Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: Management of Women/Pregnant People with a Body Mass Index (BMI) greater than (>) 30 Guideline

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Sponsor (position/ role):	Obstetrics and Gynaecology Head of Service

Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Policy	Not Applicable
Associated Procedure(s)	Not Applicable
Associated Pathway(s)	Not Applicable
Associated Standard Operating Procedure(s)	Not Applicable
Other associated documents e.g. documentation/ forms	Raised BMI in pregnancy leaflet – accessible for use via the Trust's external website pil202402-06-bmi-raised-body-mass-index-and-pregnancy.pdf (sfh-tr.nhs.uk)

Consultation Undertaken:	Consultation and review during the development and update of this guideline has been undertaken by Consultant Obstetricians and Anaesthetists and the membership list from the 'antenatal clinical subgroup' with ratification from the Maternity & Gynaecology clinical Governance meeting.
Template control:	v2.0 September 2023

Amendments from previous version(s)

Version	Issue Date	Section(s) involved	Amendment
V7.0	05-11-2024	Whole document review undertaken	• Evidence base reviewed and updated. • Antenatal pathway updated to include 28 week VTE risk assessment • Language updated to represent Equality, Diversity, and Inclusivity
		Updated practice throughout	• Referrals to the anaesthetic clinic changed to: To refer/ review women/pregnant people with a BMI of ≥50, or ≥40 with other significant comorbidities, at the obstetric anaesthetic clinic in the antenatal period 32-34/40 • Saving Babies Lives V3 algorithm/pathway incorporated into guidance.

CONTENTS

1 INTRODUCTION/ BACKGROUND

The increasing prevalence of obesity in the United Kingdom has been widely publicised. The complications of obesity during pregnancy have far reaching implications for both mother and newborn. During 2015-17 the MBRRACE-UK Report identified more than a third (34%) of the women/pregnant people who died in this triennium were obese and a further 24% were overweight [1]. Maternal obesity has significant health implications contributing to increased morbidity and mortality for both mother and baby. Worldwide adult obesity has more than doubled since 1990 [2]. The prevalence of obesity in pregnancy has also been seen to increase, rising from 9–10% in the early 1990s to 16–19%in the 2000s [3].
The national increase in obesity is reflected in increasing numbers of women/non-pregnant people with raised BMI, becoming pregnant. Maternal obesity is recognised as an important risk factor for adverse outcomes in maternity care including stillbirth. A snapshot audit across East Midlands providers in 2015 suggested that where data was collected, between 6.67% and 13.34% of pregnant women/people had a BMI of more than 35 at booking [4].

Antenatally, obesity increases the risk of miscarriage, gestational diabetes mellitus (GDM), gestational hypertension, thromboembolism, and pre-eclampsia [5]. Obesity is associated with poor labour outcomes, with obese women/pregnant people less likely to go into labour spontaneously. They are more likely to have prolonged pregnancies and have their labour induced, and less likely to achieve a vaginal birth, being at increased risk of caesarean birth [6].

Postnatally, obese women/pregnant people are less likely to breast/chestfeed successfully, have a longer postnatal stay in hospital, and are at risk of postnatal infections [7]. Obesity is also associated with a higher risk of adverse neo-natal outcomes, including stillbirth, congenital anomalies, neonatal intensive care admission, and neonatal death [7].

2 SCOPE OF DOCUMENT (including Related Trust Documents)

This clinical guideline applies to:

Staff group(s)

- Midwives
- Health Care Support Workers/Maternity Support Workers
- Antenatal Clinic receptionists
- Obstetricians
- Obstetric Anaesthetists

- Ultrasonographers
- Registered Nurses

Clinical area(s)
- Community Midwifery
- Antenatal Clinic
- Pregnancy Day Care
- Sherwood Women's Centre
- Sherwood Birthing Unit (SBU)
- Maternity Ward
- Early Pregnancy Unit/Ward 14

