FAST FIND: antenatal care; place of birth; risk assessment, midwife-led care pathway, routine antenatal care, anaesthetic referral, non-attendance for care, DNA,

DOCUMENT OVERVIEW: provides advice on the care of healthy pregnant women for the use of clinicians providing antenatal care. It also provides the information and factors needing to be considered by women when making an informed choice concerning place of birth and lead professional.

This document may be made available to the public and persons outside of the Trust as part of the Trust’s compliance with the Freedom of Information Act 2000
1. INTRODUCTION

1.1 Pregnancy is a normal physiological process and as such, any interventions offered should have known benefits and should be acceptable to pregnant women. Women should be the focus of maternity care, with an emphasis on providing choice, easy access and continuity of care. Women, their partners and families should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman, her partner and 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. Good communication between healthcare professionals and women is essential. It should be supported by evidence-based, written information. Care and information should be culturally appropriate and tailored to the women’s needs. This policy aims to provide advice on the care of healthy pregnant women for the use of clinicians providing antenatal care. It also provides the information and factors needing to be considered by women when making an informed choice concerning place of birth and lead professional. (NICE 2008)

2. DEFINITION

2.1 Antenatal care begins with conception and ends with the birth. It constitutes screening for health and socioeconomic conditions likely to increase the possibility of adverse pregnancy outcomes, providing therapeutic interventions known to be effective and education women about safe pregnancy and birth (World Health Organisation, 2008)

3. ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
</tr>
</thead>
</table>
| All groups named below      | • following this and associated policies/procedures
• utilise the information within this guideline to provide the best evidence and practice
• take reasonable care of self and others |
| Named Midwife and GP        | • Ultimately responsible for coordination of care for woman and newborn
• To ensure plans for care are clearly documented in the maternity health record and that when women miss appointments, clear documented evidence of attempts to make contact.
• communicate with the multi-professional team
• care for women with an uncomplicated pregnancy, providing continuous care throughout the pregnancy
• referral to obstetric services when risks are identified |
| Midwives                    | • work closely with members of the multidisciplinary team to ensure women receive optimum care to achieve the best outcome
• document and record all observations and management plans
• ensure excellent communication between team members
• To act as experts in the field of normal care and refer when deviation from the normal care pathway occurs
• To inform named community midwife of any missed appointments. |
**Specialist Midwives – Antenatal Screening coordinator, Substance Misuse, Teenage Pregnancy, Vulnerable women’s team, Infant feeding**

- Will act as a resource for women and other maternity healthcare staff caring for woman known to the specialist midwifery team
- Provide expert knowledge during care provision to women identified as in need of specialist services
- To inform named community midwife of any missed appointments.

**Maternity Care Assistants Nursery Nurses**

- To support the midwife and woman / family during the antenatal care period

**Obstetricians**

- should be involved when additional care is needed
- work closely with members of the multidisciplinary team to ensure women receive timely interventions and optimum care to achieve the best outcome
- document and record all observations and management plans
- ensure excellent communication between team members

**Anaesthetists**

- work closely with members of the multidisciplinary team to ensure women receive timely interventions and optimum care to achieve the best outcome
- document and record all observations and management plans
- ensure excellent communication between team members

**Laboratories (haematology / pathology / microbiology)**

- work closely with members of the multidisciplinary team
- process samples and provide results in a timely manner
- provide expert opinions and support
- early senior team member consultant level advice

**Obstetric Gynaecology Audit group**

- Monitoring effectiveness of policy
- Audit and actions

**GOGG (Gloucestershire Obstetric Guidelines Group)**

- Approval and maintenance
- Implementation
- Responsible for review and amendment

**Maternity Clinical Governance**

- Ratification
- Outstanding audit actions

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4. **PROVISION OF ANTENATAL CARE, RISK ASSESSMENT AND CRITERIA FOR PLACE OF BIRTH**

