NHS
Manchester University
NHS Foundation Trust

DOCUMENT CONTROL PAGE

Title:	Antenatal Care Management
Version:	1.3
Supersedes:	Version 1.2
Application:	All Staff

Originated / Modified By:	L Shaw / P Norris / Dr B Singhania / Dr E Church / M Ryan / K Dewhurst
Designation:	Matron Antenatal Services / Governance Midwife / Consultant Obstetrician / Consultant Obstetrician / Matron for Antenatal Services / Midwife
Ratified by:	Site Obstetric Quality and Safety Committee
Date of Ratification:	12th October 2022

Issue / Circulation Date:	15th September 2023
Circulated by:	Clinical Governance Team Maternity
Dissemination and Implementation:	Clinical Governance Team Maternity
Date placed on the Intranet:	15th September 2023

Planned Review Date:	31st October 2025
Responsibility of:	Clinical Governance Team Maternity

Minor Amendment (If applicable) Notified To:	Site Obstetric Quality and Safety Committee: • Re-added to screening offered at booking - urinalysis. (MSSU) sent to screen for asymptomatic bacteriuria (14th December 2022); added appendix for ongoing referrals for booking appointments in Hive (8th March 2023). Editorial changes throughout to clarify existing processes in accordance with SBL3.
Date notified:	13th September 2023

EqIA Registration Number:	2011-354R2

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1 Introduction

Women with an uncomplicated pregnancy should be offered midwife led care. Routine involvement of obstetricians does not appear to improve perinatal outcomes compared with referral to obstetricians when complications arise.

Antenatal care should be readily and easily accessible while being sensitive to the needs of individual women and the local community.

2 Details of the guideline

2.1 First point of contact and organising the booking appointment

NICE: Offer early pregnancy health and wellbeing information before the booking appointment if seen face to face for a first point of contact. This should include information about modifiable factors that may affect the pregnancy, including stopping smoking, avoiding alcohol, taking supplements and eating healthily.

Online self-referral forms are also available for those booking out of area.

The process for ensuring that women have their first full booking appointment by ten completed weeks of pregnancy:

2.1.1 Saint Mary's at Oxford Road Campus (ORC)

Women who live in a Manchester Foundation Trust (MFT) zoned postcode under the care of the Oxford Road Campus (ORC) community team may access a midwife directly to arrange a booking visit and maternity care. The midwife will arrange an appointment with the woman by ten completed weeks of pregnancy.

For women who do not live in a MFT zoned postcode and wish to deliver at ORC, it is the responsibility of the outpatient triage clerk following receipt of the referral for care to enter the woman's details onto HIVE and to ensure that women are offered a timely appointment for a full booking history by 10 completed weeks of pregnancy.

2.1.2 Saint Mary's Wythenshawe Campus

Women who live in a Wythenshawe campus zoned area can phone or be referred by their midwife. Following the receipt of this referral, maternity clerks enter the women's details onto HIVE. Community midwives give the clerk a time frame for the booking appointment within the community setting to ensure within ten completed weeks of pregnancy.

Women who book out of area are given any appointment within appropriate time frames to attend antenatal clinic.

2.1.3 Saint Mary's North Manchester

Women who live in a Manchester Foundation Trust (MFT) zoned postcode under the care of the Saint Mary's North Manchester community team may access a

midwife directly or via online referral to arrange a booking visit and maternity care. The midwife will arrange an appointment with the woman by ten completed weeks of pregnancy.

For women who do not live in a MFT zoned postcode and wish to deliver at Saint Mary's North Manchester, it is the responsibility of the outpatient department following receipt of the referral for care to enter the woman's details onto HIVE digital system and to ensure that women are offered a timely appointment for a full booking history by 10 completed weeks of pregnancy.

2.1.4 For women who are already ten or more weeks pregnant on referral to maternity services, an appointment must be offered for them to be seen within two weeks.