Patient group(s)
- Women/Pregnant people with a BMI >30

Exclusions
- None

Related Trust Documents
- Antenatal care provision guideline
- Gestational diabetes mellitus management guideline
- Bariatric surgery and screening for gestational diabetes SOP
- Hypertension in pregnancy guideline
- Thromboprophylaxis and the management of venous thromboembolism in pregnancy and the puerperium guideline
- Moving and Handling Trust intranet homepage
- Guideline for pressure ulcer prevention and management (maternity)
- Facilitating choice & shared decision-making within maternity care guideline
- Use of Anti-D Prophylaxis for D Negative women/pregnant people guideline
- Induction of labour guideline
- Maternity Early Warning Scoring (MEWS) Policy
- Caesarean birth guideline

3 ROLES AND RESPONSIBILITIES

It is the responsibility of the Community Midwife to:
- Perform a risk assessment at booking and refer for appropriate care inline with the current SFHFT Antenatal Care Provision Guideline[8].
- Offer healthy eating advice and ensure the women/pregnant people with a BMI >30 are sign posted to the the Patient Information leaflet "Raised Body Mass Index and Pregnancy" found in the electronic patient records (EPR)[9]
- Refer to 'A Better Life' weight management services via the EPR
- Refer to Antenatal Clinic (ANC) for assessment of risk for Gestational Diabetes with an oral glucose tolerance test (GTT) appointment, to be performed between 24-28 weeks of pregnancy[10].
- Or perform an HbA1c and random plasma glucose at booking and at 28 weeks of pregnancy. Method of GDM assessment to be guided by current guidance following bariatric surgery. [11-12].

- Promote exercise throughout pregnancy aiming for at least 150 minutes of moderate activity each week [13].

It is the responsibility of the Obstetrician to:

- Refer women/pregnant people with a BMI of ≥50, or ≥40 with other significant comorbidities, to the Obstetric Anaesthetic clinic
- To discuss labour, birth and possible intrapartum complications with all women/pregnant people who have obstetric complications and a BMI ≥35.
- Instigate serial growth scans (BMI ≥35) as per Saving Babies Lives V3 flowchart/guidance [14].
- Promote exercise throughout pregnancy aiming for at least 150 minutes of moderate activity each week [13].

It is the responsibility of the Obstetric Anaesthetist:

- To review women/pregnant people with a BMI of ≥50, or ≥40 with other significant comorbidities, at the obstetric anaesthetic clinic in the antenatal period 32-34/40 weeks gestation, and document a management plan for labour and birth
- To review all women/pregnant people with a BMI≥40 on arrival at the Sherwood Birthing Unit

4 GUIDELINE DETAILS (including Flowcharts)

Women/pregnant people with a BMI >30 are at increased risk of pregnancy complications and morbidity. Risks include [1-6].

Miscarriage	Failed induction of labour	Increased risk of having a macrocosmic baby
Obstructive sleep apnoea	Shoulder dystocia	Stillbirth
Fetal congenital abnormality	Increased risk of instrumental birth and caesarean birth	Neonatal death
Hypertension	Failed spinal/ epidural	Poor wound healing/infections
Pre-eclampsia	Failed intubation	Post operative infection
Increased risk of mental health problems	Severe postpartum haemorrhage	low breastfeeding initiation
Gestational diabetes	Thrombosis	

Accurate risk assessment, early detection, appropriate referral and on-going monitoring are essential to reduce the risks.

4.1 Calculation and recording of the Body Mass Index (BMI) for all women/pregnant people

All women/pregnant people should have their weight and height measured and their body mass index calculated at the antenatal booking appointment. BMI should be recorded on the electronic patient records (EPR) [8-11].

Routinely reweigh all women/pregnant people at 28 and 36 weeks to recalculate BMI and reassess VTE calculation. Do not weigh women/pregnant people repeatedly during pregnancy as a matter of routine. Re weigh again if clinical management can be influenced or if nutrition is a concern [17].

Classification table according to BMI [17].

Classification	BMI (kg/m^2)
Underweight	< 18.50
Normal range	18.50 – 24.99
Overweight	≥ 25.00
Pre-obese	25.00 – 29.99
Obese class I	30.00 – 34.99
Obese class II	35.00 – 39.99
Obese class III	≥ 40.00

If BMI >30 commence **Antenatal Care Pathway** as appropriate.

	Obese Class I[2] BMI 30-34.9	**Obese Class II[2] BMI 35.0 - 39.9**	**Obese Class III[2] Morbidly Obese BMI > 40.0**
Booking referral	**Book for maternity team care.** (Midwife lead professional unless other risk factors. *Obstetric consultation not required unless other risk factors)* Refer for GTT at 25-28 weeks	**Book for maternity team care and refer for Obstetric consultation.** Refer for GTT at 25-28 weeks	**Referral for maternity team care and Obstetric consultation.** Refer for GTT at 25-28 weeks
Booking assessment	Advice re healthy diet. Sign post to appropriated leaflets embedded in the EPR. Referral to Weight Management Services using EPR. Advise 5mg folic acid throughout first trimester. Advise 10mcgs vitamin D throughout pregnancy and while breast/chest feeding. Complete the 'fetal growth and pre-eclampsia (aspirin) risk assessment' in the EPR and consider low dose aspirin 150mgs	Advice re healthy diet. Sign post to appropriated leaflets embedded in the EMP. Referral to Weight Management Services using EMP. Advise 5mg folic acid throughout first trimester. Advise 10mcgs vitamin D throughout pregnancy and while breast/chest feeding. Complete the 'fetal growth and pre-eclampsia (aspirin) risk assessment' in the EMP and consider low dose aspirin 150mgs	Advice re healthy diet. Sign post to appropriated leaflets embedded in the EMP. Referral to Weight Management Services using EMP. Advise 5mg folic acid throughout first trimester. Advise 10mcgs vitamin D throughout pregnancy and while breast/chest feeding. Complete the 'fetal growth and pre-eclampsia (aspirin) risk assessment' in the EMP and consider low dose aspirin 150mgs

	Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and prescription at appropriate gestation.	Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and prescription at appropriate gestation.	Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and prescription at appropriate gestation.
First hospital Antenatal appointment	N/A	Obstetrician to discuss implications of raised BMI≥35 Arrange serial growth scans and obstetric review from 32/40 weeks if no other risk factors. Refer to SBLV3 risk assessment flowchart/algorithm	Obstetrician to discuss implications of raised BMI≥40 Refer women/pregnant people with a BMI of ≥50, or ≥40 with other significant comorbidities, to the obstetric anaesthetic clinic Arrange serial growth scans and obstetric review from 32/40 weeks, if no other risk factors. Refer to SBLV3 risk assessment flowchart/algorithm
16 weeks	Routine Community midwife appointment or Antenatal Clinic appointment if appropriate for history	Routine Community midwife appointment or Antenatal Clinic appointment if appropriate for history	Routine Community midwife appointment or Antenatal Clinic appointment if appropriate for history
18-22 weeks	Routine anomaly scan	Routine anomaly scan	Routine anomaly scan
25 weeks onwards	Blood pressure and urinalysis every 3 weeks (25 - 34 weeks gestation) and every 2 weeks after 34 weeks . Any deviations refer to current SFHFT Hypertension in Pregnancy guideline [18]. Assessment for GDM 25-28 weeks dependant on method.	Blood pressure and urinalysis every 3 weeks (25 - 34 weeks gestation) and every 2 weeks after 34 weeks. Any deviations refer to current SFHFT Hypertension in Pregnancy guideline [18]. Assessment for GDM 25-28 weeks dependant on method.	Blood pressure and urinalysis every 3 weeks (25- 34 weeks gestation) and every 2 weeks after 34 weeks Any deviations refer to current SFHFT Hypertension in Pregnancy guideline [18]. Assessment for GDM 25-28 weeks dependant on method.
28 weeks	Routine antenatal care with symphysis fundal height measurement [14] Birth plan discussion regarding labour, intrapartum and birth complications by midwife or obstetrician responsible for 28 week assessment. Reassess BMI at 28 weeks gestation. If BMI ≥35 refer for obstetric consultation for updated management plan. Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and	Routine antenatal care with symphysis fundal height measurement. Commencing serial growth scans from 32 weeks [14]. Birth plan discussion regarding labour, intrapartum and birth complications by midwife or obstetrician responsible for 28 week assessment. Reassess BMI at 28 weeks. If BMI of ≥50, or ≥40 with other significant comorbidities, at the obstetric anaesthetic clinic in the antenatal period 32-34/40 weeks gestation, and document a management plan for labour and birth	Routine antenatal care with symphysis fundal height measurement. Commencing serial growth scans from 32 weeks [14]. Birth plan discussion regarding labour, intrapartum and birth complications by midwife or obstetrician responsible for 28 week assessment. Reassess BMI at 28 weeks. If BMI of ≥50, or ≥40 with other significant comorbidities, at the obstetric anaesthetic clinic in the antenatal period 32-34/40 weeks gestation, and document a management plan for labour and birth

