WOMENS HEALTH AND PAEDIATRICS
MATERNITY UNIT

Antenatal care including booking appointment, maternity care pathway and antenatal clinical risk assessment

Amendments			
Date	Page(s)	Comments	Approved by
24/11/09	Various	This guideline supersedes the assessing client suitability for midwifery led care in pregnancy and labour the Antenatal non attendance guideline	Women or pregnant people's' Health Guidelines Group
April 2012		Addition of CNST update detailing process identifying risk factors	Women or pregnant people's Health Guidelines Group
Nov 2014		Roles and responsibilities of named midwife and Community Team Leaders Use of Interpreting services Review and update of antenatal risk factors Liaison with Health Visitor	Women or pregnant people's Health Guidelines Group
Jan 2016		Non-attendance to scan appointments	
Feb 2018		Document review, remove references to Supervisor of Midwives	Head of Midwifery
October 2018	5	Addition of Carbon Monoxide Testing	Women or pregnant people's Health Guidelines Group
August 2019	4	Addition of referral to consultant at booking when requesting care outside of guidance >37 weeks	Women or pregnant people's Health governance and guidelines group

October 2021	Whole document review	Change to reflect current NICE guidelines. Guideline split into three guidelines to incorporate the referral to maternity care process and pathway for non-attendance for maternity care	

Compiled By: Katie Spiers – Community Matron
In Consultation with: All consultant obstetricians and senior midwives
Ratified by: Woman's Health Guidelines Group
Date Ratified:
Date Issued
Next Review Date:
Target Audience: All staff working within the Maternity Services

See also:
Aspirin in Pregnancy SOP
Tommy's Application SOP
VTE in pregnancy guideline
Iron Deficiency Anaemia (IDA) in Pregnancy
Ultrasound Protocol
Homebirth Guidelines
Induction of Labour Guideline
Obesity in Pregnancy Guidelines
Maternity Safeguarding Children Guideline
Obstetric Referral Indications to Antenatal Clinic (SOP)
Antenatal Care (NG201)

Introduction
Routine antenatal care focuses on maintaining and improving health and wellbeing, ensuring that women or pregnant people are equal partners with healthcare professionals in planning their care. Regular antenatal care gives the opportunity to review and update the plan of care to reflect any changes in maternal or fetal health. Women or pregnant people should have the opportunity to make informed decisions about their care and treatment in partnership with health care professionals. Midwives are responsible for women or pregnant people with a low risk pregnancy and who have identified risk factors referral to an obstetrician may be required recommending an appropriate care pathway (See Appendix 1). The Confidential Enquiry into Maternal and Child Health 2007 (CEMACH) *Saving Mother's Lives* identified that around 20% of women or pregnant people who died from direct or indirect causes either booked for maternity care after 20 weeks gestation, missed over four routine appointments, did not seek care at all or actively concealed their pregnancies. Furthermore the 2020 MBRRACE-UK reports on maternal and perinatal mortality, women or pregnant people and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support.

Role and Responsibilities of the Named Midwife
Women or pregnant people should be allocated a named midwife and team prior to booking, The named midwife is a registered midwife who is responsible for planning and providing all or most of women or pregnant people's antenatal care and coordinating care.

The named midwife will engage and build a relationship with the women or pregnant people and their partner to understand and help meet their needs throughout pregnancy and in the postnatal period. Where possible continuity of care by the named midwife in the antenatal and postnatal periods will support these relationships. The named midwife is responsible for ensuring that women or pregnant people and their families are aware of arrangements for on-going midwifery support and coordination should they not be available. The named midwife and where appropriate the named link or specialist consultant obstetrician will be documented in the 'Circle of Care' on the woman or pregnant person's electronic notes.

A woman or pregnant person can be supported by a partner during her pregnancy so healthcare professionals should involve partners according to the woman or pregnant person's wishes and inform the woman or pregnant person that she is welcome to bring a partner to antenatal appointments and classes.

Furthermore the named midwife should liaise with the woman or pregnant person's GP and Health Visitor and other health care professionals, when the woman or pregnant person is identified as vulnerable and/or with high risk social factors. To ensure appropriate liaison and joined up care pathways, there will

be a minimum of three contact opportunities during the antenatal and postnatal care pathways. These are as follows:-

Contact 1 Following the booking, the midwife will confirm and save the clinical antenatal booking summary report that sends an email copy to the GP and HV, notifying them of any risk factors identified at the booking.

