Antenatal Care Pathway

Classification:	Guideline
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Guideline to be followed by (target staff): All maternity staff

To be read in conjunction with the following documents:

- BCG Immunisation Neonates and Paediatrics (MIDW/GL/147)
- Breech Presentation at Term and External Cephalic Version Guideline (MIDW/GL/128)
- Diabetes in Pregnancy Guideline (MIDW-GL-122)
- Fetal Anomalies Guideline (MIDW/GL/146)
- Induction of Labour Guideline (MIDW/GL/11)
- Interpretation, Translation and Accessing Information to meet individual needs (DOC215)
- Maternity Multidisciplinary Confidential Communiqué Guideline (MIDW-GL-116)
- Non-Attendance/No Access for Planned Antenatal and Postnatal Care Guideline (MIDW/GL/104)
- Perinatal Mental Health Guideline (MIDW/GL/103)
- Prophylactic Anti-D Immunoglobulin Guideline (MIDW/GL/67)
- Safeguarding Adults Policy (ORG/GL/51)
- Screening in Pregnancy Guideline (MIDW-GL-145)
- Thromboprophylaxis in Pregnancy and Puerperium Guideline (MIDW/GL/152)
- Vulnerable Team Operational Guidelines (MIDW/GL/159) Women who decline Blood and Blood Products- Treatment and Management (MIDW/GL/82)

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 18 – Staffing

Disclaimer –

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This guideline has been developed in line with current NICE Guidance to provide a standardised care pathway for the provision of routine antenatal care to maternity service users.

Executive Summary

To provide high quality antenatal care for maternity service users in Milton Keynes, which is consistent and in line with current national guidance. (NICE, 2019).

To provide a standardised care pathway, for all health professionals involved with providing antenatal care including Community Midwives, Obstetricians, and allied maternity staff (Department of Health, Department for Education and Skills, 2004).

Key priorities

Maternity Service User Centred care
Maternity service users, their partners and their families should always be treated with kindness, respect, and dignity. The views, beliefs and values of the maternity service user, her partner, and her family in relation to her care and that of her baby should always be sought and respected, even when her views are contrary to your own. Maternity service users should be provided with the opportunity to discuss concerns and ask questions; ensure that she understands the information provided and given enough time to make decisions (NICE, 2019; Better Births, 2016).

Access to antenatal care
Any pregnant women/birthing people in Milton Keynes and the surrounding areas can access care at the Milton Keynes Maternity Unit by completing a self-referral on Milton Keynes Hospital website or via the GP surgery. maternity service users living out of area should be referred by their local community midwife for care or complete the online self-referral antenatal booking form on the Milton Keynes Hospital website. They should continue access midwifery care via their GP and consultant care through Milton Keynes Antenatal Clinic.

Choice
maternity service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. They should have equal access and opportunity to all maternity services. This includes choice of access to maternity service, where they will be seen and by whom, place of birth and antenatal screening (NICE CG62 2008 last updated 2019).

Communication

Good communication between healthcare professionals and women/birthing people is essential. It should be supported by evidence-based, written information tailored to the maternity service user's needs. Care and information should be culturally appropriate. All information should be accessible to women/birthing people with additional needs such as physical, sensory, or learning disabilities, and to maternity service users who do not speak or read English. **Refer to Interpreting, Translation and Accessing information to meet individual needs DOC215**

Every opportunity should be taken to provide the maternity service user and their partner or other relevant family with the information and support they need (NICE, 2019).

Continuity of Carer & Personalisation of Care

Better Births, the report of the National Maternity Review (2016), set out a vision for maternity services in England which are safe and personalised; that put the needs of the maternity service user, baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that maternity service users should have continuity of the person looking after them during their maternity journey, before, during and after the birth. At Milton Keynes University Hospital we are committed to implementing this transformation of maternity services, keeping women/birthing people at the heart of our care.

1.0 Roles and Responsibilities

It is the responsibility of the midwife to ensure that all maternity service users requiring maternity services can access their care either directly with a midwife or via a self-referral form. An antenatal booking appointment should ideally be completed by 10+6 weeks of pregnancy for haematological screening and before 12+6 weeks and subsequent care planned as recommended by NICE (2019).

Obstetricians – to plan and provide care for maternity service users that are referred to Consultant Care at any point during their pregnancy in collaboration with the midwife

Practice managers and other reception staff in GP surgeries, and Children Centres should promote early access to maternity care and advise the midwives of maternity service users who are unable to access care due to capacity.

All practitioners accessing this document should ensure they are conversant with the details contained within and use it within their sphere of professional responsibility and code of practice.

2.0 Implementation and dissemination of document

This guideline will be available on the Trust Intranet.

3.0 Processes and procedures

- Referral for maternity care
- Booking appointment
- Breakdown of antenatal appointments as recommended by NICE (2019)
- Missed appointments
- Access to Antenatal Day Assessment Unit (ADAU)
- Antenatal admission for non-obstetric emergency care

3.1 Referral for Maternity Care

- Maternity service users are encouraged to access antenatal care early via self-referral on Milton Keynes Hospital website, their midwife or GP. This process is advertised via posters in GP surgeries and Children Centres, as well as staff verbally promoting 'early access'.

- All maternity service users should be offered a booking appointment with their named midwife for a booking assessment, ideally between 8+0 and 9+6 weeks but before 12+6 weeks of pregnancy (PHE, 2018).

- All referrals for maternity care will be using the eCare Maternity Antenatal Booking Assessment and the Antenatal Booking Risk Assessment - Referral for Maternity Care form (Appendix 1).
  - The booking midwife uses the form to determine which care pathway is appropriate for each maternity service user.
    - Maternity service users with medical or obstetric risk factors that are in the red highlighted area of the referral form will be managed by a named Consultant.
    - Those that fall within the amber highlighted area should be discussed with the Consultant Obstetrician, Consultant Midwife, or appropriate Lead Midwife
    - Those who are low risk will be managed within Midwife Led Care (MLC)
  - The care pathway should be clearly recorded on eCare.
  - The completed referral forms are forwarded to the antenatal clinic for any relevant appointments to be made.

- Maternity service users accessing care later than 12+6 weeks of pregnancy should be booked for an urgent appointment with the midwife to complete their Booking Risk Assessment (Appendix 1)**.** If a dating scan is not arranged, the midwife must organise an urgent scan appointment.

- Where the Booking Risk Assessment has not been completed by 12+6 weeks, the reason should be clearly documented. Such as: transfer from abroad or late access for care.

- Maternity service users transferring their care from abroad, those who have never seen their GP or are new to the practice should be encouraged and supported to see the GP for a full medical assessment. Notify the Overseas Department MKUH of the woman/birthing person's pregnancy booking.

- Maternity service users who are transferring their care from another NHS hospital should not be referred as a late booking and should have their first appointment with the midwife within 1 week of transferring their care or sooner if urgent care is required. At this appointment, the midwife should complete the booking assessment again and repeat booking bloods. The maternity service user should be provided with Milton Keynes University Hospital eCare booking records and relevant contact numbers.

Maternity service users for whom English is not their first language and who may require an interpreter, should have their first booking appointment with an interpreter present, and increased

time allowed for the history taking and risk assessment. **Refer to Interpreting, Translation and Accessing information to meet individual needs DOC215**

3.2 Booking appointment (ideally by 9+6 weeks and before 12+6 weeks): Checklist of activities to be completed

- From completing the Antenatal Booking Risk Assessment, the midwife will identify maternity service users who require a named Consultant or those that can remain under the care of their midwife. At the initial appointment, the midwife will explain the pattern of care for the pregnancy using the pregnancy planner for timing of midwifery appointments.

- Discuss and give specific patient information leaflets as appropriate, including:

  - Issue Personalised Care Plan

  - Lifestyle and dietary advice to be discussed and documented. Promote the Healthy Start initiative for those who may be eligible.

  - Provide information and advice about smoking in pregnancy and referral to Stop Smoking Services

  - All maternity service users should be recommended to take 10 µg of Vitamin D a day

  - Maternity service users should be recommended to take a daily supplement of 400 micrograms Folic Acid until the 12th week of pregnancy.

  - Consider and give advice for babies that will require BCG.

  - Between September – March provide advice, recommend, and offer flu vaccination at any time during pregnancy

  - Offer and recommend Pertussis vaccination from 16 weeks gestation. The best time is 16 to 32 weeks. Maternity service users may still be immunised after 32 weeks, but this may not offer as high a level of passive protection to the baby.

  - Offer and discuss choice of place of birth, give leaflet, record wishes and refer to homebirth team when appropriate (Refer to Homebirth SOP).

  - Give FW8 Maternity Exemption Certificate.

  - All maternity service users will be placed on the appropriate pathway with reference to one or more of the five elements of the Saving Babies Lives Care Bundle Version Two (SBLCBv2).

- Complete the Social Risk Assessment Matrix for Pregnancy form to identify maternity service users who should be cared for by the Safeguarding Team. (See Vulnerable Team Operational Guidelines). If referral to safeguarding team is required, handover of care should be face-to-face.

The Multi-Disciplinary Confidential Communiqué should be generated at any time during the antenatal period where there are concerns regarding the woman/birthing person's physical / mental health and social well-being and to safeguard and promote the welfare of children. Safeguarding Children Policy provides further guidance.

- Recommend and offer to measure height and weight; BMI is calculated by eCare. (These measurements will be used for customised GROW charts).
- The Maternity Antenatal Booking Assessment in eCare must be completed
- Recommend and offer to measure blood pressure.
- Offer and recommend that urinalysis test is performed and send Mid-Stream Urine (MSU) sample if the woman/birthing person consents.

SBLCBv2 recommends screening for asymptomatic bacteriuria by sending a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.

Urinary tract infection (UTI): As indicated in NICE guidance, midstream urine sample (MSU) should be taken and sent for culture and sensitivity in all pregnant maternity service users at booking. Culture positive samples, even in symptom-free (asymptomatic bacteriuria), they should be promptly treated. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended. Those who have a recurrent episode require review in secondary care.

- Recommend and offer to perform Carbon Monoxide (CO) monitoring.
    - All maternity service users either with CO ≥4ppm, have stopped smoking within the last 2 weeks or current smokers, need to be referred to Smoke Free Milton Keynes as an opt-out service (see Appendix 2).
- Determine risk factors for pre-eclampsia to assess the need for Aspirin 150mg (MBRRACE-UK 2019). Maternity service users requiring aspirin should be referred to the GP for low dose 150mg Aspirin to be prescribed from 12 weeks until birth. A lower dose of 60 – 75mg Aspirin may be considered more appropriate for women/birthing people known to have hepatic or renal disease in line with guidance from SBLCBv2. Ensure that Aspirin requirement is documented on the Antenatal Booking Risk Assessment form and in eCare. (See Appendix 1)
- Antenatal Booking VTE (Venous Thromboembolism) risk assessment is completed as part of the Maternity Antenatal Booking Assessment in eCare.
    - Maternity service users at intermediate or high risk of VTE at the booking appointment should be referred for consultant led care, as per Antenatal Booking Risk Assessment
- Determine risk factors for SGA (small for gestational age) (see Appendix 4). Maternity service users at increased risk of SGA should be referred for consultant led care and serial scans.

- Complete centile calculation of previous babies and refer all babies =/ <10th centile for small for gestational age (SGA) pathway

- Determine risk factors for gestational diabetes and if indicated complete glucose plasma bloods. Complete referral to Specialist Diabetes Midwife. **Refer to Diabetes in Pregnancy Guideline**.

- Maternity service users with pre-existing diabetes or a BMI >30 should take 5mg Folic Acid daily

- Offer blood tests to determine blood group and Rhesus D status; screen for anaemia, haemoglobinopathies, red-cell antibodies, hepatitis B virus, HIV, and syphilis in line with National Screening Guidance. Identify maternity service users who decline blood and blood products and ensure they are referred to a Consultant and managed within the guidance for **Treatment and Management of people who decline Blood and Blood Products.**

- All maternity service users should be informed of and offered antenatal screening in line with NHS Antenatal and Newborn Screening Programme and local screening guidelines. **Refer to Screening in Pregnancy Guideline.**

    - Offer ultrasound scan for gestational age assessment, explain, and offer screening for Down's syndrome, Edwards' syndrome and Patau's syndrome.

    - Offer ultrasound screening for structural anomalies at 18+0 – 20+6 weeks gestation.

- Maternity service users that decline screening must be referred to the Screening Team either by telephone or email.

- From sensitive discussion, identify maternity service users who have had female genital mutilation (FGM). **Refer to Female Genital Mutilation Management Guideline**.

- Ask about any, past or present, severe mental illness or psychiatric treatment and document. Refer to **Perinatal Mental Health Guideline**.

    - Ask about mood and complete GAD7 and PHQ9 in eCare to identify possible depression and complete relevant assessments and referrals.

- Ask about the maternity service user's occupation to identify potential risks and advise them of their maternity rights and benefits. This information can be found on the government website.

- Inform maternity service users younger than 25 years about the high prevalence of Chlamydia infection in their age group and give details of their local National Chlamydia Screening Programme.

- Maternity service users who are receiving care from a Continuity of Carer (CoC) team will remain with their Midwife in the CoC team.

3.2.1 Out of area bookings

For maternity service users living out of area but intending to give birth at Milton Keynes maternity unit the out of area booking appointment (ideally completed by 9+6 weeks and before 12+6 weeks) should take place in the out of area booking clinic at the hospital. The checklist of activities to be completed is identified above in section 3.2.

3.2.2 Transfer of care to other hospitals

For maternity service users wishing to transfer their care to another hospital, they should be advised to seek support to do so via their community midwife or to self-refer to another hospital via their self-referral service.

3.3 Breakdown of Antenatal Appointments

Routine auscultation of the fetal heart is unlikely to have any predictive value and therefore not recommended as part of routine antenatal care. However, it can be performed if requested by the mother for reassurance. (NICE CG62 2008 last updated 2019)

For all antenatal appointments

- Measure blood pressure and perform urinalysis.
- Perform CO measurement for all smokers or previous CO ≥4ppm
- Discuss fetal movements (supported by written information, see Appendix 3)
- Provide opportunity for maternity service users to discuss any issues and ask questions
- Undertake routine enquiry at every opportunity when the woman/birthing person is alone (if concerns, refer to safeguarding pathway)
- For all pregnancies identified as low risk of SGA, measure symphysis-fundal height and document on customised GROW chart, every 2-3 weeks, from 26 weeks.
- Within appointment documentation all clinicians must demonstrate how women/birthing people have participated equally within the decision-making processes about their care in order to make informed choices.
- Complete agreed autotext for each antenatal appointment, as per Appendix 11.

All maternity service users must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.

3.3.1 16-week appointment

- Community midwife to review, discuss and record the results of screening tests. Where results are incomplete, check with the lab and repeat outstanding tests as appropriate.

- The community midwife should check that any maternity service user who has a Rhesus D negative blood group has received a letter and information leaflet from the blood blank about Rhesus D Negative blood groups. The midwife should clarify that the maternity service user understands the letter and information leaflet and should use the translation service to clarify and explain the information in the letter and information as needed. See appendix 9 for the letter and appendix 10 for the leaflet sent.

- Investigate a haemoglobin (Hb) level below 110 g/100 ml and consider iron supplements

- Ensure combined screening has been offered. If not obtained at scan, and still requested, offer a quadruple test. **Refer to the Screening in Pregnancy Guideline.**

- Remind and provide information on the routine anomaly scan.

- For maternity service users who have had a previous caesarean section, the midwife will provide and discuss the vaginal birth after caesarean section (VBAC) patient information leaflet.

- Ensure consultant appointment has been arranged if required.

- Discuss onset of fetal movements, i.e., can commence from 16 to 24 weeks, with the number of movements increasing up to 32 weeks. A pattern of movements can be expected from 28 weeks, if this changes to contact maternity unit**. Refer to Fetal Movement Guideline and Tommy's Leaflet – Appendix 5.**

- Complete request for Anti D where required in eCare (See Prophylactic Anti D Immunoglobulin Guideline).

3.3.2 Anomaly scan: 18+0 to 20+6 weeks

- If the maternity service user chooses, an ultrasound scan should be performed to detect structural anomalies.

- **If there are any fetal anomalies or maternal conditions where additional monitoring of the baby is required, a Baby Alert must be placed on the maternity service user's record on eCare alerting all staff. The Baby Alert can be completed by midwifery or obstetric staff at any point in pregnancy as required.**

3.3.3 25 weeks – for nulliparous maternity service users

- Full antenatal assessment

- Give Mat B1 form.

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3.3.4 28 weeks – for all maternity service users

- Full antenatal assessment

- Offer a second screening for anaemia.

    - Investigate Hb level below 10.5 g/100 ml (by testing Ferritin, Folate, B12) and consider iron supplements.

- Offer anti-D prophylaxis to maternity service users who are rhesus D-negative after taking blood for antibodies. Please refer to **Prophylactic Anti-D Immunoglobulin Guideline.** Documentation of administration of Anti D prophylaxis should be recorded within Assessments/Fluid Balance Anti D management in eCare. This documentation

should include the product label for the Anti D; the blood product administration notification to be returned to Pathology

- Recommend, offer, and commence, if accepted, fundal height measurements from 26-28 weeks gestation

- Re-assess VTE

- Give Pelvic Floor Exercise leaflet

- Give Mat B1 form to multiparous women/birthing people

- "Fit to Fly" letter (see Appendix 6) can be issued, as required, to low-risk women/birthing people due to travel from 28 weeks.

- Complete Antenatal classes booking form for women/birthing people that accept.

- Begin to discuss "Meaningful Conversations" such as:
  - Connecting with baby
  - Responding to baby's needs
  - Feeding your baby
  - Birth preferences.

3.3.5 31 weeks – for nulliparous maternity service users

- Full antenatal assessment

- Review and discuss the results of screening tests undertaken at 28 weeks, including any appropriate action.

- Check if antenatal classes have been booked and offer further information as appropriate.

- Provide birth preferences information leaflet pack.

3.3.6 34 weeks – all maternity service users

- Full antenatal assessment

- Review and discuss the results of screening tests undertaken at 28 weeks for multiparous maternity service users.

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- If Hb was below 115g/100ml at 28-week appointment, then offer a third screening for anaemia.

- Offer nasal MRSA screening.

- Discuss birth preferences and complete birth preferences form on eCare (Appendix 8). The birth preferences form can be accessed in eCare via 'Ad Hoc' and then selecting 'Maternity Birth Preferences'. A clinical note using the 'Maternal Birth Preferences'

should then be created and a copy to be printed and given to the woman/birthing person if she does not have MYCARE.

- Book homebirth assessment for those maternity service users requesting to give birth at home. **Refer to Homebirth SOP.**

3.3.7 36 weeks – all maternity service users

- Full antenatal assessment
- Review results of MRSA swab and ensure if any treatment is required it has been commenced.
- Recommend and offer carbon monoxide testing and document results in eCare
- Review and discuss the results of any screening tests undertaken at 34 weeks.
- Check the position of the baby. If thought to be breech, arrange a presentation scan. **Refer to Breech Presentation at Term and External Cephalic Version Guideline.**
- Give and discuss specific information (at or before 36 weeks) on breastfeeding: technique and good management practices, such as detailed in the UNICEF Baby Friendly Initiative (https://www.unicef.org.uk/babyfriendly/).
- Discuss care of the new baby, vitamin K prophylaxis and newborn screening tests, postnatal self-care, awareness of 'baby blues' and postnatal depression.

3.3.8 38 weeks – all maternity service users

- Full antenatal assessment.

3.3.9 40 weeks – for nulliparous maternity service users & VBAC

- Full antenatal assessment.
- Give specific written information on options for management of pregnancies post due date.
- Discuss and offer a membrane sweep. **Refer to Induction of Labour guideline**.

3.3.10 41 weeks – all maternity service users

For maternity service users who have not given birth by 41 weeks:

- Full antenatal assessment.
- Discuss and offer a membrane sweep. **Refer to Induction of Labour guideline**.
- For maternity service users under MLC and requiring induction for postdates, this can be booked by the Community Midwife, outpatient induction should be offered to all maternity

service users who fulfil the criteria. The relevant patient information should be given and documented. **Refer to Induction of Labour guideline**

3.3.11 42 weeks

- From 42 weeks, offer maternity service users who decline induction of labour increased monitoring (at least twice weekly cardiotocography and ultrasound examination of maximum amniotic pool depth).

3.4 Missed Appointment

Any maternity service users who have not accessed care on two or more occasions and there is no response from telephone contact within 24hrs should be managed within the guidelines for missed appointments. **Refer to Non-Attendance/No Access for Planned Antenatal and Postnatal Care Guideline.**

3.5 Referral to Consultant Midwife Clinic

These clinics are dedicated to supporting and empowering maternity service users in their birth choices by providing evidence-based information to facilitate informed decision making for their birth. Access to the clinics is via the individual referral forms from their Community Midwives or Obstetrician. See Appendix 7 for referral form and criteria, please note this criterion is not exhaustive.

3.6 Access to Antenatal Day Assessment Unit (ADAU)

The Antenatal Day Assessment Unit is dedicated to the monitoring of maternal and fetal health and wellbeing from 18 weeks gestation. Access to the service is via a referral from women/birthing people themselves, midwife, GP, or obstetrician where concerns have been identified. **Refer to Antenatal Day Assessment Unit SOP**

3.7 Access to Labour ward

All maternity service users with concerns should call the maternity unit and be triaged. All maternity service users after 18 weeks of pregnancy who need to access urgent care regarding their pregnancy should call Labour ward.

3.8 Antenatal Admission for non-obstetric emergency care

For the assessment and management of pregnancy and non-pregnancy related problems all antenatal maternity service users attending the hospital should be managed according to the flow chart, see Appendix 5. **Refer to Maternity Outliers SOP** for documentation of management plan from obstetricians.

- Over 18 weeks gestation must be seen by the Obstetric Registrar prior to leaving the hospital. They are then admitted to the appropriate ward for any medical or surgical problem (see Appendix 5).
- Under 18 weeks gestation should be reviewed in current hospital ward. Doctors to refer to Early Pregnancy Assessment Unit (EPAU) where appropriate. Ward admission should be specific to any medical/surgical problem.

4.0 Statement of evidence/references

References:

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5.0 Governance

5.1 Record of changes to document

Version number: 10		**Date: February 2022**		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
Appendix 5	Action plan for supporting pregnant teenagers	**Yes**		No longer relevant. Duplicated in Vulnerable Teams SOP
3.3 & Appendix 3	Smoking cessation advice & flowchart for care pathway		**Yes**	Updated in line with Saving Babies Lives Version 2 & current eCare practice.
Key Priorities	Information regarding personalisation and continuity of carer.		**Yes**	As per Better Births.
Appendices 6, 7 and 8	Fit to Fly letter, Referrals for VBAC and Consultant Midwife Clinic		**Yes**	Requested to add to this guideline
Appendices 1-9	Renumbering of appendices. Inclusion of SBL2 recommendations and Continuity of Carer teams. Added in use of eCare		**Yes**	Updated in line with SBL2 and Better Births
3.3, 3.5 & Appendix 7 and 8	Added in birth preferences discussion and form and adjustment of consultant midwife clinic referral form as out of date. VBAC referral form removed.		**Yes**	Following regulation 28 and change of clinic role

5.2 Consultation History

Stakeholders Name/Board	**Area of Expertise**	**Date Sent**	**Date Received**	**Comments**	**Endorsed Yes/No**
Doctors and Midwives in Women's Health		31/12/2019 & 05/03/2020			
Rebecca Daniels	Consultant Midwife	31/12/2019 & 05/03/2020	22/01/2020	Appendices for VBAC and Consultant midwife clinic	Yes
Julie Cooper	Head of Midwifery	31/12/2019 & 05/03/2020	10/01/2020	Comments about recommendations from SBL2 and flu & smoking	Yes
Janice Styles	Matron	31/12/2019 & 05/03/2020	03/02/2020	Answers about risk assessment and CoC teams	Yes
Olivia Albaradura	Community Midwife	31/12/2019 & 05/03/2020	02/01/2020	Direct referral service to be included. Vitamin D and folic acid Change in aspirin dosage, flu, and	Yes

				whooping cough vaccines	
Mr Mulki	Obstetrician	31/12/2019 & 05/03/2020	05/03/2020	Suggestion about completing VTE at each antenatal appointment	
Guidelines meeting discussion	Obstetric Doctor's and Midwives	28/05/2020	28/05/2020	Include MSU at booking as per SBL2 Include information on out of area bookings Amend audit criteria as induvial conditions are monitored in their own guidelines	Yes
Guidelines meeting discussion	Obstetric Doctor's and Midwives	24/06/2020	24/06/2020	Section 3.3.1 amended to include discussion of VBAC at 16 week appointment	Yes
Maternity and obstetric team	Doctor's and midwives	21/01/2022	24/01/2022 1	Remove teenage MW referral	Yes
MVP	Service users	21/01/2022	08/02/2022		

5.3 Audit and monitoring

The following conditions within this guideline will be audited through their own specific guidelines and therefore, this guideline does not need an additional audit criterion.

10 sets of notes or 1% (whichever is higher) will be audited quarterly to show how women/birthing people are enabled to participate equally in all decision-making processes and to make informed choices about their care. Evidence would be recorded documentation of this within the woman/birthing person's notes.

Audit Criteria for smoking in pregnancy in line with SBLCBv2:
Process indicators:

i. Recording of CO reading for each pregnant woman/birthing person on eCare and inclusion of this data in our local MSDA and LMS Dashboard.
ii. Percentage of women/birthing people where CO measurement at booking is recorded
iii. Percentage of women/birthing people where CO measurement at 36 weeks is recorded.

Outcome indicators:

i. Percentage of women/birthing people with a CO measurement ≥4ppm at booking.
ii. Percentage of women/birthing people with a CO measurement ≥4ppm at 36 weeks.
iii. Percentage of women/birthing people who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment.

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women & Children's	Department	Maternity
Person completing the EqIA	Mary Plummer	Contact No.	Ext 85130
Others involved:		Date of assessment:	15/10/2019
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*midwives, obstetricians all staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	YES	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Emailed to all midwives and obstetricians, EPAU
How are the changes/amendments to the policies/services communicated?
email, meetings, intranet, newsletters
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Antenatal Booking Risk Assessment – Referral for Maternity Care

Please note that this risk assessment form is subject to change

Office use only Date received: | Antenatal Clinic Midwife Name: | Antenatal Clinic Midwife Signature:

Patient Label

Milton Keynes University Hospital NHS Foundation Trust

Antenatal Booking Risk Assessment

Referral for Maternity Care

Client Details		
Previous Surname:	Email address:	Main no.
Ethnic Group:	Home Telephone:	
First Language Spoken:	Work Telephone:	
Translator required?	Mobile Telephone:	

GP Details
GP Name:
Surgery Address:
Telephone / Fax no.

Partners Details	
Name:	Ethnic Group:
Address:	
Contact Number:	Occupation:

Next of Kin Details (if not partner)	
Name:	Relationship:
Address:	
Contact Number:	

Maternity Care			
Has the patient lived in the UK for the past 12 months?	Yes	No	If **NO**, Please send a copy of this form to Rachel Parry Ext:86267
During this pregnancy has the patient received Maternity care abroad?	Yes	No	Country: Hospital name:
During this pregnancy has the patient received Maternity care within the UK?	Yes	No	Town:

Pregnancy Status			
Gravida:		Parity:	
LMP:			
EDD:			
Gestation:			

Client Health	
Weight (kg):	
Height (cm):	
BMI:	
BP:	

Smoking Status		
CO Reading		ppm
Smoker	YES	NO
Ex-Smoker	Yes Quit Date:	
Referral Made	YES	NO

Consent	Signature of Client	Print Name	Date
I give my consent for any relevant information to be released by my GP to the Maternity Service			
I give consent for my contact details to be shared with agencies that may offer my help			

Produced by: C Auker and L Ravel
Version: 3

Please Turn Over

Date Produced: 24/10/2016

Office use only Date received: **Antenatal Clinic Midwife Name:** **Antenatal Clinic Midwife Signature:**

	Risk Factors		Score	Tick	
Consultant Led Care	**Medical Factors**				Allergies
	BMI>49		3		
	Renal Disease (nephrotic syndrome, renal failure)		3		
	Diabetes & other endocrine diseases (eg. Addison's,Cushing's,Thyroid,PCOS)		3		Current Medication
	Rhesus isoimmunisation		3		
	Cardiac Disease		3		
	Cancer		3		
	Thromboembolic disorder (previous VTE)		3		
	Central Nervous System disorder (e.g. MS, stroke, spine bifida/occulta)		3		
	Previous Organ Transplant		3		Further/ additional information/ other risks
	Cystic Fibrosis		3		
	HIV		3		
	Haemoglobinopathy (e.g. Sickle Cell, thalassaemia, von Willebrands)		3		
	Autoimmune disease (e.g. rheumatoid arthritis, myasthenia gravis)		3		
	Haematological condition: Thrombophilia or clotting disorder		3		
	Hepatitis B or C		2		
	Inherited disorder / family history of genetic disorder		2		
	Mental Health disorder		2		
	Epilepsy requiring anticonvulsants		2		
	Previous uterine surgery (LLETZ/biopsy/1 C section - refer to Consultant MW)		2		
	Previous uterine surgery (2+ C sections, myomectomy)		2		
	Hypertension		2		
	Respiratory Disease (e.g.severe asthma, COPD, TB)		2		
	Gastrointestinal disorder (e.g.crohns/ulcerative colitis/bowel/abdo surgery)		2		
	Pregnancy Associated Protein Plasma (PAPP-A) <0.415MoM		2		
	Antenatal VTE	High Risk / Intermediate Risk	-		
	Aspirin Required	Y / N	-		
	Increased risk of SGA	Y / N	-		
	Previous Obstetric History				
	Previous fetal congenital anomaly -requiring specialist fetal medicine		3		
	Previous Pre-eclampsia, eclampsia or HELLP		2		
	Previous Puerperal psychosis (mania, depression etc.)		2		
	Previous early pre-term birth (<34 weeks) or fetal loss (12-24 weeks)		2		
	3 or more consecutive miscarriages		2		
	Previous Neonatal death or stillbirth		2		
	Previous Intrauterine growth restriction		2		
	Previous Placenta accreta / Perccreta		2		
	Previous low weight term baby (<2.5kg)		2		
	Previous baby weighing (>4.5kg)		2		
	Previous fetal congenital anomaly -NOT requiring specialist fetal medicine		2		
	Previous gestational diabetes (Book urgent OGTT, copy to Diabetes MW)		2		
	Grand multiparity (parity 5+) or previous PPH requiring blood transfusion		-		
	Previous retained placenta		-		
	Previous shoulder dystocia/ previous traumatic birth		-		
	Previous 3rd / 4th degree tear		-		
	Previous anaesthetic complications		-		
	Current Factors				
	BMI >35 and <49		2		
	BMI between 30 - 34.9		-		
	BMI <18		2		
	CO>4ppm or Current Smoker		-		
	Sensory / Physical / Learning disabilities		2		
	Substance Misuse (e.g. drugs, solvents, >14 units alcohol etc.)		2		
	Genital Infections / FGM		-		
	Jehovah's Witness or refusal of blood products		-		
	Age 40 years+ at the start of the pregnancy		-		
	Age 18 or under at the start of the pregnancy		-		
Midwife Led Care	Age 19 - 20 years old at start of pregnancy		-		
	Complex Social Factors	YES / NO	2		
	Recent arrival as a migrant		2		
	Asylum seeker / Refugee		2		
	Difficulty with language (cant speak / understand English)		2		
	Domestic Abuse		2		
	Homeless		2		
	Safeguarding children and/or adults (please refer to social risk matrix)		2		
	Risk factors for diabetes (random glucose test at booking/OGTT at 25/40)		-		

Appointment			
	DATE	YES	NO
Consultant			
Consultant Midwife			
Birth Choices			
OGTT			

Referral made by:	Print Name:		Signature:	Date:
Agreed care pathway (must complete)	Consultant Led Care		Name of Lead Professional:	
	Midwife Led Care		Consultant discussed with:	

Booking risk assessment stickers placed in the woman/birthing person's handheld notes:

Preterm Birth Risk Assessment

High Risk

- Previous Preterm birth <34 weeks associated with:
  - Painless Cervical Dilatation
  - Abdominal Pain or Uterine Contractions
  - Antepartum Haemorrhage
  - Preterm premature rupture of membranes PPROM
- Previous mid-trimester loss 16-24/40
- Previous use of cervical cerclage
- Known Uterine Variant (i.e unicornuate, bicornuate or uterine septum)
- Intrauterine Adhesions (Ashermann's Syndrome)
- History of trachelectomy (for cervical cancer)

Intermediate Risk

- Previous delivery by Caesarean Section at full dilatation
- Repeated (>2) Late surgical TOP (>12/40)
- Single LLETZ where >10mm removed
- More than one LLETZ procedure carried out
- Cone Biopsy (knife or laser, typically carried out under general anaesthetic)

All women should have 400mcg Folic Acid & 10mcg (400 units) Vitamin D

Increased Folic Acid 5mg

- Diabetes
- Epilepsy/Anti-Epileptic Drugs
- Family Hx of Fetal Anomolies
- BMI ≥ 30
- Sickle Cell/Beta Thalassaemia Trait
- Coeliac
- Previous baby with Neural Tube Defect
- HIV

Increased Vitamin D 800 -1000 units

- BMI ≥ 30
- High Risk Family Origin
- Limited Sunlight Exposure
- Diabetes

Aspirin from 12 Weeks

≥ 1 High Risk Factors

150mg Once a Day

- Hypertensive Disease in a previous pregnancy
- Chronic Kidney Disease*
- Autoimmune Disease e,g systemic lupus erythematosus or antiphospho-lipid syndrome
- Type 1 or Type 2 Diabetes
- Chronic Hypertension
- Histology confirmed placental dysfunction in previous pregnancy
- Previous SGA <3rd Centile
- Previous stillbirth

≥2 Moderate Risk Factors

Consider 150mg Once a Day in cases of two or more of the following:

- Primip
- Age ≥40
- Pregnancy Interval ≥ 10 years
- BMI ≥ 35
- Family History of PET (1st Degree Relative)
- Multiple Pregnancy

* in some circumstances this dose may not be appropriate and a lower dose of 60—75mg of Aspirin OD can be used

OGTT between 24-36 weeks

BMI ≥ 30	Previous baby ≥ 4.5kg
Family Hx (1st Degree Relative) Any Diabetes including GDM	Family Origin of a high prevalence area
PCOS	Maternal Age ≥40

Urgent OGTT - as soon as possible after booking

Previous GDM

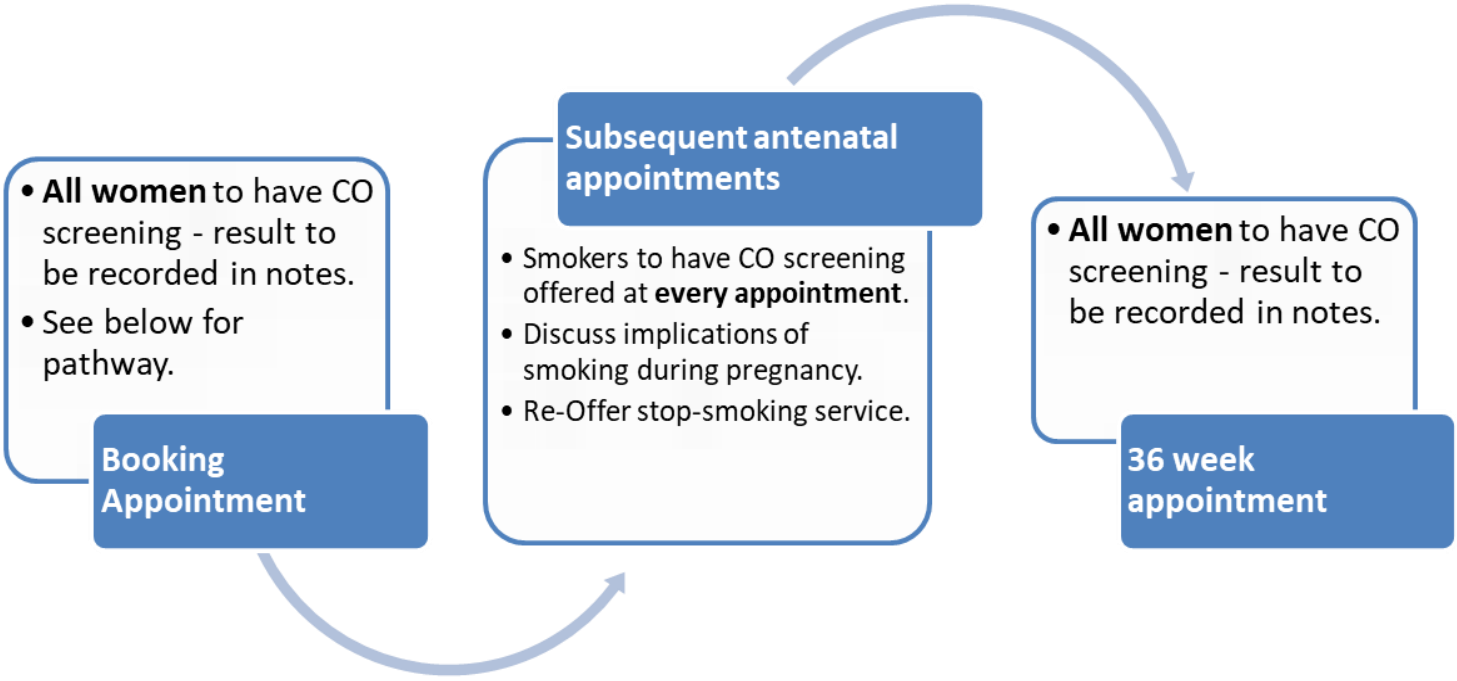
Immediate referral to Diabetes Midwife

Pre-Existing Type 1/Type 2 Diabetes

SBL CARE BUNDLE

LOW PAPP-A <0.415 MoM	Antiphospholipid Syndrome
Previous/Current PIH/PET	BMI ≥ 35
Current Smoker at Booking	Age ≥ 40
Unexplained APH	Drug Misuse
Fetal Echogenic Bowel	Previous Stillbirth/Previous SGA
Chronic Hypertension	Large Fibroids
Chronic Kidney Disease	
Diabetes	

Appendix 2: Smoking cessation in pregnancy flowchart.



