University Hospitals Sussex
NHS Foundation Trust

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TRUST CLINICAL GUIDELINE

Antenatal Care & Patient Information Guideline

Overview

The purpose of this guideline is to provide good practice evidence for staff involved in antenatal care.

To provide clear guidance on the provision of antenatal care for pregnant women and birthing people including booking appointments, antenatal risk assessments.

For use by: All medical and midwifery staff involved in antenatal care.

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Author/further information	Senior Midwifery Staff, Midwifery Matron – Community & Outpatients
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Consultation

Please select any appropriate consultation groups/ committees:

Trust Wide Governance Group	**Tick as required:**
Medicines Governance Committee (MGC - replaces 'Medicines Optimisation Committee' and 'Drug and Therapeutics Committee')	✓
Antimicrobial Stewardship Group	
Resuscitation Committee	
Resuscitation Operational Management Group (ROMG)	
Trust Transfusion Committee	
Trust Infection Prevention Committee (Chief Nursing Officer)	
Thrombosis Committee	
Health Records Committee	
BSUH Trauma Committee	
Major Trauma Committee	
Sussex Trauma Network	
Children's Safeguarding Strategy Committee	
Radiation Safety Committee	
Medical Devices & Equipment Committee	
Patient Blood Management Committee	
Patient Safety Committee	
BSUH Diabetes In-Patient Care Committee	
Carer and Patient Information Group (CPIG)	
Women's Safety and Quality Committee	
Food Improvement Group	
NIV Steering Group	
NMAHP Board	
Deteriorating Patient Group	
Other (please specify)	
Women & Children's Clinical Effectiveness Meeting	✓

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Antenatal Care &
Patient Information Guideline

1.0 Introduction

The purpose of this guideline is to assist all professional groups involved in providing antenatal care to pregnant women and birthing people.

It aims to promote a consistent, efficient and evidence-based approach to the provision of antenatal care. It also provides a framework and schedule for the delivery of care in the community and hospital setting. It does not however, replace individualised care and management.

This guideline does not provide detail on managing medical conditions. This information can be found under relevant UHSussex Maternity guidelines online.

The antenatal period is defined from conception to the birth of the baby. The purpose of antenatal care is to maintain and improve the pregnant woman and birthing person's health and wellbeing by:

- Monitor maternal and birthing parent and fetal wellbeing to prevent and manage health problems related to pregnancy.
- To provide education and advice on health and wellbeing during and after pregnancy.
- A time for preparation for labour, the birth and preparation for parenthood.

Pregnancy is a normal physiological process and as such, any interventions offered should have known benefits and be acceptable to the pregnant woman and birthing person.

Antenatal care provision is in an area local to the pregnant woman and birthing person by a team of midwives.

All health professionals involved in providing care for pregnant women and birthing people should work together to ensure the package of care offered to pregnant women and birthing people is individualised and meets their needs as suggested in the report Better Births (2016).

Each antenatal appointment should be structured and focused with adequate time for discussion to enable the women and person to make informed choices and to discuss concerns and anxieties.

2.0 Scope

This guideline applies to:

- Midwives
- Obstetricians
- Specialist midwives
- Anaesthetists
- Maternity support workers
- Sonographers

3.0 Roles and responsibilities

Midwives & obstetricians:

- To access, read, understand, and follow this guideline.
- To use their professional judgement in application of this guideline.

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used in this guideline

AN Antenatal	**SFH** Symphysis Fundal Height
MIS Maternity Information System eg Badgernet	**SGA** Small for Gestational Age
FGR Fetal Growth Restriction	**PKB** Patient Knows Best
PCSP Personalised Care and Support Plan	**BMI** Body Mass Index
GTT Glucose Tolerance Test	**FASD** fetal alcohol spectrum disorder
WEPP - Wellbeing and Exercise in Pregnancy Programme	**MSU** Mid-stream Urine
WBIP - Wellbeing in Pregnancy	**VTE -** Venous thromboembolism
ANC - Antenatal Clinic	**UTI -** Urinary Tract Infection
ADAU - Antenatal Day Assessment Unit	**MASH -** Multi Agency Safeguarding Hub
FGM - Female Genital Mutilation	**VBA -** Very Brief Advice
CO - Carbon Monoxide	**FBC -** Full Blood Count
BAC - Birth after Caesarean	**GBS -** Group B streptococcus
SFP - Smokefree Pregnancy	**GI -** Glycaemic Index

5.0 Antenatal referral pathway

Referral can be made in the following ways:

- Self-referral via the Trust's website: https://www.westernsussexhospitals.nhs.uk/services/maternity/pregnancy/
- Via Maternity Telephone Triage.
- GP referral letter to Antenatal Clinic (by post, online or email).
- Community midwife or other healthcare professional eg school nurse referral to Antenatal Clinic.
- Self-referral by phone to Antenatal Clinic.

Antenatal Clinic clerical staffs are responsible for processing referrals quickly and ensuring that the care records are open and accessible within MIS in order that the booking can take place by 8-10 weeks of pregnancy.

If a pregnant woman and birthing person contacts or are referred to maternity services later than 9+0 weeks of pregnancy, a booking appointment should take place within 2 weeks if possible.

When a pregnant woman and birthing person is referred and booked, a letter will be generated from Maternity Information System (MIS) to the General Practitioner and to the Health Visiting Team informing them of the pregnancy.

6.0 Late referrals

When an antenatal referral is received after 12 completed weeks of pregnancy the clerical staff should make contact with the relevant community team within the same working day to ensure that the booking can be undertaken as soon as possible. Refer to CG1125 Management of non-attendance for maternity care guideline for further information.

7.0 Initial antenatal risk assessment

Pregnant women and birthing people with existing health problems/medical concerns, or review of long-term medicines identified in the referral letter/form, may be reviewed by an Obstetric Consultant or other relevant doctor prior to booking, in the Antenatal Clinic for example pregnant women and birthing people with Type 1 Diabetes.

8.0 Booking appointment

The booking appointment is primarily a process of risk assessment, information giving and health promotion. This appointment should occur between 8-10 weeks of pregnancy and be undertaken by the named midwife if possible.

A full medical, social and family history of both biological parents should be taken and adequate time should be allocated to ensure an accurate history is taken.

Pregnant women and birthing people will have an antenatal risk assessment completed at booking by the midwife. This contains all relevant medical, obstetric, psychiatric and social history. This antenatal risk assessment also identifies anaesthetic risks and provides an initial VTE assessment. It also risk assesses for risk factors for preterm birth and fetal growth restriction. It is important that this risk assessment is completed as extensively as possible. This is so that timely and appropriate consultant appointments can be made, if indicated, when the risk assessment is reviewed by ANC Midwives.

Pregnant women and birthing people aged 24 and under should be offered Chlamydia & Gonorrhoea Screening in every pregnancy. CG1199 Management of Infectious Diseases

The midwife must also explain and gain consent for other blood tests and urine tests and document this on MIS. If booking blood tests are declined, this must be clearly documented and the Screening Team notified. CG1105 Maternal Antenatal Screening Tests Guideline

Pregnant women and birthing people should be asked at booking whether they give consent to receive blood and blood products. If they decline, they should be signposted to online maternity information and an appointment should be made to discuss further with an obstetrician in the antenatal clinic. It is the responsibility of the clinician ordering the tests to arrange follow up and appropriate treatment / management plan.

The midwife should discuss antenatal screening for Downs', Edwards and Patau's Syndrome as described in the national patient information leaflet "Screening tests for you and your Baby" and record consent if test required or declined on MIS. This booklet should be made available to the pregnant woman and birthing person prior to booking. (See CG1105 Maternal Antenatal Screening Tests Guideline and CG1111 Screening for Downs, Edwards and Pataus Syndrome Guideline)

The maternity records include:

- Booking data and pre conception details as appropriate.
- Clinical test results including ultrasound scans, antenatal screening tests.
- Information regarding smoking cessation.
- Safeguarding assessment.
- Subsequent antenatal visits and examinations.
- Antenatal in-patient care, blood test results.
- Documented individualised antenatal risk assessment and care plan that is regularly reviewed throughout pregnancy.
- Antenatal Infant feeding assessment.
- Birth preferences.

