Blackpool Teaching Hospitals NHS
NHS Foundation Trust

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1 PURPOSE

To optimise the care of women who undergo caesarean section.

2 SCOPE

This guideline applies to Midwives, Nurses, Student Midwives, Health Care Assistants and Medical staff working within Blackpool Teaching Hospitals NHS Foundation Trust.

3 GUIDELINE

3.1 Introduction

Where caesarean section is indicated for the following reasons the consultant should attend in person:

- Major placenta praevia
- Massive abruption.

Where the caesarean is for the following reasons, the consultant should attend in person or should be immediately available if the trainee on duty has not been assessed and signed off by OSATS (Objective structured assessment of technical skill) as competent, where these are available:

- Body Mass Index (BMI) more than 40 at booking
- Intrauterine fetal death.
- At full dilatation (or greater than 8cm if prolonged labour)
- For transverse lie
- Less than 32 weeks gestation
- or more previous caesarean sections.

3.2 Elective Caesarean Section

3.2.1 Complex surgical or high risk obstetric Caesarean section

Patients should be informed that advanced surgical treatment such as vascular (**Ligation of uterine or internal iliac artery**) and/or radiological **(interventional radiology-embolisation**) support are not available on site.

3.2.2 Referral to centers offering advanced surgical techniques

Woman with a history of previous Caesarean section, associated with abnormal or adherent placenta are at increased risk of major obstetric haemorrhage.

Women who decline blood/blood products are at increased risk of the effect of major obstetric haemorrhage.

They should be offered antenatal referral and planned delivery in centers within the region where elective and emergency advanced surgical treatments (vascular and/or interventional radiology) are readily available e.g. St Mary's Hospital Manchester, South Manchester University Hospital Wythenshawe.

- It is the responsibility of the consultant obstetrician to document agreed management plan in the woman's health record.

- If the woman declines referral to another unit after adequate counselling, measures should be put in place in anticipation of her delivery in the unit.

3.2.3 Pre-operative assessment

In most circumstances the woman will attend the Pre-Operative Assessment Clinic and the following care will be undertaken. In circumstances where this is not achievable it will be undertaken in the clinical area where the decision for Caesarean Section is made.

The following actions must be undertaken and documented in the health record by the obstetrician / midwife:

- Give the patient information leaflet, "Preparing for Your Caesarean" Section (See Section 7).
- Give the patient information leaflet, "Anaesthetic Options"
- Give the information leaflet, "Receiving a Blood Transfusion"
- Complete the Pre-Operative Assessment Form
- Complete the Antenatal VTE Risk Assessment
- Complete the Consent form.
- Ensure the woman has Ranitidine 150mg advising that it must be taken orally at 22.00 hours the night before surgery and 06.00 hours on the day of surgery.
- If surgery is within 72 hours of the pre-operative assessment blood is taken for
  - Full Blood Count
  - Group and Save
  - Group and cross match – refer to section 3.4

If the pre-operative assessment is more than 72 hours prior to surgery, the midwife gives the signed blood request forms to the woman with information of where the blood test can be undertaken. The blood must be taken within 72 hours of surgery.

- Check and record the woman's weight, but **do not** recalculate the BMI.

3.2.4 Methicillin Resistant Staphylococcal Aureous (MRSA)

All elective caesarean sections must be screened for MRSA, ideally at the time the decision for section is made.

3.3 Emergency Caesarean Section

3.3.1 Classification of urgency including agreed timescale

It is imperative that the Obstetrician performing the operation documents the urgency of the caesarean section. Each urgent / emergency caesarean section must be classified appropriately and documented in the birth record as follows:

3.3.1.1 Grade 1

Immediate threat to the life of the woman or fetus - delivery should be achieved in **less than 30 minutes**.

3.3.1.2 Grade 2
Maternal and fetal compromise, which is not immediately life threatening - delivery should be **achieved within 75 minutes**.

3.3.1.3 Grade 3
No maternal or fetal compromise but needs early delivery - delivery should be **achieved within 24 hours**.

3.3.1.4 Grade 4
Delivery timed to suit woman or service needs.

3.3.2 Documenting the reason for performing Grade 1 and Grade 2 Caesarean Sections by the person making the decision
As a minimum the Obstetrician making the decision to perform a Grade 1 or Grade 2 caesarean section must document the reason for the caesarean section in the woman's birth record.

3.3.3 Inclusion of the Consultant on Call when making the decision to perform a Caesarean Section
The decision for caesarean section must be taken after full discussion with the Consultant on call, unless doing so would cause delay and would therefore be life threatening to the woman or fetus. This discussion must be documented in the birth record by the Obstetrician making the decision.

