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| --- | --- |
| Document name: | Locked Doors Policy |
| Document type: | Policy |
| What does this policy replace | Update of V4 - previous policy  |
| Staff group to whom it applies: | All staff within inpatient services |
| Distribution: | The Trust |
| How to access: | Intranet and website |
| Issue date: | March 2022 |
| Next review: | March 2025 |
| Approved by: | Executive Management Team  |
| Developed by: | Assistant Director, Legal Services  |
| Director leads: | Medical Director |
| Contact for advice: | Mental Health Act Office |

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## Locked Doors Policy

***This policy should be read in conjunction with the Mental Health Act, 1983 Code of Practice (2015) chapters 1 and 8 and the Mental Capacity (Act 2005)***

# Introduction

Although it is recognised that the security and safety of in-patients should be managed through the provision of adequate staffing levels and good supervision, there are occasions where open wards need to be locked to protect service users, staff or the visiting public. Additionally, in some areas, where informal service users are at risk if they wander out of a ward, they are prevented from doing so by the deployment of various door mechanisms. This policy provides the procedures and protocols for locking doors to open wards and the use of other devices. However, it excludes circumstances in which doors are locked for general security purposes e.g. during the night.

The trust has taken the decision that some wards will be designated as ‘locked’, unless the nurse in charge of the shift decides otherwise. This is based on the frequency with which the ward has been ‘locked’ by the nurse in charge in the past. The following areas are currently designated as “locked”

* All wards within the forensic service
* Any ward designated as a psychiatric intensive care unit (PICU)
* All admission wards
* All older people’s wards
* All specialist learning disabilities wards

# Authority to lock or unlock doors

The decision to lock or unlock the doors to a ward must be taken by the nurse in charge.

Before the nurse takes this decision they must consider:

* The issues and risks which require the doors to be locked and any alternatives to this course of action
* The benefits of locking or unlocking the door.
* Any risks associated with the doors being locked or unlocked.
* Why locking the door is the least restrictive option.
* Whether locking the door could be considered a blanket restriction.
* Whether unlocking the door presents an unmanageable risk, taking into account the presentation of the patients.

# Action taken when the doors are locked

This section does not apply if the ward is designated as locked, below, and the status is not changed.

The Nurse in Charge will ensure that:

* All staff present and on duty understand;
	+ That the doors have be locked.
	+ Why they have been locked.
	+ The circumstances required for the doors to be unlocked again.
	+ Any specific instructions which may be required e.g. what will happen in the event of the fire alarm sounding.
	+ A notice must be displayed on the doors stating that the doors are locked and how people can leave the ward. – Appendix 1
	+ When a decision to lock the doors on an unlocked ward is taken,
		- the service user/s whose behaviour has led to the doors being locked should be informed of this action and reasons for it, if it is clinically appropriate to do so. They should be informed of the circumstances in which the locked doors decision will be lifted.
		- All patients on the ward and any visitors must be made aware that the doors are locked and that they are still free to leave the ward at any time (subject to any restrictions already imposed).
		- The impact on each patient of implementing the locked door policy should be considered and documented in each patient’s records.
		- The ward manager (or where applicable, a senior member of staff responsible for a group of wards or unit) must informed of the situation
		- The responsible clinician(s) for all patients on the ward must be informed as soon as practicable – this may be the next working day
		- A risk incident form must be completed, with details of when and why the doors were locked.

# Continuation of locked doors

The need to lock the ward doors must be kept under constant review.

For a ‘locked’ ward, the service clinical lead must formally review the ‘locked’ status of the ward on an annual basis.

For an ‘unlocked’ ward, the nurse in charge must explain the reasons for the action taken at shift handover to the nurse in charge of the relieving shift. If the relieving nurse considers it necessary to keep the doors locked, the actions outlined above will apply and are repeated, although there is no requirement to submit a further risk incident form. If a ward is locked for 24 hours, or for several periods totalling 24 hours over three days, the service manager responsible for that ward must be informed at the earliest practicable time.

# Other restrictions on service users leaving the ward

On wards where mechanical or electronic door locks are used to prevent vulnerable patients from leaving the ward and risk being exposed to hazards such as traffic, clear instructions (including codes for digital locks) must be provided on the operation of such devices on the actual doors affected. If a patient is persistently and/or purposely attempting to leave a ward, consideration must be given to assessing the service user under the Mental Health Act 1983 or Mental Capacity Act 2015.

# Locked wards

For the purposes of this policy the following wards are designated as locked wards; this policy does not apply to these wards.

* All wards within the forensic service
* Any ward designated as a psychiatric intensive care unit (PICU)
* All admission wards
* All older people’s wards
* All specialist learning disabilities wards
* Any other ward agreed by the Assistant Director, Legal Services on behalf of the hospital managers. Any such agreement must be reported to the Mental Health Act Committee.

# Definitions

|  |  |
| --- | --- |
| Code of Practice | The Mental Health Act Code of Practice 2015 |
| Detained patient | A patient detained in hospital under the MHA. |
| Informal patient | A patient who has agreed to stay in hospital of their own volition. |
| Locked ward | Any ward that has been designated as needing to be locked for the majority of the time for the safety of patients, staff and the public. |
| Hospital Managers | Hospital managers are representative of the trust as the detaining authority, who through a scheme of delegation, are authorised to undertake certain duties in respect of the MHA. |
| Mental Health Act Committee | The committee of the trust responsible for the operationalisation and monitoring of the Mental Health Act in the trust. |
| Mental Health Act Office | The department of the hospital responsible for ensuring that the paperwork and practice relating to detention of patients under the MHA. |
| Open ward | Any ward to which the main door in not locked to prevent people leaving the ward. |
| Responsible clinician | The psychiatrist responsible for a patient detained under the Mental Health Act |

# Duties

* 1. Trust Board is responsible for approving the policy, its dissemination and implementation.
	2. The Hospital Managers are responsible for agreeing which of the trust wards will be designated as locked wards, through the Assistant Director of Legal Services.
	3. The Lead Director is responsible for ensuring that the policy has been developed in line with the trust policy for the development, approval and dissemination of policy and procedural documents.
	4. Clinical Leads of areas that include designated locked wards are responsible for the annual review of this designation and recommending any changes to the Hospital Managers
	5. General managers and team managers are responsible for ensuring that staff in their area of responsibility are aware of their responsibilities under the policy and that they follow the policy.
	6. Medical, nursing and other clinical staff are responsible for ensuring that their actions comply with the policy.
	7. Mental Health Act Office staff are responsible for advising on the practice related to the policy insofar as it is governed by the Mental Health Act 1983.

# Principles

This policy seeks to identify the process through which access doors to wards can be locked to prevent people from leaving and which wards are routinely designated as locked wards. It aims to do this in such a way that there is a balance between the restrictions placed on detained and informal patients and on the safety of the patients, staff and public.

# Equality impact assessment

The policy has had an equality impact assessment, (appendix 2). Patients who have cognitive deficits, who are unable to read or whose first language is not English are at a disadvantage in understanding the notice relating to locked doors, or the concept of being able to ask to leave the ward when they want to.

# Dissemination and implementation arrangements

The policy will be disseminated through the trust information channels and through professional groups.

# Process for monitoring compliance and effectiveness

The Hospital Managers will monitor the arrangements through the Mental Health Act Committee. They will be supported by the Mental Health Act Office.

# Review and revision arrangements

The policy will be reviewed by the Assistant Director, Legal Services on behalf of the Hospital Managers and accountable director by the review date, or earlier if required. Previous copies will be archived in line with trust procedures.

# References

Department of Health (2015) Mental Health Act 1983: Code of Practice, TSO

Mental Health Act 1983

Mental Capacity Act 2005

# Associated Documents

Department of Health (2015) Reference Guide to the Mental Health Act 1983, TSO

Mental Capacity Act 2005

Ministry of Justice (2007) Mental Capacity Act 2005: Code of Practice, TSO

Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, TSO

## Appendix 1

# Locked Doors Notice

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## Appendix 2

# Equality Impact Assessment

**Date of assessment: November 2021**

|  |  |  |
| --- | --- | --- |
|  | **Equality Impact Assessment Questions:** | **Evidence based answers & actions:** |
| **1** | **Name of the document that you are Equality Impact Assessing** | Locked door policy |
| **2** | **Describe the overall aim of your document and context?****Who will benefit from this policy/procedure/strategy?** | The overall aim of the document to is to advise and guide staff in the requirements of the locking of access doors to wards to ensure compliance with the requirements of the Mental Health Act, the Mental Capacity Act, and the associated codes of practice to both Acts. The intention is to ensure that no service user is subject to an unauthorised or de-facto detention.This document applies to all wards within the Trust.The safety of patients on trust wards is paramount. Restricting patients from leaving the ward is needed for some patients to maintain their own safety and the safety of others.At times this means that access doors to wards are locked.Wards which, for the majority of the time are required to be locked for patient safety have been designated as locked wards. These wards can have their designation changed on a day by day basis if the level of risk indicates that this is possible. Locked doors in the forensic unit are not able to have their status changed.Currently the rehabilitation wards and general wards (neuro and stroke at Kendray are designated as open wards. These can be locked on a temporary basis following a risk assessment. The policy stipulates the safeguards for this process.The policy will assist staff understating what actions they need to take and on what basis to make their decisions regarding the locked status of a ward.Patients who are not detained under the Mental Health Act or subject to Deprivation of Liberty Safeguards (DoLS) authorisations (voluntary or informal patients) are allowed to leave the ward at any time. The policy stipulates the process for safeguarding this right.This policy does not relate to the locking of ward doors for security reasons, such as preventing intruders entering the ward.This policy applies the same safeguards and rights to an individual regardless of their background or protected characteristic in respect of the Equality Act. |
| **3** | **Who is the overall lead for this assessment?** | * **Medical Director**
 |
| **4** | **Who else was involved in conducting this assessment?** | * Equality and engagement
* Mental Health Act staff
* Performance and Information
 |
| **5** | **Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?****What did you find out and how have you used this information?** | This document is based on the requirements of the Mental Health Act 1983, the Mental Capacity Act and the Deprivation of Liberty Safeguards, and their associated codes of practice As this document is for review only it has been shared with clinical staff and the Matrons/Quality Governance Leads/Practice Governance Coaches.It has also been reviewed by staff from Legal services.Minor amendments required for the policy |
| **6** | **What equality data have you used to inform this equality impact assessment?** | The MCA applies to all services users. The MHA applies only to those service users who are detained or are liable to be detained to hospital. The application of the MHA is recorded on SystmOne. The status of all patients are recorded on SystmOne therefore data for all patients who were admitted to a Trust bed over the period 2020/21 has been accessed and provided by Performance and Information on which to base the EIA for this policyData provided reflects the population statistics for our localities in respect of race equality, disability, gender, age, religion and belief, marriage and civil partnership from census data. We also have access to JNA and public health profiles for our localities. **The communities we serve:**In all communities the 2011 census tells us that on average across all areas there is a 1% difference in the population reported as male and female, with female reporting higher. Across all ages Calderdale has the highest 0-15 population at 19.6% and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%. Christianity and Islam respectively are both the highest reported religion and belief.We know that White British people make up 87% of our region’s local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK’s population growth (Policy Exchange, 2014). We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in our local areas range from 8% to over 13% in the communities the Trust cover. National data shows that people from a BME group has a higher proportion of service uesrs admitted to conditions of low, medium secure services. The locked door policy applies to all settings and is for the security and safety of all staff and patients.**Workforce data**As per workforce annual report 2020 The Trust currently employs **4,328** staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.* The Trust split of 77.9% female to 22.1% male is reflected approximately across most areas, except for Medical Staff (36%/64%). As in previous years, female staff make up over three quarters of Trust staff
* As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support Services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over
* The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year.
* The Trusts staff profile has a larger White British representation than the local demographic of the people that it serves collectively. Trust wide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%). Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%. However, the Trust’s local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams)
* The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3%Islam, 12% other and 17% Atheism.
* There has been a significant increase in the number of staff reporting their religion and sexual orientation. Currently 83% of staff have provided data indicating their sexual orientation, which is a slight improvement on last year’s figures.

**Volunteers**The diversity of volunteers recruited by the Trust will be improved following a targeted piece of work to reach communities which highlighted several recommendations. The current position for volunteers is reported below and the service will aim to ensure the volunteer offer is reflective of the communities we serve.

|  |  |
| --- | --- |
| **Ethnicity** | **Number of** |
| **Arab** | **1** |
| **Asian or Asian British Chinese** | **1** |
| **Asian or Asian British Indian** | **3** |
| **Asian or Asian British Pakistani** | **4** |
| **Black British**  | **1** |
| **Black or Black British African** | **2** |
| **Black or Black British Caribbean** | **2** |
| **Black or Black British Other**  | **1** |
| **Caribbean** | **1** |
| **Mixed White & Black Caribbean** | **1** |
| **White British** | **210** |
| **White Irish** | **4** |
| **White Other**  | **3** |
| **Not Stated**  | **2** |
| **Cognitive Delay**  | **4** |
| **Learning Disability**  | **5** |
| **Long Term Condition**  | **5** |
| **Mental Health**  | **102** |
| **No Disability**  | **93** |
| **Other**  | **8** |
| **Physical Impairment**  | **13** |
| **Blank**  | **6** |
| **Bi-Sexual** | **9** |
| **Gay** | **8** |
| **Heterosexual** | **195** |
| **Lesbian** | **6** |
| **Transgender** | **0** |
| **Prefer not to say** | **13** |
| **Blank** | **5** |
| **Agnostic**  | **2** |
| **Buddhist** | **3** |
| **Christian** | **127** |
| **Hindu** | **1** |
| **Jewish** | **1** |
| **Muslim** | **6** |
| **No Religion** | **66** |
| **None stated**  | **3** |
| **Other**  | **16** |
| **Prefer not to say** | **7** |
| **Blank** | **4** |
| **No of Volunteers**  | **236** |

 |
| **7** | **What does this data say?** | The local population we serve and the staff who work in our services represent a diverse population. Our public sector equality places a legal duty to ensure we do not discriminate and ensure fair and equal access to our services making sure they are culturally appropriate and that working conditions for staff offer equality of opportunity in employment and development. From the figures shown in the data there is more work to do to ensure that our services reach and support our diverse population and that workforce and volunteers continue to reflect and represent the population we serve. This work will be reflected in the annual action plan for equality and inclusion, workforce, and volunteers.  |
| **8** | **Taking into account the information gathered above, could this document affect any of the following equality group unfavourably:** | **No** | **Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** This document is applicable to all service users who access in patient care and treatment from the Trust. The MCA applies equally to all services users irrespective of their legal status, background and characteristics over the age of 16 who access Trust services. The MHA applies specifically to patients who are subject to the MHA. Compliance with the requirements of the Acts and their associated codes of practice are monitored by CQC.All in-patients are given their rights both orally and in writing which includes matters of access and egress to the ward. The Trust has a commissioned interpreting/translation service which is available for all service users. During the period of December 2020 – May 2021, the top 3 languages that were requested in highest requests 1st was Polish, Urdu and Punjabi. An area that was notable is people requiring British Sign Language services was consistently requested within the top 5 requests.Signage should be in accessible language including BraileThe information below describes the demographic makeup of the communities we serve, and figures are based on the 2011 census. The Trust will update these figures following the information from the census completed in 2021, which will be published in 2022.  |
| **8.1** | **Race** | **No** | The Trust should consider services which meet the needs of our diverse population. Specific targeted work to ensure the **diverse population of Kirklees** are served well and the emerging growth of an **Asian population in Wakefield** will be considered in all service development and delivery. Support can be provided via the Trust commissioned service to assist people whose first language is not English. They can provide assistance to the assessor and the person being assessed in respect of obtaining consent and also development of care plans to address consent issues.**Race equality**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **White** | **Asian** | **Black** | **Mixed** | **Chinese & Other** |
| **England % av.** | **85.5%** | **5.1%** | **3.4%** | **2.2%** | **1.7%** |
| **Barnsley** |  |  |  |  |  |
| **% average** | **94.5%** | **1.9%** | **1.1%** | **1.1%** | **1.4%** |
| **Calderdale** |  |  |  |  |  |
| **% average** | **85.3%** | **5.3%** | **4.1%** | **2.9%** | **2.3%** |
| **Kirklees** |  |  |  |  |  |
| **% average** | **78.2%** | **14.6%** | **2.7%** | **2.5%** | **2.0%** |
| **Wakefield** |  |  |  |  |  |
| **% average** | **92.5%** | **3.4%** | **1.8%** | **1.4%** | **1.0%** |
| **Forensic** |  |  |  |  |  |
| **% average** | **64.3%** | **9.5%** | **19.0%** | **2.4%** | **4.8%** |

*Taken from Census 2011 for each area* |
| **8.2** | **Disability** | **Yes** | Across all communities the Trust will ensure that **services remain fully accessible. It is noted that in Kirklees and Barnsley patients have identified themselves as having a higher than national average** proportion of people whose day to day activities are limited ‘a lot’ by their disability. We will use the **service EIA to ensure we fully understand the nature of the disability** so we can adjust and adapt our services according to need, remaining person centred throughout.People who have communication difficulties, whose first language is not English or who have difficulty reading or have eyesight difficulties may be at a disadvantage in knowing how to leave the ward.It is also likely that patients with cognitive disabilities such as dementia, stroke or learning disabilities may have problems in understanding that they are allowed to leavethe ward when they want or understanding why they are not allowed to leave the wards or Trust buildings.  **Disability groups**

|  |  |
| --- | --- |
|  | **Day to day activities limited by disability** |
|  | Not at all | A little | A lot |
| England % av. | 47.2% | 13.2% | 4.2% |
| **Kirklees** |  |  |  |
| % average | 88.9 | 5.1 | 6.0 |
| **Barnsley** |  |  |  |
| % average | 79.0 | 4.6 | 16.4 |
| **Calderdale** |  |  |  |
| % average | 82.8 | 15.2 | 2.0 |
| **Wakefield** |  |  |  |
| % average | 89.7 | 6.6 | 3.7 |
| **Forensic** |  |  |  |
| % average | 94.5 | 2.4 | 3.1 |

*Taken from Census 2011 for each area* |
| **8.3** | **Gender** | **No** | Gender equality is reported as part of our workforce approach and services continue to ensure **environments and workplaces remain gender sensitive** and appropriate.

|  |  |  |
| --- | --- | --- |
|  | **Male** | **Female** |
| England % av. | 49.2 | 50.8 |
| **Kirklees** |  |  |
| % average | 53.6 | 46.4 |
| **Barnsley** |  |  |
| % average | 55.1 | 44.9 |
| **Calderdale** |  |  |
| % average | 50.5 | 49.5 |
| **Wakefield** |  |  |
| % average | 58.4 | 41.6 |
| **Forensic** |  |  |
| % average | 95.0 | 5.0 |

*Taken from Census 2011 data*  |
| **8.4** | **Age** | **No** | The Trust provides services to children and young people through to older age adults, however, does not provide in-patient services unless in exceptional circumstances. The table reflects the population age of patients who were admitted to a trust ward over the reporting year of 2020/21. **Age Profile**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | **0-15** | **16-29** | **30-49** | **50-69** | **70+** |
| England % av. |   |   |   |   |   |
| **Barnsley** |   |   |   |   |   |
| % average |   | 17.4% | 28.2% | 27.3% | 27.1% |
| **Calderdale** |   |   |   |   |   |
| % average | 0.49% | 25.0% | 36.7% | 28.9% | 8.9% |
| **Kirklees** |   |   |   |   |   |
| % average |   | 16.4% | 28.6% | 30.9% | 24.1% |
| **Wakefield** |   |   |   |   |   |
| % average |   | 24.9% | 37.0% | 24.9% | 13.2% |
| **Forensic** |   |   |   |   |   |
| % average |   | 26.3% | 58.7% | 15.1% |   |

*Taken from Census 2011 data*  |
| **8.5** | **Sexual orientation** | **No** | The Trust will **improve on the recording of sexual orientation in line with the ‘Sexual Orientation Monitoring standard’** so the Trust can ensure that services and workforce adequately represent the population they serve. The 2021 census may contain further baseline information which can be used to support the Trust understanding further. A campaign to support better data collection will improve our reporting. The Trust has developed ways to be LGBTQI friendly Leaflet to support inclusiveness. This identifies that patients will be admitted to the ward setting that aligns to their gender identity. Mandatory equality and diversity training highlights to trust staff adjustments that may be required for service users. The Locked door policy applies equitably to all gender identities.  |
| **8.6** | **Religion or belief** | **No** | Faith and spiritual care and support in an important component of **person-centred care** provided. The Trust have a **spirit in mind** service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in driving our offer. The Trust has a Pastoral care and Chaplaincy team, this service provides digital chaplaincy services to both patients and staff. Appointments can be made via the service. The service provides pastoral care and is a person centred approach. It also provides spiritual care which is a holistic approach to recovery and well-being.The service provides:Multi faith Sessional ChaplainsBereavement counsellorsBefriendersEcumenical chaplainsMuslim chaplainCanine Befrienders.The information below tells us that **Calderdale, Kirklees and Forensics require a focus on the Muslim faith, with Christian faith** **representing a large proportion of people who use our services in all areas**. Other faiths will be reflected in geographical areas and in line with **service EIAs and person-centred care and planning**. The table shows the self-reported religion or beliefs of those patients who were admitted to a Trust ward during the reporting period 2020/21**Religion or Belief**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Christian** | **Buddhist** | **Hindu** | **Jewish** | **Muslim** | **Sikh** | **Other** | **No religion** |
| England % av. | 71.8 | 0.3 | 1.0 | 0.5 | 0.7 | 10.1 | 0.2 | 15.1 |
| **Barnsley** |   |   |   |   |   |   |   |   |
| % average | 57.0 | 0.0 | 0.0 | 0.0 | 2.9 | 0.0 | 7.7 | 32.4 |
| **Calderdale** |   |   |   |   |   |   |   |   |
| % average | 47.5 | 0.0 | 0.0 | 0.0 | 14.5 | 0.0 | 8.0 | 30.0 |
| **Kirklees** |   |   |   |   |   |   |   |   |
| % average | 44.7 | 0.0 | 0.0 | 0.0 | 13.9 | 0.0 | 4.1 | 37.3 |
| **Wakefield** |   |   |   |   |   |   |   |   |
| % average | 46.0 | 0.0 | 0.6 | 0.0 | 8.4 | 0.2 | 10.7 | 34.2 |
| **Forensic** |   |   |   |   |   |   |   |   |
| % average | 52.9 | 0.0 | 0.0 | 0.7 | 19.3 | 0.7 | 2.1 | 24.3 |

*Taken from 2011 Census data* |
| **8.7** | **Transgender** | **No** | A **trans equality policy** aimed at workforce and people who use services will be co-designed and the approach endorsed by partner organisations. The policy and agenda for transgender people will remain a key focus and data collection will be reviewed and improved using a campaign to support improvements to disclosure and recording. The 2021 Census report may provide further baseline data. Trans people are treated with dignity and respect when accessing hospital services. Records that we hold reflect the correct gender identity.The Trust has developed a policy that assists staff in providing appropriate care and treatment to people who are undergoing transgender procedures. The aim of the policy is to * Ensure that Trans people are treated with dignity and respect.
* Ensure that Wards and Departments are supported to ensure they are able to comply with the legal requirements contained in the Equality Act 2010 in respect of the Transgender protected characteristic and Gender Recognition Act 2004 as well as duties contained in the Data Protection Act 1998, Human Rights Act 1998.
* Ensure that information governance and health records protocols are in place to facilitate an individual’s choice to change their name or gender at any time.

The Trust also has a carers passport which supports the Trust and carers with entering into joint working, offering the best care possible to the service user. The purpose of the passport is to record the skills and knowledge that has been developed by the carer and to offer the following as a means of support:* Carer’s champions/lead champion
* Staff and carers awareness training
* Carer information sessions
* Carer’s wellbeing workshops
* Sign posting to support services.

 The Trust has been awarded the rainbow tick-Gold Award is aware of the LGBT networks across its areas. The Trust will use the Rainbow tick in its programme to support LGBT and raise awareness within all aspects of volunteering. The Trust has developed a Ways to be LGBTQI friendly Leaflet to support inclusiveness. This guidance includes best practice in supporting people from the LGBT community. This is made available to all staff and volunteers as part of their induction and on-going training needs. People who require admission to hospital will be admitted to the ward setting that aligns to their gender identity. Mandatory equality and diversity training highlights to trust staff adjustments that may be required for service users. The Locked door policy applies equitably to all gender identities.  |
| **8.8** | **Maternity & Pregnancy** | **No** | There will be no differential impact of the policy The Trust does not have a peri-natal unit. Inpatients who are pregnant will not be affected differently to other patients.  |
| **8.9** | **Marriage & civil partnerships** | **No** | Marriage and civil partnerships will be recorded in line with **workforce** recruitment and selection procedures and as part of person-centred care and planning. The table shows the Marital status of patients admitted to a Trust ward over the reporting period 2020.21**Marital Status**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | **Married** | **Single** | **Divorced** | **Widowed** | **Separated** |
| England % av. | 46.8% | 34.6% | 9.0% | 6.9% | 2.7% |
| **Barnsley** |   |   |   |   |   |
| % average | 29.1% | 51.0% | 8.0% | 10.3% | 1.5% |
| **Calderdale** |   |   |   |   |   |
| % average | 18.5% | 67.0% | 6.3% | 3.3% | 4.8% |
| **Kirklees** |   |   |   |   |   |
| % average | 26.4% | 51.2% | 9.0% | 9.3% | 4.1% |
| **Wakefield** |   |   |   |   |   |
| % average | 23.3% | 63.8% | 5.8% | 3.7% | 3.5% |
| **Forensic** |   |   |   |   |   |
| % average | 1.8% | 90.0% | 4.1% | 2.4% | 1.8% |

Source SystmOne and 2011 Census data  |
| **8.10** | **Carers (Our Trust requirement)** | **No** | It is likely that every one of us will have caring responsibilities at some time in our lives with the challenges faced by carers taking many forms. Many carers juggle their caring responsibilities with work, study and other family commitments. Some, younger carers, are not known to be carers and this means that the sort of roles and responsibilities that carers must provide varies widely.Within the local footprint of South West Yorkshire Partnership NHS Foundation Trust, there is an estimated **160,000 unpaid carers.**The Trust will continue to record carers as part of equality monitoring and continue to develop and deliver actions to support carers as part of the strategy action plans. The Trust also has a carers passport which supports the Trust and carers with entering into joint working, offering the best care possible to the service user. The purpose of the passport is to record the skills and knowledge that has been developed by the carer and to offer the following as a means of support:• Carer’s champions/lead champion• Staff and carers awareness training• Carer information sessions• Carer’s wellbeing workshops• Sign posting to support services.Signage should be in place to explain to visitors how to access and exit the ward areas and verbal explanations should be provided as required.  |
| **9** | **What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy: -** | This document is monitored locally by the clinical services through its day to day implementation. The data is presented to the Clinical Governance Group for Trustwide oversight.CQC aims to visit each ward as a minimum every 18 month to 2 years. In each MHA CQC visit consideration is given to the Trusts compliance with the requirements of the MHA and MCA and their associated codes of practice. The locked door status of each ward is included in their visit summary report with any identified issues being raised as an action for the Trust. Monitoring relating to changes to legislation is managed and disseminated via legal services department and clinical specialists.This policy can be influenced by changes in “case law” following legal proceedings relating to the use of the Mental Health Act and Mental Capacity Act. |
| **9a** | **Promotes equality of opportunity for people who share the above protected characteristics** | The Trust ensure that all **training is recorded and monitored**, study leave forms are completed and training outcomes are identified through formal learning needs analyses. From the workforce data in 2020 the Trust sees no adverse barriers to training access for any of its staff regardless of their ethnicity, disability, age, gender or sexuality This Policy applies equally to all service users, visitors and staffLocked Door Policy breaches are monitored. Any identified breaches and would be investigated and reported to MHA committee. |
| **9b** | **Eliminates discrimination, harassment and bullying for people who share the above protected characteristics** | **Harassment & Bullying** – The Trust has introduced a new model forpreventing Harassment and Bullying and has a 12 month communications plan. A senior leadership forum with a focus on Making SWYT A Great Place to Work is being rolled out and will include local action plans on creating a team culture to prevent harassment and bullying. The RACE Forward network has been established to review the approach to harassment and bullying from service users, carers, and visitors.This Policy applies equally to all service users, visitors, and staff |
| **9c** | **Promotes good relations between different equality groups** | The Trust values promote good relations and these form part of recruitment, training, and appraisal functions. Other areas are: * Mandatory training
* Staff Networks
* WRES and WDES monitoring information
* Race forward
* Accessible information standard
* Translation and interpreter services

The accessible information standard promotes equality of access for service users by providing information in a manner that allows sometimes complex information to be shared.  |
| **9d** | **Public Sector Equality Duty – “Due Regard”** | The Equality Delivery System (EDS2) captures our progress against several standards. These standards are reported on each year and a report is shared at the Equality and Inclusion Committee who identify a grading for the Trust. EIAs are routinely completed at a service level and updated every 3 years. These documents are used in the planning and development of services. The voice of people who use our services is captured using feedback and involvement. All activity is equality monitored and the findings are reported for each protected group to ensure the reach and audience are reflective of the target audience and that any differential impact is recorded and considered.  |
| **10** | **Have you developed an Action Plan arising from this assessment?** | No action plan is indicated |
| **11** | **Assessment/ Action Plan approved by** |  |
|  | **(Director Lead)** | **Sign:** |
| **12** |  | ***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Engagement Development Managers:***Aboobaker.bhana@swyt.nhs.ukZahida.mallard@swyt.nhs.uk**Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.** |

#  Appendix 3

# Version Control Sheet

*This sheet should provide a history of previous versions of the policy and changes made*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| 1 | 2004 | Director of Nursing | Original policy | Final version approved by Trust Board |
| 2 | Nov 2015 | Assistant Director, Legal Services | Reviewed | Updated to reflect changes in the Code of Practice 2015 |
| 3 | April 2017 | Assistant DirectorLegal Services | Reviewed | Review due November 2018 |
| 4 | November 2018 | Assistant Director Legal Services | Reviewed | Review due January 2022 |
| 5 | November 2021 | Assistant Director Legal Services | Reviewed | No changes of note, changes to titles. Review due in 3 years. |
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## Appendix 3

## Checklist for the Review and Approval of Procedural Document

*To be completed and attached to any policy document when submitted to EMT for consideration and approval.*

|  | **Title of document being reviewed:** | **Yes/No/Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | YES |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | YES |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | YES |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | YES |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | NO |  |
|  | Are people involved in the development identified? | YES |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | YES |  |
|  | Is there evidence of consultation with stakeholders and users? | NO | Shared with practice governance coaches for comment. |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | YES |  |
|  | Is the target population clear and unambiguous? | YES |  |
|  | Are the intended outcomes described?  | YES |  |
|  | Are the statements clear and unambiguous? | YES |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | YES |  |
|  | Are key references cited? | YES |  |
|  | Are the references cited in full? | YES |  |
|  | Are supporting documents referenced? | YES |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it?  | YES |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | YES |  |
|  | Does the plan include the necessary training/support to ensure compliance? | N/A |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | YES |  |
|  | Have archiving arrangements for superseded documents been addressed? | YES |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | YES |  |
|  | Is there a plan to review or audit compliance with the document? | YES |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | YES |  |
|  | Is the frequency of review identified? If so is it acceptable? | YES |  |
| **11.** | **Overall Responsibility for the Document** |  |  |
|  | Is it clear who will be responsible implementation and review of the document? | YES |  |