	prescription at appropriate gestation.	Advised to give birth in hospital. Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and prescription at appropriate gestation.	Advised to give birth in hospital. Complete the 'VTE thromboprophylaxis risk assessment' in the EPR and plan administration and prescription at appropriate gestation.
32 weeks		Commence serial growth scans in ANC/SWC	Commence serial growth scans in ANC/SWC
34-37 weeks			Maternity team care review at 34-37 weeks gestation discussion regarding mode of birth.
36 weeks	Reweigh at 36 weeks gestation to provide pre-birth weight for medication dosing and BMI calculation. If unable to reweigh at 36 weeks ie doing home visit, reweigh must be completed at next clinic appt.	Reweigh at 36 weeks gestation to provide pre birth weight for medication dosing and BMI calculation. If unable to reweigh at 36 weeks ie doing home visit, reweigh must be completed at next clinic appt.	Reweigh at 36 weeks gestation to provide pre birth weight for medication dosing and BMI calculation. If unable to reweigh at 36 weeks ie doing home visit, reweigh must be completed at next clinic appt.

4.2 Antenatal discussion.

The following should be discussed with women/pregnant people with a BMI>30 in the antenatal period by the community midwife. This should be supported by sign posting the pregnant person/woman to the patient Information leaflet 'Raised body mass index (BMI) and pregnancy' found on the EPR.

- Healthy Eating guidance [10].
- Discussion regarding referral to 'A Better Life' weight management service through the EPR.
- Importance of regular attendance for BP and urine monitoring [8 & 16]
- 'VTE thromboprophylaxis risk assessment' and prophylactic measures to reduce risk [8 & 19].
- Imaging difficulties at ultrasound scan
- Difficulties in assessing fetal growth
- Increased risk of Gestational Diabetes and the importance of screening for GDM [11 & 12]
- Importance of monitoring fetal movement /changes in fetal movement
- Difficulties auscultating the fetal heart during pregnancy
- Women/pregnant people with a BMI >35 should be advised to have their baby in hospital.

All women/pregnant people with a BMI >30 should have discussion with the midwife or obstetrician about possible intrapartum complications. This includes

- The possibility of the need for electronic fetal monitoring (EFM) in labour
- Difficulties associated with anaesthesia (insertion of an epidural, spinal and GA).
- Wound healing issues in the event of a caesarean birth.

4.3 Diet and lifestyle

Women/pregnant people with a raised BMI (30 or more) to receive advice on a healthy lifestyle including diet (plus nutritional supplements) and physical activity, with referral to specialist weight management services 'A Better Life' through the EPR. Women/pregnant people need to understand the implications of controlling weight between pregnancies, benefits of long-term breastfeeding and birth spacing [10].

4.4 Moving and Handling

For women/pregnant people with a raised BMI refer to the SFHFT intranet 'Moving and Handling' home page for support and guidance [20].

4.5 Tissue Viability

All women/pregnant people to have care as per local current SFHFT guidance in pressure ulcer prevention and management [21].

4.6 Anaesthetic and theatre standards

To review women/pregnant people with a BMI of ≥50, or ≥40 with other significant comorbidities, in the Obstetric Anaesthetic clinic in the antenatal period, and document a management plan for labour and birth on the EPR.

The on-call Anaesthetist should be informed on admission of any women/pregnant people with a BMI ≥40. A senior obstetrician and a senior anaesthetist (ST6 or equivalent) should be available for the care of women/pregnant people with a BMI ≥40 during labour birth, including attending any birth in theatre. Bariatric equipment should be available on SBU and Maternity Ward to ensure comfort and dignity for the woman/pregnant person/birthing person, whilst providing safe moving and handling practices for all staff providing care.

The diagnosis of obstructive sleep apnoea (OSA) should be considered in all women/pregnant people with BMI>35 and appropriately managed after discussion with the on-call Consultant Anaesthetist and to consider on an individual person basis. There is currently no proven screening tool for OSA in pregnancy.