3.3.4 Documenting any reasons for delay in undertaking the Caesarean Section
If there is a delay in performing the caesarean section and delivery is not achieved within the required time frame as outlined in section 3.3.1, the reason for the delay must be documented in the woman's birth record by the Obstetrician performing the caesarean section.

3.4 Blood Ordering
For Elective / Emergency caesarean section cases, unless the pregnancy has been complicated, blood must be taken for group and save. Those patients who require cross-matching are detailed below.

Condition	Number of Units of Blood to be ordered
Placenta praevia	4 units
Previous antepartum haemorrhage or postpartum haemorrhage	2 units
Multiple pregnancy	2 units
Clotting disorders	Doctor decision
A haemoglobin less than 10 g/dcl	2 units
3 or more previous caesarean section	2 units
Presence of a uterine fibroid with a diameter ≥ 10cm – even though the indication for the Caesarean section is not the fibroid	2 units

Blood will normally be available within 20 minutes of the blood arriving in the blood transfusion laboratory if the patient meets the criteria for electronic cross matching. This decision will be made by Blood Bank.

3.5 Anaesthesia

Regional anaesthesia is the preferred method, but in some situations a General Anaesthetic may be appropriate for caesarean section.

3.6 Fetal Monitoring

The midwife should auscultate the fetal heart after the anaesthetic immediately prior to surgery and document in the birth record.

For Grade 1 and grade 2 emergency caesarean sections, continuous fetal monitoring must be continued up to skin preparation prior to surgery.

3.7 Prophylactic Antibiotics

Antibiotics to be given pre-incision.

- Give **1.5g Cefuroxime**. If allergic to Penicillin, give **Clindamycin (600mg IV single dose)** and **Gentamicin (3mg/kg) (given after cord clamping)**.
- Add in **metronidazole** if long labour pre-incision

The above must be documented in the Anaesthetic record by the anaesthetist

3.8 Delivery of Placenta

- A slow intravenous injection of 5 International Units of Oxytocin (Syntocinon) is given by the Anaesthetist following the birth of the infant.
- Following the delivery of the placenta an oxytocin (Syntocinon) infusion may be required, this will be decided according to patient need by the Obstetrician.
- The infusion is commenced by the Anaesthetist and will be as follows:
    - 40 International Units of Oxytocin (Syntocinon) is diluted in 500mls of 0.9% Sodium Chloride running at 125mls per hour.

3.8.1 Paired Cord Blood Samples

The midwife must ensure that paired cord blood samples are taken for all emergency caesarean sections and the result recorded in the birth record.

3.9 Thromboprophylaxis

- If there is insufficient time prior to emergency surgery to fit compression stockings, they should be fitted in recovery; and Flowtrons used during surgery.
- Following surgery all women who have had a caesarean section must have the Postnatal VTE risk assessment form completed and thromboprophylaxis prescribed.

3.10 Care of the Mother in the First 24 Hours Following Delivery

3.10.1 Recovery

Refer to Appendix 5 Post Anaesthetic Care Unit (PACU) Discharge Criteria, including Maternity (CORP-GUID-026).

One to one care is provided in the recovery area until the woman has airway control, cardio-respiratory stability and can communicate.

3.10.2 Frequency of observations on the ward–

The midwife will ensure:

- Half Hourly Modified Obstetric Early Warning Score (MOEWS), pain and sedation score for 2 hours, then hourly for 4 hours, then 4 hourly if stable.
- Record the observations on the MOEWS chart

3.10.3 Additional observations

3.10.3.1 Patient Controlled Analgesia (PCA)

Record all observations on the PCA Monitoring Chart (Appendix 1).

- Monitor all observations at least hourly for the first 4 hours and then 4 hourly if stable. Increase frequency of observations if any score 2 or greater: Take action if 2 or greater.
- Record hourly PCA tries / good and the PCA total.

3.10.3.2 If intrathecal diamorphine administered

Record all observations on the Intrathecal Morphine / Diamorphine Monitoring Chart (Appendix 2).

- OBSERVATIONS: Monitor all observations at least hourly for first 4 hours, 2 hourly for a further 8 hours, and then 4 hourly if stable. Increase the frequency of observations if any score recorded as 2 or greater.
- Take action if 2 or greater (see Appendix 4).

3.11 General Postoperative Care

Care plan for post emergency caesarean section / post elective section can be found at in Appendix 3.

- If the woman is breast-feeding, provide additional support.
- Women who are feeling well and have no complications can eat or drink when they feel hungry or thirsty
- After regional anaesthesia remove the epidural/spinal catheter immediately unless contraindicated.
- Offer non-steroidal anti-inflammatory analgesics to reduce the need for opioid analgesics
- Remove the wound dressing after 48 hours. Keep the wound clean and dry.
- Women who are recovering well are apyrexial and do not have complications

following caesarean sections should be offered early discharge (after 24 hours) from hospital and follow up at home.

3.12 Discussion Re Implication for Future Pregnancies

A discussion regarding suitability for **V**aginal **B**irth **A**fter **C**aesarean (VBAC) will be performed by a member of the medical team prior to discharge from hospital.

This will be documented in the woman's health record. The woman will also receive written documentation if she has required an emergency Caesarean section (see Appendix 5).

3.13 Monitoring

The process for monitoring compliance is identified at Appendix 6.

4 ATTACHMENTS	
Appendix Number	**Title**
1	Patient Controlled Analgesia (PCA) Monitoring Chart
2	Intrathecal Morphine/Diamorphine Monitoring Chart
3	Care plan for elective/emergency caesarean section
4	Guidelines For Care For The Following 24 Hours, Including Frequency Of Observations
5	Letter to mum re future pregnancy
6	Process for Monitoring Compliance

5 ELECTRONIC AND MANUAL RECORDING OF INFORMATION
Electronic Database for Procedural Documents
Held by Policy Co-ordinators/Archive Office

6 LOCATIONS THIS DOCUMENT ISSUED TO		
Copy No	**Location**	**Date Issued**
1	Intranet	16/10/2014
2	Wards, Departments and Service	16/10/2014

7 OTHER RELEVANT/ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
CORP/GUID/026	Post Anaesthetic Care Unit (PACU) Discharge Criteria, including Maternity – Appendix 3 Maternity Recovery http://fcsharepoint/trustdocuments/Documents/CORP-GUID-026.doc
CORP/PROC/102	Consent to Examination or Treatment http://fcsharepoint/trustdocuments/Documents/CORP-PROC-102.docx
CORP/PROC/408	Management of Methicillin Resistant Staphylococcal Aureous http://fcsharepoint/trustdocuments/Documents/CORP-PROC-408.docx

7 OTHER RELEVANT/ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
OBS/GYNAE/GUID/035	Refusal of Blood And Blood Products In Pregnancy (Including Jehovah's Witness) http://fcsharepoint/trustdocuments/Documents/OBS-GYNAE-GUID-035.docx
OBS/GYNAE/GUID/074	Anaesthetic Referral Process for Obstetric Patients http://fcsharepoint/trustdocuments/Documents/OBS-GYNAE-GUID-074.doc
OBS/GYNAE/GUID/077	Bladder Care in Labour and Following Delivery http://fcsharepoint/trustdocuments/Documents/OBS-GYNAE-GUID-077.doc
OBS/GYNAE/GUID/103	Venous Thromboembolism - Antenatal, Intrapartum and Postnatal Risk Assessments and Prophylaxis http://fcsharepoint/trustdocuments/Documents/OBS-GYNAE-GUID-103.doc
PL/085	Receiving a Blood Transfusion
PL/197	Preparing for your Caesarean
VS2026	Patient Controlled Analgesia (PCA) Monitoring Chart http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/14_23061%20VS2026%20Patient%20Controlled.pdf
VS2027	Intrathecal / Epidural Morphine / Diamorphine Monitoring Chart http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/14_23062%20VS2027%20Inthrecal.pdf

8 SUPPORTING REFERENCES/EVIDENCE BASED DOCUMENTS
References In Full
Clinical Guidance CG132 - Caesarean section November 2011 http://www.nice.org.uk/nicemedia/pdf/CG0132NICEguideline.pdf
Clinical Guidance 55 - Intrapartum Care http://www.nice.org.uk/nicemedia/pdf/CG55FullGuideline.pdf
SIGN Guideline 62 www.sign.uk
CEMACH 2007 – Saving Mothers lives

9 CONSULTATION WITH STAFF AND PATIENTS	
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Richard Cross	Consultant Anaesthetist
June Davies	Head of Department / Consultant Obstetrician
Nicola Parry	Head of Midwifery
Anneka Wan	Clinical Pharmacist (Reviewed for Medicines Management Committee)

10 DEFINITIONS/GLOSSARY OF TERMS	
BMI	Body Mass Index
IV	Intravenous

10 DEFINITIONS/GLOSSARY OF TERMS	
LLP	Low Lying Placenta
MOEWS	Modified Obstetric Early Warning Score
MRSA	Methicillin Resistant Staphylococcal Aureous
NHS	National Health Service
OSATS	Objective structured assessment of technical skill
PACU	Post Anaesthetic Care Unit
PCA	Patient Controlled Analgesia

11 AUTHOR/DIVISIONAL/DIRECTORATE MANAGER APPROVAL			
Issued By	Dr Amu	**Checked By**	Miss June Davies
Job Title	Consultant Obstetrician & Gynaecologist	**Job Title**	Head of Department / Consultant Obstetrician
Date	July 2014	**Date**	July 2014

Appendix 1: PATIENT CONTROLLED ANALGESIA (PCA) MONITORING CHART

FORM TO BE PRINTED ON PINK PAPER

http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/14_23061%20VS2026%20Patient%20Controlled.pdf

Appendix 2: Intrathecal / Epidural Morphine / Diamorphine Monitoring Chart

FORM TO BE PRINTED ON GREEN PAPER

http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/14_23062%20VS2027%20Inthrecal.pdf

Appendix 3: Post Caesarean Section Care Plan

Post Caesarean Section Care Plan

FILE IN SECTION 3

Abbreviations used in this document to be listed here with the full description:

PCA = Patient Controlled Analgesia
IV = Intravenous
MLC – Midwifery Led Care

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Postcode:
Date of Birth:
NHS Number:

DATE	TIME	PLAN	TICK	SIGNATURE
		Observe observations and record on the Early Warning Score and inform Doctors of any deviation		
		If spinal anaesthetic observe observations at least hourly for the first 4 hours, 2 hourly for a further 8 hours and 4 hourly if stable. Recorded on Intrathecal Morphine/Diamorphine Monitoring Chart.		
		If General Anaesthetic PCA insitu. Perform PCA observations at least hourly for 4 hours and then 4 hourly if stable. To increase frequency of observations if PCA score is 2 or greater		
		PCA may be discontinued once tolerating oral fluids		
		Observe for pain and give analgesia as prescribed		
		Observe wound and redress as required. May be removed after 48 hours.		
		IV Fluids as prescribed.		
		Record strict input and output on fluid balance chart. May be discontinued when voiding well post catheter removal		
		Remove urinal catheter after 12 hours.		
		May eat and drink as tolerated		
		Flowtrons insitu (post emergency C/S)		
		Encourage passive limb exercises		
		Teds in situ		
		Give Dalteparin as prescribed		
		Haemoglobin day 2		
		Debrief by doctor (post emergency C/S)		
		Give letter to mum regarding future pregnancy (post emergency C/S)		
		Discharge day 2		

SAMPLE

Appendix 3: Post Caesarean Section Care Plan	
Signature:	Print name:
Designation:	Date:

Appendix 4: Guidelines For Care For The Following 24 Hours, Including Frequency Of Observations

Recovery

One to one care is provided by the Anaesthetic and Recovery Team in the recovery area until the woman has airway control, cardio-respiratory stability and can communicate.
The midwife is in attendance in Recovery to support the woman and baby.

Frequency of observations for the first 24hours (after the recovery period) following Caesarean section– the midwife will ensure:

- Modified Obstetric Early Warning Score (MOEWS), pain and sedation score are recorded
  - half hourly for 2 hours
  - hourly if stable for 4 hours
  - then 4 hourly for 24 hours.
- Record the observations on the MOEWS chart

Additional observations - Patient Controlled Analgesia (PCA)

- Continue observations as described above 3.6.2.
- Record hourly PCA delivered/demanded
- Record PCA total 4 hourly.
- Record the observations on the MOEWS chart

Additional observations - If intrathecal diamorphine administered

- Modified Obstetric Early Warning Score (MOEWS), pain and sedation score are recorded hourly for 12 hours and document on MOEWS chart.

Additional observations - If intrathecal morphine

- Modified Obstetric Early Warning Score (MOEWS), pain and sedation score hourly for 24 hours and document on MOEWS chart.

Frequency of observations for the first 24hours (after the recovery period) following Regional or General Anaesthesia excluding Caesarean section – the midwife will ensure:

- Modified Obstetric Early Warning Score (MOEWS), pain and sedation score are recorded on transfer to the ward, as a minimum, unless the management plan advises otherwise.
- Record the observations on the MOEWS chart

Guidelines for Care

- Provide support to help women start breast feeding as soon as possible.
- Give prescribed medication as the woman requires.
- Encourage mobilisation as soon as the woman’s condition allows.
- Follow post-operative care plan and liaise with multi disciplinary team members as appropriate.

Thromboprophylaxis

- Complete the Postnatal Thromboprophylaxis Risk Assessment form.
- Administer prescribed thrombo –prophylaxis.

Appendix 5: Letter To Mum Re Future Pregnancy

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Date

Dear ____

Congratulations on the birth of your baby ____.

Having a baby may be a completely new experience for you and it is difficult to be fully prepared even when you have read a great deal and talked to many friends, family and health professionals. While most women wish childbirth to be as natural as possible, for a variety of reasons, a Caesarean Section (CS) is sometimes necessary. A caesarean birth, whether planned or emergency, is usually recommended and performed in the joint interest of mother and baby.

Because you have just had a caesarean birth, you may have questions now or in the future. For example, you may wonder:

Why did I need a caesarean birth?
How might this affect my future pregnancies and childbirth?

The best way to get answers is to ask the midwives and doctors who looked after you. They can check your records for specific details. The reason(s) given for the caesarean you have just had is;

____

It is important that you know that one caesarean on its own is not often a deciding factor in how your next baby might be born and that most women who have had one caesarean have a 70-75% chance (or more) of normal birth in a future pregnancy.

We would like to encourage you to discuss anything that is not clear about your caesarean while the experience is still fresh in your mind. Your midwives and doctors would be glad to discuss things while you are in hospital and your community midwife when you are at home. If you would rather wait, an appointment can be arranged later for you to see an experienced midwife through our 'birth afterthoughts' service or your hospital consultant obstetrician.

Remember:

-Most women who have had one caesarean birth have good prospects of normal childbirth in the future, so having a caesarean birth this time does not mean you need one in your next pregnancy. When you become pregnant again, your obstetrician during the antenatal period will discuss the plan of care with you in relation to your previous birth experience.

-Although most women can plan to have a normal birth, some may be advised to have a planned caesarean for future babies. If you fall into this group, your obstetrician will discuss it with you.

-It is best to discuss any worries as soon as possible, rather than wait until your next pregnancy.

Once again, many congratulations

Consultant Obstetrician & Gynaecologist

Appendix 6: The Process For Monitoring Compliance							
Minimum requirement to be monitored		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
a)	Classification of all caesarean sections as agreed by the maternity service	Continuous audit of all health records of women who have delivered following a grade 1 , 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
b)	Timing of each classification of caesarean section as agreed by the maternity service	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
c)	Requirement to document the reason for performing Grade 1 and Grade 2 caesarean sections in the health records by the person who makes the decision	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
d)	Need to include a consultant obstetrician in the decision making process unless doing so would be life threatening to the woman or fetus	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
e)	Requirement to document any reasons for delay in undertaking the caesarean section	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum

Appendix 6: The Process For Monitoring Compliance

		caesarean sections					
f)	Requirement for all women to be offered prophylactic antibiotics	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
g)	Care of the mother in the first 24 hours following delivery	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum
h)	Requirement to discuss with women the implications for future pregnancies before discharge	Continuous audit of all health records of women who have delivered following a grade 1, 2 or grade 3 caesarean sections	Delivery Suite Lead Obstetrician	Quarterly	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Lead Obstetrician/ Delivery Suite Forum	Delivery Suite Forum

Appendix 7: Equality Impact Assessment Form

Department	Departmental Wide	**Service or Policy**	Guideline	**Date Completed:**	July 2014

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and socio economic/deprivation.

QUESTION	**RESPONSE**			**IMPACT**
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	The Procedural Document is to ensure that all members of staff have clear guidance on processes to be followed. The target audience is all staff across the Organisation who undertakes this process.	Raise awareness of the Organisations format and processes involved in relation to the procedural document.	Yes – Clear processes identified	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	Not applicable to community safety or crime	N/A	N/A	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No	N/A	N/A	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No	N/A	N/A	
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a cohesive approach across the Organisation in relation to the procedural document.	All policies and procedural documents include an EA to identify any positive or negative impacts.		
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The Procedure includes a completed EA which provides the opportunity to highlight any potential for a negative / adverse impact.			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.			
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	N/A			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	N/A			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	N/A			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	N/A			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	N/A			
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	None identified			

ACTION:		
Please identify if you are now required to carry out a Full Equality Analysis	**No**	**(Please delete as appropriate)**

Appendix 7: Equality Impact Assessment Form

Name of Author: **Signature of Author:**	Mr Amu	**Date Signed:** **July 2014**
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**
Name of Manager: **Signature of Manager**	Miss June Davies	**Date Signed:** **July 2014**