WOMEN'S HEALTH and PAEDIATRICS
MATERNITY UNIT

ANTENATAL SCREENING GUIDELINE

Amendments			
Date	Page(s)	Comments	Approved by
Nov 09		Replaces communication of blood test results	Women's Health Guidelines Group
Nov 12		Whole document review	Women's Health Guidelines Group
Aug 14	Page 2and3 Appendix 2 and 3	Change to MCV values (increased from 100fL to 105fL)	Women's Health Guidelines Group Chairs action
Feb 16		Review and update of standard operating procedures	Women's Health Guidelines Group
April 2018		Whole document review	Women's Health Guidelines Group

Compiled by: Angie Bowles, Specialist Midwife, screening and fetal medicine

In Consultation with: Sandra Newbold Consultant obstetrician; Tanya Bernard, Consultant haematologist; Stephen Winchester, Consultant virologist; all Obstetric consultants

Ratified by: Women's Health Guidelines Group

Date Ratified: **27/11/09**

Date Issued: 24/02/16

Next Review Date: April 2021

Target Audience: All staff working within maternity services

Impact Assessment Carried Out By: Angie Bowles, Specialist Midwife, screening and fetal medicine

Comments on this document to: Angie Bowles, Specialist Midwife, screening and fetal medicine

ANTENATAL SCREENING - AT BOOKING APPOINTMENT

See also: Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal appointments

Introduction

This guideline aims to describe the process of ensuring all routine maternal screening tests are offered, consent is obtained, undertaken in accordance with woman's wishes and reported on during the antenatal period. The designated lead for antenatal screening in the maternity service is the specialist midwife (screening and fetal medicine), who liaises with laboratory teams, midwives and consultants (obstetric, neonatal, hepatology, genitourinary medicine, fetal medicine) in relation to the management of national screening tests.

Screening for infectious diseases (IDS), HIV, Hepatitis B and Syphilis and sickle cell and thalassemia (SCT) is offered in accordance with the National Screening Committee guidance https://www.gov.uk/government/collections/nhs-population-screening-programme-standards

Additional tests offered at booking include, full blood count, blood group and antibodies and urine sample for asymptomatic bacteremia.

Women should have their initial booking appointment, have initial blood samples taken (subject to consent) and be given access to the Badgernet maternity record by ten weeks gestation.

Roles and Responsibilities

- **The Associate Director of Midwifery** holds overall responsibility for the effectiveness of the Antenatal Screening process within the Maternity service

- **Specialist Midwife for Screening and Fetal Medicine** – The specialist midwife is responsible for overseeing and coordinating the National Screening Committee programmes. The specialist midwife is the communication line from the laboratories to the maternity service and is responsible for ensuring the process of recording and disseminating results is robust. This includes maintaining the failsafes for each antenatal screening programme. In addition, the specialist midwife will provide expert advice and support for all screening related issues.

  The specialist midwife will ensure all screen positive and/or incomplete results are acted on appropriately, including communication to the women concerned and the relevant teams e.g. neonatology, community midwifery teams.

  The specialist midwife is responsible for reporting any concerns regarding the screening process to the Associate Director of Midwifery.

- **Screening support midwife –** the screening support midwife reports to the Specialist midwife and is responsible for supporting the processes for implementing the National Screening programmes, as above, under the guidance of the Specialist midwife. This includes communication with the laboratories and disseminating results to women as appropriate. In the absence of the Specialist midwife, the support midwife will maintain the service, seeking the relevant specialist advice as required.

- **The maternity ultrasound department** respond to maternity referrals by sending the woman a copy of "Screening tests for you and your baby" booklet and an appointment for first trimester scan

- **Booking midwife.** This will normally be the woman's named midwife. The booking midwife is responsible for ensuring that the woman has received a copy of the screening tests booklet and that informed consent has been obtained before taking all the relevant booking bloods. A professional interpreter/language line will be used where relevant, in accordance with the Trust Guidelines for using Interpreting Services. The screening test leaflet is available in multiple languages and in easy read and audio versions

- The booking midwife is responsible for ensuring the specimens are sent to laboratory on the day of sampling and for following up the results within ten days. The midwife is responsible for recording the results onto Badgernet and liaising with the specialist midwife in respect of any screen positive results.

- If the woman declines any screening tests, the booking midwife must record this in woman's records and inform the Specialist Screening midwife.

- **Named midwife-** All women will have a named midwife responsible for overseeing her care. The named midwife is responsible for ensuring, at every antenatal review, that the woman has received all test results, and that any further investigations and/or treatment have been initiated and recorded in the hand held records. The named midwife is responsible for facilitating shared planning and working with the Screening midwives when there are screen positive results.

Late Bookers - >13/40

If a woman presents to the maternity service and is unbooked, the woman must be booked and **usual "booking bloods" must be offered and marked "fast track" on the request form**.
The notes must clearly indicate when samples have been taken so that the relevant midwife taking over the care of the woman is aware of the need to obtain results.
The results should be known and given to the woman before she is discharged from current admission or attendance.
If results for infectious diseases screening are not available (declined or in process but not yet reported) at time of birth, the neonatal team must be notified. It may be appropriate to test baby directly or test a cord blood sample).

***Any blood results or outstanding blood results must form part of the hand over and be recorded on the SBAR sticker**

In the case of a concealed pregnancy or a significant lack of antenatal care a Datix report must be made. Safeguarding referral may be needed.

Information giving

The National Screening Committee (NSC) booklet "Screening tests for you and your baby" is sent to the woman by the maternity ultrasound department with the scan appointment and specific consent form for scan/trisomy testing. A sticker is applied to the leaflet to alert women to translated material available.

Standard Operating Procedure for Booking Midwife
(or management of women with known conditions – please see section below)

1. Ensure woman has received booklet "Screening tests for you & your baby". The booking midwife should ensure that the woman understands the content and that it is offered in the appropriate format/language. Consider need for professional interpreter.
2. Discussions about the specific tests offered at the booking appointment and answer any questions.
3. Obtain consent, using the booking bloods form.
4. Ensure all sections of the booking bloods form is completed, including the following-

- Name and demographics – **please ensure the name is spelt correctly & note on form if recent change of name**
- Hospital and NHS number
- Tick the box for ASPH
- Tick boxes to indicate that the woman has consented to infectious diseases
- Complete the family origins questionnaire (FOQ) NB this is NOT nationality!
- Complete haematology and blood transfusion section
- Record on Badgernet

5. Take blood sample using one gold top, one purple top and one pink top bottle and label according to Trust policy. ***Please note stickers cannot be used on pink bottles**
6. Place the bottles into the bag attached to the booking bloods form.
7. Obtain a mid-stream urine sample and perform a dipstick test.
8. Place urine sample in red top bottle, label and complete blue pathology form as per Trust policy for microscopy, culture and sensitivity (MCandS).
9. If any **additional tests** required e.g. thyroid function test – these samples **must be sent separately**, with a separate request form.
10. All specimens must be sent to the lab the day they are taken.
11. **If woman admitted in labour unbooked/without having record of routine "booking bloods" these must be sent as "urgent" (see below).**
12. Samples are transported to the lab by the following means-

- By GP courier service
- By community midwife in person using the 'red transport box'
- By hospital porter

Women with known conditions

Women with known thalassemia, sickle cell or unusual haemglobin variants –

- Record known information on the booking bloods form and enquire if baby's father has been tested.
- Contact the Specialist Screening midwife by phone for advice and to refer.
- Specialist Screening Midwife will arrange immediate follow up.
- Booking midwife must follow up and record plan in hand held notes.

Women with known history of infectious disease, e.g. HIV, Hepatitis B etc.

- Record known information on the booking bloods form and any information about current treatment
- Contact Specialist Screening midwife by email to inform & agree management

Women who decline any screening

The woman's wishes are paramount and if she declines screening this must be respected. However, consideration should be given to the consequences of undiagnosed infection, both to staff and to the baby.

Roles and responsibilities if a woman declines testing:

- Booking midwife :
    - ensures woman understands nature and purpose of test offered
    - elicits reason for decline
    - records woman's decision & rationale on Badgernet. This will be recorded as a risk issue for labour.
    - informs specialist midwife
    - discusses with team leader
    - reoffers at 16/40 appointment, informing specialist MW of outcome
- Team leader:
    - reviews information with midwife
    - assesses need for additional appointment to discuss with woman
    - assesses if involvement of specialist and/or counselling midwife is appropriate
- Specialist screening midwife:
    - available for advice/discussion
    - will seek to meet with woman at time of anomaly scan to discuss
    - maintains database of woman who decline testing
    - records in mother and baby file details of woman who declines re-offer, to alert Neonatal team
- Neonatal doctor:
    - Has discussion with mother if testing has been declined throughout pregnancy. This will ideally be in labour , so that maternal or cord blood testing can be considered.

Results

Routine cases: All results must be obtained within 10 days of taking the blood samples**.**
Women in labour previously untested: Must be sent as urgent and results obtained before woman is transferred from labour ward

- Booking midwife to access results on Winpath
- Record results on to Badgernet, within 10 days of sampling
- Alert specialist midwife & Datix if results not available at 10 days.
- The screening team will record results which they have been informed of by the lab and are actioning.
- Any other results such as, low haemoglobin (Hb), blood group and rhesus negative status or positive urine specimen must be actioned appropriately – see below.

Rejected samples

- If Winpath shows that the sample has been rejected or a test not completed for any other reason, the booking midwife must contact the woman by telephone for a repeat blood test.
- A repeat blood sample should be taken within 10 days of the rejected sample being reported.
- If after several attempts the midwife is unable to contact the woman, a letter should be sent with an immediate appointment to repeat the blood test. A copy of this letter should be filed in the outside covers.
- As with all samples, all repeat samples must be checked within 10 days and actioned and documented on the tracker and ultimately the hand held notes.

Reviewing results

The booking midwife is responsible for checking the screening test results within 10 days and ensuring that any issues (e.g. missing samples) are resolved within 10 days of laboratory report.

It is not acceptable to wait until the woman's next appointment to check results/repeat any samples

- Normal results are discussed with the woman at the next appointment.
- Abnormal results:
    - The midwife must email/phone the specialist screening midwife as a failsafe precaution and to confirm what action has been taken/is planned
    - Screen positive results are followed up by the specialist midwife with support from community midwife as appropriate (e.g. to arrange partner testing)

Action to be taken in respect of Screen Positive Results

Screen positive (Variant result)

See SOP re sickle cell and thalassaemia screening for detailed process

- The Haematology laboratory, Surrey Pathology, informs the screening midwifes on the shared email account asp-tr.anscreening .nhs.uk.
- Screening midwife will contact the woman and arrange an appointment to discuss the results, and arrange testing for the father of the child if appropriate.
- Named midwife will liaise with screening midwives as failsafe
- Midwives providing specialist information and counselling will have completed the appropriate specialist training (i.e. PEGASUS or Kings University module)
- Written carrier information is given.
- For women who are unsure of paternity, or whose partners are not available or decline screening, prenatal diagnosis (PND) should be offered following counselling.

At Risk Pregnancy (both parents carriers of a significant Haemoglobin variant)

- Couples identified as having a pregnancy at risk are offered appointment to see specialist midwife and consultant obstetrician for counselling
- Prenatal diagnosis is offered and decisions are clearly documented.
- If a baby is diagnosed with a haemoglobin disorder following PND, parents are offered referral for specialist counselling.
- If the pregnancy is ongoing, the mother's details are recorded in the "Mother and Baby file" in the Antenatal Clinic to notify the paediatric team.
- If parents decline PND, screening midwives record mother's details in the "Mother and Baby file" as the baby is at risk of having a haemoglobin disorder.

Following birth

- Midwife/NICU Nurse should inform the Newborn Screening laboratory of any identified parental haemoglobin variants by recording relevant information on bloodspot card.

Infectious Diseases Screening

Screen positive

HIV

See SOP re infectious diseases screening for detailed process

- Specialist midwife is alerted by email from consultant virologist
- Screening midwife adds information to IDS database to facilitate tracking of follow up care
- Failsafe list is sent by lab weekly on Mondays.
- Named midwife will liaise with screening midwives as failsafe
- Specialist midwife will liaise with antenatal clinic lead midwife and speciality lead for obstetrics to ascertain if this is a new finding.
- Woman will be under care of consultant obstetrician in liaison with GUM consultant.
- If new diagnosis woman will be given appointment to come in for appointment within 2 weeks and will be informed of result by consultants. Initial GUM input will be through Blanche Herriot unit, who will then arrange ongoing care through community based HIV clinic.
- At 34 weeks, the viral load and CD4 count are checked and birth plan written on receipt of results
- At 36 weeks, the women are seen by named consultant and birth plan discussed. Women with an undetectable viral load are advised to have a vaginal birth unless there are any contra-indications.
- All women receive a personalised birth plan.
- Information is shared with neonatal team through mother and baby file.

Syphilis

See SOP re infectious diseases screening for detailed process

- Specialist midwife is alerted by email from consultant virologist
- Screening midwife adds information to IDS database to facilitate tracking of follow up care
- Failsafe list is sent by lab weekly on Mondays
- Named midwife will liaise with screening midwives as failsafe
- Specialist midwife will ascertain if this is a known /new diagnosis.
- Women found to be positive to syphilis are discussed with GUM specialist doctor (Blanche Herriot unit) who advises regarding assessment, counselling and treatment
- If this is new/current infection, woman will be under care of consultant obstetrician in liaison with GUM consultant.
- Information is shared with neonatal team through mother and baby file.

Hepatitis B

See SOP re infectious diseases screening and SOP Dealing with Hep B positive result for detailed process

- Specialist midwife is alerted by email from consultant virologist
- Screening midwife adds information to IDS database to facilitate tracking of follow up care
- Failsafe list is sent by lab weekly on Mondays
- Named midwife will liaise with screening midwives as failsafe
- Specialist midwife ascertains if this is known/new diagnosis and arranges appointment with the woman to discuss result and immunisation programme for the baby.
- Referral is made to a hepatologist
- Screening midwives record diagnosis on Badgernet with alert that that baby requires immunoglobulin and/or immunisation soon after birth
- Information is shared with neonatal team through mother and baby file.
- See paediatric guideline “Hepatitis B immunisation” for immunisation programme

Other results that require actions

- Low Hb – see flow chart (appendix 4 & 5)
- Low or high platelets – see flow chart (appendix 4 & 5)
- Increased Mean Cell Volume (MCV) (appendix 4 & 5)
- Rhesus negative – see flow chart **- see blood transfusion guideline**
- Red cell antibodies – see flow chart

Urine bacteremia

Management

Iron Deficiency Anaemia

- If the MCV is low, consider a haemoglobinopathy. Check lab report and discuss with screening midwife before providing iron supplements
- Women who are known carriers of thalassaemia should have a serum ferritin level checked each time a FBC is checked, and iron supplements should only be prescribed if <30mg/ml.
- If no haemoglobinopathy, iron supplements should be prescribed when:
  - Hb is below 110g/L at the first contact – Ferrous sulphate 200mg (or similar) twice daily (bd)
  - Normal Hb with MCV < 80fL – Ferrous sulphate 200mg bd
  - Hb is below 105g/L at 28 weeks – Ferrous sulphate 200mg bd
- If iron supplements are started at 28 weeks, a FBC should be checked at 34 weeks to ensure an adequate response. If 34 week FBC is not within normal limits arrange for the woman to have serum ferritin, B12 and folate checked and refer to consultant obstetrician.
- If the Hb is less than 95g/L at booking, further investigations are required. Community midwife should arrange for serum ferritin, B12 and serum folate to be taken and results must be reviewed in a consultant antenatal clinic.

Increased Mean Cell volume (MCV)

- An MCV greater than 100fL can be seen in normal pregnancies.
- However, MCV greater than 105fL may be present with folate or vitamin B12 deficiency.
- Check serum folate, ferritin and B12 levels.
- If folate and B12 levels are normal and MCV is still greater than 105fL, inform the antenatal clinic co-ordinator who will discuss with consultant obstetrician as further investigations may be appropriate before an obstetric review.

The results should be discussed with a consultant obstetrician if serum folate, ferritin and/or Vitamin B12 are lower than the normal range. Women who take folate supplements will have a higher level of serum folate and this is of no concern.

Platelets

Gestational Thrombocytopenia is a benign condition seen in normal pregnancy. The platelet count tends to fall progressively during pregnancy. In 5-10% of women, the count will fall below 140 10^9/L.
Reactive Thrombocytosis – the platelet count is raised following an infection or operation. The platelets return to normal slowly once the infection is resolved.

Management

At booking

- If platelets <140 10^9/L or >500 10^9/L, repeat platelet count in 4 weeks

- If still <140 10^9/L or >500 10^9/L, refer to an appropriate consultant. May need referral to consultant haematologist following discussion with the obstetric consultant.

Subsequent blood tests

- If platelets <140 10^9/L or >500 10^9/L, look up previous results and record on results chart.
- If platelets have fallen by >30 10^9/L to below 140 10^9/L, contact woman by telephone and arrange for her to attend MDAU as soon as practicable for full antenatal check, and PET screen.
  - If there is a degree of urgency and the woman is unable to be contacted by telephone, the community midwife should visit the home and ask woman to attend MDAU as soon as possible.
  - If non urgent, send letter with appointment and follow the DNA guideline if the woman does not keep appointment.
- Document follow up arrangements in notes.
- MDAU registrar to check results.
  - If woman appears to have pre-eclampsia refer to guideline *Management of hypertension in pregnancy*
  - If platelets remain low but the other results are within normal limits, refer to Consultant Obstetrician clinic who may discuss further with Consultant Haematologist.
- If platelets >500 10^9/L, repeat in 2-3 weeks after initial sample. If still raised, refer to Consultant Obstetrician who may discuss further with Consultant Haematologist.

White Cell Count

- Neutrophilia (raised neutrophils) is common in pregnancy. If neutrophils >15 10^9/L, repeat FBC in 2-3 weeks and if still raised, refer to a Consultant Obstetrician to discuss with a Consultant Haematologist.
- Neutropenia (low neutrophils) is not normally seen in pregnancy, but is common following a viral infection. If neutrophils <2.0 10^9/L, repeat FBC in 2-3 weeks and if still low, refer to a Consultant Obstetrician who may discuss further with a Consultant Haematologist.

Blood Grouping and red cell alloantibodies

- See guideline for Routine Antenatal Anti D Prophylaxis

All women are offered screening for atypical red cell alloantibodies:

- at booking
- at 28 weeks gestation.

Results

- When an antibody is detected, the lab will request additional samples. The booking midwife must action this request within 10 days. The additional sample is sent to the National Blood Service (NBS) laboratory for confirmation/quantification. The NBS will generate a report which gives instruction for frequency of maternal testing, the need for paternal testing, and management of the woman during the pregnancy. The woman may need referred to a Consultant Obstetrician and in some cases will need fetal medicine referral.
- The specialist midwife will provide advice as needed.

Monitoring
Compliance with this guideline will be monitored through audit and data collection as detailed below

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Responsibility for actions	Method for sharing lessons learned/changes to practice
Screening booklet record as having been provided to woman	Specialist midwife	Badgernet search	Annual, commencing Oct 2018 (Badgernet introduced Oct 17)	Screening committee	Specialist midwife	Information shared in monthly screening email
Proportion of women had "booking bloods" by 10/40	Specialist midwife	Badgernet search	Quarterly	KPI reviewed at screening committee	Specialist midwife	Information shared in monthly screening email
Interval between booking bloods taken & results recorded on Badgernet (target <10 days)	Specialist midwife	Badgernet search	Quarterly, from April 18	Screening committee	Specialist midwife	Information shared in monthly screening email
Unbooked women/previous decliners offered screening in labour	Specialist midwife	Notes audit	Quarterly, from April 18	Screening committee	Specialist midwife	Posters and discussions with LW staff
All staff to attend annual update regarding screening	Staff education lead midwife	Records of mandatory training	Annual	Women's health governance committee	Staff education lead midwife	

References

https://www.nice.org.uk/guidance/qs22/chapter/Quality-statement-1-Services-access-to-antenatal-care (accessed 12.1.18)

https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief (accessed 12.1.18)

https://www.gov.uk/topic/population-screening-programmes/sickle-cell-thalassaemia (accessed 12.1.18)

https://www.gov.uk/topic/population-screening-programmes/infectious-diseases-in-pregnancy (accessed 12.1.18)

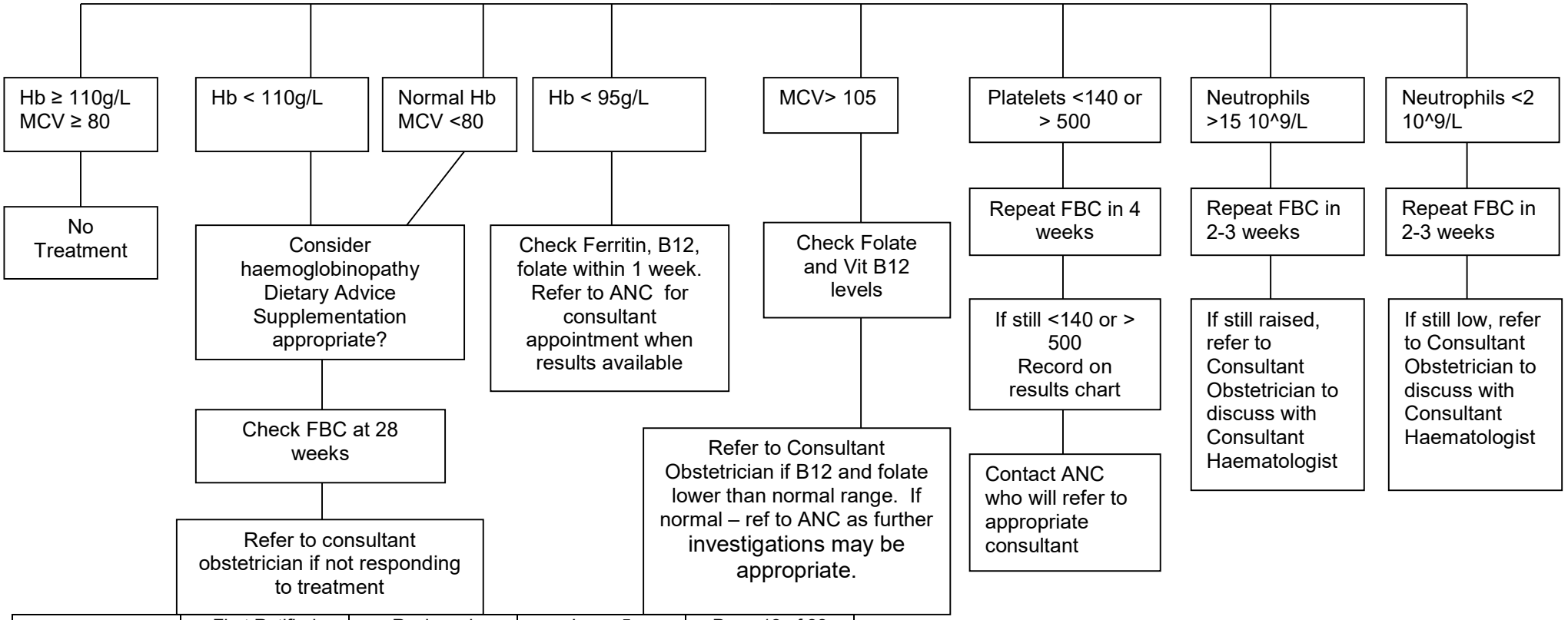
https://www.nice.org.uk/guidance/qs22/chapter/quality-statement-10-screening-national-fetal-anomaly-screening-programmes (accessed 12.1.18)

APPENDIX 1

Ashford and St Peter's Hospitals NHS Trust
Women's Health

Full Blood Count

AT BOOKING



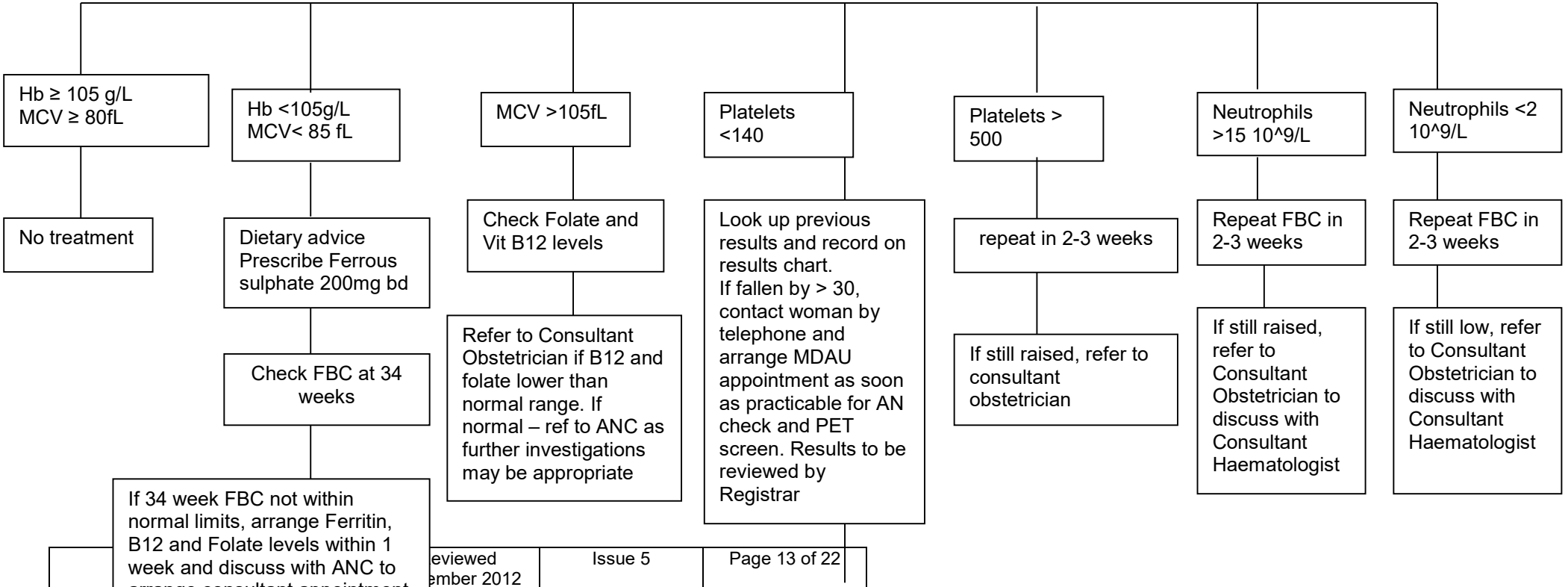
DISCUSS WITH SPECIALIST MIDWIFE IF WOMAN HAS A HAEMOGLOBINOPATHY

APPENDIX 5

Ashford and St Peter's Hospitals NHS Trust
Women's Health

Full Blood Count

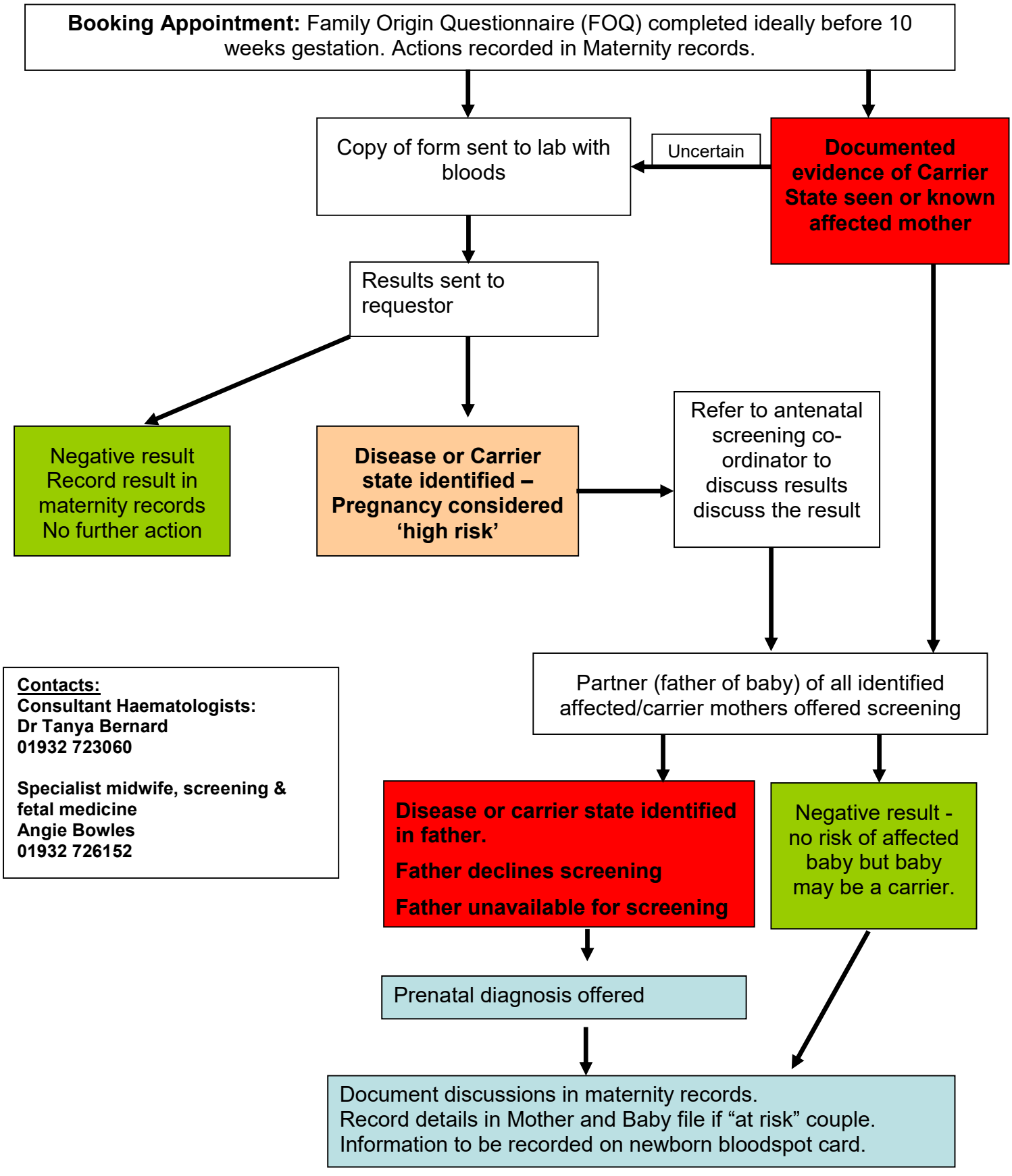
AT 28 WEEKS



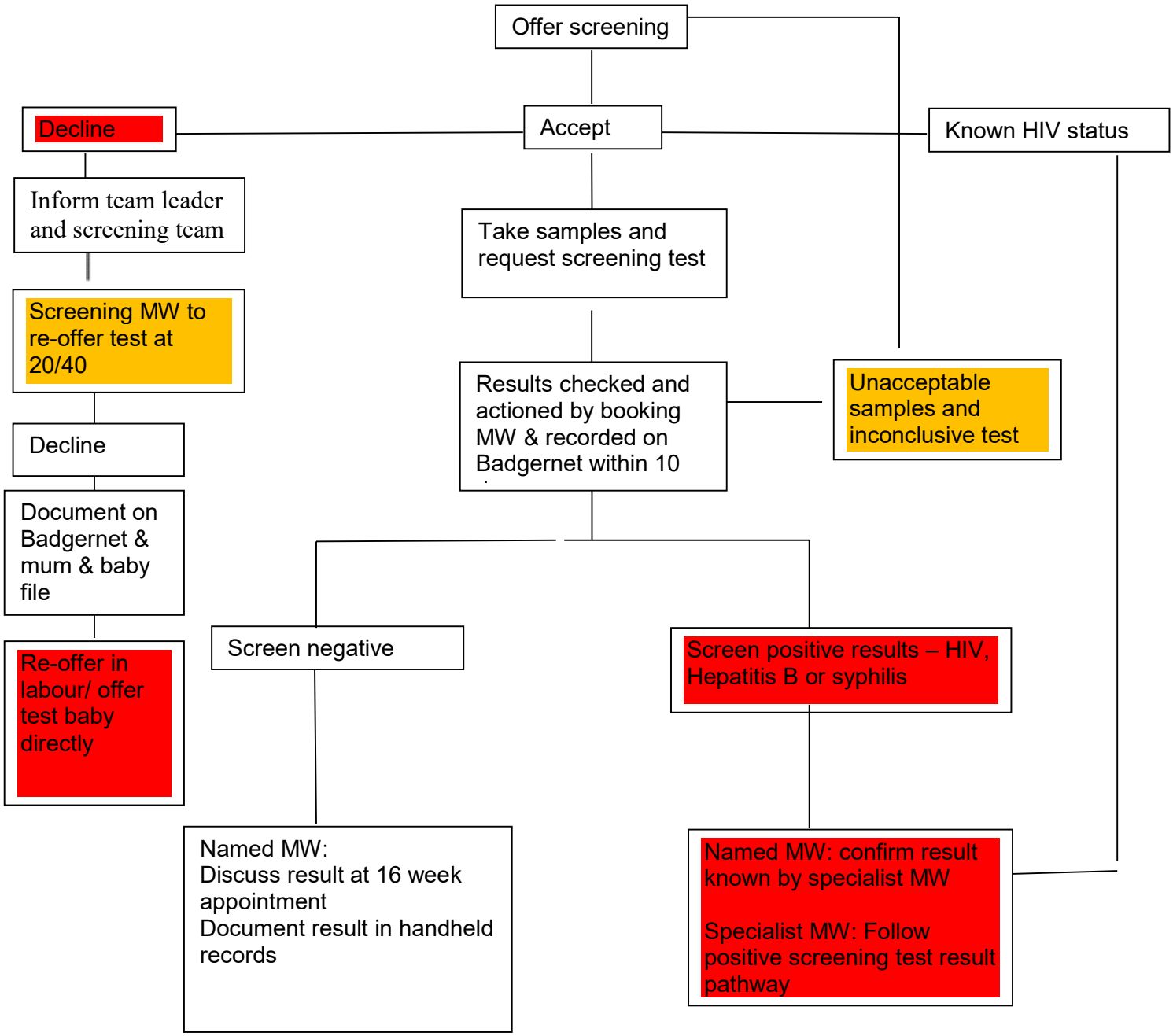
If platelets still low refer to obstetric consultant.

Appendix 6.

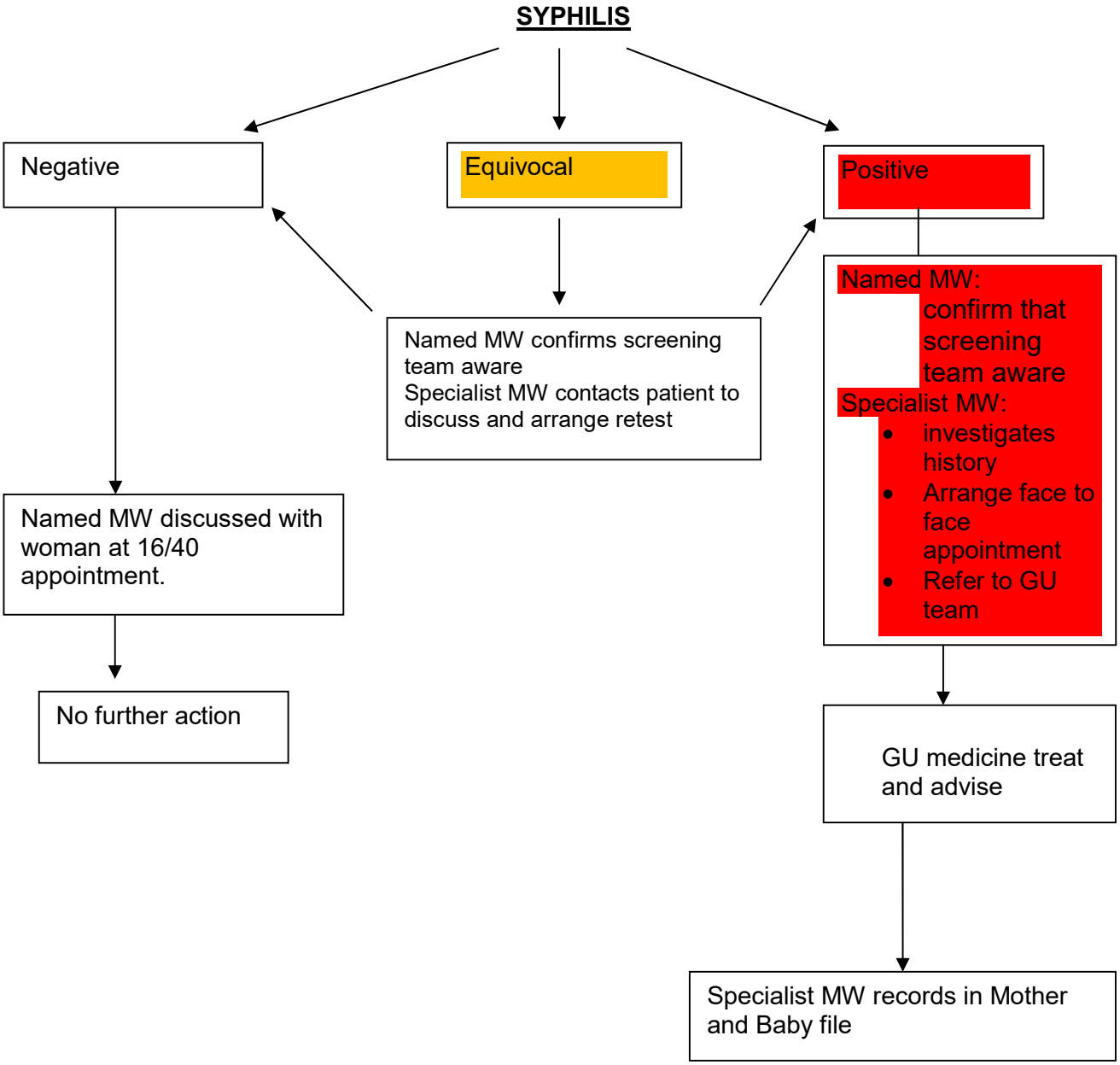
Antenatal Screening Pathway for Sickle Cell and Thalassemia with local Contacts: ASPH



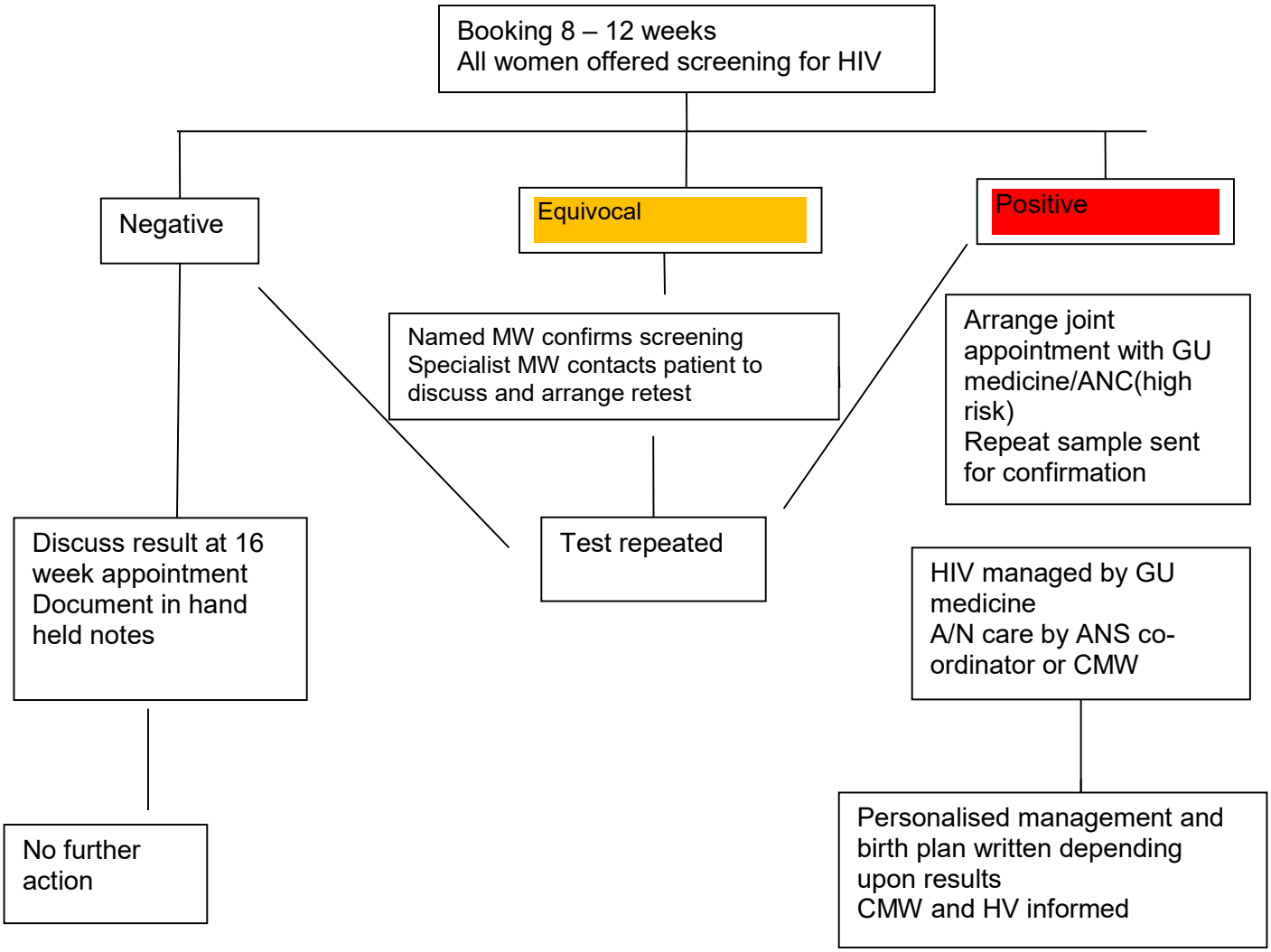
APPENDIX 7 Infectious diseases in pregnancy screening programme



APPENDIX 8 **Ashford and St Peter's Hospitals NHS Trust**
Women's Health



Appendix 9
HIV



EQUALITY IMPACT ASSESSMENT TOOL

Name: Angie Bowles

Policy/Service: Antenatal Screening Guideline

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
• To ensure all antenatal screening tests (following the guidance of the National Screening Committee) are offered, undertaken and reported on within an appropriate timescale. • This guideline is for all women booking to have their baby at Ashford and St. Peter's Hospital. • Angie Bowles, Specialist midwife, screening & fetal medicine
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
• The guideline will affect all pregnant women. Any abnormal results will be communicated either by face to face consultation or by letter. • National Screening Committee; NICE guidelines for antenatal care of the healthy pregnant woman • Dr T Bernard, consultant haematologist; Dr Stephen Winchester, consultant virologist; all consultant obstetricians, CMW team leaders
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
• There is no potentially adverse impact for any equalities groups
Conclusion • Provide a summary of the overall conclusions
• All women are offered antenatal screening tests, and any advice or treatment required is offered in a timely manner
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
• No changes required as a result of the impact assessment • The guideline will be reviewed in 3 years or sooner if need arises

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Antenatal Screening Guideline
Name of Person completing form:	Angie Bowles
Date:	February 2018

Author(s)	Angie Bowles
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Angie Bowles
Date of final draft	08/02/18
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Angie Bowles
Is this a new or revised policy/guideline?	Revised

Describe the development process used to generate this policy/guideline.
Sandra Newbold consultant obstetrician, Tanya Bernard, Consultant haematologist, all Obstetric consultants. Maternity Guidelines Group
Who is the policy/guideline primarily for?
All staff working within the maternity services
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity services only
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Bonus day training, intranet, newsletters, notice boards in clinical areas
Describe the process by which adherence to this policy/guideline will be monitored.
See monitoring section in guideline. All national screening programmes are audited in real time and reported through national KPIs
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See references section in guideline
What (other) information sources have been used to produce this policy/guideline?
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact identified
Other than the authors, which other groups or individuals have been given a draft for comment?
See development process section
Which groups or individuals submitted written or verbal comments on earlier drafts?
See development process section
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered-some incorporated following discussion
Have financial implications been considered?
Yes