Humber Teaching NHS Foundation Trust

Chaperone Policy
(N-059)

Version Number:	5.03
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Executive Lead (name & job title):	Hilary Gledhill, Director of Nursing AHP and Social Work
Name of approving body:	Quality and Patient Safety Group
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
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Date EMT as approving body notified for information:	*April 2024*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

This policy aims to provide practical advice to healthcare professionals working within Humber Teaching NHS Foundation Trust. The Trust is committed to providing a safe, comfortable environment where service users and staff can be confident that best practice is being followed at all times and that the safety of everyone is of paramount importance.

All service users, regardless of their age, gender identity or gender expression, disability, ethnic minority background, religion or belief have a right to their privacy and dignity being respected.

Medical examinations and investigations are potentially distressing and patients may feel vulnerable. All service users will be offered a chaperone to be present during any physical examination or procedure, particularly intimate examinations or procedures.

2. SCOPE

This policy applies to all health services provided by Humber Teaching NHS Foundation Trust. The Trust recognises that aspects of this policy will be more or less applicable to different healthcare professionals, depending upon the type of service they provide, and that the principles and recommendations of the policy need to be considered in context and relates to the chaperoning of adults, children and young people.

3. POLICY STATEMENT

The purpose of this policy is to present the principles and outlines the procedures that should be in place for appropriately chaperoning patients during examinations, investigations and care. It is largely based on the Model Chaperone Framework published by the NHS Clinical Governance Support Team in June 2005 and also reflects the CQC guidance and GMC guidance on intimate examinations and chaperones. All Trust employees and others working on our behalf have a duty to consider chaperoning issues as they relate to their work and to work in accordance with these principles.

4. DUTIES AND RESPONSIBILITIES

Chief Executive Officer
The chief executive officer has overall responsibility for all policies for the Trust.

Service and Divisional Managers
Service and divisional managers must ensure that all staff are aware and adhere to this policy. They are also responsible for ensuring that any deviation or errors arising are dealt with in the correct manner, according to the Adverse Incident Reporting Policy.

Responsible Clinicians/Consultants
Are responsible for ensuring this policy is implemented and adhered to.

Matrons/Senior Professionals
Will ensure systems are in place to support this policy in their areas of responsibility and that they are regularly reviewed.

Charge Nurses/Ward Sisters/Team Leaders
Will ensure that all staff adhere to this policy.
Will ensure that a Chaperone is provided where applicable.
Will ensure that staff within their area of responsibility have access to and attend appropriate training.

Clinical Staff
All clinical staff, including temporary or agency staff, contractors and students are responsible for co-operating with the policies and identified process documents, as part of their normal duties and responsibilities.

5. PROCEDURE

This policy sets out guidance for the use of a chaperone and the procedures that should be in place for consultations, examination and investigations. It aims to provide practical advice to health care professional and staff working in a variety of locations within the Trust, where availability of a chaperone may not always be possible.

This policy applies to all staff groups (clinical and non-clinical personal) who may be involved in providing care.

For most patients respect, explanation, consent and privacy take precedence over the need for a chaperone. The presence of a third party does not negate the need for adequate explanation and courtesy and cannot provide full assurance that the examination is conducted appropriately.

5.1. Consent

Consent must be obtained from a patient to proceed with any examination. All patients should routinely be offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted to ask if the patient wants a chaperone to be present. The offer of chaperone should be clear to the patient before any procedure. Ideally at the time of booking the appointment.

The patient should have the opportunity to decline a particular person if that person is not acceptable to them for the purpose of being a chaperone. They must then decide if they wish the examination to proceed without a chaperone.

If a chaperone is present to witness an examination or procedure being undertaken they must stand in a position whereby they can see the examination or procedure being carried out.

it would not be lawful to use a chaperone without patient consent if the person has capacity to refuse.

5.2. Mental Capacity

There is a basic assumption that every adult has the capacity to decide whether to consent to or refuse a proposed intervention.

Where there are concerns about a person's ability to give consent an assessment of capacity should be undertaken.

If a patient lacks capacity, a decision should be made in their best internet as to whether to proceed.

All patients have the right to have their privacy and dignity respected.

5.3. The Role of the Chaperone

The Ayling report (Department of Health 2004 identified that there is no common definition of a chaperone and their role varies considerably depending on the needs of the patient, the healthcare professional and examination on the procedure being carried out. Therefore, the role of a chaperone can be considered in any of the following areas:

- Always respecting and maintaining the privacy and dignity of the patient
- Providing emotional comfort and reassurance to patients

- To assist in an examination. For example, handing instruments during Intra Uterine Contraceptive Device (IUCD) insertion.
- To assist with undressing/dressing a patient
- Encourage questions.
- Be alert for any signs of distress from the patient verbal or non-verbal.
- Be able to observe the examination or procedure.
- To act as an interpreter
- In very rare circumstances to protect the clinicians against an attack

Identify unusual or unacceptable behaviour on the part of the healthcare professional and question or raise concerns at the time or with the line manager and may need to make a safeguarding referral Help the patient understand what is being communicated to them.

A chaperone is present as a safeguard for all parties (patient and health professionals) and is a witness to the conduct and the continuing consent of the procedure.

5.4. Types of Chaperone

The designation of the chaperone will depend on the role expected of them and of the wishes of the patient. It is useful to consider whether the chaperone is required to carry out an active role, such as participation in the examination or procedure, or to have a passive role, such as providing support to patients during a procedure. Therefore, chaperones may be termed ‘formal’ or ‘informal’.

5.5. Informal Chaperones (Non-clinical)

Many patients feel reassured by the presence of a familiar person and people attending appointments in a hospital or hospice, that do not require an overnight stay, can be accompanied by a family member, friend or advocate if they want someone with them.

An “informal chaperone” may not necessarily be relied upon to act as a witness to the conduct or continuing consent of the procedure. Under no circumstances should a child be expected to act as a chaperone. However, if the child is providing comfort to the parent and will not be exposed to unpleasant experiences it may be acceptable for them to stay.

The “informal chaperone” role may also be fulfilled by reception/administrative staff, or Volunteer as long as they are trained.

Health care professionals must not expect an informal chaperone to take an active part in the examination or to witness the procedure directly.

5.6. Formal Chaperones (Clinical and Non-clinical)

A “formal” chaperone implies a clinical health professional, such as a registered nurse or non-registered healthcare assistant, or a non-clinical staff member who has been specifically trained in the procedure. This individual will have a specific role to play in terms of the consultation and this role should be made clear to both the patient and the person undertaking the chaperone role. It is important that chaperones have had sufficient training to understand the role expected of them and that they are not expected to undertake a role for which they have not been trained.

The patient should be given the opportunity to state their preferences in relation to the sex of the chaperone The use of a male chaperone for the examination of a female patient or of a female chaperone when a male patient was being examined could be considered inappropriate. This should be carefully considered before proceeding and always reflect patient choice. For transgender patients, all decisions should be in line with the Trust’s Supporting Transgender Patients Policy.

5.7. Training for Chaperones

All staff working within the Trust are required to understand the role of the chaperone and the procedures for raising concern. Specific workplace induction of new staff should include training on the appropriate conduct of intimate examinations and care where appropriate.

Non-clinical members of staff who undertake a “formal chaperone role” should undergo training such that they develop the competencies required for this role. These include an understanding of:

- What is meant by the term chaperone?
- What is an “intimate examination”?
- Why chaperones need to be present.
- The rights of the patient
- Their role and responsibility
- Policy and mechanism for raising concerns.

It is the responsibility of each clinical service to be satisfied that staff have a good level of understanding in relation to the above. Staff have a personal responsibility to identify that they have enough understanding and support to undertake this role.

5.8. Offering a Chaperone

The relationship between a patient and healthcare professionals is based on trust. It is good practice to offer all patients a chaperone of the same sex as the patient for any consultation, examination, or procedure wherever possible. This does not mean that every consultation or procedure needs to be interrupted to ask if the patient wants a third-party present.

It is not always clear ahead of the event that an intimate or close proximity examination or procedure is required. **In the event, offer of a chaperone should be repeated at the time of the examination.**

Staff should be aware that intimate examinations or care might cause anxiety for both male and female patients and whether the examiner is of the same gender as the patient.

If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined in the clinical records.

If a chaperone is refused, a healthcare professional may insist that one is present when a practitioner feels unhappy to proceed, for example where there is a significant risk of the patient displaying unpredictable behaviour or making false accusations. In this case, the practitioner must make his/her own decision and carefully document this with the rationale and details of any procedure undertaken. This may include refusing to meet with the patient alone.

5.9. Where a Chaperone is Requested but not Available

If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe (this may include simply waiting in the clinic or practice until a member of staff arrives on duty). If the seriousness of the condition would dictate that a delay is inappropriate, then this should be explained to the patient and recorded in their notes. A decision to continue or otherwise should be jointly reached. In cases where the patient is not competent to make an informed decision then the healthcare professional must use their own clinical judgement and be able to justify this course of action. The decision and rationale should then be documented in the patient’s clinical record.

It is acceptable for a doctor (or other appropriate member of the health care team) to perform an intimate examination without a chaperone if the situation is life threatening or speed is essential in the care or treatment of the patient. This should be recorded in the patient’s clinical record.

5.10. Issues Specific to Children

Children and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and understanding. If an under 16 presents in the absence of a parent or guardian the healthcare professional must ascertain if they are capable of understanding the need for examination, they are assessed as being Gillick Competent. In these cases it is advisable for a formal chaperone to be present for any intimate examinations. For a child assessed as competent the same guidance relating to adults is applicable, including the option to decline a chaperone.

In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse. In these situations, healthcare professionals should refer to the local child protection policies and seek specialist advice from the Safeguarding Children Team as necessary.

5.11. Issues Specific to Religion, Ethnicity, Culture and Sexual Orientation

The ethnic, religious, and cultural background of some women can make intimate examinations particularly difficult, so the background of patients must be taken into account, as some patients may have strong cultural or religious beliefs that restrict being touched by others These considerations should be taken into account and discussed, not presumed. We must all recognise that each individual has very different needs and procedures should be performed by a mutually agreed healthcare professional. The chaperone should always reflect patient choice.

5.12. The patient's the first language is not English

In the situation of a non-English speaking person being examined the use of an independent translator should be enlisted; on no account should family members be used. (See the Access to Interpreter Services Procedure).

5.13. Issues Specific to People with Learning Difficulties and Mental Health Problems

For patients with learning difficulties or mental health problems that affect capacity, a familiar individual such as a family member or carer may be the best chaperone. A careful simple and sensitive explanation of the technique is vital. This patient group is a vulnerable one and issues may arise in initial physical examination, "touch" as part of therapy, verbal and other "boundary-breaking" in one to one "confidential" settings and indeed home visits.

People with a learning disability should to be provided with accessible information. Reasonable adjustments should be considered for example, extra time, low stimulus environment. Desensitization work can also be offered to support people with a learning disability to become familiar with the environment or equipment involved in invention and to ensure there is full opportunity to understand the intervention has occurred.

Adult patients with learning difficulties or mental health problems who resist an examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. In life-saving situations the healthcare professional should use professional judgement.

When the medical examination or procedure is in the best interest of the service user the Mental Capacity Act 2005 (MCA) must be followed. Where a service user is known to lack the capacity to consent to the medical examination or procedure can only be carried out if it is in the individual's best interest. The healthcare professional who has to take the decision on their behalf must involve the individual as much as possible in the decision. This will be documented in the service user's clinical notes.

5.14. Suspicion of Abusive Relationships

The patient has a right to have freedom and space to express worries, concerns and potential abuse as well as an examination in a non-controlling atmosphere. The onus is on the professional to use tact and diplomacy to exclude the person from the room and to use an independent chaperone, where there are concerns about coercion or control in respect of the relationship between with the person attending the consultation/ examination and the patient. It is important to have a chaperone in such cases as the documented case notes may be called on at a later date. In the event of the examination of a potentially abused child any extensive examination should only be undertaken by an expert in this field.

5.15. Sedation

Should a patient require sedation for a particular procedure, then it is mandatory that a chaperone must be present throughout and until they have fully recovered from the effects of the sedation. This is necessary because not only is the patient rendered more vulnerable, but also their understanding of events or recollection may be impaired. Hallucinations may also occur.

5.16. Lone Working

Where a health care professional is working in a situation away from other colleagues, for example in a patient's home or out-of-hours premises, the same principles for offering and use of chaperones should apply. The healthcare professional may be required to risk assess the need for a formal chaperone and should not be deterred by the inconvenience or complexity of making the necessary arrangements. In all instances the outcome must be documented.

5.17. Patient Confidentiality

In all cases where the presence of a chaperone may intrude in a confiding clinician-patient relationship their presence should be confined to the physical examination. Communication between the health professional and the patient should take place before and after the examination or procedure.

5.18. Communication and Record Keeping

The key principles of communication and record keeping will ensure that the healthcare professional and patient relationship is maintained and act as a safeguard against formal complaints, or in extreme cases, legal action.

The most common cause of patient complaints is due to misunderstanding or communication problems. It is essential that the healthcare professional explains the nature of the examination to the patient and offers them a choice whether to continue. Chaperoning in no way removes or reduces this responsibility.

Details of the examination including presence/absence of chaperone and information given must be documented in the patient's clinical record by the healthcare professional. It is advisable for the chaperone to ensure their correct full name has been entered within the patients' record.

If the patient expresses any doubts or reservations about the procedure and the healthcare professional feels the need to reassure them before continuing then it is good practice to also record this in the patient's notes. The records should make clear from the history that an examination was necessary.

In any situation where concerns are raised or an incident has occurred this should be dealt with immediately in accordance with Adverse Incident Reporting procedure.

5.19. Use of Virtual Chaperones

Virtual chaperone technology uses electronic and digital recording techniques to provide a record of the consultation. However, it is unlikely that it provides a sole solution to the issue of chaperoning and gives rise to further issues such as consent and data protection. Where a visual record is made the patients must be made aware of the nature and purpose of the recording and have the opportunity to decline to give consent.

Any department or practice wishing to offer virtual chaperone technology as a solution, either in part or in full, should ensure that they have explored all risks associated with such technology and put in place safeguards to address these.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

An adverse impact is unlikely, and on the contrary the policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist. For example, the ethnic, religious and cultural background of some women can make intimate examinations particularly difficult; Muslim and Hindu women have a strong cultural aversion to being touched by men other than their husbands. By having a chaperone of the same sex as the

patient present the examination may be made more acceptable. Also, alternatives would be sought, e.g. an appointment at a later date when another chaperone is available or at an alternative site if appropriate gender of chaperone is not available.

If, at any time, this policy is considered to be discriminatory in any way, the author of the policy should be contacted immediately to discuss these concerns.

7. MENTAL CAPACITY

The implications of the Mental Capacity Act have been applied to this policy with particular focus on key principles of the Act:

- Presumption of capacity.
- Support to make own decisions.
- Right to make seemingly eccentric or unwise decisions.
- Best interests.
- Least restrictive intervention.

8. IMPLEMENTATION

This policy will be disseminated by the method described in the Procedure for the Control, Review, Approval and Dissemination of Clinical Policies, Procedures, Protocols, Guidelines and Standard Operational Procedures (Proc481).

9. TRAINING

Any training requirements will be identified within an individual's Personal Development Reviews. Training is available in the Training Diary on the Trust's intranet site.

10. MONITORING AND AUDIT

- PALS and Complaints
- Documentation
- Equality and Diversity Training
- Any incidents relating to chaperones will be monitored via incident reporting

11. REFERENCES / EVIDENCE / GLOSSARY / DEFINITIONS

ASSOCIATED TRUST POLICIES

Consent to Treatment and Assessment Policy
Access to Interpreter Services Procedure
Freedom To Speak Up Procedure
Health and Social Care Records Policy

REFERENCES

- Bradford and Airedale PCT Chaperone Policy v2.0 April 2008 (with special thanks to Helen Woodward)
- NHS Clinical Governance Support Team (June 2005) Guidance on the Role and Effective Use of Chaperones in Primary and Community Care Settings: Model Chaperone

Framework
- DoH (2001) Seeking consent: working with children. Department of Health, London
- Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling.
- Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale
- Reference Guide to Consent for Examination or Treatment, Department of Health
- www.the-shipman-inquiry.org.uk
- GMC: Intimate examinations http://www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp#10
- Please refer to the intimate examinations section of this guidance
- Royal College of Nursing: The role of the nurse and the rights of patients
- Guidance for nursing staff, July 2002
- www.rcn.org.uk
- Guidelines in Practice, July 2002 Vol 5 (7), 52-53 www.eguidelines.co.uk
- Training: Primary Care Training Centre, Bradford Tel: 01274 617617 Chaperone study day www.primarycaretraining.co.uk
- Policy for Consent to Treatment or Examination (DoH)
- Mental Capacity Act 2005
- GP mythbuster 15: Chaperones - Care Quality Commission (cqc.org.uk)

Appendix 1: Chaperone Policy Poster / Notice

Chaperone Policy

This organisation is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

All patients are entitled to have a chaperone present for any consultation, examination or procedure. You may prefer a formal chaperone to be present, i.e. a clinical member of staff, in some occasions a family member or friend may be an informal chaperone. A further alternative, an informal chaperone, is provided by a member of our reception staff, who have all received chaperone training.

If you would like to see a copy of our Chaperone Policy or have any questions or comments regarding this please contact the practice manager.

Appendix 2: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Chaperone Policy		
Document Purpose	This policy is aimed to provide guidance for staff to carry out the procedure of chaperone within all areas of the Trust.		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates	2023 - 2024	Mental Health	
		Physical Health	
		Training	
		Safeguarding (adults and children)	
		Sadie Milner, Patient Safety Lead	
		Debbie Davis, Lead Nurse, Infection and Prevention Control	
Approving Committee:	QPaS	Date of Approval:	4 April 2024 (v5.03)
Ratified at:	Trust Board	Date of Ratification:	23 May 2018 (v5.00)
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Chaperone training is available at the Trust	Financial Resource Impact	No additional resources required
Equality Impact Assessment	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	• Will be placed on the intranet and on Midweek Global • Chaperone Training		
Monitoring and Compliance:	Datix reporting Root Cause Analysis		

Document Change History:			
Version Number / Name of procedural document this	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.00	*New policy*		*New policy*
2.00	*Review*	*09/11/10*	*ERYPCT policy CP/03 ratified*
3.00	*Review*	*06/08/12*	*Reviewed and harmonised.*
4.00	*Review*	*28/08/17*	*Reviewed and harmonised*
5.00	*Review*	*22/01/18*	*Reviewed with amendments following January 2018 QPaS*
5.01	*CAMHS review*	*24/07/19*	*CAMHS review at QPaS. No changes made.*
5.02	*Review*	*29/10/20*	*Minor amendments*
5.03	*Review*	*04/04/24*	*Reviewed with minor amends. Approved at QPaS (4 April 2024).*

Appendix 3: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Chaperone Policy (N-059)
2. EIA Reviewer (name, job title, base and contact details): John Duncan - EDI Lead
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?: Policy

Main Aims of the Document, Process or Service
This policy is aimed to provide guidance for staff to carry out the procedure of chaperone within all areas of the Trust.

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	There is no evidence that this protected characteristic would be adversely affected by implementing this policy.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	There is a risk, that is mitigated through this policy, where patients with learning difficulties or mental health that affect capacity, a familiar individual such as a family member or carer may be the best chaperone. Because this patient group is a vulnerable one and issues may arise in initial physical examination, the policy address how a careful simple and sensitive explanation of the technique is vital. Through such guidance the implementation of this policy will not adversely impact this community.
Sex	Men/Male Women/Female	Low	Where a patient is vulnerable to domestic abuse, the policy provides guidance around patient freedoms and space to express worries, concerns and potential abuse as well as an examination in a non-controlling atmosphere. The policy outlines how, where there are concerns about coercion or control in respect of the relationship between with the person attending the consultation/ examination and the patient, that the onus is on the professional to use tact and diplomacy to exclude the person from the room and to use an independent chaperone. Through such guidance the implementation of this policy will not adversely impact this community.

Marriage/Civil Partnership		Low	There is no evidence that this protected characteristic would be adversely affected by implementing this policy.
Pregnancy/ Maternity		Low	There is no evidence that this protected characteristic would be adversely affected by implementing this policy.
Race	Colour Nationality Ethnic/national origins	Low	There is a risk where the person being examined is a non-English speaking person, but the policy is explicit that the use of an independent translator should be enlisted and on no account should family members be used. Through such contingencies the implementation of this policy will not adversely impact this community.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Medium	There is a risk when, for example, the ethnic, religious and cultural background of some women can make intimate examinations particularly difficult; Muslim and Hindu women have a strong cultural aversion to being touched by men other than their husbands. The policy mitigates this risk through guidance around having a chaperone of the same sex as the patient present at the examination may be made more acceptable. It also provides guidance for alternatives, such as an appointment at a later date when another chaperone is available or at an alternative site if appropriate gender of chaperone is not available. An adverse impact is unlikely, and on the contrary the policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist.
Sexual Orientation	Lesbian Gay men Bisexual	Low	There is no evidence that this protected characteristic would be adversely affected by implementing this policy.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Medium	Statistically trans patients are less likely to seek out medical help due to historical discrimination of the trans community. Sensitivity around a trans patients' needs will have to be observed in line with the Trusts policy for Supporting Transgender Patients and Service Users (N-060). For the trans community a chaperone may not be a family member, but instead a trusted member of their community. However, through such practice the implementation of this policy should not adversely impact this community.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The implementation of this policy has been reviewed through an EDI lens and, where risks have been identified for specific protected characteristics, the policy provides guidance that mitigates those risks. Increased risks around disability, race or nationality, religion, sex are addressed directly in the policy by way of guidance. With gender reassignment, the risks are mitigated by implementing the Trusts policy for Supporting Transgender Patients and Service Users (N-060). Overall, we can be assured that the implementation of this policy should not adversely impact any of the protected characteristics. .
EIA Reviewer: John Duncan - EDI Lead

Date completed: 16.04.24	Signature: John Duncan