Barnsley Hospital NHS
NHS Foundation Trust

POLICY CONTROL SHEET

(updated August 2011)

Policy Title and ID number:	**Being Open Policy LfE5.10**			
Sponsoring Director:	**Medical Director**			
Implementation Lead:	Risk Manager			
Impact:	*(a) To patients*	Improved communication with staff		
	(b) To Staff	Framework to support discussion with patients when things go wrong		
	(c) Financial	Neutral		
	(d) Equality Impact Assessment (EIA)	Completed: **Yes**		
	(e) Counter Fraud assessed	Completed: **Yes / No**		
	(e) Other			
Training implications:	*To be incorporated into induction:* **Yes / No**			
Date of consultation:	***Approval Process***	**Date**	**Local Consultation**	**Date**
	Executive Team		*Joint Partnership Forum*	
	Board Committee:		*Local Negotiating Committee*	
	• *Clinical Governance*		*Infection Control Committee:*	
	• *Non Clinical Governance & Risk*		*Health & Safety Committee*	
	• *Audit Committee*		*Quality Safety Improvements & Effectiveness Board*	
	• *Finance Committee*			
	• *RATS*		*Investment Board*	
	Trust Board Approval / Ratification		*Patients Experience Board*	
	Other:		*Other:*	

Approval/Ratification at Trust Board:		Version Number:	3
Date on Policy Warehouse:		Team Brief Date:	
Circulation Date:		Date of next review:	December 2013

For completion by ET for *new* policies only:				
Additional Costs			Budget Code:	Revenue or Non Revenue
	(a) Training	£		
	(b) Implementation	£		
	(c) Capital	£		
	(d) Other	£		

Policy for Being Open

(POLICY ID: LfE 5.10)

Implemented December 2006, Updated January 2010 and January 2011

Sponsoring Director: Medical Director

Policy for Being Open

(POLICY ID: LfE 5.10)

CONTENTS

ABBREVIATIONS AND ACRONYMS USED IN THIS POLICY

- NHSLA NHS Litigation Authority
- MORI An Independent Research and Study organisation
- SI Serious Incident
- NPSA National Patient Safety Agency
- PALS Patient Advice and Liaison Service

BEING OPEN POLICY

1. STATEMENT OF INTENT

1.1. The intention of this policy is to ensure that Barnsley Hospital NHS Foundation Trust has systems in place so that in any situation where harm (injury (physical or psychological), disease, suffering, disability or death)[1] may be caused to a patient during their care at Barnsley Hospital, all members of the clinical team/s involved in the patient's treatment will know and understand the process of how to raise the issues with the patients and his or her family or carers. These procedures will provide assurance to the patients and community of Barnsley that best practice, good communication and patient safety are major priorities at Barnsley Hospital.

2. INTRODUCTION

2.1. This Policy has been developed in response to the National Patient Safety Agency (NPSA) *Safer Practice Notice* issued in September 2005 and reviewed following the issue of NPSA/2009/PSA 003 Being Open. This requires NHS Trusts to develop local policies for informing patients[2] of adverse events and encourages openness, honesty and learning. The importance of being open is emphasised within the NHSLA Risk Management Standards and the General Medical Council's *Good Medical Practice*. This Policy provides a framework to deliver the overarching *Being Open* objective

2.2. There is evidence to show that patients support openness. A MORI survey commissioned for the Department of Health's consultation document *Making Amends* [2] interviewed 8,000 people across the UK. Results showed that nearly 400 of the respondents reported that they had experienced a patient safety incident. These people wanted the NHS to respond in the following ways after a patient safety incident;

- 34% wanted an apology or explanation
- 23% wanted an enquiry into the causes
- 17% wanted support in coping with the consequences
- 11% wanted the financial compensation
- 6% wanted disciplinary action.

[1] Definition of harm taken from Being Open, NPSA 1079, November 2009

[2]Throughout the document when referring to a patient this includes a patient's next of kin / nominated representative where appropriate

[2] DoH (2003).*Making Amends*. London: The Stationery Office (available at www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf (April 2004)

3. IMPLEMENTATION

3.1 Briefing Patients and the Community

Being Open charter template has been placed in main reception, and copies distributed to all clinical areas and PALs team.

3.2 Divisional Implementation

The policy will be implemented in the Divisions, following the management responsibilities described below, and using the processes and structures laid out in the procedural document at appendix 1.

Divisions to report monthly to the Risk Manager including details of all Being Open meetings, with details of specific actions agreed.

4. MANAGEMENT ARRANGEMENTS

Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer for the Trust.

All Trust directors are responsible, collectively, for the Trust's systems of internal control and management. The Board of Directors needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively.

The Board of Directors has delegated its accountability arrangements for the Policy for Being Open to the Medical Director.

The responsibility for the effective implementation of the being open policy and supporting procedures necessarily involves the whole management chain of command, and all members of staff have a responsibility to ensure the effective implementation of the policy and procedures.

Within that system there are certain key officers whose specific functions are outlined below.

4.1. Medical Director, who will

- Ensure that policy and procedures are agreed through consultation with relevant staff groups
- Ensure that the overarching policy is updated regularly in line with national guidance and audit reports
- Keep the Chief Executive and Board of Directors up to date with progress and highlight any areas of concern
- Promote an open culture of improving patient safety across the hospital.

- Ensure that an appropriate infrastructure is available to support clinicians involved in patient safety incidents and Being Open discussions.
- Ensure that appropriate training and guidance is available for clinicians who lead Being Open discussions.

4.2. Chief Nurse will, in conjunction with the Medical Director and the Director of HR

- Ensure that an appropriate infrastructure is available to support clinicians involved in patient safety incidents and Being Open discussions

4.3. Divisional Directors, Divisional Managers, Heads of Departments

- To ensure that staff are trained to the correct level of competence
- To ensure that regular audit of agreed processes and procedures take place to monitor practice and ensure that remedial action is implemented where required
- Through divisional clinical governance committees ensure that all appropriate staff are familiar with the Being Open processes and instigate as necessary.
- Ensure that in all situations where a patient has been harmed, or might have been harmed, the Being Open policy and procedures are followed.

4.4. Risk Manager will:

- Will keep a central log of all incidents that have led to Being Open discussions and ensure that they are processed as appropriate (Serious Incident (SI) etc). This will be presented at the Trust's Clinical Governance Committee meeting annually.

4.5. Head of Patient Experience will:

- Provide support as requested/required to patients/families before, during and after Being Open discussions, and provide information to patients, family and carers about the Being Open process as requested.

4.6 All Staff:

- To follow agreed procedures
- To report any untoward incidents or near misses
- To assist where required with audit processes
- Will be aware of and ensure that the Being Open procedure is followed when harm has come to a patient.

5. SUPPORTING STAFF

The Trust will ensure that staff are supported when the Being Open procedure is implemented. Where necessary giving emotional or physical support. This will be delivered through:

- The 'Support for Staff Involved In An Incident, Complaint Or Claim' policy
- Identifying senior clinical counsellors to provide mentoring and support to colleagues and lead Being Open discussions where appropriate. The Divisional Management team (DD, ADD and ADoN) have been designated this role.

Support for Consultants:
Divisional Directors
Clinical Directors
Medical Director
Assistant Divisional Directors

Support for Nursing Staff:
Lead Nurse
Matron
Assistant Director of Nursing
Assistant Divisional Directors

6. MONITORING AND EFFECTIVENESS

To ensure that this policy operates effectively at Barnsley Hospital NHS Foundation Trust, the following will be collated:

6.1. Monthly returns detailing Being Open.

6.2. An annual report for the Clinical Governance Committee outlining how many Being Open meetings have taken place, and any specific actions that have arisen as a result to be produced by the Risk Manager. This will be in summary form as detailed actions plans for Serious Incidents and adverse events will be presented and discussed at the Clinical Governance Committee separately to provide assurance that such risks have been identified and mitigated.

7. REVIEW DATE

The Clinical Governance Committee will review this policy 2 years after its approval or sooner if a change in national legislation or local procedures make it necessary.

APPENDICES

Appendix One	Being Open Procedure
Appendix Two	The NPSA's Ten Principles of Being Open
Appendix Three	Senior clinical counsellors
Appendix Four	Monitoring Matrix

CROSS REFERENCED DOCUMENTS

- Policy for Supporting Staff involved in an incident complaint or claim
- Being Open, NPSA 1097, November 2009
- NPSA Ten principles of Being Open (attached in appendices)
- Incident Reporting Policy
- Serious Incident Policy
- Stress Policy
- Root Cause Analysis protocol
- Incident Decision Tree protocol

APPENDIX 1

BEING OPEN GUIDELINE

INTRODUCTION

The staff at Barnsley Hospital work hard to deliver the highest standards of healthcare, and provide safe and effective care to thousands of people every year. However, despite best efforts, things can and do go wrong. This guideline, in conjunction with the Trust documents listed on page 8, aims to ensure that across the Trust an environment is created where patients, healthcare professionals and managers all feel properly supported when things go wrong.

If a patient is disadvantaged and/or harmed as a result of a mistake or error, the Trust believes that they should receive an apology, be fully informed as to what has happened, have their questions answered and know what is being done in response.

Where Patients are referred to, when appropriate, this may also include family/carers.

This guideline makes a commitment that, in such circumstances, the Trust will:

- Apologise for the harm caused (an apology is not an admission of liability)
- Explain, openly and honestly, what went wrong
- Describe what the Trust is doing in response to the mistake
- Offer support as appropriate
- Provide the contact details of a named individual (within the Trust) who is responsible for updating the patient.

Key principles

All instances where a patient has suffered harm should be communicated within the clinical team, and recorded in the patient file as soon as possible afterwards.

- Details of the initial discussion should be documented and added to the patient file. It is recommended that copies should also be kept within the Division so a comprehensive record is built up for future reference.

- Any such incident should be reported and investigated in line with the Trust's SI/Incident Reporting Policy

- The method of further feedback should be agreed with the patient

- It is recognised that some patients will not want further information and this request should be respected and documented in their records

- Prevented or 'no harm' incidents need not be routinely discussed with the patient, although this can be determined locally on a case-by-case basis .

Identification of an adverse event

As soon as an adverse event is identified the main priority is to ensure that prompt and appropriate clinical care is given and to prevent further harm. Through reporting the incident an assessment of the level of harm suffered will be undertaken and the incident investigated. This will determine the required response.

The majority of adverse events will be identified immediately or very soon after the event. However in some cases it may be a considerable time after the event before it becomes apparent that something went wrong. In these circumstances consideration must be given as to how and when the patient is informed.

It is not the Trust's role to decide whether a patient should be informed as this goes against the principle of *Being Open*. However it may be sensible to wait for the patient's next outpatient appointment rather than convene a special meeting, particularly when the level of any harm suffered has been low. This decision should be taken locally and documented alongside the incident report.

Where a patient has suffered moderate or serious harm the principle of early communication still applies however the level of response will be different.

NHS Complaints Procedure

The Being Open process aims to reduce the chance of a formal complaint being received by the Trust. However patients should be advised of the Complaints Procedure at the time they are advised of the adverse event in order that they can consider their options.

Level of response

Incident	Action
No harm (including near miss)	Patients are not usually contacted or involved in investigations. These are outside the scope of the *Being Open* policy but locally decisions can be taken as to whether 'no harm' events are discussed with the patient. Record any such discussions on the patient file.
Low harm	Unless there are specific indications or the patient requests it, the communication, investigation and implementation of changes will occur at local service delivery level (whilst an inpatient or during a consultation, for example) with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient. Record any such discussions on the patient file.

Moderate or severe harm (including death)	A higher level of response is required in these circumstances. Consideration should be given as to whether the event constitutes a Serious Incident (SI). This should be discussed with the Chief Nurse. An initial, formal meeting should take place where the adverse event is discussed and an action plan agreed with the patient. Further meeting(s) may be held on completion of the investigation. The Medical Director and/or Chief Nurse should be notified to provide support and advice during the *Being Open* process. Record any such discussions on the patient file and log within the Division.

Being Open

Who should attend the preliminary meeting?

A lead staff member who is normally the most senior person responsible for the patient's care and/or someone with experience in the type of incident that has occurred who has the ability to explain what went wrong and, where possible, why it went wrong.

The 'lead' staff member should be supported by at least one other member of staff. This may be the Assistant Director of Nursing, Assistant Divisional Director or Divisional Director depending on the severity or type of the incident. For continuity one individual should be the patient's point of contact throughout any investigation. This should be the lead investigator or someone of suitable seniority such as a senior doctor, Assistant Director of Nursing, Lead Nurse or Risk Manager.

The patient should be asked who they would like to be present at the meeting/discussion, eg a supporter or family member, or a PALs representative. If it is not possible to get all the appropriate/requested people to the first scheduled meeting it is suggested that the meeting is deferred until all those required can be present.

The patient may ask for an alternative healthcare professional to lead the discussion and wherever possible this should be accommodated by the Trust.

Offer and encourage the patient the opportunity to contact the PALS for support.

A pre-meeting of Trust staff should be held so that the facts (as known at the time) and aims of the meeting are understood, and everyone knows their particular role in the preliminary meeting with the patient.

When and where should the meeting be held?

The meeting should be held as soon as practicable after the incident comes to light. The patient should be offered a choice of time, date and location. In the case of a serious incident the patient may not wish to come into NHS property and a neutral venue may be sought to avoid causing additional distress.

The meeting should not be postponed or cancelled by Trust staff under any but exceptional circumstances.

How should the discussion be structured?

- Everyone present should be introduced and their roles explained
- Acknowledge what happened and apologise on behalf of the team / Trust
- Stick to the facts known at the time and assure the patient that as more information becomes available it will be shared with them
- Do not speculate or attribute blame
- Check the patient has understood and offer to answer any questions
- Explain what will happen next and ask how the patient would like to be advised of the outcome of the investigation
- Notes of the meeting must be taken and a copy sent to the patient.

Written records of the Being Open discussions should consist of:

- The time, place and date, as well as the name and relationships of all attendees
- The plan for providing further information to the patient
- Offers of assistance and the patient's response
- Questions raised by the patient and the answers given
- Plans for follow-up meetings
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient
- Copies of letters sent to the patient and the GP
- Copies of any statements taken in relation to the patient safety incident
- A copy of the incident report.
- Assign responsibilities and deadlines. The notes should be sent within 48 hours of the meeting

Follow up

- A complete, accurate record of all discussions should be kept within the Division
- Maintain a dialogue by addressing new concerns, sharing new information and provide information on appropriate counselling and support
- The Trust may wish to invite the patient to be involved in any action planning that results from the incident, to demonstrate changes to practice/procedure

- Offer a follow-up meeting to discuss the findings of any investigation and the written report and progress of the action plan.

Litigation

The Being Open process does not place the Trust in a weaker position should a claim arise. **It is important to note that an apology is not an admission of liability**. However, as with any adverse event where it is likely that it occurred due to negligence, the National Health Service Litigation Authority (NHSLA) should be informed and the Trust complaints manager must advise the NHSLA in the normal way. Please refer to the Risk Manager for advice.

It is unusual for patients to immediately consider litigation, however in such circumstances they should be directed to the complaints manager. A threat of legal action should not prevent the *Being Open* process, although once litigation has commenced this would not be appropriate.

Human Resources issues

Where an adverse event may result in action under one of the Trust's HR policies the philosophy of *Being Open* still applies, however advice should be sought from the HR Department at the earliest opportunity.

Further information

The NPSA has developed resources for staff to refer to. These are available to download from the NPSA website at **www.npsa.nhs.uk/advice**

Appendix 2

The NPSA's Ten Principles of Being Open

Acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient and/or carers inform healthcare staff when something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. Denial of a person's concerns will make future open and honest communication more difficult.

Truthfulness, Timeliness and Clarity of Communication

An appropriately nominated person must give information about a patient safety incident in a truthful and open manner. Communication should also be timely informing the patient and/or their carers what has happened as soon as is practicable, based solely on the facts known at that time. Explain that new information may emerge as the incident investigation takes place and that they will be kept up to date. Patients and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

Apology

Patients and/or carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Verbal apologies are essential because they allow face to face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the incident, must also be given. Both verbal and written apologies should be given. Saying sorry is not an admission of liability and it is the right thing to do.

Recognising Patient and Carer Expectations

Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face meeting with representatives from the Trust. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients and/or their carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information on the Patient Advisory and Liaison Service (PALS) and other relevant support groups should be given as soon as possible.

Professional Support

The Trust must create an environment in which all staff are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process, they too may have been traumatised by the incident. To ensure a robust and consistent approach to incident investigation the NPSA has developed an Incident Decision Tree (ICT). Where there is reason for the healthcare organisation to believe that a member of staff has committed a punitive or criminal act, the organisation should take steps to

preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies.

Risk Management and Systems Improvement

Root cause analysis (RA) or similar techniques should be used to uncover the underlying causes of patient safety incident. Investigation should focus on improving systems of care, which will be reviewed for their effectiveness.

Multi-Disciplinary Responsibility

The being open policy applies to all staff who have key roles in patient care. Most healthcare provision involves multi-disciplinary teams and communication with patients and/or their carers following an incident that led to harm should reflect this. This will ensure that the Being open process is consistent with the philosophy that incidents usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the Being open process, it is important to identify clinical, nursing and managerial leaders who will champion it. Both senior managers and senior clinicians must participate in the incident investigation and clinical risk management.

Clinical Governance

Being open requires the support of patient safety and quality improvement through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to the Board to ensure that these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from patient safety incidents. Audits should be developed to monitor the implementation and effects of changes in practice following a patient safety incident.

Confidentiality

Details of a patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need to know basis and where practicable records should be anonymous. It is good practice to inform the patient and/or carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Continuity of Care

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

- Deal with the issue as soon as it emerges
- Where the patient agrees, ensure their carers are involved in discussions from the beginning
- Ensure the patient has access to support services
- Where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team
- Offer the patient and/or carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution
- Ensure the patient and/or their carers are full aware of the formal complaints procedure
- Write a comprehensive list of the points that the patient and/or carer disagree with and reassure them you will follow up these issues

Appendix 3

Senior Clinical Counsellors

Senior clinical counsellors provide mentoring and support to their colleagues implementing Being Open. They should only be asked to lead Being Open discussions when appropriate and have been identified as follows:

Support for Consultants:
- Divisional Directors
- Clinical Directors
- Medical Director
- Assistant Divisional Directors

Support for Nursing Staff:
- Lead Nurse
- Matron
- Assistant Director of Nursing
- Assistant Divisional Directors

Senior clinical counsellors should support fellow healthcare professionals with Being Open by:

- Mentoring colleagues during their first Being Open discussion
- Advising on the Being Open process
- Being accessible to colleagues prior to initial and subsequent Being Open discussions
- Facilitating the initial team meeting to discuss the incident when appropriate
- Signposting the support services within the organisation for colleagues involved in Being Open discussions
- Facilitating debriefing meetings following Being Open discussions
- Mentoring colleagues to become senior clinical counsellors

Support fellow healthcare professionals in dealing with patient safety incidents by:

- Signposting the support services within the organisation for colleagues involved in patient safety incident discussions
- Advising on the reporting system for patient safety incidents

Practice and promote the principles of Being Open

LfE 5.10 Being Open Monitoring Matrix **Appendix 4**

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible person/group/ committee	Frequency of monitoring	Responsible person/group/ Committee for review of results	Responsible person/group/ Committee for development of action plan	Responsible person/group/ Committee for monitoring of action plan
a. process for encouraging open communication between healthcare organisations, healthcare teams, staff, patients and/or their carers	Reports to Risk Manager	Divisional Directors	Monthly	Divisional Governance	Divisional Governance	Clinical Governance Committee
b. process for acknowledging, apologising and explaining when things go wrong	Reports to Risk Manager	Divisional Directors	Monthly	Divisional Governance	Divisional Governance	Clinical Governance Committee
c. requirements for truthfulness, timeliness and clarity of communication	Reports to Risk Manager	Divisional Directors	Monthly	Divisional Governance	Divisional Governance	Clinical Governance Committee
d. provision of additional support as required	Reports to Risk Manager	Divisional Directors	Monthly	Divisional Governance	Divisional Governance	Clinical Governance Committee
e. requirements for documenting all communication	Reports to Risk Manager	Divisional Directors	Monthly	Divisional Governance	Divisional Governance	Clinical Governance Committee

Equality Impact Assessment (EQIA)
Pro-Forma

The purpose of an Equality Impact Assessment (EQIA) is to ensure that the Trust does not unwittingly discriminate against groups belonging to any of the Protected characteristics (PC's) Age, Disability, Gender reassignment, Sexual Orientation, Race, Religion or Belief, sex, sexual orientation, marriage & civil partnership, pregnancy and maternity. An EqIA is a process which ensures we promote equality in the provision and take up of our services and employment practices at Barnsley NHS Foundation Trust.

Div/ Dept	Corporate
Policy/ Service	LfE5.9 Best Practice National Confidential Enquiries/Inquiries
Is this policy/ service New/Existing	Existing
Name of Assessor(s)	Sharon linter
Date of EqIA.	10 November 2011
Aims/Objectives/Purpose Of Policy/Service	To ensure that Barnsley Hospital NHS FT has robust systems in place so that all best practice recommendations and requirements arising from National Confidential Enquiries/Inquiries are considered by the appropriate clinical teams in relation to the planning and updating of clinical services.
Associated Objectives for this Service e.g. National frameworks, Equality Act.	Compliance with NCE recommendations
Who Does this policy/service Affect?	Staff
What outcomes do you want to achieve from this process?	Improved clinical services

What factors could contribute/detract from the effective delivery of this policy/service?	Contribute: Detract	Detract:
	Robust planning to bring into line with recommendations	Lack of funding/manpower to meet recommendations
Could this service/policy have a different impact on different groups protected characteristics (**PC's**)	**If Yes please circle which groups** Race Age Disability Gender reassignment Religion/belief Sexual Orientation Pregnancy maternity Marriage Civil partnership Sex	**N**
Explain any reasons/evidence to support the above question, relevant to this impact (e.g. language barriers, consultation, complaints, surveys, mystery shopper, evaluations)	NA	
If you have answered yes to the above, please describe any **planned actions**, (**SMART**), work streams which will help mitigate your EqIA and ensure your policy/service will: • **Eliminate discrimination** • **Promote equal opportunities** • **Foster good relations between others.**	NA	
Following the above actions, will there be a	• If yes please complete partial assessment.	**NA**

need for a further Equality Impact Assessment? (EqIA)	• If no this assessment needs to be completed, recorded and sent electronically to your **Equality & Diversity Advisor**	
How will your EQIA be communicated/shared?	• Emailed to Trust Equality and Diversity Advisor for agreement and sign off. • Communicated to your direct Line Manager. • Communicated to Div/Dept team brief.	. **Y** **Y** **Y**
When is the next review (Please note review should be immediate on any amendments to your policy etc.)	**1 year** **2 year** **3 year**	**2 Years**