Royal Cornwall Hospitals
NHS Trust

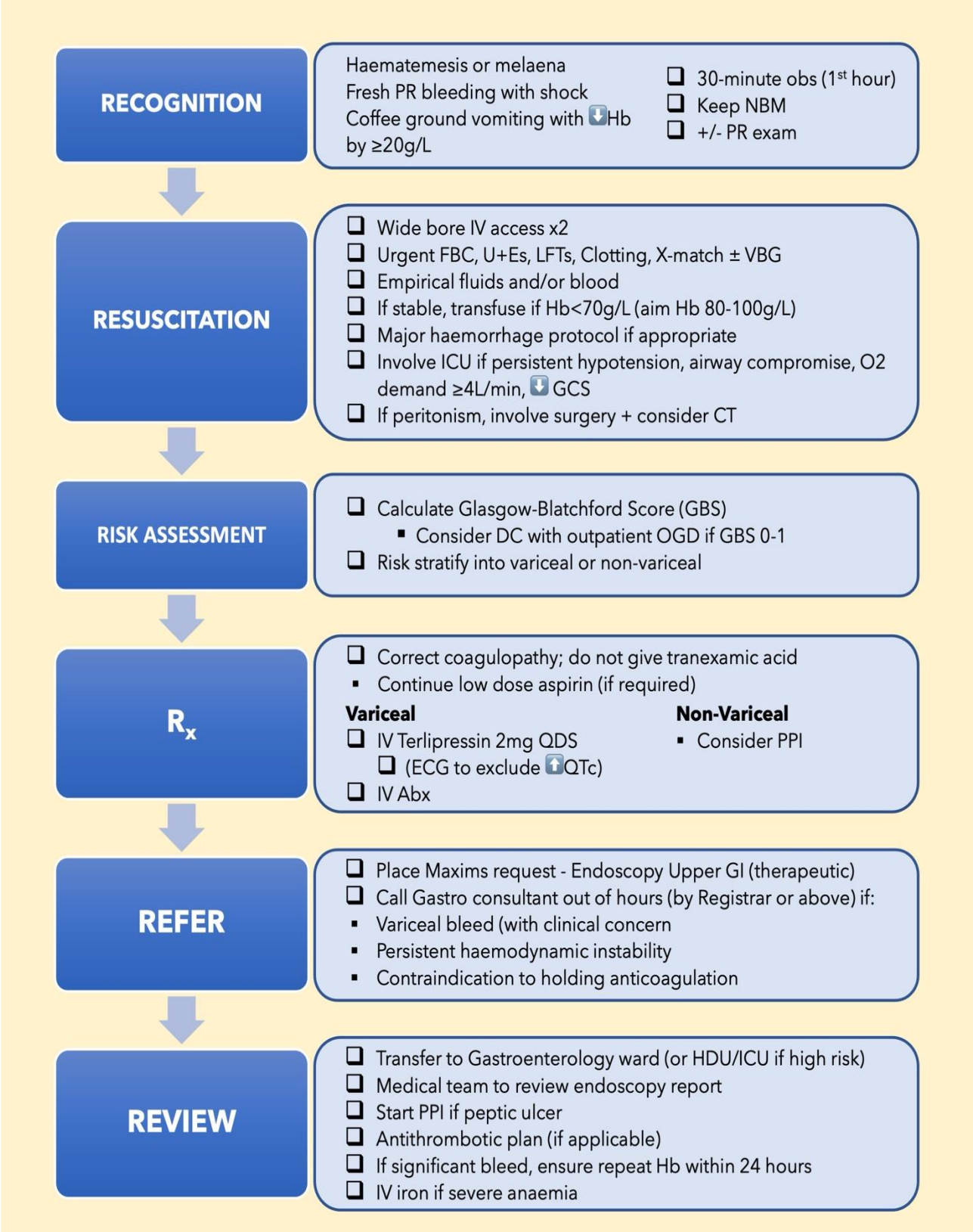
Acute Upper Gastrointestinal Bleeding (AUGIB) - Variceal and Non-Variceal – Clinical Guideline

V1.0

May 2025

Summary

Figure 1: Final approved care bundle for the early clinical management of AUGIB (within 24h of admission).