4.1 Risk assessment criteria for-choosing place of birth and identifying lead professional recommended care pathway are found on action card AC4. The initial risk assessment will highlight any deviation or potential deviation from the normal and will instigate a referral for Obstetric Opinion and plan for care if required alongside care stipulated in AC1. All women will be risk assessed using RD6 Y0846 (assessment for place of birth) and will be referred as required using Y1035 (new pregnancy referral form). For women meeting criteria for midwife led care see action card A1 and GHNHSFT Midwife Led Care Policy. Midwifery Partnership Team (MPT) care is available for women fitting the referral criteria, dependant on capacity, see AC2 MPT’s aim is to improve health and pregnancy outcomes by providing an enhanced care model for vulnerable women. Care delivery is centred around the Children’s Centre Bases using a partnership team approach.

4.2 Antenatal appointments should take place in a location that women can access easily and is appropriate to the needs of the women. Midwife to document where the woman was seen and with whom. Midwifery care card record to be commenced and completed throughout pregnancy and postnatal period

4.3 Maternity records should be structured, standardised and held by the women. Previous pregnancy notes will be screened for vulnerabilities using AC1 in A1114 Vulnerable Women: Pregnancy and Complex Social Factors. Midwives will request GP surgeries to share women’s medical record summary with maternal consent using document Y1605 ‘Midwife Request to GP for Patient Summary Record’. Information sharing box to be signed in hand held maternity care record.

Good communication between health care professionals is essential for effective care; complete Y1273 Midwife / Health Visitor / GP Liaison Form for all women and refer to A1107 Midwifery and Health Visiting Service Communication.

4.4 In an uncomplicated pregnancy, there should be:

- 10 appointments for nulliparous women
- 7 appointments for multiparous women

(see action card AC1 for the schedule of appointments and expectations for each appointment )
4.5 Women should have the opportunity to discuss sensitive issues and disclose problems. All women should be seen on their own at least once during their pregnancy. Health professionals should be alert to signs of safeguarding issues and should any concerns arise, an Y0467 Midwives Notification of Concerns Form see RD 1 should be completed.

4.6 The assessment of living situation (domestic abuse) will be discussed and the box completed and signed in the hand held record, when this discussion has taken place. A ✓ meaning discussion has taken place and no concerns have been raised, a ✗ meaning disclosure of problems and blank meaning opportunity for discussion has not yet occurred and needs to take place. GHNHSFT Safeguarding adults policy. In known domestic abuse cases women should as standard practice have the opportunity to be seen alone at key points throughout the pregnancy to discuss concerns and plan care for themselves and their unborn baby not only with midwives, but with other members of the multidisciplinary team where appropriate, refer to A1114 Vulnerable Women: Pregnancy and Complex Social Factors and A2151 Domestic Abuse Safeguarding Policy.

4.7 Safeguarding concerns should be highlighted in the special consideration boxes using the code SG. When SG is annotated the midwife caring for the woman should access the Health Records to ascertain what concerns have been identified and any plans for care.

4.8 Prediction, assessment and detection of mental health disorders is a standard aspect of antenatal care. All women will be screened using the Whooley questions at booking and 36/40 following A1078 Perinatal Mental Health guidance.

5. WOMEN CENTRED CARE AND INFORMATION GIVING
5.1 Women, their partners and their families should always be treated with kindness, respect and dignity. Care and information should be culturally appropriate.

5.2 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 Trust Protocol A0251 'Mental Capacity Act 2005'.

5.3 Good communication between healthcare professionals and women is essential. Where communication is a problem either due to special needs or language difficulties, staff should refer to Trust Translation and Interpretation Policy & Guide and A1114 Vulnerable Women: Pregnancy and Complex Social Factors

5.4 Information should be given in a timely manner appropriate for the women’s gestation; this should be documented in the maternity hand held care record. For further details on patient information and discussion please refer to A2003 Maternity Provision of Information Policy.

6. ANTENATAL SCREENING
6.1 For all antenatal screening offered at GHNHSFT please refer to A1119 Maternal antenatal screening and test results and AC1.

6.2 Pregnant women should be informed about the purpose of any test before it is performed, with Trust or national approved patient information where available. The healthcare professional should ensure the woman has understood this information and has sufficient time to make an informed decision. The right of a woman to accept or decline a test should be made clear and any subsequent decision to accept or decline screening must be documented in the hand held records.

6.2.1 For women who attend for maternity care late into their pregnancy, antenatal screening tests should be offered at the earliest opportunity. For comprehensive details of the required tests please refer to A1119 Maternal antenatal screening and test results and AC1.

6.2.2 For any concerns regarding genetic conditions please complete RD10 and refer the woman to Gloucester Clinical Genetics for further information.

7. BOOKING APPOINTMENT
7.1 When a pregnant woman makes the first contact with a health professional.
• If the first contact is with a midwife, the woman will be given the standard pre-booking information pack and asked to complete her details within the healthcare records.

• If the first contact is with a General practitioner (GP), an appointment will be made for the woman to see her midwife, at which point the standard pre-booking information pack will be given.

7.2 A booking visit should ideally be done by 10 weeks of the pregnancy, and the first full booking visit and hand-held records completed by 12 weeks, utilising Y0854 Pregnancy Booking Form see RD 2 and Y1035 New Pregnancy Referral form see RD 3 Following the booking appointment, the appropriate documentation is completed by the midwife, including the computer record, ensuring the woman is referred for midwife-led or consultant-led care and that all risk assessments are documented in the Maternity Hand Held Records. The hospital health records are then generated and all records of previous pregnancies are requested and amalgamated with current record. See GHNHSFT Maternity Health Records Policy.

7.3 All pregnant women who make their first contact with a health professional after 12 weeks of pregnancy (late bookers), should be seen within 2 weeks of their referral to the maternity service. The process for arranging such appointments is as point 7.1; the community midwife will ensure this is completed within 2 weeks of first contact and documented as so within the hand held records. When women move into area the date of booking is the original date of booking with maternity services in any area, this must be entered accurately onto the computer records.

7.4 The booking visit provides the midwife with an ideal opportunity to discuss and provide information on the all the aspects of the pregnancy, health promotion and lifestyle affecting the woman and her unborn baby (NICE, 2008).

Carbon monoxide (CO) screening is standard care and will be offered to all pregnant women, with referral to specialised services for all women with a raised CO reading (see A2006 Smoking Cessation: Antenatal).

Pregnant women should be advised to avoid alcohol in pregnancy. An alcohol screening tool will be used to inform care for women who choose to continue to consume alcohol during pregnancy.

The midwife will also risk assess the woman’s pregnancy and health, based on her medical, previous obstetric, anaesthetic, social/life style and psychological history. Based on this assessment, the midwife will make a recommendation on a suitable lead professional for this woman, in this pregnancy, as well as the most suitable place for her to birth her baby and make referral to relevant lead professional following discussion with the woman, see 7.7. Booking process see action card AC3.

7.5 Every woman will be asked at the booking visit whether they will accept blood and blood products and this will be documented in the Maternity Hand Held Records. Any woman who intends to refuse blood should be referred to a consultant obstetrician for an appointment during the antenatal period and actively encouraged to deliver in The Women’s Centre, Gloucestershire Royal Hospital, see GHNHSFT A0168 Jehovahs Witness (The Treatment of )

7.6 Risk assessment of a woman’s pregnancy is an on-going process dependant on changes of her and her unborn baby’s health. A formal risk assessment is undertaken at booking, 36 weeks and at the commencement of labour and fully documented in the hand-held records (see document Y0846 Assessment for place of birth). Best practice would be to utilise the risk assessment boxes/ special consideration boxes within the ante-natal post-natal and intrapartum sections.

7.7 At any point, if the woman develops risk factors that necessitates a change in the lead professional for her care, this should be clearly documented in her hand held records, maternity hospital records (if accessible) and computer records. However, if risk factors develop on the intrapartum period resulting in a change of lead professional; it is acceptable to omit documenting this change in the woman’s hand held notes. Documentation in the maternity hospital records should reflect discussions with the woman...
and the identified risk factors necessitating a recommended change in the lead professional in the woman’s care.

7.8.1 Where a woman who does not meet the criteria for Midwifery led care and declines consultant care, follow A1110 High Risk Women Requesting Low Risk Care for Delivery and consider referral to birth choice clinic.

7.8.2 For women who have marginal risk factors, the community midwife may choose to refer for an obstetric opinion before recommending a suitable lead professional. Dependant on the Obstetric opinion a woman may then be referred back to the midwife led care pathway. This opinion and plan for care must be documented in the maternal hand held records.

7.8.3 In some circumstances women may have no risk factors be suitable for midwife led care but request epidural for labour, in these circumstances midwife led care can be provided antenatally, with the planned place of birth at the obstetric unit to accommodate the request for epidural, opting out of midwife led care.

7.9 At booking woman are asked the routine overseas patient questions and referral to the overseas department See AC 6 – Overseas Patients referral Process

8. SUMMARY OF ANTE NATAL SCHEDULE AND EXPECTATION FOR EACH APPOINTMENT / RISK ASSESSMENT (See action card AC1)

8.1 At each antenatal visit this schedule will be followed to provide evidence based care (NICE 2008). Any deviation from the normal, highlighted during the risk assessment, warrants discussion, referral as necessary and a clear management plan documented within the maternity health care records.

8.2 When a risk is identified during the risk assessment at each antenatal visit, the midwife undertaking the examination should refer the woman to the consultant obstetrician for review and further management plan, by telephoning the antenatal clinic and making the next available appointment. If the risk identified is urgent direct contact should be made to the Triage / on-call obstetrician and admission to hospital arranged. Women who are managed on the high risk pathway should maintain the minimum schedule of appointments with their named community midwife to ensure consistency and coordination of care.

8.3 At 36 weeks a risk assessment must be undertaken, to ensure booked place of birth is still appropriate (see section 4.1).

8.7 When a risk factor is identified that will impact on the intrapartum or postnatal periods, a management plan should be recorded on the special instructions boxes in the postnatal pages and on the front of the pink birth notes. For example if a woman develops high blood pressure and is commenced on beta-blockers special consideration should be documented in the birth notes and postnatal pages regarding observations and blood glucose monitoring of the neonate.

9. PROCESS FOR REVIEWING AND FOLLOW UP OF RESULTS
For detailed arrangements for the process of reviewing, follow up and filing of antenatal tests results please refer to Trust Antenatal Screening Policy.

10. WOMEN WHO DO NOT ATTEND FOR ANTE NATAL CARE (DNA)
10.1 Women must be informed that it is their responsibility to make appointments with the midwife or the General Practitioner (GP). A schedule of visits must be outlined in the woman's hand held notes and contact telephone numbers clearly provided. Consider and review factors for non-attendance outlined in A1114 Vulnerable Women: Pregnancy and Complex Social Factors.

10.2 Midwives/ health professionals should provide clear and documentary evidence of attempts to make
contact with women who fail to attend for antenatal care. This should be easily accessible to all health professionals who may be involved with an individual's care provision. Clear documentation in the Maternity Health Care Records recording attempts to make contact and give antenatal care will assist in informing all health professionals involved in maternity care. Maintain accurate midwifery care card to highlight women who are failing to access care.

10.3 If a woman fails to attend for ante-natal care complete Y1131 Non-attendance ante-natal care proforma. Update midwifery care card accordingly and refer to A1114 Vulnerable Women: Pregnancy and Complex Social Factors.

12. MATERNITY REFERRALS FOR ANAESTHETIC ASSESSMENT

12.1 The Consultant Obstetric Anaesthetists must be informed about all patients who have a medical condition or religious beliefs that could become a problem in labour, so that they can anticipate potential problems and prepare to minimise any risks (Association of Anaesthetists' of Great Britain and Ireland and the Obstetric Anaesthesia Association 2005 & Confidential Enquiry into Maternal & Child Health 2007).

12.2 Any member of the midwifery or medical staff can directly refer a woman for an anaesthetic referral. Y0967 Anaesthetic Referral form, see RD 5 to be sent to Department of Anaesthesia, Ground Floor Tower Block, GRH

12.3 Referrals must be made as soon as any potential problem is identified in the woman’s pregnancy.

12.4 Referral Criteria

12.4.1 The following list suggests the conditions for which women should be referred for an anaesthetic assessment. Depending on the problem this may involve seeing the patient in the antenatal clinic and formulating a plan for care or a phone call may be all that is needed for patient reassurance.

<table>
<thead>
<tr>
<th>A past medical history of any anaesthetic problems</th>
<th>Have had previous difficulties with, or complications of, spinal/epidural anaesthesia or general anaesthesia. Allergy to suxamethonium; Known suxamethonium apnoea. History or family history of malignant hyperpyrexia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Problems</td>
<td>Severe asthma; cystic fibrosis; pulmonary embolus on anticoagulants; history of pneumothoraces</td>
</tr>
<tr>
<td>Neurological Problems</td>
<td>Any neuromuscular disease e.g. muscular dystrophy; multiple sclerosis; focal neurological signs; Poorly controlled epilepsy; myalgic encephalopathy (ME); spina bifida</td>
</tr>
<tr>
<td>Muscular-skeletal Problems</td>
<td>Scoliosis; Harrington rods; Rheumatoid arthritis / Still’s Disease. Connective tissue disorders associated with cardiac abnormalities eg marfans, ehlors danlos.</td>
</tr>
<tr>
<td>Endocrine problems</td>
<td>Unstable thyroid disease</td>
</tr>
<tr>
<td>Haematological problems</td>
<td>Idiopathic thrombocytopenia purpura (ITP); sickle cell disease; congenital spherocytosis; Von Willbrand’s Disease; previous or known to have VTE</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>Renal transplant</td>
</tr>
<tr>
<td>Allergies/ Drug sensitivities / Drug abuse</td>
<td>Multiple allergy syndromes; allergies to local anaesthetics; latex allergy; allergy to suxamethonium; Known scoline apnoea history or family history of malignant hyperpyrexia history of intravenous drug abuse</td>
</tr>
<tr>
<td>Airway Problems</td>
<td>Known difficult intubation; obvious anatomical features suggestive of a difficult intubation e.g. bucked teeth, receding jaw; reduced neck movement</td>
</tr>
<tr>
<td>Rare But Serious Medical Conditions</td>
<td>Malignant disease</td>
</tr>
<tr>
<td>Known Obstetric Conditions That Pose An Increased Risk</td>
<td>Placenta praevia</td>
</tr>
</tbody>
</table>
During Labour
- Planned Caesarean section with complex past surgical history; more than 3 previous Caesarean sections
- Multiple pregnancy

Cultural/Religious Beliefs
- Women who decline blood or blood products
- Any religious/cultural beliefs which may have a detrimental impact on care

Obesity
- All patients with a BMI greater than 40 at booking
- Patients with a BMI greater than 35 with co-morbidities
  (The referral letter should include both BMI and weight of the patient)

Cannulation issues
- Needle Phobia
- Known difficult iv access

Cardiovascular problems
- All patients with structural heart abnormalities or rhythm disturbance.
- Patients with new rhythm disturbances should in the first instance be referred to cardiology

13. TRAINING

<table>
<thead>
<tr>
<th>*Level of training required</th>
<th>Staff Group / s</th>
<th>Division / Department</th>
<th>Frequency of training / update</th>
<th>Method of training delivery</th>
<th>Lead and department responsible for provision of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Midwives and obstetricians</td>
<td>Women and Children's</td>
<td>Once</td>
<td>Cascade of information via meetings and newsletter</td>
<td>K.Davis, S.Claridge</td>
</tr>
</tbody>
</table>

*Levels of Training
- A = Awareness (Micro-teach, drop in session, e-learning)
- B = ½ day (2.5 – 3 hours) (workshop, training event, e-learning)
- C = Full day (5-6 hours) (workshop, training event)
- D = Course (more than one day training)

14. MONITORING OF COMPLIANCE
14.1 This list is not exhaustive and additional criteria may be included at the Trust discretion
14.2 Sample sizes selected will be dependent on the cohort size. The data collection period will be identified by the Maternity Audit Lead
14.3 Action plans will be developed and reviewed as required by the instigating body
14.4 The audit will be carried out using the standardised audit tool and methodology as agreed by the maternity audit team and in line with the audit process.
14.5 The audit results will be presented to the multidisciplinary Obstetrics and Gynaecology Audit presentation meeting.
14.6 Where deficiencies are identified, an action plan will be developed by the Multidisciplinary Obstetrics and Gynaecology Audit presentation meeting. These action plans are implemented and monitored by the appropriate forum (Maternity Newborn Clinical Forum or Divisional Board Dashboard).

15. REFERENCES

GHNHSFT Midwifery Led Care Gloucestershire Hospitals NHS Trust
GHNHSFT Anentinal Screening Policy

GHNHSFT (2012) Health Records Policy

GHNHSFT (2011) Translation and Interpretation Policy & Guide Gloucestershire Hospitals NHS Trust


GHNHSFT (2008) Trust Patient Information and Discussion guideline Gloucestershire Hospitals NHS Trust


Nursing and Midwifery Council (NMC)(2004) Midwives Rules and Standards


Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children HM Government DCSF Publications 2010
<table>
<thead>
<tr>
<th>Version</th>
<th>Reason for review</th>
<th>Ratified</th>
</tr>
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<tbody>
<tr>
<td>Version 1</td>
<td>Written September 2008</td>
<td>Sarah Claridge Community Midwifery Manager and Helen Best Community Midwife</td>
</tr>
<tr>
<td></td>
<td>New guideline with NICE Antenatal Care document</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
</tr>
<tr>
<td>Version 2</td>
<td>Review following CNST</td>
<td>Anushia Goodman Practice Development Midwife</td>
</tr>
<tr>
<td>Version 3</td>
<td>Review with Midwife led care Pathway development</td>
<td>Sarah Claridge Community Midwifery Manager and Dawn Morall Assistant Director Midwifery and Nursing</td>
</tr>
<tr>
<td>Version 4</td>
<td>Review following Audit, formal non attendance process</td>
<td>Sarah Claridge Community Midwifery Manager and Dawn Morall Assistant Director Midwifery and Nursing &amp; Kirsty Davis Practice Development Midwife</td>
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<tr>
<td>Version 5</td>
<td>Minor amendments following a risk incident regarding high risk care planning</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
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<tr>
<td>Version 5.1</td>
<td>Revision following Midwife Led review</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
</tr>
<tr>
<td>Version 5.2</td>
<td>Pt 6.1 Updated to reflect combined screening process</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
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<tr>
<td>Version 5.3</td>
<td>Addition of pt 6.2.2 and RD 10</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
</tr>
<tr>
<td>Version 6</td>
<td>Triennial Review</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
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ANTENATAL CARE POLICY V6
ISSUE DATE: December 2016
REVIEW DATE: December 2019
# ROUTINE ANTENATAL CARE POLICY

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>REFERENCE NUMBER</td>
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<tr>
<td>VERSION</td>
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| AUTHORS           | Kay Davis  
                      | Emily Beach |
| ISSUE DATE        | December 2016 |
| REVIEW DATE       | December 2019 |
| ASSURING GROUP    | Maternity Clinical Governance |
| APPROVING GROUP   | Gloucestershire Obstetric Guideline Group (GOGG) |
| APPROVAL DETAILS |  09/09/2008 item 3.3 – GOGG  
                       12/09/2008 – Trust Clinical Policy Group  
                       25/08/2009 item 4.3.2 – GOGG  
                       15/09/2009 item 9 – Trust Clinical Policy Group  
                       08/10/2009 item 138/09/35 – Senior Nurse Committee  
                       19/11/2009 item 152/09.24 – Senior Nurse Committee  
                       03/09/2010 item 4.1 – GOGG  
                       21/12/2010 item 4.1.16 – GOGG  
                       02/08/2011 – GOGG minor amendment to V3  
                       03/04/2012 – GOGG  
                       23/04/2013 item 6 – GOGG  
                       October 2013  
                       07.10.2014 item 4.4 – GOGG  
                       05.05.2015 item 3.2 – GOGG  
                       December 2016 - GOGG |
| DISSEMINATION DETAILS | Upload to Policy Site; cascade via Women and Children’s Division |
| KEYWORDS          | antenatal care; place of birth; risk assessment, DNA, Non attendance, Anaesthetic referral, |
| RELATED TRUST DOCUMENTS | AC1 Midwife led care pathway  
                          AC2 Midwifery Partnership Team (MPT) Antenatal Referral Pathway  
                          AC3 Booking process  
                          AC4 – Assessment for Place of Birth and Referral Recommendations  
                          AC5 Non attendance for antenatal care process  
                          AC 6 – Overseas Patients referral Process  
                          RD 1 Y0467 Midwives Notification Of Concerns  
                          RD 2 Y0854 Booking Proforma  
                          RD 3 Y1035 New Pregnancy Referral form  
                          RD 4 Y1191 Midwife-led Care Sticker  
                          RD 5 Y0967 Anaesthetic Referral form  
                          RD 6 Y0846 Assessment for Place of Birth  
                          RD 7 Y1131 Non Attendance for Antenatal Care Checklist  
                          RD 8 Standard Non Attendance letter  
                          RD 9 Community Midwives Calling Card |
| OTHER RELEVANT DOCUMENTS | Safeguarding adults policy  
                           Translation and Interpretation Policy & Guide  
                           Maternity Provision of Information Policy  
                           Antenatal Screening  
                           Gestational Diabetes Guideline |
Gloucestershire Hospitals
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

INITIAL SCREENING

<table>
<thead>
<tr>
<th>1. Lead Name:</th>
<th>Kirsty Davis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title:</td>
<td>Practice Development Midwife</td>
</tr>
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<table>
<thead>
<tr>
<th>2. Is this a new or existing policy, service strategy, procedure or function?</th>
</tr>
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<tbody>
<tr>
<td>New</td>
</tr>
<tr>
<td>Existing ✓</td>
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<table>
<thead>
<tr>
<th>3. Who is the policy/service strategy, procedure or function aimed at?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
</tr>
<tr>
<td>Any other</td>
</tr>
<tr>
<td>Please specify:</td>
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</table>

<table>
<thead>
<tr>
<th>4. Are any of the following groups adversely affected by this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes is this high, medium or low impact (see attached notes):</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>No</th>
<th>✓</th>
<th>Yes</th>
</tr>
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<tbody>
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<td>Disabled people</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Race, ethnicity &amp; nationality</td>
<td>No</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Male/Female/transgender</td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>Age, young or older people</td>
<td>No</td>
<td>✓</td>
<td></td>
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<tr>
<td>Sexual orientation</td>
<td>No</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Religion, belief &amp; faith</td>
<td>No</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

If the answer is yes to any of these proceed to full assessment.
If the answer is no to all categories, the assessment is now complete.

Date of assessment: 19.8.09
Completed by: K.Davis
Signature: PDM
Director: Signature:

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIA’s are completed in accordance with this procedure.