Birmingham Women's NHS
NHS Foundation Trust

Antenatal Screening Guideline

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Target audience:	All Maternity Services staff

NB. Hard copies of this policy are not permitted as they **cannot guarantee** that they contain the most up to date information and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust intranet policies link.

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
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Contents

1. Introduction

This document outlines the agreed guidelines for antenatal screening at Birmingham Women's NHS Foundation Trust (BWNFT).

Screening has the potential to save lives or improve quality of life through early diagnosis of serious conditions; it is not, however, a fool-proof process.

In any screening programme, there is an irreducible minimum of false positive results (falsely reported as being at increased risk of having the condition or not having the condition) and false negative results (falsely reported as being at reduced risk of having the condition or not having the condition). The National Screening Committee (NSC) is increasingly presenting screening as risk reduction to emphasise this point.

Antenatal screening is a public health service. Screening is different from clinical practice as it targets apparently healthy women to identify previously undiagnosed conditions for which treatment or intervention can be offered in pregnancy and around the time of birth to improve maternal and or child health. It also offers prospective parents the opportunity to make informed reproductive choices.

Patient information about antenatal screening must be given to all pregnant women in early pregnancy. This written information is given in Appendix A and includes haemoglobinopathies, infectious diseases, screening for Down's syndrome, fetal anomalies and the mid term scan. It also covers the risks and benefits of the screening tests on offer.

2. Objectives

- To provide a systematic approach to antenatal screening and ensure all screening is in line with the national screening committee recommendations.
- To ensure there is a recognised designated lead for antenatal screening in the maternity service.
- To ensure that appropriate tests are undertaken within appropriate timescales.
- To ensure there is a system for ensuring that appropriate tests are taken when women book late.
- Identify the process for review of results.
- Identify the process for reporting results back to women.
- Identify the process for reporting results to other relevant healthcare professionals.
- To ensure women with screen positive test results are referred and managed within appropriate timescales.

3. Policy Scope

This guideline applies to all women booked to deliver at BWNFT.

4. Definitions

4.1 NSC

National Screening Committee

4.2 GTT

Glucose Tolerance Test

5. Duties and Responsibilities

5.1 Designated Lead for Antenatal Screening

There is a designated lead for antenatal screening within the maternity service. This is an Obstetric Consultant who also chairs the Antenatal Screening Board.

5.2 Antenatal Screening Board

The Antenatal screening board meets quarterly and is made up of the multidisciplinary team involved in each of the antenatal screening programmes. The screening board is accountable for the general managerial and operational aspects of the screening programmes (Haemoglobinopathies, HIV, syphilis, hepatitis B, rubella susceptibility, and fetal anomaly including Down's syndrome).

The terms of reference the group work to are:

- To ensure equity & access to antenatal screening for all women in line with current guidance from the NSC.
- To develop local policy and protocols in line with current guidance from the NSC.
- To manage changes to antenatal screening programmes to ensure a quality service.

5.3 Antenatal Screening Co-ordinator

- The Antenatal screening coordinator is responsible for auditing the programmes to ensure that care pathways follow current national guidance and standards and that the outcome of pregnancies is monitored to ensure the programmes are effective.
- The screening coordinator is responsible for supplying information to the National Down's Syndrome Cytogenetic Register and Regional Congenital Anomaly Register as requested.
- The antenatal screening coordinator has an identified deputy.

5.4 Midwives and Medical Staff

- Midwives and Medical staff should ensure woman have up to date information to make an informed choice regarding antenatal screening.
- They must document clearly their discussions with women and their decisions regarding consenting for the test(s).
- They must communicate results to women and other relevant healthcare professionals appropriately.

6. 0 Procedures

6.1 Antenatal Screening Tests

The routine antenatal screening tests offered at BWNFT follows guidance from the National Screening Committee for haemoglobinopathies, HIV, syphilis, hepatitis B, rubella susceptibility, and fetal anomaly including Down's syndrome.

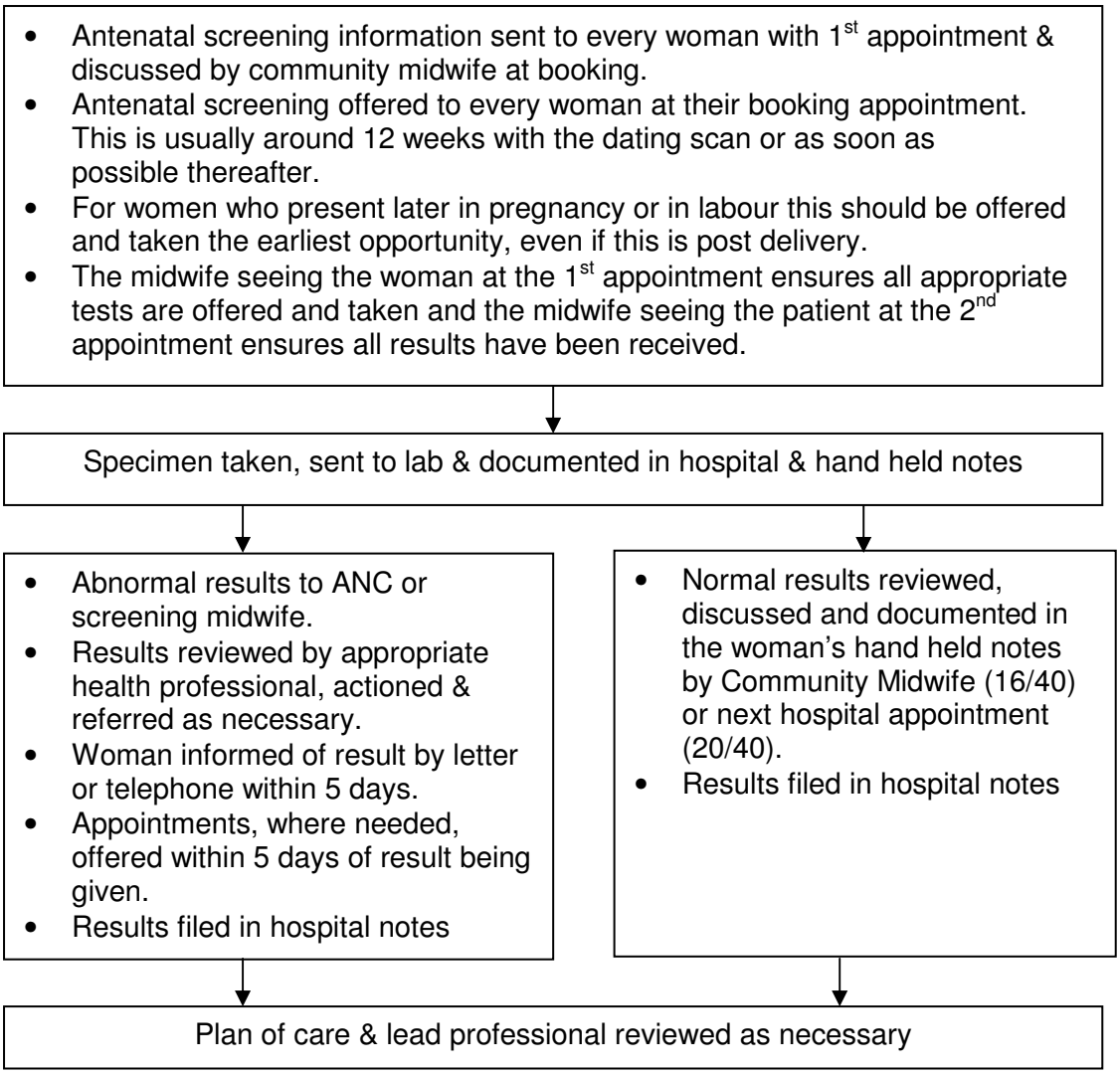
Screening tests are offered at appropriate times, following discussion with the woman; this is documented in the green hand held notes.

