GUIDELINES DOCUMENT CONTROL SHEET

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Ratification

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Name / Job Title of Chairman of Ratifying Body:	Prof Chris Grey, QHGC
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VERSION CONTROL TABLE

Date of Issue	Version Number	Status
December 2003	1.0	Superseded
15/04/10	2.0	Superseded
19/01/12	2.1	Superseded
May 2012	2.2	Superseded
14/05/13	3.0	Superseded
June 2013	4.0	superseded
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TABLE OF REVISIONS

Date	Section	Revision	Author
November 2009	Full	To ensure compliance with NHSLA Standard 2 Criterion 6 NICE Guidance Recommendations following internal review	Philippa Marsden
April 2010	Full	Audit & Monitoring process Revised following CNST assessment – taken out re debriefing and thromboprophylaxis	Lesley Heelbeck
January 2012	Partial	Reviewed and amended in line with CDDFT policy for the development and management of policy and guidance documents. Key performance indicators amended. Updated VTE risk (page 20) assessment sheet	Jean Hatton
May 2012	Partial	Changes to Antibiotic Regime for LSCS	J Woodward
February 2013	Full	Review of guideline as becoming out of date. No changes made to clinical practice	Tadala Saukila
June 2013	Full	Reviewed to ensure full compliance with NICE Moved wound care and care following LSCS to this guideline from post operative recovery guideline	Joanne Woodward Anne Holt
May 2016	Full	Reviewed as out of date Enhanced recovery included Reference to bariatric patients included Difficult Caesarean section added	Tadala Saukila

CONTENTS

1 INTRODUCTION

The Caesarean section (CS) rate has been steadily increasing during the last 50 years. In the past decade there has been a dramatic increase in the caesarean section rate worldwide, which now exceeds 30% in some regions.
The latest figures for the national CS rates are available at Health Social Care Information Centre (2015). The national CS rate is 26.5%. our rate is currently 23.2%.

2 PURPOSE

The purpose of this guideline is in assisting staff:

- To support the practice of all professionals involved in a woman's care and reflect the recommendations of national guidance thus ensuring consistency of quality of care.
- To clarify and prioritize the urgency for operative delivery to facilitate an optimal outcome for both mother and infant.
- To provide a nationally recognized audit standard by which to monitor and measure effective clinical practice.
- To ensure all necessary precautions are taken pre-operatively to identify/treat/prevent complications, which may arise intra/post-operatively.

3 SCOPE

This guideline applies to all health professionals involved in the care of pregnant women who require a caesarean section.. All staff working within the directorate are responsible for ensuring that they familiarise themselves with the content of this guideline.

4 DUTIES

This guideline defines the roles and responsibilities of midwives, obstetricians and health care workers involved in the care of women undergoing caesarean section.

5 MANAGEMENT OF CAESAREAN SECTION

Factors that reduce the likelihood of caesarean section

- Continuous support during labour from women with or without prior training reduces the likelihood of caesarean section.
- Offer induction of labour beyond 41 weeks because this reduces the risk of perinatal death and the likelihood of caesarean section for women with an uncomplicated pregnancy.
- Use a partogram.

- Consultant obstetricians involved in the decision making for caesarean section.

Antenatal Eduction NICE 2011

- Give pregnant women evidence-based information about CS during the antenatal period, because about 1 in 4 women will have a CS.

- Include information about CS such as:
  - indications for CS (such as presumed fetal compromise, 'failure to progress' in labour)
  - what the procedure involves
  - associated risks and benefits
  - implications for future pregnancies and birth after CS.

Possible reasons for caesarean sections

Breech presentation: uncomplicated singleton breech pregnancy at 36-37 weeks

- Offer ECV see CDDFT guideline for ECV
- If contraindicated or unsuccessful offer caesarean section.

Morbidly adherent placenta

- If morbidly adherent placenta refer to RVI for repeat USS and if accrete confirmed refer to them for delivery – as early as 22 weeks – important to organize MDT and early referral

Maternal request for caesarean section

- Except in exceptional circumstances maternal request is not an indication for elective CS
- Explore and record reasons for request
- Offer referral to prenatal mental health professional for support if anxiety about childbirth
- An Obstetrician unwilling to perform CS should refer the woman to an Obstetrician who will carry out CS
- Include a discussion with other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and to ensure the woman has accurate information. It may be appropriate to consider referral to a Supervisor of Midwives for the woman to discuss her request.
- If after full discussion, (including; what the procedure involves, associated risks and benefits, implications for future pregnancies and birth after CS) and offer of support vaginal birth is not an acceptable option offer a planned caesarean section.

Previous Caesarean Section

In the majority of cases a decision for VBAC will be advised – the Consultant in charge of the case should make this decision. See CDDFT VBAC guideline

Classification of Caesarean Section

Definition of type

Elective - planned caesarean section

- This is scheduled before the onset of labour for a specific clinical indication.
- The risk of respiratory morbidity is increased in babies born by CS before labour, but this risk decreases significantly after 39 weeks. Therefore planned CS should not routinely be carried out before 39 weeks.

- If planned before 39 weeks the woman should receive antenatal corticosteroids for the fetus.

Emergency – any caesarean section not planned.

Classification of Urgency

Use these as audit standards only and not to judge multidisciplinary team performance for any individual CS.

Take into account the condition of the woman and the unborn baby when making decisions about rapid delivery. Remember that rapid delivery may be harmful in certain circumstances. (NICE 2011)
Perform category 1 and 2 CS as fast as is "safely" possible after making the decision, particularly for category 1.

Grade 1 – immediate threat to life of the woman and fetus

A decision to delivery interval of within 30 minutes has been accepted as a national and local audit standard for response to emergencies within maternity services.

Ring 2222 and state obstetric and neonatal emergency , this will alert the obstetric registrar / SHO, anaesthetist/anaesthetic nurse, paediatric SHO and registrar and the coordinator on LW bleep. If a consultant obstetrician or paediatrician is required ask for these separately via switch board
Including:

- Severe APH/suspected massive concealed abruption
- Ruptured Uterus
- Abnormal Cardiotocograph e.g. Prolonged Bradycardia and / or abnormal Fetal Blood Sample less than 7.20
- Cord Prolapse
- Unsuccessful instrumental delivery
- Delivery of 2nd twin in presence of non reassuring or abnormal CTG

Grade 2 – maternal or fetal compromise, which is not immediately life-threatening

Caesarean section will become necessary because of fetal / maternal compromise that is NOT deemed immediately life threatening. Perform category 2 CS in most situations within 60 minutes of making the decision,
Remember continuum of risk
e.g.

- Failure to progress (Consider Grade 3 if less than 5cm and normal CTG – Consultant decision)
- Non reassuring / Abnormal antenatal CTG

Grade 3 – no maternal of fetal compromise but needs early delivery. Timing is dependent upon delivery suite and obstetric theatre commitments

- Failed induction - if normal CTG and less than 5cm dilated
- Patient admitted in labour but was planned for Elective Caesarean Section

Grade 4 – delivery timed to suit women and staff Timing is arranged by planning in advance and in partnership with the woman and her family, e.g. Elective CS

Management of Emergency Caesarean Section

- Consultant must be included in the decision making process unless doing so would be life threatening to the women or the fetus (If the Registrar has to go straight to theatre, e.g. for cord prolapse, the delivery suite co-ordinator should inform the Consultant on call immediately that the CS is about to take place).

- Consultant to be involved in the decision for Class of emergency CS.

- Consultant should be present for a second stage CS.

- Anaesthetist to be informed of class of CS. Choice of anaesthesia influenced by maternal status, patient preference and urgency of delivery.

- The obstetrician who makes the decision must document the reason for performing emergency or urgent caesarean section in the intrapartum care pathway.

- Once the decision has been made regarding emergency caesarean section (CS) the midwife in charge will co-ordinate staff to:

    - Follow perioperative checklist to prepare the woman for theatre
    - Obtain blood for FBC, Group and save serum (consider cross matching blood if Hb less than 9g/l or if haemorrhage anticipated)
    - Follow antacid regime – consideration to IV ranitidine – if non already given, liaise with anaesthetist. Give sodium citrate 30ml orally.
    - Document the classification

- The Operator must document any reasons for delay in undertaking the caesarean section in the intrapartum care pathway and on the emergency section Proforma. Complete audit paperwork for 2nd stage CS and decision to delivery interval audit

- Women for class 1 CS to be moved directly to theatre once the decision that a Class 1 CS has been made. The same applies for class 2 if any anaesthetic delay is anticipated.

- Consider Fetal Pillow to disimpact an engaged fetal head before an emergency CS.
- Perform a vaginal/perineal examination after the CS Fill the audit form if used.
- See appendix C for recommendations for difficult CS

Management of Elective Caesarean Section

- Consultant to be involved in the decision for all women to undergo elective CS. All for enhanced recovery unless contraindicated – consultant to state if not appropriate

- Elective CS to be planned for more than or equal to 39 weeks gestation.

- Once the decision has been made for elective CS arrange appointment for pre-assessment in the appropriate area by the multi-disciplinary team.

- Inform appropriate ward areas of planned admission and ensure relevant details are entered into ward diary.

Preoperative Assessment

- **Give Enhanced recovery leaflet**

- **MRSA screening**

- Blood to be taken for a FBC, Group and save serum (consider cross matching blood if Hb less than 9g/l or if haemorrhage anticipated eg placentation abnormalities, previous C/S more than 5)

- **Thromboprophylaxis** - Follow pre-assessment checklist including risk assessment for thromboprophylaxis (see CDDFT GUID/MAT/1215 Antenatal and postnatal thromboprophylaxis).

- **Antacid regime:**
    - Planned morning CS – ranitidine 150mg orally at 10pm the night before and 7am the morning of surgery
    - Planned afternoon CS – Light breakfast with ranitidine 150mg orally at 6am the morning of operation and ranitidine 150mg at 12 midday the afternoon of CS.
    - High risk women in labour should have ranitidine 150mg every 6 hours.
    - If none given – in an emergency give sodium citrate 30ml.

- Ensure an anaesthetic review for those with procedure-related risks has been completed antenatally. Choice of anesthetic is influenced by maternal status, anaethetist and maternal choice.

- Assess moving and handling - antenatal arrangements for those with a BMI more than 40 to have a risk assessment performed, inform ward to ensure bariatric bed available. See CDDFT obesity guideline MAT/GUID/1300

Preoperative Fasting Before Elective Caesarean Section (see appendix B)

- Ensure written information is given regarding fasting including appropriate times
- Ensure information leaflet on CS given.

On Day of Surgery

- Obtain blood results prior to surgery
- Record all information in relevant documentation
- Follow intra-operative check list prior to admission to anaesthetic room
- Ultrasound scan immediately prior to CS if elective CS being performed for breech presentation
- Auscultate Fetal Heart.
- Review by anaesthetic team.

For all women undergoing elective or emergency CS

Oxytocin 5iu by slow intravenous injection should be used at CS for third stage.

Oxytocin (Syntocinon) Infusion

Consideration should be given for syntocinon infusion (40 units oxytocin) in 500ml 0.9% sodium chloride at 125ml /hour) after delivery of the placenta in the following patients:

- Age more than 40
- Obesity (BMI more than 35)
- Multiple pregnancy
- Previous retained placenta or PPH

- Low maternal Hb below 9 g/l at onset of labour
- Grand multiparity more than 4
- Polyhydramnios
- Low lying placenta
- APH
- Women who decline blood products – a clear plan must be put in place antenatally for these women – see guideline on women who decline blood products
- Women with clotting disorders or on therapeutic anticoagulants
- Induction of labour or oxytocic use during labour
- Prolonged labour (more than 12 hours)
- Retained placenta
- PPH
- Baby weight greater than 4.5Kg / Macrosomia/suspected big baby
- Pre-eclampsia or PIH

During the delivery the surgeon where ever possible will Perform Delayed cord clamping and the placenta will be removed by controlled cord traction.

It is important to obtain paired cord samples if the C/S is being conducted for fetal compromise

Antibiotic Prophylaxis

Offer prophylactic antibiotics before skin incision. See Trust antibiotic formulary

Thromboprophylaxis

- All women undergoing CS should have a risk assessment performed prior and following elective CS and following emergency CS to assess the need for Thromboprophylaxis in the postnatal period. See CDDFT Guideline on Antenatal and Postnatal Thromboprophylaxis.

- Anti-embolic stockings.

- Observe signs of Deep Vein Thrombosis (DVT)/Pulmonary Embolism i.e painful swollen calf, cough, and shortness of breath.

- **Women who are already on prophylactic or therapeutic LMWH** - For management see CDDFT guideline on:
    - CDDFT Antenatal and Postnatal Thromboprophylaxis
    - CDDFT Management of DVT and pulmonary embolism in pregnancy.

Recovery of women postoperatively

- For initial recovery of patients see CDDFT Recovery Guideline GUID/MAT/1500
- Unless instructed otherwise follow enhanced recovery pathway. (Appendix D)

Postoperative Observations

- Observations of the respiratory rate, heart rate, blood pressure, pulse, oxygen saturation together with pain levels and sedation will continue on the postnatal ward. Observations will be recorded via the Modified Early Obstetric Warning Score.

- Observations will be made every half an hour for two hours and hourly thereafter provided that the observations are stable. Once stable, observations will be carried out four hourly (see below).

- If the observations are not stable, more frequent observations will be required together with a medical. Refer to CDDFT Care of Critically Ill Women Guideline.

- As a minimum 4 hourly maternal observations of temperature, pulse, blood pressure, respiratory rate and oxygen saturation will be required for the first 24 hours.

- As a minimum fluid input and fluid output will be recorded for the first 24 hours.

- Women's PV loss should also be monitored closely post CS, and become part of the daily postnatal examination.

Fluids and Diet

- Women who have no complications following CS may eat and drink as required.

- IVI fluids should be administered as prescribed and may be discontinued once women are tolerating oral fluids and have a satisfactory diuresis.

- The urinary bladder catheter may be removed when women are mobile following regional anaesthesia or as indicated by the Surgeon.

- Fluid balance chart should be maintained for 24 hours

- The time of removal of the urinary catheter and amount of urine in the catheter bag should be documented in the maternal records.

- Women should be encouraged to pass urine by six hours following removal of the catheter. The time and amount of urine passed should be recorded in the fluid balance chart and the maternal records.

- If a woman has not voided by 6 hours postpartum and measures to encourage micturition, such as taking a warm bath or shower, are not immediately successful, measurement of residual bladder volume and medical review should be sought and care planned as per the CDDFT Bladder Care Guideline. All care given must be documented in the maternal notes.

Analgesia

- Women should be offered opioid analgesia post CS, which may be required for up to 48 hours. Patient Controlled Analgesia (PCA) may also be used.

- Women should also be encouraged to take regular oral analgesia such as paracetamol, codeine (if not breast feeding) and anti-inflammatory medication, and should also be offered a supply to take home on discharge.

Wound Care

- On admission to the ward post CS the wound dressing should be observed for signs of oozing. The dressing should be removed 24 hours post operatively using an aseptic technique. The dressing may be removed in the shower if the woman requests.

- If re-dressing of the wound becomes necessary, this should be undertaken using an aseptic or non-touch technique.

- The wound should be observed for signs of infection e.g. redness, discharge and increased pain. If there are any deviations from the normal inform appropriate medical staff.

- Advise loose clothes and cotton underwear.

- Removal of drains should be according to the Surgeons instructions.

- Type of wound suture and plans for removal should be documented in the maternal records and undertaken according to the Surgeons instructions.

- Women should be encouraged to take over the care of the wound and advised to clean and dry the area at least daily. They should be advised to observe for signs of infection e.g. redness, discharge and increased pain. If there are any deviations from the normal they should be advised to seek medical advice.

- Women with a BMI over 35 are encourage to mobilize and drink plenty of fluids post surgery, there is a complete check list for these women in the Obesity guideline, including actions for women with a BMI over 40.

De-brief

- An obstetrician, (ideally the surgeon) will see the patient prior to discharge. A discussion should take place with the woman regarding her labour (if applicable) and the indications for the CS.

- Implications for future pregnancies and birth options to be discussed before discharge.

- A resume of the discussion to be documented in the intrapartum care pathway. Ensure “birth after caesarean section – RCOG 2008” leaflet is given prior to discharge.

6. Training

- All specialty trainees to declare competencies at induction to the department.

- If not competent, to be taught and supervised by senior trainees and on duty labour ward Consultant taking advantage of the elective section list.

7. MONITORING

7.1Key Performance Indicators

Performance will be measured on a regular basis as shown below.

7.2Compliance and Effectiveness Monitoring

Monitoring Criterion	Response
Who will perform the monitoring?	Maternity Services
What are you monitoring?	a) Classification of caesarean documented as agreed by the maternity service b) Timing for Grade 1 classification of caesarean section achieved as agreed by the maternity service c) Documentation of the reason for performing a Grade 1 caesarean section in the health records by the person who makes the decision d) Evidence that a consultant obstetrician was included in the decision making process unless doing so would be life threatening to the woman or the fetus e) Documentation regarding reasons for any delay in undertaking the caesarean section f) That all women are offered antibiotic and thrombo prophylaxis g) Care for first 24 hours follows the recovery guideline h) Documentation regarding a discussion with women on the implications for future pregnancies before discharge
When will the monitoring be performed?	Continuous audit
How are you going to monitor?	Review of intrapartum/caesarean section care pathway/ proforma Any Safeguard incidents
What will happen if any shortfalls are identified?	The audit results will be collated and reported monthly to the Obs & Gynae Operational Group
Where will the results of the monitoring be reported?	Quarterly Clinical Governance Audit Meeting
How will the resulting action plan be progressed and monitored?	Obs & Gynae Operational Group – Quarterly Clinical Audit meeting
How will learning take place?	Via Team Meeting's Newsletter, Mandatory Day, Staff Bulletins

8. REFERENCES

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9. ASSOCIATED DOCUMENTATION

This guideline should be read in conjunction with the following policies:

GUID/MAT/1215	CDDFT Antenatal and Postnatal Thromboprophylaxis
GUID/MAT/1406	CDDFT Intrapartum Fetal Surveillance Monitoring
GUID/MAT/1501	CDDFT Postnatal recovery following a Caesarean Section or other Obstetric Operative Procedure Including Enhanced Revcovery
GUID/MAT/1409	CDDFT Management of Vaginal Birth after Caesarean Section (VBAC)
GUID/MAT/1317	CDDFT External Cephalic Version
GUID/MAT/1004	CDDFT Care of critically Ill Woman
GUID/MAT/1016	CDDFT Maternal Transfer by Ambulance
GUID/MAT/1316	CDDFT Management of DVT and Pulmonary Embolism during Pregnancy and in the Puerperium
POL\CA\0001	CDDFT Policy for the Development and Management of Policy and Guideline Documents

10. APPENDICES

Appendix A – Guidelines for Preoperative Fasting Before Elective Caesarean Section

Appendix B – letter to patient

Appendix C – Ten steps for difficult delivery of the fetal head at caesarean Section

Appendix D – Enhanced recovery pathway

Appendix E - Equality Analysis/Impact Assessment

Appendix A

Guidelines for Preoperative Fasting Before Elective Caesarean Section

Fasting before general anaesthesia is considered essential to patient safety in order to reduce the risk of regurgitation of gastric contents. As there is a reduction in the reflexes that function to protect the lungs on induction of anaesthesia, if regurgitation occurs with reflexes absent, then aspiration is likely to occur. This has led to advising patients to fast for long periods before induction of general anaesthesia.

Nil by mouth from midnight is a concept that was suggested by Dr Mendelson in 1946 and is outdated. Fasting for such long periods prior to surgery is associated with problems which led to further research and a change of practice. Most national anaesthesia organisations (ASA, RCOA, AAGBI) no longer follow this. National guidelines adopted by Royal College of Anaesthetists (RCOA) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend much shorter preoperative fasting times of 6 hours for solids and 2 hours for clear fluids.

There is no credible evidence to suggest that gastric emptying is delayed in women in term pregnancy and should be considered as any other ASA 1 or 2 patients coming for surgery. There is also no evidence to show that term women undergoing elective caesarean section are at increased risk of aspiration if shorter fasting times are adopted. In fact there is credible evidence for the opposite.

The aim of this guideline is to make sure that women coming for elective Caesarean section are not being fasted for unnecessarily long periods of time, to aid in reducing fasting times in case of unforeseen delays in starting their operation and to raise awareness among all staff.

- Patients may drink clear fluids up to 2 hours prior to induction of general or regional (Spinal/Epidural) anaesthesia.
- Patients should not take solid food and milk or powdered milk from 6 hours prior to induction of anaesthesia.
- Patients should take the oral pre-medication at 7am with water.
- Use of chewing gum and any form of tobacco should be avoided in the last 2 hours prior to induction of anaesthesia.

Clear fluid- Defined as non-particulate (without bits) fluids without fat e.g. water, clear fruit juice, tea and coffee (without milk). Milk and powdered milk are considered as solid food as they contain fat. It is also important to avoid carbonated drinks.

Patients with known or suspected delay in gastric emptying (diabetes mellitus, upper gastrointestinal pathology and symptoms) should be assessed on an individual basis. The above guideline does not apply to them. As the order of list may get changed in the morning of surgery, all patients should assume 09:00 am as time of induction of anaesthesia. The following times can be taken as a guide.

22:00 pm- Time to take oral medication -1st dose

03:00 am- last time for solids prior to surgery

07:00 am- last time for clear fluids and to have a glass of water. Time to take oral pre-medication – 2nd dose

Once the order of list has been established, patients second on the list can be given further fluids on anaesthetists instructions.

Dear _____

Congratulations on the birth of your baby _____.

Childbirth 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) becomes necessary. A CS, whether planned or emergency, would have been recommended and performed in the joint interest of mother and baby.

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

1. Why did I need a CS?
2. 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.

It is important that you know that one CS 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 CS have a 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 CS while the experience is still fresh in your mind. Your midwives and doctors would be glad to discuss things while you are in hospital. If you would rather wait, an appointment can be arranged later for you to see your midwife, GP or hospital consultant obstetrician.

Remember:

1. Most women who have had one CS have good prospects of normal childbirth in future so, having a CS this time does not mean you need one in the future. When you get pregnant again, during the antenatal period, your obstetrician will discuss plans and precautions specific to you.
2. Although most women can plan to have a normal birth, some may be advised to have a planned CS for future babies. If you fall into this group, your obstetrician will discuss it with you.
3. It is best to discuss any worries as soon as possible, rather than wait until your next pregnancy.

Once again, congratulations

County Durham and Darlington Obstetrics & Gynaecology Consultants

Appendix C

Ten steps for difficult delivery of the fetal head at caesarean Section

If the fetal head is deeply engaged:
1. Stand on a step or lower the operating table
2. Ensure the table is tilted with the woman's head down
3. Wait for contraction to cease
4. Attempt to turn to the occipitotransverse position and deliver
5. Call for senior help
6. Deliver with the opposite hand
7. Administer 250 micrograms of subcutaneous terbutaline or a general anaesthetic
8. Apply pressure to the fetal shoulder
9. Push the fetal head upwards vaginally
10. Evaluate the incision (extend to a J or T shape) and deliver the breech

If the fetal head is disimpacted, and subsequently displaced superiorly:
1. Maintain longitudinal lie of the fetus (long axis of the fetus parallel to long axis of the mother)
2. Apply firm pressure from above
3. Deliver the fetal head with forceps
4. Deliver the breech

Appendix D

Enhanced Recovery

Initial Assessment

- **Observations stable as per MEWS**
- **TED stockings on**
- **Wound dressing intact**
- **Lochia normal**
- **Uterus well contracted**
- **Analgesia and antiemetics prescribed**
- **Baby's temperature checked at delivery**

2-6 hours

- **Tolerating oral fluids and offered diet if hungry**
- **First dose of enoxaparin given**
- **Assisted up out of bed as soon as able to weight bear**
- **If LSCS prior to 2pm, catheter removed once able to mobilise (if delivered after 2pm will be removed the following morning**
- **TTO's ordered by Doctor**
- **Debrief by surgeon who performed the LSCS 9 if required)**
- **Hand expression demonstrated to all breastfeeding mothers**

Discharge plan

- **Hb at 6am**
- **Examination of newnborn**
- **Discharge pack**

Appendix E

Equality Analysis / Impact Assessment

EAIA Assessment Form	v3/2013

Division/Department:	Family Health – Maternity Services
Title of policy, procedure, decision, project, function or service:	Caesarean Section – Elective & Emergency
Lead person responsible:	Evidence Based Practice Group - Chair
People involved with completing this:	Tadala Saukila EBPG

Type of policy, procedure, decision, project, function or service:

Existing	Yes
New/proposed	☐
Changed	☐

Date Completed: 06.05.16

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure women have the safest care that can be given

What outcomes do you want to achieve?

No incidents – good outcome – good experience for women and their families

What barriers are there to achieving these outcomes?

Not adhering to guidelines and policies – non-attendance at training and education

How will you put your policy, procedure, project, decision, function or service into practice?

Monitoring incidents and ensuring lessons are learned

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

CDDFT Policy for VBAC, Antenatal and Postnatal Thromboprophylaxis, Post partum Haemorrhage, Recovering Women Postoperatively, Management of Critically Ill Patient, Intrapartum Fetal Surveillance, External Cephalic Version

Step 2 – Collecting your information

What existing information / data do you have?

Incident data

Who have you consulted with?

Clinical colleagues

What are the gaps and how do you plan to collect what is missing?

N/A

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No

Sex/Gender

No

Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership (applies to workforce issues only)

No

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

No ☐

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Agreed at Obstetrics and Gynaecology Operational Group and approved at the Quality & Health Care Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please

list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Audit of maternity records using Maternity Audit toolkit annually

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk **and must be attached to any documentation to which it relates.**