Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Termination of Pregnancy

This procedural document supersedes: GSG 1 version 5 Termination of Pregnancy

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Executive Sponsor(s):	Timothy Noble – Deputy medical director
Author/reviewer: (this version)	Dr D Morgan Consultant Obstetrician and Gynaecologist
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Target audience:	All Maternity and Gynaecology service staff

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5.1	October 2024	Minor amendment about use of the Serenity suite and Bereavement care	J. Scott
Version 5	June 2023	Amendments please read full	D. Morgan
Version 4	Feb 2020	Amendments please read in full	Dr T Yin
Version 3	Feb 2017	Minor amendments	Dr H Sheehan Dr T Yin
Version 2	July 2013	Medical management amended in accordance with RCOG guidance.	A Squires
Version 1	Sept 2012	This is a new guideline please read in full. This guideline replaces WSG 12.	E Emovon A Solomonz A Squires K Cousins

Contents

IN CONFIDENCE

Certificate B

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

Certificate to be completed in relation to abortion performed in emergency under Section 1 (4) of the Act

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby certify that I *am/was of the opinion formed in good faith that it *is/was necessary immediately to terminate the pregnancy of

.....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

(Ring appropriate number) in order:

1. to save the life of the pregnant woman; or
2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

(Ring appropriate letter)

A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

B. not later than 24 hours after such termination.

Signed .....

Date .....

*Delete as appropriate
FORM H.S.A. 2

1 INTRODUCTION

Termination of pregnancy (TOP) is common: over 200 000 procedures are performed each year in Great Britain, and at least one-third of British women will have had a termination of pregnancy by the time they reach the age of 45 years. In a legal setting where sterile facilities are available, termination is a safe procedure for which major complications and mortality are rare at all gestations (RCOG 2010).

2 PURPOSE

To assist all health professionals involved in the care of women undergoing termination of pregnancy due to either social reasons, or fetal abnormality.
To ensure that all families are offered the use of the Serenity suite at Doncaster to make memories and spent and much time as they wish with their babies.

3 DUTIES AND RESPONSIBILITIES

- The obstetrician/gynaecologist has overall responsibility for the termination of pregnancy.
- In practice, a nurse or midwife may administer the drugs used for medical termination once these have been prescribed by a doctor (Abortion Act 1967).

- All staff involved in the care of a woman or couple facing a possible termination of pregnancy must adopt a non-directive, non-judgmental and supportive approach.
- The Abortion Act has a conscientious objection clause, which permits doctors (and midwives/nurses) to refuse to participate in any treatment authorised by the Act if it conflicts with their religious or moral beliefs.
- This guidance does not apply where it is necessary to save maternal life or prevent grave permanent injury to a woman's physical or mental health.
- Healthcare professionals should ensure that women have the information they need to make decisions and to give consent in line with General Medical Council guidance and the 2015 Montgomery ruling. [1]
- Fetal abnormalities: after the diagnosis, the woman will need help to understand and explore the issues and options that are open to her and be given the time she needs to decide how to proceed. She must not feel pressurised to make a quick decision but once a decision has been made the procedure should be organised with minimal delay.

4 PROCEDURE

4.1 Documentation

Doctors are under a legal obligation to complete the following forms:
HSA1 (Appendix 1): Two doctors are required to sign the HSA1 form, which is the certificate of opinion before a termination is performed under Section 1(1) of the Abortion Act 1967 and complete in FULL. The HSA1 form must be kept for 3 years. [2]

HSA2 (Appendix 2): To be completed in FULL by the doctor within 24 hours of an emergency termination and kept for 3 years. In cases such as these, the requirement for the opinion of two doctors does not apply. [2]

HSA4 (Appendix 3): Must be completed in FULL by the doctor and sent to the Chief Medical Officer (CMO) electronically only within 14 days of the termination taking place. As is the case with the manual form, only doctors terminating the pregnancy are able to authorise the electronic form. [2]

Supplementary consent form Funeral arrangements/ sensitive disposal, for all terminations

Medical Certificate <24 weeks gestation with no signs of life - for all terminations

Notification of the loss of a baby ≥14 this must accompany the POC/Fetus to the mortuary

4.2 Woman's Choice

Referral Process - social TOPs are referred to BPAS by GP or Family Planning Services

- Termination for maternal health reasons or fetal abnormality can be referred from maternity services or GOPD
- Termination should be offered within one week of assessment. [1]
- Where possible the HSA1 form should be completed by the health professional completing the referral.