Full blood count	12 weeks at dating scan appt or as soon as attends thereafter & 28 weeks
Rh D status	12 weeks at dating scan appt or as soon as attends thereafter
Red cell alloantibodies	12 weeks at dating scan appt or as soon as attends thereafter & 28 weeks
Mid stream urine	12 weeks at dating scan appt or as soon as attends thereafter
BMI	12 weeks at dating scan appt or as soon as attends thereafter
GTT	24-26 weeks
Haemoglobinopathy	12 weeks at dating scan appt or as soon as attends thereafter
HIV	12 weeks at dating scan appt or as soon as attends thereafter
Syphilis	12 weeks at dating scan appt or as soon as attends thereafter
Hepatitis B	12 weeks at dating scan appt or as soon as attends thereafter
Rubella immunity	12 weeks at dating scan or as soon as attends thereafter
Down's syndrome	11+2 – 20+0. Not possible after this.
Fetal anomaly	USS 18+0 – 20+6. Limited with advancing gestation

6.2 System and Process for Routine Antenatal Screening Tests

(Mid stream urine, blood group & antibodies, haemoglobinopathy, full blood count, hepatitis B, HIV, syphilis)

All specimens are processed either at BWNFT, Birmingham Children's hospital or by the National Blood Service (NBS). Results, where possible, are put online on the respective computer systems. Hard copy reports are generated by the laboratories.



6.3 Women who Book Later in Pregnancy or Present in Labour having not Received Care Elsewhere

6.3.1 Routine Antenatal Screening Tests

(Mid stream urine, blood group & antibodies, full blood count)

Women who present later in pregnancy or in labour should be offered these tests, which should be taken at the earliest opportunity, even if that means post delivery.

6.3.2 Rubella Immunity & Haemoglobinopathy

Women who book for care after 20 weeks gestation should be consented and screened in the usual way. The request forms should clearly state that the patient has booked late and give her gestation.

If a result for rubella immunity and or haemoglobinopathy is not available by the time a woman is ready to be transferred home postnatally then the community midwife should ensure the result is received before she discharges the woman from her care.

A woman found to be non-immune to rubella in this situation should be referred to her GP for vaccination at the earliest opportunity.

A woman found to be carry a haemoglobinopathy will be contacted by the antenatal screening midwives and referred to the Birmingham Sickle Cell and thalassaemia service for follow up.

6.3.3 Hepatitis B, HIV, Syphilis

All women should be offered screening for infectious diseases regardless of gestation. The benefits to the woman and the baby are significant as the interventions available provide a real opportunity to prevent transmission of the infection to the baby.

Every opportunity should be taken to screen a woman for HIV, syphilis and hepatitis B before a baby is born. Even if this means when she presents in labour if she has not been screened in this pregnancy.

This is particularly significant in the case of HIV where even at the latest stage of pregnancy, the use of antiretroviral drugs, delivery by caesarean section and avoidance of breastfeeding would significantly reduce the risk of perinatal infection.

Women who book for care after 20 weeks gestation but are not in labour should be offered routine booking bloods. If all microbiology tests are accepted the sample should be sent to microbiology at BWNFT for urgent testing. The pathology form should state that it is urgent and clearly state the gestation of the woman.

If the woman declines antenatal screening then they will be seen as any other woman who declines would be - by one of the screening midwives, to discuss and re-offer at their next antenatal appointment, assuming gestation allows.

If the woman is close to term and is not seen before delivery then the guidance given below regarding women who have declined to be screened who present in labour should be followed.

Women who present in labour who have not received care anywhere else and have not been offered screening should be offered screening at the earliest possible opportunity and this should be seen as a high priority on admission.

Samples should be sent to the microbiology lab at BWNFT having first telephoned the lab to inform them that a specimen is being sent and that a HIV results is required urgently as the woman is in labour and has not previously been screened.

The time a result is expected from microbiology should be documented in the hospital records and the midwife caring for the woman is responsible for ensuring that the result is received.

When a result is screen positive the midwife caring for the woman should liaise with shift leader and obstetric consultant in hours, and the obstetric SpR out of hours (and / or paediatric consultant on-call depending on the result) to ensure:

- The woman is informed about her result as soon as possible.
- A plan of care is instigated to reduce the risk of perinatal infection.

The antenatal screening coordinator should be informed when a woman has been identified as screen positive for hepatitis B, HIV or syphilis in this situation and will ensure appropriate onward referral postnatally (a message can be left on ext 6959).

If the woman declines antenatal screening in this situation it should be re-discussed and offered again as soon as possible in the post natal period.

Consideration should be given about advising a woman not to breastfeed until the HIV result is known – particularly if she has a high risk of being HIV positive e.g. from a high prevalence country, an IV drug user or known to have sexual contact with a person who is HIV positive.

If screening is declined post delivery then the consultant neonatologist on call should be notified so that this can be discussed with parents by a senior doctor who will offer to test the baby directly. If the baby is felt to be at significant risk of infection and the parents decline testing then he will seek advice about most appropriate course of action in that situation.

Further guidance about clinical scenarios and recommendations for care is given in the 2008 British HIV Association and Children's HIV Association guidelines for the management of HIV infection in pregnant women (see references).

6.3.4 Down's Syndrome and Fetal Anomaly

Only women who book for care who are less than 20 weeks and 0 days gestation can be offered antenatal screening for Down's syndrome. Screening can not be performed after twenty weeks.

Every effort will be made to offer women an ultrasound scan who present later in pregnancy or in labour, accepting the limitations of ultrasound to detect fetal abnormality with advancing gestation. Ultrasound will be used at the discretion of the admitting / lead consultant.

6.4 Results

6.4.1 Process for the Review of the Results

- Results will be documented on the investigation page in the pregnancy hand held records.
- Abnormal results relating to mid stream urine, blood group, antibodies and full blood count are reviewed and actioned by the ANC Midwife.

- Abnormal results relating to haemoglobinopathy, rubella immunity, hepatitis B, HIV, syphilis, Down's syndrome screening or fetal abnormality on ultrasound scan are reviewed and actioned by an antenatal screening midwife.
- If the woman was booked for care at a different hospital then every effort should be made to retrieve the antenatal screening results. The National Blood Service web browser can be checked under a woman's name and date of birth only, rather than by unit or unit number. Alternatively, that hospital's laboratory should be contacted directly.
- Hard copy reports are delivered to ANC daily Mon-Fri.

6.4.2 Process and Timescales for Reporting and Managing Results

The woman is informed how and when she would receive the results when the screening tests are offered.

If results are normal (screen negative), then the woman will be told at her next antenatal visit, usually at 16 - 20 weeks gestation, by the midwife or doctor seeing her at that appointment and these results are documented in the patient held records.

Abnormal results (screen positive) are notified to the antenatal screening midwives, these results are communicated directly to the woman, by phone and /or letter within 5 working days of the result being received, with two exceptions:

1. Screen positive results for Down syndrome screening are communicated within 3 working days as per NSC recommendations.
2. Women found to be rubella non-immune are informed of the result at the next antenatal visit, as no action is required in pregnancy.

Results of ultrasound scans are reported and reviewed as needed at the same appointment, following completion of the scan. Abnormal results will be referred to the fetal medicine centre in line with their policy.

Women will be offered an appointment to discuss their result and subsequent plan of care within 5 days of receiving their result.

6.4.3 Process for Reporting Results to Other Healthcare Professionals

Results when available are put online on the respective computer systems. Clinicians can access the results on line and print reports. Hard copy reports are also generated by the laboratories.

Abnormal results will be communicated directly to the relevant heath professional as needed i.e. Consultant / GP / Midwife, in person, by phone or letter by ANC midwife or screening midwife.

Individual Tests

6.5 Urine Testing

Women should be offered routine screening for asymptomatic bacteriuria by midstream urine culture (MSU) early in pregnancy. Identification and treatment of asymptomatic bacteriuria reduces the risk of pyelonephritis. (NICE 2008).