Contact 2 At around 28 weeks the women or pregnant people's care pathway should be reviewed and for those with identified social risk factors and refer for additional support if required. If concerns are identified, the midwife should discuss the plan with their team leader and facilitate a telephone or face to face contact with the Health Visitor team.

Contact 3 On discharge from community midwifery care, the midwife must ensure the Health Visitor is aware that the midwifery service is transferring care to the Health Visitor's team. For all women or pregnant people deemed at risk because of social or medical factors the midwife must transfer care through either a meeting with the Health Visitor or through a telephone discussion which then must be documented.

For vulnerable women or pregnant people and families where there is safeguarding and or mental health concerns there will be increased contact with multi-agency teams and referral to the Willows midwifery team may be appropriate.

Allocation of Midwifery Team

All women and pregnant people will be allocated a named midwife working within a midwifery team at booking. This will usually be a community team based on their postcode, providing care in a location that is easily accessible to the woman or pregnant person and their family.

In complex pregnancies (such as multiples, previous loss or pre-existing medical disorders) women or pregnant people should be referred to the Complex Care (Parks) team. This team provides midwifery care working in conjunction with the Maternal Fetal medicine team.

For women or pregnant people who live out of the geographical area (OOA) they will be referred to the Abbey Team if their pregnancy is low risk.

As detailed above, vulnerable women or pregnant people where there are significant mental health issues or safeguarding concerns may fulfil the criteria for care by the Willows midwifery team.

The Booking Appointment

For most women or pregnant people, the booking appointment will be carried out in the community in a location that is easily accessible to the woman or pregnant person and their family. For women or pregnant people who live out of the geographical area (OOA) they will be referred to the Abbey Team if their pregnancy is low risk, a continuity of care team if applicable or allocated to a community team based on their postcode.

The booking appointment should take place by 8 to 9 weeks gestation, or earlier, if possible, to allow time for booking bloods to be reviewed and be available to women or pregnant people by 10+0 weeks gestation. If women or pregnant people book after 12+6 gestation, the midwife should ask about the reasons for the late booking because it may reveal social, psychological or medical issues that need to be addressed. Women or pregnant people who book after 20+0 gestation require a request for support form (RSF) to be completed.

Midwives should offer screening for: haemoglobinopathy, anaemia, group & red-cell antibodies, hepatitis B virus, HIV, syphilis, ferritin if meets criteria via a blood sample and asymptomatic bacteriuria via urine sample. In addition midwives should share information about, and then offer screening for HIV, Syphilis and Hepatitis B. A family origin questionnaire should be completed as part of the NHS sickle cell and thalassaemia screening programme and information regarding the NHS fetal anomaly screening

programme provided. The pregnant person's height and weight should be measured and body mass index calculated. All blood results taken throughout a pregnant persons pregnancy should be checked within 10 days and recorded on badgernet.

An Antenatal Attendance folder should be completed with the patients' details to ensure she does not go unseen in her pregnancy and should be updated at each appointment. Midwives should consider reviewing the women or pregnant people's previous medical records and these should be sourced from the previous delivering hospital or if the women or pregnant people had her baby at ASPH these can be found on Evolve.

All information can be found on the women or pregnant person's maternity app and should be given in a form that is easy to understand and accessible to pregnant women or pregnant people with additional needs, such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. All midwives should be aware of the availability of Language Line and interpreting service as per trust guidance.

At booking the midwife should identify women or pregnant people who may need additional care by the obstetric team and make an appropriate referral (See Appendix 1).

Antenatal risk assessment
An antenatal risk assessment should be carried out at the initial 'booking appointment'. All findings will be documented in Badgernet and a plan documented for any identified risk factors. A further risk assessment will be carried out at every antenatal contact, including reviewing intended place of birth. This should be verbally discussed with the woman or pregnant person and documented on BadgerNet. It is essential that birth choices are enabled so women or pregnant people can participate equally in all decision making processes and to make informed choices about their care.

The risk assessment tool identifies women or pregnant people who:
• can remain within or return to the routine antenatal pathway of care
• may need additional obstetric care for medical reasons
• may need social support and/or medical care for a variety of socially complex reasons (including social services or other disciplines as appropriate).

As part of the risk assessment at every appointment women or pregnant people should be provided with a safe environment and opportunities for the to discuss topics such as concerns at home, domestic abuse, concerns about the birth (for example, if she previously had a traumatic birth) or mental health concerns.

Management plans should be completed and reviewed on Badgernet. They should include a brief summary of relevant history and current issues and be updated as the clinical situation changes.

Example of high quality management plan on BadgerNet:

Midwife's name and date
Mat age 42, previous CS x3
Previous stillbirth (34/40), previous FGR
History of depression – medicated
Current smoker
Tommy's App:
PTB – moderate risk (for cervical length at anomaly USS)
PFA – complete at 14 weeks and update management plan

Plan:
Obstetric pathway – high risk

Intermediate VTE
Referrals made – Willows team, obstetric consultant, smoking cessation

Venous Thromboembolism Risk Assessment
Woman or pregnant person's risk factors for venous thromboembolism should be assessed at the first antenatal (booking) appointment and after any hospital admission or significant health event during pregnancy.
Risk assess using the 'VTE risk assessment' section within BadgerNet in line with local and national guidance. Follow the ASPH VTE in pregnancy guideline – see Trust IntraNet. For women or pregnant people at risk of venous thromboembolism, offer referral to an obstetrician for further management.

Body Mass Index (BMI)
Each pregnant woman or pregnant person should have their Body Mass Index (BMI) calculated and recorded at their booking appointment to ensure appropriate management of their pregnancy. Pregnant women or pregnant people who are obese are at greater risk of a variety of pregnancy-related complications compared with women or pregnant people of normal BMI, including pre-eclampsia and gestational diabetes (RCOG, 2018).

- Pregnant women or pregnant people with a BMI of 30kg/m2 or more at this appointment should be offered personalised advice on healthy eating and physical activity. A referral should be made for a Glucose Tolerance Test (GTT) between 24-28 weeks.
- When a woman or pregnant person has a BMI of 35-39kg/m2 a obstetric referral should be made and the woman or pregnant person place on the intermediate growth surveillance pathway. In addition these women or pregnant people should have a repeat BMI risk assessment carried out in the third trimester.
- A BMI of 40kg/m2 or more will require an additional anaesthetic referral and be placed on the high risk fetal surveillance pathway, alongside obstetric input.

Women or pregnant people with a booking BMI of 39kg/m2 should be informed that they should increase their dose of folic acid to 5mg. When a women or pregnant people has a booking BMI of 35kg/m2 or more increases the risk of pre-eclampsia therefore accurate risk assessment for aspirin needs to be carried out before 16 weeks of pregnancy.

Gestational Diabetes Screening
It is essential that pregnant women or pregnant people are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment. Risk factors are taken from NICE's guideline on diabetes in pregnancy:

- BMI above 30 kg/m^2
- previous macrosomic baby weighing 4.5 kg or more
- previous gestational diabetes
- family history of diabetes (first-degree relative with diabetes)
- an ethnicity with a high prevalence of diabetes.
- PCOS

Testing for gestational diabetes should be carried out in accordance with local guidance aligned with the NICE guideline on diabetes in pregnancy.

Pre-eclampsia and hypertension in pregnancy risk assessment

Tommy's Placental Function Risk Assessment Tool carried out at the 14 week appointment that identifies women or pregnant people who may be at additional risk of placental dysfunction and will recommend a fetal growth surveillance pathway and if Aspirin should be advised. Midwives should measure and record the woman or pregnant person's blood pressure at every routine face-to-face antenatal appointment using a device validated for use in pregnancy and offer a urine dipstick test for proteinuria at every routine face-to-face antenatal appointment.

Monitoring fetal growth and wellbeing

Women or pregnant people should be offered a risk assessment for fetal growth restriction at the first antenatal (booking) appointment, and again in the second trimester. Symphysis fundal height measurement (SFH) should occur at each antenatal appointment after 24+0 weeks (but no more frequently than every 2 weeks) for women or pregnant people with a singleton pregnancy unless the woman or pregnant person is having regular growth scans or is unsuitable for SFH measurements . Plot the measurement onto a growth chart in badgernet and compare previous measurements to ensure consistent fetal growth.

