# POLICY FOR THE ASSESSMENT, PREVENTION AND TREATMENT OF VENOUS THROMBO-EMBOLISM

<table>
<thead>
<tr>
<th>Guideline Reference: 1695</th>
<th>Version: 2.1</th>
<th>Status: Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type:</strong></td>
<td>Clinical Policy</td>
<td></td>
</tr>
<tr>
<td><strong>Guideline applies to (Staff Group):</strong></td>
<td>All West Suffolk NHS Foundation Trust Employed SCH Staff working</td>
<td></td>
</tr>
</tbody>
</table>

As part of transition to the new service contract this Suffolk Community Healthcare (Serco) procedural document has been adopted by The West Suffolk NHS Foundation Trust NHS Trust with the following amendments:

- Pg.1 removal of Serco Equality and Diversity Impact Statement
- Throughout document replaced SCH with West Suffolk NHS Foundation Trust where refer to organisational state
- Pg.1, 4.1 Amended to read ‘This policy covers all staff employed by West Suffolk NHS Foundation Trust working within SCH relevant services including any bank/locum/agency staff working for SCH’.
- Pg.3, 6.1 Director of Nursing, Therapies and Governance replaced with ‘Medical Director’
- Pg.4 6.6 Prefix Governance Team with ‘Consortia’ and organisation replaced by ‘consortia’
- Version change to 2.1 – minor amendment as above

This policy would benefit from early review with potential to harmonise with the Hospital Policy.

Where the procedural documents refer to Suffolk Community Healthcare (SCH) this is referring to those staff employed by The West Suffolk NHS Foundation Trust NHS Trust as part of the Suffolk Community Healthcare Consortia, with The Ipswich Hospital NHS Trust and Norfolk Community Healthcare and Care Trust.

Following a 30 day settling in period, a programme of review for all SCH procedural documents aligned with The West Suffolk NHS Foundation Trust will be reviewed in consultation with subject matter experts and Suffolk Community Healthcare staff.

<table>
<thead>
<tr>
<th>Date Adopted:</th>
<th>30 September 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>No later than 31 December 2015</td>
</tr>
</tbody>
</table>
## POLICY FOR the Assessment, Prevention and Treatment of Venous Thrombo-Embolism

<table>
<thead>
<tr>
<th>Policy Reference:</th>
<th>SCHCP43</th>
<th>Version:</th>
<th>2.0</th>
<th>Status:</th>
<th>Approved</th>
</tr>
</thead>
</table>

**Type:** Clinical  
**Policy applies to:** All SCH staff within relevant groups; community hospitals, community settings

**Policy applies to (staff groups):** All appropriate clinical staff

**Required compliance:** This policy must be complied with fully at all time by the appropriate staff

<table>
<thead>
<tr>
<th>Policy owner:</th>
<th>Director of Nursing Therapies and Governance</th>
</tr>
</thead>
</table>
| Policy authors: | Clinical Effectiveness Manager  
Modern Matron |
| Other contact: | Head of Nursing and Professional Practice |
| Date this version adopted: | August 2015 |
| Last review date: | June 2015 |
| Reviewer: | CIS Nurse Consultant/ C.E. Manager |
| Next review date: | August 2018 |
| Location of electronic master: | SCH Intranet |

### AGREED POLICY/GUIDELINE REVIEW / RATIFICATION / ADOPTION PATH:

<table>
<thead>
<tr>
<th>Level 1:</th>
<th>Level 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agreed by:</strong> Medicines Management Group</td>
<td><strong>Agreed by:</strong> Clinical Policy, Audit Steering &amp; Documentation Group</td>
</tr>
<tr>
<td><strong>Date:</strong> June 2015</td>
<td><strong>Date:</strong> May 2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3:</th>
<th>Level 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agreed by:</strong> Clinical Quality &amp; Safety Assurance Group</td>
<td><strong>Noted by:</strong> SLT</td>
</tr>
<tr>
<td><strong>Date:</strong> July 2015</td>
<td><strong>Date:</strong> August 2015</td>
</tr>
</tbody>
</table>

**Name and Title of people who carried out the EQIA:** Sarah Miller, Clinical Effectiveness Manager  
**Name of Director who signed EQIA:** Pamela Chappell
Contents

1 Introduction 1
2 Purpose of this Policy 1
3 Policy Agreement Path 1
4 Scope of this Policy 1
5 Definitions 1
6 Roles & Responsibilities 2
7 VTE Assessment 3
8 VTE Prophylaxis 3
9 Treatment/ Management if VTE suspected 4
10 Compliance Monitoring, Audit and Reporting 4
11 Training and Competency Assessment 4
12 Links to Other Policies 4
13 References 5

Appendix 1: VTE Risk Assessment Tool 6
Appendix 2: Care Pathway for VTE Risk Assessment 7
Appendix 3: VTE Risk Factors 8
Appendix 4: Low Risk Cohorts 9
POLICY FOR THE ASSESSMENT, PREVENTION AND TREATMENT OF VENOUS THROMBO-EMBOLISM

1 Introduction


1.2. West Suffolk NHS Foundation Trust Trust aims to ensure that all adult patients under their care within community hospitals are risk assessed for VTE and, where appropriate receive thrombo-prophylaxis in line with the above NICE guidance.

1.3. Huge progress has been made nationally, regionally and locally in embedding a culture of VTE prevention across the NHS as part of a national programme developed by a partnership of clinical leaders which includes the Royal College of Nursing, and through the efforts of frontline workers (Department of Health 2011).

1.4. This policy should therefore be read in conjunction with the above NICE Guideline.

2 Purpose of this Policy

2.1. The purpose of this policy is to ensure that all patients within SCH community hospitals are assessed appropriately for their risk of developing a VTE and if necessary receive appropriate treatment. This risk assessment should be on-going and regularly reviewed during their episode of care.

2.2. Risk assessment should be carried out on all patients as part of the admission process and should be reviewed/ repeated as appropriate during their stay/ episode of care particularly if their condition changes in any way.

2.3. Where at risk and where appropriate, patients should receive advice and treatment on ways of reducing risk (please see SCH VTE Patient Leaflet available in the community hospitals).

2.4. All patients should be encouraged to keep as mobile as possible and prophylaxis should be given to all those assessed as being moderate to high risk. All patients are considered to be “at risk” and needing risk assessment unless they fall into nationally defined “low risk” cohorts (see appendix 4)

2.5. Patients who are transferred from acute units should be reassessed/ reviewed on admission even if an assessment has already been carried out. Any previous risk assessments completed prior to admission/ transfer should be recorded in the patient records.

3 Policy Agreement Path

3.1. See front sheet

4 Scope of this Policy

4.1. This policy covers all staff employed by West Suffolk NHS Foundation Trust Trust working within SCH relevant services including any bank/ locum/ agency staff working for SCH.

4.2. It applies equally to medical and non-medical professionals i.e. those registered with the Nursing and Midwifery Council (NMC) or the Health Professionals Council (HPC) or doctors registered with the GMC and on the local performers list.

5 Definitions

5.1. Venous Thrombo-embolism (VTE)
• Venous thrombosis is a condition in which a blood clot (thrombus) forms in a vein in any part of the venous system.
• The thrombus can reduce blood flow through the affected vein, causing pain and swelling.
• Venous thrombosis most commonly occurs in the ‘deep veins’ in the legs, thighs, or pelvis. This is known as a deep vein thrombosis (DVT).
• When a part or all of the thrombus in the deep vein breaks off from the site where it is created and travels through the venous system. This is known as an embolism.
• A dislodged thrombus that travels to the lung is known as a pulmonary embolism (PE). However, deep vein thrombosis (DVT) and PE are the most common manifestations of venous thrombosis. DVT and PE are known as venous thrombo-embolism (VTE). (Dept of Health, 2009)
• Approximately 10% of all DVT cases occur in the upper extremities. The most common cause of upper extremity DVT is placement of a central venous catheter, particularly a PICC line. Preventive measures include choosing the smallest diameter catheter necessary and careful attention to correct catheter tip position.
• Non-invasive, combined-modality ultrasound is recommended as the first test when DVT is suspected.

5.2. Thrombo-prophylaxis:
• Thrombo-prophylaxis is the treatment to prevent blood clots.

6 Roles & Responsibilities
This policy applies to every West Suffolk NHS Foundation Trust Trust employee of Suffolk Community Healthcare (SCH) involved in the care of patients who are ‘at risk’ of developing, or actually have an identified VTE, currently this applies to the inpatient services only. Community patients (with the exception of patients within the community hospitals) who are at risk of VTE or currently have a VTE remain the responsibility of their GP.

6.1. The Medical Director on behalf of the Chief Executive will ensure that a comprehensive policy for VTE assessment, prevention and management within SCH is developed, agreed and reviewed.

6.2. Local Area Managers:
   a) Will ensure that the policy is implemented within their area of responsibility
   b) Will ensure the provision of necessary training and equipment within their areas taking clinical effectiveness, educational requirements of staff and financial factors into account
   c) Will ensure all staff within their in patient units are aware of and understand the policy
   d) Will ensure compliance with the audit requirements of the policy
   e) Will take managerial action to prevent recurrence of reported incidents

6.3. Modern Matrons:
   a) Will ensure that all staff are aware of the policy and adhere to it
   b) Will incorporate VTE assessment, prevention and management into staff performance review.
   c) Will ensure the Local Area Manager is aware of all incidents/failures to comply with the policy

6.4. Doctors (inpatient settings):
a) Ensure that they are appropriately trained in VTE risk assessment and management
b) Ensure that all training is recorded and monitored
c) Prescribe any required VTE prophylaxis and treatment
d) GPs who are on the local performers list can be assumed to have current GMC registration, up to date with NHS appraisal therefore and be trained in VTE assessment.
e) GPs should also ensure that they have read and be aware of the Area Team/ CCG protocol/ SCH Policy

6.5. All Staff:
   a) Will adhere to the SCH VTE Policy
   b) Will use the information provided at clinical level to ensure correct choice of prophylactic measures and treatment options and use these in a safe manner assessing risk as part of patient care.
   c) Will identify their training need and make their manager aware of training deficit
d) Will maintain personal records of all training
e) Will report all clinical incidents around VTE assessment, prevention and management

6.6. SCH Consortia Governance Team:
   a) The team will be responsible for the co-ordination of the audit of VTE assessment, prevention and treatment and the collation of data on behalf of the consortia.
   b) Will ensure clinical practice is developed in line with evidence and best practice guidance
c) Will support the reporting required to the Area Team, National Patient Safety Agency and Commissioners.

7  VTE Assessment

7.1. GPs/ consultants will assess all newly admitted patients using the VTE Risk Assessment Tool (see appendix 1)

7.2. Patients who are transferred from one of the acute units should be reassessed within 24 hours (or the next working day if at weekends) of admission and if their condition is unchanged the acute unit assessment can be adopted.

7.3. Patients should be reassessed as their condition or level of mobility changes and the GP must be informed.

7.4. VTE risk factors can be found in Appendix 3

8  VTE Prophylaxis

8.1. Measures used within SCH for the prevention of VTE include the following
   a) Pharmacological: i.e. the use of Low Molecular Weight Heparins (LMWH) prescribed in licensed prophylactic doses (Enoxaparin in East Suffolk and Tinzaparin in West Suffolk)
   b) Mechanical: i.e. the use of graduated compression anti-embolic stockings.

8.2. VTE prophylaxis should be commenced as soon as possible after risk assessment has been completed if the patient is considered at risk and should continue until the patient is no longer considered to be at increased risk.
8.3. LMWHs are prescribed by medical practitioners either within the acute or community setting having taken the indications, cautions and contra-indications into account (see British National formulary; references, section 13).

8.4. Medical practitioners/ registered nurses must decide, following risk assessment whether consideration should be given for the administration of graduated compression anti-embolic stockings taking account of the following:
   a) Doppler assessment should be carried out on all patients prior to measurement/ application.
   b) Patients must be measured for their application by trained and competent practitioners
   c) Stockings should be worn from the day of admission until the day of discharge.
   d) Stockings should be removed daily for hygiene purposes and to enable assessment of the patient’s skin condition; they must be reapplied as soon as possible.
   e) Anti-embolic stockings should not be administered to patients with a known allergy to the material of manufacture. They are also not recommended for patients admitted with a stroke, cardiac failure or suspected or proven arterial disease.

8.5. All VTE prophylaxis measures administered must be documented within the patient’s records.

9  Treatment/ Management if VTE suspected
9.1. A D – Dimer blood test will be performed and VQ scan undertaken to enable diagnosis where VTE is suspected
9.2. A LMWH will be prescribed by the GP; the treatment dose is higher than the prophylactic one and will be determined by patient’s weight using the approved formula (see BNF)
9.3. Anti-embolic stockings will be prescribed and fitted
9.4. Current NICE Guidance (TA 256 – see below section 13.5) recommends the use of Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation.

10 Compliance Monitoring, Audit and Reporting
10.1. Safety thermometer audit
10.2. Performance monitoring data dashboard
10.3. Incident reporting for patients
10.4. Admission and discharge spreadsheet

11 Training and Competency Assessment
11.2. Application of surgical appliance training including recognition of the importance of regular VTE assessment.

12 Links to Other Policies
12.1. Incident Reporting Policy
12.2. Record Keeping Policy
12.3. Consent Policy
13 References


13.4. NPSA Alert: Reducing treatment dose errors with low molecular weight heparins http://www.nrls.npsa.nhs.uk/alerts/?entryid45=75208 (accessed 21/5/12)


Appendix 1: VTE Risk Assessment Tool

<table>
<thead>
<tr>
<th>MANDATORY VENOUS THROMBOEMBOLISM RISK ASSESSMENT FOR ALL ADULT INPATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk assessment to be undertaken on admission, within 24 hours of admission and whenever the clinical situation changes.</td>
</tr>
</tbody>
</table>

**Mobility – all patients (tick one box)**
- Medical patient NOT expected to have significantly reduced mobility relative to normal state. **Risk assessment now complete.**
- Surgical patient.
- Medical patient expected to have ongoing reduced mobility relative to normal state. **Assess for thrombosis and bleeding risk below.**

**If one or more risk factors, consider enoxaparin 40 mg and mechanical thromboprophylaxis.**

<table>
<thead>
<tr>
<th>On admission</th>
<th>Within 24hrs</th>
<th>Reassess if clinical situation changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Thrombosis risk (tick in date column if present)**
- Age > 60 years (> 35 years if pregnant)
- Active cancer/treatment
- Dehydration
- Known thrombophilia/polycythaemia/thrombocytosis
- Obesity (BMI > 30)
- One or more significant medical comorbidities (such as heart disease, metabolic, endocrine or respiratory pathologies, acute infectious diseases, inflammatory conditions)
- Personal history or first-degree relative with history of VTE
- Use of hormone replacement therapy or oestrogen-containing contraceptive therapy
- Varicose veins with phlebitis
- Pregnancy or has given birth within the previous 6 weeks (if on a maternity ward, strike through this risk assessment and complete separate obstetric risk assessment)
- Significantly reduced mobility for 3 days or more
- Hip or knee replacement
- Hip fracture
- Total anaesthetic and surgical time > 90 mins
- Surgery involving pelvis or lower limb with total anaesthetic and surgical time > 60 mins
- Acute surgical admission with inflammatory or intra-abdominal condition
- Surgery with significant reduction in mobility

**Admission-related**
- Bleeding risk/Contraindications to enoxaparin (tick in date column if present)
  - Active bleeding
  - Acquired bleeding disorders (such as acute liver failure)
  - Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR > 2)
  - Lumbar puncture/epidural/spinal anaesthesia expected within the next 12 hours
  - Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours
  - Acute stroke
  - Thrombocytopenia (platelets < 75x10⁹/l)
  - Uncontrolled systolic hypertension (230/120 mmHg or higher)
  - Untreated inherited bleeding disorders (such as haemophilia or von Willebrand’s disease)
  - Neurosurgery, spinal surgery, eye surgery or prostate surgery
  - Other procedure with high bleeding risk

**Thromboprophylaxis (tick in date column)**
- **YES**
  - Prescribe on drug chart
  - Enoxaparin 40 mg daily (or 20 mg daily if eGFR < 30 ml/min)
  - Anti-embolic stockings unless contraindicated
  - Intermittent pneumatic compression
  - Foot impulse devices
- **NO**
  - Provide reasons/comment:

**Risk assessment completed – Signature / Bleep:**

Start pharmacological VTE prophylaxis as soon as possible after risk assessment has been completed. Continue until the patient is no longer at increased risk of VTE. Encourage patient to be mobile as soon as possible.

**VTE information leaflet given to patient**
- **Signature:** Date: ---

**Advice given by physiotherapist**
- **Signature:** Date: ---
Appendix 2: Care Pathway for VTE Risk Assessment

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes.

STEP ONE
Assess all patients admitted to hospital for level of mobility (tick one box). All surgical patients, and all medical patients with significantly reduced mobility, should be considered for further risk assessment.

STEP TWO
Review the patient-related factors shown on the assessment sheet against thrombosis risk, ticking each box that applies (more than one box can be ticked).

Any tick for thrombosis risk should prompt thromboprophylaxis according to NICE guidance.

The risk factors identified are not exhaustive. Clinicians may consider additional risks in individual patients and offer thromboprophylaxis as appropriate.

STEP THREE
Review the patient-related factors shown against bleeding risk and tick each box that applies (more than one box can be ticked).

Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention.

Guidance on thromboprophylaxis is available at:

http://www.nice.org.uk/guidance/CG92
## Appendix 3: VTE Risk Factors

### Patients who are at risk of VTE

**Medical patients**
- If mobility significantly reduced for ≥ 3 days or
- If expected to have ongoing reduced mobility relative to normal state plus any VTE risk factor.

**Surgical patients and patients with trauma**
- If total anaesthetic + surgical time > 90 minutes or
- If surgery involves pelvis or lower limb and total anaesthetic + surgical time > 60 minutes or
- If acute surgical admission with inflammatory or intra-abdominal condition or
- If expected to have significant reduction in mobility or
- If any VTE risk factor present.

**VTE risk factors**¹
- Active cancer or cancer treatment
- Age > 60 years
- Critical care admission
- Dehydration
- Known thrombophilias
- Obesity (BMI > 30 kg/m²)
- One or more significant medical comorbidities (for example: heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)
- Personal history or first-degree relative with a history of VTE
- Use of HRT
- Use of oestrogen-containing contraceptive therapy
- Varicose veins with phlebitis

¹ For women who are pregnant or have given birth within the previous 5 weeks see page 23.

### Patients who are at risk of bleeding

**All patients** who have any of the following.
- Active bleeding
- Acquired bleeding disorders (such as acute liver failure)
- Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR > 2)
- Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours or expected within the next 12 hours
- Acute stroke
- Thrombocytopenia (platelets < 75 x 10⁹/l)
- Uncontrolled systolic hypertension (> 230/120 mmHg)
- Untreated inherited bleeding disorders (such as haemophilia or von Willebrand’s disease)
Appendix 4: Low Risk Cohorts

Midlands and East Regional Protocol for VTE CQUIN Implementation

It is national policy to assess the risk of VTE of every patient on admission to hospital including day cases. This regional protocol sets out the instances where Midlands and East PCT and their providers may consider the risk of VTE for a particular patient cohort overall. This would enable an agreed view to be reached, that each patient has been assessed for VTE risk, using the national tool. This can then recorded as 'not at risk of VTE'.

This approach can only apply where a cohort of patients could be deemed as not at risk of VTE according to NICE guidelines.

This document sets out the scope of patient cohorts to be included and ensures that the contribution of a "cohort" VTE risk approach captures the overall numbers assessed for the purposes of CQUIN.

All relevant organisations in Midlands and East may utilise the following approach in agreement with their commissioners. Across the NHS, SHA Medical Directors have discussed using a consistent approach to defining cohorts, in extensive consultation with Medical Directors of acute provider organisations.

Summary of final recommendations: DH Policy implementation on VTE risk assessment.

1. **Day case procedure cohorts**

   - There are no exceptions, exclusions or "opt outs" agreed by DH for the policy of assessing all adult patients for the risk of VTE on admission.
   - The "cohort approach" allows Medical Directors (local and SHA) to make a clinical decision regarding a group of patients admitted for the same procedure who are felt to have a similar risk profile and are assessed as a group as being at low risk of VTE using the DH/NICE risk assessment categories and detailed NICE guidance.
   - Clinical responsibility rests with SHA MDs for the decision to adopt a cohort approach and deem individual patient's risk assessment to have been completed when the cohort risk assessment has been made.
   - Following this detailed consideration and consultation by SHA Medical Directors with the NHS, a consensus has built around day case procedure groups, where patients admitted for the same procedure (cohorts)

2. **Those patient who have similar risk profile and have been assessed, as a group, as being at low risk of VTE using the DH/NICE risk assessment categories and consistent with detailed NICE guidance.**

   These day case procedure groups are:-

   - Haemodialysis
   - Endoscopy
   - Chemotherapy
   - Ophthalmological procedures with local anaesthetic/regional/ sedation and not full general anaesthetic
• Non-cancer ENT surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic
• Non-cancer plastic surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic
• Non-cancer dental and maxillo-facial surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic
• Other similar minor procedures lasting less than 90 minutes to be signed off by the medical director with local anaesthetic/regional/ sedation and not full general anaesthetic.

This protocol is for guidance and, in all instances; clinical judgement in individual patients would take precedence.

N.B. Importantly, neither knife-to-skin nor the use of general anaesthetic/local anaesthetic has proved useful in risk stratifying cohorts, partly because a number of highly thrombogenic procedures are performed under local anaesthetic.

The Midlands and East SHA through the agreement of its Medical Director has agreed and accepted the above as the basis for implementing the National VTE Prevention Strategy for the benefit of patients, and has communicated this to Midlands and East Acute Trust medical directors.
Any identified a potential discriminatory impact must be identified with a mitigating action plan to address avoidance/reduction of this impact. This tool must be completed and attached to any SCH approved document when submitted to the appropriate committee for consideration and approval.

### Name of Policy: VTE Policy

<table>
<thead>
<tr>
<th>Equality Impact Assessment Tool</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the policy affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>