Five Steps to Safer Surgical Interventions
### Policy Title:
Five Steps to Safer Surgical Interventions

### Executive Summary:
A definitive policy for the roles and responsibilities of the key clinical staff involved in the process of the WHO checklist 5 steps to safer surgery.

### Supersedes:
Policy V1.0

### Description of Amendment(s):

### This policy will impact on:
Clinical practices, administrative practices, employees.

### Financial Implications:

### Policy Area:
ABU

### Document Reference:
TS/

### Version Number:
V1.1

### Effective Date:
April 2013

### Issued By:
Clinical Manager Theatre Services

### Review Date:
July 2018

### Author:
Clinical Manager Theatre Services

### Impact Assessment Date:
May 2015

### APPROVAL RECORD

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<th>Date</th>
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RU/JH 2015
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### Appendices

- **Appendix 1** How to complete a checklist document
- **Appendix 2** Trust adapted WHO checklist
- **Appendix 3** Briefing template
- **Appendix 4** Debriefing template
- **Appendix 5** Equality Impact Assessment Tool
Introduction

The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to reduce the number of surgical errors and enhance patient safety during the perioperative phase of care. In one year from 1st January 2009 to 31st December 2009 the National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS) received just over 155,000 reports of patient safety incidents from surgical specialities in England and Wales. The nature of the report varied greatly with the vast number reported as leading to no harm, however over 1000 where reported to have led to severe harm or even death.

The launch saw the introduction of a new surgical safety checklist for surgical teams to use in perioperative environments, radiological suites and which can be adapted for endoscopy units as part of a major drive to make surgery safer worldwide (DH, 2008).

The NPSA (2009) has adapted this checklist for use in England and Wales and it is intended for use with ALL patients undergoing surgical procedures. The goal is to strengthen the commitment of ALL clinical staff to address safety issues in the perioperative setting. The checklist highlights generic core safety standards that may be applied to all perioperative settings and forms part of the 5 steps to safer surgery (NPSA, 2010). The NPSA guidance recommends that the core standards can be added to but must not be removed when adapting checklists for local use.

The 5 steps are:

STEP 1: BRIEFING
STEP 2: SIGN IN
STEP 3: TIME OUT
STEP 4: SIGN OUT
STEP 5: DEBRIEFING

The above process is intended to incorporate the following intentions:

- Improving communication within teams
- Improving anaesthetic safety practices
- Ensuring correct site surgery
- Reducing surgical site infections

1. Purpose

The WHO Surgical Safety Checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patients’ perioperative pathway including correct site surgery and forms part of a 5 step process. The 3 steps in the checklist (sign in, time out, sign out) are not intended as a tick-box exercise but as a tool to initiate effective communication between relevant members of the clinical team to ensure the safety of surgery. A guidance tool has been devised to inform staff how to complete the checklist (appendix 1). The checklist is intended for use within any perioperative environment including interventional radiology and endoscopy with the expectation that it can be adapted to fit local practice.
Therefore as this policy is embedded into practice there may be a need for additional appendices.

2. Roles and Responsibilities

Clinical Director – Accountable that Trust policy is adhered to

Lead Clinicians – Leads for communicating and ensuring compliance with Trust Policy to clinicians

Clinical Manager, Theatres – Responsible for developing policy, communicating policy and auditing compliance with Trust Policy

Team Leaders for scrub, anaesthetics and recovery – responsible for ensuring their teams follow Trust policy

Practice Educator (Theatres) – Ensuring all existing staff are aware of policy and that all new staff receive education and training on induction.

All perioperative, endoscopy and clinical staff are responsible for ensuring that they read and understand the policy and related documents and implement the guidance into their practice.

3. Policy

The WHO surgical checklist must be undertaken for all patients including those having procedures under local anaesthetic and or sedation. The addition of briefing and debriefing are key in delivering the cultural change required to strengthen the safety process.

The checklist is designed to be adapted for local use; however the core safety elements are not to be removed from the amended checklist (NPSA, 2009). The WHO checklist forms part of the 5 steps to safer surgery.

The Trust will use and adapt the WHO surgical Checklists (Appendix 2). Where appropriate, WHO check lists must be incorporated into the patient care plan. It is the responsibility of the registered practitioner to ensure the checklist is completed accurately and held within the patient’s care document.

Template guidance checklists are available from the WHO website as follows;

WHO Surgical Safety Checklist adapted for England and Wales
WHO Surgical Safety Checklist: for cataract surgery only
WHO Surgical Safety Checklist: for obstetric cases only
WHO Surgical Safety Checklist for paediatric cases only
WHO Surgical safety Checklist: for radiological interventions only
WHO Surgical Safety Checklist for endoscopy procedures

STEP 1: BRIEFING

Briefings are a simple way for the operating/interventional team to share vital information about patients for surgery and discuss potential and actual safety issues before and after the list/procedure takes place. Briefings should encourage an environment where the team can share this information without
fear of reprisal, integrating the reporting of patient safety incidents into everyday routine. Briefings must be methodical in ensuring vital and relevant
information is shared. A briefing template (Appendix 3) is provided for use, within the theatre list and may be used as an aid and summary of the discussion.

The briefing is led by the surgeon/anaesthetist or nominated practitioner prior to the theatre session starting. All team members involved in the session must be present. The Registered Practitioner in charge of the list is responsible for escalating issues arising from the briefing to the Theatre Coordinator if they affect the progress of the session.

STEP 2: SIGN IN

The anaesthetist and anaesthetic practitioner must ensure that this step is completed and documented involving the patient in the process where appropriate. This section includes ensuring the surgical site has been marked with an arrow that extends to or near to, the incision site. For digits on the hand and foot, the mark should extend to the correct specific digit. Correct site surgery policy must be adhered to.


During the checklist silent focus will be observed. However, when children are in the anaesthetic room, the play therapist/accompanying parent are able to occupy the child whilst the anaesthetist and the anaesthetic practitioner complete the checklist.

The Sign in section is completed prior to induction of anaesthesia and includes the following:

- Has the patient confirmed his/her identity, site, procedure and consent?
- Is the surgical site marked?
- Is the anaesthesia machine and medication check complete?
- Is the pulse oximetry on the patient and functioning?
- Does the patient have a known allergy?
- Does the patient have a difficult airway/aspiration risk?
- Does the patient have a risk of >than 500ml blood loss (7mls/kg in children)?
- Blood product available/G&S
- Two IVs/central venous access
- Has sterility of instruments (including indicator reports and integrity of wrap) been confirmed?
- Need for active warming?

The WHO checklist Sign In will be recorded on the Galaxy system and each question acknowledged.

STEP 3: TIME OUT

This must be done after the patient is safely positioned and relevant monitoring in situ and prior to the patient being prepped and draped. All members of the clinical team including the anaesthetist and operating
surgeon are required to be present during the time out phase. Involve the patient where appropriate for example during local anaesthetic procedures.

The NPSA guidance suggests that the operating surgeon leads the time out phase however this may be delegated to the person in charge of the session or nominated deputy.

Each section of the time out phase of the checklist must be read out loud systematically by the nominated lead. Team members must provide the appropriate responses to the sections.

Everybody within the team is required to STOP, LISTEN and CONTRIBUTE whilst the Time Out phase is being undertaken (Implementing Human Factors in Healthcare 2010).

The Time out section must be completed in a timely manner without due delay to the surgery commencing.

- Have all team members introduced themselves by name and role?
- Surgeon anaesthetist and Registered Practitioner confirm patient’s name, procedure and where the incision will be made?
- Has antibiotic prophylaxis been administered in the last 60 minutes?
- Has venous thromboembolism prophylaxis been undertaken?
- Any anticipated critical events

To surgeon:

- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

To anaesthetist:

- Are there any specific patient concerns?

To nursing team?

- Are there and equipment issues or concerns?
- Is essential imaging displayed/available?

The WHO checklist Time Out will be recorded on the Galaxy system and each question acknowledged.

STEP 4: SIGN OUT

This must be led by a Registered Practitioner. It must be completed immediately following the final surgical count. The sign out phase is read out loud and responses verbalised.

The Sign out section is completed for each patient before any team member leaves the operating theatre.

- Registered Practitioner verbally confirms with the team the name of the procedure to be recorded in the perioperative documentation.
• Registered Practitioner verifies that the instruments, swabs and sharps counts are correct (or not applicable)
• Have specimens been labeled correctly including patient’s name?
• Have any equipment problems been identified?
• What are the key concerns for recovery and management of this patient?

The WHO checklist Sign Out will be recorded on the Galaxy system and each question acknowledged.

Handover to recovery

The handover will be provided by the anaesthetist and a registered practitioner or delegated to a band 4 perioperative practitioner involved with the procedure. The recovery handover must include:

Procedure handover including any adverse events
Post-operative temperature recorded
Pain relief prescribed including route of administration
Patient preferred name
Patient special needs; e.g., hearing, vision, learning disabilities, autism and psychological state.

STEP 5: DEBRIEFING

It has been recognised through root cause analysis of adverse events that deficits in ‘non technical’ skills such as poor communication, lack of situational awareness and ineffective teamwork were accountable to 60-80% of cases. Debriefing is an effective way for teams to reflect on what went well and to identify and action issues which arose during the operative session. The briefing session must consist of methodical ‘trigger’ questions to ensure meaningful debriefing discussion and action planning. Every member of the team must be encouraged to participate in debriefing. An approved debriefing template is provided (Appendix 4).

This should take place before any team member leaves the session. It is recognised that teams change during the course of operating sessions thus feedback must be provided to team members not present.

A Debriefing template is available as an aid to the process and may be documented by the Registered Practitioner in charge. They are also responsible for reporting and escalating any issues that arise from the debriefing as appropriate.

4. Consultation and Communication with Stakeholders

This policy is informed by The 5 Steps to Safer Surgery (2010) and the NPSA WHO Surgical Safety Checklist Alert (2009).

This policy has been written in consultation with:

Clinical Director Acute Business Unit
Lead Clinicians
Clinical Manager for Theatres
Team Leaders Theatre

Development of this policy has been communicated with:-

Perioperative staff
Endoscopy staff
Maternity staff
Radiology staff
Angiography staff
Patient Advisory Liaison Group

5. Monitoring compliance

Compliance will be measured through the galaxy software system and by using an appropriate audit tool. The results will be communicated through SQS and for reporting purposes.

6. References

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/AboutTheChiefMedicalOfficerCMO/CMOAtLarge/DH_085832

http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286


7. Associated Documents

Patient Safety First 2008-2010 the Campaign Review (2011)
High Impact Intervention Care Bundle to prevent surgical site infection. Available at
www.clean-safe-care.uk
# SURGICAL SAFETY CHECKLIST - "HOW TO"

## SIGN IN

### Key People Involved
- Lead Anaesthetist (responsible for initiating 'sign in')
- Anaesthetic Practitioner
- Escort Nurse

### Where?
- Anaesthetic Room

### How?
- Observe a Silent Focus per checklist
- Anaesthetic Practitioner completes 'sign in' on TheatreMan

## SIGN OUT

### Key People Involved?
- Lead Surgeon (responsible for initiating 'time out')
- Lead Anaesthetics
- All Team Members

### Where?
- In Theatre

### How?
- Observe a Silent Focus on patient
- Lead Surgeon initiates and identifies team member to read checklist aloud as per checklist
- Theatre team respond as per checklist on TheatreMan completed
- Identified team member completes 'sign out' entry on TheatreMan
- The person who read 'sign out' confirms 'sign out' completed
- Lead Surgeon documents on his operation notes that all parts of the Safe Surgery checklist were completed satisfactorily

### Key People Involved?
- All Team Members - Scrub Practitioner to initiate 'sign out'
- Lead Surgeon
- Lead Anaesthetics
# Surgical Safety Checklist

## Sign in (ODA & Anaesthetist)

<table>
<thead>
<tr>
<th>Before Induction of Anaesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient confirmed his/her identity, site, procedure and consent?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>Is the surgical site marked?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Not applicable</td>
</tr>
<tr>
<td>Is the anaesthesia machine and medication check complete?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>Is the pulse oximeter on the patient and functioning?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>Does the patient have a: Known allergy?</td>
</tr>
<tr>
<td>□ No</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>Difficult airway or aspiration risk?</td>
</tr>
<tr>
<td>□ No</td>
</tr>
<tr>
<td>□ Yes, and equipment/assistance available</td>
</tr>
<tr>
<td>Risk of &gt;500ml blood loss (7ml/kg in children)?</td>
</tr>
<tr>
<td>□ No</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
</tbody>
</table>

## Time Out (Nurse, Anaesthetist & Surgeon)

<table>
<thead>
<tr>
<th>Before Skin Incision</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Confirm all team members have introduced themselves by name and role</td>
</tr>
<tr>
<td>□ Confirm the patient’s name, procedure and where the incision will be made</td>
</tr>
<tr>
<td>Has antibiotics prophylaxis been given within the last 60 minutes</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Not applicable</td>
</tr>
<tr>
<td>Has VTE prophylaxis been undertaken?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Not applicable</td>
</tr>
</tbody>
</table>

## Anticipated Critical Events

### To Surgeon:
- What are the critical or non-routine steps?
- How long will case take?
- What is anticipated blood loss?

### To Anaesthetist:
- Are there any patient specific concerns?

### To Nursing Team:
- Has sterility (including indicator results) been confirmed?
- Are there any equipment issues or any concerns?

## Sign Out (Nurse, Anaesthetist & Surgeon)

### Before Patient Leaves Operating Room
- Scrub nurse verbally confirms with the team:
  - The name of the procedure
  - Completion of instruments, sponge and needle counts
  - Specimen labelling (read specimen labels aloud, including patient name)
  - Whether there are any equipment problems to be addressed

### Surgeon, Anaesthetist and Scrub Nurse:
- What are the key concerns for recovery and management of this patient?

### Is essential imaging displayed?
- □ Yes
- □ Not applicable
Appendix 3

Pre-operative Briefing Checklist

To be undertaken before the first case of the list, with all members of the team, to ensure a shared understanding of the plan for that list

Date_____________ Theatre

Brief Leader ______________________

Please ✔ if discussed & record any issues arising.

<table>
<thead>
<tr>
<th>TEAM MEMBERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all team members present?</td>
<td></td>
</tr>
<tr>
<td>Does everyone know each other?</td>
<td></td>
</tr>
<tr>
<td>Is anyone missing?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIST</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any changes to the list order or patient location?</td>
<td></td>
</tr>
<tr>
<td>Discuss each case individually – plan, expectations, special considerations. Inform Recovery if relevant.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQUIPMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any equipment issues?</td>
<td></td>
</tr>
<tr>
<td>Do we need anything non-routine?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIMING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a risk of overrun?</td>
<td></td>
</tr>
<tr>
<td>Do we need an agreed break for lunch?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do we need input from other agencies e.g. x-ray, scan, other specialities?</td>
<td></td>
</tr>
<tr>
<td>Who will co-ordinate this?</td>
<td></td>
</tr>
</tbody>
</table>

| NOTES |  |
## Appendix 4

### Post-operative Debriefing Checklist

To be undertaken after the last case of the list, with all members of the team, to ensure a shared understanding of the plan for that list

<table>
<thead>
<tr>
<th>Date</th>
<th>Theatre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debrief Leader</td>
<td></td>
</tr>
</tbody>
</table>

Please ✔️ if discussed & record any issues arising.

<table>
<thead>
<tr>
<th>What went well and why?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did we work well as a team?</td>
<td></td>
</tr>
<tr>
<td>Did we speak up when needed?</td>
<td></td>
</tr>
<tr>
<td>Were we well prepared?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What did not go well and why?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the briefing miss any information?</td>
<td></td>
</tr>
<tr>
<td>Was there any confusion in the team?</td>
<td></td>
</tr>
<tr>
<td>Were there any errors/near misses?</td>
<td></td>
</tr>
<tr>
<td>Does an incident need reporting on Datix?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Close the loop feedback and actions!</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What do we need to change?</td>
<td></td>
</tr>
<tr>
<td>Does anything require escalation?</td>
<td></td>
</tr>
<tr>
<td>What can we do to improve?</td>
<td></td>
</tr>
<tr>
<td>Who will take forward?</td>
<td></td>
</tr>
<tr>
<td>What do we need external or senior support for?</td>
<td></td>
</tr>
<tr>
<td>Do we need to plan for the next operating session?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Plan</th>
<th></th>
</tr>
</thead>
</table>

| Team Leader Signature |  |
Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.

Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Safer Surgical Interventions Policy

Details of person responsible for completing the assessment:

- **Name:** Janet Hatton
- **Position:** Practice Development Sr
- **Team/service:** Theatres

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

- The WHO Surgical Safety Checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patients' perioperative pathway including correct site surgery and forms part of a 5 step process.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service?

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race:**

- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
• 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.
• Gypsies & travellers – estimated 18,600 in England in 2011.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
• In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
• In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
• Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
• C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
• In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
• Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
• CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
• CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
• Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
• Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
• Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
• Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
• Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
• Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
• Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
• None: 22.69%of Cheshire East and 22.0% of Cheshire West & Chester
• Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester
Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

No

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

1. RACE:

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □ No □ ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of race. If a patient’s first language was not English, staff will follow the trust interpretation policy.

2. GENDER (INCLUDING TRANSGENDER):

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes □ No □ ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of gender.

3. DISABILITY

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □ No □ ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of disability. On the checklist there is space to indicate if the patient has any particular needs such as learning disabilities, autism or sensory impairment or mental health needs so that the staff are well prepared.

4. AGE:

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes □ No □ ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of age. Any particular needs can be noted on the checklist.

5. LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by team to perform surgery, a procedure or intervention on any individual regardless of sexual orientation.

6. RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☐ No ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of religious belief. Any particular requirements such as use of blood products for Jehovah’s Witnesses or avoiding drugs with porcine content for Muslim patients would have been identified and noted prior to surgery.

7. CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☑ No ☐

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of carer status

8. OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No ☑

Explain your response:
No other impacts identified.

4. Safeguarding Assessment - CHILDREN
a. Is there a direct or indirect impact upon children? Yes ☐ No ☑

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of age.

5. Relevant consultation
Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Policy sent to and approved by Acute Business Unit SQS group

6. Date completed: 05/05/2015 Review Date: 05/05/2018

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 5.5.15