2.2 The booking appointment

2.2.1 The booking appointment is the first time in their pregnancy that a woman or pregnant person can undergo a detailed risk assessment. This should include; taking a full medical, obstetric, social and family history; determining their first spoken language and assessing / offering the need for an interpreter; a detailed discussion regarding previous or current mental health concerns; a medication review; SBL risk assessment to determine risk of fetal growth restriction and need for aspirin prescription (see Aspirin PGD), smoking status; VTE risk assessment; allergies; occupation including risks, concerns and statutory rights; family, home and support situation; contact details for a next of kin and a detailed discussion regarding modifiable lifestyle choices.

2.2.2 All women should be advised to take Vitamin D throughout pregnancy and a risk assessment should be undertaken to determine if a higher dose of Vitamin D is recommended (see Vitamin D PGD).

2.2.3 The discussions and management plan must be documented.

2.2.4 It is good practice to review any relevant previous health records available. All prior medical and obstetric history must be entered onto HIVE during the booking visit. Access to legacy information will be available via the Archive button on HIVE Archive, the electronic document management system (EDMS).

2.2.5 It is the responsibility of the booking midwife to ensure that the full booking history is completed and the options for care are discussed.

2.2.6 The midwife should provide information about the format and schedule of antenatal care, as well as highlighting contact details and where to access further high-quality information and support.

2.2.7 Following completion of the booking appointment, it is the responsibility of the midwife to ask whether the woman would like to use the MyMFT portal and to give her information about the portal.

2.2.8 For all women who do not have access to MyMFT and/or would like a hard copy summary of their visit this should be printed and filed in their maternity records folder (this will be

offered to all women at their booking visit). If the visit documentation cannot be printed (e.g. community/home visit) the essential information should be transcribed from the HIVE record onto a continuation sheet – the full visit documentation must still be completed within HIVE.

For more information regarding documentation in the antenatal period, see *Maternity Records* guideline.

2.3 Risk assessment

2.3.1 Any risks identified should be referred as directed by the risk assessment tool. The antenatal risk assessment informs the decision regarding place of birth. The chosen plan of care and the woman's choice should be documented in HIVE.

2.3.2 At the time of the first booking appointment the allocated clinical care team must be documented in HIVE. Following referral to specialist services or where complications arise, the care team must be updated to reflect the responsible lead clinician and their specialism. The lead clinician should be a named consultant for women receiving shared care, for women receiving midwifery led care, the lead clinician can be a named midwife or midwife team.

2.3.3 Women must be given information regarding choices in pregnancy and given the opportunity to discuss issues and ask questions. The woman should be advised of the reason for all screening tests to enable informed consent. (A link to the National Screening Programme Booklet should be provided prior to the appointment). The screening offered.

includes:

- Blood group, antibody screen and Rhesus status
- Full blood count
- Haemoglobinopathies
- Hepatitis B
- HIV
- Syphilis
- Trisomy Screening
- Urinalysis (MSSU) sent to screen for asymptomatic bacteriuria
- CO screening and appropriate referral to the stop smoking team

See also Guideline for Antenatal Screening and Management of Results (Antenatal, Intrapartum and Postnatal)

In addition, women should be offered an ultrasound scan to establish gestational age and a mid-pregnancy scan to screen for fetal anomalies.

2.3.4 Women requiring referral to Specialist Midwives for substance abuse, mental health, YPG or Asylum Seekers require a MIRF.

2.3.5 Domestic abuse MUST be discussed at the booking appointment and documented appropriately. If partner is present, domestic violence must be discussed at an opportune

moment e.g., whilst obtaining height/weight measurements. Any information disclosed will not be visible on the MyMFT app.

2.3.6 Information should be provided to support informed decision making and discussions documented. Further information is available via the MFT website.

2.3.7 Migrant women who have not had a full medical examination in the United Kingdom by the time of the booking appointment will be referred to their GP to have this performed. For women who have not yet registered with a GP then a member of the obstetric team will be asked to review the woman and undertake the examination.

2.3.8 Women should be asked their smoking status at booking (and each antenatal contact), performing CO Monitoring at booking (and every antenatal contact), and referring all current smokers, smokers who have quit in pregnancy and CO ≥ 4 to Smoke Free Pregnancy Service.

2.3.9 Late bookers

Late bookers are defined as those who have not accessed care prior to 25 weeks and a MIRF should be completed for information, including reasons for accessing care late in the pregnancy.

Late bookers should be dated using ultrasound scan and a discussion had around the estimated due date not being accurate. As they are out of the time frame for trisomy and anomaly screening, options including NIPT should be discussed. See also *Guidelines for Down's syndrome, Edwards' syndrome and Patau's syndrome Screening in Pregnancy including assessment of Alpha Feto Protein (AFP) and other incidental findings.*

Late bookers should be referred for consultant led care where they will be offered serial growth scans and the option of induction of labour between 40-41 weeks, or as otherwise clinically indicated.

N.B.: Those who transfer care from another unit or another country who have had regular antenatal care and an agreed EDD do **not** require a consultant NOA unless they have a reason for being under consultant led care.

2.4 Frequency of antenatal appointments

2.4.1 The schedule of antenatal appointments should be determined by the function of the appointment. In line with NICE guidance the aim is for:

- Nulliparous women with uncomplicated pregnancies to receive a schedule of 10 appointments (16, 25, 28, 31, 34, 36, 38, 40, 41, 42 weeks)
- Parous women, with uncomplicated pregnancies to receive a schedule of 7 appointments (16, 21, 28, 34, 36, 38, 41, 42 weeks)

Women may require additional visits; the women are advised to attend at these intervals but where a woman is not able to attend at these intervals the woman should be offered an appointment at or around these intervals.

At booking and as required throughout pregnancy a risk assessment should be undertaken to ensure that the woman continues to receive appropriate care. The aforementioned schedule of appointments applies to women with uncomplicated pregnancies. Women with identified risk factors will receive appointments according to their individual needs.

2.4.2 Wherever possible antenatal appointments should include routine tests and investigations to minimise inconvenience to women.

2.5 Detail of Antenatal Appointments

2.5.1 General

- Review, discuss and document the results of all screening tests and investigations, where available
- Prior to 20 weeks - review the woman's wishes regarding trisomy screening if not previously taken. If the woman consents to second trimester trisomy screening, bloods should be obtained at this point; this must be taken before and including 20^{+0} weeks gestation.

See *Antenatal Screening guideline* and *Guidelines for Down's syndrome, Edwards' syndrome and Patau's syndrome Screening in Pregnancy including assessment of Alpha Feto Protein (AFP) and other incidental findings*.

- Check that women who are Rhesus D negative have been offered fetal RhD screening to predict fetal blood group. If the woman declines fetal RhD screening test, book a routine antenatal anti D prophylaxis appointment at 28 weeks.

See *Care of the Rhesus D Negative Woman in Pregnancy and the Puerperium* guideline.

- At each antenatal appointment: Measure and document BP (this should be recorded using a digital monitor that has been validated by MFT), test urine for proteinuria and glucose, enquire about physical and mental wellbeing, enquire regarding taking of Vitamin D, ask regarding smoking status and perform CO monitoring. Re-refer those who have not engaged with the Smoke Free Pregnancy Service.
- The Symphysis Fundal height (SFH) measurement should be offered to all women before 28+6 weeks. Measurements should be plotted or recorded on charts by clinicians trained in their use. Offer SFH at each antenatal appointment after 26+0 for women with a singleton pregnancy and in accordance with the Fetal Growth Restriction Guideline Appendix 3 and discuss fetal movements. Cease SFH measurements if the woman is having regular growth scans.
- It is the responsibility of all staff to ensure all future appointments are booked and on occasions where women do not attend that each case is investigated, and future appointments are scheduled.

See *Guideline for the follow up of women who do not attend (DNA) antenatal services*.

2.5.2 In addition, between 16 and 27 weeks gestation:

- Information produced by Tommy's discussing fetal movements is included in the MyMFT app in multiple languages.
- If unable to access the MyMFT app, a Tommy's leaflet should be given in the appropriate language (staff can contact Tommy's directly to request a language that is not available on their website) and discussed before 21 weeks.
- Offer SFH at each antenatal appointment after 26+0 for women with a singleton pregnancy and in accordance with the Fetal Growth Restriction Guideline Appendix 3 and discuss fetal movements.
- Enquire about mental health and emotional well-being.
- Review screening choices/results
- Discuss vaccinations for Covid-19, Flu and Pertussis
- Discuss Parent Education; offer the opportunity to attend antenatal classes.
- Discuss infant feeding and document discussions.
- Review progress/feedback of referrals to multi agencies / teams e.g., social services, smoking cessation, GTT, Anti-D etc.

2.5.3 In addition, from/at 28 weeks gestation:

- Following risk assessment and following FGR guidelines (See Fetal *Growth Restriction – Detection and Management* guideline), The Symphysis Fundal height (SFH) measurement should be offered to all women before 28+6 weeks. Measurements should be plotted or recorded on charts by clinicians trained in their use. Offer SFH at each antenatal appointment after 26+0 for women with a singleton pregnancy and in accordance with the Fetal Growth Restriction Guideline Appendix 3 discuss fetal movements. Cease SFH measurements if the woman is already having regular growth scans.
- Reassess planned pattern of care for pregnancy and identify women who may need additional care.
- Obtain FBC (and Group and Save at Wythenshawe and North Manchester only) – check woman has not recently had an FBC with GTT/Anti-D etc. Where applicable, check that Anti-D has been given and that GTT has been undertaken.

2.5.4 In addition, between 28 and 36 weeks gestation:

- Highlight the importance of experiencing movements throughout pregnancy and at the commencement of labour, refer to the Tommy's leaflet and document discussion.
- Discuss and advise side-sleeping.
- Discuss infant feeding, reiterate the benefits of breast feeding, the benefits of skin to skin contact at birth and explain positioning and attachment and complete the relevant documentation.
- Give information on the postnatal period including care of a newborn, vitamin K, newborn screening, and postnatal care.

2.5.5 In addition, from/at 36 weeks gestation:

- Carbon Monoxide (CO) monitoring for all women and clearly documenting reading in their medical records.
- If breech, arrange an appointment in antenatal clinic for a presentation scan and to see a consultant.

2.5.6 In addition, from/at 38 weeks gestation:

- Discuss prolonged pregnancy and management options.
- Provide appropriate information and support for those whose baby is at risk of a neonatal admission.

2.5.7 In addition, from/at 40 weeks gestation:

- primigravida women and those who have had 1 LSCS offered membrane sweep.

2.5.8 In addition, from/at 41 weeks gestation:

- parous women who have not given birth will be offered a membrane sweep. When a woman declines induction of labour an individual management plan should be developed by a senior obstetrician to address any further management; this must be documented in the maternal records.

2.6 Anomaly scan

If the woman has accepted an ultrasound scan this should be performed for the detection of structural abnormalities. Women who decline the Anomaly scan must be offered a scan at 32 weeks to check placental site only.

See *Management and Referral of Fetal Anomalies* guideline**.**

2.7 Antenatal Risk Assessment and Pathway of Care for Place of Birth

2.7.1 Women must be offered adequate information to enable them to make an informed decision regarding the place of birth as appropriate. Any choices made should be clearly documented.

2.7.2 Women with identified risk factors who, after an in-depth discussion with the midwife request a home birth or midwifery-led care must be referred to a Consultant Obstetrician for further discussion. It may also be appropriate to offer a meeting with a senior midwife/consultant midwife within the relevant clinical area to discuss a plan of care. Women at ORC and Wythenshawe can be referred to the Birthtalk clinic.

2.8 Women requesting home birth.

All women who live within MFT zoned postcodes will receive a home visit at 36 weeks for completion/discussion of their birth plan including choice of place of birth. An antenatal examination must also be performed.

See *Home Birth* guideline.

2.9 Women who decline induction of labour

When a woman declines induction of labour an individual management plan should be developed by a senior obstetrician to address any further management; this must be documented.

See *Induction of Labour* guideline.

2.10 Women requiring consultant review.

2.10.1 On the occasions there are no consultants present in antenatal clinic (ANC) for a woman's appointment, one/both consultants should review the notes prior to the woman's New Obstetric Appointment (NOA) and make a provisional plan. After the clinic the secretary should ensure that the first consultant of the pair back from leave reviews the NOA records again to confirm they are happy with the plan made and no alterations are required.

If there is a complex patient they will alter the date of the NOA, if appropriate, to a clinic where a consultant will be present.

2.10.2 If at any point a referral to another medical specialty is deemed to be necessary then a consultant must be informed, and the plan of care discussed. If the woman is an inpatient this should be the consultant on for the wards or the consultant on call.

2.11 Investigations performed outside of the NHS

For anyone reporting an abnormal result from an investigation that has been performed outside of the NHS, this should be appropriately managed dependent on the clinical picture. Abnormal scan and blood results should be repeated to support assessment. These should be performed in a timely manner depending on the findings, considering the patient's experience and concern. This may include inviting in for urgent assessment to the Maternity Triage or Antenatal Day Care Service departments.

Additional clarification -

- **ANY** positive group B streptococcus result must be treated as positive, and a repeat is not required. However, treatment may be required – see Prevention of Early Onset Group-B Streptococcus Disease in the Neonate guideline.
- Abnormal scans should be repeated in the Ultrasound department and followed up with an obstetric review in Consultant ANC.

2.11.1 Those who wish to birth outside guidelines

Those expressing a wish to birth outside guidelines should be referred for a consultation with a senior midwife to discuss their wishes in detail and explore how this can be supported as safely as possible. This may be a referral to a Birth Talk clinic (ORC and Wythenshawe sites only).

3 Communication and Documentation

All women with learning disabilities, visual or hearing impairments or those whose first language is not English must be offered assistance with interpretation where applicable, and where appropriate a telephone or face to face interpreter must be used. It is paramount that clear channels of communication are maintained at all times between all staff, the women and their families. Once any decisions have been made/agreed, comprehensive and clear details must be given to the woman thereby confirming the wishes of the women and their families.

The contents of any leaflet issued must be explained in full at the time it is issued.

All communication difficulties (including learning difficulties) and language barriers must be addressed as outlined in the previous paragraph at the time the leaflet is issued.

Ensure the provision and discussion of information of the risks and benefits with women during the antenatal, intrapartum and postnatal periods.

Staff should aim to foster a culturally sensitive care approach in accordance with the religious and cultural beliefs of the parents and families in our care.

4 Equality diversity and Human Rights Impact Assessment

The EqIA score fell into low priority; no significant issues in relation to equality, diversity, gender, colour, race or religion are identified as raising a concern.

5 Consultation, Approval and Ratification Process

During development this guideline has been reviewed by senior obstetricians, senior midwives, specialist midwives and obstetric anaesthetists from across Saint Mary's MCS. It has been ratified by the Site Obstetric Quality and Safety Committee.

It will be formally reviewed 3 years following its ratification or sooner if there are significant changes in evidence-based practice.

6 Dissemination and Implementation

This guideline will be implemented and disseminated in line with the Obstetric Directorate's agreed process.

7 Process for Monitoring Compliance

This guideline will be audited at least once every three years using the appropriate antenatal audit proforma. The findings of the audit report will be presented to staff via the Site Obstetric Quality and Safety meeting and where appropriate an action plan will be developed and monitored at the Site Obstetric Quality and Safety meeting once a year.

8 References

Department of Health (2007) *Making it Better: for Mother and Baby.* London: Department of Health

National Institute for Health and Clinical Excellence (2008) *Antenatal Care*

Routine Care for the Healthy Pregnant Woman London: NICE

9 Appendices

Appendix 1 - Ongoing referrals for booking appointments in Hive.

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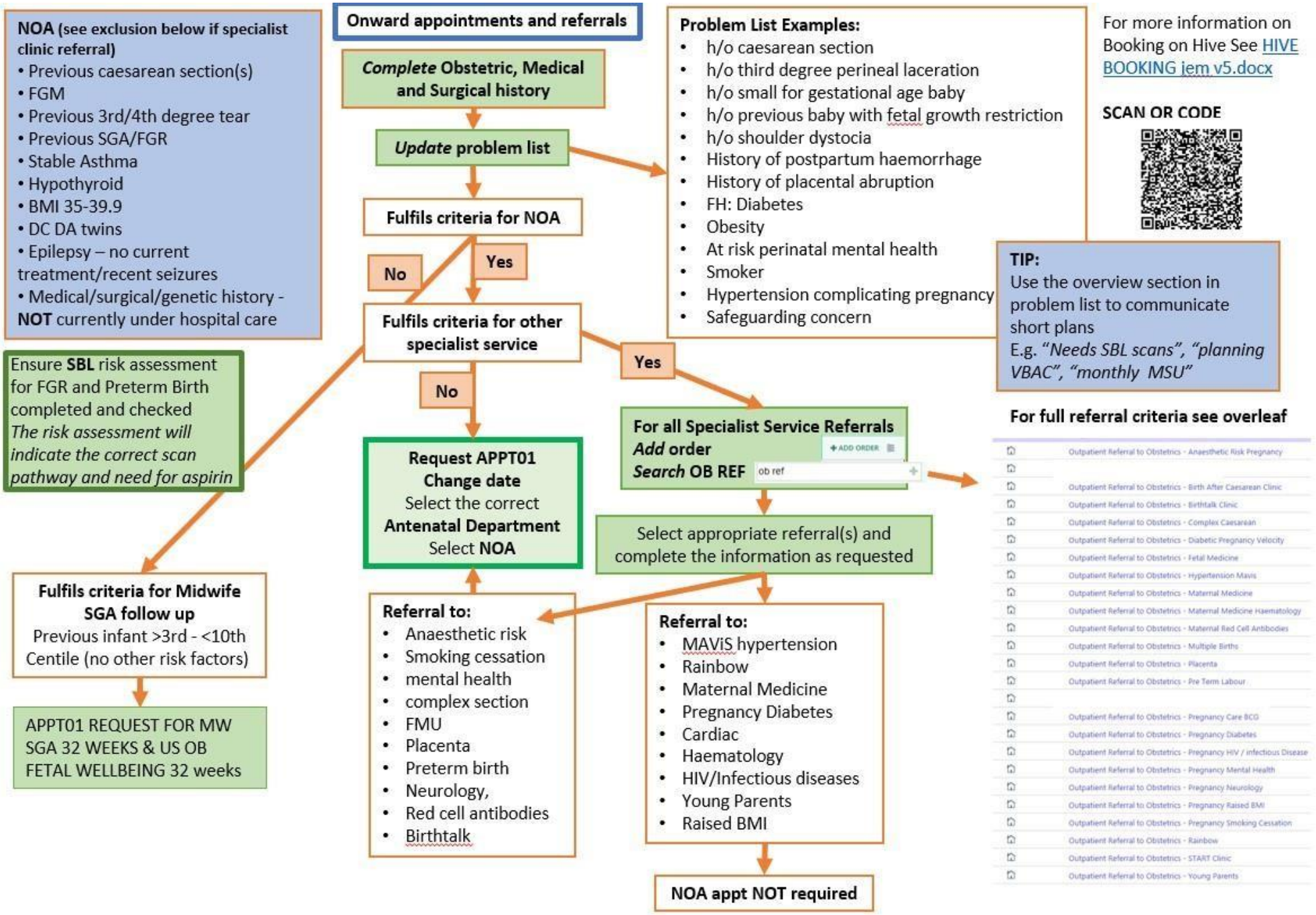

Appendix 1 - Ongoing referrals for booking appointments in Hive.

Specialist service	Referral pool	Referral criteria	Problem list
ANAESTHETIC RISK	Per site	Allergy to opioids/ anaesthetic agent; Back problem (e.g., scoliosis, rods); BMI >=40	Update allergies and problem list with diagnosis/surgery
SMOKING CESSATION	Cross - site	All current/recently ex-smokers	Smoker
PRETERM LABOUR	Cross - site	Spontaneous Pre-term delivery < 34 weeks; Previous spontaneous preterm SROM < 34 weeks; Mid trimester miscarriage; Cervical cerclage; Caesarean section at full dilatation	• Spontaneous Pre-term delivery < 34 weeks • Cervical cerclage, Caesarean section at full dilatation
MATERNAL MEDICINE	Cross - site	Women with medical disorders/malignancy under ACTIVE hospital care	Update problem list with specific diagnosis if known
MAVIS HYPERTENSION	Cross - site	Hypertension at booking: systolic >140 and or diastolic > 90 and or diagnosis of hypertension outside of pregnancy Gestational hypertension (requiring medication)/Pre-eclampsia in a previous pregnancy	• Previous hypertensive disease in pregnancy: • History of gestational hypertension • h/o pre-eclampsia • Chronic hypertension complicating pregnancy.
DIABETIC PREGNANCY VELOCITY	Cross - site	Type 1 diabetes and Type 2 diabetes (ORC), complex diabetes (e.g., nephropathy, retinopathy, concurrent hypertension) – ALL sites	Diabetes, retinopathy, nephropathy, hypertension
PREGNANCY DIABETES	Per site	Women with Type 1 and Type 2 diabetes (WYT and NMG) without additional complications (see VELOCITY above)	Update problem list
CARDIAC	Cross - site	Women with a known cardiac diagnosis under active hospital care	Update problem list with specific diagnosis if known
HAEMATOLOGY	Per site	For women with a known Haematology condition – women requiring VTE prophylaxis only – complete NOA	Update problem list with specific diagnosis if known
HIV/INFECTIOUS DISEASE	Cross - site	Women with known STIs	Update problem list
PREGNANCY MENTAL HEALTH	Per site	Current/past history of: Severe depression requiring treatment (including inpatient admission); Postpartum psychiatric illness; Puerperal psychosis;	Update problem list, SAFEGUARDING NOTIFICATION

		Schizophrenia; Other psychiatric conditions; Anxiety; Eating disorder	
PREGNANCY NEUROLOGY	Cross - site	Epilepsy requiring medication, other neurological conditions e.g. multiple sclerosis	Update problem list
PREGNANCY RAISED BMI	Per site	BMI >=40	Update problem list
FETAL MEDICINE	Cross - site	Previous fetal anomaly	h/o congenital anomaly
PLACENTA CLINIC	Cross - site	<3rd centile; <10th centile AND born <34 weeks	h/o previous baby with fetal growth restriction
COMPLEX SECTION	Cross - site	All laparotomies especially midline incisions; Laparoscopic/abdominal myomectomies; Moderate/Severe endometriosis +/- endometriomas that have had extensive excision; Radical trachelectomies; Previous cornual pregnancies; Endometrial ablation; Previous severe wound infections after C sections. Previous bowel resection +/- stoma, Major pelvic surgery; Urinary diversion/ bladder surgery.	Update surgical history with specific procedure, date and comments
RAINBOW	Cross - site	Previous Stillbirth (previous anomaly refer FMU/maternal condition refer appropriate specialist clinic)	h/o neonatal death, h/o stillbirth, h/o second trimester miscarriage
MATERNAL RED CELL ANTIBODIES	Per site	Presence of red cell antibodies	Update problem list
YOUNG PARENTS	Per site	Young parents	SAFEGUARDING NOTIFICATION
MULTIPLE BIRTHS	Cross - site	Monochorionic Twin Pregnancy, Triplet Pregnancy	Update problem list
START CLINIC	Cross - site	IVF treatment without concurrent medical disease	
BIRTHTALK		Women requiring additional specialist discussion for planning birth	
DISABILITY	Per site	Women with registered disabilities requiring additional support – not currently in use complete SAFEGUARDING NOTIFICATION	SAFEGUARDING NOTIFICATION
BIRTH AFTER CAESAREAN	Cross - site	For women requiring additional discussion regarding birth planning	h/o caesarean section