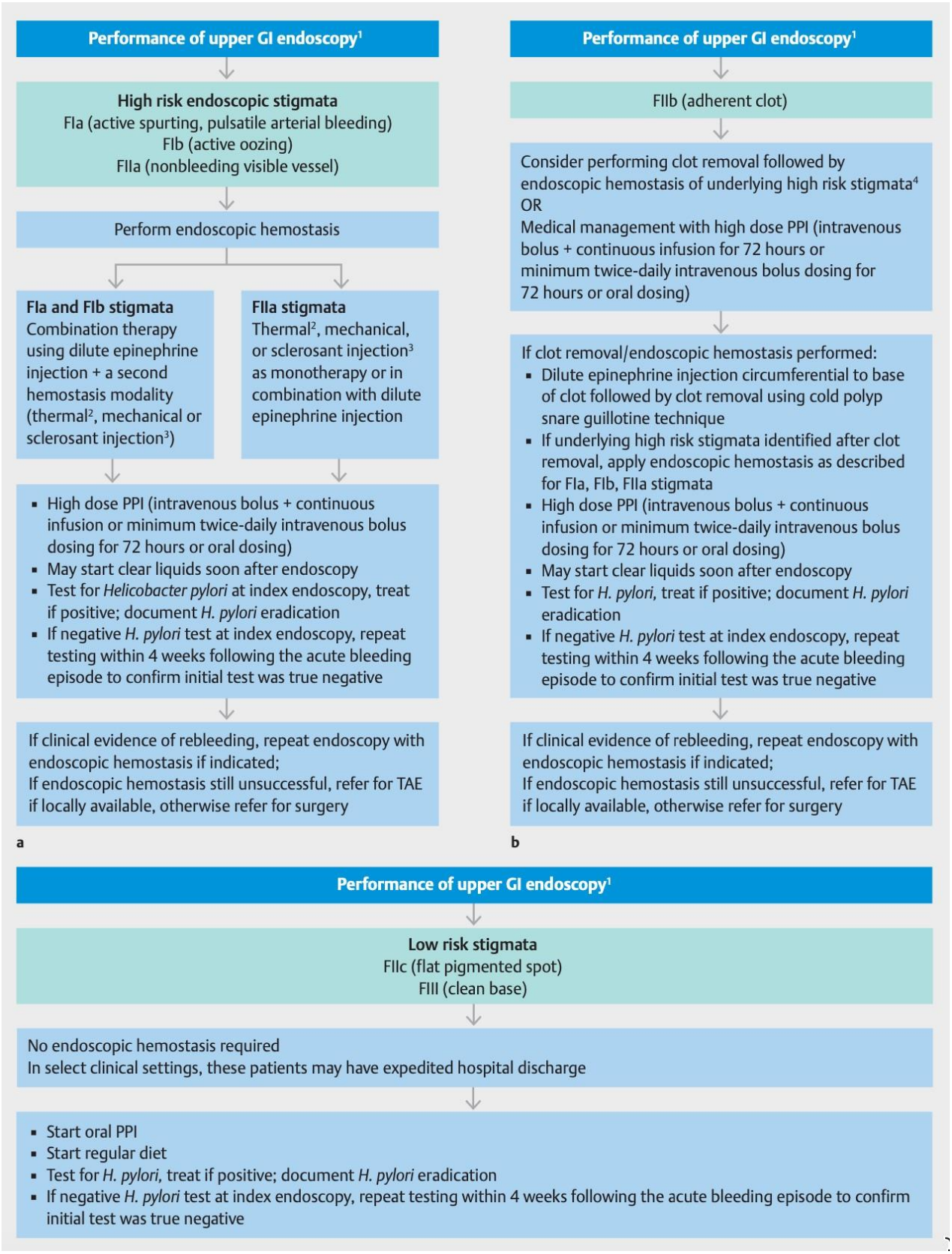


Document created by Keith Siau, adapted from BSG Guideline for RCH use.

Figure 2: British Society of Gastroenterology (BSG) guideline for the management of variceal haemorrhage (Tripathi 2015).

** - depending on local resources or consider referral to specialist centre.
* - consider shunt surgery in well compensated patients or if TIPSS not feasible.
In segmental portal hypertension consider splenectomy or splenic artery embolization
- GOV-2 and IGV. GOV-1 to be treated as oesophageal varices.
- TIPSS can be considered depending on local resources and clinical judgement.
VBL – variceal band ligation. NSBB – non selective beta-blockers.
GOV-1 – gastro-oesophageal varices type 1. GOV-2 - gastro-oesophageal varices type 2.
IGV – isolated gastric varices.