4.7 Joint birth planning

All women/pregnant people with a BMI ≥40 should have multidisciplinary input, although all women/pregnant people have options regarding their pregnancy journey facilitating choice and shared decision making as per current SFHFT guidance [22].

However, women/pregnant people with BMI ≥30 need to understand the effect of obesity on labour outcomes [6]. Women/pregnant people with obesity are at increased risk of post partum

haemorrhage (PPH). There is strong evidence from the general maternity population that active management of the third stage of labour reduces the risk of PPH, postpartum anaemia and the need for blood transfusion [17].

4.8 Fetal wellbeing

All women/pregnant people will have access to facilities, expertise and information to maintain fetal well-being. This includes advice on fetal movement, access to fetal growth monitoring via customised growth charts and for women with a BMI ≥35 ultrasound fetal growth scans as per Saving Babies Lives Care Bundle Version Three [14]. In labour to ensure fetal heart monitoring is by best modality, according to known fetal growth. If adequate monitoring cannot be undertaken discuss alternative birth options.

4.9 Thromboprophylaxis in women/pregnant people with a raised BMI

Antenatal: All women/pregnant people are to be assessed for thrombosis risk by Completing the 'VTE/Thromboprophylaxis treatment assessment' within the EPR which will indicate risk/treatment. All women/pregnant people should be risk assessed at booking and 28 weeks, and with every admission. As BMI increases, risk will rise therefore when thresholds are passed women/pregnant people should be reassessed are referred for appropriate preventative management [16 & 19].

Intrapartum: Women/pregnant people requiring thromboprophylaxis should be advised to omit their LMWH if they believe they are in labour, Women/pregnant people requiring antenatal treatment should have a written plan for intrapartum care to minimise the risk of clotting and bleeding.

Post natal: Complete the 'VTE/Thromboprophylaxis treatment assessment' within the EPR, which will indicate risk/treatment. All women/pregnant people should be risk assessed after birth and postnatal day 3 if they remain in hospital and upon hospital discharge [16 & 19].

4.10 Anti D administration

Administration of Anti D should continue to be given in the deltoid muscle as per SFHFT guidance. The use of *Rhophylac* 1500iu gives the consultant obstetrician the choice of method of administration as the product is suitable for IM and IV routes. The product comes with a long green needle for women/pregnant people with a BMI >30. For women/pregnant people with a BMI >40 IV administration should be considered [23].

4.11 Women/pregnant people who have had weight reduction surgery

Pregnant women/pregnant people who have had weight reduction surgery such as a gastric band or through removal of a portion of the stomach (sleeve gastrectomy or biliopancreatic diversion with duodenal switch) or by resecting and re-routing the small intestine to a small stomach pouch (gastric bypass surgery) will not be able to tolerate large volumes of liquid. An OGTT is therefore not a suitable test for these women/pregnant people. HbA1c and fasting blood glucose sample to be taken at booking and 28 weeks of pregnancy and if abnormal an appointment with the obstetric/endocrinology team should be made. If the sample result is normal the named consultant can plan for any repeat samples to be taken later in pregnancy or to have regular blood glucose monitoring [11 & 12].

Pregnancy can exacerbate nutritional deficiencies that predate pregnancy. Women/pregnant people, particularly those with malabsorptive procedures involving anatomical changes in the gastrointestinal tract, are at high risk of micro-nutritional deficiencies (including vitamin B12, iron, folate and fat-soluble vitamins) and macro-nutritional deficiencies (mainly fat and protein). Hyperemesis may be pathological and related to an internal hernia or gastric band slip [17]

4.12 Increased surveillance for the detection of gestational diabetes and hypertension associated with raised BMI

All women/pregnant people with a BMI ≥30 need additional surveillance for the associated risks of gestational diabetes and hypertension [14 & 24].

Testing for diabetes in pregnancy should be offered to all women/pregnant people with a booking BMI of ≥30 in line with SFHFT guidance [11].

Monitor blood pressure/hypertension and consider additional risk factors for use of low-dose aspirin by completing the 'fetal growth and pre-eclampsia (aspirin) risk assessment' within the EMP [8 & 16].

