Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/CAD/ID 3402

Please reply to:
FOI Administrator
Trust Management
Service Centre
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

03 January 2017

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Maternity patients risk classification.

1. The number of maternity patients classed as high risk, classed as low risk, and classed as intermediate risk (or any other categories) when each patient's record was last updated

2. The maternity unit's policy on referrals to midwife led units for each year: specifically the factors considered high risk (such as specific BMI, sexual activity, specific age threshold, previous history etc). If policies are not available for each year please provide the most recent versions available.

3. The name of the database software used to store information on maternity patients (e.g. Euroking, etc) and the data dictionary for that data. A data dictionary is merely a list of the column names (fields) used to store the data, such as risk classification, risk factor etc.

1.
Maidstone and Tunbridge Wells NHS Trust is unable to provide the information in the way it has been requested.

2. Please find attached the policy for the Birth Centre at Maidstone Hospital which has been open since 2011.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Criteria for giving Birth in the Birth Centre or at Home

Requested/ Required by:	Women's & Sexual Health Directorate
Main author:	Consultant Midwife (SG)
Other contributors:	Matron for Community Services (AM)
	Maidstone Birth Centre Managers (KL & CM)
	Crowborough Birth Centre Manager (EC)
Document lead:	Consultant Midwife

sarah.gregson@nhs.net

Supersedes:	Criteria for giving birth in the Birth Centre or at Home (2014);
	Vs 1.0; subsequent minor amendment so then supersedes
	Criteria for giving Birth in the Birth Centre or at Home (2016);
	Vs 2.0
Directorate:	Women's & Sexual Health Directorate
Specialty:	Midwifery
Approved by:	Guideline Group **Date:** 10 March 2016
Ratified by:	Clinical Risk Management Group **Date:** 16 March 2016
	Directorate Meeting **Date:** 18 March 2016
Review date:	March 2019

Document History

Requirement for document:	To ensure robust risk assessment and review of risk designation throughout pregnancy and birth: • RCOG • NMC • RCM
Cross References / Associated Documents:	**Cross References:** Maidstone & Tunbridge Wells NHS Trust. Trust intranet, Q-Pulse Policy & Guideline System, Women & Children's Procedures Database: • Antenatal Booking Appointments & Referral for Consultant led Care • Maternal Transfer guideline • Operational Policy for Maidstone & Crowborough Birth Centres (currently in Draft) **Associated Documents:** Hollowell et al. (2013) The impact of maternal obesity on intrapartum outcomes in otherwise obese low risk women: secondary analysis of the Birth Place study. (2013) *British Journal of Obstetrics and Gynaecology*. John Wiley and Sons National Institute for Health and Clinical Excellence (2008) Antenatal care for uncomplicated pregnancies. London: NICE. Available at: http://www.nice.org.uk/CG 62) National Institute for Health and Clinical Excellence. (2014). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: http://www.nice.org.uk/CG55 Nursing and Midwifery Council. (2012) *Midwives Rules and Standards.* London. Available at: www.nmc-uk.org Nursing and Midwifery Council. (2015) *The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics.* Available at: www.nmc-uk.org Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. (2011) *BMJ;*

	343:d7400. Available at: www.bmj.com/contents/343/bmj.d7400 Royal College of Midwives. (2009) *Standards for Birth Centres.* London: RCM

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of document	May 2011
2.0	Updating information around multiparous women with BMI 35-39 delivering in 'out of hospital' settings	February – March 2016
2.1	Minor amendment to correct Grand Multiparity to P4 Section 5.6 (page 13)	18 May 2016

Guideline Statement for

Criteria for giving Birth in the Birth Centre or at Home

Giving birth in the UK is generally safe and without major morbidity for both mother and baby (NICE, 2014). Most women have uneventful pregnancies and birth outcomes under the care of a midwife as the lead professional. This success is dependent upon robust risk assessment and review of risk designation throughout pregnancy and birth.

Criteria for giving Birth in the Birth Centre or at Home

Contents

1.0 Introduction and Scope of Procedural Document

- This document applies to all midwives and obstetricians undertaking antenatal care

Scope

- To provide midwives and obstetricians with clear guidance for booking criteria and Risk Assessment to identify LOW RISK women for midwife led care in the Birth Centres or at home.

- To provide clear guidance for staff when women request homebirth / Birth centre birth against medical advice

2.0 Definitions

Midwife Led Care

- Care is shared between community or birth centre midwife and the woman's GP
- Birth may be either in the home, in one of the Birth Centres or in the hospital, depending on the women's choice

Consultant Led Care

- If risk factors are identified, an appointment at a consultant obstetrician antenatal clinic will be offered to plan subsequent care. This may include a schedule of appointments with community midwife built around the woman's individual needs
- A referral for an obstetric opinion can be made at any point during the pregnancy. Where the consultant agrees midwife led care is suitable, the woman should be transferred back to the care of the Birth Centre / community midwife as the lead professional
- Identification of current lead professional should be documented and dated on the front of the Pregnancy Hand Held Record. The current lead professional should be amended in the records when any change to the lead is agreed

3.0 Duties

It is the registered professional's responsibility to ensure that advice re place of birth is based on current evidence, always acting in the patient's best interests.

4.0 Training / Competency Requirements

- Registered midwives and medical staff caring for obstetric patients have a professional responsibility to maintain their competence in assessing women for suitability for midwifery led care using the agreed tool

- All midwifery staff will be expected to use this documentation and their managers will ensure that they have access to guidelines and intranet guideline facilities

- All community team leaders and antenatal clinic midwives will ensure that midwives are fully competent in risk assessment and booking process. Training will be delivered when new midwives join the team

- All medical staff will be aware of the risk assessment tool and will ensure that women referred to them for an opinion will have a decision documented and if suitable for Midwifery Led Care will be referred back to the community midwife

Cross-reference to:
Trust Intranet system, Q-Pulse system, Women's & Children's Procedures Database

- Antenatal Booking & Risk Assessments guideline
- Maternal Transfer guideline
- Operational Policy for Maidstone & Crowborough Birth Centres

5.0 Procedure

5.1.1 Planning place of birth

When planning place of birth the women should be informed:

- That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications, she should be advised to give birth in hospital

- That the obstetric unit provides direct access to obstetricians, anaesthetists and paediatricians and other specialist care including an epidural service

- For 'low risk' women the incidence of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth related injuries including brachial plexus injury) is low (4.3 events per 1000 births) in all maternity settings.

5.1.2 Birth Centre Birth

- Birth Centres are safe for the baby and offer benefits for the mother. There are no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit

- Women who planned birth in a midwifery unit have significantly fewer interventions, including substantially fewer intrapartum caesarean

sections, and more ‘normal births’ than women who planned birth in an obstetric unit

- The likelihood of being transferred into the obstetric unit is 36% for first time mothers and 8-10% if they already have one or more children. The anticipated time of transfer from Maidstone or Crowborough Birth centre (or home) to hospital in the event of an emergency is approximately 24 minutes from both Birth centres to Tunbridge Wells Hospital by blue light ambulance)

- If labour is unexpectedly complicated by risk factors at home or in the Birth centre, there will be delay in accessing medical care whilst transfer takes place

5.1.3 Home Birth

Multiparous women
For women having a second or subsequent baby, home births are safe for the baby and offer benefits for the mother. There are no significant differences in adverse perinatal outcomes between planned home births and planned births in obstetric units.

For multiparous women, birth at home significantly reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy.

For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births.

Nulliparous women
For nulliparous women, a planned home birth increases the risk for the baby There were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units, and this finding was statistically significant.

For women having a first baby at home, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth. The peri-partum transfer rate was 45% for planned home births.

5.2 Risk Assessment

Place of birth should be discussed with all women at booking.

Women who wish to give birth in the Birth Centre or at home should have good general health with an uncomplicated medical and obstetric history. She should have a singleton pregnancy with a cephalic presentation, a gestational age between 37-42 weeks and a BMI of 35 or less (nulliparous women) at booking and on reweighing at 34 weeks. Multiparous women with no co morbidity should have a BMI <40.

Risk assessment should be a continuous process throughout pregnancy. However, a formal risk assessment **must** also be undertaken using the agreed Risk Assessment form (Appendix Four) at 34 weeks gestation to ensure the lead professional remains appropriate for birth. Where possible this visit will be at the Birth Centre if the woman has an uncomplicated pregnancy.

The following tables outline factors which would suggest planned birth in an obstetric unit and those women for whom an individual assessment for place of birth is indicated.

5.3 Medical Conditions indicating increased risk suggesting planned birth at an Obstetric Unit with a Consultant Obstetrician as the lead professional

Disease area	Medical condition	Rationale
Cardiovascular	Confirmed cardiac disease requiring treatment and / or antibiotics in labour	↑Risk maternal morbidity and mortality. Specialised medical care required
	Hypertensive disorders	Need for specialised medical / obstetric care for BP surveillance. ↑risk of superimposed pre eclampsia, adverse perinatal outcomes
Respiratory	Asthma requiring an increase in treatment or hospital treatment	↑Perinatal mortality rate, ↑low birth weight and pre term birth, ↑pre-eclampsia, where asthma poor controlled and affecting maternal oxygen sats.
	Cystic fibrosis	Require specialist medical input and depending upon lung function, additional fetal surveillance.
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major	Specialised medical/obstetric care, ↑ maternal and neonatal morbidity
	History of thromboembolic disorders	Unsuitable as possibly requiring treatment with low molecular weight heparin and medical surveillance. Leading cause of maternal mortality in UK.
	Immune Thrombocytopenia purpura or other platelet disorder or platelet count below 100,000.	Risk of haemorrhage, if incidentally platelets found to be <150 x 10^9/l refer to obstetric care to exclude pathological cause. Some evidence lower limit of normal is 120 x 10^9/l.
	Von Willebrand's disease	May require clotting factors in labour ↑ postpartum haemorrhage
	Bleeding disorder in the woman or unborn baby.	↑ risk of haemorrhage
	Atypical antibodies which carry a risk of haemolytic disease of the newborn.	Need for immediate access to neonatal care.
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended.	IV antibiotics should be administered in consultant unit.
	Hepatitis C with abnormal liver function tests	Need for neonatal assessment in the postnatal period and vaccination
	Carrier of/infected with HIV	Specialised medical/obstetric care during pregnancy and for the neonate in the postnatal period.

	Toxoplasmosis – women receiving treatment.	Adverse perinatal outcomes
	Current active infection of chicken pox/rubella/genital herpes in woman or baby	↑neonatal risks
	Tuberculosis under treatment	Need for specialised medical care
Immune	Systemic lupus erythematosus	↑PIH, ↑preterm delivery, ↑fetal growth restriction. Maternal VTE
	Scleroderma	↑PIH, ↑preterm delivery, ↑fetal growth restriction
Endocrine	Hyperthyroidism Hypothyroidsim	Need for specialist medical care, risks greatest if diagnosed during pregnancy See Table 5.4
	Pre Existing Diabetes (For well controlled gestational diabetes see table 5.4)	Difficulty in managing optimum glucose control, ↑perinatal mortality, ↑congenital malformations, ↑preterm birth↑, pre-eclampsia, ↑birth weight, ↑shoulder dystocia, ↑caesarean section
Renal	Abnormal renal function	
	Renal disease requiring supervision by a renal specialist	↑hypertension, ↑early onset pre-eclampsia, ↑perinatal mortality
Neurological	Epilepsy	Need to monitor seizures, and to deliver in a setting where maternal and neonatal resus available. ↑Congenital abnormality due to medication.
	Myasthenia gravis	
	Previous cerebrovascular accident	
Gastrointestinal	Liver disease associated with current abnormal liver function tests	
Psychiatric	Psychiatric disorder requiring current inpatient care (see also psychiatric disorder Table 5.4)	

5.4 Other Factors Indicating Increased Risk Suggesting Planned Birth at an Obstetric Unit and the lead professional would be a consultant obstetrician

Factor	***Additional Information***	***Rationale***
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficult	
	Previous baby with neonatal encephalopathy	
	Pre-eclampsia requiring preterm birth	↑risk of developing pre-eclampsia greater than nulliparity especially if it developed before 30 weeks
	Placental abruption with adverse outcome	
	Eclampsia	
	Uterine rupture	Need for C/S
	Primary postpartum haemorrhage (more than 500mls or any amount that required additional treatment	↑risk of recurrent 20-25%

	or blood transfusion	
	Retained placenta requiring manual removal in theatre	↑Risk of recurrent (7.9% of women who had MRP previously had further MRP as compared with 0.9% in a control group.) If placenta removed from vagina or mismanagement of 3rd stage may be considered for home/Birth centre birth
	Caesarean section	Risk of scar rupture 0.5%↑ risk placenta praevia and accrete and post partum haemorrhage. Recommended place of birth is a unit with access to CS and on-site blood transfusion. Continuous electronic fetal monitoring in labour is advised.
	Shoulder dystocia	↑risk of recurrence varies from 1%-16%
Current pregnancy	Multiple birth	
	Placenta praevia	
	Pre-eclampsia or pregnancy-induced hypertension	
	Preterm labour or ***preterm*** pre labour rupture of membranes	
	Placental abruption	
	Anaemia – haemoglobin less than 10 g/dl at onset of labour	
	Confirmed intrauterine death	
	Induction of labour	
	Alcohol or drug dependency requiring assessment or treatment	
	Onset of gestational diabetes	
	Malpresentation – breech or transverse lie after 36 weeks of pregnancy	
	Body mass index at booking or on reweighing at 34 weeks of greater than 35 kg/m^2 Nulliparous women	
	Body mass index at booking or on reweighing at 34 weeks of greater than 39 kg/m Multiparous women	Individual assessment required for BMI 35-39 kg/m^2
	Recurrent antepartum haemorrhage	
	Unbooked in this pregnancy	
Fetal indications	Small for gestational age in this pregnancy or a slowing in growth	
	Abnormal fetal heart rate (FHR)/Doppler studies	
	Ultrasound diagnosis of oligo-/polyhydramnios	↑risk of poor perinatal outcome
Previous	Myomectomy	↑risk of scar weakening

Gynaecological History		

5.5 Medical Conditions Indicating Individual Assessment When Planning Place of Birth An obstetric opinion should be offered to the woman

Disease Area	*Medical Condition*	*Rationale*
Cardiovascular	Cardiac disease without intrapartum implications	
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease	
	Sickle-cell trait	
	Thalassaemia trait	
	Anaemia – haemoglobin 10 g/dl at onset of labour	
	Idiopathic thrombocytopaenia (cut off at 100,000)	If incidentally platelets found to be <150 x 10^9/l refer to obstetric care to exclude pathological cause
Infective	Hepatitis B/C with normal liver function tests	Note Hepatitis B will require a plan for postnatal vaccination agreed with paediatric team.
Immune	Non-specific connective tissue disorders	
Endocrine	Unstable hypothyroidism such that a change in treatment is required Hyperthyroidism (see Table 5.2)	Will need a TSH at day 7 post delivery if deemed suitable for home/ birth centre birth.
	Gestational diabetes (well controlled diet only)	May require discussion with paediatric team
Skeletal/neurological	Spinal abnormalities	
	Previous fractured pelvis	
	Neurological deficits	
Gastrointestinal	Liver disease without current abnormal liver function	
	Crohn's disease	
	Ulcerative colitis	
Psychiatric disorder	Stable at present	May require discussion with MIMHS

5.6 Other Factors Indicating Individual Assessment When Planning Place of Birth

Factor	*Additional Information*	*Rationale*
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause	

	Pre-eclampsia developing at term	
	Placental abruption with good outcome	
	History of previous baby more than 4.5kg	
	Extensive vaginal, cervical, or third- or fourth-degree perineal trauma	↑risk of recurrence 4.4% as compared to 0.8% in all multiparae (95% of those with a previous 3rd degree tear deliver without further obvious trauma to sphincter) Consider extent of previous damage, and any other contributory factors.
	Previous term baby with jaundice requiring exchange transfusion	
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation):	Review by consultant team
	Body mass index 35-39 (multiparous only)	Multiparous women with a BMI >35-39 and no other co-morbidity, may be individually assessed for place of birth by their maternity team (Hollowell et al, 2013)
	Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions	
	Para 4 or more	
	Recreational drug use	
	Under current outpatient psychiatric care	
	Age over 40 at booking High head at term in a nulliparous woman Women refusing ultrasound Late booking or poor attendance for antenatal care Issues in relation to informed consent	Review by consultant team Review by consultant team at 36 weeks These are absolute risk factors for maternal death. 17% of women booking after 22 weeks or pregnancy or missing 4 routine appts. Requires assessment at 36 weeks by consultant Women who do not speak English or with learning difficulties should be offered an interpreter/advocate when discussing/consenting to birth centre/home births. Women who do not speak English should have an individual to translate for them during labour. Young women <16years, good practice to include family support for birth centre care.

Fetal indications	Fetal abnormality	
Previous Gynaecological History	Major gynaecological surgery	
	Cone biopsy or large loop excision of the transformation zone	
	Fibroids	↑risk pre-term labour, placental abruption, breech presentation, unstable lie, and poor progress in labour. Vigilance required for PPH

5.7 Referral for an Obstetric Opinion

- During the booking appointment the midwife may identify criteria requiring an opinion of an obstetrician for further assessment and to discuss the appropriate place for delivery

- When requesting an obstetric opinion the midwife must be clear on the risk assessment referral form (Appendix 4) identifying the reason for referral

- A clear plan of care must be documented in the woman's Pregnancy Hand Held Record. After the obstetric consultation, the obstetrician must advise the woman and midwife of the plan for care and if she remains suitable for LOW RISK Midwifery Led Care. The consultation should be documented within the Pregnancy Hand Held Record

- If the consultation has changed the designation of risk to HIGH RISK; this must be documented within both hospital records and Pregnancy Hand Held Record with a management plan. The lead clinician for the woman must be identified and documented

5.8 Women requiring individual assessment 'Silver Star'

Conditions requiring individual assessment in determining suitability for the Birth Centre, such as women with a 'stable' medical condition with low risk of complications for labour and birth, are reviewed by the Consultant Midwife, Birth Centre managers and Birth Centre link obstetrician as appropriate, in discussion with the woman's midwifery / obstetric team. Individualised birth plans are agreed and formulated and the final decision will be communicated to the woman and Community Midwife.

5.9 Requesting Home Birth / Midwifery Birth Centre against Medical Advice

- A woman with pregnancy complications / risk factors will not be able to give birth in the Birth Centre

- If a home birth is requested and risk factors have been identified, the midwife must discuss the potential risks with the woman and document this clearly in the woman's Pregnancy Hand Held Record. The midwife should recommend the woman has a further joint discussion with a consultant obstetrician or consultant midwife or supervisor of midwives

- Should the woman decline a further discussion with a consultant, the case notes should be viewed by a consultant obstetrician or consultant midwife who should record their opinion / advice in the records. A supervisor of midwives must also be involved with this process

- It is important that a plan of care is documented within the records and that the woman is aware of the management plan

- If the woman requests to give birth at home against medical advice full support must be given to those midwives who will be providing care. A case management discussion should take place involving community midwife, consultant midwife, supervisor of midwives and obstetrician to ensure a plan is made and available to all staff likely to be involved

6.0 Monitoring and audit

Monitoring and Audit of this guideline will be identified with issues raised via Clinical Risk / Clinical Governance.

Potential Auditable standards include:

- All women will be risk assessed at booking using the agreed tool for Low Risk criteria and/or the E3 booking printout, this must be documented clearly in the Pregnancy Hand Held Records

- Women who have identified morbidity or risk factors will be referred to the appropriate specialist consultant clinic

- Women will be risk assessed by the community midwife at 34 weeks to ensure that the management plan for birth remains the same; if there are changes this must be documented

- Women will have the lead midwife/consultant name on the front of the notes clearly identifiable

- All women who request a home birth against medical advice will have the opportunity to discuss her plans with a consultant obstetrician and consultant midwife

APPENDIX ONE
[Compulsory]

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved this policy/procedural document will be published on the Trust intranet by the Maternity Compliance & Safety Co-ordinator or Maternity Secretary (as appropriate).

1.2 On publication of any Maternity document, the Maternity Compliance & Safety Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.

1.3 On receipt of notification, all managers should ensure that their staff members are aware of the new publications.

1.4 Women & Children's Clinical Governance Newsletter (Quarterly publication)

2.0 Review

2.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.

2.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

3.0 Archiving

3.1 The Trust intranet retains all superseded files in an archive directory in order to maintain document history

3.2 Old paper guideline copies pre-dating Datix Guidelines are stored at:

Chatham Archive & Storage Document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634826665

APPENDIX TWO
[Compulsory]

CONSULTATION ON: Criteria for giving Birth in the Birth Centre or at Home

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Sarah Gregson, Consultant Midwife (email: sarah.gregson@nhs.net)

By date: Tuesday, 15 March 2016 *(all documents must undergo a minimum of two weeks consultation)-*

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	01/03/16			
Consultant Anaesthetists (Obstetric)	01/03/16			
Consultant Paediatricians (CD & Guideline lead)	01/03/16			
Head of Midwifery	01/03/16			
Consultant Midwife	01/03/16			
Maternity Matrons – Inpatient & Community	01/03/16			
Supervisors of Midwives	01/03/16			
Team Leads	01/03/16			
Governance & Risk Manager	01/03/16			
Maternity Clinical Risk Manager	01/03/16			
Midwifery Staff via email	01/03/16	18/05/16	Y	Y
Birth Centre Managers	01/03/16		Y	Y
Trust Transfusion Practitioner	01/03/16			
Theatre staff leads	01/03/16			
Consultant Haematologist	01/03/16			

APPENDIX THREE

Equality Impact Assessment
In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Criteria for giving Birth in the Birth Centre or at Home
What are the aims of the policy or practice?	To ensure robust risk assessment and review of risk designation throughout pregnancy and birth.
Identify the data and research used to assist the analysis and assessment	See References on page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	The Trust has an Interpreter Service
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not	No

require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

APPENDIX FOUR

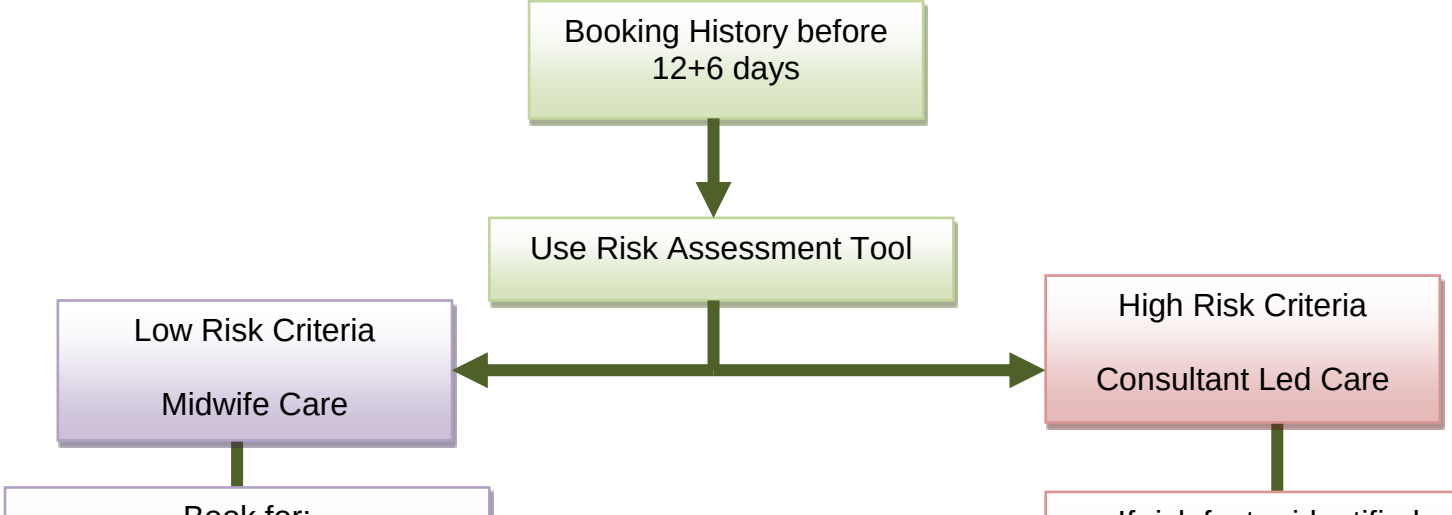
RISK ASSESSMENT FORM FOR LOW RISK CARE 34 WEEKS

Name: Address: Postcode: Hospital Number: NHS number Home phone number: Mobile phone number: Work phone number	GP Surgery Ethnic origin Interpreter required: Yes / No Gravida Para Date of birth Age Confirmed EDD
Midwifery Led Care	**Consultant Led Care** **Reason**
PLACE OF BIRTH – WOMAN'S CHOICE circle below as appropriate	
Birth Centre / Home	
Any Risk factors identified from Risk assessment indicators (see overleaf) **Request Main Hospital Records from Antenatal Clinic** (Tina Usher or Yvonne Ellender extension 24293) **PLACE IN NOTES TRAY ON OFFICE SHELF** **Place this assessment in 'Silver Star' file**	
BIRTH CENTRE OR HOMEBIRTH	
The following have been discussed Risks of transfer (Nulliparous women 36%, Multiparous women 8-10%): No medical/obstetric/paediatric or epidural services are available at Birth Centre and that if any of these services are required, the woman must be transferred to Tunbridge Wells Hospital Potential need for early postnatal discharge depending on Birth Centre capacity Woman's name (printed): Woman's signature:	

FORM COMPLETED BY **Signature** **Print name** **Designation** **Date**	
AGREED SUITABLE FOR BIRTH CENTRE **Name** **Sign** **Date**	
RISK FACTORS BELOW INDICATE REFERRAL TO CONSULTANT FOR PLAN OF CARE	
Maternal age < 16 & > 40 at term (nulliparous woman only) BMI <18 or >35 Parity of 4 or more	Drug / alcohol dependency Learning disability Physical disability Multiple pregnancy
PAST AND PRESENT MEDICAL HISTORY	
Hypertension Cardiac disease Renal or liver disease Epilepsy Anaemia Hb <10 gm / dl Diabetes Asthma (severe) Spinal, pelvic or back trauma	Clotting disorder / Thromboembolism Crohn's disease / Ulcerative Colitis MS or other active neurological problem Carcinoma Thyroid dysfunction Blood disorder (sickle cell / APS / Lupus / Autoimmune) Mental health problems
PAST GYNAECOLOGICAL HISTORY	
Fibroids Uterine Anomaly	Cervical cone biopsy and loop Sexually transmitted disease (last year)
FAMILY HISTORY First degree relative with :	
Diabetes (Does not require a referral but GTT should be arranged at 28 weeks) Cardiac abnormality	Haemoglobinopathies Genetic abnormality Ataxia
PREVIOUS OBSTETRIC HISTORY	
Previous spontaneous 2nd trimester abortion 3 consecutive miscarriages Previous birth weight < 10th centile Previous delivery < 36 weeks Stillbirth / neonatal death IUGR Shoulder dystocia Caesarean section Difficult instrumental delivery Pre eclampsia	Congenital abnormality Placental abruption / praevia Retained placenta Rhesus antibodies / incompatibility Cholestasis Gestational diabetes Previous abnormal GTT Previous 3 degree tear Pre-existing continence problems Anaemia <9.0g / dl
COMPLICATIONS ARISING DURING CURRENT PREGNANCY	
Blood group antibodies Positive VDRL / Hep B or C / HIV Distorted HCG / AFP / UE3 Hypertension Proteinurea without UTI Anaemia ,10gm Abnormal GTT	Low lying placenta (after 34 weeks) Oligo / Poly hydramnios Malpresentation after 36 weeks Confirmed chicken pox / rubella/ parvo infection Group B Strep Any mental health concerns

Small for dates Reduced fetal movements	Recurrent APH
Risk assessment is a continuous process and should be undertaken at every contact Completed form to be faxed to antenatal clinic, birth centre and then filed at front of antenatal notes	
Date and Signature of person completing form	

Pathway for Risk Assessment in Pregnancy **APPENDIX FIVE**



3. We use EuroKing E3 to store information. This is a new system to MTW (since October 2015) The data fields are vast and include all clinical data relating to pregnancy, birth and the postnatal period. The number of fields used varies according to which question sets are required for the contacts and procedures in each record. The data dictionary in use reflects national definitions where applicable. The EuroKing E3 data set is a local modification of their standard model.