At the first antenatal (booking) appointment (and later if appropriate), discuss and give information on:

- What antenatal care involves and why it is important.
- The planned number of antenatal appointments.
- Where antenatal appointments will take place.

- Which healthcare professionals will be involved in antenatal appointments.
- How to contact the midwifery team for non-urgent advice.
- How to contact the maternity service about urgent concerns, such as pain, decreased fetal movements, rupture of membranes and bleeding. If a pregnant woman and birthing person has difficulties with communication, for instance language barriers, learning difficulties or are hearing impaired, a plan must be made with them as to how they will contact the maternity unit in the event of an unscheduled event in their pregnancy and avoiding delays in contacting the unit. This should be clearly documented on MIS. The booking midwife should provide an 'emergency contact card' (see appendix 6) with the pregnant woman and birthing person's details filled out and explain that this information should be given when calling Triage. The relevant Community Team contact details sticker should also be placed on the reverse side.
- Screening programmes: what blood tests and ultrasound scans are offered and why. Pregnant women and birthing people will be offered height and weight measurement in the antenatal clinic post scanning for either combined screening or dating scan, even if combined screening is declined, to obtain an accurate BMI measurement and referral to the appropriate pathway.
- How the baby develops during pregnancy.
- What to expect at each stage of the pregnancy.
- Physical and emotional changes during the pregnancy.
- Mental health during the pregnancy.
- Relationship changes during the pregnancy.
- How the pregnant woman and birthing person and their partner can support each other.
- Immunisation for flu, pertussis (whooping cough) and other infections (for example, COVID 19) during pregnancy.
- Infections that can impact on the baby in pregnancy or during birth (such as group B streptococcus, herpes simplex and cytomegalovirus).
- Reducing the risk of infections, for example, encouraging hand washing.
- Safe use of medicines, health supplements and herbal remedies during pregnancy.
- Resources and support for expectant and new parents.
- How to get in touch with local or national peer support services.
- Nutrition and diet.
- Physical activity. Signpost to the Wellbeing and Exercise in Pregnancy Programme (WEPP) and WEPP patient information leaflet on MIS and QR code.
- Smoking cessation and recreational drug use in a non-judgemental, compassionate and personalised way.
- CO monitoring.
- Request FW8 Prescription Exemption Certificate for Maternity and document on MIS that this has been requested. Digital Maternity Exemption Service NHSBSA

A pregnant woman and birthing person can be supported by a partner during their pregnancy so healthcare professionals should:

- Involve partners according to the pregnant woman and birthing person's wishes and
- Inform the pregnant woman and birthing person that they are welcome to bring a partner to antenatal appointments and classes.
- Review regularly whether they would like their partner involved in discussions regarding care.

The community midwife should ensure the pregnant woman and birthing person has accessed and registered an account on the Patient Knows Best (PKB) platform and assigned the Personalised Care and Support Plan (PCSP). If not, instructions or a printable copy should be given if no digital means of accessing PKB and PCSP.

The community midwife should also signpost the pregnant woman and birthing person to online maternity information on pregnancy, the postnatal period and early years.

8.1 Midstream urine (MSU) at booking appointment

(See appendix 7)

A midstream urine sample (MSU) should be taken and sent for culture and sensitivity in all pregnant women and birthing people at high or intermediate risk of preterm birth. Culture positive samples, even in symptom-free pregnant women and birthing people (asymptomatic bacteriuria), 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 by an obstetrician. (SBLCBv3 2023)

Intermediate Risk	High Risk
• Previous birth by caesarean section at full dilatation. • History of significant cervical excisional event i.e., LLETZ where >15mm depth removed, or >1 LLETZ procedure carried out or cone biopsy (knife or laser, typically carried out under general anaesthetic).	• Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation). • Previous preterm pre-labour rupture of membranes. • Previous use of cervical cerclage. • Known uterine variant (i.e., unicornuate, bicornuate uterus or uterine septum). • Intrauterine adhesions (Ashermann's syndrome). • History of trachelectomy (for cervical cancer).

Routine midstream urine sample for culture and sensitivity at Booking appointment for low risk pregnant women and birthing people is no longer recommended UK National Screening Committee - GOV.UK.

8.1.1 MSU and urinalysis during pregnancy

(See appendix 7)

Urinalysis with a dip test to be performed at each antenatal appointment to check for proteinuria as part of an assessment for potential pre-eclampsia (See Hypertensive Disorders in Pregnancy for further information if positive for proteinuria) glucosuria and potential urinary tract infection (UTI).

If a pregnant woman and birthing person is symptomatic for a urine infection:

- Refer to GP or obstetrician to consider antibiotics.
- If signs of preterm labour refer into ADAU or Labour Ward as appropriate.
- Send MSU sample for culture and sensitivity.
- Re-test post treatment by sending an MSU for culture and sensitivity to confirm clearance.

If a pregnant woman and birthing person is asymptomatic for a urine infection but their urinalysis shows potential urine infection:

- Send MSU sample for culture and sensitivity.
- If positive sample refer to GP or obstetrician for appropriate treatment.
- Re-test post treatment by sending an MSU for culture and sensitivity to confirm clearance.

In all cases provide safety net advice regarding when to call Triage regarding signs of pyelonephritis and preterm labour.

Recurrent UTIs should be reviewed by an obstetrician.

The community midwife or clinical area where the MSU was sent for sensitivity and culture is responsible for reviewing results and arranging follow-up as indicated.

See Diabetes in Pregnancy guideline for management of glucosuria.

9.0 Documentation and on-going antenatal appointments

Information taken at the booking appointment is entered into MIS whilst the midwife conducts the Booking appointment.

The schedule of routine antenatal care (see Appendix 2) should be followed with regards to seeing pregnant women and birthing people at appropriate gestation and for appropriate care.

At every antenatal appointment, carry out a risk assessment and document as follows:

- Review and reassess the plan of care for the pregnancy this should include –
  - A formal risk assessment so that they have continued access to care provision by the most appropriately trained professional.
  - An ongoing review of the intended place of birth, based on the developing clinical picture.
- Provide a safe environment and opportunities for the pregnant woman and birthing person to discuss topics such as concerns at home, domestic abuse, concerns about the birth (for example, if they previously had a traumatic birth) or mental health concerns.
- Discuss PCSP in case the pregnant woman and birthing person would like to discuss anything that has come up in their pregnancy.
- Ask the pregnant woman and birthing person about their general health and wellbeing or there are any concerns they would like to discuss. Ask if they have used the Wellbeing and Exercise in Pregnancy Programme (WEPP) exercise videos and resources. Signpost if needed.
- Complete Pelvic Health Questions on BadgerNet at 16/40 and refer *to Antenatal Pelvic Health Education Class* or for one-to-one appointment as guided by the questionnaire
- Ask the pregnant woman and birthing person about their alcohol consumption. (See section 11.6).

At every antenatal contact, update the pregnant woman and birthing person's antenatal records to include details of history, test results, examination findings, medicines and discussions.

Each time a pregnant woman and birthing person is seen in the antenatal period it is imperative that the Maternity Information system (MIS) is updated; this includes any telephone or face to face consultation.

Community midwives have laptops to enable contemporaneous record keeping.

10.0 Consultant led care

Where a referral is required following identification of a new risk during the pregnancy, the clinician is responsible for making the appropriate referral promptly and documenting this. The obstetric review following this referral should include a documented revised management plan as appropriate.

