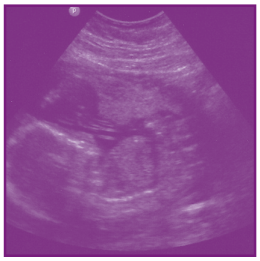
Pregnancy Information



Working in partnership with you

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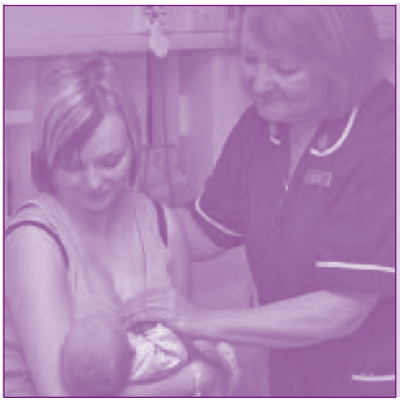


Philosophy of care

We aim to deliver high quality maternity care throughout pregnancy, birth and the postnatal period, ensuring that the birth of a child is a safe, life-enhancing experience for the woman, her partner and family.

We want women and their families to be involved in making choices about their journey through pregnancy, birth and parenthood, by giving good and timely information. We will respect their decisions and afford dignity through kind and compassionate care.

We promote normality in childbirth. Women can come straight to our midwives to access maternity care, will have a named midwife who will support them in their choice of place of birth, and then have one-to-one care in labour.

We aim to base our practice on the best available evidence. We strive continually to make every contact with women and families count towards improving their health and wellbeing.

What we offer - Maternity Services in Shropshire

Congratulations on your pregnancy! Every year around 5000 women give birth in Shropshire. We offer a caring and safe service, with a choice of where to have your care and where to have your baby.

We have Community Midwives at Centres all around the county, at Shrewsbury, Telford, Bridgnorth, Ludlow, Oswestry, Whitchurch and Market Drayton. All of these Centres offer antenatal and postnatal care. If you have a straightforward pregnancy you can have your baby in a Midwife Led Unit (at Shrewsbury, Telford, Bridgnorth, Ludlow or Oswestry). You also have the choice of giving birth at home, or in the Consultant Led Unit at the Shropshire Women and Children's Centre at the Princess Royal Hospital at Telford, although this Unit is primarily for women with more complicated pregnancies. For more information on these options please read the information below.

Our Midwife-led Units (MLUs)

Having a baby is one of the most important events in your life. The five Shropshire Midwife Led Units (MLUs) are able to offer you a place where you can feel comfortable, relaxed, confident and secure. You can contact the midwives at your local unit for advice and support during your pregnancy, when your labour is starting, and after you have your baby. It is also convenient for your friends and family to visit you when you've had your baby.

Four of our MLUs are freestanding, which means they are on a separate site from the nearest main hospital. Wrekin MLU is on the same site (Princess Royal Hospital, Telford) as the Consultant Led Delivery Suite. In MLUs experienced midwives take responsibility for your care during labour and support you to have a normal birth.

The Birthplace Study published in 2011 found that a planned birth in an MLU was just as safe as having a baby in an obstetric (doctor led) unit. This was true for women having a first baby as well as for those who had had a baby before.

Women who give birth on an MLU have less intervention in their labour and tend to report greater satisfaction with their birth.

Bridgnorth Midwife Led Unit

Tel:01746 711060

Bridgnorth is a stand-alone MLU in Bridgnorth Hospital. There is a birthing suite with a pool and a second birthing room. There are birthing balls, bean bags and mats available to help women stay active and comfortable in labour.

After birth you can stay in one of the two postnatal rooms, each with two beds and a TV, when staff can support you in feeding and caring for your baby.

Ludlow Midwife Led Unit
Tel: 01584 871120

Ludlow is a stand-alone MLU at Ludlow Community Hospital. There is a relaxed, friendly and homely atmosphere at this Unit. The staff aim to help you and your family experience the best possible start to parenting.

Shrewsbury Midwife Led Unit
Tel: 01743 261216

The Shrewsbury MLU is a stand alone unit in the Copthorne Building at the Royal Shrewsbury Hospital. The unit has recently been refurbished, with a new birth pool. CD players, birth balls, bean bag and mats are available, as active birthing is encouraged.
After birth you will stay in a four-bedded bay, or a single room may be available if you prefer. Staff will support you in feeding and caring for your baby.

If you have a low risk pregnancy, you can have your baby at any of our MLUs, even if it is not the one nearest to where you live. Please phone the MLU direct if you would like to go and see the unit. You can also come to any of our MLUs to have your baby if you live outside Shropshire.

Oswestry Midwife Led Unit
Tel: 01691 404579

The stand alone Oswestry MLU at the Robert Jones and Agnes Hunt Hospital, has two calm and relaxing birthing rooms, one with a large birthing pool. Postnatal care is in a 6 bedded area where you can forge friendships in a caring environment.

Wrekin Midwife Led Unit
Tel: 01952 641222 ext. 5706

Wrekin MLU is at the Princess Royal Hospital in Telford on the same site as the Consultant Led Unit. There are four homely birthing rooms, one with a water pool. After the birth staff will help you with the transition into motherhood in a quiet and friendly environment. Many women who have a straightforward birth on the Consultant Led Delivery Suite transfer here for their postnatal care.

Market Drayton and Whitchurch
Midwives at these community hospitals offer antenatal and postnatal care and a homebirth service.
Tel: 01630 650727 (Market Drayton)
Tel: 01948 660838 (Whitchurch)

Home birth service
For women with a straightforward pregnancy with no complications anticipated during the birth, there is the option of having a homebirth. Midwives are on call for you once you reach 37 weeks of pregnancy. A midwife will support you at home during your labour and a second midwife will join you for the birth of your baby.
You can have all forms of pain relief (including gas and air and pethidine) at home except for an epidural. You can also buy or hire a water pool for a water birth at home.

Now read our leaflet: 'Deciding where to have my baby' so that you can understand all the risks and benefits of the different options for place of birth and decide the best option for you.

Please note that in times of very high activity we may need to implement our escalation policy to ensure the safety of women and babies.

This can mean that you are not able to give birth in the unit of your choice, either because the unit is closed altogether or because staff have had to be redeployed to cover other areas.

If you are low risk, we can still offer you low risk care in our other units that remain open. It is likely that you will be able to transfer back to your unit of choice for postnatal care once the period of high activity is over.

At times when the escalation policy is implemented, we may have to ask women planning a home birth to attend one of our units instead, so that staff can be redeployed for the safety of the service.

Our Consultant-led Unit

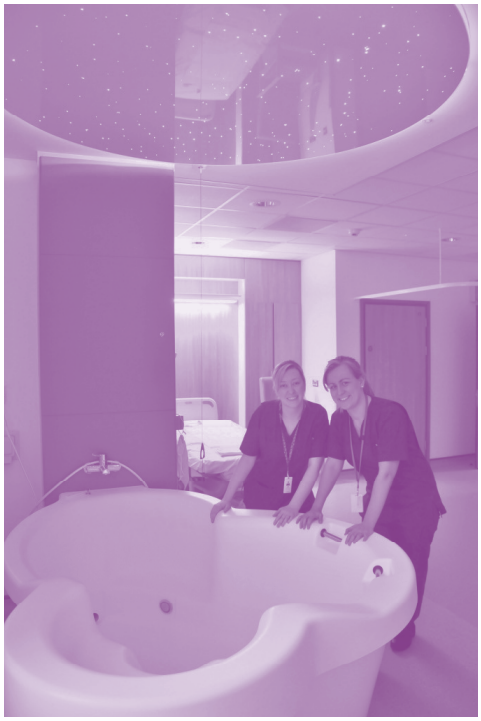
The Consultant Led Unit includes the Antenatal Ward, the Delivery Suite and the Postnatal Ward.

The Antenatal Ward

This ward offers inpatient antenatal care to women with medical and obstetric problems such as raised blood pressure or a low lying placenta. We regularly liaise with other specialities within the hospital and consultant teams from the medical and surgical centres visit as required. Induction of labour also takes place on this ward. There are six en suite side rooms and two spacious four-bedded bays which each have a dedicated shower room and separate toilet. **Please note that only one birth partner can stay on the word outside visiting times when a woman needs support.**

There is a TV monitor by each bed where patient information can be accessed, and a Pay TV system is available.

The Delivery Suite



Some women will be advised to give birth in the hospital Consultant Led Unit at the Shropshire Women and Children's Centre in Telford. This may be due to previous complications during pregnancy or birth or due to a pre¬existing medical condition. You may be at higher risk of developing complications during birth.

Our highly trained and experienced midwives will care for you with a team of obstetricians, anaesthetists and neonatologists if required.

The delivery suite has 13 en suite delivery rooms, one of which has a birthing pool. There are two dedicated obstetric operating theatres with an adjacent recovery area. Those with mobility problems can use the assisted bath/shower room.

The postnatal ward

This ward cares for women requiring consultant led postnatal care after normal and assisted deliveries. If your baby needs extra care after delivery, you will be looked after together under Transitional care (see page 9).

Most women only require consultant care for 24 - 48 hours after the birth. You can then transfer to a midwife led unit or home for the rest of your postnatal care.

The ward has 11 single en-suite rooms, three spacious four-bedded bays each with shower room and toilet. There is also a breast-milk kitchen, a room for baby care demonstrations, and other areas for staff. Women with mobility problems have an assisted bath/shower room. There is a TV monitor by each bed where patient information can be accessed, and a Pay TV system is available.

Security is important on all wards and visitors are requested to identify themselves via an intercom before being allowed access. There is also an electronic baby tagging system.

Please note that you will be able to stay on this ward for a few days if your baby is on the Neonatal Unit, but may have to leave when you are well if your bed is needed for women who have just given birth.

Additional facilities at the Consultant Led Unit

There are two rooms on the Unit for those who have suffered a loss. These rooms have double beds, en suite bathrooms and a kitchenette. There is also a counselling room where staff can speak to families affected.

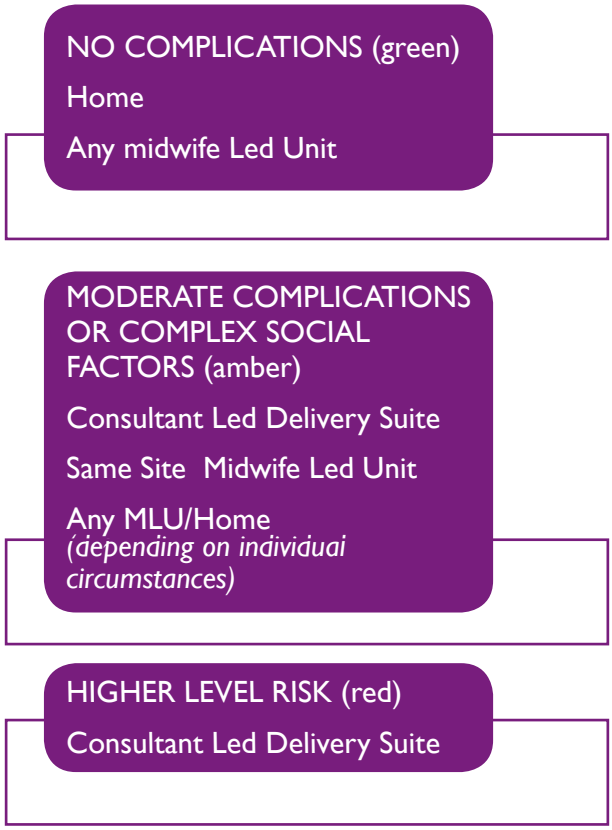
You can find a virtual tour of the Consultant Unit on our website at:
http://www.sath.nhs.uk/wards-services/az-services/maternity/

Deciding where to have your baby

It is really important that you know about the different options for where you can have your baby, what is available at each option, which options are suitable for you and the risks and benefits of having a baby in your chosen option.

Please read the section: What we offer: Shropshire Maternity Services which tells you where women can give birth in Shropshire.

The right choice for you*



This diagram shows the choice of place of birth in Shropshire and the options for women depending on their suitability

If you are low risk right up to the time you give birth, you can give birth at home or in a Midwife-led Unit (MLU).

If you are higher risk, you will be advised to give birth either on the same site MLU or on the Consultant-led Unit.

For some women it is safer to give birth on the Consultant-led Unit.

You can understand about how and why we assess risks for individual women by reading our leaflet: *Risks in pregnancy.*

Having a baby at home

For women with a straightforward pregnancy with no complications anticipated during the birth, there is the option of having a homebirth.

Is homebirth safe?

Giving birth is generally very safe for you and your baby. The 'Birthplace in England Research Programme' found that women having second or subsequent babies did not have any increase in poor outcomes for the baby compared to having their baby in a midwife-led unit or a consultant unit.

For women having their first babies, a small increased risk to the baby was found (9.3 per thousand births as compared to 5.3 per thousand), which means that 99.07% of first babies born at home have a normal outcome compared to 99.47% in hospital.

Benefits of homebirth

- You are more likely to have a normal vaginal birth with less intervention.
- You may fell more in control and better able to cope in a place you know with your family around you.
- You will be looked after by midwives in the comfort and relaxation of your own home.
- You may feel you will have more freedom to do as you wish rather than having to fit into a hospital routine.
- You may feel you will have more privacy.
- If you have other young children, there is no need to leave them to go into hospital.
- You won't have periods of separation from your partner and family after birth.

You can have all forms of pain relief (including gas and air and pethidine) at home except for an epidural. If you are considering a water birth at home please discuss this with your midwife or Midwifery Advocate and see our leaflet, *Water labour and birth.*

Risks of homebirth

- For women having their first babies, a small increased risk to the baby was found (9.3 per thousand births as compared to 5.3 per thousand), which means that 99.07% of first babies born at home have a normal outcome compared to 99.47% in hospital.

- You may have to transfer to the Delivery Suite in Telford should problems arise. The most common reasons for transferring to hospital are where your labour does not progress as well as expected or if there is concern about you and/ or the baby. Some women may wish to go into hospital for an epidural during labour.

- If you need to transfer to the Delivery Suite in Telford an ambulance will be arranged for transport.

The Birthplace in England study (2011) found that 45% of first time mothers were transferred from home to hospital in labour, and 12% of women who had had a baby before. You are more likely to be transferred if you are having your first baby because first labours tend to be longer.

If you are considering a home birth, talk to your midwife who will be able to give you a leaflet: *Why choose a home birth?*

Please note that it is illegal for any person to deliver a baby other than a registered midwife or medical practitioner, or student midwife or medical student who is being supervised by a midwife or doctor, unless in an emergency.

Having a baby at a Midwife-led Unit (MLU)

Research shows that women with straightforward pregnancies and no complications have no increased risk if they decide to give birth at a Midwife-led Unit than if they choose to give birth in a Consultant-led Unit. This applies to first time mothers and to those who have had a baby before.

Who cares for you on an MLU?

The Midwife Led Units are run by experienced midwives who undertake regular updating, training and drills so that they are able to manage any emergency situation, however rare. They are available 24 hours a day and will be able to give you all the support you need during your pregnancy, labour and the early days with your baby. The midwives are supported by experienced Maternity Support Workers at the MLUs.

There are no doctors on site, but Midwives have 24 hour access to our Consultants and can discuss and refer any problems that arise during pregnancy or labour. The MLU at Telford is on the same site as the Consultant-led Delivery Suite.

Facilities for birth

We encourage mobility during birth, and have birthing balls and floor mats, as well as adjustable beds, to help you find the most comfortable positions at different stages in your labour. TENS, Entonox (gas and air) and pethidine (injection) are available for pain relief in all units, and all the MLUs offer the increasingly popular option of having a water birth.

Benefits of an MLU birth

Research has shown that women supported only by midwives in labour:

- Need less pain relief

- Are more likely to have a normal vaginal birth with less intervention

- Are more satisfied with their experience of birth than women giving birth in Consultant-led units

- Are more able to be active during labour, which helps with coping with pain and can promote the progress of labour

Disadvantages of an MLU birth

- You may have to transfer to the Consultant-led Delivery Suite in Telford should problems arise. The most common reasons for transferring are where your labour does not progress as well as expected or if there is concern about you and/ or the baby. Some women may wish to go the Delivery Suite for an epidural during labour. You are more likely to be transferred if you are having your first baby because first labours tend to be longer.

- If you need to transfer to hospital an ambulance will be arranged for transport.

Transfers from freestanding units usually take place by ambulance. From a recent audit, average transfer times, including time taken for the ambulance to arrive and for you to be secured and ready to travel, are:

• Bridgnorth	68 minutes
• Ludlow	83 minutes
• Oswestry	87 minutes
• Shrewsbury	50 minutes
• Wrekin	5 minutes by chair or bed

All babies were born in good condition. All were vaginal deliveries and the majority were due to delay in the first or second stages of labour.

Women who need to be transferred from Newtown or Welshpool in Powys have an approximate ambulance transfer time of 80 minutes and 50 minutes, respectively, plus time for arrival and making ready for transport.

NICE guidelines advice maternity services to inform women that if something goes seriously wrong during your labour (which is rare) it could be worse for you and your baby than if you were in a hospital with access to specialised care.

If you have a low risk pregnancy, you can have your baby at any of our MLUs, even if it is not the one nearest to where you live. Please phone the MLU direct if you would like to go and see the unit. You can also come to any of our MLUs to have your baby if you live outside Shropshire.

Having a baby on the Consultant-led Delivery Suite

Some women will be advised to give birth in the hospital Consultant Led Unit at the Shropshire Women and Children's Centre in Telford. This may be due to previous complications during pregnancy or birth or due to a pre-existing medical condition. You may be at higher risk of developing complications during birth.

Our highly trained and experienced midwives will care for you with a team of obstetricians, anaesthetists and neonatologists if required.

If you have any problems during labour, obstetric and neonatal teams are available 24 hours a day on site. If you require regional (epidural or spinal) or general anaesthesia, anaesthetists are available on the delivery suite, and will attend according to the urgency. There are two operating theatres on the Delivery Suite used for planned and emergency caesarean sections, some assisted births (forceps and ventouse) and for other procedures such removal of a placenta if it does not separate after the birth.

You can read more about operative and assisted births in other leaflets:

- *Elective (planned) caesarean section*
- *Emergency caesarean section*
- *Operative vaginal birth (forceps and ventouse)*
- *Epidural anaesthesia*

Advantages of birth on the Delivery Suite

- Direct access to obstetricians, anaesthetists and neonatologists (special care baby doctors)
- The option of having an epidural for pain relief. An epidural is a special type of local anaesthetic given into your back which can numb the feelings of pain. It needs to be given on this unit as it involves an anaesthetist and means you have to be closely monitored during your labour.
- You will not need to transfer if there are problems during the labour.

Disadvantages of birth on the Delivery Suite

Research has shown that

- You may need more pain relief
- You are less likely to feel in control
- You are more likely to have interventions during the birth such as a drip and be continuously monitored
- You are more likely to need an operative birth
- You may be further from your home, depending on where you live.
- You may be less satisfied with your experience of birth

You may want to read:

1. http://www.npeu.ox.ac.uk/birthplace
This document gives you information about the best place to have your baby based on best current evidence.

2. NICE 2017 . Intrapartum care: care of healthy women and their babies during childbirth. www.nice.org.uk

Please note that in times of very high activity we may to implement our escalation policy to ensure the safety of women and babies.

This can mean that you are not able to give birth in the unit of your choice, either because the unit is closed altogether or because staff have had to be redeployed to cover other areas.

If you are low risk, we can still offer you low risk care in our other units that remain open. It is likely that you will be able to transfer back to your unit of choice for postnatal care once the period of high activity is over.

Philosophy of care

Neonatal Care is a profession based on a caring relationship. It is both an art and a science based on knowledge, skills and attitudes.

Inherent in neonatal care is sensitivity, empathy and respect for individual wishes, cultures and customs of people in order to provide holistic family-centred care in a secure and welcoming environment.

It is a dynamic process, which is responsive to the changing needs of society and evolves through the application of study and research in neonatal care.

Neonatal Services

About 1in10 babies need to be admitted to a neonatal unit after they are born. The care needed varies from a few hours of observation to those that need a lot of support and intensive observation (High Dependency Care). If you know your baby is likely to need special care, you will have the opportunity to meet staff and visit the unit before the birth.

At the Shropshire Women and Children's Centre, we have a Neonatal Unit that provides Special and High Dependency care for all babies and Intensive Care for all but extremely premature (under 27 weeks' gestation) or extremely sick babies. We have 22 cots, of which six are intensive care/high dependency. As the babies become less medically dependent, they are moved to areas where their care is less intensive, and then to a bay where they can be prepared for going home. We also have rooms reserved for parents/carers to stay in with their baby for one or more nights just before taking baby home.

The Staffordshire, Shropshire & Black Country Newborn Network

Local Neonatal Unit:	• Walsall Manor Hospital • Russells Hall Hospital, Dudley • Shropshire Women and Children's Centre
These hospitals provide Special and High Dependency care for all babies and a range of short term Intensive Care for all but the most extremely premature or extremely sick babies.	
Neonatal Intensive Care Unit:	• New Cross Hospital, Wolverhampton • University Hospital of North Staffordshire, Stoke on Trent
These hospitals provide the full range of Special, High Dependency and Intensive care for all babies.	
Surgical Care: Babies needing surgical or other specialist care not available in our network will be transferred to *the nearest hospital with an available space*. Birmingham Children's Hospital provides care for the majority of our babies, Alder Hey Children's Hospital, Liverpool, provides care for some babies in the North of our network.	

For more information visit www.networks.nhs.uk-nhs-networks-staffordshire-shropshire-and-black-country-newborn

Transitional Care

Your baby may need additional care if he or she was born between 35 weeks and 36 weeks and 6 days or weighs between 1.8 kg and 2.5 kg at birth or you have a medical condition such as diabetes or gestational diabetes.

Here, your baby will receive extra care without the need to go to the Neonatal Unit and therefore will stay with you on the Postnatal Ward. Most babies are able to go home from Transitional Care once they can maintain their own temperature and are feeding well.

Transfer out to another hospital

If your baby requires specialist support or intervention, and the Neonatal Unit is full, he or she will be transferred to the nearest suitable hospital with available space. Your baby may also be transferred for intensive care if born under 27 weeks or if needing prolonged ventilation or cooling.

You may also be transferred before your baby is born to another hospital if our Neonatal Unit is full. This can happen, for example, if you go into premature labour, or your baby needs to be delivered early for the safety of you and/or your baby.

The Neonatal Unit at the Shropshire Women Children's Centre is part of the Staffordshire, Shropshire and Black Country Newborn Network, with Walsall Manor, Russells Hall (Dudley), New Cross (Wolverhampton), and North Staffordshire (Stoke on Trent).

Babies requiring the most specialised support or intervention will usually go to The Birmingham Children's Hospital, or Alder Hey Children's Hospital, Liverpool (see website addresses on p. 59).

Where possible, we will transfer you/your baby to one of these hospitals. Sometimes, however, they are full, and we have to transfer to hospitals further away.

All transfers will be discussed and planned with you.

Transfers back closer to home

Once your baby is well enough, transfer to a hospital in the Network closer to home will be arranged once a cot becomes available.

Community

Our Neonatal Outreach Team supports:

- highly vulnerable babies - discharge weight less than 1.8 kg
- special healthcare needs - neonatal abstinence syndrome requiring medications
- technology-dependent babies - home oxygen therapy; tube/gastrostomy feeding
- vulnerable background - teenage inexperienced mothers.

Your pregnancy at a glance

0-8 weeks

- *Congratulations!!* Once you realise you're pregnant you can come straight to midwifery care by phoning 01743 261085 or texting your details to 07797 800025. We can let your GP practice know about your pregnancy.
- Some women start to feel sick or tired around this time – eat small, frequent meals and rest more.
- Take a folic acid supplement (400mcg) and try to eat a balanced diet.
- Ask your GP for a prescription for Vitamin D.

8-10 weeks

- By 10 weeks you should attend your first antenatal appointment with a midwife often called your 'booking' visit. This can be in one of Shropshire's Midwife Led Units, or a local Children's Centre.
- Get a Maternity Exemption Certificate (FW8) from your midwife or doctor. This entitles you to free prescriptions from confirmation of your pregnancy until a year after the baby is born.
- Healthy Start vouchers are available to pregnant women who are on certain benefits. All pregnant women under the age of 18 qualify for Healthy Start vouchers - whether or not they are on benefits. Vouchers can be exchanged for milk, fresh fruit and vegetables (www.healthystart.nhs.uk).
- You will be offered blood tests to check your blood group, your iron levels and to check if you have any other infections which could affect the baby. If you are under 25 years old, your midwife will offer you Chlamydia screening.
- Chromosomal abnormality Screening will be discussed and the choices available to you explained.

11-14 weeks

- You will be offered a first trimester pregnancy scan from 11 weeks. Your partner may like to see this too and it may be possible to buy a photograph of the scan.
- Chromosomal abnormality screening may be offered at the time of this scan (combined test).
- If you've been feeling sick and tired in the early weeks, you will probably start to feel better around this time.

14 weeks and 2 days to 20 weeks

- Down's syndrome screening may be offered if screening was not done at your first trimester pregnancy scan (Quad blood test).

16-20 weeks

- You may start to feel your baby move
- You can listen to the baby's heartbeat at your antenatal appointment from 20 weeks.
- Ask your midwife about Birthing and Parenting classes in your area.

18 weeks and 6 days to 20 weeks and 6 days

- You will be offered a mid pregnancy fetal anomaly ultrasound scan.

24 -28 weeks

- Your midwife may offer you a home visit. This can be an opportunity to discuss any problems or concerns in more detail with your midwife. You will also be asked questions about your feelings in pregnancy. Breastfeeding and your baby's movements will be discussed. If you have any social needs, your midwife can refer you to a Children's Centre for support.
- Your midwife or doctor can give you your certificate of pregnancy form for your employers (Mat B1).

28-32 weeks

- You will be offered blood tests to check your iron and antibody levels and also Anti-D if your blood type is Rhesus negative.
- Make arrangements to have your whooping cough vaccination

32-36 weeks

- Make arrangements for the birth, in hospital or at home. If you have children arrange who will look after them when you are in labour
- Pack your bag ready for the hospital.
- You may be more aware of your uterus tightening from time to time. These are mild contractions (Braxton-Hicks).
- You will be offered a blood test to check your iron levels.

37 weeks onwards

- Your midwife will deliver the home birth packs at 37 weeks if you are having a home birth
- Make sure you have all important telephone numbers handy in case labour starts.
- Telephone your midwife or hospital if you have any worries about labour or the birth.

40 weeks onwards

- You will be offered a membrane sweep to try to stimulate labour (from 40 weeks first baby; from 41 weeks otherwise).
- You may be offered a date for induction of labour or additional monitoring if you choose not to be induced.

Antenatal Care

WORKING IN PARTNERSHIP WITH YOU

Are you having a straightforward pregnancy?
Has your risk changed since your last appointment?
Have you asked: 'Can I have my baby at a Midwife Led Unit?'

We do a risk assessment each time we see you. Your risk can be low, medium or high. Please discuss this with your midwife or doctor at every visit.

Throughout your pregnancy you will need to arrange regular appointments with your midwife or GP. A list of routine antenatal visits can be seen in your Pregnancy Health Record but your care will be designed around your individual needs. These appointments are to check that you and your baby are well and that any problems can be picked up as early as possible. Please be aware that you are welcome to ask for a second opinion at any time.

Easier access to antenatal care

Shrewsbury and Telford Hospital NHS Trust are promoting easier access for women to their local maternity services. Women can be seen by midwives at their local Midwife Led Units, their GP surgeries, in their own homes or in a different Midwife Led Unit, if that option is more convenient for you. You can also see a midwife in a Children's Centre where appropriate; please ask your midwife for details. Children's Centres offer a variety of services including information and advice to parents/carers, family drop in sessions, early learning and childcare, links with other services and family support.

Use of hospital transport

Most people can come to hospital in their own transport, or can ask friends or relatives to bring them. If you have to use public transport, and you are on low income and in receipt of certain benefits, you may be eligible to claim these costs back. Please ask for form HC5 or download from www.nhs.uk/NHSEngland/Healthcosts/Documents/2012/HC5(T)-april-2012.pdf

If you have mobility problems you may be eligible to use non-emergency patient transport.

Your first antenatal visit

It is really important that you see a midwife early in your pregnancy. Women have their first and longest antenatal appointment between 8 and 12 weeks of pregnancy with their midwife, but you can contact us before this. This is called the 'initial consultation' although it is often known as the 'booking' visit and involves questions about your health, any illnesses or previous pregnancies. It is very important that you tell us about previous obstetric and medical problems, any medication you are taking and any allergies you have. This helps us to see if what pathway of care you need during your pregnancy. Information and time for discussion about screening are important so that you can make informed decisions. Please remember there are also lots of opportunities for you to ask questions.

A printout of your 'Key indicators' and 'History' will be filed in your Pregnancy Health Record at this appointment. Please check that there is nothing missing or incorrect on these documents.

Your named midwife

You will have a 'named midwife' and be given her contact details if you have any queries or concerns. Sometimes you may not be able to contact your midwife that day because she works part-time, is on holiday or at a home birth. Please don't worry, another midwife covering her work will be able to talk to you and offer help.

How many appointments will I need?

For a woman who is pregnant for the first time and has a straightforward pregnancy, the National Institute for Health and Clinical Excellence (NICE) Antenatal Care guideline recommends 10 antenatal appointments for those who have not had a baby before and 7 for women who are having their second or subsequent babies. If you have an uncomplicated pregnancy, you can be cared for throughout by your midwife and GP.

If you have any complications, you may need consultant care and extra appointments.

It is your responsibility to ensure you have antenatal appointments and your mid pregnancy fetal anomaly scan at the recommended times (see Schedules for antenatal care in your Pregnancy Health Record).

What does having a complicated pregnancy mean?

Complications may relate to the current pregnancy or previous pregnancies, or to a medical condition not related to pregnancy. Women with complex social needs may also be cared for under this pathway.

Your midwife will be able to discuss whether your pregnancy is straightforward (low risk) or complicated (higher risk). If you have a complicated pregnancy you will be seen more frequently and you may be referred to a hospital antenatal clinic with your care shared between your obstetrician, specialist teams and your community midwife. Once you have agreed the pattern of your care with your community midwife, she will let you know how to arrange these appointments.

People involved in your care

- Midwives: provide care and support throughout pregnancy, birth and in the early days after your baby is born.
- Healthcare assistants: support midwives in their role.
- General practitioners (GPs): doctors who work in the community, providing all aspects of care for you and your family.
- Obstetricians: doctors who specialise in the care of women in pregnancy and childbirth. Consultants are the lead obstetricians, and have other grades of doctors working with them.
- Specialists: some women with specific conditions, such as diabetes or mental health issues, may need referral to a specialist for additional care.

Feedback

Please help us to continually improve our service by completing outpatient surveys and Friends and Family Cards. Please ask for these if they are not offered to you.

Importance of Antenatal Care

Regular antenatal care is important for the health of you and your baby.

Please keep all antenatal appointments or, if you have to cancel or rearrange, please tell us as soon as possible so we can give the appointment to someone else.

Please help us to help you by:

- Arranging your own antenatal appointments
- Bringing your Pregnancy Health Record with you
- Bringing a urine sample with you - your midwife or doctor will provide you with a sample bottle

During an antenatal assessment the health of you and your baby is checked by

- Testing your urine
- Measuring your blood pressure
- Measuring your abdomen at every visit from 26-28 weeks to make sure your baby is growing well
- Listening to your baby's heart beat from 20 weeks onwards
- Testing your blood, with your consent, at your first visit with the midwife and at 28 and 34 weeks.
- Discussing any concerns you may have
- Asking if your baby has been moving well (from about 24 weeks)

Further explanations of these tests are contained in this booklet. These checks will be recorded in your Pregnancy Health Record. If abbreviations have been used, your Pregnancy Health Record contains a list of abbreviations and their meanings (inside back cover).

Please do not rely on the use of 'personal dopplers' for reassurance about your baby's wellbeing. Contact your midwife if you have any concerns.

Sometimes, especially during early pregnancy, it can feel a long time between antenatal appointments. If you experience bleeding or pain please contact your midwife or GP. If necessary, you will be referred to your nearest Early Pregnancy Assessment Unit.

Early Pregnancy Assessment Service (EPAS)

All women with bleeding and/or pain in early pregnancy (up to 16 weeks) can be seen in EPAS. EPAS provides a service whereby women are seen to assess the viability of the pregnancy and provide individual care and support. EPAS operates at both the Royal Shrewsbury Hospital and the Shropshire Women and Children's Centre at the Princess Royal Hospital.

Appointments are made initially by your midwife or GP and EPAS aims to see women within 48 hours.

Shropshire Women and Children's Centre, Telford.

Opens 7 days a week
Monday – Friday 8.30 am to 12.30 pm
Saturday, Sunday (except Christmas and New Year) 8.30 am to 12.30 pm.
Tel - 01952 565944 (At other times contact the Gynaecology Ward on 01952 565914)

Royal Shrewsbury Hospital (RSH)

Monday – Friday 8.30 am to 4 pm
Tel – 01743 261204
Out of hours – urgent appointments can be made via Gynaecology Ward at the Shropshire Women and Children's Centre, Telford on 01952 565914.

If you have severe pain or a lot of bleeding, contact the emergency services, 999.

Triage and Day Assessment Units

Often your local midwives can assess you initially if you have any concerns (contact numbers on back cover. Sometimes you will be referred to our Triage Service if you are experiencing any complications of pregnancy *after 16 weeks*, including reduced movements of your baby, vaginal bleeding or abdominal pain. You can ring the Triage Unit direct on **01952 565948.** Your local Day Assessment Unit operates on *an appointment system only* for planned procedures such as glucose tolerance tests or fetal monitoring.
Phone numbers for the Day Assessment Units are:

Telford (adjacent to Wrekin MLU)	01952 565704
Shrewsbury (within Shrewsbury MLU)	01743 261216

At times when the Triage Unit is closed, you will be referred to the Consultant Led Unit at Telford (01952 565924).

Keeping you and your baby healthy

This section describes some of the things you should think about to make sure you and your baby stay healthy during pregnancy.

What should you eat?

A healthy diet is an important part of a healthy lifestyle at any time, but particularly if you are pregnant or planning a pregnancy. Eating healthily during pregnancy will help your baby to develop and grow and will help keep you fit and well. Make sure you eat a variety of different foods every day in order to get the right balance of nutrients that you and your baby need.

- Eat plenty of fruit and vegetables and aim for at least five portions a day. Pure fruit juice can only count once towards the 5 a day.
- Starchy foods like bread, potatoes, rice, pasta, chapatis, yams and breakfast cereals are an important part of any diet. They contain important vitamins and fibre. Try eating wholemeal bread and cereals when you can.
- Lean meat, fish, poultry, eggs, cheese, beans and pulses are good sources of nutrients.
- Dairy foods like milk, cheese and yoghurt contain calcium and other nutrients needed for your baby's development. Choose low fat varieties wherever possible.
- Try to cut down on sugar and sugary foods – sugar contains calories without providing any other nutrients.
- Cut down on fat and fatty foods as well. Fat is very high in calories and can contribute to weight gain and increase the risk of heart disease. Avoid fried foods and go easy on foods like pastry, chocolate and chips which contain a lot of fat.
- Citrus fruit, tomatoes, broccoli and potatoes are good sources of vitamin C which you need to help you to absorb iron.
- Fish contains the important Omega 3 essential fatty acids which are needed for a baby's development and is also a rich source of vitamin B12.

Take care with some foods

There are certain precautions you should take in order to safeguard your baby's well-being as well as your own. Make sure you wash your hands before preparing any food.

- Drink only pasteurised or UHT milk which has had harmful germs destroyed. Don't drink unpasteurised goat's or sheep's milk or eat their milk products
- Avoid uncooked or undercooked ready-prepared meals and uncooked or cured meat, such as salami
- Don't eat liver or liver products such as liver sausage as they may contain high amounts of vitamin A which could harm your baby. Avoid high dose multivitamin supplements, cod liver oil supplements or any supplements containing vitamin A
- Listeria is very rare but it is important to take precautions as an infection during pregnancy can lead to miscarriage, stillbirth or severe illness in the newborn:
  - Avoid eating all types of pâté including vegetable
  - Avoid mould-ripened soft cheese like Brie or Camembert
  - Avoid blue-veined cheese such as Stilton or Shropshire Blue
  - Ensure the temperature of your fridge is below 5 degrees centigrade
- You can eat hard cheeses such as Cheddar and parmesan, even if they are made from unpasteurised milk, and other cheeses made from pasteurised milk such as cottage cheese, mozzarella and processed cheese, feta, cream cheese and cheese spreads
- Make sure you cook eggs well until the whites and yolks are solid to avoid the risk of salmonella food poisoning. Do not have raw or partially cooked eggs such as soft boiled eggs. Mayonnaise bought in a jar is fine as it's made from pasteurised (heat-treated) eggs
- Do not eat rare meat. Make sure all meat and poultry is well cooked so that there is no trace of pinkness or blood, to avoid the risk of toxoplasmosis. Make sure all surfaces are cleaned well after preparing raw meat

- Avoid soft-whipped ice-cream from kiosks or vans as it may contain salmonella or other bacteria which can cause food poisoning
- Avoid eating shark, marlin and swordfish as these types of fish contain high levels of methylmercury which can damage your baby's nervous system. Also try not to eat more than 4 medium size cans or 2 portions of fresh tuna steak per week
- Don't have more than 2 portions of oily fish a week. Oily fish includes fresh tuna (not canned tuna, which does not count as oily fish), mackerel, sardines, salmon and trout
- Choose cooked shellfish rather than raw as raw shellfish (e.g. oysters) could contain harmful bacteria that can cause food poisoning. Sushi can be eaten if the fish has been previously frozen or cooked
- Wash all your fresh fruit and vegetables
- Unless you are allergic to peanuts you can choose to eat peanuts or foods containing peanuts (such as peanut butter) when you're pregnant

Anaemia in pregnancy

Iron is essential for the production of haemoglobin, which helps store and carry oxygen in red blood cells. When there is not enough iron, your blood cells will carry less oxygen around your body to your organs and tissues. This condition is called anaemia.

During pregnancy it is normal for your haemoglobin (Hb) levels to be lower than when you are not pregnant, but if they fall too low you may look pale and feel tired, have shortness of breath and feel faint. Your Hb levels are normally checked at booking and when you are 28 and 34 weeks pregnant.

If your Hb level is below 110 g/l or your iron store levels (ferritin) are low, you may be advised to take iron supplements. Iron supplements will turn your stools black and some women find they cause digestive problems such as nausea, diarrhoea or constipation. If the iron supplements give you discomfort, please talk to your midwife who may suggest different dosages or different iron supplements.

It's also important to make sure that your diet contains iron-rich food such as those listed below.

- Dark green leafy vegetables such as spinach, broccoli, cabbage and watercress
- Lean meat – especially red meat. Avoid liver and liver products as they contain high levels of vitamin A which could harm your baby (see p. 12)
- Fish, particularly oily fish, including canned (such as mackerel, sardines and pilchards)
- Eggs
- Pulses – such as chick peas, canned baked beans and lentils
- Bread, especially wholemeal
- Dried fruit such as apricots, prunes and raisins
- Cereals fortified with iron

Vitamin C helps the body to absorb iron, so to get the most from the food you eat, have vitamin C rich foods with meals; e.g., fresh vegetables or fruit or drinks such as fresh orange juice. Tea may reduce absorption of iron from foods so avoid drinking tea directly before, during and after meals.

Vitamin D

It's important that you get enough vitamin D during your pregnancy and while you are breastfeeding. You are at greater risk of having lower levels of vitamin D if:

- Your family origin is South Asian, African, Caribbean or Middle Eastern
- You stay indoors for a good deal of time and if you usually cover your skin when outdoors
- You have a diet that is low in vitamin D
- Your pre-pregnancy body mass index (BMI) is 30 kg/m^2 or more

The best source of vitamin D is sunlight but having a vitamin D rich diet also helps – oily fish, eggs, meat and fortified cereals and margarine. The Department of Health recommends that all pregnant take a vitamin D supplement (10 micrograms a day) to ensure you get enough vitamin D. Your GP can prescribe this.

Folic acid

From the time you stop using contraception and for the first 12 weeks of pregnancy, it's recommended that you take a supplement of 400mcg (0.4 mg) of folic acid each day (available from any chemist and some supermarkets) as well as eating plenty of folate-rich foods such as green leafy vegetables, pulses and fortified breakfast cereals. This is to help prevent neural tube defects such as spina bifida. Current national guidelines recommend that you take a higher level of 5 mg of folic acid if your BMI is 30 kg/m^2 or more, you have epilepsy or you have a previous history of Spina bifida. You may also be prescribed the higher dose if you are taking certain medication for mental health problems.

Other sources of information:
www.healthystart.nhs.uk
www.nhs.uk/conditions/pregnancy-and-baby/pages/healthy-pregnancy-diet

Caffeine and alcohol

Limit your intake of caffeine to 200mg per day. The amount of caffeine in different foods and drinks is approximately:

1 mug instant coffee 100 mg
1 mug filter coffee 140 mg
1 mug tea 75 mg
1 can cola 40 mg
1 can energy drink 80 mg
50 g bar of dark chocolate 50 mg
50 g bar of milk chocolate 25 mg

The Department of Health recommends that pregnant women should avoid alcohol altogether as experts are unsure exactly how much is safe. If you do choose to drink, the Royal College of Obstetricians and Gynaecologists recommends you should not drink more than one or two 'units' of alcohol once or twice a week.

1 UK unit of alcohol is 10ml, or 8g of pure alcohol.

A unit is:

½ a standard (175ml) glass of wine at 11.5% ABV or

½ a pint of ordinary strength beer, cider or lager at 3.5% ABV or

a single measure (25ml) of spirits (whisky, gin, bacardi, vodka etc) at 40% ABV

Alcohol reaches your baby through the placenta and because your baby cannot process alcohol as fast as you do, your baby is exposed to alcohol for a longer period of time. Too much alcohol can harm your baby's development and in excessive cases the baby may have physical and mental problems known as Fetal Alcohol Syndrome. Binge drinking (drinking more than 5 units of alcohol in one session) is especially harmful.

If you have difficulty in reducing your alcohol intake, a referral can be made to a Substance Misuse midwife (see p. 16), who can provide additional help and support.

(See also http://www.nhs.uk/conditions/pregnancy-and-baby/pages/alcohol.)

Latex allergy

Increased exposure to natural latex has resulted in rising numbers of people with an allergy to latex (rubber). This can show itself in two ways. Some people are allergic to the protein in latex, resulting in sensitivity to products which have an elastic consistency, e.g. balloons, rubber gloves, condoms etc. Other people have an allergy to the products used in the manufacturing process.

The degree of allergic reaction can vary. Some people may have a mild reaction:

- Irritable eyes
- Itchy rash
- Sneezing and runny nose
- Wheezing

Some people can have a severe allergic reaction known as Anaphylaxis.

During the first visit with your midwife a questionnaire is offered which will help to identify any risk in relation to latex. If this risk is considered high, your midwife can provide additional information and appropriate care can then be planned.

Dealing with current uncertainty about the risks posed by environmental chemicals (from RCOG Scientific Impact Paper No. 37)

Under normal lifestyle and dietary conditions, the level of exposure of most women to individual environmental chemicals will probably pose minimal risk to the developing fetus/baby. However, women who are pregnant are exposed to hundreds of chemicals at a low level. On present evidence, it is impossible to assess the risk, if any, of such exposures. The following steps would however reduce overall chemical exposure:

- use fresh food rather than processed foods whenever possible
- reduce use of foods/beverages in cans/plastic containers, including their use for food storage
- minimise the use of personal care products such as moisturisers, cosmetics, shower gels and fragrances
- minimise the purchase of newly produced household furniture, fabrics, non–stick frying pans and cars whilst pregnant/breastfeeding
- avoid the use of garden/household/pet pesticides or fungicides (such as fly sprays or strips, rose sprays, flea powders)
- avoid paint fumes
- only take over–the–counter analgesics or painkillers when necessary
- do not assume safety of products based on the absence of 'harmful' chemicals in their ingredients list, or the tag 'natural' (herbal or otherwise).

It is unlikely that any of these exposures are truly harmful for most babies, but these steps will reduce environmental chemical exposures.

Female genital mutilation (FGM)

FGM is the mutilation of the external female genitalia for non-medical reasons. It is a serious criminal offence in the UK, with a maximum prison sentence of 14 years.

It is still a crime if a UK national or UK resident carries out FGM abroad or assists or encourages someone to do it abroad.

Anyone found guilty of failing to protect a girl from risk of FGM can receive up to 7 years in prison or a fine or both.

NSPCC FGM Helpline 0800 028 3550

Childline 0800 1111
www.childline.org

Keeping you and your baby safe

There are some lifestyle issues that pose a threat to the safety of you and your baby. Help and extra care is available, so please don't be worried or embarrassed about discussing these issues with a health professional.

Breast implants

Please tell your midwife if you have breast implants. If you have PIP implants, you may need referral to a Consultant Breast Surgeon.

Obesity

When you are pregnant, your GP or midwife will work out your Body Mass Index (BMI) from your height and weight measurements at your first visit. This information will be recorded in your notes and used to help guide and plan your care.

If your BMI is 30 and above you fall into a category of women who are at greater risk in pregnancy than the general population. You will be offered specialist advice and guidance.

The risks associated with being overweight increase with increasing BMI.

If you have a high BMI you are at greater risk of:

- Developing high blood pressure
- Developing pre-eclampsia (a condition that occurs in pregnancy, usually associated with high blood pressure and protein in the urine)
- Developing diabetes during pregnancy (problems with blood sugar control)
- Blood clotting problems (thrombosis)
- Infections of the urinary tract and the vagina and uterus

In labour you are more likely to:

- have a forceps or ventouse birth
- have a caesarean section
- have shoulder dystocia (where the baby's shoulders get stuck during the birth)
- have heavy bleeding after the baby is born
- have an infection in a wound, or in your vagina or uterus
- have pressure sores

Your baby is more at risk of

- Having birth defects
- Being stillborn
- Being overweight later in life

It may be more difficult to monitor your baby's growth and development using ultrasound scanning.

Please ask for our leaflet: 'Information for pregnant women with a body mass index (BMI) of 35 or above'.

The normal weight gain in pregnancy is between 9 and 16 kilograms, with an average of 12.5 kilograms.

Weight loss surgery

You can have a safe, healthy pregnancy following weight loss surgery, but you are recommended to wait 12 - 18 months after the operation before you become pregnant.

If you have had a gastric band, it is recommended that it is emptied during pregnancy.

During your pregnancy, you will follow the care pathway for complicated pregnancies, which means you will be under the care of a consultant.

At the beginning of your pregnancy, start taking a pregnancy-specific vitamin and mineral supplement rather than your usual supplement.

If you have had a gastric bypass, we do not recommend you have a glucose tolerance test to check for gestational diabetes. Instead, we would check your blood sugar levels before and after meals if this was necessary.

Substance misuse

The Shropshire Recovery Partnership offers a range of services for people who have problems with drugs or alcohol. The team is based at Crown House, St Mary's Street, in Shrewsbury. If you are pregnant you will get a priority appointment with the team. You can phone 01743 294 700 or drop into the office between 09.00am and 5pm Tuesday-Thursday (not between 12.00 and 2pm). There are satellite offices in Bridgnorth, Ludlow, Oswestry, Wem and Whitchurch; phone the single point of contact number: 01743 294 700.

The Telford and Wrekin Community Substance Misuse Team is based at Portico House, 22 Vineyard Road, Wellington; phone 01952 381777.

It's ok to ask for help and the teams want to be able to give the best care to you and your baby helping you to stabilise, stop or reduce your use.

What are the risks for you and your baby?

- Alcohol
  Too much alcohol can harm your baby's development and in excessive cases the baby may have physical and mental problems known as Fetal Alcohol Syndrome. Binge drinking (drinking more than 5 units of alcohol in one session) is especially harmful.
- Benzodiazepines (Valium)
  Use may increase the risk of abnormalities and cause withdrawal in the baby. You will need medical help to reduce or change from these drugs safely.
- Heroin and opiates
  These drugs have many detrimental effects before and after birth. Trying to stop on your own could be dangerous for you and your baby, so seek help in a drug treatment programme. It is vital that the maternity services know so the baby can be treated for any withdrawal symptoms.
- Cocaine and crack
  Can be dangerous to the mother. May cause physical abnormalities in the baby, bleeding or placental problems. Use can be stopped safely but get support from your midwife or doctor.
- Ecstasy
  Little is known about the effects of ecstasy on the baby although it is linked in some studies with heart and other abnormalities.
- Amphetamines (speed, Crystal meth)
  Can cause heart problems in the baby and low birth weight and placental abruption. Seek advice to stop as sudden withdrawal could cause miscarriage.
- Cannabis
  Can increase the risk of low birth weight. If taken with tobacco, you also have all the harmful effects of smoking. Recent studies have shown that it can affect a baby's brain development.

Smoking in pregnancy

Cigarette smoking is the single largest risk factor for pregnancy related complications and mortality. If a pregnant woman smokes, it is very important for her to quit, for her own health and the health of the baby. Every cigarette you smoke harms your baby – stopping smoking will benefit both you and your baby immediately. If you smoke, your midwife will refer you to a stop smoking specialist who can talk through the options with you and help you to quit if you want to.

- Cigarettes contain around 4000 chemicals and at least 80 of them are known to cause cancer.
- Smoking during pregnancy exposes the baby to these harmful chemicals at a vital time in their development.
- This can result in a higher risk of stillbirth, miscarriage, cot death, premature birth and problems with the baby's growth and development, including cleft lip.
- Babies who have been born too early or underweight are more likely to face problems with breathing, feeding and infection.
- Smoking in pregnancy can cause permanent cardiovascular damage to children putting them at a higher risk of cardiovascular disease in later life.
- Smoking in pregnancy has been linked to the development of Attention Deficit Hyperactivity Disorder (ADHD) in children.
- Smoking causes premature ageing i.e. wrinkles and dry coarse hair, as well as bad breath, yellow teeth and unhealthy gums.
- Secondhand smoke is also very harmful, as up to 75% of the cigarette is spread into the air and can cause cot death, respiratory infections and ear infections in babies.
- Stopping smoking at any time during your pregnancy will increase your chances of having a healthier baby.

Nicotine Replacement Therapy (NRT)

Ideally, pregnant women should stop smoking without using Nicotine Replacement Therapy (NRT) but, if this is not possible, NRT may be recommended to help you stop smoking. The risk to the baby of continued smoking by the mother outweighs any potential adverse effects of NRT. NRT aims to replace the nicotine a smoker gets from cigarettes in other ways, for example through patches, gum, lozenges, tablets or inhalators. Electronic cigarettes are safer than smoking but other methods are recommended for pregnant women. E-cigarettes and their chargers must not be used inside our hospitals.

NRT can double the chances of quitting smoking and combined with support, the chances of quitting are up to 4 times more likely to be successful. Always seek professional advice.

Stop Smoking Services

You can quit smoking with the benefit of expert support by accessing the free NHS Stop Smoking in Pregnancy Services. You can be seen in your own home, GP surgery, pharmacy or a community venue. You and your partner, family and friends can be fast tracked, meaning that you will be seen as quickly as possible. So if you are thinking about quitting, ask your midwife at any point through your pregnancy, or contact 'Healthy Shropshire' on 0345 6789025 or www.stop4life.co.uk

The Stop Smoking in Pregnancy Services:

- are non-judgemental
- will not tell you what to do
- will listen

You can also find useful information on the dangers of smoking during pregnancy and tips for quitting at smokefree.nhs.uk.

Carbon monoxide monitoring

At booking your midwife will measure your carbon monoxide level with a simple breath test.

What is carbon monoxide?

- Carbon monoxide is a tasteless, odourless, colourless and poisonous gas
- It is found in car exhaust fumes, faulty gas fires and gas boilers and in tobacco smoke
- When inhaled in moderate amounts it causes headaches, flu-like symptoms and makes you feel tired and lethargic
- It can cause death if inhaled in large amounts
- It damages the artery lining – resulting in narrowing and hardening of the artery
- It reduces the ability of the red blood cells to carry oxygen
- It causes the blood to become thicker and stickier and more likely to clot
- It reduces the growth and development of your baby during pregnancy by reducing the amount of oxygen available to the baby.

How can we measure carbon monoxide?

Carbon monoxide can be measured with a quick, simple breath test. You take a breath and hold it for up to 15 seconds; this allows for the exchange of gases to occur in the lungs. You then blow out slowly into a carbon monoxide monitor. The reading will show how much carbon monoxide is present in your blood.

As a non-smoker you would expect a reading of below 4 parts per million (ppm). If you have a higher reading than this it could be due to car exhaust fumes, a faulty gas fire or boiler, smoking or passive smoking (the most common cause). If you smoke and would like help to stop smoking, or a chat about what support is available, your midwife will refer you to an NHS Stop Smoking in Pregnancy Service. If you have a reading above 4 ppm and you don't smoke you should get your car and gas appliances checked for defects urgently. You should consider fitting a carbon monoxide alarm in your home.

Travel

If you are planning to travel abroad during your pregnancy you need to discuss your own individual risks with your doctor or midwife. Most women having a straightforward pregnancy won't experience any problems. However, there are higher risks if you have any medical conditions or had any previous or current problems during your pregnancy.

You will need to discuss the risks of flying, whether you need any vaccinations and the prevention of travellers' diarrhoea. If you are travelling to an area with a high risk of contracting malaria, you need to discuss this with your doctor. Malaria in pregnancy carries substantial risks to mother and baby and your doctor will discuss measures to reduce your risk of contracting malaria.

Some airlines, cruise or ferry companies will not accept you as a passenger after 32 or 37 weeks. You need to contact your travel company for details and you may need a certificate to say you are fit to travel. You also need to check with your travel insurers as some may not cover travel during pregnancy.

Body scanners have been found not to pose any additional hazard to pregnant women.

There is evidence to suggest that periods of inactivity such as long journeys will increase the risk of developing blood clots. It's recommended that you do some leg exercises to encourage blood circulation and consider wearing compression stockings/tights on long drives or flights. Drink plenty of water and try to walk around the cabin every 30 minutes to encourage good blood circulation.

Leg exercises
Sit or half lie with legs supported. Bend and stretch the ankles at least 12 times. Circle both feet at the ankle at least 20 times in each direction. Brace both knees, hold for a count of four, then relax, repeat 12 times.

Seat belt advice

- All pregnant women by law must wear a car seatbelt for protection of the baby and themselves.
- The correct way is with the lap strap across the hip below the bump, and the diagonal strap between the breasts, above the bump.
- Wearing the lap strap alone, or across the bump, is not advised as this can cause harm to you or the baby in the event of an accident.
- See http://www.rospa.com/road-safety/advice/vehicles/in-car-safety-and-crashworthiness/seat-belts/ for further information

Violence and abuse at home

Pregnancy can be the happiest time of a woman's life but for some women it is the most vulnerable. Domestic abuse affects one in four women at some point in their life, in all walks of life; two women die a week in the UK as a result. Domestic abuse often starts or intensifies during pregnancy, with the risk increasing after the baby is born. You may not recognise that you are being abused, and seek help for anxiety and depression, or develop coping strategies such as smoking, alcohol or drug use. These, together with the effects of physical and emotional abuse can have an enormous long-term impact on you, your unborn baby and other children in the home. The problem may be made worse if you are prevented by your partner from accessing antenatal care.

If you are in an abusive relationship there are three steps you can take:

- Recognise that it is happening to you
- Accept that you are not to blame
- Seek help and support

Recognising domestic abuse

Domestic abuse can be physical, sexual, psychological, emotional and financial. It is intentional, repetitive behaviour used to dominate a partner and is not as a result of stress, depression, alcohol, drugs, a 'bad childhood' or an 'anger' problem, although these can be contributory factors. We know this as abusers are often 'charming' in public, usually only being abusive in private. If they think that something negative is likely to happen to them as a result of their behaviour (such as police involvement) they are less likely to offend.

Examples of physical abuse include behaviours such as pushing, punching, slapping, kicking, biting, pinching, restraining, hair pulling, burning, strangling and raping (any unwanted or forced sex). Assaults are often on parts of the body that are normally covered, and during pregnancy the abdomen is a common target.

Recognising emotional abuse is often not as easy, but the following signs may indicate that your partner is abusing you:

- Are you afraid of your partner? Is he angry and threatening, to the extent that you have changed your behaviour so as not to 'provoke' him, or feel that you are 'walking on eggshells'?
- Does he insult or embarrass you in public, tell people you are 'mad', ignore you, sulk, shout, glare, smash things (not his) or become angry when you initiate an action or idea?
- Does he control what you wear, tell you who you can be friends with, put your friends/family down, or lie to them about you. Does he prevent or make it difficult for you to see them?
- Does he get jealous for no reason, lose his temper over trivial things or become angry if you ask for help with the housework or childcare?
- Does he blame you, or make excuses for his behaviour, such as drugs, drink, an anger problem, stress, depression, or a 'bad childhood'; or never admit he is wrong?
- Does he lie to you, withhold information from you, have other relationships, or break promises and shared agreements?
- Does your partner make all the financial decisions without consulting you, or withhold money from you; does he prevent you from getting or keeping a job?
- Is he physically violent to you or others, even if it's 'just' grabbing and pushing to get his way?
- Does he expect sex on demand or coerce you into having sex against your will.
- Has he said that the baby is not his, and that he wants a DNA test?
- After an incident, does he try to 'win you back' by invoking sympathy from others, bearing gifts/ flowers, crying, begging for forgiveness, saying it will never happen again, promising to change?
- Does he try to tell you that no one else would want you, and that you would not be able to cope without him; or that if you leave he will tell everyone; report you to social services for being a bad mother; take or harm the children; find you; kill you/the baby or himself?
- Has he been in a violent relationship before?

Accepting that you are not to blame

It may be difficult for you and your family to understand your partner's behaviour and you may be feeling ashamed or blame yourself, however:

- No one should be frightened of their partner or be prevented from making choices about their life.
- You cannot change an abuser's behaviour; only he can do that if he chooses to do so.

Seeking help and support

For many women this may be a long and painful process as they try to make the relationship work and stop the abuse. Ignoring abuse can be dangerous so it is important to talk to someone about what is happening to you. You do not have to deal with this alone, there are people from the following organisations who can support you:

(Warning: If you intend to access any of these websites but are worried that someone will know, please follow the links to 'cover your tracks'/'hide my visit' (listed in some of these sites) for guidance on how to clear your internet history.)

- Freedom Shropshire
  For people who live and work in Shropshire who need to access relevant and up to date guidance and advice on domestic abuse and violence:
  www.freedomshropshire.org.uk
  0808 2000 247 (24 hour helpline)

  www.freedomprogramme.co.uk gives information about the Freedom Programme which is open to any woman who wishes to know more about domestic abuse. Each group has a fully trained facilitator who specialises in supporting women affected by domestic abuse and understands the issues associated with this. The Freedom Programme is free and confidential. Other courses can be found on other sites on this page.

- West Mercia Women's Aid
  ☎ 0800 783 1359 (24 hour helpline)
  www.westmerciawomensaid.org

  An independent, non-biased service to support women and children affected by domestic violence or abuse. Calls from landlines are free. They offer practical and emotional support, advocacy and information, legal advice, help with rights and benefits, support with children, access to interpreters, and a temporary place of safety for you and your children.

- National Domestic Violence Helpline
  24 hour Free phone (run in partnership with 'Women's Aid' and 'Refuge').
  ☎ 0808 200 0247
  helpline@womensaid.org.uk
  www.nationaldomesticviolencehelpline.org.uk
  www.womensaid.org.uk
  www.refuge.org.uk

- Named Midwife for Safeguarding and Domestic Violence
  ☎ 01952 565993/07795 354756

  If you get the answer phone when you ring, please leave your name, telephone number and details of when it would be safe to call.

  Information you disclose relating to abuse is not discussed with your partner or written in your 'Pregnancy Health Record'. You can also speak to your Community Midwife or GP if you prefer.

- West Mercia Police
  ☎ 030 0333 3000
  In an emergency - dial 999
  www.westmercia.police.uk

  Domestic violence is a crime. Documenting incidents with the police (and your GP, Midwife, Health Visitor or a Solicitor) will provide evidence which may afford some security for you and your baby in the future.

- Southall Black Sisters
  A service aimed at women from minority ethnic backgrounds who are experiencing domestic abuse, forced marriage, and so-called 'honour' based violence.
  ☎ 020 8571 0800 (helpline)
  www.southallblacksisters.org.uk

- The Survivors Trust
  For adult survivors of childhood sexual, physical or emotional abuse.
  www.thesurvivorstrust.org
  Axis Counselling 01743 357777
  www.axiscounselling.org.uk

- Rights of Women
  Free legal advice
  ☎ 0207 251 8887
  www.rightsofwomen.org.uk

- Children and Young People
  Websites for young people about domestic abuse and healthy relationships (with games and activities).
  www.thehideout.org.uk
  www.respectnotfear.co.uk
  www.nhs.uk/livewell/teengirls/pages/relationshipviolence.aspx
  www.westmerciawomensaid.org/crush

- Respect
  This is a domestic violence prevention project for men who want to put an end to their abusive behaviour. Engaging with them to help address the root of their problems, educate them, and change attitudes and beliefs about using violence within relationships.
  ☎ 0808 802 4040
  (Free from landlines and most mobiles)
  info@respectphoneline.org.uk
  http://respect.uk.net

- Domestic violence perpetrator programmes (DVPP)

  Domestic Violence Perpetrator Programmes (DVPPs) are delivered as a court ordered activity. DVPP is a group programme for men to develop their skills and understanding, enabling them to:
  - Improve their relationship with their ex-partner and where relevant, their current partner
  - Ensure, as far as is possible, their use of violence and abusive behaviour towards a partner is not repeated
  - Develop safe, positive parenting
  - Increase their awareness of themselves and the effect of the domestic violence on their ex-partner and children
  - Resolve conflicts in intimate relationships non-abusively

Of course you can speak to a midwife or doctor too. The Department of Health asks midwives and other health professionals to ask all women if they are affected by domestic abuse. They acknowledge that many mothers in abusive relationships go to enormous lengths to protect their children, and that maternity care should therefore focus on supporting you to look after your family with the help of some of the agencies listed above. It is best if you are honest with staff about any current or previous involvement with social services. Please provide us with as much information as possible. Your midwife may discuss a referral to 'Children and Social Services' for additional support for your baby or children if they are at risk of significant harm. If it is believed that a child or unborn baby is at risk, professionals do not require the consent of parents to make a referral to Social Services. This information will only be related to child protection, not your medical history.

Safeguarding and social support

If you need additional support during or after your pregnancy your Community Midwife will offer an 'Early Help Assessment' and signpost you to other agencies with your consent to meet your individual needs. If you have additional social needs you will follow the Antenatal Care Pathway for high risk women and the 'Safeguarding and Supporting Women with Additional Needs' (SSWwAN) pathway. Midwives caring for you and your baby work in partnership with other agencies to offer holistic support to you and your family. If your baby is thought to be at risk of significant harm, your midwife will make a referral to Children's Social Services for additional support. Wherever possible she will discuss her concerns with you.

Minor problems of pregnancy

Your body goes through lots of changes during pregnancy. Sometimes, these changes can cause you discomfort and you may be worried about what is happening to you. You should mention anything that concerns you to your midwife or GP.

Nausea and vomiting

These are some of the earliest symptoms of pregnancy, and for most women the symptoms ease after the first twelve weeks. Sometimes, however, the problem exists for most of the pregnancy. It can happen at any time of the day and the severity varies with different women.

How can you help?

- Get up slowly, and eat a plain biscuit or plain toast first thing
- Eat little and often
- Avoid foods that make you feel nauseous
- Drink plenty
- Wear loose fitting clothes

When to get help
Some women suffer severe and prolonged nausea and sickness called 'hyperemesis gravidarum'. This can cause severe distress and depression. If you have severe nausea and vomiting, and are unable to keep anything down for over 24 hours, seek advice from your doctor or midwife. You may need rehydration and anti-sickness medication. For further information, ask for our leaflet: 'Pregnancy related sickness (hyperemesis)' and visit the 'Pregnancy Sickness Support website at https://www.**pregnancysicknesssupport**.org.uk/.

Heartburn

Hormonal changes relax the valve into your stomach which allows the acid contents to pass back, causing burning and pain. The growing baby pressing on your stomach increases the problem later in pregnancy.

How can you help?

- Eat little and often
- Avoid fatty or spicy foods
- Don't eat or drink for a few hours before going to bed
- Sleep propped up on pillows
- Line your stomach with milk

When to get help
If the problem is severe and persistent, ask your doctor or midwife about antacid medication.

Tiredness

This is particularly common in the early stages of pregnancy, due to changes in your body, and again late in the pregnancy due to the extra weight you are carrying.

How can you help?

- Rest as much as possible
- Get some exercise and eat well – particularly iron rich foods, (see p. 14).

When to get help
If the problem persists, ask your midwife or doctor to check the haemoglobin levels in your blood. This may show that you need to take iron tablets.

Headaches

Some women get a lot of headaches when they are pregnant.

How can you help?

- Rest when you can
- Drink plenty of water as dehydration can cause headaches.
- You can take paracetamol: 2 tablets (1 g) 4 times a day, with a minimum of 4 hours between doses. *Please take the lowest effective dose of paracetamol for the shortest possible time*

When to get help
If you have a persistent headache at the front of your head that doesn't go away with paracetamol, it can be a sign of high blood pressure. Don't hesitate to contact a midwife, especially if you also have any visual disturbances, generalised swelling, or pain in your upper abdomen on the right side (see p. 28).

Itching

Hormonal changes and stretching of the skin make itching common in pregnancy. Sometimes exposure to sunlight makes this worse.

How can you help?

- Wear loose clothing, preferably natural materials
- Avoid getting hot

When to get help
If the itching persists and is mainly on the palms of your hands and soles of your feet, ask your midwife whether you need a blood test. You may have a condition called 'Obstetric cholestasis' which is a disorder of the liver caused by pregnancy, and needs medication and increased monitoring of your pregnancy (see p. 30).

Haemorrhoids (piles)

These are swollen veins around your anus (back passage) which can be painful and itchy. They are caused by the effect of hormones in pregnancy, and the extra weight of the pregnancy.

How can you help?

- Avoid constipation by eating fibre rich foods and drinking plenty
- Avoid standing for long periods
- Take regular exercise to improve your circulation

When to get help
Ask your doctor for some ointment if you are suffering a lot of discomfort.

Feeling faint

Feeling faint is common, particularly in the middle part of your pregnancy.

How can you help?

- Get up slowly after lying down or sitting
- Avoid standing still – try to sit down
- Don't lie flat on your back

When to get help
Ask for advice from your midwife or doctor if this happens a lot.

Aches and pains, swelling, tingling and cramps

These are common in pregnancy and are usually nothing to worry about.

It is normal to get some pain in the pelvic area as your uterus grows, stretching your ligaments. Sometimes considerable pelvic pain can be caused by pelvic girdle pain which may not resolve until a few months after your baby is born. Ask for our leaflet: 'Pregnancy related pelvic girdle pain (symphysis pubis dysfunction)'.

Up to half of pregnant women can suffer from pain in their wrists. This is called Carpal Tunnel Syndrome and is caused by fluid retention putting pressure on nerves.

How can you help?

You can find information about these types of conditions and how to ease them in 'Fit for Pregnancy', a leaflet given to you at your booking appointment and available at www.csp.org.uk

When to get help
Always discuss a condition with a doctor or midwife if you are worried.

Other common problems

Feeling hot, nose bleeds, bleeding gums, passing urine often, and leaking nipples are all common and normal in pregnancy, but do ask your midwife or doctor if you are worried.

Infections in pregnancy

If you come into contact with or develop any infectious disease, or develop a rash, please seek advice.

Infections screened for in pregnancy

Some infections can be harmful to you and/or your baby in pregnancy and afterwards. You are offered screening for some of these infections, and treatment where required. Advice on how to avoid food poisoning is found on p. 13.

Asymptomatic bacteriuria

NICE recommends that all pregnant women are offered this urine test. Identification and treatment of certain infections helps reduce the risk of premature birth.

Chlamydia

If you are under 25, you will be offered screening for Chlamydia, the most common sexually transmitted infection in the UK. This is usually an infection which does not have any symptoms and is easily treatable. Your midwife or GP will give you further information, including a leaflet.

Group B streptococcus (GBS)

This is a bacterium carried by about 30% of the population. In women it is found in the intestine and vagina, in most cases causing no problems. Occasionally, however, GBS can infect a baby just before or during labour, with serious consequences.

National guidance does not recommend routine testing, but if you are found to be carrying GBS in your urine, or from a vaginal swab, you will be offered antibiotics in labour. When this is the case, you will be given a leaflet about preventing GBS infection in newborn babies. This leaflet can also be found on our website at: http://www.sath.nhs.uk/wards-services/az-services/maternity/. See also p. 59 for Group B Strep Support.

Hepatitis B

Hepatitis is a virus that affects the liver and can cause immediate and/or long-term illness. It is transmitted by exposure to infected blood or body fluids and pregnant women with hepatitis B will need specialist care in pregnancy.

Vaccination will be offered for the baby in the first 24 hours after birth as this greatly reduces the risk of the baby developing hepatitis B.

Herpes

Genital herpes is a common infection caused by the herpes simplex virus (HSV). It causes painful blisters on the genitals and surrounding areas. It is transmitted via intimate sexual contact.

If you had genital herpes before becoming pregnant, the risk to your baby is very low. Even if you have recurrent episodes throughout your pregnancy, your baby should not be at increased risk, although you may be advised to take antiviral medication. If you have an outbreak around the time of birth, you have up to a 3 in 100 chance of passing it to your baby.

The situation is more serious if you develop the infection for the first time during your pregnancy. In the first and second trimesters there is an increased risk of miscarriage, and of passing it on to your baby. You may be advised to take antiviral medication.

If you become infected in the third trimester, especially in the last 6 weeks of pregnancy, the risk of passing the virus to your baby is considerably higher and you may be advised to have a caesarean birth because the risk of transmission to your baby is 4 in 10.

HIV

Human Immunodeficiency Virus (HIV) reduces the effectiveness of the immune system. It is found in the blood and body fluids and is spread by unprotected sexual contact.

If you are found to be HIV positive you will receive specialist care in your pregnancy, and after your baby is born. Most healthy HIV positive women will not be adversely affected by pregnancy.

Treatment offered to you and your baby significantly reduces the chance of your baby being infected. You will receive advice on your birth and how to feed your baby based on the best evidence available.

Syphilis

Syphilis is a sexually transmitted infection. Most infected people do not have any obvious symptoms. If identified in pregnancy you would be referred for specialist care and may be treated with antibiotics. If it is untreated it can result in serious health problems for the baby.

Other infections

Chickenpox
Most women (95%) are immune to chickenpox from having the disease, usually in childhood. If you have not had it, and you come into contact with someone who has it, speak to your GP or midwife. You can have a blood test to check whether you are immune.

If you get chickenpox in your pregnancy it can be dangerous for both your baby (particularly before 20 weeks) and for you (around the time of the birth). If you come into contact with chickenpox, and you are not immune, you may be suitable for an immunoglobulin injection that can make the infection shorter and milder.

Cytomegalovirus (CMV)
This virus can cause serious problems if a baby catches it from its mother in pregnancy. It is important that pregnant women wash their hands after any contact with body fluids, including after changing nappies, to prevent catching and spreading the virus.

Measles
Measles is a highly infectious viral disease spread by droplets, either by breathing them in or touching contaminated surfaces.

Measles can give rise to complications, sometimes serious, and these can be worse in pregnancy, affecting mother and baby.

If you come into contact with measles and have not had the disease or been vaccinated fully against it, please speak to your midwife or GP as soon as possible.

How the situation is managed will depend on a number of circumstances, according to national advice from Public Health England.

MRSA (Methicillin-resistant Staphylococcus aureus)
Staphylococcus aureus is a bacterium that lives harmlessly on the skin and in the nose of 30% of the UK population (this is called being colonised). Staphylococcus aureus can cause an infection if it enters the body, for example, wound sites. Staphylococcus is usually treated with flucloxacillin but MRSA is resistant to flucloxacillin and some other antibiotics.

MRSA can be spread through the air and by contact with other people. In order to reduce the risk of MRSA being spread in hospital, pregnant women who are at higher risk of being colonised are offered a nasal swab at 36 weeks and offered treatment if necessary. You are at higher risk if:

- You have had MRSA before
- You have a serious medical condition
- You are diabetic and have an open wound
- You've been admitted to a hospital ward (other than Maternity) in the last year
- You are a healthcare worker with patient contact or if a household member or first degree relative is a healthcare/care home worker
- You are having an elective caesarean section

Mumps
Women who develop mumps within the first 12-16 weeks of pregnancy may have a slightly higher risk of miscarriage but there is no evidence that mumps causes defects in the unborn child. The mumps vaccine is part of the MMR jab.

Parvovirus
This is also known as 'slapped cheek virus' because of the characteristic red rash it causes on the cheeks. It is a very common infection, usually with mild symptoms, but it can sometimes be harmful to unborn babies if the mother contracts the infection during the first half of pregnancy. Sixty percent of pregnant women are immune to parvovirus because they have already had the disease, but if you come in to contact with someone who is infected, ask your GP to check you are immune (this is done by a blood test). If you are infected while pregnant you will be offered additional ultrasound scans to monitor your baby.

Rubella (German measles)
Although this virus usually causes only minor illness in childhood, if you catch rubella in the first four months of pregnancy, it can seriously affect your baby's sight, hearing, brain and heart.

Ideally you should have had two doses of the MMR (measles, mumps, rubella) vaccine before pregnancy. You can check with your GP whether you have had this. If not, you can have the vaccinations at your GP surgery after you have your baby. This will protect any future pregnancies.

Toxoplasmosis
This is caused by a parasite, and is rarely a problem in non pregnant people. Mild flu symptoms may be the only sign, but many people have no symptoms. In pregnancy toxoplasmosis can have serious effects on your baby's development, and can cause miscarriage and stillbirth. Up to 50% of pregnant women will be immune because they have already had the infection. Of those women who catch the infection in pregnancy, the risk of infecting the baby is 10-15% in the first trimester, 25% in the second trimester and 70 - 80% in the third trimester. National guidance does not recommend routine testing in pregnancy, but suggests that communicating the best ways to avoid infection is more effective. These are:

- avoiding undercooked or raw meat
- avoiding cured meat, such as parma ham or salami
- avoiding unpasteurised goats' milk
- avoiding contact with cat faeces or soil that is contaminated with cat faeces

For more information see
www.nhs.uk/conditons/Toxoplasmosis/pages/introduction

Other infections from animals
Ewes and lambs carry other bacteria which can cause miscarriage. Bird droppings can also harbour bacteria harmful in pregnancy, so ask someone else to clean bird cages, or use disposable gloves.

There is some evidence that pigs carry hepatitis E. Avoid contact with pigs or pig faeces. Cook pork thoroughly.

Tuberculosis (TB)

Tuberculosis (TB) is still prevalent in many countries. As a result some parents are more at risk of contracting this disease, which therefore increases the risk to babies. If you have not been vaccinated please discuss this with your GP after you have had your baby.

TB is a difficult infection to catch and usually requires prolonged or repeated contact with someone who is infectious. This is most likely to occur when living in the same household as someone with TB disease where they are breathing or coughing out the bacteria.

BCG vaccination is recommended for all babies who:

- are born in areas where the rates of TB are high
  or
- have one or more parents or grandparents who were born in countries with a high incidence of TB

How the BCG vaccine works:

It offers considerable protection against tuberculosis. Although it may not always prevent a person from catching TB disease, it is very effective against the most severe forms of the disease, such as TB meningitis in children.

Should your baby be identified for BCG vaccine, it is quite safe for them to receive this vaccine alongside the regular childhood immunisation programme.

For further information visit
www.nhs.uk/conditions/tuberculosis

Whooping cough

Whooping cough is a highly contagious bacterial infection of the lungs and airways.

All pregnant women are now offered vaccination against whooping cough after 20 weeks of pregnancy. Getting vaccinated while you're pregnant could help to protect your baby from developing whooping cough in its first few weeks of life. To protect your baby you need to get a vaccination in every pregnancy.

You will be given a leaflet with more information about this in the middle part of your pregnancy.

Seasonal flu and Swine (HIN I) flu

In pregnancy, the immune system is naturally suppressed. This means that pregnant women are more likely to catch flu and, if they do catch it, they are more likely to develop complications.

If you do develop complications these include cough, difficulty breathing and dehydration due to the development of pneumonia (an infection of the lungs). In pregnant women, this is more likely to happen in the middle and late part of pregnancy.

This can lead to severe ill health, premature labour, miscarriage, stillbirth or neonatal death.

All pregnant women are advised to have seasonal flu vaccination, whatever the stage of pregnancy. The seasonal flu jab currently offers protection against the HI NI virus, as well as other strains of flu virus. There is no evidence that inactive vaccines, such as the seasonal flu vaccine, will cause any harm to pregnant women or their unborn baby. The vaccine offers immunisation for your baby up to 3 months of age. Your GP or midwife will be able to give you information on the current advice from the Department of Health regarding seasonal flu vaccination. Please contact your GP surgery to make an appointment for flu vaccination.

If you think you may have flu, call your doctor for an assessment and advice.

Zika virus
Please visit www.nhs.uk/Conditions/zika-virus/Pages/Introduction.aspx for information about Zika and links to get latest advice.

Sepsis in pregnancy

The term sepsis usually refers to a severe generalised infection such as septicaemia. In the past many women would become severely unwell or even die from sepsis in childbirth. This is now much less common but still occurs. Recently Group A streptococcus has been a bacterium associated with an increase in the number of women with severe sepsis.

Group A streptococcus is the most common cause of sore throats and chest infections in children. Group A strep can also be carried without the person having any symptoms. The bacteria are spread by direct person to person contact from infected secretions from the nose or throat or infected wounds or sores on the skin. The bacteria can also enter the body through a cut or scrape.

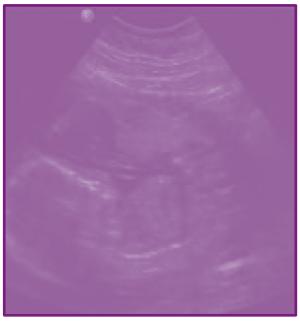
It is therefore really important that you and your family avoid the spread of germs

- Wash your hands thoroughly and often with soap and warm water, especially after coughing and sneezing, before preparing foods, and before eating.
- Good perineal hygiene is also important -especially after you've given bir th. Make sure you wash your hands before and after going to the toilet and when changing sanitary towels.
- See your GP as soon as possible if you or a close family member has a sore throat and fever.
- Keep all wounds clean, and watch for possible signs of infection such as rapidly increasing redness, swelling and pain at the wound site. Anyone with signs of an infected wound, especially if they develop a fever, should seek medical advice as soon as possible.

Your immunity is lowered when you are pregnant.

You need to seek medical advice if you have two or more of the symptoms below:

- A rapid heart rate
- A high or low temperature
- Shortness of breath
- Shaking and chills
- Abdominal or chest pain
- Diarrhoea
- Feeling generally unwell or feeling anxious and distressed



Ultrasound screening

Ultrasound scans use sound waves to build up a picture of your baby in your uterus. To date, there is no evidence that ultrasound scans such as those used during pregnancy, do any harm to the baby or mother.

In Shropshire, the Maternity Ultrasound Scan Department offers every pregnant woman a first trimester pregnancy scan between 11 and 14 weeks and a mid pregnancy fetal anomaly scan between 18 weeks and 6 days and 20 weeks and 6 days. These scans are performed by midwife sonographers.

Screening information

Screening information, including screening tests for chromosomal abnormalities is contained in the 'Screening tests for you and your baby' leaflet which you will have been given by the time of your first antenatal appointment. It is important that you read and understand this information so that you can make an informed choice. Your midwife will discuss this with you.

First trimester pregnancy scan

This scan is to check the baby's heartbeat, to see whether there is more than one baby, to measure the baby to estimate how many weeks pregnant you are, and to check for any major problems with the baby that are obvious at this early stage.

Down's syndrome screening

Down's syndrome is a learning disability that a baby is born with. Some health problems are more common in people with Down's syndrome but it is impossible to know what level of learning disability a baby with Down's syndrome may have.

You may want to know in pregnancy whether your baby may be at risk of Down's syndrome and there are screening tests that are offered to identify your baby's risk and further tests to confirm a diagnosis. Depending on your gestation you may be offered:

- A combined screening test between 11 weeks and 2 days and 14 weeks and 1 day. This involves a blood sample from you and a measurement of the fluid at the back of the baby's neck (nuchal translucency) during the first trimester scan. The information is combined to work out the baby's risk of having Down's syndrome. It will also screen for Edwards' syndrome and Patau's syndrome.
- A 'Quad' screening test which is offered between 14 weeks and 2 days and 20 weeks of pregnancy. This is a blood test from which your baby's risk of Down's syndrome can be estimated.

If either test identifies that your baby has an increased risk of a chromosomal abnormality you will be offered further tests to give a definite diagnosis:

- CVS (chorionic villus sampling), which can be done between 11 and 13 weeks of pregnancy. A fine needle is passed through a woman's abdomen and a tiny sample of placental tissue is removed and tested.
- Amniocentesis, which is done from 15 weeks of pregnancy. A fine needle is passed through a woman's abdomen to collect a small sample of the fluid surrounding the baby, which is tested.

Other rarer genetic disorders can also be tested for. You may also be offered a diagnostic test if you have had a previous pregnancy affected by a disorder, if you have a family history of a genetic disorder, of if a problem is suspected after your mid-pregnancy fetal anomaly scan.

Mid pregnancy fetal anomaly scan

This scan takes approximately 30 minutes. It is a screening test to look for physical abnormalities in the baby. Some problems can be seen more clearly than others, and there is a chance that a baby will be born with a health problem that a scan could not identify.

You may want someone with you during the scan, but we recommend children are not present as sometimes a problem can be found with the baby.

What happens during your scan?

You will need a full bladder for your first trimester scan to get a good image of your baby, but this is not necessary for the mid-pregnancy fetal anomaly scan.

In order for the midwife sonographer to get good images of your baby, the scan is done in a dimly lit room. You will be asked to lie on a couch with your abdomen uncovered. Jelly is put on your abdomen to enable a clear picture of the baby. Having a scan is not painful but may be uncomfortable if the midwife sonographer needs to apply slight pressure to get the best views of the baby.

During the scan the screen may be facing the midwife sonographer and in order to maintain concentration she may not talk much. After the scan has been completed she will explain the scan in detail and answer any questions you may have.

Sometimes it is difficult to get a good picture of the baby if it is lying in an awkward position, if it is moving a lot, or if you are above average weight. This can make interpreting the scan more difficult and you may need to return for another scan to obtain all the information needed.

Most scans show that the baby is developing as expected and no problems are found. If any problems are suspected, the midwife sonographer would discuss the findings with you and refer you to a fetal medicine consultant for further investigations.

Photographs

You can buy photographs of your baby at both the first trimester scan and the mid pregnancy scan. Please tell the sonographer during the scan that you want a photo (check current prices at the time). Photographs can become less satisfactory after about 24 weeks of pregnancy, because as the baby gets bigger, the picture becomes less clear. Scan photographs cannot be laminated but they can be photocopied. They should be kept in a dark place, but will still fade with time. They will normally last about 7 years.

Personal camera/video equipment

This equipment cannot be used in the ultrasound room as it is likely to cause lack of concentration to the sonographer and detract from your personal involvement in the examination.

Private scan to find out the gender of your baby

Finding out the gender of your baby is not part of the mid-pregnancy fetal anomaly scan. This is a social scan performed solely to try and determine the gender of your baby. Success depends on the position of the baby and maternal BMI. It is not always possible to achieve this aim. As this is a social scan, you may bring extended family members along with you to view the scan.

A photograph of the baby is included in the price of the scan (check current prices at the time), payable at the reception desk prior to the scan. Unfortunately, we can only accept cash payment as we are unable to process cheques or debit/credit cards.

This scan is not a medical examination and no measurements of the baby will be taken. It does not replace your mid pregnancy scan and will only be available after this scan has been performed, usually after 23 weeks.

Should you wish to access this service, appointments can be made by telephoning 01952 565707 (Telford) or 01743 261143 (Shrewsbury), Monday – Friday 0900-1600.

Customised antenatal growth charts

It's important that the baby's growth is monitored accurately during pregnancy. Your baby's growth is assessed by measuring your abdomen during your pregnancy and the measurements taken during the ultrasound scans. Your baby's expected growth chart is individually adjusted for you and your baby. The chart is calculated using your height, weight, ethnic origin and details about any previous babies you have had. The chart shows your baby's expected growth curve and as your baby grows, the measurements should be similar to the slope of the curves on the chart.

If you have a multiple pregnancy, a very high BMI or a large fibroid these measurements will not be useful. Please discuss this with your midwife or doctor.

Baby weight conversion chart

Find the nearest weight in grams and read off pounds from the top row and ounces from the left column.

OUNCES	POUNDS										
	0	1	2	3	4	5	6	7	8	9	10
0	0	454	907	1361	1814	2268	2722	3175	3629	4082	4536
1	28	482	936	1389	1843	2296	2750	3203	3657	4111	4564
2	57	510	964	1417	1871	2325	2778	3232	3685	4139	4593
3	85	539	992	1448	1899	2353	2807	3260	3714	4187	4621
4	113	567	1021	1474	1928	2381	2835	3289	3742	4196	4649
5	142	595	1049	1502	1956	2410	2863	3317	3770	4224	4678
6	170	624	1077	1531	1984	2438	2892	3345	3799	4252	4706
7	198	652	1106	1559	2013	2466	2920	3374	3827	4281	4734
8	227	680	1134	1588	2041	2495	2948	3402	3856	4309	4763
9	225	709	1162	1616	2070	2523	2977	3430	3884	4337	4791
10	283	737	1191	1644	2098	2551	3005	3469	3912	4366	4819
11	312	765	1219	1673	2126	2580	3033	3487	3941	4394	4848
12	340	794	1247	1701	2155	2608	3062	3515	3969	4423	4878
13	369	822	1276	1729	2183	2637	3090	3544	3997	4451	4904
14	397	850	1304	1758	2211	2665	3118	3572	4026	4479	4933
15	425	879	1332	1786	2240	2693	3147	3600	4054	4508	4961

Pregnancy complications

There are certain problems that can happen in pregnancy which your midwife and doctor will be checking for. Contact your midwife or doctor if you're worried about your health for any reason or if you experience any of the following:

- **Vaginal bleeding**
- **Recurring headaches**
- **Blurred or altered vision or flashing lights**
- **Abnormal swelling of the face, hands or feet**
- **Abdominal pain**
- **Pain in your calf or chest pain**
- **Feeling unwell**
- **Reduction in your baby's movements**
- **Your waters break**

If you need urgent help phone your nearest Midwife Led Unit, Obstetric Triage or the Delivery Suite (see back cover of your Pregnancy Health record)

Blood Pressure

Key points

- Your blood pressure will be measured at every antenatal appointment
- Raised blood pressure can be a sign of a pregnancy problem called pregnancy induced hypertension (may be called gestational hypertension)
- If you have raised blood pressure and protein in your urine you may be developing pre-eclampsia
- Most women with pre-eclampsia feel perfectly well – that's why these checks are important

What if your blood pressure is high?

Stress, worry or activity may all affect your blood pressure for a while. There is no clear line between normal and high blood pressure, although doctors and midwives may be concerned if your reading is 140/90 or higher or significantly higher than your normal blood pressure.

What are the causes of raised blood pressure?

Hypertension

- Chronic hypertension (may be called essential hypertension or pre-existing hypertension). Hypertension or high blood pressure that exists before you are pregnant or is diagnosed prior to 20 weeks of pregnancy.
- Gestational hypertension (may be called pregnancy induced hypertension). Hypertension that is new to pregnancy and resolves after delivery but is not associated with proteinuria (protein in the urine).

You will be closely monitored if you have chronic or pregnancy induced hypertension. If you have significantly high blood pressure your obstetrician may consider giving you medication to lower your blood pressure.

Pre-eclampsia

Pre-eclampsia is high blood pressure and protein in urine that starts in pregnancy, usually after 30 weeks, but sometimes after 20 weeks.

What is pre-eclampsia?

Pre-eclampsia is a complication of pregnancy that can affect the mother, her baby or both. Pre-eclampsia may affect as many as 1 in 10 of all pregnancies but more frequently occurs in a first pregnancy. It can develop at any time in the second half of pregnancy – even as late as several days after the delivery. Pre-eclampsia may have no symptoms in the early stages and may only be detected by routine screening tests carried out at antenatal clinics or home visits. If undetected, pre-eclampsia may have serious consequences for a woman and her baby.

Who is most at risk?

No one can predict with certainty who will get pre-eclampsia, however, the following factors increase the risks (NICE 2010):

- First pregnancy
- A strong family history of the condition
- Pre-eclampsia in a previous pregnancy
- Expecting twins or more
- Chronic medical problems such as high blood pressure, kidney disease and diabetes or an inflammatory disease such as Lupus
- Body Mass Index of 35 kg/m^2 or more
- More than a 10 year gap since having the last baby
- Age 40 or more

If you are at risk of developing pre-eclampsia, your midwife or GP may recommend that you take Aspirin 75 mg/day from 12 weeks until the birth of your baby. This is in line with NICE guidance. Aspirin must always be prescribed by a doctor, who will make sure that this drug is suitable for you.

What causes pre-eclampsia?

Extensive research into the causes of pre-eclampsia continues, but it seems likely that genetic factors are involved since women whose mothers and sisters have had pre-eclampsia are more likely to get it themselves. What is known is that pre-eclampsia originates in the placenta (afterbirth), and the condition will not begin to resolve until the baby and the placenta have been delivered.

Symptoms

Pre-eclampsia may cause no symptoms in the early stages, and therefore may only be discovered when high blood pressure and protein in the urine are found during routine tests.

Look out for the following, alone or in combination:

- Sudden generalised swelling caused by fluid retention
- Frontal headache, not improved by paracetamol
- Blurred vision or flashing lights
- Severe pain below the rib cage on the right side and vomiting

As pre-eclampsia may present in a variety of ways, get any unusual signs or symptoms checked as soon as possible.

Diagnosis of pre-eclampsia

If pre-eclampsia has been diagnosed, you and your baby will need close monitoring. This may be carried out in hospital or on the Day Assessment Units. Pre-eclampsia will not resolve until the baby is delivered and in some cases your baby may need to be delivered early if there are concerns over you or your baby's well-being.

HELLP and eclampsia

HELLP is the medical term for one of the most serious complications of pre-eclampsia, in which there is a combined liver and blood clotting disorder. Eclampsia is also a complication of pre-eclampsia when one or more convulsions occur.

Future risk	**Hypertensive disorder this pregnancy**	
	Gestational hypertension	Pre-eclampsia
Gestational hypertension in future pregnancy	Risk ranges from about 1 in 6 (16%) to about 1 in 2 (47%).	Risk ranges from about 1 in 8 (13%) to about 1 in 2 (53%).
Pre-eclampsia in future pregnancy	Risk ranges from 1 in 50 (2%) to about 1 in 14 (7%).	Risk up to about 1 in 6 (16%). No additional risk if interval before next pregnancy <10 years.
Cardiovascular disease	Increased risk of hypertension and its complications.	Increased risk of hypertension and its complications.
Kidney disease		If at your 6-8 week postnatal check you have no protein in your urine and your blood pressure is settling the long term risk of kidney disease is considered minimal

Further information on pre-eclampsia may be found on www.action-on-pre-eclampsia.org.uk and in the leaflet 'Pre-eclampsia'. Ask your midwife for this. If you have hypertension requiring treatment you have a postnatal appointment with your GP 6-8 weeks after the birth. You should receive a copy of the letter sent to your GP.

Urine checks

Key points

- Your urine gives vital clues about the health of you and your baby.
- Your urine will be tested at every antenatal appointment.
- Protein in your urine could indicate contamination from vaginal discharge or a urinary tract infection.
- Protein in your urine can be a sign of a pregnancy problem called pre-eclampsia and should be investigated.
- Glucose in your urine could indicate the need for further investigation for diabetes.

What if protein is found?

A tiny amount of protein found in the urine is written in your notes as a 'trace'. This is nothing to worry about. More than a trace of protein is noted as one or more + signs.

If you have one + or more of protein, your urine may be checked for causes such as an infection. If this is found and treated, then the protein will disappear. However, a plus or more of protein may also be a sign of pre-eclampsia and this should be investigated.

What if glucose (sugar) is found?

If you have a trace of glucose in your urine your midwife may ask you about your diet as it may be a simple case of excess sugar in your body.

If you have a plus of glucose or more, on more than one occasion, the midwife / doctor will arrange an appointment for you to have a Glucose Tolerance Test. This is to detect whether you have a condition called gestational diabetes. If this is found to be the case, you will have additional care from Specialist midwives and doctors (see Information leaflet; 'Glucose tolerance test').

Blood clots (Deep Vein Thrombosis)

A deep vein thrombosis (DVT) is a blood clot that forms in a deep vein of the leg, calf or pelvis. If the clot moves to the lung, it is called a pulmonary embolus. A blood clot is more likely to occur during pregnancy and in the first 6 weeks after the birth. The risk of this happening is one woman in every 500. Some women do not realise they have had a blood clot; however, there are symptoms which you should look out for.

Signs and symptoms of a blood clot in the leg include:

- Swollen painful calf or thigh
- Redness over the area
- The area may feel hot
- Pain and/or tenderness - you may only feel this when standing or walking or the leg may just feel heavy

Signs and symptoms of a blood clot in the lung include:

- Chest pain
- Shortness of breath
- Coughing up blood
- Feeling very unwell

If you experience any of the above contact your midwife or GP urgently. With prompt treatment any complications arising from the blood clot can be reduced.

Risk factors

There are certain factors which might increase a women's risk of developing a blood clot during pregnancy and afterwards. These include:

Previous history or family history of a blood clot
Severe varicose veins
Being overweight (Body Mass Index 30 or above)
Being immobile for a long period of time e.g., after an operation or when travelling for four hours or longer.
Aged 35 or more
Having an operative birth
Carrying more than one baby
Smoking
Becoming dehydrated
Some blood disorders

You can reduce the risk of having a blood clot during pregnancy and afterwards in a number of different ways:

- Stay as active as you can
- Try to stop smoking – your Community Midwife will refer you to Smoking cessation services in your pregnancy unless you decline this service.
- Wear compression stockings if you have varicose veins – these are available free on prescription from your doctor
- Wear compression stockings if you travel by air, make sure you have plenty of fluids, do some leg exercises and walk around the plane (see p. 17)
- If you are travelling a long distance by car make sure you stop frequently to exercise your legs and do some leg exercises in the car (see p. 17)
- See your doctor about reducing your weight after the baby is born

Your risk factors for having a DVT will be assessed at booking, if you have to be admitted to hospital and immediately after you've had your baby. If you are at high risk at booking, you will be given an appointment to see an obstetrician to discuss a plan of care with you. You may be advised to start treatment with injections of heparin (also known as Tinzaparin) which helps prevent blood clots forming. Your risk factors can change during your pregnancy and after the birth, e.g. if you become unwell or have a caesarean section. After you've had your baby you may be offered injections of heparin if your risk factors increase. For more information see our Leaflet: 'Venous thrombosis in pregnancy and after birth'.

Severe itching and obstetric cholestasis

It is not uncommon to experience some itching in pregnancy. However, severe generalised itching without a rash, particularly in the last four months of pregnancy, may be the sign of an uncommon condition called Obstetric Cholestasis. This is a potentially dangerous liver disorder, which if undetected or untreated may cause premature labour, stillbirth or serious health problems for the baby. If you do experience troublesome itching contact your midwife or doctor. For further information see http://www.nhs.uk/conditions/pregnancy-and-baby/pages/itching-obstetric-cholestasis-pregnant.aspx

Vaginal bleeding

It is important to tell a doctor or midwife about any bleeding in pregnancy so that the cause can be identified and appropriate care given. In early pregnancy it could be a sign of ectopic pregnancy or miscarriage, although many women who bleed do go on to have successful pregnancies. Bleeding in later pregnancy can indicate problems with the placenta or trauma to the cervix (e.g. erosion). A minor blood loss mixed with mucus is referred to as a 'show' and is normal in late pregnancy.

Baby's well-being

It is important that you are aware of your baby's pattern of movements, especially after 26 weeks of pregnancy, as this is an indication of your baby's health. If you are concerned that you haven't felt as many movements or none at all, please contact your Day Assessment Unit or Midwife Led Unit straight away.

See the leaflet: 'How active is your baby' which you will be given at 24 - 28 weeks of pregnancy.

Mental health problems during pregnancy and after giving birth

Most women go through pregnancy and the first year after giving birth without any mental health issues, but some women do have problems. If you have any concerns about your mental health please talk to your midwife who can refer you to a specialist midwife for further support.

There may be things you can do to help yourself. For example, if you are having problems sleeping, try to stick to a bedtime routine, and avoid caffeine and a lot of activity before going to bed.

In Pregnancy:

- Women who already have a mental health problem are more likely to become ill again during pregnancy or in the first year after giving birth than at other times in their life.
- Severe mental illnesses may develop much more quickly and be more serious after giving birth than at other times.
- You are more likely to suffer mental health problems if you are not supported by family and friends, if your pregnancy is unplanned, or if you have relationship problems with your partner, including domestic violence.
- Sometimes women who have a mental health problem stop taking their medication when they find out that they are pregnant without talking to their doctor or midwife. This can make their illness return or become worse.

