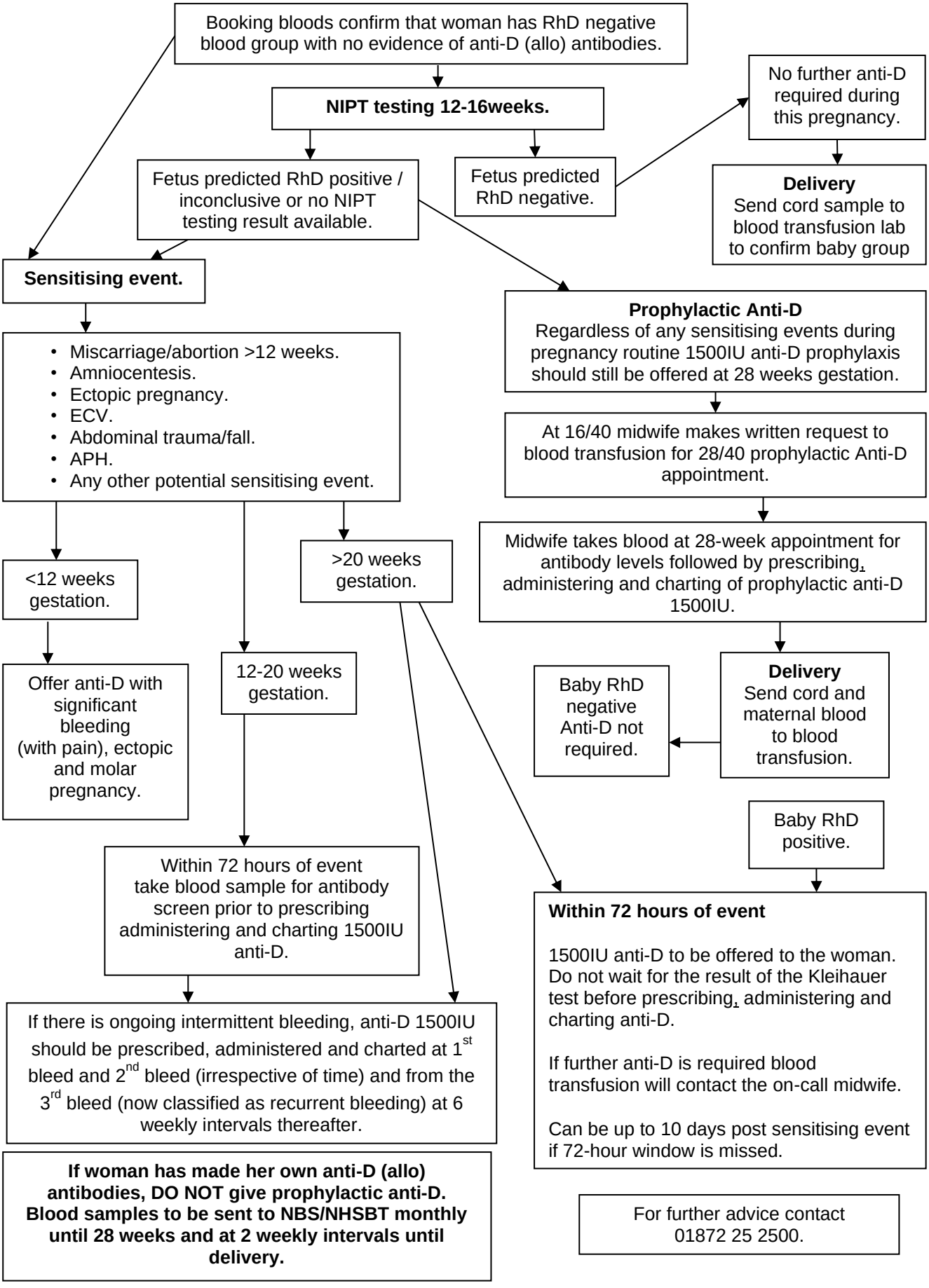
Royal Cornwall Hospitals
NHS Trust

Anti-D Immunoglobulin (Anti–D) for the Prevention of Haemolytic Disease of the Fetus and Newborn Clinical Guideline