This is usually done at the booking visit. At all subsequent antenatal visits, a urine specimen should be tested using labstix.

If any abnormalities are detected a mid stream urine sample (MSU) should be sent to the laboratory for culture and sensitivity.

If proteinuria occurs on two visits, and infection has been ruled out, then the woman should be referred for a consultant opinion.

6.6 Body Mass Index (BMI)

Maternal weight and height should be measured at the booking appointment, and the woman's body mass index should be calculated (weight [kg]/height[m]2). (NICE 2008)

This is recorded in the hospital notes and used to generate the woman's customised growth chart, which is put into the green hand held antenatal notes.

Women whose BMI is < 35 need to be booked as Consultant led. Refer to Guideline for care of women with BMI of 35 and over during pregnancy, delivery and postnatal period.

6.7 Full Blood Count

All pregnant women should be routinely offered screening for anaemia (NICE 2008):

- At the booking appointment
- At 28 weeks when alloantibody tests are being performed.
- Haemoglobin levels outside the normal UK range for pregnancy that is, **11 g/dL at first contact** and **10.5 g/dL at 28 weeks** should be investigated and iron supplementation considered if indicated.

N.B: Beta Thalassaemia carriers and anemia

It is important to consider a woman's haemoglobinopathy status when interpreting a full blood count result in relation to anemia as beta thalassaemia carriers will often have a reduced Hb with an accompanying low MCV & MCH.

Women known to carry beta thalassaemia should always have ferritin levels checked prior to commencement of iron therapy to avoid iron over-loading.

Further information & guidance available from:

- Specialist Midwife, AN Clinic
- Haematology department – ext 2737

6.8 Blood Group, RhD Status and red cell alloantibodies

All pregnant women should routinely be offered testing for blood group and rhesus D status (NICE 2008).

- At the booking appointment

- At 28 weeks – all women should be screened for atypical red-cell alloantibodies irrespective of their rhesus D status.
- Routine antenatal anti-D prophylaxis (RAADP) is offered to all non-sensitised pregnant women who are rhesus D-negative.
- Pregnant women with clinically significant atypical red-cell alloantibodies will be referred to Fetal Medicine for further investigation and advice on subsequent antenatal management.

6.9 Rubella Immunity

All pregnant women should routinely be offered screening for rubella immunity (NICE 2008, Department of Health (DH) 2003).

- At the booking appointment.
- Results will be discussed and explained with the woman, whether immune or non-immune, at 16 weeks, if booked for care with a community midwifery team, or 20 weeks if booked for care with a hospital team.
- If a woman declines to be screened, the implications of rubella non-immunity in pregnancy should be explained and screening re-offered at the next appointment, usually 20 weeks.
- All women found to be non-immune to rubella (when antibody level <10 iu/ml) will:
    - Have the results explained to them at their next appointment, usually between 16 and 20 weeks.
    - Antenatal vaccination should NOT be offered
    - Be offered post natal vaccination prior to transfer home

NB Anti-D administration is not a contraindication to vaccination.

Further information & guidance available from:
- Antenatal screening coordinator / midwife – ext 6959
- Consultant microbiologist – Ext 2727
- Department of Health (2003). Screening for Infectious Diseases in Pregnancy. See references

6.10 Hepatitis B

All pregnant women should routinely be offered screening for hepatitis B (NICE 2008, Department of Health (DH) 2003).

- At the booking appointment (if this is after 20 weeks then 'late booker' and the gestation should be clearly marked on the request form).
- All screen negative results will be given to the woman at her next antenatal appointment, usually 16-20 weeks.
- Women who decline to be screened should have this documented in their records. These women will be seen by an antenatal screening midwife later in pregnancy, usually at 20 week scan appointment. The benefits of testing to mother and baby will be reiterated and screening re-offered.
- All women found to be screen positive will:
    - Be given an appointment to discuss the results and implications with one of the antenatal screening midwives who will arrange confirmatory testing for patients with a new diagnosis.

    - Have a blood test to check liver function
    - Be given support and information as needed.
    - Be referred to the Health Protection Agency and Specialist hepatitis B liaison Nurse at UHB for further information, contact tracing and discuss neonatal vaccination / immunoglobulin.
    - Be assessed for birth centre suitability in the absence of additional obstetric factors indicating consultant care. Information and suitability form will be placed in notes by screening midwife.
- All babies born to women who are hepatitis B positive will:
    - Be offered vaccination within 24hours of birth.
    - Be offered immunoglobulin within 24 hours of birth if indicated (this is ordered on a named basis by the antenatal screening midwife well in advance of due date and is kept in the emergency drugs fridge, ground floor, BWH).
    - Be given out-patient appointment for follow up vaccination at 1, 2 and 12 months of age.
    - Have the audit and neonatal record information completed as requested by the Health Protection Agency (this is filed in neonatal notes following initial notification of maternal infection).

Further information & guidance available from:

- Antenatal screening coordinator / midwife – ext 6959
- Consultant microbiologist – Dr Gray ext 2727
- Department of Health (2003*).Screening for Infectious Diseases in Pregnancy*. See references

6.11 HIV

All pregnant women should routinely be offered screening for HIV (NICE 2008, Department of Health (DH) 2003).

- At the booking appointment (if this is after 20 weeks then 'late booker' and the gestation should be clearly marked on the request form).
- Screen negative results will be given to the woman at her next antenatal appointment, usually between 16-20 weeks.
- Women who decline to be screened should have this documented in their records. These women will be seen by an antenatal screening midwife later in pregnancy, usually at 20 week scan appointment. The benefits of testing to mother and baby will be reiterated and screening re-offered.
- Women found to be screen positive will:
    - Be given an appointment to discuss the results and implications with one of the antenatal screening midwives (who will arrange confirmatory testing for new diagnosis) and/ or the consultant obstetrician lead for HIV.
    - Be given support and information as needed.
    - Be referred to the HIV Team at Selly Oak Hospital who will arrange on-going care and treatment. Monthly multidisciplinary team meetings generate up to date, individualised birth plans which are filed in the obstetric correspondence section of the maternal notes and circulated to neonatology, lead obstetrician, lead pharmacist and delivery suite.

- All babies born to women who are HIV positive will:

- Be treated and cared for as indicated in their mother's birth plan and in-line with neonatal guidelines.
- Have out patient appointments in place before transfer home with mother. (These are usually in the paediatric bloods and immunisation clinic on Tuesday or Wednesday).

6.12 Syphilis

All pregnant women should routinely be offered screening for syphilis (NICE 2008, Department of Health (DH) 2003).

- At the booking (if this is after 20 weeks then 'late booker' and the gestation should be clearly marked on the request form).
- All screen negative results will be given to the woman at her next antenatal appointment, usually between 16-20 weeks.
- Women who decline to be screened should have this documented in their records. These women will be seen by an antenatal screening midwife later in pregnancy, usually at 20 week scan appointment. The benefits of testing to mother and baby will be reiterated and screening re-offered.
- All women found to be screen positive will:
  - Be given an appointment to discuss the results and implications with one of the antenatal screening midwives (who will arrange confirmatory testing for new diagnosis).
  - Be booked for care under a consultant obstetrician.
  - Be given support and information as needed.
  - Be urgently referred to the GUM Team at Whittall Street Clinic. They will initiate treatment and arrange follow up as needed, liaising with the antenatal screening team and consultant responsible for care.
  - Have the care pathway inserted into their notes for guidance

- All babies born to women who are syphilis positive will:
  - Be seen by a paediatrician after birth.
  - Need testing and follow up as appropriate to exclude congenital infection in line with the neonatal protocol. (Guidance will be given in correspondence from the GUM team at Whittall Street Clinic in each individual's case.)
  - Have out patient appointments in place before transfer home with mother. (These are usually in the paediatric bloods and immunisation clinic on Tuesday or Wednesday).

