POLICY ON INTERCOSTAL (CHEST) DRAINS
**Policy Title:** INTERCOSTAL (CHEST) DRAINS POLICY

**Executive Summary:** This policy governs the insertion of intercostals chest drains in adults.

**Supersedes:** Version 03

**Description of Amendment(s):** Two yearly review, minor text changes, updated guideline reference

**This policy will impact on:**
Medical and Surgical Business Unit

**Financial Implications:**
None

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<tr>
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**APPROVAL RECORD**

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INTERCOSTAL (CHEST) DRAINS POLICY

1.0 POLICY STATEMENT

1.1 This policy and the associated guidelines (Appendix 1) are aimed at the insertion and management of chest drains in the adult patient in a hospital environment. The scope of this guidance does not cover any other pleural procedures.

2.0 BACKGROUND

2.1 In current practice, intercostal (chest) drains are used in many different hospital settings and the British Thoracic Society Guidelines for the insertion of a chest drain state that doctors in most specialties need to be capable of their safe insertion. Incorrect placement of a chest drain can lead to significant morbidity and even mortality.

2.2 In May 2008 the National Patient Safety Agency (NPSA) alerted the NHS to the risks associated with inserting chest drains, commonly used on patients with chest trauma, collapsed lungs, or after surgery, to remove air and fluids.

2.3 The NPSA warned NHS organisations that the drainage tubes should only be inserted by trained staff with relevant competencies and adequate supervision. Due to the risk of damaging internal organs through poor positioning, the NPSA strongly supports the use of ultrasound when positioning a drain.

2.4 The guidance follows reports of 12 deaths and 15 incidents of serious harm following the medical procedure over three years from January 2005 to March 2008, with several other less severe cases likely to have gone unreported.

2.5 The British Thoracic Society Pleural Disease guideline was published in 2010 and emphasizes the importance of using pleural ultrasound before insertion of a chest drain for drainage of a pleural effusion.

2.6 The need for a Trust policy was therefore identified.

3.0 INTRODUCTION

3.1 A chest drain is a tube inserted through the chest wall between the ribs and into the pleural cavity to allow drainage of air (pneumothorax), blood (haemothorax), fluid (pleural effusion) or pus (empyema) out of the chest.

3.2 In each and every patient it is essential to determine the purpose of the drain.

3.3 The effective drainage of air, blood or fluid from the pleural space requires an adequately positioned drain and an airtight, one-way drainage system to maintain subatmospheric intrapleural pressure. This allows drainage of the pleural contents and re-expansion of the lung. In the case of a pneumothorax or haemothorax this helps restore haemodynamic and respiratory stability by optimising ventilation/perfusion and minimizing mediastinal shift.

4.0 INSERTION OF A CHEST DRAIN

4.1 All personnel involved in the insertion of chest drains must be adequately trained and supervised and their competency recorded on the Trust database managed by the lead for chest drains. It has been shown that physicians trained in the method can safely perform the procedure with 3% early complications and 8% late. With adequate training the risk of complications can be significantly reduced.
4.2 Insertion of a chest drain in a non-emergency situation will be a consultant led decision. It is their responsibility to make sure the doctor carrying out the procedures is adequately trained.

4.3 Insertion of a chest drain for a pleural effusion (blood, pus or fluid) has to be performed under pleural ultrasound guidance.

4.4 During normal working hours, the Respiratory team will be contacted (via referral or bleep) to provide ultrasound support. Out of hours support will be provided by Radiology.

4.5 A trained nurse or a second doctor should be present to assist in the procedure.

4.6 Insertion of a chest drain in an emergency situation will be the responsibility of the most senior, experienced available member of staff. Emergency insertions in trauma situations should follow ATLS (Advanced Trauma and Life Support) guidelines.

4.7 The Trust guidelines to support the safe insertion of chest drains are attached. All professionals involved in the procedure should be familiar with these guidelines.

5.0 TRAINING

5.1 Before insertion of a chest drain, all operators should have been adequately trained. In all other circumstances, insertion should be supervised by an appropriate trainer.

5.2 Documentation of level of competency in relation to chest drain insertion should be included in all trainees' training portfolios. A database of individual competencies in the procedure is kept by the chest drain lead and regularly updated. It is the trainee’s responsibility to contact the chest drain lead and inform him/her of their competency level.

5.3 A training programme including sessions in the clinical skills laboratory has been set up by the chest drain lead.

5.4 Individual clinical departments should specify what level of seniority is expected to insert chest drains and this should be specified in departmental induction programmes. It is the clinical specialty's responsibility to assess and evidence staff competence, with the support of the chest drain lead.

5.5 All staff involved in the insertion and management of chest drains should access this training with formal assessment of competence.

5.6 It is the responsibility of each clinical specialty to ensure any patient with a chest drain should be cared for by staff adequately trained in the management of chest drains.

6.0 ORGANISATIONAL RESPONSIBILITIES

6.1 Chief Executive
Has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated to an appropriate colleague.

6.2 Medical Director
The Medical Director is responsible for ratification and approval of the policy.

6.3 Lead Consultant Respiratory Physician
The lead for chest drains within the Trust lies with an identified consultant respiratory physician (Dr Sriram Iyer) who will be supported by individuals within the Surgery BU and A/E.

6.4 All Staff involved in the insertion and management of chest drains
It is the responsibility of each member of staff involved in the insertion and management of chest drains:

- to comply with the standards set out in this policy and the trust chest drains guidelines
- to work within their own competence
- to report all chest drain issues (including near miss events) using the Trust’s Incident Reporting procedures

These issues should be brought to the attention of the Clinical Director and Associate Director. They should then discussed at relevant Safety Quality and Standards/Clinical Governance Groups for each Business Unit and any identified actions resulting from incidents implemented. It is the responsibility of each member of staff and individual clinical departments to ensure they adhere to the training and audit requirements set out in this guidance.

7.0 **AUDIT**

7.1 Individual Business Units are required to carry out regular yearly audit to monitor compliance with this guidance.

8.0 **REVIEW**

This policy will be reviewed on a three yearly basis by the Medical Director

9.0 **APPENDICIES**

9.1 **Appendix 1: Associated Guidelines**

9.2 **Appendix 2: References**

9.3 **Appendix 3: Impact Assessment**

The purpose of an Equality Impact Assessment (EIA) is to improve the work of the Trust, by promoting equality and ensuring that policies and functions do not discriminate either directly or indirectly against staff and service users.

East Cheshire NHS Trust recognises its responsibility to ensure that no-one is discriminated against, disadvantaged or given preference, through membership of any particular group, particularly including people with disabilities, people from different ethnic backgrounds or religions, or on the grounds of their gender, age, or sexual orientation. This policy has undergone an impact assessment to ensure that it does not discriminate on the above groups either directly or indirectly.
Aim/Objectives/Introduction/Responsibilities

Aim
To rationalise the use of chest drains throughout the organisation and standardise the care of the adult patient with a chest drain.

Objectives
1. To identify the need for a chest drain and select the appropriate drain and drainage system
2. To identify the safe insertion and subsequent removal of a chest drain
3. To ensure appropriate standardised documentation is used across the Trust
4. To identify appropriate training for all personnel involved in the insertion/management of chest drains

Introduction
The British Thoracic Society Guidelines for the insertion of a chest drain state that in current practice chest drains are used in many different hospital settings and doctors in most specialties need to be capable of their safe insertion. Incorrect placement of a chest drain can lead to significant morbidity and even mortality (Griffiths 2005).

Following several adverse incidents related to the insertion and management of chest drains, the need for Trust guidance was identified. These guidelines are aimed at the insertion and management of chest drains in the adult patient in a hospital environment. The scope of this guidance does not cover any other pleural procedures.

A chest drain is a tube inserted through the chest wall between the ribs and into the pleural cavity to allow drainage of air (pneumothorax), blood (haemothorax), fluid (pleural effusion) or pus (empyema) out of the chest. In any one patient it is essential to understand what the drain is trying to achieve. The effective drainage of air, blood or fluid from the pleural space requires an adequately positioned drain and an airtight, one-way drainage system to maintain subatmospheric intrapleural pressure. This allows drainage of the pleural contents and re-expansion of the lung. In the case of a pneumothorax or haemothorax this helps restore haemodynamic and respiratory stability by optimising ventilation/perfusion and minimizing mediastinal shift.
Appendix 1: Associated Guidelines

1. Responsibilities

The lead for Chest Drains within the Trust lies with an identified Respiratory Consultant (Dr Sriram Iyer) who should be supported by links with surgery and Trauma areas.

It is the responsibility of each member of staff involved in the insertion and management of chest drains:
- to comply with the standards set out in this guidance
- to work within their own competence
- to report all chest drain issues (including near miss events) using the Trust’s Incident Reporting procedures

These issues should be discussed at relevant directorate Clinical Governance Groups and any identified actions resulting from incidents implemented. It is the responsibility of each member of staff and individual clinical departments to ensure they adhere to the training and audit requirements set out in Section 3 of this guidance.

2. Indications for Use

Identification of the indication for a drain may be made by a combination of context (pathology, mechanism of injury), clinical examination and radiological imaging with more recently the use of bed side ultrasound examination. The use of ultrasound-guided insertion is associated with lower complication rates and is particularly useful for effusions and empyema as the diaphragm can be localized and the presence of loculations and pleural thickening defined. Following full clinical assessment, if there is any doubt, further imaging should be arranged.

Pneumothorax
- not all pneumothoraces require insertion of a chest drain. Primary spontaneous pneumothorax (in those under the age of 50 and without underlying lung disease) is usually initially treated by simple aspiration. Patients with underlying lung disease and traumatic pneumothoraces usually require chest drainage. The differential diagnosis between a pneumothorax and bullous disease requires careful radiological assessment
- persistent or recurrent pneumothorax after simple aspiration
- tension pneumothorax should always be treated with a chest drain after initial relief with a small bore cannula or needle
- in any ventilated patient with a pneumothorax as the positive airway pressure will force air into the pleural cavity and quickly produce a tension pneumothorax
- large secondary spontaneous pneumothorax in patients over 50 years of age
- iatrogenic eg. following insertion of a central venous catheter. Not all will require drainage.

Pleural fluid
- malignant pleural effusion
- simple pleural effusions in ventilated patients
- empyema and complicated parapneumonic pleural effusion

Traumatic
- pneumothorax or haemopneumothorax
Appendix 1: Associated Guidelines

Peri-operative
- e.g. thoracotomy, oesophageal surgery, cardiothoracic surgery

The urgency of insertion will depend on the indication and degree of physiological derangement that is being caused by the substance to be drained.

Ultrasound guidance is strongly advised when inserting a drain for fluid. The use of ultrasound guidance is particularly useful for empyema and effusions as the diaphragm can be localised and the presence of loculations and pleural thickening defined.

3. Insertion of a chest drain

All personnel involved in the insertion of chest drains should be adequately trained and supervised and their competency recorded on the Trust database held by the Respiratory Consultant. It has been shown that physicians trained in the method can safely perform the procedure with 3% early complications and 8% late (Collop, 1997). With adequate training the risk of complications can be significantly reduced.

Because of the risks of inserting chest drains, the clinician should question:
- Do I need to do this?
- Does it need to be done as an emergency - can it wait?
- Have I had enough training to feel confident to do this? Are senior staff to hand?
- Am I familiar with this equipment?
- Is ultrasound available, with trained staff, to position it safely?

Insertion of a chest drain in a non-emergency situation will be a Consultant led decision. It is the Consultant’s responsibility to identify adequately trained doctors to perform the procedure.

A trained nurse should be present to assist in the procedure.

Insertion of a chest drain in an emergency situation will be the responsibility of the most senior, experienced available member of staff. Emergency insertions in trauma situations should follow ATLS (Advanced Trauma and Life Support) guidelines.

4. Pre–drainage risk assessment

- Risk of haemorrhage: where possible, any coagulopathy or platelet defect should be corrected prior to chest drain insertion but routine measurement of the platelet count and prothrombin time are only recommended in patients with known risk factors. Non-urgent pleural aspirations and chest drain insertions should be avoided in anticoagulated patients until INR <1.5. Platelet count ideally should be ≥50 x10^9/L.

- The differential diagnosis between a pneumothorax and bullous disease requires careful radiological assessment. Similarly it is important to differentiate between the presence of collapse and a pleural effusion when the chest radiograph shows a unilateral “whiteout”. Ultrasound guidance is advised if doubt remains or fluid is not aspirated initially.
Appendix 1: Associated Guidelines

• The drainage of a post pneumonectomy space should only be carried out by or after consultation with a cardiothoracic surgeon.

Before insertion of the chest drain

Consent
Written consent should be taken and recorded in keeping with national and Trust guidelines. The General Medical Council (GMC) guidelines for consent state that it is the responsibility of the doctor carrying out a procedure, or an appropriately trained individual with sufficient knowledge of a procedure, to explain its nature and the risks associated with it. A competent individual patient may refuse such treatment. In the case of an emergency, when the patient is unconscious and the treatment is potentially lifesaving, treatment may be carried out but must be explained as soon as the patient is sufficiently recovered to understand. If possible, an information leaflet should be given before the procedure.

The identity of the patient should be checked and the site and insertion of the chest drain confirmed by reviewing the clinical signs and the radiological information.

Pleural ultrasound
The use of pleural ultrasound is strongly recommended prior to insertion of a chest drain for pleural effusion (pus, blood or fluid).

The Respiratory team will provide sonographic support within normal working hours. If drainage of pleural effusion is thought to be necessary out of hours, this will have to be discussed with the on call Radiologist.

Aseptic technique
All drains should be inserted with full aseptic precautions (washed hands, gloves, gown, antiseptic preparation for the insertion site and adequate sterile field) in order to avoid wound site infection or secondary empyema.

Patient position
The patient should be positioned appropriately; this will depend on the reason for insertion and the clinical state of the patient.

The preferred position for drain insertion is on the bed, slightly rotated, with the arm on the side of the lesion behind the patient’s head to expose the axillary area. An alternative is for the patient to sit upright leaning over an adjacent table with a pillow or in the lateral decubitus position.

Insertion should be in the “safe triangle” illustrated here. This is the triangle bordered by the anterior border of the latissimus dorsi, the lateral border of the pectoralis major muscle, a line superior to the horizontal level of the nipple, and an apex below the axilla.
Appendix 1: Associated Guidelines

In trauma situations emergency drain insertion is more likely to be performed whilst the patient is still in supine as part of the primary trauma survey.

**Pre-Medication**

Chest drain insertion has been reported to be a painful procedure.

Premedication is advised and it could be an intravenous anxiolytic—for example, midazolam 1–5 mg titrated to achieve adequate sedation—given immediately before the procedure, or an oral opioid given 1 hour before (for example 10-20mg of Oramorph depending on size opioid naivety etc.), although neither drug has been shown to be clearly superior.

Both these classes of drugs may cause respiratory depression and patients with underlying lung disease such as COPD should be observed and oxygen saturations monitored as reversal agents—for example, naloxone or flumazenil—are occasionally necessary.

**Confirming site of Drain Insertion**

A chest drain should not be inserted without further image guidance if free air or fluid cannot be aspirated with a needle at the time of anaesthesia.

A chest radiograph must be available at the time of drain insertion except in the case of tension pneumothorax.

**Drain Insertion Site**

The most common position for chest tube insertion is in the mid axillary line, through the “safe triangle” illustrated above. This position minimises risk to underlying structures such as the internal mammary artery and avoids damage to muscle and breast tissue resulting in unsightly scarring. A more posterior position may be chosen if suggested by the presence of a locule. While this is safe, it is not the preferred site as it is more uncomfortable for the patient to lie on after insertion and there is a risk of the drain kinking.

Drain insertion should be preceded by identification of fluid using pleural ultrasound as previously described.

**Drain Size**

Small bore drains are recommended as they are more comfortable than larger bore tubes but there is no evidence that either is therapeutically superior. (10 – 18 French)

Large bore drains are recommended for drainage of empyema and acute haemothorax to monitor further blood loss (20+ French).

Drains ranging from 10 – 24 French may be put in using Seldinger technique however drains larger than this should be inserted using blunt dissection.

**5. Insertion of chest drain**

Seldinger technique should be used routinely except in emergency when fast insertion is required i.e. tension pneumothorax and for large bore chest drains (>24 French).

Aseptic technique should always be employed.
Appendix 1: Associated Guidelines

Appropriate equipment for the complete insertion of the chest drain should be available before commencing the procedure.

SELDINGER TECHNIQUE

- This is a sterile procedure therefore appropriate measures should be taken to ensure aseptic technique with full sterile field i.e. surgical gown, iodine to clean skin and surgical drapes to create a sterile field.
- Infiltrate skin with 10ml syringe of 1-2% lignocaine making sure to anaesthetise the pleura and withdrawing as progressing, also making sure to go above the lower rib.
- Allow time for local anaesthetic to take effect, make small (0.5cm) incision with provided scalpel, then take large needle from kit and advance through intercostal space stopping when either fluid or air is withdrawn into 10 ml syringe.
- Remove syringe and take guide wire from kit, using red plastic tip thread wire along needle to pleural cavity – no force should be required. If resistance is met seek advice. Guide wire should be inserted ~ 10-20 cm.
- Holding guide wire tip in left hand at all times and being careful to avoid advancing wire into chest remove needle over wire. Do not bend the guide wire.
- Advance all three plastic dilators one by one over wire (smallest first) again being careful not to push guide wire further into pleural cavity – this will require a significant amount of force especially for large dilators. Dilators should only be inserted as far the pleural cavity i.e. through the subcutaneous tissues and pleura only.
- Advance intercostal drain over guide wire and into pleural space. This should be roughly 10cm however for large subjects this can be increased. No force should be required at this stage.
- Connect drain to under water drainage system and place Micropore or other form of tape around site where drain meets under water system to prevent this coming apart.
- Stitch drain to skin tightly not using purse string.
- Place dressing over drain site. (Loofah and C view is preferred - if in doubt ask nursing staff)
- Carefully dispose of any sharps.
- Make sure drain is working appropriately – swinging, bubbling or draining fluid and order chest X-ray.

When draining large pleural effusions be careful not to drain fluid too quickly. Draining 1 litre at a time and clamping drains for 20 minutes before further drainage.

Patients with clamped drains should not leave the ward and pneumothoraces should not be clamped, especially if bubbling due to the risk of tension pneumothorax.
Appendix 2: References

REFERENCES

Pleural procedures and thoracic ultrasound: British Thoracic Society pleural disease guideline 2010

Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services. Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Chest drain policy

Details of person responsible for completing the assessment:

- Name: Sriram Iyer
- Position: Consultant Physician
- Team/service: Medicine

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

Chest drain insertion policy

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

The population of Cheshire as at the 2005 mid year figures (Cohesia Report 2008) is 684,400.

Age:
17.8% (30,500) of the population in Cheshire East is over 65 compared with 15.9% nationally. This results in a high "old age" dependency ratio, i.e. low numbers of working-age people supporting a high non-working dependant older population. The percentage of "older" or "frail" old is also considerably higher, with 2.3% (8,200) persons 85 and over compared to 2.1% nationally.

Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% (8,845) and the population aged 85+ by 41.5% (3,403).
This will have an impact on the number of patients being managed by ECT and the complexity of the health and social care issues that the older person is experiencing. In addition the staffing profile of ECT will change to include an increasing number of staff over 65 in the workforce.
Race:
The 2005 mid year estimate (Cohesia Report 2008) show that the majority of the population in Cheshire (94.6%) is White British, with 5.4% non White British. The Cheshire 2007-10 Local Area Agreement identified that minority ethnic communities account for around 3% of the population. Issues for BME communities include lack of knowledge of services, access to services, access to translation/interpretation, cultural differences, family values. Many people from BME communities experience poverty, poor housing and unemployment which make it difficult for them to lead healthier lives. 4180 migrant workers registered in Cheshire in 2006/07 and comparison to the mid-year population estimates for Cheshire in 2005 strongly suggests that Cheshire’s migrant worker population is larger than every individual BME group other than the White-Other White group.

Gypsies and travellers – at the last count (July 2006) the highest number was recorded in the Borough of Congleton (125). 42% of gypsies and travellers report limiting long term illness compared to 18% of the settled population, with an average life expectancy 10-12 years less than settled population. 18% of gypsy and traveller mothers have experienced the death of a child compared to 1% in the settled population.

Disability:
There are over 10 million disabled people in Britain, of whom 5 million are over state pension age. Nearly 1 in 5 people of working age (7 million, or 18.6%) in Great Britain have a disability.

Hearing loss: 1 in 4 has a hearing problem.

Sight problems: There are 2 million people with sight problems in the UK.

Learning disabilities: There is quite a high proportion of people with learning disabilities in the local area due to there being a number of residential homes/institutions in the area.

Problems encountered can be lack of staff awareness, communication issues, information requirements.

Dementia:
Approximately six in 100 people aged over 65 develop dementia and this rises to around 20 in 100 people aged 85 or over. Dementia affects 750,000 people in the UK.

Carers:
Around 6 million people (11 per cent of the population aged 5+) provided unpaid care in the UK in April 2001. While 45% of carers were aged between 45 and 64, a number of the very young and very old also provided care. By 2037, it is anticipated that the number of carers will increase to 9 million.

Gender:
On average in Cheshire, 49% of the population are male and 51% are female.

Transgender: No local data available, national trends show:
1/12,000 males, transgender from male to female
1/33,000 females, transgender from female to male

Specific issues around access to services, specific services for men or women, and ‘single sex’ facilities. In terms of the transgender population, GINES (Gender Identity Research and Education Society) gives an estimate of 600 per 100,000. If these figures were applied to the Cheshire East community based on the 2005 mid year estimates, there may be around 2,100 trans people in the area.

Religion/Belief:
In the Cheshire East area:

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<td>Christian</td>
<td>- 80%</td>
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<tr>
<td>Buddhists</td>
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<tr>
<td>Hindu</td>
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<tr>
<td>Jewish</td>
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The Muslim population has the highest levels of ill health amongst faith groups – this includes higher smoking rates amongst men and higher rates of coronary heart disease and diabetes.

Sexual Orientation
Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population (Dept of Trade and Industry, 2003). 13% of Gay men and 31% Lesbian women are parents (Morgan and Bell, First Out: Report of the findings of Beyond the Barriers national survey of LGB people)

The experience and health needs of gay men and women will differ. However, both groups are likely to experience discrimination, higher levels of mental ill health and barriers to accessing health care

National Health Inequalities data shows that lesbian, gay, bisexual and transgender (LGBT) people are e 2001 census showed:
significantly more likely to smoke, to have higher levels of alcohol use and to have used a range of recreational drugs than heterosexual people. They are also at greater risk of deliberate self-harm. Although most LGBT people do not experience poor mental health, research suggests that some are at higher risk of mental health disorder, suicidal behaviour and substance misuse

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

No

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □ No □×

Explain your response: If the patient's first language was not English, then the Trust interpretation and translation policy would need to be followed to ensure the patient understood what was happening.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes □ No □×

Explain your response: No impacts identified.

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □ No □×

Explain your response: If a patient had sensory loss then appropriate communication formats would need to be used, including BSL sign language interpretation. For patients with learning disabilities, there is a picture communications book in the communications box on the ward. If a patient lacked capacity, then the Mental Capacity Policy would be followed.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently? Yes □ No □×
Explain your response: No impacts identified.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes □ No □×
Explain your response: No impacts identified.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes □ No □×
Explain your response: Staff would discuss with the patient any issues surrounding the composition of any materials or drugs used and check with pharmacy if there is any porcine content if this might conflict with religious beliefs.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes □ No □×
Explain your response: See sections on disability and race.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes □ No □×
Explain your response: No other impacts identified.

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes □ No □×</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:</td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children – adult policy only.</td>
<td></td>
</tr>
</tbody>
</table>

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Not applicable
Review Date: 6.1.2019

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: 

Date: 6.1.2016