University Hospitals of Morecambe Bay NHS Foundation Trust

Document Type: **Procedure**	**Unique Identifier:** RAD/LOCSSIP/001
Document Title: **Local Safety Standards for Invasive Procedures (LocSsips) for:** **4 Steps For Patient Safety for Radiological Procedures including One Stop Breast Clinic**	**Version Number:** 1.1 **Status:** Ratified
Scope: Multi-Disciplinary Teams that are involved in the patients' interventional procedure episode	**Classification:** Departmental
Author / Title: Sue Wroe, Governance Project Lead NatSsips Quality & Governance	**Responsibility:** Radiological Teams: X Ray Department One Stop Breast Clinic
Replaces: Version 1, LocSsip for 4 Steps For Patient Safety for Radiological Procedures including One Stop Breast Clinic, Rad/LocSsip/001	**Head of Department:**
Validated By: Core Clinical Services Procedural Document Group	**Date:** 06/07/2017
Ratified By: Core Clinical Services Divisional Governance and Assurance Group	**Date:** 26/07/2017
Review dates may alter if any significant changes are made	**Review Date:** 01/08/2019

Which Principles of the NHS Constitution Apply? 1,2,3,4	**Which Staff Pledges of the NHS Constitution Apply?** 1,2,3

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: No

Reference Check completed by Tracey Roberts Cuffin Date 10/7/17

To be completed by Library and Knowledge Services Staff

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1. SUMMARY

Delivering patient care through a process of logical, timed and co-ordinated safety standards provides a quality framework for all patients who undergo interventional procedures at UHMB.

Harm free and compassionate care is a fundamental element of the University Hospital Morecambe Bay (UHMB) vision. All healthcare staff who participate in a patients' journey have a common goal which is to prevent harm and deliver safe patient care to the highest standards.

A wrong interventional procedure, or the incorrect patient, or the wrong anatomical site is rare. However, should any of these untoward events occur, experience has shown that they have a devastating impact on both patient and staff, which could affect the patient outcome.

The standards within this document have been developed to reduce the likelihood of these occurrences known as '**never events'**. Working in harmony with the principles of the World Health Organisation (W.H.O.) checklist they facilitate teams in delivering consistently high safe standards of patient care.
Further benefits of delivering care through these standards and the checklist process supports:

- Effective team communication and team harmony,
- A Systematic process for verification of the correct patient,
- An assurance that the correct procedure is consented for ,
- An assurance that (if applicable) that the correct site procedure occurs,
- Correct insertion of the right implant or device occurs,
- Specimens are verified, which ensures correct patient diagnosis.
- An opportunity to reflect and continuously improve at local level.

Audit, benchmarking, feedback and an open learning culture are crucial elements to successful and effective procedural teams. Procedural teams at UHMB through undertaking qualitative and quality audits will provide a mechanism to measure, benchmark, learn and improve from.

2. PURPOSE

The purpose of the UHMB 4 steps for Interventional Procedures is to foster a Safety Culture by ensuring patient safety through universal best practice The 'LocSsips' in this document with robust use and adherence to the 'Time Out' Checklist ensures consistent, safe, and effective care for all patients undergoing an interventional procedure.

3. SCOPE

LocSsips are to be embedded in the culture and are crucial standards that must be applied consistently for all patients who attend for an interventional procedure across all the Trusts hospital sites. UHMB requires that **all staff** who are involved in the clinical interventional pathway embrace and participate in :-

- Safety Briefings
- Sign in
- Time out
- Sign out
- Debriefs

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The Procedural team leader for the list should ensure a hard paper copy of the checklist is completed and retained in the patient notes as a mandatory standard of record keeping and to ensure it is available for audit.

4. PROCEDURE

4.1 4 Steps For Patient Safety for Radiological Catheter Lab

4.1 <u>STEP 1</u> List Safety Briefing

- Prior to commencement of any elective, procedural list a 'Safety Briefing' which involves key members of the team as a minimum (ideally all the team) must take place.
- The purpose of the brief is to discuss the sessions' list schedule of planned interventional procedures.
- The area used should be quiet and free from interruptions.
- The brief may be led by any designated member of the team
- All staff members of the procedural team are named for the session and roles identified.
- The procedural list must be visible throughout the session for staff in all areas involved in the procedural list. (This includes holding areas for patients)
- Any anticipated milestones or challenges must be considered, and plans put in place if necessary.
- Equipment checks should have already been performed and any issues highlighted, and actions put in place to address if required.
- Procedures involving implantation of devices must be discussed and availability of devices verified for the list, the list operator must confirm that they approve the device availability.
- If it is necessary to change the list order, a new printable list must be produced and communicated. (All staff should be familiar with the List Change LocSsip and follow the safety steps outlined in the LocSsip for doing so.)
- In the event of staggered admission times, a safety briefing must be undertaken for each successive list of patients for each discrete admission time

4.1.2 STEP 2 Procedural Sign In (2A) and 'Time Out' (2B)

Sign in and Time Out are safety processes whereby the prompts on the checklist ensure verification of the correct patient, procedure, which side and which implants/devices will be required.
Conscious and coherent patients should actively be encouraged to participate in these processes.

Sign In 2A

- The Sign in verification process must be performed by two team members, one will be the Operator and the other will also be involved in the procedure.
- The questions will be undertaken verbally in a clear, precise and audible tone, with the patient, their family or carer.
- The process must have both the two's checkers full attention to confirm sign in. No other task should be undertaken until this is completed.

Time Out 2B

Time out must be undertaken with all the team present and everyone must engage and give their full attention

- The steps on the checklist must be led by a trained Healthcare professional in a clear and audible manner.
- All Team members must 'stop and pause' whilst the checklist questions are asked and responded to, hence this part of the safety process is known as 'time out'.
- If there is an interruption, the 'time out' must be suspended and recommenced.
- Every team member is valuable and should feel comfortable and at ease to raise any questions or concerns they have relating to the case at this time.
- The patient should once again be included where possible in the time out.
- Team members must not enter or leave the procedural room during this time.

4.1.3 STEP 3 Sign Out

Sign Out when the procedure is completed

All patients who have undergone an interventional procedure must undergo safety checks at the end of the procedure before leaving the procedural room.
Any team member who has been involved in the procedure should not leave the room until this is completed and verified as correct

- The nominated Healthcare professional leading time out will request that all the team is present and ask the team to 'stop and pause'.
- The set questions on the designated section of the Checklist are then directed to the appropriate team member/s, who will verbally respond to the questions being asked.
- Any specimen taken must be confirmed visually that it is labelled correctly.
- Implant/device insertion logs and securing of stickers must be confirmed.
- Finally prior to transfer to the recovery/discharge area the team will review any key

plans or concerns for the handover.

- **A member of the procedural team must participate in the patient handover to the recovery/discharge area**
- The 'Time Out' sheet is then signed by a registered healthcare professional and retained in the patient's notes as evidence.

4.1.4 STEP 4 List De Briefing

National Safety Standards of compliance with debriefing state this can only occur after the last patient on the list has been transferred out of the procedural room to the recovery/discharge area.
There are also some mandatory requirements of which specific team members must be present at a debrief:

- The Operator, (this is staff member who has undertaken the procedural interventions on the list).
- Any confident team member can lead the debrief
- All members of the procedural team will have note any key points for consideration that arise throughout the list; these are presented for consideration at debrief.

All members of the team attending debrief should feel comfortable enough to contribute to the debrief discussion and raise any concerns or questions.
Any questions included in the debrief are professional and not personal and are to designed to facilitate reflection, share learning, and make improvements where appropriate.
The leader of debrief will always ensure that what went well during the list is discussed at this feedback session.
Debrief templates are encouraged to be localised, however all debriefing templates must be approved in line with the Trust Governance Processes, for procedural documents.
Examples of questions for discussion and consideration should include:

- Communication – *any issues for* improvements*?*
- Team Harmony – *for example was the best use of skills utilised?*
- Planning - *were there any planning issues, i.e. list order, missing stock how can we improve?*
- Equipment failures *what were the issues? Has the problem been resolved? What action is required? Will it impact on a forthcoming list? Who is taking responsibility to ensure actions and relevant communication are followed through?* See section 4.2 of these standards.
- The need to raise a C.I. R. – *is there one?*
- Identification of training or development that could benefit the team

The above list is not inclusive and wider learning and sharing may be an outcome from any theatre debrief.

Debriefs should be retained for analysis by the audit team.

Monthly Audits will be undertaken in the work area to ensure Debrief actions:

- have been logged

- reviewed
- lessons learned have been shared with MDT team at Staff meetings

The Governance Lead in conjunction with the Matron will ensure that quarterly reports of any themes are produced and the learning outcomes are included in the Division's learning lessons bulletin.

4.2 Non-routine issues with malfunctioning equipment

If medical equipment is thought to be the cause of an incident, it is important to follow these steps:

- Quarantine - The Medical Device and all associated equipment/consumables should be removed from service. The settings of the device should not be changed or adjusted.
- Record - One of the most important pieces of detail to include in the Trust incident report is the correct identification of the equipment through asset number, make, and model, type of equipment, site and location. Without this a technical investigation cannot commence.
- Evaluate - If a technical investigation or evaluation is required, then the originator or manager should request this through the Medical Engineering Department.

It is Trust policy that Medical Device Users should report incidents internally and any decision relating to reporting an incident to the MHRA will be approved by The Trust Medical Device Department with the Risk Office.

Radiology Equipment

- Quarantine-Radiology equipment and all associated equipment/consumables should be removed from service. The settings of the equipment should not be changed or adjusted. The equipment Preventative Maintenance provider should be informed and a date arranged for equipment review.

Record

- The Radiology equipment asset number, make, model, type of equipment, site and location must be logged; all exposure factors used and projections undertaken along with patient height and weight should be recorded. If there is reason to suspect that a patient has received a radiation dose much greater than intended, IRMER procedure for reporting a potential incident of over exposure to a patient should be followed

Evaluate

- Advice should be sought from the Preventative Maintenance provider as to the nature of the fault and recommendations. The incident should be reported also Radiation Protection Advisor to the Trust for their evaluation and recommendations. The incident may require reporting to external agencies,

HSE, CQC as part of these recommendations. Any recommendations must be shared with the Risk Office.

5 ATTACHMENTS	
Number	**Title**
1	Description of NatSsip
2	Safety Briefing
3	Safety Debrief
4	Procedural Room Safety Prompt Checklist for One Stop Interventions
5	Procedural Room Safety Prompt Checklist for Radiological Interventions
6	Equality & Diversity Impact Assessment tool

6 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Proc/022	Reporting and Management of Incidents including Serious Incidents http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx
Corp/Strat/001	Risk Management Strategy http://uhmb/cs/tpdl/Documents/CORP-STRAT-001.docx
Corp/Pol/089	Medical Devices Management http://uhmb/cs/tpdl/Documents/CORP-POL-089.docx
Corp/Proc/057	Policy for Consent to Examination or Treatment http://uhmb/cs/tpdl/Documents/CORP-PROC-057.docx
Rad/SOP/001	MBCC - Radiographic Imaging for Elective Radiological Catheterisation and Coronary Angiography http://uhmb/cs/tpdl/Documents/RAD-SOP-001.docx

7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	WHO Surgical Safety Checklist (Patient Safety Alert Update 26 January 2009)
2	NatSsips National Safety Standards for Invasive Procedures NHS England September 2015

8 DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
W.H.O	World Health Organisation
C.I.R.	Clinical Incident Report
N.B.	Note Well
I.R.M.E.R	Ionising Radiation Medical Exposure Regulations 2000
H.S.E	Health and Safety Executive
C.Q.C	Care Quality Commission
M.H.R.A	Medicines and Healthcare products Regulatory Agency

9 CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
Radiology Audit Group		12/01/2017
Caroline Kelly	Lead Nurse Radiology	18/05/2017
Dr G Mataka	Radiologist	18/05/2017

10 DISTRIBUTION PLAN	
Dissemination lead:	
Previous document already being used?	No
If yes, in what format and where?	Trust Document Library
Proposed action to retrieve out-of-date copies of the document:	N/A
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Document Library

11 TRAINING Is training required to be given due to the introduction of this procedural document? Yes		
Action by	**Action required**	**Implementation Date**

12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1		All	New	01/08/2019
1.1	14/11/2017	Appendix 5	Added/updated	01/08/2019

Appendix 1: Description of NatSsip

Description of NatSsip which are mandatory inclusion in this LocSsip. The mandatory standards in this document are not all the standards required for prosthesis verification , the only inclusion is what is relevant to this particular standard	By Whom/How	Where identified	Inclusion achieved
Pre list Safety briefing for interventional procedures as identified by NatSsip NatSsip Standard 4.7	Procedural team plus other key members	Page 4	Yes
Sign in standards NatSsip Standard 4.8	Operator and 1 other plus patient.	Page 5	Yes
Time Out Standards NatSsip 4.9	Procedural team	Page 5	Yes
Sign Out Standards NatSsip 4.12	Procedural team to handover team	Page 6	Yes
Debriefing Standards (to include feedback mechanism for anyone not present to raise concerns) NatSsip 4.13	All	Page 6 & 7	Yes
Mechanism for communication , audit and learning NatSsip 4.13	All	Page 7	Yes

Appendix 2: SAFETY BRIEFING (THIS OCCURS PRIOR TO THE START OF THE RADIOLOGY PROCEDURAL LIST.

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Attendees of this brief must include the Operator, plus the Key Staff as defined in 4 Steps to Procedural Safety

Date ----------/----------/---------- Please Specify AM or PM

List Specifics Include assigned consultant on Radiology CRIS & Lorenzo) ……

1.1 THE PRE LIST SAFETY BRIEFING

Each team member will state their name and role for the procedural list.

- ☐ Completed (Please log the information in the space provided in the adjoining column)
- ☐ Confirm the list order

Confirm availability & working status of the following equipment for the list:

- ☐ Access Needles
- ☐ Guidewires, all required lengths
- ☐ Catheters, all required lengths & French sizes
- ☐ Sheaths, dilators, all sizes
- ☐ Drains -
- ☐ Stents -
- ☐ Gastric Sets / Entuit Set & Anchor Suture

The operator must confirm they are happy with all available **stents** and **implantable devices** for the scheduled list. The list order must be confirmed.

- ☐ Confirmed

Are there any specific patient issues that the team should be aware of? Y / N (Please circle)

If yes state any actions required below

……

……

1.2 LOG OF TEAM ROLES AND NAMES

The Procedural team

1. Name of the Consultant Radiologist who is The 'Operator'.

……

2. The Team supporting the procedural list must be listed below by name and grade and include any staff who are assigned to the recovery area.

	Radiologist
	Scrub Nurse
	IV Nurse
	Circulating Nurse
	Radiographer

1.3 NOTES/ACTIONS FOR THIS LIST

On occasion visiting non department medical professionals may be present.
Any non- department visitors will have been identified and approved by the departmental manager in accordance with Trust Policy. **They must be logged in the notes/Action section of this document**

Safety Briefing Completed by:_____ Professional ID Stamp

Appendix 3

ALL TEAM MEMBERS MUST STOP AND PARTICIPATE IN THE STEPS OF THE DOCUMENT

RADIOLOGY PROCEDURAL LIST SAFETY DEBRIEF

Team Debrief-the entire team should attend this meeting *at the end* of the list after the last patient has left the treatment room.

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Date ...../...../..... am/pm **Operator** .....

TEAM in ATTENDANCE (Insert Name & Role in the Table)

- The 'Operator' must attend debrief – if the operator is not present this must be logged and the reason of absence.
- All members of the team should feel comfortable and able to raise any concerns or questions in this session.
- The prompts in debrief are professional, not personal. They are designed to promote a safety culture and facilitate reflection, share learning and, where appropriate, make improvements

	Radiologist
	Scrub Nurse
	IV Nurse
	Circulating Nurse
	Radiographer

****

Log any actions in the last column, follow them through and share learning with all departmental staff

****

SAFETY DEBRIEF DISCUSSION

What went well today? What was really good?

.....

Did the team communicate effectively? Are there any areas for improvement?

.....

Did the team work well together? Were skills best utilised within the team? .....

Were there any planning issues?

Any procedural equipment problems?

.....

Were there any X-Ray equipment issues? **Y / N**

Details -

.....

Is there a need to raise a **Clinical Incident? Y / N**

If so, submitted by .....

☐ **Does anyone in the team wish to raise any particular concerns in relation to any of today's list that we have not discussed?_____**

☐ **Have any Training or Development needs been identified? _____**

AGREED ACTIONS FROM THE DEBRIEF DISCUSSION

☐ .....

.....

.....

☐ .....

.....

.....

☐ .....

.....

.....

☐ .....

.....

.....

Scanned for Audit? Y / N

By ..... on ...../...../.....

Debrief completed by **Date ..../...../.....**

Appendix 4.

PROCEDURAL ROOM SAFETY PROMPT CHECKLIST for ONE STOP INTERVENTIONS

ALL TEAM MEMBERS MUST STOP AND PARTICIPATE IN THE STEPS OF THE DOCUMENT

University Hospitals of Morecambe Bay NHS Foundation Trust

Attach Patient Addressograph here

Date…… Site……Area/Room ……

SIGN IN /TIME OUT TO TAKE PLACE BEFORE THE PROCEDURE BEGINS

Can all team members confirm who they are and their role during this procedure?

Confirmed = ☐ Tick for yes

In the presence of the team, and with the patient, The Team Leader confirms the patients identity, and that the planned procedure and site:

1. Corresponds with the surgical site marked and with the procedural list schedule ☐ n/a
2. The consent form is signed by the patient / (carer) ☐ 7g VAB
3. That essential imaging has been reviewed ☐

Does the patient have a known allergy? **Confirmed** = YES NO (circle)

If **YES,** name of allergy and any actions: ……

Have risk factors for bleeding / renal failure been checked? YES NO NA (circle)

If **yes** – state any dates and relevant results.

……

Do you have a history of cancer? (circle) NO YES (enter details below)

……

Are all I.R.M.E.R .requirements met?

State any actions ……**Confirmed** = ☐ Tick for yes

Confirm the X-Ray equipment is tested & there is availability of all required equipment?

Confirmed = ☐ Tick for yes

SIGN OUT/ - COMPLETED AT THE END OF THE PROCEDURE WHILST PATIENT PRESENT

Will the Team Leader confirm the name of the procedure performed?

…… **Confirmed** = ☐ Tick for yes

If an implant device/s is used, confirm that all labels are logged for traceability?

Confirmed = ☐ Tick for yes

Specimens must have patient identifiable information attached and the site/type must be confirmed by the operator. This must be correctly logged into the specimen record book & the histology request form cross referenced for onward transfer to pathology.

Confirmed = ☐ Tick for yes

Confirm all invasive & procedural equipment is accounted for and disposed of safely.

Confirmed = ☐ Tick for yes

Confirm if there are any procedural or X-Ray equipment concerns.

Confirmed = ☐ Yes No

Are there any incidents which will require a C.I.R. to be logged and who will be responsible?

…… ☐ Tick for Yes

Confirmed = ☐ Tick for No

Confirm that all post procedural management of the patient are communicated and documented in the patient's notes?

☐

<u>Does any member of the team or patient wish to raise any issues or concerns before we commence the procedure?</u> …..………………….…….……………………………………………………………………… SIGNED………………………………………………………………….(Checklist Team Leader)	**Confirmed** = Tick for yes SIGNED……………………………………………………………… (Checklist Team Leader)

Appendix 5:

PROCEDURAL ROOM SAFETY PROMPT CHECKLIST for RADIOLOGICAL INTERVENTIONS
ALL TEAM MEMBERS MUST STOP AND PARTICIPATE IN THE STEPS OF THE DOCUMENT

PLACE LABEL HERE

Attach Patient Addressograph here

Date…… Site……Area/Room ……

SIGN IN /TIME OUT TO TAKE PLACE BEFORE THE PROCEDURE BEGINS

Can all team members confirm who they are and their role during this procedure?

Confirmed = ☐ Tick for yes

In the presence of the team, and with the patient, The Team Leader confirms the patients identity, the planned procedure and site for: (please circle as appropriate)

>14G biopsy & 10G VAB – that imaging has been reviewed Yes / No
>7G VAB – imaging reviewed & the consent form is signed by the patient/(carer) Yes / No
>Hook wire localisation – imaging has been reviewed, consent form signed and these correspond with surgical site marked & procedural list scheduled Yes / No

Does the patient have a known allergy? **Confirmed** = YES NO (circle)

If **YES,** name of allergy and any actions: ……

Have risk factors for bleeding / renal failure been checked? YES NO (circle)
Comments

……

Do you have a history of cancer? (circle) NO YES (enter details below)

……

Are all I.R.M.E.R .requirements met?

State any actions ……**Confirmed** = ☐ Tick for yes

Confirm the X-Ray equipment is tested & there is availability of all required equipment?

Confirmed = ☐ Tick for yes

SIGN OUT/ - COMPLETED AT THE END OF THE PROCEDURE WHILST PATIENT PRESENT

Will the Team Leader confirm the name of the procedure performed?

…… …… **Confirmed** = ☐ Tick for yes

If an implant device/s is used, confirm that all labels are logged for traceability

No implant device used/Not Applicable = ☐ **Confirmed =** ☐ Tick for yes

Specimens must have patient identifiable information attached and the site/type must be confirmed by the operator. This must be correctly logged into the specimen record book & the histology request form cross referenced for onward transfer to pathology.

Confirmed = ☐ Tick for yes

Confirm all invasive & procedural equipment is accounted for and disposed of safely.

Confirmed = ☐ Tick for yes

Confirm if there are any procedural, U/S or X-Ray equipment concerns.

Confirmed = ☐ Yes No

Are there any incidents which will require a C.I.R. to be logged and who will be responsible?
Name:

☐ Tick for Yes

Confirmed = ☐ Tick for No

Confirm that all post procedural management of the patient are communicated and documented in the patient's notes?

Does any member of the team or patient wish to raise any issues or concerns before we commence the procedure? ….. SIGNED……(Checklist Team Leader)	**Confirmed** = ☐ Tick for yes SIGNED…… (Checklist Team Leader)

Appendix 6 - EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function				
Lead Assessor				
What is being assessed?				
Date of assessment				
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Select	
Disability (Including physical and mental impairments)	Select	
Sex	Select	
Gender reassignment	Select	
Religion or Belief	Select	
Sexual orientation	Select	
Age	Select	
Marriage and Civil Partnership	Select	
Pregnancy and maternity	Select	
Other (e.g. caring, human rights)	Select	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.