

ESSENCE OF CARE:  
ADDENBROOKE'S STANDARDS  
FOR PRIVACY & DIGNITY  
SEPTEMBER 2006

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AN AUDIT SUMMARY

**Project Leads**  
**Lyn McIntyre – Assistant Chief Nurse**  
**Nicola Woodruff – Clinical Governance & Audit Coordinator**  
**Essence of Care Privacy & Dignity Working Group**

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## INTRODUCTION

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"It is vital that we see beyond the patient in the bed and instead see a person who has a past, has a present and a future, and who has a 'patchwork of life experiences' that makes a person an individual."

**Webster and Whitlock (2003), Healthcare Events Dignity Brochure**

The NHS Plan states that the government expects dignity to be a priority in care. In addition, the *Essence of Care – patient focused benchmarking for healthcare practitioners* (DoH 2001) identified eight aspects of fundamental care that were recognised as high priority for improvement. These were updated in 2003 to nine areas and include Privacy and Dignity: -

- Communication
- Continence
- Hygiene
- Nutrition
- Pressure Ulcers
- **Privacy & Dignity**
- Record Keeping
- Safety
- Self Care

Not only has the Department of Health published the Essence of Care benchmarks, but this was alongside a wider programme introduced to ensure that patients are treated with dignity and respect, in environments which meet their needs for personal privacy. The programme includes a clear public commitment to eliminating mixed-sex accommodation for hospital patients. Three objectives have been set for the NHS, designed to deliver single-sex accommodation and they apply to all NHS Trusts providing inpatient accommodation (Elimination of Mixed-sex Hospital Accommodation, DoH 2005).

Although the provision of single-sex accommodation is crucial to the protection of a patient's privacy and dignity, there are many other factors that determine whether a patient's privacy and dignity is maintained during their hospital experience. Some of these factors are also included in the DoH programme, for instance, they state NHS Trusts should be ensuring staff have the knowledge and skills to deal sensitively with the various circumstances in which the patients' privacy and dignity may be infringed.

Ensuring people's basic wants and needs are met and respected whatever their age or capacity is as much about dignity as making sure those who cannot wash themselves are clean and comfortable. The 10 year National Service Framework for Older People published in 2001 set out eight key standards for improving care in hospitals and the community, which includes dignity in care.

The NMC are also planning to reinforce the value of care, compassion and communication in the pre-registration training. The three C's are to become key skills for all qualifying nurses and will be part of all pre-registration courses from Autumn 2007. Equally, the Knowledge and Skills Framework arm of Agenda for Change also requires all NHS Staff to treat patients with dignity and respect.

The audit was instigated as part of the Addenbrooke's Essence of Care Project to assess whether the Trust is meeting the requirements set out in the Essence of Care benchmarks for Privacy and Dignity. The Essence of Care Privacy and Dignity Working Sub-Group reviewed the benchmarks and agreed standards for best practice that they felt were most important to Addenbrookes. These standards are known as the Addenbrookes Standards for Privacy and Dignity.

As part of the NHS Plan, the Trust is required to take part in mandatory annual national patient and staff surveys run by the Healthcare Commission. The inpatient survey results for 2005 have recently been published and some of the questions focus on privacy and dignity (See Appendix 1). These results have been considered within the recommendations of the report.

The Practice Development Team also conducted 73 patient stories between December 2004 and June 2005 and the themed feedback relating to privacy and dignity (See Appendix 2) has also been considered in the recommendations of this report.

On Thursday the 29 June 2006, a Focus Group meeting was held to provide invited NHS Foundation Trust members, of whom 37 attended, with information on current hospital practice and to learn their views and experience of 'privacy and dignity' provided at Addenbrooke's. A report by the focus group chair can be viewed in Appendix 5. This feedback has also been incorporated into the overall recommendations and action plan.

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## **OBJECTIVES**

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To ensure inpatient wards at Addenbrookes are meeting the requirements set out in the Addenbrookes Standards for Privacy and dignity.

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## **SAMPLE**

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35 inpatient wards

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## **EXCLUSIONS**

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Paediatric wards, ITU areas and Outpatient clinics.

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## **METHOD**

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During January 2006, an audit pack containing the Addenbrooke's standards for Privacy and Dignity, 6 patient questionnaires and a ward manager's survey were delivered to wards across the Trust. Wards were asked to complete the audit packs and return them to the audit department within a 2 week time frame.

The patient questionnaire was sent to the Local Research & Ethics Committee for ethical approval prior to distribution.

The standards and audit tools were adapted by the Clinical Audit Co-ordinator for Nursing and the Rosie Bereavement Councillor for use in the Rosie Hospital. 9 wards/clinics took part in the Rosie and in total, 51 women's questionnaires and 9 ward managers' surveys were returned. The Rosie results are not included in this report, instead they have been written up in a separate audit report, with conclusions and recommendations based solely on the audit findings in the Rosie.

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## **PRIVACY & DIGNITY STANDARDS**

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For the purpose of these standards the following definitions apply: -

Privacy = Freedom from intrusion

Dignity = Being worthy of respect

Modesty = Not being embarrassed

Respect = Courteous regard for peoples' feelings

**Standard 1:**

All patients experience care that actively promotes their privacy.

**Standard 2:**

All patients experience care that actively promotes their dignity.

**Standard 3:**

All patients experience care that protects their modesty.

**Standard 4:**

All patients experience care in an environment that actively encompasses respect for individual needs, values, beliefs and personal relationships.

**Standard 5:**

All staff will promote the privacy of confidential patient information.

Target for all standards is 100%

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## CONCLUSIONS

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### **Areas scoring 70% and over**

#### **All Patients experience care that actively promotes their Privacy (Standard 1)**

- Most patients felt that staff made good use of curtains, doors, covers, materials (including when travelling through hospital) to maintain privacy, dignity and modesty. While, 66% of wards said they 'never' attach 'do not disturb' signs to curtains, (only 3% 'always' do).
- 77% of wards said they had a dayroom.

#### **All Patients experience care that actively promotes their dignity (Standard 2)**

- Over 90% of patients felt staff had a good attitude and behaviour towards them and had respect for their privacy and dignity when talking to them and discussing their care.
- 87% of patients said they 'always' had their permission sought prior to physical contact by nurses and doctors. 89% of ward managers said it is standard practice to ask patients for their verbal consent before physical contact.
- 90% of patients 'always' felt their privacy, dignity and modesty were maintained when they were being assisted with personal hygiene.
- Only 8% of patients were not asked for their permission to allow student nurses or student doctors to stay during an examination or treatment and the focus group discussed some good experiences involving students.

#### **All Patients experience care that actively promotes their modesty (Standard 3)**

- 91% of patients in a mixed sex area felt that their privacy and dignity were maintained at all times.
- 86% of patients said they always had access to a single sex toilet. On 53% of the wards audited, all of the toilets were single sex (on 3% none were).
- 82% of patients said they always had access to single sex washing facilities. On 47% of the wards audited, all of the washing facilities were single sex (on 12% none were). The focus group expressed the desirability of single sex washing facilities on all wards.  
(DoH Elimination of mixed-sex hospital accommodation standard 2: states Trusts should achieve the Patient's Charter standard for segregated washing and toilet facilities across the NHS. Publication states Addenbrooke's are not compliant on 3 wards).
- 97% of wards said they had wet-wipes that they could give to bedbound patients to clean their hands after using the commode/bedpan, while 10% of patients said they were 'never' offered the opportunity to clean their hands after using the commode/bedpan. This was something that members at the focus group stressed as being really important in terms of maintaining the dignity of immobile patients.
- 75% of patients said they were 'always' able to get dressed after a physical examination before being given information by the person carrying out the examination.

#### **All Patients experience care in an environment that actively encompasses respect for individual needs, beliefs and personal relationships (Standard 4)**

- The majority of patients felt their relationships with visitors e.g. friends, partners, relatives were respected by staff.

## **Areas scoring under 70%**

### **All Patients experience care that actively promotes their Privacy (Standard 1)**

- Focus group feedback confirmed concerns about the lack of privacy in general wards, particularly when patients are visited by doctors, some of whom have loud voices and in particular when 'bad news' is being delivered. Almost a third of the audit participants said they were never offered the opportunity to access a private area to discuss confidential matters.

### **All Patients experience care that actively promotes their dignity (Standard 2)**

- Only 60% of patients said they were offered access to a private area e.g. quiet room for personal use and members at the focus group, felt patients needed the opportunity for more privacy when they needed time for themselves.
- Only half of the patients said they had been asked how they would prefer to be addressed by doctors (79% by nurses).

