Royal Surrey NHS Foundation Trust

Routine Antenatal Care of Healthy Pregnant Women Guideline

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Name of Review / Development Body:	W&C Quality and Safety
Ratification Body:	W&C Divisional Quality Governance
Date of Ratification/ effective from	August 2021
Review Date:	May 2024
Reviewing Officer:	Jenifer Sharman-Lavelle *Digital Audit Midwife*

If this document is required in an alternative language or format, such as Braille, cd, audio, please contact the author

Version Control

Date	Review Type (please tick)		Version No.	Author of Review	Title of Author	Date Ratified	Ratification Body	Page Numbers (where amended)	Line Numbers (where amended)	Details of change	
	Minor amendment	Full Review								Inserted	Deleted
Nov 2009		✔	1.0	Claire Tyler Matthew Koomson	Senior Midwife Consultant Obstetrician	Nov 2009	MRMG				✔
Dec 2012		✔	2.0	Mary Shewell	Community Matron	20/12/12	MRMG				✔
Dec 2014			3.0	Matthew Koomson	Consultant Obstetrician	Dec 2014					
Sept2016		✔	4.0	Amy Stubbs	Matron						
March 2021		✔	5.0	Jennifer Sharman-Lavelle	Audit Midwife	August 2021	W&C DQG				

Contents

1 INTRODUCTION / BACKGROUND

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 2008).

Pregnancy is a normal physiological process and as such any interventions offered should have known benefits and be acceptable to pregnant women.

Women should be the focus of maternity care with an emphasis on providing choice, easy access and continuity of care.

2 SCOPE OF GUIDELINE

The Guideline applies to all staff.

This guideline aims to provide advice on the care of all pregnancies and comprehensive information on the antenatal care of a healthy pregnant woman with an uncomplicated singleton pregnancy as per national recommendations.

3 DUTIES & RESPONSIBILITIES

Designated Lead for Risk
The Clinical director is responsible for implementing this guideline; this role has been delegated to the Designated Lead for Risk. It is the responsibility of the Clinical Directors, or their delegates, to ensure that all relevant staff under their management (including bank agency, contracted, locum and volunteers) are aware of and meet their individual responsibilities under this Guideline, including monitoring compliance by subordinate staff.

Clinical Staff
All clinical staff have a duty to be familiar with this guideline and to use it to guide their practice.

Local Policy Officer
The Local Policy Officer has a duty to ensure this guideline is compliant with the Trust Guideline on Policies. The Local Policy Officer must ensure this guideline is reviewed within the designated time period or as changes in national guidance arise. The guideline should comply with the current base of evidence and best practice guidance and be current and in date.

4 SUBJECT MATTER OF GUIDELINE

4.1 Aim of antenatal care

- To offer pregnant women evidence based information and support to enable them to make informed decisions regarding their care.
- To give information including details of where they will be seen and who will undertake their care, including written information on patterns of antenatal care, contact telephone numbers.
- Information will be given both verbally and in writing to include advice on routine screening in pregnancy (see Antenatal Screening Policy)
- To give women the opportunity to ask questions at all appointments as well as to discuss other issues that may arise such as domestic violence, drug or alcohol abuse.
- To ensure all women are appropriately risk assessed and have effective care planning at every contact during the antenatal period.

4.2 Antenatal information

- Women, their partners and their families should always be treated with kindness, respect and dignity. Care and information should be culturally appropriate.
- Good communication between healthcare professionals and women is essential. Where communication is a problem, either due to special needs or language difficulties, staff should refer to PALS (Patient Advice and Liaison Service).
- All information given throughout the pregnancy should be in a form that is easy to understand and accessible to women with additional needs such as learning disabilities or where women are unable to speak or read English.
- Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. In the instance of concerns regarding a woman's capacity to make an informed decision, the appropriate Trust guidance should be followed.
- Pregnant women should be offered information based on the current available evidence together with support to enable them to make informed decisions based on their needs about their care. This information should include where they will be seen and who will undertake their care.
- Information should be given in a timely manner appropriate for the woman's gestation and where possible, it should be supported by written information.
- At each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, and should provide pregnant women with an opportunity to discuss issues and ask questions.
- Women should be offered opportunities to attend participant-led antenatal classes, including breastfeeding workshops.