Dependant on the antenatal risk assessment, an appointment is sent to the pregnant woman and birthing person, with the gestation of review agreed by the consultant.

During the first obstetrician review in the antenatal clinic (for pregnant women and birthing people in whom risks have been identified), an individualised management plan for the pregnancy should be made and documented on the Maternity Information System (MIS).

For pregnant women and birthing people with birth preferences that go against medical advice for example, pregnant women and birthing people who have had a previous caesarean birth

requesting birth at home or at the birth centre, a consultant review should be undertaken and a joint meeting with their named Midwife and a Senior Midwife (Community Matron or Community Team Leader) should be encouraged to formulate a plan. An appointment with the Consultant midwife can be made to discuss the pregnant woman and birthing person's options. This plan should be documented within MIS.

Where a transfer of care is required, this should be indicated on MIS. Where the care is returned back to midwifery led care, this should be indicated on MIS and the pregnant woman and birthing person should be asked to make an appointment with their midwife.

10.1 Specialist referrals

Other referrals that may be required following booking.

Where pregnant women and birthing people disclose a history of infectious diseases or haemoglobinopathies the Antenatal Screening Team should be notified as early as possible to enable referral to the specialist service required. (See CG1105 Maternal Antenatal Screening Tests Guideline and CG1199 Management of Infectious Diseases)

The pregnant woman and birthing person should be referred for a clinical cardiac assessment where there is a cardiac concern based on the pregnant woman and birthing person's personal or family history.

Pregnant women and birthing people with high risk maternal medicine conditions such as cardiac conditions or bleeding disorders should be cared for as per CG21008 Management of High Risk Maternal Medicine Conditions Guideline.

11.0 Safeguarding concerns and vulnerabilities

11.1 Raising a safeguarding concern

To raise a safeguarding concern please go to the Maternity Safeguarding page on the intranet – 'Raise a safeguarding concern' and select the link 'Maternity Antenatal & Postnatal Safeguarding Alert'. All alerts made are triaged by the safeguarding midwives and forwarded onto MASH if appropriate.

A list of triggers for raising a concern can be found within P16007 Safeguarding Children Policy under *identification of vulnerabilities.*

If your concern is urgent, please call the safeguarding midwives.

11.2 Perinatal mental health service referrals

At booking all pregnant women and birthing people should routinely be asked the mental health questions (Whooley).

Please see CG22001 UH Sussex Perinatal Mental Health Guideline for referral processes.

11.3 Domestic abuse

At booking all pregnant women and birthing people should routinely be asked about past and current domestic abuse. If the pregnant woman and birthing person is accompanied at booking then the midwife should return to these questions at the next appointment. Record within the Maternity Information system that the routine enquiry question has been asked. (See CG17013 Domestic Abuse Guideline)

11.4 Female Genital Mutilation (FGM)

Pregnant women and birthing people at risk of FGM should be identified at the booking appointment. This should then be recorded within the Maternity Information System so that mandatory reporting can be completed by the maternity information analyst.

Pregnant women and birthing people identified as having FGM should be supported and specialist care provided accordingly. (See CG14020 FGM)

11.5 Smoking in pregnancy

At the first antenatal (booking) appointment discuss exposure to tobacco smoke and give very brief advice (VBA) about the risks of smoking and the available support to quit
Explain that:

- There is no safe level of smoking. Smokers should quit smoking altogether rather than cut down to minimise risks to the mother and birthing parent and baby
- Smoking during the pregnancy can lead to long-term harm to the baby
- Nicotine replacement combined with behavioural support is the most effective way to stop smoking
- Vaping is at least 95% safer than cigarettes and should be supported if this is the chosen quit method
- Rates of relapse are high particularly in the 12 weeks following cessation and discussions about smoking dependency should continue throughout pregnancy

Continue VBA at every appointment and continue to discuss tobacco use in a sensitive, non-judgemental way with the pregnant woman and birthing person throughout their pregnancy and document changes to smoking status; this allows personalised discussions about the risks of tobacco use as part of routine healthcare throughout pregnancy. This may reduce risks and improve outcomes for the mother and birthing parent and baby.

CO Levels:

The most common reason for a raised CO level is smoking, however exposure may come from other sources such as second-hand smoke, faulty boilers, faulty heating/cooking appliances or car exhausts (and can happen at home or at the workplace).

If pregnant women and birthing people have raised CO levels and are non-smokers environmental exposure from a source in the home should be considered and the pregnant women and birthing people should be advised to contact the Gas Emergency Line on **0800 111 999** for further advice.

Referral for further medical advice should be sought if symptoms are consistent with CO poisoning. For NICE guidance on air pollution and vulnerable groups see recommendation 1.7.7. in NICE guidance NG70.

Carbon monoxide (CO) testing should be offered to all pregnant women and birthing people at the antenatal booking appointment, with the smoking status recorded.

Referrals to smoke free pregnancy service are an opt-out. All current smokers, those who stopped smoking within last 6 weeks or raised CO 4ppm or above must be referred. CG20021 Smoking and smoking cessation in pregnancy) Smoking status should be updated at booking, 36/40 and birth. Additional CO testing should be offered to pregnant women and birthing people as appropriate throughout pregnancy at every contact, with the outcome recorded.

11.6 Alcohol consumption and fetal alcohol syndrome

At the first antenatal (booking) appointment discuss alcohol consumption and follow the UK Chief Medical Officers' low-risk drinking guidelines. Explain that:

- There is no known safe level of alcohol consumption during pregnancy.
- Drinking alcohol during the pregnancy can lead to long-term harm to the baby.
- The safest approach is to avoid alcohol altogether to minimise risks to the baby.

Alcohol consumption should continue to be discussed in a sensitive, non-judgemental way with the pregnant woman and birthing person throughout their pregnancy and documented; this allows personalised discussions about the risks of alcohol use as part of routine healthcare throughout pregnancy. It also gives opportunities to offer tailored support and interventions if the pregnant woman and birthing person wishes to cut down or stop drinking. This may reduce risks and improve outcomes for the mother and birthing parent and baby.

Pregnant women and birthing people who wish to discuss their alcohol use should be asked about the quantity, frequency and pattern of drinking, and this should be documented in their maternity records. This information may also help support early diagnosis and treatment for children with fetal alcohol spectrum disorder (FASD). (NICE QS204 2022)

Anyone disclosing alcohol use should be referred to the drug and alcohol services (CGL/Orion) details of which are on Maternity Safeguarding page on the intranet for support in reducing/stopping their use in pregnancy. A referral to Children's Services should also be made as for any substance misuse, for an assessment of risk to the baby. This should also include the partner, if the concern is around their drinking.

11.7 WBIP - Wellbeing in Pregnancy (previously Weight Management in Pregnancy)

This section focuses on those pregnant women and birthing people who start their pregnancy with a BMI <30. For pregnant women and birthing people who have a BMI ≥30 please refer to CG1139 Obesity in Pregnancy Guideline.

At booking, discuss their eating habits and how physically active they are. Find out if they have any concerns about diet and the amount of physical activity they do.

Pregnant women and birthing people should be advised of the following, on how to achieve and maintain a healthy weight during pregnancy:

- Base meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible.
- Eat fibre-rich foods such as oats, beans, peas, lentils, grains, seeds, fruit and vegetables, as well as wholegrain bread and brown rice and pasta.
- Eat at least five portions of a variety of fruit and vegetables each day, in place of foods higher in fat and calories.
- Eat a low-fat diet and avoid increasing their fat and/or calorie intake.
- Eat as little as possible of fried food; drinks and confectionery high in added sugars (such as cakes, pastries and fizzy drinks); and other food high in fat and sugar (such as some take-away and fast foods).
- Eat breakfast.
- Watch the portion size of meals and snacks, and how often they are eating.
- Make activities such as walking, cycling, swimming, aerobics and gardening part of everyday life and build activity into daily life – for example, by taking the stairs instead of the lift or taking a walk at lunchtime.
- Minimise sedentary activities, such as sitting for long periods watching television, at a computer or playing video games.
- Walk, cycle or use another mode of transport involving physical activity.

