South London and Maudsley NHS
NHS Foundation Trust

PRIVACY AND DIGNITY POLICY

Version:	1.0
Ratified By:	Trust Executive
Date Ratified:	20th June 2012
Date Policy Comes Into Effect:	June 2012
Author:	Natalie Warman, Assistant Director of Nursing for Physical and Public Health
Responsible Director:	Dr Martin Baggaley/Hilary McCallion
Responsible Committee:	Patient Experience Group
Target Audience:	All Trust Staff
Review Date:	June 2015

Equalities Equality Impact Assessment	Assessor: Natalie Warman	Date: 28.5.12
HRA Impact Assessment	Assessor: Natalie Warman	Date: 28.5.12

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1.0	June 2012	N/A	N/A	N. Warman

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
	Mar/Jun	

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
All Trust Staff	A group email will be sent alerting teams to the policy and instructing them to download for local use Education and Training to change training logs	Electronic	N. Warman

Contents

1. Introduction

As we are in the ”Business of Care” Improving the patient experience by maintaining the dignity and privacy of service users underpins the practice of everyone within South London and Maudsley NHS Foundation Trust.

It is important that service users, carers and families feel that staff are consistently approachable, courteous, trustworthy, friendly and responsive to their needs, supportive of their rights, and state that they have been treated with respect, dignity and without discrimination.

The development of this policy was done in conjunction with the views of service users and carers. Ten focus groups were facilitated by service users across the organisation, as well as consultation with a wide range of staff groups across the Trust. Their involvement has helped to compliment current privacy and dignity literature and research which has predominantly come from older adults and palliative care.

The ethos of developing mutual relationships between people is mentioned in the Trusts' Delivery Plan 2012-2015 as well as many other policies throughout the organisation, however this policy brings the aspects of respecting peoples' privacy and dignity into one document.

2. Definitions

Research has identified several over-lapping themes in relation to dignity:

Respect: shown to you as a human being and as an individual, by others, and demonstrated by courtesy, good communication and taking time.

Privacy: In terms of personal space, modesty and privacy in personal care; and confidentiality of treatment and personal information.

Self-esteem, identity, a sense of self and self worth: promoted by all the elements of dignity but also by the “little things”- a clean and respectable appearance, pleasant environment- and by choice and being listened to

Autonomy: including freedom to act and freedom to decide, based on clear comprehensive information and opportunities to participate.

3. Purpose and Scope of the Policy

This policy applies to all staff employed within South London and Maudsley NHS Foundation Trust. This includes volunteers, NHS Professionals and contractors working within SLaM premises.

4. Roles and Responsibilities

The Board

Will monitor compliance with the policy through 6 monthly reports that address the standards of this policy.

Clinical Academic Groups

- Are responsible for monitoring patient experience to ensure that privacy and dignity concerns are addressed appropriately and timely.
- Are responsible for ensuring that all their staff are aware of the policy and the standards of practice of implemented.
- Are responsible for monitoring their environments, and practice; ensuring that action plans are in place that addresses privacy and dignity concerns.
- Are responsible for implementing the Department of Health's Mixed Sex Accommodation (MSA) policy and report and MSA breaches and escalate action plans if breaches occur to the nursing directorate.

Estates and Facilities

- Will ensure that new buildings and designs respect people's privacy and dignity
- Will ensure that repairs are done promptly to maintain people's privacy and dignity

Hotel Services

- Will oversee the allocation of finances for PEAT to ensure that environment improvements reflect improving the privacy and dignity of service users.
- Will liaise with service provider to ensure that standards of food and cleanliness are implemented and maintained.

All staff

- All staff are responsible for respecting and maintaining a service user's privacy and dignity whilst in their care as detailed within the standards of practice.
- All staff should maintain the standards of practice within this policy
- All staff will report incidents that affect service users privacy and dignity and escalate concerns.
- All staff are responsible for attending training that supports the policy**.**
- Nursing staff will have had their professional behaviour and conduct competencies assessed (see Appendix A)

5. POLICY STANDARDS

Standard 1: Staff will conduct themselves with a positive attitude and professional behaviour

- Staff will ensure that service users and visitors are greeted and welcomed and that they are addressed by their preferred name

- Staff will wear their I.D badges at all times

- Staff will ensure that service users feel that they matter and promote patient experiences with the use of positive verbal and non verbal behaviour; body language and language that is easily understandable and free of jargon.

- Staff will ensure that service users feel that they matter and promote patient experiences with the use of positive verbal and non verbal behaviour; body language and language that is easily understandable and free of jargon.

- Staff answering telephones will state their name, area of work and designation

- Staff will not use their mobile phones for personal purposes whilst on duty, or answer a professional call whilst undergoing a consultation with a patient without prior consent.

- Service users concerns and complaints will be acknowledged and addressed in a timely fashion.

- Concerns regarding attitudes and behaviours are escalated to appropriate line management.

Standard 2: Treatment and care will be person centred

- Staff treat service users, carers and relatives with dignity and respect at every stage of their care and treatment.

- Staff will ensure that people are offered time to talk to enable them to voice their needs or concerns and make decisions regarding their care.

- Service users will be involved; be aware of and have copies of their treatment
- and recovery plans.

- Service users will meet regularly with those involved with their care so that they are able to express their views regarding their needs, care and treatment and have this documented within their care plan.

- If service users are placed on intermittent observations then steps must be taken to minimise and reduce the risk of inappropriate intrusion and where possible steps taken to maintain an individuals privacy and dignity

- Medication and treatment will be kept confidential

- De - escalation should be the priority and any form of physical intervention required should be done as quickly as possible and the patient moved to an area that promotes their privacy, dignity, confidentiality and modesty

- The use of physical intervention and rapid tranquilisation will be offered when all other options have been attempted.

2.2 Eating and nutritional care

- Staff will assess and record the dietary needs and preferences of individuals.

- Service users will have access to a wide range and choice of food to meet their specific dietary requirements

- Service users will have the opportunity to order in advance their meal preferences

- Service users will have access to drinks without being dependant on staff to make them for them.

- Staff will assess if people require assistance to support their nutrition and provide support to patients to enable them to eat and drink with dignity. (E.g. provide specialist cutlery, or non slip mats, serviettes). The care plan should aim to promote independence

- Food will look appetising and well presented. (People with swallowing impairments will have a variety of textured food with separated portions)

- Protected mealtimes will be insitu on all wards and appropriately staffed to ensure that service users have time and their nutritional needs met.

2.3 Personal hygiene, modesty, comfort and warmth

- All service users will have access to personal items such as toothbrushes, toothpaste, shampoo and shower gels to ensure that they are able to maintain their hygiene needs to an acceptable standard.

- Service users will have access to laundry services to ensure that their clothes can be laundered and be supported to maintain their personal hygiene.

- Service users will have access to a range of appropriate fitting clothes that meets their gender, the temperature and the environment that they are in, that reflects their personal choices and preferences.

- Service users should be encouraged to remove minimal clothing required (in privacy) to carry out procedures and then an attempt to maintain their modesty should be made whilst the service users undergoes the procedure.

- If a service user's presentation compromises their modesty, privacy or dignity staff must take the appropriate steps to rectify the situation and document within epjs

- Service users will have enough access to blankets and bed linen to ensure their modesty and comfort is maintained

- Service users in the community who have difficulty maintaining their hygiene, personal care and laundry should be offered assistance to support them to achieve this; this assistance should promote their choices and social inclusion (direct payments, benefits, volunteers

2.4 Privac*y "Service users will state that their privacy was respected"*

- Service users will have their own private space that is respected and valued by staff

- Staff will ensure that they knock and ask permission to enter a room

- All patients will have access to a private and lockable space for their personal belongings in which they can have access to.

- Service users will be given the choice to have procedures such as medical assessments carried out in their own room or in the clinic room, so that their dignity and modesty is not compromised.

- If care is carried out in an area that is a multipurpose room then a "Do Not Disturb" sign should be in place and all staff should respect the patient's right to privacy.

- Service users will have access to a private space to ensure that conversations with staff, carers, family, friends and visitors can be held privately when requested or thought by staff that the service users privacy and confidentiality may be breached, whether within the ward; using the telephone or in a community setting.

Standard 3: Improving peoples dignity by respecting their rights

- Staff will act and respect a service users autonomy and encourage service users, families and carers to make informed choices

- All service users and carers will have access to advocacy services.

- Service users, families and carers will be aware of and have access to spiritual care that supports their faith and culture

- Staff will respect the confidentiality of service users and act in accordance with the Trusts' information governance policy

- Staff will have consultations with service users in confidential areas, that can not be overlooked or overheard by members of the public

- Staff will ensure that mute buttons are used on telephones to prevent callers overhearing conversations whilst waiting to be connected to another caller.

- Service users will have regular access to the outside environment and fresh air.

- Service user information will be available and in an appropriate format (written, DVD, e.g.) for all service users and carers to understand, and that the information considers, age, disabilities, gender, culture and language

- Staff will offer people translation and culturally appropriate services for which English is not their first language, to enable people to express their needs and concerns.

- Staff will offer people alternative methods of communication to ensure that those with a disability/ impairment are equally able to express their needs and concerns.

- Consent for photographs of patients must be obtained. Photographs involving body parts must be limited to the area required to be photographed. In these circumstances the patient should not be identifiable

- Service users will be asked for their consent if medical, nursing or allied health professional students are attending them or present in ward/ clinical round discussions.

- Service users will be offered chaperones for any intimate procedures

- Service user's end of life requirements should reflect their diversity and culture and preferences

Standard 4: Reducing the discrimination and stigma of people who experience mental illnesses

- Staff will promote the social inclusion of people with a mental illness with other agencies and the public so as to reduce the service user's experience of discrimination within society, employment and education

- Staff will safeguard the needs of service users and carers and recognise their vulnerability.

- Staff will work with other healthcare providers such as GP's and A&E staff to improve the experiences of service users of these services.

- Staff should discuss the service users diagnosis and the impact of labelling of service users so as to reduce further discrimination that they experience.

- Service users will have access and be offered a range of activities that is client specific to their age, culture and gender.

- Staff will report any potential form of discrimination to their line manager

- Staff will ensure that no patient will experience discrimination through age, religion, culture, disability, race, sexual orientation or gender

Standard 5: The Care Environment

"**Service users report that the care environment feels pleasant, calm, secure, safe, reassuring and appropriate for their care"**

- The care environment will be clean, tidy and well maintained.
- Window screens/coverings on patient doors should protect and maintain the privacy of service users and prohibit the public and other service users from looking into a service user's personal space.
- The quality of the furnishings and decorations supports a therapeutic caring environment and is appropriate to the age and needs of the people requiring care.
- Service users will have access to outside space and fresh air
- The environment is suitable to accommodate people with a range of physical disabilities.
- Service users will not have to walk through areas occupied by the opposite gender to reach their own bathroom and toilet facilities
- Gender specific bathroom and toilet facilities will be separated and in appropriate designated areas.
- Bathrooms and toilets must be lockable
- All female service users will have access to a women only lounge.
- Waste is managed appropriately according to legislation and the Trust policy
- There will be a private space available for service users to spend with their visitors

6. Training

- Staff must complete the Trusts' data protection training.
- All staff must complete their safeguarding adults and children training
- All staff must attend mandatory equality and diversity training

7. Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
	Monthly reports including: Patient experience data, patient opinion, patient surveys, PEDIC Complaints Mixed sex accommodation breaches and action plans will be monitored monthly via CEOPMR The completion of local Essence of Care and other associated benchmarks and their action plans Privacy and Dignity audits Mandatory training records PEAT inspections Infection control audits Safeguarding and critical incidents involving privacy and dignity	6 monthly reports	Patient Complaints Department CEOPMR TBC Clinical Audit Team Director of Education and Training TBC Assistant Director of Nursing / Infection Control TBC	Trust Board

8. Associated Documentation

Clinical Waste Policy

Information Governance Policy
Safeguarding Adults Policy
Safeguarding Children Policy

9. References

Department of Health's Mixed Sex Accommodation Policy

10. Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

APPENDIX 1: Eliminating Mixed Sex Accommodation

Background

In February 2009 the Secretary of State pledged a rapid move towards a virtual elimination of mixed sex accommodation, unless it was clinically justified. The DH supported this pledge with the allocation of funds to improve clinical areas and a Development Review Team to further support trust efforts to achieve the standard by March 31st 2010.

In the Trust following the annual mixed sex accommodation survey in April / May 2009, all clinical services offering mixed-sex accommodation were visited and advised as to how best they could improve their service provision to meet the standard.

Clinical services within the Trust worked very hard to improve their accommodation and on the 1st April 2010 the trust declared that mixed sexed accommodation had been virtually eliminated. This information is available on the Trust website along with a trust action plan.

In August 2010 the Government announced plans to introduce robust steps to ensure NHS organisations can be held to account for managing their beds and facilities to eliminate mixed sex accommodation, where there is no clinical justification. From April 2011, routine reporting and publishing of NHS organisations' breaches was introduced and commissioners will apply sanctions to NHS organisations who declare a breach. The NHS Operating Frameworks from 2011 make it clear that NHS Organisations are expected to eliminate *mixed sex accommodation except where it is in the overall best interests of the patient, or reflects their personal choice'.*

In November 2010 the DH published further information; the remainder of this paper provides a summary of the policy in particular with regard to recognising, reporting and eliminating breaches.

Recognising Breaches of Policy

(i) Policy Statement

Mixed – sex accommodation will be eliminated, except where it is in the overall best interest of the patient, or reflects their personal choice.

(ii) Definition

A breach occurs at the point a patient is admitted to a mixed sexed accommodation outside the terms of the above policy.

The DH recognises that there are circumstances when mixing of the sexes can be justified, for example for rapid or specialist treatment, in these cases the individual's privacy and dignity must be protected and the individual must be provided with same sex accommodation immediately the acceptable justification ceases to apply.

For Transgender service users who either undergone surgery or those who have not are to be identified as their preferred sex usually assessed by their first name. The exception to this is if the risks posed to the other service users is greater than the risks posed to the individual service user.

Further examples of **justified breaches** given are:

- In the event of a life threatening emergency, either on admission or as a result of deteriorating health.

- Where a short period of close observation is required in high risk situations, adverse drug reactions or prevent self harm
- On the joint admission of couples or family groups

Examples of **unjustified breaches** include:

- Placing patients in mixed sex accommodation for convenience of clinical staff or from a desire to group patients within a clinical speciality
- Placing patients in mixed sex accommodation because of staff shortage, poor skill mix, restrictions imposed by an old or difficult estate, shortage of beds, ward closure, whilst waiting for assessment, treatment or clinical decision or for regular but not constant observation.

(iii) Reflecting Patient Choice

The DH notes that there are maybe some instances when the sharing of accommodation reflects the personal choice and therefore maybe justified, in all cases the patient's privacy and dignity must be assured. They add that the norm is to aim for segregation.

(iv) Reporting Breaches of Policy

Sleeping accommodation includes areas where patients are admitted and cared for on beds even if they do not remain overnight. This includes all admission and assessment units (Clinical Decision Units, Triage Wards). It does not include accident and emergency.

The information will be made available through the DH website, NHS Choices website and the NHS Information Centre. The data required will relate to the total occurrences of unjustified mixing in relation to sleeping accommodation only, by site, by commissioning PCO. If a patient is placed in a mixed sex accommodation more than once during their admission each occurrence will be reported separately.

Justified breaching of sleeping accommodation, bathroom and WC mixing and women only lounges for mental health are to be collected monitored locally and will need to be monitored via Client Environment Board (CEB) and CEOPMR. Unjustified breaches will be reported externally and monitored by CEB and CEOPMR.

Contracting and Sanctions

Under the NHS contract 2010/11, Commissioners have a requirement to placed upon them to make a deduction equivalent to the total cost of the service or treatment for all patient affected by the same sex accommodation requirements as set out under the Nationally Specified Events and Clause 7.23. From January commissioners will have discretion on the level of financial sanction to be applied to breaches up to and including the total cost of the service / treatment episode. This could be between 10% to 100% of the total cost of the procedure / service of patients affected by a breach. In addition that will work with providers to agree acceptable thresholds.

As part of the routine contract performance monitoring meetings breaches of sleeping accommodation will be discussed and level of financial consequence reported. Breaches of bathrooms, passing through sleeping accommodation en route to bathroom facilities and women only day rooms (Mental Health) will require a provider Remedial Action Plan with a timescale for improvement. The parties will agree a level of consequence if the Remedial Action Plan is breached.

Mixed Sex Accommodation Policy - Roles and Responsibilities

All Staff

All staff need to familiarise themselves with the contents of this paper and be clear about the definitions of justifiable and unjustifiable breaches.

Trust Contracting Team

The Trusts Contracting Team in partnership with the Privacy and Dignity Lead and the Information Department needs to agree an internal reporting process. In addition Trust Contracting Team needs to agree with the Commissioners acceptable thresholds, method of measurement of a breach and the level of financial sanction to be applied to breaches of sleeping accommodation**.**

Nursing & Education Department

The Privacy and Dignity Lead will work with services to ensure that they fully understand the definitions of breaches and the internal reporting mechanisms. N&E will collate all breaches (justified and unjustified) forms by the 31st of the month and forward the unjustified to the ICT department for external reporting by 7th of the month. The justified breaches forms need to be collated and reported to the CEB and CEOPMR.

Clinical Services

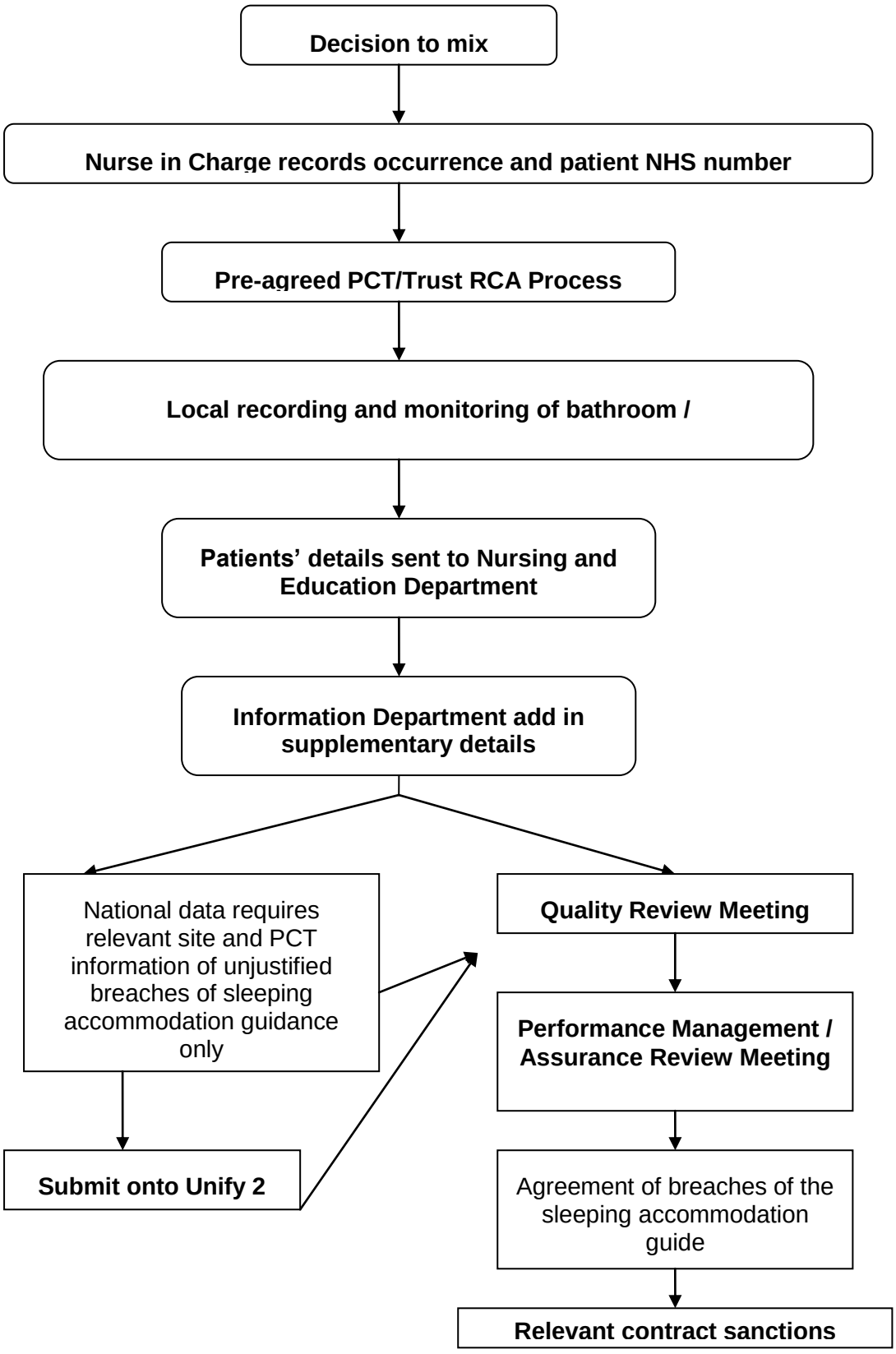
All CAG Executives team must ensure that they have robust MSA reporting mechanisms and identified leads in their services. For example the collation of this information could be the responsibility of the bed managers, Clinical Service Lead / Matron roles. All admissions need to be carefully considered to ensure that they are not breaching the MSA Policy if a breach is justified it will need to meet the criteria set out above in this paper. All CAGS need to familirise themselves with the the process for Transgender patients.
All unjustified or unjusitified breaches are to be discussed with the The Trusts' Privacy and Dignity lead Natalie Warman. Natalie.warman@slam.nhs.uk

Information Department

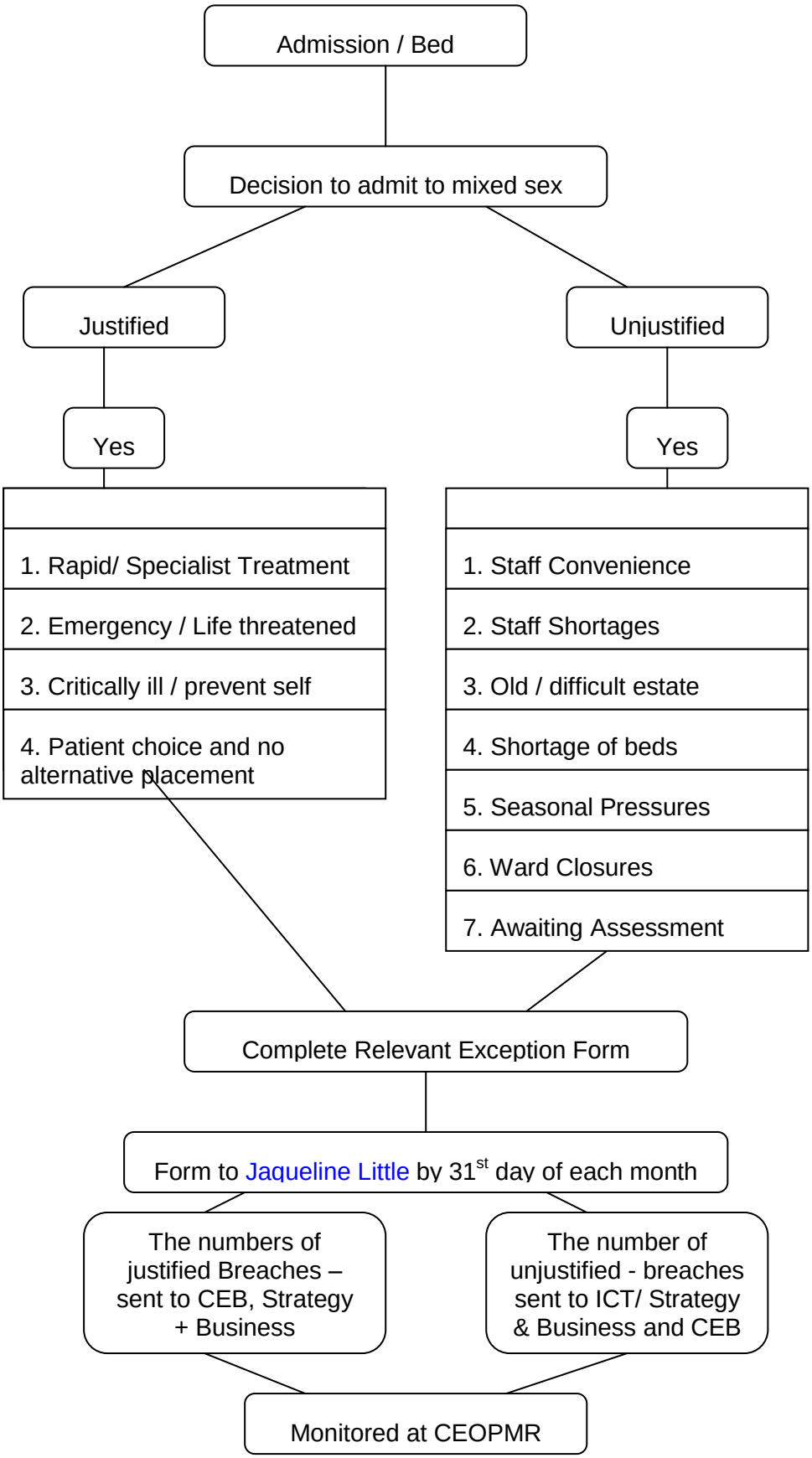
The information department will need to agree final unjustified breaches exceptions numbers with members of the contracting team and Trust Executive prior to external notification. They will also need to notify Strategy and Business for inclusion in the monthly CEOPMR agenda.

Strategy and Business

The Strategy and business department will need to add MSA breaches reporting to the CEO PMR agenda for monitoring and assuring improvements in the policy standard, and for CAGs to identify areas where they may require further infrastructure support to improve their accommodation provision.


Decision to mix
Nurse in Charge records occurrence and patient NHS number
Pre-agreed PCT/Trust RCA Process
Local recording and monitoring of bathroom /
Patients' details sent to Nursing and Education Department
Information Department add in supplementary details
National data requires relevant site and PCT information of unjustified breaches of sleeping accommodation guidance only
Submit onto Unify 2
Quality Review Meeting
Performance Management / Assurance Review Meeting
Agreement of breaches of the sleeping accommodation guide
Relevant contract sanctions

MSA Internal Process Flow Chart



South London and Maudsley NHS
NHS Foundation Trust

Eliminating Mixed Sex Accommodation
Sleeping Breaches Report Form

Name of CAG	
Name of Ward / Unit	
Name of Person Completing the Form	
No. of beds	
Type of Ward Male Only Female Only Mixed Sex	
Breach of MSA, **please highlight** Justified Yes No Unjustified Yes No	Length of time breach occurred Hours Days Month

Justified Breach	**Tick**	**Unjustified Breach**	**Tick**
Rapid / Specialist Treatment		Staff Shortage / Poor skill mix	
Life threatening emergency		Old or difficult estate	
Critical illness requires 1 to 1		Shortage of beds	
		Fluctuations in activity / seasonal	
		Ward closures	
		Awaiting assessment/ clinical deci	

Action plan in place / attached **(please highlight)**

Yes Yes
No No

If no, reason for failure to action plan

Date P&D Lead notified of breach

Date P&D Lead forwards to ICT

Rationale for MSA Breaches Reporting Form

From 1st April 2010 all NHS premises are expected to comply with the DH's Eliminating Mixed Sex Accommodation (MSA) Policy. From January 2011 we will be expected to notify the commissioners of any unjustifiable breaches of the policy and provide this information on a monthly basis. Breaches of the policy are likely to incur financial penalties levied by the commissioners.

Definition

A breach occurs at the point a patient is admitted to a mixed sexed accommodation outside the terms of the conditions stated below.

The DH recognises that there are circumstances when mixing of the sexes can be justified, for example for rapid or specialist treatment, in these cases the individual's privacy and dignity must be protected and the individual must be provided with same sex accommodation immediately the acceptable justification ceases to apply.

Further examples of acceptable breaches given are:

- In the event of a life threatening emergency, either on admission or as a result of deteriorating health.
- Where a critically patient requires one to one nursing
- Where a short period of close observation is required in high risk situations, adverse drug reactions or prevent self harm
- On the joint admission of couples or family groups

Examples of un-acceptable breaches include:

- Placing patients in mixed sex accommodation for convenience of clinical staff or from a desire to group patients within a clinical speciality
- Placing patients in mixed sex accommodation because of staff shortage, poor skill mix, restrictions imposed by an old or difficult estate, shortage of beds, ward closure an whilst waiting for assessment, treatment or clinical decision or for regular but not constant observation.

Please note that Transgender patients are to be treated as their preferred gender. This is usually identified by their name. The exception to this is when the risks to other service users significantly outweighs the risk to the individual service user. All admissions of transgender patients should be discussed with the privacy and dignity lead Natalie Warman- Natalie.warman@slam.nhs.uk

In order to ensure robust reporting measures are in place a short form has been developed to capture all MSA Sleeping breaches of the policy. If a breach occurs the form must be completed and returned to **Jacqueline Little** (Jaqueline.Little@slam.nhs.uk) **by the 31st day of each month.**

Thank you

Patient Information leaflet
Same-sex accommodation
Protecting your privacy and dignity
We know that your privacy and dignity is important to you, especially during your stay in hospital, so we have introduced same-sex accommodation throughout the Trust.

This means that if you stay in any of our wards you will either be offered your own bedroom or you will have a bed in a male-only or female-only section of the ward. You will also have access to same-sex bathroom and toilets.

What can I expect when I come into hospital?
We want to make sure that your privacy, dignity and modesty is protected at all times when you come in to hospital so wherever possible we will offer you your own bedroom.

Most of our wards are male only or female only. But, if you are admitted into a mixed-sex ward then we will place you into a same-sex section of the ward and you will either have an ensuite bathroom or else same-sex bathroom and toilets will be available close by.

Are there times when patients of different sexes have to be mixed?
There are some times when you may have to share accommodation or bathroom/toilets with members of the opposite sex but this only happens when it is in your best interest to do so. For example, if you are in need of specialist care (eg intensive care, close observation or monitoring) or if you actively choose to share mixed-sex accommodation (eg when using our rehabilitation services).

We will make every effort to protect your privacy, dignity and modesty and to discuss any accommodation issues with you, your family and/or your carers.

Will I be cared for by staff of my own sex?
No, it is likely that you will be cared for by a mixed-sex team of staff.

If you prefer to be cared for by staff of the same sex as you, then we will make every effort to try and support this but there are times when this may not be possible.

If you are unwell and need close observation then we will try to make sure that a staff member of the same sex observes you when necessary.

If there are times when you need to have a physical examination then you can choose to have someone accompany you.

Do single sex areas apply to visitors?
No, visitors are not restricted by their sex, however, because some of our patients are very unwell we do restrict visitors from certain areas. If you have concerns or questions about restricted areas for visitors then please speak to the ward manager or shift coordinator who will be able to advise you.
For further information please call our Patient Advice and Liaison Service (PALS) on freephone 0800 731 2864 or email pals@slam.nhs.uk.

Appendix 2: Privacy and Dignity Service User and Carer Consultation

SLaM Trustwide
Involvement Group:
Operations

Privacy and Dignity
Service User and Carer Consultation
March – April 2012

Commissioner: Natalie Warman (Assistant Director of Nursing with responsibility for physical healthcare)

Project co-producers: D Rosier (Service User Consultant) and Alice Glover (Patient and Public Involvement Lead: MAP CAG)

SUC / Carer Project team:
Abi Hassan
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Laurent Duriaud
Liz Dalton
Olumide Soyemi
Sara Haq

Sarah Morgan

30 April 2012

Introduction

As part of the development of a Trustwide Privacy & Dignity Strategy, Natalie Warman (Assistant Director of Nursing with responsibility for physical healthcare) approached the Operational Trustwide Involvement Group in Summer 2011.

The operational arm of the Trust Wide Involvement Group is designed to ensure that a wider range of service users are involved in the improvement and development of SLaM [South London & Maudsley] services, and to look across the Trust and externally to influence and develop good practice, innovation and service user research.

The aim of this consultation was to engage people with experience of using SLaM services in the process of identifying what is important to service users and carers about privacy and dignity.

The Process

Whilst staff were available to support the process where necessary, the management and co-ordination of the project was led by people with experience of using services:

A working group was established where service user consultants worked alongside staff to:

- Develop a consultation plan
- Develop the budget
- Identify 4 key questions that could be posed in focus groups across the 4 SLaM boroughs.

A service user consultant managed the project:

- Ensuring service user consultants were recruited, trained, briefed & supported to run a series of focus groups
- Ensuring the project ran to time
- Managing & overseeing the content analysis
- Writing the report

A service user consultant co-ordinated the arrangements for the focus groups:

- Contacting the venues
- Overseeing booking details including refreshments

A service user consultant and a carer jointly developed publicity for the focus groups.
A service user consultant and staff member delivered a training session on facilitating focus groups.

Questions

1. What does it mean to have your privacy maintained?

2. What does it mean to be treated with dignity / respect?

3. Are there any barriers that prevent you having your privacy and dignity maintained?

4. What are your suggestions for improving the privacy and dignity of people that use our services and family / carers?

Emergent themes

Environment

Stigma

Patients' Rights

Communication

Interface

Treatment

Staff

Carers

Theme: Environment

Participants reported 8 main categories with respect to environment: Safety, Ambience, Access, Activities, Fabric of the Building, Visitors, Food and Drink, and Cleaning.

Safety

In terms of Safety, participants reported a number of suggestions; including privacy and needing a safe place: ”Privacy is important for people because we all need a place to feel safe.”
Some participants reported feeling vulnerable on the ward, whilst others reported that hospitals should be a place of safety. One other participant stated that feeling safe and comfortable was important. And one participant stated that property loss affected dignity.

Ambience

In terms of the ambience of the ward environment, participants reported a number of negative issues. A number of participants felt that the ward was not a therapeutic place, and one participant reported: “It is hard to feel dignified in an environment where people are agitated.”
A number of participants reported technical problems with lighting not working correctly. The noise levels were also reported as an issue. Loud alarms and doors being slammed at 3am were noted problems.

Access

In terms of access people reported a number of issues with respect to their freedom. A number of participants reported issues related to leave: ”consistent and clearer leave” was needed, and it was desired to “have a more flexible form of hospital care.”
Others reported having restricted access to the garden for fresh air: “Patients having as much freedom as possible e.g. to get fresh air” was considered important, and “not being given access to the women’s back garden” was seen as an issue. One participant reported that locked doors were an issue, whilst another stated that Bed Blocking was an issue.

Activities

In terms of Activities some participants reported boredom as an issue impacting dignity. Others suggested more board games, and more physical activities (including Gym, Swimming, and a Walking Group).

Fabric of the Building

A number of participants commented on issues related to the fabric of the building: ”some of the buildings are terrible. The environment is a question of dignity.” A number of participants reported issues with bathrooms. These included privacy whilst using the bathroom: ”toilets and bathrooms should have locks.” It was also seen as a problem that “one bath” had to be shared “between 20+ patients.” Others commented on the fabric issues with bathrooms including: ”lights in bathroom not always working” and “no plug for the sink. I had to use toilet paper to plug the sink.” One participant suggested basic toiletries to be provided on the ward.
A number of participants reported a number of issues which impact on their Privacy and Dignity. These included having more transparency on the ward, including CCTV. Other comments included having improved TV reception and a better family room. It was seen as important to

make children feel more welcome. One participant reported the lack of resources as an issue. Another suggested: ”Separate male and female sections are important.”

Visitors

In terms of visitors participants reported a number of issues related to improving access and space for visitors. The participants commented on children visiting. One suggested ”more space for visitors”.

Another suggested allowing children to visit more often. One participant reported that space should be provided to allow privacy when visitors arrive: ”visiting times should be private, with space to be provided.”

Food and Drink

In terms of food and drink participants reported a number of issues which would improve the environment. Generally, food provision needs to be improved; including a better choice of breakfasts and hot milk. General improvements to the quality of food were desired: “food needs much improvement”, and it was felt that “diet is important”. A number of participants reported the need for easier access to hot drinks for both service users and visitors. One participant suggested having more water, refreshments, and fruit. One participant reported no enough variety for individuals with specific dietary requirements: “not enough choice with food, e.g. diabetic, Kosher, Muslim, and Caribbean meals etc.”

Cleaning

In terms of the cleanliness of the environment a number of participants reported issues with cleanliness. The toilets and bathroom need improvements: it was desirable “to have clean toilets and facilities”, and it was felt that “having clean quarters, i.e. toilets, bathrooms etc, is important.” One participant suggested “cleaners should not lock you out of the day room for hours.” It was deemed important to ”make sure everything is clean in the ward environment.”

Theme: Stigma

The general feedback around the stigma theme fell into two categories: assumptions and labels.

One participant reported that the disclosure of mental health problems in employment was an issue as “relapse may result in losing your job.”

Assumptions

Regarding assumption one participant said “it should not always be assumed that you are lying.” Another said that it was desired and important “to be regarded as innocent until proven guilty, rather than the other way around.” It was also cited that “being believed” and “having credibility” was a big issue.

Labels

In terms of labels there were a lot of comments around the negative effects of labelling, for example one person said it would be good “not to feel identified by your diagnosis.” “Labels like

borderline personality disorder are a stigma and a barrier." Also it was said that "being labelled by your mental health problem was unhelpful".

Theme: Patients' Rights

Participants reported 5 main categories with respect to patients' rights; Spirituality, Autonomy, Confidentiality, Gender, and Personal Space.

In terms of general feedback it was seen as desirable "to feel respected", and "to be spoken to as an equal."

Spirituality

In terms of spirituality participants felt that their religions were not being respected. Others also felt ignored when they asked to see a vicar: "When I first went into Mayday my diagnosis was paranoia. I asked to see a Priest but was ignored."

One participant made a positive comment about dignity and the support he/she received: "Dignity is also difficult to balance. The support systems in place in Lewisham, and the Consultant and Care Plan Worker's vision have been tremendously helpful in maintaining an inner calm and dignity. And [x] himself is a remarkably resilient person. The above all has helped us to understand things."

Autonomy

Feedback received about autonomy fell into a general category and Basic Rights. In terms of Autonomy participants felt that their opinions must count. There were a lot of negative comments: "Being physically restrained can be very undignified. Better options should be considered." It was also noted that "often it can be more comfortable to speak to one nurse as opposed to another", and "too much rigid authority" was seen as a bad thing.

Basic Rights:

In terms of basic rights most participants commented that they are not being valued:
"I felt I wasn't treated like a human being." "I felt like I did not exist. I did not feel valued". Others felt that they didn't have a choice, and were being forced to do things: "patients are not kept informed and have no choice." It was desired "not to be forced to do things." Two participants commented on not being able to smoke, while others felt they were being dependant on staff to make drinks. One positive comment was "my privacy was maintained when I was an in-patient."

Confidentiality

In terms of confidentiality participants commented that "service users should choose what information is shared with family etc." Others felt that "things said to their GP should be kept confidential (except in cases where the safety of a child, another person, or yourself is at risk)", and "staff should not discuss you (your case) in public places, e.g. on wards or in corridors." One participant commented that "privacy is so delicately balanced. On the one hand one doesn't want to be isolated. But at the same time there are areas that simply cannot be shared, even with close friends and larger family, who do not comprehend what it's like to undergo such an experience. It's only later, when things are running more normally, that one can begin to open up."

Gender

In terms of gender some participants commented that they prefer to have a mixed ward rather than a single sex ward, while others said they preferred “not to have male staff on a female ward.”

Others also commented that “male staff not to be involved in forcible actions, i.e. stripping, drugging, and so on of female patients, and vice versa.”

Personal Space

Feedback received under personal space fell under 2 categories: Physical Space and Emotional Space.

Physical Space:

Generally the participants felt that they should have their own privacy respected: ”A patients’ bedroom should be their private space – where possible no one else allowed in, not even staff.” It was also desired “to be treated fairly and respectably, to be able to wear decent clothes that aren’t too revealing,” whilst others said “everyone should have a key to their own room.” Also, people preferred “being asked, helped, and encouraged instead. People should not be forcibly stripped and washed.”

Emotional Space:

In terms of emotional space participants felt that they should be treated with respect, whilst others felt they are being treated like children: ”Having respect for when someone wishes to remain silent or be alone” was desired, and “being belittled” was seen as a negative. One participant commented “staff sometimes impose their own judgments e.g. about sexuality.”

Theme: Communication

Comments about communication fell into 3 categories: verbal communication, formal communication and poor communication.

Verbal Communication

In terms of verbal communication, the main issues were concerning how staff spoke to patients and general communication between staff and patients. It was reported that there were language barriers when staff spoke “poor English” and it was “frustrating.” A suggestion was that more training was needed. One person said they were spoken to in a way that made them feel disrespected. Another view cited was that there should be regular meetings “between patients and staff regarding privacy and dignity.”

Formal Communication

Formal communication fell in the areas of practice and procedure. It was reported that practices were sometimes unsatisfactory for instance one person said the “GP doesn’t always have my notes up to date” and another said that “assessment can be *very* repetitive and sharing personal information with mental health professionals can be frustrating when agencies don’t pass

information on." There was also another negative comment on "the NHS failing due to a lack of communication."

Poor Communication

Things that fell into the poor communication category were comments on "unclear communication" and a "lack of information." Two participants reported that they needed to be kept informed.

Theme: Interface

Participants reported the interface fell into the main areas of admission, advice and support, discharge, psychiatric liaison and general practitioners.

In terms of general comments, participants reported that it is important to remember to respect that some people "with mental health problems also experience physical health problems and vice versa." Also to note that as a mental health patient going into A&E for a physical problem it is often assumed that the matter is mental health related.

Psychiatric Liaison

In terms of psychiatric liaison it was reported that it was sometimes, "not always effective and could be seen as a barrier." Also the psychiatric liaison department, it was said, did not share personal information with the participant's GP.

General Practitioners

Regarding GPs, a positive comment was that the participant's GP "knows when I'm becoming unwell and makes the appropriate referral ASAP." A more negative comment was that sometimes when service users get "passed between GP's and A&E" this results in the participant feeling "unwanted and un-valued."

Admission

One participant suggested "if taken to hospital under a section, to be allowed to pack a bag and take it with you." Also another participant reported the desire not to automatically always have one's mobile phone taken away regardless of the particulars of the case on triage. One participant was treated indignantly by the police "(violence)."

Advice and Support

The question of a participants personal dignity came into the comments; "Croydon no longer has an out of hours advice line, now being advised to contact the Samaritans," which impacts on a participant's dignity.

Discharge

Two basic points were raised that would impact the participants very positively; one suggested that some form of therapy could be devised that could help patients and carers with the transition involved with discharge. Also it was suggested that there could be ways to "remedy the loneliness upon discharge that can poorly affect recovery."

Theme: Treatment

Participants reported 4 main categories with respect to treatment: medication, recovery, input into own care and non-consensual.

Medication

In terms of medication, most comments from participants were negative, “not to have to queue for medication” and “medication to be kept confidential from other patients.” Only one positive comment was mentioned that, “medications brought to patients rooms. Observations done in privacy.”

Input into own Care

Generally participants felt that there was a lack of involvement in their own care and they were not encouraged to get involved. “Asked my care coordinator a question about my medication and the care coordinator blew his top saying are you challenging my professionalism?” It was also mentioned that there is a lack of one to one meetings and “inconsistent regimes on the wards.”

Recovery

The overall report was that participants felt a more person-centred and more holistic approach to treatment should be implemented. While they felt life and should get better, two participants commented on respect and value, “valuing each other” and “respect is reciprocal.” One participant said that getting help outside hospital could cause external ill health.

Non-Consensual

Some participants felt they are being forced to take medication and treatment. “Medication is regulated without consent” and “patients still being forced and held down to be given medication.” Other patients felt that they should be encouraged or helped to do things, as opposed to being forced.

Theme: Staff

Participants reported 4 main themes with respect to staff: attitude, organisational, gender/ culture awareness and training.

Attitude

In terms of attitude, feedback from participants fell into 2 categories: Best Practice and Bad Practice.

Best Practice.

Participants reported that mutual trust, listening skills and politeness were of paramount importance. Staff should take “direct responsibility” when questions are asked and a few participants commented that “trust needs to go both ways.” Compassion and empathy are necessary for staff to “ respect the boundaries of patients.” One participant reported that staff

should “not always be in a rush.” “To be treated with courtesy” meant that it was possible for participants to “respect staff due to being treated well.”

Bad Practice.

There were a large amount of comments by participants on the ill-treatment by staff. Issues ranged from “staff interfering in our business” to “being ignored”, to “confrontational in exercising their authority” and “being threatened with the section system by staff.” Participants were concerned by a lack of respect, with staff “kissing their teeth”, “barging in without knocking” and “being told what to do by staff who are much younger than me.” It was recognised, however, that some problems were due to “not enough staff” and “staff overstretched.”

Organisational Issues

Participants reported shortcomings in the structural organisation of staff. A number of comments were made regarding waiting times, both for requests made on wards, where 5 minutes can take 20 minutes, and being informed “exactly when our section ends”. Staff discipline should also be taken more seriously. One participant mentioned complaints “should be taken into consideration in any reviews.” Efforts should be made to “consider terminating the employment of rude and abusive / aggressive staff.” Again it was acknowledged that there was “not enough staff to look after patient’s basic care needs” but that measures should be taken to redress the “oppressive power imbalance” between staff and service users.

Gender/ Cultural Awareness

Participants reported on various themes the most prominent one being the attitudes of female nurses; “female nurses from cultural backgrounds where women are not respected sometimes seem to lack respect for women, as ironic as this may sound, and in so doing have even less respect for women with a perceived weakness such as a mental health problem.” Female nurses also sometimes fail “to show respect to female patients.”

With regards to religion and cultural beliefs in hospital, “Priests and Chaplain’s not easy to access”. It was also noted that “staff should not impose their views on patients e.g religion”. One participant commented on the fact of “CPN(s) failing to empower service user’s due to cultural discrimination”. There was also the feeling “as though aspects of your case might be getting discussed “at the pub.”

Training

Staff training fell into three categories: general training, service user training to staff and involvement (SUCs).

General Comments.

It was reported that there was a lack of training. It was suggested that there should be “a minimum of one day training on treating patients with dignity – mandatory.” Also that there should be more “awareness from non mental health medical staff.” One participant suggested “all staff to have better training in mental health e.g. nurses, occupational therapists, psychiatrists, CPNs.” The participants also stated that there should be “attitude and awareness improvement” and “training in cultural awareness.”

Service User Training to Staff.

Participants made many comments regarding service user to staff training e.g. “service user lead training”, “training delivered to staff by service users.” Also that training should be given to all non clinical staff including cleaners, and that they should have training “from service user consultants re: dignity.” One participant suggested that “receptionists to have SUC and mental health awareness training.” Another suggested that staff should experience what it is like to be an inpatient, and that the “leaders of the CAG teams to receive training from service users.”

Involvement.

One suggestion was that “service users trained as secret shoppers on wards and in CMHTs.” One participant said “patients find it easier to talk to linkworkers, not the nursing staff.” Lastly one participant said “to not be threatened or oppressed as a service user doing involvement work (case of lead SUC being oppressive and hostile to service user consultant)-“I hope you are going to contribute more in today’s meeting than you did previously.”

Theme: Carers

Participants reported the theme of Carers fell into 4 main areas: communication, visiting, recovery and groups.

Communication

In terms of communication, most participants commented that carers should be better informed by staff and also informed about medication and diagnosis etc. Others commented “visitors and family members not informed that they can take service users off the ward even if they are sectioned.” A participant was “indignant to receive standard letter (to family) stating that “carer/ family” member has mental needs.”

Visiting

In terms of visiting, participants commented “no definite defined private space for visits between family and carers.” It was also noted that there were “unflexible visiting times” and “visit delays are provocative.”

Recovery

In terms of recovery, participants commented that they would like to have family and carers involved as much as possible “to allow patients to have family/ carers involved at important stages throughout treatment and care.” It was also suggested “to have minimal amounts of your case discussed with carers (medication & diagnosis) but not intricacies such as self-harm.”

Groups

In terms of groups participants commented that they would like to have some carers and patients groups (where carers are mixed with patients).

Appendix 1

Focus groups

Croydon:

Bethlem Community Centre (community)

Croydon (community)

River House (in-patient)

Lambeth:

SHARP (community)

LEO unit (in-patient)

Lewisham:

Catford (community)

Ladywell Unit (in-patient)

Southwark:

Maudsley Community Link Centre (community)

St Giles (community)

Carers:

Maudsley

Example flyer (carers)

We need YOU!
Help us help you

What's Privacy & Dignity to you?

Your help is needed at: **a service user run focus group**
We would like to hear your views to help shape the future of the South London & Maudsley NHS Foundation Trust

Privacy & Dignity Policy!

- **Meet other carers and join forces.**
- **Be heard and hear about privacy & dignity.**
- ***Your* view is *important***
- **Help to inform future privacy & dignity policy for the betterment of all service users and carers.**

More information

About the Privacy & Dignity Project

South London and Maudsley (SLaM) Mental Health Trust's vision is that people who use our services will be treated respectfully.

To be treated with privacy and dignity can mean many things to different people. Examples of these include, attitudes and behaviours of staff, communication, the environment, privacy to protect peoples modesty, confidentiality, to have your nutritional needs met and to be free from abuse.

People that use our mental health services are diverse; and to ensure that any strategy or policy represents the needs of service users, families and carers we would like a broad range of people to help us make things better together!

We are running some groups called 'focus groups' where people can come and give their views about privacy and dignity in SLaM services

These groups will be facilitated by people who have experience of SLaM services themselves and will ask questions like:

What are your suggestions for improving the privacy and dignity of people that use our services?

APPENDIX 3: EQUALITY IMPACT ASSESSMENT

EQUALITY IMPACT ASSESSMENT

PART 1 – INITIAL SCREENING

SLaM wants to ensure that we provide accessible and equitable services that meet the needs of our diverse community and to meet the first principle of the NHS constitution – to provide comprehensive services available to all, paying particular attention to marginalised groups who are not keeping pace with the rest of society.

Under the Equality Act 2010 we are all protected from less favourable treatment or discrimination based on
age; disability; pregnancy and maternity; gender reassignment; race; religion / belief; sex; sexual orientation; marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]. As an organisation we are legally obliged to consciously think about equality as part of the decision making process in the design, delivery and evaluation of our services and policy development/review. This is why we ask you to begin / conduct the EIA at the planning stage and in a group, using the screening tool as a prompt to the necessary conversations about the impact of your work on equality. (See guidance for further information)

1. Name of the policy / function / service development being assessed?

Privacy and Dignity Policy

2. Name of **Lead** person responsible for carrying out the assessment? (where there is a service change, this should be the individual with responsibility for implementing the change) *[The EIA should, wherever possible, be completed and considered in a group]*

Lead: Natalie Warman

Others involved:
e.g. staff, service users / service user consultants / carers / carers consultants:

Patient Experience Group
Service Users

3. Describe the main aim, objective and intended outcomes of the policy / function / service change/ development?

Aim: To improve patient experience

Objectives: To ensure privacy and dignity is maintained

Outcomes:

4 (a). What evidence do you have and how has this been collected? *[Please list the main sources of data, research and other sources of evidence reviewed to determine the impact on the equality groups, sometimes referred to as protected characteristics. Your data can include demographic data, access data, national research, surveys, reports; focus groups; information from your service?]*

None

Some

Substantial

Service user consultation focus group report

Dignity Challenge

MHOAD Services end of life care

4 (b). Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

/ NO

Which equality groups may be disadvantaged / experience negative impact? *[please base your answers on available evidence which can include for example key themes from the general feedback you receive via patient experience data (such as patient surveys; PEDIC); carer experience; complaints; PALS; comments; audits; specialist information - your personal knowledge and experience]*

Age	/	NO
Disability	/	NO
Gender reassignment	/	NO
Pregnancy and maternity	/	NO
Race	/	NO
Religion / Belief	/	NO
Sex	/	NO
Sexual orientation	/	NO
Marriage and civil partnership	/	NO

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)
Group:…… / NO

5. Have you explained your policy / function / service development to people who might be affected by it? *(Please let us know who you have spoken to and the results of these conversations and what actions/ developments/ changes have come out of them)*

Yes /

If 'yes' please give details of who you involved and what happened as a result.

Service User Consultation

6. If the policy / function / service development positively promotes equality please explain how?

Addresses the impact of discrimination and inequality and how the Trust can minimise this

7. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High (highly likely to have a negative impact)	Medium (moderately likely to have a negative impact)	Low (probably will not have a negative impact)

Neutral: High (highly likely)
Reason for your decision:
Policy promote privacy and dignity for all clients

Date completed: ……28.5.12…….

Signed ……Natalie Warman……. Print name ……..

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

South London and Maudsley NHS
NHS Foundation Trust

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

1. Name of the policy / function / service development?

Privacy and Dignity Policy

2. From the initial screening process, which groups may experience negative impact?

Age / NO

Disability / NO

Gender reassignment / NO

Pregnancy and maternity / NO

Race / NO

Religion / Belief / NO

Sex / NO

Sexual orientation / NO

Marriage and Civil partnership / NO

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)

Group:…… / NO

3. What evidence do you have? Please give details:

(a) Strong evidence

(b) Some evidence/considerable gaps

(c) Anecdotal evidence

4. Please outline steps taken during the EIA process to raise awareness and consult/involve interested parties and those who may be affected by the policy / function / service development

Service user consultation. Focus groups took place during March 2012.

5. What does available evidence / results of consultation show?

The results of the consultation have been reflected in the Standards of the Policy

6. If you have not been able to conduct consultation how do you intend to test out your findings and recommended actions?

7. What changes or practical measures would reduce the negative impact on particular groups? (Think what a successful outcome would look like and what can be done to bring about this outcome)

If changes are required please complete the action plan template overleaf

8. What are the main conclusions of the assessment?

9. Has a monitoring process been established to measure/review the effects of the policy, function or service development? (This may include statistical analysis of monitoring data, satisfaction surveys or use of networks)

Yes (if yes, please include details in the action plan overleaf)

No (if no, please state why)

Date completed: …28.5.12……..

Signed ……Natalie Warman……. Print name ……..

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your CAG Equality Lead

ACTION PLANNING

The following action plan should summarise the proposed actions, setting out the timescale, lead individual and include details of any monitoring needed in the future to check that desired outcomes are reached.

Issue / Adverse impact identified	Proposed actions	Responsible/ lead person	Timescale	Progress

Please send an electronic copy of your completed assessment to:

1. Kay.harwood@slam.nhs.uk
2. Your Service Equality Lead

Appendix 4 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Paul Bellerby, Legal Services [paul.bellerby@slam.nhs.co.uk]

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	No	
• Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	No	
• Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	No	
• Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	No	
• Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	No	
• Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]	No	
• Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	No	
• Article 11 - Freedom of assembly and association	No	
• Article 14 - Freedom from all discrimination	No	

Name of person completing the Initial HRA Assessment:	Natalie Warman
Date:	28.5.12
Person in Legal Services completing the further HRA Assessment (if required):	
Date:	

Appendix 5 – Checklist for the Review and Approval of a Policy

This checklist must be used for self-assessment at the policy writing stage by policy leads and be completed prior to submission to an appropriate Executive Committee/Group for ratification.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Style and Format**		
	Does the document follow The South London and Maudsley NHS Foundation Trust Style Guidelines? i.e.: • The Trust logo is in the top left corner of the front page only and in a standard size and position as described on the Intranet • Front page footer contains the statement about Trust copyright in Arial 10pt • Document is written in Arial font, size 11pt (or 12pt) • Headings are all numbered • Headings for policy sections are in bold and not underlined • Pages are numbered in the format Page X of Y	Y	
2.	**Title**		
	Is the title clear and unambiguous?	Y	
3.	**Document History**		
	Is the document history completed?	Y	
4.	**Definitions**		
	Are all terms which could be unclear defined?	Y	
5.	**Policy specific content**		
	Does the policy address, as a minimum, the NHSLA Risk management Standards at Level 1 where appropriate	N/A	
6.	**Consultation and Approval**		
	Has the document been consulted upon?	?	
	Where required has the joint Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination**		
	Does the document include a plan for dissemination of the policy?	Y	
8.	**Process for Monitoring Compliance**		
	Is it explicit how compliance with the policy will be monitored?	N	
9.	**Review Date**		
	Is the review date identified on the cover of the document?	Y	
10.	**References**		
	Are supporting references cited?	Y	
11.	**Associated documents**		
	Are associated SLaM documents cited?	Y	
12.	**Impact Assessments**		
	Is an Equality Impact Assessment included as the appendix of the document?	Y	
	Is a HRA Assessment included as an appendix of the document?	Y	