Northampton General Hospital NHS
NHS Trust

Antenatal Care

Pathway

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1. INTRODUCTION & AIMS

The use of the care pathways should result in the same high standard of care being provided for all women. An assessment of each woman's well being and needs are made at each contact. The plan is based on a minimum high standard of care, but some women will require additional care. The antenatal care pathway covers the process of the woman first accessing the maternity services, her booking appointment including history taking and sharing of information, and the care given at all subsequent routine antenatal appointments.

Adopting a care pathway has been shown to be the best way of providing women centred co-coordinated and clinical driven care. They provide the best evidence based approach. (CEMACH 2007).

2. SCOPE

The Care Pathway provides an evidence based framework for the health care professionals involved in the antenatal care of a woman in all settings. This involves predominantly the Midwife, but may also include the obstetrician, GP, Maternity Support Worker, and clerical staff. It is to be read in conjunction with trust policies and guidelines, which are cross-referenced within the pathway.

3. DEFINITIONS

Term/Word	Definition
ANC	Antenatal Clinic
BBA	Born Before Arrival
BMI	Body Mass Index
EDD	Estimated Date of Delivery
FBC	Full Blood Count
GTT	Glucose Tolerance Test

Hb	Haemoglobin
IOL	Induction of Labour
MSW	Maternity Support Worker
Mcg	Micrograms
MDU	Maternity Day Unit
MSU	Midstream Urine Test
NICE	National Institute for Health & Clinical Excellence
NSF	National Service Framework
SROM	Spontaneous Rupture of Membranes
USS	Ultrasound Scan

4. ROLES & RESPONSIBILITES

The Obstetrician

Is responsible for formulating and writing a clear plan of care in the woman's antenatal notes when she has been referred for shared care/consultant opinion.

This plan should also be discussed with the woman. When a woman is referred back to community care it is the doctors responsibility to clearly document this in her hand held antenatal notes, discuss this plan with her and also advise her of when she should next see her midwife.

The GP

Has a responsibility for documenting any antenatal care clearly in the woman's hand held notes, and informing the midwife of any significant information in relation to her care. If a woman has not had a full medical examination in the United Kingdom the GP is responsible for taking a medical history and making a clinical assessment of her overall health.

The Midwife

Midwives are autonomous practitioners in normal pregnancy and birth. They are responsible for taking a detailed history at the booking appointment and then referring the woman to be seen by the obstetrician if any risk factors are identified as part of this assessment. It is their responsibility to ensure that, once women have accessed the

maternity services, they are seen promptly and that the booking is completed before twelve weeks of pregnancy.

Where a woman is already twelve weeks or more pregnant, it is the midwife's responsibility to ensure that she is seen for the booking appointment within two weeks of making contact. The midwife needs to ensure that she liaises regularly with the surgery to ensure that all women who have made contact are given a booking appointment as per the care pathway.

The surgery where (s)he is based should have his/her contact details, the phone number of the community midwives office, and the triage phone number. The midwife is responsible for advising women to see a doctor for a medical history and full clinical assessment if they have not had a full medical examination in the United Kingdom. The antenatal care provided by the midwife will be an ongoing assessment of the woman's needs and instigation of the appropriate care.

Maternity Support Worker

May be involved in the antenatal care of a woman. They will work under the direction of the midwife. They are responsible for informing the midwife of any care undertaken and documenting any care or discussion with the woman in the hand held records.

The receptionist

The receptionist may be the first point of contact for many women. It is their role to ensure that the expectant mother has a booking appointment with the midwife within two weeks of the first contact - ideally by eight weeks of pregnancy. Where a woman makes contact and is at least ten weeks pregnant, it is the receptionist's role to make an appointment within 2 weeks. The date the woman contacts the surgery and LMP should be recorded on the Antenatal Summary Card. If no appointments are available the midwife must liaise with the receptionist to ensure that women needing booking appointment are seen as per the care pathway. If the receptionist is aware that a woman cancels any appointment, she/he should inform the midwife of this.

Clerical Staff in the Community Midwives Office

Are responsible for passing on the message to the community midwife if a woman has contacted them seeking an urgent booking appointment. If the midwife is unavailable

the clerical staff must inform the Team Co-ordinator so that an appointment can be arranged by an alternative midwife.

5. The Maternity Care Pathway for Antenatal Care

(5.1 Detailed Version)

CARE	RATIONALE/EVIDENCE	STANDARDS
5.1.1 6-8weeks - 1st Booking appointment. Give relevant information and leaflets. Complete hand held notes, including taking a medical, anaesthetic, obstetric, mental health, family, lifestyle and social history as part of the risk assessment. This will determine the type of antenatal care advised. Complete relevant referral forms. Ensure current contact details are obtained. When the pregnancy is confirmed, the woman usually makes an appointment at her surgery to seek maternity care. When a woman makes contact with her surgery, it is the receptionist's role to document the LMP on the summary card and make an appointment for the woman to be seen by the midwife, within two weeks of the initial contact. If the woman is ten weeks pregnant or more the receptionist should make an appointment within a week. If no appointment is available the midwife will arrange directly by liaising regularly with the receptionist in order to arrange an appointment direct. (Appendix 1) The receptionist at the surgery will inform the midwife if a woman has communication or language support needs. The midwife can then arrange for the appropriate agency/interpreter to be in place for the booking and all subsequent appointments.	Pregnant women should be offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This information should include where they will be seen and who will undertake their care. NICE (2010).	1. All women will have had their full booking appointment and hand held antenatal notes completed by twelve completed weeks of pregnancy. 2. All women are seen within two weeks of referral to the maternity services. 3. Women who have communication or support needs will have access to the same high quality antenatal care. If an interpreter/support/agency is required to assist so that a woman has full access to the maternity services this will be clearly documented in her hand held notes.

