Procedure	NHS Worcestershire Acute Hospitals NHS Trust

Infection Prevention Procedure and Practice Guidelines for Intravenous Access Devices (IVAD)

Department / Service:	Infection Prevention Team
Originator:	Marsha Jones Head of Improvement & Tracey Cooper, DIPC
Accountable Director:	Paula Gardner, CNO
Approved by:	Infection Prevention & Control Steering Group Meeting (formerly TIPCC)
Date of approval:	23rd August 2021
Review Date: **This is the most current document and should be used until a revised version is in place**	31st December 2024
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All clinical areas
Target staff categories	Nursing , Medical

Plan Overview:
This document sets out the core principles necessary to prevent infection linked to the insertion, maintenance and removal of IVAD's. It is underpinned by NICE national guidance and local policy. This guidance is based on the best critically appraised evidence currently available. Detailed procedures are contained in various Trust training and competency packages, and in the ANTT (Aseptic Non-Touch Technique) resources contained on the intranet. This replaces the following documents: WAHT-INF-017 and WAHT-INF-035

Key amendments to this Document:

Date	Amendment	By:
23rd August 2021	New document approved	Infection Prevention & Control Steering Group Meeting
July 2024	Document extended until December whilst under review	Lara Bailey

Contents:

1. Introduction

1.1 Overall purpose

This document sets out the core principles necessary to prevent infection linked to the insertion, maintenance and removal of IVAD's. It is underpinned by NICE national guidance and local policy.

This guidance is based on the best critically appraised evidence currently available.

Detailed procedures are contained in various Trust training and competency packages, and in the ANTT (Aseptic Non-Touch Technique) resources contained on the intranet.

Patients with IVAD's are placed at increased risk of harm if not appropriately managed, for example healthcare associated infections and bloodstream infections are a significant cause of morbidity and mortality (NICE, 2014). IVAD-related bloodstream infections occur regularly due to sub-optimal insertion or management of IVADs patients.

1.2 Key objectives

To reduce patient harm due to avoidable infection by ensuring the following principles are in place:

- Trained and competent staff
- Adherence to relevant policies and guidance
- Underpinning knowledge of different IVADs
- Evidence-based care and maintenance of IVADs
- Appropriate use of care bundles and accurate documentation
- Prevention, early recognition and management of complications
- Inserting IVAD only when clinically indicated and removing at earliest opportunity

1.3 Scope

This guideline is relevant to all WAHT clinical staff that insert or care for patients with an IVAD. This guideline should be used in conjunction with other relevant guidelines and standards.

2. Contribution list

This key document has been circulated to the following individuals for consultation;

Designation
Members of the *Staphylococcus aureus* BSI Quality improvement Project
Divisional Directors – all divisions
Divisional Directors of Nursing – all divisions
Practice Development Team: Kate Knight
IV Therapy Team: Linda Gatehouse
SCSD Medical Director for Patient Safety and Quality Improvement: Dr E Mitchell
Consultant Microbiologists/Co-Infection Control Doctors: Dr E Yates and Dr E Yiannakis
Infection Prevention Team
Critical Care Clinical Director: Dr A Burtenshaw
Haematology/Oncology Matron: M Squires
Director of Pharmacy – Tania Carruthers
Trust Infection Prevention & Control Committee – all committee members

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Trust Infection Prevention & Control Committee

3. Glossary of terms

Term / abbreviation	Description
ANTT	Aseptic Non-Touch Technique
IVAD	Intravenous Access Device
PVD/PVC	Peripheral vascular device/Peripheral vascular cannula
CVAD/CVC	Central vascular access device/Central vascular catheter
Phlebitis	The inflammation of the intima layer of the vein. Signs of phlebitis include localised pain, redness and swelling
VIP Score	Visual Infusion Phlebitis Score

4. Procedure Description Overview:

Selection of IVAD

Most patients who require IV access will be given a peripheral vascular device/cannula. Some of these patients then require an extended period of IV therapy, and due to their medical conditions or the nature of the drugs they require their peripheral veins may be in poor condition. This often results in repeated peripheral cannulations, including failed cannulations and in some cases blood-stream infection.

It is important that alternative IVAD are considered at an appropriate time for these patients, to ensure effective treatment, to prevent excessive damage to their veins, and reduce risk of infection. Options may include for example Midlines, or central vascular access devices such as Peripherally Inserted Central Catheters (PICC lines), Hickman lines, and Portacaths.

Several tools have been developed to support the decision-making process on device selection, including the Vessel Health Preservation Framework (Hallam et al 2020) and the Michigan Appropriateness Guide for Intravenous Catheters (MAGIC) (Chopra et al 2015). The MAGIC framework is preferred for use in the Trust and the MAGIC app can be downloaded to support decision-making.

The Trust is progressing a piece of work to streamline referrals for insertion of mid-lines and central venous access devices including PICCs. In the interim the following can be contacted to support: Dr Whitelock, Anaesthetics; Interventional Radiology; IV Therapy Team.

Insertion and Care of IVAD

The following principles should be followed for the insertion and care of IVADS. They are set out in the current national evidence-based principles for the prevention of infection (Loveday et al 2014).
https://improvement.nhs.uk/resources/epic3-guidelines-preventing-healthcare-associated-infections/

General asepsis

- ✓ Healthcare workers must decontaminate their hands before accessing or dressing a vascular access device, using an alcohol handrub or by washing with liquid soap and water if hands are contaminated. An aseptic technique must be used for inserting vascular access devices, catheter site care, when accessing the system and when administrating intravenous medication. WAHT has implemented the ANTT programme for aseptic technique. Details can be found on the intranet.

Skin preparation

- ✓ Use a single-use application of 2% chlorhexidine gluconate in 70% isopropyl alcohol (or povidone iodine in alcohol for patients with sensitivity to chlorhexidine) to clean the Intravenous Access Device site prior to insertion and during dressing changes. The solution must be allowed to air dry in order to be effective; clean for at least 30 seconds and allow to dry for at least 30 seconds.

- ✓ WAHT has implemented use of Chloraprep solution for this, and this is available in procedure packs which should be used for insertion and dressing changes.

- ✓ Do not apply antimicrobial ointment routinely to the catheter placement site prior to insertion to prevent catheter-related bloodstream infection.

- ✓ If a device is inserted under emergency conditions where there is no evidence that aseptic practice/ANTT was used, it must be removed and replaced within 24 hours. This includes devices inserted in the pre-hospital setting for example by the ambulance service as well as in-hospital emergency placement.

Vascular access device site care

- ✓ A sterile, transparent, semipermeable membrane dressing should be used to cover the vascular access device insertion site. This should be changed every 7 days; sooner if it is no longer intact or if moisture collects under the dressing.

- ✓ A procedure pack should be used for insertion and dressing changes, using ANTT principles which will guide selection of PPE and equipment to be used.

- ✓ A single-use application of 2% chlorhexidine gluconate in 70% alcohol (or aqueous povidone iodine) should be used and allowed to dry when cleaning the insertion site during dressing changes.

Catheter and catheter site care

- ✓ Use a sterile, transparent, semi- permeable polyurethane dressing to cover the intravascular insertion site.

- ✓ Transparent, semi-permeable polyurethane dressings should be changed every 7 days, or sooner, if they are no longer intact or if moisture collects under the dressing.

- ✓ Use a sterile gauze dressing if a patient has profuse perspiration or if the insertion site is bleeding or leaking, and change when inspection of the insertion site is necessary or when the dressing becomes damp, loosened or soiled. Replace with a transparent semi-permeable dressing as soon as possible.

- ✓ Consider the use of a chlorhexidine- impregnated sponge dressing in adult patients with a central venous catheter as a strategy to reduce catheter-related bloodstream infection.

- ✓ Consider the use of daily washing with chlorhexidine in adult patients with a central venous catheter as a strategy to reduce catheter-related bloodstream infection.

✓ Dressings used on tunnelled or implanted catheter insertion sites should be replaced every 7 days until the insertion site has healed unless there is an indication to change them sooner. A dressing may no longer be required once the insertion site has healed.

5. Roles and responsibilities

For the care and maintenance of any IVAD, staff should be appropriately trained and supervised until considered competent. A practitioner can be described as competent if they have had the necessary training, clinical experience, skills and knowledge to undertake a task safely and without supervision. If a practitioner deems it appropriate to adapt the guidelines, a risk assessment must be undertaken and documented appropriately.

All staff inserting, re-dressing or managing IVADs must have completed ANTT training and competency. The link to this is at: http://nww.worcsacute.nhs.uk/departments-a-to-z/infection-prevention-and-control/antt/

The ANTT policy can be found on the intranet: '*Aseptic Non-touch Technique ANTT Policy'*
http://nww.worcsacute.nhs.uk/EasysiteWeb/getresource.axd?AssetID=113164&type=full&servicetype=Attachment
All care in relation to IVADs must be documented appropriately by filling out the relevant supporting Trust documentation e.g. the PVD paperwork or the Central line LocSSIP or the daily sheet.

6. Standards

This section contains a number of recommendations aimed at improving patient safety and reducing the risk of harm for patients who have an IVAD. These recommendations are taken from epic3 guidance: https://improvement.nhs.uk/resources/epic3-guidelines-preventing-healthcare-associated-infections/

Inspecting the IVAD and Insertion Site: The device should be checked and observed any time the catheter is being accessed. If the IVAD is not being used for continuous infusions, then the patency of the device should be assessed at least once per day and/or prior to and after any medicine administration, in line with the Injectable Medicines policy.

The IVAD insertion site should be checked by a healthcare practitioner each time it is used/accessed, and at a minimum 8-hourly. Some patients may require an increased frequency of checks, for example patients receiving irritant medications.
Observation should include:

- Insertion point and surrounding tissue: VIP score
- Dressing: is it secure and fully covering the insertion site, is there pooling of sweat underneath. If no to any of these it will require re-dressing
- Integrity of IVAD: any damage
- Security of connections
- Dislodgement or migration of device

If the dressing is loose, damp or soiled it should be replaced immediately and the patency of the IVAD should be assessed. Bandages should not be used to cover cannula sites, as it is not possible to observe the site properly. If protection is required consider using a suitable size tubi-bandage which can be easily pulled down to visualise the site.

The insertion site should be visually inspected for signs of phlebitis or inflammation through the intact dressings and documented appropriately.

IVADs should be changed if clinically indicated. The need for the IVAD should be reviewed daily, and they should be removed if no longer clinically required.

If there are signs of inflammation or a VIP score of 1 or above they must be removed and replaced if access is still required.

There is no requirement for routine removal at a given time if the cannula is still required and the VIP score remains at zero.

Practices:

- ✓ Hands must be decontaminated, with an alcohol-based hand rub or by washing with liquid soap and water before and after any contact with the intravascular catheter or insertion site, and if soiled or potentially contaminated with blood or body fluids. .

- ✓ Use the aseptic non-touch technique (ANTT) for the insertion and care of an intravascular access device and when administering intravenous medication.

- ✓ Use maximal sterile barrier precautions for the insertion of central venous access devices: sterile pack, drape, gown, gloves.

Aseptic Non-Touch Technique (ANTT): Rule of ANTT: key parts must only come into contact with other key parts or key sites.

- **Aseptic:** free from pathogenic micro-organisms that can be introduced by hands, surfaces and / or equipment

- **Non-Touch:** method used to prevent contamination of key parts and key sites by hands, surfaces or equipment.

- **Technique:** assess the risk of contamination and **choosing the appropriate approach ANTT** states that the key principle to preventing infection is to maintain the asepsis of key parts and key sites. **A key part (e.g. tip of syringe)** being any part of a device that will **come into direct contact with key sites** (e.g. insertion point / needle free access device). These key parts can be protected by the use of micro critical aseptic fields such as the inside of a syringe wrapper, or a sterile cap. This minimizes the risk of contamination of key parts and key sites which can potentially lead to infection.

ANTT training and materials can be found on the intranet at:
http://nww.worcsacute.nhs.uk/departments-a-to-z/infection-prevention-and-control/antt/

Hand hygiene: Staff must undertake hand hygiene at key moments in line with the Hand Hygiene Policy.

Choice of Personal Protective Equipment (PPE): Before undertaking any procedure, staff must assess any likely exposure to blood and / or body fluids and ensure that PPE is worn to provide protection for the practitioner and does not breach aseptic non-touch technique. Sterile gloves may be appropriate if the practitioner is required to handle key parts and key sites to maintain asepsis of

these parts. It is the practitioner's responsibility to undertake a risk assessment and choose appropriate equipment for personal and patient protection.

Infection control: Current local and national guidance advise that Standard Infection and Prevention and Control Precautions should be embedded into all aspects of care delivery including the care of patients with vascular access devices. Clinical staff are expected to adhere to these principles to reduce patient harm.

Central venous access device insertion (including PICC and midline catheters) are supported by a LocSSIP processes.

Selection of catheter type

✓ Selection of device, device size and point of insertion will depend on a number of factors, including patient acuity, and planned use of the device. Use the most appropriate vascular catheter in the most distally accessible vein to reduce infection risk. Use a catheter with the minimum number of ports or lumens essential for management of the patient.

- Preferably use a designated single- lumen catheter to administer lipid-containing parenteral nutrition or other lipid-based solutions. Where multiport devices are used, keep one port solely for the administration of TPN if this is needed. It should be labelled to identify it as for TPN only.

- Where medium or long-term IV access is required it is important that alternatives to peripheral cannulae are considered at an appropriate time for these patients, to ensure effective treatment, to prevent excessive damage to their veins, and reduce risk of infection. Options may include for example Midlines, or central vascular access devices such as Peripherally Inserted Central Catheters (PICC lines), Hickman lines, and Portacaths.

✓ National guidance recommends use of an antimicrobial-impregnated central venous access device for adult patients whose central venous catheter is expected to remain in place for >5 days if catheter-related bloodstream infection rates remain above the locally agreed benchmark, despite the implementation of a comprehensive strategy to reduce Catheter-related bloodstream infection.

Selection of catheter insertion site

✓ In selecting an appropriate intravascular insertion site, assess the risks for infection against the risks of mechanical complications and patient comfort.

✓ Use the upper extremity whenever possible for non- tunnelled catheter placement unless medically contraindicated.

General principles for catheter management

✓ Antimicrobial lock solutions should not be used routinely to prevent catheter-related bloodstream infections.

✓ Do not routinely administer intranasal or systemic antimicrobials before insertion or during the use of an intravascular device to prevent catheter colonisation or bloodstream infection.

✓ Do not use systemic anticoagulants routinely to prevent catheter-related bloodstream infection.

✓ Use sterile sodium chloride 0.9% for injection or flush (Posiject) to flush and lock catheter lumens that are accessed frequently. Note that some devices may require heparinised saline as indicated by the device manufacturer recommendations.

✓ The introduction of new intravascular devices or components should be monitored for an increase in the occurrence of device-associated infection. If an increase in infection rates is suspected, this should be reported to the Medicines and Healthcare Products Regulatory Agency in the UK.

General principles for management of administration systems

✓ When safer sharps and other devices are used e.g. Bionector, Octopus, healthcare workers should ensure that all components of the system are compatible and secured to minimise leaks and breaks in the system. There is a risk of bleeding or air embolism if they are not securely connected.

✓ Administration sets in continuous use do not need to be replaced more frequently than every 96 hours, unless device-specific recommendations from the manufacturer indicate otherwise, they become disconnected or the intravascular access device is replaced. They should be labelled with the date and time opened to support this.

✓ Administration sets for blood and blood components must be changed when the transfusion episode is complete or every 12 hours (whichever is sooner). They should be labelled with the date and time opened to support this.

✓ Administration sets used for lipid-containing parenteral nutrition must be changed every 24 hours. They should be labelled with the date and time opened to support this.

All infusion sets should be labelled with the date and time they are first used in order to ensure they are changed in line with the times set out above.

Three-way taps should not be routinely connected or used, unless there is a specific need to do so due to multiple infusions, such as in critical care.

Removal of IVADs

A Cochrane Review first published in 2015 and reviewed in 2019 found no evidence to support changing IVADs every 72-96 hours (Webster et al 2019).

- If a device is inserted under emergency conditions where there is no evidence that aseptic practice/ANTT was used, it must be removed and replaced within 24 hours. This includes devices inserted in the pre-hospital setting for example by the ambulance service as well as in-hospital emergency placement.

- IVADs should be removed if no longer clinically indicated or there are signs of inflammation with a VIP score of 1 or more. Removal of the IVAD must be an aseptic non touch technique.

- If a bloodstream infection is suspected in a patient with a central line or long line, following removal from the patient the tip of the IVAD should be cut off using ANTT principles, placed into a sterile container and sent to the laboratory for culture. Clinical details on the request form should state that a bloodstream infection is suspected.

- The device should be removed carefully using a slow steady movement and pressure should be applied until haemostasis is achieved, usually 2-3 minutes, though longer may be needed if the patient is on anticoagulants or aspirin. This pressure should be firm and not involve any rubbing movement. A haematoma will occur if the device is carelessly removed, causing discomfort and a focus for infection. The site should be inspected to ensure bleeding has stopped and should then be covered with a sterile dressing (Loveday 2014). The cannula integrity should be checked to ensure the complete device has been removed RCN 2016).

- Documentation of the removal of the IVAD is also required (RCN 2016). This documentation ensures adequate records for the continued care of the device and patient as well as enabling audit and gathering of statistics on rates of phlebitis and infiltration. The VIP score on removal should also be recorded.

- Removal of central venous access devices should happen with the patient in a supine position, with the IVAD entry point lower than the heart. This is avoid air embolism on removal. Central venous access devices should only be removed by staff who have been trained in this procedure.

Catheter replacement strategies

✓ Do not routinely replace central venous access devices to prevent catheter-related infection.

✓ Do not use guidewire-assisted catheter exchange for patients with catheter-related bloodstream infection.

✓ Peripheral vascular catheter insertion sites must be inspected each time they are used/accessed and a minimum of 8-hourly, and a Visual Infusion Phlebitis score must be recorded. The catheter must be removed if complications occur, if a VIP Score of 1 or more is noted or as soon as it is no longer required.

7. Escalation process

Complications: There are many complications associated with insertion, care and maintenance of IVADs

Most complications and adverse events can be prevented or minimised through:

- Education and training to ensure practitioner competence
- Careful insertion technique
- Adhering to ANTT principles
- Allowing skin to dry following decontamination (before insertion of PC and at dressing changes)
- Securing the device appropriately
- Using appropriate dressings, covering puncture site
- Early detection of complications and appropriate management actions taken
- Optimum care and maintenance
- Regular flushing to ensure patency using 10ml syringe
- Flush should be administered before, between and following each medicine administration
- Consider removing IVAD at earliest opportunity when no longer clinically indicated

8. Training and Development

- ✓ Healthcare workers caring for patients with intravascular catheters should be trained and assessed as competent in using and consistently adhering to practices for the prevention of catheter-related bloodstream infection.
    - Specific training and competency workbooks must be completed by staff inserting, caring for, or removing IVADs within WAHT

- ✓ Healthcare workers must be aware of the manufacturer's advice relating to individual catheters, connection and administration set dwell time, and compatibility with antiseptics and other fluids to ensure the safe use of devices.

- ✓ Before discharge from hospital, patients with intravascular catheters and their carers should be taught any techniques they may need to use to prevent infection and manage their device.

9. Monitoring

Use quality improvement interventions to support the appropriate use and management of intravascular access devices (central and peripheral venous catheters) and ensure their timely removal. These may include:

- Protocols for device insertion and maintenance;
- Reminders to review the continuing use or prompt the removal of intravascular devices;
- Audit and feedback of compliance with practice guidelines; and
- Continuing professional education.

10. References

Chopra V, Flanders SA, Saint S et al (2015) The Michigan Appropriateness Guide for Intravenous Catheters (MAGIC): Results From a Multispecialty Panel Using the RAND/UCLA Appropriateness Method. Annuls of Internal Medicine. https://pubmed.ncbi.nlm.nih.gov/26369828/

Hallam C, Denton A, Weston V et al (2020) UK Vessel Health and Preservation (VHP) Framework: a commentary on the updated VHP 2020. Journal of Infection Prevention: https://journals.sagepub.com/doi/full/10.1177/1757177420976806

Loveday H et al (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection* 86S1 (2014) S1–S70. Accessed 20-12-2020: https://improvement.nhs.uk/resources/epic3-guidelines-preventing-healthcare-associated-infections/

NICE Infection prevention and control Quality standard [QS61] Quality statement 5: Vascular access devices. Published date: 17 April 2014 accessed 15-12-2020: https://www.nice.org.uk/guidance/qs61/chapter/Quality-statement-5-Vascular-access-devices

Webster J, Osborne S, Rickard CM, Marsh N. (January 2019). Clinically-indicated replacement versus routine replacement of peripheral venous catheters. Cochrane Database of Systematic Reviews 2019, Issue 1. https://www.cochrane.org/CD007798/PVD_replacing-peripheral-venous-catheter-when-clinically-indicated-versus-routine-replacement

11. Contact details

Professional Development Team: 01905 763333 or internal extension 36772
Infection Prevention Team: 01905 733095 or internal extension 38752

12. Links to relevant departmental / Trust policies and procedures

WAHT-INF-048 Aseptic non Touch Technique ANTT Policy (May 21): http://nww.worcsacute.nhs.uk/EasysiteWeb/getresource.axd?AssetID=113164&type=full&servicetype=Attachment

ANTT training materials and resources: http://nww.worcsacute.nhs.uk/departments-a-to-z/infection-prevention-and-control/antt/

13. Appendices

Appendix A: Guide for Selecting Peripheral IVAD Cannula Size

14G

CRYSTALLOID GRAVITY FLOW RATE
343 ml/min - 345 ml/min

GENERAL USE
- For rapid transfusion of whole blood, blood components or viscous fluids
- Often used in theatres or emergency interventions

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Antecubital fossa
- Median cephalic (radial side)
- Median basilic (ulnar side)
- Median cubital (in front of elbow joint)

16G

CRYSTALLOID GRAVITY FLOW RATE
196 ml/min - 210 ml/min

GENERAL USE
- For rapid transfusion of blood components or viscous fluids
- Often used in theatres or emergency interventions

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Antecubital fossa
- Median cephalic (radial side)
- Median basilic (ulnar side)
- Median cubital (in front of elbow joint)

18G

CRYSTALLOID GRAVITY FLOW RATE
96 ml/min - 100 ml/min

GENERAL USE
- For infusing blood components quickly
- Parenteral nutrition
- Stem cell harvesting and cell separation
- Large volumes of fluids

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Median cubital (radial aspect of forearm)
- Median basilic (ulnar aspect of forearm)
- Median antebrachial

20G

CRYSTALLOID GRAVITY FLOW RATE
60 ml/min - 61 ml/min

GENERAL USE
- For routine infusion therapies and infusing blood components or large volumes of fluid
- Patients on long term medication
- Patients receiving up to 2-3 litres of fluid per day

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Accessory cephalic (branches off cephalic vein along the ulna bone)
- Basilic (ulnar aspect of the lower arm along ulna bone)
- Cephalic (radial aspect of lower arm along radius bone of forearm)
- Metacarpal (on dorsum of hand)

22G

CRYSTALLOID GRAVITY FLOW RATE
35 ml/min - 36 ml/min

GENERAL USE
- Appropriate for most infusion therapies
- Standard for paediatrics

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Used in adults, adolescents, children, infants and geriatric patients
- Commonly used in the acute and chronic care setting
- May be more difficult to pierce through

24G

CRYSTALLOID GRAVITY FLOW RATE
22 ml/min

GENERAL USE
- For elderly, paediatric and neonatal patients
- Oncology patients undergoing chemotherapy
- Medications, short term infusions
- Patients with fragile veins

SUITABLE ANATOMICAL LOCATION FOR INSERTION
- Digital veins (along lateral-distal portion of fingers)
- Accessory cephalic (branches off cephalic vein along the ulna bone)
- Basilic (ulnar aspect of the lower arm along ulna bone)
- Cephalic (radial aspect of lower arm along radius bone of forearm)
- Metacarpal (on dorsum of hand)

For infusing blood, choose a suitable size cannula based upon the speed you plan to infuse the blood at/acuity of the patient.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust		Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:**
What is the aim, purpose and/or intended outcomes of this Activity?	

Who will be affected by the development & implementation of this activity?	❑ ❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)				
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Religion & Belief				
Sex				
Sexual Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval