University Hospitals of Morecambe Bay NHS Foundation Trust

Document Type: **Procedure**	**Unique Identifier:** SURG/LOCSSIP/004
Document Title: **Local Safety Standards for Invasive Procedures (LocSsip) for:** **Interventional Pain Procedures including:** • **Standards for Site Marking & Verification of scheduled pain procedures.** • **Standards for 4 Steps to Safe Invasive Procedures**	**Version Number:** 1 **Status:** Ratified
Scope: Multi-Disciplinary Teams that are involved in the patients 'interventional procedural episode.	**Classification:** Departmental
Author / Title: Sue Wroe, Governance Project Lead NatSsips, Quality & Governance	**Responsibility:** All Pain Procedural Team including the admin staff, who undertake scheduled lists currently in WSC.
Replaces: New	**Head of Department:**
Validated By: Surgery & Critical Procedural Group Chair's Action	**Date:** 10/05/2017
Ratified By: Surgery & Critical Care Divisional Governance & Assurance Group.	**Date:** 23/05/2017
Review dates may alter if any significant changes are made	**Review Date:** 01/01/2020
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	
Reference Check Completed by: ……Joanne Phizacklea……. Date……8.5.17…… **To be completed by Library and Knowledge Services Staff**	

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1. SUMMARY

UHMB is committed to the NHS England Directive of introducing NatSsips (National Safety Standards for invasive procedures) 2015. The Trust has identified invasive procedures across the organisation which are performed outside the main surgical theatres that are potentially at risk of an adverse event.
It is well evidenced that invasive procedures whereby clinical teams follow safety standards through the use of prompts on checklists can prevent an adverse or never event occurring.

Pain relief procedural block/s and or other invasive pain procedures performed on the incorrect patient, and or the incorrect anatomical site, are fortunately rare; however, should this happen, it can have a devastating outcome to both a patient and staff. Any unnecessary administered block carries the risk of complications such as nerve injury and local anaesthetic toxicity.
A wrong site block is as yet not classified by the NPSA (National Patient Safety Agency) as a Never Event, however, it is unacceptable if it occurs, it is a Serious Incident, requiring route cause analysis, and must be presented to the Trust Serious Incident Reporting Investigation Committee.

How to undertake Correct Site Marking and ensure procedural patient safety during the invasive procedure is outlined in this document. The 'time out' checklist is in electronic form in each patients' Lorenzo procedural plan. The pre briefing and debriefing checklists for the lists are in paper format.
It is through teams adopting and using the safety prompts from the checklists, that safe behaviours will become embedded into the team, and the likelihood of mistakes will diminish.

2. PURPOSE

Benefits of the NatSsips framework through use of the patient safety checklists of the 4 Steps to Safe Patient Procedural Safety supports the following :

- 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 site verification of the planned procedure occurs at the correct time.
- At the end of the scheduled procedural list the de-briefing provides the Team/s with a mechanism to reflect and continuously improve practice and patient care at a local level.
- Debriefing logs also provide an auditable trail for issues that need escalation or further actions.

3. SCOPE

Teams must recognise that LocSsips are not just a protocol or a policy. LocSsips provide a summary of safe standards, behaviours and checklists. All staff members must ensure that each patient who undergoes an invasive procedure has had their procedural episode of care to the safety standards of the LocSsip.

The success, efficiency and effectiveness of LocSsips are dependent on the team participating in the 4 Steps to Safe Invasive procedures, never just regarding any of the checklists just as TICK list but having a comprehensive understanding of the requirements for :

- Procedural Site Marking.
- Embrace and attend Team Safety List Pre and De Briefs.
- When, what and how to undertake Sign In/Time Out
- Sign Out
- Identify and promote an environment that is conjucive to learning to improve.

Pain Procedural Site marking.

This is a mandatory requirement at UHMB for all interventional pain procedures undertaken in the pain procedural room.

4. PROCEDURE

4.1 The Correct Procedural Site Marking Process

4.1.1 When to Mark

- Procedural sites must be marked shortly before the procedure; therefore marking a procedural site on the admission/ inpatient area as close as possible timewise and prior to the patient being transferred to the procedural room is the most appropriate time and place.
- The marking of the procedural site must be through verification with the patient, the family or carers along with the patient notes, consent, imagery, specific site related tests and investigations where applicable.
- Verification of the site pre procedure must wherever possible always occur prior to any premedication/sedation being administered to a patient.

4.1.2 Who must Mark

- Wherever possible the marking should be undertaken by the named clinician on the procedural list, an assistant or deputy can be nominated, in specific circumstances. (See next sentence below).
- The person who has verified the site and marked it on the patient prior to the patient being transferred to the procedural room must also be present in the procedural room at ‘time out’ when the site is verified.

4.1.3 How to Mark

- 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 procedural site. It must be an arrow that extends as near to the incision/procedural entry point/site as possible and will remain visible after skin preparation and application of any sterile drapes.
- For procedures where the patients position may be changed during the procedure, the patient must be marked in a manner in which the mark will be visible at all times.

- If the patients position is changed during the procedure the procedural site must be verified by the team through the surgical mark checks being undertaken a 2nd time and any site/s and confirmed again with the Operator and the team.

4.1.4 Where to Mark

The **non**-procedural side must never be marked in any circumstances.

- Invasive pain procedures which involve a side (Laterality) must be marked at, or very close to where the penetration for the interventional pain procedure will be.
- Arrows used to mark a digit/s on a hand or foot must extend to the base of the correct specific digit.

4.2 UHMB - 4 Steps to Safer Invasive Procedures

4.2.1 STEP 1 - List Safety Briefing

- Prior to commencement of any invasive 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/procedural list of planned interventional procedures. (For back to back lists where there are no team changes and only a planned lunch break it is acceptable to discuss the whole of the days planned list schedule).
- It is a local decision if the brief is performed more than once if there are staggered admissions to units, it is accepted that operationally the pre brief would discuss the proposed planned list.
- The area used should be quiet, allow confidentiality and be free from interruptions.
- If the elective list has commenced and a patient was late or was to D.N.A. (Did not attend) which affects the original plan or the list order, it is strongly advocated that a further pre brief occurs at the first opportunity with key team members. This is to ensure that any list or order change necessary has robust communication and that the safety processes for list order changes are followed.
- 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 the roles they will be undertaking are 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) ensuring it cannot be viewed by patients.
- Any anticipated milestones or challenges must be considered, and plans put in place if necessary.(Ensure the action is logged on the briefing sheet))
- Equipment and pharmaceutical treatment stocks and checks should have already been performed and any issues must highlighted, and relevant actions must be taken.
- If it is necessary to change the list order, a new printable list must be produced and communicated.

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

In procedures where the patient is not anaesthetised and only enters a procedural room,

the Sign in and Time Out safety processes are undertaken at the same time. Conscious and coherent patients should actively be encouraged to participate in these processes.

4.2.3 Sign In 2A & Time Out 2B

- All Team members must 'stop and pause' any tasks whilst the checklist questions are asked and responded to.
- Both Sign in and Time out must be undertaken with all the procedural team present, everyone must engage and give their full attention to the process.
- The Sign in verification process of the patient must be confirmed by the Operator and a registered practitioner.
- The questions on the checklist must be led by a trained Healthcare professional in a clear and audible manner.
- Team members must not enter or leave the procedural room during this time.
- If there is an interruption, the 'time out' must be suspended and recommenced from the beginning.
- Site verification must occur by the operator and be confirmed by all the team.
- The following must be verified:
  - The site is marked with an arrow.
  - Consent is signed with the side wrote in full and corresponds to the scheduled list and imagery.
  - The patient confirms the side
- No other task/s should be undertaken by team members or to the patient until the verification checks are completed.
- 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 and before the actual treatment of the procedure starts.

4.2.4 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' so the 'sign out' may occur.
- The safety prompts on the designated section of the electronic Checklist are then directed to the appropriate team member/s, who will verbally respond to the questions being asked.
- 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
- In non paperlite areas the 'Time Out' sheet is then signed by a registered healthcare professional and filed or scanned into each individual patients E.P.R. (Electronic Patient Record) on Lorenzo.

4.2.5 STEP 4 - List De-Briefing

The framework of National Safety Standards relating to 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, the framework identifies the standard of who must attend the debrief.
There are some mandatory requirements of which specific team members must be present at a debrief:

- The Operator, (this is staff member who has performed the procedural interventions on the patient).
- The debrief may be led by any confident team member.
- All members of the procedural team should have noted any key points for consideration at the debrief that arose throughout the list; these should be raised and presented for discussion at the debrief.
- All members of the procedural 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.
- The need to raise a C.I.R. (Clinical Incident Report) – is there one?
- Identification of training or development that could benefit the team mayalso be considered.

4.3 Governance and Audit

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

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

- That review of any lessons occurs and learning to improve can take place. Lessons learned have been shared with MDT team at Staff meetings
- Departmental managers are responsible for communication to the teams of actions for learning to improve and may keep a log of improvements.

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 inclusion Table
2	List Safety Briefing
3	Minor Day Case Plan
4	Pain Management Safety Debrief
5	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	Mears, S. C. et al. (2009) Does the type of skin marker prevent marking erasure site markings? Eplasty, Jan 2009, vol. 9, p. e36).
2	PSA/2005.06 Correct Site Surgery National Patient Safety Agency & Royal College of Surgeons Patient safety alert 06: Pre-operative marking recommendations
3	NHS England (2015) National Safety Standards for Invasive Procedures (NatSsips)
4	Hudson, M E; Chelly, J E; Lichter, J R (2015) Wrong-site nerve blocks: 10 yr experience in a large multihospital health-care system. British Journal of Anaesthesia; vol. 114 (no. 5); p. 818-824
5	NHS England Safe Anaesthesia Liaison Group (c2011) Stop before you block campaign. Available from: http://www.rcoa.ac.uk/standards-of-clinical-practice/wrong-site-block (accessed 8.5.17)

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
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
Sue Howard	Matron Surgery & CC WGH	
Deborah Collins	Manger DSU & WSCC	
Karen Paylor	Clinical Leader DSU & WSCC	
Dr L Radhakrishnan	Consultant Pain Anaesthetist	
Anaesthetic Pain Group	All pain consultants and pain nurses present.	

10 DISTRIBUTION PLAN	
Dissemination lead:	Debbie Collins
Previous document already being used?	N/A
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	Governance Lead/Admin S & CC
Proposed actions to communicate the document contents to staff:	Discuss at ward meetings Take to Westmorland surgical centre and discuss with all staff

11 TRAINING Is training required to be given due to the introduction of this procedural document? Yes		
Action by	**Action required**	**Implementation Date**
Debbie Collins to arrange training for all staff	Team training including: All staff will receive training on how to access WHO checklist	30 June 2017

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

Appendix 1 – NatSsips Table

Description of NatSsip which are mandatory inclusion in this LocSsip.	By Whom/How	Where identified	Inclusion achieved
4.6 NatSsips Procedural verification of procedural site marking No's 1, 2, 3, 5, 6, 7, 8, 9, 11, 12 & 13	Operator & team	Correct site marking safety steps pages 4 through 5. Sign in and time out sheet steps 2 A & 2 B of 4 steps to procedural Safety	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
4.11.1 NatSsip Equipment management Mal functioning equipment process for medical devices and MHRA (Device) reporting	All	4.2.6 Page 9	Yes

Appendix 2 – List Safety Briefing

SAFETY BRIEFING (THIS OCCURS PRIOR TO THE START OF THE PAIN MANAGEMENT LIST.

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

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

List Specifics Include assigned consultant on Lorenzo and pain management 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:

☐ X-Ray equipment

Confirm working status of the following equipment for the list:

- ☐ Processor, Light Source, Monitor,
- ☐ Ultra Sound equipment
- ☐ Radiofrequency equipment
- ☐ Resuscitation equipment (know where it is stored)
- ☐ Anaphylaxis kit available
- ☐ Oxygen & suction checked and ready to use if required
- ☐ Any likely additional resources

.....

The operator must confirm they are happy with all available **drugs** and **needles** for the scheduled list.

The list order must be confirmed and it ensured that all areas have the same copy?

☐ 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 Anaesthetist known as The 'Operator' who must be either a Consultant anaesthetist with specialist pain management skills, a Specialist Pain Nurse, with appropriate training or *.....(pain team please specify if anyone else will be doing procedures e.g. trainee)*

.....

2. The Team supporting the procedural list must be listed below name and grade.

1.3 NOTES/ACTIONS FOR THIS LIST

Are there any outstanding agreed actions from previous lists that may affect the smooth running of this list?

Y / N

.....

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 – Minor Day Case Plan

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Minor Day Case Care Plan

Minor Day Case Care Plan:

This clinical note is intended as a guide to clinical care and the document on which to record the patient's progress through the care encounter, but at any time clinicians/practitioners are free to exercise their own professional judgment. All deviations from this pathway (positive or negative) must be recorded as a variance.

Patient	**Dr Xxxmelxxx XXXTESTXXX**	**DOB**	01 January 1986 (31 yrs)
Address:	Academy of Fabulous Stuff 33 Cavendish Square LONDON W1G 0PW Tel No: **(02037909491)**		
GP Details:	KJ BATES,RICHMOND HOUSE SURGERY 26 BRUNSWICK STREET TEIGNMOUTH DEVON TQ14 8AF Tel No: **(01626 773339)**		
Hosp No:	RTX8442061	**NHS No:**	
Likes to be called:		**Religion:**	Not Known
Date/Time Admission:		**Occupation:**	
Date/Time Discharge:		**Consultant:**	Rob Dodd
Interpreter required:		**Gender:**	Female

Responsible Adult		Can be contacted at night	**Y/N Tel No:**

Speciality	GENERAL MEDICINE
Reason for Admission	
Anaesthetic	

Transport required	
Other information	

Access Plan Details

Medical History

Operations and Procedures

Active Allergies

Contact Lenses: ☐ Hearing Aid: ☐ Could Xxxmelxxx be pregnant? Yes / No
ID Band: ☐ Dentures: ☐ Patient to be collected by: relative / neighbour / friend

Current Medication including herbal and recreational (reference only)					
Aspirin ☐	Warfarin ☐	Clopidogrel ☐	to be stopped from:	N/A	☐
Angiotensin II receptor antagonist ☐			to be stopped from:	N/A	☐
Patients regular medication taken as usual ☐					

Alerts

Additional Comments

UHMB Individual Patient Procedural Safety Checklist for Pain Procedures (STEP 2A & 2B)	
Attended by all Pain Management procedural team prior to start of the procedure. STOP & PAUSE	
Checklist	**Y/N/NA**
Can all team members introduce themselves and the role they will be undertaking in this procedure	
Can the patient confirm, their name, date of birth, the procedure and their own signature on the consent form	
Wristband (confirm name, DOB and RTX)	
Confirm the patient demographics match the procedural schedule and consent	

Can the 'Operator' state the intended procedure	
Are there any allergies (please state)	
Pregnancy status confirmed and form complete	
Are all IRMER requirements met	
Prior to procedural start confirm the following observations: Pulse: BP: SO2: Blood Glucose	
Is there any other important information that the procedural team need to be aware of relevant to this case:	
'STOP before you block'	
The team must all agreee the site is correct and it is safe to proceed	
Is everybody happy that the injection about to be done to correct site and side? (compare consent form and verbally confirm with the patient)	

Actual Procedure Performed	**Medication Used**
See Ormis/Lorenzo	See Ormis/Lorenzo
Bed rest required: Y/N	Local Anaesthetic: Y/N

UHMB Individual Patient Procedural Safety Checklist for Pain Procedures (STEP 3)	
Pain Management Team procedural signout	
Checklist	**Y/N/NA**
Can the 'Operator' confirm the name of the procedure undertaken and side and site?	
Have all sharps been disposed of safely	
Can the operator state key post-procedural instructions of the patient? Details:	
Is bed rest required? How long:	
Any concerns to be logged on the list debrief	
Have there been any untoward incidents with this patient, do we need a CIR logging? Who will log the CIR:	

Procedure Finish Time	

Additional Information

Discharge Check List	
Cannula removed	
Mobilising safely	
Has had something to eat	
Passed urine	
Patient Information leaflet	
Copy of IDS	
Copy of Consent Form	
Pain diary required	
Discharge information given	
Outpatient apointment requried: *(date)*	
Nurse Telephone Review: *(date)*	

Discharged By:	**NMC no:**
Time:	

Appendix 4 – Pain Management Safety Debrief

PAIN MANGEMENT SAFETY DEBRIEF (THIS OCCURS AT THE END OF THE LIST)

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)	SAFETY DEBRIEF DISCUSSION	AGREED ACTIONS FROM THE DEBRIEF DISCUSSION
▪ 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	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?**	☐ .... ☐ .... ☐ .... ☐ .... **Have these actions been transferred to the Pain Management Safety Action plan?** **Scanned for Audit? Y / N** **By** ..... **on** ...../...../..... **Debrief completed by** **Date** ..../...../.....

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

Appendix 5: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Procedural Interventions			
Lead Assessor	Sue Wroe			
What is being assessed?	Local Safety Standard for Invasive Procedures (LocSsip) for: • Anaesthetic Procedural marking • 4 Steps to safe anaesthetic invasive procedures.			
Date of assessment	30/01/2017			
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.