Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 March 2021
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Enhancement of Cleaning Standards within Hywel Dda University Health Board (HDdUHB) to meet recommended Standards and Principles as described by Welsh Government (WG) for all NHS Wales Organisations
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rob Elliott, Director of Estates, Facilities and Capital Management

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

During the COVID-19 pandemic, Welsh Government (WG) prescribed a new list of Standards that every Health Board within Wales should be applying consistently to ensure that risk of infections are reduced through environmental cleaning. Although this work was undertaken partially during the pandemic, the new Standards will become the baseline for cleaning requirements in healthcare environments, with various levels of regular enhanced cleaning (green) and escalation for additional cleaning (Amber and Red) as and when required.

This paper sets out the need for the Hywel Dda University Health Board (HDdUHB) to invest in its environmental cleaning programme and thus increase and enhance its cleaning resource capacity in order to meet the new Standards set out by WG.

This investment in cleaning resources has previously been considered by the Finance Committee on 25th February 2021

Cefndir / Background

COVID-19 Key Standards for Environmental Cleanliness FINAL 04 Sep 2020 (NWSSP-SES)

It is recognised by WG through the Nosocomial Transmission Group (NTG) (led by the office of the Chief Medical Officer) that there is an urgent need to have assurance that environmental cleaning is being managed in accordance with current UK guidance for COVID-19, in order to prevent and minimise nosocomial transmission of COVID-19 as more services are reinstated. Published guidance is based on the current evidence base in relation to how the infection is transmitted, how long it survives and how to remove and kill the virus in the environment. It is important to have clear standards across Wales for cleaning in healthcare settings so that there is a common approach that organisations can adopt.

Appendix 2 sets out a series of standards and principles for all NHS Wales organisations to apply within their own establishments and to assist staff involved in environmental cleaning and

decontamination in meeting the requirements. While the focus is on ensuring acute and community hospital settings are safe environments to provide care, the Standards are generally applicable to all healthcare and ancillary support service settings.

Current resource

At present within the HDdUHB there is a budgeted provision in place for c.390 whole time equivalent (wte) domestic staff to clean all HDdUHB acute and community sites. As of December 2020 there were approximately 68 wte substantive vacancies for domestic posts across the HDdUHB. The substantive gap is currently covered by additional bank staff and some staff brought in to combat COVID-19 (on fixed term contracts), carrying out some non COVID-19 cleaning work as part of their duties. There is a recruitment campaign due to commence to ensure these vacancies are filled with substantive contract staff rather than rely on bank or fixed term. These positions should be appointed to by first quarter 2021/2022.

COVID pressure

As well as the additional workforce required to enhance the standards of cleaning within the HDdUHB to the new basic standards, it is also the requirement for the HDdUHB to enhance its cleaning provision to the escalated levels for specific COVID-19 related cleaning. This includes both enhancement at acute and community sites, and also at field hospitals and vaccination centres. Part of this enhanced standard is currently being met by the fixed term COVID-19 staff that were employed as a result of the first and second wave of COVID-19. The third wave is currently in process and an accelerated recruitment effort has been introduced to fill these positions in conjunction with the permanent enhanced cleaning staff; these staff will commence with the HDdUHB during the week commencing 1st March 2021. The total staffing requirement is detailed at Appendix 1.

Other factors to be considered

As well as the additional requirement to fulfil COVID-19 cleaning requirements both internally and externally, there is also the added pressure of higher than usual sickness rates due to COVID-19. The current rate of sickness for domestic staff is around 8% with additional staff shielding/self-isolating due to COVID-19. This workforce gap is currently being filled by Phase 1 and 2 COVID-19 staff and bank staff members.

Asesiad / Assessment

Meeting the Key Standards

An assessment was carried out across the HDdUHB by the Facilities Operations Team to determine the gap between the current budgeted establishment and the staffing level required to achieve the new baseline for cleaning in line with the Standards described in the Appendices. It should be noted that although this work has been accelerated/implemented on the back of the recent pandemic, the Standards will be the new basic cleaning requirement for the HDdUHB at all times and therefore become the current and future baseline. At present, there will still be a need to for additional cleaning staffing requirement to service all current HDdUHB sites (including Field Hospitals & Vaccination Centres). This requirement does not form part of the additional staff requirement described in this report, and will be managed through the COVID-19 funding process.

In order for the HDdUHB to meet the Key New Enhanced Standards, in line with the low risk pathway on a permanent basis and with the sufficient capacity to flex up to Amber and Red Areas when required (Appendix 3), the HDdUHB will be required to increase its workforce by

approximately 113 wte. This will include additional domestic staff (waste operatives, housekeepers and ward domestics), designated trainers and additional supervisors. The increased cost for the staff element will be circa £2.8m on top of the current substantive establishment requirements. The additional non-pay required to facilitate the enhancement in cleaning provision would be circa £0.1m.

The Human Resources challenges are significant in a recruitment campaign of this magnitude, and significant consultation together with collaborative working has been undertaken between all parties involved in this campaign, to enable the process to be streamlined, with staff expected to take up these substantive positions during the first quarter of 2021/2022.

STANDARD	RESOURCE REQUIRED (Banding in brackets)	REASON	RECURRING COST
Standard 1	7 Waste Operatives (B2) & 12 additional housekeepers (B2)	Clutter- free environment / Office cleaning and cleaning of shared areas (inc accommodation)	£449,730
Standard 2	7 Rapid Response Team Housekeepers (B2) and 58 additional ward domestics (B2)	Additional frequency of decontamination	£1,538,550
Standard 3	Hygiene Technicians	Monitoring and disinfection of mobile and communication devices not currently in HS remit	£0
Standard 4	Disposable Products	Increase of disposable mop heads & microfibre stock	£95,000
Standard 5	4 senior supervisors - 1 per acute (B5) and 5 trainers (B3)	To support Assistant Site Ops manager and develop training plans and act as deputy when required (possibly existing supervisors promoted and position backfilled) / Update induction and undertake refresher training for all staff involved in cleaning tasks	£282,697
Standard 6	7 Housekeeping supervisors (B3)	Control of rotas to allocate staff to COVID and Non-COVID pathways and support standard 6	£181,951
Standard 7	6 Rapid Response Team Housekeepers (B2)	Enhance current RRT's for UV and HPV decontamination	£142,020
Standard 8	7 additional staff for assurance team (B3), C4C and Quality Monitoring Tool	Review of schedules; liaison with clinical staff; formal audits / Update site plans to reflect departmental changes / Risk assessment; document additional cleans ensuring fully auditable	£191,951
Standard 9	No additional resource required as part of core responsibilities		£0
Total annual cost to meet all standards			**£2,881,899**

Summary of Benefits

The benefits from investment in this initiative would be:

- The ability to meet the guidance issued by the WG on the new Enhanced Cleaning Standards;
- Potential to reduce clinical incidents as a result of Enhanced Standards of Cleanliness;
- Enhanced resilience of current workforce through recruitment of additional staff;
- Capacity to deep clean areas and maintain patient flow effectively, promptly and safely.

Argymhelliad / Recommendation

The Board is asked to:

- Note the content of this paper
- Approve the allocation of additional resources to this purpose when approved by WG

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 975 Score 10
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	2.4 Infection Prevention and Control (IPC) and Decontamination
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Welsh Government standards and principles on environmental cleaning and decontamination.
Rhestr Termau: Glossary of Terms:	In body of text
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Please see Integrated Impact Assessment
Ansawdd / Gofal Claf: Quality / Patient Care:	Please see Integrated Impact Assessment
Gweithlu: Workforce:	Please see Integrated Impact Assessment
Risg: Risk:	Please see Integrated Impact Assessment
Cyfreithiol: Legal:	Please see Integrated Impact Assessment

Enw Da: **Reputational:**	Please see Integrated Impact Assessment
Gyfrinachedd: **Privacy:**	Please see Integrated Impact Assessment
Cydraddoldeb: **Equality:**	Please see Integrated Impact Assessment

APPENDIX 1 – Total additional staffing requirements

Facilities staff requirements for cleaning	WTE	Annual Cost	Funding Source	Comments	Recruitment notes
COVID requirement - including Field sites and vaccination centres (expectation is to end of June 2020)	124	£0.72M	Funded through COVID	This would be the total additional requirement on top of current level of staffing/spend for COVID as of present. The requirement will be pro-rated for the duration of COVID (expected to end of June 2020) and staffed through fixed term and additional bank usage, so no ongoing liability for Health Board. Note that the total COVID requirement for cleaning (for acute and community sites) will be part of the Enhanced cleaning requirement below. The only additionality for COVID once enhanced cleaning in full operation will be for vaccination centres and field hospitals.	In line with Workforce and OD Support a fast track recruitment process has been undertaken. Staff have been interviewed by phone, pre – employment checks being undertaken. OH clearance clinic planned for 13/02/2021, First staff could commence at GGH W/C 01/03/2021.
Enhanced cleaning requirement	**113**	**£2.8m**	**Additional funding via WG (as requested in this paper)**	**As per paper to Welsh Government - detailed breakdown per standard provided in financial table.**	**Intensive recruitment campaign to commence once final approval of funding is received. It is anticipated that a number of these substantive positions will be filled by temporary and bank contract staff currently in post. Substantive recruitment to take place in first quarter of 21/22.**
Substantive vacancy gap	68	£1.6M	Within existing budget, no additional funding required	Approximately 30%-40% of this gap is currently covered via domestic bank staff usage. An element of the remaining hours are being filled by COVID staff wherever possible but there is still a current shortfall in domestic numbers. Fast track recruitment will assist in filling this shortfall until substantive appointments are made.	Normal recruitment process via TRAC to be processed. Any improvement in the current recruitment period will be actively pursued Some of these posts may also be filled by temporary and bank contract staff currently in post. Substantive recruitment to take place in first quarter of 21/22.

Appendix 2

Standards;

1) **Policies and Pathways** – there should be robust polices in place that details the cleaning plans for different patient pathways during pandemic. This includes

- *Existing risk based cleaning protocols by area/ward/dept. are in place that adhere to existing National Cleaning Standards for the NHS (2009)*
- *Specific cleaning protocols have been agreed to respond to and manage high, medium, low risk patient pathways for COVID-19*
- *Having specific protocols to address non clinical areas*
- *increased frequency of cleaning / disinfection is incorporated into the environmental decontamination schedules for all areas*
- *Infection prevention and control policies to support best practice e.g. Standard Infection Control Precautions (SICP) and Personal Protective Equipment (PPE) for cleaning staff*
- *Guidance highlights the need to keep care environments clutter free, with all shared non-essential items removed from reception, consulting and waiting areas.*
- *Clear protocols for clinical staff on decontamination of care equipment and medical devices in accordance with local policy and manufacturers 'Instructions For Use' in the high, medium, low risk patient pathways*

2) **Cleaning frequency** – The frequency of cleaning all environments must be increased. This includes;

- *The frequency of cleaning for single rooms, cohort areas and clinical rooms must be risk assessed*
- *Organisations have a set of frequencies in place outside of COVID-19-19 requirements*
- *Increased frequency where there may be higher environmental contamination rates*
- *Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff*
- *Surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails must be cleaned according to frequencies set out in cleaning matrix and when known to be contaminated with secretions, excretions or body fluids;*
- *Touch points in public areas such as lifts and corridor handrails;*
- *Electronic equipment, including mobile phones, desk phones and other communication devices, tablets, desktops, and keyboards (particularly where these are used by many people), should be decontaminated according to frequencies set out in cleaning matrix*

3) **Cleaning Agents** – Decontamination of equipment and the care environment must be performed using products that are effective in removing/killing the virus. This includes;

- *Only using cleaning and disinfecting agents and materials supplied by employers*
- *A combined detergent/ disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or*
- *A general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl or*
- *Any alternative cleaning agents/disinfectants to be used must conform to EN standard 14476 for virucidal activity.*
- *70% alcohol or product as specified by manufacturer should be used to decontaminate electronic equipment*
- *Cleaning agents must be prepared and used according to the manufacturers' instructions and recommended product 'contact times' must be followed*
- *Any use of alternative or validated novel technologies are used as an adjunct to manual cleaning / disinfection*

4) **Cleaning equipment** – sufficient and suitable cleaning equipment must be available to undertake all cleaning duties. This includes;

- *Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination.*
- *Reusable equipment (such as mop handles, buckets) must be thoroughly decontaminated after use*
- *Communal cleaning trollies should not enter isolation rooms.*
- *Cleaning trollies should be stocked with minimal stock before use*
- *Ensure reusable items and trollies are decontaminated and stored correctly between use*
- *Re-usable cleaning cloth systems must be used according to manufacturer instructions and decontaminated correctly*

5) **Training and Education** – all staff who undertake environmental cleaning tasks have the skills and knowledge to perform their tasks safely and effectively. This includes;