- Information about antenatal screening should be provided in a setting where discussion can take place; further information refer to Antenatal Screening Policy
- Women should be informed about the purpose of any test before it is performed. The healthcare professional should ensure the woman has understood this information and has sufficient time to make an informed decision. The right of a woman to accept or decline a test should be made clear and any subsequent decision to accept or decline screening must be documented in the electronic patient records.
- Pregnant women should also be informed of their maternity rights and benefits.

4.3 Organisation of Antenatal Care

- Antenatal care should be provided by a small group of healthcare professionals with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period. The named midwife is responsible for the coordination of the woman's care. Excellent communication must be maintained between team members to ensure the woman receives optimum care to achieve the best outcome.
- The woman's GP should always be made aware of the pregnancy by the midwife at the 16 week appointment and provided with the opportunity to provide additional medical, mental health and social history that may influence the care provided in this pregnancy (NICE 2014). The community midwives send this by electronic referral
- At each antenatal visit, the schedule for each appointment will be followed to provide evidence based care (NICE 2008). This schedule can be found in Appendix A. The woman should be informed of any deviations from normal, documented in the electronic maternity records and an appropriate plan of care put in to place. This could include referral to the patient's obstetrician, to the maternity department or to the GP.
- Midwifery led models of care should be offered to women with an uncomplicated pregnancy.

4.4 Schedule of Appointments

- In an uncomplicated pregnancy there should be 10 appointments for all women
- The pattern of antenatal care should be agreed by the relevant clinician responsible for that woman's care at the initial booking visit. Clinical risk assessment of a woman's pregnancy is an ongoing process and should be reviewed at every antenatal contact in the form of a Risk Assessment and Management plan.
- At any point if the woman develops risk factors that necessitate a change in the lead professional for her care, this should be clearly documented in her

electronic maternity records, and the management plan for the remainder of her pregnancy should be considered.

4.5 First contact with a healthcare professional

Women access antenatal care by completing the self-referral via the RSFT website. The Booking's Co-ordinator will arrange the first appointment within the maternity team linked to that woman's GP and inform the woman of the date, time and location.

- An appointment will be made for a full booking assessment ideally between 8-10 weeks' gestation.

4.6 Women who refer or book late for Antenatal Care

- Women who book late in pregnancy (i.e. after 12+0 weeks) will be offered a booking appointment within two weeks of the maternity service being made aware of her pregnancy.
- If the woman contacts the GP surgery, the GP receptionist will refer the woman to the online Royal Surrey maternity booking form and the booking coordinator fast tracks any urgent bookings by emailing the appropriate midwifery team. Team emails are checked daily by the midwife working on the team. Referrals into the Antenatal Clinic, by whichever means, will be actioned by the ultrasound reception team immediately and a booking appointment made.
- Once the booking has been completed, an urgent ultrasound scan can be arranged by: telephoning the Antenatal Clinic, or in person by the booking midwife. Appropriate screening will be offered depending on gestation, as below;
    - 11+0 - 14+1 weeks Combined screening
    - 14+2 - 20+0 weeks the Quadruple test (optimum time 16+0 weeks)

(NSC – Best Practise 2015)

4.7 Booking Appointment – 8-10 weeks

4.7.1 Medical, Obstetric and Social History

- A booking history should ideally be done between 8 – 10 weeks of pregnancy. The booking visit provides the midwife with an ideal opportunity to discuss and provide information on all aspects of the pregnancy, health promotion and lifestyle affecting the woman and her unborn baby (NICE 2019). The midwife will also risk assess the woman's pregnancy and health, based on her medical, previous obstetric, anaesthetic, social/life style and psychological history. This should include consideration of:
    - The woman's mental health history
    - Female Genital Mutilation

- Social history and safeguarding needs
- Acceptance of a blood transfusion
- The woman's occupation

4.7.2 Clinical Assessment:

The following clinical measurements and assessments should be performed:

- Blood Pressure
- Height
- Weight – should be measured at booking. If the woman's BMI is greater than 25, the woman should be weighed at least once in each trimester – care should be given in accordance with the *"Guidelines for the care of the pregnant women with a booking BMI of 30 or more"*
- Calculate body mass index (BMI) (completed at booking)
- Urinalysis
- Carbon monoxide monitoring - offer carbon monoxide monitoring to all women during the booking appointment and at 36 weeks gestation
  - If the result is ≥4ppm, refer the woman to smoking cessation services via BadgerNet
  - Offer Very Brief Advice to the woman who smoke cigarettes at all appropriate moment during pregnancy and the postnatal period
  - If the woman smokes cigarettes, repeat carbon monoxide monitoring at all antenatal appointments and continue to offer Very Brief Advice
  - Women who use e-cigarettes should not be considered a 'smoker'

4.7.3 Information and Discussion:

The process of screening should be discussed and the woman given the National Screening Committee's information booklet. Women should be given information, as appropriate, about Vitamin D, folic acid, smoking cessation and alcohol consumption. Diet and exercise should also be discussed.

All women should be offered the Flu and Pertussis vaccination as early as possible during their pregnancy. (NHS England South, 2016)

The Flu vaccine should be administered at a routine antenatal appointment at any point during the pregnancy.

Pertussis can be given at any point between 16 and 32 weeks.

- The following information (supported by information leaflets within the patient maternity App) should be given with an opportunity to discuss issues and ask questions:
  - breastfeeding, including workshops
  - participant-led antenatal classes
  - maternity benefits
  - exercise, including pelvic floor exercises

  - pregnancy care pathway
  - place of birth
  - fetal movements

- **Nutritional supplements**
  - The recommended daily allowance for folic acid is 400mcg per day. This has been shown to reduce the risk of having a baby with a neural tube defect and should be taken pre conceptually until 12 weeks gestation.
  - Women should be advised to avoid vitamin A supplementation and liver supplements as high levels of vitamin A may be teratogenic.
  - Women should be advised that a healthy level of vitamin D is of benefit throughout pregnancy and whilst breastfeeding. A supplement of 10 micrograms per day is recommended. Women from a Black, Asian and Minority Ethnic background should be advised to take 1000 units of vitamin D. If the woman is taking a pregnancy multi-vitamins (such as Pregnacare) the 1000 units of vitamin D should be taken in addition.
- **Food acquired infections**
  - Pregnant women should be advised how to reduce the risk of listeriosis by drinking only pasteurised milk, avoiding eating ripened soft blue cheeses or soft cheeses with white rind, avoiding eating pate and uncooked ready prepared meals.
- **Alcohol Consumption**
  - Pregnant women should be advised to avoid drinking alcohol.
  - Binge drinking (more than 7.5 units on one occasion) may be harmful to the baby.

Ask the woman about incidence of domestic violence, and safety at home for her and any children, if there is opportunity to do this and record in the electronic notes.

All information provided should be documented in the electronic health care record.

4.7.4 Screening:

Blood should be taken for the following investigations:

- Anaemia,
- Blood group and antibodies
- Haemoglobinopathies
- Syphilis
- Hepatitis B
- HIV

- Ferritin levels should not be routinely taken unless under direction of obstetrician/ GP or as specified in the teenage pregnancy care pathway.
- All women who take thyroxine for an underactive thyroid gland, should have a TSH measured. The result of this test will be reviewed in the consultant led antenatal clinic during the woman's next appointment.
- All antenatal screening, including risks and benefits of the screening tests.

Urine should be taken and sent for an MSU to test for the presence of asymptomatic bacteriuria.

Women under 25 years of age at booking should be offered screening for chlamydia and gonorrhoea.

