University Hospitals of Morecambe Bay NHS Foundation Trust

Document Type: **Procedure**	**Unique Identifier:** DERM/LOCSSIP/001
Document Title: **(LocSsip) Local Safety Standard for Invasive Procedures for:** • **Site/Lesion Marking & Verification in Dermatology Invasive Procedures** • **4 Steps to Safe Invasive Procedures**	**Version Number:** 1 **Status:** Ratified
Scope: Operating Dermatologists & Multi-Disciplinary Teams that are involved in the patients' procedural episode.	**Classification:** Departmental
Author / Title: Sue Wroe,Governance Project Lead NatSsips Quality & Governance	**Responsibility:** All Dermatology Procedural Team including the admin team.
Replaces:	**Head of Department:** Simon Glover, Matron
Validated By: Medicine Divisional Procedural Document Group	**Date:** 06/07/2017
Ratified By: Medicine Divisional Governance and Assurance Group	**Date:** 21/07/2017
Review dates may alter if any significant changes are made	**Review Date:** 01/07/2020

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

Evidence Checked Completed by: …….Joanne Phizacklea…….. Date…10/05/207……..

To be completed by Library and Knowledge Services Staff

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1. SUMMARY

UHMB is embracing the NHS England Directive of NatSsips (National Safety Standards for invasive procedures)[1]. A number of services and procedures have been reviewed that will benefit from local safety standards from the National framework known as LocSsips. An invasive dermatological procedure performed on an incorrect patient, the incorrect anatomical site or lesion, are fortunately rare; however, should this happen, it can have a devastating outcome to both a patient and staff.

Overall, the occurrence for wrong site surgery is more of a risk in dermatology than in some other surgical specialities because of anatomic and technical difficulties which are inherent in identifying skin biopsy sites. At UHMB the Dermatology Site / Lesion Procedural Site Marking Classification Standards are supported on the day of surgery by the 4 steps to Procedural Safety through the use of safety checklists

The checklists if used correctly will promote safe behaviours in the team by providing prompts relating to patient safety at the right point in time during the procedure.

It is the consistent practice of these safe behaviours that will eliminate never events in the procedural setting and research has shown that the use of checklists improve patient outcomes

Further benefits of the NatSsips framework and checklists:

- 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 the correct verification of site and or lesion occurs
- A process for correct specimen/s verification prior to onward transfers to pathology
- The list safety briefs facilitates a mechanism for teams to reflect and continuously improve the patients care at a local level.

2. PURPOSE

The purpose of the standards in the LocSsip/s and the localised safety checklists is to improve patient experience and outcomes though embedding safe behaviours and practices. The safety behaviours and standards 'LocSsips' in this document have been formulated to facilitate the procedural team in achieving this.

3. SCOPE

The safety standards in this document must be applied consistently by all staff in the dermatology procedural team for all patients attending the Trust across all the 3 hospital sites.
To ensure safe and consistent patient care UHMB requires that all staff who are involved in the dermatological procedural pathway to participate in the following:-

Undertake all of the 4 steps to safe invasive procedures including:

- Team Safety List Pre and De Briefs,
- Engage and participate in the procedural checklist, ensuring that each patient

undergoing an invasive procedure has received safe care.
- Learn to Improve through the debrief sessions.

At UHMB Surgical Site marking at UHMB is mandatory for all procedures where it is possible to do so.

Operating Dermatologists are faced with a unique challenge that goes beyond the decision of left or right when identifying the correct anatomical lesion and area for surgery. Excisional skin cancer surgery is a common procedure, with no formal consensus for mitigating the risk of wrong-site cutaneous surgery. Often a biopsy site is expected to be identified on a background of severely intrinsically damaged skin, of which scales, erythema or scars from a previous procedure and only a biopsy report indicating nose, or cheek are present.[1]

This LocSsip provides the Operator and Procedural Team with safety steps to navigate these challenging situations. It recognises the problems faced by dermatologists in surgical site marking and provides a classification system known as **simple** or **complex surgical marking** which will ensure safe identification and verification of the operative site/lesion from initial consenting at the outpatient clinic through to on the day surgical marking and verification of this in the procedural room.

4. PROCEDURE

4.1 UHMB Standards For Correct Surgical Site Marking Process and Classification

4.1.1 Procedural Site Marking 'Simple Classification'

Simple site marking is used where there is little or no scope for misidentification of the lesion to be operated upon. This would be in cases of whereby a lesion is singular (not part of a cluster) and the laterality and an anatomical landmark is clearly identifiable by use of written indication..

An example of this is: Biopsy of singular mole left side lower lip.

Who and How to Mark (Simple)

- The process of marking sites classified as simple is undertaken on the day of the admission/procedure, the side, site, & individual lesion must always be verified prior to the procedure with the patient and carer by the 'Operator'.
- An indelible marker pen must always be used, the ink of which is not easily removed by alcoholic solutions.
- An arrow is drawn to identify the lesion. The arrow must extend to the incision site and will remain visible after the skin preparation and application of any procedural drapes.
- For procedures where the patients position may be changed during procedure, the patient must be marked whereby the mark will be visible at all times.
- If the patients' position is changed during the procedure the surgical site must be confirmed again by the team undertaking the correct site marking safety checks again.

4.1.2 Procedural Site Marking 'Complex Classification'

The method for marking complex lesions must be undertaken when a lesion cannot be

safely identified through formal consensus by just the written use of terminology, using just laterality and naming the anatomical area.

An example would be whereby a mole is one of a group and there maybe multiple lesions of which only one is to be removed or biopsied.

Who and How to Mark (Complex)

The following steps must be followed in consenting for lesions which meet complex classification for consenting and future identification and verification of a lesion.

- Firstly explain the rationale to the patient and ensure the patient is consented for imagery
- A patients' hospital addressograph must be applied close to the lesion which is to be marked
- It is important to ensure the patients hospital addressograph will be captured in the field of view of the photograph you are taking
- In the marking and procedural consenting process the Clinician/Practitioner must use as accurate an anatomical description as possible; this may be supported by using triangulation through protractor measurements with reference points to verify the location in relation to two or more anatomical landmarks
- Draw a ring around the lesion with a black marker pen
- Ensure an arrow is drawn near to but not obscuring the lesion to indicate the midline
- Ensure you write the name of the anatomical landmark on the consent form
- Write the laterality on the consent form and the patients hospital addressograph l if applicable
- Only use Trust equipment i.e. the digital camera provided by the Trust
- Verify the captured image on the camera screen with the patient
- Ensure you upload the digital image into the patient electronic record in Lorenzo
- Ensure the written consent is completed

See Page 6 for Visual Imagery Standards

The operating clinician has consented the patient to the standards outlined above.

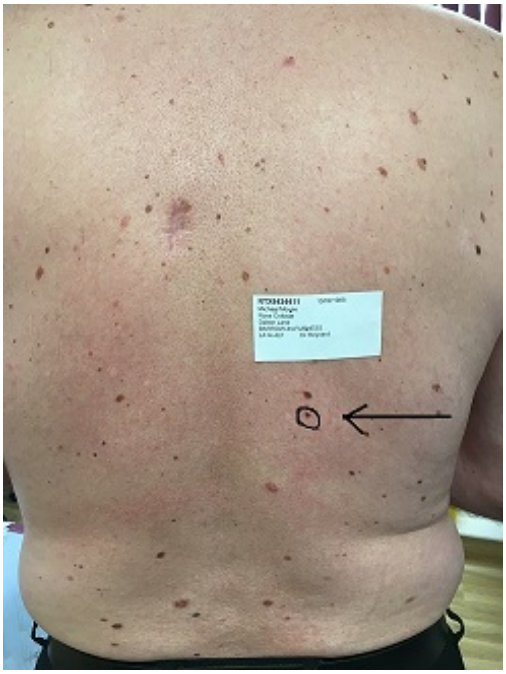
Two photographic images have then been taken and uploaded into the patient E.P.R. (Electronic Patient Record) which will be used for verification in the 4 steps to safer invasive procedures that are undertaken in the procedural room.

Note

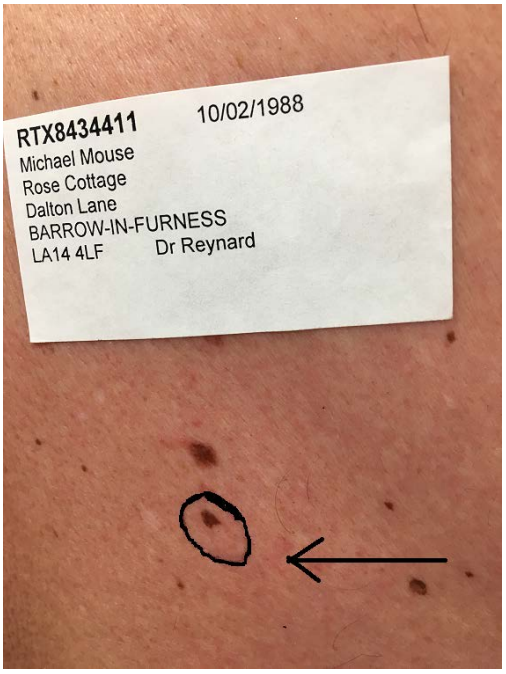
Image 1 clearly shows the anatomical body part where the lesion is situated.
The patients' hospital addressograph has been attached, an arrow points towards the midline thus providing a landmark, the lesion consented for removal is encapsulated in the circular mark.

Image 2 is a close up image of image1, ensure when you take this image that the patient addressograph is clear. No alterations should be made for the close up, it is vital the images match.

DIGITAL IMAGE 1



DIGITAL IMAGE 2



4.2 UHMB 4 Steps to Safer Invasive Procedures

4.2.1 STEP 1 List Safety Briefing

- Prior to commencement of any elective procedural list a 'Safety Briefing' which involves key members of the team and the Operator as a minimum (ideally all the team) must take place
- The purpose of the brief is to discuss the sessions' schedule of planned interventional procedures, confirm equipment, and highlight any concerns relating to planned patients, or raise any issues by any team member that would impact on patient safety
- The area used should be quiet and free from interruptions
- The brief may be led by any confident designated member of the team
- All staff members of the procedural team are named for the session and roles being undertaken in the list are clearly identified and logged on the pre-brief sheet
- The procedural list must be visible throughout the session for staff in all areas that are involved in the procedural list. (This includes holding areas for patients). Please ensure patient data cannot be viewed by other patients or relatives
- Any anticipated milestones or challenges must be considered, and plans put in place if necessary. These should be logged on the sheet
- Equipment checks should have already been performed and any issues highlighted, and actions put in place to address if required
- If it is necessary to change the list order, a new printable list must be produced and communicated.
- If there unforeseen circumstances which could impact on the list i.e. major changes to the list order then a new safety briefing must be undertaken

4.2.2 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, site, side/lesion and outline any individual risk factors.

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

Continue straight to Time Out

Time Out 2B All the procedural team must participate.

- Time out must be undertaken with all the team present and everyone must engage with full attention. The verbalising the prompts on the checklist must be by a trained Healthcare professional and said 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.
- Site verification of the operative lesion must include the 'Operator' the patient and carer if applicable and is verified and agreed by the procedural team
- Laterality where applicable is confirmed, along with consent and the team must ensure that the operative lesion verification is cross referenced to any consenting aids or imagery in complex marking

4.2.3 STEP 3 Sign Out

- 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 sign out 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 answer to the questions being asked
- Any specimen taken must be confirmed visually that it is labelled correctly

- Where an area is non paperlite the ‘Time Out’ sheet is signed by a registered healthcare professional and retained in the patient’s notes
- 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

4.2.4 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 the staff member who has undertaken the procedural interventions on the list)
- The debrief may be led by any confident team member
- Members of the procedural team should have noted any key points for consideration at the debrief that arose throughout the list; these should be presented for consideration at the 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 the debrief should 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.
- Is there a need to raise a C.I.R?
- Identification of training or development that could benefit the team

4.3 Governance & Audit

Audit, benchmarking, feedback and an open learning culture are crucial elements to successful and effective procedural teams.

Qualitative and quality audits will be part of the specialities yearly audit program and the following must occur for the process to be undertaken.

Debrief sheets must be retained, for analysis by the department manager to ensure:

- that review of the lessons occurs 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 Divisions' of learning lessons bulletin.

4.4 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.

5. ATTACHMENTS	
Number	**Title**
1	NatSsips Table
2	List Safety Briefing and Debriefing
3	Dermatology Procedural Checklist
4	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/Pol/089	Medical Device Management Policy 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

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	NHS England (2015) National Safety Standards for Invasive Procedures (NatSSIPs) Available from: https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/ (accessed 10/05/2017)
Bibliography	
Murad Alam et al (2014) A Multistop Approach to Improving Biopsy Site Identification in DermatologyP Physician, Staff, and Patient Roles Based on a Delphi Consensus. JAMA Dermatology. 150(50): 546-849	
Sharad, PP (2015) Errors in Surgical Site Identification during Cutaneous Surgery for Skin Cancer: Review and Recommendations. Surgical Science Vol. 6: 327-335. Available from: http://www.scirp.org/JOURNAL/PaperInformation.aspx?PaperID=58186 (accessed 10/05/2017)	
Mears, S. C. et al. (2009) Does the Type of Skin Marker Prevent Marking Erasure Site Markings? Eplasty Published online Vol 9: e36	
PSA/2005.06 Correct Site Surgery National Patient Safety Agency & Royal College of Surgeons Patient safety alert 06: Pre-operative marking recommendations	

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
C.S.S.	Correct Site Surgery
C.I.R.	Clinical Incident Report
N.B.	Note Well
M.B.H.T.	Morecambe Bay Hospital Trust
NatSsips	National Standards of Safety for Invasive Procedures
E.P.R.	Electronic Patient Record
LocSsips	Local Safety Standards for Invasive Procedures

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**
Nigel Capewell	Associate Specialist in Dermatology	
Denise Hines	Unit Manager	
Simon Glover	Matron	
Dermatology business meeting.	Team present recorded on minutes of 9/3/17	

10. DISTRIBUTION PLAN	
Dissemination lead:	Denise Hines & Dr Y Moosa
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:	To be archived by Trust Policy Team
To be disseminated to:	
Document Library	All Dermatology Staff Cross Bay – Clinical and Admin
Proposed actions to communicate the document contents to staff:	

11. TRAINING Is training required to be given due to the introduction of this procedural document? No		
Action by	**Action required**	**Implementation Date**
Denise Hines	Team training including: to be discussed at Team Meeting	30.9.17

12. AMENDMENT HISTORY				
Revision No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**

Appendix 1: NatSsips Table

Description of NatSsips which are mandatory inclusion in this LocSsip.	By Whom/How	Where identified	Inclusion achieved
Procedural Site Marking	Consenting clinician	Pages 4,5 & 6 UHMB standard of Simple or Complex marking	Yes
Verification of procedural site marking at the operative procedural episode.	Operating clinician Procedural Team	Page 7 & 8	Yes
All the following harmonised: 4 Steps to Invasive Procedures Pre List Safety Briefing Sign in Standards Time Out Sign Out De Briefing Safety Standards	All	Pages 6, 7, 8 & 9	Yes
Mal functioning equipment process for medical devices and MHRA (Device) reporting	All	4.2.6 Page 9	Yes
Action Logs and dissemination of learning lessons	Team Leader Theatre Coordinator	Section 4.3 Page 10	Yes

Appendix 2: List Safety Briefing and Debriefing

University Hospitals of Morecambe Bay NHS Foundation Trust

ACTION 1 SAFETY BRIEFING (THIS OCCURS PRIOR TO THE START OF THE DERMATOLOGY PROCEDURAL LIST.

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 Lorenzo and endoscopic procedure type) ……

1.1 THE PRE LIST SAFETY BRIEFING

Each team member will state their name and role.

☐ Completed (Please log the information in the space provided in the adjoining column)

Confirm equipment availability of the following for the list:

☐ Procedural Instrument Kits

Confirm working status of the following equipment for the list:

- ☐ Patient operating couch
- ☐ Operating light
- ☐ Diathermy/Cautery
- ☐ O2 and Suction
- ☐ Hyfaecator
- ☐ Local Anaesthetic quantity is sufficient for the list
- ☐ The list order must be 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. The Endoscopist known as The 'Operator' who must be either a Consultant gastroenterologist or Surgeon, or a trained Nurse Endoscopist Practitioner.

……

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

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

ACTION 4 DERMATOLOGY 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 abstinence.
- 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

SAFETY DEBRIEF DISCUSSION

What went well today? What was really good?

……

……

The Following questions are a guide and the outcomes/actions must be logged in the 3rd column of the debrief sheet.

- Did the team communicate effectively?
- Were there any equipment issues?

Consider the following for equipment issues:

- Is the issue fully resolved? **OR**
- Could a future lists be affected?
- Who will be responsible for ensuring actions and communication?
- Can we make an improvement so it does not happen again?
- Discuss if the team harmonised well? i.e. utilisation of skills.
- Were there any planning issues?
- List order? Missing stock?
- Is there a need to raise a Clinical Incident? If yes log in the last column of the debrief with the name of who will enter the CIR on the Trust Incident Reporting System

☐ **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

☐ ……

……

……

☐ ……

……

……

☐ ……

……

……

☐ ……

……

……

Have these actions been transferred to the Endoscopy Safety Action plan?

Scanned for Audit? Y / N

By …… on ……/…../……..

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

Appendix 3 – Invasive Procedural Checklist Dermatology

Date…….. Site……Room Number……

Attach Patient Addressograph here

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

1. All Team members confirm role in procedure ☐
2. Patient identity is correct and matches the list schedule? ☐
3. Consent Signed ☐
4. Site/lesion marked (Photo verification must be used in complex marking)
5. The infection risk/s to the patient ☐
6. Ensures any relevant jewellery is removed. ☐
7. Any allergy? (Details) ……**Y** **N**
8. Anticoagulation medication Details……
9. Any Implants, a pacemaker or metal prosthesis? **Y** **N**

   Action if **yes**……

10. Instruments & equipment available and functioning & sterile ☐

IF ANYONE HAS ANY CONCERNS PLEASE SPEAK UP NOW

.

.....

SIGNED……..(Checklist Leader)

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

Will the Operator confirm the name of the procedure performed?

……..

Specimen Safety Prompts

1. Confirm the anatomical specimen name and site
2. The patient addressograph is attached to the specimen pot and histology request form

Confirmed = Yes ☐ N/A ☐

Confirm completion of all patient documentation
Instrument sterility labels have been secured in the patients' ICP?

Confirmed = Yes ☐ N/A ☐

Any incidents which will require a C.I.R. to be logged and who will be responsible? Insert name/position on dotted line.

Confirmed = Yes ☐ N/A ☐

……

Ensure any key concerns/requirements for recovery and/or the post procedural management of this patient are communicated and logged?

……

……

SIGNED……..(Checklist Leader)

Appendix 4: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Dermatology			
Lead Assessor	Sue Wroe			
What is being assessed?	Local Safety Standard for Invasive Procedures (LocSsip) for: • Surgical Site Marking • 5 Steps to Safer Surgery using the W.H.O. Theatre Time Out' Checklist			
Date of assessment	15/09/2016			
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:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ 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)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	
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.