# THE STATE HOSPITALS BOARD FOR SCOTLAND

# SUICIDE AWARENESS AND PREVENTION POLICY

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| Lead Author | Senior Nurse - Practice Development |
| Contributing Author | Head of OD and Learning |
| Advisory Group | Mental Health Practice Steering Group |
| Approved By | Policy Approval Group |
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| Next Review Date | 26 February 2028 |
| Accountable Executive Director | Director of Nursing and Operations |

The date for review detailed on the front of all State Hospital policies/procedures/guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/procedure/guidance at any time due to organisational or legal changes.

Staff are advised to always check that they are using the correct version of any policy, procedure or guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies, procedures and guidance can be found on the Hospital's Intranet policies page.

**SHOULD YOU NEED SUPPORT PLEASE CONTACT THE FOLLOWING EXTERNAL AND INTERNAL RESOURCES.**

**24 hour external websites and contact numbers:**

- Talk to us on the Phone | Samaritans (Dial 116 123).
- Mental health services at NHS 24 (Dial 111).
- Breathing Space (Dial 0800 838 557).
- National Wellbeing Hub.

**Internal Resources:**

- Your line Manager.
- Staff Care Specialist - Staff Care Helpline **(Dial 01698 752000)** 24-hour 7-day service.
- Peer Support Network **(orange lanyards)**.
- Occupational Health Self-Referral.

**REVIEW SUMMARY SHEET**

**Changes required to policy (evidence base checked)** **Yes ☒** **No ☐**

**Summary of changes within policy:**

**2024 Review**

- Updated data and population data were added alongside the strategic drivers; The Scottish Government's Action plan was updated to include the most recent evidence base and recommendations.
- Changes made to practice; the inclusion of the recent evidence base for an individualised formulation approach to risk assessment and management of a patient being cared for under this policy. This is in keeping with the NICE guidelines.
- No removal of paragraphs was carried out.
- Paragraphs were edited to incorporate the Clinical Care Policy.

**CONTENTS**

## 1 BACKGROUND AND CONTEXT

It is estimated that 720,000 people worldwide die by suicide each year (WHO, 2024.) For every suicide there are many who people who attempt suicide. A prior suicide attempt is an important risk factor for suicide in the general population. Suicide occurs throughout the lifespan and was the third leading cause of death among 15–29-year-olds globally in 2021 (WHO, 2024.) The reasons for suicide are multi-faceted, influenced by social, cultural, biological, psychological, and environmental factors present across the life-course.

### 1.1 Suicide and links with mental health

- People with a mental illness are the highest 'at risk' group for suicide, with a rate of suicide 10 times that of the general population.
- The risk of suicide further increases in individuals experiencing severe and/or enduring mental ill health.
- Approximately one-third of probable suicides involve people receiving treatment for a mental health issues or who have had contact with mental health services in the 12 months prior to their death.

### 1.2 Suicide in the Scottish Population

- Figures published by the National Records of Scotland (NRS) show there were 792 deaths recorded as probable suicides in 2023, an increase of 30 from 2022.
- In 2023, 590 suicides were males. While 202 deaths were female.
- The age-specific rate of suicides in Scotland is highest at age 25-44 and age 45-64.The rate at age 25-44 is at a lower level now than at its peak in 2011. The rate for age 45-64 has been somewhat consistent over time. In comparison, the age-specific rate of suicides in age 65-74 has increased in each of the last five years.

### 1.3 Creating Hope Together: Suicide Prevention Action Plan 2022-2025

Our vision is to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities which contribute to suicide. To achieve this, all sectors must come together in partnership, and we must support our communities, so they become safe, compassionate, inclusive, and free of stigma. The Scotland Suicide Prevention Action Plan (Scottish Government, 2022) is available to view here.

### 1.4 Role of HealthCare staff

To support achievement of the Scottish Government's suicide reduction target, it is essential that all healthcare staff are able to identify and assess individuals using their services who may be at increased risk of self-harm or suicide, and know how to provide help and support for these people. The State Hospital (TSH) is committed to ensuring that staff receive training and education in recognising and assessing the risk of suicide, and on strategies for preventing and managing suicide risks.

## 2 PURPOSE

This policy provides a framework for person-centred, least-restrictive care that outlines and promotes good practice in relation to suicide awareness and prevention.

## 3 AIMS

The policy aims to:

- Highlight some of the links between mental ill health and deaths by suicide.
- Explain the role of State Hospital staff in identifying and assessing patients who may be at increased risk of self-harm or suicide.
- Ensure there are robust, evidenced based processes and procedures in place for assessing whether a patient poses an increased risk of suicide.
- Ensure that any patient identified at increased risk of suicide is provided with appropriate care and treatment, and that the risks identified are sensitively and effectively managed in order to reduce such risks and support recovery.
- Ensure that any patient who is at increased risk of suicide is reviewed regularly by relevant members of the clinical team.
- Ensure that the care environment is safe and that environmental risks for suicide are assessed and effectively managed.
- Ensure that appropriate training on suicide awareness and prevention is made available to all relevant staff groups.

## 4 SCOPE

This policy applies to all clinicians who contribute to the delivery of patient care within the TSH.

## 5 DEFINITIONS

The following terms have been adopted from *"Every Life Matters: Scotland's Suicide Awareness and Prevention Plan"* (Scottish Government, 2018):

- **Suicide** is death resulting from an intentional, self-inflicted act.
- **Suicidal behaviour** comprises both completed suicide attempts and acts of self-harm that do not have a fatal outcome, but which have suicidal intent.
- **Non-fatal self-harm** is self-poisoning or self-injury, irrespective of motivation or extent of suicide intent (excluding accidents, substance misuse and eating disorders).
- **Probable Suicide:** The National Records of Scotland (NRS) define probable suicides as deaths resulting from intentional self-harm and/or events of undetermined intent.

**Intentional self-harm** includes cases where it is clear from the evidence available (e.g. a note that was left, or something that the deceased had said or done) that the person's intention was suicide.

**Events of undetermined intent** are cases where it is not clear whether the death was the result of intentional self-harm or was accidental (e.g. if a person dies as a result of substance misuse, it may not be possible to establish whether the person took the substance with suicide in mind or died as the result of an accidental overdose.)

## 6 KEY PRINCIPLES

Predicting suicide is a major challenge for all healthcare professionals. However, it is important that we are able to understand and identify risk factors and particular groups of people who may be at an increased risk of self-harm or suicide, and know how to provide help and support for these individuals, families and carers.

## 7 SUICIDE RISK ASSESSMENT

Risk assessment involves gathering and analysing information to identify risk factors of relevance specific to that individual and the context in which they may occur. Risk assessment and management are integral components of suicide prevention. However, given the low predictive value that static or dynamic risk factors have for assessing the immediate risk of self-harm it is important to remember that clinical judgement is also of paramount importance.

### 7.1 Initial Risk Assessment

On admission to TSH, every patient will have an initial Suicide and Self-Harm risk assessment completed. As a minimum, this assessment should have input from the medical and nursing team with consideration being given to any risks identified pre-admission. The Initial Admission Risk Assessment is located on RiO, within the Risk Information folder. Where a suicide risk has been identified in the Initial Admission Risk Assessment this must be clearly documented in all relevant risk assessment paperwork and communicated to all members of the patient's multidisciplinary care team. The multidisciplinary team should then agree what interventions should be in place to manage the individual patients' risk.

### 7.2 Risk Assessment Review

A dynamic and person-centered approach should be taken to review and manage a patient who is at risk of suicide; a tailored approach should allow for regular reviews in keeping with best practice to mitigate risk. As a minimum the Suicide and Self-Harm risk assessment should be discussed and reviewed by the multidisciplinary team at least twice per year (i.e. at each annual and intermediate case review.) A Risk of Suicide and Self Harm Scenario plan should also be completed within the Suicide and Self-Harm risk assessment section of the Care Programme Approach (CPA) document.

Risk assessments should, as a minimum, consider the following:

- Does the patient have a history of previous suicide attempts/self-harm?
- What was the frequency and severity of any previous suicide attempts/self-harm?
- Is there any identifiable pattern to previous suicide attempts/self-harm? (e.g. at night time, after specific events, etc.).
- Is there evidence of current suicidal ideation?
- If evidence of suicidal ideation is present, does the patient have a suicide plan? (and if so, what is it).

### 7.3 Tools to support suicide and self-harm risk assessment

The hospital uses a number of tools that can help guide and support the multidisciplinary team to monitor concerns about self-harm or suicidal intent (e.g. The Behavioural Status [BEST] Index; Psychosis Evaluation Tool for Common use by Caregivers [PECC]; Dynamic Risk Assessment and Management System [DRAMMS]; Historical Clinical and Risk Management Tool [HCR-20]. A therapeutic assessment, formulation and risk management should be carried out to support the individual patient's needs in relation to their risk of suicide.

### 7.4 Multidisciplinary Formulation

All patients within the State Hospital should have a multidisciplinary assessment and formulation completed as part of their Care Programme Approach (CPA). This should indicate, amongst other things, if there have been or are any concerns about self-harm or suicidal intent. Where possible, the multidisciplinary formulation should be developed in collaboration with the patient and others involved in their care and should identify any predisposing, precipitating, perpetuating and protective factors, pertaining to self-harm or suicidal risk. This formulation should be reviewed at least once a year as part of the CPA process. However, a person centred approach should be taken, and the multidisciplinary team can identify how often reviews should be carried out.

## 8 MANAGING CONCERNS ABOUT SELF-HARM AND/OR SUICIDE RISK

Suicide risk factors can be thought of as two distinct groups:

1) **Long term / static risk factors** - which are historical, fixed, or likely to endure for many years (e.g. age, gender, social class, employment status, history of mental illness, previous suicide attempts, family history of suicide).

2) **Short term / dynamic risk factor**s – which are concerned with an individual's current state of mind and/or behaviour and are therefore usually better predictors of suicide (e.g. agitation, delusions, hallucinations, feelings of hopelessness and helplessness).

Long-term risk factors may help to form a useful and necessary framework for any suicide risk assessment and give a general indication of increased risk. However, they do not capture the variable nature of risk. Instead, dynamic risk factors may be more helpful.

Suicidal thoughts, feelings and behaviours are not static. They can be influenced by many factors and can change over time. Therefore, assessment of suicide risk should be an ongoing process and reviewed on a regular basis. It should also be conducted after significant events and/or prior to changes in the patient's care arrangements.

The most obvious warning sign for suicide is a direct statement of intent. There is no truth in the idea that people who talk about suicide do not act on this. Asking a person about their suicidal intentions does not make suicidal behaviour more likely. On the contrary, if the person already has thoughts of suicide they are likely to feel better understood when the issue is raised, and this in itself may reduce the risk.

### 8.1 Reporting Concerns about Self-Harm or Suicide Risk

Any concerns raised by any member of staff about the risk of suicide for any patient within TSH must be reported immediately to the Nurse in Charge of that area and recorded in the patient's RiO record.

The Nurse in Charge should subsequently inform the Senior Charge Nurse (SCN) for that area, or Senior Clinical Cover (SCC) in the SCNs absence, and the patient's Responsible Medical Officer (RMO), or duty RMO in their absence. If there are any specific security concerns that pertain to the patient's safety, the safety of others, or to the safety of the organisation then the duty Clinical Security Liaison Manager (CSLM) should also be appraised of these concerns. Each of these discussions will help to inform any management strategies that are required to maintain the patient's safety and a safe environment for others. At the earliest opportunity this information should also be shared with the patient's multidisciplinary team (MDT) and recorded in the patient's notes and risk assessment.

## 8.2 Clinical Care Policy

If an individual has been identified as being at increased risk of self-harm or suicide then it is necessary to apply the interventions specified within the Clinical Care Policy, and this should have input from the multidisciplinary team.

Where an increased risk of suicide has been identified; a therapeutic assessment, formulation and risk management interventions should be carried to support the individual patient's needs. Interventions to reduce imminent risk of suicide should be applied under the Clinical Care Policy and other relevant policies. The Psychology service will advise which assessment approaches to apply. Whilst suicide risk assessment tools are important to the assessment process they are not designed to be used on their own or replace clinical judgment. Instead, the assessment tools can provide additional information which helps inform decisions about risk and treatment planning.

To help manage any imminent risks safeguards the patient should be cared for under the Clinical Care Policy (located within PMVA policy section on the Intranet.) The Enhanced Care Plan should explicitly detail the MDT interventions required to support and manage the risk of suicide and maintain the safety of the patient. The plan should consider the What Matters to Me Plan and the patient's multidisciplinary formulation, be based on the individual's specific clinical and risk needs and should also identify any protective factors unique to that individual. Protective factors are psychosocial conditions or individual attributes that can lessen the likelihood of an individual acting on suicidal thoughts. Protective factors can include:

- Connectedness / social support.
- Sense of self-efficacy.
- Hopefulness or reasons for living.
- Religion, faith, or spirituality.

Efforts should always be made to involve patients in decisions about their care and proposed risk management strategies, and consideration given to the format in which this information is shared (e.g. adaptations to reading materials; information provided in picture format; use of talking mats etc.) Any decision made about care should always be consistent with the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Details of all discussions, agreed MDT interventions, and the patient's views on any proposed Enhanced Care Plan must be documented in the patient's progress notes and Clinical Care Policy Documentation within RiO. Likewise, any intervention updates should be recorded in the scenario planning section of the patient's risk assessment and CPA paperwork.

Any key actions and interventions specific to day-to-day nursing care should also be used to inform a specific Clinical Care Plans.

## 8.3 Reviewing Risk Assessment

Every self-harm or suicide risk assessment should detail timescales for review. As a very minimum, risk assessments should be reviewed as part of the Care Programme Approach (CPA) process. However, patients being cared for under the Clinical Care Policy should be reviewed in keeping with the policy guidelines whilst adopting a person cantered tailored approach to each individual risk and risk management. A continual assessment of risk and risk management should be applied and changes made to the patient's individual care documented and communicated with the MDT, family and carer where appropriate.

### 8.4 Restricting access to means of self-harm or suicide

Restricting access to the means of self-harm or suicide is often a key element of prevention and risk management. In keeping with the Clinical Care Policy and national drivers; a patient should have access to tailored personalised activity as agreed by the MDT. What this entails will vary depending on the individual patient and the situation.

However, it may include:

- Restricting access to items that could be used to self-harm (e.g. belts, shoe laces, metal cutlery, razors, sheets and towels, etc).
- No unsupervised access to high risk areas such as toilets, shower rooms, bedrooms or other areas of the ward that allow the patient opportunities to be isolated from others.
- Increased vigilance during administration of medicines to prevent potential secretion of medication
- Temporary withdrawal of grounds access.
- Ensuring staff awareness of potential ligature points.

In addition to restricting access to means of self-harm or suicide, it may be necessary to increase the frequency of searches carried out by staff in order to maintain safety (i.e. searching of the patient, their possessions and/or their room area). Staff should be familiar with the hospital's searching policies and procedures, and alert to items that could be used for self-harm or suicide intent.

## 9 ENSURING A SAFE PHYSICAL ENVIRONMENT

Hanging has been identified as the most frequent method for suicide in inpatient areas, with the most commonly reported ligature points being doors and windows and the most common ligatures being belts, shoelaces, sheets and towels. Therefore, ensuring a safe physical environment is an essential part of TSH's overarching risk management strategy and all staff involved in the delivery of patient care must be alert to the potential risks within the clinical environment.

Ligature point risk assessments identify any structures or fittings, in addition to any other risks hazards, that could be accessed for the purpose of self-harm or suicide. Where possible, potential ligature points within patient areas should be removed. Where this involves fixtures and fittings, this should be done in consultation with the Head of Estates. If it is not possible for potential ligature points to be removed (e.g. safety railings within disabled toilet facilities) then all staff must be made aware of where they are. Enhanced Care plans as Clinical Care Policy should outline these potential ligature points, and discussed and agreed by the MDT to help mitigate risk. As per ward area; all forms of communication within the team and MDT should also handover these potential ligature points in addition to changes to risk and presentation.

Ensuring regular assessments of the ward and hub environments are the responsibility of the Senior Charge Nurse (SCN) for that area. All fixtures and fittings, plus any equipment or other items that patients have access to should be included in the risk assessment for that area. Findings from all assessments, and details of any associated risk management assessment and formulation, Clinical Care Policy care plans must be recorded within the ward/department control book and communicated to all relevant staff.

## 10 ADDITIONAL SAFETY MEASURES

In order to manage self-harm and/or suicidal risk the use of a Modified Safe Room (MSR) and strong clothing/bedding may be necessary. However, this would only be in exceptional circumstances.

Any decision to use strong clothing/bedding should be made in consultation with the SCN for that area (or SCC in their absence) and the patient's RMO (or duty RMO) and must be carried out in accordance with TSH's Use of Strong Clothing / Bedding Policy.

Likewise, any decision to place a patient in an MSR should only be made as part of a clinically indicated plan to ensure safety, and should only happen only after approval from the SCN for that area (or SCC in their absence) and the patient's RMO (or duty RMO).

## 11 ROLES AND RESPONSIBILITIES

**Directors and Senior Managers will:**

Make arrangements for the effective implementation and monitoring of this policy.

**Chief Executive or Deputy will:**

Report any death of a Restricted patient to The Scottish Executive.

**RMO will:**

- Ensure that a Suicide Risk Assessment is included in the CPA care plan for all patients and that the risk of suicide is discussed by the multidisciplinary team at the initial case review and thereafter at each annual and intermediate case review.
- Contribute to the development of risk management plans and offer advice and support on suicide risk assessment and management to nursing staff and other members of the clinical team
- Report any death by suicide/suspected suicide to the Mental Welfare Commission.

**Lead Nurse / Departmental Manager will:**

- Have operational responsibility for the implementation of this policy within own areas of management accountability.

**Senior Charge Nurse will:**

- Ensure implementation of the processes and procedures outlined within this policy to effectively identify and manage risk of suicide and self-harm.
- Ensure that environmental risk assessments are carried out in all patient areas within their ward and that any necessary remedial action is carried out to eliminate or reduce identified risks.
- Ensure that all staff receive appropriate training on suicide awareness and prevention.

**Key / Associate Worker will:**

- Ensure that nursing assessments (Initial admission risk assessment, BEST & PECC) are completed for all patients and that the risk assessment and any associated management plans are reviewed regularly by the patient's multidisciplinary team.
- Ensure that details of all nursing suicide risk assessments are clearly documented in the relevant sections in the patient's RiO record and communicated to all relevant staff.
- Ensure that a detailed nursing care plan is in place for all patients assessed as being at risk of suicide or self-harm, and that details of this nursing care plan are communicated to all relevant staff.

- Ensure that nursing suicide risk assessments and management plans are reviewed following any significant incidents, major changes in the patient's mental state or behaviour, and at key transition points in the patient's care.

**All clinical staff will:**

- Adhere to the processes and procedures outlined within this policy to effectively identify and manage risk of patient suicide and self-harm.
- Follow individual nursing care plans and CPA risk management plans for all patients in their care.
- Be aware of factors associated with increased risk of suicide and be alert to any changes in a patient's mood, presentation or behaviour that could indicate a potential suicide risk.
- Report any concerns relating to a patient's suicide risk to the nurse in charge.
- Ensure that all information relating to suicide risk assessment and management is clearly document in the relevant section on RiO.
- Maintaining their individual knowledge and skills in relation to suicide awareness and prevention and attend training on suicide prevention, risk assessment and management as required by their role.

**Risk and Resilience Department will:**

- Produce management reports which provide thematic and trend analysis of suicide-related incident data to inform organisational learning and future clinical practice.
- Support clinical leads in undertaking critical incident reviews in the event of a patient suicide or near miss incident, and monitor implementation of any resulting action points to address care and service delivery issues.
- Ensure the sharing and dissemination of lessons learned from all critical incident reviews and serious untoward incident investigations.

## 12 PATIENT DEATH RESULTING FROM SUICIDE / SUSPECTED SUICIDE

Patient deaths in TSH are considered as deaths in custody and require the police to be notified. In the event that a patient within TSH dies as a result of suicide, or suspected suicide, then this should be managed in accordance with the "Death of a Patient" Policy.

Following a patient suicide/suspected suicide the hospital must conduct a critical incident (Level 1/Level 2) review to analyse what happened and identify, through lessons learned, where changes can be made to make things safer for other patients at risk. It is the responsibility of the senior management team to ensure that this review is carried out.

The death of a patient, as a result of suicide, can impact significantly on both staff and patients. The SCN or, in their absence, the nurse in charge of the ward should ensure that support is offered to all those affected.

Support options for staff could include:

- Providing opportunities for debriefing - individually or in groups.
- Access to clinical supervision.
- Sign-posting to suicide bereavement resources.
- Providing opportunities to promote closure and healing (e.g. allowing the staff member to be involved in bereavement rituals such as attending the funeral if appropriate).
- Referral to the occupational health service (e.g. for counselling support).

- Supporting staff who may be required, post-incident, to give evidence in court (e.g. Fatal Accident Inquiry, criminal or civil court proceedings).

Support options for patients should be discussed and agreed by the clinical team and may include:

- Providing written information leaflets on coping with bereavement.
- Referral to the hospital's spiritual and pastoral care team.
- 1:1 support from the key or associate worker or other member of the patient's care team.
- Referral to psychology (e.g. for bereavement counselling).

In Scotland all deaths resulting from suicide are reported by the police to the Procurator Fiscal. In cases where an individual has been in contact with mental health services in the 12 months prior to their death all NHS Scotland Health Boards also have a duty to report suicide/suspected suicide to the Healthcare Improvement Scotland (HIS) Suicide Reporting and Learning System (SRLS). It is also the responsibility of the RMO (or duty RMO) to report any death by suicide/suspected suicide to the Mental Welfare Commission (MWC).

## 13 TRAINING

All clinical staff commencing employment within TSH should receive suicide awareness online module. Line managers are then responsible for identifying any further training needs relating to suicide awareness and prevention.

## 14 RECORDS

All decisions and reviews relating to a patient's care, or changes to that care, should be documented within the patient's notes on RiO.

## 15 RAISING CONCERNS

Any member of staff can raise concerns about a patient or their care. These concerns can be raised via the Nurse in Charge, SCC, the patient's RMO, or any member of the multidisciplinary team.

All members of the multidisciplinary team have a professional and legal responsibility for wellbeing and safety of patients in their care.

## 16 COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within the State Hospital via email, the hospital's intranet and through the staff bulletin.

The Person Centred Improvement Team will facilitate communication with Patients, Carers and Volunteers.

The Mental Health Practice Steering Group will be the advisory group for this policy. Monitoring and implementation responsibilities are with each clinical area and practitioners within the multidisciplinary team.

Any deviation from policy should be notified directly to the policy Lead Author. The Lead Author will be responsible for notifying the Advisory Group of the occurrence.

This policy will be reviewed every three years or earlier if required.

## 17 EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect.
Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Team on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

## 18 STAKEHOLDERS ENGAGEMENT

| Key Stakeholders | Consulted (Y/N) |
|---|---|
| Patients | Y |
| Staff | Y |
| Carers | Y |
| Volunteers | N |