Non Smoker — With CO<4ppm

- Record result
- No action required.

Smoker/Recently Quit — With CO>4ppm

- Discuss effects of smoking during pregnancy
- Refer to stop-smoking service as opt-out system
- Refer to consultant led care.

Non-Smoker — With CO>4ppm

- Enquire regarding passive smoking (offer CO screening to partner), ensure gas safety
- Repeat CO reading at subsquent appointments
- Refer for consultant led care if CO>4ppm on 2 subsequent readings.

Appendix 3: Fetal Movements Leaflet

Feeling your baby move is a sign that they are well

Most women usually begin to feel their baby move between 16 and 24 weeks of pregnancy. A baby's movements can be described as anything from a kick, flutter, swish or roll. The type of movement may change as your pregnancy progresses.

How often should my baby move?

There is no set number of normal movements.

Your baby will have their own pattern of movements that you should get to know.

From 16-24 weeks on you should feel the baby move more and more up until 32 weeks then stay roughly the same until you give birth.

It is NOT TRUE that babies move less towards the end of pregnancy.

You should CONTINUE to feel your baby move right up to the time you go into labour and whilst you are in labour too.

Get to know your baby's normal pattern of movements.

You must NOT WAIT until the next day to seek advice if you are worried about your baby's movements

If you think your baby's movements have slowed down or stopped, contact your midwife or maternity unit **immediately** (it is staffed 24 hrs, 7 days a week).

- **DO NOT** put off calling until the next day to see what happens.
- Do not worry about phoning, it is **important** for your doctors and midwives to know if your baby's movements have slowed down or stopped.

Why are my baby's movements important?

A reduction in a baby's movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a stillbirth noticed their baby's movements had slowed down or stopped.

Do not use any hand-held monitors, Dopplers or phone apps to check your baby's heartbeat. Even if you detect a heartbeat, this does not mean your baby is well.

What next...see overleaf

For more information on baby movements talk to your midwife

What if my baby's movements are reduced again?

If, after your check up, you are still not happy with your baby's movement, you must contact either your midwife or maternity unit straight away, even if everything was normal last time.

NEVER HESITATE to contact your midwife or the maternity unit for advice, no matter how many times this happens.

Milton Keynes University Hospital
Antenatal Day Assessment Unit **(01908) 996481** 0700-2030hrs
Labour Ward Triage **(01908) 996478**
24-hour service

Health & care information you can trust
The Information Standard Certified Member

Version 1, published in Jan 2016 under the Tommy's accredited production process (www.tommys.org/informationstandard).
Review date: Jan 2019

Sources and acknowledgements

The information in this leaflet is based on RCOG Green–top Guideline No. 57 *Reduced Fetal Movements* (2011) and RCOG Patient Information Leaflet *Your baby's movements in pregnancy: information for you* (2012).

Thank you to the following organisations for supporting the development of this leaflet

MAMA Academy positive about pregnancy
Sands Stillbirth & neonatal death charity
KICKS COUNT™ empowering mums-to-be with knowledge & confidence
Tommy's Funding research Saving babies' lives

Appendix 4: SGA Risk Assessment Tool and Algorithm

Low Risk
- No known risk factors

Increased Risk
One or more of the following:

Maternal Risk Factors
- Maternal age >40 years
- Ongoing smoker (at booking)
- Drug misuse

Previous Pregnancy History
- Previous SGA baby (<10th centile)
- Previous Stillbirth

Maternal Medical History
- Chronic hypertension
- Diabetes
- Renal Impairment
- Antiphospholipid syndrome

Unsuitable for monitoring by fundal height
- Large fibroids (>5x5cm)
- BMI>35

Current Pregnancy Complications

Early Pregnancy
- PAPP-A <0.415 MoM
- Fetal echogenic bowel

Late Pregnancy
- Severe pregnancy induced hypertension or pre-eclampsia
- Unexplained APH

No risk factors → **Low Risk Care**
Serial assessment (2-3 weekly) of symphysis fundal height (SFH) from 26-28 weeks until delivery
SFH measurements plotted on chart.

↓

Suspected abnormal growth (SFH<10th centile or serial measurements which demonstrate slow or static growth)

↓

Direct referral for assessment (as soon as practically possible, ideally within 72 hours) for estimated fetal weight (EFW), liquor volume and umbilical doppler.

→ Normal → ↑

↓

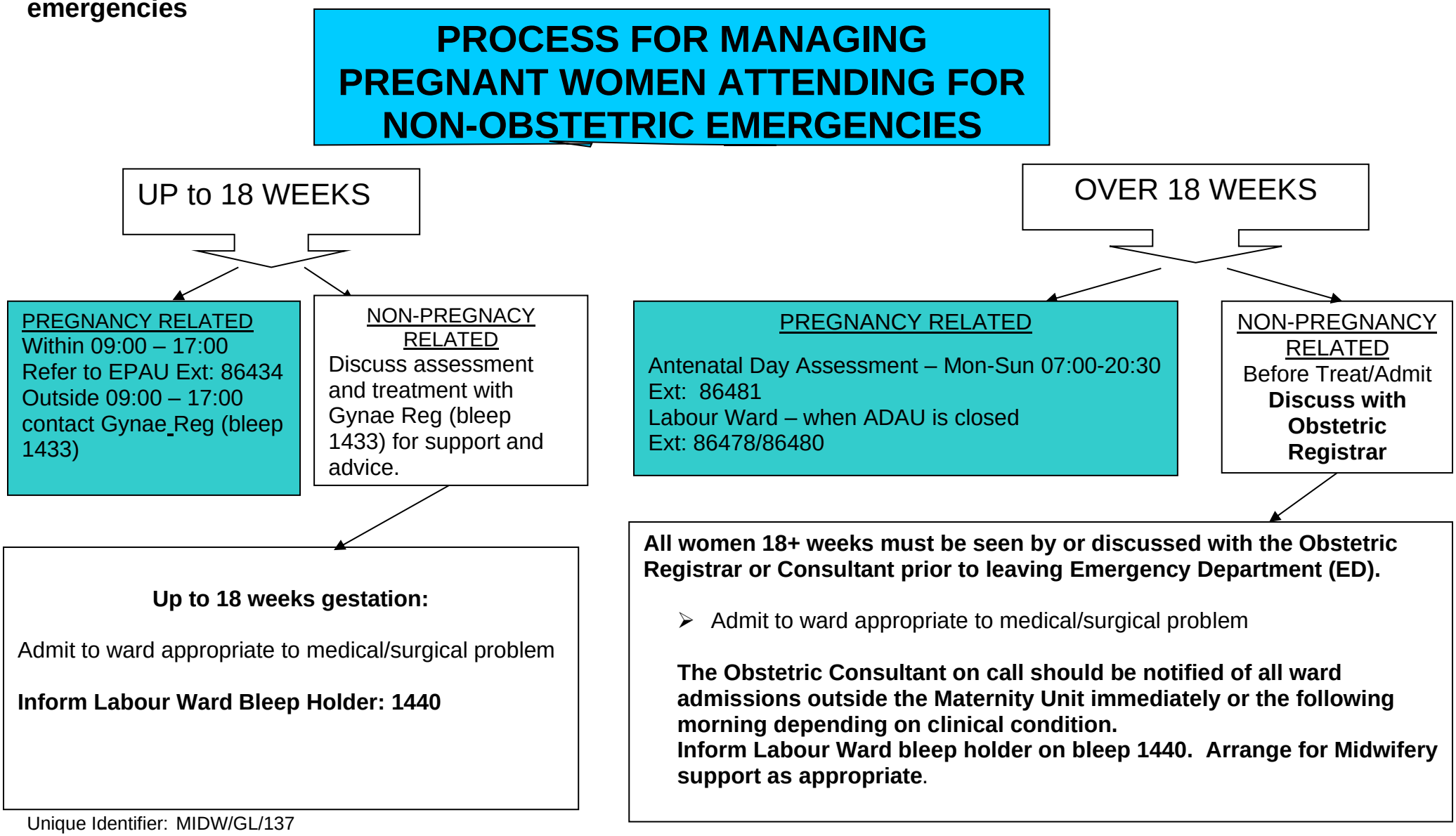
Abnormal growth or abnormal umbilical artery pulsatility index

→ Refer to RCOG guidance on management of the SGA fetus.

↑

One or more risk factors → **High Risk Care**
Serial ultrasound scans to estimate fetal weight from 30 weeks until delivery.
EFWs plotted on chart.

Appendix 5: Flowchart – Process for Managing Pregnant Women/birthing people attending for non-obstetric emergencies



Appendix 6: Fit to Fly Letter

TheMKWay
CARE. COMMUNICATE. COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes University Hospital
NHS Foundation Trust
Standing Way
Eaglestone
Milton Keynes
MK6 5LD
01908 660033
www.mkuh.nhs.uk

Patient Addressograph

GP Surgery:

Reference: Fit to Fly

Date:

I am the named Midwife for ..... who is currently ..... weeks pregnant at the time of travel with an expected due date of .....
The departure date for travel is ..... with a return date of .....

I have assessed the pregnancy to be safe to travel within the dates given.
The risk of developing a DVT has been explained with advice to drink plenty of fluids and mobilise when safe to do so.

Yours sincerely,

Pin:

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

Chief Executive: Joe Harrison
Chairman: Simon Lloyd

Appendix 7: Referral for consultation with Consultant Midwife

Consultant Midwife Referral Form

Clinic Times:

- Tuesday 0900-1300
- Thursday 0930-1230

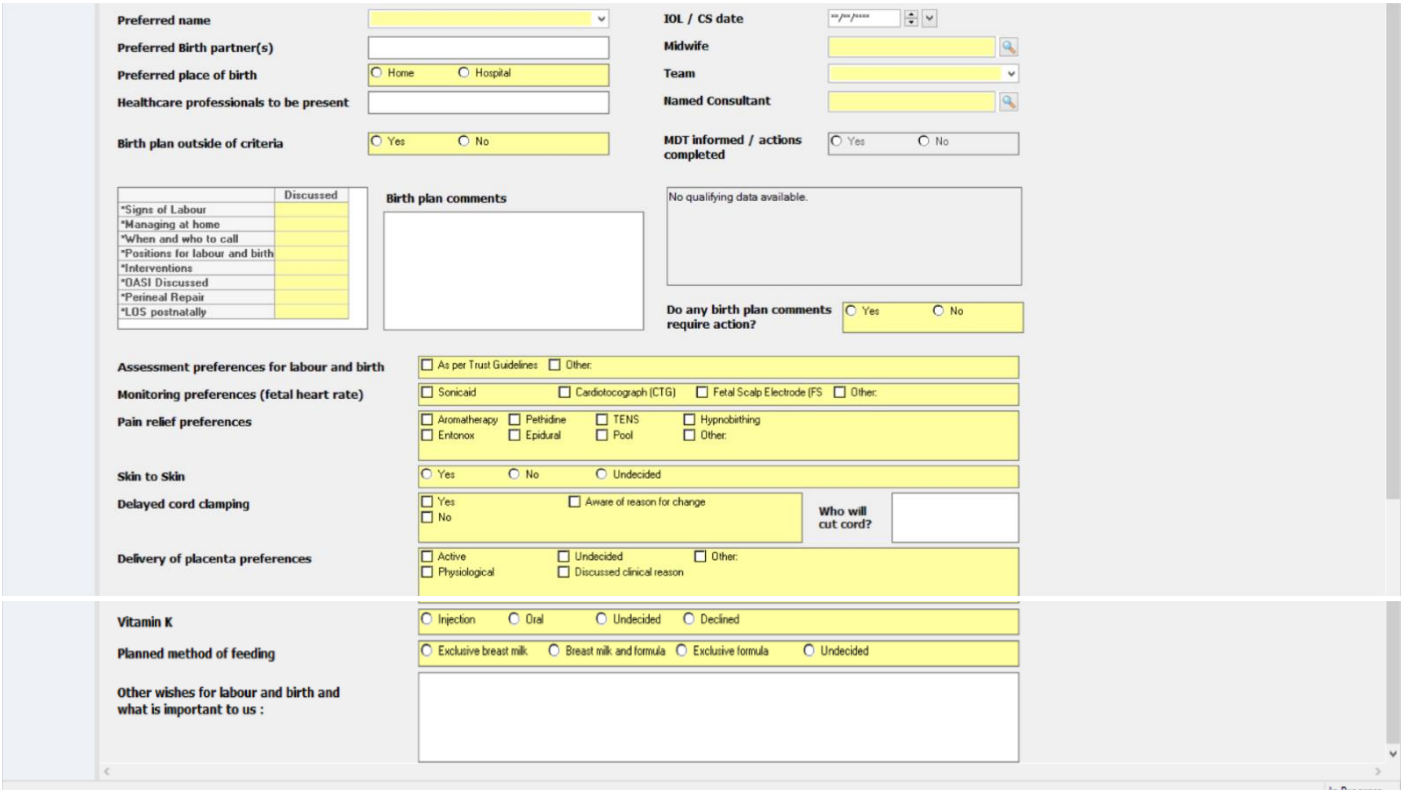
Please complete the referral form and email to MKConsultantmidwives@mkuh.nhs.uk

Name		Named MW	
MRN		Named Consultant	
NHS no.		Name of referrer	
D.O.B		Date of referral	
Telephone number:			
EDD		Gestation	
Medical/obstetric history			
Reason for referral	o ELCS for maternal request o Severe fear or anxiety of birth o Homebirth outside of guidelines o Requesting care outside of guidelines o VBAC		

For Consultant Midwife use:

Date referral received	
Phone call/Appointment Date	
Outcome of appointment	

Appendix 8: Birth preferences form in eCare



Appendix 9: Blood bank RhD letter

TheMKWay
CARE. COMMUNICATE. COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Standing Way
Eaglestone
Milton Keynes
MK6 5LD
01908 660033
www.mkuh.nhs.uk

Date:

Dear

The blood tests taken at your booking appointment have shown that you have a **Rhesus (RhD) Negative** blood group. This is a normal result and about 15% of the UK population are Rh(D) Negative.

If your baby has Rh(D) Positive blood, different from yours, there is a chance if the two bloods mix you may develop antibodies. At present, we will not know the group of your baby until your baby is born.

"This is called "sensitisation ". As a general rule the first child that triggers this sensitisation does not suffer any adverse consequences as it will already have been born by the time antibodies have developed. However, if the woman becomes pregnant again with an Rh(D) positive baby, antibodies may cross into the baby's bloodstream and attack baby's red blood cells which can lead to the baby suffering anaemia, heart failure, brain damage or even to the death of the baby"

In order to prevent you developing antibodies if your bloods are different your midwife will offer you **Anti D** when you are 28 weeks pregnant. It is an injection in your arm which prevents your Rh(D) negative blood from reacting to your baby's blood if it is Rh(D) Positive. This injection protects the baby and is very effective at preventing problems caused by mum and baby having different blood groups.

It is also important for you to know that if you have any vaginal bleeding during your pregnancy or have an impact to your stomach such as a car crash or heavy fall there is a chance you could react to your baby's different blood group. If this happens it is important that we know, and we would like you to call Ante-natal Day Assessment Unit (**ADAU) on 01908 996481** and let them know what happened and that you have Rh(D) Negative blood. They will arrange for you to have an Anti D injection regardless of however many weeks pregnant you are and even if you have already had the 28 week injection. It is a safe treatment and can be given a number of times in pregnancy if needed.

After the birth of the baby the midwife will check your baby's blood group by taking some blood from the cord. If your baby is Rh(D) Positive you will be offered another Anti D injection to prevent this reaction happening in future pregnancies.

Appendix 10: Prophylactic anti-D patient information letter by blood bank

prhophylac-anti-d-patient-leaflet.pdf

Appendix 11: Antenatal appointment autotexts

/matbooking
Routine booking leaflets given ▼Yes/No
PCP given ▼Yes/No
Tommy's leaflet provided ▼Yes/No
Booking bloods and MSU taken with consent ▼Yes/No
FW8 given ▼Yes/No
BP_/_
GROW chart generated ▼ Yes/No

Care pathway: _▼ Consultant Led Care/Midwife Led Care
Indication for care pathway:

SBL▼ prev PET, SGA, PIH/BMI>35/ current smoker/ prev stillbirthhyperemesis/ large fibroids/ chronic hypertension/ fetal echogenic bowel/ low pappa <0.415/ unexplained APH/ chronic kidney disease/ antiphospholipid syndrome/ not required, for fundal height
OGTT▼ not indicated at present/ for BMI >30/ for family hx of diabetes 1st degree relative/ prev baby >4.5kg/ PCOS / for ethnicity/ for mat age >40/ for prev GDM/ urgent referral to diabetes midwife for type 1/type 2 diabetes)
Dating scan▼ requested/ already has appointment/ declined- referred to screening
Vitamin D▼ 10mcg/to commence higher dose 800-1000IU
Aspirin ▼ not required/ 150mg from 12 weeks
Routine Enquiry ▼ not done/ NAD
Mental Health▼ feeling mentally well / reports not feeling mentally well/ offered and accepted IAPT
Social Matrix ▼ Red/ Amber/ Green
CC▼commenced for_/ no SG concerns at present
VTE Score:
VTE risk factors:
Smoking: _▼Current smoker/Non-smoker
Smoking Referral: _▼Accepted/Declined
Preterm Birth Risk: _▼ High risk/Low risk
VBAC ▼Yes/No
If yes, VBAC leaflet provided ▼Yes/No

/mat16weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough▼ booked/to be booked/ had vaccination/declined
RE▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined

Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced.

Booking bloods reviewed
Hb: ▼ Iron medication not required/ Iron medication commenced
Platelets:
Blood Group
Serology ▼ Negative / abnormal - referred
Infectious diseases ▼ Negative / abnormal - referred
Anti D ▼ ordered / not required
Dating scan ▼ Had dating scan and combined result- low risk screening/ Had dating scan- declined combined screening/ Had scan – for quad clinic/ Declined dating scan- screening aware
Anomaly scan ▼ booked / not booked – requested today
OGTT ▼ Booked / Not required
Consultant apt booked ▼ Yes / No/ Not required

Antenatal Risk Assessment
Current Care Pathway _ ▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_ ▼ Obstetric Led unit/ Home

/mat25weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

Anomaly scan ▼ completed – NAD / completed – abnormal and referred / not yet completed – referral made
OGTT ▼ result / booked / not yet booked- arranged today
MATB1 ▼ issued / already has / declined

Antenatal Risk Assessment
Current Care Pathway _ ▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -

Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat28weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

28 week bloods ▼ FBC & Group and Antibodies taken with consent / FBC, Group and Antibodies and Ferritin, Folate and B12 taken with consent / declined
Anti – D ▼ Required - Given with consent / Required – declined / Not Required
OGTT ▼ Not required / normal result / GDM diagnosed
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Pelvic floor leaflets given ▼ Yes/No
VTE risk reviewed – Antenatal Dalteparin required ▼ Yes/No
Antenatal classes ▼ Accepted – referral made / declined

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat31weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced

Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

28 week bloods reviewed ▼ NAD / antibodies – referral made / low Hb, tasked GP to prescribe iron tablets
Hb:
Platelets:
Birth preferences pack provided ▼ Yes/No
Antenatal classes ▼ Booked / not booked – referral made / declined

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat34weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

MRSA swab ▼taken with consent / declined
Last Hb:
Bloods ▼ Not required / FBC with consent /FBC with Ferritin, folate and B12 taken with consent / declined
Birth preferences discussion completed ▼ Yes / No
Homebirth Assessment ▼ Completed / not required

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat36weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼ Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan

Weight today: _
CO level:
GBS3 trial swab ▼ taken with consent / declined
Bloods ▼ Results discussed / Not checked at 34 weeks
MRSA result:
Palpation with consent ▼ Cephalic / Not cephalic – referred for scan

Antenatal Risk Assessment
Current Care Pathway _ ▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼ Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_ ▼ Obstetric Led unit/ Home

/mat38weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼ Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼ Cephalic / Not cephalic – referred for scan

GBS results ▼ Negative / Positive – baby alert completed, and implications discussed

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat40weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: bpm
FH after S&S: bpm No decelerations audible.
IOL ▼ Post-dates IOL offered and accepted. Discussed inpatient/outpatient IOL. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined at present - will rediscuss at 41 weeks / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat41weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today, completed NAD, see CC
Tommy's advice given ▼ Yes/ No

Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: bpm
FH after S&S: bpm No decelerations audible.
IOL ▼ Post-dates IOL offered and accepted. Discussed inpatient/outpatient IOL. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined at present - will rediscuss at 42 weeks / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home

/mat42weeks
Accompanied by ▼ seen alone/ partner/ child/ family / friend
Flu vaccination ▼ booked/to be booked/ had flu vaccination/declined/not in season
Whooping cough ▼ booked/to be booked/ had vaccination/declined
RE ▼ not appropriate today / completed NAD / see CC
Tommy's advice given ▼ Yes/ No
Smoking_ ▼Smoker/ Non-smoker
Smoking referral ▼ Yes/No/Declined
Mental health ▼ feeling mentally well / not feeling mentally well.
(if not feeling well) IAPT offered and accepted / IAPT offered and declined/ CC commenced
Fundal height ▼ Not measured - serial scans / Normal growth / Reduced Growth - referred for urgent growth scan / Accelerated growth – referred for growth scan
Palpation with consent ▼Cephalic / Not cephalic – referred for scan

Stretch and Sweep explained and Offered ▼Declined / Performed with consent
Bishop's score_
FH prior to S&S: _bpm
FH after S&S: _bpm. No decelerations audible.
IOL ▼ Post-dates IOL offered and accepted. Leaflet given. IOL booked for_ / Post-dates IOL offered and declined completely - referred to obstetric team for plan

Fetal Monitoring and plan >42 weeks organised ▼ Yes / No

Antenatal Risk Assessment
Current Care Pathway _▼ Consultant Led Care/Midwife Led Care
Lead Clinician:
New Risk Factor Identified -
Any change in management plan? ▼Yes/No
Personalised Care Plan Reviewed ▼ Yes/No
Intended Place of Birth_▼ Obstetric Led unit/ Home