East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST WIDE DOCUMENT

Delete as appropriate	**Policy**
DOCUMENT TITLE:	**Guidance for the Safe Transfer of Patients**
DOCUMENT NUMBER:	**C074 Version 5.1**
DOCUMENT REPLACES Which Version	**Version 5.0**
LEAD EXECUTIVE DIRECTOR DGM	Executive Director of Nursing
AUTHOR(S): Note should not include names	Advanced Clinical Practitioner – Acute Care Team Deputy Clinical Director for Anaesthetics

TARGET AUDIENCE:	All Clinical Staff and On-Call Managers
DOCUMENT PURPOSE:	• To ensure all patients are transferred safely • To support the undertaking of more complex surgery on the Burnley General Hospital Site (BGH) in a safe, personal and effective manner • To ensure the efficient and safe transfer of patients from BGH to RBH
To be read in conjunction with (identify which internal documents)	• CO29 V6.1 Safer Handling Policy 2021 • SOP 002 ELHT Intra organisation adult patient transfer • ELHT/IC15 Admission and transfer of suspected or confirmed infected patients • Maternity Services Clinical Guidelines – Maternal Transfer G27 and Handover of Care G49 • Site Suitability Guidelines for Surgery at BGH • SOP – Burnley General Hospital Medical Escalation Plan • Escalation Procedures for Deteriorating Surgical Patient at BGH

	• Escalation Procedures for Deteriorating Medical Patient at BGH • Surgical Escalation Contact Guide Bullet points 4-8 all available at http://elht-sharepoint/sites/ICG/ACT/_layouts/15/start.aspx#/Burnley%20General%20Teaching%20Hospital/Forms/AllItems.aspx
SUPPORTING REFERENCES	North West Critical Care Network Intra and Inter Hospital Critical Care Transfer (Adult) 2016

CONSULTATION		
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AMENDMENTS:	Amended see below: • Document Title – Adult removed • Document Number – updated to 5.0 following full review • Document replaces which version – updated to 4.1 • Author - updated to Advanced Clinical Practitioner • Contents page titles and numbers updated to reflect corresponding page numbers and amendments • Previous Policy Item 2.0 Purpose – removed and incorporated into Policy Item 1.0 Introduction • Previous Policy Item 2.1 Definitions now Policy Item 2.0 • Policy Item 2.0 – Paediatric Definition added • Policy Item 2.0 – Scope added • Previous Policy Item 3.0 Risk Assessment – removed • Policy Item 3.0 now updated to Roles & Responsibilities	

	• Policy Item 3.1 – Timing of Transfer added • Policy Item 3.3 – Additional reference inserted re Appendix 1 • Policy Item 3.5 - Paediatric Patients added • Policy Item 3.6 – Additional line inserted following rapid and acute deterioration added • Policy Item 3.7 - Arranging Transport via NWAS added • Policy Item 3.10 – Additional line around training in the emergency care of tracheostomies and laryngectomies added • Policy Item 3.12 – Additional line around relevant treatment plans added • Policy Item 3.13 - EWS updated to NEWS2/PEWS/MEOWS • Previous Policy Item 4.0 Decision to Transfer – removed • Previous Policy Item 4.2 Late / Out of Hours Transfers – removed • Previous Policy Item 4.6 Acutely Unwell Transfer of Care – removed • Previous Patient Transfer Decision Matrix (Appendix 1) replaced with the revised ELHT Patient Decision Matrix for the Safe Transfer of Patients • Previous Transfer of Care Document (Appendix 2) - removed • Previous Paediatric Transfer Decision Matrices (Appendix 5) removed • Previous Inter Healthcare Transfer Form (Infection Control Appendix 3) – removed • Previous Acutely Unwell Transfer of Care (Appendix 4) – removed • Previous Registered Nurse & Porter ID/Procedure Checklist (Appendix 6) – removed • Appendix 3 NWAS Categories - added

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1. Introduction

Patient movement between wards, departments, other hospital sites and other health care providers is an inevitable part of the patient care journey.

Transfer of patients can pose a clinical risk to the patient. There is a need to ensure that appropriate clinical risk assessments are carried out, that appropriate accompanying staff and equipment are used and that an accurate patient handover takes place to maximise a safe patient transfer.

Poorly performed transfers lead to a worse outcome for the patient. East Lancashire Hospitals NHS Trust (ELHT) is committed to the safe transfer of all patients, who require transfer to a different environment determined by their care needs.

A Patient Transfer Decision Matrix for the Safe Transfer of Patients *(Appendix 1)* and patient SBAR handover (Situation Background Assessment and Recommendations) will enable a safe transfer and ensure all essential patient information is handed over between staff.

The clinical assessment of patients prior to transfer will:

- Minimise the risk to patients
- Ensure complete and accurate communication between the transferring and receiving ward, department or unit
- Ensure appropriate staff and equipment are involved in the transfer.

2. Scope

To be completed for all patients (Adult, Paediatric & Maternity) in all areas including the Emergency Department and Critical Care (excluding Outpatients) at East Lancashire Hospitals NHS Trust: Royal Blackburn Hospital, Burnley General Hospital (including Rakehead), Pendle Community Hospital, Clitheroe Community Hospital and Accrington Victoria Hospitals.

Additional guidance for specialist patient group processes have been identified and relevant hyperlinks have been incorporated into this policy.

2.1 Definitions

- **An adult patient:** In this context refers to all patients above the age of 16
- **An acutely/critically ill patient:** is defined as one who is at risk of, or is showing signs of deterioration and who requires transfer to an area providing higher levels of care for any form of organ support
- **A Paediatric patient:** In this context refers to all patients under the age of 16
- **Inter Hospital Transfer:** This is a transfer between hospital sites or between two Trusts
- **Intra Hospital transfer:** This is a transfer within a hospital site / building.

3. Roles & Responsibilities

3.1 Timing of Risk Assessment

The Assessment to transfer should be carried out within one hour of the time to transfer. The responsible Registered Nurse/Midwife should assess that there has been no significant change in the patients risk category immediately prior to transfer.

For High Risk and Critically ill patients (identified within the red category of the Patient Decision Matrix for the Safe Transfer of Patients – *Appendix 1*) the assessment should have been carried out as close to the time of transfer as possible. It is the responsibility of the Registered Nurse/Midwife managing the patients care to ensure the patient and where required that the next of kin have been informed of the reason for transfer.

3.2 Clinical Flow team role

The Clinical Flow Team must ensure that the patient is allocated to an appropriate bed for their on-going care based upon their level of care and clinical requirements. This will include meeting any relevant infection control and mixed sex accommodation issues.

Further detail is included in SOP 002 ELHT Intra organisation adult patient transfer.

3.3 SBAR handover & Patient Decision Matrix

An SBAR handover and Patient Decision Matrix (Appendix 1) **must be** completed by the transferring/receiving Registered Nurse/Midwife for all patients transferring from a ward/department except for:

- Patients transferring between theatres and wards. (see SOP 002 for this process)
- Patients attending for investigations where appropriate staff will remain with them throughout the procedure.

It is the responsibility of the Registered Nurse/Midwife to complete the SBAR handover and undertake the Patient Decision Matrix for the Safe Transfer of Patients (*Appendix 1*) risk assessment. The transferring nurse must provide an electronic/ paper / telephone SBAR to the receiving ward.

The transferring nurse should assess the patient to determine no significant change has occurred to the patient's risk category immediately prior to transfer.

The appropriate level of personnel, utilising any equipment required, must accompany the patient on transfer as per the Patient Decision Matrix for the Safe Transfer of Patients.

All patient records, medication and property must accompany the patient as per the Trust Management of Patient Valuables and Property Policy F10 V4.4.

3.4 Maternity Patients

Processes for transfer of care are already established locally. These are outlined in Maternity Services Clinical Guideline Maternal Transfer G27 and Handover of Care G49. The specific SBAR for Maternity patients is contained within this.

A limited number of Registered Midwives, working within the Close Observation Unit (COU) will undertake the Critical Care Network standard Transfer Training, to support the transfer of high risk obstetric patients.

3.5 Paediatric Patients

Processes for transfer of care are already established locally and an additional STOPP checklist is available https://www.nwts.nhs.uk/_file/fGbuuPfYbt_301452.pdf to ensure the safe transfer of paediatric patients out of hospital.

3.6 Transfers to other ELHT sites or other Trusts

Decisions about the appropriateness/suitability of transfer of patients to other ELHT sites or other Trusts should be made as per SOP 002 ELHT Intra organisation adult patient transfer.

Where possible, transfers should occur within working hours and out of hours transfers avoided. The Senior Clinician **must be** aware of the transfer of a patient to another site. The receiving clinical team **must have** accepted the patient and be aware that a transfer is being organised.

Inevitably some patients cared for in other ELHT sites may deteriorate and require transfer to the acute site at RBH for further management. This may be a rapid and acute deterioration that requires an emergency response. In these circumstances, the Acute Care Team and/or Senior Clinician should ensure the patient is transferred to receive the appropriate level of care.

Decisions regarding accompanying personnel should be made utilising the Patient Decision Matrix for the Safe Transfer of Patients *(Appendix 1).*

Please note that in some circumstances, a paramedic crew may undertake the transfer in place of a registered nurse/ midwife dependent on the needs of the patient and the skills of the ambulance crew. This decision should be made by the senior responsible clinician.

3.7 Arranging Transport via NWAS

Clear communication with NWAS is essential in ensuring a transfer process is smooth and takes place in an appropriate time frame.

NWAS should be contacted via (9) 0345 140 0144 (health care professional line) at the point of decision for transfer. In a life threatening emergency (9) 999 may also be used.

A clear description of the following must be given:

- Emphasis that the patient is not in a site of safety and a transfer is indicated

- Expected category of transfer and headline description as assessed by on-site clinician N.B. it is likely that most transfers will be Category 2 *(Appendix 3)*
- Patient details
- A clear summary of the clinical picture including indication for transfer.
- Exact patient location and destination
- Type of ambulance required e.g. paramedic crew

A category of transfer and expected response time will be allocated by NWAS.

Ensure the time of call, category of transfer and identification number are documented in the patient notes (this may be required if further calls need to be made).

If the responsible clinical team is unhappy with the category of transfer allocated by NWAS or the response time then a further clinician-to-clinician conversation should be requested with NWAS. Contact the receiving clinical team with an updates SBAR handover when the transfer is leaving the site.

3.8 Critical Illness transfers

Generally, a transfer should not be undertaken until a patient has been resuscitated and stabilised. A 'scoop and run' philosophy is only appropriate on rare occasions when the urgency of the situation and the need for definitive treatment at another site will limit the time available for stabilisation before transfer.

Decisions regarding accompanying personnel should be made utilising the Patient Decision Matrix for the Safe Transfer of Patients *(Appendix 1)* and in accordance with the North West Critical Care Networks Intra and Inter Hospital Critical Care Transfer (Adult) Transfer guidelines. https://www.lscodn.org/uploads/1/2/6/7/126781913/northwestcriticalcarenetworkstransferpolicymay2016finalv3.1.pdf.

At least one of the personnel undertaking transfer of critically ill patients should have undertaken the appropriate Critical Care Network standard Transfer Training. This is currently provided to Critical Care staff, ED staff, Anaesthetic staff and Acute Care team.

Patients requiring advanced respiratory support or support of two or more organ systems may require an escort by an advanced airway competent doctor or practitioner. This should be decided by a Senior Clinician.

3.9 Monitoring, drugs and equipment

It is the accompanying personnel's responsibility to ensure that patients are appropriately monitored and relevant drugs and equipment are available.

Any equipment specific to the patient care requirements must be transferred with the patient e.g. wheelchairs, bariatric beds, walking aids etc. All transfer equipment and medications, should be checked prior to departure; it is especially important that the escorting personnel are familiar with and competent in the operation of all equipment used in the transportation process.

Any equipment stored on wards or provided by Patient Services Assistants for transfer of patients must be checked and in working order prior to use e.g. trolleys, wheelchairs.

Portable oxygen cylinders must be checked prior to use and have sufficient oxygen to last the expected journey (*Appendix 2*), with back up provision if required. **Oxygen therapy must be checked and commenced by a Registered Nurse/Midwife.**
The transferring personnel are responsible for ensuring any equipment used during the transfer is returned to the original area.

3.10 Tracheostomy patients

Patients with tracheostomies **must be** transferred by a Registered Nurse/Midwife, who should have undertaken training in the emergency care of tracheostomies and laryngectomies as per the Trust CP38 V2.0 Tracheostomy Policy 2020.

They **must always** be transferred with *a* tracheostomy emergency equipment box. Please contact the Acute Care Team for a tracheostomy emergency equipment box.

3.11 Safeguarding

Risks relating to transfer of patients who are considered to be vulnerable adults e.g. safeguarding concerns, learning disabilities, lack of capacity must be considered as part of the Patient Decision Matrix for the Safe Transfer of Patients *(Appendix 1).*

The patient's privacy and dignity **must be** maintained during transfer and patients **must be** appropriately dressed/covered.

3.12 Infection Control

Infection control practices must be applied for all transfers. It is the responsibility of the transferring Registered Nurse/Midwife to ensure that known infection control issues and relevant treatment plans and/or microbiology results are clearly communicated to the receiving ward/area via the SBAR Handover and any advice required is obtained from the Infection Control team.

3.13 Documentation

Patient observations and medical/nursing notes **must be** continued at the same frequency as in the treatment area prior to transfer. This is particularly important in the on-going monitoring of **Critically Ill** patients. Any clinical changes, problems or safety issues during transfer **must be** documented in the patients' case notes.

For all patients the NEWS2/PEWS/MEOWS **must be** documented before the start of the transfer process and after arrival and any deterioration escalated accordingly.

When escorted patients arrive at the receiving ward/area, there must be a formal handover of care from the escorting personnel to the medical and/or nursing staff of the receiving unit who will then take over responsibility for that patient.

4.0 Compliance with transfer policy.

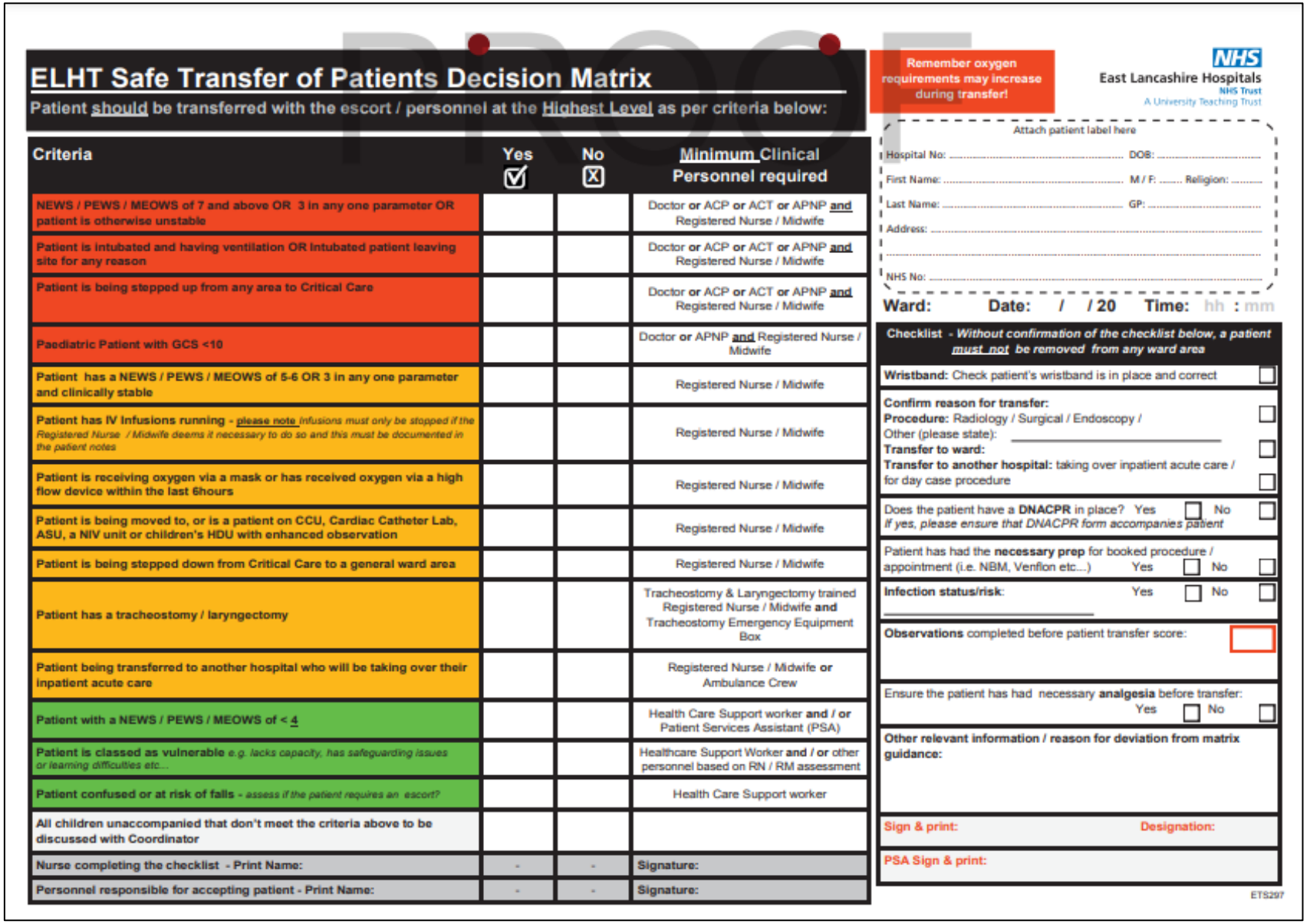
Patients requiring clinically urgent interventions **must not** have delays in transfer to appropriate care. Any concerns about the appropriateness / unexpected delays of a transfer should initially be escalated within the local ward/area to a senior nurse / matron/ site manager.

Additionally an IR1 should be completed for any problems or safety issues that occur during the course of transfer e.g. unexpected delays, appropriate staff availability, equipment availability or failure, unexpected clinical deterioration.

4.1 Monitoring Mechanism

Aspect of compliance being measured or monitored.	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Group or Committee for monitoring
Correct Minimum Clinical Personnel Required undertaking transfer Patient Decision Matrix present	Acute Care Team	Audit Tool	Quarterly	Deteriorating Patient Steering Group
Compliance with Policy	Acute Care Team	Audit Tool	Annually	Deteriorating Patient Steering Group
Any problems or safety issues that occur during the course of transfer e.g. unexpected delays, appropriate staff availability, equipment availability or failure, unexpected clinical deterioration	Acute Care Team	Datix IR1's	Monthly	Deteriorating Patient Steering Group

Appendix 1 – ELHT Patient Decision Matrix for the Safe Transfer of Patients (ETS297)



ELHT Safe Transfer of Patients Decision Matrix

Patient should be transferred with the escort / personnel at the Highest Level as per criteria below:

Criteria	Yes ☑	No ☒	Minimum Clinical Personnel required
NEWS / PEWS / MEOWS of 7 and above OR 3 in any one parameter OR patient is otherwise unstable			Doctor or ACP or ACT or APNP and Registered Nurse / Midwife
Patient is intubated and having ventilation OR Intubated patient leaving site for any reason			Doctor or ACP or ACT or APNP and Registered Nurse / Midwife
Patient is being stepped up from any area to Critical Care			Doctor or ACP or ACT or APNP and Registered Nurse / Midwife
Paediatric Patient with GCS <10			Doctor or APNP and Registered Nurse / Midwife
Patient has a NEWS / PEWS / MEOWS of 5-6 OR 3 in any one parameter and clinically stable			Registered Nurse / Midwife
Patient has IV Infusions running - please note *infusions must only be stopped if the Registered Nurse / Midwife deems it necessary to do so and this must be documented in the patient notes*			Registered Nurse / Midwife
Patient is receiving oxygen via a mask or has received oxygen via a high flow device within the last 6hours			Registered Nurse / Midwife
Patient is being moved to, or is a patient on CCU, Cardiac Catheter Lab, ASU, a NIV unit or children's HDU with enhanced observation			Registered Nurse / Midwife
Patient is being stepped down from Critical Care to a general ward area			Registered Nurse / Midwife
Patient has a tracheostomy / laryngectomy			Tracheostomy & Laryngectomy trained Registered Nurse / Midwife and Tracheostomy Emergency Equipment Box
Patient being transferred to another hospital who will be taking over their inpatient acute care			Registered Nurse / Midwife or Ambulance Crew
Patient with a NEWS / PEWS / MEOWS of < 4			Health Care Support worker and / or Patient Services Assistant (PSA)
Patient is classed as vulnerable *e.g. lacks capacity, has safeguarding issues or learning difficulties etc...*			Healthcare Support Worker and / or other personnel based on RN / RM assessment
Patient confused or at risk of falls - *assess if the patient requires an escort?*			Health Care Support worker
All children unaccompanied that don't meet the criteria above to be discussed with Coordinator			
Nurse completing the checklist - Print Name:	-	-	Signature:
Personnel responsible for accepting patient - Print Name:	-	-	Signature:

Remember oxygen requirements may increase during transfer!

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Attach patient label here

Hospital No: ..... DOB: .....

First Name: ..... M / F: ..... Religion: .....

Last Name: ..... GP: .....

Address: .....

.....

NHS No: .....

Ward: **Date:** / / 20 **Time:** hh : mm

Checklist - ***Without confirmation of the checklist below, a patient must not be removed from any ward area***

Wristband: Check patient's wristband is in place and correct ☐

Confirm reason for transfer:
Procedure: Radiology / Surgical / Endoscopy / ☐
Other (please state): _____
Transfer to ward: ☐
Transfer to another hospital: taking over inpatient acute care / ☐
for day case procedure

Does the patient have a **DNACPR** in place? Yes ☐ No ☐
If yes, please ensure that DNACPR form accompanies patient

Patient has had the **necessary prep** for booked procedure / appointment (i.e. NBM, Venflon etc...) Yes ☐ No ☐

Infection status/risk: Yes ☐ No ☐
_____

Observations completed before patient transfer score: ☐

Ensure the patient has had necessary **analgesia** before transfer: Yes ☐ No ☐

Other relevant information / reason for deviation from matrix guidance:

Sign & print: **Designation:**

PSA Sign & print:

ETS297


Please note that this document supersedes the previous: Patient Decision Matrix, Registered Nurse and Porter ID/Procedure Checklist, Transfer of Care document, Inter-Healthcare Transfer Form (Infection Control) & Acutely unwell Transfer of Care document

It supports the Paediatric STOP documents.

This document should be used in conjunction with ELHT Policy CO74 Guidance for the Safe Transfer of Patients

Purpose

This guidance is to be followed whenever the transfer of a patient is undertaken. This document aims to assist the Trust and individuals in improving the treatment of patients who require transfer between a range of different areas. This document covers the transfer of all adult, maternal and paediatric patients within the organisation.

Risk Assessment

The ELHT Safe Transfer of Patients Decision Matrix enables the Medical Team and/or Registered Nurse/ Midwife to risk assess the suitability and appropriateness of a transfer assessing the patient's needs and identifying their level of risk. The matrix identifies the appropriate personnel required to accompany the patient during transfer.

Decision to Transfer

The decision to transfer a patient to another area must be made considering the potential risks and benefits to the patient's condition. It is the responsibility of the Medical Team and/or Registered Nurse/ Midwife in charge of the patient's care to assess the risk to the patient and ensure a safe transfer, as per the ELHT Safe Transfer of Patients Decision Matrix.

Equipment & Medication

Patients may require monitoring during transfer. The decision regarding the level of monitoring lies with the transferring personnel. All patient medication to accompany patient during transfer if appropriate and as per policy CO64 Medicines Management Policy, section 6 Transport and Transfer of Medicines.

Deviation from ELHT Patient Decision Matrix for the Safe Transfer of Patients

This document does not cover all clinical scenarios and should be used as guidance. Transfers can be made outside of this guidance, however must be discussed with the Senior Nurse/Midwife in charge and documented in the box provided overleaf initially and continued below if applicable.

Notes / Documentation

Appendix 2 - Oxygen Utilisation Chart

Oxygen run time (minutes) = **Volume of cylinder (litres)**
Flow rate (litres per minute)

DO NOT RISK RUNNING OUT OF OXYGEN!
PLEASE CONSIDER WHERE YOU INTEND TO TRANSFER YOUR PATIENT.
ENSURE THE SUPPLY IN THE CYLINDER IS ADEQUATE?

IF NOT ADEQUATE DO NOT TRANSFER THE PATIENT WITH THIS CYLINDER.

Size 'D' Cylinder – (340 litres)

Flow rate	If the cylinder is FULL (340 litres)	If the cylinder is ½ FULL (170 litres)	If the cylinder is ¼ FULL (85 litres)
1 litre per minute	5 hours 40 min	2 hours 50 min	1 hour 25 min
2 litres per minute	2 hours 50 min	1 hour 25 min	42 min
3 litres per minute	1 hour 53 min	56 min	28 min
4 litres per minute	1 hour 25 min	42 min	21 min
6 litres per minute	56 min	28 min	14 min
8 litres per minute	42 min	21 min	N/A
10 litres per minute	34 min	17 min	N/A
12 litres per minute	28 min	14 min	N/A
15 litres per minute	22 min	N/A	N/A

Size ‘E’ Cylinder (680 litres)

Flow rate	If the cylinder is FULL (680 litres)	If the cylinder is ½ FULL (340 litres)	If the cylinder is ¼ FULL (170 litres)
1 litre per minute	11 hours 20 min	5 hours 40 min	2 hours 50 min
2 litres per minute	5 hours 40 min	2 hours 50 min	1 hour 25 min
3 litres per minute	3 hours 46 min	1 hour 53 min	56 min
4 litres per minute	2 hours 50 min	1 hour 25 min	42 min
6 litres per minute	1 hour 53 min	56 min	28 min
8 litres per minute	1 hour 25 min	42 min	21 min
10 litres per minute	1 hour 8 min	34 min	17 min
12 litres per minute	56 min	28 min	14 min
15 litres per minute	45 min	22 min	N/A

Appendix 3 - NWAS Categories

Category:	Headline Description:	Subscription:	Example: *(N.B. each case is unique and must be assessed as such)*	Average response target:	90th centile response target:
1	Life-threatening	A time critical life-threatening event requiring immediate intervention	E.g. Life-saving care immediately indicated but cannot be provided onsite such as major head injury requiring neurosurgery, immediate PCI indicated, Insufficient resources onsite to manage an immediately life threatening issue.	7 min	15 min
2	Emergency	Potentially serious conditions requiring urgent intervention and transport	E.g. Potentially life-saving care indicated urgently such as return to theatre indicated within next few hours.	18 min	40 min
3	Urgent	An urgent problem (not immediately life threatening) that requires intervention within a clinically appropriate time frame.	E.g. Care indicated urgently such as urgent out of hours investigations unavailable onsite.	None (mean indicator 60 min)	2 hrs
4	Less-urgent	Problems that are less-urgent but require intervention within a clinically appropriate time frame.	E.g. Care indicated less-urgently such as less-urgent out of hours investigations unavailable onsite.	None	3 hrs

Appendix 4 – Equality Impact Assessment Screening Form

Department/Function	Patient Transfers			
Lead Assessor	Clinician or Nurse responsible for patient care			
What is being assessed?	The safe transfer of patients			
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: Undertook a review of current state and cause and effect with service users both pre and post implementation. Presented at Corporate, Divisional, Local Forums as part of consultation, sign-off and information for key stakeholders.			

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)	Neutral	
Disability (Including physical and mental impairments)	Positive	Addressing the explicit needs of this group e.g. those with increased risk of falls and without capacity
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Positive	Addressing the explicit needs of all age ranges e.g. additional section added specific to Paediatrics
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Positive	Addressing the explicit needs of this group e.g. additional section added specific to maternity
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?	It helps to improve the equality of care provision across ELHT Patient Groups.

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 automatically be inserted as an appendix in all Policies and Procedures which are presented for ratification at the Policy Council. Please do not hesitate to contact the qualityandsafetyunit@elht.nhs.uk if you have any queries.