Delivering Same Sex Accommodation Policy

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Change History

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5	April 2015	Sarah Lafbery	Requiring updating
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CONTENTS

1 Introduction

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. This is one of the guiding principles of the NHS Constitution (2009) and at the

core of local NHS visions.

Patients should not normally have to share sleeping accommodation or sanitary facilities with members of the opposite sex. This applies to all areas of hospital care. However, there are some exceptional circumstances (such as where the patients' needs require specialised or urgent care), where providing fast effective care for the patient may take priority over ensuring same-sex accommodation. Where mixing does occur, it must be in the interest of all the patients affected.

For clarity, the Department of Health (2009) have produced detailed definitions, and these are appended. They cover patients admitted in an emergency, those undergoing day treatment and those in critical care environments. Separate definitions are also appended for children, young people and transgender people.

The definitions set out what we expect in terms of ward accommodation (including emergency wards and critical care) and focus mainly on inpatients and those receiving treatment. However, good standards of privacy and dignity must apply across the Trust, and many of the principles outlined within the definitions can be used in other areas, including when patients are moving around the hospital sites.

The policy is based on the following definition of same-sex accommodation:

Men and Women should not have to share sleeping accommodation or toilet facilities and should not need to pass through opposite sex accommodation or toilet and washing facilities to access their own **(The Institute for Innovation and Improvement 2008 & DH 2009).**

This Policy contributes to the achievement of:

- CQC Outcome 4 – The patient will receive care, treatment and support in single sex accommodation wherever it is available.

2 Same-Sex Accommodation

Same-sex accommodation can be provided in:

- Same-sex wards
- Single rooms with adjacent same-sex toilet and washing facilities (preferably en-suite)
- Same-sex accommodation within mixed wards (i.e. bays or rooms which accommodate either men or women, not both; with designated same-sex toilets and washing facilities within or adjacent to the bay or room)
- All areas should segregate men and women into separate bays.

Children, and in particular adolescents, need special consideration. The Hospital Standard of the National Service Framework (NSF) for Children requires children to be treated in accommodation that meets their needs for privacy and is appropriate to their age and development.

3 Duties and responsibilities

The nursing team must take extra care to safeguard privacy. This may require:

- Moving beds around in a bay to ensure that the new patient is closest to the bay exit and therefore the bathroom and toilet facilities

- Keeping the bedside curtains partially drawn at all times if clinically safe to do so
- Taking the patient out to the toilet rather than using commodes / bedpans
- Finding a private area for examinations / consultations

If mixing occurs, the most Senior Nurse on duty must:

- Explain and apologise for the situation to the patient. Gain the patient's/next of kin consent and discuss the issue with the other patients in the bay. These actions must be documented in the patient's nursing notes.
- Rectify the situation as soon as possible and keep the patient informed. These actions must be documented in the patient's nursing notes.
- Inform the Matron and Head of Nursing of the Policy breach.
- Record and report all episodes of mixed sex accommodation breaches using the Trust's Electronic Incident Reporting System (Datix) each 24-hour period the bay is mixed
- The Head of Nursing/Matron must inform the Chief Nurse/Deputy Chief Nurse at the earliest opportunity.
- Escalate to the Operations manager so that clinically appropriate patients can be transferred to resolve the situation where possible.
- Out of Hours inform the Senior Nurse on-call and the Operational Manager who will inform the Senior Manager.

All breaches of sleeping accommodation must be reported, for each patient affected. "Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles.

All staff are responsible for protecting patients' privacy and dignity in relation to sleeping accommodation and sanitary facilities. Staff must have the knowledge and skills to deal sensitively with the various circumstances in which the patient's privacy and dignity may be infringed.

Senior Sisters/Charge Nurses and Matrons will be responsible for ensuring there is a culture at ward level which promotes the importance of maintaining the patients' privacy and dignity at all times. The ward manager should always ensure that staff, including doctors, are always aware of the current status of each bay, side room, bathroom and toilet area as these may change during shifts due to the admission and discharge of patients.

4 Ward Environment

Bedside curtains must be correctly fitted with overlaps, so that you cannot see through the curtains.

Individual washing and toilet facilities should be lockable and patients must be made aware of a nurse call system *(hospital staff must be able to gain access in an emergency)*.

Separate toilets and washing facilities should be provided for men and women, which are directly adjacent to the same sex sleeping area.

5 Process for Monitoring Compliance and Effectiveness

Patient Surveys

- The Trust participates in the annual National Survey programme
- Friends & Family Test includes a question on privacy and dignity for patients

PLACE Inspections

- PLACE inspections provide an annual assessment of the Trust with a specific focus on aspects of privacy and dignity.

Complaints

- Concerns or complaints relating to inadequate care - privacy and dignity issues will be monitored via the informal route - PALS and formal route - Trust Complaints process

Audits

These Guidelines will be audited in the following way:

- Matron Quality Checks
- Bi-annual Privacy and Dignity Self-Assessments
- Incidents of breaching recorded onto Datix

6 Decision matrix for Providers regarding Mixed sex accommodation

Category	Acceptable?	Notes
Critical Care , Level 2 &3 eg: ICU/ Coronary care unit High Dependency areas Hyperacute stroke units recovery units attached to Theatres/ procedure rooms	Almost always G	*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)
Acute wards, e.g.: Medical/ surgical(general and specialist) Elderly care Orthopaedic	Never R	*All* episodes of mixing in acute wards should be discussed individually with commissioners
Intermediate and Continuing care wards	Never R	*All* episodes of mixing in intermediate and continuing care wards should be discussed individually with commissioners

Admissions Units , e.g.: Medical/ Surgical admissions Observation wards Clinical decision units	Almost Never R	*Not acceptable* for organisational convenience (e.g. to 'park' patients whilst awaiting admission *Not acceptable* as a routine occurrence
Day Surgery	Rarely R	Acceptable for very minor procedures(e.g. operations on hands/ feet that do not require patients to undress)
Endoscopy Units	Rarely R	*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, e.g. if bowel prep is needed
Patients with long- term conditions admitted frequently as part of a cohesive group(eg renal dialysis)	Sometimes A	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 admissions , and there is no recognisable group identity
Children / young people's units(including neonates)	Sometimes A	Children and young people should have their choice of whether care is segregated according to age or gender
Mental Health and LD	Never R	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, en suite room in the opposite- gender area of the ward. In such cases, a full risk - assessment must be carried out and complete safety, privacy and dignity maintained.

7 References and Appendices

Department of Health (2010) Chief Nursing Officer and Deputy NHS Chief Executive Statement – PL/CNO/2010/3. Gateway No. 15024. DH:London.

Department of Health (2009a) Delivering Same Sex Accommodation – Principles DH: London.

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Appendix 1 DELIVERING SAME-SEX ACCOMMODATION WHEN PATIENTS ARE ADMITTED IN AN EMERGENCY

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including when admission is unplanned.

High standards usually involve a presumption that men and women do not have to sleep in the same room, or use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, it is recognized that in some emergencies, mixing of the sexes can be justified. Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. This means that mixing must be justifiable for all patients in the room.

Further Detail & Background

This note explains our expectations in relation to patient perceptions in emergency and unplanned admissions, whether direct to a ward, or via an admissions unit[1]. Separate guidance is available for children's services, intensive care units and day treatment areas.

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment or the convenience of staff.
- Admissions units should be capable of delivering segregation for most of the patients for most of the time.
- Patient preference should be sought, recorded and where possible, respected. Ideally, this should be in conjunction with relatives, carers and loved ones.
- The reasons for mixing, and the steps being taken to put things right should be explained fully to the patient and his/her family and friends.
- Staff should make clear to the patient that the Trust considers mixing to be the exception, never the norm.
- Greater segregation should be provided where patients' modesty may be compromised (e.g. when wearing hospital gowns/nightwear, or where the body (other than the extremities) is exposed.
- Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated).
- Where mixing is unavoidable, transfer to same-sex accommodation should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.
- Within the clinical decisions unit bays 1,2 & 6 should have patients of the same sex. Bays 4&5 should also have patients of the same sex. Bay 3 however must be used as a seated area for patients who are dressed and able to sit in a chair. No more than three patients should be in this area. The exception would be if all patients were of the same sex.

Implications & Examples

When a patient's survival and recovery depend on rapid admission, the requirement for full segregation clearly takes a lower priority, but this does not imply a blanket exemption for all emergency admissions. Nor does it imply a blanket exemption for admissions units.

Clinical needs must be judged for each individual patient. If a patient is admitted into a multi-bed room, then either all patients must be same gender, or mixing must be clinically justified for *all* patients in the room, not just the newly-admitted one.

Where patients cannot be immediately admitted to the “right bed” (i.e. one in the right specialty, with same-sex accommodation), then the final placement should weigh the benefits and disadvantages of each available option. Wherever possible, the patient or their family should be consulted.

Clearly, patient safety is paramount, but the requirement for segregation should not be ignored. It should be demonstrably possible for the large majority of emergency patients to have their clinical needs met within segregated accommodation.

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[1] “Admission Unit” includes all units where a patient may be admitted for assessment, treatment or observation, pending a final decision on treatment. This covers clinical decision units, emergency admission wards, observation wards, medical assessment units and so on.

Appendix 2 DELIVERING SAME-SEX ACCOMMODATION IN DAY TREATMENT AREAS

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including day treatment areas.

High standards usually involve a presumption that men and women do not have to be cared for in the same room, or use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, we recognize that in some day treatment areas, mixing of the sexes can be appropriate, or even desirable. Decisions should be based on the needs of each individual patient, not the constraints of the environment or the convenience of staff.

Further Detail & Background

This note explains our expectations in relation to patient perceptions in day treatment areas. Separate guidance is available for children's services and for intensive/high dependency care and emergencies.

What is a "Day Treatment Area" in this Context?

Examples of "day treatment areas" include, amongst others:

- Renal dialysis units
- Day surgery units
- Endoscopy units
- Elderly care day hospitals
- Chemotherapy units

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment or the convenience of staff.
- Greater segregation should be provided where patient's modesty may be compromised (e.g. when wearing hospital gowns/nightwear, or where the body (other than the extremities) is exposed.
- Staff should make clear to the patient that the Trust considers mixing to be the exception, never the norm.
- Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated).
- Patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives, carers or loved ones.

Implications & Examples

Using these principles allows staff to make sensible decisions that may vary from day to day. For instance, in a renal dialysis unit, if all patients are well established on treatment, wear their own clothes and have formed personal friendships, mixing may be a good thing. By contrast, a new dialysis patient, with a femoral catheter, and wearing a hospital gown, should be able to expect a much higher degree of privacy.

Similar considerations apply wherever treatment is repeated, especially where patients may derive comfort from the presence of other patients with similar conditions. Thus, for instance, it may be appropriate to nurse a mixed group of patients together as they receive regular blood transfusions.

Likewise, it is clearly reasonable for both men and women to attend an elderly care day hospital together - as long as toilet and bathroom facilities are separate, and very high degrees of privacy and segregation are maintained during all clinical or personal care procedures.

Day Surgery & Endoscopy Units

The presumption of same-sex accommodation applies in day surgery units, especially those where patients may remain overnight. The exception might be where very minor procedures are being undertaken - e.g. “lumps and bumps” on the hand or foot. As a starting point, if the patient is in a hospital gown, and may have difficulty in preserving their own modesty due to sedation or anaesthesia, then segregation should be the norm.

Appendix 3 DELIVERING SAME-SEX ACCOMMODATION IN CRITICAL CARE ENVIRONMENTS

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including critical care environments.

High standards usually involve a presumption that men and women do not have to be cared for in the same room, or use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

On occasion, however, a minority of patients may have a clinical condition which requires immediate access to potentially life-saving treatments which can only be delivered within critical care environments. At these points in a patient's journey, access to and treatment within appropriate locations is paramount. In these situations, mixing of the sexes can be justified.

Patients that are medically fit to step down get classified as level 1 patients and breech the mixed sex accommodation guidance if they are not moved to same sex accommodation

Further Detail & Background

This note explains our expectations in relation to patient perceptions in critical care environments. Separate guidance is available for children's services emergencies and day treatment areas.

Principles

- Decisions should be based on the needs of the individual patient whilst in critical care environments, and their clinical needs will take priority.
- Decisions should be reviewed as the patient's clinical condition improves and should not be based on constraints of the environment or convenience of staff.
- The risks of clinical deterioration associated with moving patients within critical care environments to facilitate segregation must be assessed.
- Where mixing does occur, there should be high enough levels of staffing that each patient can have their modesty constantly maintained by nursing staff. This will usually mean one-to-one nursing, or at least, a constant nurse presence within the room or bay.
- Where possible (for instance for planned post-operative care) patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives or loved ones.

Recommended actions when a patient becomes a level 1 patient

- The locally agreed operational standard is if the patient has been identified as medically fit before 12.30pm on a daily basis, the patient will be stepped down to same sex accommodation within 24 hours (NICE guidelines state there should be no discharges from ITU between 22.00hrs and 08.00hrs)
- A patient will be declared as a Mixed Sex sleeping breech if not moved to same sex accommodation within this timescale
- This operational standard **should not stop** any patient being identified as appropriate to be moved to a ward if a bed is available before these timescales
- The information on numbers of Level 1 patients identified by 12.30pm is to be reported to the Operational site management team by the ICU senior nurse on a daily basis
- The critical care unit staff are responsible for reporting the MSA breaches

Implications & Examples

When a patient's survival and recovery depend on the presence of high-tec equipment and very specialist care, the requirement for full segregation clearly takes a lower priority, but this does not mean that no attempt at segregation is necessary. At the very least, staff should consider whether it is possible to improve segregation. In new units, the design should support segregation as far as possible.

The same principles apply to theatre recovery units where patients are cared for immediately following surgery, before transfer to the ward. Whilst separate male and female recovery units are not required, some degree of segregation remains the ideal. High levels of observation and nursing attendance should mean that all patients can have their modesty preserved whilst unconscious.

Watford ICU Guidelines for Delivering Same Sex Accommodation

Staff will take great care in maintaining privacy and dignity of all the patients at all times

1. Where possible (for example for planned post-operative care) the preference will be sought, recorded and fulfilled, whenever possible.
2. Patients kept covered at all times by the use of hospital gowns and nightwear.
3. Staff to consider turning the beds and beams around so patients can face looking out of window and receiving more privacy.
4. Wardable/HDU patients are moved into Phase 2 of the unit with women or men, whichever is the minority nursed in side rooms to maintain single sex accommodation.
5. Staff to use the hard screens with curtains to aid privacy. Use the Do Not Disturb signs to aid privacy.
6. Patient toilet/ shower room available for use.
7. Signs in the relatives rooms highlighting the issues and prompting relatives to speak to staff.
8. Patient/ relative information booklets highlighting same sex issues to be made available in relative's room.
9. Wardable patients to be highlighted as early as possible to the Operational Management Team so that the safest and appropriate ward bed can be found.
10. At each bed meeting the acuity levels of patients in ICU are reviewed to ensure early transfers are expedited and communicated to the ICU team. If transfers cannot be facilitated due to Trust capacity the ICU team will be advised and anticipated time frames provided where possible.

Appendix 4 DELIVERING SAME-SEX ACCOMMODATION IN CHILDREN'S UNITS

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including children's and young people's units.

High standards in relation to adult care usually involve a presumption that men and women do not have to be cared for in the same room, or use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, we recognise that for many children and young people, clinical need and age and stage of development may take precedence over gender considerations and mixing of the sexes is reasonable, or may even be preferred. There is evidence that many young people find great comfort from sharing with others of their own age and often, this outweighs their concerns about mixed sex rooms. Young people should be given the choice.

Washing and WC 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).

Further Detail & Background

This note explains our expectations in relation to patient perceptions in children's areas. Separate guidance is available for day treatment areas and for intensive/high-dependency care and emergencies.

Decisions should be based on the clinical, psychological and social needs of the child. This approach should be conveyed to the child (where they are old enough to understand), and their parents. If they would prefer to be nursed in proximity to members of their own sex, then this preference should be accommodated.

Principles

- Privacy and dignity is an important aspect of care of children of all ages 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.

Implications & Examples

Using these principles allows staff to 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 interest of each patient. 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. Such flexibility is encouraged. It is not acceptable to apply a blanket approach that assumes mixing is always excusable.

In children's units parents are 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.

Appendix 5 DELIVERING SAME-SEX ACCOMMODATION FOR TRANS PEOPLE AND GENDER VARIANT CHILDREN

Transsexual people, that is, individuals who have proposed, commenced or completed reassignment of gender, enjoy legal protection against discrimination. In addition, good practice requires that clinical responses be patient- centred, respectful and flexible towards all transgender people who do not meet these criteria but who live *continuously or temporarily* in the gender role that is opposite to their natal sex.

General key points are that:

- Trans people should be accommodated according to their presentation; the way they dress, and the name and pronouns that they currently use.
- This may not always accord with the physical sex appearance of the chest or genitalia.
- It does *not* depend upon their having a gender recognition certificate (GRC) or legal name change.
- It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities).
- Views of family members may not accord with the trans person's wishes, in which case, the trans person's view takes priority.

Those who have undergone full-time transition should **always** be accommodated according to their gender presentation. Different genital or breast sex appearance is **not** a bar to this, since sufficient privacy can usually be ensured though the use of curtains or by accommodation in a single side room adjacent to a gender appropriate ward. This approach may only be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite gender ward. Such departures should be proportionate to achieving a 'legitimate aim', for instance, a safe nursing environment.

This may arise, for instance, when a trans man is having a hysterectomy in a hospital, or hospital ward that is designated specifically for women, and no side room is available. The situation should be discussed with the individual concerned and a joint decision made as to how to resolve it. At all times this should be done according to the wishes of the patient, rather than the convenience of the staff (see http://www.gires.org.uk/assets/trans-rights.pdf section 1.4, pp9, 10).

In addition to these safeguards, where admission/triage staff are unsure of a persons' gender, they should, where possible, ask **discreetly** where the person would be most comfortably accommodated. They should then comply with the patient's preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their *continuous* gender presentation (unless the patient requests otherwise).

If upon admission, it is impossible to ask the view of the person because he or she is unconscious or incapacitated then, in the first instance, inferences should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary in order to carry out treatment.

In addition to the usual safeguards outlined in relation to all other patients, it is important to take into account that immediately post-operatively, or while unconscious for any reason, those trans women who usually wear wigs, are unlikely to wear them in these circumstances, and may be 'read' incorrectly as men. Extra care is therefore required so that their privacy and dignity as women is appropriately ensured.

Trans men, whose facial appearance is clearly male, may still have female genital appearance,

so extra care is needed to ensure their dignity and privacy as men.

8 Particular Considerations for Gender Variant Children & Young People

Gender variant children and young people should be accorded the same respect for their self-defined gender, as are trans adults, regardless of their genital sex.

Where there is no segregation, as is often the case with children, there may be no requirement to treat a young gender variant person any differently from other children and young people. Where segregation is deemed necessary, then it should be in accordance with the dress, preferred name and/or stated gender identity of the child or young person.

In some instances, parents or those with parental responsibility may have a view that is not consistent with the child's view. If possible, the child's preference should prevail even if the child is not Gillick competent.

More in-depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that they are extremely likely to continue, as adults, to experience a gender identity that is inconsistent with their natal sex appearance so their current gender identity should be fully supported in terms of their accommodation and use of toilet and bathing facilities.

It should also be noted that, although rare, children might have conditions where genital appearance is not clearly male or female and therefore personal privacy may be a priority.

Appendix 6 Equality Impact Assessment

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
	Marriage & Civil partnership	No	
	Pregnancy & maternity	NO	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	No	

If you have identified a potential discriminatory impact of this procedural document, please refer it to (Insert name and position) together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact (Insert name and position).

Policy Ratification Form

Name of Document: **Ratification Date:**

Name of Persons	Job Title	Date
Divisional Support (Direct Line Manager / Matron / Consultant / Divisional Manager)		
Consultation Process (list of stakeholders consulted / staff groups presented to)		
See Page		
Endorsement By Panel/Group		
Name of Committee	**Chair of Committee**	**Date**

	Document Checklist	Yes / No
1.	**Style & Format**	
	Is the title clear and unambiguous?	
	Is the font in Arial?	
	Is the format for the front sheet as per Appendix 1 of the policy framework	
	Has the Trust Logo been added to the Front sheet of the policy?	
	Is it clear whether the document is a guideline, policy, protocol or standard operating procedure?	
2.	**Rationale**	
	Are reasons for development of the document stated?	
3.	**Content**	
	Is there an introduction?	
	Is the objective of the document clear?	
	Does the policy describe how it will be implemented?	
	Are the statements clear and unambiguous?	
	Are definitions included?	
	Are the responsibilities of individuals outlined?	
4.	**Evidence Base**	
	Is the type of evidence to support the document identified explicitly?	
	Are key references cited?	
	Are supporting documents referenced?	
5.	**Approval**	
	Does the document identify which committee/group will approve it?	

Document Checklist		Yes / No
6.	**Review Date**	
	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
7.	**Process to Monitor Compliance and Effectiveness**	
	Are there measurable standards or Key Performance Indicators to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	

Standard Equality Impact Assessment Tool	
Persons likely to be affected by policy change / implementation	Staff
Are there concerns that the proposed documentation / change could have an adverse impact on:	
Race. Ethnicity, National Origin, Culture, Heritage	
Religion, Faith, Philosophical Belief	
Gender, Marital Status, Pregnancy	
Physical or Learning Disabilities	
Mental Health	
Sexual Orientation / Gender Reassignment	
Age	
Homelessness, Gypsy / Travellers, Refugees / Asylum Seekers	
Please give details of any adverse impact identified:	
If adverse impacts are identified, are these considered justifiable? (Please give reasoning)	
There is unlikely to be an adverse impact on different minority groups	

Name of Person completing Ratification Form	**Job Title**	**Date**

Ratification Group/Committee	**Chair**	**Signature**	**Date**