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Consent & Capacity for Information Sharing Policy

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Document Information

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| Information Governance Operational Group | | | |
| Information Governance Steering Group | | February 2025 | |
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| Links or overlaps with other policies: | | | |
| <p>We are committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.</p> <p>We are committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.</p> | | | |

Amendment History

| Issue | Status | Date | Reason for Change | Authorised |
|-------|----------------------|-----------|--|--|
| 0.1 | Draft | Sept 2020 | New policy | Information Governance Steering Group |
| 2 | Final | July 2021 | No change | Information Governance Steering Group |
| 2.1 | Final | Nov 2021 | Removal of duplication | Information Governance Steering Group |
| 2.2 | Final | Feb 2023 | No change | Information Governance Steering Group |
| 3 | Final | Feb 2024 | Minor updates | Information Governance Steering Group |
| 4 | Final | Jan 2025 | No change | Information Governance Steering Group |
| 5 | Final (this version) | Feb 2026 | Update to assurance routes to reflect new Trust structures | Information Governance Operational Group |

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1. Introduction

- 1.1. Sharing personal Information can bring many benefits. It can support more efficient, easier to access services. It can help to make sure that the vulnerable are given the protection they need and organisations can co-operate to deliver the care those with complex needs rely on.
- 1.2. This document sets out the obligations and commitments that staff must follow to ensure that legislation is not breached, and the confidentiality of patients / clients / families / carers and employees is maintained.
- 1.3. This policy ensures that appropriate consent and capacity considerations are made prior to information sharing.

2. Aims and objectives

- 2.1. The objectives of this policy are to ensure that appropriate consent and capacity considerations are made prior to information sharing.

3. Consent

- 3.1. Consent is required in all cases of sharing patient/employee identifiable information unless disclosure is required by law or there is an overriding public interest in disclosure.
- 3.2. Definition of Consent: Consent to disclosure may be explicit or implied. It may also be consent to disclosure of specific information to a particular person or body for a particular purpose or it may be consent to general future disclosure for particular purposes. In either case consent should be informed and freely given.
- 3.3. Consent is defined in [Confidentiality: NHS Code of Practice - GOV.UK](https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice) (<https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>)

3.4. Informed Consent

- 3.4.1. All consent should be informed. Every patient should be informed about what happens to the information they give to the NHS (it is the minimum requirement under Data Protection Legislation). For each episode of care staff should ensure that the patient is aware of who will see their information, what they will be doing with it and give them the opportunity of saying 'no' to information sharing, unless legislation dictates otherwise.
- 3.4.2. All patients should receive the following information:
 - who the Data Controller is
 - why the information is needed
 - the purposes for which the information will be processed and who will see the information
 - any disclosures that may need to be made to other organisations (e.g. other acute hospitals, social care, clinical audit, GP, mental health teams, drug and alcohol teams etc.)
 - the circumstances in which information may be disclosed without consent, where there is an overriding public interest (e.g. adult / child protection or serious crime)
 - information restricted by legislation (e.g. serious communicable diseases)
 - information that must be passed on because of legislation (e.g. births, deaths, terminations).

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3.4.3. If patient/employees have any reservations about information sharing then it should be explained that direct continuing care could be affected by restrictions placed on sharing. If patients still refuse to share any information then consent has not been gained and patient's wishes must be respected unless there is a legal requirement or an overriding public interest in disclosure.

3.5. Implied Consent

- 3.5.1. Patient agreement that has been signalled by the behaviour of an informed patient.
- 3.5.2. Implied consent is not a lesser form of consent but in order for it to be valid it is important that patients are made aware that information about them will be shared, with whom it will be shared and of their right to refuse.
- 3.5.3. Health professionals bear responsibility for the disclosures they make so when consent is taken to be implied they must be able to demonstrate that the assumption of consent was made in good faith and based on good information. If not, consent has not been given and some other justification will be needed for its disclosure.
- 3.5.4. In addition to information provided face to face in the course of a consultation, leaflets, posters and information included with an appointment letter can play a part in conveying to patients the reality and necessity of information sharing. Implied consent is usually sufficient for direct patient care, with the exception of where additional legal protections for information sharing exist.

3.6. Explicit or Expressed Consent

- 3.6.1. Explicit consent is articulated patient agreement. Clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear. Explicit consent is the ideal as there is no doubt as to what has been agreed.
- 3.6.2. Explicit consent should be clearly documented and ideally signed by both the healthcare professional and the patient / service user.

