Excellent, lifelong, integrated care

NHS
Southport and Ormskirk Hospital
NHS Trust

PATIENT INFORMATION

Pregnancy Booking Information

An integrated care organisation

SO985 04/18

We are pleased that you have decided to have your baby with us at Southport and Ormskirk NHS Trust. This booklet will give you general information about your care during pregnancy at the Maternity Services at Southport and Ormskirk Hospital NHS Trust. Further written information will be given to you during your pregnancy and the postnatal period depending on your needs.

Useful telephone numbers

Department	Telephone number
Early Pregnancy Assessment Unit	01695 656064
Antenatal Clinic Midwives	01695 656949 (Out of hours emergency 18 weeks gestation or below ring 01695 656901)
Community Midwives	01695 656668 Contact between 0900-1000 and 1600-1700
Maternity Assessment Unit	01695 656507
Triage	01695 656604
Delivery Suite	01695 656919 /6091
Maternity Ward	01695 656947 / 6920
Antenatal Records Office for appointments/ultrasound scan appointments	01695 656924

Your carers in pregnancy

Midwife Your Midwifery team are usually the main carers throughout your pregnancy. They will provide care and support for you and your family during pregnancy, childbirth and in the early days after the birth. They will work in partnership with you and your family to ensure that you can make informed decisions about the care you receive. Your Midwife will usually arrange to see you at the clinics in the local community and will visit you at home following the birth of your baby. Contact telephone numbers are included with this information booklet.

Please remember that if you are worried about anything relating to the pregnancy telephone the Triage Midwife at the Maternity Unit. (01695 656604, they are available 24 hours a day 7 days a week for advice and support)

Student Midwives: Student Midwives will work under the supervision of a qualified Midwife. Students will be undertaking a degree course at University but spend time gaining experience in the clinical setting. They work in all areas of Maternity including clinics and in the Community.

Maternity Support workers/Health Care Assistants: They support Midwives and are a valuable part of the Midwifery team. They have had appropriate training and supervision to enable them to provide information, guidance and reassurance on a variety of subjects including infant feeding.

Obstetricians: Are doctors who specialise in the care of women during pregnancy and childbirth. You may be referred to their care at the beginning of your pregnancy if you already have a medical problem or you may be referred to them if you develop a problem during your pregnancy or if there are any concerns about the health of you or your baby.

Health Visitors: Are all either qualified nurses or midwives who have done additional training in family and child health, health promotion and public health development work. They work as part of a team alongside your GP, other community nurses and your Midwifery team. Your Health Visitor will visit you at home and after you have had your baby they will arrange further visits.

General Practitioner (GP): These are Doctors who work in the Community and provide care on all aspects of health for you and your family throughout your life.

Specialists: Some women with medical problems such as diabetes, may need to be referred to a specialist for additional care during pregnancy. They may continue to provide care after you have had your baby.

Ultrasonographers: These are specially trained to carry out ultrasound scans. They will perform your dating scan, mid pregnancy anomaly scan and any other scan that you may need, based on your individual needs.

Anaesthetists: Are doctors who specialise in women who are having operative interventions and who provide epidurals in labour. You may also be referred to the anaesthetist during your pregnancy if you have already have a medical problem or a previous problem with an anaesthetic.

Paediatricians: Are doctors who specialise in the care of the newborn baby.

The obstetricians, anaesthetists and paediatricians are available 24 hours a day.

Information sharing

Some of the information about you and your baby contained in your pregnancy records will be recorded electronically on our Maternity Information system. This information helps your Health care professionals to provide the best possible care.

The National Health Service (NHS) also wishes to collect information about you and your baby to help it to:

- Monitor Health trends
- Strive towards the highest standards
- Increase our understanding of adverse outcomes
- Make recommendations for improvements in Maternity care

The NHS has strict confidentiality and data security procedures in place to ensure that personal information is not given to unauthorised persons. The data is recorded and identified by NHS number and your name and address is removed to safeguard confidentiality. Other information such as your date of birth and postcode are included to help understand the influences of age and geography. In some cases, details of the care are looked at by independent experts working for the NHS, as part of special investigations ('confidential enquires'), but only after the records have been completely anonymised. While it is important to collect data to improve standards and quality of the care of all mothers and babies you can 'opt out' and have the information about you and your baby excluded. This will not in any way affect the standard of the care you receive. For further details, please speak to your lead Health Professional.

However your information will be shared with other agencies such as safeguarding teams, where there are concerns for you or your baby's safety. In these cases information may be shared without your consent.

Place of birth

Your midwife will discuss place of birth with you.
If you are low risk, giving birth is generally very safe for you and your baby.

Home birth

Why choose a home birth?
Women may plan a home birth because they:

- have had a previous positive birth experience in hospital, and now feel confident about birth at home,
- want continuity of care, with a midwife they know attending the birth,
- dislike being in hospital,
- are worried about the effect of a hospital environment on their labour,
- want to keep birth normal and avoid interventions,
- want to reduce the risk of infection,
- don't want to be separated from older children,
- hope to use a birth pool and cannot be sure that this will be possible in hospital,
- want privacy,
- want to feel more in control, or
- Ultimately, the decision to have your baby at home is yours but it always helps to have support and information in making that choice.

Planning birth at home is associated with a higher rate of spontaneous vaginal birth, a lower rate of interventions and the outcome for the baby is the same as giving birth at an obstetric unit.

If you are having your first baby, planning birth at home is associated with a higher rate of spontaneous vaginal birth and a lower rate of interventions. There is an overall small increase (about 4 more per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings.

Previous pregnancy information

Details of previous pregnancies are relevant when making decisions about the care that you receive. Some of the main topics are described below. If there is anything else you think may be important, please tell your midwife or Doctor.

Para
This is a term which describes how many babies you already have. Usually early pregnancy losses are also listed after a 'plus sign'. For example, the shorthand for two previous births and one miscarriage is 2 +1.

High Blood pressure and/or pre-eclampsia
If you had this condition last time you are more likely to have it again, although it is usually less severe and starts later in pregnancy. If you have a new partner, in further pregnancies it is possible to develop this condition.

Premature birth
This means any birth before 37 weeks but the earlier the baby is born, the more likely that it will have problems and need special or intensive neonatal care. The chance of a premature birth is increased because of smoking, infection, ruptured membranes, bleeding or poor growth. Having had a baby prematurely increases the chances of it happening again.

Small babies (fetal growth restriction)
If one of your previous babies was growth restricted, there is a chance of it happening again. Arrangements will be made to watch this baby's growth more closely, offering ultrasound scans and any other tests necessary.

Big babies (macrosomia)
A baby over 4.5kg is usually considered big – but this also depends upon your size and how many weeks pregnant you were when the baby was born. You may be offered a blood test to check for high blood sugar (diabetes), which may be linked to having bigger babies.

Previous Caesarean Section
If you have had one Caesarean Section in the past you have a good chance (75%) of having a vaginal birth this time. This is known as VBAC – vaginal birth after caesarean section. Your Midwife or Doctor will discuss with you the reason for your last caesarean section and your options for childbirth this time. **(See VBAC section)**

Bleeding after birth
Postpartum haemorrhage (PPH) means a significant loss of blood after birth (usually 500mls or more) often this happens when the womb does not contract strongly and quickly enough. There is a chance of it happening again, but the maternity team will make sure there is a plan in place.

Postnatal wellbeing
The postnatal period lasts for up to 6 weeks after the birth and it is during this time your body recovers. However for some women problems can occur, including feeding difficulties, slow perineal healing or concerns with passing urine, wind or stools. If you have experienced these or any other problems, talk to your Midwife or Doctor.

Mental Health
It is common to feel low for a little while after having a baby because of hormonal changes and tiredness. However, some mothers do become seriously depressed. This can carry on for months or even years and may require help, counselling and or medication. Depression can happen again, so it is important that we know about it. We can then discuss any worries or anxieties you may have and arrange care to suit your needs. You can access more information via www.mind.org.uk

Miscarriages
A miscarriage (sometimes also called spontaneous abortion) is usually thought to happen because of a one off problem with the baby's chromosomes, causing an abnormality. After one miscarriage, the chances of a successful pregnancy are as good as before. If you have had three or more miscarriages, there is still a good chance that this pregnancy will go well, but special tests may be required.

What if I have had a termination (abortion) but do not want anyone to know?
This information can be kept confidential between yourself, your midwife and your Doctor and will be recorded confidentially on the maternity information system.

Blood tests and investigations

Please see "Screening tests for you and your baby" leaflet sent out with your booking letter.

You will be offered blood tests at your booking appointment for the following tests.

Blood group & antibodies
This test is to find out if you are rhesus positive or rhesus negative and whether you have any antibodies (foreign blood proteins).This test is undertaken at the booking appointment and repeated at approximately 28 weeks gestation.

If you are rhesus negative you will be offered further blood tests to check for antibodies. If the baby has inherited the rhesus positive gene from the father there is a chance that you may develop antibodies to the baby's blood cells in your blood. To prevent this happening you will be offered Anti-D injections. Anti-D is offered routinely to all women in later pregnancy. Anti-D will be offered if you have had a miscarriage, amniocentesis, CVS (Chorionic Villas Sampling) or after the birth where there is a chance that some of the baby's blood cells may have spilled into your blood stream.

Hepatitis B
This is a virus which affects the liver. If you are found to be a carrier of hepatitis B or become infected during pregnancy then further specialist care will be offered. You will be advised to have baby immunised after birth.

Syphilis
This is a sexually transmitted disease which if untreated can damage your baby and may result in miscarriage or stillbirth. If syphilis is detected you will be offered antibiotic treatment.

HIV (Human immunodeficiency virus)
This virus affects the body's ability to fight infection. HIV can be passed to your baby during pregnancy, birth and through breastfeeding – treatment can be given in pregnancy to reduce the risk of passing the virus from mother to baby.

Anaemia
This is where there is too little haemoglobin (Hb) in the blood. Haemoglobin carries oxygen and nutrients to your baby. Your Hb level will be checked as part of your full blood count. If required you will be offered advice on diet and iron supplements.

Sickle cell and thalassaemia
These are disorders of the blood which affect the haemoglobin. You will be offered screening for thalassaemia.

Depending on your family origins you may be offered the screening for sickle cell. The midwife will complete a questionnaire with you - if you are low risk you will not be offered the test. Further testing of your partner may be required.

Additional tests may be offered depending on your individual needs. If you develop a rash or have been in contact with someone who has any of the following infections, contact your midwife or doctor – chicken pox, parvovirus (slapped cheek), toxoplasmosis, or cytomegalovirus (CMV).

You may be offered screening for chlamydia if you are under 25. This is a sexually transmitted disease and may result in pelvic inflammatory disease or infertility. The test is simple - either a urine test or a vaginal swab. Treatment for a positive result is antibiotics for both you and your partner.

Screening for Down's, Edwards and Patau's syndrome

You will be offered a screening test to show if you have a higher chance of your baby being affected by one of the syndromes.

Each of the syndromes is caused by there being an extra chromosome in baby's cells.

Babies with Down's, Edwards or Patau's syndrome are born to mothers of all ages but the chance of this increases with increasing maternal age.

A baby born with Down's syndrome will have a learning disability – this can vary from mild to severe. Some health problems, for example, heart conditions, problems with the digestive system, hearing and vision are more common in people with Down's syndrome. This affects 1 in every 1000 births.

Sadly most babies born with Edward's or Patau's syndrome will have a wide range of problems and will die before they are born, be stillborn or die shortly after birth. Some babies may survive into adulthood but this is rare.

A baby born with Edward's syndrome can have heart problems, unusual head and facial features, growth problems and be unable to stand or walk. This affects 3 in every 10,000 births.

A baby born with Patau's syndrome can have heart problems, cleft lip and palate, growth problems, poorly formed eyes and ears, problems with their kidneys and be unable to stand or walk. This affects 2 in every 10,000 births.

Screening for these conditions is available between 11 and 14 weeks of pregnancy and is done using a test known as the Combined Test. At your dating scan between 11 weeks 2 days and 14 weeks 1 day, a measurement is taken of the fluid at the back of the baby's neck is measured (known as the nuchal translucency). A blood test is also taken at this time and the information from both tests is combined to work out the chance of baby having Down's, Edward's or Patau's syndrome.

If your pregnancy is more than 14 weeks 1 day or if for technical reasons we are unable to measure the nuchal translucency, a screening test for Down's syndrome only, known as the quadruple test can be done up to 20 weeks. This test requires a blood test only. You will also be offered a detailed scan at approximately 20 weeks to check all the baby's anatomy which will be looking for any structural abnormalities, the presence of which may lead to concerns regarding Edward's and Patau's syndrome.

The screening tests do not harm you or the baby, neither do they tell you if your baby has the condition or not, they are just estimating whether you have a higher or lower chance of your baby being affected. It is important that you consider whether to have the test or not.

The test result will show if you are at a higher chance or a lower chance. If the result shows you to be at a higher chance then you will be contacted to discuss the option of having a diagnostic test to determine if the baby is affected or not, however these tests do carry a small risk of miscarriage.

There are 2 diagnostic tests available:

Chorionic villus sampling (CVS)
This is usually done from 11 to 14 weeks. A fine needle is passed through the mothers abdomen to take a very small sample of tissue from the placenta. These cells are then tested for Down's, Edwards and Patau's syndrome.

Amniocentesis
This is usually done after 16 weeks of pregnancy. A fine needle is passed through the mothers abdomen into the uterus to take a small sample of fluid from around the baby. The fluid contains cells which are tested for Down's, Edwards and Patau's syndrome. If you have a baby affected by one the conditions you have 2 options. Some women continue with their pregnancy and prepare for their child with the condition. Some women choose not to continue their pregnancy and will have a termination. You will have the advice and support of specialists in the Fetal Medicine Clinic if you are faced with this choice.

A lower risk does not mean that you will not have a baby affected by a condition. Screening will detect 70-90% of cases of Down's, Edwards and Patau's syndrome.

From the end of 2018 a further option, known as the Non Invasive Prenatal Test (NIPT), will be available for women who have higher chance of Down's, or Edward's and Patau's from the combined or Quadruple tests, and are having a single baby. This is a more accurate screening test which involves taking a blood sample from Mum to exam the baby's DNA, which is present from approximately 10 weeks onwards. This test will only be available on the NHS to those women with a higher chance of Down's, or Edward's and Patau's from the combined/quadruple tests. However it is available as a private service to all women, information can be obtained from your midwife.

Ultrasound scans

You will routinely be offered 2 scans during your pregnancy

Dating scan
This scan is offered to confirm your pregnancy, to check the number of babies and to calculate the expected date of delivery. The scan date is more accurate that your last menstrual period. You will be offered combined screening at this time.

Mid-pregnancy (anomaly) scan
This scan is offered between 18 and 20 week + 6 days. The purpose of this scan is to look for physical abnormalities of the head, spine, limbs, abdomen, face, kidneys, brain bones and heart. The scan looks for certain problems and cannot find everything that may be wrong.

If an abnormality is detected you will be referred to the specialist in the Fetal Medicine Clinic.

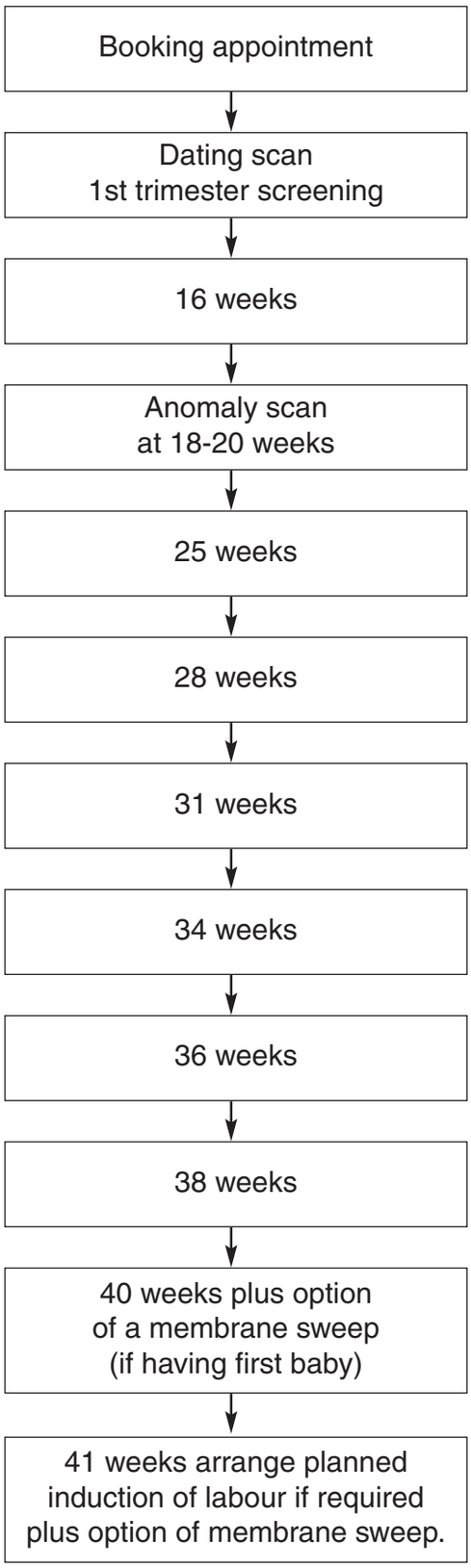
Later pregnancy
You may be offered further scans depending on individual need. This may be if there are concerns about the baby's growth, if you are expecting more than one baby or if you have a medical condition where closer monitoring of your baby is required.

You may have an additional scan if your placenta was shown to be low lying on the mid-pregnancy scan. If the placenta is low lying you are at increased risk of bleeding later in pregnancy.

For further information please refer to the national screening information leaflet "Screening tests for you and your baby" which will have been sent to you with your booking appointment letter.

You can find out further information at www.screening.nhs.uk/annbpublicsations

Schedule Antenatal checks



If you are under the care of the Consultant Obstetrician you may need additional visits depending on your individual needs

Antenatal checks

At each visit your Midwife or doctor will check you and your baby's well-being. This is also your opportunity to discuss any worries or questions you may have. The check will include:

Blood pressure This will be checked at each antenatal visit to detect any increase which may indicate pregnancy induced hypertension or Pre-eclampsia. If you have experienced any headaches or visual disturbances you should report them to the Midwife.

Urine checks You will be asked to provide a urine sample at each antenatal visit. The sample is checked for the presence of protein/sugar etc. that may indicate pre-eclampsia or diabetes.

Abdominal palpation The Midwife or Doctor will perform a gentle examination of your abdomen. This examination is performed to check on: the position that your baby is in, assess that the liquor volume(amniotic fluid) is neither too low or too high. From 26 weeks the Midwife or Doctor will measure your abdomen with a tape measure. This is to check on the growth of your baby. **(See assessing fetal growth)**

Fetal Growth Between 26-28 weeks gestation your Midwife will measure you from top of the uterus (Fundus) to the Symphysis pubis (Pubic bone) using a tape measure. This measurement will be plotted on a customised growth chart. This will enable you and the Midwife to see the growth of your baby. If the measurement when plotted identifies either slow or accelerated growth you will be referred for an Ultrasound scan.

Fetal Heart The Midwife or Doctor will listen to your baby's heartbeat from 24 weeks gestation using either a handheld Doppler (sonicaid) or a pinard stethoscope (ear trumpet). If the doppler/sonicaid is used you will be able to hear your baby's heartbeat yourself. The use of a home fetal doppler is not recommended. Even if you detect a heartbeat this does not mean your baby is well and you may be falsely reassured.

Fetal movements You will usually start to feel baby's movements between 16-24 weeks. This will range from kicks and jerks to rolls and ripples. Sometimes your baby will hiccup. You will quickly come to know your baby and its pattern of movements. At each Antenatal visit your midwife will ask about baby's movements. A change, especially a reduction in movements, may be a warning sign that the baby needs further checks such as ultrasound and Doppler.

Become familiar with your baby's pattern and contact your Midwife or Maternity unit **(Triage 01695 656604)** immediately if you feel that the pattern of movements has altered.

Your sleep position

Studies have shown that the optimal sleeping position in late pregnancy is on your side. You may find it useful to use pillows to prevent sleeping on your back. Do not worry if on waking you are no longer on your side.

Feeling your baby move is a sign that they are well

Most women usually begin to feel their baby move between 16 and 24 weeks of pregnancy. A baby's movements can be described as anything from a kick, flutter, swish or roll. The type of movement may change as your pregnancy progresses.

How often should my baby move?

There is no set number of normal movements.

Your baby will have their own pattern of movements that you should get to know.

From 16-24 weeks on you should feel the baby move more and more up until 32 weeks then stay roughly the same until you give birth.

It is NOT TRUE that babies move less towards the end of pregnancy.

You should CONTINUE to feel your baby move right up to the time you go into labour and whilst you are in labour too.

Get to know your baby's normal pattern of movements.

You must NOT WAIT until the next day to seek advice if you are worried about your baby's movements

If you think your baby's movements have slowed down or stopped, contact your midwife or maternity unit **immediately** (it is staffed 24 hrs, 7 days a week).

- **DO NOT** put off calling until the next day to see what happens.
- Do not worry about phoning, it is **important** for your doctors and midwives to know if your baby's movements have slowed down or stopped.

Why are my baby's movements important?

A reduction in a baby's movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a stillbirth noticed their baby's movements had slowed down or stopped.

Do not use any hand-held monitors, Dopplers or phone apps to check your baby's heartbeat. Even if you detect a heartbeat, this does not mean your baby is well.

For more information on baby movements talk to your midwife

What if my baby's movements are reduced again?

If, after your check up, you are still not happy with your baby's movement, you must contact either your midwife or maternity unit straight away, even if everything was normal last time.

NEVER HESITATE to contact your midwife or the maternity unit for advice, no matter how many times this happens.

Body mass index

Your body mass index (BMI) is calculated in early pregnancy by dividing your weight in kilograms by your height in metres squared. The calculation is done to see if you are a healthy weight for your height. During pregnancy there is an increased risk of certain complications if your BMI is less than 18 or more than 30, if this is the case an individual plan of care will be agreed.

Assessing fetal growth

Accurate assessment of the baby's growth inside the womb is one of the key tasks of good Antenatal Care. Problems such as fetal growth restriction can develop unexpectedly, and are linked to a significantly increased risk of adverse outcomes, including stillbirth, fetal distress during labour, neonatal problems, or cerebral palsy. Therefore it is essential that the baby's growth is monitored carefully.

Growth restriction.
Slow growth is one of the most common problems that can affect the baby in the womb. If fundal height measurements suggest there is a problem an ultrasound scan will be arranged.

Large baby (macrosomia)
Sometimes the growth curve is larger than expected. A large fundal height measurement is usually no cause for concern, but if the plotted slope measurements are too steep your carers may refer you for an ultrasound scan to check the baby and the amniotic fluid volume.

Seasonal Flu vaccine

Pregnant woman are more at risk from seasonal flu; it is recommended that you should have the seasonal flu vaccine. It is safe to have at any stage in your pregnancy. The vaccine is available from September through to January/February and is free when you are pregnant. Your midwife will advise you where you can get the vaccine locally. For further information please visit www.nhs.uk

Whooping cough vaccine

Whooping cough (pertussis) is a serious disease that can lead to pneumonia and permanent brain damage, in some cases a risk of dying. Young babies are at an increased risk, and they remain so until they can be vaccinated against it, the vaccine is offered to babies from 2 months of age.

To help protect your baby in the first few weeks of life, it is now recommended that you should be vaccinated against Whooping cough. Ideally this would be done between 16 – 38 weeks of your pregnancy. However the optimal time is from 20 weeks gestation. Your Midwife/GP will advise you where you can get the vaccine locally. Your baby will still need to be vaccinated when he/she reaches 2 months of age.

Feeding your baby

Deciding how to feed your new baby is very important but you do not need to decide until you are holding them in your arms. Your decision may be based on previous experience or what family or friends have told you. It is really important to have as much information as you can about your feeding choices.

This will help you to get feeding off to a good start and then good support will help you to keep going. You can get information from your midwife, parentcraft classes and infant feeding workshops.

Because of the extensive health benefits for both mother and baby breastfeeding or giving breastmilk is the healthiest way for a mother to feed her baby(s). It contains all the nutrients your baby needs for the first 6 months of life but you can breastfeed your baby for as long as you want. If you are having twins or more your choices are just the same. Breastfeeding also has the added bonus that most women lose weight naturally whilst doing this.

Breastfeeding provides all the nutrition your baby needs to grow and develop. It also helps to comfort your baby and to protect them too. Babies who are breastfed or given breastmilk have a reduced risk of:

- gastroenteritis and diarrhoea
- chest infections
- insulin dependent diabetes
- eczema, asthma and wheezing
- sudden infant death syndrome (cot death)
- childhood leukaemia
- obesity
- necrotising enterocolitis (NEC)…. Particularly important if your baby is born prematurely

Breastfeeding has a number of health benefits to you including reducing the risk of:

- Breast cancer
- Ovarian cancer
- Hip fractures in later life.

Every day counts…… the longer you breastfeed your baby the greater the benefits.

Further information can be found in the “Off to the best start” leaflet which will be given to you at booking and also on the Bump to Breastfeeding DVD which you can access at www.bestbeginnings.org.uk.

However you choose to feed your baby we are here to support you in your feeding choice. Please ask your midwife if you have any questions about feeding your baby. You can find infant feeding information in Arabic, Bengali, Polish, Romanian, and Urdu on the UNICEF UK Baby friendly website

https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/leaflets-and-posters/foreign-language-resources/

Infant Feeding Coordinator
The infant feeding coordinator can give you infant feeding support during and after pregnancy. You can ask your midwife to arrange for an appointment to discuss any worries or concerns that you have about feeding your new baby. If you have Type 1 diabetes or have been diagnosed with gestational diabetes please contact the infant feeding coordinator to talk about breastfeeding and diabetes.

Breastfeeding Peer Supporters
There will be support from breastfeeding peer support services on the maternity ward and at home.

Relationship building

Taking time to begin to develop a relationship with your unborn baby will have a positive impact on you and your baby's wellbeing. This will also help their brain to develop and grow. You can begin to connect with your baby by talking to them, playing music and responding to your baby's movements. Encourage close family members to do the same.

Parent Education

Expectant mothers who attend parent education classes and prepare for the birth of their baby and parenthood often find that it helps them to cope better. The additional information and support also gives you the confidence to make your own personal choices.

Birth and Beyond classes at Ormskirk Hospital To find out dates and to book your place please speak to your community midwife or phone 01695 656668 between 0900-1000 and 1600-1700	**Location:** Parentcraft Room, Antenatal Clinic **Day:** held once a month on a Saturday from 0930 until 1630 (1 session) or Tuesday and Thursday from 1830 to 2000 (4 sessions)
Birth & Beyond classes at Southport and Formby Hospital To find out dates and to book your place please speak to your community midwife or phone 01695 656668 between 0900-1000 and 1600-1700	**Location:** Southport and Formby Hospital, Town Lane, Kew **Day:** held once a month on a Saturday from 0930 until 1630
Antenatal Education Classes Southport and Formby To find out dates and to book your place please phone 01704 532343 (option 2)	**Location:** Linaker Childrens Centre **Day:** Monday evenings from 1830 to 2000 (3 sessions)
Aquanatal classes	Park Pool, Ormskirk 01695-576325 Mondays 0915 Splashworld, Southport 01704 537160 Wednesdays 1815
Infant Feeding Workshop All you need to know about feeding choices for your baby.	**Location:** Parentcraft Room, Ormskirk Hospital **Day:** Held twice a month. To find out dates please phone 01695 656668 between 09:00-09:30 and 16:30-17:00

Hypnobirthing sessions are available:

4 seminars 18:00 – 21:00, on Monday and Wednesday cost £120.00. For more information contact us on soh-tr.hypnobirthing@nhs.net These sessions are available as part of your PMCB choices at no cost.

Pregnancy complications

You may experience a number of symptoms during pregnancy. Most are normal and will not harm your baby, but if they are severe or you are worried about them speak to your midwife or Doctor. Common symptoms of pregnancy are: tiredness, sickness, nausea, headaches or other mild aches and pains. You may also experience heartburn, constipation and or haemorrhoids. There may also be some swelling of your face, hands or ankles or you may develop varicose veins. Changes in mood and sex drive are common. Sex is safe unless you are advised otherwise by your Midwife or Doctor. Some problems in pregnancy will require additional visits or test and surveillance of you and your baby's well-being. Many conditions will only improve after the delivery of the baby; however your Midwife or Doctor will be able to make some recommendations to alleviate your symptoms.

Important symptoms

Most pregnancy symptoms are normal, however, you need to be aware of certain symptoms that could indicate a more serious complication. Contact the Triage midwife if any of the following occur:

- Abdominal (stomach) pains
- Vaginal bleeding
- Membranes (waters) breaking early
- Severe headaches
- Blurred vision
- Persistent itching
- Change or reduced fetal movements

Pregnancy symptoms / complications

Abdominal pain

Mild pain in early pregnancy is not uncommon. You may have some discomfort due to your body stretching and changing shape. If you experience severe pain, or have pain with vaginal bleeding or need to pass urine more frequently – contact your Midwife/GP for advice.

Vaginal Bleeding.

Bleeding can come from any part of the birth canal, including the placenta (afterbirth). Occasionally there can be an 'abruption', where part of the placenta separates from the uterus; this puts the baby at great risk. If the placenta is low lying any tightenings or contractions can cause bleeding. Any vaginal blood loss should be reported immediately to your Midwife or the Maternity Unit. **(Contact Triage – 01695 656604)** Do not wait until your next appointment. If you are Rhesus negative you will require an injection (Anti D)

Abnormal vaginal discharge

It is normal to have an increased discharge when you are pregnant. This is due to the muscles of your vagina becoming softer and to help prevent infections. Any discharge that you have should be clear and white. It should not smell unpleasant, you will need to seek medical advice if the discharge changes colour, smells unpleasant or if you feel itchy or sore.

Diabetes
Diabetes is when there is a higher than normal amount of glucose in the blood. It may be present before pregnancy or develop during pregnancy (gestational Diabetes). High sugar levels cross the placenta and can cause the baby to grow large (macrosomic). If you have or develop diabetes, you will be looked after by a specialist team who will check you and your baby throughout the pregnancy. Keeping your blood glucose as near as normal as possible can prevent problems for you and your baby. Gestational diabetes usually disappears after pregnancy but can happen again in future pregnancies.

High blood pressure
A rise in blood pressure can be the first sign of a condition known as Pre-eclampsia or pregnancy induced hypertension. Your blood pressure will be checked often during your pregnancy. You need to tell your Midwife/Doctor or nearest Maternity Unit if you get bad headaches; blurred vision/spots before your eyes; bad pain below your ribs and or vomiting as these can be signs that your blood pressure has risen sharply. If there is also protein in your urine you may have pre-eclampsia which in its severe form can cause blood clotting problems and fits. It is also often linked to growth restriction in the baby. Treatment may start with rest, but some women will need medication that lowers the blood pressure. Occasionally, this can be a reason to deliver the baby early.

Thrombosis (clotting in the blood)
Your body naturally has more clotting factors during pregnancy, this helps to prevent excessive bleeding after delivery of the placenta. This, however means that pregnant women are at a slightly increased risk of developing blood clots in pregnancy and in the weeks following delivery. The risk is increased if you are over 35, overweight, smoke or have a family history of thrombosis. You are advised to see your doctor **immediately** if you have any pain, or swelling in your leg, pain in your chest or cough up blood.

Intrahepatic Cholestasis in pregnancy (ICP)
ICPIs also known as obstetric cholestasis is severe itching especially on the hands and feet, is caused by a liver condition. It affects 1 in 140 women in the UK every year; ICP can affect the baby and can result in stillbirth. If you have severe itching a blood test is offered to check to see if you have the condition. If you do, you may require medication and the baby will require careful monitoring. The timing of the delivery should be discussed with your doctor and a plan will be agreed according to your individual needs.

Premature delivery
Labour may start prematurely (before 37 weeks), for a variety of reasons. If this happens before 34 weeks, medication will be prescribed to stop labour. You will be prescribed steroids that will be given in two separate doses to mature the baby's lungs. Babies born prematurely can often need assistance with breathing, feeding and temperature control, so they may be cared for on the Neonatal Unit depending on gestation and need.

Breech presentation
Most babies will adopt a head down position in the latter stages of pregnancy. If your baby is not 'head down', there is an increased chance that labour will not be straightforward. If your baby is presenting bottom first (breech), it is usual to attempt to turn the baby after 36 weeks and before labour begins. This procedure is called External cephalic version (ECV).

The procedure is not always successful. Your Midwife or Doctor will discuss the options on how best to deliver your baby should it stay in a breech position.

Multiple pregnancy
Twins, triplets or other multiple pregnancies need close monitoring. More frequent test and scans are recommended. Your Midwife/Obstetrician will discuss and agree a plan with you for your pregnancy. Later in pregnancy your obstetrician will discuss the options for delivery of your babies. Options will take into account the position your babies are in and whether they share a placenta.

