GUIDELINES FOR THE USE OF NASAL HIGH FLOW OXYGEN ON THE ACUTE RESPIRATORY UNIT AND WARD 5

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Nasal high flow oxygen (NHFO) has become increasingly utilised in the management of patients with Type 1 Respiratory Failure (De Lerk, A 2008; Frat JP et al 2013). It can deliver a humidified high inspiratory gas flow via nasal cannula (up to 60L/min), warmed to body temperature with accurately titrated oxygen content (21-100%).

Oxygen is one of the most commonly prescribed drugs in hospital. This is often in the form of low flow nasal cannula but these are limited in the flow they can deliver. Other oxygen delivery methods including venturi masks can provided increased FiO2 but cause drying of mucosa.

Nasal high flow oxygen (NHFO) is the delivery of high FiO2 of oxygen between 0.21 to 1.0 at flows of up to 60L min. The machine is composed of air/oxygen blender, active heated humidifier and nasal cannula. It is used in the treatment of hypoxic respiratory failure due to the high FiO2 it is able to provide.

Nasal high flow has physiological advantages over conventional oxygen therapy. These include the wash out of carbon dioxide from anatomical dead space, a degree of positive end expiratory pressure (peep) – aiding with recruitment, constant FiO2 as there is little difference between inspiratory flow of patients and delivered flow. The humidified and warmed nature of NHFO aids with mucociliary function and compliance.

This guideline is for use by the following staff groups:

All doctors, registered nurses and physiotherapists who deal with patients requiring NHFO.

Lead Clinician(s) Andrew Crawford	Consultant, Respiratory
Approved by Respiratory Department Meeting on:	August 2025
Review Date: This is the most current document and should be used until a revised version is in place	August 2028

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

Key amendments to this guideline

Date	Amendment	Approved by:
	New document	Respiratory Department Meeting

Abbreviations

NHFO – Nasal high flow oxygen
ABG - Arterial Blood Gas
CBG – Capillary Blood Gas
CPAP – Continuous Positive Airway Pressure
NIV – Non-invasive ventilation
PaO_2 – Partial pressure of oxygen in blood
$PaCO_2$ – Partial pressure of carbon dioxide in blood
FiO_2 – Fraction of inspired oxygen
ARU – Acute Respiratory Unit
ITU – Intensive Care Unit
CCOT – Critical Care Outreach Team
PPE – Personal Protective Equipment
DNACPR – Do not attempt Cardio pulmonary resuscitation

Competencies required

NHFO is a medical intervention that should be requested by medical staff or used as part of a closely monitored treatment plan by appropriately trained physiotherapists or nursing staff.

Set up of the equipment or alteration of settings must be by a health care professional (doctor, registered nurse or physiotherapist) who has received appropriate training and achieved skill based competencies. (Appendix 1 and 2)

NHFO is currently available in Critical Care, ARU and Surgical HDU at Worcester Royal Hospital, and in Critical Care and Ward 5 (Respiratory Support or Marlow Unit) at the Alexandra Hospital, Redditch. The provision of this guideline is solely for the use of NHFO on the Acute Respiratory Unit at Worcester Royal Hospital and Ward 5 at the Alexandra Hospital.

Inclusion criteria/Patients covered by this guideline

- Patients with hypoxemia/Type 1 respiratory failure defined as a PaO_2 of below 8kpa and a normal $PaCO_2$
- Patients with increased work of breathing
- Patients unable to tolerate mask therapy where oxygen requirements are high or increasing
- Patients weaning from NIV/CPAP
- Patients with increased secretion viscosity and an impaired ability to clear secretions

Patient groups who should be excluded from HHFNC

Absolute contraindications

- Profound hypercapnia/Type 2 respiratory failure requiring NIV or mechanical ventilation
- Profound hypoxaemia /Type 1 respiratory failure requiring CPAP or mechanical ventilation
- Patients with new basal skull fractures
- Patients with cerebro-spinal fluid leaks
- Abnormalities of nasal passages or recent nasal surgery
- Epistaxis
- Respiratory arrest, peri-arrest or apnoea
- High risk of bleeding, including deranged clotting and/or low platelets
- Exacerbation of Asthma

Relative contraindications

- Patients at risk of acute hypercapnic /Type 2 respiratory failure secondary to oxygen delivery
- Progressive Interstitial Lung Disease

Initiation and initial monitoring of HHFNC

Ward based Nasal high flow oxygen delivered on ARU or Ward 5 should be considered in patients who have a persistent oxygen requirement greater that 60% FiO2.