Offer practical and tailored information. This includes advice on how to use Healthy Start vouchers to increase the fruit and vegetable intake of those eligible for the Healthy Start scheme (pregnant women and birthing people under 18 years and those who are receiving benefit payments).

Many pregnant women and birthing people ask health professionals for advice on what constitutes appropriate weight gain during pregnancy. However, there are currently no evidence-based UK guidelines on recommended weight-gain ranges during pregnancy.

The amount of weight a pregnant woman and birthing person may gain in pregnancy can vary a great deal. Only some of it is due to increased body fat – the unborn child, placenta, amniotic fluid and increases in maternal and birthing parent blood and fluid volume all contribute.

Pregnant women and birthing people should be routinely weighed at Booking Appointment, at 28 weeks and 34 weeks. See Appendix 4 for the recommended pathway for excessive weight gain in pregnancy and Appendix 5 for care if raised BMI is calculated.

All pregnant women and birthing people are referred to Wellbeing in pregnancy for an official appointment via healthy weight referral on MIS. The pregnancy risks and the pathway of care will be discussed. Ongoing support with the weekly wellbeing group will offered.

11.8 Symptomatic of Gestational Diabetes

Where a pregnant woman and birthing person have the following symptoms, in the presence of a normal Glucose Tolerance Test (GTT), they should be referred to the diabetic team for discussion of possible 1-2 weeks Blood Glucose Monitoring.

- Increased thirst
- Increased urination - rule out infection first
- Excessive lethargy - with a normal Full Blood Count (FBC) or improving anaemia.

If a GTT has not been carried out, please complete one.

Referrals should be made to uhsussex.diabetesmaternity@nhs.net

12.0 Monitoring fetal growth and wellbeing

There is strong evidence to suggest that Fetal Growth Restriction (FGR) is the biggest risk factor for stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely birth of the baby at risk. (SBLCBv3.1)

A risk assessment for FGR should be performed at the Booking Appointment and again in the second trimester at the 16-17 week appointment. See **Figure 1** of CG01191 SGA / FGR guideline for FGR risk factors.

12.1 Symphysis Fundal Height measurement (SFH)

SFH is a widely used method of fetal growth surveillance for low risk pregnancies in the third trimester. The cost effectiveness and non-invasive nature makes it a useful primary screening tool. Saving babies' lives Care Bundle v3 recommends that measurements are commenced from 26-28 weeks gestation. MIS allows for documentation of 0.5cm values when measuring SFH. However if this half centimeter is the difference between referring or not referring for growth scans or obstetric review, the preference is to refer to avoid missing a diagnosis such as FGR.

The Intergrowth chart is automatically commenced on MIS. SFH should be entered in to MIS at each appointment from 26-28 weeks. If regular serial growth scans have been commenced, SFH measurements should be stopped, however this is not the case for ad hoc growth scans

when SFH measurements should be continued. It should be documented on MIS that this is the reason SFH measurement is not being performed. SBLCBv3.1

See Appendix 3 for recommended SFH measurement from the Perinatal Institute: Perinatal.org.uk - Fetal Growth / Fundal Height

Refer to CG01191 SGA / FGR guideline for management if SFH is less than expected.
Refer to CG1192 Large for Gestational Age guideline for management if SFH is consistently more than expected with other risk factors such as diabetes.

Referrals for growth scan should be arranged if:

- The first fundal height measurement plots below the 10th centile line.
- Consecutive measurements show SLOW or NO growth = growth rate between plots is slower than the slope of the 10th centile line, over the same gestational age interval (regardless of whether any of the measurements are above or below the 10th centile line).
- Consecutive measurements show EXCESSIVE growth = growth rate between plots faster/steeper than the slope of the 90th centile line, over the same gestational age interval (regardless of whether any of the measurements are above or below the 90th centile line).

NB measurements above the 90th centile with normal growth rate are NOT an indication for scan, unless there is suspicion of polyhydramnios.

13.0 Common problems during pregnancy

13.1 Nausea and vomiting

- Reassure pregnant women and birthing people that mild to moderate nausea and vomiting are common in pregnancy and are likely to resolve before 16 to 20 weeks.
- Recognise that by the time pregnant women and birthing people seek advice from healthcare professionals about nausea and vomiting in pregnancy, they may have already tried a number of different interventions.
- For pregnant women and birthing people with mild-to-moderate nausea and vomiting who prefer a non-pharmacological option, suggest that they try ginger.
- When considering pharmacological treatments for nausea and vomiting in pregnancy, discuss the advantages and disadvantages of different antiemetics with the pregnant woman and birthing person. Take into account their preferences and their experience with treatments in previous pregnancies. See NICE 2021 Table 1: Advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy

Refer to: CG13003 Management of Hyperemesis Guideline for pharmacological and in-patient management.

13.2 Heartburn

- Give information about lifestyle and dietary changes to pregnant women and birthing people with heartburn including advice on healthy eating.
- Advise to avoid known precipitants such as chocolate, fatty foods.
- Smoking cessation and/or being overweight can also increase heartburn. If not already done so, refer to Smoking Cessation or Weight Management in Pregnancy if appropriate.
- Raising the head of the bed and having a main meal a few hours before going to bed may help some pregnant women and birthing people.
- Consider a trial of an antacid or alginate for pregnant women and birthing people with heartburn.

13.3 Symptomatic vaginal discharge

- Advise pregnant women and birthing people who have vaginal discharge that this is common during pregnancy, but if it is accompanied by symptoms such as itching, soreness, an unpleasant smell or pain on passing urine, there may be an infection that needs to be investigated and treated (see section 8.1.1).
- Consider carrying out a vaginal swab for pregnant women and birthing people with symptomatic vaginal discharge if there is doubt about the cause.
- If a sexually transmitted infection is suspected, consider arranging appropriate investigations.
- Offer vaginal imidazole (such as clotrimazole to treat vaginal candidiasis in pregnant women and birthing people. (See Obstetric - genital tract (microguide.global)).
- Consider oral or vaginal antibiotics to treat bacterial vaginosis in pregnant women and birthing people. Refer to Obstetric - genital tract (microguide.global) and CG20013 Preterm Birth Risk Pathway for further information on management.

13.4 Pelvic girdle pain

For pregnant women and birthing people with pregnancy-related pelvic girdle pain**,** signpost to WEPP PGP section https://sussexlmns.org/wepp/ for initial information and advice. Advise re: physiotherapy self-referral or refer during session if indicated.

13.5 Unexplained vaginal bleeding after 13 weeks

- Offer anti-D immunoglobulin to pregnant women and birthing people who present with vaginal bleeding after 13 weeks of pregnancy if they are rhesus D-negative and at risk of isoimmunisation. See CG01195 Fetal D Group DNA Screening and Routine Anti-D Prophylaxis for further information on management.
- Refer pregnant women and birthing people with unexplained vaginal bleeding to EPAC if under 16 weeks. Pregnant women and birthing people over 16 weeks should be reviewed on labour ward. Refer to CG12004 APH and Intrapartum Haemorrhage for further information on management.

14.0 Pregnant women and birthing people from minority ethnic backgrounds and deprived areas

Pregnant women and birthing people and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support. 2020 MBRRACE-UK reports showed that:

- Compared with white pregnant women and birthing people (8/100,000), the risk of maternal and birthing parental death during pregnancy and up to 6 weeks after birth is:
  - 4 times higher in black pregnant women and birthing people (34/100,000)
  - 3 times higher in pregnant women and birthing people with mixed ethnic background (25/100,000)
  - 2 times higher in Asian pregnant women and birthing people (15/100,000; does not include Chinese pregnant women and birthing people)
- Compared with white babies (34/10,000), the stillbirth rate is
  - more than twice as high in black babies (74/10,000)
  - around 50% higher in Asian babies (53/10,000)
- Pregnant women and birthing people living in the most deprived areas (15/100,000) are more than 2.5 times more likely to die compared with pregnant women and birthing people living in the least deprived areas (6/100,000).
- The stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for pregnant women and birthing people living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000).

MBRRACE-UK 2020

Midwives and obstetricians should ensure that pregnant women and birthing people from minority ethnic backgrounds feel supported to access the maternity service for any urgent concerns. They may require additional reassurance that their concerns will be treated appropriately. Staff should recognise that minority ethnic pregnant women and birthing people may delay seeking help and as such when they do present via telephone or in person, ensure any further delays from an organisational perspective are avoided where possible to make certain there is equity in care.

14.1 Migrant pregnant women and birthing people

Migrant pregnant women and birthing people, who have not previously had a full medical examination in the United Kingdom, should either be referred back to their GP or seen by an obstetrician, to have a medical history taken and clinical assessment of their overall health.

Interpreting services must be used if necessary. Interpreters should be independent of the pregnant woman and birthing person rather than using a family member or friend. During the initial Risk Assessment undertaken at booking interpreting requirements should be assessed and appropriate arrangements made.

14.2 Language support

For providing help for patients requiring language support, staff can access interpreting services by opening this this link:

Interpretation & Translation Toolkit

or:

CARDIMEDIC translation tool on work iPads.

The booking midwife should ensure that the pregnant woman and birthing person understands how to contact Maternity Telephone Triage and provide an 'emergency contact card' (see appendix 6) with the pregnant woman and birthing person's details filled out. It should be explained that this information should be given when calling Triage. The relevant Community Team contact details sticker should be placed on the reverse side.

A referral to the overseas team should be considered if there are any questions regarding the patients being eligible for NHS maternity care.

15.0 Key principles of communication and patient information

Pregnant women and birthing people and their partners should have access to unbiased information which includes benefits, risks and alternatives (as appropriate) in order to make an informed choice regarding their care and options.

Pregnant women and birthing people should be signposted to online maternity information. For pregnant women and birthing people without internet access, hard copies of relevant leaflets should be made available.

When giving pregnant women and birthing people (and their partners) information about antenatal care, use clear language, and tailor the timing, content and delivery of information to the needs and preferences of the pregnant woman and birthing person and their stage of pregnancy.

Explore the knowledge and understanding that the pregnant woman and birthing person (and their partner) has about each topic to individualise the discussion and how it relates to them. Provide regular opportunities to ask questions, and set aside enough time to discuss any concerns.

Information should support shared decision making between the pregnant woman and birthing person and their healthcare team, and be:

- Offered on a one-to-one or couple basis.
- Supplemented by group discussions.

- Supplemented by written information in a suitable format, for example, digital, printed, braille or Easy Read.
- Offered throughout the pregnant woman and birthing person's care.
- Individualised and sensitive.
- Supportive and respectful.
- Evidence-based and consistent.
- Translated into other languages if needed.

Pregnant women and birthing people should be signposted to online maternity information as clinically relevant and it should be documented in the health record when this has been done. Examples are:

- Birth after Caesarean (BAC) - to be given to pregnant women and birthing people who have had a previous caesarean who are suitable for vaginal birth at booking or during antenatal clinic consultation.
- Caesarean Section (EIDO)
- General Anaesthetic (EIDO)
- External Cephalic Version (EIDO & RCOG)
- Induction of Labour
- Screening for diabetes in Pregnancy
- Declining Blood and Blood Products
- Multiple Pregnancy
- Placenta Praevia (RCOG)
- Group B streptococcus (GBS) infection in newborn babies.
- Mother/birthing parent’s blood test to check their unborn baby’s blood group.

16.0 Responsibilities of midwives and obstetricians

Antenatal care should be provided by a small group of healthcare professionals with whom the pregnant woman and birthing person feels comfortable. There should be continuity of carer throughout the antenatal period.

Pregnant women and birthing people with complex pregnancies must have a named consultant lead.

Health professionals who order blood/specimen tests are responsible for documenting this and the follow up of results. They should ensure subsequent action/referrals are made promptly, with efficient communication between healthcare professionals involved in the care of that pregnant woman and birthing person.

Pregnant women and birthing people with complex medical problems involving multiple specialties, the responsible consultant obstetrician or physician must show clear leadership and be responsible for coordinating care and liaising with anaesthetists, midwives, other physicians, and obstetricians and all other professionals who need to be involved in the care of these pregnant women and birthing people. MBRRACE-UK 2023

Throughout the pregnancy, the midwife should discuss and give information on:

- Physical and emotional changes during the pregnancy.
- Relationship changes during the pregnancy.
- How the pregnant woman and birthing person and their partner can support each other.
- Resources and support for expectant and new parents.
- How the parents can bond with their baby and the importance of emotional attachment.
- The results of any blood or screening tests from previous appointments.
- Start talking with the pregnant woman and birthing person about their birth preferences and the implications, benefits and risks of different options from 16-18 weeks.

17.0 Previous pregnancy health records

The notes of pregnant women and birthing people who have previously birthed within this Trust are available from Medical Records for review by clinicians. Clinicians should review the previous obstetric notes of high risk pregnant women and birthing people.

For pregnant women and birthing people who have previously birthed in another Trust where the pregnancy or birth was medically or socially complicated, a letter will be sent to the relevant hospital(s) requesting obstetric/social details. The midwife is responsible for this (see Appendix 1) and for notifying antenatal clinic**.** These notes will be reviewed in antenatal clinic by a midwife/obstetrician and appropriate action taken regarding appointments. This should be documented on MIS.

18.0 Location of antenatal appointments

Antenatal care is provided in a variety of settings such as GP surgeries, children's centres, hospital, the pregnant woman and birthing person's home or in other community based settings.

Wherever the care is provided it should be welcoming and accessible. The pregnant woman and birthing person's privacy and dignity should be maintained at all times and enabling them to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use.

The environment in which antenatal care is provided should be risk assessed to ensure safety for the pregnant woman and birthing person and family.

19.0 Monitoring

Suggested audit questions:

Booking appointment

- Has the booking appointment occurred between 8-10 weeks of pregnancy and be undertaken by the named midwife?
- If pregnancy referral occurred later than 9+0 weeks of pregnancy, has the booking appointment taken place within 2 weeks?
- If the pregnant woman and birthing person is aged 24 and under, has Chlamydia & Gonorrhoea Screening been offered?
- If consent for blood products is declined, has it been documented that the pregnant woman and birthing person has been signposted to information on declining blood products and an obstetric consultant appointment been offered to discuss further?
- Has antenatal screening for Downs', Edwards and Patau's Syndrome as described in the national patient information leaflet "Screening tests for you and your Baby'' been discussed and documented on MIS as either accepted or declined.
- Has the pregnant woman and birthing person has accessed and registered with an account on the Patient Knows Best (PKB) platform and assigned the Personalised Care and Support Plan (PCSP)?
- Has the pregnant woman and birthing person been signposted to patient information on MIS?
- Has the booking information has been fully completed including Risk Assessment forms and VTE assessment?
- Have the mental health questions (Whooley) been asked?
- Has Carbon monoxide (CO) testing been offered and result recorded at every contact?
- Have all current smokers been referred to SFP Team?
- Has a weight and BMI been performed and documented at the booking appointment? Has the weight been measured and documented at 34 weeks?

High risk pregnancies and consultant led care

- Has the pregnant woman and birthing person with complex pregnancies a named consultant lead?
- Has an individualised management plan for the pregnancy been made and documented on Maternity Information System during first obstetrician review in the antenatal clinic (for pregnant women and birthing people in whom risks have been identified)?
- Where a transfer of care is required, has this been indicated on MIS?
- Where the care is returned back to midwifery led care, has this been indicated in the notes and the pregnant woman and birthing person asked to make an appointment with their midwife?
- Has a referral been made for clinical cardiac assessment where there is a cardiac concern based on the pregnant woman and birthing person's personal or family history?

Monitoring fetal growth

- Have SFH measurements been commenced from 26-28 weeks gestation and recorded at each appointment?
- Has a referral for a growth scan been made if:
  - The first fundal height measurement plots below the 10th centile line.
  - Consecutive measurements show SLOW or NO growth = growth rate between plots is slower than the slope of the 10th centile line, over the same gestational age interval (regardless of whether any of the measurements are above or below the 10th centile line).
  - Consecutive measurements show EXCESSIVE growth = growth rate between plots faster/steeper than the slope of the 90th centile line, over the same gestational age interval (regardless of whether any of the measurements are above or below the 90th centile line).

University Hospitals Sussex
NHS Foundation Trust

Appendix 1: Clinical records request letter

Date: ……..

To Whom It May Concern: ……

At……...

Re: ……

DOB: ……..

The above patient delivered their baby with you on: ……

They are now pregnant again and planning to birth at Worthing Hospital / St Richards Hospital, Chichester.

Please would it be possible for you to send or email a copy of the patient's previous births and social records to us.

For Worthing the Antenatal Clinic – uhsussex.wor.antenatalclinic@nhs.net
For Chichester the Antenatal Clinic – uhsussex.antenatal.clinic@nhs.net

Or, alternatively, send the records to the Antenatal Clinic choosing the appropriate address above.

Thank you for your assistance with this matter.

Yours sincerely

Senior Midwife,
Antenatal Clinic,
Worthing Hospital / St Richards Hospital, Chichester

Appendix 2: Schedule of routine antenatal visits

SCHEDULE OF ROUTINE ANTENATAL VISITS

Weeks of pregnancy	Routine Antenatal Care
Before 10 weeks Booking appointment Direct access to midwife	**All women and people:** • Full antenatal risk assessment. • Antenatal care plan and place of birth discussed. • Antenatal management plan documented and shared with woman and person. • Assessment of vulnerability issues & alcohol usage. • Routine enquiry-safeguarding children & young adults. • Consider early help plan and refer to MASH if required. • Document Screening Tests for you and your baby leaflet given. • Blood pressure & urinalysis. • Send MSU for women and people at intermediate and high risk of preterm birth as per SBLCBv3.1. • Routine booking bloods and GTT for women/people with risk factors. • Body Mass Index/Weigh. Commence BMI pathway and refer to WBIP. • VTE risk assessment. • Complete FGR and PET risk assessment. • Assess for risk factors for PET for aspirin. • CO Monitoring, smoking status & VBA. Refer any women and people meeting criteria. Document smoking status. • Give emergency contact card with relevant details completed. • Give FW8. • Signpost Wellbeing and Exercise in Pregnancy Programme (WEPP) and WEPP patient information leaflet on MIS with QR code*
11^{+2} to 14^{+1} weeks	**All women and people:** • Combined Screening/Dating scan.
16 weeks	**All women and people:** • Review screening tests to date & authorise. • If too late for previous screening, offer Quadruple Test between 14 – 20 weeks. • Blood pressure & urinalysis. • Give information for parent education & infant feeding class. • Give Information re flu & pertussis. • Reassess for risk factors for PET for aspirin. • Reassess for risk factors for FGR. • Discuss birth preferences, implications, benefits and risks of different options. • CO Monitoring, update smoking status & VBA. • Confirm on MIS Fetal Movements leaflet has been received. • Promote Wellbeing and Exercise in Pregnancy Programme (WEPP) and *WEPP Pelvic Floor Exercises.* • Complete Pelvic Health Questions on MIS and refer *to Antenatal Pelvic Health Education Class* or for one-to-one appointment as guided by the questionnaire. **Multiparous women and people** • Arrange GTT for 26 weeks.
$18 – 20^{+6}$ weeks	**All women and people:** • Anomaly Scan.
25 weeks *(Nulliparous only)*	**Nulliparous women and people:** • Blood pressure & urinalysis. • Discuss fetal movements and document Tommy's patient leaflet given. • Mat B1. • Review parent education needs-& conversations In pregnancy Ensure flu & pertussis given. • Advise not to sleep on their backs from 28 weeks as may be linked to stillbirth. • CO Monitoring, update smoking status & VBA. • Arrange GTT for 26 weeks.
28 weeks	**All women and people:** • Full blood count & antibodies, GTT for women/people with risk factors. • Offer Anti D for Rh negative women/people. • Re-offer booking bloods if declined at booking. • Measure and document SFH (cms) from 26-28 weeks. **NB** If serial growth scans are commenced this should not be performed after the first scan has been performed. • Discuss fetal movements. • Blood pressure & urinalysis – assess need for glucose testing. • Review parent education needs & conversations In pregnancy. • Discuss Vitamin K and newborn screening, caring for newborn.

	• Weigh & reassess for VTE prophylaxis and ensure correct dose. • Discuss fetal movements. • Discuss Birth Preferences, preparing for, coping with and recognising labour, and fetal monitoring in labour. • CO Monitoring, update smoking status & VBA. • Promote Wellbeing and Exercise in Pregnancy Programme (WEPP) and WEPP Yoga for Birth Preparation. **Multiparous women and people:** • Mat B1. • Review parent education needs & conversations In pregnancy Ensure flu & pertussis given. • Discuss fetal movements and document Tommy's patient leaflet given. • Advise not to sleep on their backs from 28 weeks as may be linked to stillbirth.
31 weeks *(Nulliparous only)*	**Nulliparous women and people:** • Measure and document SFH (cms). • Discuss fetal movements. • Discuss postnatal self-care including pelvic floor exercises and postnatal mental health. • Blood pressure & urinalysis. • Discuss Vitamin K and newborn screening, caring for newborn. • CO Monitoring, update smoking status & VBA.
34 weeks	**All women and people:** • Measure and document SFH (cms). • Discuss fetal movements. • Blood pressure & urinalysis. • Weigh. • ICON. • Discuss contraception. • CO Monitoring, update smoking status & VBA. • Promote Wellbeing and Exercise in Pregnancy Programme (WEPP) – BadgerNet push notification *WEPP Rest and Relaxation* audios. **Multiparous women and people:** • Discuss postnatal self-care including pelvic floor exercises and postnatal mental health. • Discuss Vitamin K and newborn screening, caring for newborn.
36 weeks	**All women and people:** • Measure and document SFH (cms). • Discuss fetal movements. • Blood pressure & urinalysis. • CO monitoring, VBA and update smoking status. • Position of baby (if breech offer ECV & refer for scan).
38 weeks	**All women and people:** • Measure and document SFH (cms). • Discuss fetal movements. • Blood pressure & urinalysis. • Discuss prolonged pregnancy and options for management. Membrane sweeps can be offered from **39** weeks. • CO Monitoring, update smoking status & VBA. **Multiparous women and people:** • Offer appointment for membrane sweep at 40 weeks.
40 weeks *(Nulliparous only)*	**All women and people:** • Measure and document SFH (cms) • Discuss fetal movements. • Blood pressure & urinalysis • Offer membrane sweep (all women/people) • CO Monitoring, update smoking status & VBA.
41 weeks	**All women and people:** • Measure and document SFH (cms). • Discuss fetal movements. • Blood pressure & urinalysis. • Offer membrane sweep (all women/people). • Plan induction of labour date. • CO Monitoring, update smoking status & VBA.

January 2024

* WEPP should ideally be promoted at all additional AN appointments.

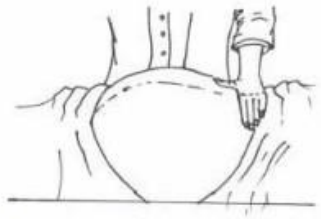
Appendix 3: Symphysis Fundal Height Measurement

Source: Perinatal Institute

Fetal Growth - Fundal Height Measurements

1. Mother semi-recumbent, with bladder empty.

- Explain the procedure to the mother and gain verbal consent
- Wash hands
- Have a non-elastic tape measure to hand
- Ensure the mother is comfortable in a semi-recumbent position, with an empty bladder
- Expose enough of the abdomen to allow a thorough examination



2. Palpate to determine fundus with two hands.

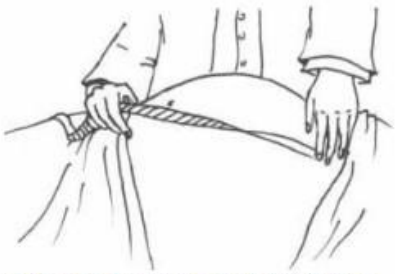
- Ensure the abdomen is soft (not contracting)
- Perform abdominal palpation to enable accurate identification of the uterine fundus.

3. Secure tape with hand at top of fundus.

- Use the tape measure with the centimetres on the underside to reduce bias
- Secure the tape measure at the fundus with one hand

4. Measure to top of symphysis pubis.

- Measure from the top of the fundus to the top of the symphysis pubis
- The tape measure should stay in contact with the skin



5. Measure along longitudinal axis of uterus,

- Measure along the longitudinal axis without correcting to the abdominal midline
- Measure only once

Appendix 4: Excessive Weight and Abnormal Symptoms Pathway

Please follow this pathway if you or the pregnant woman and birthing person, is concerned about excessive weight gain or abnormal symptoms during pregnancy.

Body Mass Index (BMI) kg/m^2	Classification	Weight Gain
<18.5	Underweight	1-2 kgs above normal BMI
18.5 - 24.9	Normal/Healthy	11.5-16 kgs (25-35 lbs)
25 - 29.9	Overweight	<11.5 kgs (25 lbs)
30 - 34.9	Obesity (I*)	4.5-9 kgs (10-25lbs)
35 - 39.9	Obesity (II*)	0-4 kgs (0-9lbs)
>40	Obesity (III*)	0-4 kgs (0-9lbs)

Weight measured at 28 or 34 weeks gestation indicates an excessive weight gain.

See chart.

If experiencing symptoms:

- Increased Thirst
- Increased Urination (with normal MSU)
- Excessive Lethargy (with normal FBC)

with normal previous GTT, refer to diabetes team to discuss 1-2 weeks Blood Glucose Monitoring.

If no previous GTT & <34 weeks:

- Complete GTT.

If previous GTT normal:

- Refer to Diabetes Team who will forward to Diabetic Dietician for advice on low glycaemic index (GI) diet

uhsussex.diabetesmaternity@nhs.net

To discuss with Obstetric Registrar/ Consultant:

- If >34 weeks
- To review any growth USS/ consider growth USS

Appendix 5: Guidelines for BMIs

BELOW 30
• Normal diet advice and discuss recommended weight gain pregnancy, plus check weight at 28 & 34 weeks. • If more than recommended gained – refer to weight management team.
30-35
• Accurate height and weight at initial contact- workout BMI. • Offer weighing at each contact. • Refer to patient information 'Wellbeing in Pregnancy Programme'. • Discuss healthy diet, 2000 calories a day etc. • Discuss recommended weight gain in pregnancy. • Ensure 5milligrams of folic acid and 10micrograms of Vit D are being taken. • At Booking refer to Wellbeing in Pregnancy Programme via MIS. Risks will be discussed, advice and support given. Please encourage pregnant women and birthing people to attend. THIS IS AN OFFICIAL APPOINTMENT! • GTT at Booking and 26 weeks.
35-40
• Accurate height and weight at initial contact-workout BMI. • Offer weighing at each contact. • Refer to patient information 'Wellbeing in Pregnancy Programme'. • Discuss recommended weight gain in pregnancy. • Ensure 5milligrams of folic acid and 10micrograms of Vit D are being taken. • At Booking refer to Wellbeing in Pregnancy via MIS. Risks will be discussed, advice and support given Please encourage pregnant women and birthing people to attend. THIS IS AN OFFICIAL APPOINTMENT! • GTT at Booking and 26 weeks. • Consultant appointment if there are added co-morbidities. • Refer to anaesthetist if BMI 40 and above via MIS. • Serial growth scans from 32 weeks which are generated from the risk assessment sheet by ANC.
ABOVE 40
• Accurate height and weight at initial contact-workout BMI. • Offer weighing at each contact. • Refer to patient information 'Wellbeing in Pregnancy Programme'. • Discuss healthy diet, 2000 calories a day etc. • Discuss recommended weight gain in pregnancy. • Ensure 5milligrams of folic acid and 10micrograms of Vit D are being taken. • At Booking refer to Wellbeing in Pregnancy via MIS. Risks will be discussed, advice and support given. Please encourage pregnant women and birthing people to attend. THIS IS AN OFFICIAL APPOINTMENT! • GTT at booking and 26 weeks. • Serial growth scans from 32 weeks which are generated from the risk assessment sheet by ANC. • Refer to anaesthetist if BMI 40 and above via MIS. • Consultant appointment. • Weight management team/named midwife to complete birth plan and incorporate manual handling.

Appendix 6: Antenatal & postnatal emergency contact card

Do not print from guideline

Antenatal & Postnatal Emergency Contact Card

Any concerns in your pregnancy such as bleeding, reduced fetal movements, pain, labour, rupture of membranes. Or any concerns with yourself or your baby after your baby is born

Call without delay

01903 285269

State:

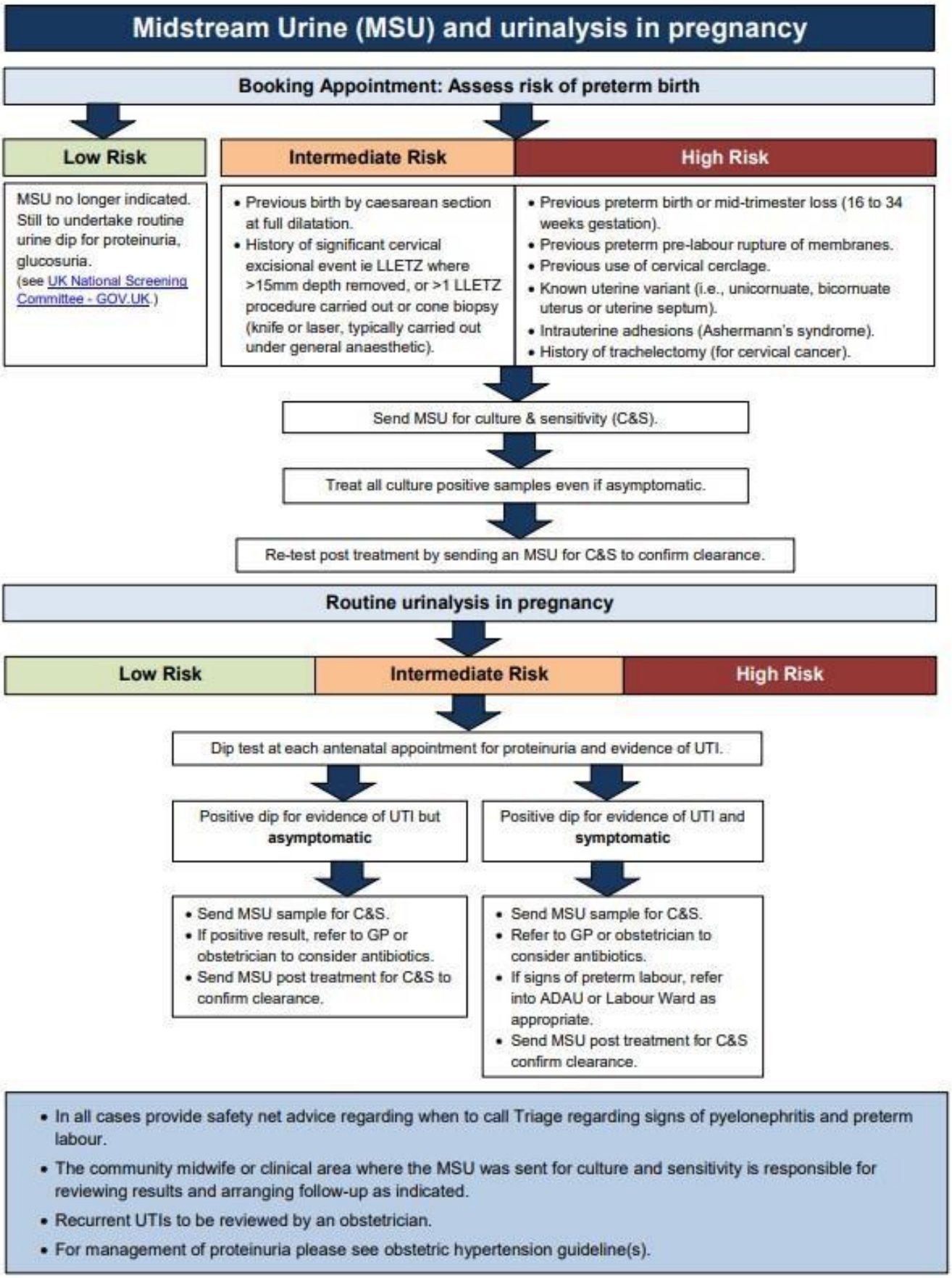
Name:	.....
DOB:	...../...../.....
Hospital Number:	.....
Language spoken:	.....

Community Team Contact Details

Please do not leave urgent messages with your community midwife. Call **01903 285269** with urgent concerns.

Affix community team sticker here

Appendix 7: MSU in pregnancy flowchart



References: UK National Screening Committee: Asymptomatic bacteriuria (2020), SBLCBv3 (2023)
MSU flowchart v1.1 Jan 2024

Appendix 8: Guideline Version Control Log

This should be included for all updated guidelines, summarising the changes between the current and previous version. (Earlier changes should be deleted from the list when the guideline is updated.)
Do not list minor and stylistic changes or changes which do not alter the processes described.
If the update includes a significant reorganisation of the material, indicate this and list the main areas where the process itself has changed.

Change Log – Antenatal Care and Patient Information

Version	Date	Author	Status	Comment
1.0	November 2010	Antenatal Clinic Managers	Archived	New Trust wide guideline
2.0	February 2011	CNST Lead Midwife	Archived	Administrative update
3.0	January 2012	CNST Midwife	Archived	Interpreting information added
4.0	October 2012	CNST Midwife	Archived	Minor update
4.1	July 2013	CNST Midwife	Archived	Leaflet information updated
5.0	November 2013	CNST Midwife	Archived	3 year review and update
6.0	May 2016	Midwife (H. Boiling)	Archived	Addition of management of missed appointments and update to patient information section with regard to on-line leaflets
7.0	June 2017	Midwifery Matron – Community & Outpatients Fetal Medicine Midwife Specialist Antenatal Clinic managers	Archived	Review and updated to remove Midwifery Supervision Addition of Fetal Echo Referral
8.0	September 2019	Midwifery Matron – Community & Outpatients	Archived	Full review of guideline
9.0	January 2022	J. Collard, Clinical Effectiveness Support Midwife	Archived	Full review in line with NG201 Antenatal Care NICE 2021 Guidance on management of excessive weight gain added.
9.1	October 2022	J. Collard, Clinical Effectiveness Support Midwife	Archived	Antenatal discussion and assessment of alcohol consumption added in line with NICE QS204 Fetal alcohol spectrum disorder 2022 SFH to be from 26-28 weeks. Signposting to FGA & Preterm risk assessment forms added.
9.2	March 2023	H.Challen, Clinical Effectiveness Support Midwife	Archived	Appendix 2: added CO Monitoring at every antenatal appointment.

9.3	June 2023	CE Team	Archived	• Plan to be made of how to contact the maternity unit if the pregnant woman and birthing person has communication difficulties. • MRSA no longer required at 36 weeks.
9.4	January 2024	E. Meadows, Maternal Medicine Midwife K. Lundie, Antenatal and Newborn Screening Midwife CE Team	Archived	• SFH to be commenced at 28 weeks and can be stopped once regular growth scans have been commenced. • Booking MSU for culture and sensitivity only to be performed with intermediate or high risk women as per SBLCBv3. • Proof of cure repeat culture and sensitivity to be sent post treatment for asymptomatic bacteria or confirmed UTI. • Schedule of care reverted back to follow NICE schedule of care. • Smoking in pregnancy updated.
9.5	July 2024	Clinical Outcomes & Effectiveness Team	LIVE	Transferred into guideline template.

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.
If in doubt contact a senior colleague or expert.

Appendix 9: Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guideline affect one group less or more favourably than another on the basis of:**		
	Age	*no*	
	· Disability	*no*	
	· Gender (Sex)	*no*	
	· Gender Identity	*no*	
	· Marriage and civil partnership	*no*	
	· Pregnancy and maternity	*no*	
	· Race (ethnicity, nationality, colour)	*no*	
	· Religion or Belief	*no*	
	· Sexual orientation, including lesbian, gay and bisexual people		
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*no*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*no*	
4.	**Is the impact of the document likely to be negative?**	*no*	
5.	**If so, can the impact be avoided?**	*N/A*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*N/A*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*N/A*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to Senior Midwifery Staff, Midwifery Matron – Community & Outpatients, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Appendix 10: Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	**Comments**
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and Obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination of update to all maternity staff is carried out via work emails, notice boards, social media, safety huddles and Leading Learning emails to obstetricians. If indicated, it is included in maternity mandatory training.
	How have you linked the dissemination of the guideline with induction training, continuous professional development, and clinical supervision as appropriate?	All staff are shown how to access maternity guidelines on SharePoint when they join the Trust. It is confirmed at performance appraisals.
2.	How and where will staff access the document (at operational level)?	Maternity clinical documents are uploaded to SharePoint which all maternity staff have access to.

		Yes/No	**Comments**
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Archiving of previous version is part of our process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	This is part of our dissemination process – see above.

Appendix 11: Additional guidance and information

NHS England (2016) National Maternity Review: Better Births. Improving Outcomes of Maternity Services in England. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

NHS England (2023) Saving Babies' Lives Version Three. NHS England » Saving babies' lives version three: a care bundle for reducing perinatal mortality (accessed 06/09/23)

National Institute for Health and Clinical Excellence (2023) NG235 Intrapartum Care (accessed 20/11/23)

Recommendations | Weight management before, during and after pregnancy | Guidance | NICE 2010

NG201 Antenatal Care NICE 2021

NICE QS204 Fetal alcohol spectrum disorder 2022

MBRRACE-UK 2023 Lessons learned to inform maternity care from the UK and Ireland confidential enquires into maternal deaths and morbidity 2019-2021.

Gov.UK (2020) Asymptomatic bacteriuria - UK National Screening Committee (UK NSC) - GOV.UK (view-health-screening-recommendations.service.gov.uk) (accessed 06/09/23)