4.13 Induction of Labour in women/pregnant people with a BMI ≥40

If induction of labour is decided[37] consideration should be given to the following:

- Induction should be considered for a weekday.
- The Consultant on call should be informed and available.
- The Obstetric Anaesthetist should be informed and available.
- The Coordinator on Sherwood Birthing Unit should be informed.

4.14 Caesarean Birth Standard

Provide a standardised care package for women/pregnant people with a raised BMI undergoing planned caesarean birth. To include

- Equipment
- Surgical technique: a vertical midline incision may be required for some clinical indications in morbidly obese women/pregnant people [10] and use of disposable caesarean birth ring retractors
- Wound care: use of negative pressure wound therapy for women/pregnant people with a BMI ≥40 or assessed to benefit from the dressing based on clinical assessment.
- Antibiotic prophylaxis
- Thromboembolic prophylaxis
- Recovery /postnatal care: particular care to measure BP with an appropriate device and assess saturations in the immediate postoperative period in line with current SFHFT guidance [26]
- Postnatal advice

4.15 Caesarean birth in women/pregnant people with a BMI ≥ 40

<u>Planned caesarean birth:</u>

The decision for a woman/pregnant person with maternal obesity to give birth by planned caesarean should involve a multidisciplinary approach, taking into consideration the individual comorbidities, antenatal complications and wishes [17.]

Planned Caesarean birth should be a considered option in those morbidly obese women/pregnant people.

- Where the woman/pregnant person is not mobile
- Where vaginal examination is not possible
- Where it is not possible to monitor the fetal heart adequately

Planned caesarean birth should be carried out after 39 weeks' gestation to decrease the risk of neonatal respiratory morbidity [27].

Pre-operative assessment includes a weight from 36 weeks onwards to ensure accurate medication dossing.

The on-call Consultant Obstetrician and Anaesthetist for the booked day of birth should be informed. The theatre co-ordinator should be informed as an experienced scrub nurse may be needed. Necessary arrangements should be made for specialist equipment i.e. long instruments prior to the procedure to avoid delay or distress to the woman/pregnant person.

Emergency**:**

Any emergency carries an increased risk of morbidity and mortality[25]. Therefore, it is essential to inform both the Consultant Obstetrician and Anaesthetist at the earliest opportunity to allow for them to be present if needed.

Postnatal:

It is recommended that early mobilisation is encouraged, and the 'VTE/Thromboprophylaxis Treatment' pathway is completed in the EPR with thromboprophylaxis given in line with current SFHFT guidance [19].

The 'Pressure Ulcer Prevention and Management in Maternity Standard Operating Procedure' should be referred to aid the assessment and management of potential pressure injury [33].

As the risk of wound infection is increased[20] observation should be made of all wounds and advice given regarding care. Further opinion should be sought immediately if wound infection/ breakdown is suspected [21].

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28. NHS Resolution, Maternity Incentive Scheme year 6 2024-25 Maternity Incentive Scheme - NHS Resolution [accessed 17/09/2024]

6 MONITORING COMPLIANCE AND EFFECTIVENESS

- Clinical pathways to be reviewed as part of investigations of care provided.
- NICE benchmarking of the following guidance when updated by the national team
  - NICE NG201
  - NICE PH27
  - NICE NG3
- Auditing of the Saving Babies Lives care bundle v3 (2023) for all six elements as per NHS Resolution CNST safety action six requirements [28.]

7 EDUCATION

E-learning package available for all staff: https://www.e-lfh.org.uk/programmes/obesity/
Non-compulsory.

8 EQUALITY IMPACT ASSESSMENT

Name of policy/procedure being reviewed: Management of women/pregnant people with a Body Mass Index (BMI)			
New or existing service/policy/procedure: Existing			
Date of Assessment: 09.05.24			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None		
Gender:	Women only service		
Age:	None		

Religion:	None		
Disability:	None		
Sexuality:	None		
Pregnancy and Maternity:	Policy is for pregnancy and maternity service		
Gender Reassignment:	None		
Marriage and Civil Partnership:	None		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None		

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- Information from within this guideline and the evidence base

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Leanne Butler

Signature: Leanne Butler

Date: 09.05.24