East Sussex Healthcare
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

FOI REF: 22/740

16th January 2023

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

1. **Copy of any maternity/midwifery/obstetric care guidelines or policies specifically relating to the care of obese women/women with a raised BMI (>30kg/m²)**

   Please see attached policy - Clinical Guideline for the Management of the Obese Pregnant Woman

2. **Copies of any other maternity/midwifery/obstetric care guidelines or policies which contain information relating to the care of obese women/women with a raised BMI (>30kg/m²) even if this is not the sole focus of the guideline/policy**

   Not applicable.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Cont…/

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Clinical Guideline for the Management of the Obese Pregnant Woman

Document ID Number:	988
Version:	V3
Ratified by:	Women and Children's Governance and accountability members
Date ratified:	November 2021
Name of author and title:	Catherine O'Callaghan, Named Midwife for Safeguarding and Public Health Smoking Cessation Dr Nicky Roberts, Consultant Obstetrician
Date Originally Written:	November 2008
Date of current version was completed:	September 2021
Name of responsible committee/individual:	Chair of the Guideline Implementation Group for Maternity Services
Date issued:	24 December 2021
Review date:	November 2024
Target audience:	All staff caring for women / pregnant people within ESHT maternity services
Compliance with CQC outcome:	Person Centred Care Dignity and Respect
Compliance with any other external requirements (e.g. Information Governance):	NICE, RCOG
Associated Documents:	N/A

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2008283	November 2008	Gayle Clarke	New document	
V2 2009297	December 2009	Gayle Clarke		
V1.0 2013054	January 2013	Catherine O'Callaghan		
V2.0	December 2014	Catherine O'Callaghan et al	Practice Changes	Implementing 3rd trimester assessments
V2.0 2018326	December 2017	Catherine O'Callaghan	Review and update	
V2.1	February 2020	Gayle Clarke	Clinical Update	Replacing Syntocinon with Oxytocin
V3	September 2021	Sarah Keeling Gayle Clarke	Clinical Update	Replacing Syntocinon with Oxytocin Updating NICE guidance

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Guideline Implementation Group	Obstetrics and Gynaecology	Oct 2008 Oct 2009
Women and children's Clinical Directorate Team	Obstetrics and Gynaecology	Oct 2008
Strategic Business Unit Women's Health Operational Meeting		Oct 2009
Guideline Implementation Group		October 2012
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	December 2012
WRASH	Obstetrics and Gynaecology	April 2014
Women and Children's Guideline Implementation Group		March 2018
Women and Children's Governance and Accountability meeting		May 2018
Women and Children's Guideline Implementation group		September 2021
Raisa Buss (previously Rampersad) Lead Pharmacist for Women's, Children and Sexual Health		September 2021
Women and Children's Governance and Accountability		October 2021
Medicines Optimisation Group		November 2021

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss

Table of Contents

1. Introduction

Obesity in pregnancy is usually defined as a Body Mass Index (BMI) of 30kg/m² or more at the first antenatal consultation. Maternal obesity has become one of the most commonly occurring risk factors in obstetric practice. Obesity in pregnancy is associated with an increased risk of a number of serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth, and neonatal death.

There is also a higher caesarean section rate in this group of women **/ pregnant people**. Maternity services must develop and implement robust processes to manage the risks associated with obesity and consistently provide sensitive, comprehensive and appropriate multidisciplinary care. Obesity in women **/ pregnant people** can cause serious pregnancy complications, but it is a risk factor that can be modified to improve birth outcomes.

2. Rationale

This guideline is intended to inform the practice of all clinical maternity staff and medical staff involved in providing care to the pregnant woman with a raised BMI.

3. Scope

This guideline is of reference to all midwives, medical staff and support workers with involvement in providing care to the pregnant woman with a raised BMI in the outpatient, community and acute hospital setting.

4. Definitions

Obesity - Defined epidemiologically using the Body Mass Index (BMI), calculated as weight (in kg) divided by the square of height (in metres squared)

- BMI = weight/height^2

Clarification - The standard measure for determining obesity is the classification by the World Health Organisation, as shown in the following table

OYES – OneYou East Sussex

Classification	BMI (kg/m2)	Risk of obstetric/anaesthetic complications
Normal range	18.5-24.9	No increased obstetric or maternal risk
Overweight	25-29.9	No increased obstetric or maternal risk
Obese 1	30-34.9	Mildly increased obstetric and maternal risk
Obese 2	35-39.9	Moderately increased obstetric and maternal risk
Obese 3 (previously known as morbidly obese)	Greater than or equal to 40	Significantly increased obstetric and maternal risk

5. Accountabilities

5.1 Midwives , Obstetricians and Anaesthetics

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline

5.2 Management

- To ensure the guideline is reviewed as required in line with the Trust and National guidelines
- To ensure the guideline is accessible to all relevant staff
- To monitor the audit process

6. Process

4.1. Pre-Pregnancy Care

All women / pregnant people planning a pregnancy with a BMI ≥ 30 be advised of the risks of pregnancy associated with obesity and encouraged to loose weight.

Women **/ pregnant people** with a BMI ≥ 30 should be advised to take ***5mg folic acid*** supplementation daily starting at least one month before conception and continuing through the first trimester.

6.2 Antenatal Management

All women / pregnant people must have their BMI calculated at booking and the result recorded in the maternal clinical record Women **/ pregnant people** not consenting to be weighed must have all the risks identified to them and documented in their pregnancy record.

Direct woman to the following NHS Choices web-sites for information:

- Overweight and Pregnant
  https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/

- Exercise in pregnancy – Pregnancy and baby guide
  https://www.nhs.uk/conditions/pregnancy-and-baby/pregnancy-exercise/

- Have a healthy diet in pregnancy
  https://www.nhs.uk/conditions/pregnancy-and-baby/healthy-pregnancy-diet/

Consider referral from a lower BMI (e.g. ≥27.5kg/m2) for patients of black African, African-Caribbean and Asian family origin as they are at an increased risk of conditions, such as type 2 diabetes, at a lower BMI. (Let's Talk About Weight - step by step guide www.publishing.service.gov.uk

6.2.1 Women / pregnant people with a BMI>30

Advise that a healthy diet and being physically active will benefit both the woman and her unborn child during pregnancy and will also help her to achieve a healthy weight after giving birth. (NICE 2010)

Advise to take ***Vitamin D 10 micrograms (400units***) once a day as supplementation during pregnancy (NICE 2021)

Offered a GTT at 28 weeks

Blood pressure should be checked with an appropriately sized cuff at each visit

Assess for antenatal thromboprophylaxis

Have a documented antenatal consultation with an appropriately trained health professional

for assessment, to discuss possible intrapartum complications, personalised advice on healthy eating and how to be physically active

6.2.2 Women / pregnant people with a BMI>35

All of the above plus:

Must be booked for shared care with a consultant and to deliver in a consultant unit

In line with the NHS Fetal Anomaly Screening Programme (2015, updated 2021) two separate scan appointments can be offered to complete the anomaly scan. Where an adequate assessment of the fetal anatomy remains compromised after the second scan, all women **/ pregnant people** should be told that the screening is incomplete and this should be recorded in all formats.

No referral to the consultant specialist scan list is necessary under these circumstances unless there is a suspected fetal anomaly.

Blood pressure should be checked with an appropriately sized cuff at each visit

Women **/ pregnant people** with a BMI >35 plus one additional risk factor for hypertensive disease should be prescribed ***Aspirin 150mg/day*** *from 12 weeks* to 36 weeks and consider lower for patients with hepatic or renal disease.

Assess for antenatal thromboprophylaxis

BMI ≥35 with any co-existing medical conditions must be referred to an obstetric anaesthetist antenatally.

This must be:

- Documented in the maternal clinical record
- Plan made for labour and delivery

Ultrasound scan should be booked for women **/ pregnant people** at 34 and 38 weeks if BMI ≥35 however; additional scans and aspirin maybe required if any additional risk factors exist.

ADDITIONAL RISK FACTORS

Medical history

- Maternal medical conditions
- (chronic kidney disease, hypertension, autoimmune disease (SLE,APLS), Diabetes, cyanotic heart disease

Obstetric history

- Previous FGR (<3rd centile)
- Hypertensive disease in a previous pregnancy
- Previous SGA stillbirth

Current pregnancy

- PAPPA ≤ 0.4 MoM
- Echogenic bowel
- Significant bleeding (Consultant decision)
- EFW <10th centile

If any of the above risk factors exist please see the scanning algorithm in *Appendix C*

6.2.3 Women / pregnant people **with a BMI ≥40**

All of the above plus:

Women / pregnant people with a BMI ≥40 must be referred to an obstetric anaesthetist antenatally.

This must be:

- Documented in the maternal clinical record
- Plan made for labour and delivery

Women / pregnant people with a BMI ≥40 must have a risk assessment relating to antenatal, intrapartum and postnatal care carried out in the 3rd trimester.

This must be:

- Documented in the maternal clinical record include: Manual Handling assessment – follow Appendix E from the Moving and Handling Policy

- Tissue viability assessment – will be performed using the modified waterlow assessment tool which is found in the maternity booklets

- Re-measurement of maternal weight - Only weigh again if clinical management (i.e. medication) can be influenced or if nutrition is a concern (NICE)

- Ultrasound scan should be booked for women / pregnant people at 34 and 38 weeks if BMI ≥40 again if additional risk factors present see page 6 above for risk factors and ***Appendix C*** for the additional scans required.

For women / pregnant people presenting in labour with a BMI ≥40 who have not seen an anaesthetist antenatally, the anaesthetic middle grade should be contacted to organise an urgent anaesthetic consultation

Specific anaesthetic risks due to a raised BMI ≥ 40

- Increased maternal risk of morbidity and death for both mother and baby
- Difficult patient positioning (patient cannot lie flat)
- Regional anaesthesia for surgery is the preferred route but is more difficult to site with unpredictable spread of local anaesthetics
- Epidural more likely to dislodge or fail
- Increased risk of difficult and failed intubation and other methods of airway management
- Difficulty securing peripheral access
- Increased risk of regurgitating gastric contents during general anaesthesia
- Non-invasive BP cuffs may be unreliable
- High dependency and/or intensive care may be needed
- Need for extra resources (staffing and equipment)

Day Assessment Unit / Admission to hospital in the antenatal Period

Monitoring of the fetal heart in the antenatal period

- Pre term labour
    - Individualised plan of care
    - If unable to monitor fetal heart continuously due to BMI with a CTG escalate

to the Registrar
- Registrar to discuss with Obstetric Consultant and plan to be discussed and documented in the maternal clinical record

- Assessment in DAU and over 24 weeks
  - 24 – 27+7 Record fetal heart with pinnard/sonic-aid
  - If 28+ weeks and CTG is required and you are unable to do a CTG due to BMI escalate to the Registrar
  - Registrar to discuss with Obstetric Consultant and plan to be discussed and documented in the maternal clinical record

6.2.3 Antenatal risks due to raised BMI

- Gestational diabetes
- Hypertension, pre-eclampsia
- Macrosomia or IUGR
- Sleep apnoea
- Undiagnosed fetal anomaly due to difficult ultrasound examination

6.3 Intrapartum

Women / pregnant people with a raised BMI ≥30 in an otherwise uncomplicated pregnancy does not have to have continuous fetal monitoring
Women / pregnant people with a BMI ≥40:

- Are at significantly higher risk of operative delivery and such operative deliveries carry an increased obstetric and anaesthetic risk
- If in labour, an IV cannula should be inserted early in labour and a group and save and FBC taken
- There is no specific requirement for continuous electronic fetal monitoring in an otherwise uncomplicated pregnancy
- If there are indications for continuous monitoring a fetal scalp electrode should be considered
- Presentation of the fetus should be checked with the portable labour ward scanner
- There is an increased risk of shoulder dystocia
- Midcavity instrumental delivery should be discussed with the consultant before being attempted
- Waterbirth is contraindicated

If an obese woman is going to be induced, staff should aim for these women / pregnant people to deliver in normal working hours when a full complement of staff (including consultant anaesthetists) are present in the hospital.

Intrapartum risks due to raised BMI

- Failure to progress in labour
- Shoulder dystocia
- Difficulties monitoring the fetal heart
- Difficulties with labour analgesia
- Emergency caesarean section Technically difficult surgery with associated increased morbidity and mortality

6.4 Postpartum

Oxytocin infusion should be considered once the placenta is delivered for women / pregnant people with a BMI >35 to anticipate post-partum haemorrhage. The following should be prescribed and administered; Oxytocin infusion 40units Sodium Chloride 0.9% 500ml over 4 hours.

All women / pregnant people re-assess for postnatal thromboprophylaxis after the delivery

Offer referral to OYES adult weight management programme. Encourage breastfeeding and advise women **/ birth parent** that losing weight by eating healthily and taking regular exercise will not affect the quantity or quality of their milk. (NICE 2010)

Advise that 10 micrograms of vitamin D per day for pregnant and lactating women / pregnant people / birth parent and population groups at increased risk of vitamin D deficiency.

Postpartum risks due to raised BMI

- Wound infections post-operative delivery
- Thromboembolic events
- Postnatal depression

6.5 Occupational Health and Safety issues

- Safe working Load of equipment is stated on the equipment
- Elective caesarean section women **/ birth parent** are encouraged to walk to theatre wherever possible.
- Women **/ birth parent** with a BMI>30 should have a blue canvas slide sheet inserted on their labour ward bed on admission in labour or prior to any intervention
- Maximum weight equipment can tolerate:
    - Main theatre operating table 200kg
    - Labour ward bed 180kg
- A high weight tolerance critical care/bariatric bed should be requested for any woman weighing more than 160kg through the EME equipment library
- Large patient gowns should be made available to maintain the woman's dignity
- Large BP cuffs are available throughout the care the woman receives, to ensure accurate readings.
- Patient Lifting equipment is available: refer to the ***Moving and Handling Policy*** http://eshealthcare/guideline/361.pdf

6.6 Home Environment delivery

If the mother intends to deliver in the home environment a risk assessment should be carried out and documented in the maternal clinical record. Ensuring the risks to the mother and the attending midwives are reviewed.

The midwife continues to have a duty of care for women **/ birth parent** that decide to deliver at home even if hospital birth is advised.

The community midwife should develop an action plan which may need to involve other agencies.

The maternity service manager should be informed
The woman's named Consultant obstetrician should be informed of her intention to deliver at home.

6.7 Moving and handling

Refer to the ***Moving and Handling Policy***

6.8 Maternity Pressure Ulcer Risk Assessment

Refer to ***Guidelines for the Prevention of Pressure Ulcers***

The Modified from Plymouth Maternity Pressure Sore Risk Assessment Tool 2012 must be completed when in labour every 2 hours from the initial assessment (***Guideline for the Prevention of Pressures Ulcers*** appendix 3, page 32)

7 Special Considerations

When using this guideline refer to the following:

- ***Moving and Handling Policy***
- ***Guidelines for the Prevention of Pressure Ulcers***
- ***Clinical Guideline for Thromboprophylaxis and Treatment of Venous Thromboembolism in Maternity***

8 Evidence Base/References

'NHS Screening Programmes Service Specification No 16 NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 and 13), Public Health England and NHS England Public Health Commissioning, April 2017.

National Institute for Health and Clinical Excellence (NICE). 2006. Updated 2015. *Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (NICE). 2021. *Antenatal care: Routine care for healthy pregnant women.* London: NICE

National Institute for Health and Clinical Excellence (NICE). 2015. *Nutrition: improving maternal and child nutrition.* London: NICE

National Institute for Health and Clinical Excellence (NICE). 2010. *PH27 Weight management before, during and after pregnancy.* London: NICE

Royal College of Obstetrics and Gynaecologists & Centre for Maternal and Child Enquires. 2010. *Management of Women with Obesity in Pregnancy*. London: RCOG

Royal College Obstetrician Gynaecologist (RCOG) 2015. *Guideline No. 37a Reducing the risk of Thrombosis and Embolism during Pregnancy and the Puerperium.* London: RCOG.

National Institute for Health and Clinical Excellence (NICE). 2014 *Vitamin D: supplement use in specific population groups Public health guideline*. London. www.nice.org.uk/guidance/ph56

9 Competencies and Training Requirements

Refer to the maternity training needs analysis.

10 Monitoring Arrangements

Document Monitoring Table

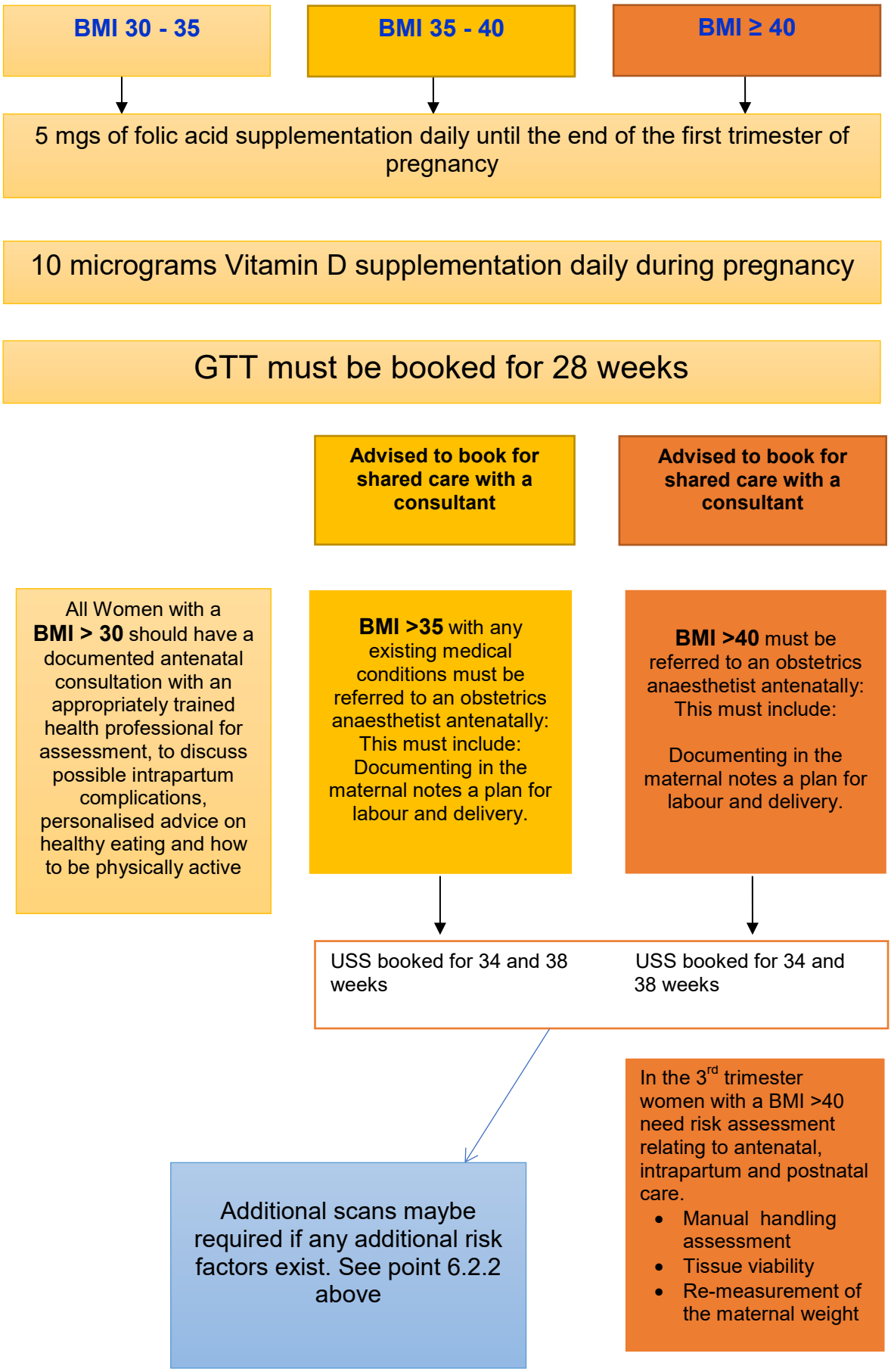
Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
BMI has been calculated at booking and documented in the maternal clinical record	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Was the BMI recorded electronically	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 30 have been advised to take Folic Acid 5 mgs and vit D 10 mcg	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 35 have been referred for shared care	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 40 or BMI> 35 with	Consultant audit lead	Audit	Every 3 years Or 6-9 months	Obstetrics and Gynaecology audit meetings and any	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead

co-existing medical conditions were referred to an obstetric anaesthetist antenatal			after a practice change.	other appropriate meetings		
Ultrasound scan at 34 and 38 weeks for BMI over 35	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI >40 had a risk assessment carried out in the 3rd trimester	Lead Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI >40 had their weight recalculated in the 3rd trimester	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI over 40 are seen antenatally by an Anaesthetist	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead

11 Equality and Human Rights Statement

An Equality and Human Rights Analysis Form has been completed for this document.

Appendix A - BMI pathway



Appendix B – EIA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Clinical Guideline for the Management of the Obese Pregnant Woman
Date of completion	September 2021
Name of the person(s) completing this form	Click here to enter text.
Brief description of the aims of the Strategy/ Policy/ Service	This guideline is intended to inform the practice of all clinical maternity staff and medical staff involved in providing care to the pregnant woman with a raised BMI.
Which Department owns the strategy/ policy/ function	Women and Childrens
Version number	V3
Pre Equality analysis considerations	Click here to enter text.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	Women requiring additional monitoring and care during pregnancy
Review date	Click here to enter text.
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.

Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td>Choose:
Negative</td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassign ment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td></td><td>Click here to enter text.</td></tr>
</table>

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
What impact will this have on people receiving a positive experience of care?	Choose: Negative	Click here to enter text.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Does the proposal impact on the responsiveness to people's needs?	Choose: Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?	Choose: Positive Neutral Negative	Click here to enter text.

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassign ment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Access Could the proposal impact positively or negatively on any of the following:		
• Patient Choice	Choose: Positive Neutral Negative	
• Access	Choose: Positive Neutral Negative	
• Integration	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassign ment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>

Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose: Positive Neutral Negative	
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose: Positive	
Age	Choose: Positive	
Disability and Carers	Choose: Positive	