Ensure all women are signposted towards information leaflets within their Maternity Notes App regarding Screening, and this is documented in the electronic maternity notes.

Screening for Trisomies 13, 18 and 21 should be offered in accordance with the Screening Policy.

4.7.5 Risk Assessment:

On completion of every antenatal appointment, including the booking appointment, a risk assessment should be completed with the aim of:

- Determining whether it is appropriate for the woman to receive midwifery led or consultant led care. Where factors relevant to the woman's social, medical, obstetric or mental health are identified which may impact on the woman's health and wellbeing during pregnancy, birth or the postnatal period, women should be allocated to receive consultant led care.
- Place of birth should also be reviewed and discussed. Women undergoing a low risk pregnancy should be considered suitable for midwifery led care in the home birth or midwifery led environments. Women with risk factors should be advised to give birth in the consultant led delivery suite.
- The risk assessment should be documented on the BadgerNet Risk Assessment Form
- Where risk factors are identified such that the woman required consultant led care, women should be informed that they will require consultant led care and an appointment arranged with an obstetrician.
- On completion of the appointment, the community midwife should complete relevant referrals utilising the referral function on BagerNet. This should include:
    - Referral to the obstetric team
    - Referral to smoking cessation services
    - Referral to the mental health team
    - Referral to the safeguarding team

4.7.6 Care Planning

Following completion of the Badgernet Booking Form including Risk Assessment the midwife should recommend that the woman receive either midwifery led or obstetric led care during pregnancy. In the presence of risk factors, as identified in the Antenatal Booking form, women should be advised to receive consultant led care. This should be documented on the Badgernet Care Plan as part of the electronic maternity records.

In the absence of risk factors, women should be advised to receive midwifery led care. Should any deviations from the norm or complications be identified during the woman's pregnancy, she may be advised to receive consultant led care.

Where a woman with risk factor(s) declines consultant care, the midwife must act in accordance with the Code (NMC, 2015).The midwife should explain why a referral to an obstetrician is necessary and seek to understand why the woman does not wish to be referred. Advice should be sought from a consultant obstetrician. . A risk assessment should be undertaken to enable a plan of care to be formulated with the woman.

The midwife undertaking the booking should identify whether the woman should receive screening for gestational diabetes during pregnancy.

4.7.7 Referrals:

- If the woman has not had a full medical examination in the UK, she should be referred to the GP for this
- The woman's GP should be informed of the woman's pregnancy by 16 weeks gestation with a request to provide additional information with regards to the woman's mental, physical or previous history as relevant.
- Women should be referred to the Jasmine Team as indicated in the Booking form.

On completion of the first booking appointment, the midwife should discuss electronic records and gain access for, and set up, the woman's Portal Access to view and use her own notes via a Patient interface App (MatNotes). If the woman requires a Referral to an Obstetric Consultant or any other specialist service, this can be done through the Referrals pathway within the electronic notes.

A second booking appointment for when the woman is between 10+1/40 – 14+1/40 should be arranged, to take bloods for the combined screening test. The woman should be encouraged to attend this appointment alone to allow a discussion regarding domestic abuse.

4.7.8 Women with Complex Pregnancies:

Women with complex pregnancies must have a named consultant lead. Those with pre-existing endocrine disorders, hyperthyroidism (Grave's Disease), pre-existing diabetes, Cushing's, Addison's, pituitary disorders and prolactinomas should be booked under Dr

Morton – patients will receive care under the joint obstetric/endocrine clinic. All other patients should be booked under Mr Koomson.

If the patient has complex maternal medicine and fetal medicine needs, the maternal medicine consultant should lead the patient's care in collaboration with the fetal medicine consultant.

Women identified as having pre-existing medical conditions that require secondary care input should be referred at booking to the Maternal Medicine Clinic (run by Mr Matthew Koomson). These may include pre-existing cardiac, respiratory, gastrointestinal, renal, dermatological or autoimmune conditions that have previously required surgery or require ongoing medication and follow up in a hospital/specialist setting. Women should be allocated to Mr Koomson on BadgerNet and a referral made indicating that he is the consultant and the patient's conditions via BadgerNet.

In all instances, women should receive an early appointment (at least before 24 weeks) in accordance with their individual need.

Women who require a level of maternal medicine input that exceeds the expertise available at RSFT will be discussed by their lead consultant with the Maternal Medicine team at St George's Hospital regarding advice, additional care or transfer of care (contacts: Miss Ingrid-Cootes and Mr Matthew Cauldwell). This may include women who are expected to require inpatient treatment, who may require additional monitoring around the time of delivery, or those who require facilities not available at RSFT.

4.8 Decision Making and Informed Choice

At every contact during pregnancy, women should be provided with information to enable them to make an informed choice or decision about their care. This should include the intended benefits, risks and alternatives. The woman should be considered an equal in all decision making processes. Further patient information is available via the BadgerNotes patient portal or the Royal Surrey maternity website.

Any conversations should be documented in a clinical note or as a part of the contact. For antenatal appointments, this should be further documented by indicating that the management plan has been discussed with the woman and whether she agrees with it.

Should a woman chose or request care outside medical advice, the woman should be supported by ensuring appropriate safety netting steps are undertaken. A full narrative of the all of the discussions, options, benefits and risk factors should be documented in BadgerNet. This should include the opportunity to discuss her care with an alternative and appropriate member of staff, and an appropriate care plan developed with the aim of mitigating any risks. In the instance that a woman is offered an induction of labour for risk factors but this is declined, care planning should include place of birth and method of monitoring fetal wellbeing during pregnancy and labour. Consideration should be given to offering a referral to the Birth Options Clinic to facilitate a further discussion.

4.9 Routine Antenatal Care and summary of antenatal schedule/expectation for each appointment

- At each antenatal visit this schedule will be followed to provide evidence based care (NICE 2008). This schedule allows for regular antenatal review of the woman and will identify any risks which exist or develop during the pregnancy. Any deviation from the normal, highlighted during the risk assessment, warrants discussion, referral as necessary and a clear management plan documented in the electronic records.
- Auscultation of the fetal heart may confirm that the fetus is alive but is unlikely to have any predictive value and routine listening is therefore not recommended (NICE 2019). Auscultation of the fetal heart should not be attempted prior to 16 weeks. However, if after 16 weeks the mother requests it, auscultation of the fetal heart may provide reassurance. If on auscultation a fetal heart cannot be heard, the midwife must contact the Antenatal Clinic/Acute Assessment Unit to arrange for the woman to be seen and presence of fetal heart confirmed, or not, and reassurance or plan of care arranged.
- From 24 weeks symphysis fundal height should be measured at each antenatal appointment and plotted on the fundal height chart. Midwives should follow the Small for Gestational Age Guidance in addition to the following. Women should be referred to the antenatal clinic in any of the following instances:
    - If serial measurements demonstrate slow or static growth (i.e. the measurement crosses centiles)
    - If SFH is ≤10th or ≥ 95th centile
- If a risk is identified during the risk assessment at any antenatal visit, the midwife should refer the woman to a Consultant Obstetrician for review and further management plan. The midwife should telephone the Antenatal Clinic and make an appointment for review at the next available appointment. If the identified risk is urgent then direct contact should be made with Acute Assessment Unit for review to be arranged immediately.
- If a woman, after being referred to the Consultant or Acute Assessment Unit, is considered suitable to receive midwifery led care, she should be referred back to midwifery led care and this documented in the healthcare record. The woman will be advised when to make an appointment to see her midwife
- On completion of every antenatal appointment, midwives and obstetricians should discuss any change in risk factors and update management plans regarding the woman's intended place of birth. Intended place of birth should be discussed at every antenatal visit. This should be demonstrated by completing a Risk Assessment and Management Plan form.

Severely Abnormal Laboratory results

Any severely abnormal laboratory result(s) in the antenatal period should be discussed with the relevant specialty consultant to ensure appropriate joint care for the patient.

Treatment of Iron Deficiency Anaemia in Pregnancy (RSCH Trust Guidance 2017)

Following review of the full blood count at booking and at 28 weeks women with haemoglobin below the following levels would require iron supplementation with or without further investigation:

- Women with first trimester haemoglobin of less than 110 g/l, or 105 g/l in the second or third trimester should be referred for a trial with ferrous sulphate, except in contra-indicated patients. Community midwives caring for women outside of the acute trust setting should request prescription from the GP, unless nearing the end of pregnancy when a referral to secondary care should be made earlier. The expected increment following iron supplementation or treatment is 20g/l over 3-4 weeks. Women who demonstrate suboptimal increment should be referred to secondary care. Reassess haemoglobin levels after 2 weeks as per the Trust Guidance for Anaemia in Pregnancy.

4.10 Women who do not attend for antenatal care (DNA)

- Women must be informed that it is their responsibility to make sure appointments with the midwife suit them. A schedule of visits must be outlined in the booking appointment and is available on the RSFT Website .Contact telephone numbers for her Community Midwifery Team and the Pregnancy Advise Line should be clearly identified.
- Midwives/health professionals must provide clear and documentary evidence of attempts to make contact with women who fail to attend for antenatal care. This must be documented in the woman's electronic maternity records as per the DNA guidance. This will enable all staff to track non-attendance and investigate if further appointments are needed.
- If a woman fails to attend an antenatal clinic/community midwife antenatal appointment it is important to first check in the maternity unit that the woman has not delivered or been admitted to the hospital via the Badgernet or PAS system. If not she should first be contacted by telephone to try and arrange a further appointment. If you are unable to make contact by telephone, a letter should be sent to the woman's address with a date for a second appointment as well as updated within her Mat Notes App.
- If a woman does not attend a further appointment, the antenatal clinic/ community midwife should again try to make contact by telephone and if this is not successful, a community midwife should attempt to visit the women at her address for an antenatal check-up and investigate the reason for non-attendance. Further to this, the GP and Health visitor should be contacted to see if the woman has moved out of the area or if there is any information as to why they may not have attended.
- Finally, a third attempt should be made to telephone and visit the women at her address with a note asking her to contact the GP or midwives if she requires further Antenatal Care.

- DNA for antenatal clinic appointments- the community midwife must be informed via email to NHS mail account. The relevant team leader should be copied in.
- OOA women, details for contacting the relevant teams can be found in the ante natal clinic midwives office.
- A record of all attempts to achieve contact with the woman should be documented in the electronic maternity notes, In antenatal clinic DNAs must be recorded in the DNA file in the antenatal clinic office.
- It is important that the midwife confirms the woman's address at every antenatal visit as it appears that a large number of women appear to change address during pregnancy (RCOG 2004)

4.11 Domestic Abuse in Pregnancy

- Routine enquiry at a minimum of three occasions throughout pregnancy, one of which should be at the second booking appointment. The midwife should encourage the woman to attend unaccompanied, so that she has an opportunity to disclose information.
- The midwife should record who accompanies the woman at every appointment. If she is continually accompanied by her partner/ family member and there is no opportunity to see her alone this should raise concerns. This should be escalated to the safeguarding team.
- Ask whether the woman has ever been abused by some-one she trusted (if her partner is not present)
- If the woman's partner is present the midwife must try to find some time in the appointment to be alone with the woman e.g. accompanying her to the toilet. If this is not possible, another appointment must be made to carry out enquiries. Note - often where domestic abuse is present the partner will accompany the woman at every appointment – *this is itself an indicator of domestic abuse.*
- If domestic abuse is suspected, the midwife must raise her concerns to the safeguarding midwives using a Referral form and refer to children's services if appropriate.

5 TRAINING

There is no specific training required for the implementation of this Guideline.

6 IMPLEMENTATION

No action plan applicable as systems already in place.

7 REVIEW, RATIFICATION AND ARCHIVING

The guideline will be reviewed every 3 years or earlier if national guideline or guidance changes are required to be considered. The review will then be subject to review and re-ratification.

The Governance and Membership Officer or Local Policy Officer is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management: NHS Code of Practice, 2009. (Refer to Policy Development and Management: including policies, procedures, protocols, guidelines, pathways and other procedural documents)

8 MONITORING

Minimum requirement	Monitoring Process	Monitoring/ implementing Job title(s)	frequency of the monitoring	Name of responsible committee	Monitoring/ implementing committee (s)
that is to be monitored	e.g. review of incidents/ audit/ performance management	of individual(s) responsible for the monitoring and for developing action plan	(Minimum)	(that is responsible for review of the results and of the action plan)	of individual(s)/ committee responsible for monitoring implementation of the action plan
The process for ensuring women have their first full booking visit and hand held notes by twelve weeks of pregnancy.	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, In Patient Matron, Antenatal Screening Co-ordinator
Process for ensuring women who on referral to the maternity service are already twelve weeks or more are seen within two weeks of referral.	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, In Patient Matron, Antenatal Screening Co-ordinator
Process for ensuring any women who has not had a full UK examination are offered one	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator, Obstetric Consultants
Process for ensuring that women who miss any type of appointment are followed up and	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator

Minimum requirement	Monitoring Process	Monitoring/ implementing Job title(s)	frequency of the monitoring	Name of responsible committee	Monitoring/ implementing committee (s)
that is to be monitored	e.g. review of incidents/ audit/ performance management	of individual(s) responsible for the monitoring and for developing action plan	(Minimum)	(that is responsible for review of the results and of the action plan)	of individual(s)/ committee responsible for monitoring implementation of the action plan
seen.					
Correct timings of risk assessment performed	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator, Obstetric Consultants
Medical conditions, previous pregnancies and lifestyle are considered	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator, Obstetric Consultants
Identification of women who decline blood products	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator, Obstetric Consultants
The development of an individual management plan for women in whom risk are identified during a clinical risk assessment.	Audit	Audit MW	Annually	MRMG	Antenatal/Community Matron, Antenatal Screening Co-ordinator, Obstetric Consultants
Process for referral of women whom risk are	Audit	Audit MW	Annually	MRMG	Antenatal/Community

Minimum requirement	Monitoring Process	Monitoring/ implementing Job title(s)	frequency of the monitoring	Name of responsible committee	Monitoring/ implementing committee (s)
that is to be monitored	e.g. review of incidents/ audit/ performance management	of individual(s) responsible for the monitoring and for developing action plan	(Minimum)	(that is responsible for review of the results and of the action plan)	of individual(s)/ committee responsible for monitoring implementation of the action plan
identified					Matron, Antenatal Screening Co-ordinator, Obstetric Consultant

9 DISSEMINATION AND PUBLICATION

Dissemination of the final guideline is the responsibility of the author. They must ensure the guideline is uploaded on Trust Net via the Governance and Membership Officer. The Governance and Membership Officer is responsible for informing the Communications team to issue a trust-wide notification of the existence of the guideline.

Clinical Directors, DMDs, DDOs Speciality Business Unit (SBU) or supporting services management teams, ward managers and heads of department are responsible for ensuring that all relevant staff under their management (including bank, agency, contracted, locum and volunteers) are made aware of the guideline.

10 EQUALITY IMPACT ANALYSIS

The author of this guideline has undertaken an Equality Impact Analysis and has concluded there is no impact identified. The analysis is available via the Governance and Membership Officer.

11 ASSOCIATED DOCUMENTS

- RSCH Haemoglobinopathies Policy
- RSCH Policy for the Management of Screening in the Antenatal & Postnatal Period
- RSCH Treatment of Iron Deficiency Anaemia in Pregnancy
- RSCH Guideline for Obstetric Ultrasound
- RSCH Policy of Policies
- RSCH Guideline for the Development of Maternity Policies and Ratification Process

12 REFERENCES

- Confidential Enquiry into Maternal and Child Health (CEMACH 2004) Why Mothers Die 200-2002. The sixth report of the Confidential Enquiry into Maternal Deaths in the United Kingdom. London:RCOG Press
- Department of Health (2001) Reference Guide to Consent for Examination or Treatment. Crown Copyright.
- National Collaborating Centre for Women's & Children's Health (2003) *Antenatal Care; Routine Care for Healthy Pregnant Women.* London: RCOG Press

- National Institute for Health and Clinical Excellence (2008) *Antenatal Care. Routinecare for the healthy pregnant woman*. London

- NICE (2014) Antenatal and Postnatal mental health: Clinical management and service guidance. London.

- Nursing and Midwifery Council (NMC2012) *Midwives Rules and Standards*

- *DOH 2005 Responding to domestic abuse; a handbook for professionals*

- *DOH (2000)Domestic Violence*

- Jürgen Stein, Axel U. Dignass. Management of iron deficiency anemia in inflammatory bowel disease – a practical approach. Ann Gastroenterol. 2013; 26(2): 104–113.

- Saving Lives, Improving Mothers' Care 2011-13 (2015) APPENDIX A

13 APPENDIX A - Schedule of Routine Antenatal Appointments

First Baby	Had a Baby Before	Weeks of Pregnancy	Guideline of Your Routine Appointments in Pregnancy
●	●	Before 12 Weeks	Information on diet, vitamins and lifestyle considerations, pregnancy care services, maternity benefits and screening tests. Measure your blood pressure, height and weight. Calculate BMI. Test your urine for the presence of protein/MSU Offer of screening tests and making sure you understand what is involved before you decide to have any of them Find out if you need additional care. Offer of help to stop smoking Offer of an ultrasound scan for Nuchal Translucency(11+0 to 13+6 weeks optimum time 12+2 weeks) and to estimate when your baby is due. Offer of an ultrasound scan at about 21 weeks to check the physical development of your baby. Chlamydia Screening offered to pregnant women aged 24 or under. Offer emotions and wellbeing questions.
●	●	16 Weeks	Measure blood pressure and test your urine. Review and discuss results of all screening tests.
●	●	18+6 – 20+6	Ultrasound scan to check the physical development of your baby.
●		25 Weeks	Measure blood pressure and test urine. Measure the size of your abdomen. Mat B1 issued.
●	●	28 Weeks	Enquire regarding emotions/wellbeing. Measure blood pressure and test urine. Measure the size of your abdomen. Blood screening test to check for anaemia, antibodies and blood glucose level. If your blood glucose is raised a glucose tolerance test (GTT) will be performed. A GTT will also be performed if your BMI is greater than 30, if you have had a previous big baby, have a multiple pregnancy, have a family history of diabetes, history of pcos or you are of Asian or Afro Carribean ethnicity. Discuss complications in labour/delivery of BMI 730. Anti D injection offered if Rhesus negative. Discuss infant feeding.
●		31 Weeks	Enquire regarding emotions/wellbeing. Measure blood pressure and test urine. Measure the size of your abdomen. Review results of screening tests taken at 28 weeks.
●	●	34 Weeks	Measure blood pressure and test urine. Measure the size of your abdomen. Blood screening tests for anaemia. If rhesus negative, blood screening for antibodies and Anti D injection offered Review results of screening tests taken at 28 weeks.
●	●	36 Weeks	Measure the size of your abdomen. Measure blood pressure and test urine. Check to see if your baby is head first (presentation). Discuss the options to turn your baby if it is feet/bottom first (breech). Review results of screening tests taken at 34 weeks. Discuss birthplace and place of birth
●	●	38 Weeks	Measure blood pressure and test urine.

			Measure the size of your abdomen. Check presentation your baby.
●		40 Weeks	Measure blood pressure and test urine. Measure the size of your abdomen. Check presentation of your baby.
●	●	41 Weeks	Measure blood pressure and test urine. Measure the size of your abdomen. Check presentation of your baby. Discuss option of membrane sweep. Discuss induction of labour.