Information for women requesting TOP

Reassure women that having a termination is not associated with increased risk of infertility, breast cancer or mental health issues [1]

Surgical and medical methods of termination carry a small risk of failure to end the pregnancy (1-2 per 100 procedures)

What will happen during and after the termination.

What pain management options are available.

Side effects, risks and complications of termination methods

How to be sure the pregnancy has ended for those having a medical termination at home.

How to identify the need to seek urgent medical attention during or after the termination

Medical termination:

A medical termination involves taking medication to end the pregnancy. It can be used at any stage of pregnancy and mimics miscarriage.

It is:

- controlled by the woman and may take place at home (if gestation is less than 10 weeks of pregnancy),
- can take time (hours to days) to complete termination, and the timing may not be predictable. women experience bleeding and cramping, and potentially some other side effects such as nausea and vomiting,
- women may see the products of pregnancy as they are passed (need to explain what the products of pregnancy will look like and that there may be movement). [1]
- women may need to attend on several occasions.

There is a small risk (5 in 100) of the need for further intervention to complete the procedure i.e., surgical intervention.

In emergency situations or where medical termination has failed the need for surgical termination may be required.

For women referred from BPAS for terminations because of co-morbidities such as uncontrolled epilepsy, diabetes, heart conditions, or cancer, medical termination is only offered up to 12+6 gestation in this Trust.

Contraindications [2]

- known or suspected ectopic pregnancy
- previous allergic reaction to mifepristone or misoprostol
- severe uncontrolled asthma*
- chronic adrenal failure*
- inherited porphyria*

** Mifepristone should not be used as there is a theoretical risk of exacerbation of the underlying condition, but use of misoprostol alone could be considered.*

Extra considerations[3]

- on long-term steroid therapy – mifepristone is a steroid receptor antagonist; it might inhibit the action of the steroid therapy and exacerbate the underlying condition; seek specialist input on whether dose adjustments to a corticosteroid regimen are required
- on anticoagulant medication – anticoagulants may need to be stopped before termination medications are administered and then restarted after the termination
- with a bleeding disorder, who may need care in a clinical setting rather than at home
- with symptomatic anaemia, where the haemoglobin concentration should be measured and who may need additional care in a hospital setting.
- with an IUD in place – the IUD should ideally be removed in advance of treatment; if the IUD cannot be retrieved, it is important to confirm that it is expelled during the procedure, by using imaging such as an abdominal X-ray after the termination.

Surgical termination

Surgical termination requires instrumentation of the uterus and cervical dilatation, which carries a small risk of uterine or cervical injury.

- ***At DBTH this is offered*** in emergency situations following medical termination

Possible complications of surgical termination [3]

- Uterine infection - occurs in up to 1 in every 10 terminations
- Retained products - occurs in up to 1 in every 20 terminations
- Continuation of the pregnancy – occurs in less than 1 in every 100 terminations
- Excessive bleeding – occurs in about 1 in every 1,000 terminations
- Cervical injury– occurs in up to 1 in every 100 surgical terminations

- Uterine injury – occurs in 1 in every 250 to 1,000 surgical terminations and less than 1 in 1,000 medical terminations.

Contraindications and extra considerations [3]

- if the pregnancy cannot be removed through the cervix, e.g due to an obstructing fibroid: if medical termination is also not suitable; hysterotomy or gravid hysterectomy may be undertaken.
- Medical (or other) conditions affecting choice of anaesthetic or require additional or specialised equipment: termination need to take place in hospital. These include bleeding disorders, abnormal placentation, use of anticoagulant medication, and severe cardiopulmonary disease.
- Very high body mass index (BMI), distortion of the uterine cavity by fibroids or another anomaly, previous cervical surgery or type 3 female genital mutilation (FGM).
- Procedure planning: patient positioning, longer instruments for evacuation, ultrasound guidance, and cervical preparation.

4.3 Fetal Abnormalities

- Please see MSG 133 Antenatal Screening and MSG 114 Fetal abnormality, identification of suspected condition, for information about screening for fetal anomalies.

4.4 Assessment and Process

It should be confirmed that women are seeking termination voluntarily

Consider providing termination assessments by phone or video call, for women who prefer this

- Assessment for Women's Choice will be completed in Clinics or BPAS.
- Suitability for management will be determined by obtaining a full medical history and confirming gestation via ultrasound scan.
- Women will be assessed to ascertain whether they are medically fit for day care procedure. Those who need specialist care eg. women with serious medical conditions should be referred as soon as possible to an appropriate service.[1]
- A risk assessment for STIs (including HIV and syphilis) should be undertaken for all women.
- Prophylactic antibiotics should be used for surgical/ incomplete termination. Do not delay surgical termination if antibiotics not available.[1]
- Regimen: oral doxycycline 100mg twice a day for 3 to 7 days, starting within 2 hours of the procedure; 3-day course is as effective as a 7-day course.[1]
- Future contraception will be discussed

- All women will be seen by a doctor who will obtain consent for the procedure and arrange the admission date.
- FBC and G&S bloods will be taken to determine Rhesus blood status.
- For women who need pharmacological thromboprophylaxis, consider low-molecular-weight heparin for at least 7 days after the termination.[1]
- Termination will not be considered based on fetal gender.[1]

4.5 Medical Management

The treatment is provided in two stages, 24-48 hours apart. *(3)* The second stage of treatment differs depending on gestation. Mifepristone in combination with misoprostol shortens induction to termination interval, reduces side effects and decreases the rate of ongoing pregnancy.

Stage 1 – Mifepristone [3]

- One dose of Mifepristone 200mg orally 24-48hrs before misoprostol.
- Any indication of cardiac side effects (i.e., chest pain, dysrhythmias, hypotension), inform the Consultant Obstetrician/Gynaecologist and the Anaesthetic Consultant on call and instigate full cardiac monitoring.
- The woman may be discharged home if her condition remains stable after 30 minutes.
- Provide information leaflet, online links e.g., https://www.bpas.org/termination-care/ , contact numbers, advise the patient there is a small risk that she may pass products of conception (POC) within the 48 hours and therefore if she experiences severe pain or bleeding, she should ring the hospital for advice immediately.
- Arrange re-admission in 24-48 hours. Ensure patient is aware can come into hospital sooner if bleeding or pain occurs.

Stage 2 – Misoprostol[3]

- Baseline measurements of Blood Pressure, Pulse, and Respirations will be recorded and documented in the clinical notes.
- Prior to discharge women who are Rhesus (D) negative will receive 500iu Anti D Immunoglobulin administered IM within 72 hours, if >12 weeks' gestation.[2]

Gestation: up to and including 11+6 weeks

- Misoprostol 800mcg (PV, buccal or sublingual)
- If pregnancy not passed within 4 hours, give a further 400 mcg misoprostol by the same routes.

- If mifepristone is not available, use misoprostol 800 mcg by the above routes, then misoprostol 400 mcg every 3 hours until the pregnancy has passed.

- ***Gestation: between 12^{+0} and 24^{+0} weeks***
- Misoprostol 800 mcg pv, buccal or sublingual, then misoprostol 400mcg by the same routes every 3 hours until termination occurs (this is the same course even if mifepristone is not available)

Gestation: after 24^{+0} weeks/ Previous LSCS/ uterine surgery

Misoprostol 400mcg pv, buccal, sublingual every 3 hours until termination occurs

4.6 Surgical Management - <12 weeks/emergencies

- mifepristone 200mg orally, 24–48 hours before the procedure, or
- misoprostol 400 micrograms sublingually, 1–2 hours before the procedure, or
- misoprostol 400 micrograms vaginally or buccally, 2–3 hours before the procedure.[1]
- Analgesia should always be offered and provided without delay

Pre-operative Assessment

Pre-assessment:
Arrange admission with the appropriate ward/Day Surgery Unit
Prescribe Misoprostol and Prescribe antibiotics and analgesia
Take FBC and G&S
Contraception - prescribe TTO Advise re self-referral to Contraceptive and Sexual Health Services (CASH)
Disposal consent discussed and signed for both maternal choice and fetal abnormality TOP
Information is given to the woman
A stamp is available and used for this checklist (HSA1 form, contraception and disposal form)
Enter details of patient in the Termination of pregnancy folder on the B Drive and upload HSA1 and consent forms on medisec/ K2 to facilitate completion of the HSA4 form

On Admission/Pre-Operative

Admission:
Check results from pre-operative investigations
Ensure all documentation present, completed, signed, up to date
Assessment by Anaesthetist
Nursing staff to commence surgical IPOC

Medical staff to administer Misoprostol/ antibiotics as prescribed, pre-operatively having confirmed that the patient wishes to go ahead with planned procedure and Certificate A (HSA1) is complete
Complete theatre check list, escort to theatre

Post-Operative Recovery

Recovery:
Continue day case IPOC recovery.
Observations: blood pressure, pulse, respirations, oxygen saturation/MOEWS chart, blood loss and pain (approximately 2hours)
Check Blood Group and Administer Anti-D 500iu if Rhesus Negative
Assess suitability for discharge.
Discharge, complete documentation, ensure patient has transport arranged
Complete National Termination Audit HAS4 form electronically

4.7 Management of incomplete termination

Options include surgical and medical methods of uterine evacuation.

Assessment

- Incomplete termination should be suspected when any woman of reproductive age with vaginal bleeding and/or abdominal pain after one or more missed periods.

Infection[3]

- It is vital to identify women who may have an infection and to manage this urgently.
- Clinical features suggestive of infection:
- Temperature above 37.5^{o}c
- Abdominal tenderness, rebound or guarding
- Foul odour or pus visible at the cervical os
- Uterine tenderness
- Features suggestive of sepsis and indicating the need for urgent intervention
- Hypotension
- Tachycardia
- Increased respiratory rate

Management

- If there is no suspicion of infection and uterine size is less than 14 weeks:
    1. Uterine evacuation with antibiotic prophylaxis;
    2. Misoprostol 400mcg PV/ buccal or sublingual 3 hourly

If infection is present the uterus should be evacuated urgently Start broad spectrum antibiotics immediately – IV if severe

4.8 Feticide

- A fetus that is born alive after termination of pregnancy is deemed to be a child, irrespective of the gestational age at birth, and should be registered as a live birth. The coroner must be informed; birth and death certificates and registration must be completed.[4]
- Feticide should be performed before medical termination after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.
- All women requiring feticide will be referred to the most appropriate tertiary unit.

4.9 Ongoing Care

For all terminations: When necessary, a follow up appointment will be arranged by the Consultant in the gynaecology outpatient department.

Fetal abnormality:

- Referral to the Bereavement Midwives by email: dbh-tr.bereavement-midwives@nhs.net for counselling and support should be offered to women > 16 weeks following termination of pregnancy for fetal abnormality and to the Early pregnancy loss nurses by email dbth.epln@nhs.net if < 16 weeks
- The woman will be offered a visit from her Community Midwife, where appropriate. If the woman wishes this, the visit must be detailed in the discharge book.
- Please ensure that all families are offered the use of the Serenity suite at Doncaster to make memories and spent and much time as they wish with their babies.

5 TRAINING/SUPPORT

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to

Example: An electronic register is maintained on the shared B drive	The medical/ administrative team.	Quarterly	Quarterly audit of compliance in relation to the completion of the HSA forms will be undertaken

7 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 6)

8 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Mental Capacity Act 2005 Policy and Procedure Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19 Privacy and Dignity Policy - PAT/PA 28].
SOP – Completing forms required for Termination of Pregnancy
SOP - Termination of Pregnancy for Medical Conditions

9 REFERENCES

*1.*NICE (2019) Termination care [NG 140]. NICE, London Public Health England (2018) Fetal anomaly screening: programme handbook;

2. DOH; Guidance in Relation to Requirements of the Abortion ACT 1967

*3.*RCOG (2022) Best practice in termination care. RCOG Press, London

*4.*Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy (2023)

APPENDIX 1

IN CONFIDENCE

CERTIFICATE A

ABORTION ACT 1967

Not to be destroyed within three years of the date of operation
Certificate to be completed before an abortion is performed under Section 1(1) of the Act

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....
(full address of place at which patient was seen or examined)

on .....

and I .....
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....
(Full address of place at which patient was seen or examined)

on .....

We hereby certify that we are of the opinion, formed in good faith, that in the case

of .....
(Full name of pregnant woman in block capitals)

of .....

.....(
Usual place of residence of pregnant woman in block capitals)

(Ring appropriate letter(s))

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;

D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;

E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.

Signed ..... **Date** .....

Signed ..... **Date** .....

* Delete as appropriate

Form HSA1 (revised 1991)

IN CONFIDENCE **Certificate B**

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

Certificate to be completed in relation to abortion performed in emergency under Section 1 (4) of the Act

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby certify that I *am/was of the opinion formed in good faith that it *is/was necessary immediately to terminate the pregnancy of

.....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

(Ring appropriate number) in order:

1. to save the life of the pregnant woman; or
2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

(Ring appropriate letter)

A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

B. not later than 24 hours after such termination.

Signed .....

Date .....

*Delete as appropriate
FORM H.S.A. 2

APPENDIX 2 – HAS 4 TERMINATION NOTIFICATION

IN CONFIDENCE

Form HSA4 (Revised Sept 2006)

ABORTION NOTIFICATION

ABORTION ACT 1967 – FORM OF NOTIFICATION FOR PREGNANCIES TERMINATED IN ENGLAND AND WALES

This form is to be COMPLETED BY THE PRACTITIONER TERMINATING THE PREGNANCY and sent in a sealed envelope within FOURTEEN DAYS of the termination to:

The Chief Medical Officer

The Chief Medical Officer

No longer in use - only done electronically. **To register, use this link**: H:\register HSA4.html

Did the practitioner named at a. certify that s/he saw/and examined the pregnant woman before giving the certificate? YES NO

Did the practitioner named at b. certify that s/he saw/and examined the pregnant woman before giving the certificate? YES NO

* delete as appropriate

Page 1

APPENDIX 3 – CARE PATHWAY

Social Termination of Pregnancy

Refer to BPAS: 084575 30 40 30

Fetal Anomaly: Termination of pregnancy.

Woman to be counselled, information provided and consent completed in antenatal clinic (DBTH)

GSG 1 Version 4
Maternal medical issues/referral from BPAS, Termination of Pregnancy:

Woman to be counselled, information provided and consent completed in Gynaecology outpatients department (DBTH)

HAS 1 and 2 to be completed

Management plan stage 1

- Take FBC and Group and Save
- Mifepristone 200mg orally- Obtained from controlled drug cupboard LW/CDS
- May go home after 30 minutes if well.
- Arrange 24-48 hour follow up <16 weeks on G5 or >15+6 weeks on CDS/LW
- Enter details on B Drive, scan paperwork on medisec/ K2

Paperwork to be completed following the delivery of POC/fetus

1. Supplementary consent form (funeral / sensitive disposal form)
2. Medical certificate if no signs of life < 24 weeks
3. Send to the mortuary if >14 weeks, discuss option of post mortem if termination for fetal abnormalities
4. Send to histopathology if <14 weeks
5. Notification of baby loss
6. **Any Baby born alive following TOP at any gestation MUSTBE referred to the Coroner, will require birth registration and death registration. Where uncertain of funeral arrangements will require crem 4 and 5 to be completed. Please see MSG 225 for more comprehensive guidance**
7. **TOP >14 for fetal abnormalities or any woman who wishes to make memories**
   Follow MSG223 Pregnancy loss/ fetal loss checklist and "use the Grace Pack"

APPENDIX 4

Definition of Terms

Termination of pregnancy (termination) is the process of ending a pregnancy so that it does not result in live birth.

Legal requirements relating to the termination of pregnancy are contained within The Abortion Act 1967 which covers the UK Mainland (England, Wales and Scotland) but not Northern Ireland.

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy TOP	Women's and Children's	Denise Morgan	Existing	June 2023

1) Who is responsible for this policy? Name of Division/Directorate:

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes?

3) Are there any associated objectives? Legislation, targets national expectation, standards:

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] -

 If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.			
Date for next review:	**July 2026**		
Checked by:	**Alex Merriman**	**Date:**	**17/07/2023**