Further information & guidance available from:
- Antenatal screening coordinator / midwife – ext 6959
- Consultant microbiologist – Dr Gray ext 2727
- Whittall Street GUM Clinic – 0121 237 5737
- Department of Health (2003).Screening for Infectious Diseases in Pregnancy. See references

6.13 Haemoglobinopathies

All pregnant women, irrespective of their ethnic background, should be offered screening for haemoglobin variants and thalassaemia (NICE 2008, NHS Sickle Cell and thalassaemia Screening Programme 2006).

- At the booking appointment, unless their status is already known and documented in their hospital records from previous testing.
- Women requesting a diagnostic test because both parents are known to carry a significant haemoglobinopathy should be referred to the screening midwives as early as possible in pregnancy who will liaise with the haemoglobinopathy clinical nurse specialist and/ or the Clinical Genetics Unit as appropriate to arrange a timely onward referral.
- If the woman is identified as a carrier of a clinically significant haemoglobinopathy then the couple is offered an appointment at the next specialist clinic for counselling regarding the results and its implications . She may also be identified as having a significant HBO disorder and therefore needs specialist care. This would include referral to Consultant Haematologist. (Refer to Guidelines for the care of women with Sickle Cell Disease and Thalassaemia during pregnancy.)
- The father of the baby of all identified carrier women will be offered haemoglobinopathy screening at this appointment.

Clinically significant haemoglobin variations are:

- HbS
- HbC
- HbD Punjab
- HbE
- HbO Arab
- Hb Lepore
- β thalassaemia
- δ β thalassaemia
- ά zero thalassaemia
- HPFH (hereditary persistence of fetal haemoglobin)

When a couple are both found to carry a significant haemoglobinopathy there is a 1:4 chance that their children will inherit a major haemoglobin disorder. These couples should be offered counselling by a professional with suitable professional knowledge (at BWH this is usually the Clinical Genetics Unit (CGU). Any woman wishing to access PND should be referred urgently to the CGU.

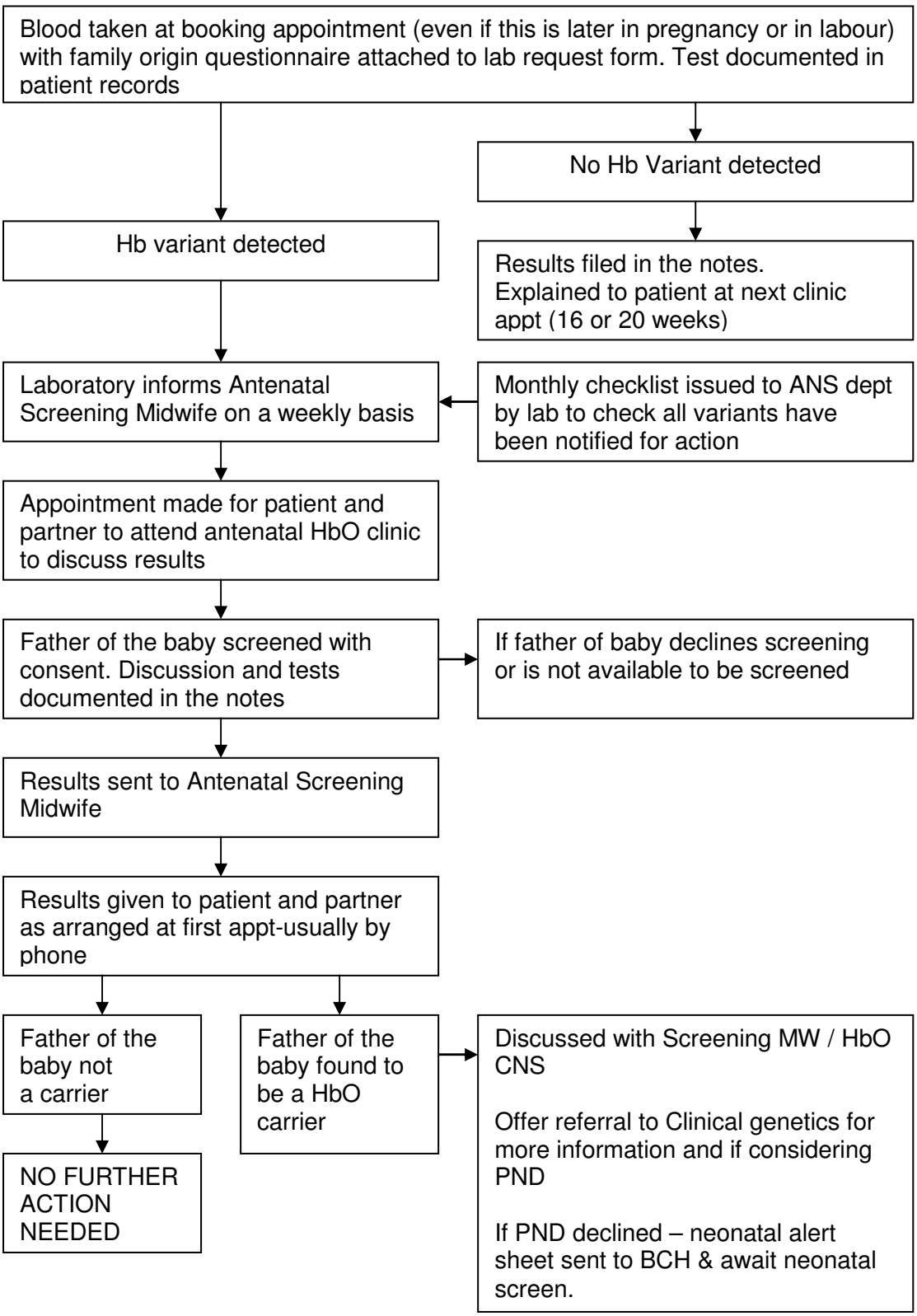
Women who carry a significant haemoglobin variant, but when the father of the baby is not available for testing, should be offered prenatal diagnosis as above.

The results of prenatal diagnosis will be discussed and explained. Those pregnancies found to be affected by a significant haemoglobin disorder will be offered an appointment with a paediatrician specialising in haemoglobinopathy (usually at Birmingham Children's Hospital) to discuss implications and prognosis of the disorder. The option of termination of pregnancy will also be discussed.

Further information & guidance available from:

- Antenatal screening coordinator / midwife – ext 6959
- Haematology – Ext 2735
- NHS Sickle Cell and thalassaemia Screening Programme (2006). Standards for the linked Antenatal and Newborn Screening Programme. See references

Care Pathway when Screening for Haemoglobinopathy



6.14 Glucose Tolerance Tests (GTT)

Glucose tolerance tests are performed every morning Monday to Friday in the GTT clinic on ward 6 and there are 27 available appointments each day. Patient information leaflets are available in the antenatal clinic, the Community office and Clinical Chemistry.

A GTT can be booked by contacting the Medical Records Department on extension 2650.

A medical history and family history are taken at the booking visit. The following criteria put patients in the high risk category for developing gestational diabetes (GDM) and therefore a 75g oral GTT should be offered at 24-28 weeks and arranged at booking for ONE or more of the following:

- First degree relative (parent or sibling)
- Previous baby >4500g or 95th percentile
- Body mass Index (BMI) > 30 Kg/m^2
- Ethnic origin: South Asia (India, Pakistan, Bangladesh), Black Caribbean, Black African or Middle Eastern (Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon, Egypt)
- History of polycystic ovary syndrome
- Medication which has a diabetogenic effect e.g. Prednisolone or tacrolimus

For women with previous gestational diabetes discuss at booking and:

- Advise and offer screening at 16-18 weeks
- If negative at 16-18 weeks repeat GTT at 28 weeks

Book an urgent GTT if:

- 2+ glycosuia on two or more occasions
- 3+ glycosuria on one or more occasions
- Polyhydramnious AND fetal macrosomia >4000g or > 95^{th} centile

When risk factors develop after 28 weeks the GTT should be performed as soon as possible up to 35+6. After this gestation offer a random blood glucose (venous plasma sample) and if > 6.0mmols contact the Diabetes Specialist Midwife (DSM) or a member of the diabetes team.

If the GTT is positive for GDM, the DSM will contact and inform the woman to explain the result and arrange for her to be reviewed in the midwife led GDM clinic. Women with GDM previously booked under consultant care will be referred to the joint diabetes consultant led clinic. (See Guideline for the Management of Gestational Diabetes).

6.15 MRSA

Routine MRSA Screening is offered to appropriate women as per BWHFT MRSA Screening policy, following Guidance from the Department of Health.

Other high risk group i.e. pregnant healthcare workers should be screened at their 36-week antenatal appointment ***or*** on admission if they present to Delivery Suite before 36 weeks.

No request from any woman to be screened for MRSA should be declined.

Women will be informed that if their result is negative, they will be informed at their next antenatal visit.

If the result is positive, they will be contacted by phone and letter and invited to a specialised clinic to discuss results and treatment (See MRSA Screening guideline).

6.16 Down's Syndrome

All pregnant women should routinely be offered screening for Down's syndrome inline with the National Screening Committee model of best practice. (NICE 2008, NSC 2008[2]).

Written information about Down's syndrome screening is sent to all women with their first hospital appointment and further information is given at the booking appointment (see appendix A).

Screening for Down's syndrome should be discussed with a woman at first contact with a midwife to provide the opportunity for discussion before embarking on screening. Specific information at this stage should include:

- Information about Down's syndrome.
- That it is a woman's choice to embark on screening for Down's syndrome.
- The method of Down syndrome screening – i.e. which test(s) are on offer
- The pathway and process for both screen-positive and screen-negative results, including how and when results would normally be received.
- The decisions and choices that would need to be made at each point along the pathway and their consequences and implications.
- That screening does not provide a definitive diagnosis and an explanation of the format of the risk result obtained following screening.
- Information about chorionic villus sampling and amniocentesis.

The woman's decision to accept or decline screening must be documented in the patient records before they attend for their dating scan appointment.

All women should have a first trimester ultrasound scan to accurately establish gestation and the number of fetus before screening tests are performed. These details should be recorded in the patient held records.

The method of screening used by the Trust is monitored and reviewed by the antenatal screening board. Changes to the programme will be appropriately consulted and training given to staff as needed before policies or guidelines are changed.

Women pregnant with twins will be seen at their first appointment by a member of the consultant team in multiples clinic to discuss the options and implications for screening in a multiple pregnancy. Only first trimester screening is offered as second trimester maternal serum screening is not available in multiple pregnancies (NSC 2007). These women should receive the additional leaflet "Screening for Down's syndrome in multiple pregnancy" (given in appendix A).

First trimester screening (combine test) will be offered to all women with a singleton or twin pregnancy who have their dating scan before 14 weeks and 1 days (CRL measuring less than 84mm)

- Women who present too early for first trimester screening (CRL less than 45mm, gestation less than 11+2) will be offered another scan appointment at 12 weeks when the nuchal translucency can be measured and the appropriate maternal biochemistry taken. NB: If parents are considering a Nuchal Translucency Scan, advice should be given not to have triple test as well.
- Women who present for their dating scan where the CRL measures between 45-84 mm, gestation 11+2 – 14+1, will be offered 1st trimester screening at this appointment.
- Women who present for their dating scan at the appropriate gestation (as above) but where a nuchal translucency measurement is not possible will not be offered a repeat appointment. These women will be offered second trimester screening at their standard 16 week antenatal appointment.
- Women who present for their dating scan where the CRL measures over 84mm (HC minimum 101mm), over 14+2 gestation, will be offered 2nd trimester screening at this appointment.

Second trimester screening (quadruple test) will be offered to all women with a singleton pregnancy who have their dating scan from 14+2 – 20+0 days or to those women who where a nuchal translucency measurement was not possible at their dating scan.

- Women who access first trimester screening should be advised not to have 2nd trimester screening.
- The implications of receiving an increased risk result later in pregnancy should be explained to the woman – i.e. that there may be limited time for decision making regarding amniocentesis and the options available should the pregnancy be affected by Down's syndrome.
- Women should not be offered a diagnostic test for Down's syndrome based on their age related risk alone (NSC 2007). Any woman requesting an elective CVS or amniocentesis should be referred to the antenatal screening midwives in the first instance for further discussion about screening and diagnostic options and the implications of choices.

When the results of the screening test give a lower risk a letter will be sent to the woman to inform them of the result, usually with 14 days. A contact number is given on the letter for women who wish to discus the result further.

When the results of the screening test give a higher risk the woman will be contacted by one of the screening midwives and offered an appointment within 3 working days to discuss their result and subsequent options, including prenatal diagnosis.

Raised AFP Woman are reviewed by an antenatal screening midwife and automatically referred for detailed ultra-sound scan. This is followed up at 24 weeks with uterine Doppler's. – if 'notching' seen at anytime on USS, the woman will be transferred to obstetric care.

If no 'notching' seen – monitor symphysio- fundal height as prone to small for dates and arrange USS for 28 & 34 weeks. If growth within normal limits – suitable for midwife led care and birth centre. Otherwise transfer to consultant care as requires continuous fetal monitoring in labour.

Nuchal translucency greater than 3.5mm identified at booking scan (NSC 2008[3])

Nuchal translucency measurements found to be 3.5mm or more are associated with an increased risk of fetal cardiac defects, syndromic and chromosomal problems. Even if Down's syndrome screening has been declined, these women should be referred to the screening midwife for onward referral to the Fetal Medicine Centre for review.

Normal variant screening in pregnancy (formally known as soft markers) (NSC 2009)

The appearances which are listed below should be reported and the woman referred to the screening midwife for onward referral to the Fetal Medicine Centre for review:

1. Nuchal fold greater than 6mm
2. Ventriculomegaly, where the atrium is greater than 10mm
3. Echogenic bowel, where he density is equivalent to bone
4. Renal pelvic dilatation greater than 7mm
5. Small measurements compared to the dating scan

The screening midwife should follow the Care Pathway for when a Fetal Anomaly is identified on an Ultrasound Scan, which is given later in this guideline.

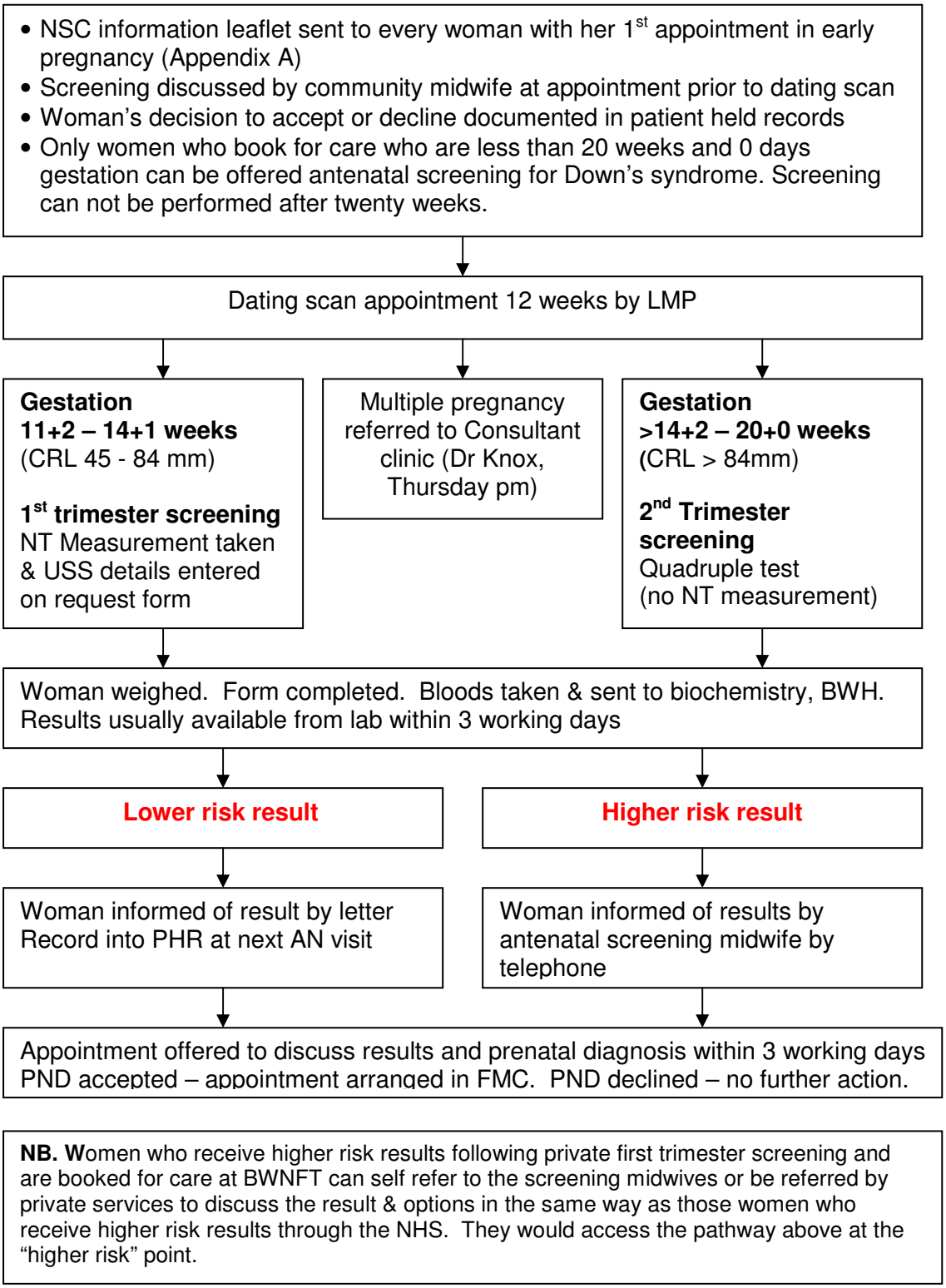
The appearances listed below are considered normal variants (NSC 2009) and should not be referred.

1. Choroid plexus cyst(s)
2. Dilated cisterna magna
3. Echogenic foci in the heart
4. Two vessel cord

Further information & guidance available from:

- Antenatal screening coordinator / midwife – ext 6959
- Fetal Medicine Centre - ext. 2683
- NSC Down's syndrome screening programme Model of Best Practice & Working standards (see references).

ANTENATAL SCREENING FOR DOWN'S SYNDROME



NB. Women who receive higher risk results following private first trimester screening and are booked for care at BWNFT can self refer to the screening midwives or be referred by private services to discuss the result & options in the same way as those women who receive higher risk results through the NHS. They would access the pathway above at the "higher risk" point.

6.17 Ultrasound Scans

6.17.1 Dating ultrasound scan

Ultrasound scans in pregnancy are currently performed in the hospital, at community clinics and by outside agencies (under contract).

All women are routinely offered an ultrasound scan at around 12 weeks to establish single or multiple pregnancies, exact gestation, identify gross fetal abnormalities such as anencephaly and measure the nuchal translucency if a woman has decided to have screening or Down's syndrome.

6.17.2 18- 20+6 ultrasound scan

All pregnant women should routinely be offered a mid term ultrasound scan to screen for fetal anomalies, including neural tube defects, between 18+0 and 20+6 (NICE 2008, NSC 2008[2])

- Pregnant women should be informed that taking a folic acid supplement of 400 micrograms 12 weeks prior to conception and for the first 12 weeks reduces the chance of having a baby with a neural tube defect such as spina bifida.
- Screening for fetal anomaly should be discussed with a woman at first contact with a midwife to explain the purpose and implications of the anomaly scan. Specific information should include:
    - The mid term anomaly scan is optional.
    - The possibility that the scan may identify a fetal abnormality and that this may lead to discussions about intrauterine therapy/ treatment/disability/palliative care/termination of pregnancy.
    - Women should understand the limitations of routine ultrasound screening and that detection rates vary by the type of fetal anomaly.
- The woman's decision to accept or decline screening should be documented in the patient records.
- Additional information is given to all women when they attend for the anomaly scan in the main scan department to ensure the purpose of the scan and the limitations of ultrasound are understood (see Appendix 1).
- The mid-term anomaly scan routinely screens to detect neural tube defects – as such, alpha-fetoprotein (AFP) testing is not required; although this will continue to be offered whilst the triple test is used as the screening test for Down's syndrome (of which alpha-fetoprotein is a part). Where an elevated AFP level is identified a woman would be referred to the fetal medicine centre within 5 working days.

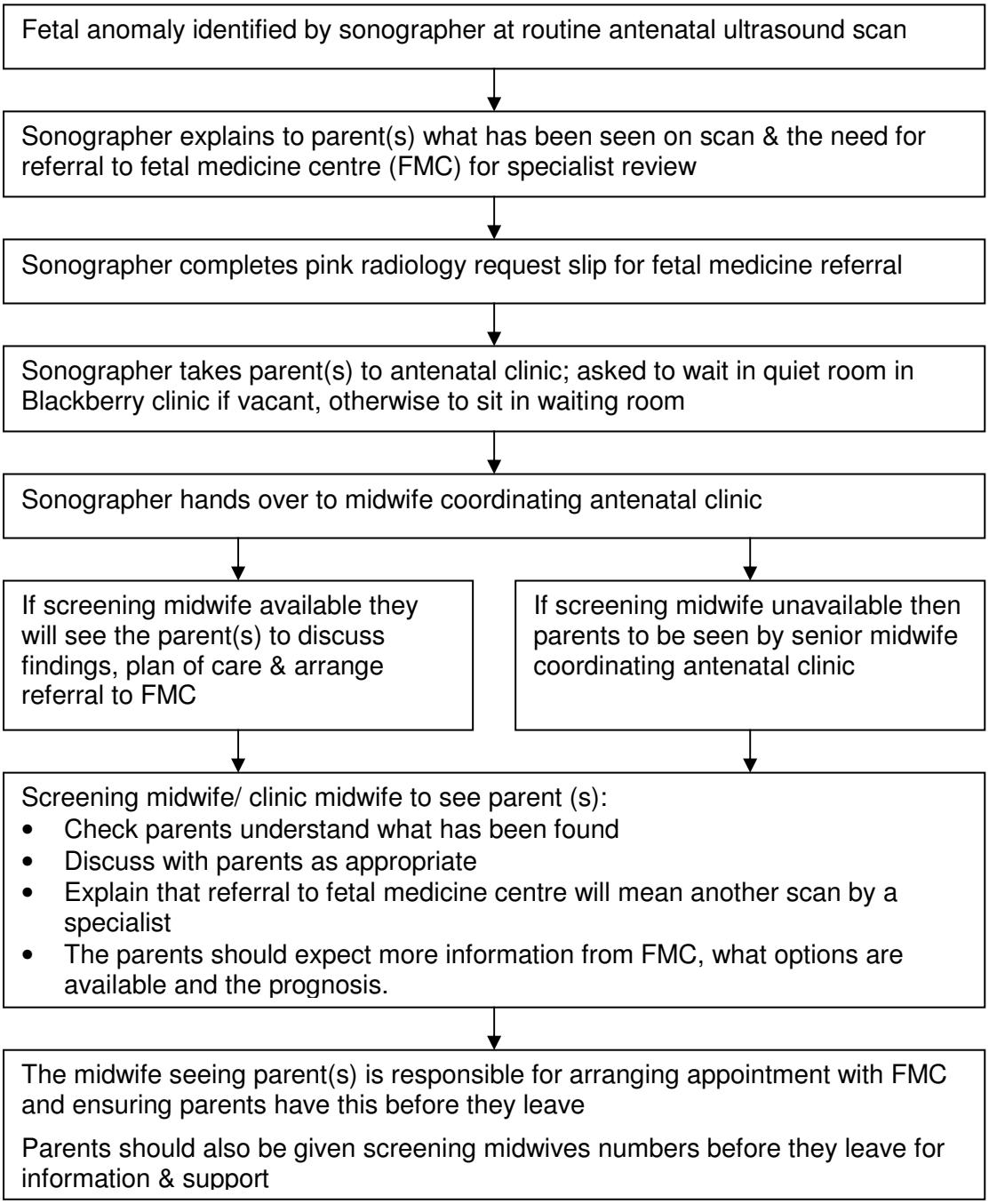
When an anomaly is detected the woman will be informed of the findings by the professional performing the scan in the first instance. They will then be seen by one of the screening midwives (following Care Pathway for when a Fetal Anomaly is identified on an Ultrasound Scan, given later in this guideline) who will arrange referral to the Fetal Medicine Centre for review.

The length of time to appointment from referral will vary depending on the fetal medicine centre and which specialist opinion is required.

A regional congenital anomaly register (CAR) form should be completed and submitted at the time the anomaly is identified and following the baby's birth.

Further information & guidance available from:
- Antenatal screening coordinator / midwife – ext 6959
- Fetal Medicine Centre - ext. 2683

Care pathway when a fetal anomaly is identified at the 18-20+6 ultrasound scan



6.18 Guidance for women who request prenatal diagnosis, are known carriers of a condition or are at increased risk of condition due to past or family history

Women should not be offered a diagnostic test for Down's syndrome based on their age related risk alone (NSC 2007). Any woman requesting elective CVS or amniocentesis should be referred to the antenatal screening midwives in the first instance for further discussion about screening and diagnostic options and the implications of choices.

Women requesting a diagnostic test for any other reason should be referred to the antenatal screening midwives as early as possible in pregnancy who will arrange an appointment to discuss the request in detail and ensure the woman has up to date information. They will liaise with the Fetal Medicine Centre and/ or a consultant obstetrician as appropriate to discuss each case on an individual basis and arrange a timely onward referral if needed.

If, for any reason a woman does not receive care due to failures in the processes:

Incident Form Trigger

6.19 Training

Please refer to the Maternity Services Training Needs Analysis in the Trust's Mandatory and Statutory Training Policy for details.

7. Review, Monitoring, and Revision Arrangements

All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to	Action Plan Review
• Designated Lead for antenatal screening • Antenatal screening tests, which follow the UK National Screening guidance • System for ensuring that appropriate tests are undertaken within appropriate timescales • System for ensuring that appropriate tests are undertaken when women book late • Process for review of results • Process for reporting all results to women • Process for reporting results to other healthcare professionals • Process for ensuring that women with screen positive test results are referred and managed within appropriate timescales	Audit	Annual	Antenatal Screening Co-ordinator and team	Antenatal Group	Antenatal Group

The maternity services expectation in relation to staff training for Antenatal screening, as identified in the training needs analysis.	Audit	Annually	ProfessionalDevelopment Midwife	Maternity CIG	Maternity CIG
Actions resulting from deficiencies identified from any of the above.	Review	As specified in audit report	Antenatal Screening Co-ordinator	Antenatal Group	Antenatal Group

7.1 Audit Proforma

All women

Patient ID: Date of Delivery:

	Yes	No	N/A
Were the following tests performed within the specified timescales:			
FBC- 12 weeks at dating scan and 28 weeks			
Rh D status- 12 weeks at dating scan			
Red cell alloantibodies- 12 weeks at dating scan and at 28 weeks			
MSU- 12 weeks at dating scan			
GTT- 24-26 weeks			
Haemoglobinopathies- 12 weeks at dating scan			
HIV- 12 weeks at dating scan			
Syphilis- 12 weeks at dating scan			
Hepatitis B- 12 weeks at dating scan			
Rubella immunity- 12 weeks at dating scan			
Down's syndrome-11+2 – 20+0. Not possible after this.			
Fetal anomaly USS- USS 18+0 – 20+6			
If the woman booked late were the above tests done at the earliest opportunity?			
Results			
Were all of the above results documented on the investigation page in the pregnancy hand held records?			
Were the results reviewed by a midwife, and if applicable, was the patient informed of any abnormal results relating to; mid stream urine, blood group & antibodies, haemoglobinopathy, full blood count, hepatitis B, HIV, syphilis by telephone or letter within 5 working days?			
If no, reason?			
Was an appointment, where needed, offered within 5 days of the abnormal result being given.			
If applicable, were relevant healthcare professionals informed of abnormal results?			

Down's Syndrome Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Was first trimester screening performed if dating USS between 11+2 and 14+1 weeks gestation?			
If nuchal translucency measurement was not possible at the dating USS were they offered second trimester screening at 16/40?			
If the dating USS was performed between 14+2 and 20+0 were they offered second trimester screening?			
Once reported as a higher risk (on blood result form)			

was it documented in the antenatal records that the woman was informed of results by telephone, and offered an appointment within 3 working days?			
If no, reason			
Compliant			

HIV Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Once reported as screen positive result (on blood result form) was it documented in the antenatal records that the woman was contacted by letter or telephone within 5 working days?			
If screen positive result was an appointment given to discuss the results and implications within 5 working days of it being documented that the result was given?			
If no, reason			
Was the woman referred to HIV team?			
Were individualised birth plans from monthly multidisciplinary meetings filed in the obstetric correspondence section of the maternal notes and circulated to neonatology, lead obstetrician, lead pharmacist and delivery suite?			
Compliant			

Hepatitis B Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Once reported as screen positive result (on blood result form) was it documented in the antenatal records that the woman was informed of results by letter or telephone, and offered an appointment within 5 working days?			
If screen positive result was an appointment given to discuss the results and implications within 5 working days of results being given?			
If no, reason			
Did woman have LFT's taken?			
Was woman referred to HPA and Specialist Hep B Nurse at UHB?			
Was immunoglobulin indicated?			
Compliant			

Syphilis Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Once reported as screen positive result (on blood result form) was it documented in the antenatal records that			

the woman was informed of results by letter or telephone, and offered an appointment within 5 working days?			
If screen positive result was an appointment given to discuss the results and implications within 5 working days of results being given?			
If no, reason			
Was woman referred to GUM Clinic?			
Was the care pathway insertrd into case notes for guidance?			
Compliant			

Rubella Susceptability Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Were screen positive results discussed and explained with the woman at her next appointment (between 16 and 20 weeks)?			
If no, reason			
Was Postnatal vaccine offered prior to discharge home?			
Compliant			

Haemoglobinopathy Screen Positive Results

Patient ID: Gestation test performed: Date of Delivery:

	Yes	No	N/A
Once reported as screen positive result (on blood result form) was it documented in the antenatal records that the woman was informed of results by letter or telephone, and offered an appointment within 5 working days?			
If screen positive result was an appointment given to discuss the results and implications within 5 working days of results being given?			
If no, reason			
Was partner screened?			
Were couple identified as high risk?			
Was PND accepted if indicated?			
Compliant			

8. Associated Documents

- Antenatal Care Guidelines
- MRSA Screening Policy.
- Clinical Chemistry Manual
- Guidelines for the care of women with Sickle Cell Disease and Thalassaemia during pregnancy

- Guideline for care of women with BMI of 35 and over during pregnancy, delivery and postnatal period
- Guideline for the management of Gestational Diabetes.)
- Infection Control Guidelines
- Guidelines for the Management of Infectious Diseases in Pregnancy
- Fetal Abnormality Guideline
- Trust Mandatory and Statutory Training Policy

9. References

British HIV Association and Children's HIV Association (2008). *Guidelines for the management of HIV infection in pregnant women 2008.*
Available from: http://www.bhiva.org/cms1221368.asp

Confidential Enquiry into Stillbirths and Deaths in Infancy. (2001). *8th Annual Report.* London: Maternal and Child Health Research Consortium. Available at: www.cemach.org.uk

Department of Health (2003*).Screening for Infectious Diseases in Pregnancy – Standards to support the UK Antenatal Screening Programme.*
Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066191.pdf

NHS Sickle Cell and thalassaemia Screening Programme (2006). *Standards for the linked Antenatal and Newborn Screening Programme*.
Available from: http://www.sickleandthal.org.uk/Documents/ProgrammeSTAN.pdf

National Institute for Health and Clinical Excellence. (2008). *Antenatal care: Routine care for the healthy pregnant woman*. London: NICE. Available at: www.nice.org.uk

Maternity Care Working Party. (2006). *Modernising Maternity Care - A Commissioning Toolkit for England (2nd Edition)*. London: The National Childbirth Trust, The Royal College of Midwives, The Royal College of Obstetricians and Gynaecologists. Available at: www.rcog.org.uk

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

UK National Screening Committee (2010) *18+0 to 20+6 weeks fetal anomaly scan - National standards and guidance for England 2010*. Available from: http://fetalanomaly.screening.nhs.uk/standardsandpolicies

UK National Screening Committee (2009*). Normal variant screening in pregnancy – programme statement dated 01/07/09* Available from: *http://fetalanomaly.screening.nhs.uk/programmestatements*

UK National Screening Committee (2008). *Policy Positions June 2008.* Available from: http://www.nsc.nhs.uk/pdfs/Policy_Position_Chart%20_Final_07072008.pdf

UK National Screening Committee (2008)[2]. *NHS Fetal Anomaly Screening Programme – Screening for Down's syndrome: UK NSC Policy recommendations 2007-2010 Model of Best Practice.*
Available from: http://www.fetalanomaly.screening.nhs.uk/images/Fetal/Publications/NR1%20MOBP%2012pp%20A4.pdf

UK National Screening Committee (2008[3] *) Nuchal Translucency greater than or equal to 3.5mm*
Available from: *http://fetalanomaly.screening.nhs.uk/programmestatements*

UK National Screening Committee (2007). *NHS Antenatal and Newborn Screening Programme – Working Standards for Down's syndrome Screening 2007.*
Available from: http://nscfa.web.its.manchester.ac.uk/publications#fileid439

UK National Screening Committee (2007). *Antenatal screening - Working Standards for Down's Syndrome Screening 2007*. London: UK NSC. Available at: www.screening.nhs.uk

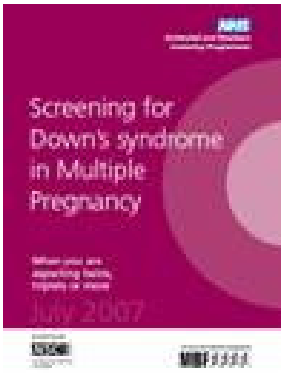
World Health Organization. Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications: Report of a WHO Consultation. Geneva, 1999. WHO/NCD/NCS 99.2

Appendix A – Written Information Regarding Antenatal Screening

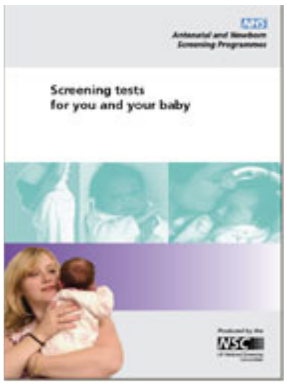
Written information regarding antenatal screening and diagnostic tests are given to women in-line with current UK National Screening recommendations.

Patient information is reviewed annually by the antenatal screening coordinator and updated as necessary.

Current publications:



Available from AN Clinic, BWNFT and online:
http://fetalanomaly.screening.nhs.uk/publicationsandleaflets



Available from AN Clinic, BWNFT and online:
http://fetalanomaly.screening.nhs.uk/publicationsandleaflets

NHS
Antenatal and Newborn Screening Programmes

Having an 18-21 week mid-pregnancy scan?

What is the scan for?

- This is a detailed examination that checks for possible physical problems with your baby.
- A scan is offered to all women, but not everyone will choose to have it. Remember, if you decide not to have the scan your choice will be respected.
- It is a happy experience for most people, but not for everybody.
- The scan does not pick up all problems.
- Scanning is not thought to be harmful to you or your baby.

What will happen when I go in to the scan room?

- You will be introduced to your sonographer (the person who does the scan) when you are called into the scan room.
- If possible, please leave children in the waiting area, supervised by a friend or relative.
- Once in the scan room you will be asked to lie on your back to have the scan with only your tummy uncovered. The lights in the room will be dimmed to give a clear view of the screen.
- Gel is spread on your tummy so that a hand-held probe can be easily passed backwards and forwards over it.
- The probe sends sound waves through your tummy. The sound waves bounce back off the baby and are translated into an image on the screen.
- During the scan, many sonographers will have the screen in a position that gives them a good view. This helps them concentrate on checking your baby. You will get the chance to see your baby on the screen, either during the scan or when the sonographer has finished the check completely.
- The length of time the scan takes varies, but it is usually about 20 minutes.

Will I need to come back for another scan?

You may be offered a further scan on another day if the sonographer cannot complete all the checks, perhaps because:-

- Your baby is lying in a position which makes it difficult to see everything clearly.
- It is too early in your pregnancy for the scan to be completed.
- You are above-average weight. This makes looking at your baby more difficult because the images are often not as clear.

What will happen if a problem is found, or suspected during the scan?

- The sonographer may ask for a second opinion, but the exact nature of the problem might not be clear at this stage.
- You may be offered further tests. You will be helped to choose whether you want to have them or not.

More information on ultrasound can be found in Screening tests for you and your baby (page 32) available from your midwife.

Appendix B – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Antenatal Screening Guidelines		
Date finalised:	18th May 2012	**Dissemination lead: Print name and contact details**	Diana Wylie
Previous document already being used?	Yes		
If yes, in what format and where?	Intranet		
Proposed action to retrieve out-of-date copies of the document:	Replace version on the intranet		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All staff	Intranet	Electronic	

Dissemination Record to be used once document is approved.

Date put on register / library of procedural documents	24th July 2012	**Date due to be reviewed**	18th May 2015

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**
Email	Electronic	24th July 2012	0	

Appendix C – Equality Impact Assessment Tool

Policy/Function Details	
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Antenatal Screening Guidelines
Is this a new policy or function?	New ☐ Existing ☐ Updated ☒
Responsible Manager	Jenny Henry
Date Assessment Completed:	18th May 2012
Sources of Data	NICE, National Screening Committee

Screening Assessment					
Equality Group	**Impact**		**Status of Impact**		**Brief Detail of impact**
	Yes	**No**	**Positive**	**Negative**	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		X			
Gender or Marital Status of Men or Women		X			
Gender or Marital Status of Transsexual or Transgender people		X			
Religion or belief		X			
Physical or Sensory Impairment		X			
Mental Health Status		X			
Age or perceived age		X			
Sexual Orientation (Gay, Lesbian, Bisexual)		X			
Offending Past		X			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		X			

[1] Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?
N/A
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?
Maternity Directorate. AN Screening Team.
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?
N/A
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?
On trust Intranet
How will the impact of the policy/service be monitored and reviewed?
Review as in guideline

Assessor Name:	**Jenny Henry**
Assessor Job Title:	**Head of Midwifery**
Date Completed:	**18th May 2012**

Appendix D – Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Has all the information on the front page been completed?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Maternity Directorate
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	**Format**		
	Does the policy conform to the prescribed policy format?	Yes	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited using Harvard referencing?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
8.	**Document Control**		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11	**Equality Assessment**		
	Has an equality impact assessment been carried out?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Jenny Henry	Date	18th May 2012
Signature			

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Tracey Johnston	Date	18th May 2012
Signature			