GENITAL EXAMINATION OF PATIENTS WITHIN RCHT SEXUAL HEALTH SERVICES - CLINICAL GUIDELINE

1. **Aim/Purpose of this Guideline**
   All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of genital examination of patients within RCHT sexual health services.

2. **The Guidance**
   Genital examination of patients within RCHT sexual health services.

   All examinations must be carried out by an appropriately trained practitioner. Intimate examinations may be embarrassing or distressing for patients especially if they have not attended a sexual health clinic before. Practitioners must be sensitive to this and take care to demonstrate respect and courtesy at all times.

   The examination and its explanation should not be rushed. It should be carried out in a professional manner.

   Practitioners should ensure they have the necessary competencies to carry out examinations and that they are familiar with this guideline. If they feel an examination would be appropriate for which they do not have competency they should make arrangements for the patient to be reviewed by a senior doctor, either at the same clinic or booked for a repeat visit with an appropriate member of staff.

   **Before conducting an intimate examination.**
   - Explain to the patient why an examination is being offered and give the patient an opportunity to ask questions.
   - Patients have the right to decline an examination. Sometimes an examination may be preferable for patient management but self-taken swabs may be more acceptable to the patient.
   - If the patient expresses anxiety about the genital examination then the benefits and drawbacks of not examining the patient or of limiting the examination (e.g. external genitalia only) should be explored.
   - Explain what the examination will involve in a way which the patient can understand. The patient should have a clear idea of what to expect including any likely discomfort. Always tell the patient they can ask for the examination to stop at any point.
   - Get the patient’s permission before the examination and record that the patient has given it in the patient record.
   - When caring for a child, young person, or an adult with a learning disability you must assess their capacity to consent to the examination and record this. If in doubt seek help from a senior colleague or a member of the relevant safeguarding team.
   - If a learner is to be present or to undertake the examination, express permission for this should be gained from the patient before they undress and documented in notes.
Use of chaperones

It is departmental policy to provide a chaperone for all intimate examinations.

- Advise the patient that it is clinic policy to have an assistant present during the examination for their support/comfort and also to help with sample taking etc. The chaperone should act as an advocate for the patient and provide a reassuring presence during the examination. The chaperone is also present in a safeguarding capacity, to protect the patient against any unnecessary discomfort, humiliation or intimidation.
- The chaperone also has a role in mitigating against and providing evidence in the very rare occurrence of accusations of abuse or misconduct against the practitioner.
- The presence of a chaperone should be recorded and a note made of their identity.
- If the patient does not want another person in the room, this must be discussed at the time with the most senior member of the clinical staff available and a decision made whether to proceed with the intimate examination. This discussion and the outcome should be recorded in the patient record. In the event of there not being a more senior person available the practitioner must make the decision whether or not to proceed and explain their reasoning in the record.
- If either you or the patient does not want the examination to go ahead without a chaperone, or if either you or the patient is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a suitable chaperone will be available as long as the delay would not adversely affect the patient’s health.

If you don’t want to go ahead without a chaperone present and the patient has refused one, you must explain clearly why you want a chaperone present. Ultimately the patient's clinical needs must take precedence. You may wish to consider referring the patient to a senior colleague as long as a delay would not adversely affect the patient’s health. Do not simply book the patient in to a clinic without confirming that the senior colleague is aware of the circumstances and has agreed to see the patient.

- If a chaperone is declined, the option of self-taken samples and a syndromic approach to treatment should be discussed.
- The patient may want a friend, relative or another individual (e.g. support worker) present to support them during the examination. The wishes of the patient should be paramount, but remember to assess that this is truly what the patient wants. You must be sure there has not been any degree of coercion by the supporting person. A relative or friend should not take the place of a chaperone.
The role of the chaperone

- To be sensitive and respect the patient’s dignity and confidentiality.
- To reassure the patient they show signs of distress or discomfort.
- To be familiar with the procedures involved in a routine intimate examination.
- To assist the doctor or nurse in the collection of samples in order to reduce possible contamination of the outside of sample collection pots and to minimise the time required for the examination.
- To ensure the correct labelling of specimens.
- To stay for the whole examination and be able to see what the doctor or nurse is doing, if practical.
- To be prepared to raise concerns with their line manager if they are concerned about the behaviour or actions of the doctor or nurse.

