Antenatal Care Guidelines

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Target Audience:

People who need to know about this document in detail	All obstetric and midwifery staff working within maternity services at CTM UHB
People who need to have a broad understanding of this document	*As above*
People who need to know that this document exists	*As above*

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: April 2025** **Outcome: no negative impact**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
April 2025	review			1 to 2	Mo Elnasharty

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Contents

1. Introduction

The guideline has been developed with the following aims: to offer information on best practice for baseline clinical care of all pregnancies and comprehensive information on the antenatal care of the healthy woman with an uncomplicated singleton pregnancy. It provides evidence-based information for use by clinicians and pregnant women to make decisions about appropriate treatment in specific circumstances.

2. Definition

The ethos of this guideline is that pregnancy is a normal physiological process and that, as such, any interventions offered should have known benefits and be acceptable to pregnant women.

3. Rationale

Midwives should care for women with an uncomplicated pregnancy, providing continuous care throughout the pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve Perinatal outcomes compared with involving obstetricians when complications arise. Obstetricians and specialist teams should be involved where additional care is needed. Antenatal appointments should take place in a location that women can easily access. The location should be appropriate to the needs of women and their community.

Each antenatal appointment should have a structure and a focus. Appointments early in pregnancy should be longer to provide information and time for discussion about screening so that women can make informed decisions. Women should feel able to discuss sensitive issues and disclose problems. Staff should be alert to the symptoms and signs of domestic Abuse. A schedule of antenatal appointments should be determined by the function of the appointments. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate (NICE 2008)

4. Woman-centred care

Antenatal services should be accessible and welcoming so that all women, including those who currently find it difficult to access maternity care, can reach them easily and earlier in their pregnancy

Women, their partners and their families should always be treated with kindness, respect and dignity. The views, beliefs and values of the

woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.
Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.
If women do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government. (NICE 2008)
Good communication between healthcare professionals and women is essential. It should be supported by evidence-based, written information tailored to the woman's needs. Care and information should be culturally appropriate. All information should be accessible to women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Every opportunity should be taken to provide the woman and her partner or other relevant family members with the information and support they need (NICE 2008). Women should also have had their first full booking visit and hand held record completed by 10 completed weeks of pregnancy Pregnant women who, on referral to maternity services, are already 12 or more weeks pregnant should be seen within two weeks of referral.

5. Migrant women

All pregnant mothers from countries where women may experience poorer overall general health, and who have not previously had a full medical examination in the United Kingdom, should have a medical history taken and clinical assessment made of their overall health, including a cardiovascular examination at booking, or as soon as possible thereafter. This should be performed by an appropriately trained doctor, who could be their usual GP. Women from countries where genital mutilation or cutting is prevalent should be sensitively asked about this during their pregnancy and management plans for delivery agreed during the antenatal period. Migrant women may need support with housing benefits and access to healthcare.
Specialist support-Advice line 020 7251 6189 Monday and Thursday (2pm-4pm) or email- migrantwomensrights@maternityaction.org.uk

6 Mental Health

All women should be routinely asked in early pregnancy and subsequent antenatal contacts about current and previous mental health problems (Nice 2008). Maternity staff should sensitively, but explicitly, enquire into the nature and severity of these problems. They should check with the woman's General Practitioner (GP) for further information. Where Mental Health problems have been identified referral to Perinatal Mental Health services should be undertaken.

7. Substance Misuse

At the Booking interview the midwife will enquire about the mother and fathers history regarding the use of prescribed and non-prescribed medicines including both legal and illegal substances. Pregnant women with substance misuse problems should not be managed by GP's and midwives alone but by an integrated specialist service nested within maternity services. This should include the GP, Named Midwife, Substance misuse lead midwife, Obstetrician, Safeguarding midwife specialist drug treatment professionals who can manage alcohol and drug problems.

Where substance misuse problems have been identified the Substance misuse flowchart & guidelines will be followed. Close multidisciplinary and multi-agency care should be continued not only through pregnancy but also into the postnatal period even if the infant is placed into the care of the local authority.

8. Domestic abuse

Domestic abuse often begins or exacerbates in pregnancy, with over a third of domestic violence starting or getting worse when a woman is pregnant. All women will be asked about domestic abuse during the antenatal period in line with the All Wales Routine Enquiry into Domestic Abuse. It is good practice to ask routine enquiry on more than one occasion when a woman is alone and to document in the "attended with" column in the All Wales case notes antenatal section when accompanied at her appointment.

Where there is disclosure of domestic abuse or following a PPN report from the police the DASH RIC (DA2) Risk Assessment Form (available on file share) is to be completed. Each case is to be discussed with Safeguarding specialist midwife for support and advice...

All health professionals should make themselves aware of the importance of **"Ask & Act"** about domestic abuse in their practice.

9. Confirmation of Pregnancy (1st Contact with Midwife)

All pregnant women will be allocated a named midwife. The named midwife will usually be attached to the GP surgery with whom the woman is registered. For women who are suitable for midwife led care (MLC) the named midwife will take overall responsibility for the provision and co-ordination of maternity care. For women with additional risk factors a named obstetrician will provide consultant led care (CLC) and will co-ordinate a plan of care, taking responsibility with the named midwife for the provision of care. It must be clear at all times the lead professional co-ordinating her care.

At first contact with a midwife, women should be provided with information booklets on screening tests available from Antenatal Screening Wales (ASW), Bump, Baby and Beyond book (Public Health Wales) which gives information and advice on a range of pregnancy topics. Information about types of antenatal care available during pregnancy should be given.
Women who speak little or no English should have interpreter service available at each visit. The use of family members as interpreters should be avoided. Interpreter services should be booked via Antenatal Clinics. Communication and information should be provided in a form that is accessible for pregnant women who have additional needs such as those with physical, cognitive or sensory disabilities (see accessible information for women on the ASW public website).

Antenatal Screening

Antenatal Screening is offered to all pregnant women to detect conditions either present in the mother or the baby which are likely to have an effect on the health of either. For some conditions preventative treatment is available during the antenatal period or after delivery to improve the baby's health. For other conditions identified during the antenatal period where there is no preventative treatment available, women should be offered expert counselling. This will enable women to make a personalised informed choice whether to they wish to continue with the pregnancy. Appropriate support should be offered to women whichever choice they make

10. Nutritional supplements

Folic acid 400mcgs per day is recommended up to 12 weeks gestation;

Folic acid 5mg per day is recommended up to 12 weeks gestation for women who have epilepsy, are diabetic or have a family history of abnormalities, Body Mass Index (BMI)>30;

Iron supplements should not be offered routinely to all women as increased vitamin A intake (Through supplementation or liver products) may be Teratogenic and therefore should be avoided.

All Women should be informed at the booking appointment about the importance of adequate Vitamin D stores during pregnancy and whilst breastfeeding. Women should be advised to take a Vitamin D supplement (10 micrograms of vitamin D per day), as found in the Healthy start multivitamins. Particular care should be taken to ensure women at greatest risk are following advice to take this daily supplement. These include:

- Women of South Asian, African, Caribbean or Middle Eastern family origin.
- Women who have limited exposure to sunlight, such as women who are predominantly housebound, or usually remain covered when outdoors.
- Women who eat a diet particularly low in vitamin D, such as women who consume no oily fish, eggs, meat, vitamin D-fortified margarine or breakfast cereal.
- Women with a pre-pregnancy body mass index above 30 kg/m2.

Midwives should follow guidance on Healthy Eating. This information should be given to the women at the first contact.

11. Baby Friendly Standards

All pregnant women should have the opportunity for a discussion about skin to skin contact, feeding their baby and about recognising and responding to their baby's needs. This discussion should be offered by 34 weeks gestation. At each contact with a midwife, they should be encouraged to develop a positive relationship with their growing baby in utero.

12. Medicines

Prescription medicines should be used as little as possible during pregnancy and should be limited to circumstances where the benefit outweighs the risks;

Very few over the counter medicines and complementary therapies have been established as being safe and effective and therefore should not be recommended.

13. Exercise in Pregnancy

Beginning or continuing a moderate course of exercise during pregnancy is not associated with adverse outcomes however contact sports, high impact sports and vigorous racket sports may involve the risks of abdominal trauma, falls or excessive joint stress. Advantages of being active throughout pregnancy should be discussed aiming for minimum of 150 minutes per week. Women who have conditions which limit activity should be advised of these contraindications on an individual basis.

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14. Sexual Intercourse in Pregnancy

Is not known to be associated with any adverse outcomes.

15. Alcohol

Pregnant women should be informed that there is no 'safe' time for drinking alcohol during their pregnancy and there is no 'safe' amount.

16. Smoking

Pregnant women should be informed about the specific risks of smoking during pregnancy to include the risks of passive smoking and the benefits of smoke free homes.

All women to be offered carbon monoxide monitoring at each contact (regardless of smoking status).

Women who smoke, or who have recently stopped should be offered smoking cessation intervention at any gestation.

17. Working during pregnancy

The majority of women can be reassured that it is safe to continue working during pregnancy. A woman's occupation during pregnancy should be ascertained to identify those who are at increased risk through occupational exposure. Any increased risks identified women should be advised to discuss these with their employer.

Further information about possible occupational hazards during pregnancy is available from the Health and Safety Executive (www.hse.gov.uk.)

Pregnant women should be informed of their maternity rights and benefits.

18. Travel

Women should be given advice about the correct use of seatbelts (*Above and below the bump and not over it)*;
Women should be informed that air travel is associated with an increased risk of venous thrombosis; advice about reducing the risk should be discussed with women intending to travel by air;
Women should be advised to seek advice regarding air travel and insurance from their own GP/airline/travel Company;
Pandemic flu advice refer to website www.directgov.uk

19. Vaccinations

Discuss at booking appointment and recommend whooping cough vaccine at 16-32 weeks gestation. The seasonal flu vaccination should be recommended.

20. Booking Assessment

The booking appointment should take place at the woman's home address and the All Wales Maternity Record (AWMR) completed. At the booking assessment women will be offered evidence based information and support to enable them to make informed decisions regarding their care. Information will include details of where they will be seen and who will undertake their care.

A needs and risk assessment (physical and social) should take place to ensure that every woman has a flexible individual plan for her antenatal care. This plan will be reviewed at each visit, and if required altered to reflect changing needs**.** At each antenatal appointment midwives and doctors should offer consistent information and clear explanations providing women with the opportunity to discuss issues and ask questions.

The midwife will undertake a full risk assessment at the booking appointment in order to identify women who are suitable for Midwifery Led Care (MLC). Women who are in a higher risk category will require a referral for to either Obstetric Led Care (OLU) or Obstetric opinion (appendix 3). Where women are under OLC midwives would continue to work in partnership with her named Obstetrician to ensure the women receives the appropriate level of midwifery care. If a woman with high risk factors declines OLC the case must be discussed with a Senior Midwife and the Consultant Midwife as soon as possible so that relationships can be established and care plans developed. A plan of care for the pregnancy must be documented in the woman's notes. If the woman is choosing to birth in a birth centre or at home a clinical alert will need to be completed and shared with the wider team (Appendix 4)

(Please note in cases where women book late or have no antenatal care it is the responsibility of the midwife to undertake a full antenatal booking interview in line with late booking/concealed pregnancy guideline).

Late bookings can be associated with underlying issues such as vulnerability and child protection. In addition, women may book too late to be offered antenatal screening tests for Down's syndrome , Edward's syndrome and Patau syndrome screening or the anomaly scan. However other routine antenatal screening tests can be offered later in pregnancy. During the booking interview the midwife must ensure that the reason for the late access to maternity services is explored. In cases where vulnerability and/or safeguarding concerns have been highlighted the appropriate risk assessments/referrals/care pathways must be followed. All cases must be discussed with the Named Midwife – Child Protection and a plan of care agreed. In addition, where the woman requests to give birth at home or in the birth centre, advice should also be sought from the Senior Midwife – Community Services.

For women living in Flying Start areas the Flying Start Midwifery and Health Visiting pathway must be followed.

Maternity Information Technology Database (MITS)

The booking midwife is responsible for ensuring accurate inputting of the antenatal booking history into the antenatal section of the MITS database.

21. Antenatal Visits for Healthy Primigravida Women

	Antenatal Appointments	Comments
1	**Booking appointment**	”Baby , Bump & Beyond” Antenatal Screening Wales (ASW) leaflets
2	**Dating Scan Screening tests BMI**	HB <11g/dl offer iron supplements GROW – Generate personal growth chart and risk assessment for serial growth scans 1st trimester combined screening Discuss whooping cough and seasonal flu vaccination. Raised BMI≥35 to follow weight management guideline
3	**16 weeks**	Discuss tests results If combined screening not undertaken offer Quad test to singleton pregnancies only.
4	**18-20 weeks**	Offer: - Anomaly scan
5	**24 weeks**	BP and urinalysis Discuss signs of Pre-Eclampsia and Fetal movements. Antenatal class and health promotion information. Advise appointment for whooping Cough vaccine 16-32 weeks at GP practice
6	**28 weeks.** **31 weeks** **And 34 weeks**	BP and urinalysis Measurement symphysis Fundal height(SFH)and 1st plot on GROW chart at 28 weeks Screening bloods Full Blood Count (FBC) and Rhesus antibodies screen at 28 weeks. Offer prophylactic Anti-D for women who are Rh Negative(in hospital) at 28 weeks HB<10.5g/dl offer iron supplements Re offer screening for Syphilis, Hepatitis B and HIV screening if declined at booking.
	36 weeks	BP and Urinalysis Measurement of SFH or growth scan at hospital depending on risk assessment. End of pregnancy weight to be measured between 36 to 40 weeks. Weight changes to be documented in All Wales notes and input into Maternity information system.
9	**38 weeks**	Antenatal check
10	**40 weeks**	Antenatal check Arrange date for 40+4>weeks
11	**40+4> weeks**	Antenatal check Offer Membrane Sweep Book date for IOL process T+12

22. Antenatal Visits for Healthy Multiparous Women

	Antenatal Appointments	Comments
1	**Booking appointment**	”Baby , Bump & Beyond” Antenatal Screening Wales (ASW) leaflets
2	**Dating Scan Screening tests BMI**	HB <11g/dl offer iron supplement GROW – Generate personal growth chart and risk assessment for serial growth scans 1st trimester screening Discuss whooping cough and seasonal flu vaccination. Raised BMI ≥35 to follow weight management guideline
3	**16 weeks**	Discuss tests results Offer quad test if unable to have NT screening
4	**18-20 weeks**	Offer: - Anomaly scan
6	**28 weeks**	Antenatal check Measure & plot fundal height Antibody screen & Full Blood Count (FBC) Offer Anti-D Rh Negative Investigate HB<10.5g/dl (Iron therapy) Repeat scan for Placenta Praevia at 32 weeks
7	**31 weeks**	Antenatal check Infant feeding / relationship building discussion, record on page 40 of All Wales Maternity Record
8	**34 weeks**	Antenatal check
	36 weeks	Antenatal check Position of the baby (1st time) Birth plan & Normal labour pathway discussion Breech presentation - Refer to Consultant for 37 week appointment. End of pregnancy weight to be documented 36 to 40 weeks in All Wales hand held notes
9	**38 weeks**	Antenatal check
11	**40+4> weeks**	Antenatal check Offer Membrane Sweep Book date for IOL process T+12

23. Midwifery Led Care (MLC)

Women with normal pregnancies should be cared for by midwives – please refer to The All Wales Midwifery Led Care Guidance.

24. Women who do not attend (DNA)

There may be many reasons why women do not attend clinic appointments. Women who are victims of domestic abuse often default from antenatal clinic appointments. Women who default are at higher risk of maternal and fetal complications and death. Midwives should have a strategy to identify those women who fail to attend antenatal clinic appointments. The midwife should personally and actively follow up regular non-attendance. If the reasons why the woman failed to seek care are ascertained through sympathetic questioning, alternative arrangements must be made that suit the particular circumstances of the woman.

1st appointment missed: The woman will be contacted by telephone or post and a new appointment will be arranged. This will be the responsibility of the midwife attending the clinic.

2nd appointment missed: Urgent follow up by community midwife. If contact is established, the community midwife will discuss and plan further antenatal care with the woman. If the plan of care does not reflect the woman's risk factors, the Senior Midwife- Community Services/Senior Midwife Vulnerable Women must be informed.

Unable to make contact: The Senior Midwife - Community Services/Safeguarding specialist midwife must be informed and a plan of care and how to proceed with the case will be discussed taking into account the woman's wishes, any risk factors or safeguarding concerns.

25. Medical Conditions indicating increased risk suggesting birth at an obstetric unit

Disease Area	*Medical Condition*
Cardiovascular	Confirmed cardiac disease. Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment.

Haematological	Haemoglobinopathy-sickle-cell disease, beta-thalassaemia major. History thromboembolic disorders. Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100x10 9/litre. Von Willebrand's disease. Bleeding disorder in the woman or unborn baby. Atypical antibodies which carry a risk of Haemolytic disease of the newborn (HDN)
Endocrine	Hyperthyroidism / Hypothyroidism Diabetes
Infective	Risk factors associated with Group B streptococcus whereby antibiotics in labour would be recommended. Hepatitis B/C with abnormal liver function test Carrier of / infected with HIV. Toxoplasmosis – women receiving treatment. Current active infection of chicken pox/rubella/genital herpes in the woman or baby. Tuberculosis under treatment.
Immune	Systemic lupus erythematosus.

	Scleroderma.
Renal	Abnormal renal function. Renal disease requiring supervision by a renal specialist.
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests.
Psychiatric	Psychiatric disorder requiring current inpatient care.

Other factors indicating increased risk suggesting planning birth at an obstetric unit.

Factor	*Additional Information*
Previous complications	Unexplained stillbirth, neonatal death or previous death related to intrapartum difficulty. Previous baby with neonatal encephalopathy. Pre-eclampsia requiring preterm birth. Placental abruption with adverse outcome. Eclampsia. Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion. Retained placenta requiring manual removal in theatre.

	Caesarean section. Shoulder dystocia
Previous gynaecological history	Myomectomy. Hysterotomy.

Medical Conditions indicating individual assessment when planning place of birth

Disease area	*Medical Conditions*
Cardiovascular	Cardiac disease without intrapartum implications.
Haematological	Atypical antibiotics not putting the baby at risk of haemolytic disease. Sickle cell trait Thalassaemia trait. Anaemia- haemoglobin 85-105 g/litre at onset of labour.
Infective	Hepatitis B/C with normal liver function tests.
Immune	Non-specific connective tissue disorders.
Endocrine	Unstable hypothyroidism such that requires a change in treatment.
Skeletal /neurological	Spinal abnormalities. Previous fractured pelvis. Neurological deficits.
Gastrointestinal	Liver disease without current abnormal liver function.

	Crohns Disease. Ulcerative colitis.

Other factors indicating individual assessment when planning place of birth

Factor	*Additional Information*
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause. Pre-eclampsia Placental abruption with good outcome. History of previous baby more than 4.5kg. Extensive vaginal, cervical or third or fourth degree perineal trauma. Previous term baby with jaundice requiring exchange transfusion.
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation). BMI at booking of 30-35 kg/m2 and weight gain in current pregnancy Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on two occasions. Clinical or ultrasound suspicion of macrosomia. Para 4 or more. Recreational drug use. Under current outpatient psychiatric care. Age over 35 at booking

Fetal indications	Fetal abnormality.
Previous gynaecological history	Major gynaecological history

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Appendix One

Pathway for Midwifery Clinical Alerts

1. Triggers for Clinical alert:

- Outside criteria for midwife led care
- Home Birth or Birth Centre Birth against midwifery or medical advice.

Process:

- All clinical alerts need to be discussed with the line manager and Consultant midwife.
- Agree appropriate actions to be taken with the line manager/ Consultant Midwife and document in woman's handheld notes.
- Complete clinical alert and distribute as appropriate
- Update line manager if any changes or additions need to be made to clinical alerts
- Following birth complete feedback form on clinical alert and send to the line manager.

Midwife:

Date :

Name:

Address:

EDD: **Gravida:** **Para:**

Reason for clinical alert:

Actions taken:

Discussions:-

Plan :-

Obstetric opinion/Outcome:
.

Directions & Grid reference (if required)

N/A

Has Management Plan been updated	**Yes/No**
Copied to:	
Head of Midwifery	**Yes/No**
Senior Midwife Community	**Yes/No**
Midwifery Matrons	**Yes/No**
Consultant Midwife	**Yes/No**
L/W lead Consultants	**Yes/No**
Labour Ward	**Yes/No**
Ambulance	**Yes/No**

Feed Back Form:

Date of Birth:

Place of Birth:

Mode of birth:

Outcomes:

Please email feedback form to line manager.