3.7. Recording consent

- 3.7.1. Consent should be recorded in the patients' notes if they have been provided with and understood the notice/leaflet regarding information sharing and has not said 'no' to sharing any part of their information.
- 3.7.2. Where a patient has refused to share information, this should be recorded in the patient's record, dated, timed and signed. That information must not be shared unless there is a legal requirement or an overriding public interest in disclosure.

3.8. Maintaining consent (keeping consent up to date)

- 3.8.1. It is essential that persons who have been unwell are asked to confirm their own choice regarding consent, when they regain capacity as a previous recorded choice will have been made by another party on their behalf.
- 3.8.2. It may also be essential to revisit the consent at other times e.g. when changes which impact on how information is used are introduced.
- 3.8.3. Consent should also be reviewed whenever there are changes to information

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sharing/disclosure during an episode of care.

3.9. Obtaining consent for children and young people

- 3.9.1. Medical professionals need to consider Gillick competency when a person under the age of 16 wishes to exercise their rights to consent or dissent without their parents' or carers' consent or, in some cases, knowledge.
- 3.9.2. A medical professional should consider whether a child under the age of 16 is able to consent without their patient or carers knowledge. This is called assessing 'Gillick competency.'
- 3.9.3. Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidentiality as adults. Children under the age of 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to make decisions about the use and disclosure of information they have provided in confidence (e.g. they may be receiving treatment or counselling about which they do not want their parents to know.)

4. Mental capacity and information sharing

4.1. Sharing information between healthcare professionals

- 4.1.1. Patients are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care they receive. Health professionals share what is necessary and relevant for patient care on a 'need to know' basis.
- 4.1.2. The duty to share information with other health and social care professionals for direct care purposes is outlined in the Health and Social Care Act 2012. We have existing arrangements to share necessary and relevant information with other health and social care organisations; these are outlined in the Health Adult Social Care Records Policies or by Information Governance on tsdft.igteam@nhs.net.
- 4.1.3. Sharing with other health professionals outside of this prescribed list can be led by clinical decision making, and a Consultant who has seen the patient within the last 6 months is able to authorise the sharing of relevant and minimal clinical information on a 'need to know' basis via a secure means (NHSMail, Egress, or recorded delivery.)
- 4.1.4. Sharing for health and social care do not always fall into the same category and disclosures of information to social care usually require explicit consent from competent patients.
- 4.1.5. Sometimes the patient's informed refusal to allow disclosure and the need to provide effective treatment to that person are in conflict. A patient's refusal to allow information sharing with another health professional may compromise patient safety. If this is an informed decision by a competent person it should be respected.
- 4.1.6. Where a patient's refusal to share information and the clinical need to share information are in conflict, the Trust's Caldicott Guardian may make the decision to approve the sharing without consent. This is usually when the 'vital interests' of a person are at risk if sharing is not facilitated.

4.2. Multi – Agency Working

- 4.2.1. During the course of treating patient's health professionals will have contact with partner

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organisations from time to time. These include social care, housing and benefits agencies.

- 4.2.2. Health professionals should discuss with patients the desirability of sharing information with other agencies as appropriate. Other agencies may wish to be involved in discussions about patients at various points in their treatment, or to attend case conferences, or multi-disciplinary meetings.
- 4.2.3. Health professionals may also be invited to attend external case conferences organised by partner organisations to discuss the health and welfare of patients. In these circumstances information sharing should take place with explicit consent or in the absence of explicit consent where disclosure is required by law, or there is an overriding public interest in disclosure.

4.3. Assessment of capacity

- 4.3.1. All people aged 16 and over are presumed in law to have the capacity to give or withhold their consent to disclosure of confidential information unless there is evidence to the contrary.
- 4.3.2. A patient who is suffering from a mental disorder or impairment does not necessarily lack the capacity to give or withhold their consent. Patients who would otherwise be competent may be temporarily incapable of giving valid consent due to factors such as extreme fatigue, drunkenness, shock, fear, severe pain or sedation.
- 4.3.3. An individual who has made a decision that appears to others to be irrational or unjustified should not be taken on its own as conclusive evidence that the individual lacks the mental capacity to make that decision. If the decision is clearly contrary to previously expressed wishes or is based on a misperception of reality, further investigation into the apparent lack of capacity will be required.
- 4.3.4. There is no presumption of capacity for people under 16 in England and Wales and those under this age must demonstrate their competence by meeting certain standards set by the courts. The central test is whether the young person has sufficient understanding and intelligence to understand fully what is proposed.
- 4.3.5. To demonstrate capacity individuals should be able to:
 - understand in simple language (with the use of communication aids, if appropriate) what is to be disclosed and why it is being disclosed
 - understand the main benefits of disclosure
 - understand in broad terms the consequences of disclosure
 - retain the information long enough to use it and weigh it in the balance in order to arrive at a decision
 - communicate the decision (by any means)
 - make a free choice (i.e. free from undue pressure).