- *Current mandatory training in Infection prevention and control.*
- *Staff are trained and undergo COVID-19 competency assessment in SICP and TBP (including the appropriate use of PPE) prior to working in any clinical environment, according to pathway and by task*
- *Hand hygiene audits of cleaning staff are undertaken monthly*
- *All staff are taught the principles of cleaning and disinfection along with specific cleaning methods*
- *Safe use of cleaning agents, materials and equipment and their disposal*

6) **Staffing and Supplies** – adequate resources have been allocated to ensure these standards can be achieved. This includes;

- *Cleaning staff are allocated to specific area(s) and not be moved between COVID-19 and non-COVID-19 pathways, except in exceptional circumstances*
- *Organisations need to have the ability to act and react rapidly to urgent requests for cleaning support.*
- *Adequate supplies of cleaning agents, materials and equipment are assessed daily and stock maintained*
- *Bank and agency staff are used in same areas (ideally non-Covid-19 zones) and movement is minimised*
- *Adequate staffing is maintained to ensure that the standards are delivered and meet demand resulting from increased cleaning frequencies.*
- *Adequate supervision*
- *Assessment of individuals staff risk is documented before working in COVID-19 areas*
- *Robust support of other services to maintain and increase staffing levels*

7) **Technological Solutions** – the use of technology to support and augment traditional cleaning methodologies. This includes;

- *Use of new technological solutions such as UVC-light (Ultra-Violet) and Hydrogen Peroxide Vapour (HPV)in COVID-19 areas as an adjunct to other methods*
- *Recognising that a manual clean and preparation of the area is required prior to use of UVC-light or HPV*
- *Ensuring staff using such technologies adhere to protocols for safe use*
- *Employing as part of the organisational cleaning protocol in managing other HCAI*

8) **Audit Compliance** – robust audit and monitoring processes are in place to ensure the cleaning standards are effective. This includes;

- *Having protocols in place to identify that cleaning measures are achieving compliance with local and national standards.*
- *Current audit monitoring tool should include an additional generic element specifying Cleaning Schedules.*
- *There is audit sign off across all patient pathways for wards/departments*
- *Existing audit processes within low risk pathways are continued and reported and actioned*
- *Ensure protocols and procedures are in place to provide monthly reports on compliance, highlighting areas of non-compliance via an exception report.*
- *Prior to audit an increased reporting system needs to be in place in order to capture compliance in cohort areas.*
- *Considering the use of more objective indicators in monitoring cleaning efficacy in addition to visual inspection.*

9) **Responsibility & Accountability** – there are clear lines of accountability within the organisation to ensure these standards are implemented and monitored. This includes;

- *Board level responsibility for oversight of environmental cleanliness during pandemic*
- *There is a designated lead for environmental cleanliness across all sites from Facilities and Estates and IP&C link*
- *A rapid and robust process in place to report, escalate and address non-compliance with the standards*
- *A cleaning responsibility matrix highlighting service responsibilities of all staff reflecting wards and departments*

Appendix 3 Cleaning Frequency Matrix

Level of risk	**High Risk COVID-19 Pathway Section 9: SICPs & TBPs**	**Medium Risk COVID-19 Pathway Section 8: SICPs & TBPs**	**Low Risk COVID-19 Pathway Section 6: SICPs**
Description	Any care facility where; a) untriaged individuals present for assesment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID 19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting for test results OR d) symptomatic individuals who decline testing	Any care facility where triaged/ clinically assessed individuals are asymptomatic and are; a) waiting a SARS-CoV-2 (COVID-19) test result and have no known recent COVID-19 contact OR b) where testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing in any care facility	Any care facility where; a) triaged/clinically assessed individuals with no symptoms, no known recent COVID-19 contact, who have recently shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the point of the test OR b) patients who have recovered from COVID-19 and had at least three consecutive days without fever or respiratory systems and a negative COVID-19 test OR c) patients or individuals in any care facility where testing is undertaken regularly (remain negative)
Cleaning frequency	**High risk pathway - Daily frequency**	**Medium risk pathway - Daily frequency**	**Low risk pathway - Daily frequency**
Occupied Emergency / Assessment Areas	Four times	Three times	Twice
Inpatient rooms / cohort – occupied	Three times	Three times	Twice
Private Patient bathrooms/ toilets	Twice	Twice	Twice
Inpatient rooms – unoccupied (terminal cleaning)	When vacated and then twice daily	When vacated and then twice daily	When vacated
Occupied inpatient areas	Three times	Three times	Twice
Shared patient bathrooms/ toilets	Four times	Three times	Twice
Unoccupied inpatient areas	Twice	Once	Once
Outpatient / ambulatory care rooms	Between patients	Between patients	Twice
Frequently used hallways and corridors	Twice	Twice	Twice
Frequently touched areas in hallways and corridors	Four times	Four times	Twice
Hallways and corridors that are not frequently used	Once	Once	Once
Outpatient / ambulatory care rooms	Between patients	Between patients	Between patients

Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed By	Evidence (Insert)
Financial/Service Impacts				
1. Has the new proposal/service model been costed? If so, by whom?	**Y**	**Contained within SBAR**	**Finance/Facilities Teams**	
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?	**Y**	**Subject to Welsh Government support on funding**		
3. Is the new proposal/service model affordable from within existing budgets?	**N**	**Additional funding will be required from WG**		
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?	**Y**	**Impact on pay/cleaning materials**		
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?	**N**			
6. What is the financial or efficiency payback (prudency), if any?	**N**	**To achieve revised standards of cleaning and decontamination**		
7. Are there risks if the new proposal/service model is not put into effect?	**N**			
8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)	**N**			
9. Is there a need for negotiation/lead in times i.e.	**Y**	**Will be subject to recruitment processess**		

short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?				
10. Are capital requirements identified or funded?	**N/A**			
11. Will capital projects need to be completed in time to support any service change proposed?	**N/A**			
12. Has a Project Board been identified to manage the implementation?	**Y**	**A team has been established to manage the recruitment process**		
13. Is there an implementation plan with timescales to performance manage the process and risks?	**Y**	**This is currently being established to identify how the revised standards will be phased alongside the recruitment process**		
14. Is there a post project evaluation planed for the new proposal/service model?	**N**			
15. Are there any other constraints which would prevent progress to implementation?	**N**			
Quality/Patient Care Impacts				
16. Could there be an impact on patient outcome/care?	**Y**	**Positive impact due to improved cleanliness standards**		
17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.	**N**			
18. Is there any potential for inconsistency in approach across the Health Board?	**N**			
19. Is there are potential for postcode lottery/commissioning?	**N**			
20. Is there a need to consider exceptional circumstances?	**N**			

21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?	**N**			
22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?	**N**			
23. Can clinical engagement be evidenced in the design of the new proposal/service model?	**N**			
24. Are there any population health impacts?	**N**			
Workforce Impact				
25. Has the impact on the existing staff/WTE been determined?	**Y**	**Costed plan identifying WTE requirements**		
26. Is it deliverable without the need for premium workforce?	**Y**			
27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?	**N**			
28. Is there potential for professional body/college/union involvement?	**N**			
29. Could there be any perceived interference with clinical freedom?	**N**			
30. Is there potential for front line staff conflict with the public?	**N**			
31. Could there be challenge from the 'industries' involved?	**N**			
32. Is there a communication plan to inform staff of the new arrangements?	**N**	**Will need to be developed as part of Team Brief when full implementation**		

		plan is available		
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?	**N/A**			
34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?	**Y**	**Part of the implementation plan**		
Risk Impact				
32. Has a risk assessment been completed?	**N/A**			
33. Is there a plan to mitigate the risks identified?	**N/A**			
Legal Impact				
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made?	**N**			
35. Is there a likelihood of legal challenge?	**N**			
36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?	**N**			
37. Is there any existing contract and/or notice periods?	**N**			
Reputational Impact				
38. Is there a likelihood of public/patient opposition?	**N**			
39. Is there a likelihood of political activity?	**N**			
40. Is there a likelihood of media interest?	**N**			
41. Is there the potential for an adverse effect on recruitment?	**N**			

42. Is there the likelihood of an adverse effect on staff morale?	**N**			
43. Potential for judicial review?	**N**			
Privacy Impact				
44. Has an initial Privacy Impact Assessment (PIA) been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738	**N**			
45. Has a full PIA been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738	**N**			
Equality Impact (unless otherwise completed as part of the accompanying SBAR)				
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516	**N**			
47. Has a full EqIA been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516	**N**			
48. Have any negative/positive impacts been identified in the EqIA documentation?	**N**			