Infections
Your immune system changes when you are pregnant and you are at higher risk of developing an infection. It is very important that if you are unwell and experiencing any of the following symptoms: please seek immediate medical advice as treatment may be required:-

- High temperature (38 degrees Celsius)
- Fever or chills
- Foul smelling vaginal discharge
- Pain or frequently passing urine
- Abdominal pain
- Rash
- Diarrhoea
- Vomiting
- Sore throat
- Respiratory infection

If you require any advice regarding the above please telephone Triage Midwife on 01695 656604

General information

Work and benefits
Having a baby does not come cheap, there may be changes in your household income. The 'Parents Guide to money' is available via www.moneyadvice.org.uk. This gives you information on all financial aspects of the arrival of a new baby including budgets, benefits and work options. You should discuss your options regarding maternity leave and pay with your personnel officer or employer early in pregnancy: ensure that everything is in writing. An FW8 certificate will be issued early in pregnancy entitling you to free prescriptions and dental treatment. Dental treatment is free throughout pregnancy and for 1 year following the birth of your baby. It is recommended that you visit the dentist regularly as gum disease is common in pregnancy and you may require treatment. Your Midwife will also supply you with a Maternity certificate at 20 weeks of pregnancy (Mat B1) to claim your entitlement. Families on certain benefits can get some support known as Healthy Start and will receive vouchers for free milk, fruit, vegetables and vitamins.

Baby Boxes
We are pleased to be involved with the baby box initiative. This is a health improvement programme supporting women and families throughout their antenatal and postnatal journey.

Your midwife will provide you with a baby box card in the antenatal period and families will then become members of the baby box University. This online platform provides health advice on a range of topics including nutrition and exercise in pregnancy, safe sleeping, breastfeeding and perinatal mental health.

Once you have the card then access the baby box University online and input the unique code on the back of your card. Then click the 'Cheshire & Merseyside' syllabus, you will then need to watch the promotional health videos and successfully complete the quiz.

From 28 weeks you can then collect your box from one of our local collection points advised on the University. This box provides a safe space for newborn babies to rest. It is important that you collect the box yourself to allow staff to discuss the baby box guidelines.

Health & Safety issues
If you are working your employer has a responsibility to assess any health and safety risks to you. Your job might involve a lot of bending and stretching or travelling long distances these are things that may be more difficult now you are pregnant. If any risks are identified your employer should put measures in place to remove/reduce or control these risks. For further information contact your Occupational Health Dept. or visit www.hse.gov.uk

Healthy eating and drinking
Make sure you eat a variety of different foods to get the right balance of nutrients for your growing baby and for your body to deal with the changes taking place. It is important to prepare and cook your food carefully to prevent food poisoning. Foods such as ready meals, meat, poultry, shellfish and eggs need to be thoroughly cooked(eggs stamped with the 'Lion' mark do not need to be cooked thoroughly. Avoid pate and mould ripened soft cheeses, liver and liver products and unpasteurised milk. Latest evidence shows that if you would like to eat peanuts or food containing peanuts (e.g. peanut butter) during pregnancy, you can choose to do so as part of a healthy balanced diet, unless you are allergic to peanuts or your health professionals advise you not to do so. Check NHS choices for more information.

Have no more than two portions of oily fish a week and avoid Marlin, swordfish and shark. It is advised that you take supplements of folic acid, which helps to prevent abnormalities in the baby (e.g. spina bifida). The recommended dose is 0.4mg per day for at least 8 weeks before pregnancy and up to 12 weeks into the pregnancy. If you have a BMI > 30, or are taking anti-epileptic drugs or have a family history of fetal abnormalities the recommended dose is 5mg per day.

Weight control
It is important that you accept you are going to gain weight during your pregnancy. The normal changes in your body during pregnancy and the growing baby can add up to an average of around 11kg. The more weight you put on above the recommended amount in pregnancy, the more weight you will be left carrying after the birth of your baby. It is recommended you are weighed at the beginning of your pregnancy and again near the end.

Vitamin D is needed for healthy bone development. To protect your baby and yourself from the problems caused by low levels a 10mcgs vitamin D supplement is recommended as found in Healthy Start vitamins. **Vitamin A** supplements should not be taken in pregnancy and any other supplements should be discussed with your Midwife. If you require more advice about your diet your Midwife can refer you for additional support.

Caffeine is a stimulant that is contained in tea, coffee, energy and cola drinks. Too much caffeine should be avoided as it is passed through the placenta and may affect your baby.

Alcohol increases the risk of miscarriage and may lead to Fetal Alcohol Syndrome.

Drugs - taking street drugs during pregnancy is not recommended as it may seriously harm you and your baby. Over the counter medications should also be avoided.

If you are taking any medication for pain relief, please note that some combined preparations contain paracetamol. Please discuss any medication you take with your midwife or doctor.

Smoking
Stopping smoking is the most important thing you can do for your future health and that of your baby. We know that it can be difficult to stop smoking but we also know that you want to give your baby the best possible start in life.

Benefits of stopping smoking

for your baby - your baby is less likely to

- have a low birth weight
- be at risk of cot death
- suffer breathing problems, asthma, wheezing or ear infections

for you - you are less likely to

- have a miscarriage or stillbirth
- go into early labour
- have complications at birth

it is usual practice to refer all women who smoke (or who have stopped smoking within the last 2 weeks) for help to quit to a specialist advisor who will contact you to offer support.

Your local Stop Smoking Service can see you on a one to one basis or together with members of your family. With this support, you are 4 times more likely to succeed. When your Midwife has referred you your stop smoking advisor will be in contact with you.

You can also contact your local Stop smoking advisors on the following numbers

Lancashire	0800 328 6297	**Knowsley**	0151 426 7462
Sefton	0300 100 1000	**St Helens**	01744 586247

You can also contact NHS Smokefree helpline on 0300 123 1044

The sooner you stop smoking the better, to give your baby the best start in life. Your Midwife can arrange referral to your local smoking cessation coordinator or group. (see NHS Pregnancy Smoking helpline). Cannabis smoking should also be avoided during pregnancy as it produces higher levels of carbon monoxide. The risks of e cigarettes to your unborn are still not understood. Please seek advice from your local smoking cessation coordinator.

Carbon Monoxide is a poisonous gas produced by cigarettes that you breath in every time you smoke a cigarette or every time you breath in someone else's smoke.

The carbon monoxide replaces some of the oxygen in your bloodstream which means that both you and your baby have lower levels of oxygen overall. As part of your routine antenatal care your Midwife will test the level of carbon monoxide in your system by a simple breath test., explaining your results. This may be repeated throughout your pregnancy. Environmental factors such as traffic emissions or leaky gas appliances can also cause a high reading.

Second hand smoke
Pregnant women exposed to passive smoke are more prone to premature birth and their baby is more at risk of low birthweight and cot death. Your Stop smoking advisors are there to help your family members stop smoking too.

Home visits
If you or a family member smokes please could you try to have a smoke free room to be seen in by the community midwives on home visits – this is a room that is well ventilated and has been smoke free for at least 1 hour. This is because of the risk of second hand smoke.

Home Fire safety check. Your local fire service can visit your home to carry out an assessment free of charge. You may be eligible for free smoke alarms to be fitted. It is advisable for all households to have a working fire alarm.

Hygiene. When you are pregnant your immune system changes and you are more prone to infections. It is really important that you try and reduce the risk of infection by: good personal hygiene, washing your hands properly before and after preparing food, using the toilet or sneezing/blowing your nose. Always wear gloves when gardening or handling cat litter trays as toxoplasmosis can be found in cat faeces. If you feel unwell, have a sore throat or respiratory infection contact your Midwife or GP **immediately.** You may need treatment.

Travel. If you are planning to travel abroad, you should discuss flying, vaccination and travel insurance with your Midwife or doctor. Long haul flights can increase the risk of deep vein thrombosis (DVT)

Car safety. To protect both you and your baby, always wear a seatbelt with the diagonal strap across your body between your breasts and the lap belt over your upper thighs. The straps then lie above and below 'your bump', not over it. Also make sure that baby/child seats are fitted correctly according to British Standards.

Relationships. Some women find pregnancy to be a time of increased stress and physical discomfort. It can greatly affect your emotional state, your body image and relationships. If you feel anxious or worried about anything, discuss this with your Midwife or GP.

Domestic violence. 1 in 4 women experience domestic abuse at some time in their lives, many cases start in pregnancy. It can take many forms, including physical, sexual, financial control, mental or emotional. Where abuse already exists it has been shown that it may worsen during pregnancy and after the birth. Domestic abuse can lead to serious complications which affect you and your baby. You can speak in confidence to your healthcare team who can offer help and support. Or you may prefer to contact a support agency such as The National Domestic Violence Helpline.

Exercise. Regular exercise is important to keep you fit and supple. Make sure that your instructor knows that you are pregnant. Providing that you are healthy and have discussed this with your midwife, exercise such as swimming or aquanatal classes are safe. Scuba diving and any contact sports should be avoided. It is recommended that you do pelvic floor exercises daily during pregnancy. You should aim for 8 contractions 3 times per day, your midwife will advise you how to do these.

Complementary therapies. Please seek further advice regarding the safety of any complementary therapies as few complementary therapies have been established as safe in pregnancy.

Family & Friends test. This is an important opportunity for you to provide feedback on the services that provide your care and treatment. Your feedback will help NHS England to improve services for everyone. You can ask a member of staff for more information about how this information is used. Completion of the test is voluntary, but if you do provide feedback it will provide valuable information for your hospital to celebrate good practice, and identify opportunities for improvement. You will be asked to complete this survey at around 36 weeks of your pregnancy. For more information about this programme visit NHS Choices.

Use of blood products. Blood or blood products are only ever prescribed in specific medical conditions and a decision to decline their use should only be taken after you have considered all the issues involved. Your wishes will always be respected; it is important you discuss your wishes with your midwife and Obstetrician so that an individualised plan of care can be made.

Raised BMI in pregnancy

Women with a BMI >30 are at mildly increased risk of complications in pregnancy and birth. Women with a BMI >35 are at moderately increased risk of complications in pregnancy and birth.

Being overweight puts extra strain on your heart, lungs, joints and muscles and during pregnancy can cause additional complications and problems for you and your baby.

Risks of Complications

Complications that may arise during pregnancy are as follows:

Antenatal

- Difficulty in getting a good quality ultrasound scan to monitor your baby's growth and development
- Tiredness and breathlessness
- Back and joint pain
- Increased risk of developing gestational diabetes
- Increased risk of blood clotting problems (eg Deep vein thrombosis)
- Increased risk of developing raised blood pressure
- Abnormal growth of your baby

During labour and delivery

- Increased risk of induction and acceleration of labour
- Difficulty monitoring baby's heartbeat
- Shoulder dystocia
- Increased risk of emergency caesarean section
- Difficulties siting epidural and its effectiveness
- Increased risk of anaesthetic problems

Post delivery

- Increased risk of post-partum haemorrhage
- Increase risk of blood clotting problems (eg deep vein thrombosis)
- Increased risk of wound/urine infections

What You Can Do To Reduce These Risks
To reduce the risk of you developing these complications it is essential that you monitor your diet to avoid gaining too much weight whilst you are pregnant.

You can do this by eating a healthy diet with plenty of fresh fruit and vegetables and avoiding foods high in fat and sugar.

Keep as active as you can by gently or moderately exercising for 30 minutes 5 times a week. You may find non weight bearing exercise easier such as swimming and aquanatal especially later in your pregnancy.

Antenatal Care
If your BMI is 30 – 34, you will be advised to have an appointment with a Consultant Obstetrician to discuss possible complications in labour.

If your BMI is 30 and above, due to increased complications your care will be booked for shared care under the Midwife and Consultant Obstetrician and you will be advised to have a hospital birth.

Investigations/Management
If your BMI is 35 and above, you will be offered a glucose tolerance test (GTT) when you are 24 - 28 weeks pregnant to check for gestational diabetes.

Besides routine ultrasound scans an additional scan will also be performed when you are 32 - 36 weeks pregnant to check your baby's growth.

BMI over 40
You will be referred to the Anaesthetist to ensure that you have been assessed in case you require anaesthetic for delivery or are thinking about having an epidural.

If your BMI is over 40 a management plan will be discussed with you to ensure that any additional equipment that may be required for when you have your baby will be available.

How will a raised BMI affect labour and delivery?
Your Consultant Obstetrician will discuss the risks and benefits of different types of delivery with you, however in most cases women are encouraged to aim for a vaginal delivery.

Due to the difficulties which may be experienced in monitoring your baby's heartbeat it may be necessary to monitor you continuously using a cardiotocograph (CTG) or by a small clip attached to your baby's scalp.

Pain management options (such as TENS and Entonox) are unaffected by BMI, however epidurals can be more difficult to site and be less effective.

Because your BMI is raised it is likely that you will have a larger baby and therefore you have an increased risk of having a caesarean section or need other assistance with delivery (such as Forceps).

Following Delivery
You should try and mobilise as soon as possible after delivery to reduce the risk of you developing blood clotting problems and infections.

Breastfeeding
One of the best things you can do for your baby is to give him/her a healthy lifestyle and prevent problems of becoming over weight. The best way to start this is by breastfeeding.

Whilst you are breastfeeding it is not advisable for you to start any strict weight reducing diets.

Your Future Health
Unfortunately many women find it difficult to lose the weight gained during pregnancy, but do try and return to at least your pre pregnancy weight. Not only will this mean that you are fitter and healthier to care for your young family but will help ensure future pregnancies are problem free.

A woman with raised BMI is more likely to have difficulties conceiving and is at greater risk of miscarriage.

You can contact your GP, Practice Nurse or Health Visitor to discuss losing weight and signpost you to the best place to get support.

Glucose tolerance test

A glucose tolerance test (GTT) is a screening test performed to detect a condition known as gestational diabetes. This is a type of diabetes that is only relevant to pregnant women. If detected, this condition can be well controlled and monitored.

Before undergoing this screening, it is important to know that:

- In most women, gestational diabetes will respond to changes in diet and exercise.
- Some women (between 10% and 20%) will need oral hypoglycaemic
- medication or insulin therapy, if diet and exercise are not effective in controlling gestational diabetes.
- If gestational diabetes is not detected and controlled, there is a small risk of birth complications such as shoulder dystocia.
- A diagnosis of gestational diabetes may lead to increased monitoring and interventions during both pregnancy and labour.

Why a glucose tolerance test has been advised
A glucose tolerance test is offered in the following circumstances, if you have a history of:

- Past history of abnormal GTT
- Previous gestational diabetes
- Previous large baby ≥ 4.5kg or >95th centile on grow chart
- BMI ≥ 35
- Family history of diabetes in a first degree relative
- Family origin with a high prevalence of diabetes – South Asian, Black Caribbean or Middle Eastern
- A previous unexplained stillbirth or neonatal death
- A previous congenital abnormality
- Polycystic ovarian syndrome

In your current pregnancy:

- Polyhydramnios – this means that you have an increased amount of fluid around your baby
- Suspected large baby
- Several episodes of glucose detected in your urine
- If you are taking steroids
- At the request of your Consultant

Preparation for the test
You should not have anything to eat from midnight. You can have plain water, black tea of coffee (without sugar or sweeteners). It is also advisable not to smoke from midnight until completion of the test and not to have chewing gum.

What the test involves
On arrival, the midwife will take your history. After this, a blood sample will be taken to check your blood sugar level and iron count. You will then be given a glucose drink. A second blood sample is taken 2 hours after taking the glucose drink. In between, you can have plain water, black tea or coffee (without sugar or sweeteners) but not anything to eat. You are advised to rest during this time.

The results will be followed up on the same day and you will be informed if the results are not within normal limits and follow-up appointments will be arranged.

Following the test
If you have any queries or concerns, please contact a midwife via the telephone numbers at the front of this booklet.

Venous Thrombosis In Pregnancy & After Birth

What is venous thrombosis?
Your blood has a mechanism that normally forms a 'plug' or clot to stop the bleeding when you are injured, for example when you have a cut to your skin. Sometimes the blood's clotting mechanism goes wrong and forms a blood clot when there has been no injury. When this happens the blood clot is called a thrombus. When the blood clot is deep inside one of the veins in your body, most commonly in the leg, it is called deep vein thrombosis (DVT).

Who is at risk of venous thrombosis?
A DVT is more likely to happen when people are unwell and inactive or less active than usual. It can happen at any time during a hospital stay or after leaving hospital. However pregnant women are 10 times more likely to develop a DVT than women of the same age and who are not pregnant.

Venous thrombosis related to pregnancy can occur at any stage of pregnancy and for 6 weeks after birth. Some women have increased risks of developing a DVT than others.

These additional risks include if you:

- have had a previous venous thrombosis
- have a condition called thrombophilia
- have hepatitis or rheumatoid arthritis
- are over 35 years of age
- are a smoker
- are overweight with a body Mass Index (BMI) of over 30
- are having an operation (including caesarean section)
- are dehydrated
- have phlebitis
- have had a previous venous thrombosis
- have a condition called thrombophilia
- have hepatitis or rheumatoid arthritis
- have lost a lot of blood or had a blood transfusion
- are carrying more than one baby
- develop severe pre-eclampsia
- have just had a caesarean section
- are immobile for long periods of time – 3 days confined to bed, unable to walk or spend a lot of time in a chair or bed

Your risk of developing a venous thrombosis will be assessed by the midwife at booking, in labour and following delivery and you should inform the midwife if any of your risk factors alter.

Symptoms of a DVT during pregnancy
The symptoms of a DVT usually occur in one leg and include:

- a red and hot swollen leg
- a swelling in your entire leg or just part of it
- pain or tenderness – you may only experience this when standing or walking or it may just feel heavy

Seek advice from your doctor or midwife if you notice one or more of these symptoms. During pregnancy swelling and discomfort in both legs is common and does not always mean there is a problem. Always ask your midwife or doctor if you are worried.

Why a DVT is serious
If the blood clot comes loose it can travel through your bloodstream to your lungs. This is called pulmonary embolism and it can be life threatening. DVT and pulmonary embolism together are known as venous thromboembolism.

The symptoms of a pulmonary embolus
The symptoms of a pulmonary embolus may include:

- Sudden unexplained difficulty in breathing
- Tightness in the chest or chest pain
- Coughing up blood (haemoptysis)
- Feeling very unwell or collapsing

Although a pulmonary embolus is rare it can be life threatening and you should seek help immediately if you experience any of these symptoms.

The risk of developing a pulmonary embolus once a DVT has been diagnosed and treated is extremely small.

Treatment
Depending on your risk factors or if a thrombosis is suspected you may be offered:

- Anti-Embolic stockings to keep the blood in your legs circulating

and/or

- A drug called an anticoagulant which thins the blood

Before offering you this treatment you will need to be assessed for any problems which may increase your risk of bleeding. If your risk of having problems with bleeding is higher than your risk of DVT, you should not be offered a drug to help prevent a DVT.
The risks of bleeding include:

- You already taking a drug that 'thins the blood'
- You have had an epidural or spinal in the previous 4 hours
- You are likely to have a spinal or epidural in the next 12 hours
- You have a condition called thrombocytopenia
- You have very high uncontrolled blood pressure
- You have an inherited blood disorder (such as Von Willebrands Disease)

Your risk of developing a DVT and risk of bleeding should be assessed if you are admitted to hospital and again 24 hours after you are admitted and whenever your condition changes.

Heparin
There are different types of heparin but the most common one used in pregnancy is a "low molecular weight heparin" (LMWH) This is given by injection.

Heparin works by:

- Preventing the clot getting any bigger so that your body can gradually dissolve the clot.
- Reducing the risk of pulmonary embolus.
- Reducing the risk of another DVT occurring.

Risks of heparin to the unborn baby
Heparin cannot cross the placenta to the baby and therefore it is safe to take whilst you are pregnant.

Breastfeeding
Your treatment may have to continue for at least 6 weeks after birth and may include other medication such as Warfarin. Both warfarin and heparin are safe to take whilst breastfeeding

Vaginal birth after caesarean section

For most women pregnancy and birth is a normal healthy life event, but for a number of reasons, for some women ends in a caesarean birth rather than a vaginal birth.

For many women who have had one caesarean section it is possible to have a vaginal birth for the next delivery, we call this vaginal birth after caesarean section (VBAC). National recommendations support women having the option of VBAC but the risks and benefits will vary greatly depending on many things including the reason for the caesarean section and whether or not you have had a vaginal delivery already.

Overall about 72-75% of women will successfully give birth vaginally following one caesarean section (CS). For women who have already had a vaginal birth either before or after a CS about 85-90% will have a vaginal birth in the next pregnancy.

Care during pregnancy

If you have had a CS for a previous birth it is recommended that you are cared for during your pregnancy by a Consultant Obstetrician, along with your Midwife. During your pregnancy you will have the opportunity to discuss your previous birth and your options for care and birth on this pregnancy including VBAC. There is a VBAC clinic run by the Consultant Midwife which you can be referred to for further information and support.

During your pregnancy and in early labour it is important that you contact the Maternity Unit Delivery Suite if you experience any vaginal bleeding or tenderness over the area of your scar – the contact details are on the back page of this booklet.

Benefits associated with VBAC

Overall attempted vaginal birth following one CS appears to be safer than a planned caesarean with a lower risk of complications for both mother and baby.

CS is a major operation which can have both surgical and anaesthetic risks. In comparison your recovery time following a normal birth is less and you are less likely to develop further problems requiring surgery or complications in future pregnancies. Your baby is less likely to develop breathing problems and you are less likely to have difficulty in starting breastfeeding.

If you have had more than one CS it may be possible to aim for a vaginal birth – this will be discussed further as you consider your options.

Disadvantages of VBAC

A woman who has had a previous CS is more at risk of scar weakening or rupture than a mother who has not had a previous CS. This is a rare complication, 1 in 200 and overall the risk of maternal complications with planned repeat CS remains higher than with VBAC. You are more likely to need a CS for another reason such as bleeding or concern with the baby's heartbeat.

If labour is induced, the risk of uterine rupture does increase, therefore it is usually preferable for you to go into labour on your own rather than be induced. If you go over your due date by more than a week, your plan for birth should be reviewed.

In addition, induction of labour is associated with an increased risk of caesarean section.

When you labour after a previous caesarean section, the risk of the baby dying or being damaged in labour is very small, and is no different to women in labour for the first time, about 2 in 1,000. But this is greater compared to a planned CS, 1 in 1,000. However this has to be balanced with the risks for you if you choose a caesarean birth.

Care during labour

During labour it is recommended that your and your baby are monitored continuously to make sure that any problems are picked up quickly. Therefore it is advised that you give birth in the Consultant Maternity Unit at Ormskirk & District General Hospital. You are advised to contact the Delivery Suite early in labour or if you have any concerns.

If you are planning to have a repeat CS but you go into labour before the planned CS date, delivering vaginally may be more appropriate, for example if the baby is premature or if you are in advanced labour.

It is possible for you to have an epidural for labour and your midwife can give you further information regarding this. You will have the opportunity to discuss this with an anaesthetist when you attend Delivery Suite in labour.

Depression during and after pregnancy

A woman's body goes through many physical and hormonal adjustments during the nine months of pregnancy. Many women find these changes very exciting; however, a significant number of pregnant women will become anxious or unhappy as they begin to prepare for the birth of their baby.

Having a baby is a life-changing event. As hormonal levels alter throughout the pregnancy, many women have overwhelming feelings of worry and inadequacy. Will they cope with motherhood? Is the baby ok?

It is not uncommon for women to become emotional and irritable at some point in their pregnancy; this is mainly due to changing hormonal levels and is a normal response. However, if you're feeling upset and anxious for most of the time during your pregnancy, it is really important to discuss this with your midwife or GP. Quite often you just need reassurance that everything is all right. During pregnancy you may be referred to the perinatal mental health midwife for support.

Symptoms of depression, during pregnancy may include:

- Low mood for all or most of the time, for a week or more.
- Not really enjoying anything. Lack of interest in yourself and your baby.

If you are depressed during your pregnancy, don't despair. Most women fully recover. Some women have suffered depression before they get pregnant. If you have been depressed in the past, please do not be afraid to discuss this with a health professional for support and reassurance.

Depression in pregnancy may directly affect the baby by making you feel less positive and less motivated. It is also known that depression can increase a woman's uptake of alcohol and they may smoke more.

If you are on anti-depressants when you find out that you are pregnant.
It is safe to take the majority of anti-depressants without harming the baby, but this must be discussed with your GP/ mental health professional. Some women look towards other therapies such as counselling to help them.

Practical support
Partners, family and friends are in a good position to help a woman who is suffering from depression either in pregnancy or following the birth. Living with a depressed person is not always easy, and it can sometimes cause problems in relationships.

Support from a person whom a woman can trust is vital to get her through this difficult time. Partners and family can help by:

- Encouraging her to talk to close friends and family or to a health professional.
- Giving practical support. Offer to look after the children, ensure she gets food and rest.
- Being patient and understanding. Give encouragement, be loving.
- Finding out more about postnatal depression. Having an understanding of the condition is always useful.
- Seeking help. Encourage her to join community groups. Don't let her become isolated.

Postnatal depression is very common. About 1 in 10 mothers develop it. Yet far too often, new mothers are left to suffer in silence, struggling alone, because the problem is not well recognised.

There are 3 main types of depression after childbirth:

- 'Baby Blues' this is so common that it can be considered normal. Symptoms include feeling weepy, irritable and generally low. This usually starts around 3 days after the birth, but should have subsided by day 10.
- Postnatal Depression this condition occurs in about 1 in 10 mothers. It usually starts within the first 4-6 weeks following the birth, but can even develop several months after the baby's birth. Treatment is advised - this is discussed later in the leaflet.
- 'Postnatal Psychosis' this is an uncommon but severe form of depression. It develops in about 1 in 1000 mothers.

Many women are able to hide their depression. However you don't need to suffer the condition in silence. Seek help.

Symptoms of postnatal depression
The symptoms are similar to those that occur with depression at any other time. They usually include one or more of the following:

- Repeated tearfulness.
- Feeling irritable a lot of the time.
- Feelings of guilt, rejection or inadequacy.
- Poor concentration, like forgetting or losing things.
- You may also get thoughts of harming yourself or your baby. Around half the women with postnatal depression get these thoughts. If things are very bad, you may get ideas of hurting or killing yourself. The reality is only in very rare cases is anyone harmed.

Symptoms may interfere with your ability to carry out normal day-to-day activities.
In addition, you may also have less energy, disturbed sleep, poor appetite, and a reduced sex drive. However, these are common and normal for a short time after childbirth and may not necessarily mean that you have postnatal depression.

There are a number of reasons why you should get help:

- To help yourself get better quickly. It is not a sign of weakness to admit that you are depressed.
- To help your partner or family. If you are depressed it can cause problems in your relationships, your job and life in general.
- To help your child. If you are depressed your relationship with your baby may not be as good as it could be.

What causes postnatal depression?
The cause is not clear. Any mother can develop the condition. The main cause seems to be stressful events after childbirth, such as feelings of worry, isolation and new responsibilities.

You are at greater risk if you have any of the following:

- Mental health problems in the past.
- Depression during pregnancy.
- Marital or relationship problems.
- No close family or friends around you.
- Money troubles.
- Physical health problems following the birth.

Postnatal depression is usually diagnosed by a doctor, based on the information received from you or those close to you.

You may not recognise that you are depressed; however those close to you may recognise that you are acting differently and may suggest you see a doctor. Sometimes the doctor may do a blood test to make sure there is no physical reason for the symptoms.

In a recent study only 1 in 4 women with postnatal depression sought any help. Because of this a short and simple questionnaire has been designed to help diagnosis.

This is called the **Edinburgh Postnatal Depression** Questionnaire and has 10 simple questions.

Your Health Visitor may ask you to fill it in, irrespective of whether you are showing signs of being depressed.

It is also used in some areas during the pregnancy to try and highlight women who are more likely to become depressed after birth.

Support & Advice
An understanding and supportive network of family and friends can help you recover.

It is often best to talk to those close to you. Explain how you feel, rather than bottling up your thoughts.

Independent advice about social problems you may be encountering could prove very helpful. Ask your health visitor what is available in your local area.

Primary Care Mental Health Workers
These professionals provide an in-surgery service for all people with mild to moderate mental health problems.

The service promotes assisted self-help, goal setting and problem solving along with listening and support to ensure a speedy recovery.

Primary Care Mental Health Workers are not yet available in all GP practices. However do ask your GP or Health Visitor if this service is available in your surgery.

Psychological (Talking) Treatments
Talking treatments are very useful and will mostly be focused upon counselling. Around 8 in 10 women with postnatal depression are likely to recover quite quickly with counselling.

Anti-depressants
Anti-depressants are a type of medication that works well for sufferers of depression. They are not tranquillisers and are not addictive.

They work by lifting the mood and easing the symptoms of depression. They usually take 2-4 weeks to become effective.

A normal course of anti-depressants lasts for several months. If you are taking anti-depressants and they are working for you, it is important to complete the course. If the treatment is stopped too early the depression quickly returns.

Some anti-depressants are found in breast milk, but the amounts are so small that most experts consider their use safe for breastfeeding mothers.

Seek advice from your midwife, health visitor or GP if you have any queries regarding medication for depression.

Visiting times

Maternity Ward and Maternity Assessment Unit
Partners are welcome

All other visitors: **1400-1600 and 1800-2000**

When you are an in-patient your own children are welcome but no other children are allowed to visit.

Delivery Suite

There is limited visiting on Delivery Suite. There may be circumstances where you remain on Delivery Suite for an extended period and visiting is agreed on an individual basis.

Find us on Facebook – Ormskirk Maternity

Useful contact numbers & support groups

Infant Feeding Coordinator	01695 656502 (Southport and Ormskirk Hospital)
Alcohol concern	0300 123 1110
Antenatal results and choices (ARC)	0207 713 7486
Childline	0800 1111
Citizens Advice Bureau	03444 111 444
Frank about drugs	0300 123 6600
Group B Strep Support Group	www.gbss.org.uk
La Leche League National Breastfeeding	0845 120 2918
Maternity Action Advise Line	0845 600 8533
MIND – for better mental health	0300 123 3393
Miscarriage Association	01924 200 799
National Breastfeeding Helpline	0300 100 0212
National Childbirth Trust (NCT)	0300 330 0700
National Domestic Violence Helpline	0808 200 0247
NHS Choices	www.nhs.uk
NHS 111	
NHS Information Service for Parents	www.nhs.uk/parents
NHS Pregnancy Smoking Helpline	0300 123 1044
NSPCC's FGM Helpline	0800 028 3550
Samaritans	08457 909090
Stillbirth & Neonatal Death Charity (SANDS)	0207 436 5881
Tommy's Pregnancy Line www.tommys.org	0800 0147 800
Working Families (Rights & Benefits)	0300 012 0312
Stop Smoking Helpline (Sefton)	0300 100 1000
Stop Smoking Helpline (West Lancashire)	0800 328 6297

References

NICE (2014) Intrapartum care: care of healthy women and their babies during childbirth

NICE (2008) Antenatal care routine care for the healthy pregnant woman

NICE (2006) Routine Postnatal Care of Women and their Babies.

www.fsid.org.uk

www.gov.uk/topic/population-screening-programmes

www.screening.nhs.uk/annbpublicsations

www.bestbeginnings.org.uk.

During your contact with us, it is important that you are happy with your care and treatment. Please speak to a member of staff and/or the ward/department Sister/Senior Midwife if you have any questions or concerns.

Matron

A Matron is also available during the hours of 0900 to 1700 Monday to Friday. During these periods, ward/department staff can contact Matron to arrange to meet with you. Out of hours, a Senior Midwife can be contacted via the ward/department to deal with any concerns you may have.

Infection Control Request

Preventing infections is a crucial part of our patients' care. To ensure that our standards remain high our staff have regular infection prevention and control training and their practice is monitored in the workplace. We ask patients and visitors to assist us in preventing infections by cleaning their hands at regular intervals and informing staff of areas within the hospital that appear soiled.

As a patient there may be times that you are unsure whether a staff member has cleaned their hands; if in doubt please ask the staff member and they will be only too happy to put your mind at ease by cleaning their hands so that you can see them.

Contact information if you are worried about your pregnancy / self or baby in the postnatal period

You can contact your own GP
Maternity Unit – contact Triage – see contact numbers on page 1.

Please call 01704 704714 if you need this booklet in an alternative format

Southport and Ormskirk Hospital NHS Trust

Ormskirk & District General Hospital
Wigan Road, Ormskirk, L39 2AZ

Tel: (01695) 577111

Southport & Formby District General Hospital
Town Lane, Kew, Southport, PR8 6PN

Tel: (01704) 547471

FOR APPOINTMENTS

Telephone (01695) 656680
Email soh-tr.appointments@nhs.net

Author: Catherine Boyle & Josie Hughes
Ref: 16/5
Version: 1
Written: March 2016
Reviewed: February 2018
Review Date: February 2021