions are listed in 41.2.4.1 above (this list is not exhaustive).

Who to refer to?

Referrals should be addressed to:
Obstetric Anaesthesia Consultation Clinic
Department of Anaesthesia
Burnley General Hospital
Casterton Avenue
Burnley
BB10 2 PQ

How to refer?

Referrals should be made as early as possible. This helps with planning clinics and appointments.

If referrals are made late in pregnancy (after 34 weeks) the referral should be faxed to the Anaesthetic Department at BGH (14856) FAO Obstetric Anaesthesia Consultation Clinic.

Verbal or phone referral (Anaesthetic Department, BGH: 01282 804644 / Internal ext. 14644) are acceptable in special circumstances, but should be followed up by a written referral.

The referral letter must contain as a minimum

- Patient Name and identifier
- Estimated date of delivery
- Brief obstetric history
- Plan for delivery
- Reason for referral

Allocation and communication of anaesthetic appointments

Patients will be given an appointment typically between 28 and 34 weeks.

The appointment will be sent in writing 2-3 weeks ahead.

The patient will be required to confirm the appointment by phone

Any patient who has not confirmed the appointment one week ahead may be contacted by phone

Unconfirmed appointments may be reallocated.

Communication of outcome of anaesthetic consultation to referring team

The content, discussion and conclusion of the consultation will be summarised either by hand written notes and/or a letter, or in a summary form.

Missed anaesthetic appointments

Patients who miss an anaesthetic appointment will normally receive a further appointment and their obstetrician will be informed with a request to encourage the patient to attend for anaesthetic consultation.

If a patient fails to attend on two occasions, no further appointment will be arranged unless the Consultant Obstetrician requests it after discussing with the patient the purpose and benefit of attending.

Issues identified from the patients notes will be summarised in a letter together with clear instructions to inform the Obstetric Anaesthetist as soon as the patient is admitted to hospital or delivery suite, so that he can familiarise himself with the patient's history, review the patient and address any problems early.

Monitoring

A report regarding the obstetric anaesthesia consultation service will be presented annually to the obstetric anaesthesia interest group and the lead clinicians group.

The report will include

Number of referrals

A breakdown according to reason for referral

Number of consultations

DNA rate

Where the report identifies deficiencies, recommendations will be made and an action plan developed, and monitored through the Obstetric Anaesthesia Interest Group to ensure changes are implemented effectively. Exception reports will be forwarded to Womens Newborn Quality and Safety Board.

Appendix 2 Clinical Risk Assessment in Labour

Hospital Number .....DOB.....

First Name .....M / F.....

Last Name .....Religion.....

Address.....GP.....

.....

NHS Number .....

CLINICAL RISK ASSESSMENT IN LABOUR

To be completed for all women within one hour of the commencement of labour and in all care settings.

Please file in case notes

***May be entered prior to labour if neonatal plan has been agreed in the antenatal period.**

Date and time of risk assessment -	
Gestation -	**<u>Current</u> VTE risk -**
Relevant medical conditions, including anaesthetic history	
Relevant factors from previous pregnancies	
Relevant factors from current pregnancy	
Relevant lifestyle/social history	
***Relevant neonatal conditions/plans of care following birth**	
Chosen place of birth still appropriate from clinical perspective and Womens perspective?	Clinical Perspective **YES NO** Womens Perspective **YES NO** *please circle
Has women requested transfer to LWNC?	**YES NO**
Management plans documented if risk identified?	
NB: If the woman requests transfer of care at any point to LWNC transfer MUST be arranged if it is safe to do so.	
Name and designation	**Signature**

Appendix 3 Caseload Midwifery Team Referral Form <u>Caseload Midwifery Team Referral Form</u>

Hospital Number .....DOB.....

First Name .....M / F.....

Last Name .....Religion.....

Address.....GP.....

.....

NHS Number .....

Contact Number…….

LMP/EDD…….

Referrer Details…….

Reason for Referral			
Severe diagnosed mental health problems. Recent psychotic episodes, schizophrenia, acute mental health, bipolar. History of attempted suicide or self-harm, depression diagnosed and treated by a health professional, under core of CMHT, not GP.		Safeguarding; Current children's social care involvement for complex issues, such as women in a refuge – family on a CP plan.	
Asylum seeker with complex health and social care issues		Teenager with complex issues	
Sexual Exploitation Trafficking		Diagnosed Learning Disabilities.	
Additional information		Problem Drug/Alcohol use.	

<u>Agencies Involved – please provide names and contact details</u>

……..

<u>Consider referral to</u>:

Single point of Access (mental health) 01282 6657116

Healthy Minds 01282 657268

Blackburn WISH Centre 01254260465

Burnley Womens Refuge 01282 414130

Pendle Womens Refuge 01282 661661

Children`s Social Care (where appropriate) 01254 666400 (BwD) / 03001236720(HRV)

Local Children`s Centre

Local Womens Centre

Louise Slater Midwife substance use team (BwD/HRV) 07711177293

Elizabeth Maddran Midwife substance use team (BPR) 07507839057

APPENDIX 4

Pathway for any disclosures made at the booking and 28 weeks antenatal appointment.

Mental Health →

Consider a referral to Perinatal Mental Health and Enhanced Midwifery Team, consent needed and follow Perinatal Mental Health pathway.

Domestic Abuse →

IF THE WOMAN IS IN IMMEDIATE DANGER

- Contact police 999 / 101
- Consider any dependents - * Think Family* - Where are they? Are they safe?
- Escalate to your manager and inform ELHT Safeguarding Team, and our Hospital Independent Domestic Violence Advisor (IDVA) - contact details below
- If risk within the department, contact security
- Consider admission
- Inform Children's Social Care

IF NO IMMEDIATE DANGER

- Ensure the woman feels safe to go home - * Think family,* are there any other dependents in the family home.
- Obtain consent from the woman for our Hospital IDVA to contact her. Obtain a safe time for the IDVA to contact the woman, a safe contact number and ask the woman to choose a 'safe word'.
- Refer to the hospital IDVA, contact details below IDVA will then assess risk, support and refer appropriately.
- Inform ELHT Safeguarding Team

Sexual Abuse

IF THE WOMAN IS IN IMMEDIATE DANGER

- Contact police 999 /101
- Consider any dependents - * Think Family* - Where are they? Are they safe?
- Escalate to your manager and inform ELHT Safeguarding Team, and our Hospital Independent Sexual Violence Advisor (ISVA) – contact details below
- If risk within the department, ring security
- Consider admission
- Inform Children's Social Care

IF NO IMMEDIATE DANGER

- Ensure the woman feels safe to go home - * Think family *, are there any other dependents in the family home.
- Obtain consent from the woman for our Hospital ISVA to contact her. Obtain a safe time to call, a safe contact number and please ask the woman to choose a 'safe word'.
- Then refer to the hospital ISVA by telephone and referral form. ISVA will then assess risk, support and refer appropriately.
- Inform ELHT Safeguarding Team

IF A FAMILY MEMBER REFUSES FOR THE WOMAN TO BE SEEN ALONE THIS IS A RED FLAG. CONTINUE WITH THE APPOINTMENT, INFORM THE SHIFT CO-ORDINATOR, SO THEY CAN SUPPORT AND A FOLLOW UP CALL TO ELHT SAFEGUARDING TEAM AFTER TO DISCUSS. NEVER USE FAMILY MEMBERS / FRIENDS TO TRANSLATE, PLEASE USE THE PREFERED METHOD ADVOCATED BY THE TRUST E.G. LANGUAGE LINE.
IF THE WOMAN DISLCOSES ANY OTHER INFORMATION SHE DOES NOT WANT TO DISCUSS IN FRONT OF HER PARTNER, IF THE WOMAN FEELS SAFE, OFFER ANOTHER ANTENATAL APPOITNMENT TO SEE THE WOMAN ALONE.

USEFUL CONTACT NUMBERS

POLICE – 999 / 101
ELHT SAFEGUARDING TEAM – 01282 803125
PERINATAL MENTAL HEALTH TEAM – 01282 804012
IDVA – 07899 682092 / 01254 732848 – email - safeguarding-adults_alerts@elht.nhs.uk
ISVA - 07584218596 / 01282 803125 – email - bfwh.isva.eastlancs@nhs.net