BOOKING PROCEDURE MATERNITY GUIDELINE

<table>
<thead>
<tr>
<th>Version:</th>
<th>2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified by:</td>
<td>Maternity Quality Board</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>27th February 2014</td>
</tr>
<tr>
<td>Approving Committee/Group (Date):</td>
<td>Maternity Guidelines &amp; Practice Review Committee 05/02/2014</td>
</tr>
<tr>
<td>Date Approved by Medicines Management Committee:</td>
<td>N/A</td>
</tr>
<tr>
<td>Name and Title of originator/author:</td>
<td>Karen Rooke, CNST/Risk Midwife</td>
</tr>
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<td>Date issued:</td>
<td>27th February 2014</td>
</tr>
<tr>
<td>Review due date:</td>
<td>January 2016</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All maternity staff</td>
</tr>
<tr>
<td>Superseded documents</td>
<td>V2.1</td>
</tr>
<tr>
<td>Relevant Standards(e.g. NHSLA, CQC, HSE)</td>
<td>NHSLA CNST 4:1</td>
</tr>
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<td>Acknowledgements</td>
<td>Community Midwifery Team leaders</td>
</tr>
<tr>
<td>Key Words</td>
<td>Screening, referral, risk assessment, booking appointment</td>
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</table>
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1 INTRODUCTION

Saving Mother’s Lives (CEMACE 2011) identifies that approximately 20% of women who died from direct or indirect causes either booked for maternity care after 20 weeks gestation, missed over four routine antenatal appointments, did not seek care at all or actively concealed their pregnancies. This delay denied them the opportunities that early maternity care provides.

The Care Quality Commission, NICE Guidance, National Screening Committee and Maternity Matters recommend that a pregnant woman should be booked for antenatal care by 12 weeks and 6 days gestation and the care provided should be according to their individual risk status.

2 PURPOSE


It describes the process for booking women and ensuring that they have their first full booking appointment and hand held maternity notes completed by 12 weeks and 6 days of pregnancy.

3 DEFINITIONS

Appropriate timescale for booking – the first full booking visited and hand held records are completed by twelve completed week of pregnancy

Risk Assessment – Risk assessment is a step in a risk management procedure.

4 ACCOUNTABILITIES AND RESPONSIBILITIES

Chief Executive
Has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust

Clinical Leads/Head of Midwifery
Have responsibility to ensure that the requirements of this guideline are followed and that this is audited and monitored through the Maternity Quality Board

Practice Review and Guidelines Group
As a group are responsible for the consultation and approval process required during the development of guidelines for the Maternity Unit.

The Maternity Quality Board
The Maternity Quality Board is responsible for the ratification of guideline and the final ratification prior to implementation of the guideline. This ratification process will take place following the consultation and approval process.

All Staff
It is incumbent on relevant staff when asked, to provide comments and feedback on the content and practicality of the guideline.
Community Midwife Team leader
The team leader is responsible for the orientation and welcome pack for orientating midwives which includes the booking appointment and awareness of the policy.

Any policy changes or non compliance with the policy identified will be highlighted and disseminated amongst the team by the team leader.

Midwives
Carry out the booking appointment in line with the policy and are responsible for referring women appropriately when risks are identified.

5 THE BOOKING PROCEDURE

A woman with an uncomplicated pregnancy will be provided with community based care and a midwife as the lead professional. All women whether high or low risk should be allocated a named midwifery team (DoH 2007).

Women are to be offered a choice of place of birth. Consideration should be given to all risk factors when discussing this choice. A woman with high risk factors or potential complications should be advised about the referral pathways available to them. All risk assessments should be documented by the staff member undertaking the risk assessment.

The lead professional providing the substantial part of the care is responsible for communicating with the multi-disciplinary team and other specialist staff to ensure that the woman has access to care from other professionals. The name of the midwifery team and/or lead professional is documented on the front of the pregnancy notes. If a change in lead professional occurs, either from midwife to obstetrician or vice versa this plus the reason for transfer of care is documented in the woman's records. Contact numbers for the maternity unit should be clearly written on the front of the pregnancy notes.

