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| **Document Type:****Guideline**  | **Unique Identifier:**CORP/GUID/133 |
| **Document Title:****Enoxaparin Use in Adults – Shared Care Guideline** | **Version Number:**8 |
| **Status:**Ratified |
| **Scope:**This guideline is relevant to all staff caring for adults | **Classification:**Organisational |
| **Author / Title:**Andrea Scott, Medicines Management Pharmacist | **Responsibility:**Pharmacy |
| **Replaces:**Version 7, Enoxaparin - Shared Care Guideline, SCG/007 | **Head of Department:**Kam Mom, Trust Chief Pharmacist and Accountable Officer for Controlled Drugs |
| Does this document refer to and account for the prescribing, supply, storage or administration of medication (especially via electronic media)? **Yes** **If yes, Pharmacy Dept. must be consulted and provide approval date below.** |
| **Pharmacy Department approval code: CE13022024B****To be completed by Pharmacy Department staff** | **Date: 13/02/2024** |
| **Validated By:**Pharmacy SMT | **Date:**13/02/2024 |
| **Ratified By:**Core Clinical Services Quality MeetingTrust Procedural Document Group | **Date:**21/03/202414/08/2024 |
| **Review dates may alter if any significant changes are made** | **Review Date:**01/02/2027 |
| * Does this document meet the requirements under the Equality Act 2010 in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation? **Yes**
* Does this document meet our additional commitment as a Trust to extend our public sector duty to carers, veterans, people from a low socioeconomic background, and people with diverse gender identities? **Yes**
 |
| **Document for Public Display: No**  |

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| SUMMARY |
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| Enoxaparin is one of several available low-molecular weight heparins (LMWHs) administered by subcutaneous injection. LMWHs are now widely used for a number of licensed and off-license indications including the prophylaxis and treatment of thromboembolic events, including Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE). In this shared care guideline, the term Venous Thrombo-Embolism (VTE) covers both DVT and PE. |

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| PURPOSE |
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| To aid safe transfer of prescribing from secondary care to primary care. To advise primary care clinicians regarding monitoring requirements |

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| SCOPE |
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| All UHMB staff involved in the care of adult patients being treated with enoxaparin, including prescribers, medical, nursing, pharmacy and other staff. Clinicians in Primary Care accepting ongoing care for patients being treated with enoxaparin.This guideline does not apply to pregnant people. |
|  |
| 3.1 Roles and Responsibilities |
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| **Role** | **Responsibilities** |
| UHMB Prescribers | Prescribe an appropriate dose of enoxaparin and perform baseline monitoring as described in document. Request primary care to assume responsibility for prescribing and monitoring. Ensure relevant information is passed on to primary care |
| Primary care clinicians | Respond to request for shared care. Prescribe and monitor as described in notification from secondary care |

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| GUIDELINE |
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| 4.1 Indications |
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| The following approved uses of enoxaparin are suitable for shared care between the specialist and the patient’s GP:* Extended treatment of VTE and prevention of its recurrence in patients with active cancer
* Treatment of VTE or suspected VTE in patients unable to stabilise on warfarin or direct-acting oral anti-coagulants (DOACs) or with a contraindication to warfarin or DOACs.
* Prophylaxis of DVT or PE when unable to stabilise on warfarin or DOACs, with an allergy or contraindication to warfarin and/or DOACs
* Extended prophylaxis for patients at high risk of DVT or PE due to suspected or confirmed COVID-19 infection
* Extended prophylaxis of high-risk patients in the primary care setting, e.g., immobile patients or those deemed to be at particularly high-risk of DVT at home or in a care situation and who are unable to tolerate/take warfarin or DOACs.
* All other indications not included in the RED list below.
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|  |
| The following indications are agreed RED (**full supply from hospital**):* Prophylaxis of VTE in oncology patients on VTE-inducing therapy \*\*
* Treatment of VTE in pregnancy (pre- and post-partum)
* Prophylaxis of VTE in pregnancy (high-risk patients pre- and post-partum)
* Prophylaxis of VTE post-operatively, e.g., hips, knees, general surgery
* Post-operative use in all surgical specialties, in conjunction with warfarin whilst waiting for the INR to come into range
* Pre-operative use as a replacement for warfarin in high-risk patients, i.e., ‘Bridging Therapy.’ (Primary care to prescribe if, due to unforeseen circumstances, patients require additional doses)
* Prophylaxis of VTE in patients with a lower limb plaster cast

\*\* VTE-inducing therapy refers to systemic anti-cancer therapy (SACT) regimens which include thalidomide, lenalidomide or pomalidomide. In these cases, enoxaparin is supplied by the hospital as part of the SACT regimen. In addition, some patients on SACT, who were previously on an anticoagulant such as warfarin, will be transferred to a LMWH because of concerns that the SACT will cause erratic and potentially dangerous control. In these cases, enoxaparin would be prescribed and supplied alongside the SACT.NB: **Travel prophylaxis**: **AMBER**. See Clinical Knowledge Summaries for further information: National Institute for Clinical Excellence (NICE) 2018 ‘DVT prevention for travellers’ [Online] Available from:<https://cks.nice.org.uk/topics/dvt-prevention-for-travellers/> (accessed 13/09/2023) and consult a haematologist for advice. |

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| 4.2 Dose & Administration |
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| Enoxaparin is available in boxes of 10 as:* 20mg, 40mg, 60mg, 80mg and 100mg pre-filled syringes containing 100mg/mL enoxaparin.
* 120mg and 150mg pre-filled syringes containing 150mg/mL enoxaparin.
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| 4.2.1 Treatment of DVT |
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| Enoxaparin can be administered subcutaneously (SC) either as a **ONCE DAILY** injection of 1.5mg/kg (150units/kg) or as **TWICE DAILY** injections of 1mg/kg (100units/kg). The regimen should be selected by the secondary care physician based on an individual assessment including evaluation of the thromboembolic risk and of the risk of bleeding. The dose regimen of 1.5mg/kg administered once daily should be used in uncomplicated patients with low risk of VTE recurrence. The dose regimen of 1mg/kg administered twice daily should be used in all other patients such as those with obesity, with symptomatic PE, cancer, recurrent VTE or proximal (*vena iliaca*) thrombosis.NICE Clinical Guideline (CG) 189 classifies obesity as a body mass index measurement (BMI) greater than 30.**For treatment of VTE (uncomplicated) dose banding has been agreed as follows:**

|  |
| --- |
| **Enoxaparin 1.5mg/kg subcutaneously once daily** |
| **Weight (kg)** | **Dose** |
| 40 - 46 | 60mg once daily |
| 47 - 59 | 80mg once daily |
| 60 - 74 | 100mg once daily |
| 75 - 89 | 120mg once daily |
| 90 - 110 | 150mg once daily |
| 111 - 130 | 180mg once daily (80mg plus 100mg) |
| In renal impairment (GFR <30ml/min) give 1mg/kg once daily  |

|  |  |
| --- | --- |
| **Higher weight patients** |  |
| >130kg, BMI <40 | 1mg/kg twice daily, rounded to the nearest syringe |
| >130kg, BMI >40 | 1.5mg/kg daily dose split to be given TWICE daily, rounded to the nearest syringe with factor anti-Xa monitoring |

**For treatment of complicated VTE, dose banding has been agreed as follows:**

|  |
| --- |
| **Enoxaparin 1mg/kg subcutaneously twice daily** |
| **Weight (kg)** | **Dose** |
| 35 - 44  | 40mg twice daily  |
| 45 - 64  | 60mg twice daily  |
| 65 - 84  | 80mg twice daily  |
| 85 - 104  | 100mg twice daily  |
| 105 - 124  | 120mg twice daily  |
| 125 +  | 150mg twice daily  |
| In renal impairment (GFR <30ml/min) give 1mg/kg once daily  |

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| 4.2.2 Prophylaxis of DVT |
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| The dose of enoxaparin should be amended in accordance with the patient’s weight. The suggested doses of enoxaparin for thromboprophylaxis in non-pregnant adults are:

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| --- | --- | --- | --- | --- |
| **Weight** | **<50kg** | **50 - 100kg** | **100 - 150kg** | **> 150kg** |
| **Enoxaparin** | 20mg daily  | 40mg daily  | 40mg twice daily  | 60mg twice daily  |

 |
|  |
| **The following table indicates recommended prophylactic doses in patients with reduced renal function:**

|  |  |  |
| --- | --- | --- |
| **Renal Function** | **Bodyweight** | **Enoxaparin dose** |
| GFR <15ml/min | All weight | 20mg once daily(unlicensed) |
| GFR 15-30ml/min | Less than 100kg | 20mg once daily |
| GFR 15-30ml/min | 100kg + | 20mg twice daily(unlicensed) |

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| 4.2.3 Prophlaxis of DVT/PE in COVID-19 patients |
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| This table represents the prophylactic enoxaparin guidance that is recommended in suspected or confirmed COVID-19 patients at UHMBT.

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| **Patient Weight** | **Renal Function** | **Enoxaparin** |
|  **35-59kg** | **CrCl >30ml/min** | **40mg S/C ONCE DAILY** |
| **CrCl <30ml/min** | **20mg S/C ONCE DAILY** |
|  |  |  |
|  **60-120kg** | **CrCl >30ml/min** | **40mg S/C TWICE DAILY** |
| **CrCl <30ml/min** | **40mg S/C ONCE DAILY** |
|  |  |  |
|  **>120kg** |  | **Consider higher dosing on discussion with haematology** |

The continued need for enoxaparin must be reviewed regularly based on the patient’s clinical response and the review of the clinical picture will dictate the duration of treatment. On discharge, the duration of treatment must be clearly documented if it is to be continued post discharge. |

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| 4.3 Secondary Care Responsibilities |
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| 1. Confirm the diagnosis of VTE or the indication for extended prophylaxis.
2. Perform baseline blood tests: full blood count, renal function tests
3. Discuss the benefits and side effects of treatment with the patient.
4. Patients should be taught how to self-administer enoxaparin injections, and the majority of patients will be able to do so or have a carer do so. It is the responsibility of the prescriber initiating treatment to ensure patients and/or their carers are adequately trained where they are to self-administer.
5. For those patients unable to self-administer, arrangements must be made for the administration to take place e.g., by practice nurses or equivalent.
6. Provide sufficient enoxaparin for 28 days and an appropriately sized sharps bin.
7. Arrange for the patient to have a full blood count (FBC) at the specified times during the first 14 days of treatment (see Monitoring below) to rule out heparin-induced thrombocytopenia (HIT). Ensure that the patient knows when and where to attend for blood tests and ensure that the General Practitioner (GP) is informed of the baseline and subsequent platelet counts.
8. Arrange shared care with the patient’s GP.
9. Advise the GP on:
* the indication for which enoxaparin is being used
* the treatment to be prescribed including dose, frequency, and expected duration
* baseline bloods: full blood count and platelets
* the patient’s weight and initial renal function, including potassium level and creatinine clearance
* any monitoring that is required. It is vital that the frequency of any required monitoring (platelets, renal function) is clearly communicated to the patient’s GP.
* when to stop treatment
1. Review the patient every 3 months, as necessary.

11. Ensure that clear backup arrangements exist for GPs to obtain advice. |

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| 4.4 Primary Care Responsibilities |
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| 1. Provide the patient with prescriptions for enoxaparin and a 1 litre sharps bin for the duration of treatment.
2. Ensure systems are in place for daily or twice-daily administration of enoxaparin if the patient is not self-administering.
3. Check that the dose is appropriate for the patient’s weight and renal function.
4. Arrange to carry out any monitoring that is advised by the consultant and consult the secondary care specialist if a problem develops.
5. Report any adverse effects to the consultant.
 |

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| 4.5 Monitoring in Primary Care |
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| Heparin induced thrombocytopenia (HIT) is a rare side effect of heparin including LMWH. Thrombocytopenia, should it occur, usually appears between days 5 and 21 of treatment.* All patients should have a platelet count before starting treatment.
* For patients who have been exposed to heparin of any sort in the last 100 days a platelet count 24 hours after starting enoxaparin should be obtained.
* All patients should have a platelet count on days 7 and 14 post initiation and 3-monthly thereafter. If a significant decrease in the platelet count is observed (greater than 30% drop from the initial value) then enoxaparin must be discontinued immediately.

Serum creatinine or eGFR, weight, and full blood count should be monitored every 3 months and the dose of enoxaparin reviewed. All patients should have an annual liver function test and renal function test (even those patients not believed to be at risk of renal impairment).Heparin can suppress adrenal secretion of aldosterone leading to hyperkalaemia. Potassium should be monitored before and during treatment in patients at risk e.g., patients with chronic renal failure, diabetes mellitus, patients with pre-existing metabolic acidosis and patients taking potassium sparing drugs. The referring consultant will specify if and with what frequency potassium should be monitored.Routine anti-Xa activity monitoring is not usually required but may be considered in patients at risk of under or over anticoagulation, e.g., in those with renal or hepatic impairment or at extremes of bodyweight. The referring consultant will specify if and with what frequency anti-Xa should be monitored. |

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| 4.6 Adverse Effects |
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| * Bleeding may occur in the presence of associated risk factors e.g., lesions liable to bleed, invasive procedures or the use of medicines affecting haemostasis. Rarely, major haemorrhage.
* Mild, transient, asymptomatic thrombocytopenia during the first few days of therapy. Rarely HIT (see MONITORING above).
* Injection site reactions, usually mild and should not cause discontinuation of therapy. Seek advice if severe.
* Long-term treatment with heparin (greater than 3 months) increases the risk of osteoporosis. Clinicians should advise adequate calcium and vitamin D intake. Monitoring of bone mineral density should be considered in patients who are at increased risk for bone loss or fractures (older age, cancer, and certain other medications)
 |

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| 4.7 Drug Interactions |
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| **Drugs affecting haemostasis**It is recommended that some agents which affect haemostasis should be discontinued prior to enoxaparin therapy unless strictly indicated. If the combination is indicated, enoxaparin should be used with careful clinical and laboratory monitoring when appropriate. These agents include medicinal products such as:* Systemic salicylates, aspirin (anti-inflammatory doses), and NSAIDs including ketorolac
* Other thrombolytics (e.g., alteplase, streptokinase, tenecteplase, urokinase) and anticoagulants

The following medicinal products may be administered with caution concomitantly with enoxaparin:* Platelet aggregation inhibitors including aspirin used at antiaggregant dose (cardioprotection), clopidogrel, ticlopidine, and glycoprotein IIb/IIIa antagonists indicated in acute coronary syndrome due to the risk of bleeding
* systemic glucocorticoids
* Dextran 40

Medicinal products that increase serum potassium levels may be administered concurrently with enoxaparin under careful clinical and laboratory monitoring. |

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| 4.8 Contra-Indications |
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| * Hypersensitivity to enoxaparin sodium, heparin, or its derivatives, including other low molecular weight heparins (LMWH) or to any of the excipients.
* History of immune mediated heparin-induced thrombocytopenia (HIT) within the past 100 days or in the presence of circulating antibodies
* Active clinically significant bleeding and conditions with an elevated risk of haemorrhage, including recent haemorrhagic stroke, gastrointestinal ulcer, presence of malignant neoplasm at substantial risk of bleeding, recent brain, spinal or ophthalmic surgery, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral abnormalities.
* Acute bacterial endocarditis.
* Enoxaparin is not recommended in pregnant women with prosthetic heart valves.
* Spinal or epidural anaesthesia/analgesia or lumbar puncture is not recommended within 12 hours of prophylactic doses or within 24 hours of treatment doses of enoxaparin.
 |
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| **This guidance does not replace the SPC’s, which should be read in conjunction with this guidance.** |

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| ATTACHMENTS |
| **Number** | **Title** | **Separate attachment** |
| 1 | Monitoring | N |
| 2 | Values and Behaviours Framework | N |
| 3 | Equality & Diversity Impact Assessment Tool | N |

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| OTHER RELEVANT / ASSOCIATED DOCUMENTSThe latest version of the documents listed below can all be found via the [Trust Procedural Document Library](https://nhscanl.sharepoint.com/sites/TrustProceduralDocumentLibrary/) intranet homepage. |
| **Unique Identifier** | **Title and web links from the document library** |
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| --- |
| SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS |
| Every effort been made to review/consider the latest evidence to support this document?  | Yes |
| **If ‘Yes’, full references are shown below:** |
| **Number** | **References** |
| 1 | Electronic Medicines Compendium (emc) (2022) ‘[Clexane Pre-filled Syringes with ERIS needle guard safety system – summary of product characteristics](https://www.medicines.org.uk/emc/product/12804),’ (Accessed 14.08.24)<https://www.medicines.org.uk/emc/product/12804> |
| 2 | NICE (2023) ‘[Clinical Knowledge Summary - DVT prevention for travellers](https://cks.nice.org.uk/topics/dvt-prevention-for-travellers/),’ (Accessed 14.08.24) |

| DEFINITIONS / GLOSSARY OF TERMS |
| --- |
| **Abbreviation or Term** | **Definition** |
| VTE | Venous Thrombo-Embolism |
| DOACS | Direct-Acting Oral Anti-Coagulants |
| DVT | Deep Vein Thrombosis |
| PE | Pulmonary Embolism |
| SACT | Systemic Anti-Cancer Therapy |
| SC | Subcutaneously |
| BMI | Body Mass Index |
| FBC | Full Blood Count |
| HIT | Heparin induced thrombocytopenia |
| GP | General Practitioner |
| LMWH | Low Molecular Weight Heparins |

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| CONSULTATION WITH STAFF AND PATIENTSEnter the names and job titles of staff and stakeholders that have contributed to the document |
| **Name/Meeting** | **Job Title** | **Date Consulted** |
| Dr David Howarth | Clinical Lead for Haematology | 24/07/2024 |
| Carrie Eddy, Jenny Bowler, Andrea Scott, Vickie Rose | Pharmacy Senior Management Team | 13/02/2024 |
| Jenny Oakley | Lead Pharmacist for Surgery & Women’s and Children’s Services | 22/07/2024 |
| Sue Bennett | Medicines Optimisation Pharmacist, Morecambe Bay locality of ICB | 24/07/2024 |
| Jo-Anne Halliwell | Quality & Service Improvement Matron, Integrated Community Care Group | 22/07/2024 |

|  |
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| DISTRIBUTION & COMMUNICATION PLAN |
| Dissemination lead: | Andrea Scott |
| Previous document already being used? | Yes |
| If yes, in what format and where? | Trust Procedural Document Library |
| Proposed action to retrieve out-of-date copies of the document: | Contact Policy Coordinator |
| **To be disseminated to:** |  |
| Document Library |  |
| Proposed actions to communicate the document contents to staff: | Include in the UHMB Weekly News. New documents uploaded to the Document Library. |

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| TRAINING Is training required to be given due to the introduction of this procedural document? **No****If ‘Yes’, training is shown below:** |
| **Action by** | **Action required** | **To be completed (date)** |
|  |  |  |
|  |  |  |

| AMENDMENT HISTORY |
| --- |
| **Version No.** | **Date of Issue** | **Section/Page Changed** | **Description of Change** | **Review Date** |
| 8 | 14/08/2024 | Page 4 | Clarification about supply of enoxaparin in patients undergoing SACT | 01/02/2027 |
| Page 5 | Dosing in higher weight patients added |
| Page 7 | Secondary care responsibilities expanded |
| Page 1 | Title changed to show this is only applicable to adults. |
| Section 3, Scope | Pregnant people excluded from the scope |

# Appendix 1: Monitoring

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| **Section to be monitored** | **Methodology (incl. data source)** | **Frequency** | **Reviewed by** | **Group / Committee to be escalated to (if applicable)** |
| All | Review the doses prescribed in line with patient weight | On verification | Verifying Pharmacist | n/a |
| All | Review of clinical incidents entered on Ulysses Management system | Quarterly | Medication Safety Group | MMDTG |
|  |  |  |  |  |
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# Appendix 2: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a positive workplace culture. By following our own policies and with our **ambitious** drive we can cultivate an **open, honest and transparent culture** that is truly **respectful and inclusive** and where we are **compassionate** towards each other.



# Appendix 3: Equality & Diversity Impact Assessment Tool

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| Equality Impact Assessment Form |
| Department/Function | Pharmacy |
| Lead Assessor | Andrea Scott |
| What is being assessed? | Prescribing appropriate dose of enoxaparin for treatment or prophylaxis |
| Date of assessment | 06/06/2024 |
| What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process. | Patient Experience and Involvement Group? | NO |
| Staff Side Colleague?  | NO |
| Service Users?  | NO |
| Staff Inclusion Network(s)?  | NO |
| Personal Fair Diverse Champions?  | NO |
| Other (including external organisations): |
|  |
| 1. **What is the impact on the following equality groups?**
 |
| **Positive:*** Advance Equality of opportunity
* Foster good relations between different groups
* Address explicit needs of Equality target groups
 | **Negative:*** Unlawful discrimination / harassment / victimisation
* Failure to address explicit needs of Equality target groups
 | **Neutral:*** It is quite acceptable for the assessment to come out as Neutral Impact.
* Be sure you can justify this decision with clear reasons and evidence if you are challenged
 |
| **Equality Groups** | **Impact****(Positive / Negative / Neutral)** | **Comments*** Provide brief description of the positive / negative impact identified benefits to the equality group.
* Is any impact identified intended or legal?
 |

|  |  |  |
| --- | --- | --- |
| **Race** (All ethnic groups) | Neutral |  |
| **Disability**(Including physical and mental impairments) | Neutral |  |
| **Sex**  | Neutral |  |
| **Gender reassignment** | Neutral |  |
| **Religion or Belief** | Neutral |  |
| **Sexual orientation** | Neutral |  |
| **Age** | Neutral |  |
| **Marriage and Civil Partnership** | Neutral |  |
| **Pregnancy and maternity** | Neutral |  |
| **Other** (e.g. carers, veterans, people from a low socioeconomic background, people with diverse gender identities, human rights) | Neutral |  |

|  |  |
| --- | --- |
| 1. In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?
 |  |
|  |
| 1. If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**
* This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
* This should be reviewed annually.
 |
| Action Plan Summary |
| **Action** | **Lead** | **Timescale** |
|  |  |  |
|  |  |  |
|  |  |  |

This form will be automatically submitted for review once approved/noted by Trust Procedural Document Group.

For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.