CARE	RATIONALE/EVIDENCE	STANDARDS
Women who have not previously had a full medical examination and history taken in the UK, and clinical assessment made of their overall health will be advised by the midwife to see their GP. If they are not registered with a GP they can access a doctor at 'The Maple Access Centre'.		4. Women who have not previously had a full medical examination and history taken in the United Kingdom, and clinical assessment made of their overall health, will be advised by the midwife to see doctor. This discussion will be documented in their handheld notes.
The combined screening test should be offered to screen for Downs Syndrome. The scan also determines gestational age, and detects multiple pregnancies. Midwife must book a scan and issue information leaflet re screening tests and ultrasound scans. The anomaly scan should also be discussed.	This will ensure consistency of gestational age assessments, improve the performance of screening for Down's Syndrome and reduce the need for induction of labour after 41 weeks. *NICE (2008) Induction of Labour* *NICE (2008) Antenatal care*	5. Every woman to be offered a dating/screening scan and information given about the anomaly scan also shared.
Discuss screening tests including Screening for sickle cell diseases and thalassaemias, hepatitis B, HIV, Rubella, Syphilis, red cell alloantibodies, group and FBC.		6. All blood tests are discussed with the woman and the leaflet 'Screening test for you and your baby' given
Discuss need for MSU	Identification and treatment of asymptomatic bacteriuria reduces the risk of pyelonephritis *NICE (2008) Antenatal care*	7. Discuss the need for MSU with every woman

CARE	RATIONALE/EVIDENCE	STANDARDS
Offer Chlamydia screening in under 25's and give information on the local programme	Chlamydia is the most commonly diagnosed sexually transmitted infection in the UK; affecting both men and women. Chlamydia often has no symptoms and can lead to pelvic inflammatory disease,	8. All women under the age of 25 to be offered Chlamydia screening.
Risk assess need for screening for gestational diabetes- and explain rationale behind testing. See NGHT 'Diabetes in pregnancy' guideline Women at increased risk of developing gestational diabetes will be offered a glucose tolerance test at 26 weeks gestation. (16 and 26 weeks on MDU if history of gestational diabetes (Appendix 2)	Screening for gestational diabetes using risk factors is recommended in a healthy population- risk factors include: • BMI above 30kg/m2 • Previous gestational diabetes • First degree relative with diabetes (parent, sibling or child) plus grandparents • Family origin with a high prevalence of diabetes: • South Asian (specifically women whose country of origin is India, Pakistan or Bangladesh • Black Caribbean • Middle Eastern (Specifically women whose country of family origin is Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon or Egypt) • Previous baby weighing 4.5kg or above • Unexplained stillbirth • Polycystic ovary Syndrome	9. All women who are at increased risk of developing gestational diabetes are identified and offered screening with glucose tolerance test.
Carry out antenatal checks in accordance with National Guidelines (Appendix 3) and woman's choice. Document who is present at each consultation. Antenatal Summary (in yellow folder) to be completed at each contact	Plans will be open to change at any point during pregnancy and any risks carefully assessed Shribman (2007) Making it better for Mother and Baby	10. Blood pressure and urinalysis for proteinuria and glycosuria to be assessed at every visit.

CARE	RATIONALE/EVIDENCE	STANDARDS
Discuss health/lifestyle issues including food hygiene, diet, alcohol, smoking cessation and recreational drugs (see Substance Misuse in Pregnancy - NGHT 2009)	There are significant risks to the health, and life, of a baby if the mother smokes. These include the risk of miscarriage, premature birth and stillbirth, of placental abnormalities, low birth weight and, after birth, sudden infant deaths. It is estimated that about one third of all perinatal deaths in the UK are caused by smoking. There is also a significant risk to fetal development with women misusing drugs or alcohol *NSF (2004) Standard 11* *NICE (2008) Antenatal care* *RCOG (2008) Standards for Maternity Care* *Shribman (2008) The Child Health programme* *NGHT (2009) Substance Misuse in Pregnancy(NGHT 2009)* *Women should be advised to avoid drinking alcohol in the first three months of pregnancy as it may be associated with an increased risk of miscarriage Those who choose to drink alcohol should be advised no more than 1-2 units per week (NICE 2010).*	11. All pregnant women who smoke should receive clear information about the risks of alcohol and smoking and the support available to them to stop.
Discuss rationale behind taking folic acid	Ideally women should take 400mcg folic acid before conception until 12 weeks gestation. This is known to reduce the risk of neural tube defects. *NICE (2008) Antenatal Care*	12. All women to be advised on the benefits of taking folic acid

CARE	RATIONALE/EVIDENCE	STANDARDS
Discuss importance of maintaining Vitamin D stores, and advise supplementation to those at greatest risk.	All women should be informed of the importance for their own and their baby's health of maintaining adequate Vitamin D stores during pregnancy and whilst breastfeeding. In order to achieve this, women may choose to take 10 micrograms of Vitamin D per day, as found in the Healthy Start multivitamin supplement. Particular care should be taken to enquire as to whether women at greatest risk are following advice to take this daily supplement. These include: − women of South Asian, African, Caribbean or Middle Eastern family origin − women who have limited exposure to sunlight, such as women who are predominantly housebound, or usually remain covered when outdoors − women who eat a diet particularly low in Vitamin D, such as women who consume no oily fish, eggs, meat, Vitamin D-fortified margarine or breakfast cereal − women with a pre-pregnancy body mass index above 30 kg *NICE 2008 (Antenatal Care)*	13. Supplementation of Vitamin D discussed with women at greatest risk.
Allergies must be identified as part of the antenatal assessment		14. Allergies must be identified as part of the antenatal assessment
Identify and document women who would decline blood or blood products. See guideline for 'Women who decline Blood Products'	*'Women who decline Blood Products' NGHT (2009)*	15. Ask all women if they give consent to blood/blood products-this will be documented in the hand held antenatal notes

CARE	RATIONALE/EVIDENCE	STANDARDS
Measure height and weight and calculate BMI (Refer to bolt on guidelines for 'The Management of Women Who Present With a High Body Mass Index At Booking)	Body mass index is calculated by taking a persons weight in kg and dividing it by the square of their height (weight kg/height m2) Normal Range:18.50 - 24.99. Women with a low BMI, or who gain inadequate weight in the third trimester, are more likely to give birth preterm Women with a raised BMI have a higher mortality and morbidity rate. There is also evidence that babies of obese women have significantly increased risks of adverse outcomes, including fetal congenital anomaly, prematurity, stillbirth and neonatal death. *WHO (2004)* *CEMACH report (2003-2005) Saving Mothers lives* *NICE (2008) Antenatal Care* If BMI above 35 - unsuitable for midwife-led care *'The Management of Women Who Present With a High Body Mass Index At Booking) NGHT (2009)*	16. BMI to be calculated at booking and documented in the handheld notes

CARE	RATIONALE/EVIDENCE	STANDARDS
Discuss choices of care/lead professional/place of birth (See Appendix 4a, 4b & 4c) 'planning place of birth' - tool to aid assessment for home birth suitability. To make a referral for Consultant care a referral form is completed and then faxed to Gynae bureau stating 'routine' or 'urgent' appointment required. An urgent referral is seen within 7 days. (Appendix 5) Where shared care is declined, the midwife must ensure that an individual management plan is identified following discussion with the obstetrician. If at any time during pregnancy the midwife has any concerns; a direct referral to ANC; MDU or Labour Ward should be made as appropriate to needs.	Midwives in partnership with pregnant women and their partner, will discuss all realistic options and draw up a personalised, individual flexible plan for care. *DOH (2007) Maternity Matters* The midwife should promote normality and choice in maternity care *NSF (2004) Standard 11* *NICE (2007) intrapartum care* *Standards for Maternity Care (2008) Standard 11 and Standard 6* For multiparous women, birth in a non-obstetric unit setting significantly and substantially reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy. *(Birthplace Study 2011)* Every woman is able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have. *NSF (2004) Standard 11* *NICE (2008) Antenatal Care*	17. Antenatal records to clearly show who the lead professional is i.e. midwife or consultant 18. Women with complex medical conditions or any identified risk factors to be offered assessment by consultant obstetrician 19. Where risks are identified, A clear management plan to be documented by the obstetrician, in the antenatal records following discussion with the woman. 20. Written and verbal information given on options for place of birth, and documented in the antenatal records.

CARE	RATIONALE/EVIDENCE	STANDARDS
Assess: • Mental health If mental health issues identified, refer to guideline 'Perinatal mental Health' (2009)	Mental disorders during pregnancy and the postnatal period can have serious consequences for the Mother, her infant and other family members. Ask about: • past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the • postnatal period and severe depression • previous treatment by a psychiatrist/specialist mental health team including inpatient care • a family history of perinatal mental illness. • During the past month, have you often been bothered by feeling down, depressed or hopeless? • During the past month, have you often been bothered by having little interest or pleasure in doing things? *(Whooley questions)* A third question should be considered if the woman answers 'yes' to either of the initial questions 1. • Is this something you feel you need or want help with? *NICE (2008) Antenatal Care* *NICE (2007) antenatal and postnatal mental health* *NSF-Standard 11 Pre-birth Mental Health* *DOH (2002) Women's Mental Health: Into the mainstream*	21. Discussion of mental health issues with all women

CARE	RATIONALE/EVIDENCE	STANDARDS
• Safeguarding issues All women who meet criteria on trigger list for safeguarding are referred to appropriate agencies where relevant	*CEMACH Report 2003-2005 (2007) Saving Mothers Lives* *NSF (2004) STANDARD 11* *Perinatal mental Health Guideline NGHT 2009* Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. All those who come into contact with children and families in their every day work, including professionals who do not have a specific role in relating to child protection have a duty to safeguard and promote the welfare of children. *Working together to Safeguard Children (2006)* *Childrens Act (2004) Section 11* *NSF (2006) Standard 5* *Every Child Matters: Next steps (2004)* *Northampton Child Protection Policy 2007*	
• Domestic violence issues *(NGH Guideline for Domestic Violence - draft 2009)* • Midwife to document who woman is accompanied by at all antenatal appointments	Almost a third of domestic violence begins with pregnancy. Feedback from pregnant women already in abusive relationships is that existing abuse often intensifies during pregnancy. The effect of violence on the unborn baby can lead to miscarriage, stillbirth, intra-uterine growth retardation and premature birth as well as to long lasting physical disability. For the mother, violence can cause life-threatening complications and sometimes result in her death. *DOH (2000)Domestic Violence* *CEMACH report 2003-2005(2007) Saving Mothers Live*	22. All women are asked, (when not accompanied by partner) if they are affected by domestic violence 23. Complete full risk assessment at booking, 28 and 36 weeks
Complete initial risk assessment as part of the booking appointment. This will be fully reassessed at 28 and 36 weeks. This not only identifies any deviation from the norm and action taken, but also provides an assessment of any antenatal risk factors	The risk assessment identifies if there is any deviation from the low risk care pathway. Every woman develops and is encouraged to regularly review, her individual care plan in partnership with a health care professional. The plan is based on an assessment of each woman's	24. .When a woman returns from consultant to midwife led care this is clearly documented in the antenatal records, including the plan of care. The woman will be advised of the plan, and also the timing of her

CARE	RATIONALE/EVIDENCE	STANDARDS
including personal, medical, anaesthetic, surgical, mental health and obstetric history.	clinical and other needs and she and her health care professional are able to discuss changing it at any point in her pregnancy *DOH (2004) NSF*	subsequent appointment with her midwife. This will be documented in her hand held antenatal records.
Women who do not attend appointments must be actively followed up (See guideline for 'Non attenders to Antenatal Appointments')	Children born to women from more vulnerable groups experience a higher risk of death or morbidity and face problems with pre-term labour, intrauterine growth restriction, low birth weight, low levels of breastfeeding and higher levels of neonatal complications. The findings of the CEMACH report demonstrate that those women who need maternity services most use them the least. *CEMACH (2003-2005) 2007 Saving Mothers Lives* *'Non attenders to antenatal appointments' NGHT (2009)*	25. Women who do not attend appointments are actively followed up
Risk assess for VTE (Appendix 6(1)	Thromboprophylaxis in the antenatal, intrapartum and postpartum period (NGHT 2009)	26. Risk assess for VTE - and refer to Antenatal Clinic if indicated
Risk assess for pre eclampsia And consider more frequent BP measurements for women with any of the identified risk factors (Appendix 6(2))	*Hypertension in Pregnancy: NICE 2010*	27. Risk assess for pre eclampsia and refer to ANC if indicated.

CARE	RATIONALE/EVIDENCE	STANDARDS
5.1.2 **8 - 10 weeks** 2nd Booking appointment. Blood Tests obtained and consent documented (results to be followed up within 10 days)	Screening for sickle cell diseases and thalassaemia should be offered to all women. *NICE (2008) Antenatal Care* Booking should be undertaken over two appointments *RCOG Standards for Maternity Care (2008)*	28. All women will see a midwife for a second booking appointment, to include blood tests, by 10 weeks of pregnancy
	NSF (2004) Standard 11	29. All women to have contact numbers of midwives in team and of the triage phone number
Discuss breastfeeding and options for antenatal classes	Promotion of health and wellbeing includes the discussion of breastfeeding with prospective parents and the risks of not breastfeeding *Shribman (2008) The Child Health Programme* *UNICEF 2006*	30. Breastfeeding to be discussed with all women before 16 weeks of pregnancy.
Offer to review labour notes of previous birth, if appropriate	*CEMACH Report (2003-2005) Saving Mothers Lives*	
Send MSU sample to screen for asymptomatic bacteriuria	*NICE (2008) Antenatal Care*	31. Send MSU in early pregnancy
Discuss importance of pelvic floor exercises	Pelvic floor muscle training should be offered to women in their first pregnancy as a preventive strategy for postnatal urinary incontinence *NICE (2006) Urinary Incontinence*	32. Discussion of pelvic floor exercises with all women
Scan performed at the hospital And 20 week anomaly scan to be booked	11-13 +6 week scan and bloods. *National Screening Committee (2008)*	33. All women who have requested an ultrasound scan to have had ultrasound scan before 13+6 wks

CARE	RATIONALE/EVIDENCE	STANDARDS
5.1.3 16 weeks Carry out appropriate checks in accordance with National Guidelines and woman's choice. (Appendix 3) Document blood results in handheld notes Offer second trimester screening if combined screening has not be offered. Information on prophylactic Anti-D for women who are rhesus negative	*NICE (2008) Antenatal Guidelines*	34. All women who have missed the nuchal scan to have been offered the Quadruple Test by 20 weeks gestation 35. All booking bloods, and dating scan results will be discussed and documented by 16 weeks gestation
5.1.4 18 – 20+6 weeks If the woman chooses, an ultrasound scan is performed. For a woman whose placenta is found to extend across the internal cervical os at this time, a further scan at 32 - 34 weeks is offered	A mid-pregnancy scan should be offered to detect structural anomalies *NICE (2008) Antenatal Care* *National Screening Committee (2008)* *Assessment of Fetal growth*	36. All women to be offered an anomaly scan by 20+6 weeks of pregnancy.
5.1.5 25 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice (Appendix 3) *1. All primips should be seen at 25+ weeks to carry out a full antenatal assessment including fundal height measurement*	Measuring and plotting symphysis-fundal height at each appointment is good practice. This can help to detect large or small for gestational age infants. *NICE (2008) Antenatal Care* *'Although NICE advise that all primips are seen at 25/40 and have the fundal height measured and plotted at this stage, the Perinatal Institute who provide*	37. Measure and plot symphysis-fundal height at each routine appointment on the customised growth chart. From 25 weeks in all nulliparous women and 28 weeks for parous women.

CARE	RATIONALE/EVIDENCE	STANDARDS
2. If this appointment occurs when a primip is 24+ weeks, carry out an antenatal assessment but ask the woman to return in two weeks (at 26+ weeks) for a fundal height measurement. *3. All multips should be seen at 28 weeks for a full antenatal assessment and fundal height measurement.'*	*the growth chart training, advise that this is done at 26/40.* *In order to detect pre eclampsia in early pregnancy it is important that primips are seen prior to 26/40. The disadvantage of measuring fundal height at this stage is an increase in the number who plot below the 10th centile.*	
5.1.6 28 weeks Carry out antenatal checks in accordance with National guidelines and woman's choice. Screening tests will be dependent on consent of individual. FBC and red cell alloantibodies Administer prophylactic Anti-D to those women who are blood group rhesus negative and who have consented. All bloods should be reoffered if declined previously Offer and book antenatal classes Repeat 28 week risk assessment Discuss options for place of birth	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if needed *NICE (2008) Antenatal Care* *UK National Screening Committee (2008)* *NSF (2004) Standard 11:* *Standards for Maternity Care (2008) Standard 10*	38. All women are offered repeat blood tests. 39. If rhesus negative, consent completed ensure Anti D is given at 28 weeks 40. All women and their partners to have been offered programme of education for childbirth and parenthood 41. Infant feeding to have been discussed again with all women by 28/40 42. Repeat 28 week risk assessment
5.1.7 31 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 3) Sign Surestart form	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if needed. To ensure Health Visitor is kept updated if appropriate	

CARE	RATIONALE/EVIDENCE	STANDARDS
Document 28 week blood results in all nulliparous women	*NICE (2008) Antenatal Care* *UK National Screening Committee (2008)* *NSF (2004) Standard 11*	
5.1.8 34 weeks Carry out antenatal checks in accordance to National guidelines and woman's choice (Appendix 3). Discuss breastfeeding. Repeat FBC – if Hb at 28 weeks was below 10.5. if no improvement consider parental supplementation Discuss option of a 36 week home visit to/home assessment in labour for low risk women Women who have had a previous BBA /precipitate labour to be referred to the Homebirth team for a risk assessment	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To reduce the risk of a BBA a midwife from the Homebirth team will offer a home visit at 36 weeks to complete a risk assessment.	. 43. All 28 week screening tests to have been reviewed, discussed and recorded by 34 weeks. 44. Breastfeeding to have been discussed at 34 weeks . 45. Low risk women to be given information and choice around home assessment in labour 46. Women who have had a previous BBA /precipitate labour to be referred to the Homebirth team for a risk assessment
5.1.9 36 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice. (Appendix 3) Complete risk assessment form 'women choosing a homebirth Review scans for placental location. Review all screening results. Refer for presentation scan if appropriate. Homebirth team contact details to go in notes of low risk women who are suitable for home assessment in labour. Give specific information on care of the newborn including screening tests, Vit K, postnatal self care, baby blues and postnatal depression.	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle. To include support from other agencies if needed. To detect any deviation from norm. *NGHT (2008) Home Birth Policy* *NSF (2004) Standard 11:* *NICE (2008) antenatal Care* Breastfeeding rates are higher in women who receive breastfeeding education *NICE (2008) Antenatal Care* *UNICEF (2006)* *NSF (2004) Standard 11:* *RCOG (2008)Standards for Maternity CARE Standard 15*	47. Complete risk assessment at home at 36 weeks for women choosing to birth at home 48. Women who have an uncomplicated singleton breech pregnancy from 36 weeks should be offered external cephalic version. . 49. Homebirth team contact details to go in notes of low risk women who are suitable for home assessment in labour 50. Complete 36 week risk assessment 51. Postnatal care to be discussed with all

CARE	RATIONALE/EVIDENCE	STANDARDS
Discuss early labour assessment at home for low risk women irrespective of place of birth. Give specific information on Preparation for labour and birth, including the birth plan, recognising active labour and coping with pain. Place of birth to be re-discussed.		women, including information on Vitamin K 52. All women are given the opportunity to discuss preparation for labour and birth at 36 weeks
5.1.10 38 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 3) Discuss options for management of prolonged pregnancy	To continue to offer consistent information and clear explanations and provide the opportunity to discuss issues and ask questions. To review health/lifestyle • using health promotion opportunities • integrated woman and baby centred care • what women want; kindness, support and respect • promotion of normality *NICE (2008) Antenatal Care* *NSF (2004) Standard 11:*	53. Management of prolonged pregnancy to be discussed with all women.
5.1.11 40 weeks Carry out antenatal checks in accordance with National Guidelines and woman's choice. (Appendix 3) Date for induction of labour can be offered and arranged	Membrane sweeping makes spontaneous labour more likely, and so reduces the need for formal induction of labour to prevent prolonged pregnancy *NICE (2008) Antenatal Care* *NICE (2008) Induction of labour* *NGHT (2007) Induction of Labour*	
5.1.12 41 weeks Carry out antenatal checks, in accordance with National Guidelines and woman's choice. Date for induction arranged Induction offered and booked T + 12 weeks. This should only be considered when vaginal	*NICE (2008) Induction of Labour* *NICE (2008) Antenatal Care*	54. All women are offered a stretch and sweep from 40 weeks and / or prior to formal induction of labour 55. All women with uncomplicated pregnancies are offered induction of labour at T + 12

CARE	RATIONALE/EVIDENCE	STANDARDS
delivery is felt to be the most appropriate mode of delivery. Due consideration should be given to maternal preferences and priorities prior to commencement of induction.		
5.1.13 Record keeping **(see bolt on Maternity Records Management NGHT 2009)**	Record keeping is an integral part of nursing midwifery and specialist community public health nursing practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow. Good record keeping helps to protect the welfare of patients and clients by promoting • high standards of clinical care • continuity of care • better communication and dissemination of information between members of the inter-professional health care team • an accurate account of treatment and care planning and delivery • the ability to detect problems such as changes in the patient's or client's condition at an early stage The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner whilst careless or incomplete record keeping often highlights wider problems with the individual's practice. *NMC (2007) Record Keeping*	56. An annual notes audit is carried out

5.2 Maternity Care Pathway for Antenatal Care (Summary)

APPOINTMENT	INFORMATION/ISSUE	COMPLETE	PROCEDURE	DISCUSS
6- 8 weeks First Booking appt with midwife Identify communication needs e.g. interpreter	Pregnancy hand held notes 'Tests for you and your baby' Contact numbers of named midwife/team/triage/GP/ other referral agencies FW8 prescription form Bounty pack Healthy Start Leaflet 'Routine antenatal care for healthy pregnant women' (NICE) Pregnancy Book available to download from http://www.dh.gov.uk	Pregnancy hand held notes- documenting who is present at each consultation Complete electronic booking Antenatal Clinic referral form, if appropriate Smoking referral form and return to community office FW8 Antenatal Summary at each appointment (in yellow folder) Risk Assessments including mental health Assess for PET, VTE and GTT Acceptance/decline Blood/products identification in the handheld notes	Previous obstetric history: Review hospital notes if appropriate Height, weight and BMI BP and urinalysis Confirm contact details are current on IT system or midwives register. Take history performing risk assessments Book scan	Pattern of care/lead professional Blood tests including FBC, syphilis, Hep B, HIV, rubella, haemoglobinopathies, group and red cell alloantibodies. Need for GTT if relevant (see Appendix 5) Identify women who have had FGM Health/lifestyle issues-diet, food hygiene, smoking cessation, recreational drug use, alcohol consumption Maternity benefits Benefits of Folic acid (400mcg) Vit D (10mcg) Supplements for those at risk of Vit D deficiency Previous labour/birth if applicable Local Chlamydia Screening Programme Mental health/Safeguarding issues Domestic violence issues (if seen alone) Nuchal scan plus screening bloods, or quadruple test if late booking. Anomaly scan. Benefits and risks of screening/ diagnostic tests. Acceptance/decline Blood/products
8 - 10 weeks Second booking appt with midwife Women who do not attend appointments need to be actively followed up	Off to the best start' breastfeeding leaflet UNICEF/NHS/DOH 2007 'Choices ' leaflet	Pregnancy hand held notes Blood test forms, Consent, Family Origin Questionnaire	MSU BP Venepuncture (results to be followed up within 10 days)	Pelvic floor exercises Place of birth MSU Breastfeeding Antenatal Classes Further discussion of screening tests
11 - 13^{+6} weeks Ultrasound Scan with Sonographer		Scan report by sonographers	Attend scan – if abnormal, refer to PND, inform Community Midwife	
16 weeks With midwife	" Parents Guide to Money" 'Prophylaxis for women who are Rhesus D negative (NICE)	Risk assessment EDD from dating scan Pregnancy hand held notes Blood results documented in notes	BP and urinalysis Reassess planned pattern of care – identify any need for additional care Make appointment in Anti D clinic	Scan report Relevant health/lifestyle issues Individual queries of the woman/partner Blood test results Relevance of rhesus negative blood group-Anti D
18 - 21 weeks With Ultrasound Department			Anomaly scan	Low lying placenta – Repeat scan at 32 - 34 weeks gestation if placenta covering or reaching internal os
25 weeks With Midwife (nulliparous only)	MATB1 (Eligible from 20/40)	Pregnancy hand held notes MATB1 (eligible from 20/40)	BP and urinalysis Reassess planned pattern of care – identify any need for additional care Measure and plot symphysis-fundal height Auscultation of fetal heart	Relevant health/lifestyle issues Individual queries of woman /partner Feedback re: Quadruple Test Scan results Blood results Infant feeding choices Antenatal classes

APPOINTMENT	INFORMATION/ISSUE	COMPLETE	PROCEDURE	DISCUSS
28 Weeks With Midwife	Continue to offer consistent information and clear explanations about care	Pregnancy hand held notes including risk assessment Full blood count and antibodies form If rhesus negative, Anti D consent in antenatal notes.	BP and urinalysis Weigh if BMI >30 (booking) FBC/Antibodies Administration of prophylactic Anti- D 1500iu for rhesus neg women who have consented Measure and plot symphysis-fundal height Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Discuss place of birth Ensure antenatal classes booked if required Infant feeding choices (multips)
31 Weeks With Midwife Nulliparous women only	Sign Surestart grant if requested	Pregnancy hand held notes – blood results documented in notes	BP and urinalysis Measure and plot symphysis-fundal height Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Blood test results
34 Weeks with Midwife	'Mothers guide to breastfeeding' 'Care of women and their babies during labour' (NICE)	Pregnancy hand held notes – blood results documented in notes (multips)	BP and urinalysis Measure and plot symphysis -fundal height Auscultation of the fetal heart	Breastfeeding Relevant health/lifestyle issues Individual queries of woman/partner. Early labour assessment at home for low risk women irrespective of place of birth. Refer previous BBA/precipitate labour to Homebirth Team
36 Weeks With Midwife – Clinic or Home visit	Home birth notes and ID stickers for woman's notes Homebirth team contact details for women who are suitable for home assessment in labour Vitamin K Information leaflet NGHT 'Caesarean Section' 'Your choice of Anaesthesia' 'External Cephalic Version' available from antenatal clinic	(see Homebirth policy if choosing to birth at home) Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis – fundal height and check presentation Reassess planned pattern of care/identify need for additional care Auscultation of the fetal heart	Preparation for labour and birth, including the birth plan, recognising active labour and coping with pain. SROM at term. Latent phase of labour Place of birth, Birth plan, vitamin K, third stage, birth partners, postnatal care Reassess health/lifestyle issues Individual queries of woman/partner Contact information for home assessment in labour
38 Weeks With Midwife		Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis –fundal height and check presentation Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Management of prolonged pregnancy
40 Weeks With Midwife		Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis-fundal height and check presentation Offer vaginal examination for membrane sweep –for all women with an uncomplicated pregnancy Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner Management of prolonged pregnancy
41 Weeks With Midwife	Date for IOL can be offered and arranged 41– 42 weeks 'Induction of Labour' (NICE)	Pregnancy hand held notes	BP and urinalysis Measure and plot symphysis-fundal height and check presentation Offer vaginal examination for membrane sweep Book induction of labour Auscultation of the fetal heart	Relevant health/lifestyle issues Individual queries of woman/partner

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Northampton General Hospital NHS Trust *(2008) Protocol for Growth Scans*

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Northampton General Hospital Guideline for Domestic Violence - draft 2009

Northampton General Hospital Guideline for Teenage Pregnancy - draft 2009

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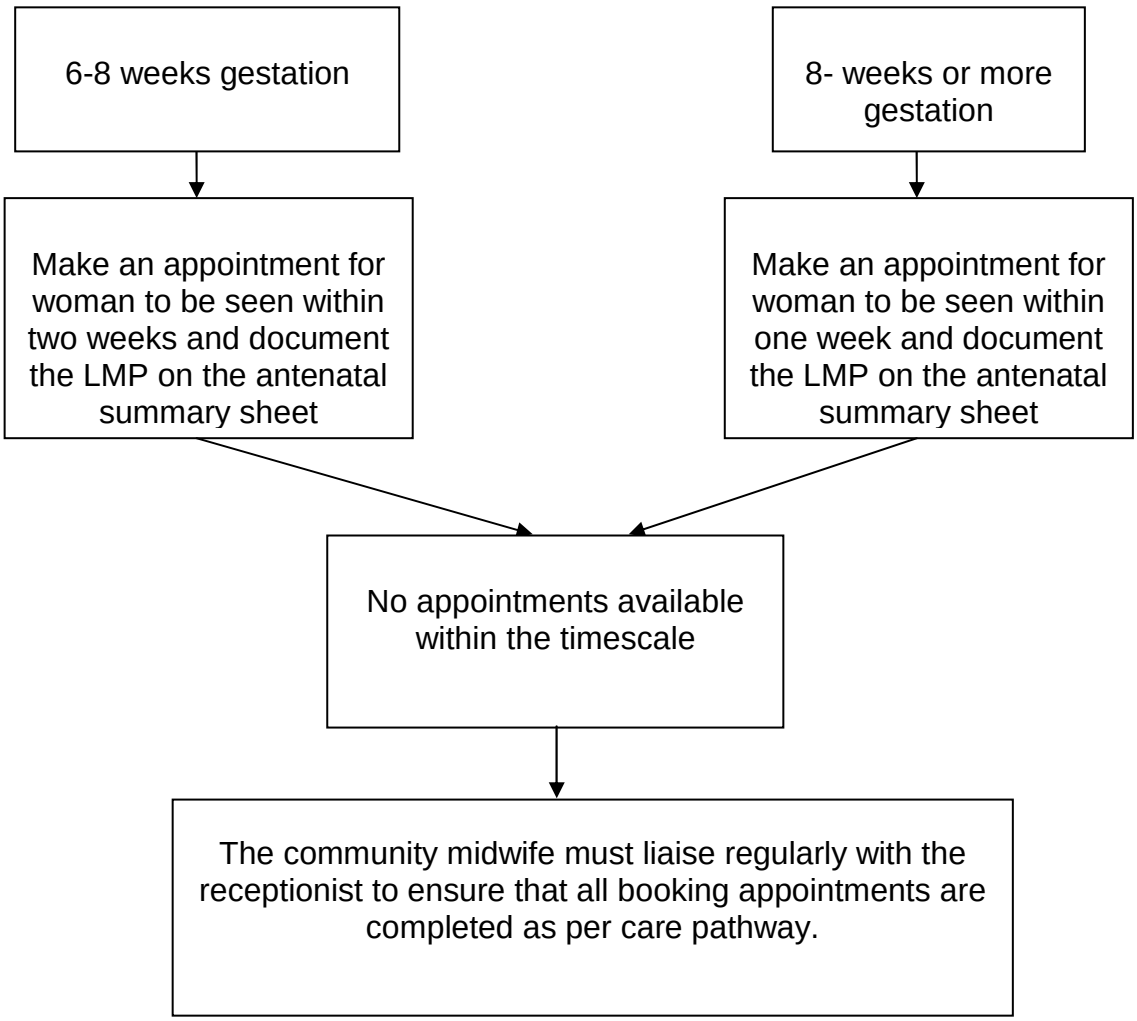
Appendix 1

The Booking Appointment should be **completed** before 10 weeks of pregnancy.



Appendix 2

DIRECTORATE OF OBSTETRICS & GYNAECOLOGY

Referral for Obstetric Opinion

Mother's Name :	GP: Dr.
Address:	Surgery Address/Stamp:
Date of Birth:	Tel:
NHS. No.:	GP Code:
Gravida Parity	Practice Code:
LMP EDD	Fund Holder Code:
Gestation……..wks……..days	
Allergies:	Interpreter required: Yes / No
SG2 referral: Yes / No	Spoken language:
Appointment: Urgent (less than 7 days) / Routine	

Date……

Dear Colleague

I refer this expectant mother for an obstetric opinion as to the most appropriate plan of care for her pregnancy and would therefore be grateful if you would arrange for an antenatal appointment.

Yours faithfully

Name……Designation……

Please send completed form to:

Antenatal Clinic Appointments
Gynae Bureau
Northampton General Hospital
NORTHAMPTON
NN1 5BD

Telephone: 01604 545495

Fax: 01604 545906

FOR HOSPITAL USE ONLY	
Appropriate referral or Obstetric opinion	Yes / No
Referral back for Community Led Care	Yes / No
Hospital Number	Consultant
Date & Time of Appointment	

Indications for referral *Please tick to indicate reason(s)*

Patient's Name & Hospital Number

Personal History

	✓	Code*
Body Mass Index (BMI) by 12 weeks gestation: greater than 35, >100kg or less than 18		A
Women >40 years old who may be at risk of developing complications		
Women declining blood products		
Women at risk of developing VTE/PET		

Medical History		
Anaesthetic problems		
Asthma - severe		B
Cardiovascular disease		B
Deep Vein Thrombosis or Pulmonary Embolism		B
Diabetes Mellitus – ***Contact MDU on 01604 545435***		B
Drug / Alcohol / Medication dependency		A
Epilepsy / Neurological factors		A
Essential Hypertension – (BP 140/90 or above)		A
Family history of note		
Fertility Treatment		
Haematological disorders		B
Haemoglobinopathies		B
HIV positive		B
Hep B or C positive		A
Mental Health		A
Renal Disease		B
Thyroid or any other endocrine disorder		B
Any other medical condition		

Surgical History		
Hysterotomy or Myomectomy		A
Fractured pelvis/pelvic abnormality		

Obstetric History		
Preterm delivery – before 34 weeks gestation		A
Mid-trimester miscarriage		A
Disabled child / Fetal anomaly - ***Contact Prenatal Diagnosis on 01604 545899***		A
Previous Stillbirth or Neonatal death		A
A small for gestational age infant (<10th centile as identified on the customised growth chart)		A
A large for gestational age infant (>90th centile as identified on the customised growth chart))		A
3 consecutive miscarriages – if causative factors identified or no investigations		A
Previous gestational diabetes		
Rhesus or other antibodies		B
Eclampsia, HELLP syndrome or severe Pre-eclampsia		A
Previous caesarean section		
Previous shoulder dystocia		
Previous 3rd /4th degree tear		
PPH > 1000mls		
Previous placenta accreta		A

Present Pregnancy		
Late booker (>20 weeks gestation)		
Malpresentation >36 weeks gestation (refer direct to MDU)		
Maternal Request		
Multiple pregnancy		B
Pregnancy Induced Hypertension (referral through MDU)		

Additional Information

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*Code: A = intermediate
B = Intensive

Appendix 3

Routine Antenatal Assessment

Standard: "Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies."

DH (2004)

Rationale: "Care pathways and managed care networks link maternity and neonatal services with a range of services and professionals to ensure all women and their babies have equal access to high quality care"

DH (2004)

Antenatal Examination/assessment:

- Blood Pressure
- Urinalysis for **proteinuria and glycosuria**
- Measure symphysis/fundal height from 25 weeks and plot
- Check presentation from 36 weeks
- Routine auscultation of the fetal heart is of no benefit and should not be routinely undertaken
- unless specifically requested by the woman.

Risk assessment is a continual process and midwives need to use their professional judgment at each visit. If the woman is referred and seen by a consultant obstetrician, if no problem has been confirmed/present, then the woman is referred back to the community midwife. Good communication and mutual respect between the multidisciplinary team is vital.

Appendix 4a

Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000 Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Endocrine	Hyperthyroidism Diabetes
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Other factors indicating increased risk - suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia
Current pregnancy Fetal indications	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 8.5 g/dl at onset of labour Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie Body mass index at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate (FHR)/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Medical conditions indicating individual assessment when planning place of birth

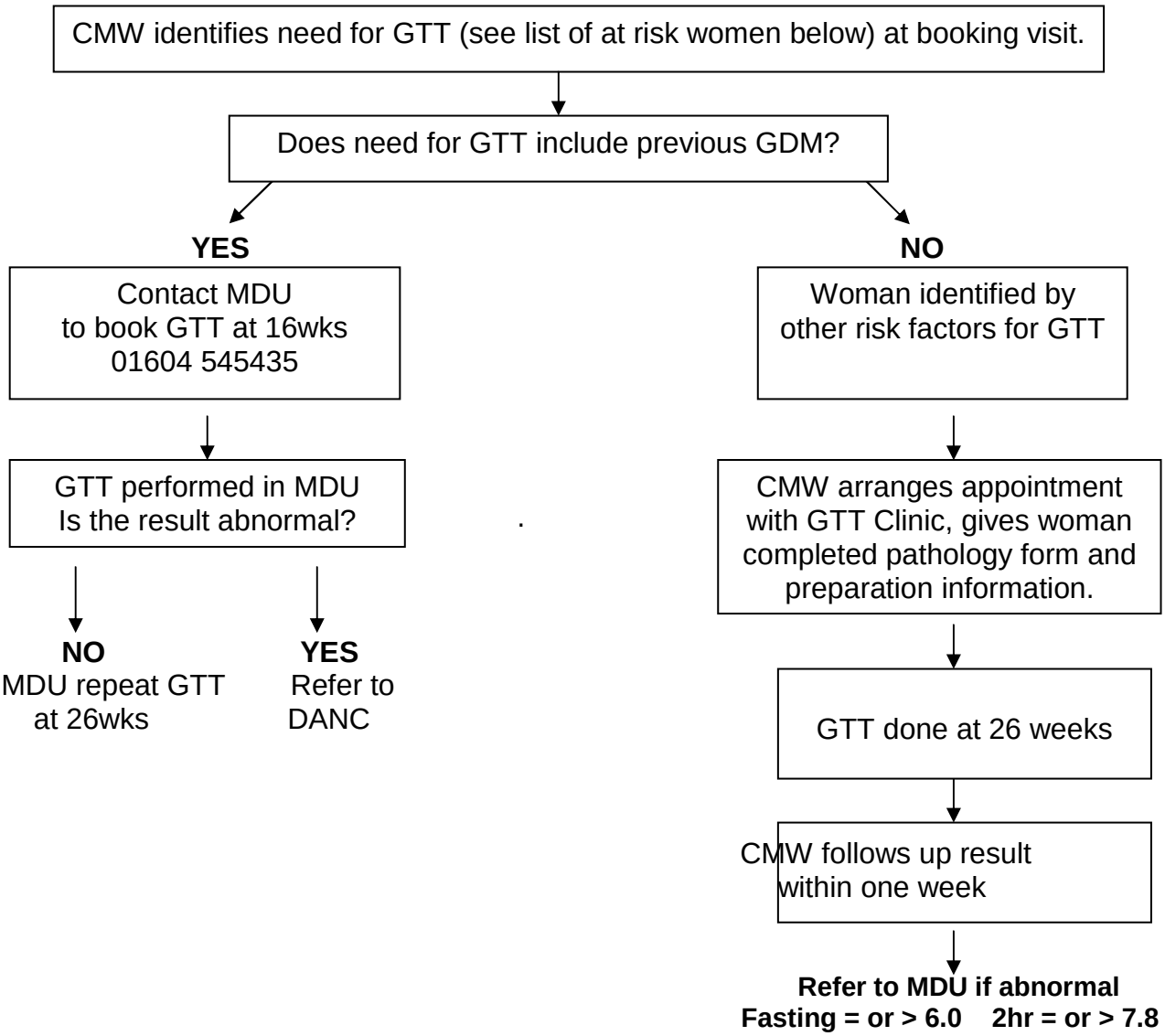
Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle-cell trait Thalassaemia trait Anaemia – haemoglobin 8.5–10.5 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 4 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) Body mass index at booking of 30–34 kg/m^2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions Clinical or ultrasound suspicion of macrosomia Para 6 or more Recreational drug use Under current outpatient psychiatric care Age over 40 at booking
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

NICE clinical guideline 55 – intrapartum care 15

Northampton General Hospital NHS
NHS Trust



All women with risk factors including:

- **BMI above 30kg/m2**
- **Previous gestational diabetes**
- **First degree relative with diabetes (parent, sibling or child) plus grandparents**
- **Family origin with a high prevalence of diabetes:**
- **South Asian (specifically women whose country of origin is India, Pakistan or Bangladesh**
- **Black Caribbean**
- **Middle Eastern (Specifically women whose country of family origin is Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon or Egypt)**
- **Previous baby weighing 4.5kg or customised birth weight centile greater than 90th**
- **Unexplained stillbirth**
- **Polycystic ovary Syndrome**
- **Refer for GTT at 26 weeks (consider GTT at 16 weeks if multiple risk factors)**

Please give the woman:

- **A completed blood form, including the surgery code and 'copy to GP'.**
- **Bottle of glucose for her to take to her appointment. She must NOT drink the glucose prior to her appointment.**

It is your responsibility to follow up the blood result within a week, or to hand over to another midwife to follow up if you are not working.

Booking risk assessment sheet

(1) Risk of VTE

Antenatal Risk Factors for Thromboembolism	Tick
Thrombophilia (congenital or acquired)	
Previous VTE	
Medical disorders – heart or lung disease, SLE, cancer, inflammatory conditions, nephritic syndrome, sickle cell disease, intravenous drug user	
Age greater than 35	
Booking BMI greater than 30	
Parity greater than or equal to 3	
Smoker	
Significant varicose veins	
Current systemic infection	
Immobility e.g. paraplegia, SPD, long-distance travel	
Current hyperemesis/ dehydration/ ovarian hyperstimulation syndrome	
Current Pre-eclampsia	
Multiple pregnancy or Assisted Reproductive Therapy	

Red - **refer to Consultant clinic to consider thromboprophylaxis in antenatal period**

3 ambers – **refer to Consultant clinic to consider thromboprophylaxis in antenatal period**

2 ambers – **general advice to patient re reducing risk of thromboprophylaxis (remaining mobile and well hydrated) and warn about possible need for thromboprophylaxis if admitted during pregnancy and after delivery (depending on labour and mode of delivery**

(2) Risk of PET

Risk Factors	Action
Hypertension during previous pregnancy Chronic kidney disease Autoimmune disease e.g. SLE or antiphospholipid syndrome Type 1 or type 2 diabetes Chronic hypertension	**If one risk factor**, refer to Consultant clinic (ideally before 12 weeks) as would benefit from 75mg Aspirin to continue from 12 weeks until birth.
First pregnancy Greater than 40yrs Pregnancy interval of greater than 10 yrs BMI greater than 35 Family history of PET Multiple pregnancy	**If more than one risk factor**, refer to Consultant clinic (ideally before 12 weeks) as would benefit from 75mg Aspirin to continue from 12 weeks until birth.

Submission Documents

7. IMPLEMENTATION AND TRAINING

Prior to implementation, the document will be circulated to the Supervisors of Midwives. The document will be discussed with them at their meeting, including their role in the implementation of compliance to the document.

The care pathway will be implemented through workshops that will be available to all midwives and obstetricians working within the organisation.

Training in how to use the pathway will be part of the Preceptorship/Induction Programme

Workshops in the implementation of the pathway will be facilitated for the teams of community midwives, at their team meetings.

Receptionists at the surgeries and clerical staff will be will be advised of their roles and responsibilities by the Matron for Community and Primary Care Services

All midwives to sign for a copy of the maternity care pathways

8. MONITORING AND REVIEW

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
1.4.1	To determine whether women have their full booking visit and hand held notes completed in line with the defined timescales.	a) Women have their booking appointment and hand held record completed by ten completed weeks of pregnancy. b) Women who are ten or more weeks pregnant on referral are seen within a week of referral to the maternity services.		antenatal notes reviewed against the standards.	Clinical Effectiveness Group	Annually	Directorate Governance Group

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
		Where the standards described within (a) and (b) are not met the records will be scrutinised to determine whether responsibilities as defined in this document have been met. Women who have not previously had a full medical examination in the UK will be referred by their midwife to a doctor. The doctor will take a medical history and a clinical assessment will be made of their overall health.		antenatal notes of women will be reviewed against the standards	As Above	As Above	As Above

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
1.4.3	To determine that the maternity service has approved documentation which describes the process of clinical risk assessment during the antenatal period.	The antenatal risk assessment form is completed at each routine antenatal appointment-the timing of which, is stated on the form. At the booking appointment a full history is taken Including history of: Medical conditions Anaesthetic history Obstetric Surgical, Family Lifestyle/social Mental Health		antenatal notes of women will be reviewed against the standards.	As Above	As Above	As Above

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
1.4.3	To determine that the maternity service has approved documentation which describes the process of clinical risk assessment during the antenatal period.	All women choosing a homebirth will have a risk assessment completed as part of the homebirth policy.(NGHT 2008) Where risks are identified during a clinical risk assessment, a clear individual management plan should be documented in the hand held antenatal records		antenatal notes of women who had a planned homebirth will be reviewed against the standards. antenatal notes of women who have will be reviewed against the standards.	As Above	Annually	As Above

No	Purpose of the Audit	Auditable Standards	Target % Compliance	How data will be collected	Responsibility for Audit	Frequency of Audit, when audit last done and next due	Group to which audit will be submitted
1.4.3	To determine that the maternity service has approved documentation which describes the process of clinical risk assessment during the antenatal period.	All women will be referred to Antenatal clinic to see an obstetrician when risks are identified through the clinical risk Assessment. When women are referred back to midwifery led care, this is clearly documented by the obstetrician, in the antenatal notes.		antenatal notes of women will be reviewed against the standards.	As Above	Annually	As Above

Monitoring

An annual audit of the above standards will be co-ordinated by the Maternity Clinical Effectiveness Group. The subsequent audit report will be made available to staff and Supervisors of Midwives via the Maternity Governance Group. If any deficiencies are identified, the Maternity Governance Group will instigate the development of an action plan with clear timescales and responsibilities. The action plan will remain an agenda item until completed.

9. COMPLIANCE STATEMENTS

Equality & Diversity

This policy has been assessed against the Trust's Equality Impact assessment tool as required by the Service Equality Scheme 2006 and Race Relations (Amendment) Act 2000.

General Statement of Intent

This Trust aims to design and implement services, policies and measures that meet the diverse needs of the population it serves and its workforce ensuring that none are placed at a disadvantage over others.