The Midwife/Obstetrician caring out the antenatal review must undertake and document a risk assessment of the woman at booking, 28 weeks and at 36-38 weeks gestation. An individualised management plan should be agreed with the woman. The plan should be reassessed and amended if appropriate as the pregnancy progresses. The woman may require hospital high risk care at any stage of pregnancy. Any changes to the plan of care should be clearly documented.

5.1 Referral for antenatal care

The referral letter is written by the GP/midwife. Women also have the option to access a midwife as the first point of contact (DoH 2004) by self referring to the maternity service via Croydon Health Services website.

The following information should be included in the letter if known.

- Full name and address including the post code
- Date of birth and marital status
- Telephone number (day time) – home, work, mobile.
- LMP and EDD to arrange screening (11 weeks to 14+1 for dating scan and combine screening and 20-22 week for the anomaly scan)
- Parity and relevant obstetric history.
- Responsibility for care - whether “High Risk” (Consultant) or “Low Risk” (GP/MW) care is appropriate.
Reason for “High Risk” Care and state at what gestation the appointment should be
given.
- Social, child protection issues and mental health.
- Whether an interpreter is required
- Booking BMI (Based on pre-pregnancy weight).
- Screen for risk factors for gestational diabetes see Guideline Gestational diabetes 2009.

A notification of pregnancy or self-referral letter is received in the Antenatal clinic office, date
stamped and arranged in order of EDD (expected date of delivery).

The notifications are screened by a midwife who identifies high risk or vulnerable women. These
Women are prioritised and referred to the relevant specialist midwives for antenatal booking by
the Midwife screening the notifications.

Women are allocated booking appointments using the Antenatal Centralised booking system.
Women are invited to attend their initial booking appointment between 8-10 weeks gestation
(Appendix D Antenatal Care Pathway).

Referrals received for any woman currently 10-12 weeks gestation are marked as urgent and
actioned straightaway so as to ensure that the woman receives her appointment, either by letter
or by telephone for the first full booking visit by 12+6 weeks gestation.

Any woman, who is greater than 12 weeks gestation when referred, is sent an appointment to
complete the booking appointment within two weeks. Appointments are allocated and the
woman is contacted by phone, post and text messaging system.

The midwife responsible for the centralised booking system records the names, dates and
details of all the referrals received and appointments allocated. The notifications are then sent
to the antenatal clinic clerks, where scan and consultant appointments are arranged and sent.
Women booked before 14+1 weeks gestation are sent an appointment for a first trimester scan.
First trimester scans and combined screening for Down’s syndrome are performed between 11
–14+1 weeks gestation. Anomaly scans are offered and booked as appropriate.
Referrals that are marked ‘urgent’ and women who are identified as ‘high risk’ are sent a
consultant appointment as appropriate, see Guideline, Clinical risk assessment Antenatal 2012

5.2 Information sent to the woman with the booking appointment

The ANC clerical staff send women:
- The National Screening booklet “Screening tests for you and your baby” with their
  antenatal booking appointment.
- The leaflet “Ultrasound in Pregnancy” is posted with the first trimester ultrasound scan
  appointment

5.3 Booking Appointment (ideally between 8-10 weeks)

The first booking interview is undertaken by 12 + 6 weeks gestation and ideally between 8- 10
weeks. This provides an opportunity for the woman to discuss her concerns and be given the
information she needs to enables her to make informed decisions.
During the first full booking appointment the hand held record are completed.
An interpreter is booked and is present at the booking appointment if required.

Allow 1 hour for the appointment.

At the first appointment the midwife must undertake a full health and social needs assessment
and a risk assessment taking into consideration past obstetric history, medical and surgical
history and social circumstances (Clinical risk assessment Antenatal)
The midwife undertaking the booking will assign the woman to either midwifery or consultant led care depending on the risk assessment.

- Initially document the woman's details which include faith, citizenship and ethnicity.
- Confirm with the woman that she wishes to have her baby at Croydon University Hospital or with the Croydon Homebirth team (Crocus team).
- Take a full medical, surgical, mental health, social and obstetric history.
- Whether the woman would be prepared to receive blood and blood products.
- Family History including that of the baby's father including consanguinity.
- 1st antenatal bloods are taken with informed consent. The midwife is responsible for ensuring the results are available, actioning the results and sending them to the woman.
- Complete a VTE risk assessment form.

**Check and record:**
- Blood Pressure
- Test urine, send a MSU to microbiology for asymptomatic bacteriuria
- Weight/Height, is measured and recorded. The BMI is calculated (based on current weight). All women with a BMI of 30 or more must be referred to a Consultant Obstetrician, women with a BMI of 40 or over or who weigh 120kg and over are referred to an Anesthetist (See Obesity Guideline 2012) by faxing the appropriate referral form to the Anesthetic department. Women with a low BMI, 18 or below, are referred to the Consultant Obstetrician.

**Discussion & advise**

The following will be discussed at the appointment.

- Life style including - diet, nutrition including food hygiene and Vitamin supplements, smoking, exercise, drugs and alcohol. Information on vouchers for milk, fruit and vegetables. Give information on early pregnancy class.
- Antenatal screening - Dating scan combined screening for Down's syndrome/anomaly scan, blood tests. Ensure the woman have a copy of the NSC Booklet “Screening Tests for you and your baby”. Discuss risks, benefits and limitations of the screening tests.
- Screen for gestational diabetes using the risk factors and offer a GTT test at 28 weeks gestation.
- Assess risk of mental illness/ depression
- Confirm whether the woman would accept blood/blood products if clinically indicated.
- The options for place of birth are discussed.
- Give information on Parent education and a booking form.
- FW8 Form is given, if not already received from the GP.
- Maternity Benefits
- The benefits of breastfeeding

**5.4 Women requiring additional care (NICE 2008)**

Pregnant women with the following conditions require care additional to that detailed in this guideline and should be referred for consultant care see Guideline, Clinical risk assessment Antenatal 2012, for the timing of the appointment.

- Cardiac disease, including hypertension
- Renal disease
- Endocrine disorder, diabetes requiring insulin.
- Psychiatric disorder (on medication)
- Haematological disorder, including thromboembolic disease, autoimmune diseases such as antiphospholipid syndrome.
- Epilepsy requiring anticonvulsant drugs
- Malignant disease
- Severe asthma
- Drug use such as heroin, cocaine (including crack cocaine) and ecstasy
- HIV or HBV infected
- Autoimmune disorders
- Obesity (BMI 30 or more at first contact) or underweight (BMI less than 18 at first contact.
- Women who may be at a higher risk of developing complications e.g. women 40 years

**Women who have experiences any of the following in previous pregnancies**

- Recurrent miscarriage (three or more consecutive pregnancy losses) or a mid-trimester loss
- Preterm birth
- Severe pre-eclampsia, HELLP syndrome or eclampsia
- Rhesus isoimmunisation or other significant blood group antibodies
- Uterine surgery including caesarean section, myomectomy or cone biopsy
- Significant Antenatal or postpartum haemorrhage
- Retained placenta
- Past or present mental illness
- Grant multiparity (more than five pregnancies)
- A stillbirth or neonatal death
- A small-for-gestational-age infant (less than fifth centile)
- A large-for-gestational-age infant (greater than 95th centile)
- A baby weighing less than 2500g or more than 4500g
- A baby with a congenital anomaly (structural or chromosomal)

Women should be referred back to low risk community care after a consultant opinion whenever possible. This decision should be documented in the woman’s hand held notes and the woman advised by the antenatal clinic midwife when the appointment with the community midwife is required and how to arrange it.

**5.4.1 Migrant women medical history and clinical assessment**

During the booking appointment women have a full medical history taken and a clinical assessment of their overall health is made, if risks are identified they are referred to a Consultant Obstetrician. An interpreter is booked and is present at the booking appointment if required.

An interpreter should be arranged for women who who have communication or language support needs inline with:
NHS Croydon Interpreting Services Guide for Staff – 2010

**5.5 Booking bloods & results**

Booking bloods are taken following counselling and discussion. These include: FBC and electrophoresis for major Haemoglobinopathies, blood group and Rh status (including atypical antibodies), Hep B and HIV, Rubella and syphilis see Appendix C

Following the booking appointment the pregnancy notes are taken to the ANC, the blood results are accessed and entered into the pregnancy notes.
The notes are returned to the woman at the early ultrasound scan.
If the woman books late (after 12+6 weeks) or for Women that decline USS will have their notes returned to them by the Community team responsible for her care.

16 week appointment

- Review, discuss and ensure bloods and scan results are entered in the notes, taking appropriate action if abnormal
- Discuss anti-D prophylaxis with RhD neg women.

5.6 Screening tests

Discuss the Screening tests - and ask the woman to contact the team if she doesn’t receive an appointment for the combined screening for Down’s syndrome between 11-14+1 weeks or the anomaly scan between 20-22 weeks. Women booking between 14+2 -20 weeks gestation should be offered the quadruple test as a screen for Down’s syndrome. Women that transfer their care from another unit must have all of their screening bloods repeated in this unit even if already taken at a another unit.

5.7 Plan of Care & referral

A plan of care is discussed, agreed with the woman including the frequency of appointments and type of care, this is documented in the hand held notes. The Midwifery Team Contact details and the hospital contact details are included on the hand held pregnancy notes. Women are responsible for their own notes and are asked to bring them to all appointments. The woman is advised about the likely length of stay in hospital after delivery, 2 -6 Hours following normal birth and 24 hours to 3 days following caesarean section.

When the information is correlated the Midwife should assess the woman’s risk and make the appropriate referrals e.g. Consultant Obstetrician; Psychiatric referrals; Anaesthetic; Dietician referral. Identify women at risk are referred as appropriate e.g. Maple clinic, FGM. The appropriate forms are completed in line with Clinical Risk Assessment (Antenatal) 2012.

5.8 Health Records

- When risk factors are identified, either when the notification or pregnancy is screened by the midwife or at the booking appointment, the midwife will identify those women whose medical records from previous pregnancies will require review by a clinician and refer them for an appointment at the hospital antenatal clinic.
- Following referral the medical notes are obtained for all women who have had a previous pregnancy at Croydon University Hospital from the Health Records Department and filed in alphabetical order in the clerk’s office in the Antenatal Clinic until the woman has given birth.
- The medical records are available for all hospital appointments. The medical records must be collected from the ANC clerk’s office for all women admitted to the Maternity Unit during the antenatal period or in labour. This is undertaken by the ward clerk for the area of admission during the daytime. At the weekend or during the night a Health Care Assistant will go to the ANC and collect the records. A member of staff from the Security team, tel: 3333 must be asked to ensure that the alarm to the ANC has been deactivated first and accompany the HCA to the ANC.
- Where a woman has delivered at another Trust, the Consultant will write to the previous Trust requesting a copy of the notes from the previous Trust if required.

6 TRAINING

Staff who are orientating to the community receive an orientation period and are given a welcome pack. This includes information on how to access relevant policy for the booking
appointment. Team leader are responsible for the orientation of new staff and the contents of
the welcome pack.

Newly ratified guidelines are uploaded to the intranet, staff are informed of this via the
departmental newsletter. All staff have the responsibility to ensure awareness of the contents of
the guideline.

Staff have the responsibility to inform their line manager of any training needs which may affect
their ability to follow this guideline

**Equality Impact Assessment**

The Equality Impact Assessment for this policy is attached in Appendix A.
7 MONITORING COMPLIANCE

In order to monitor compliance the guideline will be audited in line with the Key Performance Indicators identified in the NHS Litigation Authority CNST Maternity Standards

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
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</thead>
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<tr>
<td>a. responsibilities of relevant staff groups</td>
<td>Clinical Midwifery Manager Out-Patients</td>
<td>A single audit tool will be used to capture the key elements of this policy</td>
<td>An annual audit of the key elements to be monitored will be carried out</td>
<td>The audit report will be submitted to the Maternity Quality Board meeting.</td>
<td>The lead for any necessary action planning will be identified and actions will be agreed at the Maternity Quality Board meeting. The action plan will specify the time frame and will be monitored at the maternity quality board meetings.</td>
<td>Required changes in practice will be identified and implemented. Changes will be shared both internally and externally where appropriate.</td>
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<td>b. process for ensuring that women have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy</td>
<td></td>
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</tr>
<tr>
<td>c. process for ensuring that women who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral</td>
<td></td>
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</tr>
<tr>
<td>d. process for ensuring that migrant women who have not previously had a full medical examination in the United Kingdom have a medical history taken and clinical assessment made of their overall health, using an interpreter if necessary</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>e. process for identifying for which women health records from previous pregnancies are required for review by clinicians</td>
<td></td>
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<tr>
<td>f. process for arranging the availability of health records for women for which health records from previous pregnancies are required for review by clinicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8 REFERENCES


9 ASSOCIATED DOCUMENTATION

- Patient Information & discussion Maternity Guideline
- Missed Appointments Maternity Guideline
- Antenatal Screening & communication of results Maternity Guideline
- Mental Health Maternity Guideline
- Women who refuse blood or blood products Maternity Guideline
- Obesity in pregnancy Maternity Guideline
- Venous Thromboembolism Maternity guideline
- Clinical Risk assessment Antenatal Maternity Guideline

10 VERSION HISTORY TABLE

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Ratified by</th>
<th>Comment/Reason for change</th>
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<tr>
<td>1.0</td>
<td>May 2009</td>
<td>Mary Fosbrook</td>
<td>Maternity QB</td>
<td>New Document</td>
</tr>
<tr>
<td>2.0</td>
<td>June 2012</td>
<td>Karen Zedgitt</td>
<td>Chair’s Action</td>
<td>Updated guideline in line with NHSLA standards and Trust format</td>
</tr>
<tr>
<td>2.1</td>
<td>Jan 2013</td>
<td>Karen Zedgitt</td>
<td>Chair’s Action</td>
<td>Monitoring section revised</td>
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<tr>
<td>2.2</td>
<td>February 2014</td>
<td>Karen Rooke</td>
<td>Maternity QB</td>
<td>Women that transfer their care from another unit must have all of their screening bloods repeated in this unit even if already taken at another unit</td>
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APPENDIX A – EQUALITY IMPACT ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6. What alternative are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Maternity Risk Manager, 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 the Maternity Risk Manager bleep 354.
APPENDIX B – CONSULTATION TEMPLATE.

1. Procedural Document’s Name: Booking Procedure
2. Procedural Document Author: Mary Fosbrook
3. Group/Committee Consulted: Midwives and Obstetricians
4. Date of Consultation: 5/2/14
5. Comments Received:
   Reviewed by
   Community midwife Team Leaders
   Clinical midwifery Manager Outpatients
   Maternity P&G
   5/2/14 Maternity P&G group happy with addition

6. Highlight where policy changed following consultation or state reasoning why comments not incorporated:
APPENDIX C - ANTENATAL SCREENING BLOOD TESTS.

All women should be offered screening for the following blood tests at booking.

<table>
<thead>
<tr>
<th>Stage of Pregnancy</th>
<th>Type of Test</th>
<th>Blood Bottle</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Booking</td>
<td>Full blood count</td>
<td>Purple</td>
</tr>
<tr>
<td></td>
<td>Haemoglobinopathies</td>
<td>Purple</td>
</tr>
<tr>
<td></td>
<td>Blood Group and RhD status, Atypical red cell alloantibodies</td>
<td>Pink</td>
</tr>
<tr>
<td></td>
<td>HIV Infection</td>
<td>Yellow</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Virus</td>
<td>Yellow</td>
</tr>
<tr>
<td></td>
<td>Rubella susceptibility Syphilis</td>
<td>Yellow</td>
</tr>
</tbody>
</table>

All women should be offered screening for the following blood test at 28 weeks gestation.

| At 28 Weeks       | Full blood count                                      | Purple       |
|                   | Blood Group and RhD status, Atypical red cell antibodies | Pink        |
**APPENDIX D - ANTENATAL CARE PATHWAY FOR LOW RISK WOMEN**

<table>
<thead>
<tr>
<th>On confirmation</th>
<th>G.P. / M.W</th>
<th>Assessment of risk factors. Identify women who need additional care. Booking referral letter completed and sent to Croydon University Hospital ANC. Folic acid / Vitamin D advice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booking 8 - 10 WEEKS</td>
<td>Midwife</td>
<td>History &amp; 1st Antenatal blood tests See appendix C. Calculate BMI. Discussion and advice for pregnancy. Discuss plan of care and place of Birth options with the woman. Discuss antenatal screening tests. Complete AN risk assessments &amp; VTE risk assessment, arrange necessary referral if risks identified</td>
</tr>
<tr>
<td>11- 14+1 WEEKS</td>
<td>Dating scan/ Combined screening</td>
<td>If a woman books after 14+1 weeks gestation discuss further screening i.e. arrange an ultrasound dating scan and offer Quadruple test 14+2 to 20 week’s gestation.</td>
</tr>
<tr>
<td>14-16 WEEKS</td>
<td>Midwife.</td>
<td>Confirm EDD. Review scan and check blood results. Confirm 20-22 week anomaly scan appointment. Ensure blood results are filed in the woman’s antenatal notes.</td>
</tr>
<tr>
<td>20-22 WEEKS</td>
<td>Anomaly scan.</td>
<td>If abnormal appropriate consultant referral will be made by the Ultra sonographer.</td>
</tr>
<tr>
<td>25 WEEKS</td>
<td>Primips only</td>
<td>Antenatal assessment Measure and record symphysis-fundal height in cms at each antenatal visit.</td>
</tr>
<tr>
<td>28 WEEKS</td>
<td>Midwife.</td>
<td>2nd antenatal blood tests for full blood count blood group antibody screen before anti-D 1500IU given if woman is RhD neg (blood tests should be taken at hospital where the woman has booked for delivery) Repeat An risk assessment. Confirm woman has booked preparation for birth classes. Complete MAT B1 form if not already done. Measure SFH.</td>
</tr>
<tr>
<td>31 WEEKS</td>
<td>Primips only</td>
<td>GP. Review blood results, antenatal assessment Measure SFH. Please file all blood results in the woman’s antenatal notes.</td>
</tr>
<tr>
<td>36 WEEKS</td>
<td>GP.</td>
<td>Antenatal assessment Measure SFH. Refer suspected Malpresentation to FAU.</td>
</tr>
<tr>
<td>38 WEEKS</td>
<td>Midwife</td>
<td>Antenatal assessment. Measure SFH. Repeat An risk &amp; VTE risk assessment.</td>
</tr>
<tr>
<td>40 WEEKS</td>
<td>GP/M.W.</td>
<td>Primips only. Antenatal assessment. Offer membrane sweep and induction of labour by 41 + 5 weeks.</td>
</tr>
<tr>
<td>41 WEEKS</td>
<td>Midwife</td>
<td>Offer membrane sweep to all women. Book induction of labour for 41 + 5 weeks gestation.</td>
</tr>
</tbody>
</table>