1.0.7 DOC EIA (2019)

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Antenatal care

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

3.0 Guideline development: before consultation (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The subgroups identified during the scoping process which might require equalities consideration are listed below. Apart from people with cognitive or neurological disability, the equalities issues identified for all other subgroups were at the time considered to be covered by the NICE guideline on pregnancy and complex social factors (CG110). Cross references to the CG110 guideline has been made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16). Furthermore, during the development of the guideline, the committee made recommendations that addresses equalities issues which may be relevant to these groups. Throughout the guideline, consideration for the woman's individual needs and circumstances are made so that the care and information provided can be tailored. No mention of particular subgroups or conditions have necessarily been made in the recommendations but they aim to address different individual needs and circumstances which, if not considered, might lead to disadvantage for these individuals. **Disability (cognitive or neurological)** Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be particularly relevant for disabled women. (Evidence review I and J) A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. It also advises to give written information in a suitable format depending on the need, for example Easy Read. (Evidence review B) A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for disabled women who might have difficulty accessing mainstream antenatal classes and who might experience stigma or discrimination. (Evidence review E) **Sensory or physical disabilities** Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F) A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be particularly relevant for disabled women. (Evidence review I and J) A recommendation (1.1.9) was made about ensuring that reliable interpreting services were available for those who needed them. This includes sign language interpreters. (Evidence review J) A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. It also advises to give written information in a suitable format depending on the need, for example braille or Easy Read. (Evidence review B) A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

might be particularly relevant for disabled women who might have difficulty accessing mainstream antenatal classes and who might experience stigma or discrimination. (Evidence review E)

Women from some socioeconomic groups

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16).

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals or for example community centres. The recommendations also highlight that the referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be relevant for women from disadvantaged backgrounds. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. (Evidence review E)

Teenage mothers

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16). The CG110 guideline includes a section on young pregnant women under 20 years.

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals including school nurses or for example community centres. The recommendations also highlight that referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. This might be particularly relevant to teenagers and a cross-reference to the NICE guideline on pregnancy and complex social factors was made which includes a section on young women. (Evidence review J and I)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendation highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. This might be particularly relevant for teenagers. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for teenagers who might benefit from antenatal classes among their age peers and a cross reference was made to the section on young pregnant women under 20 years in the NICE guideline pregnancy and complex social factors. (Evidence review E)

Gender reassignment

The guideline recognises that not all people who are pregnant identify as women. The guideline uses the term 'woman/women' throughout but the following text has been added in the beginning of the guideline: "For simplicity of language, this guideline will use the term 'woman' or 'mother' throughout, and this should be taken to include people who do not identify as women but who are having a baby." Throughout the guideline, the importance of tailoring care and approaches to the woman's individual needs and circumstances has been emphasised and this may be the case for pregnant trans people.

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. In some situations, this might be relevant for pregnant trans

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

people. (Evidence review I and J)

A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendations highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive. This might be particularly relevant for pregnant trans people. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for pregnant trans people who might face stigma or discrimination. (Evidence review E)

Religion

Nothing specific to religion has been recommended, however, religion may relate to some of the equalities issues that were addressed and further discussed under the other categories, for example migrants and refugees, and ethnic minorities.

Migrants and refugees

As stated above, cross references to the NICE guideline on pregnancy and complex social factors (CG110) were made in various sections of the guideline (recommendations 1.18, 1.2.6, 1.3.4, 1.3.7, 1.3.16). The CG110 guideline includes a section on women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.

Recommendations about starting antenatal care (1.1.1 to 1.1.3) were made which highlight that there should be a variety of straightforward ways of initiating antenatal care which consider the women's needs and circumstances. The recommendation specifically mentions making referral available via different routes, including self-referral, GP, other healthcare professionals including school nurses or for example community centres or refugee hostels. The recommendations also highlight that the referral form should be easy-to-complete, and it should identify women with particular health or social care needs or risk factors. (Evidence review F)

A recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman's medical, social and emotional needs. A cross-reference to the NICE guideline on pregnancy and complex social factors was made which includes a section on recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.

1.0.7 DOC EIA (2019)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
(Evidence review I and J) A recommendation (1.1.9) was made about ensuring that reliable interpreting services were available for those who needed them. (Evidence review J) A recommendation (1.2.3) was made about considering clinical assessment by a doctor to detect cardiac conditions if there is a concern based on the woman's personal or family history. The committee agreed that this might be particularly pertinent to women who were brought up in countries with high incidence of rheumatic fever, such as many countries in sub-Saharan Africa and South Asia. These women might have an undiagnosed rheumatic heart disease. This notion also links with the findings of the MBRRACE-UK report 2019 which highlights that cardiac causes were the main cause of maternal mortality and Black and Asian women had a significantly higher risk of dying in pregnancy, childbirth or postnatally. (Evidence review G) A recommendation (1.2.7) was made about discussing and assessing risk of female genital mutilation (FGM) at the booking appointment. A cross reference was made to the Department of Health and Social Care's practical guideline for health care professionals, which gives advice on countries where FGM is practiced and how to have the discussion about it. The committee recognised the need to identify women who have undergone FGM or whose unborn baby girl might be at risk of FGM so that appropriate safeguarding can take place. In the context of this guideline, this could be the pregnant woman, or the unborn baby when there is a family history or tradition of FGM. There is a mandatory duty to report suspected or known FGM in under 18s. (Evidence review G) A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendations highlights that the information provision should be tailored to the woman's individual needs and preferences, be individual and sensitive and translated into other languages if needed. (Evidence review B) A recommendation (1.3.15) was made to consider antenatal classes for multiparous women (and their partners) if they could benefit from attending, for example if they have never attended antenatal classes before. This might be relevant for some recent migrants or refugees who have not had antenatal classes in their previous country of residence. A further recommendation about antenatal classes (1.3.16) says to ensure that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. This might be particularly relevant for areas

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

with many migrants or refugees. (Evidence review E)

British born women of colour

In the stakeholder consultation for the guideline scope, “British born women of colour” were identified as a potential group requiring particular consideration due to equalities issues. The committee agreed that equalities issues relating to Black and minority ethnic women need consideration, however, the committee did not think their citizenship (being British or not) was relevant.

The committee took ethnicity into consideration in a number of evidence review protocols (for example by planning stratified analysis if there was such evidence): evidence A on information provision, evidence review B on approaches to information provision, evidence review C on involving partners, evidence review E on antenatal classes, and evidence review J on referral and delivery of antenatal care. In most cases, evidence pertinent to particular ethnic groups were not available but where they were, the committee considered whether the evidence warranted a particular recommendation to be made.

The committee were aware of the disproportionate risk of maternal mortality among Black, Asian and mixed ethnicity women, as reported by the MBRRACE-UK report 2019. No recommendations were made that were specific to ethnicity because the evidence reviews did not identify interventions that would particularly beneficial for women from minority ethnic backgrounds, however, various recommendations where individual consideration or flexibility is advised might be relevant for Black and minority ethnic women because of their increased risk of adverse outcomes. For example, a recommendation (1.1.8) was made about offering flexibility in the number and length of antenatal appointments depending on the woman’s medical, social and emotional needs. (Evidence review I and J)
A recommendation (1.3.1) was made to give advice on how information should be provided in antenatal care. This recommendations highlights that the information provision should be tailored to the woman’s individual needs and preferences, be individual and sensitive. (Evidence review B)

A recommendation (1.3.16) was made about ensuring that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. (Evidence review E)

1.0.7 DOC EIA (2019)

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
The committee recognises the varying family and home situations that pregnant women may have, including single mothers and same-sex couples. Throughout the guideline, we refer to 'partner' which we have defined as "A partner could the baby's father, the woman's partner, family member or friend, or anyone who the woman wishes to involve in her antenatal care." Where we refer to 'parents' we have clarified this to also include people who will be the baby's main caregivers, and single parents. Partner involvement has been considered throughout the guideline and in particular in recommendations 1.1.11 to 1.1.13 (evidence review C), however, the committee recognises that any involvement of the partner should be done according to the woman's wishes. When discussing the involvement of partners in antenatal care, the committee recognised that some women may be in an abusive or coercive relationship and involving partners without the woman's consent might be harmful. No other equalities issues were identified which have not already been addressed in box 3.1. However, the committee made recommendations (1.3.17 and 1.3.18) about discussing potential benefits of peer support and giving information about how to access local or national peer support services. The committee did not specify any particular subpopulations in the recommendations but noted in the rationale and impact section that evidence on peer support was identified among some subpopulations, such as migrant women, women from a lower social-economic backgrounds, women with intellectual disabilities, or younger women and noted that peer support is likely to be particularly beneficial when the peer support comes from women (or partners) in similar circumstances to themselves. (Evidence review D)

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?
The committee's considerations have been included in the recommendations, rationale and impact sections or the committee discussion sections of the evidence reviews as outlined in the sections above.

3.4 Do the preliminary recommendations make it more difficult in practice for a

specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
No, the committee thinks the preliminary recommendations are intended to make it easier for specific groups to access services.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No, the committee does not think the preliminary recommendations will have an adverse impact on people with disabilities because of something that is a consequence of the disability.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality?
No, the committee does not think there are any further recommendations or explanations that could remove or alleviate barriers to, or difficulties with, access to services but we look forward to hearing from stakeholders at consultation.

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
Disability One stakeholder suggested to include deaf, blind and those with learning difficulties or intellectual impairment to the list of people who may need additional support in relation to the recommendation referring to the NICE guideline on pregnancy and complex social factors. Cognitive and neurological disabilities and sensory impairments were already identified as potential inequalities issues and have been discussed in the previous

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?

equality impact assessments, however, in response to the stakeholder's comment, the committee evaluated the issue again.

The recommendation the stakeholder was referring to was signposting to the NICE guideline on pregnancy and complex social factors and listed the population groups covered by that guideline. Therefore, it would have been inappropriate to add more groups to the list. In order to avoid confusion, the recommendation was revised and moved to a different section. In terms of deaf, blind and those with learning difficulties or intellectual impairment needing additional support, this is covered by a number of recommendations throughout the guideline, some of which are new or have been revised since consultation:

- Recommendation 1.1.2 states that early pregnancy information provided at the point of referral to antenatal care services should be provided in different formats and languages, including braille and Easy Read.
- Recommendation 1.1.3 states that the referral form should capture information about the woman's health and social needs, so that her care can be tailored according to her needs.
- A new recommendation 1.1.6 was added which states that for those women who book late, the reasons for this should be enquired because they can reveal underlying social, psychological or medical issues or vulnerabilities that may need addressing.
- Recommendation 1.1.10 states to offer longer or additional appointments depending on the woman's individual needs, including medical, social and emotional needs.
- Recommendation 1.1.11 states that reliable interpretation services, independent of the woman, should be provided, and the committee added British Sign Language as an example.
- Recommendation 1.2.10 states that at every antenatal appointment the woman's plan of care should be reviewed and reassessed and those who need additional support should be identified.
- A new recommendation 1.3.1 was added which states to listen to the woman and be responsive to her needs and preferences.
- Recommendation 1.3.4 states to use clear language and tailor the timing, content and delivery of information provision/discussions according to the woman's needs and preferences.
- Recommendation 1.3.5 states to explore the woman's knowledge and understanding about each topic to individualise the discussion.
- Recommendation 1.3.6 states to check that the woman understands the information that has been given and how it relates to her, and to provide

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?

regular opportunities to ask questions, and set aside enough time to discuss any concerns.

- Recommendation 1.3.21 states that providers should ensure that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities.

One stakeholder raised the issue of communication with deaf people and consideration on the use of personal protective equipment which might cause difficulty for people who are relying on lip reading and emphasised the importance of providing British Sign Language interpreter services.

The committee agreed with the stakeholder and added British Sign Language as an example in recommendation 1.1.11 about providing interpreters as needed. Regarding personal protective equipment, the committee did not comment on this as this is an issue specific to the current pandemic and various other considerations related to it are also not featured in the guideline. The guideline makes a reference to the COVID-19 guidance for all midwifery and obstetric services from the Royal College of Obstetricians and Gynaecologists, which notes the issue about face masks and their impact on people with hearing loss.

Sexual orientation and gender identity

One stakeholder commented that care and support for LGBTQ+ people in the antenatal care pathway should be considered.

Gender reassignment was identified as a potential equalities issue already and was covered in the previous equality impact assessment. The committee has carefully thought about the inclusiveness of the guideline and how it applies to people in different situations. The guideline makes it clear that antenatal care, appointment number and length, partner involvement, information provision, discussions and support should be tailored based on the individual's needs and preferences (including recommendations 1.1.3, 1.1.10, 1.2.10, 1.3.1, 1.3.4, 1.3.21). There are a number of social, psychological, medical and other reasons to tailor antenatal care, for example being in a same sex relationship or being trans may be some of them. The guideline refers to 'partner' throughout and does not assume the partner is male or the father of the child. The guideline refers to 'woman' throughout but acknowledges in the beginning of the guideline that this should be taken to include people who do not identify as women but who are pregnant. The term 'woman' is used because NICE has chosen to align their terminology in relation to pregnancy with NHS website for consistency.

Virtual appointments

One stakeholder commented on the use of virtual appointments and how there is a need to be cautious that disadvantaged groups are not further disadvantaged by

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
blanket policies on virtual appointments. The committee did not review evidence on the benefits, harms or experiences related to virtual appointments in antenatal care and thus have not commented on this apart from in relation to partner involvement where providing opportunities for remote attendance should be considered (recommendation 1.1.16). The committee discussed the potential inequalities that this could bring as raised by the stakeholder and highlighted these in the 'Why the committee made the recommendations' section related to the above recommendation. Remote/virtual appointments could disadvantage for example people who have sensory impairments or language barriers, some minority groups, or in relation to access to devices or internet connection and these issues should be carefully considered. **Late booking** Two stakeholders commented that it would be useful to have a recommendation to have processes in place to better understand the factors which may cause women to book late, adding that these women are often vulnerable and there may be inequalities that need addressing. The committee agreed with this and added a recommendation 1.1.6 which states that reasons for booking late should be asked because it may reveal social, psychological or medical issues that need to be addressed.

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
No changes were made to the recommendation that would make it more difficult in practice for specific groups to access services compared with other groups.

4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

1.0.7 DOC EIA (2019)

The changes that were made to the recommendations should not have an adverse impact on people with disabilities.

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in question 4.2, or otherwise fulfil NICE's obligations to advance equality?
Nothing has been identified that would have changed since the previous version of the guideline documents.

4.5 Have the Committee's considerations of equality issues been described in the final guideline, and, if so, where?
Equalities considerations relating to late booking is discussed in the 'Why the committee made the recommendations' in relation to the section 'Antenatal appointments' and in the section 'Benefits and harms' in the evidence review H. Equalities considerations in relation virtual attendance at appointments is discussed in the 'Why the committee made the recommendations' in relation to the section 'Involving partners' and in the section 'Discussion of findings' in the evidence review C.