Worcestershire Acute Hospitals NHS Trust

Outpatient Hysteroscopy Guideline

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.

Introduction

Outpatient hysteroscopy (OPH) is an established technique for directly visualising the inside of the uterus for diagnostic and therapeutic reasons. The aim of these services is to provide a safe, effective and convenient option for women. Alongside this the technique also removes the need to use formal theatre services and avoid regional or general anaesthetic. Common additional procedures include endometrial polypectomy, fibroidectomy, endometrial ablation and removal of contraceptive devices. Although well tolerated, outpatient hysteroscopy has the potential to be painful and associated with anxiety and embarrassment. Appropriate steps need to be taken to minimise these issues, helping reduce failed procedures and improve patient satisfaction.

The aim of this guideline is to provide staff with information to facilitate delivery of a high quality, efficient and evidence based service.

In this Trust, OPH is undertaken at the Women's Health Unit at The Alexandra Hospital, Redditch.

Lead Clinician(s)

Mr Jonathan Chester	Consultant Obstetrician and Gynaecologist, Ambulatory Gynaecology Lead.
Approved by Gynaecology Governance Meeting on:	10th March 2023
Review Date:	10th March 2026
This is the most current document and should be used until a revised version is in place	

Key amendments to this guideline

Date	Amendment	Approved by:
Feb 23	Guideline re-written	Ambulatory gynaecology team
March 2024	Minor Amendment made. New version issued.	Gynaecology Governance

2. Scope of this document

This policy is designed for all medical and nursing staff involved in the delivery of outpatient hysteroscopy. It does not cover the management of particular conditions (such as heavy menstrual bleeding or post-menopausal bleeding) or operative hysteroscopy as these are covered in other guidelines. It sets out the basic standards and steps for provision of the outpatient service.

3. Definitions

Term	Definition
Outpatient hysteroscopy	Hysteroscopy procedure performed in the outpatient setting with no anaesthetic or use of local anaesthetic only.
Clinician	Any person responsible for carrying out outpatient hysteroscopy to include doctors, consultants and specialist nurses.
Post-menopausal	A person more than 12 months since their last menstrual period.

4. Responsibility and Duties

It is the responsibility of the medical and nursing staff involved in OPH to ensure they are familiar with the contents of this guideline.

It is the responsibility of the Ambulatory Gynaecology lead consultant to ensure this guideline is appropriately reviewed and updated as per new evidence or developments.

5. Recommendations

5.1 Patient selection for Outpatient Hysteroscopy

5.1.1 Indications for OPH

- Patients may be referred for outpatient hysteroscopy via the ICE system.
- To be eligible for the procedure they must meet the following criteria:
  - Have capacity to understand and consent to the procedure;

- Have a uterus;
- Be likely (as per the clinician's and patient's opinion) to tolerate the procedure;
- Have one of the conditions listed in the below table:

Condition	Notes
Heavy menstrual bleeding	This must be refractory to at least two treatments: • Tranexamic acid • Progesterone only pill • Depot injection • Implant • Mirena coil
Bleeding after endometrial ablation	Patient must be <50yrs old – those ≥50 should be referred via the 2ww PMB pathway.
Persistent intermenstrual bleeding	With no obvious other cause which is not responsive to other treatment.
Suspected uterine pathology	Including: • Endometrial polyps; • Submucosal fibroids; • Abnormal/cystic endometrium on USS • Uterine abnormalities
Retained IUD/IUCD	• After appropriate imaging to ensure the coil/device is still in situ.
Recurrent miscarriages	• Following appropriate assessment and referral by the infertility team
Failed assisted contraception	• Following appropriate assessment and referral by the infertility team
Post-menopausal bleeding	• See the Post-Menopausal bleeding guideline
Other suspected pathology which would be diagnosed by outpatient hysteroscopy	• This needs to be discussed and approved by one of the ambulatory consultants. • This discussion should be documented on the ICE referral

5.1.2 Contraindications to OPH

- Contraindications to outpatient include (but are not limited to):
  - Unprotected sexual intercourse within the last two weeks with absence of a period since intercourse;
  - A positive pregnancy test;

- Absence of a uterus;
- Uncontrolled anticoagulation (see anticoagulation section);

- Prior to the appointment the patient should receive appropriate information regarding the timing and location of their appointment as well as their responsible clinician. This will be via the appointment letter sent out to patients. Alongside this they should receive:
  - Outpatient hysteroscopy patient information leaflet;
  - Information regarding suitable analgesia prior to the procedure (contained in the patient information leaflet);
  - Example consent form;
  - Appropriate links/QR codes to allow access to other patient information leaflets for related treatments which may become necessary.
  - Contact numbers to allow rearrangement of their appointment or for any relevant questions
- Where the appointment is booked at short notice the patient should be offered the option of receiving this information by e-mail.

5.3 Prior to the procedure

- Patients should be welcomed to the ward appropriately
- Patients should have the appropriate admission documentation completed on admission
- A set of observations should be completed prior to the procedure, to include:
  - Heart rate
  - Oxygen saturations
  - Temperature
  - Blood pressure
- There are no specific values for the above observations which are contraindications to OPH, but any values which are outside the norm should be reviewed by the clinician and it is at their discretion as to whether they will proceed based on a risk vs. benefit decision.
- Patients should be asked whether they have taken analgesia prior to the attending for the procedure. If they have yet to take any analgesia then they should be offered (subject to allergy status):
  - Paracetamol 1g PO STAT and/or
  - Ibuprofen 400mg PO STAT
- The pregnancy status of the patient should be ascertained prior to any procedure or drug administration:
  - A pregnancy test should be performed only if the patient is pre-menopausal or there is doubt about her menopausal status.
  - Pregnancy tests are not required in those aged over 55 or those who are clearly post-menopausal.
  - Where a patient is pre-menopausal they should be rebooked if they have had unprotected sexual intercourse in the last two weeks and have not had a period in that time since the unprotected intercourse.
- A standard urinalysis is not required unless the patient is symptomatic of a urinary tract infection.

- Appropriate clerking by a clinician should take place with a final decision as to how to proceed made. The patient should be included in this decision making.
- Patients and clinicians should have a discussion regarding the most appropriate options for proceeding with hysteroscopy. This discussion should discuss the benefits and risks of each option and a recommendation from the clinician as to the best option in their opinion. This should include:
    - Do nothing/watching and waiting;
    - Alternative options to hysteroscopy;
    - Proceeding with outpatient hysteroscopy including analgesic options:
        - Local anaesthetic
        - Entonox
        - Other appropriate analgesia;
    - Opting to return to have the procedure performed under general anaesthetic.
- Patients should be allowed time to make their decision and be offered the opportunity to be rebooked if they are unsure or wish to have further time to consider.
- The patient's decision regarding how they wish to proceed should be documented and respected.
- Patients should have it clearly discussed with them that they are able to stop the procedure at any point they wish.

5.4 Preparing for the procedure

- The room and equipment should be set up as per the outpatient hysteroscopy SOP;
- The room should have minimum staffing of one nurse and one health care assistant (both with appropriate experience in outpatient hysteroscopy) in addition to the person carrying out the hysteroscopy.
- Women should be given an appropriate private area to change for the procedure, with access to toilet facilities. They should be given an appropriate draw sheet or other covering to maintain dignity whilst transfer to couch/bed occurs.
- Electronic or written consent should be obtained from the patient.
    - Where the patient themselves is unable to consent there should have been appropriate capacity assessment.
    - If the patient lacks capacity appropriate discussion should be undertaken according to the trust guidance on obtaining consent.
- The appropriate WHO based checklist (appendix 1) should be completed prior to the procedure commencing.

5.5 Undertaking the procedure

- The clinician undertaking the procedure should be appropriately trained to perform the procedure or appropriately supervised if in a training role.
    - Where clinicians are training, the overall responsibility for the safety of the patient lies with the supervising clinician.

- Where specialist nurses or competent non-consultant doctors are undertaking outpatient hysteroscopy independently, they must have appropriate recourse to a consultant advice as required.
    - This person is not required to be on site, but must be contactable in the event of a query or issue.
    - In practice this may be the on-call gynaecology consultant (on bleep 474).
    - This person is not responsible for the running of the clinic or the safety of the clinic but is available for senior advice in the event of an issue.
- The patient should be appropriately positioned and covered to help maintain dignity and cleanliness.
- Throughout the procedure one member of staff should be stood with the patient, to provide support and relay any communication to/from the patient as required.
- The procedure should be undertaken using appropriate non-touch techniques to minimise contamination.
- Entonox should be available to all women during the procedure if they want to use it.
    - Its routine use is not recommended but it can be used as an adjunct where patients need extra analgesia during the procedure.
- Conscious sedation is not recommended for outpatient hysteroscopy and should not be carried out in the Women's Health Unit.
    - There is no evidence it improves patient satisfaction;
    - There is increased risk of life-threatening complications;
    - Staff training and appropriate monitoring are not sufficient for this to be carried out in the Women's Health Unit.

5.5.1 Cervical preparation and dilatation

- Routine administration of cervical preparation (prostaglandins/misoprostol) should be avoided.
- Local anaesthetic via an intra-cervical or paracervical block should be considered where larger diameter scopes are required (>5mm) or where cervical dilation is required/likely (e.g post-menopausal women). This is associated with a reduction in pain during the procedure.
- Cervical dilatation should be undertaken only where necessary as this provides a source of discomfort to the patient and in many cases is unnecessary.
- Cervical dilatation should avoid unnecessarily small dilators where possible to minimise the risk of perforation.
- Dilatation should occur to the minimum size necessary to complete the procedure.

Local anaesthetic dosage information

	Maximum doses[16]
Lignocaine	4mg/kg/4hrs
Lignocaine with adrenaline	7mg/kg/4hrs
Bupivacaine	2mg/kg/4hrs
Prilocaine *(Citanest®)*	6mg/kg/4hrs
Prilocaine with adrenaline *(Octapressin ®)*	8mg/kg/4hrs

5.5.2 Hysteroscopy

- Hysteroscopy equipment should be prepared as per the Outpatient Hysteroscopy SOP
- The clinician performing the procedure is responsible for selecting the appropriate hysteroscope for completion of the procedure. This should take into account:
    - The parity and age of the patient;
    - The possible likelihood of pathology which may need biopsy/treatment;
    - The need to use the smallest diameter hysteroscope possible;
    - Whether the hysteroscope has the option of multiple channels to reduce the chance of needing to open a further hysteroscope or need to re-insert the hysteroscope.;
    - The aim to complete diagnosis and treatment in one appointment where feasible.
    - The patients BMI and the need for extended length hysteroscopes.
- Where possible the hysteroscopy should be performed using a vaginoscopic approach. This will be sufficient for a large proportion of hysteroscopies and reduces patient discomfort and can aid manoeuvring the hysteroscope.
    - After cervical blocks and cervical dilation have occurred – consideration should be given to removing the speculum and proceeding with a vaginoscopic approach to aid patient comfort.
- 0.9% sodium chloride should be used as the distension medium for outpatient hysteroscopy.
    - The amount used should be closely monitored to prevent fluid overload.
    - Amounts over 2L should be used with caution.
- Clinicians should be aware that increased distension pressures lead to increased discomfort/pain for women. They should, however, ensure they have adequate distension to allow appropriate diagnosis and/or treatment of the patient during hysteroscopy.

- Routine observations are not required during the procedure unless the clinician feels they are required due to a pre-existing medical condition or intra-procedure complication.

5.6 Post Procedure

- Following the procedure patients should be debriefed about the procedure and the findings.
- Patients should be invited to ask any questions they may have.
- Appropriate follow up or further procedure should be discussed and arranged.
- The findings of the procedure should be clearly documented and a letter dictated to the patient with a copy to the general practitioner.
- The appropriate histology/microbiology requests should be completed and the specimens labelled and checked.
- The WHO based checklist should be completed and signed.
- Patients should be moved to the recovery area. Whilst in this area they should:
    - Be offered further analgesia as required;
    - Be offered refreshments;
    - Be invited to complete feedback on their experience including a pain score;
    - Have a set of observations undertaken:
        - Heart rate
        - Blood pressure
        - Oxygen saturations
        - Temperature
- Patients may be discharged after a minimum of 15minutes in the recovery area if their observations are stable.

5.7 Management of patients on anti-coagulation therapy

- Differing procedures carry varying risks for bleeding and so the requirement to stop/reduce anticoagulation will vary.
- It is also important to understand the reason for anticoagulation as this will alter the risks and benefits of adjustments/withholding doses.
- Ultimately it is the clinician's responsibility for assessing the risks to a patient of stopping their anticoagulation.
- Changes to anticoagulation therapy (dose or agent) should be clearly discussed with the patient and where possible written confirmation provided.
- Any decision regarding stopping/changing anticoagulant therapy should be made based on the planned procedure.
- Any procedure which is required outside of the planned procedure can be done at the clinicians discretion, taking into consideration the recommended guidance for the procedure to be done.

- Most procedures done in the outpatient setting are considered low bleeding risk and so the need to change/stop anticoagulation is low.

Medical procedures and their bleeding risk.

Bleeding risk	Type of procedure
No bleeding risk	Pelvic examination Smear test
Low bleeding risk	Cervical biopsy Large loop excision of transformation zone Diagnostic hysteroscopy Pipelle biopsy/Endometrial biopsy Hysteroscopy and resection of polyp, including type 1 fibroid polyps <3cm MyoSure polypectomy Vulval biopsy Labial/Bartholin's abscess Endometrial ablation
High bleeding risk	All day case and inpatient surgery

5.7.1 Low bleeding risk procedures

- Warfarin
    - A recent INR should be available prior to the outpatient hysteroscopy.
        - Any result within 1 week of the procedure can be used as long as the INR has been stable and there have been no major dose adjustments;
        - Where the INR has been unstable the clinician may want a more recent INR before performing the procedure.
        - Warfarin should only be stopped where operative hysteroscopy is planned. In this case appropriate bridging therapy should be prescribed.

Warfarin dosing table

INR	Recommendation
<1.5	Continue with procedure. *Patient may need to discuss with anticoagulation clinic regarding dose adjustment.*
≥1.5 but ≤3.0	Continue with procedure.
>3.0	Procedure to be postponed until INR ≤3.0.
Any INR with heart valve	Discuss with cardiology prior to procedure.
Any INR with thrombosis <6/52 prior to procedure	Discuss with haematology prior to procedure.

- Direct oral anticoagulants (DOAC)
    - These include Apixaban, Rivaroxaban and Edoxaban
    - DOACs provide a similar level of anticoagulation to Warfarin with a target INR of 2.5.
    - They are more susceptible to produce peaks and troughs.
    - They are usually taken as a twice a day dosing.

DOAC Recommendations Table

Procedure timing	Recommendation
AM procedure	Omit dose prior to procedure Take omitted dose 2hrs after procedure Take evening dose as normal.
PM procedure	Take morning dose *prior* to 7am. Take evening dose at usual timing *or* two hours after the procedure, *whichever occurs latest.*

- Other anticoagulants
    - Clopidogrel, Prasugrel, Ticagrelor, Aspirin
        - There is currently no requirement to stop Clopidogrel, Prasugrel, Ticagrelor or Aspiring prior to low bleeding risk procedures.
    - Other anticoagulants not listed should be discussed with haematology prior to the procedure.

5.8 Outpatient hysteroscopy following previous endometrial ablation

- Patients who have had a previous endometrial ablation are at increased risk of a failed hysteroscopy, uterine perforation and gaining limited information from the hysteroscopy.
- This should be discussed with the patient prior to the procedure.
- The clinician and patient should make a shared decision on whether to proceed with the hysteroscopy or not, taking into account the clinical indication and the possible treatment options.

5.9 Management of particular findings during outpatient hysteroscopy

5.9.1 Cervical stenosis

- Cervical stenosis is a common finding, especially in the post-menopausal population.
- Cervical stenosis increases the risk of perforation. This risk should be minimised by:
    - Knowing if the uterus is anteverted or retroverted
    - Using hydrodilation with high pressure fluids or dilation under direct vision where possible
    - Using soft, flexible dilators where possible – e.g. an endometrial sampling device such as a Pipelle ®.
    - Use of a narrow diameter hysteroscope.
- Where cervical stenosis is diagnosed the clinician should re-evaluate the patient's analgesic needs, and consider a cervical block if not already given.
- Where appropriate dilation cannot be performed in the outpatient setting (either technically or due to patient discomfort/pain) the clinician should discuss with the patient about having trying the procedure under general

anaesthetic. This improves patient comfort and allows easier management of any complications such as perforation should they occur.

5.9.2 Pyometria (pus within the endometrial cavity)

- If pyometria is suspected then outpatient hysteroscopy should not be routinely performed. The hydrostatic pressure during the procedure can force the pus through the tubes into the abdominal cavity. In this situation:
    - Perform a speculum examination;
    - Take triple swabs to help diagnosis and treatment;
    - Gently dilate the cervix being mindful of the increased risk of perforation in the presence of infection;
    - Send a sample of the pus for microbiological assessment;
    - Take a endometrial biopsy for histological assessment;
    - Prescribe an appropriate antibiotic regimen:
        - Co-amoxiclav 625mg PO TDS for 7 days.
        - Clindamycin 300mg PO QDS for 7 days if penicillin allergic.
    - Review the patient in 2 weeks and re-assess the need for hysteroscopy.
- If pyometria is found during hysteroscopy, the procedure should be abandoned and the above steps followed.

5.8 Management of complications during outpatient hysteroscopy

- Guidance for the management of complications during an outpatient hysteroscopy is contained in the '*Management of Complications During Outpatient Hysteroscopy'* guideline.
- Clinicians performing outpatient hysteroscopy should be aware of how to manage common complications which may occur.
- Where possible they should follow the appropriate treatment algorithms, but should ensure care is individualised to each patient.
- Clinicians should be aware that there are limited gynaecology services at the Alexandra Hospital and timely transfer to Worcester Royal Hospital may be required in some situations.
- Where serious or life threatening complications have occurred the emergency medical response team should be called, by dialling 2222 from any hospital phone.

6.0 Implementation

- This guideline will be available via the trust intranet, as well as being available as a printed copy on the Women's Health Unit.
- All staff will be made aware of the new guideline via the Gynaecology Governance Meeting.
- It remains the responsibility of those staff who are responsible for performing and assisting in outpatient hysteroscopy to remain up to date with the relevant guidance.

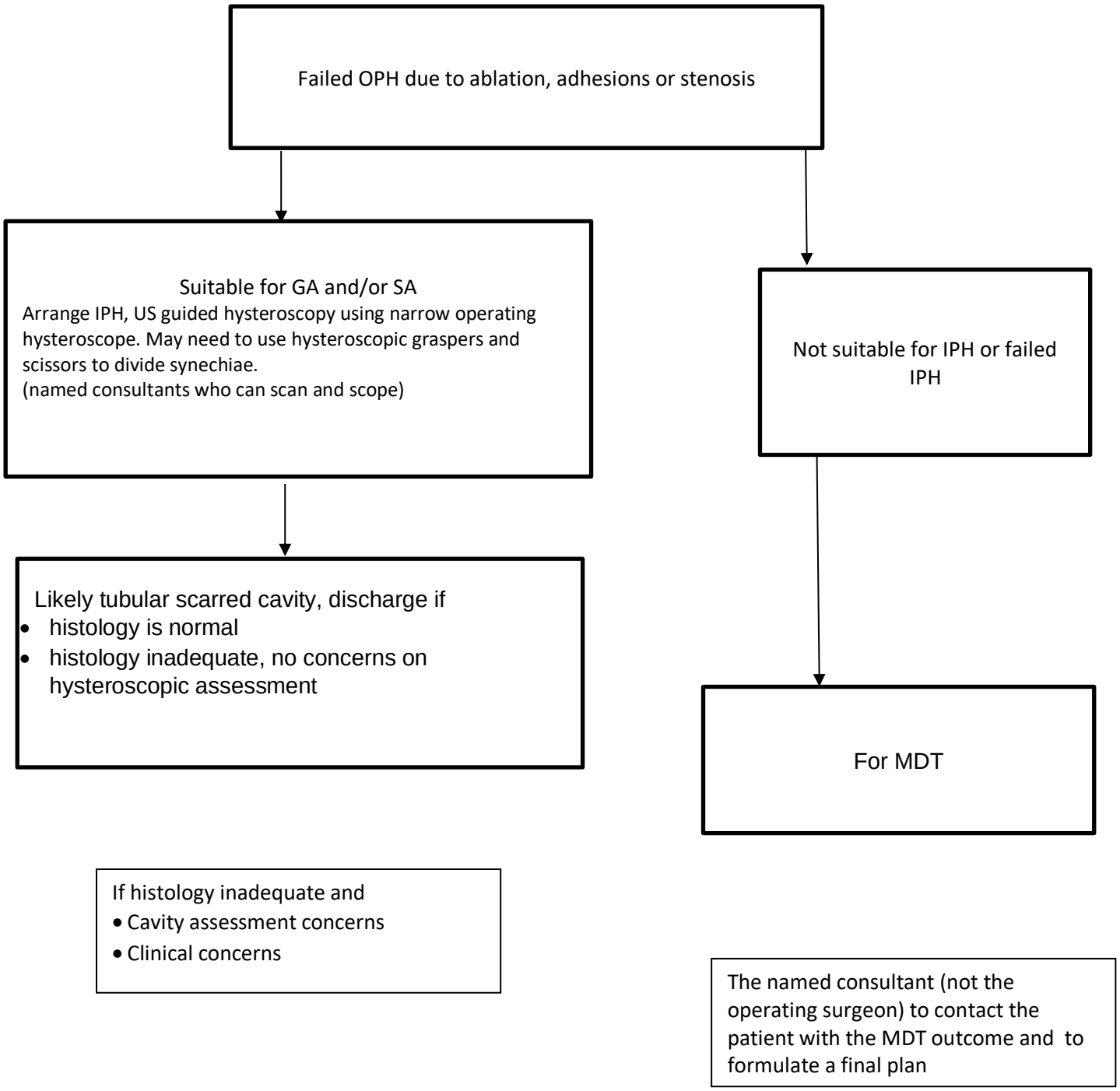
7.0 Monitoring and Compliance

- Any incidents will be reported via Datix and appropriately investigated.
- It is the responsibility of the clinician to be compliant with the recommendations in this guidance.

8.0 Review of policy

- This guideline will be reviewed after 3 years or in significant national guidance is published which may make this guideline outdated.
- It is the responsibility of the lead clinician for Ambulatory Gynaecology to ensure this is done.

9.0 Pathway for investigating cases of failed OPH with history of endometrial ablation



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- WAHT-HAE-002A, Endoscopy Standard Operating Procedure: Prescribing/omission of oral anticoagulants for elective endoscopy
- RCOG/BSGE. (2018) Outpatient Hysteroscopy – Information for You. RCOG/BSGE
- WAHT-CG-075 Policy for Consent to Examination or Treatment
- eMedicines Compendium: https://www.medicines.org.uk/emc/product/870/smpc
- WAHT-KD-017 Warfarin and Other Anticoagulants Guidelines and Procedures

Contribution List

Contribution List

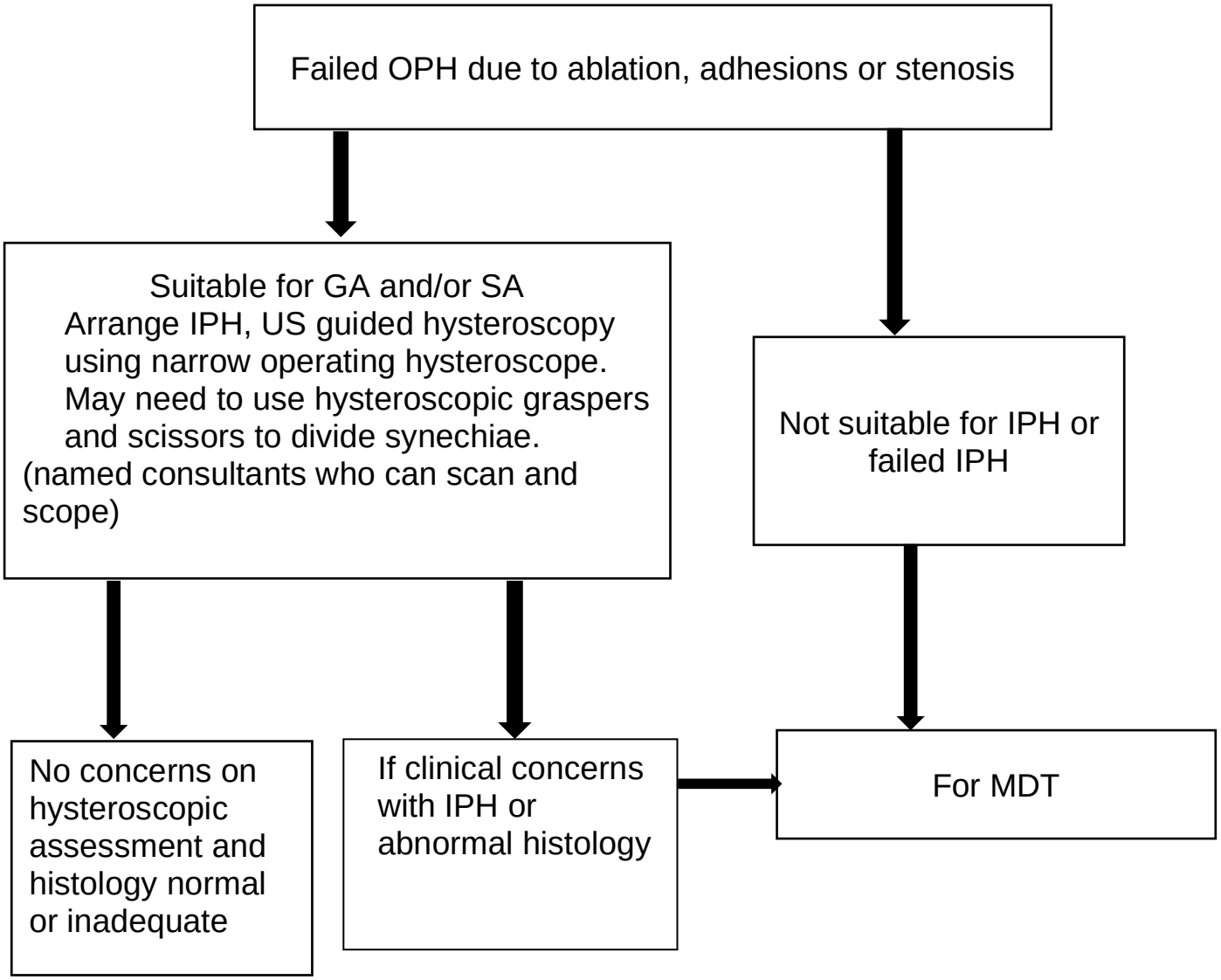
This key document has been circulated to the following individuals for consultation;

Name	Designation
Mr Jonathan Chester	Consultant Obstetrician and Gynaecologist
Dr Salim Shafeek	Consultant Haematologist
Elisabeth Newton	Matron for Gynaecology Sevices (author of previous guideline)

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

Committee
Ambulatory gynaecology team

Pathway for investigating abnormal uterine bleeding with history of endometrial ablation:



Appendix 1 – Outpatient hysteroscopy checklist

WHO checklist & Ambulatory Procedure form

Date: Time: Clinician:

Putting Patients First

Worcestershire Acute Hospitals NHS Trust

PATIENT DETAILS	
Admission observations	LMP: _____ Pregnancy test indicated: Yes ☐ No ☐ HR ___bpm BP ___/___ RR ____ Sats____ Temp ____ Height_____ Weight_____ BMI _____ Any Allergies? YES ☐ NO ☐ Any pre medications taken? YES ☐ NO ☐ Pregnancy test: Lot: Expiry: Result: Performed by:_____ Checked by: _____
Team briefing (Pre-procedure)	**Relevant patient co-morbidities** YES ☐ NO ☐ _____ **Confirm indication for procedure** _____ **Confirm equipment present, correct and in date** ☐
Sign in/ Out Time (perform when the patient is in the room)	**Confirm Name, DOB, Hospital Number** ☐ **Introduction of all members present within the clinic room** ☐ **Indication for procedure is understood YES ☐ NO ☐** **Written informed consent obtained** YES ☐ NO ☐ **Is the patient on any anti coagulants?** YES ☐ NO ☐ _____ **Infection Status** (CJD/ HIV/ HEP)_____ **Medication for procedure ready checked and in date** ☐ **What procedure is planned?** _____ **Who is performing the procedure?** _____ Name Nurse/ HCA 1:.....Sign:..... Name Nurse/ HCA 2:.....Sign:.....
Procedure start time:	
Procedure end time:	

Post Procedure	**Was the procedure completed?** YES ☐ NO ☐ _____		
	Are all swabs/sharps/instruments correct? YES ☐ NO ☐ _____		
	Does the patient require any analgesia? YES ☐ NO ☐		
	Any samples obtained? YES ☐ NO ☐ **How many samples?** _____		
	Labelled and correctly checked by whom (please initial) _____		
	Person completing procedure	**1st Check**	**2nd Check**
	Signature _____	Signature _____	Signature _____
	Name _____	Name _____	Name _____
	Date _____	Date _____	Date _____
Recovery	**Time into recovery:**		
	HR _____bpm BP ___/____ RR _____		
	Sats _____% Temp_____oC		
	What is the patient's pain score (/10)?		
	Does the patient require any analgesia? YES ☐ NO ☐		
	Has the patient had appropriate discharge information? YES ☐ NO ☐		
	Any other concerns? YES ☐ NO ☐		
Notes			

Supporting Document 1 - Equality Impact Assessment Tool

NHS Worcestershire Acute Hospitals NHS Trust

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	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Mr J. Chester**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Mr J. Chester	**Cons O&G Interim Ambulatory Gynae Lead**	**j.chester@nhs.net**
Date assessment completed	**16/2/23**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Guideline**			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide a guideline for standardised care during outpatient hysteroscopy.			
Who will be affected by the development & implementation of this activity?	X X q q	Service User Patient Carers Visitors	X q q q	Staff Communities Other _____
Is this:	X Review of an existing activity q New activity q 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.	National guidelines for Outpatient Hysteroscopy (RCOG) Previous trust guidelines for OPH			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Guideline circulated to and approved by Ambulatory gynaecology team Sent for approval at Gynaecology Governance.			
Summary of relevant findings				

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		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		
Race including Traveling Communities		X		
Religion & Belief		X		
Sex		X		
Sexual Orientation		X		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			Provides standard of care for all patients within the OPH service.

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
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

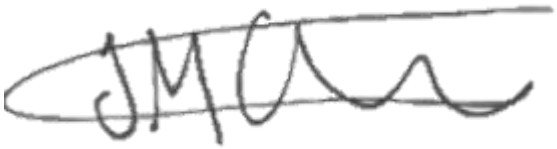
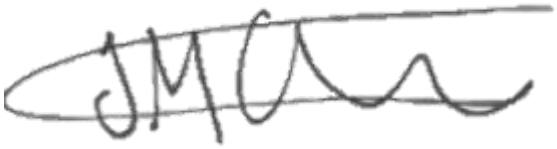
Section 5 - Please read and agree to the following Equality Statement

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	
Date signed	16/2/23
Comments:	
Signature of person the Leader Person for this activity	
Date signed	16/2/23
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.