At every appointment/contact after 24+0 women or pregnant people should be asked if they have any concerns about their baby's movements at each antenatal contact after 24+0 weeks. Women or pregnant people should be advised to contact the 'Call the Midwife' line at any time of day or night if they have any concerns about their baby's movements or if they notice reduced fetal movements.

Fetal Auscultation should be discussed with women or pregnant people in line with the NICE guidelines. It is worth noting that NICE does not recommend routine antenatal fetal heart ausculatation. However,if fetal heart auscultation is requested the midwife should auscultate the fetal heart with a Pinard stethoscope prior to using a hand held Doppler and should also palpate the maternal pulse to distinguish between the two different heart beats

Tommy's Application

The Tommy's App has been developed in conjunction with the Tommy's National Centre for Maternity Improvement and is supported by both the RCOG and RCM. It is to be used to ensure safe and effective delivery of care to women or pregnant people by using validated algorithms to more accurately assess a woman or pregnant person's risk of premature birth and of developing pregnancy complications that can lead to stillbirth. This web based application should be used by midwives at the women or pregnant people's booking appointment and then again at between 14-16 weeks gestation to allow a placental function assessment to be generated. The midwife should document within the Management Plan box on Badgernet if the woman or pregnant person is excluded from the Tommy's App or has declined participation. However, women or pregnant people should still recommended to register on the App as a source of information. Further reference should be made to the Tommy's app SOP.

Schedule of Antenatal Care

The schedule of antenatal care should be explained to all women or pregnant people. NICE (NG201) Antenatal care guideline recommends that the schedule of antenatal appointments is determined by the woman or pregnant person's needs. For a woman or pregnant person who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman or pregnant person who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate. Women or pregnant people should be reminded that these are the minimum number of antenatal appointments and those with increased risk factors will receive an individualised care plan of maternity appointments.

CO Testing

All women or pregnant people should be offered Carbon Monoxide (CO) testing at the booking appointment, as determined by the Saving Babies' Lives Care Bundle. There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth, premature birth, miscarriage, low birth

weight, and Sudden Infant Death Syndrome (SIDS). Midwives should explain the purpose of the CO screen to the woman or pregnant person and that it is conducted routinely. Ask the woman or pregnant person to take a big deep breath, and hold it for a 15 second countdown, and then exhale completely into the monitor.

If the reading is below 4ppm, tell the woman or pregnant person that her recent level of exposure to CO is low. Check whether the woman or pregnant person has recently given up smoking, and refer to Smoking Cessation service if smoked within 3 months of pregnancy.

If the reading is 4ppm or above tell the woman or pregnant person that the reading is at a level consistent with someone who smokes or who has been exposed to CO. Ask her if she, or anyone else in her household, smokes. If she uses tobacco, explain your concerns and the risks of continuing to smoke. Outline the effects of CO on the placenta and the fetus. Explain that quitting is the best thing she can do to improve her health and the health of their baby. Refer to Smoking Cessation service, unless she decides to opt out. If her partner or others in the household smoke advice should be given for them to contact Smoking Cessation service directly. Where a referral has been sent, this should be followed up by the midwife at the next antenatal appointment to check if the referral was taken up by the woman or pregnant person. Offer to re-refer if necessary. CO testing can be repeated at each appointment if a woman or pregnant person is identified as a smoker at booking and is a required field on Badgernet.

If the reading is 4ppm or above, and the woman or pregnant person insists she is a non-smoker, has stopped smoking, or has not been exposed to second-hand smoke a high CO reading could also be due to a faulty gas appliance or a faulty car exhaust. Ask her to call the Gas Safety Advice Line on 0800 300 363 for expert help. A woman or pregnant person who is lactose intolerant may also have a high reading if she has been consuming dairy products. If women or pregnant people is a non-smoker CO levels should be rechecked at the next appointment.

CO testing should be offered, and the result recorded, if the woman or pregnant person attends this appointment in her 35th or 36th week of pregnancy. If at any subsequent appointment or hospital admission it is apparent that CO testing at the 36 week appointment has been missed the practitioner should offer CO testing then. Testing of all women or pregnant people at the 36 week appointment can be used to reassure women or pregnant people with a low CO level regarding their exposure, to congratulate and encourage those who have stopped smoking, and to refer women or pregnant people with a CO measurement of 4ppm or above for specialist support, highlighting importance of a smoke free home for their baby.

28 Weeks Gestation

If a woman or pregnant person is found to be RhD negative at booking and has a negative antibody screen, she should be offered a Fetal RhD test. These results will available within 14 days. Women or pregnant people with fetus predicted RhD negative do not require any Anti-D in their pregnancy. Women or pregnant people who fetus is predicted positive require both Anti-D prophylaxis between 28 and 30 weeks and sensitising event prophylaxis should this be required. Where the result is inconclusive please refer to the Blood Transfusion Policy.

In addition a further blood test to check full blood count, Ferritin levels, blood group and antibodies should be taken at 28 weeks gestation.

Advice should be provided to women or pregnant people regarding sleep position and avoiding going to sleep on their back after 28 weeks of pregnancy and to consider using pillows, for example, to maintain their position while sleeping.

After 28 weeks health care professionals should discuss and give information on:

preparing for labour and birth, including information about coping in labour and creating a birth plan

- recognising active labour
- On fetal movements in pregnancy and signpost to the Your Baby's Movement in Pregnancy Leaflet
- the postnatal period, including:
- care of the new baby
- the baby's feeding
- vitamin K prophylaxis
- newborn screening
- postnatal self-care, including pelvic floor exercises
- awareness of mood changes and postnatal mental health.

Abdominal palpation should be offered at all appointments after 36+0 weeks to identify possible breech presentation for women or pregnant people with a singleton pregnancy.

Responsibilities of the Community Team Leader
All community and continuity of carer teams are led and managed by a band seven midwifery team leader. The team leader is responsible for the overall management of the team of midwives and for its organisation and running. This includes the adequate staffing for the workload, enabling continuity of care and for ensuring communication and liaison with GP's, Health Visitors and other relevant agencies.

A key role of the team leader is in providing support, advice and overall responsibility for high risk/vulnerable women or pregnant people within the caseload ensuring there is continuous support for the named midwife to enable them to coordinate, plan the antenatal and postnatal care and continuously monitor the plans. The team leader will liaise with the team's named consultant, the community matron and safeguarding team as necessary for support and advice.

Personalised Care Plans
Depending on their circumstances, women or pregnant people and their partners will be able to choose between midwifery led care or care provided by a team of maternity health professionals including midwives and obstetricians. Women or pregnant people should also be offered a choice of place of birth taking into consideration any identified risk factors when making choices. All identified women or pregnant people who are low risk at should be given information about the midwifery led Abbey Birth Centre and will reassessed at 34 -36 weeks gestation about suitability of using the birth centre or for having a home birth.

A Personalised Care and Support Plan is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person. These plans should be proportionate, flexible and coordinated/adaptable to a person's health condition, situation and care and support needs. An individual care management plan will be developed for those women or pregnant people with an identified clinical risk and will be documented in the pregnancy and birth record. Women or pregnant people should be informed at booking of the possible pathways of care which are available to them and where they will be seen and who will undertake their care.

Homebirth
All low risk women or pregnant people should be offered a planned home birth. At booking, and during the antenatal period, the midwife should discuss the choices available to the woman or pregnant person regarding place of birth including homebirth. This should include an individualised risk based discussion. A home visit should be arranged at 36 weeks to assess the birthing environment, and to discuss plans for the birth and preparation for labour. The midwife should discuss practical arrangements and complete a 'Notification of a Woman or pregnant person's Intention to have a Home Birth' (found in appendix 2 of the Home Birth Policy) and complete a 'Home Birth Assessment' on badgernet.

If a high risk woman or pregnant person requests to have a home birth, the Consultant Midwife should be referred to for advice via a Badgernet referral.

Induction of labour and Membrane Sweeps
At antenatal visits after 39+0 weeks, discuss with women or pregnant person if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them. As per NICE guidance women or pregnant people with uncomplicated pregnancies should be offered induction of labour (IOL) at 41+0.

Please refer to the Induction of Labour guideline

Infant Feeding discussions and preparation
Midwives should discuss feeding choices and relationship building at least once in each trimester. Conversations regarding infant feeding should be documented in the electronic patient notes as 'conversations in pregnancy'. Breastfeeding/breastmilk should be promoted as the healthiest way to feed a baby and midwives should share the '*term, well baby' feeding leaflet* antenatally to help parents make informed choices and prepare to feed their baby safely.
Midwives should signpost parents to the antenatal infant feeding workshops from 32-34 weeks gestation and promote/ facilitate collecting colostrum antenatally for all birth parents from 36 weeks gestation. The *Vulnerable baby feeding leaflet* should be shared if a small, sick or preterm birth is anticipated and the *Milk as Medicine* parent leaflet if it is likely that a baby will be admitted to NICU.

Safeguarding
Child Protection is the responsibility of all midwives and the Maternity Safeguarding Children Guideline aids health care professionals to recognise any child where there is a safeguarding concern and respond appropriately. Midwives should consider the pregnant persons parenting capacity and consider family, household and environmental factors. Midwives have a responsibility in the management of a child where a safeguarding concern has been recognised and ensure that all affected children receive appropriate and timely therapeutic and preventative interventions.

Referrals should always be made in any of the following circumstances:

- Children in the household/family currently subject to a child protection plan/child in need plan or previous child protection concerns.
- A sibling (or other child in the household of either parent) has previously been removed from the household either temporarily or by court order.
- There has been a previous unexpected death of a child whilst in the care of either parent.
- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children.
- Severe mental illness, domestic violence, or substance misuse.
- Concerns about parental ability to self-care and/or care for the child e.g. unsupported, young parents, or parents with learning disabilities.

- All teenagers age 16 and under.
- Avoidance of antenatal care, non-compliance with necessary services, non-compliance with treatment with detrimental effects for the unborn baby.
- Booked for maternity care at 20 or more weeks with no previous antenatal care.
- X3 or more DNA of appointments with no legitimate explanation.
- Any other concerns that the baby may be at risk of significant harm.

Referrals should be made as soon as the midwife is aware of the concerns, using the Request for Support Form (RSF). Parents should be informed of the decision to make a referral to Children's Services.

Interpreting Services
All health care professionals should ensure that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman or pregnant person rather than using a family member or friend. All use of interpreting services must be documented in the electronic maternity record. The midwife must also ensure that interpreting services are booked for any further antenatal appointments. A labour birth plan should also consider use of an interpreter.

Internal resources such as 'In-House Interpreters' List (which includes staff from a range of clinical and non-clinical backgrounds) can be used when comfort needs are addressed. For accurate clinical interpretation or urgent translation external professional resources such as Language Line, British Sign Language (BSL) or Professional translators especially when gaining consent.

Language Line 0800 028 0073 (Client ID – 270016)

Hounslow Interpreting and Translation Services
Face to Face interpretation or BSL is organised by Hounslow Interpreting Services via on-line link
www.hounslow.gov.uk/translation cost centre 900811

References

Lewis, G (ed) 2007. The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confi dential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH.

Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021.

NICE (2021) Antenatal Care. London: RCOG.

Weekly clinic schedule

Day	Morning	Afternoon
Monday	**Dr Jo Hale (JH)** Multiple births/cardiac OBJHMU	**Miss Ngozi Izuwah-Njoku (NIN)** General Obstetrics OBMOMU Runs 3 out of 4 weeks
Tuesday	**Dr Karin Leslie (KL)** Maternal Medicine OMMEMU	**Mr Jay Choudhury (JKC)** General Obstetrics OBTUMU Alternate Tuesdays **Mr James Phillips (JPH)** General Obstetrics OBTUMU Alternate Tuesdays
Wednesday	**Mr Gans Thiagamoorthy (GTH)** Prev 3rd/ 4th degree tears. Urogynae OBGTMU Alternate Weeks 1&3 **Mr James Thomas/ Dr Ward (JMT)** Diabetic / Medical Clinic DBWEMU	**Miss Sadiya Hussain (SMH)** Perinatal Mental Health OBWEMU Alternate Weeks 1&3
Thursday	**Dr Sian McDonnell (SCM)** Fetal Medicine OBFMMU	**Miss Lilian Ugwumadu (LU)** OBTHMU Preterm birth clinic Recurrent Misc, LLETZ, cone biopsy Alternate Weeks 1&3
Friday	**Miss Abigail Le-Bass (ALB)** General Obstetrics OBFRMU	