

Booking and Antenatal Care, including the Management of Non-Attendance to Antenatal Appointments

Key Points

- Women with identified medical, gynaecological or obstetric risk factors will have input from the multi-disciplinary teams to ensure that all aspects of maternal and fetal conditions are managed in combination with the most appropriate professional.
- At each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, providing women with the opportunity to discuss issues and ask questions in order to facilitate informed choice and decisions.

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**This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition.
Print copies must be destroyed after use.**

Abbreviations

AN	Antenatal
ANC	Antenatal clinic
CAL	Community Advice Line
DNA	Did Not Attend. Refers to pregnant women who miss any antenatal appointment
EDD	Expected date of delivery
GP	General practitioner
GTT	Glucose tolerance test
HV	Health visitor
ICE	Integrated Clinical Environment (pathology requesting and reporting system)
IOL	Induction of labour
IUGR	Intra uterine growth restriction
MAC	Maternity Assessment Centre

Contents

1. Purpose of the guideline	4
2. Responsibilities of relevant groups	4
3. Process for ensuring that women have their first full booking visit and maternity hand-held notes completed by ten completed weeks of pregnancy	5
4. Process for ensuring that women who on referral to the maternity unit are already ten weeks or more pregnant are seen within two weeks of the referral	6
5. Taking a booking history.....	6
6. Management of Non-Attendance to Antenatal Appointments.....	9
7. Implementation plan	12
8. Monitoring Compliance of Guideline.....	12
9. References.....	13
Appendix 1: Schedule of Antenatal Care	15
Appendix 2: Criteria used to identify women who should be referred to consultant led care.....	20
Appendix 3: SOP Clinical process for women who request to give birth at Wexham Park Hospital outside of our geographical area.....	26
Appendix 4: SOP Clinical process for women who request to give birth at Frimley Park Hospital outside of our geographical area.....	31
Appendix 5: Non-Attendance Letter	33
Appendix 6: Caseload Tracking / Audit Folder sheet.....	34
Appendix 7: Transfer of Care from Frimley Park Maternity Service	35
Appendix 8: Transfer of Care from Wexham Park Maternity Service	36
Full version control record	38

1. PURPOSE OF THE GUIDELINE

- 1.1. This guideline is designed to support the electronic patient record.
- 1.2. Pregnant women need to be seen for their first antenatal booking ideally between 8 – 9 weeks enabling them to have a first trimester scan if they choose to do so which is carried out between 11⁺² weeks and 14⁺¹ weeks (www.nice.org.uk), and to carry out Thalassaemia and Sickle cell screening and all booking bloods and baseline MSU before 9⁺⁶ weeks gestation. Culture positive MSU samples, even in symptom-free pregnant women (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 referral to an obstetrician.
- 1.3. The purpose of this guideline is to illustrate that the maternity service has approved documentation which describes a process for ensuring that women have their first full booking visit and risk assessment documented in their electronic records in line with appropriate timescales, and also that those women who miss antenatal appointments are followed up appropriately.
- 1.4. Women with identified medical, gynaecological or obstetric risk factors will have input from the multi-disciplinary teams to ensure that all aspects of maternal and fetal conditions are managed in combination with the most appropriate professional. A named consultant should be clearly identified for these women.
- 1.5. It has been established that vulnerable women are far less likely to seek antenatal care early in pregnancy or to stay in regular contact with maternity services (MBRRACE-UK Saving Lives, Improving Mothers' Care, 2022) therefore it is important that the service has a system in place to monitor these women.
- 1.6. At each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, providing women with the opportunity to discuss issues and ask questions in order to facilitate informed decisions and choices.
- 1.7. Each antenatal appointment includes an assessment of the woman and her pregnancy at the said gestation to determine if any of her risk factors are changed and if referral to any other clinician/service is required.
- 1.8. At each antenatal appointment the intended place of birth needs to be discussed.

2. RESPONSIBILITIES OF RELEVANT GROUPS

2.1. The midwife

- 2.1.1. Midwives are the experts in normality. They are responsible for taking a detailed history at the booking appointment and then referring the woman to be seen by the obstetrician if any risk factors are identified as part of this assessment. An interpreter must be used for a woman whose first language is not English or have a sensory impairment.
- 2.1.2. It is the midwife's responsibility to ensure that, once women have accessed the maternity services, they are seen promptly and that the booking is carried out before 10 weeks of pregnancy. Where a woman is already 10 weeks or more pregnant, it is the midwife's responsibility to ensure that she is seen for the booking appointment within two weeks of making contact. Once booked, the woman will receive details via the My Frimley Health Record app and she can also contact the midwife via the same app.
- 2.1.3. When a woman moves or wishes to change hospital, she must be informed that it is her responsibility to contact a maternity unit; Frimley Health is responsible for contacting her

chosen unit/hospital by sending the transfer of care letter on Appendix 7 for FPH and Appendix 8 for WPH. If there is safeguarding involvement, the community midwife must contact the current social worker to inform the service that the woman has requested her maternity care be transferred. This information must be documented in full on the EPR (electronic patient record).

2.2. Clerical staff in the community midwives' office

2.3. Antenatal Clinic Clerical staff are responsible for passing on the message to the relevant community midwife if a woman has contacted them seeking a booking appointment. If the midwife is unavailable the clerical staff must inform the team leader so that an appointment can be arranged to see an alternative midwife.

2.4. The obstetrician

2.4.1. The obstetrician is responsible for writing a clear plan of care in the woman's health record when she has been referred for shared care/consultant opinion. This plan must also be discussed with the woman.

2.4.2. When a woman is referred back to community care it is the obstetrician's responsibility to clearly document this in her electronic patient record, discuss this plan with her and also advise her when to next see her midwife.

2.5. The GP

2.5.1. The GP has a responsibility to advise a pregnant woman to see a midwife for antenatal booking before their 10th week of pregnancy.

2.6. Women

2.6.1. Women are responsible for their own health and for accessing medical and midwifery care as soon as they become aware of their pregnancy; ideally an appointment must be made to see the midwife before their 10th week of pregnancy.

2.6.2. Women are responsible for accessing care if they move or choose to have their care at another unit/hospital. It is expected that they would inform their Frimley health community midwife so the transfer of care letter can be sent to the provider specified.

3. PROCESS FOR ENSURING THAT WOMEN HAVE THEIR FIRST FULL BOOKING VISIT AND MATERNITY HAND-HELD NOTES COMPLETED BY TEN COMPLETED WEEKS OF PREGNANCY

3.1. Women can access antenatal care in any of the following ways:

- See a GP who will advise the woman to complete the online registration form on Frimley Health website at <https://www.frimleyhealthandcare.org.uk/maternity>. GPs and surgery reception staff are aware of the need to book an appointment to see a midwife before the 10th completed week of pregnancy.
- Women will be directed to the Frimley maternity website, they will be advised to complete the notification of pregnancy form (NOP) by their GP surgery. This form will be collated by the maternity admin staff and sent to the appropriate community team. The community team will contact the lady within 10 working days of the NOP being completed. These appointments are completed by their named midwifery team within the maternity hub. Each GP surgery is linked to a specific maternity hub. If there are insufficient slots available, the midwife concerned should be informed in order for alternative arrangements to be made – the midwifery team fit in extra bookings at drop-in clinic or hub or occasionally in the woman's home as

necessary. Direct access to a midwife is promoted to women via posters placed on display in GP surgeries (which stress the importance of booking before 10 weeks gestation), communication with other healthcare professionals such as HV, or information on the Maternity Unit section of the hospital website:

<https://www.frimleyhealthandcare.org.uk/maternity>

- Every woman that wishes to access maternity services at Frimley Health should be advised to complete the online registration form.

- 3.2. The booking appointment can be undertaken at the hub or woman's home (rarely) to ensure that the appointment takes place before the 10th completed week of pregnancy.

4. PROCESS FOR ENSURING THAT WOMEN WHO ON REFERRAL TO THE MATERNITY UNIT ARE ALREADY TEN WEEKS OR MORE PREGNANT ARE SEEN WITHIN TWO WEEKS OF THE REFERRAL

- 4.1. If, on referral to the maternity services, the woman is already more than 10 weeks gestation, she must be seen within 2 weeks of the referral, either by the community midwife:
 - Adding the booking appointment onto an already established clinic,
 - Arranging to see the woman at home or in the overflow booking clinic or hub.
- 4.2. The community midwife must detail a reason for late booking onto the relevant electronic maternity information system for any woman booking to deliver within the trust who is more than 12⁺⁶ weeks of pregnancy – the reasons are collated by the community midwife matron who monitors compliance and any need for adjustments to the service in order to facilitate additional booking appointment provision.
- 4.3. All women booking after 20 weeks gestation that have received no previous care must be referred for consultant-led care and an appointment made in the Antenatal Clinic (see Appendix 1) for a consultant appointment. Follow the concealed pregnancy multiagency guidance on the intranet.

5. TAKING A BOOKING HISTORY

- 5.1. A full and accurate history must be taken, entering all information requested onto the electronic patient record.
- 5.2. Antenatal clinic staff will manage the referrals coming into the ANC basket on EPIC.
- 5.3. Women should be offered a combined test which screens for Down's Syndrome (Trisomy 21), Patau's Syndrome (Trisomy 13) and Edwards Syndrome (Trisomy 18), consisting of a nuchal fold scan followed by a blood test. This will be ordered by the community midwife on EPIC and the blood form generated should be available for the phlebotomist to release from EPIC after the scan appointment. FPH women will receive a written result letter directly from the Oxford screening lab. WPH women will see an updated scan report in their My Frimley App. Scan sites available include: Wexham Park Hospital, St. Marks Hospital, Heatherwood Hospital, or King Edward VII Hospital for WPH; and Frimley Park Hospital or Aldershot Centre for Health for FPH. See antenatal and newborn screening guideline.

- 5.4. It is the responsibility of the midwife booking the woman to ensure she is fully informed of all antenatal screening tests. Consent or decline must be clearly documented in the EPIC record and where applicable on the EPIC Order. The midwife must ensure that the woman has a scan and combined screening blood test order completed on EPIC and all women should be supported to download the 'Screening Tests for you and your baby' link and save to their phone's home screen as an ongoing resource. Full explanation and consent must also be documented for sickle cell and thalassaemia screening and infectious disease screening, HIV, Hepatitis B and Syphilis. Any woman booking and informing the midwife that she is a carrier of unusual haemoglobin or is HIV, Hepatitis B or Syphilis positive should be referred directly to the screening team, but all bloods should still be completed. Information must be given regarding the routine blood tests: Full Blood Count, Blood Group and Antibodies. All community teams should have a process in place to ensure all screening requested has been completed. For infectious disease and sickle and thalassaemia screening this needs to be completed within 10 days of the bloods being sent. Any unreported screens identified should be investigated immediately and if any repeats are required these must be completed within a further 10 days. Community midwives should document on the EPIC Booking blood flow sheet to aid this important check. The booking blood flow sheet should be fully completed at the 16-week appointment.
- 5.5. Women who transfer care from other units must complete the pregnancy notification form. Midwives must ensure that copies of any maternity notes from other units are available. Midwives must book the woman on to the relevant electronic patient record and a full set of booking bloods should be taken so that results are available on Trust electronic patient record system which includes all tests and results. Midwives must contact the previous hospital to ask about any safeguarding concerns.
- 5.6. Women who are too late for Combined Screening will be offered Quadruple test screening. Quadruple test can be carried out between 14⁺¹ weeks and 20 weeks gestation but can only screen for Down's syndrome.
- 5.7. In the event of a high chance combined or quadruple screening result, see the antenatal screening guideline.
- 5.8. At booking women younger than 25 years should be informed about the high prevalence of Chlamydia infection in their age group. Packs are available at each hub/surgery to be given to women for self-testing.
- 5.9. The community team will check the results from the community team basket/pool within 10 days and update the woman's EPR immediately, managing any abnormalities appropriately. It is the responsibility of the midwife checking the results to ensure repeat testing is arranged and completed for anything outstanding as soon as possible.
- 5.10. A Glucose Tolerance Test (GTT) should only be performed on women who fit the criteria for screening (see Diabetes in pregnancy guideline and the relevant section of the maternity electronic records).
- 5.11. The electronic patient record must be completed so that risk factors for pre-eclampsia and FGR are determined, and care planned appropriately. Aspirin 150mg daily should be advised for women with 1 high or 2 moderate risk factors (See APPENDIX 9). Aspirin is kept in all hubs and will be given by the midwife. Women should be advised of the contraindications.
- 5.12. Contraindications to Aspirin: Those with known aspirin allergy (e.g., urticaria) or hypersensitivity to other salicylates and NSAIDS at risk of anaphylaxis. Aspirin should be

avoided in asthmatics with a history of aspirin-induced acute bronchospasm and those with nasal polyps as it may result in life-threatening bronchoconstriction.

Relative contraindications: Gastrointestinal bleeding, active peptic ulcer disease, other sources of gastrointestinal or genitourinary bleeding, and severe hepatic dysfunction. Use with caution. The decision to continue low-dose aspirin in the presence of obstetric bleeding or risk factors for obstetric bleeding should be considered on a case-by-case basis.

- 5.13. Dietary advice should be given including foods to avoid in pregnancy, this is available on the website <https://www.frimleyhealthandcare.org.uk/maternity/> and included in the information section of the handheld notes. Pregnant women should be advised to take 10 micrograms of Vitamin D daily.
- 5.14. Other lifestyle considerations are available on the website <https://www.frimleyhealthandcare.org.uk/maternity/> including folic acid, nutritional supplements, working during pregnancy, emotional changes, medicines, exercise, alcohol and smoking during pregnancy.
- 5.15. Offer personalised information, advice and support on how to stop smoking (Very brief advice- VBA). Encourage pregnant women to use local NHS stop smoking services and complete a referral for every pregnant woman who smokes, whether they agree to access stop smoking services or not. CO monitoring and documentation of smoking status should take place at booking, 36 weeks and at each encounter for smokers. Nicotine replacement therapy should be offered and when accepted, a 2 week supply of NRT should be provided. This should include a long acting patch and a short acting product. Refer to guideline for Nicotine replacement therapy (NRT). Pregnant women should be advised to wear the patch for 16 hours and remove the patch at night.
- 5.16. The midwife will discuss the electronic patient record and the choices and pattern of care appropriate for the woman.
- 5.17. Antenatal education must be discussed, and information given to the woman – antenatal education is available online on the Trust website <https://www.frimleyhealthandcare.org.uk/maternity/>.
- 5.18. Women should be offered an infant feeding conversation, according to their individual needs, between 28-34 weeks of gestation. This discussion should include connecting with the baby during pregnancy, health benefits of breastfeeding, the benefits of skin-to-skin and responsive feeding once baby is born. Women should be signposted to the Baby Friendly Initiative (BFI) website for further information on relationship building and feeding.
- 5.19. In the case of previous late miscarriage, stillbirth or neonatal death, the midwife will discuss with the woman the use of the SANDS 'flag' on EPIC - use as appropriate.
- 5.20. If referral to social services is required, the midwife will complete the referral form for the appropriate area, document in EPIC under a safeguarding note that a referral has been sent, and document in a safeguarding note the name and contact details of the social worker once known. They must complete a 'safeguarding assessment' form for the mother of the unborn and this will automatically be sent to the safeguarding midwifery team. They must then save this as a PDF and share with their Team Leaders, the GP and the HV.
- 5.21. Referral must be made to the vulnerable women team in the case of teenage pregnancy, substance misuse, homelessness, mental health issues and victims of domestic abuse (refer to the relevant guidelines/policy: substance misuse in pregnancy, perinatal mental

health and domestic abuse policy). This may be for information only if the woman would prefer to continue her care with the community midwife (WPH only). At FPH, women continue their care under their normal community midwife.

- 5.22. If there are any suspected or known safeguarding issues, then the midwife must complete a safeguarding assessment via EPIC which is sent to safeguarding.
- 5.23. Midwife to inform the HV of pregnancy via email and share the EPIC generated booking details (we are currently sharing the PDF of the booking form).
- 5.24. The community midwife must ensure that their name is documented in the electronic patient record as the named midwife and a contact number given for those deemed as vulnerable. EPIC messaging is the preferred contact method for non-urgent issues.
- 5.25. For referral criteria for consultant led care, see Appendix 2. The named consultant should be clearly identified and documented in the woman's EPIC profile.
- 5.26. **A risk assessment for the level of care will be carried out and documented at every appointment to check that it is appropriate in view of the progress of the pregnancy (Ockenden Report 2020), and the schedule of care discussed with the woman, see Appendix 1. The schedule of care is sent to the women via a return email once the notification of pregnancy has been entered. This is in the form of a link to the maternity website.**
- 5.27. **Trust approved SMART phrases will be used within the documentation for AN and PN care.**

6. MANAGEMENT OF NON-ATTENDANCE TO ANTENATAL APPOINTMENTS

6.1 Roles and Responsibilities

All healthcare professionals involved in maternity care have a responsibility to ensure that pregnant women are provided with every opportunity to receive routine antenatal care. The NICE Guidelines for Routine Antenatal Care 2020 recommend that antenatal care is to be provided by a small group of health professionals, providing 10 antenatal appointments for a primigravid woman and 7-9 antenatal appointments for a multiparous woman. Obstetricians and specialists must be involved where additional care is needed and will provide additional antenatal appointments according to the individual needs of the woman.

- 6.1.1 The antenatal clinic clerks and midwives are responsible for responding to a woman who DNAs and to give the woman another opportunity to attend for antenatal care to ensure that a safe and appropriate pathway of care is offered to all women.

Please note: All remote contacts and ATTEMPTED contact with the woman must be recorded on EPIC.

- 6.1.2 The Antenatal Clinic clerks and midwives will:

- Ascertain whether a pregnancy is ongoing by checking EPIC. If the pregnancy has ended or the woman has moved out of the area, then the records will be updated, episode archived, and no further appointments will be made.
- Clerks inform antenatal clinic midwives of all women who DNA appointments.

- If the pregnancy is ongoing, then a further appointment is arranged for the woman via the app. If there is a known medical complication, e.g., diabetes, then attempt will be made to contact the woman by telephone.
- If the woman does not attend a total of two appointments, then the antenatal clinic midwives will inform the relevant community midwife by email and cc to the generic team email address. The woman will also be contacted directly by the ANC midwives.
- The community midwife is asked to make direct contact with the woman to ascertain the reason for non-attendance, and to ensure appointment is rearranged. This will be communicated to the midwife in the antenatal clinic.
- All hospital DNAs are recorded on EPIC.
- Women living out of area – ANC midwife (Kingfisher Team Midwife in WPH, if MLC) to contact maternity unit of woman's local hospital to inform them of DNA
- If the woman does not attend the 12 week or 20 week ultrasound scan, the screening team will follow the relevant DNA process for screening.

6.2 Maternity Assessment Centre or Day Assessment / Triage (MAC/Triage)

Midwives are responsible for responding to a woman who DNA and to give the woman another opportunity to attend for antenatal care to ensure that a safe and appropriate pathway of care is offered to all women.

- Ascertain whether a pregnancy is ongoing by checking on EPIC. If the pregnancy has ended or the woman has moved out of the area, then the records will be updated and no further appointments will be made.
- Midwife will call women who DNA. If the pregnancy is ongoing then a further appointment is made.
- If unable to contact the woman, the community midwife is asked to make direct contact with her to ascertain the reason for non-attendance, and to rearrange an appointment.
- If a woman has DNA a time-critical appointment, it may be necessary for the on-call CMW to attend the woman's home out of hours, arranged via liaison with the on-call community midwife. During normal office hours the woman's CMW should be contacted.
- Women living out of area – midwife to contact woman's local hospital to inform them of DNA.

6.3 The Community Midwife is responsible for responding to a woman who DNAs and to give her another opportunity to attend for antenatal care to ensure a safe and appropriate pathway of care.

Caseload Tracking / Audit Folder: All CMWs track their caseloads with the use of MS teams or Excel spreadsheets (Appendix 6). The community midwife will check the caseload after each clinic to confirm attendance.

If the pregnancy is ongoing and the woman remains resident in the area, the community midwife will:

- Ascertain whether a pregnancy is ongoing by checking on Trust applications. If the pregnancy has ended or the woman has moved out of the area, then the records will be updated and no further appointments will be arranged.
- Telephone all non-attendees of community antenatal appointments to arrange another appointment. Document attempted contacts on EPIC.
- DNAs will be recorded on EPIC. The DNA process should be followed for the women identified.
- If a telephone contact is not possible, a letter will be hand-delivered to the woman's home address (Appendix 5).
- If a woman does not attend for a second time, the community midwife will re-visit the woman's home address to ascertain the reason for the DNA.
- If unsuccessful in making contact, the Community Midwife will document this on EPIC. Women who DNA on two consecutive occasions will be referred to the Safeguarding midwife and a referral to the Health Visitor will be completed.
- Refer women who do not comply with the antenatal schedule of care to social care as appropriate and inform safeguarding lead midwife.
- The CMW will inform and regularly update the community team leader.

6.4 The Named Midwife for Safeguarding is responsible for ensuring that all families known to have safeguarding concerns do not fall through the gaps in service provision, and for ensuring that a safe and effective pathway of care is offered to these women. The Named Midwife for Safeguarding has a close link with the Trust Safeguarding Children's Team and has an advisory role within the community team with regard to women that DNA. The Named Midwife for Safeguarding will:

- Provide support and advice to the Community Midwife.

7. IMPLEMENTATION PLAN

7.1. This guideline will be implemented as follows:

- Guidelines are approved locally at Obstetric Clinical Governance Group, the minutes of which are available on the maternity shared drive and Trust intranet.
- The guideline will be placed on the Trust intranet for viewing by any member of staff.

8. MONITORING COMPLIANCE OF GUIDELINE

8.1. The details of all women booked after 10 completed weeks gestation are collected electronically and are available for audit purposes. Monthly figures are collated from the clinical data system which identify gestational age at booking and late bookers. The

numbers of late bookings form part of the Key Performance Indicators which are presented to the quarterly screening board and community team leaders.

- 8.2. The community matron also collects the figures provided by community midwives which reflect whether women who on referral to the maternity unit are already 10 weeks or more pregnant are seen within two weeks of the referral.
- 8.3. These figures are collated by the community matron and forwarded to the Head of Midwifery and screening co-ordinator; the benchmark is also held as part of the statistics on the service outcomes as part of the Maternity Clinical Dashboard.
- 8.4. The screening co-ordinator in conjunction with the Head of Midwifery will highlight any shortfalls in the desired benchmark and make recommendations and an action plan.
- 8.5. Any action plans will be taken to the antenatal screening board and progress will be reviewed by Head of Midwifery on a quarterly basis, and any recommendations are forwarded to the cross site clinical governance group.
- 8.6. Monitoring will be carried out during the monthly documentation audit of notes and through the RL6 incident reporting system.

9. REFERENCES

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APPENDIX 1: SCHEDULE OF ANTENATAL CARE

6-10 weeks	All women	<u>The following information will be provided:</u> The NHS UK National Screening Committee information booklet: 'Screening Tests for your and baby' Advise on how to download the NHS Pregnancy Book from NHS website. Discuss and advise folic acid prophylaxis & vitamin D supplements. Provide named midwife contact information. Arrange booking appointment before 10 weeks. For women already 12 weeks or over they MUST be seen by a midwife within 2 weeks of referral Determine midwife or consultant led care pathway and complete referral as necessary. Generate customised growth chart on GROW 2.0 (linked to EPIC) Discuss the use of the personalised care app. Online FW8 Determine risk factors for gestational diabetes and PET. Determine risk factors for thromboembolism and immediate referral to ANC for an obstetric appointment if high risk for anti-coagulation therapy. Organise combined screening [if requested] Discuss: CO screening for all women Ask and document smoking status. Provide VBA, Offer referral to stop smoking services and NRT for women who smoke Healthy lifestyle, diet, food hygiene including reducing the risk of food acquired infection, exercise, screening and local services. High BMI over 30-5mg folic acid daily to be prescribed by GP- signpost to the 'Risk of obesity' leaflet. Well-being to include, mental health and social circumstances (core services). Place of birth and birth choices, offer homebirth if low risk. Signpost to the 'Off to the best start' leaflet. Clinical Examination to include as minimum: BP*, urinalysis, weight, BMI, Take Screening bloods with informed consent [Including full blood count, Haemoglobinopathy screen, blood group/rhesus/antibodies, Hepatitis B, HIV and syphilis] *All blood pressures readings should be recorded using a digital monitor that is validated for use in pregnancy. Women aged under 25 years should be offered screening for Chlamydia. From 12 weeks Aspirin 150mg daily should be advised for women with 1 high or 2 moderate risk factors on the booking risk assessment (APPENDIX 9)
Midwife		

		Undertake a risk assessment of the pregnancy and determine that correct care pathway is followed. Make appropriate referrals according to risk assessment. As part of the risk assessment, blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy. Send MSU sample
16 weeks Midwife	All women	B/P, urine check, abdominal palpation and fetal heart. CO monitoring for smokers. Discuss well-being to include, mental health and social circumstances (core services). Quadruple Test if required (request on EPIC) – if Combined Screening not completed. Discuss anomaly scan - confirm appointment made if relevant. Discuss health in pregnancy and signs and symptoms of PET, and ensure women know when and how to contact GP/midwife. Ensure booking blood results are discussed and recorded. Take blood for cell free fetal DNA in rhesus negative women: https://ourplace.xfph-tr.nhs.uk/media/20476/blood-transfusion-policy-for-adults-with-related-guidelines.pdf Advise women to make next appointment with midwife (at 25 weeks for primips, 28 weeks for multips) for antenatal check. Book GTT if required (GTT needs to be completed by 27+6 weeks) Discuss intended place of birth. Discuss the use of the personalised care app. Discuss MAMAS line and provide contact details. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
25 weeks GP or MW	Primips only	Screen for Pre-eclampsia: B/P, urine check, oedema CO monitoring for smokers. Record and discuss movements, signpost to information on the website. Record fetal heart. Discuss well-being to include, mental health and social circumstances (core services). Ensure Quadruple test/ and anomaly scan results are on EPIC. Mat. B1 Certificate if appropriate. Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.

28 weeks Midwife	All women	Screen for Pre-eclampsia: B/P, urine check, oedema CO monitoring for smokers. Monitor for IUGR: measure, record and plot fundal height on customised growth chart. Abdominal palpation: record presentation. Record fetal heart and movements. Reduced fetal movements information leaflet to be provided to women via link to Frimley health website. Discuss feeding, document discussion. Take FBC and antibody screen, give Anti D 1500iu IM if required. Discuss well-being to include, mental health and social circumstances (core services) Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
31 weeks GP/MW	All women	Screen for Pre-eclampsia: B/P, urine check, oedema CO monitoring for smokers. Monitor for IUGR: measure, record and plot fundal height on customised growth chart. Abdominal palpation Record fetal heart and movements. Discuss well-being to include, mental health and social circumstances (core services). Ensure 28wk blood results are discussed and recorded. Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
34 weeks Midwife	All women	Screen for Pre-eclampsia: B/P, urine check, oedema. CO monitoring for smokers. Monitor for IUGR: measure, record and plot fundal height on customised growth chart. Abdominal palpation: record presentation and, if confirmed breech by presentation scan, refer to breech clinic if appropriate (WPH only) Record fetal heart and movements. Offer low risk women a home birth or the birth centre. Discuss well-being to include, mental health and social circumstances (core services).

		Discuss personalised care plan. Discuss intended place of birth. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
36 weeks Midwife	All women	Screen for Pre-eclampsia: B/P, urine check, oedema. CO monitoring for smokers. Smoking status enquiry and documented in EPR Monitor for IUGR: measure, record and plot fundal height on customised growth chart. Abdominal palpation: record presentation and fifths palpable Refer to breech clinic (WPH), refer for USS (FPH) if concerned about presentation. Record fetal heart and movements. Discuss well-being to include, mental health and social circumstances (core services) Discuss and record place of birth and birth preferences. Discuss onset of labour and ensure woman has contact numbers for advice and when labour begins. Repeat FBC if Hb was below 10.5g/dl at 28 weeks. CO monitoring. Discuss colostrum harvesting (to start at 37 weeks). Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
38 weeks GP	All women	Screen for Pre-eclampsia: B/P, urine check, oedema. CO monitoring for smokers. Monitor for IUGR: measure, record and plot fundal height on customised growth chart. Abdominal palpation: record presentation, fifths palpable and position. Record fetal heart and movements. Discuss well-being to include, mental health and social circumstances (core services). Discuss IOL options and explain stretch and sweep. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.

40 weeks Midwife	Primip	Screen for Pre-eclampsia: B/P, urine check, oedema. CO monitoring for smokers. Monitor for IUGR: measure, record and plot fundal height. Abdominal palpation: record presentation and fifths palpable. Record fetal heart and movements. Discuss well-being to include, mental health and social circumstances (core services). Discuss IOL options and explain stretch and sweep. Book IOL if required. Offer stretch and sweep for nulliparous women. Discuss onset of labour and ensure woman has contact numbers for the MAMAS line to gain advice for any concerns and when labour begins. Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.
41 weeks Midwife	All women	Screen for Pre-eclampsia: B/P, urine check, oedema Abdominal palpation: measure, record and plot fundal height, record presentation, fifths palpable and position. Record fetal heart and movements. Discuss well-being to include, mental health and social circumstances (core services). Offer stretch and sweep. Offer and book post-dates clinic if available. Discuss intended place of birth. Discuss the use of the personalised care app. Undertake a risk assessment of the pregnancy and review that correct care pathway is followed. Make appropriate referrals according to risk assessment.

APPENDIX 2: CRITERIA USED TO IDENTIFY WOMEN WHO SHOULD BE REFERRED TO CONSULTANT LED CARE.

Please continue to refer all CLC women at booking.

Criteria	Approximate target timescale for booking appointment	Consultant clinic
General		
Age over 40 at booking	32 weeks with USS	Any
Under 18 years old	Consultant after anomaly scan for plan due to risk of pre-term birth	Any
Women expecting 5 th or subsequent baby (Grand Multip)	32- 34 weeks	Any - Telephone consultation
Current substance misuse including women on treatment programme e.g., methadone and excess alcohol use.	After Anomaly scan but before 24 weeks.	WPH – Vulnerable clinic FPH – Any ANC to ensure referral to safeguarding has taken place
Declining blood/blood products	16-24 weeks	FPH- ATiHaem3 WPH - Antenatal Haematology clinic
BMI 35 and above @ booking (No other risk factors)	32 weeks with USS	Any
BMI 18.5 or below	Consultant after anomaly scan	Any
Concerns regarding Weight loss after booking – either from patient or health care professional	Referral to consultant once weight loss identified for plan	Any
High risk (Prev VTE, family history of thrombophilia)	By 12 weeks	Obstetric Haematology clinic
Cumulative risk for VTE of 4 or more	By 12 weeks	Any
3 or more risk factors for VTE (3 + risk factors in lower box of risk assessment)	By 28 weeks	Any
Multiple Pregnancy	See Multiple Pregnancy Pathway	MCDA –ANC with USS 16/40 DCDA – Any consultant with USS 24/40
Smoker in Pregnancy (at booking)	32/40 with USS & Consultant	Any
IVF pregnancy	24 weeks	Any
Low risk woman electing for Consultant Led Care	28-31 weeks	Any - Telephone consultation

Previous Obstetric History		
Previous Caesarean or Hysterotomy (Once seen by Obs cons, Refer to Consultant Midwife if require further discussion around mode of birth)	24-28 weeks for mode of birth assessment	Any
Previous Caesarean at Fully dilated	ASAP After nuchal translucency scan	Preterm Birth Clinic
Previous Stillbirth/Neonatal death	After Anomaly by 24/40	Any - Unless stated otherwise
Previous Fetal Abnormality	Refer to Screening for Triage	Refer to screening for Triage
Recurrent Miscarriage (3 or more consecutive)	14- 16 weeks	Telephone Consultation FPH – Any consultant WPH – Recurrent Miscarriage Specialist
Mid Trimester loss	ASAP After nuchal translucency scan	Preterm birth clinic
Previous Premature baby before 34 weeks or pre-term prelabour rupture of membranes before 34 weeks	ASAP After nuchal translucency scan	Preterm birth clinic
Expected fetal weight less than 10th centile	Refer to Fetal medicine	Fetal Medicine – to make plan for ongoing care.
Gap and grow shows previous SGA	32 weeks with USS	Any
Previous Shoulder dystocia requiring manoeuvres	24-28 weeks	Any
Previous Significant APH/PPH (More than 1000mls +/- Blood Transfusion)	24-28 weeks	Any
3 rd or 4 th degree tear	24-28 weeks	Lead consultant for 3 rd / 4 th degree tears
Previous Pregnancy induced hypertension PIH/PET CMW to advise 150mg OD Aspirin from 12/40 Please ensure U&E sent with booking bloods and uPCR sent alongside MSU CMW responsible for checking results. Any abnormal results to be forwarded to ANC.	Before 16 weeks with U&E's and PCR	Any consultant. For fetal medicine input if requiring delivery before 36 weeks

Previous Gynaecological History		
Pelvic floor repair/ Colposuspension	After anomaly by 24 weeks	Urogynae lead consultant
Untreated abnormal smear	14-16 weeks	Colposcopy consultant
Uterine abnormality	After anomaly, by 24 weeks	Any
Previous cervical cerclage	ASAP After nuchal translucency scan	Preterm Birth Clinic
Myomectomy	After anomaly before, by 24 weeks	Any Telephone consultation
Previous abdominal surgery	After anomaly, by 24 weeks	Any
Ovarian Cysts	After anomaly, by 24 weeks	Any
Fibroids	After anomaly scan. ANC to triage	Any
PCOS – On Metformin	Not for consultant led care	Stop metformin @ 14/40 GTT at 26/40
LLETZ or Cone Biopsy - LLETZ where >15mm depth removed or if the depth is unknown. >1 LLETZ procedure carried out or cone biopsy	ASAP After nuchal translucency scan	Pre-term birth clinic
Endometriosis	No appointment required	
FGM	After anomaly before, by 24 weeks	FGM lead consultant
History of trachelectomy (for cervical cancer)	ASAP After nuchal translucency scan	Pre-term birth clinic
Intrauterine adhesions (Ashermann's syndrome).	ASAP After nuchal translucency scan	Pre-term birth clinic

Previous Medical History		
Diabetes	As soon as identified if TYPE 1 OR TYPE 2	Diabetic Team Screening Team to be notified if type 1 diabetic for fetal cardiac scan.
Cardiac Disease / Essential HTN in Mother Cardiac Disease in 1 st degree relative Please ensure aspirin 150mg ON commenced ASAP	After nuchal translucency scan, 12-16 weeks Refer to screening team for cardiac scan at 23-24 weeks	Maternal medicine consultant and Fetal medicine consultant
Renal disease Please ensure U&E sent with booking bloods and uPCR alongside MSU. Please ensure aspirin 150mg ON commenced ASAP CMW responsible for checking results. Any abnormal results to be forwarded to ANC	By 12 weeks, with U+E's	Maternal medicine consultant
Hypothyroidism Please take TFT's – TSH/FT4 CMW responsible for checking results. Any abnormal results to be forwarded to ANC.	ASAP After nuchal translucency scan	Any
Endocrine disorders e.g. hyperthyroidism, pituitary disease	ASAP After nuchal translucency	WPH- joint Endocrine clinic FPH – Joint Diabetes- Endocrine clinic
Haematology – if on disorders list	After nuchal translucency scan before 16 weeks	Maternal medicine / joint haematology clinic
Haematology – if not on disorders list	After nuchal translucency scan before 16 weeks	Maternal medicine consultant
Epilepsy	ASAP after nuchal translucency scan	Maternal medicine consultant
Neurological (excluding Epilepsy)	ASAP after nuchal translucency scan	Maternal medicine
Pre-existing hypertension Please perform U&E with booking bloods and send uPCR with MSU. CMW responsible for checking results. Any abnormal results to be forwarded to ANC.	By 12 weeks with U&E's and PCR	Maternal medicine consultant

Respiratory disease e.g., Asthma requiring hospitalisation Cystic Fibrosis	After nuchal translucency scan, before 16 weeks	Maternal medicine consultant
Auto immune disorders & Connective tissue disease e.g., SLE, Rheumatoid arthritis	After nuchal translucency scan, before 16 weeks	Maternal medicine consultant. ANC to refer patients with Lupus to the screening team
GI Disease e.g., Crohn's Ulcerative colitis, Gastric band, Gastric bypass	After nuchal translucency scan, before 16 weeks	Maternal medicine consultant
Psychiatric illness, significant depression, bipolar disorder, psychosis	Refer to PMH team to triage	Refer to PMH team to triage
Infectious diseases e.g., HIV, Hepatitis, current STI (Previously treated STI does not require referral)	After nuchal translucency scan, before 16 weeks	Lead consultant for infectious diseases. Screening team to be notified of patients that are HIV or Hep B +ve
Other chronic illness e.g., Malignancy	ASAP after nuchal translucency scan	Maternal medicine consultant
Spina bifida (Mother or Child) 5MG Folic acid for 1st 12 weeks of pregnancy	CMW to refer to ANC.	ANC to Refer to Screening for Triage and HRAC
Relevant family history		
Inherited or genetic conditions	ASAP after nuchal translucency scan	5MG Folic acid for 1st 12 weeks of pregnancy Refer to screening for triage
Spina bifida (other family members) 5MG Folic acid for 1st 12 weeks of pregnancy	Refer to screening for triage. No consultant clinic required	

Referral criteria to obstetric anaesthetic clinic	
BMI >40	Maternal request
Anaesthetic history; difficult or failed intubation, sensitivity or allergy to anaesthetic or analgesic drugs, malignant hyperpyrexia, past history of adverse event e.g., difficult or failed epidural or spinal	Musculoskeletal disorder; previous back/neck surgery, marked scoliosis, severe joint disease, connective tissue disease, muscle abnormality
	Cardiovascular disease; congenital, valvular or ischaemic
Respiratory disease; restrictive disorders, severe or poorly controlled obstructive disorders	Haematological disease; coagulation disorders, therapeutic anticoagulation
Neurological disease; cerebrovascular disease, multiple sclerosis, degenerative disorders	Other significant maternal medical history e.g., porphyria, any syndrome.

If there is no space at the correct time, then ANC MW can attempt to find alternative slot if no alternative slot available then email the consultants RE overbooking.

Women with 2 or more differing criteria for CLC e.g., Cystic fibrosis and 3rd degree tear need to be referred at the earliest time slot if unsure then ask for consultant to triage.

Complications which require referral to a Senior Obstetrician (ST3 or above) during Antenatal period.

Maternal	Pregnancy induced hypertension Persistent proteinuria Abnormal GTT result Abnormal antibody results Placenta praevia after 34 weeks Any bleeding through antenatal period
Fetal	Small for dates Large for dates Increased or significantly reduced liquor Malpresentation or unstable lie after 36 weeks Abnormal ultrasound scan. IUD Reduced fetal movements on more than 2 occasions Any circumstance where midwife has concerns.

APPENDIX 3: SOP CLINICAL PROCESS FOR WOMEN WHO REQUEST TO GIVE BIRTH AT WEXHAM PARK HOSPITAL OUTSIDE OF OUR GEOGRAPHICAL AREA

1. On-line pregnancy notification should be completed. Located in the maternity section of the Frimley Health website. This form can be completed by the women or with the support of the GP surgery or community midwife. Link:
<https://www.frimleyhealthandcare.org.uk/maternity/your-pregnancy/>
2. A Midwife booking appointment will be arranged on the Juniper Birth Centre, WPH with the Kingfisher Team Midwife via EPIC and received by the safeguarding team. A Docman letter will be sent to the GP and the Health visitor should be sent a PDF of the booking summary via email. The woman will be contacted by phone or an appointment letter sent. A copy of 'Screening tests for you and your baby' will be included with the letter or a copy will be given at the booking appointment.
3. Kingfisher Team Midwife will see the woman at booking, 16 weeks, 25 weeks, 28 weeks, 31weeks, 34 weeks, 36 weeks, 38 weeks 40 weeks and 41 weeks (Stretch & sweep and IOL will be booked)
4. If any Safeguarding or mental health concerns are identified appropriate referrals will be completed by the midwife at the 16 week antenatal appointment with the (Kingfisher Team Midwife) Out of area Midwife.
 - A Safeguarding referral will be completed and emailed to both the safeguarding teams at Wexham Park Hospital: Fph-tr.maternitysafeguardinghwph@nhs.net and Buckinghamshire: Buc-tr.safeguardingmidwives@nhs.net
 - A copy of this referral will also be sent to the named community midwife for Buckinghamshire.

If the woman meets the criteria for additional services, these referrals will be made at the time of booking. (Teenage pregnancy midwife, family nurse partnership, mental

health or drug and alcohol support services). Family nurse partnership referrals will be sent to the following email address buc-tr.fnp-bucks@nhs.net

- secure-childprotection@buckscc.gov.uk will be notified of any safeguarding referrals.
- It is important that the named community midwife for Buckinghamshire liaises directly with the Wexham Park Hospital out of area lead Midwife (Kingfisher Team) with any ongoing concerns. It may not be possible for the Kingfisher Team lead Midwife at Wexham Park to be in attendance at any Initial child protection conferences or Core group meetings, however a report detailing the care provided by Wexham Park and any concerns we have will be supplied to the relevant agencies.
- Buckinghamshire Safeguarding Team will be responsible for ensuring any police reports that concern women booked to deliver at Wexham Park Hospital will be emailed through to the Wexham Park Hospital safeguarding team and the out of area lead midwife. If the police report is before 28 weeks of pregnancy, then it will be the responsibility of the Wexham Park Out of area (Kingfisher Team) lead midwife to ensure a safeguarding referral is completed. If the police report is received after the 28th week of the women's pregnancy, then the responsibility will be with the named Buckinghamshire Midwife to ensure a social care referral is made.

Midwife booking appointment:

5. Wexham Park will complete maternity booking on EPIC.
6. All antenatal screening bloods and routine booking bloods will be completed. All booking bloods will be reviewed on EPIC by Kingfisher Team Midwife within 10 days and appropriate action will be taken. The screening team will inform the named community Midwife & GP of any positive or high chance results and if a fetal abnormality is identified. In addition, HV will be informed if decision is made to terminate the pregnancy
7. Kingfisher Team will obtain informed consent and arrange appropriate first trimester scan and complete combined or quadruple screening.

8. The Kingfisher Team Midwives will send a booking printout to GP and community Midwives booking via EPIC using Docman.
9. Following review of the booking print out the named community Midwife /GP is responsible for informing Wexham Park Lead Midwife for OOA (Kingfisher Team Midwife) women of any on-going safeguarding or mental /physical health concerns that may not have been disclosed by the patient.
10. Women will leave the booking appointment with details of her 16 week Midwife appointment. The first trimester scan will be requested and an appointment will be posted to the woman's home address. GTT appointment if required will be arranged at Wexham Park.
11. Any consultant referral required will be made by Wexham Park.

16 week Midwife appointment

12. Full antenatal check will be completed.
13. All booking bloods will be reviewed with the women and entered into EPIC.
14. The individualised Gap & Grow chart will be generated and documented in EPIC.
15. Information and blood test will be offered and completed for all Rhesus negative women for cffDNA to establish baby's blood group.
16. This result will be reviewed and anti D ordered for the 28 week appointment if required.
17. Health Visitor liaison form will be completed and emailed to
bht.cyphvadmin@nhs.net
18. Safeguarding or mental health referrals will be completed or reviewed by Wexham Park as necessary.

28 week appointment

19. Full antenatal check will be completed.

- 20. If applicable GTT results will be reviewed and documented and the appropriate action taken.
- 21. Newly diagnosed gestational diabetics will be seen by the diabetic team and the named community midwife and GP will be informed.
- 22. Routine 28 week bloods will be taken reviewed and documented and the appropriate action taken if necessary.
- 23. Safeguarding or mental health referrals will be completed or reviewed by Wexham Park.

41 week appointment

- 24. Full antenatal check
- 25. Stretch and sweep will be offered
- 26. Induction of labour information will be given and a date arranged for the post-dates clinic if suitable, a medical induction appointment will also be made.

DNA Process

- 27. Lead Midwife for (Kingfisher Team) OOA women is responsible for following up all DNA's but will require support from the named community midwife for Buckinghamshire. If the OOA Midwife is unable to contact the women by telephone on the first DNA she will arrange for a follow up appointment to be sent by post. If on the second DNA the OOA midwife is still unable to make telephone contact with the patient, then the OOA will communicate directly either by telephone or email with the named community midwife for Buckinghamshire to discuss a plan of action which may include an unscheduled home visit.

COMMUNICATION

- 28. If a woman has a miscarriage or has any abnormal results from screening the GP and CMW will be informed by the Wexham Park screening Midwife.
- 29. Wexham Park will send a Docman letter to the GP and a PDF booking summary to the Health Visitor via email.

Bht.wexhambookingscommunitymidwives@nhs.net

30. Important contact details for Wexham Park Hospital

	Wexham Park Generic email	Telephone number
Lead Midwife for OOA (Kingfisher Team)	fhft.kingfisherteamwexham@nhs.net	0738752279
Safeguarding	Fph-tr.maternitysafeguardinghwph@nhs.net	0300 6155392
Antenatal screening	Fph-tr.antenatalandnewborn@nhs.net	0300 6153301

APPENDIX 4: SOP CLINICAL PROCESS FOR WOMEN WHO REQUEST TO GIVE BIRTH AT FRIMLEY PARK HOSPITAL OUTSIDE OF OUR GEOGRAPHICAL AREA

1. On-line pregnancy notification should be completed. Located in the maternity section of the Frimley Health website. This form can be completed by the women. Link:
<https://www.frimleyhealthandcare.org.uk/maternity/your-pregnancy/>
2. Frimley Park clerical staff will receive the form and register the patient on the hospital patient record system EPIC.
3. A midwife booking appointment will be arranged either at Farnham hospital and centre for health or at Bracknell maternity hub. The woman will be contacted by phone, or an appointment letter sent. A copy of 'Screening tests for you and your baby' will be emailed in reply of the NOP (notification of pregnancy).
4. Frimley Park midwife will see the woman at booking as per antenatal schedule above.
5. Women linked to a GP surgery for Wexham Park Hospital will be booked by a Wexham Park midwife and all routine follow ups will be with the Wexham Park Midwife. Women linked to a GP surgery choosing to deliver at FPH will have any obstetric or scan appointment at FPH.
6. If any Safeguarding or mental health concerns are identified appropriate referrals will be completed by Frimley Park at the booking appointment.
 - A Safeguarding referral will be completed via EPIC and received by the safeguarding team. A Docman letter will be sent to the GP and the Health visitor should be sent a PDF of the booking summary via email.
 - Any referrals for Children's social care will be completed by identification of need, GP, Community Midwife and Health Visitor will be informed and kept updated.
 - Any referrals for Children's social care will be completed by identification of need GP, Community Midwife & Health Visitor will be informed and kept updated.

- It is important that the named community midwife, GP and Health visitor liaise directly with the Frimley Park Antenatal Clinic sister with any ongoing concerns. The out of area midwifery team will attend any Initial child protection conferences or Core group meetings, as well as providing a report detailing the care provided by FPH and any concerns we have will be supplied to the relevant agencies.

Antenatal care for out of area women will be provided as per antenatal schedule of care above

DNA Process

- If a woman DNA's her appointment a Frimley midwife will attempt to contact her. If the midwife is unable to contact the woman by telephone on the first DNA, she will arrange for a follow up appointment to be sent by post. If on the second DNA the midwife is still unable to make telephone contact with the patient, then the midwife will communicate directly either by telephone or email with the named community midwife to discuss a plan of action which may include an unscheduled home visit.

COMMUNICATION

- If a woman has a miscarriage or has any abnormal results from screening the GP and CMW, and Health Visitor will be informed by the Frimley Park Midwife.
- Frimley Park will send a Docman letter to the GP, and a PDF booking summary to the Health Visitor via email.
- Important contact details for Frimley Park Hospital

	Frimley Park Generic email	Telephone number
Antenatal Clinic generic email	Fhft.antenatalclinicfph.midwives@nhs.net	0300 6134127
Safeguarding	Fph-tr.maternitysafeguarding@nhs.net	0300 6139338
Antenatal screening	Fph-tr.antenatalscreening@nhs.net	0300 6136989

APPENDIX 5: NON-ATTENDANCE LETTER**Frimley Health**
NHS Foundation Trust

Surgery / Hub.....

.....

.....

Date.....

Dear:

NHS Number:

I was sorry to see that you were unable to attend your Antenatal appointment with me today and as I have been unable to contact you by telephone, I have made a further appointment for you:

Date.....

Time.....

Venue.....

If for any reason this is not convenient, please telephone the surgery to make another appointment.

It is very important for the health of you and your baby that all Antenatal appointments are kept and I look forward to seeing you.

Yours sincerely

Midwife

Contact Telephone Number.....

APPENDIX 6: CASELOAD TRACKING / AUDIT FOLDER SHEET

(can be customised by CMW)

[illegible]

APPENDIX 7: TRANSFER OF CARE FROM FRIMLEY PARK MATERNITY SERVICE

Frimley Park Hospital
Portsmouth Road
Camberley
GU16 7UJ

Transfer of Care from Frimley Park Maternity Service

[Dear (trust name)] FAO: Antenatal Clinic, Trust name

This lady booked for care at Frimley Park Hospital on

she is now weeks pregnant and wishes to transfer her care to your service for delivery.

Name

DOB

NHS number

Phone number:..... Email:.....

Old address.....

New address (if known):.....

GP

This letter is a formal notification of her request for transfer; we will continue to see her as part of the antenatal scheduled of care for community midwifery appointments as appropriate / relevant. She understands that she will need to be re booked for care in your trust, she will have access to her electronic patient notes from Frimley Park Hospital which you can gain access to through the share anywhere option. We have also provided a hard copy of their booking letter.

If you require any further information, please contact [add in name of community midwife who sends the letter]

Yours sincerely

signed by midwife.

Sent via email to avoid delay to trust and GP

APPENDIX 8: TRANSFER OF CARE FROM WEXHAM PARK MATERNITY SERVICE

Wexham Park Hospital
Wexham Street
Wexham
Berkshire
SL2 4HL

Transfer of Care from Wexham Park Maternity Service

[Dear (trust name)] FAO: Antenatal Clinic, Trust name

This lady booked for care at Wexham Park Hospital on

she is now weeks pregnant and wishes to transfer her care to your service for delivery.

Name

DOB

NHS number

Phone number:..... Email:.....

Old address.....

New address (if known):.....

GP

This letter is a formal notification of her request for transfer; we will continue to see her as part of the antenatal scheduled of care for community midwifery appointments as appropriate / relevant. She understands that she will need to be re booked for care in your trust, she will have access to her electronic patient notes from Frimley Park Hospital which you can gain access to through the share anywhere option. We have also provided a hard copy of their booking letter.

If you require any further information, please contact [add in name of community midwife who sends the letter]

Yours sincerely

signed by midwife.

Sent via email to avoid delay to trust and GP

APPENDIX 9: ASPIRIN RISK ASSESMENT**Risk level: High**

Risk factors:

- hypertensive disease during a previous pregnancy
- chronic kidney disease
- autoimmune disease such as systemic lupus erythematosus or antiphospholipid syndrome
- Type 1 or Type 2 diabetes
- chronic hypertension
- Previous fetal growth restriction or history of placental dysfunction

Recommendation: Recommend low dosage aspirin if the woman has 1 or more of these high-risk factors

Risk level: Moderate

Risk factors:

- first pregnancy
- 40 years or older at booking
- pregnancy interval >10 years
- body mass index (BMI) ≥ 35 kg/m² at first visit
- family history of pre-eclampsia in a first-degree relative
- multiple pregnancy

Recommendation: Consider aspirin if the woman has 2 or more moderate risk factors

Adapted from: NHS England (2023) *Saving Babies' Lives Care Bundle Version 3*, Version 3.1 – July 2023. Updated 23 April 2025. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/saving-babies-lives-version-3/> (Accessed: 10 September 2025).

Full version control record

Version:	2.3
Guidelines Lead(s):	T. Santacaterina, (Community Matron FPH), M. Warren (Community Matron WPH)
Contributor(s):	E Luhr, Director of Midwifery
Lead Director / Chief of Service:	Miss Anne Deans, B. Sagoo (Interim)
Professional Midwifery Advocate:	E. Luhr
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Pharmaceutical dosing advice and formulary compliance checked by:	Ruhena Ahmad, 31.07.2023
Key words:	Booking, booking and transfer criteria, antenatal risk assessment, out of area, schedule of care, non attendance, non attendees, appointment, did not attend (DNA), community midwife, Caseload Tracking Folder, Green Folder

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Policy Lead(s)	Status	Comment
1.0	March 2020	L. Heppolette, H. Jones	Final	First cross site version
1.1	September 2020	L. Heppolette, H. Jones	Interim	Addition of non attendance section, approved at OGCGC 30/09/2020
1.2	June 2021	L. Heppolette, H. Jones	Interim	Addition of intended place of birth discussion in schedule of care (by E. Luhr DoM)
2.0	July 2023	T. Santacaterina, M. Warren, A Roberts	Final	2.1.3 & 2.6.2 added as per request from PS&Q group, updated with EPIC, Ratified at OGCGC 28.07.23
2.1	August 2023	N. Rose Stone	Interim	Updated with SVBL3, Ratified at Obstetric Clinical Governance Committee 21.11.23
2.2	August 2024	N. Rose Stone	Interim	Appendix 2: criteria to identify women who should be referred to consultant led care updated. Signed off as chair's action by CoS A.Deans and DoM E. Luhr 01.08.2024

2.3	September 2025	N. Rose Stone	Interim	Appendix 9 added (Aspirin risk assessment) Signed as chair's action by CoS B. Sagoo and DoM E. Luhr on 11.09.2025
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Related documents

Document Type	Document Name
Guideline	Assessment of fetal growth restriction in low risk women
Guideline	Antenatal and newborn screening
Guideline	Perinatal mental health
Guideline	Substance Misuse in Pregnancy
Guideline	Diabetes in pregnancy
Trust policy	Domestic abuse policy