V3.1

September 2024

Summary


Booking bloods confirm that woman has RhD negative blood group with no evidence of anti-D (allo) antibodies.
NIPT testing 12-16weeks.
No further anti-D required during this pregnancy.
Fetus predicted RhD positive / inconclusive or no NIPT testing result available.
Fetus predicted RhD negative.
Delivery
Send cord sample to blood transfusion lab to confirm baby group
Sensitising event.
Prophylactic Anti-D
Regardless of any sensitising events during pregnancy routine 1500IU anti-D prophylaxis should still be offered at 28 weeks gestation.
• Miscarriage/abortion >12 weeks.
• Amniocentesis.
• Ectopic pregnancy.
• ECV.
• Abdominal trauma/fall.
• APH.
• Any other potential sensitising event.
At 16/40 midwife makes written request to blood transfusion for 28/40 prophylactic Anti-D appointment.
Midwife takes blood at 28-week appointment for antibody levels followed by prescribing, administering and charting of prophylactic anti-D 1500IU.
<12 weeks gestation.
>20 weeks gestation.
12-20 weeks gestation.
Offer anti-D with significant bleeding (with pain), ectopic and molar pregnancy.
Baby RhD negative Anti-D not required.
Delivery
Send cord and maternal blood to blood transfusion.
Baby RhD positive.
Within 72 hours of event take blood sample for antibody screen prior to prescribing administering and charting 1500IU anti-D.
Within 72 hours of event
1500IU anti-D to be offered to the woman. Do not wait for the result of the Kleihauer test before prescribing, administering and charting anti-D.
If further anti-D is required blood transfusion will contact the on-call midwife.
Can be up to 10 days post sensitising event if 72-hour window is missed.
If there is ongoing intermittent bleeding, anti-D 1500IU should be prescribed, administered and charted at 1st bleed and 2nd bleed (irrespective of time) and from the 3rd bleed (now classified as recurrent bleeding) at 6 weekly intervals thereafter.
If woman has made her own anti-D (allo) antibodies, DO NOT give prophylactic anti-D. Blood samples to be sent to NBS/NHSBT monthly until 28 weeks and at 2 weekly intervals until delivery.
For further advice contact 01872 25 2500.

1. Aim/Purpose of this Guideline

1.1. This document provides Midwives and Obstetricians with guidance on the utilisation of anti-D immunoglobulin (anti-D). Anti-D is administered to prevent sensitisation to the RhD antigen in RhD negative women to prevent Haemolytic Disease of the Fetus and Newborn (HDFN). To be used in conjunction with the Non-Invasive Prenatal Testing of Rhesus negative women for fetal rhesus blood group Standard Operating Procedure (SOP).

1.2. This version supersedes any previous versions of this document and the "Anti-D for Gynaecology Patients (Abortion and Miscarriage) Clinical Guideline".

1.3. Anti-D immunoglobulin should be offered to RhD negative women:

- Following a potentially sensitising event in pregnancy.
- At 28 weeks as antenatal prophylaxis.
- Postnatally to those who have given birth to a RhD positive baby.

1.4. The British Committee for Standards in Hematology (BCSH) (2014, update 2020 and update 2022) and the National Institute for Clinical Excellence (NICE) (2008, last reviewed 2015) has recommended that routine antenatal Anti-D prophylaxis (RAADP) is offered to all non-sensitised pregnant women along with antenatal anti-D prophylaxis (AADP) for potentially sensitizing events. This advice should now be used in conjunction with the British Journal of Obstetrics and Gynaecology (BJOG) NIPT guidance and NICE guidance for NIPT (non-invasive prenatal testing) to avoid the unnecessary administration of anti-D where the fetus is predicted to be Rh D negative during pregnancy.

1.5. The regulator for transfusion services (the Medicines and Healthcare products Regulatory Agency, MHRA) defines anti-D Ig as a medicinal product that falls under Directive 2001/83/EC and not a blood or blood component for transfusion that would be controlled under the Blood Safety and Quality Regulations 2005. Nevertheless, services are expected to maintain traceability of all doses and at RCHT this is best managed through the transfusion laboratory's systems.

1.6. NICE (2008) considered the use of single-dose and two-dose regimens. There was no evidence of a difference in effectiveness between the regimens. Royal Cornwall Hospitals NHS Trust has chosen to utilise the single 1500IU dose. If there is already iv access (e.g. in theatre or on labour ward) then it is kindest to administer Rhophylac through an IV cannula, otherwise it is usually administered as an IM injection.

1.7. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Contraindications

2.1.1. Previous allergy to anti-D. Caution should be exercised in women who have had severe allergic reactions to other blood products or medication. Refer to Consultant for advice.

2.1.2. Women who are already sensitised to the RhD antigen. Women with other RBC antibodies should still be offered anti-D.

2.1.3. Caution should be exercised in women suffering from severe thrombocytopenia or any major inherited bleeding disorder that would contraindicate intramuscular injections. For women diagnosed with **gestational** thrombocytopenia, please refer for haematological opinion, if platelet count < 100 x 10^9/L, prior to administration of anti-D.

2.1.4. There have been reports that the intramuscular administration of Rhophylac in patients with a body mass index (BMI) ≥ 30 is associated with a risk of reduced efficacy. Therefore, in patients with a BMI ≥30, intravenous administration should be considered.

DISCUSS WITH CONSULTANT AND BLOOD TRANSFUSION LABORATORY IF YOU HAVE ANY CONCERNS

2.2. Side effects

2.2.1. Short term discomfort at injection site.

2.2.2. Occasionally: fever, malaise, headache, cutaneous reactions, chills.

2.2.3. Rarely: nausea, vomiting, hypotension, tachycardia, allergic anaphylactic type reactions, dyspnoea and shock.

2.2.4. Anaphylactic reactions may occur in patients who have antibodies to IgA, or patients who have had an atypical reaction to blood transfusions or treatment with plasma derivatives.

2.2.5. As with all blood products, patients should be observed for at least 20 minutes following administration of prophylactic Anti-D.

2.3. Anaphylactic reactions

Administer both antenatal and postnatal anti-D early in the consultation to allow time for the development of any allergic reactions. Advise women to wait for 20 minutes and report any adverse effect.

2.4. Non-Invasive Prenatal Testing (NIPT)

2.4.1. NIPT is intended to avoid the unnecessary administration of anti-D to pregnant women where the fetus can reliably be predicted to be RhD negative.

2.4.2. A sample is taken at 12-16 week scanning appointment by Fetal Medicine from all women identified as RhD negative on booking bloods and this is sent to the Transfusion laboratory with a completed form for onward dispatch to the NHS Blood and Transplant International Blood Group Reference Laboratory. Results are reviewed by the RCHT Transfusion laboratory who enter results as fetus predicted RhD positive, RhD negative or inconclusive, with advice as to whether anti-D is required during this pregnancy.

2.5. Administering Anti-D (NEW 2024)

2.5.1. Check woman's handheld notes and electronic record clarifying she is RhD negative, has a NIPT result predicting the fetus to be RhD positive/ inconclusive or no NIPT result is available and fulfills criteria for administration.

2.5.2. Midwife to use EPMA protocol 'Midwife Exemption Anti-D Immunoglobulin to prescribe Anti-D on EPMA (NEW 2024).

2.5.3. Check the woman's identify: full name and date of birth.

2.5.4. Obtain and document consent.

2.5.5. Ensure an anaphylaxis pack is available in the event of an anaphylactic reaction.

2.5.6. Administer anti-D intramuscularly into the deltoid (upper arm).

2.5.7. Chart on EPMA (NEW 2024) Document in woman's handheld notes and electronic record hospital number, time and date of administration, anti-D batch number (including the subnumber in brackets), expiry date (utilising the sticker on the box), and signature. This enables traceability of anti-D administration.

2.5.8. File the compatibility report sent from Blood Transfusion with the anti-D in the patient's notes.

2.5.9. Document on anti-D audit proforma held at front of case loading file.

2.5.10. Any unused doses need to be returned to Blood Transfusion laboratory, identifying reason for non-administration.

2.6. Routine Antenatal Anti-D Prophylaxis at 28 weeks gestation

2.6.1. This prophylaxis dose is given, in addition to any sensitising event during pregnancy, at 28 weeks gestation unless NIPT has predicted the fetus to be RhD negative.

2.6.1.1. **At 16 weeks** (where fetus is predicted RhD positive/ inconclusive or no NIPT result is available):

- Order anti-D for 28 weeks following discussion, information leaflet is offered- Blood Groups and Red Cell Antibodies in Pregnancy. NHSBT leaflet -and consent being obtained. Document in notes that it has been ordered. All anti-D is issued on a named patient basis.
- Document the date you ordered the anti-D on the anti-D audit pro forma held in front of the case loading notes.

2.6.1.2. **At 28 weeks**

- Give Anti-D 1500IU **AFTER** taking blood for group and antibody screen.

2.7. Women who present for booking later than 28 weeks

If an RhD negative woman presents after 28 weeks, she should be offered anti-D prophylaxis. If in doubt discuss with Blood Transfusion laboratory.

2.8. Transfer of care

If a woman transfers into Cornwall before 34 weeks and she had previously started a two-dose regime of 500IU anti-D immunoglobulin at 28 weeks a second dose of Anti-D immunoglobulin, 1500IU, should be given when possible. If in doubt discuss with Blood Transfusion laboratory.

2.9. Women who decline Anti-D

2.9.1. All women who decline blood products (including Jehovah's Witnesses) should be seen in the anaesthetic clinic early in the second trimester of their pregnancy. An Advance Directive should be discussed and their wishes regarding anti-D and other blood products documented. Refer to Declining Blood Products in Maternity Clinical Guideline (cornwall.nhs.uk) for further details.

2.9.2. Some Jehovah's Witness women may accept anti-D, but others may still decline it as it is a blood product. Ensure that a discussion with an information leaflet is documented with the woman's decision in their hand-held notes and anti-D proforma.

2.9.3. Any women who specifically decline Anti-D should be clearly documented in the woman's notes and notified to the Blood Transfusion Laboratory.

2.9.4. In exceptional circumstances (e.g. later gestation abortion in a young patient where blood group is unknown and testing or returning for anti-D administration is declined), it would be advised to offer Anti-D immediately after the intervention without a known blood group if the patient would accept that.

2.10. Anti-D prophylaxis following sensitising events in pregnancy

Anti-D should be offered as soon as possible after the sensitising event within 72 hours. If more than 72 hours has elapsed, discuss with Blood Transfusion laboratory.

2.10.1. Anti-D 1500IU should be offered <12 weeks gestation to:

- Miscarriage where the uterus is instrumented or where there is significant bleeding and pain.
- Evacuation of Retained Products of Conception (ERPC).
- Surgical management of Ectopic pregnancy.
- Molar pregnancy.
- If PV bleeding is heavy, repeated or associated with significant abdominal pain.

For abortion care, there is no evidence of benefit for anti-D under 12 weeks and the 2022 WHO abortion care and American SFP guidelines recommend not to give anti-D. The NICE 2019 abortion care guidelines, and RCOG / RCM / FSRH / BSACP abortion care in COVID guidelines, do not recommend anti-D in early medical abortion and to "consider" it for surgical abortions under 10 weeks after discussion with the patient. In over 10 years of national surveillance, the SHOT has not found evidence of sensitization following first trimester pregnancy loss that could be attributed to a failure of administering anti-D and have found sensitization even where it was given. Therefore, anti-D is not offered in early medical abortion, and for surgical cases under 12 weeks only where it is requested after discussion with the patient, or where the surgeon considers it beneficial (e.g. if it is a difficult procedure, where gestation may be later or where curettage rather than suction is used).

Rh D status testing and anti-D prophylaxis supply should not cause any delays to women having an abortion (NICE 2020). For use by TOP and EPU clinics only, an emergency stock of Anti-D is available at RCH and WCH. Any use, including batch number and patient details must be notified to the Transfusion Laboratory immediately. This emergency stock should not be used for non-TOP or EPU cases. The stock is managed through a "one-in, one-out" process so that

only when the laboratory can account for the use of a dose will that dose be replenished. Unless there are exceptional reasons (e.g. a patient who refuses to stay for testing but is considered likely to benefit from anti-D), the blood group should be known through prior testing at RCHT or another NHS service (e.g. blood donation or abortion service). Evidence must be supplied to the RCH blood transfusion laboratory at time of administration to confirm blood group, in order to avoid any potential future incompatibilities/delays relating to blood transfusions.

2.10.2. Anti-D is not required at < 12 weeks gestation in women who present with:

- Conservatively (solely medically) managed incomplete or complete miscarriage.
- Conservatively (solely medically) managed Ectopic pregnancy.
- A threatened miscarriage (viable pregnancy seen on scan).
- A pregnancy of unknown location.
- Termination of pregnancy.

2.10.3. Anti-D 1500IU is offered > 12 weeks gestation following sensitising events:

- Spontaneous miscarriage complete or incomplete.
- Threatened miscarriage.
- Evacuation of Retained Products of Conception (ERPC).
- If there is ongoing intermittent bleeding, anti-D 1500IU should be administered at 1st bleed and 2nd bleed (irrespective of time) and from the 3rd bleed (now classified as recurrent bleeding) at six weekly intervals; A group and screen sample must be taken and sent to the Blood Transfusion laboratory to determine if further anti-D is required.

  This is in addition to the 28-week prophylactic dose.
- For any sensitising events after 20 weeks, request a Kleihauer test. If in doubt, discuss with the Blood Transfusion laboratory.

2.10.4. Other Sensitising Events requiring Anti-D

- Invasive prenatal diagnosis – CVS, amniocentesis, embryo reduction, fetocide for late medical TOP.
- Antepartum haemorrhage.
- External cephalic version.
- Abdominal trauma (e.g. Road Traffic Accident).

- Intrauterine death: n.b. confirmation of IUD and subsequent delivery are classified as separate sensitising events. This includes death of one baby in a multiple pregnancy.

  If the blood group of the baby cannot be determined, as is often the case, RhD negative mothers should always have a Kleihauer sample taken and given anti-D. If more than 72 hours have lapsed following a sensitising event, 1500IU anti-D should be given as there is some benefit for up to 10 days. Blood should be taken for antibodies four to six months later by GP and referral if required.

  Confirmation of IUD and subsequent delivery of stillborn are classified as separate, sensitising events, and both require administration of anti-D for an RhD negative mother.

- Placenta Percreta - RhD negative mothers should have Kleihauer test if no vaginal bleeding to detect silent feto-maternal bleed.

- Delivery.

2.11. Postnatal Anti-D Prophylaxis at Delivery

2.11.1. All RhD negative women should have cord blood samples sent for ABO testing, regardless of NIPT results, to confirm the predicted fetal group and determine if anti-D is required.

2.11.2. If the baby is RhD positive, anti-D 1500IU should be given within 72 hours of delivery. A maternal sample should be sent for Kleihauer testing to determine the extent, if any, of feto-maternal haemorrhage and whether sufficient anti-D has been given. Details of administration, including anti-D batch number should be recorded in the electronic patient record.

2.11.3. If the woman has received cell salvage blood the Kleihauer sample should be taken 45 minutes after the completion of the re-infusion of cell salvage blood (Refer to Intraoperative Cell Salvage Clinical Guideline (cornwall.nhs.uk)).

2.11.4. Where the cord group is different to the predicted fetal blood group during pregnancy, this incident will be recorded on the Pathology Quality Management system and reported to Serious Hazards of Transfusion (SHOT) and NSHBT by the laboratory if required. If the fetus is predicted RhD negative yet confirmed to be RhD positive, the RCHT Fetal Medicine department will liaise with the patient for any follow up and counselling, if required.

2.11.5. If the woman is discharged from hospital prior to the result being available, ensure the Community Midwife is informed that she needs to follow up the result and the necessity or not for anti-D. Complete the discharge summary on the electronic patient record.

2.11.6. Measles, Mumps and Rubella vaccination (MMR) can be given at the same time but should be administered in the other arm. Please be aware that the efficacy of the vaccine may be reduced for up to 3 months if administered in association with Anti-D.

2.11.7. Women who deliver at home or in a Birth Centre may be required to transport bloods or collect anti-D/attend for administration of anti-D from RCHT over weekends and Bank Holidays.

2.12. Non-Compliance

2.12.1. When the 72-hour window for administration has been missed or an inappropriate administration of anti-D has been given, the incident must be reported on Datix. The laboratory will also report on their Laboratory Quality Management system. These will be reported externally to Serious Hazards of Transfusion scheme by the laboratory and follow up samples may be required four to six months later to determine if immune anti-D is present.

2.12.2. There may still be some benefit on administering Anti-D up to 10 days post sensitising event if the 72-hour window is breached. If > 10 days after SE, refer to obstetric consultant for guidance.

2.12.3. When Anti-D has been handled inappropriately (e.g. stored inappropriately) or traceability of the blood product has been lost, an incident will also be reported on Datix, Laboratory Quality Management System and externally to SHOT.

2.13. Women with atypical antibodies

Discuss with Blood Transfusion laboratory and refer to Consultant Obstetrician if indicated.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Documentation of the ordering and administration of Anti-D.
Lead	Supervisors of midwives.
Tool	During Supervisory Annual Review, the supervisor of midwives will review the midwives' Anti-D audit proforma. Was the Blood group clearly documented in the Maternal Handheld notes and on the electronic record? Did the patient have a sensitising event? If so, did they receive prophylactic Anti D within 72 hours of the sensitising event? Did the patient receive prophylactic Anti D at 28 weeks? Did the patient receive Anti D following delivery if required, within 72 hours of delivery?
Frequency	Annually for each community midwife. 1% or 10 sets, whichever is the greater, of all health records of women who have delivered will be audited over the three-year lifetime of this guideline or sooner if indicated.
Reporting arrangements	Supervisor of Midwives Forum. During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Obstetric Patient Safety Forum or Clinical Audit Forum and an action plan agreed.
Acting on recommendations and Lead(s)	Individual Supervisor of Midwives to be informed if staff member is non-compliant. Action leads will be identified and a time frame for the action to be completed. The action plan will be monitored by the Maternity Patient Safety Midwife.
Change in practice and lessons to be shared	Supervisor of Midwives Newsletter. Maternity Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Anti-D Immunoglobulin (Anti–D) for the Prevention of Haemolytic Disease of the Fetus and Newborn Clinical Guideline V3.1
This document replaces (exact title of previous version):	Anti-D Immunoglobulin (Anti–D) for the Prevention of Haemolytic Disease of the Fetus and Newborn Clinical Guideline V3.0
Date Issued/Approved:	September 2024
Date Valid From:	September 2024
Date Valid To:	November 2025
Directorate/Department responsible (author/owner):	Pedro Valle Vallines, Lead Tansfusion Practitioner
Contact details:	01872 25 3093
Brief summary of contents:	To provide Midwives and Obstetricians guidance on the utilisation of anti-D immunoglobulin (anti-D) to prevent Haemolytic Disease of the Fetus and Newborn (HDFN).
Suggested Keywords:	Anti D, Rh, negative, HDFN, Haemolytic disease, newborn, fetus anaphylaxis, immunoglobulin, MMR, antibodies, blood, NIPT, rhesus.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Midwifery Guidelines Group Hospital Transfusion Team
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thrilby
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	• CNST 2.8 and 2.9. • BSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and new-born (2014) British Blood Transfusion Society (and update 03/02/2020). • The British Committee for Standards in Haematology (BCSH) (2014). • Transfusion Medicine. Official Journal of the British Transfusion Society. • NICE (National Institute for Clinical Excellence) (2008) Routine Antenatal Anti-D Prophylaxis for women who are RhD negative. Guidance 41. • BJOG (British Journal of Obstetrics and Gynacology) Use of cff DNA to avoid administration of Anti-D to pregnant women when the fetus is RhD-negative. (2014). • NICE (National Institute for Clinical Excellence) (2016) High Throughput non-invasive prenatal testing for fetal RhD genotype. Diagnostic Guidance 25 [DG25]. • Ectopic pregnancy and miscarriage: diagnosis and initial management NICE guideline [NG126] (April 2019). • Abortion care NICE guideline [NG140] (September 2019). • Soothill PW, Finning K, Latham T, Wreford-Bush T, Ford J, Daniels G. Use of cffDNA to avoid administration of anti-D to pregnant women when the fetus is RhD-negative: implementation in the NHS. BJOG. 2015 Nov;122(12):1682-6. doi: 10.1111/1471-0528.13055. Epub 2014 Aug 21. PMID: 25142171. • WHO Abortion Care Guideline (March 2022). • Horvath S, Goyal V, Traxler S, et al. Society of Family Planning committee consensus on Rh testing in early pregnancy. Contraception 2022 doi: 10.1016/j.contraception.2022.07.002. https://doi.org/10.1016/j.contraception.2022.07.002 • SHOT anti-D immunisation reporting. https://www.shotuk.org/wp-content/uploads/myimages/Chapter-25-Immune-Anti-D-in-Pregnancy-2021.pdf.

Information Category	Detailed Information
Training Need Identified?	Yes, for all staff requesting and administering Anti-D.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2015	V 1.0	Initial document	Sandra Whitehall, Specialist Midwife for Women with Complex Needs
January 2018	V 1.1	Updated 2.7 JW to be seen in anaesthetic clinic early in second trimester. Advanced directive to be discussed. 2.10 reminder re kleihauer	Nicki Jannaway, transfusion team
August 2021	V 2.0	Change to title of document to include fetus, updates throughout document to reflect change to practice after introduction of NIPT. Review and update to references and NICE guidance.	Abigail Parsons, Transfusion Team
October 2022	V 3.0	New clinical guideline template applied, used **offer** instead of **give** when referring to Anti-D. Updated flowchart and TOP guidance following WHO 2022 guidelines. Added 2.2.5, 2.8.4 and 2.11.2. Links and references updated, clarified 2.9.1 and other minor changes.	Pedro Valle Vallines, Lead Transfusion Practitioner
September 2024	V3.1	Addition of requirement for Anti-D to be prescribed on EPMA by registered healthcare professional	Sarah Harvey-Hurst Maternity Matron

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Anti-D Immunoglobulin (Anti–D) for the Prevention of Haemolytic Disease of the Fetus and Newborn Clinical Guideline V3.1
Directorate and service area:	Transfusion
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Pedro Valle Vallines, Lead Transfusion Practitioner
Contact details:	01872 25 3093

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide Midwives and Obstetricians with guidance on the use of anti-D immunoglobulin as immunoprophylaxis to prevent sensitisation to the RhD antigen during pregnancy and delivery.
2. Policy Objectives	To prevent Haemolytic Disease of the Fetus and Newborn.
3. Policy Intended Outcomes	To ensure RhD negative women receive appropriate immunoprophylaxis to prevent sensitisation to the D antigen.
4. How will you measure each outcome?	Compliance Monitoring Tool.
5. Who is intended to benefit from the policy?	All pregnant women and their babies.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Hospital Transfusion Team. Hospital Transfusion Committee. Maternity Guideline Group.
6c. What was the outcome of the consultation?	Guideline Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Pedro Valle Vallines.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis