GUIDELINE FOR THE MANAGEMENT OF NAUSEA AND VOMITING IN EARLY PREGNANCY (up to 16 weeks gestation)

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Lead Clinicians /Owners	
Mamta Pathak Elisabeth Newton	Clinical Lead for Emergency Gynaecology Assessment Unit and Consultant Obstetrics & Gynaecology Matron for Acute Gynaecology Services
Approved at Gynaecology Governance Meeting on:	8th August 2025
Approved by Medicines Safety Committee on: *Where medicines are included in document.*	
Review Date: This is the most current document and should be used until a revised version is in place	8th August 2028

Key amendments to this guideline

Date	Amendment	Approved by:
8th August 2025	New flowcharts/scoring sheets	Gynaecology Governance

Introduction

Nausea and vomiting in pregnancy (NVP) affects up to 90% of pregnant women[1] and is defined as symptoms of nausea and/or vomiting in pregnancy when onset is prior to 16 weeks gestation and where there are no other causes.[2] The severity of symptoms varies greatly between women and symptoms occur at all times of the day. NVP usually starts between weeks 4-7 of pregnancy and peaks at 9 weeks, resolving in 90% of cases by 20 weeks.[1]

Hyperemesis Gravidarum (HG) is a severe form of NVP affecting up to 3.6% of pregnant women. It can be diagnosed against a background of prolonged NVP in early pregnancy and when nausea and /or vomiting are severe enough to interfere with quality of life, appetite, taste, the ability to eat and drink normally and causing weight loss. Signs of dehydration contribute to the diagnosis rather than ketonuria.

Ketonuria is not considered an indicator of dehydration or the severity of HG.[3,4] Due to international consensus opinion, there is a shift from a historic reliance on objective measures such as weight loss and electrolyte imbalance, towards subjective patient-focused criteria which may lead to improved recognition and diagnosis of HG[5] and this is likely to increase the incidence rate. Patient-focussed criteria are discussed later in the guideline.

Possible Adverse Effects of Untreated HG

Pre-term Birth and Low Birthweight

HG and low pregnancy weight gain increase the risk of *preterm birth*.[6] HG is significantly associated with *low birthweight*, *small for gestational-age babies* and *babies more likely to undergo resuscitation and intensive care treatment*.[7] Vomiting in the first and second trimester of pregnancy (even when not perceived severe enough to warrant treatment) is associated with low birthweight.[8]

Mental Health Impact

HG is associated with poor quality of life, depression and poor mental health, similarly to mental health problems suffered by those with chronic health conditions, this includes suicidal ideation.[9,10] Pre-existing mental health conditions may also be exacerbated by HG[2] and therefore clinical assessment should be considered for depression, anxiety and postnatal depression with appropriate referral. An assessment of both physical and mental health should be carried out on attendance and a referral for psychological support if necessary.

Around 10% of women with HG will terminate a wanted pregnancy due to HG and importantly, a minority are offered the full range of treatments including steroids.[10,11]
HG is a risk factor for postnatal depression and anxiety and postpartum PTSD.[12]

Wernicke's Encephalopathy

Secondary to Vitamin B^1 (thiamine) deficiency.
Characterised by Diplopia, abnormal ocular movements, ataxia and confusion.
Typical ocular signs are a 6^{th} nerve palsy, gaze palsy or nystagmus.
This type of encephalopathy can be precipitated by IV fluids containing dextrose (glucose).
Wernicke's encephalopathy is associated with 40% incidence of fetal death.
Thiamine supplementation should be given to all women admitted with vomiting or with severely reduced dietary intake.

Hyponatraemia

Plasma sodium (less than120 mmols/l) produces lethargy, seizures and respiratory arrest.

Other Vitamin Deficiencies

Cyanocobalamin (Vitamin B_{12})
Pyridoxine (Vitamin B_6)
These deficiencies produce anaemia and peripheral neuropathy.

Mallory–Weiss Tears

Prolonged vomiting may lead to tears of the oesophagus with hematemesis.

Malnutrition

With prolonged protein and calorie malnutrition, weight loss and muscle wasting can occur.

Deep Venous Thrombosis

Women with HG have increased risk of VTE.
Women admitted with HG should have VTE risk assessment and be offered thromboprophylaxis with low-molecular-weight heparin.

Graduated compression stockings should be used when low-molecular-weight heparin is contra-indicated
Thromboprophylaxis can be discontinued upon discharge providing no other indications exist for continuation

Increased risks with co-morbidities such as diabetes mellitus or gastric band.
Advice should be sought from specialist medical teams.
Consideration should be given to the increased risk of malnutrition due to malabsorption of medication in those who have had a previous gastric reduction

Quality of Care and Patient Experience

There is variation in the care and treatment women receive, with possible lack of understanding of the severity and impact on women's physical/psychological/emotional health. There still exists a prevalent attitude among healthcare professionals that NVP/HG originates in the mind and this attitude has led to poor care and treatment experiences.[12,13] This guideline provides evidence-based options for treatment and support.

This guideline is for use by the following staff groups:

- Medical and nursing staff in gynaecology services
- Medical and nursing staff in the Emergency Department

Initial Assessment

This should include a detailed history and physical examination with time of onset and duration of symptoms being noted.

History

- Presenting complaint
- Note specific symptoms e.g. nausea, vomiting, hypersalivation, spitting, inability to tolerate food and fluids, effect on quality of life
- Weight loss
- Abdominal pain
- Urinary symptoms including oliguria or anuria
- Infection
- Past Medical History, including previous history of NVP/HG and Chronic Helicobacter Pylori infection and mental health conditions
- Past Surgical History, including gastric bypass/sleeve
- Drug history
- Allergies
- Social circumstances

Findings which may suggest alternative diagnosis include:

- *Abdominal pain or tenderness*
- *Urinary symptoms*
- *Fever/infective symptoms*
- *Headache or abnormal neurological examination*
- *Goitre*

Examination

- Temperature
- Pulse (tachycardia in dehydration)
- Blood pressure (hypotension in dehydration)
- Oxygen saturations
- Respiratory rate (tachypnoea in dehydration)
- Abdominal examination
- Signs of dehydration: *feeling thirsty, dark yellow, strong-smelling pee, peeing less often than usual, feeling dizzy or lightheaded, feeling tired, a dry mouth, lips and tongue, sunken eyes*[14]
- Signs of muscle wasting/malnutrition
- Any other examinations, as indicated by medical history
- Quantify patient's perception of the severity of symptoms using PUQE score (patient to complete)

Pregnancy-Unique Quantification of Emesis (PUQE)

PUQE Scoring System					
In the last 24 hours, for how long have you felt nauseated or sick to your stomach?	Not at all (1)	1 hour or less (2)	2-3 hours (3)	4-6 hours (4)	More than 6 hours (5)
In the last 24 hours have you vomited or thrown up?	I did not throw up (1)	1-2 times (2)	3-4 times (3)	5-6 times (4)	7 or more times (5)
In the last 24 hours how many times have had retching or dry heaves without bringing anything up?	No time (1)	1-2 times (2)	3-4 times (3)	5-6 times (4)	7 or more times (5)
Total score is sum of replies to each of the first three questions: PUQE-24 Score: Mild 6; Moderate = 7–12; Severe = 13–15					
How many hours have your slept of the last 24 hours and why?					
How would you rate your wellbeing on a scale 1-10? *(1=worst possible, 10=the best you felt before pregnancy)*					
What causes you to feel this way?					

Investigation

- **Urinalysis:** Nitrites may indicate infection.
  The presence or absence of ketonuria in pregnancy is not an indicator of dehydration. Assessing urinary ketones does not have a use in the management of NVP or HG and may be misleading
- **MSU:** if urinalysis indicates signs of UTI
- **Weight:** loss of >/= 5% pre-pregnancy weight is significant
- **Urea and electrolytes:** to guide intravenous fluid and electrolyte replacement and exclude hypokalaemia/hyperkalaemia, hyponatraemia, chronic kidney disease. High creatinine / urea may indicate acute kidney injury due to dehydration
- **Full blood count:** to exclude infection, anaemia, raised haemoglobin and haematocrit. Haematocrit levels may be raised due to dehydration
- **Blood glucose level:** diagnose diabetes, exclude diabetic ketoacidosis in patients with diabetes
- **Ultrasound scan:** assess if viable intrauterine pregnancy, multiple pregnancy or trophoblastic disease. Scans can be scheduled for the next available appointment, rather than urgent, as long as the NVP resolves with treatment and in the absence of other indications for an urgent scan
- **Faecal sample:** consider only if patient has diarrhoea

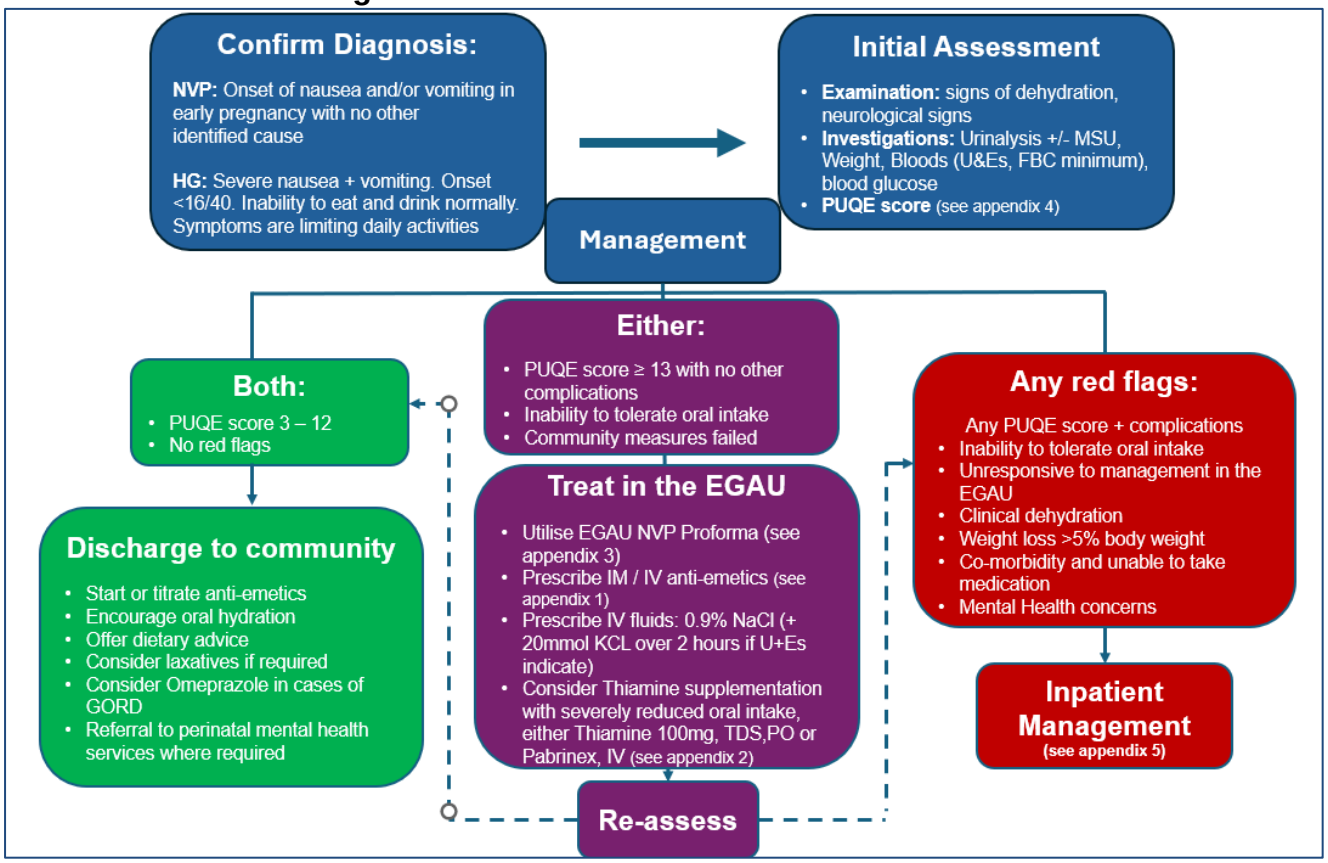
In refractory cases or history of previous admissions, check:

- **TFTs:** hypothyroid/hyperthyroid
- **LFTs:** exclude other liver disease such as hepatitis or gallstones, monitor malnutrition. Mild elevations in bilirubin and transaminases are not uncommon but should resolve as the hyperemesis improves. Significant elevations of transaminases particularly in the presence of jaundice should prompt a search for viral hepatitis.
- **Calcium and Phosphate**
- **Amylase:** exclude pancreatitis
- **VBG:** exclude metabolic disturbances to monitor severity

Differential diagnoses

- Genitourinary: UTI, ectopic pregnancy, uraemia, pyelonephritis, ovarian torsion
- Metabolic and endocrine disorders: hypercalcaemia, thyrotoxicosis, diabetic ketoacidosis, Addison's disease
- Gastrointestinal conditions: gastritis, peptic ulcer, pancreatitis, bowel obstruction, hepatitis, cholecystitis, appendicitis, gastric malignancy
- Neurological disorders: vestibular disease, migraine
- Drug-induced vomiting: iron, opioids
- Psychological: eating disorders

Flowchart for the Management of NVP



NB. Pregnancy sickness support should always be offered, there are several organisations that women may be directed to:
HER foundation, Pregnancy Sickness Support, Best Use of Medicine Pregnancy (BUMPS), UK Teratology Information Service

How should women with NVP and HG be cared for when standard treatment measures do not control symptoms

Almost a third of women[15] will be re-admitted for treatment of HG in the same pregnancy therefore it is essential that women are only discharged once

- anti-emetics have been consistently effective
- adequate oral nutrition and hydration has been tolerated
- appropriate management of concurrent conditions is carried out
- they are advised to continue to take regular anti-emetics and how to access medical care if needed

.

In women with severe, ongoing NVP or HG, input should be sought from other allied professionals such as the mental health team for emotional support and positive impact on quality of life, and dieticians for nutritional support.

If all medical therapies have failed to manage symptoms, enteral tube feeding or parenteral treatment should be considered, with a referral to gastroenterology. Their effectiveness is not well established and are most often a last resort treatment option when the only other option is a termination of pregnancy.

When should termination of pregnancy (TOP) be discussed?

- All medical therapies should have been offered and considered before consideration of a TOP
- Approximately 10% of women with HG will terminate a wanted pregnancy, due to HG. Pregnancy Sickness Support found that many of these women had not been offered a full range of treatment options and few than 10% had been offered steriods[16]
- Referral for psychiatric opinion should be sought if there are mental health concerns and a multi-disciplinary approach should be taken when a woman is considering the decision for TOP
- Women should be offered counselling before and after a decision for a TOP is made

Advice for future pregnancies

- Women who experience HG are at increased risk or post-natal depression and post partum stress disorder – the involvement of peri-natal mental health services should be considered
- Recurrence of HG in subsequent pregnancies is reported by women to be very high
- Pre-emptive anti-emetics before pregnancy or before onset of symptoms may lower the risk of HG in a subsequent pregnancy and an improvement in PUQE scores[17] and may reduce the number of hospital admissions
- Adjusting lifestyle early in a subsequent pregnancy to enable rest and an eating pattern of 'little and often' is likely to be of some benefit

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Appendix 1 Anti-Emetic Drugs to Treat Nausea and Vomiting in Pregnancy

Drug	Dose and Route	Main Side-Effects/ Safety data	Comments	Class of Drug
First line drugs				
Cyclizine	50 mg TDS, PO/IV/IM, 8 hourly	Drowsiness, dry mouth, blurred vision. Extensively used during pregnancy. No increase in rate of major congenital malformations observed		First line antihistamines H1 Receptor antagonist
Stemetil	5-10mg PO, TDS (6-8 hourly) or 3mg buccal **or** 12.5mg IM TDS **or** 25mg PR suppository daily	Extra-pyramidal reactions in some young patients. No evidence of increased risk of congenital malformations	Can be used PRN in addition to regular antihistamines	Prochlorperazine
Promethazine	12.5-25 mg 4-8 hourly PO,IM or IV	Drowsiness, extrapyramidal symptoms, arrhythmia	Neonatal irritability, paradoxical excitability, and tremor — if used in the latter part of the third trimester of pregnancy. Manufacturer advises avoid during pregnancy, but no evidence of teratogenicity	First line Phenothiazine
Second line drugs				
Metoclopromide	5-10 mg TDS (8 hourly) PO/IM/IV	Use in younger adults has been associated with dystonias and should therefore not be routinely	Can be used PRN in addition to regular antihistamines	Second Line Centrally acting

		used as first-line treatment and for longer than 5 days		
Ondansetron	4mg 8 hourly or 8 mg 12 hourly, PO **or** 8 mg over 15 minutes, 12 hourly, IV **or** 16mg daily PR	A 2018 study has suggested an increased risk of isolated cleft palate following first trimester exposure to ondansetron. Can be used following counselling if other treatments fail	Avoid in first trimester if possible	Third Line Serotonin receptor (5HT3) antagonists
Third line drugs				
Prednisolone Hydrocortisone	100mg BD, IV – once clinical improvement occurs, change to 40–50 mg daily, PO, gradually taper (by 5-10 mg per week) until the lowest maintenance dose that controls symptoms is reached	Glycosuria Psychosis fetal growth restriction	Use in rare circumstances after review by Gastro. Prescribed only by a consultant	Fourth Line Corticosteroids
Omeprazole	20-40mg daily PO/IV	Consider in cases of Gastro-oesophageal reflux disease (GORD)	Safety data on Omeprazole shows no harmful effects on pregnancy	

Appendix 2 Use of Pabrinex

One pair of Pabrinex ampoules (contains 250mg Thiamine) IV:

Draw the contents of ampoule 1 and 2 into a syringe and mix. Add to 100mls Sodium Chloride 0.9% and infuse over 15-30 minutes (given x1 weekly and repeated if vomiting persists).

Monitor closely – risk of anaphylaxis.
NOTE also contains 1g of glucose.
Consider changing back to oral thiamine if patient is able to tolerate.
Women with deranged biochemistry are at higher risk of Wernicke's encephalopathy.

Since potentially serious allergic adverse reactions may occur during or shortly after, administration it is recommended that:

- Use is restricted to patients in whom parenteral treatment is essential
- Intravenous injections should be administered slowly (over 10 minutes)
- Facilities for treating anaphylaxis must be available when administered

Appendix 3 EGAU NVP Proforma

Patient addressograph Name DOB Hospital/NHS Number			Date: Arrival time: Referred by: Assessment time: Discharge time:
Patient telephone number:			
Age:	LMP:	Gravidity:	Parity:
PUQE score (see patient's PUQE assessment):			
How many hours the patient slept of the last 24 hours and why? (see patient's PUQE assessment):			
Patient self-score for wellbeing on a scale 1-10? (1=worst possible, 10=best felt before pregnancy) (see patient's PUQE assessment):			
What causes them to feel this way? (see patient's PUQE assessment):			

Nurse Assessment

If previous pregnancy, have they experienced HG in previous pregnancy/pregnancies?	
Presenting specific symptoms e.g. nausea, vomiting, hypersalivation, spitting, inability to tolerate food and fluids, effect on quality of life	
Blood in vomit	If yes, please refer to doctor
Last tolerated fluids (24hr clock):	Last tolerated food (24 hr clock):
Weight loss	
Abdominal pain	If yes, please refer to doctor
Urinary symptoms (eg. oliguria: severe reduction in voiding or anuria: not voiding or signs of infection)	If yes, please refer to doctor
Ultrasound scan in this pregnancy Yes / No	If yes, findings:
History of diabetes mellitus:	If yes, please refer to doctor

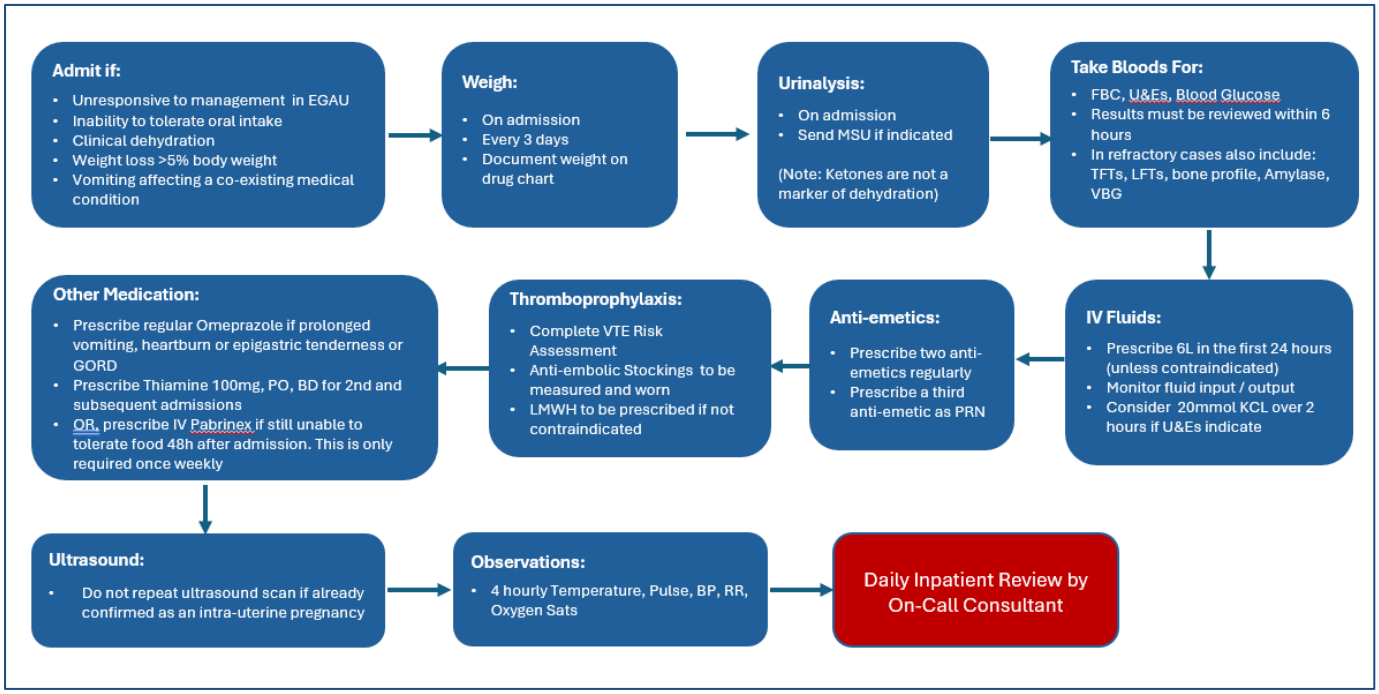
History of thyroid disease:	If yes, please refer to doctor
Medical History: Chronic Helicobacter Pylori infection?	Medications:
Surgical History: Gastric sleeve/bypass?	Allergies:
Social circumstances	
Temperature	
Pulse (tachycardia in dehydration)	
Blood pressure (hypotension in dehydration)	
Oxygen saturations	
Respiratory rate (tachypnoea in dehydration)	
Signs of dehydration: feeling thirsty, dark yellow, strong-smelling pee, peeing less often than usual, feeling dizzy or lightheaded, feeling tired, a dry mouth, lips and tongue, sunken eyes	
Signs of muscle wasting/malnutrition	
Any other examinations, as indicated by medical history (by doctor if required	
Nurse completing assessment	Sign: Print: Role: Date: Time:
Abdominal examination	If yes, please refer to doctor
Medical review (if required)	

Sign	Print	Role
Suitable for rapid hydration	Yes / No	
Investigations		
Urinalysis results:		
	Results	
Weight (kg)		
Blood Glucose:		
MSU required: sent:		
FBC		
U&Es		
TFT (if required on clinical grounds)		
LFT (if required on clinical grounds)		
Ultrasound Scan • if previous scan carried out and intra-uterine pregnancy confirmed, and no new clinical concerns then do not repeat scan • if scan required, book next available non-urgent scan slot, unless clinically indicated as urgent		
Faecal sample (consider only if patient has diarrhoea)		
Treatment		
Medications prescribed		
IV fluids prescribed		
Pregnancy Sickness Support leaflets given		
Refer to for peri-natal mental health support?		
Suitability for discharge		
Able to tolerate oral intake		
Urinalysis NAD		
Observations normal range		
No new symptoms		
TTOs prescribed		
EGAU leaflet and contact numbers given for self-referral back if required		
Person discharging	Signature: Print: Role: Date: Time:	

Appendix 4 PUQE Score Sheet (patient to complete)

PUQE Scoring System					
In the last 24 hours, for how long have you felt nauseated or sick to your stomach?	Not at all (1)	1 hour or less (2)	2-3 hours (3)	4-6 hours (4)	More than 6 hours (5)
In the last 24 hours have you vomited or thrown up?	I did not throw up (1)	1-2 times (2)	3-4 times (3)	5-6 times (4)	7 or more times (5)
In the last 24 hours how many times have had retching or dry heaves without bringing anything up?	No time (1)	1-2 times (2)	3-4 times (3)	5-6 times (4)	7 or more times (5)
Total score is sum of replies to each of the first three questions: PUQE-24 Score: Mild 6; Moderate = 7–12; Severe = 13–15					
How many hours have your slept of the last 24 hours and why?					
How would you rate your wellbeing on a scale 1-10? *(1=worst possible, 10=the best you felt before pregnancy)*					
What causes you to feel this way?					

Appendix 5 Flowchart for the Inpatient Management of Nausea and Vomiting in Pregnancy



Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	Consistent use of PUQE scoring to measure	Spotcheck medical notes audit to identify PUQE score forms completed	2 times per year	Ward Manager/Matron	Gynae Governance	Following spotcheck audit
	Responding to patients needs and adherence to treatment options	Spotcheck medical notes audit to identify PUQE score forms completed	2 times per year	Ward Manager/Matron	Gynae Governance	Following spotcheck audits

Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
O&G Consultants
Gynaecology nursing team

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Medicines Safety Committee
Gynaecology Governance Team

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Dr Mamta Pathak

Details of individuals completing this assessment	Name	Job title	e-mail contact
	Elisabeth Newton	Matron for Acute Gynaecology Services	elisabeth.newton@nhs.net
Date assessment completed	04/07/2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: Guideline for the Management of Nausea and Vomiting in Early Pregnancy (<16 weeks gestation)
What is the aim, purpose and/or intended outcomes of this Activity?	To provide an evidenced-based guideline for investigation and treatment of nausea and vomiting in early pregnancy to enable safe, effective treatment with the best possible outcomes and patient experience, with the patient as the focus.

Who will be affected by the development & implementation of this activity?	√ √ ❑ ❑	Service User Patient Carers Visitors	√ ❑ ❑ ❑	Staff Communities Other _____
Is this:	√ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	New RCOG guidance for management of nausea and vomiting in pregnancy, patient feedback via complaints and pregnancy sickness support agencies			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	• One-to-one conversations with service users. • Debrief conversation with lead consultant and a service user who experienced HG in pregnancy, following her pregnancy • One-to-one conversation in response to a complaint • Conversations with staff • Reflection, with nursing staff on a recent news article detailing a woman who took her own life, thought to be due to the impact of HG			
Summary of relevant findings	• Women and their partners have not felt listened to and felt they were being a nuisance due to repeatedly requiring treatment during a pregnancy • HG can be under-treated without all treatment options offered • The impact of HG on mental health has been under-estimated			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	√			This will be beneficial for women of child-bearing age
Disability		√		Access to treatment option for management of nausea and vomiting in pregnancy will not be affected by these factors.
Gender Reassignment		√		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Marriage & Civil Partnerships		√		
Pregnancy & Maternity	√			Pregnant women will benefit from an evidence-based guideline for effective investigation, diagnosis and treatment options for the management of nausea and vomiting in pregnancy
Race including Traveling Communities		√		Access to treatment option for management of nausea and vomiting in pregnancy will not be affected by these factors.
Religion & Belief		√		
Sex	√			Pregnant women will benefit from an evidence-based guideline for effective investigation, diagnosis and treatment options for the management of nausea and vomiting in pregnancy Male and female partners will benefit from the appropriate support and treatment that will be offered to their pregnant partner
Sexual Orientation		√		Access to treatment option for management of nausea and vomiting in pregnancy will not be affected by these factors.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		√		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the		√		It is understood that there are health inequalities that may lead to difficulties in accessing healthcare however, this guideline itself is neutral in impact.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Nil	.		
How will you monitor these actions?	N/A			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	At the time of a planned guideline update and before this, if the need arises.			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	ERNorton
Date signed	04/07/2025
Comments:	

Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.