FSRH The Faculty of Sexual & Reproductive Healthcare

Key Principles for Intimate Clinical Assessments Undertaken Remotely in response to COVID-19

Version 1 – July 2020

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK professional membership organisation working in the field of sexual and reproductive health (SRH). We support healthcare professionals to deliver high quality healthcare including access to contraception. We provide our 15,000 doctor and nurse members with NICE-accredited evidence-based clinical guidance, including the UKMEC, the gold standard in safe contraceptive prescription, as well as clinical and service standards.

The FSRH provides a range of qualifications and training courses in SRH, and we oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme to train consultant leaders in this field. We deliver SRH focused conferences and events, provide members with clinical advice and publish *BMJ Sexual & Reproductive Health* – a leading international journal. As a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK, we work in close partnership with the College but are independently governed.

The FSRH provides an important voice for UK SRH professionals. We believe it is a human right for women and men to have access to the full range of contraceptive methods and SRH services throughout their lives. To help to achieve this we also work to influence policy and public opinion working with national and local governments, politicians, commissioners, policy makers, the media and patient groups. Our goal is to promote and maintain high standards of professional practice in SRH to realise our vision of holistic SRH care for all.

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of the Royal College of Obstetricians and Gynaecologists

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Dr Emma Pearce

Dr Catherine Bateman

Dr Clare Searle

Dr Anagha (Sandhya) Nadgir

Dr Minal Bakhai (GP Representative)

Dr Madeleine Crow (Trainee member)

Dr Tony Feltbower (Revalidation Representative)

Dr Eric Chen (CEU Representative)

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Part 1 – Context

This guidance is aimed at clinicians who are consulting remotely with patients through a digital channel (e.g. online, email, text, video-link) across healthcare settings in England. We expect the key principles in this document to be generalisable across the UK.

The COVID-19 pandemic has accelerated the adoption and utilisation of online and video consultations as part of core clinical practice. This guide focuses on how to safely manage the receipt, storage and use of intimate images taken by patients for clinical purposes.

The receipt and use of intimate images of adults and children must be guided by the principle of the interests of the patient. The approach to video consulting, image sharing, and storage should be the same as it would be for face to face interactions.

The principles described in this guidance aim to support patients to access care in a way that meets their needs and to support clinicians to provide care in a way that is in the best interests of their patients, whilst protecting both from the risks associated with remote intimate assessments.

This document does not cover peer review or teaching[1]. It does not include patient or carer facing guidance[1]. It does not provide guidance for staff working within the care sector.

Definition of an intimate image[1]

Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and the perianal area, but could also include any examination the patient perceives as intimate. Be aware of cultural and religious differences in perception.

For the purpose of this guidance an image includes but is not limited to photographs, live-stream video, video recordings and screenshots.

[1] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones

Part 2 – Key Principles

1 Protect patients

Patient information and safeguarding

Provide information to patients that is clear, easy to read and accessible[2]. Make the information available where patients are most likely to see it (e.g. organisation website, within the online/video product, a link within a SMS or an online message to the patient where it has been determined that an intimate examination might be necessary) to inform them about their choices. It should be made clear to the patient how important it is to read the information and discuss any questions or concerns with the clinician prior to sending an image. It is important to ensure there are routes to support non-digital users and that patients are aware of these. This information should cover:

- that the patient should not send an intimate image without prior communication with the clinician
- what is going to happen to the image(s) once received and the options available to the patient. An image should only be stored if this is what you would do in a face to face consultation
- guidance on a code of conduct
- advice on proportionate image sharing and the safe transfer of images (and any limitations of the IT system they are using[3])
- guidance for parents sending photos of their child
- information on patients' rights in how their personal data is processed under the General Data Protection Regulation (GDPR) and the Data Protection Act (2018) as detailed in your organisation's privacy policy. Ensure that your privacy notice refers to the relevant legal grounds for processing of their personal data, is clear, open and honest with people about how and why their personal data will be used and reflects the use of online and video consultations. The information must be easily accessible and easy to understand.

Review and update your data protection impact assessment (DPIA), your clinical safety risk standard (DCB0160), chaperone and safeguarding policies to include remote consultations.

- Ensure the roles and responsibilities for clinicians and staff who have access to patients' intimate images are clear
- Ensure the operational pathway for clinicians and staff handling patients' intimate

[2] The Royal College of General Practitioners (RCGP) and the Royal College of Paediatrics and Child Health (RCPCH) will be leading the development of separate guidance for patients, parents and carers in due course.
[3] Inform patients that transmission by email of any image would not be secure unless encrypted from end-to-end, even if they send it to an official nhs.net email address.

images is clearly defined

- Where a commissioner has procured an online/video product on your behalf, they will support you with clinical risk safety assessment (DCB0160)

Remain professionally curious and vigilant

- Consider safeguarding issues and whether you can explore these fully via a remote consultation. If you have safeguarding concerns at any stage, you should convert a remote consultation to a face-to-face assessment, unless there are compelling reasons why that cannot happen, and follow existing child and adult protection referral pathways
- Clinicians should remain alert to who has taken the image, particularly if the patient is under 18 years old or is a vulnerable person
- Consider the knowledge you have about the individual, and any risks you think may exist between family members/carers and within the care environment

2 Necessity

Carefully consider whether a remote intimate assessment is clinically necessary to provide care or reach a diagnosis in circumstances where it is not reasonable or appropriate to examine the patient in person, taking into account patient choice.

You must be satisfied that the image or remote examination is necessary and justified, will be of benefit to the patient and is in their best interests. Use your clinical judgement and assess patients on a case by case basis.

Given the complexities of implementation at a local level these principles should be localised within each healthcare organisation and for each speciality.

Consider:

- how your actions will change your clinical management
- whether the patient feels comfortable with a remote intimate assessment (including concerns about security or privacy) or whether they would prefer a face-to-face examination
- the limitations of a remote assessment, whether it is likely to provide sufficient information to make the clinical judgement in question or whether you will need to undertake a more extensive assessment of the patient
- the most appropriate remote modality for assessment, for example, a photograph will often provide better resolution than a video consultation
- a risk-benefit evaluation of being able to receive and handle photographs securely versus using a video link; the potential psychological stress and anxiety for patients associated with storing an intimate image in their clinical record versus whether not storing a particular image may make it retrospectively more difficult to understand the advice you gave and the treatment recommended

- the risk of coercion and safeguarding risk in young people and vulnerable people. Be alert to the patient's psychosocial context
- the trade-off for a patient between attending in person and staying at home, where the advantages of remote consulting may outweigh limitations for some patients during the COVID-19 pandemic
- for sexual health conditions, a remote intimate assessment with a young person under 16 or a vulnerable person should only be undertaken in exceptional circumstances, if this is via a video consultation this should be with an appropriately trained chaperone present

3 Informed consent

In the circumstances described within this guidance, health and care staff will rely upon public task/official authority (Article 6 1 e of GDPR) and/or provision of care and treatment to an individual (Article 9 2 h of GDPR) as the primary basis for using and accessing confidential patient information. Consent, as described below, should not be confused with an individual right in Data Protection law (clinicians are not expected to be relying on consent for the processing of the images which constitute special category data for GDPR purposes. Alternative grounds for processing under GDPR, such as processing being necessary for medical diagnosis, are available).

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) advise that informed consent to receive and store the patient's image is necessary, irrespective of whether it is your idea or the patient's.[4]

The decision to store an intimate image in the patient's clinical record must be justifiable and transparent, and you should only store the image if this is what you would do in a face to face consultation. The remote consultation should be recorded in the same way as you would record a face to face examination by describing the findings in the notes and explaining the advice given. There must be clear justification for the need to store an intimate image in the clinical record. If the patient does not agree to retention of the image this should not automatically preclude the patient from being able to continue with a remote assessment where this is appropriate (without their image being retained). Alternative options for examination, such as a face to face examination, should also be offered to the patient.

The process of obtaining and documenting consent should include explaining:

- why an image will help in providing clinical care
- the different options for assessment available to a patient and the associated limitations and risks, including the option to have a face to face examination
- who will see the image e.g. other healthcare professionals involved in the patient's direct care (this may include administrative staff triaging the online consultation, explaining they are bound by the same duty of confidentiality as clinicians)
- how it will be used (i.e. for direct care purposes and that it won't be used for any other

[4] https://www.rcn.org.uk/professional-development/publications/rcn-remote-consultations-guidance-under-covid-19-restrictions-pub-009256

purpose without the patient's express permission)

- whether the image will be stored and why, if stored how and where it will be stored and how long it will be stored for[5]
- be clear they should not share an intimate image if they do not feel comfortable or feel under pressure and provide information on alternative options for examination. It is important the patient understands refusal to share an image does not prevent them from accessing care and treatment or result in them receiving an inferior standard of care
- detail in your fair processing notice how storage and deletion of an image is managed by the IT system(s) you use, commissioners should support you with this.
    - where an image has been saved in the clinical record system and a decision is made to 'delete' it following review, the image will not be visible to those viewing the patient's clinical record but may be kept by the clinical IT system for audit trail purposes with restricted access. To permanently delete the image, the practitioner needs to mark the section of the record for permanent deletion and seek approval from their Caldicott guardian[6]
    - where a decision has been made to discard the image upon receipt and not save it in the clinical record system, the IT system (e.g. online, video or communication system) used to share the image should not continue to retain it. The commissioner should ensure suppliers are instructed on this matter in their contract.[7]

Where an intimate image has been sent to a clinician without prior discussion, the clinician must go back to the patient or someone with the legal authority to act on the patient's behalf for healthcare decisions to confirm the patient's capacity to give consent and confirm the patient's consent. If the patient does not have the relevant capacity, strongly consider if there are wider safeguarding concerns.

Use your professional judgement on how you provide patients with the above information in a way that they can understand, so they can make an informed decision about whether or not to go ahead. Consent does not need to be written.

Check whether patients have understood the information they have been given, and whether or not they would like more information before making a decision. For true consent to be given, patients must feel comfortable to decline consent and find it easy to do so.

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[5] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016

[6] The Caldicott Guardian is a senior person tasked to ensure that the personal information about those who use an organisation's services is used legally, ethically and appropriately, and that confidentiality is maintained. The Caldicott Guardian should apply the seven principles when approving the deletion of an image from the clinical records. The Caldicott Guardian could be someone internal to your organisation or someone appointed externally.

[7] If a commissioner or organisation is using a system that sits on the Digital Care Services (GP IT Futures) or Dynamic Purchasing System for Online Consultation frameworks, these suppliers will be instructed nationally. For further clarification contact NHS Digital.

Children

The approach to video consulting and image sharing should be the same as it would be for face to face interactions, assessing the ability to make the decision using the principles of Gillick Competence.

Where a young person under 16 years old has requested care by sending an online request or using a video consultation, clinicians should determine whether the patient is capable of giving informed consent to medical treatment without the knowledge or permission of their parents and whether this is in their best interests. Follow the principles set out by the GMC when assessing a young person's competence to consent and for shared decision making.

Encourage young people to involve their parents (or legal guardian) in decision making and where possible obtain consent from both the child and person with parental responsibility.

Where a child lacks competence to make a decision about a remote assessment, you will need the permission of someone with parental responsibility (or delegated parental responsibility) unless it is not in the child's best interest, in short, you should apply the same principles used in face-to-face practice.

Where children lack the competence to consent to sharing an intimate image or to examination, still consider the voice of the child. They should have as much involvement and say in their care as possible. Where the image is being shared by a parent, advise parents wherever possible to talk directly to their child and explain why the image is required and ask if it is acceptable first. As a general rule, the child's expressed wishes should be respected. If a child is the subject of a video consultation make sure you speak to them and that you do not just talk to the adult(s). If you judge that the child does not want to proceed then you must consider alternative options. Consider very carefully whether it is necessary to overrule the child's wishes, this should only be done in exceptional circumstances taking into account the child's developmental level and the type of image.

People aged 16 and over

The principles of the Mental Capacity Act 2005 must be followed. If the patient lacks the relevant capacity you must be satisfied that the image or examination is in their best interests and have regard to whether the purpose for which it is needed can be achieved in a way that is less restrictive. In most cases the best interest's decision maker will be the person receiving the image or carrying out the examination. In this situation, it is important to remember that there may be someone who has legal authority to act on the patient's behalf in healthcare decisions and if their authority includes the procedures being proposed, their consent should be sought. Again, you should only store the image if this is what you would do in a face to face consultation and this must be justified and transparent and comply with your organisation's policy for managing patient data (which should be in accordance with the Data Protection Act 2018 and GDPR).

If the patient (adult or child) is the subject of a video consultation, you should have an appropriately trained chaperone for any situation where you would do so in a face to face consultation, with extra consideration given if the patient is a vulnerable person or where a decision to proceed with an examination is made in the patient's best interests.

Family carers and care service staff

It is important to consider the appropriateness of asking for an image where this may involve physical touching of an intimate area by a care worker(s) or carer and have regard to whether the purpose for which it is needed can be achieved in a way that is less restrictive.

There is currently no national guidance or training to support care home and domiciliary care staff in taking and sending intimate images safely and securely on behalf of the patient. Until guidance and policy has been agreed with your local social care partners you should not make request of carer workers to undertake this function. It is important care workers do not feel uncomfortable or under pressure to undertake this function, that they are aware of alternative options for examination of the patient and that they understand it will not result in the patient receiving an inferior standard of care.[8]

Where there are clear local agreements and policies between social care and health, and an agreement has been made for a member of staff within a care home or domiciliary care service to be able to take an intimate image, practitioners should consider:

- whether there are exceptional reasons why a face to face visit cannot happen or why a remote examination is of benefit to the patient
- the knowledge they have about the individual and the provider
- any risks they think may exist to people receiving a service
- the trauma that may be caused by the taking of an intimate image by another person as well as a history of previous trauma
- the access to secure IT systems/devices and protocols for taking and safely transferring images available to care workers. A personal device must not be used
- the availability of suitably trained chaperones and care workers to undertake this function, and that have responsibility to ensure images are correctly handled and communicated
- whether appropriate insurance is in place by the care provider
- the differences in support available depending on the type of care environment e.g. nursing home versus residential care home

Practitioners should also bear in mind their safeguarding duty.

If the patient needs a family carer to take the image, for example because they require physical assistance, follow the principles for informed consent outlined above and confirm the patient's consent for their carer to take the image. Use your professional judgement about whether the carer is competent and comfortable to undertake this function, the impact on the patient's dignity and whether this places an unreasonable burden on the carer.

[8] The Department of Health and Social Care are looking into equivalent care sector guidance on image sharing

4 Confirm the patient's identity

As far as is reasonably possible and act in good faith.

5 Processing and storing intimate images

The approach to storing images should be the same as it would be for face to face interactions.

Comply with your organisational policy for managing patient data (which should be in accordance with the Data Protection Act 2018 and GDPR).[9]

Use products and systems to receive, store and send images that have been assured and meet NHS safety, security and information governance standards.

It is permissible for clinicians to transfer or access intimate images securely when it is in the patient's best interests to seek another, often more experienced, clinical opinion.

- Where possible the patient's identity should be anonymised and the patient should be asked for consent to a second opinion being sought.
- Ensure transfer or access is safely undertaken in accordance with secure IT systems and local organisational policy.
- Clinicians should also be expected to confirm with the prospective recipient that they do not object to receiving the images. Any such actions should be carefully documented in the patient's notes.

Still images

Use professional judgement to decide whether the image is necessary to the provision of care of the patient and if so, whether a written description of the image will suffice or whether the image should be stored in the patient's clinical record.

You should only store an image if this is what you would do in a face to face consultation, with extra consideration given to the justification for storing images of a child.

Where images are sent to a secure NHS email account, delete the email and image from the account once uploaded into the patient's health and care record. Ensure the image has been deleted from the device on which it is viewed.

Where known, do not open an intimate image sent to you by email on your mobile phone or personal device (to avoid any risk of the image being stored on your phone and/or elsewhere, such as iCloud).

Ensure that protocols are in place to make sure that images are deleted appropriately. Do not store personal/confidential patient information on a personal device.

In some clinical settings, administrative staff managing workflow are legitimately likely to see incoming images (particularly photographs) attached to an online request from the patient;

[9] Outside primary care please also refer to the joint RCPCH/FFLM guidance which covers procedures relating to all intimate images not just those taken for the purposes of forensic investigation

administrative staff should pass these to the clinician. Ensure roles and responsibilities for safe image handling are clear to all staff. Depending on the clinical setting, where appropriate, organisations should consider role-based access controls.

During COVID-19, the NHS[X] information governance team have released guidance stating you can use your own devices to support video conferencing for consultations and home working where there is no practical alternative. Reasonable steps to ensure that using your own devices are safe include setting a strong password, using secure channels to communicate (e.g. tools/apps that use encryption), not storing personal/confidential patient information on the device, unless absolutely necessary, and that the appropriate security is in place. These steps should be communicated to the patient. Information should be safely transferred to the appropriate health and care record as soon as practical and the original deleted.[10]

Video consultations

Do not record the video or audio of the consultation or take a screenshot unless there is a specific reason to do so, and there is informed consent from the patient or someone with the legal authority to act on the patient's behalf for healthcare decisions.

- Document these discussions and decisions in the patient's clinical record. If recording, confirm when the recording starts and stops.
- Explicitly check with the supplier if the product audio and/or video records and stores the consultation as a default (your commissioner should do this on your behalf) and if so, turn this setting off.

6 Intimate examinations via a video consultation[11]

If you proceed with an examination that the patient is likely to perceive to be intimate via video-link be mindful of the following issues:

- the principles set out in the GMC guidance entitled intimate examinations and chaperones.
- the sensitive nature of the examination and the examination setting (for example, traditionally it is unusual for a clinician to undertake an examination in this way, the patient may want to relocate to another room if there are other family members in the vicinity). It is therefore important to ensure the consent of the patient is tailored to the specific circumstances of the remote examination
- the need for privacy around the practitioner's screen to ensure that no one can view or overhear the call without the consent of the patient (this may require sensitive handling if an interpreter is involved in the call e.g. asking them to switch off their camera or

[10] https://www.nhsx.nhs.uk/covid-19-response/data-and-information-governance/information-governance/covid-19-information-governance-advice-health-and-care-professionals/
[11] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf

leave the room)

- with the consent of the patient (or someone who has the legal authority to act on the patient's behalf for healthcare decisions), or where a decision to proceed with an examination is made in the patient's best interests, you should have an appropriately trained chaperone present for any situation where you would do so in a face to face consultation
- a chaperone could be present with the practitioner (either virtually or in the same room) and could witness the nature and extent of the video examination that was undertaken. The chaperone should be visible to the patient. The chaperone should be appropriately trained (consider whether the chaperone is competent and comfortable with conducting their role in these circumstances and use your professional judgement). Their role, in this context, is to ensure the nature and extent of the assessment are appropriate and to protect the patient and practitioner from any suggestion the examination was inappropriate
- a family member of the patient is not an impartial observer and so would not usually be a suitable chaperone, but you should comply with a reasonable request to have such a person present as well as a chaperone
- if a chaperone is not available (for example because you are remote working) or declined by the patient, use your professional judgement and carefully consider whether a remote examination method should proceed
- if it is not possible to adequately assess a patient's condition in this way clinicians should consider if a face to face consultation to examine the patient is necessary, or signpost to other services where appropriate
- be aware that patients or their relatives may record the video consultation. If you are concerned about how the recording may be used carefully consider whether a remote examination method should proceed

7 Good record keeping

Make clear, contemporaneous and complete written records in the patient's clinical record, as you would in a standard consultation. Follow GMC guidance on good medical record keeping.

- Record who was present for the consultation and/or who has taken the image and their relationship to the patient
- Record information given to the patient, discussions and decisions about capacity, consent and best interest decision making
- Ensure your clinical justification for examination and non-examination is clear
- Thoroughly document your justification for proceeding with an intimate examination remotely and your decision for storing or not storing an image in the patient's clinical record
- Make sure information that may be relevant to keeping a child, young person or

vulnerable adult safe is available to other clinicians providing care to the patient

- Document whether or not a chaperone was offered and either declined or was present at the consultation. If a chaperone was present, you should record their identity, including their designation and the extent of the assessment witnessed, for example 'present for the complete video-linked assessment', and where the chaperone was located both at the patient and clinician end

8 Receiving an intimate image of a child (a person who is under 18)

Criminal acquisition and misuse of such images must be recognised as a risk.

The law considers the following:

- whether the image is 'indecent' and;
- whether there is the defence of a 'legitimate reason' or;
- whether there is a 'lack of awareness' of the nature and content of the image and how this image is handled by the clinician, for example, if a patient sends an unsolicited intimate image

Where an intimate image is taken and shared for clinical purposes with a healthcare professional, provided that informed consent and appropriate clinical judgements have been made and recorded, patients (parents or legal guardians) and clinicians should not be deterred from collecting information that is clinically necessary to provide care or reach a diagnosis.

Where available, clinicians should read information and guidance that has been issued by their professional regulatory or specialty organisation and medical defence organisation (MDO).

Part 3 – Guideline Development Group

Professional body/ Organisation	Representative name and job title	Role
NHS England and NHS Improvement	Dr Minal Bakhai, Deputy Director and National Clinical Lead for Digital First Primary Care	Chair and Guideline Lead Author
British Association of Sexual Health and HIV	Dr Olwen Williams, ex-president of BASHH, Consultant in Sexual Health	Task & Finish
British Medical Association	Dr Shaba Nabi, GP committee clinical and prescribing policy group	Task & Finish
Faculty of Forensic and Legal Medicine	Dr Peter Green, Safeguarding Lead Wandsworth CCG, Consultant for Child Safeguarding St George's University Hospital, Chairman National Network of Designated Professionals	Task & Finish
Faculty of Forensic and Legal Medicine	Dr Sheila Paul, Clinical Director Thames Valley Sexual Assault Service and Child Lead.	Task & Finish
General Medical Council	Mary Agnew, Assistant Director, Standards and Ethics, Education and Standards Directorate	Task & Finish
NHS England and NHS Improvement	Kenny Gibson, National Safeguarding Lead	Task & Finish
NHS England and NHS Improvement	Louise Croney, Senior Programme Lead for Digital First Primary Care	Task & Finish
NHS England and NHS Improvement	Fiona Foxton, Project Support Officer, Digital First Primary Care	Task & Finish
NHSX Information Governance	Martin Staples, Data Sharing and Privacy Specialist, IG Policy Team	Task & Finish
NHSX Information Governance	Rukhsana Mian, Senior Data Sharing and Privacy Manager, Information Governance Policy Team	Task & Finish
National Network of Named GPs	Dr Richard Burack, Chair and & Safeguarding Lead	Task & Finish
Royal College of General Practitioners	Dr Marian Davis, Chair of the Adolescent Health Group	Task & Finish
Royal College of General Practitioners	Dr Joy Shacklock, Clinical Champion Good Practice Safeguarding	Task & Finish
Royal College of Paediatrics and Child Health	Dr Alison Steele, Consultant Paediatrician, Officer for Child Protection	Task & Finish
Faculty of Forensic and Legal Medicine	Dr Catherine White, Clinical Director Saint Mary's Sexual Assault Referral Centre	Reviewer
Faculty of Sexual and Reproductive Healthcare	Mike Passfield, Chair of the Clinical Standards Committee	Reviewer
Healthwatch	Urte Macikene, Senior Policy Analyst	Reviewer
Medical Protection Society	Dr Peter Mackenzie, Senior Medico-legal Adviser	Reviewer
Mencap	Sarah Coleman, Health Policy Officer	Reviewer

Mills and Reeve LLP Legal Advisors on behalf of NHS England and Improvement	Claire Williams, Principal Associate	Reviewer
NHS England and NHS Improvement	Brian Mpinyuri, Clinical PMO Lead, Health Improvement Learning Disabilities and Autism	Reviewer
NHS England and NHS Improvement	Dr Adrian Hayter, National Clinical Director for Older People and Integrated Person Centred Care	Reviewer
NHS England and NHS Improvement	Dr Michelle McLoughlin, National Speciality Advisor Children and Young People	Reviewer
National Police Chief's Council for child abuse and vulnerability	Gareth Edwards on behalf of the Chief Constable of Norfolk and the National Police Chief's Council lead for child abuse and vulnerability	Reviewer
North East London	Dr Helen Jones, Safeguarding Lead Tower Hamlets, CYP	Reviewer
North East London	Dr Sabeena Pheerunggee, Safeguarding Lead	Reviewer
North East London	Dr Roberto Tamsanguan, Clinical Lead WEL CCG	Reviewer
Royal College of General Practitioners	Dr Jonathan Leach, Joint Honorary Secretary, Medical Director for Armed Forces and Veterans Health	Reviewer
Royal College of Nursing	Fiona Smith, Children's Safeguarding Lead	Reviewer
Royal College of Obstetrics & Gynaecology	Dr Edward Prosser-Snelling, Consultant Obstetrician & Gynaecologist	Reviewer
Royal College of Physicians	Care Quality Improvement Department, Young Adults and Adolescents Steering Group, Joint Collegiate Council for Oncology, Joint Specialty Committee for Genitourinary Medicine	Reviewer
Vulnerable Adolescent and Youth Service	Spotlight, Tower Hamlets	Reviewer
Information Commissioner's Office		Advisory
Department of Health and Social Care		Advisory
Crown Prosecution Service		Shared

This guidance is correct at the time of publishing.

Next review date: July 2021