If this happens to you, you may need more urgent care and treatment than usual, because of the possible effects on your baby, your own health and your other children.

During pregnancy this help could include a referral to a Clinical Nurse Specialist who can help you develop a plan of how to access treatment should you become unwell and advise on treatment. There is also a mental health team at both RSH and PRH who can offer help if you are an inpatient.

Psychological support

Pregnancy and childbirth can be exciting and rewarding, but can also be stressful or frightening. Some women need extra support to deal with their anxieties, relationships, and emotions.

Your midwife will ask how you are feeling during your first (booking) appointment to see whether you need any further support. A midwife will also visit you between 24 and 28 weeks at home ask you questions to see if you need any additional help and support at that time.
Please contact your community midwife if you are feeling low at any time.

There are Psychological Wellbeing (IAPTS) can offer individual or group support about low mood and anxiety. Please ring 01952 613822 for Telford or 0300 123 6020 for Shropshire County to self refer.

It is important that all professionals involved in your care (e.g. midwife, GP or health visitor) are aware of any mental health problems so that you can get support and advice when necessary. Otherwise it will be confidential.

Blood transfusion

A blood transfusion involves the transfer of blood or blood components from one person to another person. It is often done to replace blood that has been lost due to severe bleeding and can be life-saving. A blood transfusion may be necessary in a non-emergency situation such as severe anaemia during pregnancy. In emergency situations such as during birth or afterwards, you may need a blood transfusion if you bleed very heavily. Medication and surgical techniques will be used to limit the need for blood. During your booking visit, you are asked whether you consent to a blood transfusion, if necessary. Please be aware of the risks and benefits discussed below. The reason for the blood transfusion should be explained to you. If blood is given to you in an emergency, when it is not possible to discuss the transfusion beforehand, the discussion should take place when appropriate afterwards.

You can download the leaflets: 'Will I need a blood transfusion' and 'Information for patients who have received an unexpected blood transfusion' from http://hospital.blood.co.uk/media/28307/160511-27360-will-i-need-a-blood-transfusion-final.pd for from your midwife.

Having a blood transfusion

All blood donations in the UK are tested for viruses such as hepatitis and HIV. Only blood that is free from these infections is used in a blood transfusion. The chance of getting an infection from a blood transfusion is very, very rare. Most transfusions during pregnancy and after birth are given as red blood cells only. Very occasionally, platelets and plasma may be required as well.

Once your blood type has been matched with the donor type, the blood components are transfused via a drip into your vein. You are carefully monitored before, during and after transfusion. Some people get mild side effects, such as headaches, chills and fever, a rash and itchiness. These symptoms can be relieved by paracetamol and will improve within a day or so. Very rarely, there may be more severe side effects associated with an allergic reaction, including difficulty in breathing, severe headaches and a sudden fall in blood pressure. If you get these side effects, the transfusion will be stopped immediately and the situation reviewed.

For further information see:
www.nhs.uk/Conditions/Bloodtransfusion/Pages/Introduction.aspx
and www.blood.co.uk

If you want to refuse a blood transfusion You may decide you do not want to have a blood transfusion.

If you have any concerns or know you would decline the use of blood or blood components in any situation, it is important that you discuss this with your midwife at the earliest opportunity. An appointment will be made to discuss your wishes and any concerns with a consultant obstetrician. You can also talk to the hospital transfusion practitioner.

Alternatives to blood transfusion will be discussed, such as the use of cell salvage during a caesarean section. You must be aware, however, that in some circumstances only a blood transfusion will save your life.

A management plan will be made with a consultant obstetrician for your pregnancy, labour and birth. You will be asked to complete an advanced directive if you have not already done so. Your wishes will be respected.

If at any point you change your mind, we will ensure this is documented in your casenotes, and ensure that your latest decision is respected.

Feeding and nurturing your baby

During pregnancy, your baby's brain is growing very quickly and you can help this growth by taking some time out to relax and talk to him or her, to stroke your bump and maybe play some music. Encourage other close family members to do the same. There is a leaflet called 'Building a happy baby' which can be downloaded from: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/leaflets-and-posters/building-a-happy-baby/

The time when your baby is very young is brief and very precious. Spending a lot of time close together in the first few weeks helps you get to know one another and builds the love that keeps your baby safe and secure. Holding your baby next to your skin soon after the birth may help ease the transition into independence for your baby and helps calm and comfort you. It also helps get breast feeding off to a good start.

Before your baby is born you may not have decided how you would like to feed your baby but this does not matter. Hold your baby close and see how you feel when your baby responds to the touch of your skin and the sound of your voice.

During this time, make sure your baby's breathing is easy and regular, and your baby's body and face are a good colour. Hands and feet are often bluish for a few days, because of changes to the circulation outside the womb, so don't worry about this. If you are drowsy after the birth, from tiredness or having pethidine, ask your partner or a member of staff to keep an eye on your baby too.

Breastfeeding your baby may result in an intense feeling of emotional satisfaction and love for your baby and also gives you and your baby many short and long term health benefits.

Breast milk contains antibodies that protect your baby from infection. Babies who are fed with formula milk do not receive this protection and are therefore more likely to suffer from diarrhoea and vomiting, urine infections, chest infections and if born prematurely, serious bowel infections. Research also suggests that formula fed babies are more likely to suffer from asthma, eczema, obesity, diabetes, high blood pressure and have poorer dental health.

Breastfeeding is good for mother's health too. It helps protect you from breast and ovarian cancer, gives you stronger bones in later life and helps you lose weight.

This Trust believes that breastfeeding is the healthiest way for a woman to feed her baby and recognises the disadvantages of the use of formula. For this reason all women are encouraged to breastfeed or give as much breast milk as they can or as they feel able. Breastfed babies cannot be overfed so you can use breastfeeding to soothe your baby and as a way of spending time together, or having a rest whenever you both want. Responding to your baby's needs for food and comfort will help him or her feel secure, so (s) he will cry less, which helps make your life easier too.

If you would like to attend our informal Breastfeeding support groups or workshops, please see the information at the back of this folder or ask your midwife.

At Shrewsbury and Telford NHS Trust we have several midwives who are also Lactation Consultants who can help if you have more complex feeding problems. We have achieved Stage 2 UNICEF Breastfeeding Initiative Accreditation and are working towards Stage 3.

When choosing a formula milk make sure you use a first or newborn milk. One brand is no better than another. Some manufacturers now supplement infant formula with additives that they claim have health benefits for babies. At present it is unclear if this practice is beneficial to babies (see www.firststepsnutrition.org/; https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/leaflets-and-posters/guide-infant-formula-parents-bottle-feeding/

Because formula fed babies do not receive the naturally occurring anti-infective properties of breast milk it is important that you are aware of the need for good hygiene when preparing formula feeds. Your midwife will be able to advise you about this.

However you choose to feed your baby, a midwife will be available to help and support you at all times during your care. As you grow more familiar with your chosen feeding method you will gain confidence and learn to relax and enjoy seeing your baby thrive and grow.

Information for partners

All the information in this book is for you too. By reading it you will be aware of our services, why we do the things we do and what to expect during the birth and afterwards.

There is other information which will help you understand what your partner is experiencing and what she might be feeling at different times during pregnancy, birth and in the early days after having the baby:

1. In the early weeks of pregnancy she might be feeling very tired and sick. She may not be able to face cooking certain foods and may avoid certain smells and tastes. She may not have the energy to do all the things she normally does.
2. If she's a smoker, she may be trying to stop smoking. This is probably the most important thing a pregnant woman can do for her baby. If you smoke, please try not to do so around her.
3. The pregnancy hormones will make her breasts tender and can make her skin very sensitive. You may need to be especially gentle when touching her.
4. She may become anxious about her appearance and about the birth and need reassurance from you.
5. She may become down and irritable at times. This is normal, but if it persists do get help as she may be suffering from depression.
6. She may become very impatient for the baby to be born towards the end of pregnancy because she is so uncomfortable. Please reassure her it is best to wait until the baby is ready to be born unless there is a reason for medical intervention.
7. Most women want their partners with them during the birth and most fathers want to be there. If you think, however, that you would not be the best person to support her during the birth, then discuss this with her and write down your birth preferences on the page provided in this folder.
8. If your partner is advised to have her labour induced, please be aware that the induction process can take a long time, even several days. Please support her positively and ask the staff to keep you informed about what is happening.
9. Be flexible in your ideas about what circumstances and pain relief she wants during labour. Sometimes labour does not go according to expectations and she may change her mind about what she wants. Sometimes a revised plan needs to be made for medical reasons. Discuss any questions or concerns with your midwife or doctor. In the uncommon event of an emergency you may need to debrief after the event.
10. Help your partner in labour in the way she asks for. Women are very different, some want lots of massage and touch; others don't like to be fussed or touched and just want you to be there.
11. Breastmilk gives your baby the best possible start in life, but breastfeeding is not always easy to start with. Please support your partner if she wishes to breastfeed or express breastmilk.
12. Sometimes visitors can be overwhelming, especially if your partner is very tired or has had an operative birth. You can help by suggesting visitors stay for just a short time or perhaps delaying the visit for a few days.

So far this chapter has focused on your partner, but what about you? Many men feel anxious when they are becoming a father. You may have worries about money and how you will cope. You may worry that your relationship, including your sex life, will be affected. Some men become depressed during this time.

The most important thing is for you and your partner to talk about any concerns. Often pregnancy is a very joyful time when both of you feel special and excited. Many couples have a very good sex life in pregnancy, and there is no reason not to have sex unless you have been advised not to do so.

After the baby is born both of you may be tired for a few months, and your partner may not be ready to resume a full sex life for some time. You may also feel very happy and delighted with your new baby. Remember these early months will not last for ever. Enjoy the delights, and be aware that life will settle down to a new kind of normality in time.

For further information visit: www.nhs.uk/conditions/pregnancy-and-baby/pages/dad-to-be-pregnant-partner.aspx

Getting ready for birth

Preferences for birth

It's a good idea to write down what you would like to happen during your labour and afterwards. Thinking about your birth preferences encourages you to look at all the birth options available and you can include anything you feel strongly about.

Find out as much as you can about your local maternity services. Go to any classes and workshops offered in your area, look at our website, read this booklet and access the Start4Life Information Service for Parents: www.nhs.uk/start4life.

Remember to take into account your medical history and the facilities available at home or hospital. Once in labour, the midwife who cares for you will discuss your preferences and agree a plan of care with you. However, if complications arise, your midwife and doctor will discuss these with you and will be able to let you know your options in these particular circumstances.

Some of the things you may wish to consider:

- How do I feel about labour and birth?

  Thinking about how you feel about labour and birth may help you with the other choices open to you.
- Where do I want to have my baby?

  Do I want a home birth or to have my baby in hospital? Is there a unit run by midwives in my local area?
- Who do I want to be with me?

  Think about who you'd like to be with you to support you. Often this is your partner but you may wish another close friend or relative instead. It can be very hard to see someone you care about in pain and you need to make sure they can cope with the situation. They need to support you, not the other way around!

  Are you happy to have a student midwife involved in your care? They will provide lots of support and are always supervised by an experienced midwife.
- How do I want my baby's heartbeat to be monitored during labour?

  If everything is straightforward you can choose for the heartbeat to be monitored every 15 minutes (5 minutes in second stage). The baby's heartbeat does not need to be monitored continuously unless there are any concerns.
- How would I like to give birth?

  Many women like the idea of having a water birth or being able to move around during labour. Ask whether birthing mats or rocking chairs are available if you would like to try them. Don't forget to try different positions as moving will help the labour process.

  Think about how you might like to give birth, such as kneeling, squatting, standing or sitting upright. Having these options available will enable you to do what feels best for you at the time.

  Ask if you can bring your own music in with you.

  Do you want to find out the sex of your baby yourself?

  How do you want to deliver your placenta – naturally or have an injection?
- What kind of pain relief would I consider?

  Read the section on pain relief (p. 43) for risks and benefits and keep an open mind. You may need less or more pain relief than you think. If you definitely want an epidural this is only available on the Delivery Suite at Telford and you have to be closely monitored. We have a dedicated Maternity anaesthetic team and try to get your epidural sited as soon as possible, but please be patient if the anaesthetist is dealing with an emergency or if the Delivery Suite is very busy.
- What do you think about being induced?

  Most babies arrive between 37 and 42 weeks of pregnancy. However, if your baby hasn't arrived by 41 weeks do you want your labour to be started artificially or left until you go into labour naturally? See p.37 for more information about induction of labour.

For advice on preparing your dog for the arrival of your baby, see https://www.dogstrust.org.uk/help-advice/factsheets-downloads/factsheetnewbabynov13.pdf

Perineal massage: Research has shown that massaging your perineum from about 34 weeks of pregnancy reduces the change of a tear or bruising to this area during birth. this is particularly beneficial if you are having your first baby. For more information about perineal massage, see: https://www.nct.org.uk/pregnancy/perineal-massage

- How do I feel about an assisted delivery or an emergency caesarean?

  Sometimes you may need some help to give birth to your baby. Read the section on 'Assisted births' for more information (p. 47).

- How do you feel about feeding and nurturing your baby? See p. 32 to help you think about this.

- Would I like my baby to have vitamin K? Vitamin K helps to prevent a serious blood clotting disorder and it can be given either by injection or orally (drops in the mouth) - see p. 53.

Finally, remember to be flexible, especially if this is your first baby. What might appeal to you now might not be what you actually want when in you're in labour:

Write out your birth preferences on the form provided in your Pregnancy Health Record.

Stem cell collection

You may be considering having blood collected from the baby's placenta for Stem Cells. This is not available on the NHS but there are many private companies that offer this service in the UK. These organisations will be able to provide you with specific information to enable you to make a decision which is right for you and your baby.

Packing for hospital

It's a good idea to pack two bags – one for yourself and one for your baby. Visit www.babycentre.co.uk/what-to-pack-in-your-hospital-bag to get an idea of what you will need.

If you think you may want to feed your baby with formula milk, please bring pre-prepared milk for newborn babies, preferably in 'Starter pack' form - available from many supermarkets. There is no need to bring milk if you want to breastfeed as we can supply formula if supplementary feeds are needed.

Please note that valuables are brought to the hospital at your own risk and we cannot take responsibility for looking after them.

Antenatal education and information

Provision of Antenatal classes is individual to different units in the Shropshire Maternity Service. Please talk to your midwife about any classes offered by the Maternity Services in your area. You can find out more on our website: http://www.sath.nhs.uk/wards-services/az-services/maternity/classes-workshops/

Breastfeeding workshops

Breastfeeding workshop sessions take place around the county. Please ask your community midwife for details of sessions in your area. Details of Breastfeeding Support Groups can be found in the leaflets inside the back cover of this folder.

Waterbirth sessions

If you are interested in having a waterbirth or using the water pool for pain relief, please ask your midwife for details of information sessions in your area.

Other sources of information are:

1. Reputable websites such as:
   - NHS Choices: http://www.nhs.uk
   - NCT: http://www.nct.org.uk/
   - RCOG Patient Information: http://www.rcog.org.uk/womens-health/patient-information
   - NICE Information for the public (search by topic)
   - Patient: http://patient.info
   - Start4Life Information Service for Parents: http://www.nhs.uk/start4life/Pages/healthy-pregnancy-baby-advice.aspx

Please note that every Maternity Service will have slightly different local practices which may not always be exactly as stated in external information. You should check with your midwife or doctor if there are any issues of particular interest or concern to you.

2. To find local education classes and support groups, browse the web and consult your local 'Family Grapevine' magazine at: http://thefamilygrapevine.co.uk/shrewsbury-telford/

Accredited Online Antenatal and Postnatal classes are available at: www.inourplace.co.uk.
These classes are free at least until March 2017.

A Virtual Tour of the Consultant Led Services at the Shropshire Women and Children's Centre is available on our website. www.sath.nhs.uk.

Signs of labour

You're unlikely to mistake the signs of active labour when the time really comes, but in the early stages you may not be sure. Contact your hospital or midwife for advice if you need to.

The show

Either before labour or early in labour, the plug of mucus in the cervix, which has helped to seal the uterus during pregnancy, comes away and comes out of the vagina. This sticky pink mucus is called a 'show' and it may be mixed with a little blood. This can happen several times. However, if you are losing a lot of blood please telephone the hospital straight away. It is possible to have a show and not experience contractions immediately. Some women can have a show several days before they start labour.

The waters breaking

The bag of water which surrounds your baby may break before labour starts. This happens to about 1 in 5 pregnant women. It can be a slow trickle or felt as a gush of water. Phone the hospital for advice. It is useful if you wear a sanitary pad to see if there are any further trickles and to check the colour of the water.

Not all women start contracting after the waters break and if this is the case you will be given an antenatal check and the baby's heartbeat will be monitored. If contractions have not started within 24 hours you will be offered the option of induction because of a possible risk of infection.

Contractions

A contraction is when your uterus tightens and your abdomen (tummy) feels hard. The uterus then relaxes and your abdomen feels soft again. You may feel contractions (painless, irregular tightenings), during your pregnancy (Braxton Hicks). There are three main differences between Braxton Hicks and labour contractions. Labour contractions are:

- Painful (for most women)
- Regular
- Become longer and stronger and more frequent

The latent phase of labour

In the early stages of labour, often known as the 'latent phase' the contractions are softening your cervix (neck of the womb) and making it ready to dilate (open up). Some women have backache or have contractions for a few hours which then stop and start again hours later. This is perfectly normal. Sometimes these contractions may be sharp but are usually short lasting.

The latent phase of labour can take a long time, even several days. It is therefore best to stay in your own surroundings as long as you can. Relax as much as possible, have a warm bath or listen to music. It is important to make sure you eat and drink normally. You can take paracetamol as directed as a simple form of pain relief but contact your midwife if you need advice or reassurance.

Your birthing partner can help you keep calm and relaxed. It can be helpful if they massage your back if you have backache or suggest alternative positions to encourage labour to continue. Keep upright as much as possible as this will encourage labour and gravity helps the baby go down into your pelvis. Swaying or rocking your hips can also help. You can also try a TENS machine now if you have one. However, although this can be an exciting time, remember to rest and not get overtired as you will need lots of energy later on.

The latent or early stages of labour last until your cervix is about 4cm dilated and sometimes this can take a long time, especially with a first baby. If you go to hospital before you are in established labour you may be asked if you would prefer to go and enjoy the comfort of your own home again for a while, rather than spending many extra hours in hospital. Being relaxed and confident helps labour to progress but if you are feeling very uncomfortable at this point please discuss this with your midwife.

Sometimes labour starts early before 37 weeks. If this happens, phone the Delivery Suite immediately on 01952 565924.

When to go into hospital or the Midwife Led Units

If your waters have broken, you need to telephone the hospital and they will probably advise you come in for a check. If you have any fresh red bleeding you need to contact the hospital as soon as possible. If your contractions start but your waters have not broken, wait until the contractions are coming regularly, about 5-10 minutes apart and lasting for about 60 seconds, and that they feel so strong that you want support from a midwife. If you live far away from the hospital, make sure you leave plenty of time. Second and later babies often arrive more quickly.

Don't forget to phone the hospital first and bring your Pregnancy Health Record with you.

It's natural that your family and friends are keen to know what's happening when you go into hospital. Please help us by asking them to wait for you or your partner to ring them with any news.

Having a home birth

Telephone your Midwife Led Unit and they will arrange for a midwife to come to your home.

What happens if my baby is overdue?

Most women will go into labour by themselves by 42 weeks of pregnancy. If your pregnancy lasts longer than 41-42 weeks you may be offered induction of labour where your labour is helped to start. (see next section).

Please see information on page 8 about what may happen at times when the service is extremely busy.

Induction of labour

Induction of labour can take many hours or even days. Transfer to the Delivery Suite can be delayed for women not in established labour if the unit is very busy.

Induction of labour is a process designed to start labour artificially. You may be offered induction if you or your baby's wellbeing is causing concern or if your pregnancy is nearing 42 weeks. Discuss the options with your doctor or midwife and ensure you understand the procedure and the risks and benefits.

Why is induction of labour offered?
There are a number of reasons why induction of labour may be suggested:

- Prolonged pregnancy after 42 weeks. Women with straightforward pregnancies will be offered induction of labour between 40 weeks + 12 days and 40 weeks + 14 days. This follows the National Institute for Clinical Excellence (NICE 2008) guidance on induction of labour. The risk of stillbirth increases from 1 in 1000 at 41 completed weeks to 2 in 1000 after 43 completed weeks.
- Maternal age over 40. Women who are 40 or older at their booking appointment will be offered induction of labour at 40 weeks.
- Your waters have broken before labour starts. This is known as prelabour rupture of the membranes (PROM). When this happens labour usually starts within 24 hours. However, the risk of infection increases the longer the time between the waters breaking and the birth of your baby.
- If you or your baby's wellbeing is giving cause for concern, for example, if you have high blood pressure or the baby is not growing properly.

Induction does not increase the likelihood that you will need a caesarean section in labour.

What if I prefer to wait until I go into labour naturally?
You may prefer not to be induced and to wait until you go into labour naturally. If you decline induction, you will be referred to a consultant obstetrician and offered increased monitoring, including listening to the baby's heart beat and ultrasound scans. A plan will be put in place for your baby following delivery, as there is a risk of complications from reduced energy reserves.

How is labour induced?
It is usual to offer a membrane sweep first to help you go into labour by yourself. This is performed during a vaginal examination and can be done at home, in a Midwife Led Unit, GP surgery, Day Assessment Unit or Antenatal Clinic. If the membrane sweep does not start labour other methods can then be used depending on their suitability and what is happening to your cervix (neck of the womb):

- Prostaglandin, pessary, gel or tablets
- Artificial rupture of the membranes
- Oxytocin drip

Membrane sweep
During a vaginal examination, the midwife or obstetrician places a finger into your cervix and, with a gentle sweeping movement, separates the membranes which surround the baby from the cervix. It can be uncomfortable but having a sweep means that you are more likely to go into labour naturally. Women having their first baby are offered a sweep at 40 weeks and again at 41 weeks if they have not gone into labour. Women who have had a baby before will be offered a sweep at 41 weeks.

What are the benefits?

- It reduces the need for other methods of induction of labour as you are more likely to go into labour naturally.
- It does not involve drugs and can be repeated
- You do not need to come into hospital to have it done

What are the disadvantages?

- It can be uncomfortable
- Sometimes you may get some light spotting of blood

Prostaglandin, pessary, gel or tablets
You will usually be offered prostaglandins (also known as Propess or Prostin) to help start your labour. Prostaglandins act like natural hormones and help soften the cervix gradually just as in natural labour.

The prostaglandin medication is inserted into the vagina during a vaginal examination. The programme of medication given will depend on individual circumstances. More than one does is often required, and once the maximum dose has been given, your plan of care will be reviewed by an obstetrician.

You will need to lie down for 30 minutes after the medication is given, during which time your baby's heart beat will be listened to again. After this you will be encouraged to get up and move around as this will help labour to progress. Period type pains are common and you will be offered pain relief and warm baths. You can also use a TENS machine (see p.43).

What are the benefits?

- Prostaglandin can encourage the cervix to soften and open. You might go into labour as a result, or your cervix might open enough to allow your waters to be broken, which can also help to start your labour.

What are the disadvantages?

- Sometimes more than 1 dose is needed.
- Some women experience strong contractions often called 'Prostin pains' but the cervix does not change very much. Further doses of gel may be needed and often women can become tired from this long process of induction.
- Side effects can include nausea, vomiting, diarrhoea and vaginal soreness.
- Very occasionally prostaglandins can make your uterus contract too much and you may need other medication to counteract this. Excessive uterine contractions can result in a significant complication such as uterine rupture (a tear in the uterus) or placental abruption (where the placenta partially or completely separates from the uterus); however, these complications are rare. If you have had a previous caesarean section or any other surgery to your uterus, your obstetrician will discuss and agree a management plan with you.

Some women go into labour after administration of prostaglandin. If your cervix has softened after the prostaglandin has been given, but you haven't gone into labour, the next step is to break your waters - also known as artificial rupture of membranes (ARM).

If there are any reasons why you should not have prostaglandin, your induction process might be started by having your waters broken.

Artificial rupture of the membranes
You will need to be transferred to the Delivery Suite for ARM. This may be delayed if the Delivery Suite is very busy with other women waiting for an ARM ahead of you and women arriving in active labour. This can feel frustrating for you, especially when staff may not be able to give you precise timings for your transfer.

Please bear with us; as long as you are not in labour, and you and your baby are not at high risk, it is safer for you to wait until the Delivery Suite is not too busy.

An ARM is done during a vaginal examination using a plastic hook to make a hole in the amniotic sac. This, and the baby's head being in contact with the cervix, stimulates the release of natural prostaglandins (hormones that start labour). The vaginal examination can be uncomfortable, but the actual breaking of the membranes does not hurt. Ask to use some entonox (gas and air) if you are worried about the discomfort.

After your waters have been broken you will need to have your baby's heart rate monitored for about 30 minutes. You will then be encouraged to get up and walk around to help start your labour. If you have not gone into labour 2 hours after your waters have been broken, then you will be advised to have an oxytocin drip (see section below). The oxytocin drip can be started earlier, depending on the reason for your induction of labour.

What are the benefits?
- Having your waters broken can be enough to start your labour
- No drugs are involved

What are the disadvantages?
- Once your waters have been broken, the procedure to get you into labour cannot be stopped due the risk of infection.
- There is a small chance that the baby's umbilical cord may slip past the baby's head (a cord prolapse). Cord prolapse is not common, occurring in about 1 in 200 births.

Oxytocin drip
Syntocinon is a synthetic form of the natural hormone oxytocin and encourages contractions. You will need to be on the Delivery Suite. Syntocinon is given through a drip in your arm or back of your hand. The drip is increased very slowly until you are having strong and regular contractions.

What are the benefits?
- Encourages contractions to help start your labour

What are the disadvantages?
- Your contractions and your baby's heart rate will need to be monitored continuously as some babies can become distressed by the contractions. The midwife will adjust the rate of the drip if you start contracting too much. Sometimes the drip has to be stopped.
- Your ability to move around during labour will be reduced; however, you can still sit in a rocking chair, use a birthing ball or stand.
- The contractions may be more painful than natural contractions and some women may find they need extra pain relief.

If oxytocin has been used during labour, it's recommended that you have an active third stage to deliver your placenta. This means that the midwife will give you an injection immediately after the birth to help your uterus to contract to deliver the placenta and control any bleeding.

Coming into hospital for induction
Your midwife or obstetrician will arrange a date and time for you to be admitted onto the Antenatal Ward at the Shropshire Women and Children's Centre in Telford. Please bring your Pregnancy Health Records, any prescribed medication and your labour bags. You will be welcomed by the ward staff and shown around the ward.

Please remember that the time it takes to get into labour can vary from a short time to many hours or even days. If labour ward is exceptionally busy, then it may not be safe to start your labour. Your induction may be delayed but you and your partner will be kept informed by the midwifery staff.

When you come into hospital you will have your blood pressure, pulse, and urine checked. Your baby's heart beat will be monitored and then with your consent the midwife will do a full check of you and your baby. With your consent she will do a vaginal examination to assess the readiness of your cervix for labour. A plan of care can then be made as to how best to help start your labour.

Can my birth partner stay with me?
You partner is very welcome to stay during visiting hours (see p. 8).

We are trying to accommodate as many birth partners as possible overnight when a woman is being induced. We have only 6 side rooms, so this is not always possible. Please note that we can only accommodate one birth partner to stay overnight.

All women who are transferred to the Delivery Suite can have up to two birthing partners with them all the time. The ward staff will be happy to contact your partner for you.

Pain relief
Pain relief is available for you on the Antenatal Ward. If the prescribed medication is not helping sufficiently, please ask your midwife to arrange for more pain relief.

What happens if induction is not successful?
Occasionally, despite trying all the methods of induction, labour does not begin. If this is the case, your obstetrician will make an individual plan with you for the birth of your baby.

References
1. NICE 2008: CG 70 Induction of labour www.nice.org.uk

Labour and birth

What happens when I get to hospital or the Midwife Led Unit?

When you arrive, the midwife will welcome you and ask you about what has been happening during your early labour. The midwife will:

- Take your pulse, temperature and blood pressure and check your urine
- Feel your abdomen to check baby's position and will listen to your baby's heartbeat
- She may do an internal examination with your consent to find out how much your cervix has opened and how far your labour has progressed

These checks will be repeated at intervals throughout your labour, with your consent – always ask about anything you want to know.

If you and your partner have made a birth plan, show your midwife so that she knows your wishes and can discuss them with you. Any information and discussions you have with your midwife or doctor about the care offered should include explanations and possible advantages or disadvantages. You can always change your mind about any decisions you make.

Once you are in established labour you should receive supportive one-to-one care. Having discussed your birth preferences, your midwife will be able to use this information to help and support you during labour. You should be encouraged to move around and change position to increase your comfort.

Home birth

The midwife will come to your home when you are ready. All the checks will be done with your consent, as described above.

What happens in labour?

Please be sure to read the section on the 'Latent phase of labour' (p. 36)

There are three stages to labour. In the first stage the cervix gradually dilates (opens up). In the second stage the baby is slowly pushed down the vagina and is born. In the third stage the placenta comes away from the wall of the womb and is also pushed out of the vagina.

First stage of labour

Contractions

During the start of labour, you will have increasingly regular and painful contractions. These contractions help to soften and thin the cervix and then the cervix gradually opens wide enough for the baby to be born, which is called being 'fully dilated'. Sometimes it can take a long time for labour to become 'established', which happens when the cervix is about 4 cm dilated. Before then labour can stop and restart later.

Towards the end of first stage you may feel that you want to push as each contraction comes. If your cervix is not fully dilated yet, the midwife will help you to try not to push until the cervix is ready.

How long will labour last?

The length of the first stage of labour varies between each woman. On average, labour will last about 8 hours for women who are having their first baby, and is unlikely to last over 18 hours. For women having their second or subsequent baby, labours on average take 5 hours and are unlikely to last over 12 hours[1]. Because the length of the 'latent phase' can be so variable (see p. 36), we start this time from the beginning of 'established' labour.

How your baby is monitored

It is important to monitor the heart rate of your baby during labour. The method of doing this will depend on you and your baby's individual needs. Your midwife will discuss this with you. Although most babies cope extremely well during labour, there are a few babies who have difficulties and the best way to check on how they are coping is to listen to their heartbeat. There are different ways of monitoring the baby's heartbeat.

NICE Guidelines[1] recommend that there is no need for you to be connected to a monitoring machine even for a short period unless there are concerns about your baby.

The midwife will check your pulse rate to ensure there is no confusion between your heart rate and your baby's. Your baby's heartbeat will be listened to at regular intervals during your labour using the following methods:

- Pinard – Trumpet shaped instrument which helps the midwife to listen to the heart rate
- Sonicaid – A handheld monitor which can also be used during a water birth. You can listen to your baby's heartbeat too if a sonicaid is used.

Intermittent monitoring allows you to move around freely.

Continuously monitoring your baby's heart beat

If you have had problems during your pregnancy or if there any concerns about how your baby will cope with labour, it may be advisable that your baby's heartbeat be monitored continuously. For example your baby may be premature or smaller than expected.

Continuous monitoring may also be recommended during labour if complications arise. These complications could be abnormal changes in the baby's heartbeat, if your baby has opened its bowels (passed meconium), if you start bleeding, if you develop a temperature or your blood pressure goes up. Continuous monitoring is also advisable if you need to have oxytocin to encourage contractions or if you want an epidural for pain relief.

- CTG – an electronic fetal monitoring machine which produces a printed recording your baby's heart beat and your contractions called a cardiotocograph (CTG) or sometimes called a 'trace'. Two small pads held in place with two elastic straps are placed on your abdomen. Information about your baby's heartbeat and your contractions will then be printed onto graph paper. The midwife or doctor can then interpret the trace to see how well your baby is coping with labour. Your ability to move around during labour will be limited but you can still stand, or sit in a rocking chair or on a birth ball.
- Fetal Scalp Electrode – sometimes it may be suggested that a clip is put onto your baby's scalp (instead of using one of the pads on your abdomen), so that the heartbeat can be picked up directly. The reasons for doing this should be discussed with you. The electrode is put on during a vaginal examination and the waters are broken if they have not already done so. The baby may have a small mark from the clip which should heal quickly.

Fetal blood sampling

If there is concern about your baby's heartbeat, a doctor may recommend taking a small blood sample from your baby's scalp. This is to test whether the baby has enough oxygen in the blood to check wellbeing.

The procedure involves a vaginal examination and making a small scratch on the baby's head from which blood is collected. This will heal quickly after the birth. The risk of infection is small, and the procedure helps to reduce the need for further, more serious, interventions if the result is normal, or hasten urgent interventions if the result is abnormal.

Occasionally, it is not possible to obtain a blood sample. It may then be necessary to perform an assisted birth (ventouse or forceps) or a caesarean section because it is not possible to find out how well the baby is coping.

Eating and drinking in labour

You can eat and drink during the early stages of labour although it is best to concentrate on light, energy giving foods e.g. toast, biscuits or cereal. If you don't feel like eating, high energy drinks and glucose tablets may be useful. If you are giving birth in hospital you need to bring these with you. If you use pethidine or have an epidural for pain relief you may be advised not to eat once in active labour.

It's a good idea to empty your bladder during the first stage of labour to protect it as the baby's head descends. Having a full bladder may also delay the descent of the baby's head and the midwife may need to insert a catheter to empty your bladder.

Speeding up labour

If your labour is progressing normally and you and your baby are well, any clinical intervention is not recommended. However, if your labour is slower than what may be considered normal your midwife or doctor may recommend speeding up labour to get things moving. You should be given a clear explanation of why this has been suggested and your consent will be needed.

If your waters have not broken, the midwife can offer to break them using a small plastic hook during a vaginal examination. This is sometimes called 'artificial rupture of the membranes' (ARM). Doing this may make your contractions stronger and can make your labour shorter. This is often enough to get things going.

If not, you may be offered a drip containing a hormone (oxytocin) which will make the contractions stronger. If you have the drip, the hormone will be fed into a vein in your arm. You will need to be monitored all the time using the CTG machine to check the baby's heart beat and the number of contractions. Labour can be more painful and you may need further pain relief but it will shorten the time you are in labour.

Second stage

This stage begins when the cervix is fully dilated and your baby's head starts moving down your vagina. Don't worry if you don't have urges to push straight away. We will wait an hour for the baby's head to come down until we start to encourage you to push. The time from the start of pushing until the birth of the baby can be up to 2 hours for a first baby or up to 1 hour for a woman who has already had a baby.

Positions for second stage

Mothers are encouraged to find whatever position feels natural and the midwife will discuss with you which positions are best in helping you to give birth to your baby. Upright positions such as kneeling, squatting or standing are more comfortable, less painful and pushing may be

easier. Research has also shown that there is less chance of needing an assisted delivery[2]. If you feel tired you can always lie on your side.

Pushing

You will usually feel a strong urge to push with the contractions and the baby will gradually descend with your pushing efforts. Women can have the feeling that they want to open their bowels and this is quite normal. Sometimes a woman might not have the urge to push and it is best to wait until her body is ready. Your midwife will give you lots of help and support.

When the baby is about to be born, the midwife will tell you to stop pushing, to push very gently, or pant to stop yourself pushing. This is so that your baby's head can be born slowly, giving the skin and muscles of the perineum (the area between your vagina and back passage) time to stretch without tearing. Please the information on p. 35 about perineal massage to prepare your perineum for labour. Sometimes the skin of the perineum won't stretch enough and may tear. There may be a need to deliver the baby quickly and with your consent the midwife or doctor will give you a local anaesthetic and make a surgical cut from your vagina at an angle into your perineum. This is called an episiotomy and is done to make the vaginal opening bigger. Afterwards the cut or tear will be stitched and start to heal. Small tears or grazes are sometimes left to heal without stitches because they often heal better this way.

Once the head is born, most of the hard work is done and you will be asked to give one more gentle push to deliver the baby. The baby will be dried and lifted onto your tummy so that you can hold the baby and be close to each other immediately. This is called skin to skin contact. You and the baby will be covered with a towel or blanket to keep you both warm. Usually the baby is very keen to breastfeed at this time and your midwife can help you if you wish.

Third stage[1]

After your baby is born, more contractions will push out the placenta. This usually takes between 5 minutes and 60 minutes depending on how you choose to deliver the placenta. You should be offered a choice of:

An active third stage

A drug called Syntometrine or Syntocinon is given by injection into your leg to help the uterus contract. The contractions will help to separate the placenta from the walls of the uterus. The midwife will clamp and cut the baby's umbilical cord and gently pull the cord to help deliver the placenta.

Advantages:

- The injection can help prevent heavy bleeding which some women may experience without it.
- It will shorten the time taken to deliver the placenta
- Reduces the likelihood of anaemia after you have had your baby and the need for blood transfusions

Disadvantages:

- It can make you feel sick, vomit and have a headache.

It is recommended that you have an active third stage if you have had any problems during labour, any history of bleeding in this or previous pregnancies, any problems with delivering the placenta in previous labours or you are having more than one baby in this pregnancy.

A passive third stage

This is when the placenta is delivered naturally by the uterus contracting without the injection. The midwife will not cut the cord until it has stopped pulsating and you will need to give a few gentle pushes to help push the placenta out.

Advantages:

- This is a natural way to deliver the placenta
- You won't experience any side effects such as nausea from the injection

Disadvantages:

- It may take longer to deliver the placenta
- There is a higher risk of bleeding heavily

You may prefer not to have the injection first, but to wait and see if it is necessary. You should discuss this in advance with your midwife and make a note of it in your birth plan. Sometimes it can be difficult to deliver the placenta even if you have had the injection. If this is the case, you will be offered oxytocin through a drip in your vein to strengthen your contractions to help deliver the placenta. If the placenta is still not delivered, you may have to go to theatre to have your placenta removed under a regional anaesthetic (spinal or epidural).

Once labour is complete

All mothers are encouraged to hold their babies in skin to skin contact. This helps keep your baby warm, settles his breathing and calms you both. Skin to skin contact is the best way to get to know each other and helps to get feeding off to a good start. During this time, make sure your baby's breathing is easy and regular, and your baby's body and face are a good colour. Hands and feet are often bluish for a few days, because of changes to the circulation outside the womb, so don't worry about this. If you are drowsy after the birth, from tiredness or having pethidine, ask your partner or a member of staff to keep an eye on your baby too. Partners can have skin to skin contact too.

All mothers are encouraged to let their baby breastfeed at this time and your midwife will give you lots of support. Please see the 'Feeding and caring for your new baby' guide which your midwife gave you at booking.

As long as you and the baby are well, you will have time alone with your partner to meet your new baby properly. For security reasons your baby will have two labels attached showing the name of the mother, the gender of the baby, the date and time of birth, and the baby's

hospital number. When the time is right for you the baby will be examined, weighed and dressed.

Checks soon after the birth

Your midwife will take your blood pressure, pulse and temperature. She will also monitor your blood loss, as occasionally your loss might be heavier than normal. This can happen after a long labour and the uterus is not contracting well enough to stop heavy bleeding.
If this happens you will be given oxytocin to help your uterus contract and stop the bleeding. You may also be given other drugs and if the bleeding is excessive, a blood transfusion may be necessary with your consent (see page 31).

Stitches

After the birth, your midwife will check to see if you need stitches. If you have a very small tear, you may not need stitches. If you do need stitches, you will be offered a local anaesthetic to numb the area beforehand. You may need to have your legs supported by the use of leg rests attached to short poles positioned on either side of the bed whilst this is carried out.

You will need a rectal examination (the doctor or midwife gently inserts a small finger into the rectum) before and after the stitches to ensure the stitching is done correctly. If you are found to have a more complicated tear which affects the muscle or even the inside of the back passage, you will need to go to theatre for the tear to be repaired by a doctor, with a spinal anaesthetic for pain relief. This is called a third or fourth degree tear.

Your midwife will give you advice on diet, hygiene, painkillers and pelvic floor exercises to help you heal quickly and to prevent problems with these muscles in the short or long term.

Bladder care

It is important that we know that your bladder is working properly after the birth. Midwives will ask you to pass urine in a bed pan in the hours after the birth, to ensure you are able to go, and can pass a good amount. If you had any complications in your labour and birth you may have a catheter in place for up to 24 hours after the baby is born.

Transferring to the postnatal ward

When you and your midwife are happy for you to be moved from the labour room, you will be transferred to a bed on the postnatal ward. Your partner can come with you but they may have to go home fairly soon if it is during the night. We understand that you may not wish to be apart but this is because of security reasons and to reduce any disturbance to other mothers and babies who may be asleep. You will need your rest too.

Partners can stay with you from 9am until 8.30 pm, except for mealtimes, so that you can spend time together as a family. If you have had a straightforward birth you will be able to transfer to a Midwife Led Unit or go home between 6 and 24 hours after the birth.

Visitors in hospital or Midwife Led Units

The visiting policy limits the number of people visiting during the family and friends visiting hours to 2 plus your partner. This is because of security and safety issues and also to reduce the risk of cross infection to new babies. This is why no children under the age of 14 (other than your own children) will be allowed on the ward to visit you. Please ask your visitors to use the hand gel before entering the ward and before handling your baby.

Security in hospital or Midwife Led Units

We advise parents never to hand over their baby to any person that is not known to them, even if they act or look like a member of staff. All staff should be wearing identification badges. Please let staff know if you wish to leave your baby to go off the ward. There is an electronic baby tagging system in operation in busier areas.

The doors to the Midwifery Led Units and the wards in the Consultant Led Unit are kept locked and access is via an intercom. All visitors need to press the intercom and identify themselves to get access.

When you go to the postnatal ward you will receive a postnatal information pack. The booklet 'After the birth' gives you lots of information about your time in hospital and at home with a new baby. Put this book at the back of your purple folder.

Please keep this information with you rather than sending it home with other belongings as it contains essential information.

Taking photographs and videos in hospital

The Trust recognises that patients and their families may wish to take photographs or videos while in hospital. You need to obtain the permission of patients, visitors and staff before taking their photograph, so please take images only of your relatives. Please be aware of people in the background.

Please do not take videos with sound, as this could affect patient confidentiality. To ensure that we keep within the law, members of the public recording images or sounds against Trust advice, or without appropriate consent, may be liable to prosecution.
This advice applies to all image capture devices including mobile phones.

References:

1. *NICE 2017: CG190 Intrapartum care: care of healthy women and their babies during childbirth. www.nice.org.uk*
2. *Royal College of Midwives (2012) Evidence Based Guidelines for Midwifery-Led Care in Labour.*

Pain relief

Labour is painful so it's important to find out about all the different ways pain in labour can be reduced. Talk to your midwife and you can decide what is best for you. However, be flexible as you might find you need more or less pain relief than you had planned.

Types of pain relief

Self help

The most important thing you can do to help yourself is learning to relax and having confidence in your own body. Being anxious can make pain worse, especially when you don't understand what's happening or don't feel in control. See p. 35 for further sources of information about labour and birth. Birth workshops can show you how to make yourself feel calmer and more in control. Controlling your breathing and the use of massage can help you relax your muscles and help labour to progress.

Your position can also make a difference. Upright positions such as kneeling, sitting, squatting, walking around, using a birthing ball or sitting in a rocking chair can all help. Changing position not only makes labour less painful but can also encourage contractions to be more effective and helps your baby move down through the pelvis. Research has also shown that there is less need for an epidural or pethidine if you are mobile during labour[1].

Having your partner, relative or friend to support you during labour also helps. Your midwife is also there to give you the support you need.

NICE guidelines on 'Care of women and their babies during labour'[2] suggests that some women find acupuncture, acupressure or hypnosis helpful and they may arrange this for themselves. Hypnobirthing classes are available in Shropshire - search for these on the internet.

'The most important thing you can do to help yourself is learning to relax and having confidence in your own body.'

Water

Being in water during labour; in a bath or birthing pool is recommended for pain relief.

Advantages:

- Encourages you to relax and reduces your pain
- Makes you feel more in control
- Gives your body support
- Reduces the need for an epidural
- No unwanted side effects
- You can use gas and air as additional pain relief

Disadvantages:

- Whilst you are in water you cannot use other pain relief such as TENS or Pethidine

You can leave the water at any time.

Please ask for our information leaflet, 'Water labour and birth' for more information. A recent health warning has been issued from Public Health England: Do not use heated birthing pools which recirculate water with a pump for home births, after such pools have tested positive for Legionella bacteria.

TENS

This stands for Transcutaneous Electrical Nerve Stimulation. A gentle electric current gives a tingling feeling through four pads placed on your back. TENS stimulates the release of your body's natural painkiller (endorphins) and also reduces the number of pain signals to the brain.

Advantages:

- There are no known side effects for you or your baby
- You control the strength of the current

Disadvantages:

- You cannot use it in the pool
- You need to start using it early in labour to feel the full effects

Several companies advertise TENS units for sale and hire in pregnancy magazines.

Gas and Air (Entonox)

This is a mixture of oxygen and nitrous oxide gases. It is breathed in via a mouthpiece which you hold yourself.

Advantages:

- It is easy to use and quick to start working
- You can control it yourself and you can stop if you don't like it
- You can use it at any time during your labour
- It can be used while you are in water
- It has no harmful side effects to the baby

Disadvantages:

- Gas and air won't remove all pain but it does reduce it
- It may make you feel light-headed, nauseous or dizzy for a short time.

To get the best out of using gas and air it is important to breathe it in at the very beginning of each contraction. It takes 15 to 20 seconds to work. By doing this it will be fully effective when the contraction is strongest.

Pethidine

Pethidine is a synthetic opioid drug, given as an injection into the muscle, usually the leg or buttock. It takes approximately 20 minutes to work and the effect lasts between 2 and 4 hours.

Advantages:

- Pethidine is a muscle relaxant and can help with the progress of labour

Disadvantages:

- Pethidine does cross over to the placenta and can affect the baby's breathing. However, there is an antidote to reverse this side effect if the baby has been significantly affected.
- Babies whose mothers have had Pethidine in labour feed less frequently in the first 48 hours as it can make the baby drowsy for several days
- Pethidine can make some women feel light-headed, dizzy, sleepy, and nauseous and experience difficulty in concentrating
- Pethidine does not remove all the pain but it does reduce it
- You should not use the pool if you have had Pethidine

Epidural Anaesthesia for Labour

Epidural anaesthesia is given via a small tube into the middle of the back. Any woman having an epidural will need to be on the Consultant Led Delivery Suite.

The epidural will be 'sited' by an anaesthetist who is a doctor specialising in anaesthesia. He/she will explain the procedure, discuss any risks and answer any questions before siting the epidural. It usually takes 20 minutes to set up the epidural and 20 minutes to work.

You will need to have a drip in your arm so that fluid can be given into the vein to control your blood pressure (one in 50 women will experience a significant drop in blood pressure with the epidural). You will be asked to sit up, curled forward. Your back will be cleaned and local anaesthetic injected into the skin. This may sting, but should make the epidural needle less uncomfortable. Sometimes it can be difficult to site the epidural, as the tip of the needle has to pass between the bones of your back to find exactly the right place.

It is important that you sit still whilst the anaesthetist is putting in the epidural in order to help prevent puncture of the bag of fluid that surrounds the spinal cord – such a puncture can cause you to have a severe headache afterwards. When the tip of the needle is in the epidural space a fine tube is inserted through it before the needle itself is withdrawn.

Once the epidural is in place, pain killing drugs can be injected through the small tube to provide you with relief from the pain of contractions. These drugs will also affect the nerves to your legs making them feel heavy and numb, but you should still have some movement in your legs. Your blood pressure will be monitored closely for the first 30 minutes, then at least half hourly. The midwife will remain with you continuously during this time.

If the epidural does not work well initially, it may require some adjustment. The analgesia is controlled by you; you can give yourself doses of the painkiller when you need them by pressing a button attached to a pump. The pump does not allow you to have unsafe levels of the painkiller.

If you need to have a caesarean section, this can be performed using the epidural with a stronger painkiller injected into it. If the epidural has not been fully effective you may be advised to have a spinal, which is a different injection into your back. Occasionally, if delivery is very urgent, you may be advised to have a general anaesthetic (see p. 51).

Can anyone have an epidural?

There are some medical conditions and complications of pregnancy which make an epidural unsuitable. In particular if you have had surgery to your back, or have a bleeding disorder, tell your midwife/obstetrician and he/she can arrange for you to see an anaesthetist during your pregnancy to discuss it.

The anaesthetic team may have other emergency commitments, so they may not always be immediately

available. When the labour ward is very busy it is not always possible to provide a fully 'on demand' epidural service because of the need to have a midwife with you all the time.

Advantages:

- Epidural analgesia provides the most effective method of pain relief in labour. It can be 'topped up' regularly and can be used to provide pain relief over hours without drowsiness
- In a long or complicated labour your midwife or obstetrician may recommend that you have an epidural to benefit both you and your baby, but the final choice will always be yours.
- It does not increase the likelihood of a longer first stage of labour or a caesarean section
- Can be topped up for caesarean section if required
- In general epidurals do not affect your baby

Disadvantages:

- Restriction of movement

  Whilst we use 'low dose' epidurals which tend to leave some feeling in the legs, it is unlikely that you would be able to stand or walk. We ask that you don't try to do so because of the risk of injury from falls.

  Your midwife will, however, encourage you to change position at least every 2 hours. This is important to prevent pressure sores from developing. A pressure sore, where skin or underlying tissue becomes damaged due to direct pressure blocking blood vessels, can happen if you sit or lie in the same position for a long time.

- Having a catheter

  You may also not feel the urge to pass urine, and the midwife may need to pass a small tube into the bladder to let the urine out (catheterisation). This should not cause any discomfort with a working epidural. You are more likely to need an indwelling catheter for 24 hours after the birth.

- Shivering

  Women may feel shivery following 'top ups' but this does not usually last long.

- The epidural does not work properly

  Occasionally the anaesthetist may be unable to site an epidural and may advise you to persist with other forms of pain relief. Sometimes the epidural may numb only one side of the body, or there may be a patch that is not fully numbed. It may be possible to resolve this by adjusting the epidural, or re-siting it, but it can be a persistent problem and you may need some additional pain relief, such as Entonox. About 1 in every 8 women need to use other ways of lessening the pain.

- Prolonged second stage

  An epidural may prolong the second stage of labour and reduce the urge to bear down, but given some time the uterus should push the baby out. There is potentially an increased need for the use of instruments (including forceps/ventouse) in patients with epidurals compared to those without, but you are still more likely than not to have a normal delivery. NICE Guidelines[2] suggest that if you have had an epidural you should not start pushing for at least 1 hour unless you feel the urge to push or your baby's head is visible. This helps reduce the risk of an assisted birth.

- Severe headaches

  Sometimes (1 in a 100 women) the tip of the needle can make a little hole in the membrane around the spinal cord fluid. This can result in a severe headache, which may last several days, but can be treated. If this does occur you will be seen by an anaesthetist and the options discussed with you.

- Backache

  This is common during and after pregnancy. Localised tenderness at the site of the epidural may occur and last for a few days, but there is now good evidence that epidurals do not themselves cause long term backache.

- Persistent tingling or 'pins and needles'

  About 1 in 2000 mothers get a feeling of tingling down one leg after having the baby. Such problems are more likely to result from childbirth itself than an epidural. Rarely, for 1 in every 13,000 women there can be more persistent nerve damage caused by the epidural with effects lasting more than 6 months.

- Very rare or extremely rare risks

  There are also some extremely rare complications associated with epidurals that need emergency surgery and can result in unconsciousness or paralysis. The anaesthetists are trained to be aware of these and treat them promptly on the very rare occasions that they may arise. The risks overleaf are estimates[3]:

For more information see Useful Organisations, OAA, (p 60).

Type of Risk	*How common is it? (see Table below)*	*How often does this happen?*
Significant drop in blood pressure	Common	1 in every 50 women
Not working well enough to reduce labour pain so you need other pain relief	Very common	One in every 8 women
Not working well enough for a caesarean section so you need a general anaesthetic	Common	One in every 20 women
Severe headache	Common Uncommon	1 in every 100 women (epidural) 1 in every 500 women (spinal)
Nerve damage (numb patch on a leg or foot, or having a weak leg) Effects lasting for more than 6 months	Uncommon Rare	Temporary – 1 in every 1000 women Permanent – 1 in every 13,000 women
Epidural abscess (infection) Meningitis Epidural blood clot	Very rare Very rare Very rare	1 in every 50,000 women 1 in every 100,000 women 1 in every 170,000 women
Accidental unconsciousness Severe injury, including paralysis	Very rare Extremely rare	1 in every 100,000 women 1 in every 250,000 women

- Side effects for baby

  If your epidural is in place for a long time, it could affect your baby's breathing immediately after birth and make the baby drowsy.

  If you have an epidural, you may need more help to establish breastfeeding.

Risk table (adapted from RCOG, 2010[4])

It can be difficult to assess what risk means to you. The following table may help.

Verbal description	*Risk*	*Risk description*
Very common	1/10	Someone in a family
Common	1/100	Someone in a street
Uncommon	1/1000	Someone in a village
Rare	1/10 000	Someone in a small town
Very rare	1/100 000	Someone in a large town

References:

1. *Royal College of Midwives (2012) Evidence Based Guidelines for Midwifery-Led Care in Labour.*
2. *NICE 2007: CG 55. Intrapartum care: care of healthy women and their babies during childbirth. www.nice.org.uk*
3. *Obstetric Anaesthetists' Association (2008) Epidural information card. Further information available from www.labourpains.com*
4. *RCOG (2010) Understanding how risks are discussed in healthcare. Royal college of Obstetricians and Gynaecologists, London.*

Assisted birth (operative vaginal delivery)

Your midwife will give you care and support to encourage the normal birth of your baby. Being upright or lying on your side during labour and avoiding an epidural will reduce the chance of needing an assisted birth[1]. However, if your midwife has concerns about the progress of your labour or the wellbeing of your baby, she will refer to an obstetrician. The obstetrician and midwife will always discuss their concerns with you and it may be that the obstetrician recommends that you are given help to birth your baby during the last part of labour when the cervix is fully dilated.

The most common reasons for needing an assisted birth are:

- The baby is not moving down the birth canal
- The baby is in distress during the birth
- You are unable or have been advised not to push during birth

The purpose of an assisted birth is to mimic a normal (spontaneous) birth with minimal risk to you and your baby. To do this, an obstetrician uses special instruments (ventouse or forceps) to help the baby to be born.

Assisted births are performed on the Consultant Led Delivery Suite in Telford and you will be transferred if you are in labour on a Midwife Led Unit or at home.

What happens?

Before an assisted birth, your obstetrician will check to make sure that your baby can be safely delivered vaginally. This involves feeling your abdomen and performing an internal examination.

You should be given pain relief during an assisted birth. This will either be a local anaesthetic injection inside the vagina (pudendal block) or a regional anaesthetic injection given into the space around the nerves in your back (an epidural or a spinal). Your bladder needs to be empty for an assisted birth and your obstetrician may pass a small tube (catheter) into your bladder to empty it. Your legs will be supported by the use of leg rests on either side of the bed.

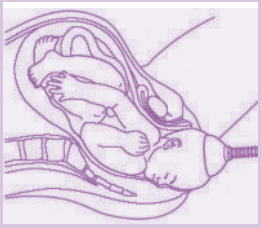
If your obstetrician is not sure that the baby can be born vaginally, your delivery may be carried out in theatre so that a caesarean section can quickly be undertaken if needed (see p. 49).

What are the risks of having an assisted vaginal birth?

An assisted birth may not be successful if you have a higher BMI, your baby is large, or is lying in a back to back position (posterior) or not lying low enough in the birth canal.

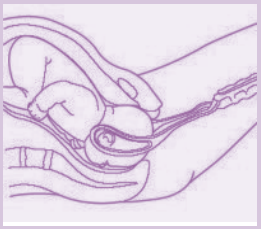
If a ventouse is used and the suction cup has come off, or if delivery has not been successful after a few pulls, the obstetrician may then decide to deliver the baby by forceps or caesarean section. In this situation the risks to the baby are increased.

What is a ventouse delivery?



A ventouse (vacuum extractor) is an instrument that uses suction to attach a soft or hard plastic or metal cup on to the baby's head. The cup is attached by tubing to a suction device. The suction cup becomes firmly applied to the baby's head by the vacuum. With a contraction and a woman's pushing, the obstetrician pulls to help deliver the baby.

What is a forceps delivery?



Forceps are smooth metal instruments that look like large spoons or tongs. They are curved to fit around the baby's head. The forceps are carefully positioned around the baby's head and joined together at the handles. With a contraction and a woman's pushing, the obstetrician pulls to help deliver the baby.

There are many different types of forceps. Some forceps are specifically designed to turn the baby round, for example, if the baby has its back to your back. Your obstetrician will choose the type of forceps to best suit your situation.

Adapted from the patient information leaflet 'An assisted birth (operative vaginal delivery), (May 2012) by the kind permission of the Royal College of Obstetricians and Gynaecologists.

Which is better – forceps or ventouse?

Ventouse or forceps are both safe and effective when used by an experienced obstetrician and he/she will recommend the type of delivery most suitable for you, the baby and your situation.

- A ventouse is less likely to cause vaginal tearing and less severe pain afterwards. However, it is not suitable if the baby is less than 34 weeks because the baby's head is softer.
- Forceps are more successful in delivering the baby.
- There appears to be no difference in longer-term health effects for mother and baby between the use of forceps or ventouse.
- As with all procedures there are risks to consider.

Serious risks for an assisted vaginal birth include:

- The risk of having a 3rd or 4th degree perineal tear is 1 - 4 women out of every 100 who have a ventouse delivery and 8 - 12 women out of every 100 having a forceps delivery (very common)
- Significant vaginal/vulval tears can occur in 1 out of every 10 women who have a ventouse delivery and 1 out of every 5 women having a forceps delivery
- The risk of your baby having a blood vessel injury between the skull and the scalp is uncommon: (3-6 in every 1000 assisted births)
- The risk of your baby having a blood vessel injury in the brain is rare (5 -15: 10,000 assisted births)
- The chance of your baby having a problem with facial nerves is rare (1:1000 to 1:10,000)

Frequent risks include:

- Vaginal tear or graze (very common)
- Heavy bleeding after the birth is very common; 1-4 women in every 10 having an assisted delivery. However, this may be due to the reasons why you would need an assisted birth such as your uterus not contracting properly. We anticipate this and have measures in place to help stop the bleeding
- Problems with passing urine or opening your bowels - sometimes a small tube (catheter) may be needed in your bladder for up to 24 hours while you are recovering after the birth. Women who have had an epidural are more likely to need a catheter after delivery.
- It is very common for forceps to leave small marks on the baby's face and 1 in 10 babies will have small facial or scalp lacerations but these will disappear
- The suction cup (ventouse) can leave a mark on the baby's head called a chignon. The suction cup can also cause a bruise on the baby's head called a cephalhaemotoma in 1 to 12 babies in every 100. Both will disappear with time. Your midwife will explain these and you will find information about bumps and bruises common in babies in the booklet: 'After the birth' that you will be given after you have had your baby.
- Having an assisted delivery does increase the risk of your baby having jaundice (5-15 in every 100 babies having an assisted delivery)
- Babies can also have retinal haemorrhage (17-38 in every 100 babies having an assisted delivery). These normally resolve by the time the baby is one month old.

What happens when the baby is born?

As the baby is being born, a cut (episiotomy) may be needed to enlarge the vaginal opening. If you have a vaginal tear or cut, this will be repaired with stitches.

A paediatrician may attend the birth to check the baby to see if there are any concerns about the baby's wellbeing.

You may need antibiotics afterwards. You may also be prescribed a course of treatment to prevent blood clots (thrombosis).

Will I need an assisted birth next time?

If you need an assisted birth in your first pregnancy, it is unlikely that you will need one in your next pregnancy. Most women have a normal birth next time.

How will I feel after I leave hospital?

After a normal or an assisted birth, you may feel a little bruised and sore. The stitches and swelling may make it painful when you go to the toilet. Any stitches will heal within a few weeks. Pain relief will help.

A few women may be upset their experience of birth. Speak with your obstetrician or midwife, if you feel worried about this. You can ask to attend our 'Talkabout' Service if you feel you would like to discuss your labour and birth. Ask your midwife about this or see your 'After the birth' booklet.

What alternatives do I have?

Your doctor and midwife will discuss the options with you and answer any questions you may have. If you do not want to have an assisted birth you may choose to wait for your baby to be born naturally. However, if there is any concern about you or your baby's health, we would recommend an assisted birth and it is only performed when absolutely necessary.

A caesarean section can be an alternative but this is a major operation which should be avoided if at all possible as there can be serious complications for both you and your baby, especially at this stage of labour. Having a caesarean section at this time seriously increases the likelihood of tears to the lower part of the uterus, excessive bleeding or bladder injury. These risks must be considered against the higher likelihood of a successful vaginal delivery with assisted birth and a lower risk of injury.

The obstetrician will take into account the wellbeing of you and your baby and discuss the options for your situation with you. Approximately 10% of women delivering in Shropshire in 2015/16 had an assisted birth using ventouse or forceps[2]. Women who have assisted births have a less than 10% chance of needing ventouse or forceps with their next birth.

Women who have assisted births have less than 10% chance of needing ventouse or forceps with their next birth

References:

1. *RCOG (2011) Operative Vaginal Delivery. Greentop Guideline 26. Royal College of Obstetricians and Gynaecologists, London.*
2. *SaTH (2015) Maternity Services Statistics*

Caesarean section

Caesarean section is major surgery where the baby is born through a cut in the mother's abdomen and uterus. There are two kinds of caesarean section - an elective or planned caesarean, where the decision is taken before labour begins, and an emergency caesarean section. The decision to have an emergency caesarean section usually takes place when you are already in labour and there is an unexpected problem. Caesarean sections take place in dedicated maternity theatres on the Delivery Suite at the Shropshire Women and Children's Centre.

During 2015/ 16 the caesarean section rate in Shropshire (both planned and emergency) was 19.4%. This compares with the caesarean section rate for England (2014) of 26.2%. In Shropshire in 2015/ 16, 7.8% of births were planned caesarean sections, and 11.9% were emergencies. Only 3% of births were classed as 'Category 1' emergencies, which means that there is a possible immediate risk to the mother or baby.

When might a caesarean section be performed?

You may be offered an elective caesarean if:

- Your baby is not lying head down at the end of your pregnancy
- The placenta lies close to or covers part or all of the cervix
- You have had previous caesarean births
- You or your baby have certain medical conditions
- You are expecting twins, triplets or more - you may be offered a caesarean section if it is not appropriate for the babies to be born vaginally

During labour an emergency caesarean may be needed if there is concern about your baby's health or if your labour is not progressing or, if an emergency arises before you are in labour such as heavy vaginal bleeding.

What alternatives do I have?

A caesarean section is only performed when absolutely necessary to ensure the health of you and your baby because there are risks associated with the operation and future pregnancies could be affected. To help you make a decision your doctor and midwife will discuss their recommendations and the benefits and risks of having a caesarean section compared with a vaginal birth before you give consent to the operation. You have the right to decline a caesarean section even if this will harm you or your baby's health. If you decide against a caesarean section, a comprehensive birth plan will be developed with you, a supervisor of midwives and your obstetrician.

What if I request a caesarean section?

Some women have concerns that they might not be able to cope with labour or have had a previous difficult birth. Some are worried that a vaginal birth will cause bladder, bowel or vaginal problems and want a caesarean section for these or other reasons. Your hospital doctor will discuss this with you and all the benefits and risks of a caesarean section and a vaginal birth. Your doctor has the right to decline your request if he/she thinks that the risks of a caesarean section would be greater than the benefits to you and your baby's health. However, they should offer to refer you to another doctor if you wish.

Benefits of having a caesarean section

- It can be a life saving operation for you or your baby
- You are less likely to have bladder incontinence 3 months after the birth
- You are less likely to have a prolapse of the uterus (slipping of the uterus from its normal position into the vagina) although this is very rare

Risks of having a caesarean section

The risks below do not apply to all women and the risks may be different if you are having a planned caesarean section rather than an emergency section.

- It is more likely that women will take longer to recover, both physically and emotionally after a caesarean section.
- Around 9 women in every 100 (common) will feel persistent wound and abdominal discomfort in the first few months after surgery

- Developing severe infection (6 women in every 100 - common)
- Developing a blood clot - this affects approximately 4-16 women in every 10,000 (rare)
- Bladder or bowel injury will affect 1 in every 1000 women (uncommon)
- Unsightly wound or delayed wound healing
- Increased chance of heavy bleeding (5 women in every 1000 - uncommon)
- Heavy bleeding requiring a blood transfusion
- Hysterectomy (removal of the uterus) – around 7 to 8 women in every 1000 (uncommon).
- 5 women in every 1000 (uncommon) may need further surgery at a later date
- Increased risks associated with a general anaesthetic, if this is necessary
- Longer hospital stay
- It may be more difficult to become pregnant again after a caesarean section than vaginal birth
- There is an increased risk of the scar breaking down during subsequent pregnancies or births, 2-7 women in every 1000 (uncommon)
- After having a caesarean section, future pregnancies are at increased risk of miscarriage, ectopic pregnancy, placental problems (4-8 women in every 1000 - uncommon) and unexplained stillbirth (1-4 women in every 1000 - uncommon)
- Women are still five times more likely to die from caesarean section than from vaginal birth (1 woman in every 12,000 - rare) although it is not clear whether this is from the operation itself or the reason why it is being performed, e.g. a woman being very ill.
- Babies are more likely to have breathing problems
- 1 to 2 babies in every 100 (common) will have a superficial injury such as a small cut when the uterus is being opened up[2]
- You will need more support to establish breastfeeding

If you are overweight, have had previous surgery, or have pre-existing medical conditions, your risks of complications may be increased. For helping in considering risks please see the table on p. 46.

Planned (elective) caesarean section

You will have an appointment with an obstetrician at around 36 weeks, where you can discuss what will happen, ask any questions and decide on a date for the operation. Please note that planned caesarean sections are not normally done before 39 weeks.

Once you have an agreed date for your caesarean section, you will be asked to attend the Elective Section Clinic the week before your operation. You then have another opportunity to discuss your operation, and you will be asked to sign a consent form. For information about consenting to treatment, see our leaflet, 'Consent to treatment or procedures' or visit http://www.nhs.uk/Conditions/Consent-to-treatment.

In addition:

- You will have some blood taken to check your haemoglobin levels and to save in case of need for cross matching for transfusion.
- You will be weighed to ensure you receive the correct dose of any medication given.
- You will have a nose swab taken to screen for MRSA.
- If there is a need to have your operation before 39 weeks, you will be offered a course of two corticosteroid injections to lesson the chance of your baby having breathing problems after birth.
- You will be given some ranitidine tablets to take before your operation (see below).
- You will be advised what time to come in on the day of your operation.

Before coming in to hospital

- Please take two of your 75 mg ranitidine tablets at 10 pm the night before your operation. Take the other two tablets at 6 am on the morning of your operation.
- Please do not eat or drink for 6 hours before the operation, except for a small amount of water with your medication.
- Please have a shower on the morning of your operation without using any oil or moisturiser afterwards
- Please do not shave your pubic area as it has been shown that clipping the area reduces the risk of infection. We will do this when you come in.
- Please remove any nail polish on your fingers and toes.
- Please leave jewellery safely at home. If you wish to keep your wedding ring on, we can tape around it for the operation. Please note that we cannot take responsibility for any valuables that you bring in to hospital.

The day of the operation

Please go to the Antenatal Ward on the morning of your operation. Bring with you any prescribed medication (tell the midwife about this), your Pregnancy Health Record and anything you need for you and your baby while you're in hospital.

An antenatal check will be carried out and the midwife will listen in to your baby's heartbeat.

An anaesthetist will come and discuss which anaesthetic is best for you (see p. 51) and answer any questions. About 30 minutes before, the midwife will complete the pre-operative checklist and give you a gown to change into. As well as make-up, nail varnish and jewellery, you will need to remove any contact lenses, dentures and hearing aids.

If your partner wants to go into theatre with you, he will be shown where to change into theatre scrubs. Please have a set of baby clothes ready. Partners cannot be present if a woman has a general anaesthetic.

Please note that no photos of the operation or staff can be taken in theatre.

We try very hard to make sure that your operation goes ahead at the time you were given, but sometimes it might be delayed, and occasionally it might be postponed to another day. This might be due to unforseen emergencies, lack of available postnatal beds or non-availability of essential staff. If the risk to you or your baby increases in any way, you would then become a priority for an emergency caesarean section.

Sterilisation at the time of caesarean section

If you and your partner do not want to have any more children, you might want to have female sterilisation at the the time of the caesarean section. If you are considering this, please see the leaflet: 'Sterilisation for men and women'.

If you have sterilisation at the same time as a caesarean section, you have a 1 in 133 chance of becoming pregnant in the next 10 years, compared to a 1 in 200 chance if you have it done at another time.

If there are any concerns about the baby the obstetrician may not perform the sterilisation to allow you time to consider your options.

Emergency caesarean section

All the procedures mentioned above will be carried out when an emergency caesarean is necessary, although they might have to be done very quickly depending on how urgently a caesarean is needed. Everything will be explained to you and your consent will be needed to carry out the operation.

The overall complication rates are higher with an emergency as compared to a planned caesarean section (24 in 100 compared to 16 in 100).

Anaesthesia

Regional anaesthesia

A spinal or epidural is recommended as the safest form of anaesthesia. This is where a local anaesthetic is injected into your back to numb you from the bottom of your chest area downwards. See page 44 for more information about regional anaesthesia.
You will be awake during the operation; this means you will be aware of pressure and touch, tugging and pulling, but will feel no pain.

General anaesthesia

Sometimes a general anaesthetic is needed:

- If you do not want to be awake
- If there is not enough time to site a spinal or epidural
- If there is any difficulty in siting the spinal or epidural, or it does not work well enough
- If you have a blood clotting disorder

In this case, you will be asleep during the operation and your partner can wait for you in the waiting room until you are fully recovered from the anaesthetic.

Risks of general anaesthetic

The following risks are estimates[3]. For help in considering risks please see the table on p. 46.

Type of risk	How common is it?	How often does this happen?
Shivering	1 in every 3 women	Very common
Chest infection (most not severe)	1 in every 10 women	Very common
Sore throat	1 in every 5 women	Very common
Feeling sick	1 in every 10 women	Very common
Cuts or bruises to lips or tongue	1 in every 20 women	Common
Airway problems leading to low blood-oxygen levels	1 in every 250 women	Uncommon
Fluid from the stomach entering the lungs	1 in every 1000 women	Uncommon
Corneal abrasion (scratch on the eye)	1 in every 600 women	Uncommon
Damage to teeth	1 in every 4500 women	Rare
Awareness (being awake part of the time during your anaesthetic)	1 in every 400 women	Uncommon
Anaphylaxis (a severe allergic reaction)	1 in every 10,000 women	Rare
Death or brain damage	Death: less than 1 in 100,000 women Brain damage	Very rare (1 or 2 a year in the UK) Very rare – exact figures not known

You will be offered antacids to reduce the acidity in your stomach and help reduce the risks associated with an anaesthetic. The anaesthetist will give you oxygen to breathe through a face mask for a few minutes while everyone is preparing for the operation. When everyone is ready, the anaesthetist will put some anaesthetic into your drip in your hand or arm to send you off to sleep. To help stop any fluid from your stomach going into your lungs the anaesthetist will apply pressure to the front of your neck. A tube will then be placed in your windpipe and you will be given oxygen via a machine. The anaesthetist will carefully monitor you throughout the operation and will continue the anaesthetic to keep you asleep.

In theatre

There are lots of staff working in an operating theatre. The midwife will be there to look after you and your baby; the anaesthetist and their assistant; the obstetrician will also have an assistant; a scrub nurse/midwife and a support worker who is responsible for fetching extra equipment.

When you go into theatre the staff will check your details. Equipment will be attached to you to measure your blood pressure, heart rate, and the amount of oxygen in your blood. This won't hurt. The anaesthetist will put a cannula (a thin plastic tube) into a vein in your hand or arm and will set up a drip to give you fluids. You will also be given antibiotics to help reduce the risk of infection. The anaesthetist will then put the spinal or epidural in. Before the operation starts the anaesthetist will check to see if the anaesthetic is working. If you are having a general anaesthetic this would be done now.

For the operation you will be positioned into a comfortable position lying flat, the bed will have a slight tilt to the left. Once the anaesthetic is working, a urinary catheter (plastic tube) will be passed into your bladder as it is important that your bladder remains empty during the operation and until the next morning. If you feel sick at all during the operation please tell your Anaesthetist - this is often caused by a drop in blood pressure.

The operation

An antiseptic solution will be applied to clean your tummy and help prevent infection. If you are awake, a screen will be placed between you and your partner and the lower part of your body. This creates a sterile (clean) environment for the operation. You will not be able to see the operation, but when the baby is born, the doctor can show you your baby above the screen.
You will feel no pain during the operation just some tugging and pulling. If you experience any discomfort please tell your anaesthetist. The cut is usually 20cm long and along the bikini line.
The operation itself usually takes around 40 minutes with the baby being born in the first 10-15 minutes. If you have had a caesarean section before this part of the operation can take much longer because of internal scarring.
Sometimes the baby's head is delivered using forceps and this can help protect the head of premature babies. Breech babies are delivered bottom first. The remaining time is spent delivering the placenta and repairing the uterus, muscle and skin.

After the operation is complete you maybe given a suppository (medication given into your back passage) for pain relief or an alternative is available if this is contraindicated for medical reasons such as asthma.

In the recovery room

You will be closely observed in the recovery room to make sure you recover from the anaesthetic properly and there are no immediate complications. If you have had a general anaesthetic, your throat may feel sore, you may feel sleepy and a little nauseous. You will be able to have skin to skin contact and breastfeed your baby.

Please note, no visitors other than your partner are allowed into the recovery room.

After the operation

If you are well, you and your baby will be transferred to the consultant led postnatal ward. This can be done whilst you have skin to skin contact with your baby if you wish. For the first 24 hours after the operation you will be closely monitored. You will have your pulse, blood pressure and temperature taken regularly. You will be offered regular pain relief – if it is not sufficient please ask your midwife who can then arrange additional pain relief.

It is really important to mobilise as soon as possible after the operation and avoid staying in bed. You will be encouraged to move around after the first six hours to reduce the risk of blood clots and chest infections delaying your recovery. You will be offered an injection for the next seven days to thin the blood to help prevent any blood clots forming. You will receive help with hygiene until you are to mobilise to the shower. This will usually be within the first 24 hours.

The obstetric and anaesthetic doctors will normally come and see you within the first 24 hours after the operation to make sure everything is okay. A blood test is taken after the operation (approximately 48 hours) to make sure that you are not anaemic.
The ward staff will help you with caring for your baby until you feel able to do so yourself. Please feel free to ask for help when you need it. A midwife will be available on the ward to answer any of your questions and help you with feeding your baby. For further information about your postnatal care, see the booklet: 'After the birth' that you will receive when you go to the postnatal ward.

Useful information and References

1. HES (2013) Hospital Episode Statistics. NHS Maternity Statistics 2012/13. Health and Social Care Information Centre.
2. RCOG (2009) Caesarean Section Consent Advice No. 7. Royal College of Obstetricians and Gynaecologists, London.
3. Obstetric Anaesthetists' Association (2008) Epiduralinformation card. Further information available fromwww.labourpains.com

Simple pain relief is not routinely given for you to take home when you leave hospital after having your baby. We encourage you to have some paracetamol and (if suitable for you) ibuprofen at home.

Vitamin K

What is vitamin K?

Vitamin K is found in certain foods, but bacteria living in the gut make most of the vitamin K the body needs. Vitamin K is essential to help the blood clot.

Why give babies vitamin K?

Studies have found that babies naturally have low levels of vitamin K in their blood. Very occasionally babies can suffer from a rare but serious and sometimes fatal bleeding disorder known as Vitamin K Deficiency Bleeding (VKDB). This condition is rare – about 1 in every 10,000 babies.

It most commonly happens in the first week of life but it can happen at any time in the first six months. Bleeding can occur from the nose, mouth or in the brain, which can cause brain damage or death.

Which babies are more at risk?

Babies are at greater risk of bleeding who

- have had a complicated delivery, e.g. a forceps delivery
- are premature
- are ill for other reasons
- are failing to take or absorb feeds
- have a liver disease that may show as prolonged jaundice
- are born to mothers taking anti-coagulants (blood thinning drugs), anti-convulsants (drugs taken to control epilepsy) or drugs taken to treat tuberculosis (TB)

Some babies who do not have any of these risk factors can bleed unpredictably. As yet there is no way of identifying these babies. The most effective way of protecting them is to give vitamin K to all babies.

How is vitamin K given?

By injection

Research has shown that one intramuscular injection into the baby's thigh, given shortly after birth, prevents bleeding in virtually all babies. It is estimated that less than one baby in a million given the injection, including those at greater risk of bleeding, will suffer a bleed. That means it is very effective. The National Institute for Health and Care Excellence (NICE) guideline recommends the injection as the best method to give your baby vitamin K[1].

By mouth

If you don't want your baby to have the injection, vitamin K can also be given by mouth (orally) to your baby. Two doses are given in the first week. If you are breastfeeding a third dose is given when your baby is 4 weeks old. Bottle fed babies do not need a third dose because vitamin K is added to formula milk. It is estimated that 1 in 300,000 babies given a full course of oral vitamin K will suffer bleeding (very rare).

In Shropshire all doses will normally be administered by a midwife, who will make a special visit for the third dose.

Breastfeeding and VKDB

Very small amounts of vitamin K occur naturally in breast milk. However, to ensure that your baby is fully protected it is important that a third dose of oral vitamin K is given at 4 weeks.

Is vitamin K safe?

A government joint expert group reviewed all the research evidence on vitamin K. It concluded that previous concerns about a link between childhood cancers and vitamin K by injection have not been confirmed by further studies and that chance was the most likely reason for these early findings.

What are the advantages and possible disadvantages of each method of giving vitamin K?

Disadvantages of vitamin K by injection:

An intramuscular injection is painful and can upset the baby.

The injection can, very rarely, cause infection, bruising and swelling.

Advantages of vitamin K by injection:

It is the most effective way of preventing bleeding.

A single dose is all that is required.

There is no need for follow up doses so there is no possibility of missing a dose and not being adequately protected.

Advantages of vitamin K by mouth:

It avoids the possible disadvantages of an injection.

Disadvantages of vitamin K by mouth:

The drops have to put into the baby's mouth. This may upset the baby.

The baby may not swallow all of the drops and not get the full dose. One dose is not enough to give adequate protection.

It is possible that a baby could miss a follow up dose and could go on to have bleeding.

What are the recommendations?

The Department of Health advises that all newborn babies receive vitamin K.

However, it is the right of parents to decide whether or how Vitamin K is given. If a baby is in any of the high risk groups, parents will be strongly advised to allow their baby to have vitamin K by injection. (See the Consent form in your Pregnancy Health Record.)

Babies born before 36 weeks of pregnancy need to be considered on an individual basis. Babies who are ill or admitted to the Neonatal Unit will be given vitamin K by injection.
Parents of babies who do not have vitamin K need to be especially watchful and seek urgent medical attention for:

Bruising and minor warning bleeds

- Jaundice (when the baby looks yellow) for more than 2 weeks in formula fed babies, and 3 weeks in breastfed babies.
- Pale stools or dark urine

If you would like more information please talk to your midwife or doctor. Once you have made a decision, you can record this on the consent form in your pregnancy health record if you will have parental responsibility for the baby (see below).

References:

1. NICE 2014: CG 37 Postnatal Care: routine postnatal care of women and their babies. www.nice.org.uk

Parental responsibility

Unless a baby is adopted, the baby's birth mother will always have parental responsibility for her baby. The father also has parental responsibility if he is married to the mother at the time of the baby's birth or if he is named on the baby's birth certificate. The mother has to be present when the birth is registered if she is not married to the father. There are other ways that a father can have parental responsibility: court order, residence order, or appointed baby's guardian.

There may be other circumstances where the birth mother may need to give written consent for examinations, screening etc., for example in cases of surrogacy or voluntary private fostering arrangements.

Rights and benefits

You are entitled to certain rights and benefits when you are having a baby. Some benefits are for everyone; others depend on your circumstances. The benefits available, and what you are entitled to, change over time. For the most up to date information visit the relevant websites or ask your midwife, doctor or health visitor for advice. Please note that between April 2013 and October 2017 some benefits are being phased out to be replaced by Universal Tax Credits. Current information on all benefits can be accessed via the Money Advice Service at www.moneyadviceservice.org.uk.

All families

Child benefit

If you and your partner each earn less than £50 000 per year you receive the full amount. If either of you earns more than this, you have to pay some back in extra income tax. The claim form is in the Bounty pack you receive after the birth. You can also claim online via the HMRC website.

Free prescriptions and dental treatment

In Scotland, Northern Ireland and Wales, prescriptions and dental treatment are free to all. In England, they are free for women while pregnant and for a year after the birth.

Depending on circumstances

Statutory Maternity Pay (SMP)

Expectant and new mothers who work. 39 weeks pay, usually less than normal pay. You have to have worked for your employer for 26 weeks by 15 weeks before your due date.

Maternity Allowance

For expectant and new mothers not eligible for SMP, e.g. self employed, or if you haven't worked long enough to get SMP. If you can't get this, you may get ESA (Employment and support allowance).

Statutory Paternity Pay (SPP)

New father are entitled to up totwo weeks pay. You may also be entitled to up to 26 further weeks of paternity leave, 20 of which will be paid if transferred from the mother.

Families on low income

Healthy start

Vouchers for milk, fruit, vegetables and vitamins for all pregnant women under 18 and those over 18 on certain benefits. Ask your midwife for an application form. Fill in your details, ask a health professional to sign it, and send by Freepost. You should start receiving your vouchers within 2 weeks.

SureStart maternity grant

£500 available for women on low incomes having their first baby. Download a claim pack from the Gov.uk website.

Child tax credit

Help with childcare costs. Use the Tax Credits calculator on the Money Advice Service website.

Income support

For a single parent not working, or working less than 16 hours a week, whose youngest child is under 5. If you are in a couple, your partner must work less than 24 hours per week.

Income-based Jobseeker's allowance

For families where no one is working more than 16 hours (sometimes 24 hours) a week, but at least one adult is seeking work.

Other benefits available include: Housing benefit, Council tax benefit, free school meals, and various allowances for those with children who wish to continue their education. See the Money Advice Service for further details.

Your rights

Time off for antenatal care

You are entitled to paid time off for your antenatal appointments. Your employer can ask to see your appointment card and a certificate stating that you are pregnant.

Health and safety

If you notify your employer in writing that you are pregnant, have recently given birth, or are breastfeeding, your employer must ensure that your work and working conditions do not put your health or that of your baby at risk.

Flexible working

You can apply in writing to your employer for flexible working if you have worked for them for at least 26 continuous weeks before the request, and you have parental responsibility (see p. 54) for a child under 17. See www.direct.gov.uk/flexible-working for more details.

Sex discrimination

You might have a case under sex discrimination law if you have been dismissed or treated unfairly if you are pregnant, or if you have had a request for flexible working turned down without due consideration or just cause. Seek advice from your Trades Union representative, Citizen's Advice Bureau or the Equality and Human Rights Commission.

Maternity leave

You are entitled to one year's leave, however long you have been in the job. This is made up of 26 weeks ordinary maternity leave and 26 weeks additional maternity leave. The earliest you can begin your leave is 11 weeks before your due date.

Visitors to the United Kingdom

Hospital treatment is free to people who live permanently in the United Kingdom (UK), including anyone who has been lawfully living in the UK for 12 months.

There are many other people who have either full or partial eligibility for NHS Hospital treatment.

Examples of full entitlement

- Anyone working in the UK for an employer based in the UK or registered in the UK.
- Any full time student on a course of at least 6 month's duration or substantially funded by the UK government.
- Refugees and asylum seekers whose application is being considered.
- Anyone working abroad for not more than 5 years as long as they have lived legally in the UK for 10 continuous years at some point.

Examples of partial entitlement

- Anyone receiving treatment only in an Accident and Emergency Department or an NHS Walk-in Centre providing services similar to an A&E department. However, if you are admitted to hospital you may be charged.
- Anyone receiving treatment for certain infectious diseases.
- Anyone needing compulsory psychiatric treatment.
- Anyone requiring family planning services. This does not include maternity care or termination of pregnancy.
- Anyone from the European Economic Area (EEA) if the condition occurs after arrival in the UK.
- Anyone living in a country with which the UK has a bilateral healthcare agreement if the condition occurs after arrival in the UK.

More details can be found at:
www.nhs.uk/NHSEngland/AboutNHSservices/uk-visitors

Trust Privacy Notice:

Informing you how we use your information

This section explains:

- Why the NHS collects information about you and how it is used
- Your right to see your medical record
- How we keep your information confidential
- Your right to restrict disclosure

Please note that information that is shared for statistical/audit purposes is usually anonymous. In other words, your identity is not revealed, just facts about your care.

Why does the NHS collect information about you?

To help you:

Your doctor and the team of health professionals caring for you keep records about your health and any treatment you receive from the NHS. This information will either be written down (manual records), or held on a computer. These records are then used to guide and manage the care you receive. This is to ensure that:

- Your doctor, midwife/nurse or any other health professional involved in your care has accurate and up-to-date information to assess your health and decide what care you need when you visit in the future
- There is a good basis for assessing the type and quality of care you have received. This will lead to better care both for you and other patients
- Your concerns can be properly investigated if you need to complain about the care you receive
- If you see another doctor, or are referred to another part of the NHS, they can see your medical history

To help others:

Your information may be used to help protect the health of other people and to help create new services and healthcare methods in the future. Under the law, your doctor may have to give information to certain organisations.

- Under the 1984 Public Health (Control of Disease) Act and the 1988 Public Health (Infectious Diseases) Regulations doctors have to pass on information that is needed to prevent the outbreak of certain diseases.
- If you have an infectious disease which might endanger the safety of others (e.g. meningitis or measles but NOT HIV / AIDS) then your doctor must tell the relevant organisations.
- Some non-NHS services need information to support research and follow trends in diseases. This makes sure that:
  - Healthcare organisations can plan ahead and provide the right services in the right places and to the right people
  - Progress can be made in diagnosing and managing diseases
  - Drugs can be made more effective for example, by identifying and reducing side effects

To help the NHS:

Your information is also used to help manage the NHS. It may be used to:

- Review the care given to patients to make sure it is the highest possible standard
- Make sure services are planned to meet patients' needs in the future
- Investigate complaints, legal claims or important incidents
- Check and report on how effective the NHS has been
- Make sure that the NHS and its services give value for money
- Help teach health care professionals

How can you get access to your own health records?

The 1998 Data Protection Act allows you to find out what information is being held about you on computer and in manual records. This is known as a 'right of subject access', and it applies to all of your health records.

If you want to see your health records write to Patient Services at the hospital where you are being treated.

You are entitled to either look at your records or to receive a copy, but should note that a charge (£10 plus 50p per sheet up to a maximum of £50) will usually be made. In exceptional circumstances your right to see some details in your health record maybe limited in your own interest or in the vital interest of others.

Sharing information

To ensure that the best possible care and advice can be given to you and your baby, information may be shared with other organisations. These may include services for smoking cessation or weight management, health visitors or for screening purposes. You can opt out of these services if you wish.

You may also be receiving care from organisations outside the NHS, such as social services. If so, we may need to share some information about you so that everyone involved in your care can work together for the benefit of you and your baby. Only relevant information about you that is genuinely needed will be passed on.

In limited circumstances we have a legal duty to provide information about people without seeking their consent. When we do this we will only provide the minimum of information needed and will inform you whenever possible. Examples of this are: notification of a birth; reporting some infectious diseases; protecting children or vulnerable adults who are unable to decide whether their information should be shared.

Copy of letters to patients

Patients have a right to a copy of any letter written about them from one healthcare professional to another. If you would like to receive a copy of your letter inform the doctor during your appointment.

The guiding principles of confidentiality

Your information may be used for reasons other than your direct care. Whenever this is necessary, your information will be handled in the strictest confidence and will be subject to the principles of confidentiality. These principles are legally binding to ensure the highest standard possible is applied at all times.

- Whenever possible only information that does not identify you will be passed on to others and only if they have a legitimate reason to access it
- Only the minimum amount of information needed will be passed on
- Anyone receiving information about you is under a legal duty to keep it confidential

What if you do not want your personal information to be disclosed?

Make it clear to the doctor or a member of the team that you do not want your personal information to be disclosed. Where there is not a legal requirement to share information, the hospital will have to comply with your request. This could affect the quality of your care. If you would like to know more about how we use your information you can also contact the Information Governance Lead of the NHS hospital where you are being treated.

Freedom of Information Act 2000

If you want any information about the organisation, which is not personal data, please write to us.
If you require this information in another language or large print please contact the Patient Services at the respective Hospital.

Our guiding principle is that we are holding your records in strict confidence.

Notification

The Data Protection Act 1998 requires public organisations to register with the Information Commissioner to describe the purposes for which they process personal information.

The details are publicly available from the Information Commissioner's office at:

Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

or see ico.org.uk

MBRRACE

This is a national programme of confidential enquiries investigating deaths of mothers and babies. Any medical records used are anonymised so that identities are protected. Mothers and babies cannot be identifed from information in published reports. MBRRACE has permission from the Secretary of State for Health to use these records without seeking the permission of the women and families involved. The information is used so that any lessons to be learned from tragic events are acted upon to prevent other such incidents. However, if you do not wish information about you or your baby to be used, please phone 01865 289715 or email to mbrrace-uk@npeu.ox.ac.uk

Patient Advice and Liaison Service

As a patient, relative or carer sometimes you may need to turn to someone for on-the-spot help, advice and support.

We act on your behalf when handling patient and family concerns, liaising with staff, managers and where appropriate, relevant organisations to negotiate immediate or prompt solutions. We can also help you get support from other local or national agencies. PALS is a confidential service and you have a right to see any records we may keep regarding your enquiries. To speak to a Patient Advisor please call:

Royal Shrewsbury Hospital
01743 261691 or 0800 783 0057
(answer phone out of hours)

Princess Royal Hospital

01952 282888 or 01952 641222 ex 4382

Hours: Monday – Friday 0900 - 1700
(answer phone out of hours)

See also http://www.sath.nhs.uk/patients-and-visitors/pals

Compliments, comments and complaints

We welcome any feedback from you as we continually monitor our services to try to ensure we give women and their families the best possible experience with us.
You can make comments in a number of different ways – visit our website at www.sath.nhs.uk.

If you have a concern or a complaint about our services, we would like to know. We want to provide the best possible care, and your views and suggestions will help us to improve our standards. If you do have a problem its better if you let a member of staff know straight away. If you want to talk to a senior manager or to someone who has not been involved in your care, we can usually arrange this during office hours. You can also speak to a member of the Patient Advice and Liaison Service (contact details above).

If we can't sort out your problem in this way and you wish to make a complaint, please let us know as soon as possible. Sometimes we need more details and it can help to get things down in writing. We have a complaints procedure to make sure that complaints are carefully investigated and action taken if necessary to put things right.

Healthwatch

Healthwatch England is the national consumer champion in health and care. They have statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

For contact details in Shropshire and Telford and Wrekin see p. 59

Useful organisations (in alphabetical order)

ACAS (Advisory, Conciliation and Arbitration Service)

0300 123 1100
www.acas.org.uk

Offering advice on time off for antenatal care and on maternity rights, parental leave and matters like unfair dismissal.

Active Birth Centre

0207 281 6760
www.activebirthcentre.com

Promotes a holistic approach to active childbirth and parenting.

Alder Hey Children's Hospital

www.alderhey.nhs.uk
0151 228 4811

Antenatal Results and Choices (ARC)

Helping parents and healthcare professionals through antenatal screening and its consequences

www.arc-uk.org
0845 077 2290 (helpline)

APEC (Action on Pre-eclampsia)

0208 427 4217 (helpline)

www.action-on-pre-eclampsia.org.uk

National charity offering support and information about pre-eclampsia via its helpline and newsletters. Also provides a befriender service.

Association for postnatal illness (APNI)

0207 386 0868
www.apni.org

Network of telephone and postal volunteers who have suffered from postnatal illness and offer information, support and encouragement on a one-to-one basis.

Best Beginnings Baby Buddy App

Baby Buddy is an interactive app developed by Best Beginnings to support you during pregnancy and as a new parent. Find it at: www.bestbeginnings.org.uk/baby-buddy

Birmingham Children's Hospital

www.bch.nhs.uk
0121 333 9999

Birth Trauma Association

www.birthtraumaassociation.org.uk

Care of the next infant scheme (CONI)

0808 802 6868 (bereavement support) or
0800 802 6869 (information and advice)
www.lullabytrust.org.uk/coni

Co-ordinated help and support for parents who have suffered a cot death or infant death who was discharged home from maternity aged from 7 days to 1 year.

Child Poverty Action Group

0207 837 7979
www.cpag.org.uk

Campaigns on behalf of low income families. Information and advice for parents on benefits, housing and welfare rights etc

CLAPA (Cleft Lip and Palate Association)

0207 833 4883
www.clapa.com

Support for families of babies born with cleft lip and/or palate. Feeding equipment available.

Count the Kicks

Helping women to be aware of their baby's movements to ensure the healthy delivery of their babies:

www.countthekicks.org.uk/

CRY-SIS

0845 1 228 669
www.cry-sis.org.uk

Offers support for families with excessively crying, sleepless and demanding babies.

Disability pregnancy and parenting international

info@dppi.org.uk
www.dppi.org.uk

For disabled people who are already parents and their families, those who wish to become parents and also for health and social work professionals concerned with disability and/or pregnancy and parenting.

Down's Syndrome Association

0333 121 2300
www.downs-syndrome.org.uk

Drink Aware

0300 123 1110 (Drinkline)
www.drinkaware.co.uk

Easyhealth

Information for those with learning difficulties, using easy words with pictures.

www.easyhealth.org.uk

Epilepsy Action

0808 800 5050 (helpline)
www.epilepsy.org.uk

Group B Strep Support

gbss.org.uk
01444 416 176

Healthwatch

An independent Charity working to make local health and social care services better.

Shropshire 01743 237884
www.healthwatchshropshire.co.uk/

Telford 01952 739540
www.healthwatchtelfordandwrekin.org.uk

Healthy Start

www.healthystart.nhs.uk
0345 607 6823 (helpline)

Free vouchers for milk, fruit, vegetables and vitamins for those on low incomes

Home-Start

01743 241443 (Shropshire)
www.homestartshropshire.org.uk

01952 243991 (Telford and Wrekin)
www.homestarttelfordandwrekin.co.uk

Home-Start helps families with young children as they learn to cope, improve their confidence and build better lives for their children.

Useful organisations (continued…)

MENCAP

Mencap is the leading UK charity for people with a learning disability and their families.
0808 808 1111
www.mencap.org.uk

MIND (National Association for Mental Health)

0300 123 3393
www.mind.org.uk

Money Advice Service

0300 500 5000
www.moneyadviceservice.org.uk

National blood service

0300 123 2323
www.blood.co.uk

National Childbirth Trust (NCT) Helplines:

Enquiries line: 0300 330 0700
www.nct.org.uk
Support in pregnancy, birth and early parenthood. Antenatal classes, breastfeeding support and campaigning for better maternity care and services for new parents.

NHS screening

http://www.nhs.uk/Livewell/Screening/Pages/screening.aspx

NHS Choices

www.nhs.uk, including 'Start4life', an information service for parents. www.nhs.uk/start4life

NSPCC

Child protection helpline
0808 800 5000
www.nspcc.org.uk
If you have concerns about a child call the NSPCC Child Protection Helpline; a free 24-hour service that provides counselling, information and advice to anyone concerned about a child at risk of abuse.

Obstetric Anaesthetist's Association (OAA) Information for Mothers

A resource for women seeking information about pain relief in labour and anaesthesia for caesarean section.
Translation in up to 37 languages
www.labourpains.com

PANDAS

Pre and Postnatal Depression Advice and Support HelpLine 0843 2898401 9 am to 8 pm
www.pandasfoundation.org.uk

PNI UK

www.pni.org.uk
enquiries@pni.org.uk
For women and their families with postnatal depression or illness.

Pregnancy Sickness Support

www.pregnancysicknesssupport.org.uk

Psychological Therapies Team

Talking therapies for people with low mood and anxiety
Shropshire County 0300 123 6020
Telford and Wrekin 01952 613822

Shropshire Telford and Wrekin Sexual Health Services

0300 123 0994
www.staffordshireandstokeontrent.nhs.uk/

Terrence Higgins Trust

01952 221410
(Shropshire)
www.tht.org.uk
Terrence Higgins Trust is the leading and largest HIV and sexual health charity in the UK
Simple HIV testing available

Twins and Multiple Births Association

TWINLINE 0800 138 0509
(freephone) www.tamba.org.uk
asktwinline@tamba.org.uk

Healthy Mums

Would you like help to minimise weight gain during pregnancy and help with weight loss after the birth?
If you live in Telford and Wrekin, contact the Healthy Families Team on 01952 385465 or find them at www.telford.gov.uk/info

If you live in other parts of Shropshire, visit www.healthyshropshire.co.uk or ring 0345 678 9025

Women's Aid

0808 2000 247 (Domestic violence helpline)
24 hour freephone
www.womensaid.org.uk

This section aims to direct you to quality websites: these are correct and active at the time of production. The Shrewsbury and Telford Hospital NHS Trust is not responsible or liable, directly or indirectly, for ANY form of damages whatsoever resulting from the use (or misuse) of information contained in this booklet or found on web pages linked to by this booklet.

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