### **All Patients experience care that actively promotes their modesty (Standard 3)**

- Only 58% of patients who wore hospital pyjamas, clothes or gowns 'always' felt they protected their modesty and dignity (5% 'never' felt they did). Feedback at the focus group reflected this low score, with people saying there is a need to re-design the current hospital gowns and give more thought to adequate levels of cover for varying sizes of patient.
- The focus group highlighted that patients should be able/encouraged to wear their own clothes. By emphasising this to patients and involving families/carers more, it would reduce the need for the hospital to provide clothing provisions, something that is often difficult on the wards. 52% of ward managers said they do not have adequate clothing provisions for patients without their own clothes. Of those with adequate provision, half say it isn't suitable and reasons given include: - Infringes Privacy & Dignity and not enough provisions for larger patients.
- 17% of patients that needed to use a commode by their bed said they were 'never' offered the opportunity to be taken to the toilet in a wheelchair instead. The focus group highlighted the same issue, saying there is a need for patients to be given the opportunity and assistance to use toilets rather than bedpans.
- Perhaps interestingly, 90% of patients using commodes/bedpans felt their modesty was always maintained. Some members at the focus group, felt improvements were necessary in the length of time it took to provide and then remove a bedpan or commode.
- 47% of patients said they had to walk through the ward to access the washing facilities.
- There are some issues with chaperoning, one third of patients were 'never' able to have someone of the same sex to chaperone them while they were undergoing an examination or procedure. 56% of wards said they do not chaperone patients of the opposite sex when they are being examined by nurses, 19% do not when examined by doctors, 42% by student doctors and 81% by physiotherapists.

### **All Patients experience care in an environment that actively encompasses respect for individual needs, beliefs and personal relationships (Standard 4)**

- When asked about non-medical needs and choices, a number of patients commented on their dietary requirements and said they couldn't get special foods/diets such as low potassium and diabetic snacks.

- 60% of patients were not asked whether their circumstances or needs (social, physical, mental) had changed during their stay.

**All staff will promote the privacy of confidential patient information (Standard 5)**

- 53% of patients were not able to lock their valuables securely by their bed.
- Only 55% of patients said they were 'always' able to have confidential conversations with staff without being overhead by other patients (15% were 'never' able to). 14% of wards said they do not have a room where they can discuss confidential and sensitive issues with patients and their family.
- On 67% of the wards audited, none of the patient notes had a notice on the front stating they could only be accessed by staff and 25% do not transport patient notes in sealed envelopes.

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## RECOMMENDATIONS

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- Assistant Chief Nurse to disseminate findings to SCN Forum, the Nursing & Midwifery Strategic Advisory Committee, the Nursing and Midwifery Forum, the Strategic Planning Group and the Operations Board.
- To disseminate a summary of the report and directorate results for discussion at Directorate and SDU Clinical Governance meetings.
- To distribute individual ward results, so that wards can think about local action planning using Trust / Local Effectiveness Trail Action Planning.
- To distribute benchmarking charts to compare some of the audit results by ward and directorate.
- To discuss findings at the Essence of Care Privacy and Dignity Working Group in order to identify areas for project work.
- To feedback findings to Estates and Facilities to discuss: -
  - Conducting a review of bedside locker space with a view to establish lockable areas for patient valuables.
  - The difficulties in the use of toilet roll holders for some patients, with an aim to pilot a new system on 2 wards and audit patient feedback.
  - The results regarding non-medical needs and choices (dietary and food requirements) with a view to developing a patient information sheet.
  - The comments made at the focus group regarding general hygiene and to monitor these within the PEAT framework.
- To feedback dietary needs and special diet information to the Trust Assessment Group with a view to ensuring this information is acquired on admission.
- To use the audit findings to provide evidence in the re-design of the patient property form and re-launch the form once it has been altered.
- To develop Trust Chaperone Guidelines in order to outline a clear process for staff and patients.
- To consider a small project to audit patient gowns and access to appropriate clothing for patients when in hospital.
- To set up a group to review the spread of patient quiet rooms, the process of breaking bad news and finding quiet areas.
- To utilise the Trust Vulnerable Adults training in order to provide clear guidelines for staff and raise the profile of client-practitioner boundaries.
- Where appropriate to remind staff to offer patients the opportunity to be taken to the toilet in a wheelchair rather than using a commode and to offer patients the opportunity to wash their hands after using the bedpan/commode in line with the campaign planned by the British Geriatrics Society to be themed "Dignity by Choice, Privacy by Right: Behind Closed Doors".
- To link findings regarding dietary requirements into the Essence of Care audit of food and nutrition standards action plan.
- Assistant Chief Nurse to discuss with the Senior Clinical Nurses, Estates and Facilities and Security how to meet the demands of the confused/difficult to nurse patient, in order to protect their privacy and dignity and that of other patients.
- To highlight to staff at induction the impact of having private conversations in front of patients.
- To discuss findings relating to confidentiality of patient notes with Susan Wood and the Medical Records Review Group.
- To disseminate the audit findings to Homerton School of Healthcare Studies in order

to incorporate the results into the Student Nurse training.

- To send the audit report to Debbie Coggins, NVQ Course Manager based in the Learning Centre, so that the findings can be incorporated in the NVQ Training Programme.
- To liaise with the Patient Information Manager regarding producing a comment card to provide patients with a channel to air their views.
- Assistant Chief Nurse and Clinical Governance & Audit Coordinator to publish audit findings nationally.
- To disseminate the Trust Findings to CNO Chris Beasley's office to inform the current Department of Health Privacy and Dignity Initiative.

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## REFERENCES

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**FULL REPORT DISTRIBUTED BY NICOLA WOODRUFF**

**CLINICAL AUDIT CO-ORDINATOR FOR NURSING**

**ON: 18/09/06**

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## APPENDIX 1: NATIONAL INPATIENT SURVEY RESULTS – PRIVACY & DIGNITY

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### **Context**

- Mandatory annual national surveys (patient & staff)
- Run by the Healthcare Commission
- Focus on issues that patients say are important to them.
- Survey responses provide more detailed information on how patients feel about the service they receive and they form part of the assessment of trusts against the Healthcare standards.
- Healthcare Commission publish comparative data for each Trust to inform the public and guide funding

### **Results**

- Response Rate 62% (515 respondents)
- Comparison with 9400+ acute patients

### **Patient details**

- Women = 57%
- Men = 43%
- Emergency = 51%

Some of the Inpatient Survey questions provide feedback relating to privacy and dignity, these are outlined below: -

### **Environment**

- Bothered by noise at night from patients = 38% (All Trusts = 38%)
- Bothered by noise at night from staff = 18% (All Trusts = 18%)
- Hospital food very good / good = 48% (All Trusts = 50%)

### **The Doctors**

- Always got understandable answers = 66% (All Trusts = 66%)
- Always had confidence and trust = 82% (All Trusts = 80%)
- Doctors never talked as if patient wasn't there = 72% (All Trusts = 72%)

### **The Nurses**

- Always got understandable answers = 55% (All Trusts = 64%)
- Always had confidence and trust = 66% (All Trusts = 73%)
- Nurses never talked as if patient wasn't there = 78% (All Trusts = 78%)
- Always enough nurses to care for patients = 52% (All Trusts = 55%)

### **Care and treatment**

- Often/sometimes got conflicting information = 42% (All Trusts = 37%)
- Definitely involved in decisions about care = 55% (All Trusts = 52%)
- Not given enough information = 17% (All Trusts = 21%)
- Family definitely could talk to doctor = 43% (All Trusts = 43%)
- Could talk to someone about worries/fears = 37% (All Trusts = 41%)
- Given enough privacy discussing condition = 67% (All Trusts = 69%)
- Given enough privacy being examined = 88% (All Trusts = 87%)

### **Overall**

- Always treated with respect and dignity = 77% (All Trusts = 78%)
- Rating of how well doctors and nurses worked together – excellent / v good = 74% (All Trusts – 76%)

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## APPENDIX 2: PATIENT STORIES 2005. TRUST ANALYSIS

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### PATIENT STORY REPORT 2005: PRIVACY AND DIGNITY

The purpose of taking patient stories is to understand and learn from the patient experience and take action in response to findings at both ward and Trust level, whilst also developing practitioners' skills and clinical practice.

The process was first developed and used with Research Ethic Committee approval across the Trust in 2003 and has been undertaken again in 2005.

73 stories have been taken between December 2004 and June 2005 from the areas indicated in Table 1. The aim was to take 6 stories from each area.

56 staff (nurses, RCN Clinical Leadership programme and HCA's) have been trained to take stories using a detailed protocol developed by practitioners. The training has particular emphasis on understanding any moral, ethical and consent issues and focuses on developing the skills of listening, probing and exploring the patient experience.

Patients are asked the question 'what is it like to be a patient here', and also, 'is there anything you would like to see changed or any suggestions for improvement?'

Stories take anything from 10 minutes to 2 hours. They are tape recorded and themes identified from the story. Patients are asked to validate notes and make any additions, retractions or changes.

A template has been developed to group themes and comments and to provide feedback to ward areas. All stories from a ward area are collated and presented as a report.

Feedback is given to as many of the ward team as possible by at least one person who took the stories. The ward then identifies key areas to celebrate and areas they will take action on. The feedback provides an 'all round' picture of the experience of patients on that area. The wards are encouraged to use the 'Local Feedback for Local Action'

Table 1. Area and numbers of stories taken

<b>Specialist</b>	<b>Peri Operative</b>	<b>Medicine</b>
D2, Parents (6)	ICU, Patients/Carers (3)	G5 (5)
NICU, Parents (6)	NCCU, Patients/Carers (2)	D5 (6)
C9 (6)	<b>Surgery</b>	D10 (2)
Women's (6)	K3 (6)	F3 (6)
D6 (7)	D9 (6)	G3 (6)
	C8 (3)	

In addition to the ward reports, all the comments from across the Trust have been reviewed to highlight any particular issues requiring a corporate action plan and the dissemination of information to a wider staff group.

The complete set of comments from across the Trust made specifically about **PRIVACY and DIGNITY** have been themed to provide an overview of key areas of feedback.

POSITIVE	NEGATIVE
Discrete Sensitive 6 bedded bay Sense of community	'Embarrassed' Lack of privacy <ul style="list-style-type: none"> <li>o Pay phone in corridor</li> </ul> Felt on show Attitude of nurses

In reviewing the information from all the patient stories across the Trust, it is clear that the issues of privacy and dignity are incorporated within other themes.

There are many positive comments and feedback but the **key areas to address** are:

### VERBAL COMMUNICATION

#### Doctors' rounds

- o Feeling intimidated by the number of Drs on a round and being unable to ask questions
- o 'Less Drs on the ward rounds – I dread them. Even in clinic 3 – 4 people. You just cannot express yourself properly.'
- o Missed the Dr because I was in the toilet
- o 'Can't handle the whole gaggle'

#### Nurses/Midwives explaining and informing

- o Overhearing conversations about other patients
- o Offer information only if asked
- o Don't spend time talking to patients

### CONTINENCE

- o Embarrassment at incontinence
- o Lack of assistance
- o Being left on a bedpan

### PERSONAL AND ORAL HYGIENE

- o Help for mobile patients
- o Soap - cold water
- o Lost teeth
- o Difficult to ask for help

### FEELINGS

- o Frightened
- o Abandoned
- o Worried
- o Bored
- o Embarrassed

**CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

**REPORT OF THE FOCUS GROUP CHAIR**

PRIVACY AND DIGNITY FOCUS GROUP

**Thursday 29 June 2006 – 1800 hrs**

**David Dunn Suite, Addenbrooke's Hospital**

**In attendance:**

Jo Birrell – Senior Clinical Nurse

Dr Sara Booth – Consultant, Palliative Medicine

Maureen Hart – Patient Governor and Focus Group Chair

Brenda Hennessy – Director of Administration

Anne Jackson – Acting Membership Manager

Lyn McIntyre – Assistant Chief Nurse

Sally Rees – Governor Service Administrator

Nicola Woodruff – Clinical Governance and Audit Co-ordinator

**1. Introduction**

- 1.1 The Focus Group meeting was organised to provide invited NHS Foundation Trust members, of whom 37 attended, with information on current hospital practice and to learn of their views and experience of 'privacy and dignity' provided at Addenbrooke's.
- 1.2 The meeting was also an important component of the programme established by, and for, the Membership and Patient and Public Involvement (PPI) Governor/Director working group.
- 1.3 Details of the agenda and key questions are included as appendices. A full list of members' comments may be requested from the NHS Foundation Trust Membership Office (01223 256256 or email: [foundation.trust@addenbrookes.nhs.uk](mailto:foundation.trust@addenbrookes.nhs.uk)).

**2. Presentation**

- 2.1 In a presentation entitled 'Privacy and Dignity' Lyn McIntyre and Nicola Woodruff identified three key areas:
  - Clothing/gowns in hospital and on discharge
  - Personal Hygiene
  - Privacy and confidentiality at the bedside
- 2.2 Following the presentation members were invited to provide written responses to a number of questions relating to their expectations and experiences of these three areas. These have been summarised below.

**3. Member Views**

- 3.1 **Clothing/Gowns in Hospital and on Discharge**  
Members' experiences were in the main complimentary, but there were some

instances where clothing had been lost during bedding changes, wrap around clothing unsatisfactory and embarrassment when moving through outpatient areas.

Improvements suggested focused mainly on the need for a redesign of gowns with thought given to adequate levels of cover for varying sizes of patient. It was thought important that patients were able/encouraged to wear their own clothing and washing machines made available (charity supplied?)

Group feedback reinforced the views on gown redesign, including access for drips/drains, involving the family more, consider disposable versus cloth for choice and the possibility of 'ward based' shopping for products. Comments were made, in a context not understood or questioned, about staff being introduced and patients being made aware of staff hierarchy, skills and nationality.

### 3.2 **Personal Hygiene**

Members expectations included the facility to have a bath or shower daily, to wash or be washed morning and evening, and to be offered a degree of privacy where needed. If patients are immobile then being offered the opportunity to wash before meals and after using toilet/bedpan was considered important, as was the maintenance of clean bath and toilet areas.

Improvements were believed to be necessary in the length of time it took to provide, and remove, a bedpan/commode, the cleanliness of toilets and bathrooms, understanding the needs of elderly and incontinent patients, and in the provision for oral/dental care.

Other comments made reference to the need for automatic doors to allow wheelchair access to bathroom and toilets, addition of bidets, the desirability of single sex washing facilities on all wards and in the opportunity (assistance) for patient use of toilets rather than bedpans.

Group discussions confirmed the strength of feeling about cleanliness in general and in knowing who was responsible for ensuring this, the perceived need for better training of staff in hygiene and for them to have sufficient time to be more aware of, and help, those patients who need extra support.

### 3.3 **Privacy and Confidentiality at Bedside**

The good experiences covered those involving students, space between beds and privacy of conversations. However, these were also listed amongst those seen as bad experiences, and included teams of doctors being felt intrusive and intimidating.

The improvements members felt necessary were the opportunity for more privacy when patients needed time to themselves and during visiting times. The lack of privacy when visited by doctors, some of whom have loud voices, was a widely held view and particularly so when 'bad' news was being delivered. Curtains are not able to provide confidentiality – can a quiet area be made available which patients can choose when felt necessary. Some elderly patients were not comfortable being addressed by their first names, and felt staff can seem patronising to elderly patients.

Other comments welcomed the transparency of the information given in the presentations but expressed concern that only fifty percent of patients felt that nurses gave 'understandable answers' to questions about their health. Patients may not know how to ask about their health and it can be stressful not knowing what is happening or is planned.

Group feedback confirmed the concerns about lack of privacy in normal wards and for the desirability of an acceptable policy on visitors respecting the need some patients have for quiet during their recovery. There was an acceptance of not being able to satisfy everyone's needs simultaneously.

### 3.4 **General Comments**

These were largely about the information provided in the presentations and, not surprisingly, tended to focus on the statistics or practices that they felt were disappointing. Statistics from the audit of patient satisfaction that showed a success figure of even 77 percent were felt to be less than adequate. There was an interest in what happens to information on patient opinion and whether any of it influences future action.

Some concern was expressed at the confusion that can result from the lack of good language and/or communication skills on the part of some doctors and nurses as well as patients. Other general comments referred to matters outside of the theme 'Privacy and Dignity' and have not been included.

## 4. **Evaluation and Close**

4.1 Brenda Hennessy thanked members for their contribution to a very interesting and worthwhile discussion of their expectations, experiences and suggestions in this important aspect of Addenbrooke's interface with patients – Privacy and Dignity. A report would be made of the Focus Group's comments and included on the agenda of an early meeting of the Governing Body.

4.2 Maureen Hart added her thanks to members for the time and contributions they had made, and to Lyn McIntyre and Nicola Woodruff for so expertly providing the introduction to Privacy and Dignity at Addenbrooke's.

## 5. **Summary**

The very satisfying response by members to the invitation to this Focus Group is an indication of the interest and relevance that they see in the subject area chosen, and to the good work in the NHS Foundation Trust Membership Office in its promotion of the Focus Group meeting.

Although some of the issues raised were, inevitably, similar to those raised in the earlier (February 2005) members focus group meeting on 'Hygiene' there is evidence that there is a clearer understanding on the part of members and Addenbrooke's of their individual needs and responsibilities. Perhaps one of the remaining tasks is for members to see more clearly their own role in securing the level of hygiene so urgently sought.

### **List of appendices:**

Appendix 1: Agenda for Privacy and Dignity Focus Group – 29 June 2006

Appendix 2: Key questions addressed

Please contact the audit report authors, if you would like copies of the appendices.

**Maureen Hart – Patient Governor  
Cambridge University Hospitals NHS Foundation Trust  
10 July 2006**