Worcestershire Acute Hospitals NHS Trust

Teenage Pregnancy Guideline

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Approved by Maternity Governance Meeting on:	17th January 2020
Review Date This is the most current document and should be used until a revised version is in place:	15th November 2022

Key Amendment

Date	Amendment	Approved by
17th Jan 2020	New document	Maternity Governance

Introduction:
The UK has the highest rates of teenage pregnancy in Western Europe. Teenage pregnancies are generally unplanned, high risk and need to be treated accordingly to reduce these risks where possible and provide support throughout the antenatal and postnatal period.

Over the last 18 years there has been a significant reduction in teenage pregnancy. The under-18 conception rate has fallen by 59.7% and the under-16 conception rate by over 60%. These rates are the lowest since 1969 (Public Health England, 2018).

Pregnancy in young people is an important public health concern as it generally occurs in the context of poor social support and maternal well-being. Young people and their babies have poorer access to maternity services and experience poorer outcomes than older people.

Definition:
This policy applies to all pregnant women less than 20 years of age at estimated delivery date.

Maternal risks associated with teenage pregnancies:

1. Increased incidence of sexually transmitted diseases
2. Increased alcohol and substance abuse
3. Smoking (twice as likely to smoke before and during pregnancy, and 3x more likely to smoke throughout pregnancy)
4. Poor diet and increased pregnancy weight gain, with increased postnatal weight retention
5. Present late
6. Decreased attendance to Antenatal Clinic (ANC)
7. Increased risk of miscarriage
8. Increased risk of anaemia
9. Higher incidence of pregnancy induced hypertension (PIH)
10. Higher risk of Pre-Eclampsia (PET)
11. Decreased breast feeding rates (third less likely to start, half as likely to still breast feed at 6-8 weeks)
12. Postnatal depression (3x more likely, and poor mental health can last for up to 3 years after delivery)
13. Relationship breakdown (2 in 3 mothers in pregnancy or within 3 years)
14. Increased risk of domestic abuse of all categories

Fetal/infant risks associated with teenage pregnancies:

1. Premature delivery (<32 weeks, especially in 13-15 year olds)
2. Small for gestational age (SGA): more marked in ‘growing’ verses ‘non-growing’ adolescents due to competition for nutrients
3. Decreased birth weight (30% higher rate)
4. Increased rate of still birth (30% higher)
5. Increased neonatal mortality (60% higher)

Long-term complications:

6. Sudden Infant Death Syndrome (1.9x more likely to die from SIDS)
7. Poorer cognitive development and lower educational attainment
    a. At 5 years old: children are 4 months behind on spatial ability
    b. 7 months behind on non-verbal ability
    c. 11 months behind on verbal ability

8. Gastro-enteritis and accidental injury (twice as likely to be hospitalised for)
9. Increased criminal activity
10. Higher levels of abuse and neglect
11. Behavioural problems in childhood
12. Living in poverty (63% higher risk)

Risk factors for teenage pregnancy:

1. Socioeconomic deprivation (6x more likely)
2. Low educational achievement (12% of 16-17 years olds not in education, employment or training were teenage parents)
3. Having teenage parents
4. Being in the care of social services
5. Poor transition from education to work at age 18 years
6. Sexual abuse
7. Mental health problems
8. Crime
9. Manual background (10x more likely than if professional background)

Antenatal management: specialised/individualised care

- Identified at booking and referred to the Teenage Link Midwife in their area
- Be mindful not all pregnancies are unplanned. Positive professional attitudes are essential as pregnancy in young people is often viewed negatively and young people can feel stigmatized. This may prevent them from seeking adequate support or attending ANC
- Booking completed by Teenage Link Midwife
    - Risk factors assessed
        - Including smoking, alcohol, drug use
            - Discuss the risks and refer all to smoking cessation
            - CO levels at every appointment
            - Offer drug screen if discloses use
        - Discuss housing, social support, finances, education requirements
    - Information to be given including:
        - Teenage Parents 2 Be group offered in an environment that is identified as young people friendly.
        - Maternity grant
        - Healthy start vouchers and nutrition
        - Access to services provided by local Children Centres
        - Food banks
        - Antenatal education provided to teenager and her support network in the home environment/Teenage Parents 2 Be group.
- Ensure taking folic acid 400 micrograms OD, or 5mg OD if clinically indicated (until 12 weeks) and Vitamin D 10micrograms OD (throughout pregnancy and breast feeding)
- Aspirin 150mg from 12 weeks to 36 weeks if clinically indicated
- Dating scan and screening bloods at 12 weeks as routine
- Anomaly scan at 20 weeks
- Seen by Teenage link Midwife
    - At booking
    - 16 weeks
    - Every 3 weeks until 28 weeks (19, 22, 25, 28 weeks)
    - Every 2 weeks until 36 weeks (30, 32, 34, 36 weeks)
    - Then weekly until delivery
- Haemoglobin and antibody screen at 28 weeks
- Chlamydia screen at booking, provided consent gained

  - Self-taken yellow-topped LVS.
  - If positive result treat and refer to the Sexual Health Team for further management (contact tracing and post-treatment follow-up).
  - Azithromycin 1gram oral stat on day 1 followed by 500mg once a day for 2 days
  - Generic Sexual Health team email address whcnhs.wishmaternityu25referral@nhs.net
- If patient is admitted antenatally to an outlying ward i.**e. Riverbank, the Obstetric Team and Teenage Link Midwife should be informed of admission/discharge.**
- If less than 16 years of age serial growth scans in ANC at 32, 36 and 40 weeks gestiation with consultant input as required.
- If older than 16 years of age serial growth scans as above if clinically indicated
- Consideration to be given to Gillick competency and Fraser guidelines if 16 years of age and under. These aid people who work with teenagers to balance the need to listen to their wishes with the responsibility to keep them safe.

Intrapartum care for teenagers:

- Theoretical risk of obstructed labour due to immature pelvis
- No indication for early induction or elective CS
- Book induction of labour (IOL) at 40+12 as per IOL guideline, if no spontaneous labour. To have sweeps prior to this with midwife if accepted by patient
- To deliver on the consultant LW if <16 years old
- Can deliver on Meadow Birth Centre (MBC) if 16 years or older (and fulfill other criteria)
- 'Support' person able to stay with them on the ward during admissions (both antenatally and postnatally)

Postnatal care for teenagers:

- Mothers reviewed up until 28 days postnatally, at least weekly, but more frequently if needed by the midwife and health visitor
  - Smoking cessation to continue with ongoing support, due to high risk of relapse
  - New smoking-cessation referral to be actioned if requested by patient
  - Advice regarding exercise and healthy eating
  - Breast feeding support
  - Discuss finance and returning to education
  - Contraception to be discussed on the by Midwife prior to discharge from ward/care. GP/Family Planning appointment to initiate contraception
  - Home safety including safe sleeping advice
  - Discuss importance of continuing to engage with support from health professionals
  - Discuss postnatal support groups available

Child protection issues:

- There is an increased association between teenage pregnancy with underage sex, self-harming, neglect and domestic abuse.
- The Teenage Link Midwife should raise a safeguarding referral to the Specialist Midwife for Vulnerable Women.
- If there are safeguarding issues a cause for concern will be raised with Children's Social Services and information will be shared with relevant health professionals.
- Consent from the patient should be gained prior to referral; unless this would endanger the patient or unborn due to specific child protection concerns
  - Highlight the benefits of referral: the capacity of social care to assess and support their needs

Child abuse: if disclosed or suspected:

- The principles of confidentiality apply to a person under 16 years; but the right to confidentiality is not absolute. Where there is a serious safeguarding risk to the health, safety or welfare of a young person or others, this outweighs the young persons right to privacy.
    - It is important to discuss your concerns with the young person, especially if you are going to break their confidentiality
- Opportunity should be made to see the pregnant teenager alone in order to enable issues to be addressed sensitively and to maintain confidentiality
- Avoid initiating questions regarding sexual abuse / domestic abuse in the presence of family members/friends/partners
- If there is a history/risk factors for mental health problems, this must be clearly documented as a risk factor on the antenatal page. A referral should be made to the Perinatal Mental Health team. Inform the GP, Midwife or other support services necessary.
- All referrals should be discussed with the patient and documented in the hospital notes

Statutory rape:

- Rape: Adults engaging in sex with minors under the age of consent. Safeguarding issues must be considered, as the minimum legal age for young people to consent to have sex is 16 years.
- Sexual activity with a child under 16 is an offence. If it is consensual, it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the child.
- Sexual activity with children under 13 years of age is always illegal, as they are not legally capable of giving consent. When a young person under the age of 13 is found to be pregnant a referral to social services must be made
- Between the ages of 13-15, young people must have their needs assessed. Consider discussion with other agencies, and whether a referral should be made to Children's social care depending on the level of risk.
- Between the ages of 16-17 years sexual activity is not an offence, however young people under 18 are still offered the protection of child protection procedures. Staff must consider issues of child sexual exploitation and offences of rape and assault
- Young people aged 16 and 17 are deemed not able to give consent if sexual activity is with an adult in a position of trust or a family member
- Statutory rape describes illegal sexual activity and the law assumes even if he or she willingly engages in sexual intercourse with a legal adult, his or her sex partner may well have manipulated or coerced the younger person
- In cases where statutory rape is identified or suspected a social care referral is required and the Child Abuse Investigation Team should be informed

References:

1. TOG. Management of teenage pregnancy 2007
2. Public Health England, 2019. A Framework for supporting teenage mothers and young fathers. London: Public Health England
3. MBRRACE (2018) Saving Lives, Improving Mothers' Care. Oxford

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All members of the Maternity Quality Governance Meeting

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race		
	Ethnic origins (including gypsies and travellers)		
	Nationality		
	Gender		
	Culture		
	Religion or belief		
	Sexual orientation including lesbian, gay and bisexual people		
	Age		
2.	**Is there any evidence that some groups are affected differently?**		
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the policy/guidance likely to be negative?**		
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.