During the examination

- Give the patient privacy to undress and dress behind a curtain if possible and keep them covered as much as possible during the examination to maintain their dignity. Patients usually need only to remove clothing from the lower half. Women who are wearing skirts may be given the option to simply remove underwear. Men usually need to lower clothing (e.g., trousers and underwear) to above the knee. This needs to be explained clearly to minimise misunderstandings. An adequate length of paper towel should be provided to cover the genital area. Do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help. Provide somewhere (e.g. a chair) for patients to put any clothes they have removed.
- The examination should take place in a closed room and you should ensure nobody will enter the room during the examination.
- The couch should if possible be facing away from the door, or should be curtained off.
- The room should be stocked in advance with the necessary supplies to allow the examination to proceed as quickly and smoothly as possible. A range of speculum and proctoscope sizes should be to hand.
- Explain what you are going to do before you do it and if this changes during the examination then explain why and seek the patient’s permission to proceed.
- Stop the examination if the patient asks you to.
- Keep all discussion relevant; don’t make unnecessary comments, especially of a personal nature.
- Be mindful during the examination not to cause unnecessary discomfort.
- Mark the end of the examination clearly by telling the patient they can now get dressed and if relevant offer tissue to wipe away any lubricant or discharge. Ensure there is access to washing facilities and sanitary pads, if needed.
- If a second opinion is sought requiring the clinician to leave the room temporarily dignity of the patient must be maintained:
  - For male patients the couch can be lowered and they can be asked to put their underwear back on
  - For female patients the couch can be lowered enabling them to bring their legs together and rest their feet on the floor with the modesty cover over their genital area.
- The chaperone should stand outside of the curtain or the door explaining what is happening until the clinician returns
Female examination.
Purpose: the assessment of/sampling for sexually transmitted infections and performing cervical cytology.

- It may be more comfortable for the woman to empty her bladder before the examination. This is an opportunity to collect a urine sample for urinalysis, culture and or pregnancy testing if indicated.
- Women should usually be examined in the lithotomy position (on their back) if possible using a couch with 'stirrups.' However, some women find it less threatening to be examined in the left lateral position.
- If indicated, examine the lower abdomen by palpation (gloves do not have to be worn for this part of the examination).
- Clean hands and put on non-latex gloves.
- Ensure the light source is adequate and is positioned correctly.
- Examine the pubic area and groin.
- Palpate the inguinal regions to feel for enlarged lymph nodes.
- Examine the external genitalia, introitus, perineal and perianal areas.
- If required, at this point a vaginal swab from the chlamydia/gonorrhoea NAAT collection kit can be inserted into the vagina by about 5 cm, rotated several times and put into the collection media.
- If clinically indicated take genital skin swabs for herpes simplex virus (HSV) PCR and culture for yeast and skin bacteria.

Speculum examination

- If indicated by the history and with the agreement of the patient a Cusco speculum should be inserted into the vagina. Choose the size of speculum carefully. Applying a very small amount of lubricant to the outside of the speculum is occasionally necessary but can adversely affect cervical cytology and microscope slide interpretation so should be avoided where possible.
- Ensure that the blades of the speculum are closed for insertion. The speculum should be inserted into the vagina with a slightly downward [posterior] direction. Gently opening the labia with the other hand limits dragging or pulling. Insertion should be a slow and seamless procedure until flush with the perineum. Ensure no pubic hair is caught, and that there is no pressure on delicate structures such as the urethral meatus and clitoris.
- In the case of prolapsed vaginal walls sheath the speculum with a condom or a non-latex glove finger with the end cut off or use a wider or long-bladed speculum.
- Continuously check the woman’s comfort; either with eye contact, verbally or by actively involving the chaperone.
- Carefully open the speculum and look for the cervix (it is usually not necessary to fully open the speculum). To find it you may need to ask the woman to cough or change position.
- If the cervix cannot be readily visualised seek help from an experienced colleague rather than persist with the examination.
- Fix or hold the Cusco speculum in the correct position.
- Observe appearance of cervix and vaginal walls and any vaginal discharge.
• If collecting a sample for cervical cytology, take this sample first in the correct manner.
• Take a loop sample of vaginal discharge. Check and record pH. If raised, consider further tests for TV.
• Depending on history and clinical findings other vaginal samples may be appropriate. These may include a vaginal wall smear for subsequent Gram stain, a vaginal sample from the posterior fornix for wet preparation, vaginal charcoal swab for culture, vaginal sample into TV broth for TV culture.
• In cases of cervicitis, PID or suspected gonorrhoea take a charcoal swab from the cervix for gonorrhoea culture.
• In cases of severe cervicitis take a sample from the cervix for HSV PCR.
• Remove the speculum carefully ensuring that you have not trapped the vaginal walls or cervix in the speculum as it closes. Remove the speculum slightly open.
• Examine the vagina as the speculum is removed. In older women you will need to be aware that the vaginal walls are thinner and drier and be careful not to cause damage with the speculum.
• Samples may also be required from the rectum. Examples of cases where this may be indicated include women with rectal discharge, women where gonorrhoea is suspected, if anal sex has occurred and in some cases of sexual assault.
• In asymptomatic women a 'blind' rectal swab may be taken by inserting a moistened Chlamydia/Gonorrhoea NAAT collection swab a few cm into the rectum, rotating briefly before removing and inserting swab into collection pot. The patient may prefer to take this sample herself.

**Rectal examination**

• If indicated by symptoms or history and with the agreement of the patient a rectal examination should be carried out. See section on male examination.
Bimanual examination

Bimanual examination may be carried out by an appropriately trained practitioner. It may be indicated in cases of pelvic pain, abnormal vaginal bleeding, lower abdominal distension and dyspareunia. It is necessary before fitting an intrauterine device. A bimanual examination may also be considered as routine in all women aged over 40 where serious pelvic pathology such as malignant ovarian cysts may be more common and may be asymptomatic.

- Bimanual examination should be carried out in the lithotomy position.
- Gently insert a gloved and lubricated index and middle finger into the vagina. Assess the vagina and note findings such as vaginal tone, tenderness, protrusions (e.g. rectal fullness) and foreign bodies.
- Place the other hand on the abdomen and press towards the fingers inside the vagina.
- Locate the cervix and lightly feel this between two fingers. Then assess its size and movement; it should move freely. Palpate the cervix; it should feel smooth and firm (hard and lateral displacement could indicate the presence of tumours/fibroids).
- The abdominal hand should be midway between the umbilicus and the symphysis pubis. The vaginal hand with palmer surface facing anteriorly should maintain contact with the cervix so that the practitioner examining the woman can use the cervix as a ‘landmark’ for palpating the uterus.
- Lightly applying pressure to the posterior portion of the cervix with the vaginal hand will bring the uterus towards the abdomen. Once the uterus is raised use the external hand to palpate; taking note of size, shape, position and consistency. If the uterus is retroverted or retroflexed it will not come up between the examining hands; differentiation between an anteverted and retroverted uterus is vital for certain procedures.
- Assess the uterus, taking note of size, shape, position, consistency, mobility and tenderness.

Palpation and examination of the adnexa:

- Move abdominal hand to the lower abdominal quadrant on the same side as the internal hand. Move fingers in the vagina to either the right or left sides of the lateral fornix.
- Apply firm and steady pressure. Start medial to the anterior iliac crest. Note any tenderness or masses.
- When palpating the ovaries, advise the woman that some discomfort is likely. The ovaries are approximately 2-4 cm in length, smooth, firm, mobile, sensitive to touch but not tender and, if palpable, should feel the size of an unshelled almond. In post-menopausal women they are smaller.
- Gentle moving of the cervix slightly from side to side will demonstrate ‘cervical excitation’; discomfort on the opposite side to that of the movement of the cervix. This indicates inflammation in the fallopian tube or adnexal structures on the side of the pain.
Throat and mouth examination and tests

- Samples from the mouth and/or throat may be required if indicated by sexual history or symptoms. This examination should usually be carried out when the patient is dressed.

Following the examination

- Switch off the examination light and provide privacy for the woman to get dressed or rearrange her clothing. Ensure the woman has tissue available to wipe away any lubricant or discharge and that there is access to washing facilities and sanitary pads, if needed.

- Ensure a full record is made of the examination performed, and that any tests taken and findings observed are recorded clearly and contemporaneously in the woman’s notes.

- The following points should be included in your records: lymph nodes, external genitalia, vagina, cervix, as well as uterus, adnexae and abdomen if these have been examined. If peri-anal area, rectum, mouth and/or throat are examined, findings should be clearly documented.

- If swabs have been taken the notes made should include how and when the results will be communicated and the patient should be advised of this.
Male examination

Purpose: the assessment of/sampling for sexually transmitted infections.

- It is usual to examine men before they empty their bladder in order to observe the presence or absence of urethral discharge. However, if the practitioner is certain that no urethral samples will be required it may be more comfortable for the man pass urine before the examination. This is an opportunity to collect a first catch urine sample for chlamydia and gonorrhoea NAAT testing and an additional midstream sample for urinalysis and culture if indicated.
- Although an initial examination may be done with the man lying on his back, it is important to examine him standing up if the history or initial examination suggests any swelling or pain in the groin or scrotum. Hernias and varicoceles are otherwise easily missed.
- If indicated, examine the lower abdomen by palpation (gloves do not have to be worn for this part of the examination).
- Clean hands and put on non-latex gloves.
- Ensure the light source is adequate and is positioned correctly.
- Examine the pubic area and groin. Palpate the inguinal regions to feel for enlarged lymph nodes.
- Examine the external genitalia, including the penis, urethral meatus, glans prepuce and the subpreputial and coronal skin. For uncircumcised men, it may be more comfortable for them to retract their own foreskin for inspection.
- If the patient is complaining of a urethral discharge, this may be readily visible. If not it may necessary to ask the patient if they can demonstrate the discharge, if they are happy to do this.
- If required i.e. if there is a visible urethral discharge, a urethral sample, using a green loop should be obtained for subsequent Gram-stain and an orange topped narrow charcoal swab to culture for gonorrhoea.
- Examine the scrotal skin and gently palpate the scrotal contents. If examination of the perineal and perianal areas is required this is best carried out in the left lateral position.
- The scrotal contents are palpated in turn checking the body of the testis for size, consistency and any irregularities. The epididymis and cord are then likewise palpated and then the procedure repeated on the other side.
- If any testicular abnormalities are detected it is important for the findings to be confirmed by an experienced doctor to consider what if any action to take next. If there isn’t a senior doctor available and there is concern that there may be significant pathology then the patient should be booked an urgent review appointment in the department. If that is not acceptable to the patient [for example they were seen at a peripheral clinic and would find a trip to Truro difficult] then they may choose to see their GP instead – the practitioner should seek permission to liaise with the GP to hand over the case formally. If cancer is likely the practitioner should immediately liaise with a member of the urology team for urgent scan and review and follow the 2 week wait process.
- Swabs from the external genital skin may be required for herpes simplex virus (HSV) PCR and or culture for yeast and skin bacteria.
Rectal examination

- If indicated by symptoms or history and with the agreement of the patient, a rectal examination should be carried out.
- Rectal examination of men is usually carried out with the patient in the left lateral position.
- With good illumination the perianal skin is inspected. If a fissure or herpetic ulceration is visible consider whether a full proctoscopy is required.
- A lubricated proctoscope should be passed gently into the anal canal. Consider using a paediatric proctoscope. Rest the tip of the proctoscope on the posterior anal margin and angle it slightly forward [pointing towards the base of the penis]. In order not to separate the obturator from the proctoscope apply gentle pressure to the obturator base rather than to the proctoscope handle. As the anal sphincter relaxes insert the proctoscope slowly, letting it follow the anatomical curves rather than controlling its angle. Then remove the obturator.
- Observe appearance of rectal mucosa. Swabs can then be taken directly from the rectal mucosa, as indicated by the history and clinical findings including chlamydia/gonorrhoea NAAT, gonorrhoea culture, a sample of any discharge for subsequent Gram stain and HSV PCR if any ulcers or fissures. Tests for syphilis may also be considered if an ulcer is present i.e. Syphilis PCR(sent to reference lab with appropriate form B3).
- A digital rectal examination should be carried out by an appropriately trained practitioner in cases of rectal bleeding, as most rectal cancers are palpable.
- Digital examination as part of the examination in men with pelvic pain or urinary flow symptoms should only be performed by practitioners with the appropriate competencies.

Throat and mouth examination and tests.

- Samples from the mouth and/or throat may be required if indicated by sexual history or symptoms. This examination should usually be carried out when the patient is dressed.

Following the examination

- Switch off the examination light and provide privacy for the patient to get dressed or rearrange clothing. Ensure there is tissue available to wipe away any lubricant or discharge and that there is access to washing facilities if needed.
- Ensure a full record is made of the examination performed (including peri-anal area, rectum, mouth and/or throat if these have been examined). Any findings should be documented clearly and contemporaneously in the patient’s notes.
- Any tests taken should also be clearly recorded and notes made should include how the results will be communicated and when to expect results. The patient should be informed of this and given a sheet to show which tests have been done and to describe the results process.
3. Monitoring compliance and effectiveness

<table>
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<tr>
<th>Element to be monitored</th>
<th>Use of Chaperones</th>
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<tr>
<td>Lead</td>
<td>Pam Gates - matron</td>
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<tr>
<td>Tool</td>
<td>EPR Record monthly Audit</td>
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<td>Frequency</td>
<td>Monthly Monitoring</td>
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<td>Reported to commissioners as part of quality assurance system.</td>
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<thead>
<tr>
<th>Acting on recommendations and Lead(s)</th>
<th>Sexual Health Directorate</th>
</tr>
</thead>
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| Change in practice and lessons to be shared | A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>GENITAL EXAMINATION OF PATIENTS WITHIN RCHT SEXUAL HEALTH SERVICES - CLINICAL GUIDELINE</th>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>01/07/2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>01/07/2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>01/07/2020</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Lisa Haddon  
GU consultant  
Sexual Health |
| Contact details: | 01872 258595 |

**Brief summary of contents**

Genital examination of patients within RCHT sexual health services. All examinations must be carried out by an appropriately trained practitioner. Intimate examinations may be embarrassing or distressing for patients and practitioners must be sensitive to this and take care to demonstrate respect and courtesy at all times. The examination and its explanation should be carried out in a professional manner. Practitioners should ensure they have the necessary competencies to carry out examinations and that they are familiar with this guideline. Findings and tests taken need to be carefully documented in the patient record. A chaperone must be present for all intimate examinations, or clear documentation as to why not present. Use of chaperone will be audited regularly with a target of 100%.

**Suggested Keywords:** Sexual Health Chaperone bimanual vaginal rectal examination mouth throat disease speculum cervical cytology

**Target Audience**

- RCHT  
- PCH  
- CFT  
- KCCG  
- ✔

**Executive Director responsible for Policy:** Medical Director

**Date revised:** 31/03/2017

**This document replaces (exact title of previous version):** GENITAL EXAMINATION OF PATIENTS WITHIN RCHT SEXUAL HEALTH SERVICES - CLINICAL GUIDELINE
Approval route (names of committees)/consultation: Specialty doctor’s meeting, Specialty Governance meeting, Specialty board meeting, Divisional board meeting

Divisional Manager confirming approval processes Karen Watkins Women & Children's Divisional Director

Name and Post Title of additional signatories Not Required

Signature of Executive Director giving approval {Original Copy Signed}

Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet ✓ Intranet Only

Document Library Folder/Sub Folder Clinical / Sexual health

Links to key external standards None

Related Documents: /DocumentsLibrary/PeninsulaCommunity Health/ClinicalGovernance/ChaperoneGuidelines.pdf

Training Need Identified? No

Version Control Table

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<th>Date</th>
<th>Versio n No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>30 Jul 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Lee Azancot Data Administrator</td>
</tr>
<tr>
<td>11.5.17</td>
<td>V2.0</td>
<td>Minor changes only. Removal of section on male urethral massage as this practice is not deemed necessary and may cause undue embarrassment and distress in some patients– patient to demonstrate discharge himself if not immediately visible</td>
<td>Lee Azancot Data Administrator</td>
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</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as <em>policy</em>)</th>
<th>(Provide brief description): Genital Examination Of Patients Within RCHT Sexual Health Services - Clinical Guideline</th>
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<tbody>
<tr>
<td>Directorate and service area: Women, Children &amp; Sexual Health</td>
<td>Is this a new or existing Policy? Existing</td>
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<tr>
<td>Name of individual completing assessment: Helen Ross-McGill</td>
<td>Telephone: 01872 252143</td>
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</table>

1. **Policy Aim***
   - Who is the strategy / policy / proposal / service function aimed at?
   - All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of genital examination of patients within RCHT sexual health services

2. **Policy Objectives***
   - As above

3. **Policy – intended Outcomes***
   - As above

4. **How will you measure the outcome?**
   - See section 3

5. **Who is intended to benefit from the policy?**
   - All Sexual Health patients

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
   - No

   b) If yes, have these *groups been consulted?

   C). Please list any groups who have been consulted about this procedure.

### 7. The Impact

Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
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Clinical Guideline Template

Page 15 of 16
<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
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<td>Sex (male, female, transgender / gender reassignment)</td>
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<td>Race / Ethnic communities /groups</td>
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<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.           Yes | No | X
9. If you are not recommending a Full Impact assessment please explain why.

Not required

Signature of policy developer / lead manager / director                   Date of completion and submission
11.5.17

Names and signatures of members carrying out the Screening Assessment    1. Helen Ross-McGill 2. Lisa Haddon

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________
Date ____________________