5. Adults who lack capacity

5.1. Temporary or permanent mental incapacity

- 5.1.1. Patients with mental disorders or learning disabilities should not automatically be regarded as lacking the capacity to give or withhold their consent to disclosure of confidential information.
- 5.1.2. Unless unconscious, most people suffering from a mental impairment can make valid decisions about some matters that affect them.

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- 5.1.3. An individual's mental capacity must be judged in relation to that particular decision being made. If a patient has the requisite capacity disclosure of information to relatives or third parties requires patient consent.
- 5.1.4. One of the most difficult dilemmas for health professionals occurs where the extent of such patient's mental capacity is in doubt. In such cases health professionals must assess the information which is available from the patient's health record and from third parties.
- 5.1.5. They should attempt to discuss with patients their needs and preferences as well as assess their ability to understand their condition and prognosis. If there is still doubt about a patient's competence to give or withhold consent, health professionals should seek a second opinion.

5.2. The role of relatives, carers and friends (including next of kin)

- 5.2.1. If a patient lacks capacity, health professionals may need to share information with relatives, friends or carers to enable them to assess the patient's best interests. Where a patient is seriously ill and lacks capacity, it would be unreasonable to always refuse to provide any information to those close to the patient on the basis that the patient has not given explicit consent.
- 5.2.2. This does not mean that all information should be routinely shared and where the information is sensitive a judgement will be needed about how much information the patient is likely to want to be shared and with whom. Where there is evidence that the patient did not want information shared this must be respected.
- 5.2.3. Although widely used, the phrase 'next of kin' has no legal definition or status. If a person is nominated by a patient as next of kin and given authority to discuss the patient's condition that person may provide valuable information about the patient's wishes to staff caring for the patient. However, the nominated person cannot give or withhold consent to the sharing of information about the patient and has no rights of access to the patient's medical records.
- 5.2.4. The patient may nominate anyone as next of kin.
- 5.2.5. Next of kin should be recorded on the patients' medical record and refreshed at any admission to Trust services.
- 5.2.6. In the absence of such a nomination no-one can claim to be next of kin.

5.3. Proxy decision-makers (attorneys)

- 5.3.1. In England and Wales, the Mental Capacity Act 2005 allows people over 18 years of age who have capacity to appoint a welfare attorney to make health and personal welfare decisions once capacity is lost. The Court of Protection may also appoint a deputy to make these decisions.
- 5.3.2. Persons who have appointed attorneys should register these with the Trust by providing a copy to their healthcare professional who will send this on for registration with the Data Access and Disclosure Office on tsdft.dataprotection@nhs.net
- 5.3.3. Where a patient lacks capacity and has no relatives or friends to be consulted the Mental Capacity Act requires an Independent Mental Capacity Advocate to be appointed and consulted about all decisions about 'serious medical treatment' or place of residence.
- 5.3.4. There are two types of deputyship available in England and Wales by the Court of

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Protection, these deputies are authorised to make different types of decisions on a person's behalf:

- Personal Welfare deputies: are individuals appointed to make decisions regarding a person's health and wellbeing deemed 'in their best interest'. The Court of Protection does not usually appoint deputies to make ongoing decisions about someone's health and welfare unless they need regular treatment or supervision.
- Property and affairs deputies; are individuals appointed to make decisions regarding a person's financial affairs and assets

6. Abuse and neglect

- 6.1.** Where health professionals have concerns about a patient lacking capacity that may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body.
- 6.2.** Where there is any doubt as to whether disclosure is considered to be in the patient's best interests it is recommended that the health professional discusses the matter on an anonymised basis with a senior colleague. Health professionals must ensure that their concerns and the actions they have taken or intend to take, including any discussion with the patient or professionals in other agencies, are clearly recorded in the patient's medical records.

7. Children and Young People

7.1. Competent Children

- 7.1.1. There is no presumption of capacity for people under 16 in England, Wales and Northern Ireland and those under that age must demonstrate they have sufficient understanding of what is proposed.
- 7.1.2. Children who are aged 12 or over are generally expected to have the capacity to give or withhold their consent to the release of information. Younger children may also have sufficient capacity.
- 7.1.3. When assessing a child's capacity, it is important to explain the issues in a way that is suitable for their age. If the child is competent to understand what is involved in the proposed treatment the health professional should respect the child's wishes if they do not want parents or guardians to know, unless there are convincing reasons to the contrary e.g. abuse is suspected. However, every reasonable effort must be made to persuade the child to involve parents or guardians particularly for important or life-changing decisions.
- 7.1.4. A competent child can not refuse treatment.

7.2. Children who lack capacity

- 7.2.1. The duty of confidentiality owed to a child who lacks capacity is the same as that owed to any other person. Occasionally, young people seek medical treatment e.g. contraception but are judged to lack the capacity to give consent.
- 7.2.2. An explicit request by a child that information should not be disclosed to parents, guardians or any third party must be respected unless exceptional circumstances. (where it puts the child at risk of significant harm in which case disclosure may take place in the 'public interest' without consent).
- 7.2.3. Even where the health professional considers a child to be too immature to consent to the treatment requested confidentiality should still be respected concerning the consultation

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unless there are very convincing reasons to the contrary. Where a health professional decides to disclose information to a third party against a child's wishes, the child should generally be told before the information is disclosed. The discussion with the child and the reasons for disclosure should also be documented in the child's record

7.3. Parental Responsibility

- 7.3.1. Anyone with parental responsibility can give or withhold consent to the release of information where the child lacks capacity. Not all parents have parental responsibility.
- Children born after 1 December 2003; both of a child's biological parents have parental responsibility if they are registered on a child's birth certificate.
 - Where the child has been formally adopted the adoptive parents are the child's legal parents and automatically acquire parental responsibility.
 - Where the child has been born as a result of assisted reproduction, there are rules under the Human Fertilisation and Embryology Act 2008 that determine the child's legal parentage.
 - In some circumstances people other than parents acquire parental responsibility e.g. by the appointment of a guardian or on the order of a court.
 - A local authority acquires parental responsibility (shared with the parents) while the child is the subject of a care or supervision order
 - In some circumstances parental responsibility can be delegated to other carers such as grandparents and childminders.
- 7.3.2. If there is doubt about whether the person giving or withholding consent has parental responsibility, legal advice should be sought from Child Health and Children's Safeguarding.
- 7.3.3. Where an individual who has parental responsibility refuses to share relevant information with other health professionals or agencies and the health professional considers that it is in the best interest of the child (e.g. not sharing information puts the child at risk of significant harm) disclosure may take place in the public interest without consent.

7.4. Safeguarding

- 7.4.1. Where health professionals have concerns about a child or adult who may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body in order to prevent further harm.
- 7.4.2. The best interests of the child or adult involved must guide decisionmaking at all times. Health professionals should not make promises about confidentiality. Trust is best maintained if disclosure is not made without prior discussion between the health professional and the child or adult, unless to do so would expose them or others to an increased risk of serious harm.
- 7.4.3. Where there is any doubt as to whether disclosure is in the child or adult's best interests it is recommended that the health professional consult an experienced colleague, the Caldicott Guardian, the Data Protection Officer (DPO) or their professional defence body.
- 7.4.4. Health professionals must ensure that their concerns and the actions they have taken, or intend to take, including any discussion with the child or adult, colleagues or professionals in other agencies, are clearly recorded in the medical record. Health professionals may be involved in case reviews for which the records may need to be disclosed but care should be taken not to disclose the notes of other family members without consent unless it can be justified in the public interest.

8. Best interests sharing

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- 8.1.** In the absence of patient consent, a legal obligation or anonymisation, any decision as to whether identifiable information is to be shared with third parties must be made on a case-by-case basis and must be justifiable in the public interest.
- 8.2.** Disclosures in the public interest based on the common law are made where disclosure is essential to prevent a serious and imminent threats to public health, national security, the life of the individual or a third party or to prevent or detect serious crime. Ultimately, the public interest can only be determined by the courts.
- 8.3.** When considering disclosing information to protect the public interest health professionals must:
- consider how the benefits of making the disclosure balance
 - against the harms associated with breaching the patient's
 - confidentiality both to the individual clinical relationship and to maintaining public trust in a confidential service
 - assess the urgency of the need for disclosure
 - discuss with and encourage the patient to disclose voluntarily
 - inform the patient before making the disclosure and their consent, unless to do so would increase the risk of harm or inhibit effective investigation
 - disclose the information promptly to the appropriate body
 - reveal only the minimum information necessary to achieve the objective
 - seek assurance that the information will be used only for the purpose for which it is disclosed
 - document the steps taken to seek or obtain consent, and the reasons for disclosing the information without consent
 - be able to justify the decision
 - document both the extent of and grounds for the disclosure
- 8.3.2.** Health professionals should be aware that they risk criticism and even legal liability if they fail to act to avoid serious harm. There is no specific legislation which tells health professionals whether or not to disclose information but general guidance about the categories of cases in which decisions to disclose may be justifiable are below.
- 8.3.3.** Guidance should be sought from the Caldicott Guardian, Data Protection Officer, Trust Solicitor, professional body or defense body where there is any doubt as to whether disclosure should take place in the public interest.

9. Training

- 9.1.** All staff will attend, as part of their induction, training sessions on Information Governance and additional annual training will be provided to all staff through a mandatory training online or face-to-face programme.

10. Distribution

- 10.1.** This policy document will be made available to staff via ICON, the Trust Website and signposted in the Staff Bulletin.
- 10.2.** Awareness will be raised through Equality Impact Assessment training, all ratifying committees/groups, policies and procedures training and ICON.

11. Key Contacts

| Contact | Email | Phone |
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| Data Protection Officer | Tsdft.dpo@nhs.net | 07393 799539 |
| Information Governance Team | tsdft.igteam@nhs.net | 01803 654868 |
| Data Access & Disclosure Office | tsdft.dataprotection@nhs.net | 01803 654868 |
| Senior Information Risk Officer | tsdft.siro@nhs.net | |
| Caldicott Guardian | tsdft.caldicottguardian@nhs.net | |
| Freedom of Information Team | tsdft.foirequests@nhs.net | |

12. Appendices

Appendix 1: Rapid Equality Impact Assessment

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Appendix 1: Rapid Equality Impact Assessment

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Appendix 1

Rapid Equality Impact Assessment (for use when writing policies and procedures)

| | | | | | |
|---|---|--|---|-----------------------------|---|
| Policy Title (and number) | | Consent & Capacity for Information Sharing Policy | | Version and Date | 5 |
| Policy Author | | Information Governance Officer | | | |
| An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected. | | | | | |
| EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i> | | | | | |
| Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below) | | | | | |
| Age | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Disability | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Sexual Orientation | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Race | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Gender | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Religion/Belief (non) | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Gender Reassignment | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Pregnancy/ Maternity | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Marriage/ Civil Partnership | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees) | | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Please provide details for each protected group where you have indicated 'Yes'. | | | | | |
| VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion | | | | | |
| Is inclusive language ⁵ used throughout? | | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Are the services outlined in the policy/procedure fully accessible ⁶ ? | | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Does the policy/procedure encourage individualised and person-centered care? | | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Could there be an adverse impact on an individual's independence or autonomy ⁷ ? | | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| If 'Yes', how will you mitigate this risk to ensure fair and equal access? | | | | | |
| EXTERNAL FACTORS | | | | | |
| Is the policy/procedure a result of national legislation which cannot be modified in any way? | | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?) | | | | | |
| To facilitate a standardized approach to policy documents across the Trust | | | | | |
| Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions? | | | | | |
| | | | | | |
| ACTION PLAN: Please list all actions identified to address any impacts | | | | | |
| Action | | | Person responsible | Completion date | |
| | | | | | |
| AUTHORISATION: | | | | | |
| By signing below, I confirm that the named person responsible above is aware of the actions assigned to them | | | | | |
| Name of person completing the form | | Information Governance Officer | Signature | | |
| Validated by (line manager) | | Data Protection Officer | Signature | | |

Any issues Please contact Diversity & Inclusion Lead

For Torbay and South Devon NHS Trusts, please email tsdft.diversityandinclusion@nhs.net

¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travellers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy