

Completing a Medical Certificate of Cause of Death (MCCD)

Department / Service:	Bereavement Office
Originator:	Laura Knowles
Accountable Director:	CMO
Approved by:	ISAG
Date of approval:	6 th October 2026
First Revision Due:	6 th October 2029
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments:	All
Target staff	Clinical Staff
Categories:	Inc medical.

Policy Overview:

Prompt and accurate completion of an MCCD is essential because it serves a number of functions. It enables the death to be registered, providing a permanent legal record of the fact of death and the medical cause of death. It allows the deceased person's representative to take steps to arrange disposal of the body and to begin the process of settling the deceased person's estate. By law, deaths must be registered within 5 days of receipt of the MCCD by the registrar unless there is to be a coroner's investigation.

This document is to support the process above.

Key Amendments to this Document

Date	Amendment	Approved by:
07/10/26	Trust log in details for coroner's portal removed.	ISAG

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Appendix 1: Advice for AP on ability to complete MCCD.

1. Introduction.

The purposes of death certification:

Prompt and accurate completion of an MCCD (medical certificate of cause of death) is essential because it serves a number of functions. It enables the death to be registered, providing a permanent legal record of the fact of death and the medical cause of death. It allows the deceased person's representative to take steps to arrange disposal of the body and to begin the process of settling the deceased person's estate. By law, deaths must be registered within 5 days of receipt of the MCCD by the registrar unless there is to be a coroner's investigation.

After the death has been registered, the 'informant' can buy a certified copy of the register entry - the 'death certificate' - which includes an exact copy of the cause of death information described on the MCCD. This gives them information on how the person died, which may be important for their own health and that of future generations. The informant is someone who meets the legal criteria to register the death with the registrar. The informant is often a member of the deceased person's family.

Information from death registration, which includes information from the MCCD, is used to produce statistics on causes of death, mortality rates, life expectancy and other important measures. Statistical information on deaths by cause is important for:

- monitoring the health of the population
- surveillance of epidemics and pandemics
- designing and evaluating public health interventions
- recognising priorities for medical research and health services
- planning health services and assessing their effectiveness
- Death registration data is extensively used in medical research and to understand the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.

2. **Definitions of medical practitioner and medical examiner:**

All references to 'medical practitioner' in this document mean a qualified medical practitioner who holds a valid registration from the General Medical Council (GMC) and a licence to practise, in accordance with the Medical Act 1983. A medical certificate of cause of death (MCCD) completed by a physician who does not have a current licence to practise at the time of completion would not be legally valid.

Under the Coroners and Justice Act 2009, the medical practitioner responsible for completing an MCCD is also referred to as the 'attending practitioner'. All references to 'medical examiner' refer to senior medical practitioners, as defined above, who are employed by an NHS body to provide independent scrutiny of the causes of death.

3. Information in the MCCD:

MCCD's are kept in the bereavement office and should be completed with the guidance and support of the medical examiner (ME). The only exception for this, is ED (Emergency department) and ICCU (Intensive care unit), where it has been agreed with the lead ME, that the MCCD book can be kept in a locked safe, to be completed at the time of death. The AP's in these departments have been made aware that they will need to discuss the case with the ME and may be required to attend the bereavement office, to make any required amendments.

Sequencing cause of death, underlying cause and contributory causes.

On the non-neonatal MCCD, APC 1, the cause section of the MCCD is set out in 2 parts, in accordance with World Health Organization (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD).

Part 1.

The attending practitioner is asked to start with the immediate, direct cause of death on line a of part 1. Having started with the immediate, direct cause of death you should go back through the sequence of events or conditions that led to death on subsequent lines (lines b to d) of part 1, until you reach the condition that started the fatal sequence.

If the MCCD has been completed properly, the condition on the lowest completed line of part 1 will have caused all of the conditions on the lines above it. This initiating condition, on the lowest completed line of part 1, will usually be selected as the underlying cause of death, following ICD coding rules.

WHO defines the underlying cause of death as: "a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury."

From a public health point of view, preventing this first disease or injury will result in the greatest health gain. Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health services and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

Part 2.

You should also enter any other diseases, injuries, conditions or events that contributed to the death, but were not part of the direct sequence, in part 2 of the MCCD. The conditions mentioned in part 2 must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time.

Duration.

Wherever possible, you should provide the duration of each disease or condition, referred to as the 'approximate interval between onset and death' on the MCCDs, although the medical record may not always support this.

Medical examiners should strongly encourage completion of duration information. This is because complete duration information helps to ensure that the order of the sequence of conditions is accurate and affects mortality coding and the selection of underlying cause in some cases such as where there is a separate ICD code for 'late effects' or 'sequelae'. It also provides additional information for medical research.

For example, it matters for underlying cause selection if a stroke occurred more than 12 months ago rather than more recently, as does a myocardial infarction being 28 days or more between onset of the condition and death.

Never use abbreviations or symbols.

Do not use abbreviations on MCCDs. Their meaning may seem obvious to you in the context of your patient and their medical history, but it may not be clear to others. For example:

- does a death from 'MI' refer to myocardial infarction or mitral incompetence?
- is 'RTI' a respiratory or reproductive tract infection, or a road traffic incident?
- The medical examiner should not accept an MCCD that includes any abbreviations. The same applies to medical symbols.

Neonatal deaths.

The layout of the MCCD for a live-born child dying within the first 28 days of life is different from the non-neonatal MCCD. It provides space for both the infant's and mother's conditions.

It starts with the main disease or condition affecting the infant (line a), followed by other diseases or conditions affecting the infant (line b).

Line c is for the main maternal disease or condition affecting the infant and line d is for other maternal diseases or conditions affecting the infant. Line e is for other relevant factors or circumstances.

Deaths involving infections and communicable diseases.

Mortality data is important in the surveillance of infectious diseases, as well as monitoring the effectiveness of immunisation and other prevention programmes. If the patient's death involved a notifiable disease, you have a statutory duty to notify the proper officer for the

area, unless the case has already been notified. This is normally a consultant in communicable disease control (CCDC) in your local health protection team (HPT).

If you're not sure whether a case is notifiable, you can get advice from your local HPT who will also advise on appropriate microbiological investigations. Further information about notification of infectious diseases is available from the UK Health Security Agency.

In deaths from infectious disease, you should state the manifestation or body site, for example pneumonia, pyelonephritis, hepatitis, meningitis, septicaemia or wound infection. You should also specify, giving as much detail as is available:

the infecting organism, such as pneumococcus, influenza A virus, meningococcus antibiotic resistance, if relevant, for example methicillin-resistant *Staphylococcus aureus*, or multiple drug resistant *Mycobacterium tuberculosis* the source and/or route of infection, if known, such as food poisoning, needle sharing, contaminated blood products, post-operative, community or hospital acquired, or healthcare-associated infection

Injuries and external causes.

All deaths involving any form of injury or poisoning must be referred to the coroner. If the death is not one that must be investigated by the coroner and they instruct you to certify, remember to include details of how the injury occurred and where it happened, such as at home, in the street or at work.

Completing other sections.

Many of the fields on the MCCD are self-explanatory, such as name of deceased, date of birth and NHS number. However, some of the fields may be less clear to the attending practitioner and this section should provide greater clarity on the purpose of those fields and how to complete them.

Place of death.

'Place of death' is the address where the deceased person died. Often this will be the address of a hospital, hospice or residence.

In circumstances where the death occurred outside a recognised address (and which did not trigger the coroner's duty to investigate) the attending practitioner should include the best available information. For example, where the death occurred in St James's Park, the attending practitioner would write 'St James's Park.'

4. Role of the medical examiner:

Medical examiners scrutinise the cause of death provided by the medical practitioner completing the MCCD. The statutory system of medical examiners was introduced on 9 September 2024, in response to the findings of numerous independent inquiries, including the Shipman Inquiry. All deaths not investigated by the coroner must receive appropriate scrutiny by a medical examiner.

In addition to scrutinising the cause of death, medical examiners will offer a conversation about the cause of death with the deceased's representative, which provides an opportunity for them to raise concerns. This conversation can be carried out by the medical examiner officer. This is an important step in helping the bereaved to understand the cause of death and the sequence of conditions that led to it. For the attending practitioner, engaging the medical examiner as soon as possible to discuss their thinking on the cause of death can positively impact these subsequent conversations with the representative of the deceased and limit any potential delays to the death's eventual registration.

Once the medical examiner has scrutinised the cause of death and signed the declaration, the medical examiner office will send the MCCD to the registrar for registration of the death. The medical examiner office will also inform the representative of the deceased that the MCCD has been transferred to the registrar for registration of the death without unreasonable delay.

You can read more about the role of medical examiners in the National Medical Examiner's guidance for England and Wales, published by NHS England.

5. Maternal deaths:

There are 2 questions relating to maternal deaths in the non-neonatal MCCD (APC 1):

- was the deceased pregnant within the year prior to their death?
- if the deceased was pregnant within the year prior to their death, did the pregnancy contribute to their death?

Each question lists multiple choice answers. For the first question the available answers are:

0. Not applicable
1. Pregnant at the time of death
2. Pregnant 1 to 42 days before death
3. Pregnant 43 days to a year before death
4. Not pregnant
9. Unknown

The use of '0. Not applicable' is for the deaths of those that the attending practitioner deems incapable of being pregnant. The use of '4. Not pregnant', is for the deaths where the attending practitioner believes the deceased was capable of being pregnant, but they were not at the time of death.

This will be subjective in many cases, especially in terms of age and with regards to other medical conditions impacting on fertility.

If in doubt, then select '4. Not pregnant'. The inclusion of 'not applicable' was intended for clear-cut cases where the selection of 'not pregnant' may have otherwise felt inappropriate.

You only need to answer the second question if option 1, 2 or 3 is selected for the first question. For the second question, the available answers are:

1. Yes
 2. No
 9. Unknown
- Employment

The employment section asks whether the death may have been due to, or contributed to, by the employment followed at some point by the deceased.

You should select 'yes' if you believe that the employment followed at some point during the deceased person's lifetime could have influenced the cause of death. Examples could include respiratory diseases in a person who had been a miner during their working life.

6. Ethnicity:

The categories used for the ethnicity question correspond to those used for the 2011 census. The attending practitioner should record the ethnicity of the deceased as it is recorded in the patient record. The attending practitioner should never guess the ethnicity of the deceased.

Select '19. Not known' if:

- there is no match with the listed categories
- there is no ethnicity recorded
- Do not ask the representative of the deceased to confirm the ethnicity.

7. Implantable medical devices:

The information on the MCCD about implantable medical devices will be transferred to the certificate for burial or cremation (the green form). The attending practitioner must indicate if

they believe a hazardous implantable medical device is inside the body. Not providing this information represents a risk to cremation equipment and staff and can lead to delays to funerals.

The MCCD refers to 'implantable medical devices'. However, you only need to state whether there is a hazardous implantable medical device in the body of the deceased person, and if so, the type of device and whether it has been removed.

Hazardous implants may damage cremation equipment and/or cause harm to crematorium staff if not removed from the body of the deceased before cremation. Some radioactive treatments may also endanger the health of crematorium staff.

For burials, hazardous implants may have environmental impacts which the burial authority may wish to consider.

Previously, the medical practitioner provided information relating to hazardous medical devices on the medical form used to release a body for cremation (Cremation 4). This form was removed on 9 September 2024, but the medical practitioner should provide the same information on the MCCD as under the previous system.

Non-exhaustive list of potentially hazardous implantable medical devices
Implants that could cause issues during a cremation include but are not limited to:

- pacemakers
- implantable cardioverter defibrillators
- cardiac resynchronization therapy devices (CRTDs)
- implantable loop recorders
- ventricular assist devices (VADs):
- left ventricular assist devices (LVADs)
- right ventricular assist devices (RVADs)
- biventricular assist devices (BiVADs)
- implantable drug pumps including intrathecal pumps
- neurostimulators (including for pain and functional electrical stimulation)
- bone growth stimulators
- fixation nails
- any other battery powered or pressurised implant
- radioactive implants used to treat tumours, such as metal wires, seeds or tubes
- radiopharmaceutical treatment (via injection)

8. Qualifications:

The attending practitioner must include their primary medical qualifications, as registered by the GMC, in the relevant field in the attending practitioner declaration box. 'MBBS' or similar is acceptable here and the field does not need to contain any additional qualifications or information.

MCCDs that do not contain the attending practitioner's qualifications cannot be used to register a death and will be returned to the attending practitioner.

9. Additional information for more precise statistical classification:

Where applicable, circle '2. Information from post-mortem may be available later' on the MCCD. In these cases, there is no need to tick the box indicating that the attending practitioner may be in a position to give, on application by the Registrar General, additional information as to the cause of death for the purpose of more precise statistical classification.

Otherwise, where more information will be available later from tests where a post-mortem is not being held (for example, histological, microbiological or genetic tests), please indicate this by ticking this box.

Registrars will not follow up with a form requesting these details. However, ONS will use the information from this tick box to monitor the frequency with which such testing information is outstanding, and report this to users of the mortality data in accompanying user guides and metadata.

10. Guidance on referrals to the coroner:

The coroner's duty to investigate is engaged where it is suspected that the deceased person died a violent or unnatural death, that the cause of death is unknown, or that the deceased died while in custody or otherwise in state detention. For such deaths, the coroner investigates and an MCCD is not required.

A coroner referral should be made in the following circumstance:

The registered medical practitioner suspects that the person's death was due to:

- (i) poisoning, including by an otherwise benign substance;
- (ii) exposure to or contact with a toxic substance;
- (iii) the use of a medicinal product, controlled drug or psychoactive substance;

- (iv) violence;
- (v) trauma or injury;
- (vi) self-harm;
- (vii) neglect, including self-neglect;
- (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
- (ix) an injury or disease attributable to any employment held by the person during the person's lifetime;
- (b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);
- (c) the registered medical practitioner—
 - (i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;
- (d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention(3);
- (e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;
- (f) the registered medical practitioner reasonably believes that—
 - (i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;
- (g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

When a patient safety incident is highlighted by the medical examiner review, the ME team will complete a datix incident report, to ensure that the incident is quickly highlighted to the Trust patient safety team.

Worcestershire coroner referrals are submitted via the following portal:

<https://www.worcestershire.gov.uk/council-services/births-deaths-marriages-civil-partnerships-and-citizenship/death-registration-services/welcome-worcestershire-coroner-service>

Coroner's Portal Login Details:

These details are available from the bereavement and medical examining office, and the doctor will be given them when they attend to office, to complete a referral.

11. SJR process:

The Trust completes internal investigations when certain triggers are met. The Medical examining service will highlight when these triggers are met and the governance team will allocate that case to the parent team, to investigate and identify improvements and learning.

12. Changes with cremation documentation:

Following the statutory implementation of the medical examining service, in September 2024, the separate cremation form was discontinued, and this is now incorporated in the body of the MCCD. There are no longer separate payments received for this documentation.

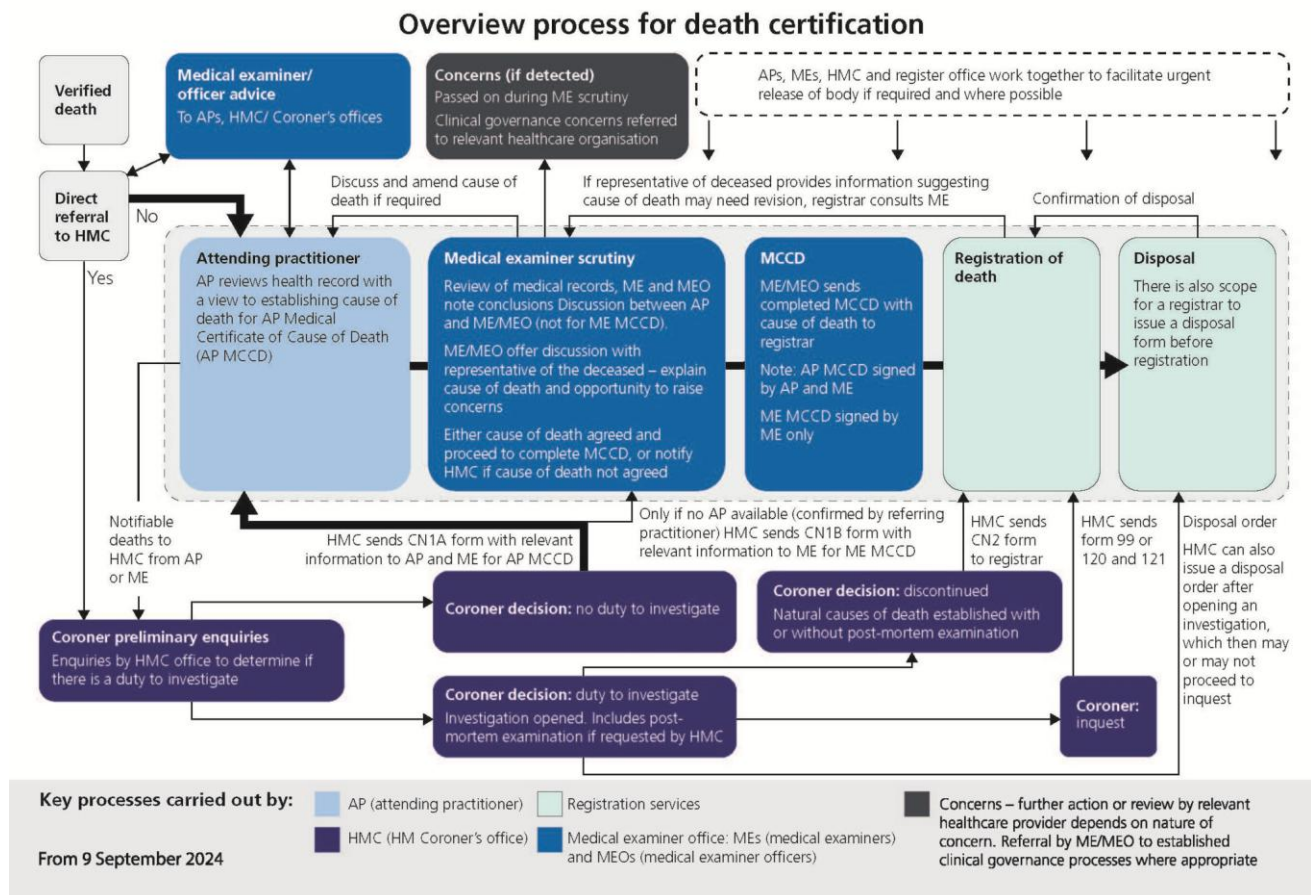
13. GMC responsibilities for completion of MCCD:

The GMC responsibilities for the completion of an MCCD include ensuring that the MCCD is completed accurately and promptly.

This involves:

- Establishing the cause of death to the best of the attending practitioner's knowledge and belief.
- Ensuring that the death is registered within the required time frame.
- Providing a permanent legal record of the death and the medical cause of death.
- Supporting bereaved individuals and ensuring the accuracy of the MCCD.
- Interacting with the attending practitioner completing the MCCD and reviewing medical records.
- Ensuring timely and accurate notification in line with statutory requirements.

14. Overview process for death certification:



15. Implementation of Document

15.1 Plan for implementation

This is to be implemented following Trust approval to all clinical areas and on the Trust key documents file and intranet.

15.2 **Dissemination**- to be led and communicated by the CMO and CD's of each division.

15.3 Training and Awareness

This policy will be available in the Trust key documents file, available on the intranet.

16. Supporting Documents

<https://www.gov.uk/government/publications/medical-certificate-of-cause-of-death-mccd-guidance-for-medical-practitioners>

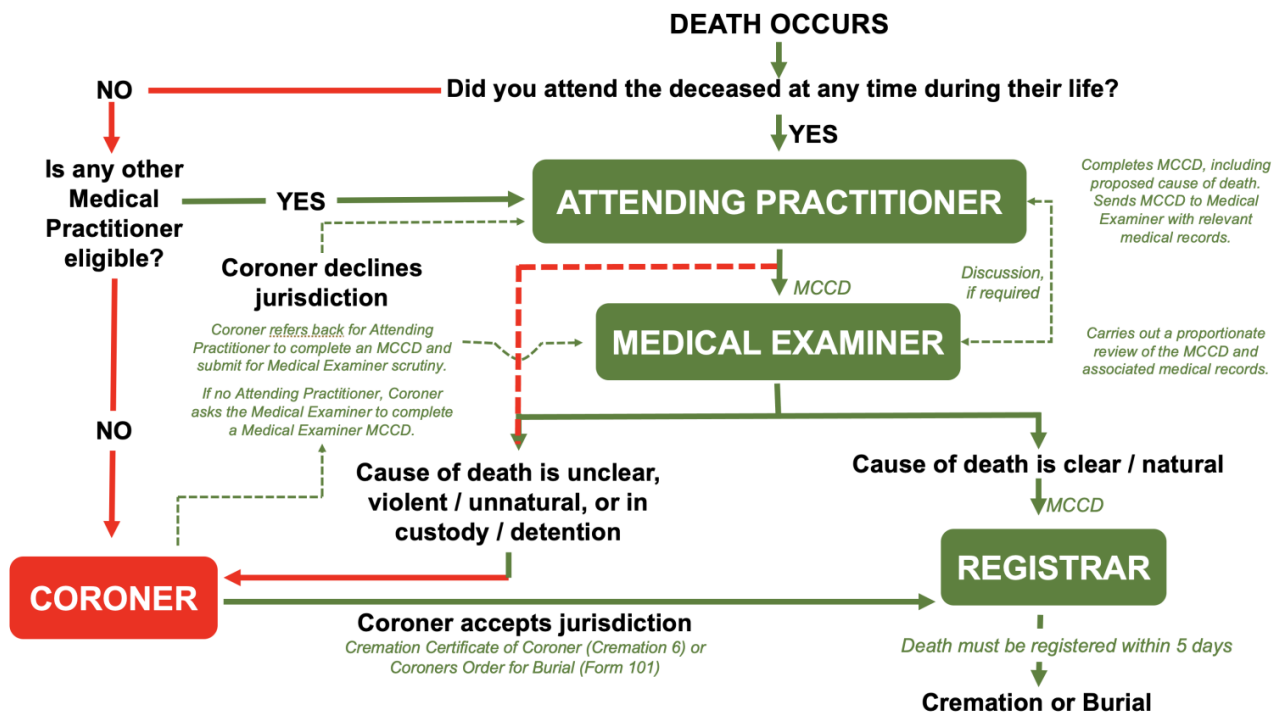
<https://www.england.nhs.uk/publication/national-medical-examiners-guidance-for-england-and-wales/>

<https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance>

17. Policy Review

This policy should be reviewed annually.

18. Appendix 1: Advice for AP on ability to complete MCCD.



Monitoring and Compliance

This section should identify how the Trust plans to monitor compliance with, and the effectiveness of, this policy.

NB-When the document is due to be reviewed and re-published, the owner/s of this document will be required to provide a supporting statement and/or evidence that the key controls within this monitoring tool have been completed.

Section / page no:	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out?	Responsible for carrying out the check:	Results of the check reported to: <i>(Responsible for also ensuring actions are developed to address areas of non-compliance)</i>	Frequency of reporting:
No.	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
P. 5	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy?	Who will receive the monitoring results?	Use terms, such as, '10 times a year' instead of 'monthly'.
1.	Bereavement officers following process.	As per SOPs, training and guidance.	Day 1 – day after patient death.	Bereavement officers. Bereavement lead.	Bereavement office.	Day 1 – day after patient death.

2.	Attending practitioners (doctors) completing the MCCD.	With support and guidance from the ME service. Training. Policy.	As soon as possible, after death.	Attending practitioners (doctors)	Bereavement office. ED ICCU	As soon as possible, after death.
3.	Medical examiners process.	Reviewing the patients file and discussing the case with the AP. Supporting the process, MEO, BO and AP's. SOPS Policy. National guidance. Legal guidance.	As soon as possible, after death	Medical examiners.	Bereavement office.	As soon as possible, after death
4.	Medical examiner officer phone call to NOK.	To inform them of the COD, explain this and answer any questions. Discuss registration process,	As soon as possible, after death	Medical examiner officer- overseen by ME's.	ME office.	As soon as possible, after death

		Discuss any feedback, concerns, complaints and signposting to relevant services. Completion of the bereavement application ME process form. Supported by ME if required.				
5.	Medical examiner to agree process is complete and accurate. Countersignature of MCCD provided by ME.	To agree to the COD and process being completed.	As soon as possible, after death	Medical examiners.	ME office.	As soon as possible, after death.
6.	Bereavement office process to send MCCD to registry office and input data into spreadsheets and bereavement application.	To scan and email the MCCD to the registry office	As soon as possible, after death	Bereavement officers.	Bereavement office.	As soon as possible, after death.
7.	Lead of the service to review and audit datix data annually.	Audit of datix data for escalation SOP.	Annually	Bereavement lead.		Annually

Consultation

Contribution List

This key document has been circulated to the following individuals for consultation:

Name	Designation
Steve Graystone	Lead Medical examiner.
Paul Freeth	Patient Safety Learning and Improvement lead.
Kira Beasley	Head of CMO services.

This key document has been circulated to the chair(s) of the following committees / groups for comments:

ISAG- improving safety action group- 6/10/2026

Approval Process

Approved at ISAG by Hayley Flavell, Dr Jules Walton and patient safety lead, Karen Apps.

Supporting Document 1 – Equality Impact Assessment Form

Equality and Health Inequalities Impact Assessment (EHIA) Tool

Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact Assessment (HEIA) Form

Please read HEIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust	
Other (please state)			

Name of Lead for Activity	Laura Knowles
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Details of individuals completing this assessment	Name	Job title	e-mail contact
	Laura Knowles	Bereavement lead nurse/ Lead MEO	Laura.knowles5@nhs.net
Date assessment completed	14/10/2026		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: Completing an MCCD policy.		
What is the aim, purpose and/or intended outcomes of this Activity?	Prompt and accurate completion of an MCCD is essential because it serves a number of functions. It enables the death to be registered, providing a permanent legal record of the fact of death and the medical cause of death. It allows the deceased person's representative to take steps to arrange disposal of the body and to begin the process of settling the deceased person's estate. By law, deaths must be registered within 5 days of receipt of the MCCD by the registrar unless there is to be a coroner's investigation. This document is to support the process above.		
Who will be affected by the development & implementation of this activity?	☐ Service User ☐ Patient ☐ Carers ☐ Visitors	☒ Staff ☐ Communities ☐ Other _____	
Is this:	☒ Review of an existing activity		

	☐ New activity ☐ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.)	Datix reports of incidents linked to this subject. Increased due to complaints about delays in process and an increased use of the bereavement escalation SOP, which incorporates coroner referrals for CN1B request, where no Trust doctor has been able to complete the MCCD.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Engaged with CMO team, medical examining team and patient safety.
Summary of relevant findings	Recommended policy from the above discussions and datix findings to guide staff with process.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale.** Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			No negative connotations for any equality group as all deceased patients should be treated in the same manner.
Disability	X			
Gender Reassignment	X			
Marriage & Civil Partnerships	X			
Pregnancy & Maternity	X			
Race including Traveling Communities	X			
Religion & Belief	X			

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex	X			
Sexual Orientation	X			
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	X			
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	NONE IDENTIFIED			
How will you monitor these actions?	N/A			
When will you review this HEIA? (e.g in a service redesign, this HEIA should be revisited regularly throughout the design & implementation)	N/A			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing HEIA	L. H Knowles
Date signed	29/04/2026
Comments:	
Signature of person the Leader Person for this activity	L.H Knowles
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	NO
2.	Does the implementation of this document require additional revenue	NO
3.	Does the implementation of this document require additional manpower	NO
4.	Does the implementation of this document release any manpower costs through a change in practice	NO
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	NO
Other comments:		
[Insert comments here]		