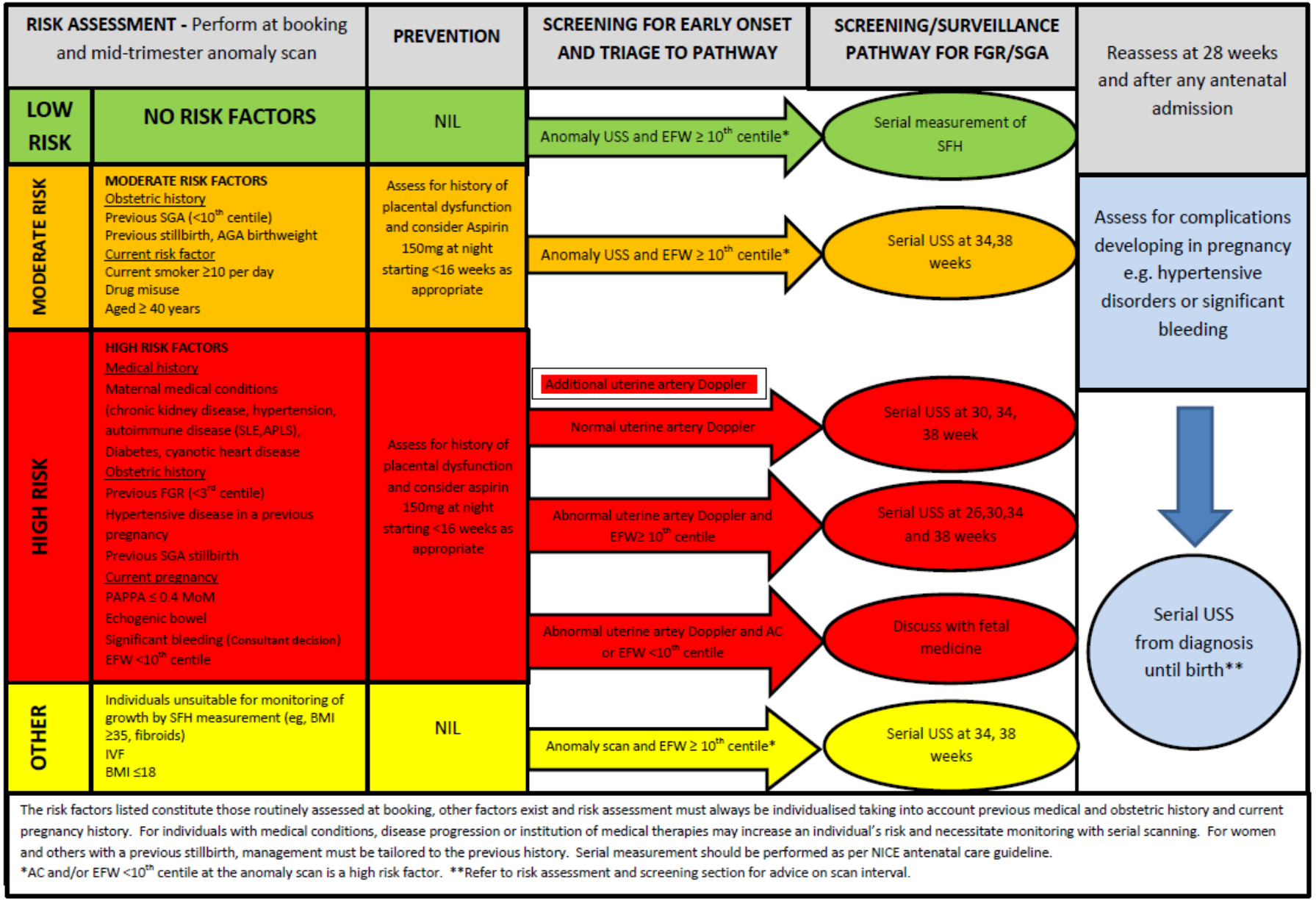
Religion or belief	Choose: Positive	
Sex	Choose: Positive	
Sexual orientation	Choose: Positive	
Gender re-assignment	Choose: Positive	
Pregnancy and maternity	Choose: Positive	
Marriage and civil partnership	Choose: Positive	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**Y/N**
A3	Prohibition of torture, inhuman or degrading treatment	**Y/N**
A4	Prohibition of slavery and forced labour	**Y/N**
A5	Right to liberty and security	**Y/N**
A6 &7	Rights to a fair trial; and no punishment without law	**Y/N**
A8	Right to respect for private and family life, home and correspondence	**Y/N**
A9	Freedom of thought, conscience and religion	**Y/N**
A10	Freedom of expression	**Y/N**
A11	Freedom of assembly and association	**Y/N**
A12	Right to marry and found a family	**Y/N**
Protocols		
P1.A1	Protection of property	**Y/N**
P1.A2	Right to education	**Y/N**
P1.A3	Right to free elections	**Y/N**

Appendix C
Scanning Algorithm



The risk factors listed constitute those routinely assessed at booking, other factors exist and risk assessment must always be individualised taking into account previous medical and obstetric history and current pregnancy history. For individuals with medical conditions, disease progression or institution of medical therapies may increase an individual's risk and necessitate monitoring with serial scanning. For women and others with a previous stillbirth, management must be tailored to the previous history. Serial measurement should be performed as per NICE antenatal care guideline.
*AC and/or EFW <10th centile at the anomaly scan is a high risk factor. **Refer to risk assessment and screening section for advice on scan interval.