Nasal high flow should be considered where there is evidence of acute reversible respiratory pathology that requires temporary support with an increased FiO2 whilst other medical treatment is provided. Examples of this would include acute community acquired pneumonia and infective exacerbation of intestinal lung disease. NHFO would not be recommended in patients with hypoxia as part of a progressive deterioration in a chronic condition, examples of this would include aspiration pneumonia with a background of progressive dementia and known progressive fibrotic ILD without reversible pathology.

Patients should have clear decisions about escalation of care as ward based nasal high flow does not replace the need for admission to ITU for CPAP or invasive ventilation. The FLORALI trial (Frat JP et al 2014) showed that NHFO did not reduce intubation rate in immunocompetent individuals. In patients who are for invasive ventilation, there should be consideration about provision of NHFO in a Level 2 enviroment incase the need for intubation arises

Esclation decisions should be discussed with the patient/relative and documented in the medical notes. Ideally this should be done before NHFO is started; however in some situations it may be appropriate to commence NHFO immediately, in order to prevent delays in optimal management.

Patients who present with decompensated type 2 respiratory secondary to conditions including COPD, OHS and neuromuscular disorders should not be started on NHFO. Instead they should be managed with acute non invasive ventilation as per the British Thoracic Society Guideline, Respiratory physios are available in hours via bleep 303 and out of hours via switchboard.

Acute pulmonary oedema should be managed with CPAP via CCU and patients with covid pneumonitis and high oxygen requirement should be managed with CPAP rather than NHFO

Before commencing NHFO, an ABG (Ref: WAHT-RES-006) should be obtained in order to assess both the extent of hypoxaemia and possible carbon dioxide retention.

The decision to start nasal high flow should be made by a doctor of consultant or registrar level. When available, advise should be sought from either the respiratory consultant of the week or respiratory registrar to aid with decisions about NHFO. In some situations, it may be appropriate for NHFO to be set up by a suitably trained senior nurse or physiotherapist; however the patient should be reviewed by the medical team and CCOT/ Hospital at night team as soon as possible, preferably within 2 hours of commencement

Flow rate should be titrated according to the patient's comfort, respiratory rate, oxygen saturations and PaO_2. FiO_2 should be titrated to meet target saturations as prescribed on the Drug Chart. Please refer to WAHT-RES-001 for guidance on setting target oxygen saturations and prescribing oxygen therapy.
The patient should be on continuous pulse-oximetry and have hourly observations recorded for a minimum of four hours, continuing with routine observations as recommended in WAHT–RES-001.
An ABG/CBG should be obtained 30-60 minutes after commencing treatment (Ref: WAHT-RES-006/7) where clinically indicated.

It is recommended that patients requiring a flow of ≥ 40L/min and/or FiO_2 of ≥ 60% are nursed in a monitored bed.

<u>Set up</u>

- Explain procedure/equipment to the patient and gain consent where possible (refer to consent policy)
- Wash hands and wear appropriate PPE
- Check disinfection status of unit (Appendix 3)
- Position patient comfortably, sitting upright if possible
- Unpack and set up the equipment, following the instructions in Appendix 4
- When equipment is ready, connect to the patient as shown in Appendix 4
- Ensure nasal cannula do not occlude nasal passage
- Choose appropriate settings for Temperature, Flow and FiO_2

  Temperature *usually set at 37ºC but can be reduced to 34ºC/31ºC if not tolerated by the patient*
  Flow *set between 10 and 60 L/Min –Higher respiratory rates are likely to require higher flows – titrate according to patient comfort and measurable markers – respiratory rate, work of breathing, Oxygen Saturations*
  FiO_2 *set between 21 -95% to meet target oxygen saturations specified on the drug chart and in the medical notes. Adjusted via oxygen Flow meter.*

If the flow is altered after set up, the FiO_2 will change and will need to be adjusted.

- Place the patient on continuous pulse oximetry.
- Ensure Oxygen is prescribed on the patients prescription chart by the appropriate medical team, with highlighted target oxygen saturations. Record saturation levels on the observation chart and sign the prescription chart if NHFO is being administered at each drug round (Ref WAHT-RES-001)

- Document settings, including Temperature, FiO_2 and Flow, on the observation/ NHFO chart, along with patients clinical observations. Observations and monitoring should then be as above.

Ongoing care

- Ensure that cold air from a window or fan is not directed onto the tubing as this could cause excessive condensation
- If water collects in the tubing, care should be taken to empty it AWAY from the patient by disconnecting the tubing from the water chamber and emptying it into a disposable container.
- This device does not have battery backup and needs to be connected to the mains electricity. Alternative Oxygen (e.g. non rebreathe mask/Humidified circuit) must be available for the patient in case of power/device failure.
- Sterile water bag needs to be replaced when empty
- Nebulisers should be administered via a face mask in the usual way

Treatment failure

Once treatment has been optimised, if there is a failure to reverse hypoxaemia, the patient should be reviewed by the medical team. A decision should then be made regarding either escalation to CPAP/invasive ventilation or palliation of symptoms, as discussed and documented at initiation of NHFO.

NHFO can be continued for palliation of symptoms if appropriate.

Weaning

NHFO should not be stopped abruptly. Weaning should be considered when the patient demonstrates correction of hypoxaemia, reduced work of breathing and an ability to clear their own secretions.
There is little firm evidence of how to wean NHFO. Consensus is that the FiO_2 should be reduced first, and that flow can be gradually reduced (by 5 cmH2O increments) once $FiO_2 \leq$ 50%. The patient can then be weaned onto standard oxygen therapy when tolerated, with monitoring of Respiratory rate and Oxygen saturations during weaning.
Discontinuation may occur sooner if the patient is non-compliant or requires escalation of treatment.

Mobilisation

The patients Oxygen requirements must be considered when mobilising, and a comparable level of portable Oxygen therapy provided, with monitoring of Oxygen saturations and clinical observation before, during and after mobilisation.

Infection Control

The nasal cannula, tubing and circuit are for single patient use only, and must be disposed of in the offensive waste stream (yellow and black stripe). If used on a patient with confirmed or suspected infection, then the infected waste stream (orange bag) must be used. Nebuliser masks or equipment that has been in contact with medicinal products must be disposed of

into the medicinal waste stream (yellow) via either a soft medicinal waste container (Frontier clinisafe) or a yellow topped sharps container.

Schedule for changing accessories:

- Nasal cannula/tracheostomy interface: 1 week
- Tubing and chamber: 1 week
- Air filter – 3 monthly (machine displays a reminder when due)

Following use, the machine should be disinfected as per the manufacturer's instructions – see appendix 3. When this is complete, the electrical equipment should be unplugged and cleaned with a disinfectant wipe then labelled as clean and fit for re-use using the Trust recommended green label system.

The electrical equipment must be serviced and checked for electrical safety yearly.

Appendix 1: Medical Device competency for HHFNC

Appendix 2: Nursing Competency HHFNC

Appendix 3: Disinfection process

Appendix 4: Set up guide

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
P1	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

References

De Klerk A (2008) Humidified High Flow Nasal Cannula. Is it the new CPAP? Advances in neonatal care 8 (2): 98-106

Frat JP, Goudet V, Girault C. (2013) High flow, humidified-reheated oxygen therapy: a new oxygenation for adults Rev Mal Respir 30 (8): 627-643

Gotera C, Diaz Lobato S, Pinto T, Winck JC (2013) Clinical Evidence on high flow oxygen therapy and active humidification in adults Elsevier 19 217-27

Schwabbauer N, Berg B, Blumenstock G, Haap M, Hetzel J, Riessen R. (2014) Nasal high-flow oxygen therapy in patients with hypoxic respiratory failure: effect on functional and subjective respiratory parameters compared to conventional oxygen therapy and non-invasive ventilation BMC Anesthsiol 66 (10) 1186-1471

Frat J. P., Thille A. W., Mercat A., et al. High-flow oxygen through nasal cannula in acute hypoxemic respiratory failure. New England Journal of Medicine . 2015 Jun; 372(23):2185–2196.

WAHT-RES-001: Guideline for the Prescribing, Monitoring and Administration of Oxygen in Adults: Version 4, January 2014

WAHT-RES-006: Arterial Blood Gas Sampling for Trained Professionals: Version 2, September 2012

WAHT-RES-007: Ear Lobe Capillary Blood Gas Sampling for Respiratory Practitioners: Version 1, December 2013

Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
Dr Hooper
Dr Raven
Medicine Governance Team

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Respiratory Department Meeting

Appendix 1

Medical Device Competency - NHFO

Make (s) and Model (s)

1) _____

PERFORMANCE CRITERIA:	Attained	Deferred	Date	Signature of Assessor
Discuss appropriate practice with reference to Infection Control and Health and Safety • Pre-operational safety checks including disinfection status • Hand washing/alcohol gel • Transportation of device • Positioning of patient and clinician				
Discuss and demonstrate safe practice of setting up of the NHFO device. This should include the function of all switches, dials, indicators and display				
Discuss and demonstrate how the machine should be applied to the patient and including • Assessment of required nasal cannula size • Assembly of water bath, fluid feed bag, tubing and nasal cannula • Correct fitting to patients face • Clear explanations to patient regarding treatment				
Discuss the clinical indications for use, including choice of initial settings and explain setting changes in a variety of clinical situations				
Discuss and know the contraindications and precautions for NHFO				
Discuss the procedure to be followed should NHFO device be working incorrectly				
Discuss and demonstrate appropriate note writing with reference to the use of NHFO • Recording of settings(FiO_2/flow/ /temperature) • Use of NHFO observation chart/ High Care charts				
Discuss and demonstrate understanding of principles and practical application of removal of NHFO for mobilisation and weaning from NHFO .				

ASSESSMENT SPECIFICATION: **The candidate should be able to demonstrate competence using the specified NHFO devices using the following knowledge evidence and performance criteria**

KNOWLEDGE EVIDENCE: **The candidate should be able to:**

a) Demonstrate knowledge of local guidelines for NHFO
b) Demonstrate an awareness of the Medical Devices Training Policy – in particular the criteria for authorised users of medical devices.
c) Discuss potential problems/contra indications that may be encountered and how to prevent/resolve them
d) Discuss their role, responsibility and accountability with reference to the most up to date clinical guidelines and rules of professional conduct
e) Discuss safety aspects of the procedure and disposal and storage of equipment

Competencies may be assessed by designated individuals within each area. Individuals would have attended a trust recognised training programme for this device. This may be training provided by Worcestershire Acute Hospitals NHS trust or external training.

If the candidate still feels they lack competence or have been deferred in any aspect they should contact their Line manager for further advice, training and support.

- **Any problems, please contact Professional Development on 01905 760600 or Ext 33742**

I declare that I have supervised this practitioner and found Him/her to be competent as judged by these knowledge and performance criteria.

Key Trainer (please print) ----------

Signature---------- **date**----------

I declare that I have expanded my knowledge and skills undertaken to practice with Accountability for my decisions and actions in Accordance with WAHT trusts policies for the above medical device.

Candidate (please print) ----------

Role/Band ----------

Signature---------- **date**----------

Worcestershire Acute Hospitals NHS Trust

Appendix 2

Worcestershire Acute Hospitals NHS Trust
ASSESSMENT OF COMPETENCY FOR USE OF NHFO

ASSESSMENT SPECIFICATION: **Where the Oxygen competency is used within the Trust, this should be completed prior to NHFO competency**

The candidate should be able to demonstrate competence in the setting up and administration of Humidified High flow Nasal Cannulae (HHFNC) using the following knowledge evidence and performance criteria.

KNOWLEDGE EVIDENCE: The candidate should be able to:

a) Discuss the knowledge based evidence/rationale for safe administration of oxygen via the NHFO device Airvo2.
b) Explain roles, responsibilities and accountability with regard to the safe administration of NHFO in reference to the Code of Professional Conduct.
c) Discuss the indications, contraindications and risks with this method of oxygen administration.
d) Understand the need for patient monitoring throughout therapy and the importance of titrating and weaning oxygen.
e) Demonstrate safe device setup and application of NHFO
f) Discuss safety aspects of the procedure and strategy rationale for complications and monitoring.
g) Demonstrate correct daily and weekly cleaning requirements and correct disposal of equipment as Trust Guideline

Clinical Supervisor (*please print)* ..... Signature..... Date .....

Candidate (*please print)* ..... Signature..... Date.....

Ward/ Department .....Directorate .....

Comments by Supervisor	**Comments by Candidate:**

When you have completed your competencies a copy should be retained as evidence of your competency for your professional portfolio and a PHOTOCOPY of this form sent to your manager for your personal folder and to Training & Development, Charles Hastings Education Centre, WRH.

Worcestershire Acute Hospitals NHS Trust
PERFORMANCE CRITERIA FOR ASSESSMENT OF COMPETENCY FOR ADMINISTRATION OF HUMIDIFIED NASAL HIGH FLOW OXYGEN THERAPY

PERFORMANCE CRITERIA	1	2	3
1 Patient Preparation			
Ascertain appropriateness of NHFO			
Ensure oxygen is correctly prescribed on the prescription chart with highlighted target saturations			
Explain procedure and obtain consent where possible			
Record patients observations			
2 Preparation of equipment			
Check disinfection status of device			
Select appropriate interface (cannulae should not occlude nostrils)			
Select appropriate equipment for device setup.			
Assemble the Airvo2 correctly ready for application.			
3 Procedure			
Ensure patient is in an appropriate and comfortable position			
Switch on Airvo2			
Adjust settings of temperature and flow according to Trust Guideline			
Adjust Fi02 according to Trust Guideline			
Connect the patient to the Airvo2 as per Trust Guideline			
Trouble shoot problems with therapy e.g Leak, blockage, oxygen concentration too high			
Check/Monitor patients oxygen saturations			
Ensure patient feels comfortable and vital signs are stable			
4 Documentation and Monitoring			
Document procedure and record observations in patient notes			
Sign prescription chart at each drug round whilst NHFO is in use			
Acknowledge any required cleaning, maintenance or equipment replacements on a daily and weekly basis as per manufacturer instructions and Trust Policy			

I declare that I have supervised this practitioner and found him/her to be competent as judged by these knowledge and performance criteria

Clinical Supervisor (*please print*): .....

Signature: ..... **Date:** .....

Appendix 3

Cleaning and Disinfection of NHFO

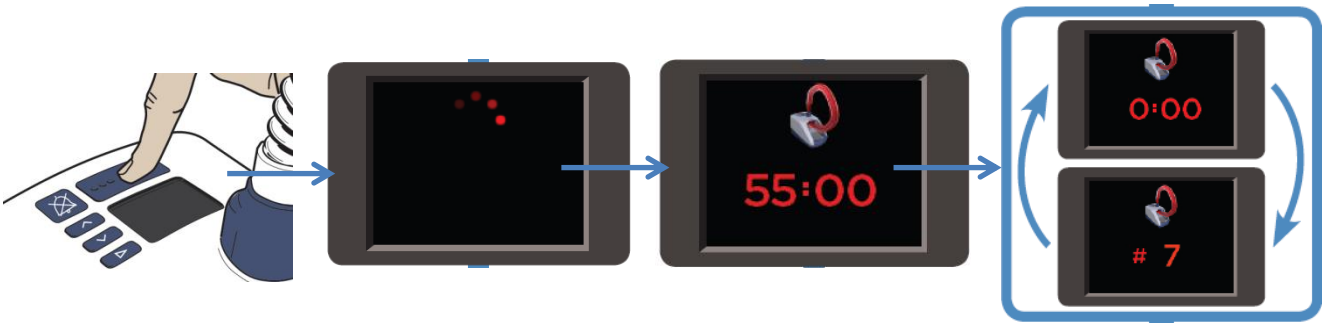
After each individual use the Airvo 2 needs to be cleaned and disinfected before use on another patient.

Step 1: Discard previous Tubing

All tubing is single patient use, therefore disconnect and discard the nasal cannula, tubing circuit, chamber and irrigation bag as per guideline

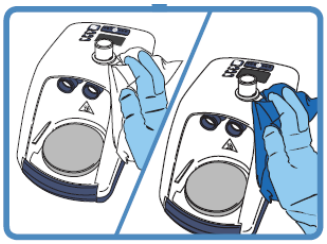
Step 2: Connect Disinfection Tubing

Step 3: Start the Cycle



Connect the machine to the mains once tubing is in place. Press the  button and the disinfection cycle will be begin. This will take 55 mins, when it has finished the count will be at 0:00. At this point turn the machine off  BEFORE turning the power off at the wall.

Step 4: Clean the machine with Clinell sanitising wipes (green packet)



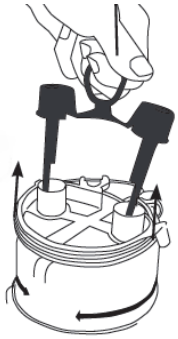
Step 5: Label Machine as clean and fit for re-use using the Trust recommended green label system.

Appendix 4: Setting up of NASAL HIGH FLOW OXYGEN THERAPY (NHFO) Circuit

Step 1: Ensure the machine has been disinfected

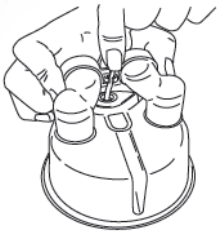
See cleaning and disinfection in Appendix 3

Step 2: Unpacking and connecting the circuit

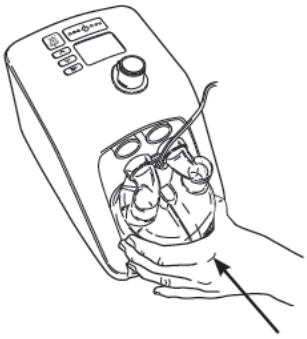


a).Discard the blue cover, unwrap the drip line, and remove plastic ring

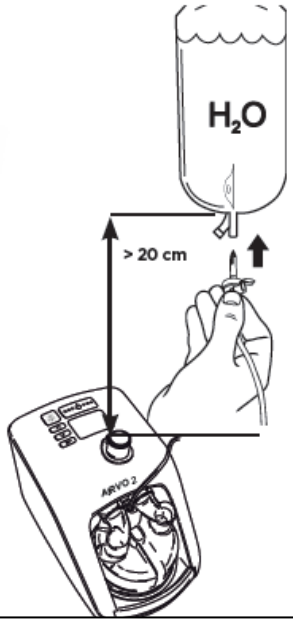
b).Pull the drip line over the front of chamber along the central groove. Then connect the clear adaptor as above.



c).Pull the drip line up from groove to clip into adaptor as above



d).Depress the front lip of the machine and slide the chamber inside, ensuring that the adaptor connects onto machine correctly, as above.

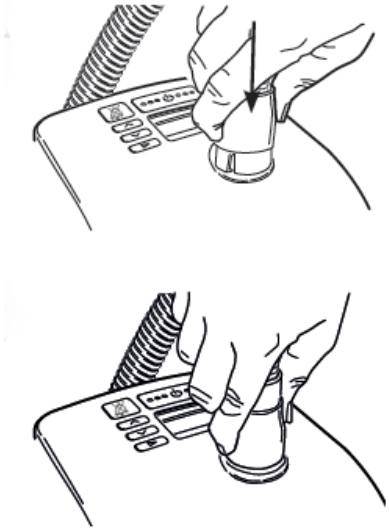


e).Connect drip line to **STERILE WATER bag**

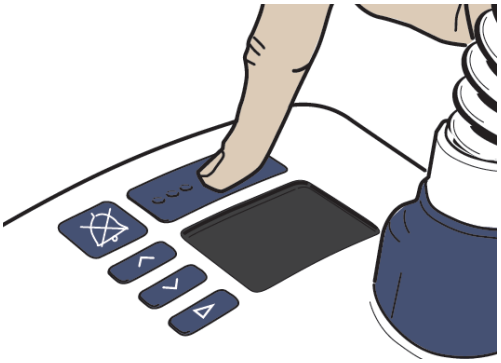
Step 3: Connecting Oxygen

50L Machine: Use High flow meter provided to connect the oxygen from the wall to port on the side of the machine using green oxygen tubing
60L Machine: Connect the white Oxygen Pipe directly into the oxygen port at the wall. You will then need to use green oxygen tubing to connect the flow meter (which is attached to the unit stand) to the port on the side of the machine.

Step 4: Connecting tubing circuit and interface



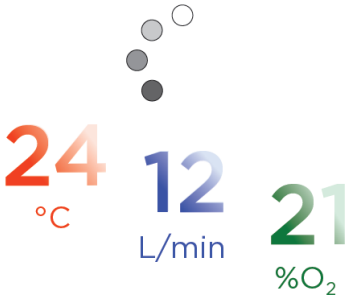
Clip tubing circuit ensuring pins are correctly aligned. Push down blue outer cover to secure.



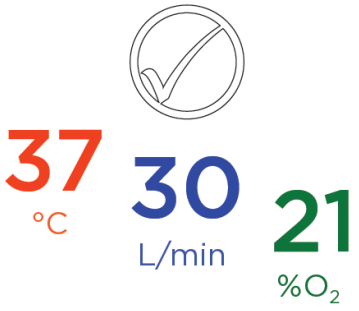
Ensure machine plugged into mains and turn on by holding down on/off button

Once turned on, the above screen will appear if the device is clean for new use. (NB, if the device has already been set up on a patient and simply turned back on after brief period off, an amber light will appear and it is ok to connect to the same patient)

If the RED light appears, DO NOT USE – The machine needs disinfecting first

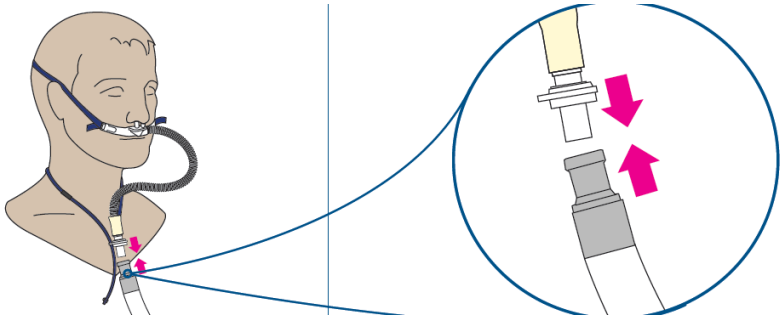


While the machine gets ready, the above screen will show



When the machine is ready for use, a beep will sound, and a tick will appear. You are now ready to connect to the patient

Step 5: Connecting to the patient

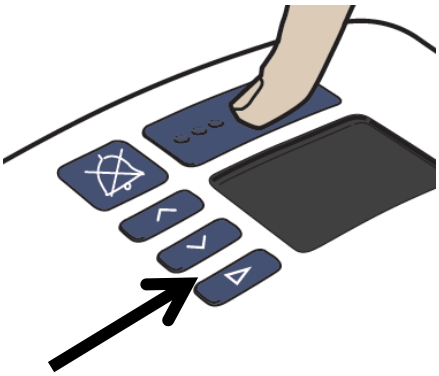


Connect the tubing circuit to the nasal interface by clipping firmly into place. Place lanyard of the interface around the patient's neck and tighten as appropriate to relieve any pulling from the tubing. Fit the nasal prongs to the patient, ensuring they are facing the correct way i.e. the curve in the prongs should be pointing towards the patient.

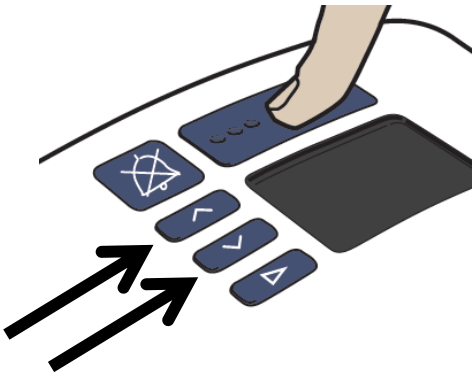
Step 6: Adjusting parameters

A: Temp
B: Flow Rate
C: FiO2

Firstly you must unlock the machine to be able to adjust the parameters:



Press the mode button to cycle through the menu to select which parameter to change.
YOU CAN ONLY CHANGE TEMP OR FLOW RATE THIS WAY.
(See below for FiO2)



Press and hold the up/down arrows together until you hear a beep to unlock the machine. Then use the same buttons to go up or down on the settings. The machine will automatically lock with the new settings after a few seconds

To change the FiO2, use the oxygen flow meter. As you increase or decrease the O2 flow the machine will adjust the FiO2 it is delivering to the patient, and display the percentage on the display screen.

If the flow is altered after set up, the FiO_2 will change and will need to be re adjusted.

Paediatric settings can be accessed if needed by pressing and holding the mode button for 5 seconds. This will limit available settings to 34 ºC and 5-20 l/min.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	Name	Job title	e-mail contact
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title:			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ❑ New activity			

	❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				
Religion & Belief				
Sex				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be				

revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.