Clinical Record Keeping Standards O-SOP

Solent NHS Trust O-SOPs can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This Standard Operating Procedure (SOP) outlines the standards expected of staff when creating, using and documenting in patient records
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V1	September 2022			Amended to a O-SOP – new document	Trust Documentation Group, Policy Steering Group, Clinical Executive Group

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Clinical Record Keeping Standard Operating Procedure

1. INTRODUCTION & PURPOSE

1.1 This SOP outlines the standards expected when staff are creating, using and documenting in clinical records, and includes both electronic and paper held records. A variety of electronic recording systems is used in the Trust, and local procedures may be in use. This SOP outlines general principles.

1.2 This SOP must be read in conjunction with the information Governance Policies' available on the Trust intranet and listed in the links to other policies section.

1.3 The aim is to have consistent, clear, accurate and quality records which:

- provide evidence of the care given, decisions made and the rationale for those decisions including the assessment and management of clinical risk
- adhere to trust and local procedures and guidelines regarding record keeping including consent, capacity, chaperoning, advocacy, involvement of family/others and information governance
- support patient's involvement in their care
- provide continuity of care and allow appropriate sharing of information about the patient and the care they have received
- support evidence based clinical practice
- meet legal requirements
- enable data collection, clinical audit and research activity
- support improvements in clinical and social care practice
- ensure information is available, whenever and wherever there is a justified need, and in whatever media it is required.

1.4 Under the General Data Protection Regulations (2018) patients and other relevant individuals have the right to access their records. This should be remembered when records are being used.

2. SCOPE & DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers and Patient Safety Partners), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 **Definitions**

- **Clinical Record/ Healthcare record:** information relating to the physical or mental health or condition of an individual or about the care they receive is recorded and stored in a health and care record. The record may be electronic, paper held or a mix of both.
- **Contemporaneous:** A record is completed during or shortly after the episode of care or intervention.
- **Countersign:** To add a second signature to a record to ensure Trust standard of documentation are met. The first signature would be a student or non-registrant who had not yet been deemed competent in records completion
- **Patient Held Records:** Patient held Records are defined as healthcare records which are kept within the home of the patient or family.
- **Patient**: It is recognised that different services across Solent NHS Trust refer to the people they work with by different terminology. The term patient has been used throughout the document, but represents all terms e.g. person, people, child, young person, client, service user etc.

3. PROCESS/REQUIREMENTS

3.1 **Creation of Records**

3.1.1 Wherever possible, within our services, patients will have a single, structured, multi-professional and agency record (SystmOne or other Trust approved systems) which supports professional and integrated care.

3.1.2 All services should have in place a process for documenting its activities in respect of records management. This process should take into account the legislative and regulatory environment in which the unit operates. All records should be complete and accurate, to facilitate an audit or examination of the organisation, its patients, staff and others affected by its actions, and provide authentication of the records so that evidence derived from them is shown as credible and authoritative.

3.1.3 Records created should be arranged in a record keeping system that enables quick and easily retrievable information.

3.1.4 A patient record should always be searched for by NHS number in the first instance. This is the Trust's preferred way of searching. If this information is not available, patients may be registered/searched by other methods although staff must be 100% certain when selecting the correct patient. The key identifier for all patients is their NHS number. This should be given on the referral letter but can be checked via the Summary Care Record system (SCR). If the patient record cannot be identified on the Electronic Patient Record system or Summary Care Record then the user should refer to local System Operating Procedures before creating a brand new record.

A manual record folder may also need to be created and should carry the appropriate details, including NHS number and Year Label (affixed on the right hand side).

3.2 **General Requirements**

3.2.1 All clinical records made must be on Trust approved recording systems or, if on paper, using the most up to date version of documentation which has been approved via the appropriate Governance route for the area. Storage of records must comply with the Records Management and Lifecycle Policy

3.2.2 Primary Records: Services within Solent NHS Trust have transferred the management of records from a paper based system to an electronic system e.g. SystmOne, R4, Inform, etc… Where services have moved over to electronic record management systems and summary of key information and scanned copies of important documents must be transferred/copied over, with validation checks in place. The electronic records management system will then become the primary source for health records for the service.

3.2.3 The record must demonstrate an accurate chronology of the patient's progress.

3.2.4 Any document must be identified with the patient's full name and NHS number on each sheet, if paper, or each document, if electronic, unless local procedures require a different method of identification

3.2.5 All written documentation must be made in black ink, unless an alternative colour is specified in a local process (for example allergies written in red on medication administration record charts), be legible and indelible.

3.2.6 If both paper and electronic records are used for a patient, duplication must be kept to a minimum and paper records must be either referred to in the electronic record or added to the electronic record e.g. by scanning as soon as possible or as per local requirements. Similarly, some teams use more than one electronic recording system, for example in integrated teams, and local processes must be in place to ensure duplication is kept to a minimum and clearly recorded

3.2.7 Write factual, accurate, clear, relevant, unambiguous, concise entries.

3.2.8 Write in terms that the patient can easily understand, including not using any jargon, and with the involvement/collaboration of the patient wherever possible. If this is not possible, record the reason in the record

3.2.9 Do not use abbreviations that are ambiguous or those that cannot be understood. If a Trust approved abbreviations list is in use, this must be readily available to anyone accessing the record

3.2.10 Records should be dated and timed (using 24-hour clock) and made contemporaneously; ideally during or shortly after the episode of care or intervention (but must be written within 24 hours of interaction). If for any reason the entry is not able to be made in the electronic record in the required time frame (for example IT access issues), the area/service Business Continuity Plan (BCP) must be followed for how to record contemporaneously. This may be to record on a word or paper template or other means as per BCP. Any reason for delay must be recorded. Electronic records systems will automatically record the time the entry is made but should be dated/timed to reflect the date/time of the activity. Anything written in retrospect must be clearly recognisable as such, and the rationale for not having recorded at the time of the event recorded e.g. recorded in retrospect as unable to record yesterday due to workload etc

3.2.11 All record entries must be signed including staff members designation. Electronic records will add this automatically. If this is a paper signature, a signature sheet must be held within the record, or by the team or service and be available to anyone who requires it. Anyone who makes an entry into the record must add their details to the sheet

3.2.12 If recording on behalf of someone else this should be clearly indicated including the reason why. For example, a bank member of staff who does not have access to the electronic record. In some circumstances this is routine practice, such as a person in charge of an inpatient unit recording activity for the shift, which will have been carried out by different staff

3.2.13 The method of contact should be recorded e.g. face to face, telephone, administration, remote consultation etc

3.2.14 Errors must be marked as per the Information Governance processes. For paper records, errors are crossed through with a single line, signed and dated and the reason indicated if not obvious. For electronic records, where the system allows, these should be marked in error and the reason given. Entries made in the wrong patient record must be reported via the Trust Incident Reporting system Ulysses, in order for them to be deleted by the Information Governance team. In Dental services, no deletion is possible after midnight on the day of recording

3.2.15 Any relevant information about the patient must be included in the record including photographs, e-mail conversations, discussions with colleagues, text messages etc. Clinical judgement must be used to decide what information is relevant

3.2.16 Records should only pertain to the care of the patient. Professional discretion should be used when it is relevant to include comments and discussion from others about the patient. If more than one patient is cared for at the same address, a separate record must be in use for each

3.2.17 All professionals present during the consultation/visit should be named along with their designation. For a Clinic or Trust premises visit, the name and designation of anyone accompanying the patient must be recorded. For Community visits, where relevant, reference to other individuals present should be made e.g. carers present on arrival, family in attendance., and consideration given to a need to record names and designations. For patients in any setting who do not have capacity, the decision maker present during the visit must be identified in the record.

3.3 Clinical entries

3.3.1 Clinical Information will vary depending on clinical service provided and if relevant must include:

- Consent, including a permission to share information as per local process and National requirements
- Preferred contacts and who not to share information with
- The patient's mental capacity status as per Deprivation of Liberty Safeguards and Mental Capacity Policy
- Documenting that safeguarding concerns have been considered when relevant
- An initial assessment of needs and clinical risks and the steps taken to manage them

- A record of any investigations and results, including clinical observations
- A record of any medication prescribed, including prescribing rationale and discussion with the patient/their representative such as relevant side effects, patient information etc as per Trust Medicines Policy and Non-Medical Prescribing Policy
- Discussions with patients or those close to them and advice given/decisions made including their perceptions of their planned treatment or care
- A record of treatment and care given, decisions made and outcomes where known, with explanation or rationale if appropriate
- A management / care plan with goals that are specific and measurable, developed in collaboration with the patient wherever possible. In some areas there is a requirement for the patient to sign the care plan
- Advanced care plans as appropriate, ensuring these are made available to relevant staff who may not have access to the health record
- Any information given to the patient and in what format e.g. the pressure ulcer leaflet was given and explained verbally

3.3.2 For inpatient units, an entry per shift should be made as a minimum. This entry should summarise clearly the main elements of the care given and interaction with the patient over the course of that shift, identifying the staff involved if appropriate. Separate entries may, of course also be made.

3.3.3 If handover sheets are used, they should not contain any information not already recorded in the clinical record. They should contain everything relevant and should be reviewed for currency each shift. They must be confidentially destroyed at the end of each shift if a printed copy is used.

3.4 **Delegating**

3.4.1 Record keeping can be delegated to non-registrants and students/learners by a Health Care Professional so that they can document the care they provide, provided they have their own access to the recording system.

3.4.2 These records must be countersigned and verified only until the non-registrant has been deemed competent (see section 3.7 and Appendix A). In areas where this is not currently possible on the electronic record, a local process must be developed and followed for verifying records

3.4.3 Students will require countersigning for the entire period of their placement. This requirement should be set as part of their induction and a task will be sent to the designated countersigner(s) when an entry has been made

3.4.4 Registrants who countersign may not have been present or observed the interaction being recorded. In this case, it should be clearly recorded when countersigning, that they are countersigning that they have checked the record, but have not observed the interaction

3.4.5 Non-registrants may countersign an entry from a student or non-registered colleague who is not yet competent, provided it is an activity they are competent to undertake and it is in their sphere of practice. If it is not, then a registrant is required to countersign

3.5 **Dictating records**

3.5.1 Any notes dictated and typed in records should include the name and position of the practitioner, be checked and corrected if necessary and dated and signed by the practitioner who dictated them (but see 3.4.2 below).

3.5.2 Letters must be reviewed by the practitioner who dictated them or a defined alternative. This may be performed electronically on the electronic patient system, using encrypted mail e.g. Solent to Solent e-mail, or on a shared network drive with restricted access. They may then be digitally signed to avoid delay in sending.

3.6 Patient held records

3.6.1 When clinical records are left in the patient's home it is the responsibility of the member of staff leaving the record to explain to the patient (and/or their carer if appropriate) that the record is NHS property and must be kept securely and returned to the Trust on the conclusion of treatment. A written statement to this effect must be included at the front of the record. Duplication between paper and electronic records should be avoided wherever possible, and the reason recorded in both records.

3.6.2 As soon as the record is no longer needed it must be amalgamated with the electronic record, ideally by scanning, or as per local process, for example uploading a photograph

3.6.3 Where care or treatment is likely to be delivered over a sustained period of time, it is good practice to regularly archive any paper patient record that is no longer required or relevant to the episode of care, for example full Medication Administration Charts. Electronic records are not archived and remain part of the live record

3.6.4 If there are concerns about a record being kept within the home for example when they are regularly destroyed by someone in the home, or there are confidentiality or safeguarding concerns , then a risk assessment must be made and a decision made regarding how records will used to manage those risks.

3.6.5 A Personal Child Health Record commonly known as the "Red Book" is issued to children at birth. Although this remains NHS property, it is kept at the family (carers) home and normally retained by the young person or family when the child becomes an adult. However, it is a clinical record and can be requested at any time.

3.6.6 Transporting of any records must comply with the Records Management and Information Lifecycle Policy available on the intranet

3.7 Competencies

3.7.1 A set of competencies is included as Appendix A. All staff must complete this as part of their induction

3.7.2 Non-registrants, including students and learners MUST complete the tool given in Appendix A and be deemed competent by a Registrant before they can record without countersigning. Students will require countersigning throughout their placement

3.7.3 All staff must complete the self-assessment audit tool (Appendix B) annually and highlight any areas of concern to their line manager

4. ROLES & RESPONSIBILITIES

4.1 The **Chief Finance Officer and Deputy CEO** is the Senior Information Risk Owner and has the responsibility for safe keeping of all trust records

4.2 The **Trust Documentation Group** has the responsibility to

- Understand current practise across the organisation in relation to documentation quality
- Understand gaps within organisations approach to standards of documentation and current practise
- Agree standards in quality of documentation and measurement/audit framework
- Recognise and share best practice in documentation across the trust
- Improve the quality of documentation across the Organisation in line within the Service Line by sharing documentation standards and results of quality improvement activities regarding documentation
- Develop documentation standards and processes to ensure shared developments across service lines

4.3 **Heads of Quality and Professions** will ensure that review and audit of clinical records occurs in their service line, is included on the Service Line Audit plan and that learning is shared

4.4 **Service leads/Line Managers** will

- Ensure that their staff are aware of the contents of this policy and any local associated standard operating procedures (SOPS) and comply with them
- Enable their staff to complete annual IG training
- Identify the need for additional training regarding clinical records and requesting this via Learning and Development
- Encourage participation of their staff in review and audit of clinical records and implementation of any learning
- Ensure an up to date signature sheet is kept if paper records are used

4.5 **Clinical Staff** will

- Adhere to any relevant Professional documentation standards
- Ensure their interactions with Clinical Records comply with this policy and any local (SOPS)
- Complete their annual IG training
- Attend required training in the use of electronic records, both generic and pertaining to their clinical areas
- Inform their line manager if they have other training needs regarding documentation
- Report issues, incidents and near misses
- Participate in review, audit and research activity using clinical records as appropriate
- Ensure any staff they delegate to are compliant with this policy
- Complete a signature sheet for any patient where they use paper records. This may be kept in the patients' record or as a master list at a base as per local processes. Signature sheets for Medicines Management may also be required
- Supervise and countersign entries by a student or non-registrant who is yet to be deemed competent as required
- Complete an annual self-assessment audit and discuss any concerns with their line manager

4.6 **Non-Clinical Staff** will

- Ensure their interactions with Clinical Records comply with this policy and any local SOPS
- Complete their annual IG training

- Attend required training in the use of electronic records, both generic and pertaining to their clinical areas
- Inform their line manager if they have other training needs regarding documentation
- Report issues, incidents and near misses

5. TRAINING

5.1 All staff must complete annual Information Governance online training

5.2 All staff inputting into Clinical Records must complete the Competency tool (Appendix A).

5.3 Training on electronic patient records systems is available from the Information Systems Team or locally as agreed

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 An Equality Impact Assessment was conducted in relation to this document, with no impact. (See Appendix B).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 All Services must undertake review of the quality of documentation as per local agreement

7.2 Service lines should identify which of the audit toolkit proforma they will use and this should be included on their Service Line audit plan. Other audit activity may also be carried out, for example via perfect ward

7.3 Results and learning from the above will be shared via the Service Line Governance processes and via Trust Documentation group

7.4 Reported incidents will also be reviewed and compared for themes within each Service Line as per local process, and learning shared via the Trust Documentation Group

7.5 Non-compliance with this policy must be reported using the form in the Policy on Procedural Documents and reported using the Trust Incident Reporting system if there is any impact on patient care

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 Links to Trust Policies and Procedures:

Being open and Duty of Candour Policy
Chaperone Policy
Consent to examination and treatment policy
Data protection compliance policy
Deprivation of Liberty Safeguards and Mental Capacity Policy
Incident reporting, investigation and learning policy

Information request policy
Management of audio-visual records policy
Medicines Policy
Non-medical prescribing policy
Records management and information lifecycle management policy for clinical and corporate records
Safe use of Display screen equipment and mobile devices policy

10. GLOSSARY

BCP - Business Continuity Plan

SOP - Standard Operating Procedure

Appendix A

CLINICAL RECORD KEEPING COMPETENCY TOOL

VERSION: 1

DATE 22/8/22

Name:

Team:

Line Manager/Professional Lead:

Date Competency Pack Commenced:

Date Completed:

About this competency tool

Guidance

The pack should be used in conjunction with Solent's Competency Framework for Registered and Unregistered Nursing, Allied Health Professional and Dental Care Practitioners (2016) and the induction checklist for new staff.

It is the responsibility of the member of staff to take ownership of their own learning and to work with their supervisor/s to complete the required competencies within the first year in post.

The supervisor is responsible for monitoring progress of completion of the relevant competencies, although it is recognised that a variety of team members/others will be involved in signing the competencies off.

The supervisor should discuss progress with their Clinical Manager on a regular basis and identify any problem areas or additional support that is required.

To be completed within one year of commencement in post and reviewed as part of the first appraisal

Accountability

It is recognised that evidence may be produced in varying ways. The accountability for assessing the member of staff as competent lies with the registered professional signing off the competency.

Producing Evidence

Competence will be demonstrated by the production of relevant evidence. There are a range of evidence types which may be suitable, and each piece of evidence may cover many competencies. Some ideas for evidence are:

- Observations during work activities
- Reflections on practice
- Product evidence e.g. a dressed leg, records
- Testimony of others
- Attendance at training events (best used with reflection or competencies to show how you will use what you have learned)
- Involvement in working parties, projects, audits, meetings etc

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Theory = Theoretical knowledge and observation
Observation = Observation of skill being performed by expert
Observed = Observed performing skill and feedback given
Signed off = Signed by registered professional as competent

N – Nurse, P – Physiotherapist, O – Occupational Therapist, SW – Social Worker/Care Manager, SLT- Speech and Language Therapist, POD – Podiatrist, CP- Clinical Psychologist, Other - (specify)

Signature Record

Print Name		Designation		Signature		Initials	
Print Name		Designation		Signature		Initials	
Print Name		Designation		Signature		Initials	
Print Name		Designation		Signature		Initials	
Print Name		Designation		Signature		Initials	
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Print Name		Designation		Signature		Initials	
Print Name		Designation		Signature		Initials	

A Awareness of policy/legislation		Theory	Observation	Observed	Self-Assessment	Level Expected	Level Reached	Evidence and Comments	Date Signed Off	Signed Off
A1	Demonstrates an awareness of the requirements for clinical record keeping as per Trust policies and procedures and can state where they can be located									
A2	Has completed the annual Information Governance mandatory training									
A3	Can discuss and demonstrate principles of maintaining confidentiality									
A4	For Registrants, is aware of relevant content of their professional code									
A5	Can demonstrate correct filing and storage requirements									
A6	Are aware of retention periods for clinical records									

B Making entries in clinical documents		Theory	Observation	Observed	Self-Assessment	Level Expected	Level Reached	Evidence and Comments	Date Signed Off	Signed Off
B1	Entries in clinical records are factual, legible, accurate, unambiguous, clear and concise									
B2	Entries do not contain jargon and only contain approved abbreviations									
B3	Entries are signed, dated, and timed									
B4	Entries are made in a timely way – ideally at the time of the activity (contemporaneous) or within 24 hours									
B5	If an entry is made in retrospect, this is clearly indicated in the record, including the reason why									
B6	Entries made are in black ink									
B7	Entries contain relevant information									

	about the condition of the patient and any action taken or intervention made									
B8	Details any assessment, care planning, goal setting and/or provision of care with review if relevant									
B9	Records involvement of patient/client and/or those close to them									
B10	Any errors made in clinical records are managed according to policy and procedures									

C Monitoring compliance		Theory	Observation	Observed	Self-Assessment	Level Expected	Level Reached	Evidence and Comments	Date Signed Off	Signed Off
C1	Be aware that records made by non-registered staff must be counter-signed by a Registrant until deemed competent, and that ongoing recording in a clinical record is a delegated activity									
C2	Be aware that records made by students must be countersigned throughout their placement									
C3	Be aware of and participate in audit of clinical records as required, including annual self-audit									

Appendix B

Documentation Self Audit

Look at a record that you completed last week/last visit and answer the following:

No.	Question	Y/N/Na	Notes/comments
1	Is it clear who made the entry in the record?		
2	Is the entry readable, understandable, concise and objective (i.e. contains facts only)		
3	Has the record been made in a timely way (i.e. during the visit/shift/event or within 24 hours)		
4	Is there a clear story about what happened during the shift/visit/event?		
5	Has consent been obtained and recorded?		
6	If there is an associated care plan, has it been performed? (if n/a mark q7 as n/a)		
7	Do the elements of the plan that have been performed agree with the other evidence in the record (e.g. if TIMES wound assessment has been ticked as performed, has it been completed)?		
8	Is there evidence that the patient/those important to them have been involved in the care or treatment given?		
9	If there are patient goals set, have they been reviewed, and progress recorded?		
10	If anything is recorded as needing follow up (e.g. referral to other team, speak to GP etc), is there evidence this has been done?		
11	No abbreviations or jargon have been used, unless they are explained in the entry		
12	You would be happy with the record if you were the patient or a relative		

Appendix: C

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Trust wide	
Title of Change:	Clinical Records Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Introduce standards for completion of clinical records	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	

Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	No	
Have you taken into consideration any regulations, professional standards?	Yes	National and local legislation and guidance

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Sarah Oborne*	*Date:*	*04/08/2022*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	Accessibility Communication formats (visual & auditory) Reasonable adjustments. Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	Caring responsibilities Domestic Violence Equal pay Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	Communication Language Cultural traditions Customs Harassment and hate crime "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	Assumptions based on the age range Capabilities & experience Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	Lifestyle Family Partners Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	Disrespect and lack of awareness Religious significance dates/events Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	Pensions Childcare Flexible working Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	Employment rights during pregnancy and post pregnancy Treating a woman unfavourably because she is breastfeeding Childcare responsibilities Flexibility	Further guidance can be sought from: Solent HR team