Figure 3: ESGE guidelines on the management of peptic ulcer bleeding) (Gralnek 2021).



1. Aim/Purpose of this Guideline

- Acute upper gastrointestinal bleeding (AUGIB) is a potentially life-threatening medical emergency with an incidence of 0.1%, equating to approximately 500 cases per year in Cornwall. AUGIB can be categorised into non-variceal and variceal causes which will determine empirical medical management.

- This guideline on acute upper gastrointestinal bleeding (AUGIB) amalgamates the previously separate RCHT guidelines for non-variceal and variceal bleeding entitled: “Management of non-variceal upper GI haemorrhage V3.0” and “Acute upper gastrointestinal bleeding due to gastro-oesophageal varices V4.0”.

- This document aims to provide a clear and streamlined approach to the early clinical management of adult inpatients (16 years +) with AUGIB, regardless of non-variceal or variceal aetiology.

- It incorporates the British Society of Gastroenterology (BSG) AUGIB care bundle which emphasises the 6 Rs of early **recognition**, effective **resuscitation**, **risk assessment**, **Rx** (treatment), early **referral** (for endoscopy), and post-endoscopy **review**, all of which are evidence-based interventions that have been shown to affect patient outcomes. The guideline also includes best practice recommendations from recent European guidelines (ESGE 2021 non-variceal upper GI bleeding, ESGE 2022 variceal bleed, and Baveno VII).

- This guideline applies to clinical staff caring for adult inpatients with AUGIB, including Emergency Department, Acute Medicine, General Internal Medicine, Gastroenterology and Hepatology. Detailed management of UGIB beyond endoscopic management, i.e. TIPS, BRTO, BATO, EUS-guided haemostatic techniques, and surgical salvage measures is considered beyond the scope of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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2. The Guidance

2.1. Recognition of AUGIB.

2.1.1. Acute upper gastrointestinal bleeding (AUGIB) should be suspected in patients presenting with:

- Haematemesis or melaena.
- Coffee ground vomiting in the absence of an alternate cause (e.g. clinical bowel obstruction) AND with a Hb drop of ≥20g/L.
- In up to 20% of cases AUGIB may mimic lower GI bleed by presenting as bright red rectal bleeding with associated:
  - Haemodynamic compromise.
  - Raised serum urea: creatinine ratio.

2.1.2. If there is doubt about whether there is a gastrointestinal (GI) bleed, check for melaena on rectal examination.

2.1.3. Patients with suspected AUGIB should have urgent clinical assessment and observations (NEWS2 score) performed at the point of presentation/admission.

2.2. Resuscitation

2.2.1. Patients should be promptly assessed and resuscitated using an ABCDE approach.

2.2.2. Assess for hypovolaemia (consider lying and standing BP) and medical complications, e.g. encephalopathic, sepsis, aspiration.

2.2.3. All patients should be triaged for early fluid/blood product resuscitation at the earliest opportunity. If shocked at presentation (BP<100 systolic, pulse>100bpm) or hypovolaemic:

- Start volume replacement with crystalloids (e.g. 500ml over 15 minutes) until blood is available.
- Reassess observations after fluid bolus.

2.2.4. Send bloods for Hb, U and E, LFT, glucose, clotting and G and S. If unstable or clinical concern, send a VBG.

2.2.5. Patients with features of shock should have two peripheral cannulas (ideally Green or larger).

2.2.6. If persistent haemodynamic instability (persistent hypotension or tachycardia despite rapid IV fluid resuscitation of 2L of crystalloid):

- Refer to ICU.

- Inform on-call gastroenterologist.

  Consider triggering major haemorrhage protocol if signs of major haemorrhage (50% blood volume loss within 3 hours or a rate of loss of 150 ml/min) to obtain O-negative blood, platelets and fresh frozen plasma.
  (https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Haematology/BloodTransfusionPolicy.pdf

- Consider urinary catheterisation.

- Discuss management with the Intensivist and Gastroenterologist (or if out of hours on-call the endoscopist).

2.2.7. Early ICU involvement is recommended in unstable patients if:

- Persistent haemodynamic instability (2.2.6).

- Airway compromise.

  - Haematemesis with hypoxia (requiring >4L/min).

  - Reduced consciousness, e.g. in hepatic encephalopathy (GCS <8 likely to require intubation).

2.2.8. A 12-lead ECG is advisable.

2.2.9. Ensure adequate volume replacement (aim for systolic BP >100 mm Hg) and close monitoring of fluid status and urine output.

2.2.10. Transfuse patients with massive bleeding with blood, platelets, and clotting factors in line with local protocols for managing massive bleeding.

2.2.11. Blood transfusion: aim for Hb 7-8g/dl- restitution of the Hb to higher than this may result in a higher portal pressure than at baseline.

2.2.12. Give platelets if platelet count <50 with active bleeding.

2.2.13. Low-dose aspirin for secondary cardiovascular prophylaxis (i.e. in patients with coronary artery disease/stroke) should be continued unless there is life-threatening bleeding.

2.2.14. In cases where dual antiplatelet therapy and / or anticoagulants are required and complicated by GI haemorrhage, these patients require multidisciplinary decision-making on individual bases. The discussion should involve the patient, gastroenterologist, cardiologist, and haematologist as appropriate.

2.3. Risk Stratification

2.3.1. Calculate the Glasgow Blatchford Score (GBS).

2.3.2. Patients with GBS scores of 0-1 should be considered for discharge with outpatient upper GI endoscopy within 2 weeks. This should be requested on Maxims under Patient Internal Referrals List > Endoscopy OP Upper GI Bleeders Request Service.

2.3.3. All patients with suspected AUGIB with GBS of 2 or more should be considered for inpatient endoscopy. This should be requested on Maxims under Patient Internal Referrals List > Endoscopy Upper GI (Therapeutic) Request Service > Procedure (Upper GI Bleed).

Figure 4: Glasgow Blatchford Score.

Criteria (on admission)		Score
Hb - Male (g/L)	**Hb - Female (g/L)**	
120-130	100-120	**1**
100-120		**3**
<100	<100	**6**
Urea (mmol/L)		
6.5-8		**2**
8-10		**3**
10-25		**4**
≥25		**6**
Systolic blood pressure (mmHg)		
100-109		**1**
90-99		**2**
<90		**3**
Others		
Pulse ≥100		**1**
Melaena		**1**
Syncope		**2**
Hepatic disease		**2**
Cardiac failure		**2**

2.3.4. Stratify patients into suspected variceal vs non-variceal bleeding to guide empirical treatment (Section 2.4).

2.3.5. Treat empirically as variceal bleed if any of the following are present:

- History of varices.
- History of cirrhosis.
- Peripheral stigmata of chronic liver disease, e.g. jaundice,

encephalopathy, ascites, spider naevi.

- Biochemical or radiological stigmata of chronic liver disease.

2.4. Pre-endoscopic Treatment

2.4.1. Proton pump inhibitor (PPI) therapy, e.g. pantoprazole / omeprazole, may be given in cases of non-variceal bleeding at the discretion of the clinician. PPIs do not reduce mortality or transfusion requirements but may reduce endoscopic stigmata of bleeding.

2.4.2. For patients requiring emergency endoscopy, metoclopramide 10mg IV or erythromycin 250mg IV may be considered to improve mucosal visualization.

Variceal Measures.

2.4.3. **Consider starting terlipressin** before endoscopy in patients with known varices or **likely** variceal bleed.

2.4.4. 2mg IV stat bolus, and then QDS IV boluses (dose based on body weight):

- <50kg: 1 mg.
- 50-70kg: 1.5 mg.
- >70kg: 2 mg.

2.4.5. Continue until clinically certain haemostasis is achieved.

2.4.6. Terlipressin is contraindicated in patients with ischaemic heart disease, peripheral vascular disease, severe hyponatremia, prolonged QTc and respiratory failure.

2.4.7. Start prophylactic antibiotics for all patients with cirrhosis who develop AUGIB. All patients with variceal bleeding should be started on a broad-spectrum antibiotic (as per Trust formulary). This reduces mortality by reducing the rate of early rebleeding.

Patients with Coagulopathy and Antithrombotics.

2.4.8. If coagulation tests are grossly deranged, discuss with haematologist.

2.4.9. Offer prothrombin complex concentrate to patients who are taking warfarin and actively bleeding.

2.4.10. If anticoagulation is taken for high-risk indications, e.g. metallic heart valve, pulmonary embolism, or deep vein thrombosis, discuss with haematologist **and** the on-call endoscopist. Consider bridging therapy with low molecular weight heparin if the AUGIB is not life-threatening.

2.4.11. For patients on direct oral anticoagulants with life-threatening bleeding, discuss with haematologists regarding Andexanet alfa for the reversal of Factor Xa antagonists (apixaban/rivaroxaban/edoxaban) or Idaricizumab for dabigatran.

2.4.12. Treat patients who are taking warfarin and whose upper gastrointestinal bleeding has stopped in line with local warfarin protocol.

2.4.13. Tranexamic acid should not be routinely used.

2.4.14. In patients with cirrhosis and high INR, avoid the use of FFP unless there is life-threatening bleeding, as this can exacerbate portal hypertensive bleeding. Discuss with a haematologist first.

Sepsis in Decompensated Liver Disease

2.4.15. Ensure a full septic screen is performed on every patient with decompensated liver disease.

2.4.16. Follow the BSG-BASL care bundle for decompensated liver disease.

2.4.17. Send off ascitic fluid (10 ml) for WCC in FBC bottle (send to haematology) and in blood culture bottles as well as ascitic albumin level.

2.4.18. Switch to oral therapy should be as soon as the patient can take oral medication, and therapy should stop at five days with re-culture.

2.5. Referral for Endoscopy

2.5.1. Patients should ideally undergo endoscopy within 24 hours of admission.

2.5.2. There is an inpatient endoscopy list at RCHT for stable patients with AUGIB on Monday-Friday mornings and Sunday mornings. There is a 24-hour, 7-day-a-week service for emergency cases.

2.5.3. Referrals for AUGIB should be made on Maxims: Patient Internal Referrals List > Endoscopy Upper GI (therapeutic) request > Procedure: Upper GI Bleed). The referral can be made by any clinician, but if the indication is unclear, the decision should be reviewed by a registrar or above or discussed with the gastroenterology consultant.

2.5.4. Inform the endoscopy unit (Ext 3247) within working hours if the patient is in the Emergency Department, after placing the electronic referral.

2.5.5. For an emergency endoscopy that is to be performed in theatre, the referring doctor should place a CEPOD referral (via NerveCentre) after a discussion with the anaesthetist.

2.5.6. Place the patient nil by mouth (NBM) to prepare for endoscopy (ideally >6hrs before endoscopy) to optimise mucosal views.

2.5.7. Most patients with a suspected variceal bleed should be intubated for endoscopy especially if there are concerns with airway maintenance or encephalopathy - inform the anaesthetist early (via critical care or 4th on-call CEPOD).

2.5.8. Patients should be placed nil by mouth appropriately. For elective GI bleed lists, we recommend nil by mouth for >4 hours. Unstable patients should be placed nil by mouth immediately in case an emergency endoscopy is required.

2.5.9. Only phone the endoscopy consultant on call out of hours for the following situations:

- Persistent haemodynamic instability.
- Suspected variceal bleeding with clinical concern.
- Contraindication to withholding anticoagulation.

2.6. Endoscopic Management

Management of non-variceal upper GI bleeding.

2.6.1. Adrenaline should not be used as monotherapy.

2.6.2. For actively bleeding ulcers (Forrest Ia or FIb), combination therapy using adrenaline injection + a second haemostasis modality (contact thermal or mechanical therapy) should be considered.

2.6.3. For patients with an ulcer with a non-bleeding visible vessel (Forrest 2a), contact or noncontact thermal therapy, mechanical therapy, or injection of a sclerosing agent, each as monotherapy or in combination with adrenaline injection should be considered.

2.6.4. In patients with persistent bleeding refractory to standard haemostasis, the use of a topical haemostatic spray/powder or cap-mounted clip should be considered.

2.6.5. Endoscopic haemostasis should not be delivered to patients with low-risk ulcers (Forrest 2c and 3).

Management of Variceal upper GI Bleeding.

2.6.6. For oesophageal varices, band ligation therapy should be first line.

2.6.7. For gastric varices, consider glue injection. Band ligation can be considered for GOV-1 gastric varices.

2.6.8. If unable to control variceal bleeding, insert a Sengstaken-Blakemore tube and inform Derriford team.

2.6.9. Deployment of a fully covered metal stent is an alternative treatment to Sengstaken-Blakemore tube.

2.7. Review Post Endoscopy

General Principles.

2.7.1. The endoscopy report should be read by a clinician and the post-procedure management plan followed.

2.7.2. All patients should have a clear rebleeding plan. If this is unclear, clarify with the endoscopist or gastroenterologist on call.

2.7.3. Repeat endoscopy should be arranged for patients at high risk of rebleeding if there is doubt about adequate haemostasis.

2.7.4. All patients on antithrombotic therapy with AUGIB should have an antithrombotic resumption plan that is personalised according to the risk of rebleeding and risk of thrombosis. They should be resumed as soon as the bleeding has been controlled, preferably within 7 days.

2.7.5. Patients with AUGIB should be allowed to resume oral intake within 24 hours of endoscopic therapy unless stated otherwise.

2.7.6. Patients requiring endoscopic therapy should have a repeat full blood count within 24 hours.

2.7.7. All patients should be transferred to Gastroenterology and Liver Unit (GLU) for further management and to ensure appropriate follow-up.

2.7.8. A restrictive transfusion threshold is associated with reduced mortality. Patients should only be transfused if Hb <70g/L (or <80 if cardiac comorbidity). Consider IV iron therapy in anaemic patients who do not meet transfusion criteria.

2.7.9. If there has been clinical evidence of AUGIB without a satisfactory cause on endoscopy, discuss further management with the gastroenterology team.

Variceal Bleeding.

2.7.10. Consider early referral for TIPSS if portal vein patent - in selected patients with Child's B cirrhosis and active bleeding or Child's C cirrhosis with Child's score <13 (MELD score > 18).

2.7.11. If a patient has had variceal band ligation for variceal bleeding, repeat endoscopy should be arranged in 2-4 weeks for further band ligation.

2.7.12. Request early abdominal ultrasound (or CT imaging) to assess patency of portal vein and feasibility of TIPSS in case of rebleeding.

2.7.13. Discuss need for further hepatic imaging and hepatic venous pressure gradient (HVPG) measurements early.

2.7.14. Patients with variceal bleeding should be started on a non-selective beta-blocker (Carvedilol 6.25-12.5 mg od or Propranolol 40mg bd) to reduce portal pressures and prevent recurrent variceal bleeding. This should be commenced in the absence of contraindications and once Terlipressin has been withdrawn.

2.7.15. All patients with variceal bleeding should be observed for decompensation of liver disease.

2.7.16. Rapid removal of blood from the GI tract (with oral lactulose or phosphate enema) should be used to prevent hepatic encephalopathy.

2.7.17. Patients who have received endoscopic band ligation for variceal bleeding should have a repeat endoscopy within 2-4 weeks for reassessment and repeat band ligation.

Non-Variceal Bleeding.

2.7.18. Following therapy of high-risk peptic ulcers, PPI (IV pantoprazole or omeprazole) should be given as an 80mg bolus then 8mg/hr for 72 hours. Twice daily PPI (IV or oral) is an acceptable alternative if there is a strong confidence in endoscopic haemostasis (discuss with endoscopist/consultant). Patients should continue high-dose oral PPI for 6-8 weeks in total.

2.7.19. Helicobacter pylori eradication should be given if infection is detected.

2.7.20. If H. Pylori eradication therapy is provided, H pylori eradication should be checked with an H. pylori faecal antigen test 4-6 weeks after treatment.

2.7.21. All gastric ulcers need a repeat OGD and biopsy 6-8 weeks unless specified otherwise; ensure this is requested prior to discharge.

2.7.22. Patients who are taking ulcerogenic drugs/ anticoagulants/ antiplatelets or have significant/multiple co-morbidity associated with a high risk of GI bleeding should be on long-term PPI.

2.7.23. Repeat further therapeutic endoscopy should be offered to patients who rebleed and if it is considered endotherapy may be beneficial.

2.7.24. Interventional radiology treatment or emergency surgery may be appropriate if rebleeding occurs after a second failed therapeutic endoscopy.

3. Monitoring compliance and effectiveness

Information Category	Detail of Process and Methodology for Monitoring Compliance
Element to be Monitored	Management of AUGIB (NICE and JAG yearly audit). Rebleeding and mortality rates (7 and 30 day) post endoscopy.
Lead	Dr Keith Siau.
Tool	HICSS Endoscopy Database.
Frequency	Annual with report to GI Governance.
Reporting arrangements	Monthly GI Governance Meeting.
Acting on recommendations and Lead(s)	GI Governance Group.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment.

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Acute Upper Gastrointestinal Bleeding (AUGIB) Variceal and Non-Variceal Clinical Guideline V1.0.
This document replaces (exact title of previous version):	Acute Upper Gastrointestinal Bleeding due to Gastro-Oesophageal Varices Clinical guideline V4.0 and Management of non-variceal upper GI haemorrhage V3.0. (documents combined new V1.0)
Date Issued/Approved:	February 2025.
Date Valid From:	May 2025.
Date Valid To:	May 2028.
Directorate/Department responsible (author/owner):	Dr Keith Siau, Consultant Gastroenterologist. Monica Andrawes, IMT3 (co-author).
Contact Details:	01872 252717.
Brief Summary of Contents:	This document is intended to provide guidelines for medical staff when caring for patients with acute upper GI bleeding.
Suggested Keywords:	GI bleeding, Digestive system, Gastrointestinal system, Oesophagus, Stomach, peptic ulcer, Gastroenterology health services, Emergency treatment, Diagnostic techniques, Diagnostic imaging, Radiography, Endoscopy, Oesophageal varices, Variceal bleeding.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Specialist Services and Surgery Senior Management Team Governance Meeting and Specialist Services and Surgery Care Board.
Manager confirming approval processes:	Ian Moyle, Head of Nursing (HON), Specialist Services and Surgery.
Name of Governance Lead confirming Consultation and Ratification:	Michele Reed, Governance Manager.

Information Category	Detailed Information
Links to key external standards:	None required.
Related Documents:	NICE guidelines GI bleeding CG141. ESGE 2021 Guidelines. **References** NICE CG 141: Acute upper gastrointestinal bleeding in over 16s: management June 2022, Updated August 2016. Tripathi D, et al. UK guidelines on the management of variceal haemorrhage in cirrhotic patients. Gut 2015;0:1–25. doi:10.1136/gutjnl-2015-309262. Siau K, Hearnshaw S, Stanley AJ, et al, British Society of Gastroenterology (BSG)-led multisociety consensus care bundle for the early clinical management of acute upper gastrointestinal bleeding, Frontline Gastroenterology 2020;**11:**311-323. de Franchis R, Bosch J, Garcia-Tsao G, et al. Baveno VII - Renewing consensus in portal hypertension. Journal of Hepatology. 2022 Apr;76(4):959-974. Gralnek IM, Stanley AJ, Morris AJ, et al. Endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage (NVUGIH): European Society of Gastrointestinal Endoscopy (ESGE) Guideline - Update 2021. Endoscopy. 2021 Mar;53(3):300-332. Gralnek IM, Camus Duboc M, Garcia-Pagan JC, et al. Endoscopic diagnosis and management of esophagogastric variceal hemorrhage: European Society of Gastrointestinal Endoscopy (ESGE) Guideline. Endoscopy. 2022 Nov;54(11):1094-1120.
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Gastroenterology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
May 2025	V1.0.	Combined variceal and non-variceal bleeding document (as per gastroenterology governance with hepatology governance approval). Incorporated BSG Care Bundle. ESGE non-variceal 2021 and variceal bleeding 2022.	Dr Keith Siau Consultant Gastroenterologist.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team. rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Acute Upper Gastrointestinal Bleeding (AUGIB) - Variceal and Non-Variceal Clinical Guideline V1.0.
Directorate and service area:	Specialist Services and Surgery, Gastroenterology.
Is this a new or existing Policy?	New (Combines and replaces Acute Upper Gastrointestinal Varices Clinical Guideline).
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Keith Siau, Consultant Gastroenterologist.
Contact details:	01872 252717.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Local management of acute upper gastrointestinal bleeding (AUGIB).
2. Policy Objectives	Optimise clinical management of AUGIB.
3. Policy Intended Outcomes	Minimise mortality and morbidity from AUGIB. Ensuring compliance with national and international evidence based best practice recommendations.
4. How will you measure each outcome?	Annual AUGIB audit (JAG mandated).
5. Who is intended to benefit from the policy?	All patients who present with AUGIB, Medical and Nursing Staff.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category).	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: Yes • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Gastroenterology Governance Group. Hepatology Governance.
6c. What was the outcome of the consultation?	Ratified.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and Civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and Maternity	No	
Sexual Orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Dr Keith Siau.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis