Privacy, Dignity and Respect Policy incorporating Same Sex Accommodation Guidance
**Policy Title:** Privacy, Dignity and Respect Policy incorporating Same Sex Accommodation Guidance

**Executive Summary:** The purpose of this policy is to provide staff with guidance regarding aspects of patient care affecting their privacy, dignity and respect.

**Supersedes:** Privacy, Dignity and Respect Policy incorporating Chaperone Same Sex Accommodation Guidance V4 March 2014-17

**Description of Amendment(s):**
- Policy Title: See above
- Effective and review date amended to reflect new version (5)
- Chaperone element of policy withdrawn in view of standalone policy
- Updated with patient ‘hot board’ information
- Amended Appendix C
- Approval record: to include Quality Forum including Patient Experience, Directorate SQS meetings
- Policy amended throughout to reflect removal of chaperone policy due to new safeguarding national guidance

**This policy will impact on:**
All staff within the Trust

**Financial Implications:**
This policy does not have any financial implications

<table>
<thead>
<tr>
<th>Policy Area:</th>
<th>Department of Nursing, Performance and Quality</th>
<th>Document Reference:</th>
<th>ECT002746</th>
</tr>
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<tbody>
<tr>
<td>Version Number:</td>
<td>5</td>
<td>Effective Date:</td>
<td>March 2017</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Director of Nursing, Performance and Quality</td>
<td>Review Date:</td>
<td>March 2020</td>
</tr>
<tr>
<td>Author:</td>
<td>Liz Owen, Emergency Care Matron Jeanette Sarkar HoN</td>
<td>Impact Assessment Date:</td>
<td>March 2017</td>
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**APPROVAL RECORD**

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Consultation:</td>
<td>March 2017</td>
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</tbody>
</table>
| Quality Forum inclusive of patient experience
| Equality Lead |
| March 2017 |
| Approval:          | May 2017   |
| Divisional Directorate SQS Meetings |
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Appendix A

Appendix B

Appendix C
1.0 Policy Statement

East Cheshire NHS Trust’s principle aim is to ensure that the organisational values and behaviours expected from each employee is embedded within the Trust’s culture and everyday practice, placing the patient and family at the forefront of everything we do.

This reflects the principles within the NHS Constitution and Same Sex Accommodation Guidance which denotes the importance of respecting individual human rights and maintaining privacy and dignity at all times. People admitted to East Cheshire NHS Trust will therefore be cared for in an environment that is of the same sex where sleeping and bathroom facilities are not shared between male and female genders unless for clinically justified reasons such as admission to Intensive Care Units as per DoH guidance.

In line with the NHS Operating Framework East Cheshire NHS Trust are also committed to improve patient perception and experience. We aim to deliver quality care within same sex accommodation as per DoH guidance and compliance of standards.

In addition, the Trust’s Quality Strategy refers to the NHS Constitution and aligns to Jane Cummings, Chief Nursing Officer NHS England pledge ‘To develop a Culture of Compassionate Care’, widely known as the 6 C’s that focuses and builds upon the six values and behaviours:

‘We will care with compassion, ensuring we communicate effectively, have the necessary competence to understand your health and social care needs and the courage to speak up for you. We will demonstrate our commitment by working together, combining our knowledge, skills and expertise to maximise opportunities for innovation and excellence.’

East Cheshire NHS Trust is committed and strives to ensure that all patients within our services receive the highest quality of care possible; that they feel safe; are treated by all members of staff equitably; with dignity and respect, acknowledging personal values, preferences, religions and beliefs without prejudice thus making ‘every contact count’.

2.0 Organisational Responsibilities

2.1 The Director of Nursing, Performance and Quality will ensure that the policy is monitored and complied with.

2.2 All managers and heads of departments are responsible for monitoring application of the policy.

2.3 All staff are responsible for adhering to the standards, values and behaviours described within the policy.
### 3.0 Scope of Policy

To inform and guide all staff groups of their individual and collective responsibilities whilst caring for patients in line with the 6 C’s as follows:

- **CARE** is our core business and that of our organisations and the care we deliver helps the individual and person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

- **COMPASSION** is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.

- **COMPETENCE** means all those in caring roles must have the ability to understand an individual’s health and social needs.

- **COMMUNICATION** is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for ‘no decision without me’. Communication is the key to a good workplace with benefits for those in our care and staff alike.

- **COURAGE** enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.

- **COMMITMENT** to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients. We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

### 3.1 Best Practice Standards – ‘Make every contact count’

- Staff will care for patients in a smoke free, clean and welcoming environment that actively promotes and maintains an individual’s right to respect, privacy and dignity.

- Without undue delay, staff will introduce themselves on initial contact with patients, carers, relatives etc, including telephone conversations, by stating their name and role.

- Staff should pay particular attention and be aware of the needs of patients in their care who are either blind or deaf and use all available resources to support them. An explanation of what is going to happen and who is present around the bed area prior to any examination or procedure being undertaken should be established.

- Staff will wear name badges and identification passes at all times.

- Staff will ask each patient how they wish to be addressed, e.g. Mr/Mrs/Ms and NOT lapse into over familiarity, using first names or colloquial titles such as “dear” or “petal” unless this is acceptable to, and agreed by the patient first. This should be displayed.
Visually on each bedside patient ‘hotboard’ that denotes personalised preferences. If the patient is unable to communicate properly ensure consultation takes place with relatives/carers of how to address individuals appropriately.

- Staff will deal with a patient’s request for assistance promptly. Where there is an unavoidable delay, staff must ensure an apology is given.
- Staff will avoid personal conversations with co-workers over a patient to the exclusion of that patient from the conversation.
- Staff will discuss with patients whether they have any objections to healthcare professionals not directly involved in their care being present at ward rounds or examinations e.g. medical student, volunteer etc. is discussed prior to these events occurring, to provide an opportunity for the patient to decline.
- Staff must be aware of how body language may be interpreted by a patient or carer, as this may lead to a patient or carer feeling that an interaction was impersonal and/or intimidating.
- Staff must have an understanding about the religious and cultural background of a patient so as not to lead to any confusion, misinterpretation or misunderstanding about the care being given. It is important that staff remain sensitive to these issues and diligent to ensure that each patient does not perceive they have had their religious or cultural beliefs discarded or potentially perceive they are a victim of abuse. For example a Jehovah Witness may decline a blood transfusion as they believe that the bible prohibits ingesting blood and the associated primary components of whole blood such as red cells, white cells, plasma and platelets even in an emergency situation. Other fractions such as albumin would need to be considered but would be a matter of personal choice.
- Staff will ensure facilities are available to translate/interpret for patients who may have hearing difficulties or English is not their first language.
- Each patient should expect their diagnosis, care and treatment to be explained to them in a manner that they are able to understand and that does not demean them.
- Staff must ensure they use language that is inclusive of lesbian, gay, bisexual and transgender people and not demonstrate any attitude or behaviour that may be considered challenging or prejudiced.
- Staff must ensure patients do not share a bay with patients of the opposite sex unless in an emergency, whilst waiting to be moved, or whilst being cared for in a critical care or assessment area where segregation is not possible.

3.2 Maintaining privacy and dignity

- A chaperone may be considered to ensure that the patient's privacy, dignity and interests are protected and respected at all times throughout the consultation, examination, treatment or care. E.g. patients who may be intoxicated, lack mental capacity or children.
• The nature and status of the chaperone should be recorded in the Healthcare Records

• All patients have the right, if they wish to have a chaperone present during any intimate care, irrespective of organisational constraints. Please refer to Chaperone Policy

• Staff will ensure curtains/doors are closed during all examinations and procedures. Where curtains/doors are closed staff will gain permission before entering to ensure privacy

• Staff will ensure patients do not feel vulnerable to intrusion and that curtains, which do not remain tightly closed, do not compromise privacy and dignity

• Patients will be encouraged to wear their own night attire to sleep in. When this is not appropriate or possible, patients should have access to hospital clothing that protects their modesty and is acceptable to them

• Patients will always be dressed or covered prior to leaving a clinical area for any reason, including being transported out of the hospital, so that their modesty can be maintained

• Patients unable to help themselves will never be left without a covering to maintain their decency, even during bed bathing and changing of linen/night attire

• Staff will ensure that privacy and dignity are respected and maintained during visiting times and that both patients and their carers are receptive to the needs of other patients and carers within the ward environment e.g patient using a commode at the bedside

• Patients who have a mental health problem or are confused and continually expose themselves will be shielded from the view of other patients and visitors in order to protect theirs and others privacy and dignity. Similarly patients who are lucid, but expose themselves need to be made aware of other patients’ privacy and dignity and asked to cover themselves

3.3 Maintaining confidentiality to protect each patient’s privacy and dignity

• Staff ordinarily will avoid displaying patients’ personal information at the bed head such as the patient’s address or unnecessary information regarding the patient’s condition. However, it is recognised that the use of patient ‘hot boards’ that contain personalised information that supports their care, maintains patient safety or may be requested by the patient and/or their family

• Staff will only share information that a patient discloses with staff who are directly involved with the patient’s care and with the patient’s verbal consent. Exceptions to this may be in emergency situations, and in some circumstances regarding the protection of vulnerable adults and children from abuse (see Trust safeguarding policies)

• Written consent must be obtained from patients before any clinical photographs are taken for the purpose of assessing or treating a patient, and only after having informed the patient of what to expect. In all circumstances staff will be expected to consult and adhere to trust policy on the consent to examination or treatment and the Standard Operating Procedure for Photography and Video Recordings of Patients: Confidentiality, Consent and Storage’ prior to any photographs being taken
• Staff will obtain the patient’s consent prior to disclosing information to family and friends. If appropriate and able, ask patients on admission to nominate one key person who will be responsible for liaising directly with nursing and medical staff.

• Staff will be aware of their responsibilities around confidentiality and information governance at all times and be aware of anyone who may overhear conversations, e.g. when handing over, at the bedside, when on the phone, and when discussing confidential matters behind closed curtains in bay areas. It is not acceptable to discuss clinical information in public areas even if a patient’s name is not used.

• Staff will ensure written patient information e.g. handover sheets, ward round changes and medical data, which contain confidential details are disposed of in designated confidential waste bins prior to leaving the hospital.

• Staff will ensure precautions are taken to prevent information being shared inappropriately, computer screens being viewed and white boards being read.

3.4 Same Sex Accommodation Standards

• Definition of Same Sex Accommodation

This refers to where a patient is placed within the clinical setting following admission and one or more of the following criteria apply:-

➢ The patient occupies a bed space that is either next to or directly opposite a member of the opposite gender.

➢ The patient occupies a bed space that does not have access to same-sex washing and toileting facilities.

➢ The patient has to pass through an area that is designated for the opposite gender in order to gain access to bathroom facilities.

➢ Where no clinical justification exists or where a clinical justification applied is no longer appropriate.

3.4.1 Scope of Same Sex Accommodation Standards

The definition and Department of Health guidance relating to Same Sex Accommodation is applied during the whole of the patient’s pathway regardless of which clinical area the patient is admitted to.

It is important for staff to be aware that we live in a diverse society and respect that some patients admitted to our care may disclose transgender, differing sexual orientation or fluid gender identity opposed to our own beliefs. For a person who has a planned, elective or emergency admission it is important therefore for staff to establish and have an open and honest conversation about where the person would be best placed in a hospital setting whilst taking account of their preferred gender, same sex accommodation guidance or constraints e.g. male or female accommodation, side room availability.
3.4.2 Clinical Justification for exceptions to Same Sex Accommodation Standards

There are times when the need to treat and admit can override the need for complete segregation. This might apply, for instance, with:

- A patient who requires high-tech care with one-to-one nursing, e.g. ICU, HDU. (See Appendix A & B)
- Critical Care settings key principles
- A patient who requires very specialised care, where one nurse might be caring for a small number of patients (see also Appendix 4 regarding children’s units key principles)
- A patient who requires very urgent care, e.g. rapid admission following heart attack.(see Appendix A & B) Emergency admissions key principles

Where mixing does occur, it must be clinically justifiable for all the patients affected. There are no blanket exemptions for particular specialties.

The locally agreed parameters for clinical justification are as described above.

In circumstances where there is clinical justification, the same-sex occurrence reporting procedure must still be followed.

3.4.3 Children/Paediatric Units (DoH 2009a Annex D)

For many children and young people, clinical need, age and stage of development may take precedence over gender considerations. Mixing of the sexes may be wholly reasonable and even preferred. There is evidence that many young people find great comfort from sharing with others of their own age and that this often outweighs their concerns about single sex rooms. Washing and toilet facilities need not be designated as same-sex as long as they accommodate only one patient at a time, and can be locked by the patient (with an external override for emergency use only).

Staff must make sensible decisions for each patient. This may mean segregating on the basis of age rather than gender, but such decisions must be demonstrably in the best interests of each child. It is not acceptable to apply a blanket approach that assumes mixing is always excusable. Flexibility may be required: for instance patients might prefer to spend most of their time in mixed areas, but to have access to single gender spaces for specific treatment needs or to undertake personal care.

Parents
Parents are often encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care should be taken to ensure this does not cause embarrassment or discomfort to patients.

Key principles:

- Privacy and dignity is an important aspect of care for children and young people
- Decisions should be based on the clinical, psychological and social needs of the child or young person, not the constraints of the environment, or the convenience of staff
- Privacy and dignity should be maintained whenever children and young people’s modesty may be compromised (e.g. when wearing hospital gowns/nightwear), or where the body (other than the extremities) is exposed, or they are unable to
preserve their own modesty (for example following recovery from a general anaesthetic or when sedated)

- The child or young person’s preference should be sought, recorded and where possible respected
- Where appropriate the wishes of the parents should be considered, but in the case of young people their preference should prevail

3.4.4 Same-Sex Accommodation Procedure

In the event of a same-sex occurrence, including those with clinical justification, the following procedure must be followed:

- Explain the reasons why we have not been able to provide same sex accommodation to the patient and/or their relatives, carers or loved ones
- Record the discussion in the patient notes
- Review the impact on all patients involved
- Use the recording and reporting process (see appendix C – same sex occurrence form)
- Move the person to same-sex accommodation as soon as possible

3.4.5 Recording & reporting

The bed managers / night sisters will record every decision to mix within the wards, (except ICU/HDU and CCU) which will be collated on a weekly basis by the clinical areas and forwarded to the Bed Management Administrator. This information should include name, NHS number, date, time and location inclusive of any other patients affected in a bay and specific specialty requirement.

ICU/HDU and CCU will report on an exception basis if decision to mix is not clinically justified.

If a decision to mix is taken and not clinically justified, this will be identified as a breach and will be subject to a financial penalty. In these circumstances the same sex breach must be escalated to the Head of Nursing who will liaise with the corporate governance and commissioners

A datix incident report for all non-clinically justified breaches must be completed.

If a patient has been a clinically justified breach but their clinical condition no longer requires that level of increased clinical support following clinician review; the date and time the decision was made must be recorded in the clinical notes inclusive of specialty bed required.

The nurse in charge must immediately inform the bed manager to facilitate and ensure an appropriate clinical area is identified for the patient’s planned transfer within the specified timeframe (patient to transfer within 12 hours from decision made).

Failure to identify an appropriate clinical placement or transfer the patient within the specified timeframe will constitute a non-clinically justified breach as the patient has remained in a
mixed sex area. This must be escalated to the relevant Head of Nursing and Service Manager during normal working hours. Out of hours it must be escalated to the Site and Senior on-call Manager.

3.4.6 Root Cause Analysis

To aid the investigation and analysis of same-sex occurrences, the DH / NPSA Root Cause Analysis tool (DH / NPSA 2009) will be used where clusters of mixing occur and / or where further investigations and action is needed and / or as requested by the commissioner.

3.4.7 Board Reporting

The Trust Board will receive a monthly report with data analysis and action plan if indicated. The lead commissioner will receive quarterly reports. Triangulation with other data sources (e.g. PALS, complaints, capacity & flow, patient survey) will be a routine part of the analysis and subsequent action planning.

4.0 Measuring Performance/ Audit

Privacy, dignity and respect and same sex accommodation guidance are measured through a variety of different areas including:

- National annual patients survey
- Local Quarterly patient experience survey
- Complaints
- Patient Advice & Liaison Service issues and themes
- Same Sex Accommodation breach data

Compliance and monitoring of this policy will be measured through the Quality Forum.

5.0 Summary

This policy is not exhaustive, but provides staff with the expected standards and guidance to ensure they have the necessary knowledge and skills to deal sensitively with the various circumstances in which patients’ privacy and dignity or respect may be infringed.

For more information, please refer to the appendices of this policy, Department of Health Guidance available via the internet or seek senior advice if further clarity is required.

6.0 Policy Review

This policy will be checked annually and reviewed 3 yearly to reflect changes in best practice, guidance or legislation and to bear in mind any other factors which may render the policy out of date.
### Decisions matrix for providers and commissioners re: Same Sex Accommodation - Appendix A

<table>
<thead>
<tr>
<th>Category</th>
<th>Acceptable?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care, levels 2&amp;3 eg: • ICU/coronary care units • High dependency units • Hyper acute stroke units • Recovery units attached to theatres/procedure rooms</td>
<td>Almost always G</td>
<td>• Not acceptable when patient no longer needs level 2 or 3 care, but cannot be placed in an appropriate ward • Not acceptable in recovery units where patients remain until discharge (eg some day surgery/endoscopy units)</td>
</tr>
<tr>
<td>Acute wards, eg: • Medical/surgical (general and specialist) • elderly care • orthopaedic</td>
<td>Never R</td>
<td>• All episodes of mixing in acute wards should be discussed individually with commissioners.</td>
</tr>
<tr>
<td>Intermediate and continuing care wards</td>
<td>Never R</td>
<td>• All episodes of mixing in intermediate and continuing care wards should be discussed individually with commissioners</td>
</tr>
<tr>
<td>Admissions units, eg: • Medical/surgical admissions • Observation wards • Clinical decision units</td>
<td>Almost never R</td>
<td>• Not acceptable for organisational convenience (eg to “park” patients whilst awaiting admission) • Not acceptable as a routine occurrence</td>
</tr>
<tr>
<td>Day surgery</td>
<td>Rarely R</td>
<td>• Acceptable for very minor procedures (eg operations on hands/feet that do not require patients to undress)</td>
</tr>
<tr>
<td>Endoscopy units</td>
<td>Rarely R</td>
<td>• May be acceptable for pre/post-procedure waiting areas as long as high standards of privacy can be assured. • Not acceptable where dignity is likely to be compromised, eg if bowel prep is needed</td>
</tr>
<tr>
<td>Patients with long-term conditions admitted frequently as part of a cohesive group (eg renal dialysis)</td>
<td>Sometimes A</td>
<td>• Patients may choose to be cared for together, as long as this is the decision of the whole group and does not adversely affect the care of others. • Not acceptable where the only justification is frequent admission, and there is no recognisable group identity</td>
</tr>
<tr>
<td>Children/young people’s units (including Neonates)</td>
<td>Sometimes A</td>
<td>• Children and young people should have the choice of whether care is segregated according to age or gender.</td>
</tr>
<tr>
<td>Mental health and LD</td>
<td>Never R</td>
<td>• There is no acceptable justification for admitting a mental health patient to mixed-sex accommodation. • May be acceptable, in a clinical emergency, to admit a patient temporarily to a single, ensuite room in the opposite-gender area of a ward. In such cases, a full risk-assessment must be carried out and complete safety, privacy and dignity maintained.</td>
</tr>
</tbody>
</table>
Same Sex Accommodation Decision Tree – Appendix B

Patient requires admission

Yes

Is there an appropriate bed of the right sex?

Yes

Transfer the patient to the bed

No

Does the patient need a bed urgently, e.g. clinical need, ICU, CCU, telemetry

Yes

Transfer the patient to the bed. Record as Clinically Justified breach

No

Can patients be moved around on the ward to enable same sex bed?

Yes

Move patients Transfer the patient to the bed

No

Can patients be out- lied safely to enable same sex bed?

Yes

Out- lie Patients. Transfer the patient to the bed

No

Is the only bed safely available the wrong sex?

Yes

See flow chart. Inform appropriate manager. Transfer the patient to the bed. Record as Non-clinically Justified Breach

No

Yes

Transfer the patient to the bed
SAME-SEX OCCURRENCE FORM – Appendix C

NB. If a subsequent patient moves into the now mixed-bay, this will also constitute a further mixed-sex occurrence so please add patient details. Clinical Teams to complete and inform specialty matron and escalate to their flow manager who will share at the next Operations Meeting for planning.

<table>
<thead>
<tr>
<th>DATE / TIME &amp; REASON MIXED-SEX OCCURRENCE OCCURRED</th>
<th>CLINICAL AREA</th>
<th>PATIENT NAME and hospital number</th>
<th>NUMBER OF OTHER PATIENTS AFFECTED</th>
<th>COMMUNICATION CONVEYED TO PATIENT/FAMILY MEMBER eg EXPLANATION/ APOLOGY GIVEN BY:</th>
<th>DATE &amp; TIME MIXED-SEX OCCURRENCE ENDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>As soon as decision to place patient is made</td>
<td>Where mixed-sex occurrence took place</td>
<td>Affix patient ID self-adhesive label of patient who triggered the mixed-sex occurrence</td>
<td>Total number of other occupants within room</td>
<td>Print name and designation</td>
<td>When patient was relocated to same sex accommodation</td>
</tr>
</tbody>
</table>
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?

Privacy, Dignity and Respect and Same Sex Accommodation Guidance

Details of person responsible for completing the assessment:

- Name: Lyn Bailey
- Position: Equality & Patient Experience Manager
- Team/service: Communications & Engagement

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)

East Cheshire NHS Trust’s principle aim is to ensure that the organisational values and behaviours expected from each employee is embedded within the Trust’s culture and everyday practice, placing the patient and family at the forefront of everything we do. This reflects the principles within the NHS Constitution and Same Sex Accommodation Guidance which denotes the importance of respecting individual human rights and maintaining privacy and dignity at all times.

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In addition, the Trust’s Quality Strategy refers to the NHS Constitution and aligns to Jane Cummings, Chief Nursing Officer NHS England pledge ‘To develop a Culture of Compassionate Care’, widely known as the 6 C’s that focuses and builds upon the six values and behaviours:

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East Cheshire NHS Trust is committed and strives to ensure that all patients within our services receive the highest quality of care possible; that they feel safe; are treated by all members of staff equitably; with dignity and respect, acknowledging personal values and preferences without prejudice thus making ‘very contact count’.
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

Area has an older demography. The numbers of BME groups has risen, therefore there could be issues around the needs of different cultures and beliefs. There are groups of vulnerable people using Trust services such as those with dementia or leaning disabilities who may need extra support to maintain their privacy and dignity. Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population.

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?

Main issues identified are: Overhearing others’ conversations on wards due to proximity of other patients

- Lack of information from BME and transgender individuals/groups
- Communications with patients, relatives, carers in curtained cubicles
- Same sex accommodation issues

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: Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics. For patients whose first language is not English, staff will follow the trust interpretation policy.

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:** We tend to have more females than males in numbers coming through the trust, older females tend to react more negatively to issues around same sex accommodation. However the Trust has been proactive in this area and has no breaches of the standards.

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### 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:** Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics. Reasonable adjustments should be made according to the needs of the patient to enable them to be an informed participant in decisions re care and treatment.

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### 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:** This area has an older demography. The population using our services is reflective of the local population. It is therefore likely that we will have issues around same sex accommodation and must ensure the policy is implemented properly. Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics. See also gender and children.

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### 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:** Staff will treat all partners, including same sex with respect and dignity. Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics. See also gender and children.

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### 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:** Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics. It must be recognized that the numbers of people from BME groups in the local community is growing, and staff need to be mindful of the needs of other cultures and religious beliefs. Robust interpretation policy in place.
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: Many of our patients have short or long term carers. Many of our staff are carers, being aware of this and the limitations on their availability to take relatives to appointments means that we can alleviate the potential discrimination against people with a carer by offering a choice of appointments and times of attendance.

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: Because there is an emphasis in the policy on treating people according to individual needs, there is the potential to improve the way we deal with people with different protected characteristics.

4. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? Yes ✓ No ☐ |
|---|---|
| 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: If the policy is not implemented properly, then there could be an adverse impact on teenage children, also of patients with learning disabilities who have just gone through transition and are now being cared for on an adult ward for the first time. |
| c. If no please describe why there is considered to be no impact / significant impact on children |

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?

Issues identified from the consultation:

- Consultation included core members of Quality Forum, Matrons, Directorate SQS membership
- Specific elements in previous policy were removed following national guidance re: safeguarding and chaperone principles – therefore standalone chaperone policy is now in place
6. Date completed: March 2017       Review Date: March 2020

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?

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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: [Signature]

Date: March 2017